

Barriers in Accessing Healthcare Services by Patients with Disabilities in Nigerian Hospitals

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Abstract

Disability has turned several disabled individuals into popular patients easily to be identified, when moving or interacting with other members of society. Disability is not a problem associated with people of a particular nationality, but across the globe and sufferers are rendered incapacitated. The condition of these patients make them perpetual visitors to the hospital for treatment of the existing health challenge, injuries caused by accidents or new symptoms from other diseases. This paper employed qualitative research and analytical approach to gain an insight into the barriers experienced by PWDs in Nigerian hospitals. The source of data was solely secondary, accessed from various academic journals including online articles relevant to the issue. Findings revealed that systemic barriers and attitudes of the healthcare providers affect the access and quality of healthcare services received by PWDs. It was also revealed in this paper the level of healthcare providers' adherence to the ethics of consent is abysmally poor. The paper recommends the removal of barriers through adequate training of medical staff, proper monitoring of activities, adequate distribution of medical resources, positive attitudes towards patients, among others.

Keywords: Abuse, Attitude, Health Provider, Healthcare Services, Patients, disabilities

Introduction

Disability is a global issue, renders the sufferers powerless and exposes them to several challenges in all spheres of life. The concept of disability has been used to discuss impairments resulting from diseases and injuries including physical and mental functional difficulties experienced by persons within their environments and how such conditions restrict their participation in all spheres of life. The World Health Organisation (WHO, 2011), notes that the concept of meaning and understanding of disability is beyond a physical or medical perspective and has taken into account a person's physical, social and political context. This understanding is generated from the interaction between a person's health condition and their environment. The report of WHO (2013), revealed that more than a billion people, constituting about 15% of the world's population, have some form of disability. In Nigeria, the report of WHO (2011), shows that about 25 million

people in Nigeria have one form of disability or the other. The figure accounts for at least 15% of Nigeria's current population of 200 million. The World Bank (2020) reports that persons with disabilities face several barriers including transportation problem, lack of assistive technologies and devices and non-adapted means of communication. The reports also showed that service delivery, discriminatory prejudice and stigma were more pronounced against PWDs, while accessing medical services and demanding for full social and economic inclusion.

In Nigeria, Ojo (2017) acknowledged that patients with disabilities feel disjointed for being treated as people in need of social support and charity, particularly, basic needs of life. The disjointed feeling aligns with an obvious lack of access to public infrastructure, ICT infrastructure, public policies, electoral system, transport systems, employment, education, housing and health care delivery. The lack of these basic needs and social amenities prevents the enjoyment of the privileges and full rights as citizens, is capable of hindering them from living a productive life. Conversely, people with disabilities are subjected to various forms of abuse both at home and in the public. Ojo (2017) claims that patients with disabilities are living witnesses to social, economic and political barriers that have impacted their abilities to harness their potentials in life. Accordingly, there are extraordinarily talented persons with disabilities who are denied opportunities and more likely to fall into poverty. However, the barriers caused by individuals and organisations make life difficult for these patients, not only in the hospitals but also in all spheres of life.

In Nigeria, with no doubt, several barriers await persons with disabilities in the hospitals, preventing them from accessing quality healthcare services, actualising their dreams and full potentials. Unfortunately, the healthcare providers, charged with the responsibility of promoting health, complicate it through systemic and attitudinal means. The attitudes of the health professionals have impacted mental health and psychosocial disabilities by rendering the disabled disadvantaged and vulnerable to various forms of abuse, injuries and diseases. Guaranteeing the mental wellbeing, protecting the fundamental human rights and ensuring the social inclusion of patients with disabilities are uncertain. It is a common practice among healthcare providers to apply medication on patients with disabilities without recourse to their consent, which is against the ethics governing their conduct. Additionally, patients are treated as fakers of symptoms which may associate with their insufficient knowledge on how to handle patients with disabilities. This implies that disabled patients experience violence from those entrusted to take care of them either consciously or unconsciously, directly or indirectly.

