ResearchGate

See discussions, stats, and author profiles for this publication at: https://www.researchgate.net/publication/314539643

The Right to Emergency Medical Treatment in Kenya

Article *in* SSRN Electronic Journal · January 2015

DOI: 10.2139/ssrn.2695134

CITATION
1

READS
1,315

2 authors:

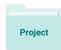
Maurice Oduor
Moi University
6 PUBLICATIONS **7** CITATIONS

SEE PROFILE

Dan Wafula Simiyu
1 PUBLICATION **1** CITATION

SEE PROFILE

Some of the authors of this publication are also working on these related projects:



The right to emergency medical treatment View project

The Right to Emergency Medical Treatment in Kenya View project

All content following this page was uploaded by Maurice Oduor on 31 January 2018.

The user has requested enhancement of the downloaded file.

The right to emergency medical treatment in Kenya

Maurice Oduor[*]
Dan Wafula Simiyu [**]

1. Introduction

A recent, widely publicized incident, in which a patient died after spending 18 hours in an ambulance, awaiting emergency treatment,[1] puts into sharp relief, the *Constitution of Kenya's* declaration; first, that every person has the right "to the highest attainable standard of health", and, secondly, and more importantly, the edict that, "[a] person shall not be denied emergency medical treatment."[2] This paper is limited to the implications of these provisions, especially the right to emergency medical treatment, on private health care providers. In view of what the *Constitution* says in terms of the right to health including emergency medical treatment, how should the actions of private health care providers who refuse to render critical interventions at times of emergency be rationalised within the framework of law? What legal issues emerge especially in terms of the right to emergency medical treatment? Is the right to emergency medical treatment a real right? How might the law be brought to bear upon private institutions, who because of a callous refusal to provide life saving intervention, cause a patient to die from a condition that the patient would otherwise have survived? What types of obligations inure to private health care providers in relation to emergency medical treatment? What sorts of obligations arise against the State itself in relation to this particular right? What kinds of jurisprudential conflicts may be engendered by a claim against a private health care provider in relation to the right to emergency medical treatment?

2. The Alex Madaga case[3]

[*] LLB (Moi), LLM (Pittsburgh), LLD Candidate (Pretoria), Lecturer & Head, Dept. of Legal Aid Clinics & Externships, Moi University School of Law. The author teaches Health Law and Tort, among other courses.
[**] LLB IV (Moi).
[1] See part 2 below.
[2] *Constitution of Kenya* 2010, article 43 (2).
[3] The story of Alex Madaga was widely reported and commented upon in all types of media in Kenya for over two weeks. The account here is based on these various sources including: Eunice Kilonzo, 'Car accident survivor spends over 18 hours waiting in ambulance', Daily Nation, 7 Oct 2015, available at <http://www.nation.co.ke/news/Pain-of-patients-18-hours-in-ambulance/-/1056/2903538/-/at8in9/-/index.html> accessed on 31st October 2015 ; Eunice Kilonzo, 'Ambulance patient Alex Madaga has hours to live', Daily Nation, 9 Oct 2015, available at <http://www.nation.co.ke/news/Ambulance-patient-has-hours-to-live/-/1056/2906242/-/vetdlaz/-/index.html>, accessed on 31st Oct 2015; Eunice Kilonzo, 'Private hospital criticised for failing to admit crash victim', Daily Nation, 10th Oct 2015, available at <http://www.nation.co.ke/news/Private-hospital-criticised-admit-crash-victim/-/1056/2907574/-/q67q2dz/-/index.html>, accessed on 31st Oct 2015 Eunice Kilonzo, 'Ambulance patient Alex Magada dies at KNH', Daily Nation, 9 Oct 2015, available at <http://www.nation.co.ke/news/Ambulance-patient-Alex-Madaga-dies-at-KNH/-/1056/2906238/-/x6uc58z/-/index.html> accessed on 31st Oct 2015; Eunice Kilonzo, 'Teen who fought 18 hours for road crash victim's life', Daily Nation, 13th Oct 2015, available at <http://www.nation.co.ke/news/Teen-recalls-accident-victims-last-hours/-/1056/2910894/-/12g36dh/-/index.html> accessed on 31st Oct 2015

Alex Madaga, a 37 years-old man, sustained serious head injuries following a hit-and-run motor-vehicle accident along a city road around 9 pm. He was initially taken to Kikuyu Mission Hospital, a church run institution, which, not having an Intensive Care Unit (ICU), which is what was required to deal with his critical injuries, had no choice but to refer him to another hospital. The paramedics rushed him to Nairobi Women's Hospital, another private facility, where again, he could not be admitted, the reason being lack of bed space in the ICU. The patient was then taken to Kenyatta National Hospital (KNH), a national referral facility. There he could not be admitted since all the beds in the ICU were occupied. The paramedics, considering it to be too risky to move him around in search of another hospital opted to wait at KNH in the hope that the situation might change. 8 hours later, the patient had not been admitted, and since their oxygen supply was running low, the paramedics took the risk and decided to search for another hospital. They ended up at Coptic Hospital, a private entity. Here, a demand of KShs 200 000 deposit was made before the patient could be admitted. Mrs Madaga, who all along had accompanied her husband in the ambulance, could not raise these funds, so Mr Madaga could not be admitted. The ambulance then left for Kikuyu Mission, the original referring hospital. Here, the patient was transferred to another ambulance, which then took off in search of alternative help. This time, the quest led the group to Ladnan Hospital, another privately run entity. A demand of KShs 200 000 was made as deposit. Mrs Madaga could, of course, not raise it, so the patient was denied admission. This was around 10.30 am. The paramedics decided to take Mr Madaga back to KNH. They arrived at around 11 am and waited. By then, Madaga's condition had changed; he now could only breathe through a ventilator whereas all along he had been able to do so without help. He was eventually admitted at KNH. By then, it was too late, and Alex Madaga died at KNH, 18 hours after he had first been taken into the ambulance following the accident.[4] Mrs Madaga had to suffer the pain and anguish of watching helplessly as her husband's life ebbed away right before her very eyes, and, in the full knowledge that, at least two hospitals, were in a position to help, but refused on account of non-payment of a deposit.[5]

