APPRAISING THE LEGAL AND REGULATORY FRAMEWORK ON MEDICAL NEGLIGENCE IN KENYA

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By

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DECLARATION

I, **SYLVIA WANDIA WANJOHI**, assert that this dissertation is, to the best of my knowledge and belief, completely an original work of mine, and it has never been beforehand, entirely or in part, been presented for a degree or diploma programme in any other institution of higher learning. Any works referenced are cited accordingly and acknowledged.

Sign:……..

Date:……..

This work has been presented for examination with my consent as a University Supervisor.

Sign:……..

MS. MUKAMI WANGAI

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ABSTRACT

The medical profession is one that is heavily regulated in Kenya. However, the cases of medical negligence are rampant and most offending medical practitioners go unpunished. There exists a regulatory and legal framework through which complaints against offending medical practitioners are handled. This research seeks to examine the efficiency of these frameworks and if there are improvements that can be made.

This study found that the regulatory framework has extensive and multiple moving parts. Many of the statutory regulators each regulate only a sector of the medical professionals. For example, a nurse, a lab technician and a dentist will be governed by different regulators, each with its own set of rules. Moreover, most of them cannot even give orders on compensation to a victim and are mainly focused on the profession and the professional's transgressions. This raises the issue of the proper forum for a victim to air a complaint when, in most cases, they are treated by a number of these professionals and are seeking damages for the injury suffered due to negligence.

The legal framework, though it does have the power to award damages, is still using the 'Bolam test' and other English decisions to determine negligence without due consideration to emerging trends and jurisprudence in the area. Furthermore, in cases of criminal proceedings brought against a medical practitioner, there does not seem to be room for a victim to bring forth a civil claim for damages.

There are emerging trends such as the use of new technologies, traditional remedies and even social media to diagnose and treat patients that are considered.

This study essentially puts forth the idea of use of a key, super regulator with the powers to both punish the offending medical practitioner and award compensation to the victim of the medical negligence. The legal framework would need to consider the evolving nature of the medical care field as well as the jurisprudence around it, and act accordingly.

LIST OF ABBREVIATIONS

ODPP- Office of the Director of Public Prosecutions.

PCC- Professional Conduct Committee.

PIC- Preliminary Inquiry Committee.

LIST OF CASES

AAA v Registered Trustees – (Aga Khan University Hospital, Nairobi) [2015] eKLR

Airedale NHS Trust v Bland [1993] AC 789.

Atsango Chesoni v David Mortons Silverstein [2005] eKLR.

Bolam v Friern Hospital Management Committee (1957) 1 WLR 582 6.

Bolitho v City and Hackney Health Authority [1997] 3 WLR 1151, HL.

Donoghue v Stevenson [1932] AC 362.

General Medical Council v Spackman (1943) AC 627.

George Moga v Nairobi Women's Hospital & 3 others [2015] eKLR.

Goodwill v British Pregnancy Advice Service (1996) 7 Med LR 129

J.O.O. & 2 others v Praxades P Mandu Okutoyi & 2 others [2011] eKLR.

Jimmy Paul Semenye v Aga Khan Health Service, Kenya T/A The Aga Khan Hospital & 2 others [2006] eKLR

M (A minor) v Amulega & Another [2001] KLR 420

Muchoki v AG [2004] KLR 518.

Munene v Republic (1978) KLR 181.

P.M.N v Kenyatta National Hospital & 6 others [2015] eKLR.

Pope John Paul's Hospital & Another vs. Baby Kasozi [1974] EA 221.

Re F (Mental Patient Sterilization) [1990] 2 AC 1.

Renison Mukhwana & another v Medical Practitioners And Dentists Board [2013] eKLR.

Republic V Kenya Medical Practitioners And Dentists Board & 2 Others (2013) eKLR

Ricarda Njoki Wahome (Suing as administrator of the estate of the late Wahome Mutahi (Deceased) v Attorney General & 2 others [2015] eKLR

Sidaway v Board of Governors of the Berhlem Royal Hospital and the Maudsley Hospital [1985] 1 AC 871

West Bromwich Albion FC v El-Safty (2006) 92 BMLR 179.

LEGISLATION

African Charter on Human and Peoples' Rights (1986).

Clinical Officers (Training, Registration and Licensing) Act, No. 20 of 2017.

Code of Professional Conduct and Discipline, (2012).

Counsellors and Psychologists Act, No. 14 of 2014.

Health Act, No. 21 of 2007.

International Covenant on Economic, Social and Cultural Rights (1976).

Medical Laboratory Technicians and Technologists Act, No. 10 of 1999.

Medical Practitioners and Dentists (Disciplinary Proceedings) (Procedure) Rules, (1979).

Mental Health Act, Cap 248, (1991).

Nurses Act, Cap 257 (1983)

Nutritionists and Dieticians Act, No. 18 of 2007.

Pharmacy and Poisons Act, Cap 244 (1957).

Public Health Act, Cap 242, (1921)

Radiation Protection Act, Cap 243, (1984).

The Constitution of Kenya (2010).

The Declaration of Geneva (Physician's Oath) (1948).

The Medical Practitioners and Dentists Act, Cap 253, (2012).

The Office of The Director of Public Prosecutions Act, Act No. 2 of 2013.

Universal Declaration of Human Rights (1948).

CHAPTER 1 INTRODUCTION

1.1 Background

Medicine, like law, is among the pillars upon which the civil society is built upon. As old as disease itself, medicine is sometimes shrouded in secrecy, aloofness and limited to the chosen few. Medics are revered as they are akin to the gatekeepers of Hades, having the powers to intercede between life and death. In light of this position, the Hippocratic Oath and the Declaration of Geneva (Physician's Oath)[1] are used to ensure a humanitarian code of ethics in this line of work. However, medics are still human prone to excesses and deficiencies, and as the shroud is lifted, medicine's soft underbelly is revealed.

There has been a rampant reporting of cases regarding medical malpractice and negligence in Kenya. However, the cases seem to be limited to the media with very few actually having their day in court. Some of the media stories range from wrongful diagnosis to rape of patients while under anaesthesia. Which begs the question, what hinders victims of such grave misconduct by medical professionals from seeking justice through courts? Are the challenges linked to the system of litigating medical negligence itself or do the victims lack knowledge or capacity to do so? Can these challenges, if any, be addressed effectively?

The right to health and access to justice as guaranteed under Articles 43 and 28 of the Constitution[2] are inextricably linked to medical negligence suits. Under Article 2[3], there is also the operation of international law, for instance the International Covenant on Economic, Social and Cultural Rights under Article 12[4] on the right to health. Even with these laws there seems to be a fissure between the law and the actual practice.

This research seeks to analyse the role and effectiveness of Kenya's regulatory and legal framework governing medical care in addressing medical negligence. What is of note is that the current regulatory framework is disjointed with different healthcare professional regulated by different regulators and legal regimes. Furthermore, legal redress through the courts will be investigated, with emphasis on medical negligence. Some aspects of legal redress through criminal law mechanisms will be considered.

[1] A modernized version of the oath of Hippocrates- The Declaration of Geneva (Physician's Oath) (1948).
[2] Article 43, and 28, Constitution of Kenya (2010).
[3] Article 2, Constitution of Kenya (2010).
[4] Article 12, Constitution of Kenya (2010).

1.2 Background to Problem

The right to health is inextricably linked to the right to life, an inalienable right. The Universal Declaration of Human Rights, medical care is included under the right to a standard of living sufficient to health and well-being[5]. The right to health is also recognized in other international instruments such as the International Covenant on Economic, Social and Cultural Rights[6], the African Charter on Human and Peoples' Rights[7] and even a special rapporteur to further article 25 of the UDHR[8]. The Kenyan constitution also recognizes this right, by including the right to healthcare services[9] and The Medical Practitioners and Dentists Act[10] to regulate the conduct of health professionals.

In spite of all these laws protecting the right to life, international[11] and local, there seems to be a lack of correspondence with what is happening as common place in Kenya. There is a lack of proper maternal healthcare due to increase in cost, unavailability and poor quality of services, there is also an increase in sexual violence cases especially with healthcare professionals, such as the MugowaWairimu case[12], with structural barriers and lack of awareness inhibiting access to remedies for victims[13].