Human Rights Watch (2019) reports that persons with disabilities are more likely to experience violence from a caregiver. The violence may be physical, sexual or psychological and can intimidate, threaten or coerce the disabled persons to misbehave or act violently towards their caregivers. The barriers experienced by patients in the hospitals prevent them to enjoy adequate healthcare like other non-disabled patients. These barriers lead to neglect in terms of failure to provide medication, supervise medical or dental care that could expose the patients to undue risk through unsafe environments or practices. Negative attitudes of the health providers can contribute to withholding or failure to provide the necessities of life, wilful deprivation of assistance to and restricting social, intellectual and emotional wellbeing of the patients with disabilities. The barriers created in the hospitals are capable of leading to a serious disregard of responsibility by the healthcare providers and exploitation, injury or harm of the patients with disabilities.

The awareness, lamentation and agitation of the persons with disabilities who are educated, enlightened, cosmopolitan and high net worth individuals, brought the strident voice for the eradication of barriers created not only in the hospitals but also in all areas of life. Ojo (2017) identified organisations like National Association of the Blind, Centre for Citizens with Disabilities, Association of Lawyers with Disabilities in Nigeria, Joint National Associations of Persons with Disabilities, among others, as the means through which the voices of the disabled persons are heard and barriers are removed. The 2018 Act on Discrimination Against Persons with Disabilities (Prohibition), which Nigeria's President, Muhammadu Buhari claimed that he had not received as of January 17, 2018 on national television was later signed on January 23 after 9 years of relentless advocacy by disability rights groups and activists.

The law "prohibits discrimination based on disability and imposes sanctions including fines and prison sentences on those who contravene it. It also stipulates a five-year transitional period for modifying public buildings, structures, and automobiles to make them accessible and usable for people with disabilities". The law will establish a National Commission for Persons with Disabilities, responsible for "ensuring that people with disabilities have access to housing, education, and healthcare where it will be empowered to receive complaints of rights violations and support victims to seek legal redress amongst other duties". With the implementation of these laws and several campaigns carried out to make the patients with disabilities have equal access to quality healthcare services as non-disabled patients, they are, however, restricted by the barriers which are systemic and attitudinal in nature.

This paper sets to examine the behaviours of healthcare providers on the assumption of symptoms faking by patients with disabilities; to explore healthcare providers' level of adherence to the ethics of consent while treating and applying medication to PWDs; to determine the attitudes of health providers towards the wellbeing of PWDs; to identify how healthcare providers' knowledge can influence access to quality healthcare services; to highlight the forms of abuse and neglect perpetrated against PWDs by health providers; and to find out the systemic barriers against access to quality healthcare services by PWDs.

Methodology

The paper adopted qualitative approach of data collection and thematic analysis. The justification for this approach is to produce contextual real world knowledge about the behaviours of the healthcare providers towards PWDs. The adoption of this approach was to enable the researcher contribute to knowledge through reviews and interpretation of secondary data including journal articles, internet information, and several empirical works on disabilities. The analysis and submission of this work reflected the happenings in Nigeria

Healthcare Providers' Assumption of Symptoms Faking by Patients with Disabilities

In hospitals, patients with intellectual disabilities e.g. deaf and dumb persons, are disrespected when they complain of any health challenge. Their condition makes it hard for them to holistically discuss their problems with doctors and several hospitals lack the facilities to ensure equal treatment of all patients. Perry (2018) asserts that doctors find it hard to believe patients diagnosed with an intellectual disability. Accordingly, medical workers are fond of carelessly assuming that symptoms and illnesses are faked by persons with intellectual disabilities. This can infuriate patients who have a hard time discussing their conditions and can also cause the medical staff to demand psychiatric evaluations of the patient. It is so unfortunate that patients with disabilities are readily judged mentally imbalanced when visiting hospitals for treatment or diagnosis. Patients with disabilities indeed face challenges in accessing routine care for managing the symptoms of their co-occurring genetic conditions and are sometimes ignored and disrespected by the medical staff based on the assumption that their condition may not be real as claimed. On this assumption, patients are subjected to derogatory words and get discouraged to access medical care when the need arises. The concept of mental retardation has been used to describe persons with intellectual disability to render their voices impotent and that is considered abuse on the part of such patients.

