HERMAN NYANGALA TSUMA…….....…….…....PLAINTIFF

VERSUS

THE KENYA HOSPITAL ASSOCIATION

T/A THE NAIROBI HOSPITAL….....1ST DEFENDANT

DR JAMES MBUVI……..…..……2ND DEFENDANT

DR ERNEST KIOKO…….3RD DEFENDANT

JUDGEMENT

1. The Plaintiff, **Herman Nyangala Tsuma**, by his amended plaint dated 26th June 2007 and amended on 2nd August 2007 and filed in this Court on 2nd August 2007 seeks from the Defendants jointly and severally General Damages, Special Damages, Costs and interests arising from his management while admitted at **Nairobi Hospital**, the 1st defendant herein (hereinafter referred to as the Hospital). According to the plaintiff, as a result of the professional negligence on the part of the defendants, the plaintiff was put to great mental distress and suffered and continues to suffer loss and damage and he has thereby been exposed to the need for future and continued therapy. The particulars of negligence and future medical therapy were particularised in the said amended plaint.

2. The first and second defendants filed a joint defence on 12th September 2007 in which they denied that the 3rd defendant is employed by the first defendant and hence denied that the 1st defendant is vicariously liable for the acts or omissions of the 3rd defendant. While admitting that the 2nd defendant is employed by the 1st defendant, they however averred that the 2nd defendant has no admission rights in the Hospital and hence denied the plaintiff's claim that he was so admitted. According to the said defendants, the 1st defendant is a nursing hospital and admits patients strictly on the instructions of independent consultants who are fully responsible for the treatment of their patients. They admitted that on 12th February 2007, the plaintiff was attended to by the 2nd defendant in the Accident and Emergency Department when he was very ill and in the company of his spouse. As the plaintiff stated that he had no doctor or medical insurance the 2nd defendant after diagnosing right pneumonia of Chest referred the plaintiff to the 3rd defendant who was the consultant on duty on that day since the plaintiff's condition required immediate admission. According to these defendants, they did not by the fact of such reference accept responsibility for the 3rd defendant's management of the plaintiff. Thereafter it was the duty of the plaintiff to appoint a consultant physician of his choice and is hence responsible for the delay in appointing his consultant physician up to 24th February 2007. They deny any unethical, unprofessional or unreasonable conduct on their part and aver that after the plaintiff's admission they did not give any orders or direct his further management or care and further deny that the plaintiff disclosed that he had a doctor. Accordingly, the defendants denied liability and prayed that the suit be dismissed with costs.

3. On his part the 3rd defendant apart from challenging the competency of the suit admitted that the

plaintiff was under his management. He, however, denied that he carried any tests on the plaintiff and further denied that the plaintiff developed any complications attributed to him. According to him, he diligently attended to the Plaintiff and no liability or cause of action accrued against him as alleged by the plaintiff. The medical surgery, according to the 3rd defendant was carried out with the plaintiff's full knowledge and consent hence the doctrine of *volenti non fit injuria* applies. In the 3rd defendant's view the suit ought to be dismissed with costs.

4. There was a reply to these defences in which the plaintiff pleaded ignorance of the Hospital's administrative structures and professional echelons and averred that even had he consented to the surgery that would not diminish the doctor's duty to the patient.

5. In his evidence, the Plaintiff, **Herman Nyangala Tsuma**, PW1 stated that on 11th February 2007 he started feeling feverish and had a lot of pain in his chest. Initially he thought the pain would go away but the following day 12th February 2007, his condition worsened and his vision was blurred. He, in the company of his wife went to the Hospital where he met **Dr Mbuvi**, the second defendant at the Accident and Emergency Area. The second defendant examined him and carried out some tests on him after which he was told he had pneumonia and was admitted from the said 12th February 2007 to 11th March 2007. On admission, he was wheeled to the ward where **Dr Kioko**, the third defendant went and told him that he was under the third defendant's care. He never saw **Dr Mbuvi** after that. He later became aware that the third defendant is a renal specialist. According to him his problem was in his chest and he had no renal problems. He was under **Dr Kioko's** care for two weeks until 25th February 2007. For the said two weeks there was no improvement in his condition and in fact according to him he felt worse. On 24th February 2007 the plaintiff asked if he could be seen by his family physician, **Dr Chunge**. On 25th February 2007 having not seen **Dr Chunge**, he called him and requested the said doctor to go and see him. However, the doctor told him he required authorisation from the Hospital. On 26th February, 2007 **Dr Chunge** informed him he had been permitted to see him. After examination **Dr Chunge** informed him that his conditions had worsened and recommended that a chest specialist, **Dr Gathua** be called since **Dr Chunge**, just as **Dr Mbuvi** had diagnosed pneumonia. **Dr Gathua** told him after examination that had he seen him earlier he would have put the plaintiff on oral treatment and the plaintiff would have gotten well. However, in his state he had to undergo an operation. When **Dr Chunge** and **Dr. Gathua** came, the plaintiff was told by **Dr Kioko** that he had brought him two senior doctors to take care of him and that he would nolonger take care of the plaintiff.

6. The plaintiff consented to the said operation which was carried out on 2nd March 2007 about 2½ weeks after admission. The operation, he was told was to remove what was accumulating in his chest. The said operation was carried out by **Dr. Munene** on instructions of **Dr Gathua**. After the surgery, he felt better although the pain was still there and he was discharged on 11th March 2007 when his condition had improved. According to him, his complaint is that between the period of admission and the time of operation there must have been something amiss and that had he been properly managed he would not have suffered the way he did. In his view the defendants were negligent yet he expected high quality treatment. He ended up spending a sum of Kshs. 720,781/= which sum he would not have spent had he been treated properly. As a result of the said operation his lifestyle was disrupted since he can nolonger take cold bath and is on regular medication. Asked about **Dr. Lwai Lume**, the plaintiff said he has no knowledge of the person. He produced his bundles of documents filed in this case as exhibits 1 and 2 save that the admissibility of the medical reports was subjected to the calling of the makers thereof.

7. In cross-examination by **Ms Kiptoo**, learned counsel for the 1st and 2nd defendants, he reiterated that when he went to the hospital on 12th February 2007 he was having a lot of pain on the right side of his chest coupled with coughing and blurred vision. He, however, denied giving history of smoking or being alcoholic. While admitting that he took alcohol, he denied being alcoholic. He admitted that he had smoked before. He denied having given the history that he had experienced similar pain in the past and stated that although in pain he could recall what he said. He reiterated that he was accompanied by his wife but was able to talk and could not remember his wife giving the history. He identified **Dr Mbuvi** from his nametag and said the doctor examined him and told his he was suffering from pneumonia though

he did not carry out further tests. Although he did not request for his doctor he informed them that he had a doctor and it was not until 24th February 2007 that he asked for **Dr Chunge**. He reiterated that **Dr Mbuvi** is renal specialist though he did not expect a chest specialist since he was only interested in being treated. Whether by 24th February 2007 the doctor had formed on opinion to call a chest specialist. According to him, it is **Dr Chunge** who informed him that he needed a chest specialist and although he was not sure of the date when **Dr Gathua** was called. He was categorical that **Dr Gathua** came after **Dr Chunge**. He insisted that although the cheque came from his employer, it is him who paid the money. Referred to the receipt at page 11 of his bundle, he confirmed that the same is in the name of Kenindia which paid on his behalf. Further referred to a receipt by **Dr. Jane Wanjiru Maina** he confirmed that same is for May 2007 after he had left the Hospital though he insisted it was related to his treatment. He however agreed that when he went to the Hospital he was unwell and expected to incur some costs. According to him it is **Dr. Mbuvi** who recommended **Dr Kioko** to him and that they parted ways with **Dr. Mbuvi** after the latter informed him that he had pneumonia.

8. Cross-examined by **Mr Ochieng** for the third defendant, the plaintiff stated that he worked for Kenindia Assurance and left in May 2007. Although he was discharged from the Hospital on 11th March 2007, he did not resume work immediately but resumed in April 2007 and opted to resign. He said that he is an underwriter and on 12th February 2007 he passed by the office and that his employer prescribed Nairobi Hospital as one of the Hospitals he could be attended at. Although there are categories of hospitals he chose the Hospital because he wanted the best treatment. He admitted that Kenindia provided medical covers for its employees and that he went to the Hospital on the basis of the cover. He admitted that it is Kenindia which pays the bills incurred and cushions him from paying from his pocket and in this case he was covered and the said information he relayed to the hospital. He disclosed that he had been admitted to Aga Khan Hospital and M M Shah and was aware that hospitals do require deposit though he did not pay any since he was covered by Kenindia. He said that **Dr Mbuvi** left him in care of **Dr Kioko** whom he blamed for not giving him proper treatment. By the time of the operation, however, **Dr Mbuvi** had left. Although suffering from pneumonia, it took 2 weeks before the specialist was called. Although he did not know how long his treatment was to take he would have been happier if he had been treated without admission and believed that had he been treated properly he would not have stayed in hospital for that long. His claim is for the whole bill and for negligence and although he confirmed that with proper treatment he would have incurred a bill but not to that extent. What has given rise to his claim is the negligence although he cannot tell how much of the bill is attributed to the said negligence. He admitted that he used to smoke cigarettes but stopped although could not tell when but the stoppage was not due to medical advice. Although he still to partakes of alcohol, according to him, he was not an alcoholic. Although he started smoking 25 years ago and is now aged 59 years he stopped because smoking was not assisting him. On average he could have smoked for 20 years. On the payment the plaintiff insisted that although payment was made by Kenindia he was the one paying since he was on cover. He went with his wife but answered the question that were put to him and was not aware of any questions asked besides himself and said he did not say anything about treatment in October. He reiterated that it was him who recommended that **Dr Chunge** be called and not **Dr Kioko** and further that **Dr Gathua** was similarly called by **Dr Chunge**. **Dr Kioko** continued with the treatment alone. While admitting that **Dr Chunge** is a friend he denied saying that they come from the same village despite coming from the same region and speaking the same language. Though **Dr Chunge** told him he had been given permission, he did not know who gave the permission though he dealt with the Hospital. According to him **Dr Kioko** told him "I have brought you one *Mrembe* doctor and one senior doctor to treat you" although he did not come with them. Initially he did not know that **Dr Kioko** was a renal specialist although he learnt of this later from his Sister who is a nurse and who happened to have worked with **Dr Kioko**. According to him he does not know what a renal specialist can handle and cannot handle and whether or not he can handle pneumonia. His problem with the dust, smoke and cold weather started from the time of the operation and that it is not this condition that stopped him from smoking and it was not smoking that caused this condition in which condition he is forced to put on a T-shirt inside even in hot whether something he does not relish. He has since been forced to attend a gym and requires allergy vaccines for the rest of his life at the cost of Kshs. 2,000.00 though he does not have any receipts. A follow up was recommended by **Dr Gathua** although he gets his vaccines from **Dr Chunge**. His claim is for special and general damages.