Although the Kenya Medical Practitioners and Dentists Council[14] can handle disciplinary procedures and have available remedies[15], these remedies are directed towards the medial practitioner's misconduct and the victim would have to seek the court to offer a remedy for medical negligence[16]. There are some problems a victim may encounter when seeking redress from the court such as costs, proceedings are lengthy, lack of access to medical documents held by hospitals, unwillingness of medical personnel to testify as expert witnesses against their own and a lack of awareness of their rights or redress mechanisms as victims of medical malpractice. In the J.O.O. v Praxades Okutoyi case, the medical board

[5] Article 25, Universal Declaration of Human Rights (1948)
[6] Article 12, International Covenant on Economic, Social and Cultural Rights (1976)
[7] Article 16, African Charter on Human and Peoples' Rights (1986)
[8] Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health (Commission on Human Rights Resolution 2002/31)
[9] Article 43 (1)(a), Constitution of Kenya (2010)
[10] See preamble, The Medical Practitioners and Dentists Act (chapter 253) 1983
[11] By virtue of Article 2(5) and (6), Constitution of Kenya (2010)
[12] Agoya V, ''Doctor' MugowaWairimu charged with rape' Daily Nation (October 2, 2015)
[13] Kenya National Commission on Human Rights: A Report of the Public Inquiry into Violations of Sexual and Reproductive Health Rights in Kenya (April 2012)
[14] Created under section 4 of the Kenya Medical Practitioners and Dentists Act (chapter 253) 1983 (hereafter the 'KMPD Act')
[15] Section 20, KMPD Act.
[16] Omiti H, Fundi E, 'Assessing The Legal Mechanisms For Redressing Medical Malpractice In Kenya: Just How Effective Are They?' (September 15, 2014) available at SSRN :http://ssrn.com/abstract=2496267

sought to strike out the case from court for being scandalous, frivolous and vexatious as it had already been heard before the board as part of an inquiry into the nasal-fracture-turned-brain-damage case. A distinction was made between an inquiry before the board and a civil proceeding concerning medical negligence before court, and the suit was allowed to continue[17].

With these instances of medical negligence, the numbers reported do not coincide with those that make it to court. The challenges faced by victims who are the ones who bear the brunt of medical negligence are to be addressed in this research.

1.3 Statement of the problem

The law under the constitution and statute envisages access to justice for all that is affordable, proportionate and expeditious for victims of medical negligence.

However, access to justice for victims of medical malpractice is largely limited by, among other reasons, lack of knowledge of their rights, ineffective procedures and lack of access to medical files.

Hence there is need for victims of medical negligence to have knowledge on the processes and documents needed, among others, to facilitate the realization of access to justice envisioned in the constitution.

1.4 Conceptual Framework

The lens through which this research addresses the efficiency of handling medical malpractice or negligence, is through the legal and regulatory frameworks governing this area of law.

The rights to health and access to justice are essential as they are the focal point of medical negligence. The negligence in the context of a patient and his physician is peculiar as it would infringe on the patient's right to health and the subsequent challenges faced by victim in litigation impinges on the right of access to justice. Health is necessary to enjoy the right to life hence the interdependency and interrelatedness of rights. This would be done through the capability approach proposed by Amartya Sen and Martha Nussbaum which entails the principles of achievement of well-being is of primary importance and to do so should be

[17] J.O.O. & 2 others v Praxades P ManduOkutoyi& 2 others [2011] eKLR

understood in terms of human capability[18]. The context within which Kenya operates is paramount in realizing the right to health and access to justice. The recommendations offered should be tailored to the victims of medical negligence.

1.5 Limitations

Research done regarding medical malpractice or even medical systems is scarce especially in the context of developing countries. Most texts focus on a select few countries when doing comparative analysis leaving most developing countries such as American law reviews focusing on Canada, the United Kingdom, France, Germany, Japan, and Australia with some mention of China, Haiti, India, Peru and Venezuela[19]. This has been noted by Nathan Cortez but even in his "*A Medical Malpractice Model for Developing Countries?*" he still fails to cover countries like Kenya, mainly focusing on India and Mexico noting the difficulty of carrying out research in developing countries. In Kenya, research on medical malpractice is also limited usually to analysis of the medical tribunal and reproductive health of women[20]. There is a knowledge gap in Kenya's medical law, thus accessing the necessary information for this research will be hampered.

There is a time constraint since this research has to be completed in a short amount of time.

Given the nature of medical negligence cases, the information sought is sensitive and usually privileged (doctor-patient confidentiality). Hence, there may be uneasiness parties may face in releasing such information.

1.6 Objectives of Research

This research seeks to address these questions:

a) What is the regulatory framework governing the different medical care professionals in Kenya? How effective is the regulatory framework in addressing cases of medical negligence?

[18] Crocker, D. A., "Functioning and capability: the foundations of Sen's and Nussbaum's development ethic", in Nussbaum, Martha; Glover, Jonathan, Women, culture, and development: a study of human capabilities, Oxford New York: Clarendon Press Oxford University Press (1995), pp. 153–199.
[19]Medical Malpractice: U.S. and International Perspectives, 33 J.L. Med. &Ethics (2005), p. 411.
[20] Opondo, E., 'Sexual and Reproductive Health Rights: Legislative Perspective' and Kiama, W., 'Constitutional Provisions, Practice & Procedures before the Tribunal' , presented at a Law Society of Kenya Continuing Professional Development seminar under the theme Health Laws: emerging Practice Areas & Opportunities.

b) What is the standard and burden of proof, as well as remedies available, in a case of medical negligence? How effective is the legal/judicial system in addressing medical negligence?
c) Are there alternative regimes in addressing medical negligence in Kenya? How effective is it?

Consequently, these questions will be addresses by pursuing the following objectives:

d) To examine the nature of the regulatory framework governing the different medical care professionals in Kenya and evaluate its effectiveness in addressing medical negligence.
e) To analyse the standard and burden of proof, as well as remedies available, in a case of medical negligence and determine whether the legal/judicial system is effective in addressing medical negligence.
f) To establish whether there are alternative regimes and, if any, determine their effectiveness in addressing medical negligence in Kenya.

1.7 Hypothesis

This research will be working under some assumptions, namely:

1. Medical professionals include doctors, pharmacists, nurses, clinical officers and laboratory technicians.
2. There is a lack of harmony in the regulatory and legal frameworks.
3. The inefficiency of the regulatory and legal frameworks are not only systemic and procedural, but also there is an inability or lack of willingness by the parties to ensure the system works.

Subsequently, this paper puts forth that the legal and regulatory frameworks are disjointed with multiple, and often times overlapping jurisdictions, governing different medical professions both at county and national levels.

1.8 Methodology

This research will utilize both qualitative and limited quantitative approaches.

Desktop research will be used as a qualitative method of research. The information gathered will be used in the outlining and analysis of regulatory and legal frameworks in addressing medical negligence.

Various research institutes shall be visited as part of conducting limited quantitative research. Information will be acquired on surveys, reports, and working papers done in both the medical and legal fields with regard to medical negligence cases and complaints.

1.9 Chapter breakdown

Chapter 2 will outline and evaluate the regulatory framework within which medical professionals operate under, at both county and national levels.

Chapter 3 will outline and evaluate the regulatory framework within which medical professionals operate under the Kenya Medical Practitioners and Dentists Council.

Chapter 4 will then outline and evaluate the legal framework within which medical negligence is litigated through the court system in Kenya.

Chapter 5 will provide a summary of the research findings and propose recommendations.