It is common for the medical personnel to keep patients, most especially patients with disabilities waiting for a longer period, while seeking medical assistance or healthcare when they are assumed to be faking symptoms. This action against the patients can metamorphose into several other health challenges depending on the problems experienced by the patients. Take, for instance, the condition of a person suffering from autism, who has visited a hospital for complaints, and is kept in the emergency room for long hours due to inability to communicate through speech, may worsen if the person experiences shaking of the body, chattering of teeth or sweats profusely (Perry, 2018). This condition can be best attended to where the patient can write their experience on a piece of paper before the situation worsens beyond normal.

Perry (2018) observes that several types of research have revealed that the risks for patients with disabilities were higher and that the outcomes were worse in the hospitals. The suspicion of the patients with disabilities by the medical personnel has contributed to the mislabelling, misidentification, dehumanising and ignoring of patients in the hospital settings. The routine diagnosis of patients with disabilities can be fraught with suspicion by medical personnel most especially when an autistic patient is extraordinarily fluent in medical knowledge, passionate, articulate, and extraordinarily well-educated. As such, the patient can be accused of faking ailments or wrongly diagnosed for factitious disorder or psychosomatic disorder or both. Perry (2018) further notes that it is common to discharge patients with disabilities from hospitals before full health recovery with the notion that they will be fine on their own. Patients, who are conscious of their conditions, take the case of persons on wheelchairs, are dissatisfied with such hurried discharge. The patients may require in-patient treatment rather than home treatment. Where reverse is the case, they are wheeled out of the hospital environments to the door of the homes.

Patients' Treatment and Medication Application without Consent in Hospitals

Hospitals have been reported to administer medications and attend to patients with disabilities without adequate compliance to consent which is contrary to the ethics of medicine. The Human Rights Watch (2020) reports that it is a common practice among health practitioners to administer medication forcibly to persons with cognitive disorders especially those living with schizophrenia, without obedience to their consent. In psychiatric hospitals and government-run rehabilitation centres, medical workers are known to give both oral and injectable medication without the consent of patients suffering from mental problems. The administration of medication without consent happens when health professionals fail to learn and

understand the signs and symptoms of the peculiarities of their illnesses, most especially understanding their communication or allow them to speak up before administration of treatment.

The administration of electroconvulsive therapy (ECT) on patients with cognitive problems has also been reported where it is adopted and applied on patients without due diligence to their acceptance, knowledge or consent. The ECT is a medical treatment commonly used for treating patients with depression or bipolar disorder that is severe and has failed to respond to other treatments. The ECT involves a brief electrical stimulation of the brain while the patient is under anaesthesia. The conditions of the patients may warrant medication to be applied by a team of trained medical professionals without their consent. This action amounts to the abuse of the patient's consent, although, such abuse is termed warranted abuse. However, it is important that where such consent cannot be sought, medical personnel inform the guardian of the patient.

Children with disabilities are treated without consent seeking by doctors with the belief that their privacy and dignity are not important during treatment. It is believed that examining their bodies or exposing it during treatment does not make them feel embarrassed. Patients with learning disabilities or mental health conditions are not giving enough attention by the health professionals and as such, they may not be properly consulted about their health needs and wrongly or poorly treated because of prejudice or wrong ideas about their physical health problems. For instance, a patient with a learning disability who finds it difficult to understand things may be required to go for a risky operation, sign a consent form without due understanding which no one has taken the necessary time to explain. The inability to give consent puts the patient at a disadvantage even though it is understood and allowed by the significant others of the patient.