9. In re-examination by **Mr Mutubwa**, the plaintiff said that he did not expect lesser treatment because

he was drinking although it is his right to smoke and drink. According to him he was subjected to several tests include HIV Test whose consistent result was negative. To him he went to the hospital because he wanted to be treated and get well as fast as possible. His complaint, however, is that the right doctor ought to have been called to treat him and the costs incurred were unnecessary. The costs incurred by Kenindia were because he was on cover and he would not have incurred the anaesthetic costs if he had not been required to undergo the surgery.

10.The second witness for the plaintiff was **Dr. Charles Chunge** who testified as PW2. **Dr Chunge**, from his evidence is a Consultant Microbiologist who specialises in infections or microbes. He also specialises in Tropical medicine and infectious diseases. He has Bachelor of Medicine and Surgery from the University of Nairobi, Masters of Science in Parasites from London University, Diploma in Nuclear Medicine from Cairo, PhD in Tropical Medicine, Masters in Tropical Medicine and Epidemiology from Canada, Diploma in Tropical Medicine and Hygiene from London, Fellowship in Travel Medicine and Infections. He is a retired University lecturer now in full time private practice and a consultant in all the big hospitals such as Nairobi Hospital, Aga Khan Hospital, M P Shah Hospital, Mater and Nairobi Women Hospitals. He is also a Honorary Professor at the University of Nairobi and Aga Khan University.

11.According to PW2, a microbiologist is trained in recognising and treating infections (germs) which enter the body and cause disease and Tuberculosis infection is one of the microbes and part of his specialisation. Any chest infection, according to him is called pneumonia and then you have such types as tuberculosis pneumonia

12.He testified that he has known the plaintiff as his patient since 1980 and is well versed with his medical history. Referred to his report in the plaintiff's bundle he confirmed having prepared the same. On 25th February 2007 the plaintiff called him in a panicky state and asked to see him complaining that he had been hospitalised for 2 weeks and was getting worse. From the nurse he confirmed that **Dr Kioko** had written that he be called. On arrival at the Hospital she met the nurse who told him that she felt **Dr Kioko** should have called him. From the medical records he was able to see that the Plaintiff was admitted on 12th February 2007 with diagnosis of lobar pneumonia which is just a detailed description of pneumonia. The same was done by **Dr Mbuvi** who referred the plaintiff to a specialist **Dr Ernest Kioko** a Consultant in the Hospital. According to the witness **Dr Kioko** is his senior and he has known him since 1975 as one of the top specialists in Kidney nephrologist in East Africa. **Dr Kioko** according to the witness is a consultant physician specialist in kidney problems. However, the plaintiff did not suffer from kidney problem. He was tested for kidney, liver, total blood count and then was admitted. X-rays were done 2 or 3 days after admission and specimen also taken by sucking liquid from the lungs. The result was pneumonia and no other ailment since even HIV test proved negative. As all the tests kept on indicating pneumonia and **Dr Mbuvi**, according to him, ought to have referred the plaintiff to a chest specialist on admission. After looking at the file and examining the plaintiff he found him to be very ill as the chest was clinically full of water and he was breathless and feverish. The liquid was rising and was at the breast level. He quickly formed the opinion that the plaintiff needed to be seen by a chest specialist since the antibiotics on which the plaintiff had been put would have knocked out any other infection save for Tuberculosis. Per the regulations, he sought permission from **Dr Kioko** who accepted that **Dr Gathua**, a T B specialist, be called. **Dr Gathua** arrived within half an hour of his departure, saw the patient and told informed him that it was T B. He tried removing the fluid but due to its thickness could not do so. According to the witness they managed the plaintiff together since **Dr Kioko** recorded that he was pulling out from the case the same day. **Dr Gathua** recommended an operation to remove the pus from the chest. According to the witness the possibility of death or complete debilitation if the pus was not removed could not be ruled out since the chest would rot if not removed. According to him if the plaintiff had not been treated he would probably be dead. However, in his view, the surgery could not have been avoided by **Dr Gathua** though it could have been if the treatment had started immediately. The delay, according to him of 2 weeks was significant and he attributed the delay to the wrong referral and the resultant delay involving a T B specialist. This case, he said required an urgent attention of a chest specialist. In his view **Dr Mbuvi** ought to have called a chest specialist and not a renal specialist and this amounted to an error of clinical judgement. According to him patients should be referred at the earliest to the correct specialist when water is accumulating in the lungs as a delay of 24 hours means the water rises to another level. Therefore the failure to call him for 24 hours was unnecessary delay since every patient

with water in the chest can easily collapse. He testified that he has no personal differences with either **Dr Kioko** or **Dr Mbuvi**. He confirmed that they has managed patients together with **Dr Kioko** and respect his professionalism though he was surprised. With respect to **Dr Mbuvi** he said he knows him as a Medical Officer trained in seeing the patient first and recognising what is required and consulting senior colleagues. **Dr Mbuvi** is the doctor at first point meeting. He confirmed that he has known the plaintiff as a patient and that they are on friendly terms. Although the plaintiff is not an alcoholic he admitted that he drinks alcohol and he has also cautioned the plaintiff against smoking tough he is not a heavy smoker. The plaintiff is now disabled and requires care such as antibiotics and should avoid cold, air pollution and certain activities like sports. Although he does not know what the plaintiff was doing before, he is now susceptible to infections. The pain from the scar cannot be gotten rid of which would have been avoided if he had not undergone operation. Asked about **Dr Lwai Lume** he confirmed knowing him although she was not part of the team and did not examine the plaintiff at all though she is the overall manager of the Casualty Department and doubles up with clinical work

13.On cross examination by **Ms Kiptoo**, PW2 admitted that he did not have his academic papers with him. He confirmed that he is a consultant at Nairobi Hospital and has known the plaintiff since 1980. He confirmed that he sees the plaintiff twice a year though at time the plaintiff consults him on phone. His common complaints were stomach upsets such as food poisoning and might have treated him for malaria. The plaintiff according to the witness used to have colds and was cautioned against smoking despite that he never saw him smoking though he could smell the breath. However, this caution they gave to all people to stop smoking since it may lead to lung cancer and bronchitis. T B, according to him is an infection that attacks the lungs but smoking irritates the lining of the lungs and this is what is called bronchitis. Smoking, according to him does not cause respiratory complications. Before qualifying as a Consultant he said he used to treat the plaintiff as a General Practitioner and could diagnose Pneumonia and TB and refer the patient to special units. He however confirmed that he knew the treatment for TB. He knew the plaintiff had chest problems although by 25th February 2007 he had not talked to the plaintiff for about 3 months and was unaware of his admission in hospital. While aware of the plaintiffs past several admissions, the witness testified that he had never treated him for chest problems. He was, however, not surprised that the plaintiff did not disclose that he was his doctor because he advices the plaintiff to do that whenever he is not around or when referred by the insurance company. From the records the plaintiff was indicated to be instable condition and the witness had no issue with the diagnosis made. Although everyone are at risk when exposed to extreme situations, if you have a disability like the plaintiff the risk is higher.