CHAPTER 2: REGULATORY FRAMEWORK OF MEDICAL CARE PRACTICE IN KENYA

2.1 Introduction

Medical care practice is one of the most heavily regulated industries in Kenya and other parts of the world. Governments enact regulation for protection of consumers, promotion of allocative and productive efficiency, reduction of informational asymmetry between the regulator and the regulated, for avoidance of regulatory capture and advancement of credible commitment, among other things. The medical sector has prescribed codes and regulations that the industry must conform to, establishing minimum standards for operation. The success of these legal systems is dependent upon an informed society and existence of a well-functioning judicial system that ensures punishment for violation of the rules.[21]

The current regulatory regime is vast, with different healthcare professionals regulated by different regulators and under different legal regimes. This means that the regulations for a pharmacist, a nurse, a clinical officer and a laboratory technologist are all regulated under different regimes from each other. The various regulators overseeing different professionals makes the sector seem disjointed, ineffective, behind the modern practices of a key super regulator of the profession and creates difficulty for a consumer of medical care to seek redress in case of misconduct. When a patient at the Kiambu County Referral Hospital develops complications from medical malpractice, having being attended to by a doctor, a nurse, a clinical officer, lab technologist and pharmacist, where are they to ventilate their complaint? Would it be the Nursing Council of Kenya, the Pharmacists and Poisons Board, the Kenya Medical Laboratory Technicians and Technologists Board, the Kenya Medical Practitioners and Dentists Council, the County Government of Kiambu, the Ministry of Health or a court of law?[22] The process would be arduous for an ordinary citizen to determine the proper forum to gain justice.

This chapter will cover the mainstream regulators, what could be termed as administrative regulators including the county governments. The Kenya Medical Practitioners and Dentists Council will be covered in the next chapter for it has a more elaborate redress mechanism and is the main focus of this research.

[21] Muthaka D, Kimani D, Mwaura S, 'A Review of the Regulatory Framework for Private Healthcare Services in Kenya', KIPPRA, Discussion Paper No. 35 (2004), p. 32-33.
[22] Githu, J.M., 'Whose Patient is She? Appraising the Law on Medical Malpractice in Kenya', The Law Society of Kenya Journal, Volume 12 No. 2 (2016), p. 153.

2.2 The Ministry of Health

Under Article 43, every individual is guaranteed the right to the highest attainable standard of health, including the right to health care services, reproductive health care and emergency medical treatment.[23] The national government discharges these duties through the Ministry of Health, with national health policy, national referral health facilities and consumer protection, falling under its responsibility.[24]

Historically, health services have been provided by the Ministry of Health and therefore there has been a time lag since the coming in to force of the Constitution to the time of this research on the devolution of the health services to the county governments as a requisite under Schedule 5 of the Constitution.[25] The national government regulates various facets of medical care such as formulating policy on training, licensing, disciplinary and qualifications of health professionals, as well as medical supplies, research and development, among others. This is done through tools such as semi-autonomous regulators, policy and legislation through the Ministry of Health.

The Ministry of Health's functions include designing and effectuating of the health policy at a national level, production and enactment of national health development plans, organisation and administration of central health services, reviewing health related statutes and regulations in consultation with the relevant stakeholders, training of health and allied personnel, advocacy of medical science and preservation of standards in the medical and health fields, liaise and co-ordinate with other departments within the government and non-governmental agencies, as well as ensure internal health regulations.[26]

However, the Ministry of Health does not have a direct input on matters of medical negligence, but does have an unseen hand in regulation of the medical care industry in the country. The Director and Deputy Director of Medical Services, are key officers in the Ministry of health with powers under some regulators, like the Medical Practitioners and Dentists Council and its committees. A complaint may not be lodged directly to the Ministry

[23] Article 43 (1) and (2), Constitution of Kenya (2010).
[24] Fourth Schedule, Constitution of Kenya (2010).
[25] Obala, R., 'Show commitment to devolution, Governors tell President Uhuru Kenyatta' Standard Newspaper, 11 February 2016: https://www.standardmedia.co.ke/article/2000191272/show-commitment-to-devolution-governors-tell-president-uhuru accessed on 3 October 2016.
[26] Githu, J.M., 'Whose Patient is She? Appraising the Law on Medical Malpractice in Kenya', The Law Society of Kenya Journal, Volume 12 No. 2 (2016), p. 154.

of Health, but any complaint brought before the relevant regulators is dealt with in accordance with rules prescribed by the Ministry of Health, other than before a court of law.

2.3 The Central Board of Health

The Central Board of Health (hereinafter 'the Board') is created under Section 3 of the Public Health Act.[27] It consists of the Director-General for health who shall serve as chairman, a sanitary engineer, a secretary, and up to six people appointed by the Cabinet Secretary for Health, of whom three shall be medical practitioners.

The Board's functions include to counsel the Cabinet Secretary for Health on all aspects affecting public health; to avert and avoid the introduction of infectious disease in the country; to advocate for the public health and prevent, limit or suppress infectious, communicable or preventable diseases; to guide and direct local authorities on matters affecting the public health; to research and investigate matters in connection with the avoidance and management of diseases affecting people; to prepare and publish reports in relation to public health; and generally to perform any other functions in relation to public health in consensus with the directions, powers and duties conferred under the Public Health Act.[28]

The Board is yet to be constituted, a paper body only existing in statute. Its main function is to counsel the Cabinet Secretary for Health on all aspects concerning public health. It is meant to be an important check and balance to the Ministry of Health and the Director of Medical Services by having a statutory body with a professional membership. The Cabinet Secretary, on the advice of the Board, may, as he may see fit, direct inquiries into any matters, in any place in relation to public health.[29] Should the Cabinet Secretary disregard the advice of the Board on a public health issue and a person(s) suffers injury as a result of that disregard, questions touching on liability would arise.

The Board does not have a clear role in regulating medical malpractice. However, given that the Board doesn't exist, who advises the Cabinet Secretary on public health matters?[30]

[27] Chapter 242 of the Laws of Kenya.
[28] Section 8 and 10 (2), Public Health Act.
[29] Section 11, Public Health Act.
[30] Muthaka D, Kimani D, Mwaura S, 'A Review of the Regulatory Framework for Private Healthcare Services in Kenya', Kenya Institute for Public Policy Research and Analysis, Discussion Paper No. 35 (2004), p. 28.

2.4 The County Government

With the advent of the new Constitution of Kenya (2010), came devolution and the creation of the 47 county governments charged with various responsibilities. The county government is responsible for health services such as health facilities within the county and pharmacies; ambulance services; advocating for primary health care; control and licensing of establishments that sell food to the public; veterinary services (excluding regulation of the actual profession); cemeteries, funeral parlours and crematoria; and refuse removal, dumps and the disposal of solid waste.[31] The extent of these powers are yet to be clearly defined, given the relative newness of devolution in Kenya.

The county government has a regulatory role in the administrative and even technical capacity as it employs and manages nurses, doctors, clinical officers, among other healthcare providers. Therefore, the county government can be one of the respondents in a case of medical malpractice in a county health facility, and can be held liable, vicariously or otherwise. This raises the question of whether the county government can be held liable for suffering caused due to a strike by healthcare professionals, which is a right guaranteed under the Constitution.[32] These issues may be addressed with the passage of time.