3. The nature and scope of the right to emergency medical treatment

That the provision that "[a] person shall not be denied emergency medical treatment",[6] is set out in negative terms, exalts this right to the realm of immediately realizable constitutional claims, akin to civil and political rights. The circumstances under which it can be enforced, especially against private practitioners, however still needs to be clarified. What obligations they bear and how violations can be determined are matters that are ambiguous and need to be specified. The Constitution offers some start but the concrete implications are matters that must be established elsewhere. And since there is no legislative provision creating any clarity, our courts would have to seek recourse in international law and principles as contemplated under the *Constitution*. [7] Further, courts would have to rely on the "horizontality" of the bill of

[4] Eunice Kilonzo, Ambulance Patient Alex Madaga dies at KNH, *Daily Nation*, 9 October 2015.
[5] Ibid.
[6] Supra note 2.
[7] Ibid, article 2(5) and (6).

rights when considering the reach of these principles in relation to private entities. But first, courts would have to appreciate what emergency medical treatment constitutes of.

3.1 What does emergency medical treatment entail?

Neither the Constitutional nor statutory law framework is helpful. However, this issue has been litigated and/or legislated in other jurisdictions facing largely similar issues. As far back as 1989, the Supreme Court of India established a duty to provide emergency treatment for accident victims, regardless of the ability to pay. In the case of *Parmanand Katara v. Union of India,*[8] the Supreme Court of India observed that:

> Every injured citizen brought for medical treatment should instantaneously be given *medical aid to preserve life*… There is no legal impediment for a medical professional when he is called upon or requested to attend to an injured person needing his medical assistance immediately. *The effort to save the person* should be the top priority not only of the medical professional but even of the police or any other citizen who happens to be connected with that matter or who happens to notice such an incident or a situation.[9]

From this case, emergency treatment should be the type that is meant to "preserve life" or "save" the patient. It must intend to sustain life before other measures can be taken depending on the circumstances. In *Paschim Banga Khet Mazdoor Samity & Ors v State of West Bengal & Anor*[10], the court held that the State had an obligation, emanating from the right to life, to preserve human life. Thus, an injured victim of an accident was entitled to interventions meant to *preserve life*, regardless of financial constraints at the time. The hospital where an accident victim is taken must be seen to have responded positively by admitting the patient if they have facilities for dealing with the condition. Lack of bed space could not be a justifiable reason for turning away a critically ill patient whose condition needed to be stabilized, urgently. The medical facility should be able to make internal arrangements to accommodate the patient if challenges relating to bed space arose. Just like in the Madaga case, the petitioner in this case had been refused admission to six government hospitals due to lack of facilities or unavailability of bed space. In *Pravat Kumar Mukherjee v Ruby General Hospital & Ors*,[11] the National Consumer Disputes Redressal Commission of India considered the case of a boy, who sustained serious injuries in an accident, but succumbed to those injuries, because the doctors in the hospital he was admitted in, having commenced treatment, refused to continue, since some required cash deposit had not been made. Finding a violation, the Commission, on the basis of the *Parmanand* decision, pointed out that an injured and critically ill patient brought for medical treatment, "should be instantaneously given medical aid to preserve life."[12] The emergency intervention should be one that is necessary to preserve life. The thrust of the Supreme Court's jurisprudence is that emergency treatment is needed if the patient's life is endangered, i.e., that the patient might die if no stabilizing treatment is rendered.

---

[8] AIR 1989 SC 2039.

[9] Para 6.

[10] (1996) AIR SC 2426; (1996) 4 SCC 37.

[11] Original Petition No. 90 of 2002, available at <http://indiankanoon.org/doc/173553/> accessed on 26th October 2015

[12] Ibid, p 8.

In order to lend further clarity, and in taking up the challenge posed by the Supreme Court, the Law Commission of India, set out to develop model rules on emergency medical treatment.[13] In the model rules, the Commission stated that the purpose of emergency medical treatment should be to stabilize the patient. No hospital or medical practitioner should "refuse to provide emergency medical care to victims of accidents or those in emergency medical condition on the ground that it is a medico-legal case or that the person is not able to pay immediately or that he has no medical insurance or other reimbursement facilities." The Model Law, while fashioned along the United States' *Emergency Medical Treatment & Labor Act (EMTALA)* discussed below, defines emergency medical condition as follows:

> 'emergency medical condition' means a medical condition manifesting acute symptoms of sufficient severity (including severe pain) where the absence of emergency medical treatment could reasonably be expected to result in (i) death of the person, or (ii) serious jeopardy in the health of the person (or in the case of a pregnant woman, in her health and the health of the unborn child), or (iii) serious impairment of bodily functions, or (iv) serious dysfunction of any bodily organ or part.
> Explanation: In the case of a pregnant woman who is having contractions, an 'emergency medical condition' shall be deemed to exist where (i) there is no adequate time to effect a safe transfer of the person to another hospital before delivery, or (ii) the transfer may pose a threat to the health or safety of the woman or her unborn child.

From this it is clear that the Commission views emergency condition as being one that does not merely threaten life, but also one that can seriously hamper the state of the body of the patient if not addressed in a timely manner. It is not just death that has to be prevented but also serious impairment of bodily functions. The contemplated medical intervention must therefore be one that fits within this framework. Thus, the *Model Act* defines emergency medical treatment as:

> the action that is required to be taken, after screening of a person injured in an accident or who is in an emergency medical condition, *as to the stabilization of the person and the rendering of such further treatment as may, in the opinion of the hospital or medical practitioner be necessary for the purpose of preventing aggravation of the medical condition of the person or his death and in the case of a pregnant woman, for the purpose of a safe delivery and safeguarding the life of the woman and the child*.

While stabilization is key, further treatment necessary to prevent aggravating the medical condition, or to preserve life, or in the case of a pregnant woman, intervention that is necessary to safely deliver the child and safeguard the life of the mother and child are also factors to consider.

This is the trajectory taken by United States, whose law largely influenced the position of the Law Commission of India. The United States has a complete legislative framework on emergency medical treatment, the *Emergency Medical Treatment & Labor Act (EMTALA)*, which was enacted by Congress in 1986 to provide public access to emergency services regardless of ability to pay.[14] This Act arose out of Congress's concern of increasing reports about hospitals

[13] Law Commission of India, *Report on Emergency Medical Care To Victims Of Accidents And During Emergency Medical Condition And Women Under Labour, No. 201*, August 2006.