Attitudes of Health Providers and the Wellbeing of Patients with Disabilities

The attitudes of health providers are key determinants to the general well-being of not only patients with disabilities but for all categories of patients. Where the attitudes are negative, it impacts negatively on the health of the patients. Sanchez et al. (2000) observed that the poor attitudes of the healthcare providers towards patients with disabilities significantly deter good quality care and that many physicians saw nothing wrong with their perception of disabilities and attitudes towards the disabled. On this note, Antonak and Livneh (2000) claimed that the negative attitudes of the physicians towards patients with disabilities create several difficulties and mirror the perception of society in general. It is indicative that

attitudes of health professionals are key determinants to access quality health services for patients with disabilities, influence physicians' judgments and interventions and can also have profound effects on the treatment process. Poor judgement or attitude can make a person's disability to be perceived as a negative trait, an abnormality or even an illness.

Perceiving disability as an illness by the health professionals is disrespectful to the disabled who perceive it as a condition of life (Jorgensen, 2005). Both illness and disability often co-exist, but they generate different responses from clinicians. According to McColl et al. (2008), illness implies an acute, curative response, which does not apply to a disability that is part of patients' everyday life. McColl and Bickenbach (1998) submit that the concept of illness inappropriately defines the "sick" role and disempowers patients with disabilities who are already being challenged by their disabling conditions. The report by Veltman et al. (2001) showed that adequate account of disability was not taken by one-fifth of doctors, and that fifth of them attributed everything to the disability. This, therefore, is responsible for the failure to thoroughly explore new complaints as warranted. Iezzoni et al. (2003) observe that misunderstandings and discordant expectations between disabled patients and health professionals exist regarding patients' overall health, the potential for recovery and even life expectancy.

The challenges experienced by patients with visual impairments have also been documented. Health professionals hardly look at the direction of patients with visual impairments with the perception that it does not add any value to their treatment. Doctors are known for leaving them in the offices for other services without prior notice. There is no doubt that such behaviour could result in disorientation. Some nurses are not well trained on how to handle blind patients. While assisting blind patients with canes, some nurses fail to offer their arms on the patients' free sides. Nurses are fond of walking at an abnormal pace with or faster than the patients. McColl et al. (2008) observed that the nonchalant attitude of the health personnel against patients with disabilities, cannot be dissociated from the time required to transfer, position and undress the patients. This implies that doctors were less likely to examine disabled patients and more likely to accept their verbal report of a problem. The role of undressing patients with disabilities during appointment and examination may not be considered doctors' primary responsibility but as ordinary assistance that cannot be forced on them.

McColl et al. (2008), in their study, claimed that the attitudes of the health professionals towards disabled patients fail to accommodate their special needs in

the practice. Based on this, disabled patients are required by several physicians to bring an attendant to assist with special functions like transferring, dressing and undressing, communication and follow-through. Particularly, disabled patients face challenges while trying to find an assistant or family member who will be available on the scheduled appointment. Where patients fail to secure assistants, they are forced to unnecessarily postpone scheduled appointments and when they finally come to the hospital without an assistant, they are left untreated or poorly attended to by healthcare practitioners. It should be noted that the requirement of disabled patients to come along with an assistant to the hospital during appointments enhances access to the office and equipment, and access to a high standard of primary care), however, it also impedes confidentiality and full disclosure because of the lack of privacy between patient and doctor.

Reports have it that healthcare providers are fond of prolonging or changing the appointments of patients with disabilities. This attitude exposes the patients with disabilities to all sorts of health challenges, abuse and neglect. Healthcare professionals have been found to giving short time to patients with disabilities in their offices while attending to their health problems even though, non-disabled persons are giving sufficient and longer hours. By implication, patients that demand more time and attention are influenced to give incentives, exorbitantly charged and exploited at the benefit of the physicians. McColl et al. (2008) acknowledge that several disability groups have rejected the use of incentives by patients with disabilities to access the same standard of care provided to non-disabled patients. The emphasis here is that primary care is considered an entitled service for all patients, hence, patients with disabilities need not explicitly reward for service provision. The fact that patients with disabilities are equal to other citizens, they deserve to be treated equally but not like other patients because their conditions require special treatment. McColl and Shortt (2006) asserted that disabled patients remain the most users of healthcare, hence, they experience considerable unmet needs within the healthcare system.