14.When cross examined by **Mr. Ochieng**, the witness confirmed that he saw the plaintiff for the first time on 25th February 2007 in respect of the subject illness. His visit to the Hospital took 30 minutes although he could not be exact. He did not meet **Dr Gathua** though they talked on phone and knew that the plaintiff was discharged on 11th March 2007. He, however, saw the plaintiff daily since he became his primary doctor. He was, however, certain that **Dr Gathua** did not meet with **Dr Kioko**. Since meeting the plaintiff for the first time in 1980 he has been seeing him at least twice a year and he became the plaintiff's personal doctor. He was not surprised that he saw other doctors because insurance companies do force people to see doctors. According to him the plaintiff was forced to go to Nairobi Hospital though he mentioned his name on admission. On further questioning he stated that the plaintiff was not forced but said that he was discouraged from calling him because he is not on the insurance list. He therefore was not aware of the plaintiff's admission. He admitted that he never met **Dr Kioko** but only saw his notes. Although the patient was being seen daily there was no indication of any improvement and was from his examination getting worse and **Dr Kioko** agreed that he should call **Dr Gathua** because the case required a specialist to step in. When **Dr Gathua** took over **Dr Kioko** left but there was nothing wrong with that and that the patient was treated. Although he is still being consulted by the plaintiff he has not seen him this year. According to the doctor there are two types of vaccines recommended for a person with chest problems and although vaccines were recommended, he does not administer them. According to him he specialises in lung diseases and pneumonia is one of them. In Nairobi the number of chest specialists could be between 15 and 20 while Nairobi Hospital could be having 5. However, in the entire country they cannot reach 50 in number. Although TB is common and high in the country the rate of prevalence is not easy to be known. Whereas pneumonia can be treated by a General Practitioner TB must be referred to a specialist. Whereas he is aware that the plaintiff drinks, the plaintiff has informed him that

he stopped smoking. The plaintiff according to him is now disabled though he can participate in some sports such as swimming and cycling. He knew the plaintiff before his specialisation and the plaintiff had no respiratory complication save for colds. Despite him and the plaintiff coming from the same region he does not know the plaintiff's home. According to him things went wrong at the time of referral and admission and the length of time taken during management without calling a chest specialist. Had a specialist been called the plaintiff would have taken 2 weeks and he would have never known of the plaintiff's condition. He admitted knowing **Dr Kioko** as his senior and confirmed that **Dr Kioko** is capable of treating straightforward pneumonia but not T B Pneumonia. A specialist, according to him can treat other ailments due to his basic training so long as it does not require another specialist such as TB.

15.In re-examination, he clarified that it is normal to revisit the earlier reports even though not his own findings. He said specialists are not restricted to hospitals and that it took him 5 minutes to get **Dr Gathua** on telephone. According to him hospitals do not treat people differently simply because of smoking or alcohol.

16.The third witness for the plaintiff was **Dr Samuel Gathua** who testified as PW3. In his own evidence he is a medical doctor, a physician specialising in respiratory medicine, that is to say the diseases of the chest. He qualified in 1981 as a physician and holds Bachelor of Medicine and Surgery, Masters in Medicine and Diploma in chest medicine from the University of Cardiff attached to Glasgow University. According to him the country does not have more than 15 chest specialist while Nairobi Hospital may be having 6. He confirmed having seen the plaintiff in 2007 and prepared a report in November 2007. According to the witness he was called by **Dr Chunge** and asked to see the plaintiff on 25th February 2007. When he saw him, the plaintiff had pneumonia in the side of the chest and had accumulated fluid on the same side as a result. The pneumonia was right lower lobe pneumonia also called lobar pneumonia. He read the medical notes from which he found that the plaintiff had been admitted on 12th February 2007 and had come with one day history of dizziness and weakness and severe chest pain with a non-productive cough. He was diagnosed with aspiration pneumonia which affects one segment of the lung. According to him the plaintiff was being investigated for TB and sputum was in the process of being collected. From the initial x-ray there was progressive increase in the water level and the situation had not been corrected and persisted. He ultimately recommended surgery. Had the plaintiff not gone for surgery he would have developed fluid which turns to pus and can cause death or permanent defect. However, it is difficult to estimate the time when that would take. When pus forms it has to be drained and since it was not easy to aspirate it required the chest to be opened. He however said that one can see patients in different disciplines and it is only when one realises that there little that can be done that one calls a specialist. By the time he was called the situation required a specialist though the surgery could have been avoided by inserting the chest tube early although at time surgery may be inevitable. The surgery, in this instance, was called Thoracolum Surgery which is the opening of the chest. According to him, had the tube been inserted to drain the water perhaps he would not have gone to that state. The process according him was delayed. This is called under water seal drainage which refers to the insertion of a tube into the chest. According to him this is not a matter of days but depends on the characteristic of the fluid and the decision is made by the physician. According to him one would say there was a delay looking at the time when the specimen was taken and when they came back which could delay the judgement. He accordingly produced his report in evidence.

17.In cross-examination by **Ms. Kiptoo**, he said that he is a Chest Specialist though he did not have any documentation. He reiterated that he came into contact with the plaintiff on 25th February 2007 and had no problem diagnosing aspiration pneumonia. He said the patient had complained of symptoms for one day which is a short history. He however, stated that he was not certain if his coming one day earlier would have made any difference.

18.On cross-examination by **Mr Ochieng**, he stated that he own Menelik Clinic and was the one who prepared the report. **Dr Munene** was cardiothoracic surgeon and planed the surgery. According to him the idea of taking the patient for surgery was **Dr Munene's** although they consulted and evaluated the patient. He, however, did not carry out the surgery but examined the patient before **Dr Munene** and looked at the notes which he also referred time while preparing his report. He said that the hospital records would however be more detailed and that his report was prepared for the purposes of evidence.

He, however, had to write the patient's background. According to him the clinical notes would show that he was seeing the patient daily from 25th February 2007 and that what is contained in his report is not guesswork. Although he could not remember when he left the patient, he did leave him in the care of **Dr Irimo** and the patient was discharged before he went back and the plaintiff did not go to see him though he was supposed to go for review although he did not find out whether the plaintiff was aware of this. Whether he saw another doctor he could not tell. He however did not know how many doctors were attending to him but said that his report was prepared 9 months after the plaintiff's discharge and referred to the file. After he left **Dr Munene** and **Dr Irimo** continued attending to the plaintiff and if there were other doctors attending to him the record would show this. **Dr Chunge**, however, was there throughout since he was the primary doctor. Therefore, as far as he was concerned, the patient was left in the care of **Dr Munene** and **Dr Chunge**. He denied that he did not care about the patient.

19.On re-examination he said he was not a surgeon while **Dr Munene** is the surgeon who performed the surgery after he determined the chest problem. According to him once you invite the specialist he takes over.

20.At the close of the plaintiff's case, the report by **Dr. Munene** was expunged from the record since he was not called.

21.The first defence witness was **Dr Louise Lwai-Lume** the accident and emergency co-ordinator for the Nairobi Hospital. According to her he has worked with the Hospital for 22 years initially as a medical officer then at the Intensive Care Unit for 11 years and resuming back to the Emergency Unit in 2008 as co-ordinator. She is responsible for overseeing medical officers who are responsible for seeing and admitting patients under visiting consultants and the discharge process. According to her the patients are received in the Accident and Emergency and are treated in accordance with their illness. They are then seen by Medical Officers who advise on admission if required and where they have their own physician they are admitted under the said physician. If under insurance they are admitted under the doctors in the insurance panel. The Hospital, however, has panel of consultants on call for patients who do not fall under the two categories who are called at the time of the admission. On 12th February 2007 she was in charge of Accident and Emergency Department the plaintiff was presented with a one day illness and complained of dizziness, general weakness, right side upper abdominal pain radiating to the lower chest and dry cough. There were no symptoms relating to diarrhoea, vomiting or nausea with findings of tenderness on respiratory system in the lower ribs and lower chest. The diagnosis was made of lobar pneumonia and was admitted under on-call physician. He was first seen by **Dr Mbuvi** who was the medical officer and was the one who diagnosed pneumonia and proceeded to call consultant and advised on medical care required. The on-call consultant doctor was **Dr Ernest Kioko** who is a visiting Consultant in private practice. The Hospital's policy is that the Medical Officer only sees the patient in the casualty, Accident and Emergency and the ward but his care stops when he hands over to the consultant. The medical officer in question was **Dr James Mbuvi** who is a Medical Officer with no admitting rights to Nairobi Hospital. The patient was admitted on 12th February 2007 and placed on intravenous treatment and was advised by **Dr Kioko** and started in intravenous antibiotics, cough expectorant and intravenous fluids. Laboratory tests were carried out on admission including chest x-ray and total blood count, sugar, kidney and liver tests. The tests confirmed right sided chest pneumonia. He was screened for positive TB and antibiotics were escalated. On realising that the fluid accumulation was complicating the pneumonia and the TB test was positive **Dr Kioko** advised that due to the slow response to the chest complications a Chest Consultant be Consulted and **Dr Gathua** was then called at which point the patient revealed that he had a Doctor and wanted **Dr Chunge** to see him as well. Subsequent care was therefore under **Dr Chunge** and **Dr Gathua**. Depending on the diagnosis the patient is usually seen by one physician but they may consul. Once you hand over a catalogue the 1st physician hands over unless he is requested to stay on by the second physician. According to the witness the patient was presented with a one day pneumonia which is managed with the physician and it is only when complicated that a chest specialist is required. The referral to **Dr Mbuvi** was in accordance with the medical care and procedures of management by the Nairobi Hospital. At the time of the admission the patient required a physician, since it was severe but uncomplicated acute pneumonia which is managed in most cases by general physician. From the records the patient never indicated that he had a personal physician. The Hospital's policy is that the doctor at the emergency evaluates the patient and informs the

Consultant who involves the Management. The nursing staff have no authority to refer a patient to another doctor. According to the witness the patient was managed well by the physician of long standing and only due to slow response to treatment was a chest specialist called as is required. The complication according to her was not due to poor management and the response was being checked twice a day and the decision to call a chest specialist was due to poor response to treatment and accumulation of fluids that was not there initially. The clinical progression depends on the bacterial and underlying general health and therefore it cannot be said that there could have been other treatment. The patient was advised to go to the gym which is normal in post surgery. The witness testified that she was unable to say the contribution of prior health vis-à-vis his present complaints. She conceded that the patient filed a complaint to the Hospital and when such a complaint is filed it went to the Customer Service and was handed over to the Standards and Ethics Committee which reviewed the same and gave its feedback that the diagnosis was correct and found that the Casualty Department followed the correct procedure and indicated that Pneumonia and TB are commonly managed by Physician and follow up were carried out and appropriate treatments carried out.