[14] Medicare participating hospitals must meet the *Emergency Medical Treatment and Labor Act (EMTALA)* statute codified at §1867 of the Social Security Act, (the Act) the accompanying regulations in 42 CFR §489.24 and the related requirements at 42 CFR 489.20(l), (m), (q), and (r).

refusing to accept or treat patients with emergency conditions if they did not have medical insurance. Hospitals are obliged to assess the emergency facing a patient who presents to them, and provide *stabilizing treatment* if the situation is considered an emergency medical condition. If the hospital has no capacity, or if the patient so requests, it must forthwith initiate and implement an appropriate transfer. The implementing rules of *EMTALA* (codified in s 1867 of the *Social Security Act*) are to be found in s 489.24 of the Federal Regulations entitled *Special responsibilities of Medicare hospitals in emergency cases*.[15] This provision, in terms of the required emergency intervention, states that, in the case of a hospital with an emergency department, if an individual comes to the emergency department, the hospital must:

> (i) Provide an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. The examination must be conducted by an individual(s) who is determined qualified by hospital by laws or rules and regulations and who meets the requirements of § 482.55 of this chapter concerning emergency services personnel and direction; and
> (ii) *If an emergency medical condition is determined to exist, provide any necessary stabilizing treatment*, as defined in paragraph (d) of this section, *or an appropriate transfer* as defined in paragraph (e) of this section. If the hospital admits the individual as an inpatient for further treatment, the hospital's obligation under this section ends, as specified in paragraph (d)(2) of this section.

An emergency medical condition is defined in paragraph (b) to mean:

> (1) A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in—
> (i) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
> (ii) Serious impairment to bodily functions; or
> (iii) Serious dysfunction of any bodily organ or part; or
> (2) With respect to a pregnant woman who is having contractions—
> (i) That there is inadequate time to effect a safe transfer to another hospital before delivery; or
> (ii) That transfer may pose a threat to the health or safety of the woman or the unborn child.

Thus, the very clear obligations imposed on the relevant hospitals take into account their capacities such that no hospital should be compelled to do that which it has no ability to do either in terms of facilities or personnel. However, it is patent that a hospital should not turn away a patient and must, in the minimum, intervene to stabilize the patient, or, set in motion the process that leads to stabilization of the patient, for example, through an appropriate transfer.

Kenya, too, is grappling with the issue of emergency medical treatment and the responsibilities that hospitals and health care providers should bear in these situations. *The Health Bill 2014*, currently pending before Parliament contemplates a legislative framework that will provide guidelines to hospitals and health care practitioners. Clause 3 provides in part that the object of the contemplated law is to "protect, respect, promote and fulfill the health rights of all persons in Kenya to the progressive realization of their right to the highest attainable standard

[15] 42 CFR §489.24 a.

of health, including reproductive health care and *the right to emergency medical treatment*."[16] A "medical emergency" is deemed to be "an acute situation of injury or illness that poses an *immediate risk to life or health* of a person or *has potential for deterioration in the health of a person* or if not managed timely *would lead to adverse consequences in the well-being*." What is anticipated here is intervention that not only is capable of saving life at the point of the emergency, but also, one that prevents the deterioration of a patient's condition or prevents adverse consequences in a patient's well-being. As anticipated in clause 2, emergency treatment must be the "necessary immediate health care that must be administered to prevent death or worsening of a medical situation."[17] Clause 7, which seeks to implement the right to emergency medical treatment, is more elaborate when it states:

> For the purposes of this section, emergency medical treatment shall include-
> (a) Pre-hospital care;
> (b) Stabilizing the health status of the individual; or
> (c) Arranging for referral in cases where the health provider of first call does not have facilities or capability to stabilize the health status of the victim. [18]

The bill thus seeks to go farther and encapsulate care given before an emergency patient is wheeled into a hospital. Also, use of the open-ended "include" suggest possible context-based extrapolation, as circumstances dictate. As the enactment process continues, one must continue the search for the meaning of the right to emergency medical treatment.

3.2 Legal parameters of the right to emergency medical treatment

Statutory law is of limited use in establishing the legal expectations of the relevant actors in relation to emergency medical treatment. One reason maybe that most of the statutes applicable to health matters were passed well before article 43(2) of the *Constitution* and hence cannot be expected to have encompassed the right to emergency treatment. It seems possible though to cull out basic criteria for dealing with emergency medical treatment under some statutes. For example, the *Medical Practitioners and Dentists Act*, which is the framework law on registration of medical practitioners and regulation of their conduct, may to some certain limited degree be interpreted to give a guideline on how doctors should conduct themselves in the face of a medical emergency. A major limitation of using this Act is the fact that it is a complaint based mechanism for regulating doctors' conduct and so may suffer from a lack of certainty. Nevertheless, the Act provides for a disciplinary process where a medical practitioner may be prosecuted, and sanctioned for what has been referred to as "any infamous or disgraceful conduct in a professional respect".[19] The Act does not define "infamous or disgraceful conduct". However, under the *Code of Professional Conduct and Discipline*, it is explained that disciplinary measures may be undertaken where a medical or dental practitioner is alleged to have acted in a manner amounting to "serious professional misconduct".[20] Serious professional conduct, is, under the code equated to "infamous conduct in a professional

[16] *The Health Bill 2014*, Clause 3(b), emphasis added.
[17] Clause 2.
[18] Clause 7(3).
[19] *Medical Practitioners and Dentists Act* s 20.
[20] See *Code of Professional Conduct and Discipline, 6th ed.*, Part IV(b).

manner, and hence subsumes the concept as set out in the Act. The *Code* further clarifies the matter as follows:

> 1. "If it is shown that a medical man, in the pursuit of his professional duties has done something with regard to which would be reasonable regarded as disgraceful or dishonorable by his professional brethren of good repute and competence", then it is open to the Board, if that be shown to say that he has been guilty of "infamous conduct in a professional manner." (Lord Justice Lopes)
>
> 2. Infamous conduct in a professional respect means no more than serious misconduct judged according to the rules, written or unwritten, governing the profession (Lord Justice Scrutton).