Knowledge of Health Providers and Access to Quality Healthcare Services

Health care personnel at the rural community level lack adequate basic mental health and psychosocial skills for effective task sharing and task shifting to effectively manage the conditions of patients with mental disorders without abusing or violating the fundamental human rights of the patients or the ethics guiding medical practice. Persons with learning disabilities experience various forms of discrimination and abuse in hospitals due to the difficulties in understanding things connected to their disabilities. This can render the medical staff who are not

conversant with this condition incapacitated and unable to make reasonable adjustments.

In the case of patients with cerebral palsy, having speech impairment, health professionals do fail to ask them to repeat the complaints they do not understand. They assume that the condition is well understood without asking the patients for the repetition of the information. By this, they wrongly attend to the patients and fail to address the challenges reported. Sometimes, patients with cerebral palsy are neglected in hospitals when they request assistance from nurses. It is also common to address adult patients with mental retardation as kids by healthcare assistants. Also, while giving instructions or directions to patients with mental retardation, health professionals usually speak too lengthy, fast and sometimes unclear to the patients. This undermines their patients' status and the etiquette for attending to patients. Patients with hearing impairments can hardly be attended to without the presence of their significant others. It is based on this that they are attended to through third parties.

In a study conducted by McColl et al. (2008), it was discovered that many health professionals lacked the adequate knowledge to diagnose and address, had no training on how to relate with or assist patients with disabilities and experienced personal discomfort while treating them for the avoidance of perceived potential professional liability e.g. an incident such as a fall. Corroborating this, Bernatsky et al. (2006) claimed that expertise-related problem primarily impacts on the standard of care delivered through the inability to diagnose disabling conditions accurately and to anticipate further disabling consequences. There is no doubt that such a problem significantly deters high-quality primary care.

McColl et al. (2008) note that many physicians interviewed in the study revealed that they had adequate knowledge on primary care but lacked more information about disability, because the practice passed through while learning, contained only a few patients with disabilities. Therefore, it would be difficult for doctors to develop an understanding of the issues related to disabilities. Affirmatively, Claxton (1994), in a study conducted among doctors, revealed that medical practitioners had relatively little exposure to adult disability in medical school or residency training, and were more familiar with the concept of disability in their elderly patients. By implication, it justifies the compelling case for the absence of special attention to disability-related issues.

Abuse and Neglect of Patients with Disabilities by Health Providers

Deep-rooted problems in Nigeria's healthcare and welfare systems leave most Nigerians unable to get adequate mental health care or support in their communities. There is a perception among Nigerian people that disability e.g. mental illness, is caused by supernatural forces and is contagious. Stigma and misunderstanding about mental health conditions, including the misperception that they are caused by evil spirits or supernatural forces, often prompt relatives to take their loved ones to religious or traditional healing places as against medical centres. It is believed that medical practitioners usually fail to address patients' mental illness, maltreat them, and subject the families and the relatives of the patients to financial exploitation. Among some health practitioners, patients in wheelchairs or who are mentally ill, are sometimes treated with no respect and their conditions are considered contagious. Convincingly, such patients can be abused, treated poorly or poorly assisted. Patients in wheelchairs are troubled by being forced or conditioned to look up repeatedly while discussing with health professionals who are standing or not ready to kneel or sit down. This can strain their necks.

