

**RESOLVING MEDICAL MALPRACTICE CLAIMS: A CRITICAL STUDY OF
DISCIPLINARY PROCEEDINGS IN KENYA**

Submitted in partial fulfilment of the requirements of the Bachelor of Laws Degree,
Strathmore University Law School

By
KIFAYA ABDULKADIR IBRAHIM
077941

Prepared under the supervision of
MUKAMI WANGAI

January, 2017

DECLARATION

I, **KIFAYA ABDULKADIR IBRAHIM**, do hereby declare that this research is my original work and that to the best of my knowledge and belief, it has not been previously, in its entirety or in part, been submitted to any other university for a degree or diploma. Other works cited or referred to are accordingly acknowledged.

Signed:

Date:

This dissertation has been submitted for examination with my approval as University Supervisor.

Signed:.....

MUKAMI WANGAI

ACKNOWLEDGEMENT

I am greatly indebted to Ms *Mukami Wangai*, my supervisor and a Strathmore lecturer for her constant support, motivation and patience throughout the duration of this project.

I am also grateful to the Strathmore Law School Faculty members for their support and guidance.

My immense gratitude also goes to anyone else who directly or indirectly contributed to the completion of this project.

Table of Contents

ACKNOWLEDGEMENT III

ABSTRACT VI

LIST OF ABBREVIATIONS VII

LIST OF CASES..... VIII

LEGISLATION IX

CHAPTER 1: INTRODUCTION 2

1.1 Background 2

1.2 Statement of Problem 6

1.3 Justification of Study 6

1.4 Statement Of Objective 6

1.5 Research Questions..... 6

1.6 Hypothesis..... 6

1.7 Research Design and Methodology 7

1.8 Limitations..... 7

1.9 Chapter Summary 7

CHAPTER 2: THEORETICAL FRAMEWORK..... 8

2.1 Introduction..... 8

2.2 Sociological Jurisprudence..... 9

2.3 Theory of Corrective Justice..... 10

2.4 Regulatory Capture Theory..... 11

2.5 Conclusion 12

**CHAPTER 3: LEGAL FRAMEWORK FOR MEDICAL MALPRACTICE
REGULATION..... 14**

3.1 Introduction..... 14

3.2 Jurisdiction and Standard of Proof..... 15

3.3 Legal and Regulatory Framework of Medical Malpractice 17

3.4 Conclusion	22
CHAPTER 4: ANALYSIS OF THE EFFICIENCY OF THE REGULATORY FRAMEWORK	23
4.1 Introduction.....	23
4.2 Inadequacy of The Law	24
4.2.1 Focus on Retributive as Opposed to Restorative Justice.....	24
4.2.2 Legal Remedies.....	25
4.3 Inefficiency of The Board.....	27
4.3.1 Self-Regulation.....	28
4.3.2 Scarcity Of Skilled Medical Practitioners.....	33
4.4 Conclusion	35
CHAPTER 5: CONCLUSION AND RECOMMENDATIONS.....	36
5.1 Introduction.....	36
5.2 Findings and Recommendations.....	36
5.3 Conclusion	38
BIBLIOGRAPHY	40

ABSTRACT

Medical malpractice is one area that is rife in Kenya and yet not well established in law, policy and practice. There is a disciplinary body, established by law that ought to be working on correcting this phenomenon. This research study sought to examine the efficiency of the disciplinary process for medical malpractice regulation in the country.

What it found was that the law was inadequate in that it merely focuses on punishing the offenders and does not have provisions for ways in which the victim may be compensated or granted legal remedies. In addition, this study found that the Kenya Medical Practitioners and Dentists Board, tasked with representing the doctors and also regulating medical malpractice is marred by conflicts of interest as it is geared towards protecting the practitioners, its own peers, as opposed to the public.

This study recommends that the medical profession no longer remain a self-regulated profession. At a time when many countries are moving away from placing both representative and regulatory roles in one body for good reason, it is only right that Kenya take the same path in order to rectify its disciplinary process. It also emphasises on the need for a more victim-restorative oriented reform that seeks to suggest ways in which the victim can achieve the justice they need. Punishing the offender does not return them to the position they were in before the occurrence of the negligent acts. Very rarely do complainants leave the Board content.

It is also necessary for the Kenya Medical Practitioners and Dentists Board to be more transparent in its operations. Majority of Kenyans are not aware that there is a body mandated to deal with their complaints on negligent actions by doctors and so they do not take action thereby providing more leeway for practitioners to get away with their misdeeds.

This study essentially calls for an overhaul of the current malpractice system. The CoK 2010 paved the way for health reform in Kenya and now the public is more aware and expectant of the fulfilment of their rights, which must be upheld.

LIST OF ABBREVIATIONS

PIC – Preliminary Inquiry Committee.

PCC – Professional Conduct Committee.

KMPDB – Kenya Medical Practitioners and Dentists Board.

LIST OF CASES

Muchoki v AG [2004] KLR 518.

Munene v Republic (1978) KLR 181.

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

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

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

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

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

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

Atsango Chesoni v David Mortons Silverstein [2005] eKLR.

K & K Amman Limited vs. Mount Kenya Game Ranch Ltd. & 3 Others Nairobi (Milimani) HCCC 6076 of 1993.

Allinson v. General Council of Medical Education and Regulation [1894]1 QB 750.

Roylance v. General Medical Council [2000] 1 AC 311.

General Medical Council v Spackman (1943) AC 627.

LEGISLATION

Constitution of Kenya (2010).

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

Code of Professional Conduct and Discipline, (2012).

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

CHAPTER 1: INTRODUCTION

1.1 Background

Pursuant to Article 43(1)(a) of the Constitution,¹ every person has the right to the highest attainable standard of health. Health facilities, for this purpose, are required to ensure their hospitals are fully stocked and their medical personnel well trained, in order to provide the required level of care to their patients. In *Muchoki v AG*,² the court stated that “*when a hospital accepts a patient for treatment, it must not only use reasonable care and skill to cure him of his ailment, but must also provide a safe and secure environment for such treatment.*”

It is therefore necessary to ensure professionalism in this sector by regulating services offered by health care providers and also in protecting the rights of the patients, the consumers of the health care services. In Kenya, the Medical Practitioners and Dentists Board (hereinafter referred to as the Board), established under Cap 253³ is the regulatory body for medical and dentistry practitioners and has undertaken the obligation of ensuring provision of quality and ethical health care through appropriate regulation of training, registration, licensing, inspections and professional practice.⁴

The Medical Practitioners and Dentists Act⁵ (henceforth referred to as the Act) is the law that governs the Board in carrying out its two-fold function; representing medical practitioners and regulating medical practice.

The Board is composed of; a chairman, appointed by the Cabinet Secretary, Ministry of Health; The Director of Medical services who is the Registrar; A Deputy Director of Medical Services appointed by the Cabinet Secretary; Four medical/dental practitioners nominated by the Cabinet Secretary and A representative of each of the universities in Kenya which have the power to grant a medical/dental qualification that is registrable under the Act.⁶

In the event that a medical practitioner or dentist is convicted of an offence either under The Act or under the Penal Code, then The Act elaborately provides for disciplinary proceedings,⁷ to be undertaken by the Board and also grants it the freedom to regulate their procedure in the

¹ Article 43(1)(a), *Constitution of Kenya* (2010).

² *Muchoki v AG* [2004] KLR 518.

³ *The Medical Practitioners and Dentists Act*, Cap 253, 2012.

⁴ <http://medicalboard.co.ke/about-us/mission-vision/>.

⁵ *The Medical Practitioners and Dentists Act*, (2012).

⁶ *Code of Professional Conduct and Discipline*, 2012.

⁷ Section 20, *The Medical Practitioners and Dentists Act*, (2012).

proceedings.⁸ Medical malpractice, which is the failure of the medical practitioners in exercising reasonable skill and care to treat patients is one of the offences that would warrant disciplinary proceedings before the Board.

This disciplinary role of the Board is undertaken by the Preliminary Inquiry Committee (PIC), consisting of 7 members elected from the members of the Board and the Professional Conduct Committee (PCC) that is set up on an ad hoc basis upon the recommendation of the PIC.

The procedure for filing a complaint with the Board is that when a complaint is lodged, the Board writes to the person against whom the complaint is made, requesting for necessary documents such as copy of the patients file, statements of all medical personnel involved in the patients care, to be delivered within 7-21 days. Once the required documents are provided, the Board forwards the information to the PIC who then picks a specialised person from the Board to go through the documents and make a written report. After the written report has been done, it is returned to the committee who deliberate on the issue. The members thereafter use the information received from the written report and their discussions with both parties to make a decision, which is supplied to the Board. The Board after receiving the findings of the PIC similarly deliberates on the verdict and thereafter decide whether they will ratify the decision or give further directions on it. If the Board finds that the case has merit and requires reference to Full Board Tribunal, concerned parties are informed in writing and the preparation of the Tribunal begins.⁹ The tribunal is the full Board exercising judicial or quasi-judicial functions and acts as a court in order to determine disciplinary matters.¹⁰

Despite this regulatory framework provided, the claims of medical malpractice have been on an increase in the country of late, hence the need to ask ourselves, where is the country falling short?¹¹ A statistical analysis of complaints brought before the Board for years 2007-2012 was supplied by Kenya Medical Association; and the analysis, hinging on the frequency of

⁸ Section 20(4), *The Medical Practitioners and Dentists Act*.

⁹ *Code of Professional Conduct and Discipline*, 2012.

¹⁰ *Code of Professional Conduct and Discipline*, 2012.

¹¹ Ndemo B, *Our Medical Malpractice Crisis*, July 21 2014. <http://www.nation.co.ke/oped/blogs/dot9/ndemo/-/2274486/2391482/-/2w7q2pz/-/index.html> (Accessed on 14/12/2015).

complaints, the type of health facility and the category of the complaint clearly shows the increasing trend of complaints in the country.¹²

TYPE OF HEALTH FACILITY

HEALTH FACILITY	Private Hospitals and Clinics	Government	Mission Hospitals	Insurance firms	Laboratories and Diagnostic facilities
PERCENTAGE %	70	16	13	1	1

FREQUENCY OF COMPLAINT

FREQUENCY OF COMPLAINTS	CASES DETERMINED AT PIC	CASES DETERMINED AT TRIBUNAL	CASES DETERMINED AT PCC
NUMBER	659	15	8

CATEGORY OF COMPLAINTS

CATEGORY OF COMPLAINT	PERCENTAGE %
OBS/GYN	27
FINANCIAL	16
SURGICAL	12
PAEDIATRIC	11
MEDICAL	11
ANAESTHETIC	10
WITHHOLDING PATIENTS RECORD	4
DENTAL	4
CASES RELATED TO NURSES, CLINICAL OFFICERS AND LAB TECH.	2
FAILURE TO REFER/SEEK SECOND OPINION	2

¹² Magoha George, 'Medical Litigation and How to Manage It', 2013.