22.In cross examination by **Mr.Okello**, she said that she does not deal with financial aspects and in her opinion the patient was managed properly. She reiterated that **Dr Kioko** recommended that a specialist be called and the patient asked for **Dr Chunge**. This recommendation was made on 22nd February 2007 since the patient had poor response to second line treatment. The previous notes indicated that there had been impediments. In her view the patient came with community acquired pneumonia and there are standards of care for community acquired pneumonia. The complications did not arise from the treatment since response depends on bacteria and treatment prescribed so she was not in apposition to say that it was due to treatment. She stated that the primary doctor in consultation with the patient called another physician and he recommended **Dr Gathua** while the patient recommended **Dr Chunge**. According to the notes on 25th February 2007 **Dr Kioko** called the two and subsequently the patient had two senior physicians and so **Dr Kioko** pulled out of the case. A patient, according to her, is only abandoned if he is not being looked after by a medical physician.

23.On cross examination by **Mr Mutubwa**, the witness said that she started working in Nairobi Hospital in 1981 and had worked in Uganda and the United Kingdom. She possesses Bachelors of Medicine and Surgery and Masters in Medicine from the Nairobi University and Healthcare Management. She conceded that she is not a chest specialist but is the co-ordinator of the Accident and Emergency Department under the auspices of the Chief Executive Officer. She said that although she saw the patient she did not examine him. She was not a primary doctor and the information she obtained was from **Dr Mbuvi**. From the records the words used are “known heavy alcoholic and smoker” in reference to the plaintiff. The patient, she admitted was diagnosed with Lobar Pneumonia because it was less that 7 days and was not chronic. The opposite of acute is chronic and chronic denotes long duration and not necessarily the severity. She said that **Dr Gathua** is one of the Consultants but could not confirm the number of the Consultants since every year the list of specialists is updated and all she is given are the names of the doctors on call. On being referred to the Staff Admission Manual which has the procedures for admission prepared by Medical Advisory Committee, she said she was unaware why the entire documents were not produced. She informed the Court that **Dr Mbuvi** is out of the country on further studies and is nolonger an employee of the Hospital. She, however, denied that he was relieved of his duties due to this case. He was a locum on temporary employment. According to her the Hospital is a good Hospital and can deal with many complications and do timely diagnosis and properly timely interventions which is the Hospital’s policy. All physicians, according to her, are general physicians before they become specialists and are capable of handling pneumonia. Initially, the notes show, there was improvement but the response was slow. Determination according to her, is clinical and radiological and it is not the Hospital’s policy to call a specialist only when the patient is on deathbed. While admitting that **Dr Gathua** is highly respected she said that response to treatment depends on the health of the patient. She also admitted knowing **Dr Chunge** as a Tropical Disease Specialist and admitted that the patient told **Dr Kioko** that **Dr Chunge** was his physician. She was, however, unaware that the patient cried out although from the Medical Report of **Dr Chunge** it is indicated that the patient called him in a panicky state because he was getting worse. According to her the medication given to the plaintiff was the recommended prescription and the patient is reviewed daily. She said that the Accident and Emergency Department does not deal withy patient care and that they have an on-call doctor and not every

Pneumonia is to be treated by a specialist and this pneumonia was initially not complicated. **Dr Kioko**, she said, is a private practitioner with admitting rights and the Hospital draws a rota on daily basis. However, the notes do not indicate that **Dr Kioko** called **Dr Gathua** and just states "thank you". The notes of **Dr Kioko** talks of consultation of chest specialist while the notes of 25th February 2007 refer to a chest specialist but do not refer to him by name. According to her the identification of the bacteria is the work of the doctor though not all cultures are positive. According to her allergy can start any time in one's life and is not necessarily related to surgery while pain is expected to follow surgery. She admitted that the Medical Profession is guided by Codes of Ethics and Discipline which she agrees with and that the Hospital does not show any preference to a patient due to alcoholism though the factor is to be taken into account without interfering with the treatment.

24.On re-examination by **Ms Kiptoo**, the witness stated that she is made aware of the patients requiring second opinion and not all the patients. She was, however, aware of the plaintiff's condition on admission and the plaintiff was accompanied by a lady and the history was given by the wife and the patient. History is part of the general requirement though the plaintiff was not treated differently due to alcoholism. According to her the patient did not indicate that he had a doctor nor is she aware that he asked for **Dr Tsuma** or any other doctor. According to her the plaintiff required a physician and not a specialist. The notes of 22nd February 2007 by **Dr Kioko** indicated that a chest specialist be consulted after the x-ray. According to her on 20th February 2007 the plaintiff's condition was not worse. In her evidence smoking was predispose a person to bronchitis. The witness proceeded to produce the 1st and 2nd defendants' filed bundle of documents as Defence Exhibit 1 and thereafter the 1st and 2nd defendants' case was closed.

25.Thereafter, the 3rd defendant, **Dr Ernest Muinde Kioko,** gave evidence as PW2. PW2 testified that he is a senior consultant physician and has a Bachelors degree in Medicine and Surgery and Masters in Internal Medicine and a Post graduate Fellowship in Kidney Medicine. He is a graduate of the University of Nairobi, Calcutta and Southampton in the United Kingdom. He has experience and practice of medicine for the last 41 years. He then proceeded to adopt his statement filed in this case. Referred to the 1st and 2nd defendants' bundle of documents, he said that he would rely on the same. He testified that he is qualified to treat Pneumonia and that over 99% of Kenyans with Pneumonia and in other countries are treated not even by physicians and specialists but by medical and clinical officers. As a medical officer who qualified in 1971, he said he has acquired experience in medical management including pneumonia. As a qualified medical doctor of long standing, he manages critical patients with pneumonia and other complications in intensive care unit. On 12th February 2007 he was the consultant on call at the Nairobi Hospital when late in the afternoon he was informed from the ward that there was a patient by the name of **Nyangala Tsuma** who was admitted with diagnosis of right lower lobar pneumonia. He examined the patient who was complaining of being very weak with pain in the lower region of the chest and dizziness with blurred vision. He was found to be ill-looking and weighed 56 Kilograms and the blood pressure was very low 70/60. A chest x-ray confirmed the diagnosis of pneumonia of the lower zone of the right lungs. He had to normalise his blood pressure and as a result of the infection having permeated he was in a shock. He started the patient on intravenous antibiotics and pain management and nutrition. In 2 days they were able to get him on his feet, the bold pressure had normalised, he was eating well, pain was a little less and follow-up with x-ray and blood tests and all the relevant tests were carried out. The general aspect of the patient was, according to him, very good and he was able to walk on several occasions 3 or 4 times to his office accompanied by his wife, a distance of not less that 150 metres. Follow up x-ray every second day or so showed improvement and no worsening. Until the 10th day when it was noted that pneumonia patch was not clearing. Whereas in some patients with simple pneumonia, improvement is seen within a week, in others despite treatment the patch of pneumonia may not clear as fast as adequately and expected. In this case they were dealing with complicated pneumonia and after conducting other tests diabetes, cancer and HIV were excluded. In patients who are malnourished and exposed to lifestyle mismanagement these conditions are seen and so they started to address these. Extra antibiotics were added but on 22nd February 2007 he ordered for a chest x-ray and recommended that depending on the findings therefrom he would call a chest specialist. On receipt of the results on 24th February 2007 he went to the plaintiff morning and explained his findings and the need to call a chest specialist to look at the lungs and possibility of a tumour or TB. And consider starting him on the therapy. During the discussion the plaintiff asked for **Dr Chunge** to be called as someone he knew and who hailed from his

place although he did not indicate that he was his doctor. The third defendant said there was no objection although he was told that a chest specialist would still have to be called because **Dr Chunge** was not into this type of case. He spoke to **Dr Chunge** the same day and informed the nursing staff and informed **Dr Gathua** on the 24th February 2007 and they saw the patient on 25th February 2007. He, in company of the doctors saw the patient, thanked and informed the plaintiff that he was pulling out of the case and informed the nursing staff accordingly as well as the two doctors. His pulling out was due to professionalism since this was a simple case and he had no further role. Once a specialist is called and he has no further role to play he has to bow out. According to him, other than giving the patient moral support, **Dr Chunge** had no role at all. Apart from Pneumonia, they had planned that the plaintiff undergoes TB test as well as chest operation. According to him the chest operation was inevitable because of the nature of his pneumonia which gets complicated quite often because the patient has no defence and the body system is not fighting the infection on the pneumonia. According to him the fluid was little but thin and he was able to draw out the fluid for diagnosis. The tube, however, could not be inserted without damaging the lungs. When the time came what was required was the opening of the region for the collection because it is surrounded by thick wall in order to drain it in the same way that abscess is drained. A chest fluid is only used where the fluid is plenty and thin. According to him he was the issue of smoking and alcoholism and these could have aggravated the plaintiff's condition since the prior health is very important in some of these cases. With age, malnutrition, excessive alcoholism weighing only 53 kilos there was every reason to believe that he was in poor lifestyle management which was confirmed during many sessions with his wife. He had been previously treated for the same problem the year before so his state of health and habits did contribute to his illness. According to him Medical Practice, Ethics and Professionalism require that where a patient wants to be seen by another doctor or if the family request, there would be no objection and it is customary that the sitting doctor informs the doctor requested and the nursing staff which was done in this case. According to him it is unethical for a doctor so informed to walk away. According to him, there is no scientific evidence that a person who has undergone surgery has to develop the symptoms complained of. When drawing fluid from any part of the body, admittedly there is pain which goes away with time and the only time one requires vaccines is when the spleen is removed or one has tumours or malignancy or various body deficiencies which the plaintiff did not have. However, they do not make unnecessary tests and that he requested for tests only once on 15th February 2007 though the report showed the blood was drawn twice. According to him he would have failed in his duty of care if he did not go out to look for causes of the plaintiff's lack of response to good therapy. However, his state of alcoholism and smoking did not come out loudly to him and his tests on TB and HIV were only due to the fact that the commonest cause of this type of pneumonia at the age of 53 years is HIV and the therapy would definitely fail unless identified. A chest specialist according to him is a physician who apart from being able to treat chest infections is also trained to obtain material directly from the lungs using specimen tubes into the lungs for further analysis and not all doctors are trained to do that. According to him the management and treatment of the plaintiff was adequate since the plaintiff presented himself as a patient overloaded with infection and ordinarily one day history of chest pain, cough, chest x-ray pneumonia is sorted out within a few days and within a few days he was well save for one area which he diagnosed. To him they did a good job with the plaintiff and the group that joined in later did not have to do extra tests to make the diagnosis which they had already made halfway by testing for TB which was positive and TB therapy had already been decreed even before the laboratory confirmation because TB is common, treatable but hides. According to him he did not require **Dr Mbuvi's** assistance thereafter. He, however, did not use the plaintiff's history to his detriment to him the specimen was kept and examined every week and in March one of them showed positive result.