2.5 The Nursing Council of Kenya

The Nursing Council is established as a corporate body by Section 3 of the Nurses Act[33] with the following as its members: Director of Medical Services; Director of Education; Chief Nursing Officer; Attorney-General; chief executive officer of the Kenya Medical Training College; and as appointed by the Minister:

a) an elected midwife by registered midwives;
b) an elected community health nurse by registered community health nurses;
c) an elected psychiatric health nurse by registered psychiatric health nurses;
d) an elected general nurse by registered general nurses;
e) a nominated nurse by the National Nurses Association of Kenya;
f) a nominated nurse by the Kenya Progressive Nurses Association;

[31] Fourth Schedule, Constitution of Kenya (2010).
[32] Article 41, Constitution of Kenya (2010).
[33] Chapter 257 of the Laws of Kenya.

g) a nominated nurse educator, who is involved actively in the training of nurses, by recognized universities within Kenya;
h) two nurses via nomination by registered religious organizations providing health services in the country; and
i) a professional in human resource management.[34]

The functions of the Nursing Council include establishment and improvement of standards the nursing profession in all their dimensions and health care within the community while safeguarding the interests of all nurses; to set the standard for the training and instruction (prescribing and regulating syllabuses and courses of training) for persons who seek to become registered nurses; to recommend institutions of training for approval to the Minister; to have concern with the comportment of registered, enrolled or licensed persons, and take such disciplinary action as may be needed to uphold an acceptable benchmark of conduct; have concern with the standard of nursing care, qualified staff, nursing supplies, facilities, condition and environment of health institutions; to take such disciplinary action or relevant measures as may be needed to preserve a suitable standard of nursing care in health institutions; and to advise the Minister on all aspects of nursing.[35]

A nurse may be found culpable of professional misconduct if he/she lobbies clients for professional work or advertises professional accomplishments or services, contravening the Council's published guidelines; divulges information to any other person besides the client acquired in the course of professional engagement, without the client's consent or otherwise permitted by law; failure to observe and apply professional, technical, ethical or other standards stipulated by the Council; is guilty of gross negligence while conducting his/her duties in a professional capacity; articulates an opinion based on insufficient information on any affair with which he/she is affiliated in a professional capacity; fails to keep the client's funds in a separate banking account or uses the funds for a purpose not intended by the client; knowingly includes anything false in a statement, return or form to be given to the Council; or any other act which may be prescribed.[36]

The Council may on its own or through a committee, inquire into an allegation of misconduct[37] and may resolve that: no additional action be taken against that nurse; the nurse

[34] Section 4, Nurses Act.
[35] Section 9 (1), Nurses Act.
[36] Section 18A, Nurses Act.
[37] Section 18B (1), Nurses Act.

be reprimanded; the nurse pays to the Council such fine as may be deemed appropriate; the nurse undergoes training at his/her own cost, of such nature and duration and at such establishment as the Council may determine; the nurse carries out his/her professional duties under any contractual arrangement subject of the purported wrongdoing; suspension of any practising certificate held by the nurse for such a period as may be appropriate; or the nurse be de-registered from the register.[38]

The Council has a membership representative of the nursing industry and powers to reprimand a registered nurse for professional misconduct. They can institute an inquiry by themselves or through a complaint from the public. The decision of the Council can be appealed to High Court of Kenya.[39]

2.6 The Clinical Officers Council of Kenya

The Clinical Officers Council is created under Section 3 of the Clinical Officers (Training, Registration and Licensing) Act[40] with a membership that includes a chairperson chosen by the President, the Director General for health; the Chief Clinical Officer; an elected clinical officer by members of faculty of Clinical Medicine from Kenya Medical Training College; one clinical officer as representative of the Kenya Clinical Officers Association, put forward by the Association and selected by the Cabinet Secretary; one clinical officer representing universities training clinical officers, elected by the teaching staff among them; the Registrar who will be an ex-officio member and the Council's secretary; two clinical officers, one in public practice and the other in private practice, from either gender, as proposed by the Cabinet Secretary; an expert knowledgeable in finance or audit as designated by the Cabinet Secretary; and one public representative suggested by consumer associations and chosen by the Cabinet Secretary.[41]

The Council's functions include to direct the government on policy issues in relation to the practice of clinical medicine; set the minimum standard for educational entry requirements for persons looking to be trained as clinical officers; register and license clinical officers and maintain a register and record of all clinical officers registered under this Act; endorse advancement and acceptance of standard codes of practice; standardise the professional comportment of its members and ensure the preservation and improvement of the standards

[38] Section 18B (3), Nurses Act.
[39] Section 18B (5), Nurses Act.
[40] Act No. 20 of 2017, (hereafter the 'Clinical Officers Act').
[41] Section 4 (1), Clinical Officers Act.

of practice of clinical medicine; work in partnership with other professional associations, organisations and other relevant bodies in the medical field, to further execute the Council's functions and of those bodies; and execute other tasks in relation to the putting into practice of this Act.[42]

Disciplinary measures for clinical officers are undertaken by the Disciplinary Committee[43] whose members include the chairman of the Kenya Clinical Officers Association (who shall be chairman of the Committee); the Principal Secretary in the ministry for health or a designated representative; two clinical officers not being members of the Council, competitively and transparently selected by the Cabinet Secretary (one shall be in the public service and the other from the private practice); the Attorney-General or a designated representative; and the Registrar, an ex-officio member and the Committee's secretary.[44]

The Disciplinary Committee has power to take in and investigate complaints by the public against clinical officers; to go into and examine any grounds run by a clinical officer under scrutiny; seize and remove any item from any properties in relation to the issue under inquiry; and appeal to the Attorney-General and or the Director of Public Prosecutions to provide counsel on any recommendation made via an inquiry by the committee.[45] The Disciplinary Committee may request and receive assistance from the police, any other governmental body or person(s) as it may deem essential in its own opinion in enforcing its powers.[46]

During an inquiry, the Disciplinary Committee shall regulate its own procedures,[47] may administer oaths, and compel attendance of people as witnesses and the presentation of books and documents.[48] It may withdraw or suspend the registration and practicing license of a clinical officer, or levy a fine as may be prescribed by the Council if that officer has been convicted of an offence indictable by imprisonment, which in the Council's estimation has besmirched the reputation of the profession in the public eye; has been found guilty of negligence or malpractice in carrying out his/her professional duties; or is guilty of

[42] Section 5 (2), Clinical Officers Act.
[43] Section 24 (1), Clinical Officers Act.
[44] Section 24 (2), Clinical Officers Act.
[45] Section 24 (3), Clinical Officers Act.
[46] Section 24 (4), Clinical Officers Act.
[47] Section 24 (5), Clinical Officers Act.
[48] Section 25 (3), Clinical Officers Act.

impropriety or misconduct, with regard to his/her profession or not.[49] The decision of the Disciplinary Committee may be appealed to the High Court of Kenya within sixty days.[50]

2.7 The Pharmacy and Poisons Board

Section 3 of the Pharmacy and Poisons Act[51] establishes the Pharmacy and Poisons Board with the following members: a chairperson appointed by the President; the Director of pharmaceutical services; the Principal Secretary in the ministry or his or her representative; two persons representing the pharmacy training institutions, of which one shall be a pharmacist and one shall be a pharmaceutical technologist; the Chief Executive Officer (ex officio member); one medical practitioner put forward by the Kenya Medical Association and chosen by the Cabinet Secretary and three persons selected by the Cabinet Secretary as follows:

a) one pharmacist acting for institutions of higher learning;
b) one pharmaceutical technologist representing mid-level colleges; and
c) one enrolled pharmaceutical technologist with expertise in community pharmacy nominated by the Kenya Pharmaceutical Association.[52]

The powers and functions of the Board regulates health products, technologies and the profession of pharmacy.[53] Any person who has at any time been found guilty, whether in Kenya or abroad, of any criminal offence or of any wrongdoing which in the Board's opinion renders the convicted or guilty person unsuitable to have his/her name on the register, the Board may, after an investigation into the issue, refuse to register, delete or remove their name from the register.[54] Professional misconduct is investigated via the Enquiries and Disciplinary Committee established by the Board.[55]

Where on the recommendations of the Enquiries and Disciplinary Committee the Board is satisfied that a pharmacist or pharmaceutical technologist is in contravention of any of the terms or conditions of practice endorsed by the Board, the Board may issue the pharmacist or pharmaceutical technologist with an admonishment letter; enforce a fine as may be prescribed in regulations; suspend the registration or enrolment of the pharmacist or

[49] Section 25 (1), Clinical Officers Act.
[50] Section 25 (6), Clinical Officers Act.
[51] Chapter 244 of the Laws of Kenya, (hereafter the 'Pharmacy Act').
[52] Section 3 (1), Pharmacy Act.
[53] Section 3A and 3B, Pharmacy Act.
[54] Section 12, Pharmacy Act.
[55] Section 13A (1), Pharmacy Act.

pharmaceutical technologist for a definite period not exceeding five years; or remove the pharmacist's name or pharmaceutical technologist from the Register as may be appropriate.