Patients with disabilities are abused every day in hospitals consciously or unconsciously by medical practitioners including physicians, nurses, radiologists, virologists, psychiatrists, anaesthesiologists, among others. Patients with disabilities most especially the children, are vulnerable to poor treatment from medical personnel. Thus, they are more likely to experience abuse not only in the hospital environment but also at home than non-disabled children. Children with disabilities are often maltreated and abused by healthcare practitioners who see nothing wrong in it and consider it normal while managing the health of these individuals. There are practices in the hospitals shrouded under normal clinical routines and continue unchallenged but construed as abuse. People with a mental health condition may be disadvantaged when accessing and using health services. This challenge can make them aggressive towards medical personnel, especially when they become aware of the abuse and poor treatment given to them.

Human Rights Watch (2019) reported that patients at psychiatric hospitals were found chained in some Northern hospitals in Nigeria. The report shows that the staff of some of the hospitals refuted chaining patients but wards were discovered where people had iron shackles around their ankles. Olawale (2019) observes that several hospitals classified illegal treatment centres exist in the country where patients with disabilities, most especially those with mental illnesses, are maltreated while receiving treatment. Accordingly, the treatments given to these 'inmates' are unorthodox mental health care and psychosocial services which particularly violate

the rights of persons with mental health and psychosocial disabilities. Getting the attention e.g. speaking with the patients, is very much difficult, hence, health professionals are forced to tap them on the shoulders or wave in their direction. However, it is often common to see these patients being insulted or abusively tapped by health practitioners while seeking their attention.

Disability Rights California (2020) notes that incidents of abuse or neglect of patients with disabilities exist in hospital settings including nursing homes or board and care homes. Accordingly, patients lacked insight into the abuse subjected to by the hospital personnel. In some cases, patients with mental illness, are subjected to using buckets as toilets, served on outdoor picnic tables during rainy or dry periods and their meals are cooked and prepared in open spaces. Disability Rights California (2020) reports that aggressive patients with disabilities are injured by medical staff while trying to apply medication. Accordingly, several incidents such as unexpected/suspicious deaths and sexual assault allegations of patients with disabilities perpetrated by medical staff have been reported to law enforcement agencies.

Physical and sexual abuses are perpetrated by medical professionals and hospital workers against patients with disabilities. Long (1992) discusses a case of a nurse convicted and sentenced to two years in prison for indecent assault on two 13-year old boys and at Booth Hall Children's Hospital in Manchester. Similarly, Westcott (1993) reveals that adult patients with disabilities interviewed, who had spent a long time in hospitals and psychiatric institutions, reported having been abused by doctors in the hospitals as children and as adults. In a study conducted by Robin (1982), it was discovered that patients in psychiatric hospitals in the US were abused through depersonalised rules and regulations, isolation and seclusion, the use of locked doors, and the use of drugs for the management of disruptive behaviour.

Systemic Barriers against Patients' Access to Quality Healthcare Services

There are several barriers obtainable in the hospitals which are indicative of the way and manners the patients with disabilities access healthcare services. These barriers pose challenges in accessing medical services and contribute to inequality in the system of treating patients. In Nigerian hospital settings, there is inadequate information in Braille and large print on disease prevention and signs and symptoms identification that can be easily read and understood by persons with vision impairments. Therefore, such patients can hardly understand the trends of health challenges and take measures to prevent the contraction of diseases. Centres

for Disease Control and Prevention (2019) observes that access to medical services consists of both communication and physical access which have rendered the services given by the health professionals to patients with disabilities, most especially the deaf or those with a speech, vision, or intellectual disabilities ineffective. Materials like pencils and paper handy to communicate with the patients are also not provided for patients with hearing impairment. Most Nigerian hospital surfaces are slippery and uneven in structure. This poses problems for people walking with assistive devices like canes, wheelchairs, etc.