There are a number of inadequacies of the Act in providing for the Board to regulate medical malpractice in the country and the Board in actually carrying out their obligations. The Act on one hand grants the Board the freedom to investigate cases of medical malpractice but it is silent on the matter of compensation available to the victims. The Board therefore, cannot provide for something that it has not been granted the power to provide.

The Board, on the other hand, has the power to revoke the licence of practitioners or dentists found guilty of malpractice, yet it is in most cases unwilling to exercise this power. Cases of malpractice presented to the Board in the past have often ended with a lenient penalty, a one-year suspension for the offending doctor and/or a recommendation for retraining or merely a warning to the practitioners.

This could, to some extent, be attributed to the conflict of interest present in the double role the Board plays. It has been mandated with regulating medical practice and also representing medical practitioners thereby causing the suspicion that the Board is more geared towards supporting doctors as opposed to protecting the patients. Separating regulatory functions from representative bodies in most cases causes the risk of conflict of interest.¹³

In addition, while exercising their discretion to determine whether they will take up a complaint, the Board at times throws out cases before carrying out due diligence. In the famous reproductive rights case of *M.N.N v AG of Kenya*,¹⁴ the Board underwent heavy criticism for dismissing the claims of M.N.N without explanation and without allowing her to present her case. In this particular case, a Kenyan woman's genitals were mutilated in a private hospital without her knowledge or consent and had been turned away by both the police and the Board upon raising a complaint.

These are some of the inadequacies present in the operation of the Board and the Act. The question to ask then would be, where exactly does the weight of the problem lie? Is it a

¹³ Vries H, Sanderson P, Janta B, Rabinovich L, Archontakis F, Ismail S, Klautzer L, Marjanovic S, Patrui B, Puri S, Tiessen J, *International Comparison of Ten Medical Regulatory Systems*, RAND Corporation, 2009.

¹⁴ Kenya National Commission on Human Rights, 'Realising Sexual and Reproductive Health Rights in Kenya: A myth or reality?', 2012

problem of the law being insufficient in providing redress for medical malpractice or does the fault lie with the Board in being unable to effectively carry out its function.

1.2 Statement of Problem

The problem that arises is whether the Kenya Medical Practitioners and Dentists Board is efficiently regulating medical malpractice in the country or is the reason for the increasing rate of complaints due to the Medical Practitioners and Dentists Act that has not sufficiently provided for its regulation. This research study seeks to address these questions and assess whether the current disciplinary proceedings for medical malpractice provided are efficient and where exactly they fall short, if they do.

1.3 Justification of Study

This paper aims to contribute to the knowledge gap in the medical-legal field in Kenya, specifically medical malpractice that has not been developed extensively.

1.4 Statement Of Objective

The overall objective of this research is to assess the efficiency of the disciplinary proceedings of medical malpractice in Kenya.

The specific objectives of the research study will be to determine:

- 1.) Whether the current legal framework sufficiently provides for medical malpractice regulation and redress.
- 2.) Whether the Medical Practitioners and Dentists Board is efficiently carrying out its mandate of regulating medical malpractice in the country.

1.5 Research Questions

1. What is the legal and regulatory framework of medical malpractice regulation in Kenya.
2. To what extent are those frameworks capable of redressing medical malpractice claims.
3. Is the current system for complaint and disciplinary proceedings for medical malpractice efficient.

1.6 Hypothesis

The hypothesis of this study is that the measures set up for medical malpractice regulation in Kenya are inadequate and that the Medical Practitioners Board is not fully carrying out its functions as it is in a situation of conflict of interest.

1.7 Research Design and Methodology

This research shall be conducted using both qualitative and limited quantitative approaches. Qualitative methods that shall be used will include desktop research. The desktop research information procured shall seek to analyse the legal and policy framework of medical malpractice regulation in Kenya.

In conducting limited quantitative research, various medical research centres shall be visited in order to acquire more information on the surveys done in the medical field that touch on the complaints made. Information shall also be sought from the Board, in order to acquire information on the number of cases filed and any other information that can be acquired without infringing on the principle of confidentiality.

An interview shall be conducted with the Kenya Medical Practitioners and Dentists Board representatives to gather more information.

1.8 Limitations

There is an information gap on medical law in the country thus procuring necessary information on medical malpractice will be difficult.

There is the doctor-patient confidentiality rule that might be broken by seeking information on cases of medical malpractice from either doctors or the board hence the uneasiness that parties might face on releasing such information.

Time constraints prompted by the fact that the study is to be done within a short period of time.

1.9 Chapter Summary

Chapter Two will highlight the theories employed to justify this research study and provide the basis for responding to the research questions and fully examine the dissertation. Chapter Three will highlight the legal and regulatory framework for medical malpractice regulation in the country and the problems that arise therein. Chapter Four will furthermore expound on these issues and analyse the efficiency of this regulatory framework, fully tackling the research questions. Chapter Five will finally provide a summary of the findings of the study and propose recommendations and the way forward.

CHAPTER 2: THEORETICAL FRAMEWORK

2.1 Introduction

The relationship between a patient and a medical practitioner is essentially privileged, depending on the patient's trust in the medical practitioner's professionalism. Medical practitioners should be guided by their responsibility to act in the best interests of their patients and to safeguard their rights. Despite the fact that a Board, the Kenya Medical Practitioners and Dentists Board, has been set up to regulate instances of medical malpractice, due to one reason or another there have been multiple claims of malpractice that have not been addressed well. This leads to the assumption that there must be a problem somewhere, either in the Board and the way it handles disciplinary proceedings or with the legislation enacted that governs medical practitioners. This is, in essence, the fundamental purpose of this research study- to determine the efficiency of the disciplinary proceedings of medical malpractice.

The concept of regulation of medical malpractice is what this chapter seeks to demystify. It will do so by highlighting and setting out the legal theories that underpin and support the research concept. The research study will rely on three theories to further its hypothesis, that is the *sociological jurisprudence, corrective justice theory and regulatory capture theory*.

Sociological jurisprudence theory will seek to analyse the efficiency of the legal framework of medical malpractice and whether it enhances the welfare of its people and caters for the social interests of all those at stake. The theory of corrective justice will furthermore lay the foundation for determining the efficiency of the disciplinary proceedings and whether the Board has made attempts to correct the injustice caused by physicians. The Regulatory Capture theory analyses whether the Kenya Medical Practitioners and Dentists Board, formed to act in the public's interest, has come to be controlled by the industry they were charged with regulating thus becoming a 'captured agency'.

2.2 Sociological Jurisprudence

This theory analyses the actual effects of the law within society and the influence the social phenomena has on the substantive and procedural aspects of law. The foundation of this theory is that securing social interests is the proximate end of the law.¹⁵

Roscoe Pound, who was the main proponent of this school of thought, stated that the law has always been concerned with social interests and that some certain great social interests have determined the growth of law from the beginning.¹⁶ He also argues that the law should be constructed in such a manner that the various social interests at stake are balanced. According to him, there are three categories of legal interests, namely, individual, public and social interests. The main aim of sociological jurisprudence is to find a balance between these interests.¹⁷

On one hand, interests are classified as individual if they are claims or desires that are directly involved in the lives of individuals. These can be sub-categorised as, interests in personality, which affect the health, life and reputation of individuals; interests of substance that are asserted by individuals in title of an individuals economic existence such as property and finally interests in domestic relations such as those between spouses and parents.¹⁸ On the other hand interests are classified as public if they are claims and desires directly involved in a politically organized society and asserted in title of that organization. The final classification of interests is social interests, which are, according to Pound, claims or desires involved in the social life of a civilized society, what could now be classified as public policy.¹⁹ Roscoe Pound asserts that when determining what claims to recognize and in what limit, the general individual interest behind it should be determined and weighed against the social interest.²⁰

According to this school of thought, the main aim of any law, whether constitutional statutory or case, should be to enhance the welfare of the society. As Roscoe Pound put it,

¹⁵ Verhelle J C, *Roscoe Pound and His Theory of Social Interests*, Loyola University Chicago, 1958, 20.

¹⁶ Graber M, *Transforming Free Speech: The Ambiguous Legacy of Civil Libertarianism*, University of California Press, 1991.

¹⁷ Nalbandian E, *Sociological Jurisprudence: Roscoe Pound's Discussion on Legal Interests and Jural Postulates*, 2014.

¹⁸ Pound R, *A Survey of Social Interests*, Harvard Law Review 57.1, 1943, 1-39.

¹⁹ Pound R, *A Survey of Social Interests*.

²⁰ Pound R, *A Survey of Social Interests*.

'the law must be judged by the result it achieves, not by the niceties of its eternal structure...'²¹. He called for a 'jurisprudence of ends' rather than a 'jurisprudence of conceptions' through the formulation of laws that sought to balance the social interests of all those at stake.²²

One of the main research questions that this study seeks to answer is whether the current regulatory framework is efficient in dealing with medical malpractice. This standard of efficiency is dependent on whether the legal interests of the three categories mentioned have been balanced. Therefore in as much as the regulatory mechanism of medical malpractice has been set up, whether or not it has been effective will be largely dependent on the results that have come out of it, which is essentially what this study seeks to research on. With medical malpractice, there are three interests: that is the interest of the individual who is the victim; the interest of the public, which would be the legal institution i.e. the Kenya Medical Practitioners and Dentists Board and finally the third interest, which is the State's duty to the citizens to ensure protection of their rights. A well-developed regulatory framework would therefore be one that balances the interests of these parties.

2.3 Theory of Corrective Justice

The theory of corrective justice is derived from the concept of equality with the notion that liability rectifies injustice rendered by one to another.²³ Aristotle formulated this idea in the *Nicomachean Ethics* Book V, where he focused on instances where one party has committed and the other has suffered transactional injustice.²⁴

The law, according to this theory, should seek to correct the injustice committed by one party against another thus restoring equality. Where parties enter into a transaction and one party occasions a gain and the other a corresponding loss, corrective justice seeks to rectify the injustice by depriving the party of the gain and restoring it to the one who realizes a loss.²⁵

²¹ Verhelle J, *Roscoe Pound and His Theory of Social Interests*, 32.

²² James A. Gardner, *The Sociological Jurisprudence of Roscoe Pound*, (Part I), 7 *Vill. L. Rev.* 1 1961.

²³ Weinrib, Ernest J. *Corrective Justice in a Nutshell*, *The University of Toronto Law Journal*, 52.4, 2002, 349-56.

²⁴ Aristotle, *Nicomachean Ethics*, Book V, Kitchener, Ont: Batoche Books, 1999.

²⁵ Weinrib E, *The gains and losses of corrective justice*, *Duke Law Journal*, 1994, 279.