It is patent that the Code is deriving its definition of infamous and disgraceful conduct from the judgment of Lopes LJ in the case of *Allinson v General Council of Medical Education and Registration*[21]and also the judgment of Scrutton LJ in the case of *R v General Council of Medical Education and Registration of the United Kingdom.*[22] While both of these cases defined the phrases "infamous conduct in a professional respect" and "infamous conduct" respectively, the *Code* uses the term "serious professional misconduct" which is not to be found in the Act. In fact, this latter phraseology is to be found in later English legislation, the *Medical Act 1969*, which replaced the *Medical Act 1858*. However, it has been argued that "infamous conduct" may actually mean "serious professional misconduct".[23] Be that as it may, it is possible that this definition is wide enough to cover circumstances where a medical practitioner deliberately refused to render emergency medical treatment.

Indeed, such an approach has been taken in Australia where a doctor was found guilty of "improper professional conduct" for failing to render emergency assistance to a victim of an accident that happened in her presence, and which she was part of. In the case of *Medical Board of Australia v Dekker,*[24] it was alleged that Dr Dekker was guilty of infamous or improper conduct in a professional manner when she failed to stop and render assistance after an accident involving her motor vehicle and another. As Dr Dekker stopped at an intersection waiting to proceed with her journey when it was safe to do so, a second vehicle travelling at high speed came towards her stationary car. She then drove through the intersection to avoid the other car. However, this second car veered off the road, drove over an embankment and rolled over. Dr Dekker did not stop but nevertheless went and reported to a police station in the immediate vicinity that there might have been an accident at the intersection. Despite the fact that Dr Dekker was not acting in a professional capacity, the State Administrative Tribunal of Western Australia found that:

> [I]t is improper in a professional respect for a practitioner who is aware that a motor vehicle accident has or may have occurred in their vicinity and that anyone involved has or may have suffered injury not to make an assessment of the situation, including the nature of any injuries and needs of the person involved, and render assistance by way of first aid, when the practitioner is physically able to

[21] [1894] 1QB 750.

[22] [1930] 1 KB 562.

[23] Deepak Raja & Khattar Wong, 'Infamous Conduct' in the Medical Profession, http://www.lawgazette.com.sg/2005-8/Aug05-feature2.htm <accessed on 28th October 2015>

[24] [2013] WASAT 182 available at http://www.austlii.edu.au/au/cases/wa/WASAT/2013/182.html <accessed on 28th October 2015>

> do so, notwithstanding that the practitioner immediately reports the matter to police or other emergency services.[25]

In fact, the tribunal observed that had Dr Dekker not stopped and reported the matter to the police, she would have been found guilty of infamous conduct in a professional manner because

> [F]ailure to stop, make an assessment and render assistance, and failure even to report the matter to police or other emergency services, would reasonably be regarded as disgraceful or dishonourable by professional colleagues of good repute and competency, and there is a sufficiently close link or nexus with the profession of medicine.[26]

The distinction between these two categories of conduct was that "'Infamous conduct' is conduct that would reasonably be regarded as disgraceful or dishonourable by professional colleagues of good repute and competency, whereas 'improper conduct' is conduct that would reasonably be regarded as improper by professional colleagues of good repute and competency."[27] The justification for this decision was that there was "a sufficiently close link or nexus between the conduct and the profession of medicine" notwithstanding that the conduct did not occur in the course of the doctor's practice. What this case established was that a doctor would be under a legal obligation to assist when he/she is aware that his/her professional assistance is required and when they are in a position to do so.[28] It might be strenuous to justify a finding of serious professional misconduct in circumstances arising outside of a professional relationship. However, it should not be difficult to make such a finding in the case where a practitioner deliberately declines to render emergency assistance when a patient in a medical emergency has been brought to him/her or to a hospital.

Besides the *Code of Professional Conduct and Discipline*, the Ministry of Health's *Patients' Rights Charter*[29] elucidates a specific duty to render emergency medical treatment. The *Charter* provides that every person, patient or client has the right to receive emergency treatment *in any health facility*.[30] The *Charter* very instructively declares that "in emergency situations, irrespective of the patient's ability to pay, treatment to stabilize the patient's condition shall be provided."[31] A hospital, or health care provider, is clearly under obligation to stabilize a patient in a medical emergency without considering the issue of payment. That the aim of the intervention is to stabilize the patient should mean that even the question of unavailability of equipment should not arise. The doctor should do the barest minimum possible under the circumstances, and then, consistent with accepted practice, refer or transfer the patient to another facility. Generally applicable ethical standards would also seem to support this view.

---

[25] Ibid, para 39

[26] Ibid, para 38

[27] Ibid para 1

[28] M Eburn, "Improper professional conduct when a doctor fails to render assistance at a motor vehicle accident", Australian Emergency Law 2008, <https://emergencylaw.wordpress.com/2013/11/28/improper-professional-conduct-when-a-doctor-fails-to-render-assistance-at-a-motor-vehicle-accident/> accessed on 28th October 2015

[29] Ministry of Health, The Kenya National Patient's Rights Charter (2013).

[30] Ibid, chapter 1 para 1.

[31] Ibid, para 2.

For example, the World Medical Association *Declaration of Geneva*,[32] binds newly admitted medical practitioners and dentists pledge themselves "to the service of humanity", to practice their profession "with conscience and dignity", to make the health of their patients the "first consideration", to "honor the noble traditions of the medical profession" and to "maintain utmost respect for human life". The *International Code of Medical Ethics, 1949*[33] which amplifies the *Declaration of Geneva*, provides that a doctor's practice should not be influenced by motives of personal profit. Further, the Code provides that, in relation to patients, a physician has the duty to "give emergency care as a humanitarian duty unless he/she is assured that others are willing and able to give such care."