The Board may order a pharmaceutical technologist or pharmacist to reimburse costs and expenses incurred in the course of a disciplinary hearing. The costs shall be a civil debt which the Board can recover summarily. [56]

2.8 Other Regulators

The medical industry has other regulators with quasi-regulatory roles including the Kenya Medical, Laboratory, Technician and Technologists Board, [57] the Radiation Protection Board,[58] the Nutritionists and Dietician Institute,[59] the Kenya Board of Mental Health[60], the Counsellors and Psychologists Board, [61] and the Kenya Professions Health Oversight Authority, [62] among others, established under various laws, with different redress mechanisms for the various professionals.

2.9 Conclusion

It is clear that almost every aspect of the medical profession is regulated by their own set of regulations including nurses, clinical officers, and radiologists, among others. There are too many to be covered fully under this chapter. Though each regime may work effectively for that specific profession, it becomes a hurdle for a victim of medical malpractice who has suffered injury from receiving medical care from multiple professionals. Which is why there is need to establish a key super regulator that handles complaints regarding everyone under the medical profession umbrella.

[56] Section 12A (2) and (3), Pharmacy Act.
[57] Established under the Medical Laboratory Technicians and Technologists Act, No. 10 of 1999.
[58] Established under the Radiation Protection Act, Cap 243 of the Laws of Kenya.
[59] Established under the Nutritionists and Dieticians Act, No. 18 of 2007.
[60] Established under the Mental Health Act, Cap 248 of the Laws of Kenya.
[61] Established under the Counsellors and Psychologists Act, No. 14 of 2014.
[62] Established under the Health Act, No. 21 of 2007.

CHAPTER 3: REGULATORY FRAMEWORK OF MEDICAL CARE PRACTICE IN KENYA- THE KENYA MEDICAL PRACTITIONERS AND DENTISTS COUNCIL

3.1 Introduction

The Kenya Medical Practitioners and Dentists Act[63] (hereinafter 'the Act') establishes the Kenya Medical Practitioners and Dentists Council [64] (hereinafter 'the Council'). The Council[65] is the most prominent of all regulators as it regulates professionals at the apex of the medical field i.e. fully fledged doctors and dentists, including interns and medical institutions. [66] In the event of professional wrongdoing or malpractice, the Council is authorized to discipline the medical practitioners, including imposing fines and cancelling licenses. However, the disciplinary regime is wanting as analysis will show.

This chapter will evaluate the powers and rules governing the Council, as well as address criticisms and effectiveness of its mandate.

3.2 Medical Practitioners and Dentists Council

3.2.1 Composition and Functions of the Council

The Council is created as a body corporate[67] headed by a Chairperson appointed by the President.[68] The Chairperson shall be a medical or dental practitioner of good reputation with at least ten years' experience. The other members include:

1. The Director General for Health or his/her selected representative;
2. Four persons appointed by the Cabinet Secretary, nominated from two nominees presented by each organisation as follows:
    a. A representative of universities in Kenya which have the power to award a qualification, registerable under the Act;
    b. A Kenya Medical Association representative;
    c. A Kenya Dental Association representative;
    d. An oral health practitioners' representative;
3. Three persons as appointed by the Cabinet Secretary, nominated from two nominees presented by each organisation as follows:

[63] Chapter 253 of the Laws of Kenya, hereafter the KMPD Act.
[64] Section 3, KMPD Act.
[65] Previously the Board, now the council after amendments through Act No. 5 of 2019.
[66] Section 2, KMPD Act.
[67] Section 3, KMPD Act.
[68] Section 3A, KMPD Act.

a. A nominee of the Kenya National Commission on Human Rights;
b. A private health sector representative; and
c. An expert in finance or audit; and

4. The Chief Executive Officer (CEO) who is the Registrar, the Council's secretary, and an *ex officio* member.[69]

The members of the Council, apart from the CEO, shall serve for a maximum of 2 three-year terms, choose to resign by tendering a three-month notice or is otherwise removed from office due to absence from three consecutive Council meetings without the chairperson's permission; is found guilty of an offence that involves dishonesty or fraud; is found guilty of a criminal offence and condemned to imprisonment for a term beyond six months; is otherwise incapacitated by a protracted physical or mental ailment; or is deemed otherwise unfit to execute his/her duties as a member of the Council.[70]

The Council is to meet at minimum once every three months, with 6 members constituting quorum at any meeting and the Council's powers will not be affected by any membership vacancy.[71]

The Council's functions include to establish uniform norms and standards on the learning of medicine in Kenya; approve and register medical schools for training of practitioners; maintain a register of medical students, licensed practitioners, interns and health institutions; license and accredit medical institutions; regulate the conduct of registered medical practitioners and take such disciplinary action in the event of any professional misconduct; and do all such other things necessary for the attainment of all or any part of its functions.[72]

3.2.2 Professional Misconduct Raising Disciplinary Proceedings

A Guide to Professional Conduct and Ethics for Registered Medical Practitioners[73] suggests that as a medical practitioner, one has a responsibility to inter alia, maintain clinical competence, demonstrate uprightness, compassion and concern for others in their daily practice, cultivate and uphold a sensitive and understanding approach with patients, exercise good judgment and present sound clinical advice to patients, quest for the best evidence to guide their professional practice and be devoted to continued advancement and excellence

[69] Section 3A (1) and (10), KMPD Act.
[70] Section 3A (2) and (4), KMPD Act.
[71] Section 3A (5), (6) and (7), KMPD Act.
[72] Section 4, KMPD Act.
[73]Guide to Professional Conduct and Ethics for Registered Medical Practitioners, Comhairie Na NdochtuiriLeighis Medical Council, 7th Edition 2009.

in the delivery of health care, whether they work individually or as part of a team. It goes further to suggest that medical practitioners: '…must always be guided by their primary responsibility to act in the best interests of their patients, without being influenced by any personal consideration'.[74]

The Act, as read in conjunction with the Medical Practitioners and Dentists (Disciplinary Proceedings) (Procedure) Rules[75] (hereinafter 'the Rules'), refers to conduct warranting disciplinary proceedings. They include a case relating to conviction, where it is alleged that a medical practitioner has been found guilty of an offence either under the Act or under the Penal Code;[76] [77]and infamous or disgraceful conduct in a professional respect, meaning 'serious misconduct judged according to the rules, written or unwritten, which govern the medical and dental professions'.[78] It is up to the Council, through its committees, to determine what constitutes serious professional misconduct, including:

1. Termination of pregnancy unless as specified under Law[79];
2. Gender re-assignment on demand;
3. In-vitro Fertilisation (IVF) and assisted reproduction by a non-accredited centre;
4. Sex selection;
5. Abuse of professional confidence, though there are exceptions to this rule;
6. Abuse of relations between practitioner and patient by virtue of their position;
7. Abuse of financial opportunities;
8. Advertising, canvassing and related offences;
9. Conduct negatively affecting the standing of the profession; and
10. Medical errors including failure to diagnose, patient abandonment, lack of informed consent, psychiatric malpractice, among others.[80]

[74]Guide to Professional Conduct And Ethics For Registered Medical Practitioners, Comhairie Na Ndochtuiri Leighis Medical Council, 7th Edition 2009. P. 4.
[75] Medical Practitioners and Dentists (Disciplinary Proceedings) (Procedure) Rules, 1979 (hereafter 'the Rules').
[76] Rule 2, the Rules and Section 19A, KMPD Act.
[77] The Penal Code, Chapter 63 of the Laws of Kenya.
[78] Rule 2, the Rules.
[79] Section 228, Penal Code.
[80] The National Patient's Rights Charter, 2013 1st Edition, p. 4-5: https://kmpdc.go.ke/resources/PATIENTS_CHARTER_2013.pdf

3.2.3 Process of Lodging a Complaint before the Council

Any person may lodge a complaint directly to the Council if dissatisfied with professional services received from a medical practitioner. The Council, or through a committee, may inquire into the complaint of professional misconduct, malpractice or any breach of standards.[81] The Council can regulate its own proceedings and may administer oaths, compel the attendance of people as witnesses and presentation of books and documents.[82] The Council is governed by the Rules as read with the Act. The practitioner whose conduct is under inquiry has the right to be heard, either in person or through a representative and any party may possibly appeal the Council's judgement to the High Court within 30 days of the decision.[83]

According to the Rules, the Chairman of the Council shall submit a complaint once received to the Preliminary Inquiry Committee and Professional Conduct Committee.[84]

3.2.3.1 The Preliminary Inquiry Committee

Rule 3 of the Rules establishes the Preliminary Inquiry Committee (hereinafter 'the PIC') and sets out its powers and functions under Rule 4.