This theory generally governs the law of contract, tort and even criminal law. Aristotle however does not distinguish the justice dealing with legal commerce or that dealing with criminal matters but merely referred to the former as voluntary justice and the latter as involuntary justice.

By correcting the injustice that one party has inflicted upon another this theory asserts a connection between the remedy and the wrong thus fulfilling its rectifying function. Aristotle argues that a court when faced with a matter of injustice will not look at it as a morally neutral occurrence and then look at what the best course for the future is. Rather it will look at the specific matter at hand, as it aims to, in as much as possible, correct the injustice done and will thus ensure the remedy responds to the injustice.²⁶

One of the main functions of medical malpractice law is to deter physicians from shirking in their duty to avoid medical accidents. The tort framework of deterrence holds that physician's liability should efficiently increase whenever their productivity in accident avoidance increases.²⁷ Therefore the extent of physician liability should vary depending on an increase in physician's productivity, especially by increased technological ability; when the opportunity costs of physicians' time increases, or when the cost to physicians of defending against malpractice claims decreases.²⁸

2.4 Regulatory Capture Theory

The regulatory capture theory is the theory associated with George Stigler, a Nobel Laureate economist. It is a form of government failure that occurs when a regulatory agency created to act in the public interest, instead advances the commercial or political concerns of the industry it is charged with regulating, or benefits special interest groups dominating the industry rather than the public.²⁹ The interests the agency is tasked with protecting are ignored in favour of the regulated industry's interests.

²⁶ Weinrib, E., *Corrective Justice in a Nutshell*. The University of Toronto Law Journal, 2002, 52(4), 349-356.

²⁷ Olsen R N., *The Efficiency of Medical Malpractice Law: Theory and Empirical Evidence*, Southwest Missouri State University, 2000.

²⁸ Olsen R N., *The Efficiency of Medical Malpractice Law: Theory and Empirical Evidence*, 17.

²⁹ Stigler G, *The Theory of Economic Regulation*, University of Chicago, 1971, 3.

An agency is considered captured when it is unduly influenced by interest groups directly affected by its decisions or it shapes its regulations and policies primarily to benefit its favoured client groups at the expense of less organized and less influential groups as opposed to designing them in accordance with a more inclusive conception of the public interest.³⁰

The KMPDB, a statutory establishment, is tasked with ensuring provision of quality and ethical health care and has the responsibility to act in the public's interest. One of the questions that this research paper seeks to answer is whether the Medical Practitioners Board, with its doubled edged role of regulating medical practice and representing medical practitioners is more geared towards supporting doctors as opposed to protecting the patients, thus becoming a captured agency.

Stigler furthermore progresses the capture theory from two primary premises:³¹

1. The most important asset controlled by the state is the power to coerce. Any group that can control how this power is used will profit tremendously.
2. Since we are self-interested actors, we will seek to get the state's coercive power to support our interests. Efforts to do so, however, are costly, thereby benefitting the group that has more money.

With such a scenario occurring, the medical practitioners and dentists interests will always win as compared to the public interest. This favoured by the advantage they have of being able to deal with collective action problems due to their homogenous nature and the similarity and cohesion of their interests. Consumers on the other hand cannot organize themselves for collective actions for two major reasons: they lack a homogenous nature as that of their counterparts and the costs of doing so are higher than the benefits sought. The public therefore remains rationally ignorant and the regulatory body continues favouring the industry in spite of the injustices occasioned against the patients.

2.5 Conclusion

The purpose of this chapter was to highlight the theories that lay the foundation for this research study. It is instrumental in introducing and explaining the existence of the research problem, which shall be discussed in the following chapters. The sociological jurisprudence theory seeks to determine whether the legal framework is efficient and is catering to the

³⁰ US Legal, *Captured Agency: Law and Legal Definition*. <https://definitions.uslegal.com/c/captured-agency/>

³¹ Stigler G, *The Theory of Economic Regulation*, 4.

social interests of all those at stake. The theory of corrective justice looks at whether the law is correcting the injustice that has been inflicted by one party on another and whether the correction corresponds to the harm done. The regulatory capture theory furthermore has laid the foundation for determining whether the Board, which regulates and represents the medical profession, has become a captured agency and is working towards advancing its regulatees' interests as opposed to the public interest.

CHAPTER 3: LEGAL FRAMEWORK FOR MEDICAL MALPRACTICE REGULATION

3.1 Introduction

The Kenya Medical Association supplied a statistical analysis of complaints brought before the Board for the years 2007-2012. The analysis, which focused on the frequency of complaints, the type of health facility and the category of the complaint pointed towards an increasing trend of complaints of medical malpractice in the country.³² The analysis showed that majority of medical malpractice took place in private hospitals with a percentage of 70% and the highest type of complaints mostly had to do with gynaecology and obstetric matters ranking at 27%.

The Kenya National Commission on Human Rights (KNHCR) published a report on a public inquiry into the violations of sexual and reproductive health rights in Kenya, following a FIDA-Kenya and Centre for Reproductive Rights (CRR) about extreme cases of violations of women reproductive rights in health facilities. The report found that there was extreme medical malpractice especially when it came to female reproductive health.³³ There were complaints of mistreatment of patients by inebriated practitioners. Women who gave birth were also in some cases asked to clean items they soiled after delivery, several women had processes done on them without their consent, some of which had horrendous consequences. Health professionals also ignored the patients and failed to give them information on risks of medical interventions and procedures.³⁴

There has also been an unprecedented increase in exposure of medical negligence due to the increase in media coverage and the general awareness of all Kenyans on their rights to access quality care and free access to emergency service following the promulgation of the New Constitution.³⁵

³² Magotha George, *Medical Litigation and How to Manage It*, 2013.

³³ Kenya National Commission on Human Rights, *Realising Sexual and Reproductive Health Rights in Kenya: A myth or reality?* 2012, 50.

³⁴ Kenya National Commission on Human Rights, *Realising Sexual and Reproductive Health Rights in Kenya: A myth or reality?* 52.

³⁵ Mwaura N, Rogo K, Wafula F, *Focusing on Patient Safety and Quality of Care: Preventing Medical Malpractice and Negligence in Kenya*, The World Bank, 2016. Available at

This Chapter seeks to explore the overall scheme for medical malpractice liability regulation in the country. It will begin with a brief overview of the jurisdiction of the Medical Practitioners and Dentists Board and then discuss the legal and regulatory system currently in place. This section will raise the challenges facing medical malpractice in the country which shall be expounded on in the next chapter.

3.2 Jurisdiction and Standard of Proof

Justice Ringera in *K & K Amman Limited vs. Mount Kenya Game Ranch Ltd. & 3 Others* stated that in order to prove professional negligence against a professional person, evidence has to be produced showing that the professional did not conduct himself with the competence, diligence and skill expected of an ordinary professional in his field or must persuade the Court that the acts or omissions complained of were manifestly or patently dangerous.³⁶

Section 20 of the Medical Practitioners and Dentist's Act stipulates the conduct that can raise disciplinary issues as being *infamous or disgraceful conduct in a professional respect*.³⁷ Infamous Conduct in a Professional Respect was defined by Lord Justice Lopes as an act committed by a medical man in the pursuit of his professional duties that would be reasonably regarded as disgraceful or dishonourable by his professional brethren of good repute and competence.³⁸ Lord Justice Scrutton further defined it as serious misconduct judged according to the rules, whether written or unwritten that govern the profession.³⁹

Rule 5(1) of the Medical Practitioners and Dentists (Disciplinary Proceedings) (Procedure) Rules as well as the Code of Professional Conduct and Discipline take the latter definition.⁴⁰

While it has been referred to over the years, serious professional misconduct is not statutorily described or capable of being given a precise description.⁴¹ As Lord Wright stated in *General Medical Council v Spackman*, the precise meaning and scope of what constitutes infamous

<http://blogs.worldbank.org/health/focusing-patient-safety-and-quality-care-preventing-medical-malpractice-and-negligence-kenya> Accessed on 28th November 2016.

³⁶ *K & K Amman Limited vs. Mount Kenya Game Ranch Ltd. & 3 Others* Nairobi (Milimani) HCCC 6076 of 1993.

³⁷ Section 20(1), Medical Practitioners and Dentists Act, 2012.

³⁸ *Allinson v. General Council of Medical Education and Regulation* [1894]1 QB 750.

³⁹ *General Medical Council, Professional Conduct and Discipline: Fitness To Practice*. London: GMC, 1987.

⁴⁰ Medical Practitioners and Dentists Board, *The Code of Professional Conduct and Discipline*, 20.

⁴¹ *Roylance v. General Medical Council* [2000] 1 AC 311, 330-332 .

conduct in any professional respect is left to the council. It has to decide whether infamous conduct has been made to its satisfaction, in any professional respect and to decide what standards to apply.⁴²

However in *Munene v Republic* the court held that according to Section 23 (1) of the earlier Act (which is equivalent to Section 20 of the current Act) the Board had no jurisdiction to consider charges of infamous or disgraceful conduct based on allegations of facts, which constituted criminal offence.⁴³ It was argued that there were certain facts that bordered the line of infamous or disgraceful conduct and criminal offence and the Board could therefore not be barred from treating them as infamous or disgraceful conduct without waiting for the verdict of the court of law. The court however held that the Board had the jurisdiction to look into a matter with criminal elements only if it resulted in a conviction in a court of law and since there was no proof of conviction, the Board was incompetent in dealing with the offences in any event.

The standard of proof for ‘serious professional misconduct’ has generally been held to be higher than that of civil law matters but slightly lower than that of criminal law matters, on a preponderance of evidence. In *Pope John Paul’s Hospital & Another vs. Baby Kasozi*,⁴⁴ the East African Court of Appeal held: *‘To the extent of not confusing negligence with misadventure, clear proof of negligence is necessary in cases involving medical men, but it cannot be accepted that the burden of proving such negligence is higher than in ordinary cases. The burden is to prove that the damage was caused by negligence and was not a question of misadventure, and that burden must be discharged on a preponderance of evidence...’*

In the Kenyan context however, the exact standard of proof with regard to Inquiries on medical malpractice has not been well established. While the courts have attempted to clarify this, their holdings keep shifting between that of civil law jurisdiction with the standard of proof being a balance of probabilities and quasi criminal law jurisdiction with the standard of proof being almost beyond reasonable doubt or on a ‘preponderance of evidence’.

⁴² General Medical Council v Spackman (1943) AC 627.

⁴³ *Munene v Republic* (1978) KLR 181.

⁴⁴ *Pope John Paul’s Hospital & Another vs. Baby Kasozi* [1974] EA 221.