4. Emergency medical treatment and human dignity

Kenya's *Constitution* is replete with values that include the advancement of individual welfare, protection of the well-being, as well as, enhancement of human dignity. The preamble, for instance, sets up Kenya as a country that is committed to "nurturing and protecting the well-being of the individual", and the enhancement of human rights.[34] Moreover, human dignity occupies a central place; it not only forms part of the "national values and principles of governance",[35] it is also a core value in the whole human rights framework in the *Constitution*,[36] not to mention that is also set out as a right on its own, by dint of article 28, which provides that, every person has "inherent dignity and the right to have that dignity respected and protected." Anne Hughes tells us that "[t]he dignity of the person refers to the special status given to all individuals by virtue of being human."[37] It must mean that the "humanity" of an individual must be respected and protected. It would be "inhuman" to abandon a suffering patient, to the extent of death, on account of anticipated pecuniary loss that will be occasioned by any intervention geared to saving life, even if it the barest minimum. Humanity implies a value laden conceptualisation of an individual. An individual is not a thing, devoid of vitality, or, an animal, and, must be assisted to maintain that "humanness" whenever such assistance is called forth. Hughes renders it thus: "In philosophical terms, 'human dignity' has been

---

[32] Adopted by the 2nd General Assembly of the World Medical Association, Geneva, Switzerland, September 1948 and amended by the 22nd World Medical Assembly, Sydney, Australia, August 1968; and the 35th World Medical Assembly, Venice, Italy, October 1983; and the 46th WMA General Assembly, Stockholm, Sweden, September 1994; and editorially revised by the 170th WMA Council Session, Divonne-les-Bains, France, May 2005; and the 173rd WMA Council Session, Divonne-les-Bains, France, May 2006, available at <http://www.wma.net/en/30publications/10policies/g1/index.html> Accessed 28th October 2015.

[33] Adopted by the 3rd General Assembly of the World Medical Association, London, England, October 1949; and amended by the 22nd World Medical Assembly, Sydney, Australia, August 1968; and the 35th World Medical Assembly, Venice, Italy, October 1983; and the 57th WMA General Assembly, Pilanesberg, South Africa, October 2006; available at <http://www. wma.net/en/30publications/10policies/c8/index.html.> Accessed 28th October 2015.

[34] Supra note 2, preamble.

[35] Ibid, article 10.

[36] Ibid article 19(2) providing that "[t]he purpose of recognising and protecting human rights and fundamental freedoms is to *preserve the dignity of individuals* and communities and to promote social justice and the realisation of the potential of all human beings." Emphasis added. See also articles 20(4)(a), and 24(1).

[37] Anne Hughes, *Human dignity and fundamental rights in South Africa and Ireland* 2014, 36.

recognised since ancient times. It and the term 'human being' are synonymous. Each person is unique. Humanity has always been regarded as superior to animals and other species."[38] The preservation of dignity is the preservation of life. Failing to act in a manner consistent with maintaining life is destroying human dignity, it is to fail to care, to lack compassion, or pity. Citing Nussbaum, Hughes states that "...Nussbaum... considers that the good of other human beings is worth pursuing in its own right. She attributes this caring characteristic to the basic social emotion of compassion. One feels disturbed when bad things happen to others."[39]

Dignity is at the core of many international human rights instruments. Article 1 of the *Universal Declaration of Human Rights* declares that "All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood."[40] The Charter of the UN in its part reaffirms faith "in the dignity and worth of the human person."[41] It is instructive that the dignity of the human person now occupies a central place in most international and regional human rights instruments.[42] The United Nations has itself formally made human dignity a central element in its human rights standards by requiring that human rights standards should "derive from the inherent dignity and worth of the human person."[43] More recently, the Vienna World Conference on Human Rights reiterated dignity as being the foundation of all human rights generally.[44] The *African Charter on Human and People's Rights* also makes references to human dignity. Article 5 in particular provides in part that: "Every individual shall have the right to the respect of the dignity inherent in a human being and to the recognition of his legal status."[45] Some courts have in fact read human dignity to be an important value system in the African context. The South African case of *S v Makwanyane* illustrates that human dignity is core to the African understanding of a human person.[46] In his elucidation of the place of *ubuntu* in the human

[38] Ibid, 37.
[39] Ibid, 44.
[40] Universal Declaration of Human Rights (adopted 10 December 1948) UN General Assembly (UNGA) Res 217 A(III), article 1.
[41] Charter of the United Nations (signed 26 June 1945, entered into force 24 October 1945) 59 Stat 1031, UNTS 993, 3 Bevans 1153 (UN Charter) Preamble.
[42] International Convention on the Elimination of All Forms of Racial Discrimination (adopted 7 March 1966, entered into force 4 January 1969) 660 UNTS 195; International Covenant on Civil and Political Rights (adopted 16 December 1966, entered into force 23 March 1976) 999 UNTS 171 (ICCPR); International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 993 UNTS 3 (CESCR); International Convention on the Elimination of All Forms of Racial Discrimination (adopted 7 March 1966, entered into force 4 January 1969) 660 UNTS 195; UNGA Res 1904 (XVIII) (20 November 1963) UN Doc A/RES/1904 (XVIII); Convention on the Elimination of All Forms of Discrimination against Women (adopted 18 December 1979, entered into force 3 September 1981) 1249 UNTS 13; Convention on the Rights of the Child (adopted 20 November 1989, entered into force 2 September 1990) 1577 UNTS 3.
[43] UNGA Res 41/120 (4 December 1986) UN Doc A/Res/41/120, para 4(b).
[44] World Conference on Human Rights 'Vienna Declaration and Programme of Action' (25 June 1993) UN Doc A/CONF.157/23, Preamble.
[45] African Charter on Human and Peoples' Rights (adopted 27 June 1981, entered into force 21 October 1986) (1982) 21 ILM 58.
[46] *S v Makwanyane* 1995 6 BCLR 665.