The PIC is composed of seven members elected from the Council and chaired by the Director or the Deputy Director of Medical Services, in his absence.[85] It may also bring on board any person into the Committee whose knowledge and skills are essential for the proper resolution of an issue, though they have no right to vote at the meetings.[86]

Under Rule 4 (1), the PIC's functions include: conducting inquiries into complaints and make recommendations as they deem appropriate; confirm that the administrative and evidential measures needed are satisfied; advocate for mediation and arbitration between the concerned parties (as they may decide); and of its own accord, record and implement mediation agreements or compromise between the parties on the agreed-upon terms and subsequently notify the chairperson.

[81] Section 20 (1) and (2), KMPD Act.
[82] Section 20 (4) and (5), KMPD Act.
[83] Section 20 (3) and (9), KMPD Act.
[84] Rule 5 (1), the Rules.
[85] Rule 3 (1) and (2), the Rules.
[86] Rule 3 (4) and (5), the Rules.

After considering the complaint, the PIC can either discard the complaint, and apprise the Chairman, or refer it, together with its findings and recommendations, to the Professional Conduct Committee.[87]

In consultation with the Council, the PIC has the authority to demand reasonable costs of the hearings from parties; compel the medical practitioner to receive continuous professional development; suspend the licence of a medical institution; order the closure of an institution; and make such further recommendations.[88]

3.2.3.2 The Professional Conduct Committee

The Professional Conduct Committee (hereinafter 'the PCC') is established upon the recommendation of the PIC (ad hoc basis), comprising of a chairperson; two registered professionals in the same medical field as the defendant; a Council member; a general public representative; the Council's advocate (the legal advisor); and the Council's Chief Executive Officer.[89]

The functions of the PCC include to conduct inquiries into county complaints through sittings as specified by the Council and make appropriate recommendations; confirm that the administrative and evidential measures required are satisfied in order to ensure an effective inquiry; promote arbitration between the parties (as the parties may agree).[90]

The PCC, subject to previous or subsequent approval by the Council, has the powers to impose reasonable costs of the proceedings from the parties; direct a practitioner to undertake continuous professional development; suspend an institution's license(s); order closure of institutions until the requirements of the operating licence are complied with; admonish a practitioner and settle a case; and make any other recommendations. The PCC may, as it deems necessary, summon or correspond with persons to whom a complaint relates and may inspect all instruments relating to the complaint.[91]

[87] Rule 4 (2), the Rules.
[88] Rule 4 (3), the Rules.
[89] Rule 4A (1), the Rules.
[90] Rule 4A (2), the Rules.
[91] Rule 4A (3) and (4), the Rules.

3.2.3.3 The Full Council as a Tribunal

The PIC and PCC may refer matters to the Council, who may then hear the matters as a tribunal. The tribunal exercises quasi-judicial functions in determination of disciplinary matters before it.[92]

The Council, after determining that a practitioner is guilty, may:

1. Reprimand, or issue a caution, in writing;
2. Direct remedial training for the practitioner;
3. Direct probation, nor more than six months, for the practitioner;
4. Withdraw, cancel or suspend the practitioner's license;
5. Permanently remove the practitioner's name from the register, with at least 7 members of the Council present;[93]
6. If Council deems appropriate under the circumstance, impose a fine;[94]
7. Admonish the medical practitioner and conclude the case;
8. Order that medical institutions remain closed until the requirements of operating licenses are complied with; or
9. Order the payment of costs for the tribunal's meeting(s) by the practitioner or institution.[95]

3.2.4 Criticisms

The three-tier process of the PIC, PCC and the Tribunal, have been criticised for being a protracted process, seen as a way of safeguarding the profession from scrutiny. Out of the 886 complaints brought before the Council between 1997 and 2016, only one doctor has been found guilty of misconduct and suspended.[96] This points to a problem with the redress mechanism.

The PIC and PCC have identical powers, with the only difference being that the PCC has the power to summon or correspond with persons to whom a complaint relates to.[97] The two committees can be merged, streamlining the process of concluding a complaint, making it

[92] Rule 6 and 7, the Rules.
[93] Section 20 (10), KMPD Act.
[94] Section 20 (6), KMPD Act.
[95] Rule 6, 7 and 10, the Rules.
[96] Kilonzo E, 'Only one doctor has been found guilty of misconduct in 19 years', Daily Nation, 2016. http://www.nation.co.ke/news/Only-one-doctor-has-been-found-guilty-of-misconduct/1056-309620817s5wv/index.html accessed on 15th January 2017.
[97] Rule 4A (4), the Rules.

more affordable, effective and quicker. The PIC and PCC also have different compositions, with the PIC having its full membership from the Council and the PCC with a more diverse cast. This raises issues of fairness, where the PIC and PCC are required to act in consultation with the Council, from which the majority of their membership is from. Instead, the merged committee proposed, would have a more diverse cast with more members of the public or from other professions, so as to have a more balanced panel. The membership should have more than 7 people, as that is the minimum requirement of striking a practitioner's name from the register and the quorum required for a meeting. More people sitting in the committee would ensure issues of quorum will be deftly handled.

The PIC and PCC are encouraged to promote mediation and arbitration among parties, which is in line with Article 159.[98] However, this should not prevent the committees from reporting cases that are brought before it. There should be a database that records the complaints and the reasons of the judgement reached by the committees. This will enable the committees to be open and allow the public to access information on the cases.

The committees seem to mainly focus on disciplining the medical practitioner, leaving the complainant to seek redress from the courts. In the J.O.O. & 2 others v Praxades P Mandu Okutoyi & 2 others[99] case, the High Court observed that '… the scope and jurisdiction of the Board cannot be assimilated with the Industrial Tribunal or other similar Tribunals which hear and determine the civil claims of the party. The element of penalty attached to the inquiry before the Board and the fact and circumstances of the inquiry heard and determined definitely removed the Board from the ambit of a civil tribunal.' The court noted that 'the standard which the Board adopted was of strict responsibility or the ponderance of probability.'

Every medical practitioner and institution is required to take a professional indemnity cover against professional liability[100] and the Tribunal has powers to order the offending medical practitioner to pay a fine as it deems appropriate. However, there is no guidance as to whether victims are entitled to compensation from the fines or insurance covers and if so, how they are to do so. The Council should consider this when enacting rules that provide for indemnity for clients against loss or damage arising from any claims of liability incurred by a

[98] Article 159, Constitution of Kenya (2010).
[99] J.O.O. & 2 others v Praxades P Mandu Okutoyi & 2 others [2011] eKLR.
[100] Section 15A, KMPD Act.

practitioner or a health institution or the employee of a practitioner or health institution.[101] The Tribunal or the proposed merged committee, should be given the powers to order for the compensation of victims, so as to ease the process of seeking justice. The victims would no longer have to go to the courts to seek damages, after undergoing the redress mechanisms by the Council.

The PIC, PCC and the Tribunal, as governed by the Act as read with the Rules, exercise qausi-judicial powers. The consequences for a medical practitioner whether convicted under the Penal Code or found guilty by the Council or its committees, are the same. Equating a criminal conviction with professional misconduct under the description 'infamous and disgraceful conduct' is questionable in light of the principles of proportionality or legitimate expectations which are some of the grounds for judicial review. Further, it is contentious in light of the powers vested in the Office of the Director of Public Prosecutions (hereinafter 'the ODPP').[102] In the Munene v Republic*[103]* case, the court held that '…the Board has no jurisdiction to consider charges of infamous or disgraceful conduct based on allegations of facts which constituted criminal offence'. It should be considered that the issues raised as criminal offences, do give rise to issues of professional misconduct. The two are inextricably linked and there should be guidelines for the Council on how to handle such matters effectively, without delay and in collaboration with the ODPP for the benefit of the victims and their families.