In both *J.O.O. & 2 others v Praxades P Mandu Okutoyi & 2 others*⁴⁵ and *Atsango Chesoni v David Mortons Silverstein*,⁴⁶ the jurisdiction of the Board was established to be that of quasi-criminal jurisdiction. However the standard of proof applied in both cases were different. In the appeal case of *Atsango Chesoni v David Mortons Silverstein*, the appellant, during the Inquiry before the Board was tasked with proving the quasi-criminal charges nearly beyond reasonable doubt, which he failed and upon appeal, the Court upheld the Board's decision.⁴⁷ While in *J.O.O. & 2 others*, the standard of proof the Board had adopted which was that of strict responsibility or the preponderance of evidence, was upheld by the Court. On the other hand, Justice Rawal, in the J.O.O case stated that the standard of proof before the Board was different from the standard of proof that was within the ambit of the Court, which was on a balance of probability.

This uncertainty concerning the exact standard of proof that plaintiffs would need to prove their case needs to be rectified. 'Beyond reasonable doubt' is the highest standard of proof reserved for criminal charges and a 'balance of probabilities' for civil matters is on the other end of the spectrum. Somewhere in between is 'preponderance of the evidence' which is the amount of evidence sufficient to make a contested fact more likely true than not. The burden of proof in medical liability cases across the globe has generally been either a balance of probabilities for instance in the UK or on a preponderance of evidence,⁴⁸ therefore a fixed standard of proof needs to be established by the Kenyan courts that would apply to determinations of both the Board and the Court. Otherwise having a lower standard of proof in Courts than in the Board will serve as a hindrance to victims raising their complaints in the Board.

3.3 Legal and Regulatory Framework of Medical Malpractice

Any legal, policy or administrative framework must always measure up to the Constitutional benchmark. The number of provisions on the right to and protection of health have greatly increased in the new Constitution.

⁴⁵ *J.O.O. & 2 others v Praxades P Mandu Okutoyi & 2 others* [2011] eKLR.

⁴⁶ *Atsango Chesoni v David Mortons Silverstein* [2005] eKLR.

⁴⁷ *Atsango Chesoni v David Mortons Silverstein* (2005) eKLR.

⁴⁸ Crisler J, *The burden of proof in medical liability cases: A preponderance of the evidence*, <http://www2.aaos.org/bulletin/feb06/rskman2.asp> on 12th January 2017.

Article 43 (1) (a) and (2) of the Constitution guarantees every person the highest attainable standard of health inclusive of health care services, maternal and reproductive health care and the right to emergency medical treatment.⁴⁹

Article 46 (1) (a), (c) and (d) of the Constitution provide for a right to goods and services of reasonable quality,⁵⁰ to the protection of their health, safety, and economic interests,⁵¹ and to be compensated for loss or injury arising from defects in goods and services.⁵²

Article 21 as read together with Article 56 (e) of the Constitution ensures that the vulnerable groups, marginalized groups and minorities (including but not limited to the illiterate, the medically incapacitated, the uneducated and uninformed) should have reasonable access to health care services. Article 53 (1)(c) of the Constitution protects the right of the child to basic nutrition, shelter and health care.⁵³

The Medical Practitioners and Dentists Act read together with Medical Practitioners and Dentists (Disciplinary Proceedings) (Procedure) Rules confer disciplinary powers upon the Board. Section 4 of the Act establishes the Medical Practitioners and Dentists Board whose functions among others is discipline. They are expected to conduct preliminary inquiries on professional conduct and medical malpractice and hold and conduct tribunal meetings and inquiries into the health and fitness of practitioners.

Disciplinary cases generally come before the Board in two ways: One arises from the conviction of a doctor or dentist in regular courts or tribunals.⁵⁴ A charge of professional misconduct can be brought against a practitioner with respect to any conduct before the courts or tribunals for which he is placed on probation, acquitted or is discharged. Even if the criminal offence of the practitioner did not involve professional misconduct, a conviction itself grants the Board jurisdiction. A conviction of a practitioner before the court of law will

⁴⁹ Article 43, *Constitution of Kenya* (2010).

⁵⁰ Article 46(1)(a), *Constitution of Kenya*.

⁵¹ Article 46(1)(c), *Constitution of Kenya*.

⁵² Article 46(1)(d), *Constitution of Kenya*.

⁵³ Article 53(1)(c), *Constitution of Kenya*.

⁵⁴ Rule 5A, *Medical Practitioners And Dentists (Disciplinary Proceedings) (Procedure) Rules*, 1979.

affect his/her fitness to practice thereafter.⁵⁵ The second is where a practitioner is alleged to have acted in a manner that amounts to serious professional misconduct.⁵⁶

This disciplinary role of the Board is undertaken by the *Preliminary Inquiry Committee (PIC)*, consisting of 7 members elected from the members of the Board,⁵⁷ the *Professional Conduct Committee (PCC)* that is set up on an ad hoc basis upon the recommendation of the PIC,⁵⁸ and the full Board exercising judicial or quasi functions to determine disciplinary matters is known as a Tribunal.

The rules governing disciplinary proceedings seem to point towards a perceived protection of the profession. Rule 7, in discussing the procedures related to conduct, provides multiple leeway for the practitioner to escape a conviction. For instance, it states that when a complaint is raised and evidence adduced, the practitioner can make two submissions: that no sufficient evidence has been adduced upon which the Board could find that the facts alleged have been proved and that the facts of which evidence has been adduced are insufficient to support a finding of infamous or disgraceful conduct in a professional respect.⁵⁹ If those submissions are made then the Board shall determine whether or not to uphold that submission and if they do uphold it then the Chairman shall announce that the medical practitioner or dentist is not guilty of infamous or disgraceful conduct in a professional respect.⁶⁰ Not once in the entire Rule 7 is there mention of a finding of the practitioner being guilty and the consequences of such, yet a finding of the practitioner being not guilty of infamous or disgraceful conduct has been mentioned a total of three times.

Upon completion of the disciplinary proceedings, the sanctions placed differ, depending on the level of authority the matter has come before. If it was decided at the Preliminary Inquiry Committee or Professional Conduct Committee and the doctor has been found guilty of professional misconduct or is found to have breached the applicable law then the Committees shall by simple majority decide whether the matter will be further referred to the Tribunal or

⁵⁵ Medical Practitioners and Dentists Board, *The Code of Professional Conduct and Discipline*, Republic of Kenya, 2012, 20.

⁵⁶ Rule 5B, *Medical Practitioners And Dentists (Disciplinary Proceedings) (Procedure) Rules*.

⁵⁷ Rule 3, *Medical Practitioners And Dentists (Disciplinary Proceedings) (Procedure) Rules*.

⁵⁸ Rule 4A, *Medical Practitioners And Dentists (Disciplinary Proceedings) (Procedure) Rules*.

⁵⁹ Rule 7(1) (d), *Medical Practitioners And Dentists (Disciplinary Proceedings) (Procedure) Rules*

⁶⁰ Rule 7 (1) (e), *Medical Practitioners And Dentists (Disciplinary Proceedings) (Procedure) Rules*.

decide on one of the following courses:-⁶¹ Admonish the doctor, dentist or the institution for the conduct, done by sending warning letters to the concerned practitioner or institution; Order payment of costs for the Committee's sitting payable by the Practitioner or Institution on terms that are deemed just and fit under the circumstances; Levy reasonable costs of the proceedings from parties; Order the medical practitioner to undergo continuous professional development for a maximum of up to 50 points; Suspend the license of the medical institution for up to six months; Order the closing of the Institution until compliance with the requirements of operation license has been met and Record and adopt a mediation agreement or compromise between the complainant and the practitioner or the institution, on the terms that parties have agreed upon and thereafter inform the chairman.

Once an inquiry has been completed before the Tribunal and the practitioner found culpable of a criminal offence or of serious misconduct in a professional respect, the courses the Tribunal can take are similar to those afforded to the PIC with the following additional penalties such as Placing the practitioner on probation for a period not exceeding six months- the decision shall be by a simple majority vote; Directing suspension of doctors or dentist's registration or license for a period not exceeding twelve months or directing removal from the register, which will remain effective indefinitely until the doctor or practitioners makes a successful application for restoration of his/her name in the register. In accordance with the Act, an order for suspension or removal from register of a practitioners name can only be made by a two-thirds majority vote of the Board Members.

While there is a great range of punishments available to the Board, in practice, they tend to grant lenient sanctions to the practitioners. Even where the Board finds the practitioner guilty, they at times let them go with a slap on the wrist such as suspension for a couple of months or ordering the practitioner to undergo continuous professional development for a maximum of up to 50 points or even merely admonishing the practitioner.⁶² Such penalties cannot measure up to the consequences or effects the medical malpractice has had on the victim, who will most likely have to live with it for life.

⁶¹ Rule 4(3), *Medical Practitioners And Dentists (Disciplinary Proceedings) (Procedure) Rules*.

⁶² 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> Accessed on 28th November 2016.

Evidence also shows that the Board is more tilted towards protecting doctors even where the doctor was negligent.⁶³ In some instances they will find in favour of the practitioner despite evidence of their guilt as they did in the case of *George Moga v Nairobi Women's Hospital & 3 Others*.⁶⁴ Upon appeal of the Board's decision, the Court, in this matter, found that the Board was contradictory in the findings and recommendations of their report as their findings clearly showed that the two doctors had failed to exercise the duty of care expected of a doctor while the recommendations found that they were not negligent in the management of the deceased. The facts of the case were that the deceased was referred to the Nairobi Women's Hospital to be attended to but was instead instructed by Dr. Wahome to continue previous wrong medications ordered by a doctor from Kenyatta National Hospital. The deceased's condition worsened so she returned the following day for further examination and treatment. She was however not treated but casually attended to by Dr. Kigundu who relied on the wrong diagnosis of depression and admitted her, awaiting Dr. Mucheru's arrival from Dadaab. The deceased continued to complain of chest pain and inability to breathe and when Dr. Mucheru finally arrived, her condition had already deteriorated. The doctor however relied on the same initial diagnosis of depression even after noting that the deceased's condition was worsening rather than improving. She later recommended that a physician be called to examine the deceased but left before ensuring it was done. No physician examined the deceased as recommended and she later died that same day. When a post mortem was conducted on the deceased's body, the cause of death was found to be acute colpulmonale secondary to Pulmonary Thrombo-embolism. The matter was taken before the Board. The findings of the Board were that, Dr. Wahome had failed to properly assess the patient hence he did not recognise how seriously ill the patient was; that Dr. Mucheru had failed to make arrangements for the patient to be seen while away in Dadaab and when she did see her she did not assess the patient's condition and finally that Dr. Kigundu was asked to help with sustaining only. The recommendations on the other hand stated that the cause of death was thrombo-embolism, which cannot be detected and that the doctors were not negligent. These

⁶³ Kilonzo E, *Only one doctor has been found guilty of misconduct in 19 years*, Daily Nation, 2016. Available at <http://www.nation.co.ke/news/Only-one-doctor-has-been-found-guilty-of-misconduct/1056-3096208-17s5wv/index.html> Accessed on 28th November 2016.