26.In cross-examination by **Ms Kiptoo**, he said that he was satisfied with the work done by **Dr Mbuvi** before he was called and he did not use the history obtained to discriminate against the plaintiff because had he said that the cause of pneumonia is drunkenness and smoking he would fail since drinking and smoking are not common causes of illness.

27.In cross examination by **Mr Mutubwa**, he admitted that he is not a chest specialist but specialises in internal medicine as opposed to surgery. According to him they are trained to treat all organs without surgery. On top of being a physician he is also a renal specialist. On the first day the pneumonia was not complex but as time progressed one patch was not clearing and that became complicated. This, according to him, was on the 10th day. He saw many patients between 20 and 30 and cannot fail to remember a case

which went that way with a history of one day of chest pain and x-ray showing pneumonia. According to him the case was not out of the ordinary. He said that he had a pneumonia which put him into surgery and surgery is not done for pneumonia which has no fluid. He did not agree that there was negligence and confirmed that he was the one handling the patient. He insisted that he did call **Dr Gathua** and said that he spoke to **Dr Gathua** and informed him about the plaintiff. He recorded the patch on 22nd February 2007 when the plaintiff was coughing more than the previous day with little sputum. He recorded the patient's complaint and his examination. He denied that this was a new version since everything was recorded. Due to the hidden pneumonia he put him on different antibiotics. If things go against the intended line you have to call a chest specialist. He said he would have failed had he not made the cause of the diagnosis. According to him what **Dr Gathua** stated was incorrect because his own record for 25th February 2007 he stated the patient had developed a fluid which remained small and encased into the tissue. He denied that para-pneumonic effusion was delayed because the effusion was small and was inaccessible with a tube. By 25th February 2007 the surgery was inevitable since the tube could not go in. **Dr Chunge** role was that of family physician and he was not aware that **Dr Gathua** was called by **Dr Chunge**. According to him he informed the patient that though he would call **Dr Chunge**, he would still have to call the chest specialist since **Dr Chunge** was not going to obtain the material required. **Dr Chunge** according to him is a microbiologist and that there is no time frame when to decide to call a specialist. According to him it is matter of judgement with guidance and the patient's condition. When the disease takes another turn you bring in someone who will bring in more material. They had to restore his blood pressure, and whatever they did is all in his report and if his services were required. He denied exhibiting characteristics of gross negligence.

28.On re-examination by **Mr Okelo**, the 3rd defendant reiterated that the idea to call the specialist was his on seeing the x-ray results on 22nd February 207 and that he contacted **Dr Githua** after concluding that surgery was inevitable. According to him **Dr Gathua's** report does not comply with his notes since on 25th February 2007 he concludes that the fluid remained small and encased by tissue and so it was impossible to drain the fluid in the tube because it was so little. If it was thick the tube would not draw it since the tube is for large thin fluid and the best option was to open it up and draw it. **Dr Chunge** was not into the case because he would not have been able to pull out the fluid.

29.With that evidence, the curtain was drawn on the hearing.

30.Parties then filed written submissions.

31.According to the plaintiff's submissions, three issues fall for determination and these are:

1. Are the Defendants, jointly and/or severally, liable for negligence in their management of the Plaintiff?

2. If the answer No. 1 above is in the affirmative, what quantum of damages should be awarded to the Plaintiff against who?

3. Who bears the costs of this suit?

32.With respect to the first issue, it is submitted that the plaintiff's case is that the care he received from the Defendants fell short of that which he reasonably expected of medical professions and institution of the Defendants' standing or at all. It is submitted that the defendants failed in their discharge of the standard of care expected of professionals such as they profess hence causing the plaintiff pain, loss and suffering. To establish a case of negligence, one has to demonstrate the existence of a duty of care, its breach and resultant injury/loss or prejudice. On the duty of care it is submitted that the 2nd defendant offered no evidence in rebuttal of the Plaintiff's case against him or in support of his Defence and therefore the 2nd defendant's case should be weighed in such light. It is submitted that whereas pneumonia is a chest infection the 2nd defendant chose to refer the plaintiff to a kidney specialist which action was defended on the basis of the Hospital's policy which policy was not produced. Accordingly, it is submitted that a patient who presents with a history which is properly diagnosed as being a chest

complication or thoracic ailment to a renal specialist is patently and on the face of it is negligent and a mismanagement of the patient. It is submitted that the 2nd and 3rd defendants were not competent to deal with the Plaintiff's ailment and as a result of his mismanagement the plaintiff suffered pain, loss and disability due to lengthy stay in hospital and debilitating surgery and its attendant effects. Quoting from academic writings, it is submitted that empyema is a complex disease to diagnose and requires specialist to drain pus so as to identify and isolate the pus and diagnose the disease and signs of empyema should of necessity trigger a Doctor treating a pneumonia patient seek specialist intervention. This, it is submitted, was confirmed by the expert evidence of **Dr Chunge** and **Dr Gathua** who confirmed tat that the plaintiff's management was not proper and that the patient underwent unnecessary surgery which could have been avoided contrary to **Dr Kioko's** evidence that surgery was unavoidable from the onset. Citing **Jimmy Paul Semenye vs. Aga Khan Hospital & 2 Others [2006] eKLR**, it is submitted:

"There exists a duty of care between the patient and the doctor, hospital or health provider. Once this relationship has been established, the doctor has the following duty;-

a) Possess the medical knowledge required of a reasonably competent medial practitioner engaged in the same specialty.

b) Posses the skills required of a reasonable competent health care practitioner engaged in the same specialty.

c) Exercise the care in the application of the knowledge and skill to be expected of a reasonably competent health care practitioner in the same specialty and

d) Use the medical judgment in the exercise of that care required of a reasonably competent practitioner in the same medical or health care specialty.

To define a duty of care in medical negligence a physician has a duty of care and skill which is expected reasonably competent practitioner in [the] same class to which physician belongs acting in [the] same or similar circumstances. When a physician or other medical staff member does not treat a patient with the proper amount of quality care, resulting in serious injury or death they commit medical negligence…In the case law of Blyth v Birmingham Co. [1856] 11 exch.781.784, Negligence was defend as the omission to do something which a reasonable man, guided upon those considerations which regulate the conduct of human affairs would do, or doing something which a provident and reasonable man would not do. In strict legal analysis, negligence means more than needless or careless conduct, whether in omission or commission, it properly connotes the complex concept of duty, breach and damage thereby suffered by the person to whom the duty was owing… A duty of care arises once a doctor or other health care professional agrees to diagnose or treat a patient. That professional assumes a duty of care towards that patient".

33.According to the plaintiff, the Defendants did not meet the duty of care as defined by the Courts and feel short and breached the duty of care, jointly and severally by accepting to treat but failing to properly and timeously diagnose, treat the plaintiff and by engaging in an area which they were not adequately trained hence resulting in the Plaintiff suffering an unnecessary thoracotomy and long stay in hospital. Citing the ***Code of Professional Conduct and Discipline 5th Edition***, it is submitted that though initially properly diagnosed, the Defendants failed in properly treating the patient and did not have adequate training in the area in question. Accordingly the issue no. 1 ought to be answered in the affirmative.

34.With respect to the second issue it is submitted that the principle of law in the assessment of damages in tort is that damages in tort are meant to serve a compensatory role so as much as possible , put the injured person to as nearly as possible as money can, to his original state before the injury. On special damages it is submitted that the plaintiff has proved that he paid personally or on his behalf Kshs. 720,781/- which ought to be allowed. On general damages, it is submitted, based on **Alec Asustsa vs. Samuel Sammy Ndei Nairobi HCCS No. 1251 of 2006**, the plaintiff urged the Court to award Kshs. 10,000,000.00 for General damages and Kshs 1,000,000.00 for Future Medical needs.

35.On the issue of costs it is submitted that due to the complexity of this case, being a case of medical negligence, which is rare and requires research in highly specialised area of medicine for which advocates are not ordinarily trained, the Court ought to invoke its powers under paragraph 5 of the Advocates Remuneration Order and pursuant to the decision in **Atsango Chesoni vs. David Morton Silverstein HCCA No. 105 of 2000** and increase the fees on scale by one Half.