3.3 Conclusion

The Council, through the Act and the Rules, carries out an important function in regulating doctors and dentists as well as training and medical institutions. Its redress mechanisms, through the PIC, PCC and the Tribunal, could benefit from a streamlining of structure and powers as proposed to promote better practices by practitioners under its mandate, reduce the medical malpractice cases that end up in court and improve public perception of the Council in the process.

[101] Section 23 (e), KMPD Act.
[102] See Article 157 of the Constitution of Kenya (2010) and The Office of The Director of Public Prosecutions Act, Act No. 2 of 2013.
[103] Munene v Republic (1978) KLR 181

CHAPTER 4: LEGAL FRAMEWORK OF MEDICAL CARE PRACTICE IN KENYA

4.1 Introduction

Cases of medical negligence or malpractice usually lead to serious consequences. In one case, an abdominal pack was left in inside a woman after delivering a baby. She however did not have the money requested to correct the mistake, and sadly passed away.[104] In another case, neither the doctor or his practice face any further repercussion, apart from a four-month suspension, after causing the death of a mother and her baby by ordering an unnecessary C-section.[105] It is clear that many medical practitioners culpable of medical malpractice, negligence or professional misconduct either go scot-free or do not receive sufficient punishment.[106]

The standard of care and fiduciary duty anticipated from the medical fraternity has greatly diminished in Kenya over the decades, with numerous patients suffering as a result. It is reported that about 20% of all hospital patients perish or are injured due to medical malpractice in Kenya, and as stated by a research done by medical lawyers and independent pathologists, 3 out of 10 patients get misdiagnosed in hospitals.[107]The Courts have noted that it cannot have escaped the *Council's* attention that the kind of medical services presently received by the Kenyan public has worsened to the lowest possible standards. Going further to note that '…., the *Council* can do more to improve the standard of professional medical service to the people. The Medical *Council* need not wait until a case such as this arises before it can stamp its supervisory authority and mandate on doctors and health institutions. '[108]

[104]Africa health, *Medical Negligence and Malpractice Is Rife In Kenya's Health Facilities, A Public Inquiry Report*, 2012. https://africahealth.wordpress.com/2012/07/02/medical-negligence-and-malpractice-is-rife-inkenyas-health-facilities-a-public-inquiry-reports/

[105]Mukumu I, *Medical Board Plans To Overhaul Malpractice Rules*, Business Daily, 2009. Available at http://www.businessdailyafrica.com/539444-627476-view-printVersion-vg50a/index.html

[106]Kilonzo E, *Only one doctor has been found guilty of misconduct in 19 years*, Daily Nation, 2016. http://www.nation.co.ke/news/Only-one-doctor-has-been-found-guilty-of-misconduct/1056-309620817s5wv/index.html.

[107]Were E, Jamah A, *The shocking truth on 'killer doctors',* Standard Media, 2011. Available at https://www.standardmedia.co.ke/article/2000083356/the-shocking-truth-on-killerdoctors/?pageNo=1

[108]Renison Mukhwana & another v Medical Practitioners And Dentists Board [2013] eKLR.

This chapter analyses the law on medical negligence and its treatment by law courts in Kenya.

4.2 Negligence

When litigating medical malpractice, majority of cases are brought forth under the tort of negligence.[109] For a claim of negligence to prove successful, a claimant must prove three things, namely:

1. A duty of care was due to the claimant by the professional in question.
2. There was a breach of that duty of care by the professional.
3. Damage/injury was suffered by the claimant as a result of the breach of duty of care.[110]

4.2.1 Duty of Care

In the medical care field, the duty of care is rarely in contention. This is because a legal duty of reasonable care automatically emerges once a medical practitioner or institution undertakes care or treatment of a patient. Once a patient is taken in by a medical practitioner, they must exercise skill and reasonable care to treat the patient, while providing a safe and secure environment.[111]

However, this duty of care has its limits. For example, it was not just and equitable to foist a duty of care on a doctor to the football club his patient belonged to, when there was no implied or explicit contact between them. The player was the exclusive concern of the doctor, even though the economic loss to the club was foreseeable and there was a degree of proximity.[112] Neither should doctors have in their contemplation future sexual partners of a patient as they are of an unascertainable class, except maybe a spouse, when giving family planning advice.[113]

It is clear that the duty of care is due to a patient once they come under the care of a medical practitioner, though that duty does not extend unreasonably outside that relationship.

4.2.2 Breach of Duty of Care

[109] Herring, J., 'Medical Law and Ethics', 4th Edition (London: Oxford University Press) 2012, p. 103.
[110] Donoghue v Stevenson [1932] AC 362.
[111] Muchoki v AG [2004] KLR 518.
[112] West Bromwich Albion FC v El-Safty (2006) 92 BMLR 179.
[113] Goodwill v British Pregnancy Advice Service (1996) 7 Med LR 129.

The standard of the duty of care is dependent on the norms and practices acceptable to the particular field of medical practice the practitioner belongs to. A medical practitioner cannot be held liable if he/she acted in a manner deemed acceptable by a 'responsible body' skilled in that particular area of medicine, even if there is opinion to the contrary within the same field. This has come to be known as the 'Bolam test'.[114]

The test, since the late 1950s, has been applied to medical negligence cases. This meant that a medical professional could not be found negligent if one or more medical experts assuage the court as to the existence of a 'responsible body' and that the medical practitioner in question acted reasonably, in accordance with the prevailing practices in the particular field. If this is not satisfied, then the medical practitioner is in breach of the duty of care due to his/her patient.

Matters of the standard of care is left to medical judgement, not the court.[115] This substantially enlarged the role of the doctor as a moral arbiter to cases including involuntary sterilisation[116] and withdrawing life support from a patient.[117] However, though rarely, the court can override evidence by experts in the particular field. In the 'Bolitho' case, it was held that a judge can hold the opinion of a 'responsible body' unreasonable or irresponsible if it is demonstrated as not capable of withstanding logical analysis.[118]

4.2.3 Damage/Injury Suffered due to the Breach of Duty of Care

Once a duty of care is demonstrated and a breach occurs through the action/inaction of the medical practitioner, a claimant must prove that they suffered injury due to the breach. Proving causation is important to the success of a claim of medical negligence. The causation has to be shown on a balance of probabilities, the damage was as a consequence of the negligence of the defendant.[119] In the case of more than one medical practitioner's negligence, an action of contributory negligence may be considered by the claimant.

It should be noted that some acts of negligence can lead to criminal charges being brought against the offending doctor. A medical practitioner is most likely to face a criminal charge of gross negligence manslaughter for causing the death of a patient through negligence,[120]

[114] Bolam v Friern Hospital Management Committee [1957] 1 WLR 583
[115] Sidaway v Board of Governors of the Berhlem Royal Hospital and the Maudsley Hospital [1985] 1 AC 871, p. 881.
[116] See Re F (Mental Patient Sterilization) [1990] 2 AC 1.
[117] See Airedale NHS Trust v Bland [1993] AC 789.
[118] Bolitho v City and Hackney Health Authority [1997] 3 WLR 1151, HL, p. 1160.
[119] Wilsher v Essex [1988] 1 All ER 871.
[120] R v Adomako [1995] 1 AC 171.

or even sentenced to death for causing the death of a patient they were helping procure an abortion.[121] This raises the question of whether civil claims may be brought forward by a claimant to recover damages for their loss.

4.3 Jurisprudence

The jurisprudence on medical negligence in Kenya is not well developed but is constantly evolving. Below are some of the cases emerging from the Kenyan courts.

In the case of Ricarda Njoki Wahome (Suing as administrator of the estate of the late Wahome Mutahi (Deceased) v Attorney General & 2 others,[122] the matter related to the death of the famous Daily Nation 'Whispers' column, Wahome Mutahi. The deceased sought the removal of a growth at the base of his neck through surgery. He later died of complications arising after the surgery and his wife sued the doctors and hospital involved for wrongful death, loss of expectation of life, loss of dependency and damages for pain and suffering. In its analysis, the court found that the plaintiff had not proven negligence on the part of the doctors involved or that the operation was unlawful as alleged through the application of the Bolam test. It was held that the treatment the deceased received was in line with the practice of a respected body of professionals.