⁶⁴ *George Moga v Nairobi Women's Hospital & 3 others* [2015] eKLR.

inconsistent findings and recommendations points out the Boards aim in protecting their peers, the medical practitioners, even in instances where evidence shows their guilt.

What should also be noted is that the Act does not afford the Board the power to grant compensation to victims even after a favourable finding, there is absolutely no mention of remedies that are available to the victims. The only option the victims have is to seek compensation from the Courts, which, being an expensive and lengthy process, discourages majority of Kenyans. The Act's predisposition to merely punish the practitioners found guilty of wrongdoing and totally ignore ways on how to restore and repair the harm caused by the practitioner points towards a heavy reliance on retributive justice. This shall be discussed further in the next chapter, however in essence, this form of justice shifts focus off the victim and the protection of their right to seek compensation for loss or injury arising from defects in goods or services granted by Article 46 of the Constitution.⁶⁵

While appeals to the Board's decision can be made at the High Court within 30 days, this does not afford the victim a chance to access justice either. Lawyers say that medical negligence cases gather dust in court because expert witnesses are unwilling to testify against doctors.⁶⁶ The cases are eventually dropped due to lack of evidence thereby costing victims their right to justice under the Constitution.

3.4 Conclusion

Having identified the weaknesses in legal and regulatory framework of medical malpractice in the country, the next chapter will now fully analyse these issues on the basis of the research questions and the theoretical framework. It will look at the local context and international practices to highlight the gaps that are in need of reform.

⁶⁵ Article 46(1)(d), *Constitution of Kenya*.

⁶⁶ Ayodo H, *Why courts dismiss medical negligence cases*, Law Society of Kenya, Available at <http://www.lsk.or.ke/index.php/component/content/article/1-latest-news/511-why-courts-dismiss-medical-negligence-cases> Accessed on 28th November 2016.

CHAPTER 4: ANALYSIS OF THE EFFICIENCY OF THE REGULATORY FRAMEWORK

4.1 Introduction

There have been numerous reports of increasing complaints of medical malpractice in the country with doctors easily getting away without sanctions or sufficient punishment.⁶⁷ With 992 cases lodged with the Medical Practitioners and Dentists Board since 1977, approximately 10 doctors only have been found guilty of medical negligence.⁶⁸

Multiple cases of negligence that have garnered the public's attention have led to serious consequences. In one case a woman had a C-section performed by a doctor during which an abdominal pack was accidentally forgotten in the abdomen. Upon returning a week later with complaints of abdominal pains, she was told that it would be an additional charge to remove the pack; she however did not have enough money for that. She thereafter died of the complications caused by the pack in her abdomen.⁶⁹ In another case a doctor authorized a nurse to conduct an unnecessary caesarean on a mother, which resulted in both her and her baby's death yet the doctor was given only four months suspension and there was no legal repercussion for his practice.⁷⁰

The fiduciary duty and high standard of care expected of the medical profession has greatly deteriorated in Kenya over the years, with many patients seriously being harmed by the profession. It is reported that about 20% of all hospital patients die or are harmed of medical malpractice in Kenya, and according to a research done by medical lawyers and independent pathologists, 3 out of 10 patients get the wrong diagnosis in hospitals.⁷¹

⁶⁷ 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/1056-3096208-17s5wv/index.html> on 28th November 2016.

⁶⁸ These figures were acquired from an interview with a representative from the Board.

⁶⁹ 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-in-kenyas-health-facilities-a-public-inquiry-reports/> on 28th November 2016.

⁷⁰ 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> Accessed on 28th November 2016.

⁷¹ 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-killer-doctors/?pageNo=1> Accessed on 28th November 2016.

The Court surmised as much in *Renison Mukhwana & another v Medical Practitioners And Dentists Board*,

‘It cannot have escaped the Boards attention that the kind of medical services presently given to the Kenyan public has deteriorated to the lowest possible standards. In my view and with great respect to the Board, the Board can do more to improve the standard of professional medical service to the people. The Medical Board need not wait until a case such as this arises before it can stamp its supervisory authority and mandate on doctors and health institutions.’⁷²

This chapter seeks to analyse the challenges facing medical malpractice regulation in the country. They will be addressed in two categories: - those that are caused by the inadequacies of the law and those contributed by the inefficiency of the Board. While there may be an overlap between the factors contributing to the sad state of medical profession regulation, this Chapter will address them individually in order to decipher where the weight of the problem lies.

4.2 Inadequacy of The Law

Medical ethics is supposed to play a big role in promoting quality healthcare therefore poorly developed malpractice laws will drastically compromise these services. It is very vital for laws to be constructed in a manner that enhances the welfare of its people and caters to the social interest of all those at stake. There are a number of challenges in the law that have inhibited successful regulation of malpractice, which this section will elaborate on.

4.2.1 Focus on Retributive as Opposed to Restorative Justice.

One challenge is that the general construction of the Kenya Medical Practitioners and Dentists Act points towards a retributive justice stance as opposed to restorative justice, which is more important in this context. The penalties provided in the Medical Practitioners and Dentists (Disciplinary Proceedings) (Procedure) Rules are merely limited to punishing the practitioners such as suspension, ordering closure of institutions and admonishing doctors; and there is no mention of any form of reparation to be accorded to the victims.⁷³ While both forms of justice are desirous of vindicating the wrongful action by punishing the offender,

⁷² *Renison Mukhwana & another v Medical Practitioners And Dentists Board* [2013] eKLR.

⁷³ *Medical Practitioners and Dentists (Disciplinary Proceedings) (Procedure) Rules* (1979).

restorative justice seeks to do this by acknowledging the needs of the victim and the community at large combined with an effort to encourage offenders to take responsibility while retributive justice seeks to punish the offenders by imposing pain.⁷⁴

The Act should be more concerned with justice and restoring the balance rather than merely punishing the offender. Upon completion of an inquiry by the Board, the only legal orders that are given are to do with the guilty practitioner alone. There are no forms of remedy available to the victims even as little as an apology to the patient. Research has it that upon a medical error, victims want an apology from the practitioner, admitting they made a mistake; practitioners however fear they will be admitting liability.⁷⁵

Restorative justice presents a model that addresses medical malpractice while looking at the needs of patients, practitioners and the community at large.⁷⁶ This does not however mean that the needs of the other players in the medical field ought to be disregarded, it just emphasizes on a healing-centred framework that addresses the needs of the patients and community, especially the physician-patient care relationship.⁷⁷ Most of the medical malpractice reforms look at the needs of the practitioners, the hospitals and the insurance companies and this neglects the patients and communities grievances and their need to heal.

4.2.2 Legal Remedies

Under the Medical Practitioners and Dentists Act, the Board is not given the power to grant compensation to affected victims even where the practitioner has been found culpable. The disciplinary process for medical malpractice is a two-step process, when a victim complains to the Board, it is their duty to investigate and determine whether the practitioner accused is guilty or innocent.⁷⁸ If the practitioner is found culpable then they will proceed to determine the punishment that shall be meted out to him/her. There is no mention whatsoever of the remedies that are available to the complainants, if the complaint is successful. In order to get

⁷⁴ Zehr H, *The little book of restorative justice*, Good Books Publisher, Pennsylvania, 2002, 58-59.

⁷⁵ Hyman C, Liebman C, Schechter C, Sage W, *Interest-Based Mediation of Medical Malpractice Lawsuits: A Route to Improved Patient Safety?* Journal of Health Politics, Policy and Law, 2010, 822.

⁷⁶ Todres J, *Toward Healing and Restoration for All: Reframing Medical Malpractice Reform*, Connecticut Law Review, 667, 2006,

⁷⁷ Todres J, *Toward Healing and Restoration for All: Reframing Medical Malpractice Reform*.

⁷⁸ Omoti H, Fundi E, *Assessing The Legal Mechanisms For Redressing Medical Malpractice In Kenya: Just How Effective Are They?*, SSRN, 2007.

compensation, the victim has to file a medical negligence suit in Court, which is an expensive and lengthy process that discourages majority of Kenyans.

In *P.M.N v Kenyatta National Hospital & 6 others*, the plaintiff had first filed his complaint at the Medical Practitioners & Dentists Board but it was dismissed on the grounds that the Board had no power to make monetary awards. He therefore took it before the Court in order to be granted compensation.⁷⁹ What raised concerns in this case was that the Board dismissed the complaint because *they had no power to grant awards* and according to the submissions of the 1st Defendant in this court matter, the plaintiff had submitted the complaint before the *wrong forum*, the Medical Practitioners and Dentists Board, which can only give recommendations but not grant damages. This raises multiple questions, is the fact that the Board cannot grant compensation reason enough to dismiss a legitimate case? If the Board cannot grant compensation then has it failed in its role and purpose thereby rendering it a wrong forum for bringing complaints?

The right to compensation for loss or injury arising from defects in goods or services is a Constitutionally granted right under Article 46(d), which governs consumer's rights.⁸⁰ Any legal, policy or administrative framework must always strive to meet the constitutional benchmark. The Act's silence and absolute disregard for this matter, therefore, questions whether it is indeed capable of protecting the rights of the public and efficiently regulating medical malpractice.

Many occurrences of medical malpractice are not brought before the Court due to the general lack of awareness of the public and also because of the inability of the Board to grant compensation.⁸¹ In most instances, complainants that institute matters before the Board, drop the case upon discovery of the incapacity of the Board to grant compensation or even ordering specific performance of the accused doctor in correcting the wrong committed.⁸²

⁷⁹ *P.M.N v Kenyatta National Hospital & 6 others* [2015] eKLR.

⁸⁰ Article 46, *Constitution of Kenya* (2010).

⁸¹ Mukumu I, *Medical Board Plans To Overhaul Malpractice Rules*, Business Daily. 2009. Available at <http://www.businessdailyafrica.com/-/539444/627476/-/rwegub/-/index.html> Accessed on 27th November 2016.

⁸² According to an interview with a representative of the Board, most victims while raising their complaints, back out at the initial stages, upon discovering that they cannot be granted damages. Most people get discouraged when they learn that they will gain no monetary advantage if they raise their concerns to the Board.

Majority of Kenyans are unable to institute proceedings before the High Court due to monetary concerns and also the inability to get representation, the few that do however end up spending a long time in Court and spend a lot of money with a large chunk being set aside for the lawyer representing them. All this coupled with the fact that there is no guarantee that the Court will find in their favour serves as a great hindrance.

As discussed earlier, the Act's reliance solely on retributive justice as opposed to restorative justice shifts the focus from the victims and does not grant them a chance to access justice sufficiently. This research paper does not however deny that punishing the doctors for their negligence serves to control medical malpractice. While it may largely serve that purpose, acknowledging the need for the victims to be rehabilitated and to, as much as is possible, grant them any form of legal remedies would address the needs of the aggrieved complainant.