36.On behalf of the 1st and 2nd defendants, it is submitted that the second defendant was at the material time on temporary employment as a medical officer in the 1st defendant' Hospital and therefore his employment, or at least his duty to the plaintiff was limited to examining the plaintiff, making initial diagnosis and referring him to a consultants on call in the event that the plaintiff did not have his own doctor but had no right to admit patients. His conduct, despite the fact that he did not testify, it is submitted as clearly manifested from the evidence on record was comprehensive, adequate and sufficient to explain the extent of his liability. With respect to the 3rd defendant, a consultant on call with admission of rights, the Hospital was not vicariously liable for his acts. With respect to the duty of care owed by a medical practitioner to a patient, it is submitted based on Halsbury's Laws of England, vol. 26 at page 17 that:

"A person who holds himself as ready to give medical advice or treatment impliedly undertakes that he is possessed of skill and knowledge for the purpose. Such a person, whether he is a registered medical practitioner or not, who is consulted by a patient, owes him certain duties namely, a duty of care in deciding whether to undertake the case, a duty of care in deciding what treatment and a duty of care in his administration of that treatment".

37.It is submitted that in referring the plaintiff to the 3rd defendant the 2nd defendant was not negligent as the same does not fall within the purview of the duties of care enunciated above and reliance is sought in **Payremalu Veerpan vs. Dr Amarjeet Kaur [2001] High Court of Malaya** in which it was held:

"this court is of the view that failure to send the plaintiff to Hospital Ipoh or Kualar Lumpur as submitted by learned counsel for the plaintiff is not negligence per se as negligence does not lie in the omission to send the plaintiff to the hospital".

38.Therefore the fact that the 2nd defendant did not refer the plaintiff to a chest specialist is not negligence and is not a sign of want of care or skill. Therefore as the 2nd defendant's qualification is not in doubt and as he did diagnose the plaintiff with lobar pneumonia and pulled out as soon as he handed over the plaintiff to the 3rd defendant, any decision as to whether a specialist would be required would ideally be made by the 3rd defendant. Citing http://www.imsanz.org.au/about/genphys.cfm, definition of general physicians is given as:

"…are highly trained specialists who provide a range of non-surgical health care to adult patients. They care for difficult serious or unusual medical problems and continue to see the patient until these problems have resolved or stabilized. Much of their work takes place with hospitalized patients and most general physicians also see patients in their consulting rooms. General physicians are consultants who care for patients in their consulting rooms. General physicians are consultants who care for patients with special or difficult problems. General physicians only see patients who are referred to them by other doctors, usually by the patient's own general practitioner. Whether the referral identifies one health problem or many, the general physician's assessment is always comprehensive. This global approach enables problems to be detected and diagnostic possibilities to be considered which might otherwise be missed. General physicians are especially trained to care for patients with complex illnesses, in which the diagnosis may be difficult. The general physician's broad training provides expertise in diagnosis and treatment of problems affecting different body systems in a patient. They are also trained to deal with social and psychological impact of disease. General physicians are trained to carry out a variety of medical procedures for the diagnosis and management of patients with severe and complex illnesses. General physicians have special training in the usefulness, limitations and costs of most diagnostic tests. General physicians use diagnostic tests logically, safely and effectively to investigate difficult diagnostic

problems. General physicians are trained in the critical analysis of research reports and drug industry claims about new treatments. They are knowledgeable about complex interactions of medications given simultaneously to treat multiple illnesses in a patient. The general physician has special expertise in making treatment decisions to help patients with complex and serious illnesses. General physicians are frequently asked to review patients before surgery. They advise surgeons of a patient's risk status and can recommend appropriate management to minimize the risk of the operation. They can also assist in postoperative care and ongoing medical problems or complications."

39.From the foregoing it is submitted that a general physician is competent to deal with pneumonia and TB and the third defendant, a doctor of immense experience did not mismanage the patient's condition and therefore it was not imperative to for the 2nd defendant to refer the plaintiff to a chest specialist as his condition did not require a chest specialist, but just a physician and hence no negligence is attributable to the 2nd defendant. Accordingly the 2nd defendant was not negligent. Since both **Dr Gathua** and **Dr Kioko** were satisfied with the second defendant's diagnosis it is submitted that the second defendant did not fail to detect any underlying condition which would have compelled him to make referral to a chest specialist. Accordingly, there was no act or omission that could have exposed the plaintiff to the risk of life threatening complications. On the issue of abandonment, it is submitted that from the evidence, once a colleague steps in to manage the patient he takes full charge and the one attending the patient bows out. It is further submitted that no act or omission by the defendants necessitated any future or continued therapy on the part of the plaintiff and no evidence was adduced to prove that he actually suffered any complication necessitating therapy since it came out in cross-examination that he in fact was not attending any gymnasium as purported and the so called complications were not in fact complications. The defendants relied on an Article by **Dr Lieske Kuitert**, ***a Consultant Respiratory Physician, titled 'Pneumonia Treatment***" in which it is stated:

"Even in the modern antibiotic-era pneumonia is a significant illness. Despite antibiotics, pneumonia can be fatal, even in previously healthy individuals. In lower lobe pneumonia, there may be abdominal pain and tenderness in abdomen adjacent to the affected lobe.

<u>How is pneumonia treated?</u>

The mainstay of treatment for bacterial pneumonia is antibiotics. What antibiotics and where they are administered is dependent on how unwell the person is. In most cased 7-10 days of antibiotics is sufficient, although some may take longer to get better (the elderly or those with immune suppression). In those who are unable to tolerate oral antibiotics the treatment should be given intravenously in hospital.

Failure to improve in respond to antibiotics should prompt a review of treatment. This should include reviewing the diagnosis (is it really pneumonia?), the organism (are the antibiotics being targeted against the right bacterium?), the duration of treatment, development of complications and potential "host factors" (e.g. age, drugs, other problems such as diabetes, immune suppression that delay response.

The review of treatment may involve repeat blood tests, a chest x-ray, a sputum sample and sample of pleural fluid if necessary. If the person is unwell, the fever fails to settle or they develop complications they should be reviewed by a respiratory specialist who may request further investigations and/or treatment.

Finally, all patients admitted to hospital with community acquired pneumonia and aged over 65 should be offered pneumococcal vaccination in line with Department of Health guidelines. All patients who smoke should be offered support to stop smoking".

40.From the foregoing it is submitted that though pneumonia is a serious medical condition, the plaintiff was at all material times, managed professionally, skilfully and in accordance with standard procedures for managing his condition.

41.On special damages it is submitted that the medical expenses is not attributed to the defendant since negligence is not proved. Further the medical expenses were paid by Kenindia Assurance Ltd and the plaintiff has not indicated that he is claiming on behalf of Kenindia and having received treatment from the 1st defendant the plaintiff was under obligation to pay for it. In the 1st and 2nd defendant's view the plaintiff is according disentitled to general damages since more often than not, treatment procedures bear some element of pain and discomfort which does not point to negligence. On costs of future medical expenses, it is submitted that the same must be pleaded and strictly proved.

42.In conclusion the defendants submit that the plaintiff's ought to be dismissed and rely on **Halsbury's Laws of England vol. 26 at 17** where it is stated:

"The practitioner must bring to his task a reasonable degree of skill and knowledge, and must exercise a reasonable degree of care. Neither the very highest, nor a very low degree of care and competence judged in the light of the particular circumstances of each case, is what the law requires; a person is not liable in negligence because someone else of greater skill and knowledge would have prescribed different treatment or operated in a different way; nor is he guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art, although a body of adverse opinion also existed among medical men".

43.They also rely on **Bolam vs. Friern Hospital Management Committee [1957] 1WLR 582 at 586** where it is stated:

"Where you get to a situation which involves the use of some skill or competence, then the test as to whether there has been negligence or not is the test of the man on top of a Clapham omnibus, because he has not got this skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill... A man need not possess the highest expert skill, it is well established law that it is sufficient if he exercises the ordinary sill of an ordinary competent man exercising that particular art."

44.Further the defendants borrow from the decision of **Lord S Krishnan Unni, J** in **M Shoba vs. Dr. Rajakumari Unnithan AIR 1999 Kerata 149** referred to in **Payremalu Veerpan vs. Dr Amarjeet Kaur** (supra) that:

"A doctor cannot be held negligent simply because something goes wrong. A doctor can be found guilty only if he falls short of standards of reasonable skilful medical practice. The true test, therefore, to hold a medical practitioner guilty of negligence is to have a positive finding of such failure on his part as no doctor of ordinary skill would be guilty of acting with reasonable and ordinary care."