rights framework, Langa J stated that "[*Ubuntu*] recognises a person's status as a human being, entitled to unconditional respect, dignity, value and acceptance from the members of the community such person happens to be part of."[47] We help each other in the spirit of *ubuntu* especially if we have the capacity to do so. When a doctor is called upon to deploy his/her skills to save a life, then he/she should not refuse to act, because of a fear of foregoing profits. There is also local jurisprudence that has explored the meaning of dignity as a human right. Locally, the case of *A.N.N v Attorney General*[48] provides pointers in terms of how dignity as a human right is to be understood. The petitioner here was arrested on a charge of assault. He was however dressed as a woman. It was established during the proceedings that he may have suffered from a gender identity disorder. The police, wanting to establish his sex undressed him in the full glare of the public and media cameras. He filed a petition claiming, *inter alia*, violation of his right to dignity.[49] The court, making a finding in his favour, referred to a number of legal instruments including, the Constitution (art 28), the UDHR (preamble and art 1), the ICCPR (preamble), the ICESCR (preamble), and the African Charter (art 5). These provisions were indicative of the extent to which Kenya agreed to respect the inherent dignity and worth of all citizens.[50] Moreover, these norms were binding on "all persons".[51] Having regard to the jurisprudence in the legal instruments, as well as comparative case law, the court made the point that, respect for the inherent dignity of the human being, is a central tenet in the Kenyan society. The court held as follows:

> It is thus apparent that human dignity is the foundation for recognition and protection of human rights, which, as provided at Article 19(3)(a), 'belong to each individual and are not granted by the State.' Regardless of one's status or position, or mental or physical condition, one is, by virtue of being human, worthy of having his or her dignity or worth respected. Consequently, doing certain things or acts in relation to a human being, which have the effect of humiliating him or her, or subjecting him or her to ridicule is, in my view, a violation of the right to dignity protected under Article 28.[52]

5. Emergency medical treatment in the context of the right to health

As a derivative of the right to health, the right to emergency medical treatment is a primary and immediately realizable obligation devoid of strictures of progressive realization. In terms of paragraph 11 of General Comment No 14, the right to health envisaged under article 12(1) of the *International Covenant on Economic, Social and Cultural Rights* encapsulates, *inter alia*, access to "timely and appropriate health care."[53] Availability of life-saving treatment in emergency situations would seem to meet the criteria of timeliness and appropriateness. For

[47] Ibid para 224.
[48] [2013] eKLR
[49] Ibid, para 1
[50] Ibid, para 34
[51] ibid
[52] Ibid, para 44
[53] Committee on Economic, Social and Cultural Rights, General Comment 14, The right to the highest attainable standard of health (Twenty-second session, 2000), U.N. Doc. E/C.12/2000/4 (2000), reprinted in Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1/Rev.6 at 85 (2003). para 11.

such interventions to work there must be adequate medical personnel and equipment. Training of medical professionals, developing facilities and acquiring necessary equipment are all part of the State's obligations relating to the provision of the highest attainable standard of health. Clarifying on the aspect of availability (one of the four components of the right to health), General Comment No. 14 requires that the State makes available "Functioning public health and health-care facilities, goods and services", which will include, among others, "hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries…"[54] It is futile to expect emergency medical services in the absence of personnel and facilities through which they can be rendered. The State must invest in hospitals and doctors to make this right a reality. In terms of the Covenant, art 12 obligates the state to take enumerated measures in order to achieve full realization of the right to health. Art 12(2)(c) specifies that one of the steps to be taken will be "The prevention, treatment and control of epidemic, endemic, occupational and other diseases;" In terms of para 16 of General Comment No 14, "The right to treatment includes the creation of a system of urgent medical care in cases of accidents…"

Besides the ICESCR, the *African Charter* provides that "Every individual shall have the right to enjoy the best attainable state of physical and mental health,"[55] and further, that "State Parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick."[56] It thus echoes the essence of art 12 of the ICESCR insofar as it not only calls for the protection of the people's health, but also, requires the taking of steps which are necessary to achieve this purpose. Amongst the steps to be taken is that of ensuring that people get medical attention when they are sick. Interpreting this within the Kenyan context, it essentially means that when people are sick and in need of medical attention which at times maybe in the form of an emergency, then they are entitled to that medical attention so as to ensure that their health is protected as is required by the Charter.

6. "Horizontality" and the right to emergency medical treatment

To what extent can the right be claimed against non-state actors? It is beyond speculation that private entities are also duty-bearers when it comes to human rights. It is disingenuous to suggest that only the State and its agents may violate human rights. The political theory of the liberal state that saw the powerful state as the only real threat to liberty is obsolete.[57] The Constitution takes this matter beyond debate when it ordains that "The Bill of Rights applies to all law and binds all State organs and all persons."[58] The extent and reach of this edict has

[54] Para 12(a).
[55] The African Charter on Human and Peoples' Rights, article 16 (1).
[56] Ibid, article 16 (2).
[57] F. Michelman, 'W(h)ither the Constitution?' (2000) 21 Cardozo Law Review 1063, 1077.
[58] Supra note 2 article 20(1).

been tested, and settled, quite firmly in the courts as well. In *Isaac Ngugi v National Hospital and 3 others*[59] the court observed that:

> The issue whether the Bill of Rights applies horizontally or vertically is beyond peradventure…the real issue is whether and to what extent the Bill of Rights is to apply to private relationships. The question as to whether it is to be applied horizontally or just vertically against the State depends on the nature of the right and fundamental freedom and the circumstance of the case.

Similarly, Gacheche J (as she then was) in the case of *Mwangi Stephen Mureithi v Daniel Toroitich arap Moi*[60] observed that:

> …the rigid position that human rights apply vertically is being overtaken by the emerging trends in the development of human rights litigation…We can no longer afford to bury our heads in the sand for we must appreciate the realities which is that private individuals and bodies such as clubs and companies wield great power over individual citizenry who should as of necessity, be protected from such non-state bodies who may for instance discriminate unfairly or cause other constitutional breaches…I find that fundamental rights are applicable both vertically and horizontally save that horizontal application would not apply as a rule but it would only be an exception which would obviously demand that the court do treat (it) on a case by case basis by examining the circumstances of each case before it is legitimized.

Most importantly however, it is the court in *Satrose Ayuma and 11 others v Registered Trustees of the Kenya Railways Staff Retirement Benefits Scheme and 3 others*[61] where this position was recorded emphatically. Lenaola J in a retreat from a previous erroneously held view stated:

> Looking at the provisions of Articles 2(1), 19(3) and 20(1), I am certain that the Bill of rights can be enforced as against a private citizen, a public or a government entity such as the 1st and 2nd Respondents…The Bill of Rights is therefore not necessarily limited to a State Organ as argued by the 1st and 2nd Respondents and in saying so, I am alive to the provisions of Article 2(1) of the Constitution which provides that 'this Constitution is the Supreme Law of the Republic and binds all persons and all state organs at both levels of the Government.