What has also prevented the victims from being granted compensation is that the Board's inquiry has been considered as being a quasi-criminal process while the Court has been categorised as a civil law jurisdiction. In the case of *J.O.O. & 2 others v Praxades P Mandu Okutoyi & 2 others*, the Court held 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.⁸³ Similarly, in *Atsango Chesoni v David Mortons Silverstein*, the High Court found that the standard of proof of complaints brought before the Board is that of professional misconduct strictly and not on a balance of probability.⁸⁴ This essentially means that the inquiry is of a criminal nature and should therefore not be regarded as a civil matter. All in all, legal remedies are exercised in civil law jurisdictions therefore looking at malpractice matters as being of a criminal nature bars victims from being granted judicial relief.

4.3 Inefficiency of The Board

This section will now tackle ways in which the Board has failed to effectively regulate medical malpractice. Transparency International, while conducting a Health Integrity Study in Kenya, found that regulatory bodies have become lax in enforcing rules, regulations and

⁸³ *J.O.O. & 2 others v Praxades P Mandu Okutoyi & 2 others* [2011] eKLR.

⁸⁴ *Atsango Chesoni v David Mortons Silverstein* (2005) eKLR.

guidelines governing the quality of healthcare services in the Kenya.⁸⁵ The Kenya Health Sector Integrity Study Report observed that these bodies tend to protect the medical professionals instead of focusing on the healthcare issues that have been perpetrated. In most instances, Kenyans find out about cases that have garnered little or no action from the regulatory authorities from the media. This laxity of the regulatory bodies has led to unscrupulous medical professionals violating many health care standards through the existing loopholes without the fear of penal consequences.⁸⁶

4.3.1 Self-Regulation

A major factor that has contributed to the laxity of the Medical Practitioners and Dentists Board in carrying out disciplinary proceedings is the fact that there is substantial self-regulation, which has been proven to be weak and ineffective.⁸⁷ While self-regulation may be advantageous, given the small amount of resources required to administer it, the greater disadvantage of lack of effectiveness and transparency far surpasses it. The close relationship between the regulatory body, the Board, and the ones being regulated, the practitioners, may jeopardize the implementation of regulation, as the regulator may be protective of or can easily be manipulated by the regulatees; a phenomenon referred to as regulatory capture.⁸⁸

Self-regulation in the medical field began well beyond the 19th century, where societies, in the mid-1850's delegated their traditional powers such as regulation to the physicians.⁸⁹ The rationale for this was that the medical field required extensive and complex knowledge and skill and could thus not be handled by non-professionals. It was thought that the medical profession could be trusted to carry this task out successfully however in the 20th Century many social scientists found that the profession had abused this privileged status and their regulation was thoroughly flawed.⁹⁰ They were criticized for applying weak, variable and inconsistent standards, for using collegiality as a protection for physicians' wrongdoing and

⁸⁵ Transparency International-Kenya, *The Kenya Health Sector Integrity Study Report*, Transparency International-Kenya, (2011), 20.

⁸⁶ Transparency International-Kenya, *The Kenya Health Sector Integrity Study Report*, 20.

⁸⁷ Muthanka 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, 2004, 37..

⁸⁸ Muthanka D, Kimani D, Mwaura S, *A Review of the Regulatory Framework for Private Healthcare Services in Kenya*, 37.

⁸⁹ Larson M. *The Rise of Professionalism: A Sociological Analysis*, University of California Press, 1977.

⁹⁰ Cruess S, Cruess R, *The Medical Profession and Self-Regulation: A Current Challenge*, AMA Journal of Ethics, 2005.

for not exhibiting transparency and involvement of the public in regulatory procedures. All in all the profession was accused of lacking accountability and the need for the public's involvement was emphasized.⁹¹

Self-regulation in the medical profession is a complex task that requires many layers of oversight to ensure that practicing professionals are competent enough.⁹² For this to be achieved then the profession and its regulatory role must ensure that those in practice maintain their competence,⁹³ must take appropriate action once a problem with an individual practitioner has been identified,⁹⁴ and should sufficiently regulate conflicts of interest.⁹⁵ Many developing countries tend to focus more on licensing and regulating entry into the medical profession rather than inspecting the medical professionals performance, which thereby gives leeway to these professionals to escape effective regulation.⁹⁶

The Kenya Medical Practitioners and Dentists Board fails to fulfil this role of self-regulation by failing to ensure competence of the professionals, evidenced by the large rate of 'fake doctors' taking over many hospitals in the country,⁹⁷ by failing to take up certain complaints that come up before them and by placing lenient penalties for doctors in cases that have even caused death.⁹⁸

The conflict of interest present in the double role that the Board plays, which is representing medical practitioners and also regulating medical practice has also raised suspicion that the Board is more geared towards supporting doctors as opposed to protecting the patients.⁹⁹ For instance in the Kenyan case of *George Moga v Nairobi Women's Hospital & 3 Others*, discussed earlier, the Court found that the Board was contradictory in the findings and recommendations of their report, as their findings clearly showed that the two doctors had

⁹¹ Cruess S, Cruess R, *The Medical Profession and Self-Regulation: A Current Challenge*, AMA Journal of Ethics, 2005.

⁹² Freidson E. *Professional Dominance: The Social Structure of Medical Care*, Aldine de Gruyter, 1970.

⁹³ Houle C., *Continuing Learning in the Professions*, Jossey-Bass Publishers, 1980.

⁹⁴ Houle C., *Continuing Learning in the Professions*, 1980.

⁹⁵ DeAngelis CD., *Conflict Of Interest and the Public Trust*. JAMA, 2000, 284.

⁹⁶ Cortez N, *A Medical Malpractice Model For Developing Countries*, Drexel Law Review, 2011, 225.

⁹⁷ Fleming N, *Kenya: Fake Doctors Run Kenya's Unregulated Hospitals*, All Africa News, 2015. Available at <http://allafrica.com/stories/201509160217.html> Accessed on 21st November 2016.

⁹⁸ Mukumu I, *Medical Board Plans To Overhaul Malpractice Rules*, Business Daily, 2009.

⁹⁹ Omitti H, Fundi E, *Assessing The Legal Mechanisms For Redressing Medical Malpractice In Kenya: Just How Effective Are They?*, SSRN, 2007.

failed to exercise the duty of care expected of a doctor while the recommendations found that they were not negligent in the management of the deceased.¹⁰⁰

Devolving regulatory functions to representative bodies almost always causes the risk of conflict of interest.¹⁰¹ Countries such as South Africa and Nigeria have different bodies tackling regulatory functions and representative functions. This phenomenon of conflict of interest also occurs in more developed countries, for instance, documentary, resources and efforts by the Spanish Provincial Colleges of Doctors reveals a heavy inclination towards supporting doctors instead of protecting patients.¹⁰²

A company of equals, as defined by Barber, when applying it to the medical field, is *a social group in which each permanent member in the community of medical practitioners is roughly equal in authority, self-directing and self-disciplined, pursuing the goal of ensuring highest quality care to patients under the guidance of the medical morality he has learned from his colleagues and which he shares with them. The sources of purpose and authority are in his own conscience and in his respect for the moral judgments of his peers. If his own conscience is not strong enough, the disapproval of others will control him or will lead to his exclusion from the brotherhood.*¹⁰³

In this ‘company of equals’, physicians expect mutual trust from each other and will therefore operate with the belief that no one should be checking up on them and will avoid giving the impression that they are also checking up on others. Therefore even if a particular physician is not practicing the required standard of care, any peer that notices this will not say anything to the requisite authority. This avoidance of investigation limits the flow of information that is necessary for the success of a system of control.¹⁰⁴ Freidson and Rhea, in their Article, *Processes Of Control In A Company Of Equals*, also argue that this system of control is neither hierarchical nor collective; it operates like a free market where private individuals exercise control where their personal interests are involved.¹⁰⁵

¹⁰⁰ George Moga v Nairobi Women’s Hospital & 3 others [2015] eKLR.

¹⁰¹ Vries H, Sanderson P, Janta B, Rabinovich L, Archontakis F, Ismail S, Klautzer L, Marjanovic S, Patruni B, Puri S, Tiessen J, *International Comparison of Ten Medical Regulatory Systems*, RAND Corporation, 2009.

¹⁰² Vries H, *International Comparison of Ten Medical Regulatory Systems*, 6.

¹⁰³ Barber B, *Science and the Social Order*, New York: Collier Books, 1962, 144.

¹⁰⁴ Freidson, E., Rhea, B, *Processes of Control in a Company Of Equals*. Oxford University Press, 1963, 197.

¹⁰⁵ Freidson, E., Rhea, B, *Processes of Control in a Company Of Equals* 119-131.

The self-regulation of the medical profession in the UK is a perfect example of the failure of peer sanction. The collegial model of self-regulation managed to survive for 150 years before it was brought down by multiple scandals involving ‘bad apple’ doctors.¹⁰⁶ Some of the shocking scandals included a doctor, one Mr Harold Shipman, being convicted of 15 charges of murder, a gynaecologist Clifford Ayling convicted in 2000 of 12 counts of indecent assault on women he had treated as a GP and gynaecologist, and two surgeons operating with substandard practice resulted in the deaths of around 30 children. Despite these scandals, the GMC (General Medical Council), the regulatory body of medical practitioners, did not address the matters.

This was due to the collegium’s formal systems for addressing malpractice, which were weak and ineffective. They instead operated as a form of institutional silencing, seeking to protect their peers by subjecting the doctors to quiet chats. According to Inquiries conducted following the increased number of scandals,¹⁰⁷ the GMC had failed to successfully regulate their profession in many ways. First and foremost they made it difficult for patients to make formal complaints against doctors during the occurrences of these scandals; they also discouraged doctors from making complaints against each other where there was concern regarding a doctor’s operation. They also set a high threshold for the GMC’s intervention in cases by confining their remit to cases of serious professional misconduct only.¹⁰⁸

Following these scandals, the self-regulation era of the medical profession came to an end; powers of setting standards, monitoring practice, and managing defaults among others were relocated to outside the profession.¹⁰⁹ State-backed supervision with the powers of intervention was also established in the form of the Council for Healthcare Regulatory Excellence, in 2003. The long tradition of doctors occupying a majority of positions on the

¹⁰⁶ Dixon-Woods M, Yeung K, Bosk CL., *Why Is UK Medicine No Longer a Self-Regulating Profession? The Role Of Scandals Involving “Bad Apple” Doctors*, Social Science & Medicine, 2011. Available at <https://www.kcl.ac.uk/law/people/Bad-Apples-in-Medicine-Karen-Yeung.pdf> Accessed on 21st November 2016.

¹⁰⁷ An Inquiry was set up following each Scandal; the Shipman Inquiry was set up to investigate the Shipman Scandal and the Ayling Inquiry was looking into the Ayling Scandal. Most of these Scandals had similar observations and findings, which have been discussed altogether in the failures of the GMC.