45.On the part of the 3rd defendant it is submitted that from the evidence of both the plaintiff's witnesses and the defence witness it was shown that non complicated pneumonia was treatable by medical officer or physician and only complicated pneumonia was treatable by a chest physician or chest surgeon and therefore the third defendant was competent to deal with the plaintiff's ailment and was neither negligent nor in breach of duty of care. Further the 3rd defendant cannot be held liable for the miscommunication between the laboratory and the ward which may have contributed to the delay. The test showed that the plaintiff was responding well till 22nd February 2007 when the x-ray showed the worsening of the plaintiff's condition at which the 3rd defendant recommended that a chest consultant be called. Citing **The Administrator, H H the Aga Khan Platinum Jubilee Hospital vs. Munyambu Civil Appeal No. 18 of 1983 [1985] KLR 126** it is submitted that the Court of Appeal adopted the reasoning in the authorities herein below as a true test to be applied in establishing negligence in diagnosis or treatment on the part of a doctor:

i. **Maynard V West Midlands Regional Health Authority**reported in the times of May, 1983. **Lord Scarman** in his speech in the house of lords stated as follows:

"Differences of opinion and practice exist, and will always exist, in the medical as in other professions. There is seldom any one answer exclusive of all others to problems of professional judgement. A court may prefer on body of opinion to the other, but that is no basis for conclusion of negligence,"

If there are two respectable and responsible schools of medical thought holding different or opposing views of what is or not negligent in the circumstance of the case the trial judge ought not to choose between them.

ii. **Hunter V Harley** (1955) SC 200. The house of lords held that;

"in the realm of diagnosis and treatment there is ample scope for genuine differences of opinion and one man clearly is not negligent merely because his conclusion differs from that of other men...the true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to have been guilty of such failure as no Doctor of ordinary skill would be guilty of acting with ordinary care."

iii. **Hatcher V Black and other [1954]**Times, July 22 Lord Denning in summing up the case said that in a hospital, when a person who is still goes in for treatment, there is always some risk, no matter what care is used.

46.It is therefore submitted that there is no evidence adduced by the plaintiff to show that the 3rd defendant is guilty of such failure as no doctor of ordinary skill would be guilty of in acting with ordinary care.

47.However, should the court deem it fit to award damages, it is submitted that Kshs. 300,000.00 would suffice in terms of general damages while no award ought to be made in special damages due to the failure to prove the same.

48.In a rejoinder, it is submitted that the defendants' submissions have failed to address the issues raised in the plaintiff's submissions.

49.I have considered the pleadings, the evidence, as well as the submissions and in my view the following are the issues that fall for determination:

1. **Whether the 1st defendant is vicariously liable for acts of the 2nd and/or 3rd defendants.**

2. **Whether the defendants owed the plaintiff duty of care and what is the standard of duty of care expected of the defendants.**

3. **Whether the defendants were negligent or were in breach of the duty of care.**

4. **Whether the defendants are liable to compensate the plaintiff in general and special damages and if so to what extent.**

5. **Who should bear the costs of the suit.**

50.On the issue whether the 1st defendant is vicariously liable for acts of the 2nd and/or 3rd defendant, it is clear that the 2nd defendant was employed by the 1st defendant. The second defendant was not an independent contractor. That he was a *locum* or was in temporary employment is neither here nor there. He was an employee of the 1st defendant and was carrying out his duties pursuant to the instructions of the 1st defendant. He, for example had no admission rights and was reporting to the 1st defendant. I therefore have no difficulty in finding that the 1st defendant is vicariously liable for the acts and omissions of the 2nd defendant.

51.With respect to the 3rd defendant, this was a consultant in private practice and was only on call. However, when the plaintiff went to the 1st defendant Hospital, his main aim was to get treated. How the 1st defendant went about treating him was none of his business as long as he was treated. He did not choose who was to treat him. The position that was taken by **Denning, LJ in Cassidy vs. Ministry of Health [1951] 2 KB 342 AT 359**was that the liability of doctors on the permanent staff dependent on this: Who employs the doctor or surgeon – is it the patient or the hospital authorities? If the patient himself selected and employed the doctor or the surgeon, the hospital authorities are not liable for his negligence, because he is not employed by them. Accordingly, in the present matter the 1st defendant would not be liable for **Dr Chunge's** actions. But where the doctor or surgeon, be he a consultant or not, was employed and paid, not by the patient but by the hospital authorities the hospital authorities are liable for his negligence in treating the patient. It does not depend on whether the contract under which he is employed is a contract of service or a contract for services. That distinction, important as it is, does not apply in cases where the hospital authorities are themselves under a duty to use care in treating the patient. It is clear law and good sense that where a person is himself under a duty of care, he cannot get rid of his responsibility by delegating the performance of it to someone else, no matter whether the delegation of it be to a servant under a contract of service or to an independent contractor under a contract of services. Therefore (1) if a person is admitted as a patient to a hospital and suffers injuries through the negligence of some member of the staff it is unnecessary for him to pick upon any particular employee; and (2) The law applies the principle of *respondeat superior* in the case of a hospital just as it does in the case of master and servant in any other sphere of activity, professional, industrial or otherwise and it matters not that the servant does work of a skilful character for which he is specially qualified. The hospital is responsible for all those in whose charge the patient was. See ***Professional Negligence by J P Eddy*** **(London Stevens & Sons Limited 1956).**

52.It is therefore clear from the foregoing that the 1st defendant is vicariously liable for the actions of the 3rd defendant since the plaintiff did not choose the services of the 3rd defendant who was the consultant on call at the 1st defendant Hospital. The 1st defendant cannot escape liability for the 3rd defendant's actions simply because he was a consultant since there is no evidence that the plaintiff was liable to meet the 3rd defendant's fees directly.

53.The next issue is whether the defendants owed the plaintiff duty of care and what is the standard of duty of care expected of the defendants. That a doctor owes a duty of care to his patient is not in doubt. **Mulwa, J** in **M (A MINOR) VS. AMULEGA & ANOTHER [2001] KLR 420** held:

"Authorities who own a hospital are in law under the self same duty as the humblest doctor, wherever they accept a patient for treatment, they must use reasonable care and skill to cure him of his ailment. The hospital authorities cannot of course do it by themselves. They must do it by the staff, which they employ and if their staff are negligent in giving the treatment, they are just as liable for that negligence as is anyone else who employs others to do his duties for him…It is established that those conducting a hospital are under a direct duty of care to those admitted as patients to the hospital. They are liable for the negligent acts of a member of the hospital staff, which constitutes a breach of that duty of care owed by him to the plaintiff…Thus there has been acceptance from the Courts that hospital authorities are in fact liable for breach of duty by its members of staff of a duty owed to the patients. They cannot escape responsibility because, as it were, they themselves were not conducting the operation but rather it was a doctor, with special knowledge and skill who did and they had no control over his mode of discharging his duties… In order to succeed in negligence, the plaintiff must prove that there is a duty of care owed to him by the defendant, that there was a breach of that duty of care and that the breach of duty resulted in damage to the plaintiff which was not remote… It is trite law that a medical practitioner owes a duty of care to his patients to take all due care, caution and diligence in the treatment. If a person holds himself out as possessing special skill and knowledge, by or on behalf of a patient, he owes a duty to the patient to use due caution in undertaking the treatment and if he accepts responsibility and undertakes the treatment and the patient submits to his direction and treatment accordingly, he owes a duty to the patient to use diligence, care, knowledge, skill and caution in administering the treatment…There is no duty strictly as such, to prevent and or to stop the plaintiff from inhaling but rather that of taking such steps and actions as are reasonable in the circumstances to prevent the inhalation".

This was the position taken by Denning, LJ in Cassidy vs. Ministry of Health (supra) at 359 where he said:

"If a man goes to a doctor because he is ill no one doubts that the doctor must exercise reasonable care and skill in his treatment of him; and that is so whether the doctor is paid for his services or not. But if the doctor is unable to treat the man himself and sends him to hospital, are not the hospital authorities then under a duty of care in their treatment of him? I think they are. Clearly if he is a paying patient, paying them directly for their treatment of him, they must take reasonable care of him; and why should it make any difference if he does not pay them directly, but only indirectly through the rates which he pays to the local authority or through insurance contributions which he makes in order to get the treatment? I see no difference at all. Even if he is so poor that he can pay nothing, and the hospital treats him out of charity, still the hospital authorities are under a duty to take reasonable care of him just as the doctor is who treats him without asking a fee…In my opinion authorities who run a hospital, be they local authorities, government boards, or any other corporation, are in law under the self –same duty as the humblest doctor; whenever they accept a patient for treatment they must use reasonable care and skill to cure him of his ailment".

54.In**Nevill and Another vs. Cooper and Another [1958] EA 594**it was held:

"If he professes an art, he must be reasonably skilled in it. He must also be careful but the standard of care which the law requires is not an insurance against accidental slips. It is such a degree of care as a normally skilful member of the profession may reasonably be expected to exercise in the actual circumstances that may present themselves for urgent attention and in a major abdominal operation they include (i) the multiform difficulties presented by the particular circumstances of the operation, (ii) the condition of the patient, and the whole set of problems arising out of the risks to which he is being exposed, (iii) the difficulty of the surgeon's choice between risks, (iv) the paramount need of his discretion being unfettered, if he thinks it right, to take one risk to avoid a greater, (v) at the penultimate stage...If the defendants have produced a reasonable explanation, equally consistent with negligence or no negligence, the burden of proving that the defendants were negligent and that their negligence caused the damage rests upon the plaintiff".

55.However, the standard is not the same as the standard in normal cases of negligence. As was held by **Kuloba, J** in **Apollo Insurance Co. Ltd. vs. Flavia Rodrigues & Co. Advocates Nairobi HCCC NO. 431 of 2002:**

"Where you get a situation which involves the use of some special skill or competence, the test whether there has been negligence or not is not the test of the man on the top of a Clapham omnibus, because he has not got special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill".