In light of the above therefore, the obligation to observe, respect, protect, promote and fulfill the citizens' right to emergency medical treatment binds all State organs and all persons both natural and juristic. Patients who have been denied emergency medical treatment can therefore seek to bring a private law action alleging that they have wrongfully suffered harm. If they succeed, they may be awarded damages to compensate them for their loss. Indeed, this is made possible by the framework provided under article 23(3) of the Constitution which states, rather instructively, that:

> In any proceedings brought under Article 22, a court may grant appropriate relief, including-(a) a declaration of rights; (b) an injunction; (c) a conservatory order; (d) a declaration of invalidity of any law that denies, violates, infringes, or threatens a right or fundamental freedom in the Bill of Rights and is not justified under Article 24; (e) *an order for compensation*; and (f) an order of judicial review.[62]

The availability of compensation, that is, damages, transmutes violations of constitutional rights by private entities into the nature of constitutional torts.[63] The injury is suffered by individual

---

[59] Petition Number 407 of 2012 [2013] eKLR.

[60] *Petition Number 625* of 2009 [2011] eKLR.

[61] [2013] eKLR.

[62] Supra note 2, article 23(3).

[63] The concept of constitutional torts has now only been introduced by the Constitution. Constitutional torts are legal actions to pursue damages for violations of constitutional rights ordinarily available against state agents. (See John C. Jeffries, Jr., "Jeffries Makes Case for Reforming Constitutional Torts", available at <http://www.law.virginia.edu/html/news/2012_fall/jeffries_qa.htm> accessed on 28th October 2015 But in view of

victims and caused by an actor other than the State. Victims would thus be able to bring an action for the tort of breach of constitutional duty where they will allege that they have suffered damage due to the failure to perform a constitutional duty which exists for the benefit and is enforceable through the courts. Article 22(1) provides a firm basis for such actions by stating that "Every person has the right to institute court proceedings claiming that a right or fundamental freedom in the Bill of Rights has been denied, violated or infringed, or is threatened." The patients denied the emergency medical services could argue that the private healthcare providers had failed to perform their constitutional obligations and had harmed them. Because the constitutional duty in reference here is more specific, the suits for breach are more likely to succeed because it is easier to show that the individual was entitled to expect a service to be provided.[64] The corollary of all this is that a patient can also maintain a normal tort action in negligence where the usual elements exist.[65] There are instances where patients taken in under emergency situations and in need of emergency medical treatment, are accorded sub-standard treatment. Private healthcare providers risk negligence action for their conduct which may amount to clinical malpractice. The patients here will argue that they were improperly treated by the staff of the private healthcare providers. The basis of a claim in this instance would not be that a private healthcare carried out its constitutional duties carelessly, but that they owe a duty of care, under general tort law principles, to act properly towards those they can reasonably foresee will be affected by their actions.[66]

7. State liability for third party violation of the right to emergency treatment

As previously mentioned the Constitution of Kenya 2010 provides that 'It is a fundamental duty of state and every state organ to observe, respect, protect, promote and fulfill the rights and fundamental freedoms in the Bill of Rights.'[67] Khobe notes that the *raison d'etre* of the State is the welfare of the people and the protection of the people's rights and that it is its obligation, under international and national laws, to ensure that human rights are observed, respected and fulfilled not only by itself but also by other actors in the country. For this purpose it should regulate the conduct of non-state actors to ensure that they fulfill their obligations.[68] The obligation to 'protect' the rights in the Bill of Rights is typically understood to mean that the state must safeguard individual members of society from infringements of their rights by third parties and must ensure the adequacy of legal remedies that prevent or compensate for such infringements.[69] The state is therefore obliged to protect right-holders against other subjects

---

the general lay of the Kenyan Constitution, and the fact that art 20(1) extends liability to all persons, in Kenya, these torts may be available against private entities as the current litigation has proven time and again. See discussion and cases cited in part 6 above.

[64] Jonathan Montgomery, *Health Care Law* 2nd ed (2003).

[65] See *Donoghue v Stevenson* [1932] All ER Rep 1; [1932] AC 562

[66] Ibid.

[67] Supra note 6.

[68] Supra note 32.

[69] D M Chirwa, 'The Horizontal Application of Constitutional Rights in a Comparative Perspective,' (2006) 10(2) *Law, Democracy and Development* 559-560.

by legislation and provisions of effective remedies. Thus the state has a duty to provide for judicial remedies for violations of rights by private actors.[70]

In the context of the right to health and specifically the right to emergency medical treatment, although the *Constitution* has allowed the state to put mechanisms for the progressive realization of this right,[71] the ICESCR imposes on State Parties various obligations which are of immediate effect. These are obligations that do not require the availability or expending of any resources by the government towards their realization. Amongst these obligations is that of the State guaranteeing that the right will be exercised without discrimination of any kind.[72] This obligation is interpreted to mean that where private healthcare providers give or deny emergency medical treatment on the ground of inability to pay, they would be clearly in violation of this right. The state is obliged to ensure that this conduct by private healthcare providers does not persist. General Comment No. 14 also recognizes that the right to health and by extension the right to emergency medical treatment imposes three types of obligations on state parties: the obligations to *respect protect* and *fulfill*. Of critical importance however in this context, is the obligation to protect. This obligation requires State Parties to make measures that prevent third parties from interfering with Article 12 guarantees.[73] Further, that this obligation to protect includes *inter alia*, the duties of states to adopt legislation or to take measures ensuring equal access to healthcare and health-related services provided by third parties and also to ensure that the privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services.[74]

Moreover, the *Comment* also lists several minimum core obligations of State Parties which it provides are non-derogable and hence cannot be disregarded under any circumstance. Amongst these core obligations, is the obligation to ensure the right to access to health facilities, goods and services on a non-discriminatory basis especially for vulnerable or marginalized groups.[75] Violation of this right to health and by extension the right to emergency medical treatment can occur through the direct actions of states by say failing to prevent private healthcare providers from discriminately offering emergency treatments or by unregulated third parties themselves when they violate this right by refusing to offer or by offering the emergency services discriminately as against vulnerable and marginalized groups. The obligation to protect is further violated when a state fails to take all necessary measures to take all necessary measures to safeguard persons within their jurisdiction from infringements of

[70]*Velazquez Rodriguez v Honduras,* 1988, series C. No. 4 The decision of the Inter-American Court that 'when a State allows a private persons or groups to act freely and with impunity to the detriment of the rights recognized, it would be in clear violation of its obligations to protect the human rights of its citizens.