¹⁰⁸ Dixon-Woods M, Yeung K, Bosk CL., *Why Is UK Medicine No Longer a Self-Regulating Profession? The Role Of Scandals Involving “Bad Apple” Doctors*, <https://www.kcl.ac.uk/law/people/Bad-Apples-in-Medicine-Karen-Yeung.pdf> on 27th November 2016.

¹⁰⁹ Dixon-Woods M, Yeung K, Bosk CL., *Why Is UK Medicine No Longer a Self-Regulating Profession? The Role Of Scandals Involving “Bad Apple” Doctors*, 2.

GMC as well as controlling the membership of the Council also ended as members were appointed independently.

The Nigerian and the South African system have also made attempts to reduce the occurrence of conflict of interest by separating the regulatory function and representative function of the medical profession, as mentioned earlier.¹¹⁰

The Board has also in some instances breached the law and its own rules to unprocedurally dismiss complaints of victims without granting them a right to be heard. In the famous reproductive rights case of *M.N.N v AG of Kenya*,¹¹¹ the Board underwent heavy criticism for dismissing the claims of M.N.N without explanation and without allowing her to present her case. In this particular matter, a doctor in a private hospital, mutilated the genitals of a Kenyan woman, without her knowledge or consent. Both the board and the police turned her away without giving her a chance to present her case. In addition, *Republic v Kenya Medical Practitioners and Dentists Board and 2 others*,¹¹² the court observed that for the Committee to fully discharge its mandate, it must look at the whole matter attentively, carefully, think or deliberate upon it before reaching a conclusion. The Court was not satisfied that the Board had conducted itself in a manner that met the criteria set out in Article 47 of the Constitution with respect to procedural fairness and therefore quashed its decision. Concerning this it stated:

*“An administrative action cannot be said to be procedurally fair when the process of arriving at it is shrouded in mystery. Further an administrative action cannot be said to be procedurally fair where a decision is arrived at based on other issues which were not the subject of investigation by the Tribunal unless the charges are amended and a proper opportunity given to the party charged to respond thereto.”*¹¹³

Another challenge strongly tied to self-regulation, is that there is no transparency in the institution. While the Board may in most cases not be willing to take up matters due to the ‘overriding’ need to protect their own self interests and their peers, they fail to share

¹¹⁰ Vries H, *International Comparison of Ten Medical Regulatory Systems*, 6.

¹¹¹ Kenya National Commission on Human Rights, ‘*Realising Sexual and Reproductive Health Rights in Kenya: A myth or reality?*’, 2012

¹¹² Republic V Kenya Medical Practitioners And Dentists Board & 2 Others (2013) eKLR.

¹¹³ Republic V Kenya Medical Practitioners And Dentists Board & 2 Others (2013) eKLR.

information upon completion of their investigations therefore making it hard for the public to know whether they are carrying out their mandate successfully.

There have been instances where the Board has not publicized cases of medical malpractice for fear of shaming the doctor or damaging their reputation.¹¹⁴ The greater question to ask when dealing with transparency is how transparent the board should be in their investigations of medical malpractice in the country in order to achieve a balance between conflicting principles of professional privacy and public transparency. The Board deals with medical malpractice cases that are central to the doctor-patient relationship, which is essentially privileged and confidential information but also has a fiduciary duty towards the public that is vulnerable and reliant on them. Given the public's lack of awareness and general information concerning the Board and their rights to lodge complaints, it is very necessary for the board to release its findings if only to reassure them that their right to health is protected.

4.3.2 Scarcity Of Skilled Medical Practitioners

The general theory of self-regulation is however not the only factor contributing to the laissez-faire attitude of the Board. Nathan Cortez in his article, *A Medical Malpractice Model For Developing Countries*, while looking at medical malpractice regulation highlights the factors that affect developing countries.¹¹⁵ One factor that the author brings out is that developing countries have a scarcity of professional doctors thereby causing a monopolistic atmosphere, which eventually presents the health care professionals with an opportunity to avert meaningful external regulation and accountability. He argues that many of these developing countries educate medical practitioners and nurses locally only to watch them leave the country and take their skills to more developed countries such as Australia and the UK. This creates a shortage in the developing country, or what is referred to as brain drain, hence the need for the regulatory authorities to protect the little skill and expertise possessed by the doctors locally.

While it may seem that the effects of brain drain in countries cannot possibly be drastic, a research study done in the year 2006 analyzing the cost of health professionals' brain drain in

¹¹⁴ Muthanka D, Kimani D, Mwaura S, *A Review of the Regulatory Framework for Private Healthcare Services in Kenya*, 38.

¹¹⁵ Cortez N, *A Medical Malpractice Model For Developing Countries*, *Drexel Law Review*, 2011, 221.

Kenya clarifies this misguided notion.¹¹⁶ The objectives of the study were to estimate the opportunity cost of emigration of Kenyan doctors to the United Kingdom (UK) and the United States of America (USA); to estimate the opportunity cost of emigration of nurses to seven OECD countries (Canada, Denmark, Finland, Ireland, Portugal, UK, and USA); and to describe other losses from brain drain. The key findings were:-

The total cost of educating a single medical doctor from primary school to university was US\$ 65,997. On average, for every doctor that emigrated, a country lost about:

- i. US\$ 517,931, assuming a 6.65% interest rate;
- ii. US\$ 314,472, assuming an interest rate of 5%; and
- iii. US\$ 6,902,125, assuming an interest rate of 15.64%.

In addition, the total cost of educating one nurse from primary level to college of health sciences was US\$ 43,180 and averagely every time a nurse emigrated, the country lost about:

- i. US\$ 338,868, assuming a 6.65% interest rate;
- ii. US\$ 205,750, assuming an interest rate of 5%; and
- iii. US\$ 4,515,869, assuming an interest rate of 15%.

The application of an interest rate of 15.64% instead of 6.65% increased the economic losses resulting from emigration of a doctor and a nurse by 13-fold.

Financial losses aside, the brain drain of medical personnel leaves only a few skilled ones in the country, which causes the increasing need for the Board to retain and protect them. This also raises a desperate need for more doctors in regions, especially the rural ones, thereby resulting in insufficient checks on backgrounds of applicants or whether they have any medical training at all.¹¹⁷ Quite a number of people have taken advantage of the inadequacy of skilled practitioners in the country and are masquerading as ‘doctors’ in unregulated hospitals. These quack doctors are perpetrating the occurrences of medical malpractice thus worsening the already dire state. According to a research conducted by the Kenya Medical Practitioners Pharmacists and Dentists Union, about 90% of Kenyan clinics are run by

¹¹⁶ Kirigia JM Gbary R, Muthuri L, Nyoni J, Seddoh A, *The Cost of Health Professionals' Brain Drain in Kenya*, BMC Health Services Research, 2006.

¹¹⁷ Fleming N, *Kenya: Fake Doctors Run Kenya's Unregulated Hospitals*, All Africa News, 2015. <http://allafrica.com/stories/201509160217.html> Accessed on 21st November 2016.

unqualified personnel.¹¹⁸ Only recently, a ‘doctor’ from Meteitei Sub-County Hospital in Nandi County, Ronald Kiprotich Melly, was taken to Court for practising medicine without qualifications and possible forgery of documents. He was never a student at the University and yet had practiced for quite a number of years without detection.¹¹⁹ The Board only launched investigations after Mr. Melly presented himself at the Board offices seeking permanent registration though he had never been to university, graduated or been properly licensed to practise medicine.

In summary, the decrease in skilled practitioners in the country leads to a high intake of doctors despite their level of skill and expertise, which thereby increases the complaints of medical malpractice.

4.4 Conclusion

Taking all this into consideration, it is not correct to attribute the rise of litigation and complaints of medical malpractice solely on the actual increase of medical negligence; the increasing access to information, accountability and consumer awareness, a result of greater actualization of constitutional rights, has largely contributed to it also.

The increasing litigation of medical malpractice has however also led to defensive medicine,¹²⁰ which is the practice of recommending treatment that is not necessarily the best option for the patient but is the best way for the doctor to protect himself from liability in the event of a bad occurrence.¹²¹ Doctors order tests, follow procedures that are not necessary, all in a bid to protect themselves from future liability.¹²² This only increases the cost of health care, is a waste of resources set aside for health care and can expose the patients to unnecessary risk.

¹¹⁸ Fleming N, *Kenya: Fake Doctors Run Kenya's Unregulated Hospitals*, All Africa News, 2015.

<http://allafrica.com/stories/201509160217.html>

¹¹⁹ *Quack Doctor Was Never a Medicine Student at The University*, Daily Nation, 2016,

<http://www.nation.co.ke/news/UoN-denies-quack-doctor-was-its-medical-student/1056-3461036-i41gmjz/>

Accessed at 22nd November 2016.

¹²⁰ Magoha George, *Medical Litigation and How to Manage It*, Kenya Medical Association, 2013.

¹²¹ Studdert DM, Mello MM, Sage WM, *Defensive medicine among high risk specialist physicians in a volatile malpractice environment*. The Journal of American Medical Association. 2005, 2609.

¹²² Magoha George, *Medical Litigation and How to Manage It*, 27.

CHAPTER 5: CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter will highlight the findings, recommendations and conclusions of the study. This research study was undertaken with the intention of determining whether the current disciplinary proceedings for medical malpractice provided are efficient.

5.2 Findings and Recommendations

As has been seen, the Kenya Medical Practitioners and Dentists Act focuses more on punishing the practitioner and deterring future occurrences of the tort but has neglected the primary objective, which is to compensate victims for injuries suffered. When giving its determination the Board does not have the legal mandate to grant compensation and this discourages many victims from instituting complaints before them. The inability of the provided disciplinary proceedings to render justice to victims leads them to seek justice in the courts, which does nothing but add on to the massive case backlog that the courts are already plagued with. In addition, most people do not have the funds to secure representation or to even meet the demands in instituting proceedings in court thereby limiting their access to justice.

The Act, as read together with the Rules, only has provisions on forms of punishing the guilty medical practitioner and does not concern itself with ways to heal things and attempt to return the victim back to the position they were in before the occurrence of the tort. Both retributive justice and restorative justice seek to punish the offender, however how they go about it differs. Restorative justice seeks to do this by identifying and addressing the needs and obligations of the victim and the society at large, while retributive justice places more emphasis on exerting all forms of punishment on the offender. The medical malpractice legal framework needs to shift towards a restorative justice stance in order to transform the system and the public's belief in it.