Healthcare providers (hospitals and private clinics) make their services inaccessible to and discriminate against patients with disabilities. McColl et al. (2008), reported that the challenges experienced by patients with disabilities in hospitals are systemic in nature, which is caused by the policies and administration of hospital owners. There are shortages and mal-distribution of physician human resources in hospitals which often lead to difficulties in accessing quality and qualified doctors and long wait times due to large caseloads of patients. These challenges are experienced by all patients but more common in patients with disabilities. Barros (2003) agrees that patients with disabilities are considered an economic liability because they take more time than the standard ten-to-fifteen-minute appointment. McColl et al. (2008) express that having more patients does not add any other financial incentive to the agreed pay given to physicians by their employers. The challenges of the patients with disabilities are compounded by the absence of supports or assistance from physicians most especially those with complex patients in small practices. The lack of health professionals or even administrative staff to fulfil some of the functions that are not strictly medical but required by the patients with disabilities exposes them to several barriers, abuses, discrimination and even exploitation.

McColl et al. (2008) observe that several barriers (physical, attitudinal, expertise-related and systemic) exist in the hospitals which confront patients with disabilities. These barriers prevent to access primary care like finding a doctor, getting an appointment, entering and using the facilities in the practice, and receiving a reasonable standard of care and ultimately prevent them from accessing quality healthcare. McColl (2006) asserted that disabled patients are systematically excluded from special treatments by hospitals because of the burden they are perceived to impose on the physician's time. Patients with disabilities face a lot of systemic barriers in accessing good health and several studies have shown that they are more likely to report cases of abuse and health challenges including poorer overall health, less access to adequate health care, risky health behaviours, smoking

and physical inactivity than non-disabled people. Private hospitals are insufficiently staff, hence, there is a lack of enough staff on duty to deal with patients with disabilities. The conditions pose stressful experiences to patients with disabilities in the hospitals and could discourage them from visiting the hospital for health issues which may also compound or worsen their health problems. It is no doubt that such an experience is an infringement upon the fundamental human rights of the patients.

The hospital settings are also not designed to accommodate patients of all statuses as some of them lack the installation of automatic doors or ramps and accessible toilet facilities to enable them to move freely, access medical services and gain comfort while in the hospitals. McColl et al. (2008) reported in their study that several physicians interviewed acknowledged that their offices were not designed to accommodate wheelchairs, and lacked special facilities to accommodate cognitive disabilities. The findings showed that physicians were aware of the challenges faced by patients with disabilities in the hospital environments but lacked the correct manner to provide physical assistance to them and where there was a solution to this challenge, many of the health professionals showed a reluctant attitude to assist.

The hospital settings in Nigeria do not provide room for doctors to maintain eye contact with patients with hearing impairment and who depend on speech-reading to understand conversation due to an insufficient number of doctors to a significant number of patients. Where other patients wait for doctors, they easily get distracted and while discussing with others, speech-reader patients may think the conversation is over. The life of patients with hearing impairment is made difficult when health professionals are not familiar with sign language/reading or hospitals lack sign interpreters. Centres for Disease Control and Prevention (2019) also notes that many healthcare professionals lack the knowledge to attend to the special needs of patients with disabilities, hence, they are poorly treated. Also, the structure of the country creates transportation difficulties for patients with disabilities which are experienced in the hospitals while seeking medical care. Health providers lack available and accessible medical equipment like scales, examination tables, or chairs, for patients with disabilities. Also, the timing allotted to examining patients with disabilities is short, compared to non-disabled patients for all sorts of reasons, in the normal course of medical practice.

McColl et al. (2008) revealed in their study unequivocally that patients with disabilities took more time during the examination and were more complex.

Accordingly, physicians astutely claimed that taking care of patients with disabilities in the hospitals was more like social care rather than strictly medical care. The findings also revealed that disabled patients suffered basic primary care physical examinations and preventive health measures. They eluded these challenges to logistical difficulties and constraints on physicians' time. At the community level, the primary health care lacks mental healthcare services for enhancing effective and qualitative mental health, psychosocial services and discourage community participation. House of Commons Health Committee (1997) reported that the problems associated with disabilities are influenced by a shortage of resources such as beds and medical staff, which are capable of compromising quality healthcare and leading to unnecessary delays and even death. Accordingly, inadequate services for patients with disabilities, lack of priority given to them, and geographical inequalities in the provision of medical services are caused by the irresponsibility of owners and managers of hospital environments.