[71] Supra note 2, article. 21 (2).

[72] Ibid, article. 2 (2).

[73] Supra note 23, para 33.

[74] Ibid, para 35.

[75] Ibid, para 43 (a).

the right to health and by extension the right to emergency medical treatment by third parties. This category includes such omissions as the failure to regulate the activities of individuals, groups or corporations so as to prevent them from violating the right to emergency medical treatment and the right to health of others.[76] General Comment No. 14 stipulates that any person or group of a violation of the right to health, within which is the right to emergency medical treatment, should have access to effective judicial or other appropriate remedies at both national and international levels. All victims of such violations should be entitled to adequate reparation, which may take the form of restitution, compensation, satisfaction or guarantees of non-recurrence.

8. Observations on apparent property rights claims by private health care providers

It may be that requiring private health care actors to provide emergency treatment regardless of the patient's impecuniosity will impair the former's entitlement to a return on investment. In property rights parlance, the Constitution provides that everyone, including them, has a constitutional right to either individually or in an association with others to acquire and own property.[77] Property in this instance is interpreted as money.[78] And that they shall not be arbitrarily deprived off this their property.[79] Compelling private healthcare providers to administer emergency medical treatment to persons who cannot pay may impinge property rights. Just like the *Constitution* contemplates justifiable takings, which are compensable, so too must it be possible to cushion private health actors against denudation of their net worth through uncompensated emergency services. There has to be a balance. In the United States, as seen above, both public and private hospitals have a duty to administer medical care to a person experiencing an emergency. The basis of this is that if a hospital has emergency facilities, it is legally required to provide appropriate treatment to a person experiencing an emergency. This is because the law on emergency treatment (*EMTALA*) applies to all hospitals receiving federal funds, such as Medicare (almost all do). The law has balanced the rights of both patients and private medical providers through this arrangement. The federal government provides private hospitals with funds that will allow them to administer emergency treatment to patients as and when the situation requires. In US admission to hospital on the basis of the ability to pay is severely limited by statutes, regulations and judicial decisions. The government further strives to balance these two competing interests by requiring that all those private hospitals that have obtained financial assistance from the federal government for construction; to provide a reasonable volume of services to persons unable to pay. Most importantly also, once a patient has been duly admitted to a hospital, she or he has the right to leave at any time, or the hospital could be liable for false imprisonment. This is so even if the patient has not paid the bill or if the patient wants to leave against all medical advice. The decision to discharge is required to be solely based on the patient's medical condition and not on nonpayment of

[76] Ibid, para 51.
[77] Supra note 2, article 40.
[78] Ibid, article 260.
[79] Ibid, article. 40 (2) (a).

medical bills.[80] As it can be learnt from America, this right can be realized and at the same time cater for the rights of both patients and private healthcare providers in Kenya.

Coincidentally, the *Health Bill 2014* adopts a somewhat similar balancing approach when it comes to mandatory emergency services and the interests of the private health care giver. The bill anticipates a situation where, the Ministry of Health shall ensure progressive financial access to universal health coverage by taking measures that inter alia, include, "defining, in collaboration with the department responsible for finance, public financing of health care framework, including annual allocations towards reimbursing all health care providers responding to disasters and emergencies".[81] Private health actors forced to act to save life will be insured against loss while performing this rather public duty, just like it happens in the United States. The bill proposes to make it an offence to refuse or fail to provide emergency medical treatment whenever required. Thus "Any health care provider who fails to provide emergency medical treatment while having ability to do so commits an offence and is liable upon conviction to a fine not exceeding one million shillings or imprisonment for a period not exceeding twelve months or both."[82] Further, "Any medical institution that fails to provide emergency medical treatment while having ability to do so commits an offence and is liable upon conviction to a fine not exceeding three million shillings."[83] The key here is opportunity and ability so that those unable to extend the services should not ace unnecessary sanctions.

9. Conclusion and Recommendations

The right to emergency medical treatment in Kenya is indeed a vital right that is critical to the enjoyment of the highest attainable standard of physical and mental health. It is also true as it has been discussed that this right can and should be enforced horizontally as against private healthcare providers. This is because in the recent past, the media has been replete with stories of patients either denied emergency medical treatment or those who have been treated but are detained indefinitely due to their inability to pay their hospital bills. According to the Independent Medical Legal Unit (IMLU) Kenyan Chapter, the act of imprisoning patients for their inability to pay their hospital bill amounts to torture. Further, the International Covenant on Civil and Political Rights (ICCPR), prohibits the imprisonment of a person merely on the ground of inability to fulfill a contractual obligation.[84] This notwithstanding however, as discussed above, the government needs to come up with urgent measures of cushioning private healthcare providers through reimbursement for the costs incurred during and after the administering of emergency medical treatment to persons who cannot pay. Given that this is already contained in the 2014 Health Bill discussed above, all that the government needs to do

---

[80] Gale Encyclopedia of surgery: A Guide for Patients and Caregivers. Dictionary of American History available at www.encyclopedia.com/topic/Patients_Rights.aspx accessed on 3 September 2015.
[81] Ibid, s. 54 (1) (e).
[82] Ibid, s. 7 (4).
[83] Ibid, s. 7 (5).
[84] *International Covenant on Civil and Political Rights* (ICCPR), art. 11.

is to move with speed and enact it into law. When this is done, the law will not only be seen to be protecting both patients and private healthcare providers but it will also set the stage for the proper implementation and enjoyment of the right to emergency medical treatment and the broader right of enjoying the highest attainable standard of physical and mental health.

View publication stats