The main objectives of tort law are, to put the victim back to the position they were in before the occurrence of the tort, through compensation; to hold the tortfeasor liable and accountable for occurrence of the tort; and to deter future occurrences of tortious injuries. Laws governing medical malpractice, a subset of tort law, should therefore seek, in as much as is possible, to

fulfill the above objectives. In dealing with this the law needs to be reformed in order to allow for the recognition of the rights of the victims with regards to compensation. The penalties that can be meted by the Preliminary Inquiry Committee, the Professional Inquiry Committee and the Tribunal, during the disciplinary proceedings, provided under the Medical Practitioners and Dentists (Disciplinary Proceedings) (Procedure) Rules of 1979 should be expanded to include compensation or any other form of reparation that can be afforded to the victims. This will contribute largely to increasing the public's knowledge and interest in bringing complaints before the Board as opposed to only seeking redress in courts or not bringing complaints at all.

Another issue that has been greatly discussed in this research study is the conflict of interest present in the double role that the Board plays, in both representing doctors and also regulating the practice of medicine in the country. The self-regulation of the profession has engendered a protective attitude of the Board when it comes to investigating complaints by a patient or even rendering a judgment upon completion of an investigation. Many cases have been thrown out before due diligence was carried out or even in some instances where the practitioner has been found guilty, the penalty given to them does not correspond to the harm caused.

The representative role and the regulatory role, both currently handled by the Board should therefore be separated in order to reduce conflict of interest. The Board has become lax in enforcing the rules and regulations surrounding its disciplinary role, an occurrence highly contributed to by the fact that it is regulating its peers. As has been discussed in the previous chapter, countries such as Nigeria and South Africa have managed to deal with the conflict of interest dilemma by devolving the representative role to a different body. UK also managed to reduce the conflict of interest by transferring most of the 'exploitable' powers outside the regulatory body. The first step in reducing regulatory capture is to do away with the culture of acquiescence that has given it room to flourish. It is therefore very vital to ensure an unbiased body that does not consist of members solely from the medical field is handling the regulatory role.

Aside from that, there is a scarcity of skilled medical professionals in the country, which has lowered the standards for the acceptance of 'doctors' into the medical professions. The case

of quack doctors infiltrating the medical profession has become very critical. Measures should urgently be set up to control this and the crackdown on them needs to be intensified. The medical field is one area where mistakes cannot and should not be tolerated, there are far too many lives at stake. Therefore the process of investigating and hiring doctors needs to be more meticulous in order to reduce the large numbers of inexperienced and unskilled doctors finding their way into the medical profession. It is very important to curb this before it becomes a serious conundrum.

The effectiveness of a tort system in minimizing tortious acts, adequately compensating victims and preventing future occurrences largely depends on the public's ability to get a fair trial and the public's perception of that ability.¹²³ The tort theory therefore breaks down if the general population does not anticipate the justice or does not have access to courts or the legal structure mandated to do so. However if the legal structure tasked with managing complaints of medical malpractice, in this instance the Medical Practitioners and Dentists Board, cannot fairly and efficiently manage these claims then the law will be ineffective in being able to control the issues that the reform sought to address.¹²⁴ That being said, while the law needs to be reformed, it is also very important for the Board to ensure it effectively carries out its mandate.

5.3 Conclusion

This research has found the legal and regulatory framework for medical malpractice to be deficient. Having seen the plight facing the Kenyan medical malpractice system, this author argues that there is room for reform. However more of the reform needs to be directed towards the law as it carries the weight of the problem. While there has been some progress over the years, there is still a long way to go before the health care system is set to achieve the required standards of the World Health Organization.

No medical malpractice system is perfect, taking into consideration the costs of litigation, quality of care, deterrence, financing, and fairness of compensation simultaneously.¹²⁵ It is

¹²³ Kearney J, *Why China's 2010 Medical Malpractice Reform Fails To Reform Medical Malpractice*, Emory International Law Review, 2012, 1041.

¹²⁴ Kearney J, *Why China's 2010 Medical Malpractice Reform Fails To Reform Medical Malpractice*, 1041.

¹²⁵ World Bank, *Medical Malpractice Systems Around the World: Examples from the US- tort liability system and the Sweden- no fault system*, Available at

therefore very vital for countries to adopt medical malpractice systems that are tailored to the conditions and the needs of their country. Kenya, in shaping its reform, should seek to borrow best practices of countries whose structures are similar to it. Probing these countries systems and looking at their efficiency, will be instrumental in determining the way forward for the Kenyan system.

BIBLIOGRAPHY

Books

- Aristotle, *Nicomachean Ethics*, Book V, Kitchener, Ont: Batoche Books, (1999).
- Zehr H, *The little book of restorative justice*, Good Books Publisher, Pennsylvania, (2002).
- Freidson E. *Professional Dominance: The Social Structure of Medical Care*, Aldine de Gruyter, (1970).
- Houle C., *Continuing Learning in the Professions*, Jossey-Bass Publishers, (1980).
- Freidson, E., Rhea, B, *Processes of Control in a Company Of Equals*. Oxford University Press, (1963).
- Barber B, *Science and the Social Order*, New York: Collier Books, (1962).

Journal Articles

- Graber M, *Transforming Free Speech: The Ambiguous Legacy of Civil Libertarianism*, University of California Press, (1991).
- Weinrib, E J. *Corrective Justice in a Nutshell*, The University of Toronto Law Journal, 52.4, (2002).
- Pound, R, *A Survey of Social Interests*, Harvard Law Review 57.1, (1943).
- Verhelle J C., *Roscoe Pound and His Theory of Social Interests*, Loyola University Chicago, (1958).
- James A. Gardner, *The Sociological Jurisprudence of Roscoe Pound*, (Part I), 7 Vill. L. Rev. 1 (1961).
- Nalbandian E J, *Sociological Jurisprudence: Roscoe Pound's Discussion on Legal Interests and Jural Postulates*, (2014).
- Weinrib E J, *The gains and losses of corrective justice*, Duke Law Journal, (1994).
- Weinrib, E J, *Corrective Justice in a Nutshell*. The University of Toronto Law Journal, (2002).

Olsen R N., *The Efficiency of Medical Malpractice Law: Theory and Empirical Evidence*, Southwest Missouri State University, (2000).

Stigler G, *The Theory of Economic Regulation*, University of Chicago, (1971).

Hyman C, Liebman C, Schechter C, Sage W, *Interest-Based Mediation of Medical Malpractice Lawsuits: A Route to Improved Patient Safety?* *Journal of Health Politics, Policy and Law*, (2010).

Todres J, *Toward Healing and Restoration for All: Reframing Medical Malpractice Reform*, *Connecticut Law Review*, 667, (2006).

DeAngelis CD., *Conflict Of Interest and the Public Trust*. *JAMA*, (2000).

Omiti H, Fundi E, *Assessing The Legal Mechanisms For Redressing Medical Malpractice In Kenya: Just How Effective Are They?*, SSRN, (2007).

Larson M. *The Rise of Professionalism: A Sociological Analysis*, University of California Press, (1977).

Cruess S, Cruess R, *The Medical Profession and Self-Regulation: A Current Challenge*, *AMA Journal of Ethics*, (2005).

Studdert DM, Mello MM, Sage WM, *Defensive medicine among high risk specialist physicians in a volatile malpractice environment*. *The Journal of American Medical Association*. (2005).

Reports

Vries H, Sanderson P, Janta B, Rabinovich L, Archontakis F, Ismail S, Klautzer L, Marjanovic S, Patruni B, Puri S, Tiessen J, *International Comparison of Ten Medical Regulatory Systems*, RAND Corporation, (2009).

Cortez N, *A Medical Malpractice Model For Developing Countries*, *Drexel Law Review*, (2011).

Kenya National Commission on Human Rights, *‘Realising Sexual and Reproductive Health Rights in Kenya: A myth or reality?’*, (2012).

Transparency International-Kenya, *The Kenya Health Sector Integrity Study Report*, Transparency International-Kenya, (2011).

Muthanka 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, (2004).

Kearney J, *Why China's 2010 Medical Malpractice Reform Fails To Reform Medical Malpractice*, Emory International Law Review, (2012).

Kirigia JM Gbary R, Muthuri L, Nyoni J, Seddoh A, *The Cost of Health Professionals' Brain Drain in Kenya*, BMC Health Services Research, (2006).

Internet Sources

<http://medicalboard.co.ke/about-us/mission-vision/>.

Ndemo B, *Our Medical Malpractice Crisis*, July 21 2014. L

<http://www.nation.co.ke/oped/blogs/dot9/ndemo/-/2274486/2391482/-/2w7q2pz/-/index.html> on 14 December 2015.

Magoha George, *Medical Litigation and How to Manage It*, 2013.

http://www.rmdc.rw/IMG/pdf/KMA_PRESENTATION_FINAL-2.pdf on 14 December 2015.

US Legal, *Captured Agency: Law and Legal Definition*.

<https://definitions.uslegal.com/c/captured-agency/> on 22 November 2016.

Crisler J, *The burden of proof in medical liability cases: A preponderance of the evidence*, <http://www2.aaos.org/bulletin/feb06/rskman2.asp> on 12th January 2017.

Mwaura N, Rogo K, Wafula F, *Focusing on Patient Safety and Quality of Care: Preventing Medical Malpractice and Negligence in Kenya*, The World Bank, 2016. Available at <http://blogs.worldbank.org/health/focusing-patient-safety-and-quality-care-preventing-medical-malpractice-and-negligence-kenya> on 28th November 2016.

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> on 28th November 2016.

Kilonzo E, *Only one doctor has been found guilty of misconduct in 19 years*, Daily Nation, 2016. Available at <http://www.nation.co.ke/news/Only-one-doctor-has-been-found-guilty-of-misconduct/1056-3096208-17s5wv/index.html> on 28th November 2016.

Ayodo H, *Why courts dismiss medical negligence cases*, Law Society of Kenya, Available at <http://www.lsk.or.ke/index.php/component/content/article/1-latest-news/511-why-courts-dismiss-medical-negligence-cases> on 28th November 2016.

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-in-kenyas-health-facilities-a-public-inquiry-reports/> on 28th November 2016.

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-killer-doctors/?pageNo=1> on 28th November 2016.

Fleming N, *Kenya: Fake Doctors Run Kenya's Unregulated Hospitals*, All Africa News, 2015. Available at <http://allafrica.com/stories/201509160217.html> on 28th November 2016.

Dixon-Woods M, Yeung K, Bosk CL., *Why Is UK Medicine No Longer a Self-Regulating Profession? The Role Of Scandals Involving "Bad Apple" Doctors*, Social Science & Medicine, 2011. Available at <https://www.kcl.ac.uk/law/people/Bad-Apples-in-Medicine-Karen-Yeung.pdf> on 28th November 2016

World Bank, *Medical Malpractice Systems Around the World: Examples from the US- tort liability system and the Sweden- no fault system*, Available at http://siteresources.worldbank.org/INTRUSSIANFEDERATION/Resources/Malpractice_Systems_eng.pdf on 28th November 2016.