In the case of Jimmy Paul Semenye v Aga Khan Health Service, Kenya T/A The Aga Khan Hospital & 2 Others,[123] the hospital, doctor, and later the mother to the minor were sued for negligent actions that led to the birth of the minor with Erbs palsy, through the father. The mother had failed to disclose two previous miscarriages which would have changed the doctor's recommendation to a caesarean operation from a normal birth. The court held that the doctor was negligent and the hospital was vicariously liable, through the acts of its servants and/or agents. It was held that the mother had provided information on her miscarriages. The judge relied on the case of Blyth v Birmingham Waterworks Company[124] to find the defendants guilty of negligence and awarded costs and damages to the plaintiff.

[121] Republic v Jackson Namunya Tali, Case No. 75 of 2009, [2014] eKLR
[122] Ricarda Njoki Wahome (Suing as administrator of the estate of the late Wahome Mutahi (Deceased) v Attorney General & 2 others [2015] eKLR
[123] Jimmy Paul Semenye v Aga Khan Health Service, Kenya T/A The Aga Khan Hospital & 2 others [2006] eKLR
[124] Here, negligence is defined as 'The omission to do something which a reasonable man, guided upon those considerations which regulate the conduct of human affairs would do, or doing something which a provident and reasonable man would not do. In strict legal analysis, negligence means more than needless or careless conduct, whether in omission or commission, it properly connotes the complex concept of duty, breach and damage thereby suffered by the person to whom the duty was owing.' [1856] 11 exch.781.784.

In Atsango Chesoni v David Mortons Silverstein,[125] an appeal was lodged by the daughter of the deceased to set aside the ruling by the Kenya Medical Practitioners and Dentists Board (as it was then known) that there was no negligent conduct on the part of the defendant. In this case, the court was impressed by the care of and meticulous records kept when handling the deceased from the time of admission until his death. The court held that there was no negligence proved by either the doctor or hospital and dismissed the appeal.

In AAA v Registered Trustees – (Aga Khan University Hospital, Nairobi),[126] the plaintiff became pregnant after seeking family planning services from the defendant in the form of an implant. It later came to be known that no implant was actually put into the plaintiff though she was led to believe it was. The plaintiff sued and won damages as well as costs of raising the unexpected child due to the negligent act of the defendant. The joy of raising a child was considered cancelled out by the economic cost of bringing up a healthy child.

4.4 Conclusion

The law on negligence is unique to the medical profession, with the use of special rules such as the Bolam test. Kenyan courts also seem keen to follow the rules set out in the Bolam case and other English case decisions to determine medical negligence. It is of concern, that the Kenyan courts are yet to appreciate the limitations and criticisms levied against the Bolam test[127] or any of the new jurisprudence on the use of the test.[128]

However, it is through the courts that victims are able to claim for compensation, among other reliefs, for the damage caused by negligent acts of medical practitioners and institutions.

[125] Atsango Chesoni v David Mortons Silverstein [2005] eKLR.
[126] AAA v Registered Trustees – (Aga Khan University Hospital, Nairobi) [2015] eKLR
[127] See Samanta A, Samanta J. Legal standard of care: a shift from the traditional Bolam test. Clin Med (Lond). 2003 Sep-Oct;3(5):443-6, and Brenner LH, Brenner AT, Awerbuch EJ, Horwitz D. Beyond the standard of care: a new model to judge medical negligence. Clin Orthop Relat Res. 2012 May;470(5):1357-64.
[128] See Montgomery v Lanarkshire Health Board [2015] UKSC 11.

CHAPTER 5 RECOMMENDATIONS AND CONCLUSION

5.1 Introduction

This chapter highlights the findings, recommendations and conclusion of this research project. This research project sought to determine the sufficiency and efficiency of Kenya's legal and regulatory frameworks in addressing medical malpractice cases.

5.2 Findings and Recommendations

As explored in the second and third chapters, there exists multiple bodies tasked with the regulation of the professionals that fall under its ambit, including undertaking of disciplinary measures. Some of them have the power to impose a fine on the offending medical practitioner, but none can direct the fines or a compensation to be given to the victim. In the case of P.M.N v Kenyatta National Hospital & 6 others,[129] the plaintiff's case was dismissed by the Medical Practitioners & Dentists Board (as it was then known) as it had no powers to give monetary awards only recommendations, prompting the plaintiff to seek help from the court. This raises the question on whether the Council and other regulators like it have failed in their role and purpose, therefore making them the wrong forum(s) for a victim of negligence to bring forth a complaint.

Furthermore, given the multiple forums a victim may bring a complaint of alleged negligent practices, it becomes difficult for a victim to accuse several professionals involved as each have their own regulatory bodies to answer to. Which would explain why patients would rather seek justice from the court system than go through these bodies, if at all they will seek justice. Also, most of these regulators have the composition of its own members. This would make the body in question in the role of judge and jury of its own peers, creating a conflict of interest. This can be corrected by having a higher number of 'outsiders', not regulated by the body to be members of the board or tribunal, or by devolving some of its functions to a different body i.e. to separate the regulatory and the representative roles of the body.

The needs of the victim ought to be acknowledged. There should be a move to give powers to award compensation to the bodies administering disciplinary proceedings as well as punishing the offending medical practitioner. This will ensure responsibility is taken by the offending party while seeking to restore the victim to a position they would have been had

[129] P.M.N v Kenyatta National Hospital & 6 others [2015] eKLR. See also J.O.O. & 2 others v Praxades P Mandu Okutoyi & 2 others [2011] eKLR.

the injury from the negligence not occurred.[130] Moreover, to ensure this is effectively and efficiently enacted, there needs to be a key, super regulator to handle all the complaints against all medical professionals. The Kenya Professions Health Oversight Authority[131]could be one such regulator, if it could merge or dissolve all the other statutory regulators in the medical industry.

There is also a need to create an accessible database of the cases brought before the regulator(s) to enable the jurisprudence on medical malpractice to grow in the country. It would seem that the only way to access a case on medical negligence is if it goes through the court system in Kenya. This may be due to the proceedings before most of the medical regulators do not need to be reported or undergo mediation to resolve the matter. The cases reported would help improve policies and practices in the profession, with the confidentiality of the matters discussed and the privacy of the parties involved put under consideration.

The court system in Kenya ought to consider the new and emerging jurisprudence on the use of the Bolam test which it heavily relies on to find a medical practitioner culpable of negligence, as discussed in the previous chapter. This would enable them to keep abreast of the emerging best case practices in the world on medical negligence.

There are limitations on the scope of this writer's research. Emerging trends in the medical field such as the use of social media to give medical advice, whether the standard of care changes in the case of medical specialisation, the issue of hierarchy in the medical profession, the 'popularity' of some doctors in media or among certain circles, the place of insurance policies and indemnity in a case of negligence, use of traditional medicine and the place of herbalists; emerging technologies that would alter the professions best case practice, among others are some of the issues not covered by this research. It is the writer's hope that this research will prompt others to further investigate these matters and others, to better understand the nature of medical negligence and how best to address it.

5.3 Conclusion

The legal and regulatory frameworks governing medical malpractice needs to be revised so as to reflect the concerns raised by this research as well as the consumers of medical services.

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130 Todres J, Toward Healing and Restoration for All: Reframing Medical Malpractice Reform, Connecticut Law Review, 2006, and Zehr H, The little book of restorative justice, Good Books Publisher, Pennsylvania, 2002, 58-59.

131 Established under the Health Act, No. 21 of 2007.

There is need for a key, super regulator to effectively and efficiently handle complaints made against any and all under the medical profession umbrella; an easily accessible database of the cases lodged; the power to award damages to be given to the regulator(s); consideration by the Kenyan courts to be given to emerging jurisprudence; and concerns addressed on the ever evolving field of medical practice.

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