Conclusion and Recommendations

Centres for Disease Control and Prevention (2019) reports that persons with disabilities are more susceptible to health problems that would have been prevented, if not disabled and such status could decrease their overall health and quality of life. Accordingly, they are also prone to experience fatigue, pain, obesity and depression as a result of the disabling condition. The health disparities in the country and other health challenges caused by the disabling conditions of the persons with disabilities restrict their access to health care facilities and equipment and increase poverty among them. The implication for short timing is that doctors would not have the room to adequately educate the patients on how to live a long and healthy life, listen attentively and respond swiftly to the patient's health concerns. Similarly, patients will lack the information needed to prevent or treat a health problem. Communication with the patients becomes unclear, understanding questions and instructions of the physicians are ambiguous and incoherent to the patients with intellectual disabilities.

This paper argues that the challenges created by the hospitals and its workers through their action and inaction can subject patients with disabilities to health, economic, social, emotional problems arising from malnutrition, unsafe working conditions, inadequate access to education and health care, a polluted environment, and lack of access to safe water and sanitation. Additionally, poor attention to the conditions of patients with disabilities can complicate their conditions by resulting in a lack of employment and education opportunities, increased cost of living, lower wages and other forms of disabilities. Ojo (2017) reveals that problems experienced

by patients with disabilities in the hospitals can lead to long-term physical, mental, intellectual, or sensory impairments which as well interact with various barriers hindering their full, effective and equal participation in society with others.

Nigerian healthcare providers must be aware that access to basic healthcare services is a precondition to equal opportunities in life and is essential for being valued and considered as productive members of society. In Nigeria, patients with disabilities are subjected to inequality, discrimination, and abuse in the course of accessing healthcare services as a result of barriers that are attitudinal and systemic in nature. The negative attitudes of the health providers toward the patients with disabilities are complicated by healthcare staff's lack of special training or interpreter package to handle the medical care of persons with disabilities, most especially patients with hearing or vision impairments (Oliver, 1998). Nigeria is known for lack of equitable health services including health promotion and disease prevention services for patients with disabilities (Paris, 1993). Also, across the spectrum of Nigeria, there is a lack of health insurance or coverage for services like assistive technology, durable medical equipment to guarantee both specialty and long-term care and care coordination.

Awareness must be created that the challenges experienced by the patients with disabilities in the hospitals go beyond health problems and metamorphose into poverty, discriminatory attitudes, poor communication, lack of understanding and education. This paper also notes that inadequate knowledge of healthcare providers on how to handle patients with disabilities contributes to the challenges experienced while accessing healthcare services. It is recommended that healthcare providers are well trained on how to handle any forms of disabilities and their patients. Nigerian healthcare providers should treat patients with disabilities equally with the general public. The ministry of health should be committed to ensuring the provision of fair and equitable health service, responsive to the needs of disabled patients. There is no doubt that such commitment will positively impact productivity, quality of life and general well-being of the disabled persons in Nigeria. Foremost, the Nigerian government should put in place favourable policies to protect persons with disabilities, particularly, human rights laws to ensure access to quality healthcare services and remove all barriers.

It is recommended that the use of covert video surveillance in hospital settings to document life-threatening abuse be encouraged. Awareness should be raised among health providers and their managers on the complexity of disability and the required attitudes needed to promote patients' health. Hospital owners and managers should

heavily invest in medical human resources by allocating resources commensurate with patients' needs. Measures should be taken to identify and stop both intentional and subtle abusive practices through changes in attitudes by medical staff. Medical staff should be of the highest quality and this can be achieved through rigorous procedures in selecting, assessing and training. Measures should be taken to ensure that doctors meet the basic needs of patients with disabilities. Ultimately, there should be external systems of inspection, monitoring and standards.

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