In **Pope John Paul's Hospital & Another vs. Baby Kasozi [1974] EA 221** the East African Court of Appeal held:

"If a professional man professes an art, he must reasonably be skilled in it. He must also be careful, but the standard of care, which the law requires, is not insurance against accidental slips. It is such a degree of care as normally skilful member of the profession may reasonably be expected to exercise in the actual circumstances of the case, and, in applying the duty of care to the care of a surgeon, it is peculiarly necessary to have regard to the different kinds of circumstances that may present themselves for urgent attention...A charge of professional negligence against a medical man was serious. It stood on a different footing to a charge of negligence against the driver of a motorcar. The consequences were far more serious. It affected his professional status and reputation. The burden of proof was correspondingly greater...The practitioner must bring to his task a reasonable degree of skill and knowledge, and must exercise a reasonable degree of care...In cases charging medical negligence, a court should be careful not to construe everything that goes wrong in the course of medical treatment as amounting to negligence. The courts would be doing a disservice to the community at large if they were to impose liability on hospitals and doctors for

everything that happens to go wrong. Doctors would be led to think more of their safety than of the good of their patients. Initiative would be stifled and confidence shaken. A proper sense of proportion requires the courts to have regard to the conditions in which hospitals and doctors work. They must insist on due care for the patient at every point, but must not condemn as negligence that which is only a misadventure…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 medical cases the fact that something has gone wrong is not in itself any evidence of negligence. In surgical operations there are, inevitably, risks. On the other hand, of course, in a case like this, there are points where the onus may shift, where a judge or jury might infer negligence, particularly if available witnesses who would throw light on what happened were not called".

54. It follows that the standard must be the standard expected with the particular profession to which the defendant belongs and not that of a reasonable man and the mere fact that something has gone wrong is itself not sufficient to sustain a tort of professional negligence. As was stated by Ringera, J in K & K Amman Limited vs. Mount Kenya Game Ranch Ltd. & 3 Others Nairobi (Milimani) HCCC 6076 Of 1993"for one to prove professional negligence against a professional person one has to call evidence that the professional conducted himself with less than the competence, diligence and skill expected of an ordinary professional in his field or otherwise persuade the Court that the acts or omissions complained of were manifestly or patently negligent".

55. It is however, accepted in medical profession that there is no objective test for determining the negligence of a doctor. Whereas doctors are supposed to operate within certain known parameters of diagnosis the profession is not straight-jacketed to the extent that all doctors must respond in exactly the same way when confronted with a set of circumstances. As long as the doctor does not go outside the well known medical procedures, it is accepted that there may be variation in approaches to particular cases. It is only in cases where a doctor decides for reasons only known to himself to deviate from well known procedures that in the event that that deviation leads to injury to a patient that the court will find fault with the doctor concerned. It was this recognition that led Onyiuke, J in Whiteside vs. Jasman Mwanza HCCC No. 4 of 1970 to hold inter alia that in determining whether the duty of care has been discharged by a doctor regard must be had to the fact whether he observed the universally accepted procedures.

In **Wishaminya Vs. Kenyatta National Hospital Board [2004] 2 EA 351** the Court held:

"The duty of care to a patient is a fundamental one and a hospital is expected by its very nature to take all reasonable steps to ensure that a patient especially in the casualty wing receives emergency care...In the realm of diagnosis and treatment, there is ample scope for genuine difference of opinion and one man clearly is not negligent merely because his conclusion differs from that of the other men. The true test of establishing negligence and treatment on the part of the doctor is whether he has been proved to have been guilty of such failure as no doctor of ordinary skill would be guilty of it acting within ordinary care".

56.That was the same holding in **Aga Khan Hospital Vs. Busan Munyambu KAR 378; [1976-1985] EA 3; [1985] KLR 127.**

57.That leads me to the issue whether the defendants were negligent or were in breach of the duty of care.It is not in dispute that the first person to have seen the plaintiff when he went for treatment at the 1st defendant Hospital was the 2nd defendant. That the 2nd defendant took his history and examined him is similarly not disputed. The examination revealed that the plaintiff was suffering from pneumonia. No issue has been taken with respect to this diagnosis. In fact **Dr Gathua** conceded that this diagnosis was correct. After this he handed over the plaintiff to the 3rd defendant and thereafter took no part in the plaintiff's treatment. The plaintiff accuses the 2nd defendant of having handed him over to a "wrong" doctor and then abandoned him. From the evidence of **Dr Gathua** and **Dr Chunge**, once doctor hands over to his colleague he bows out and there is nothing wrong with this. However, it was submitted on

behalf of the plaintiff that there was no need in handing over the case to a doctor who was not a chest specialist if the 2nd defendant was competent to handle the case. The defendants' position is that the second defendant had no admission rights. It follows that even if he was competent to handle the case, he would not have been able to admit the plaintiff. He had to call a doctor who had admission rights to admit the plaintiff and he did call the 3rd defendant who was the consultant on call.

58.The evidence on record is that **Dr Kioko**, the 3rd defendant was capable of treating pneumonia. According to **Dr Chunge** he was capable of treating straightforward pneumonia but not TB. By the time the 2nd defendant called the 3rd defendant there is no evidence that the plaintiff had been diagnosed with TB. In fact according to **Dr Gathua**, by the time he was called the plaintiff was being investigated for TB. It follows that at the time the 2nd defendant called the 3rd defendant, he couldn't have known that the plaintiff was suffering from TB and as his diagnosis has not been faulted by even the plaintiff's evidence, there is no way negligence can be attributed to his action of either referring the case to the 3rd defendant or deciding to opt out of the case after the said referral.

59.With respect to the 3rd defendant **Dr Kioko**, it is not disputed that he is a doctor of many years' experience. That alone does not mean that he may not be found negligent in a particular case. If he conducts himself in a manner incompatible with the professional skills expected from a person in his position, the Court would have no difficulty in finding him negligent in respect of that particular case. It was admitted that the 3rd defendant is qualified to treat Pneumonia. According to **Dr Gathua** a specialist is only called by the physician in situations where there is nothing more to be done by the physician. According to him the process of drainage of fluid depends on the characteristic of the fluid and the decision to drain is dependent on the physician. The 3rd defendant on the other hand testified that he had made a decision to call the chest specialist by the time the plaintiff requested that **Dr Chunge** be called. Although the 3rd defendant insisted that he called **Dr Gathua**, **Dr Gathua** said that he was called by **Dr Chunge**. Again there is no record that he had decided to call **Dr Gathua** though the records indicate that he had decided that a chest specialist be called. According to him the necessity of calling a chest specialist was made on 22nd February 2007. There is no indication that as at that date he had made up his mind to call **Dr Gathua** or any other specific Chest specialist. One would have expected him to have suggested the name as he did vide his minutes of 25th February 2007. In the absence of any such minutes and in the face of **Dr Gathua's** evidence that he was called by **Dr Chunge** on 25th February 2007, I am left with no option but to find that although the 3rd defendant realised that the plaintiff's condition as at 22nd February 2007 required the services of a chest specialist, he did not make any effort to contact one and that was manifestly negligent on the part of the 3rd defendant. The exercise of reasonable care and skill, in my view, requires that doctors ought to take necessary steps as soon as possible to ensure that patients get the best possible treatment whenever the patient's condition so require especially when there is no hindrance to the facilitation of such treatment. I therefore find that in this case the 3rd defendant, in not taking any action between 22nd February 2007 and 25th February 2007 did not exercise reasonable care and skill in the circumstances of this case.

60.Having found that the 3rd defendant did not exercise reasonable skill and care within the time he was expected to do so coupled with my finding hereinabove that the 1st defendant is vicariously liable for the actions of the 3rd defendant it follows that the 1st defendant is liable for the 3rd defendant's negligence.

61.The next issue for consideration is whether the defendants are liable to compensate the plaintiff in general and special damages. In **Wishaminya Vs. Kenyatta National Hospital Board** (supra) the Court held:

"In addition to proving negligence, a claimant must prove that the negligence caused the loss of which he complains. In other words, in medical negligence, the claimant must prove that had there been no negligence, the injury, loss and damage of which he complains would have been avoided or at least have been much less".

62.It therefore follows that mere negligence will not necessarily lead to liability on the part of the defendants. The plaintiff must go further and prove that the injury, loss and damage which he alleges to have suffered would have been avoided but for the said negligence. **Dr Chunge** testified that the delay of 2 weeks was significant. However, I am unable to find that the delay in referring the plaintiff to the chest specialist before 22nd February 2007 was in the circumstances of this case unreasonable. With respect to the delay of 24 hours before he was called by **Dr Kioko**, **Dr Chunge** testified that it led to the rise in fluid level. He was not however categorical that the surgery would have been avoided if he had been called without the delay of the said period. Asked about the consequences of this delay, **Dr Gathua**, whose evidence I found very reliable, was non-committal and stated in cross examination by **Ms. Kiptoo** that it was uncertain whether his earlier arrival would have made any difference. He further stated that the complaint was for one day which is short. Accordingly, there is no basis upon which I can find that the plaintiff's surgery was necessitated by the delay in calling the chest specialist between 22nd February 2007 and 25th February 2007.

63.Having so found I am unable to find that the defendants are liable to compensate the plaintiff for the damages, injuries and loss sustained by the plaintiff. My decision is further informed by the fact that there is no concrete evidence showing the medical treatment that the plaintiff has undergone since his discharge from Hospital. According to **Dr Chunge** he has not seen the plaintiff for the whole of this year while the evidence of **Dr Gathua** is that though he left word that the plaintiff should go and see him for follow up, the plaintiff did not do so. With respect to the special damages, even if I were to find that the defendant's were liable to compensate the plaintiff, they would not have been liable to pay the expenses which were made by Kenindia Assurance Company Limited since there was no evidence that the plaintiff was claiming on behalf of the said Insurance Company.

64.Having so found, the next issue is who should bear the costs of the suit. The law is that costs follow event unless the conduct of the successful party is such that it led to litigation which would otherwise have been avoided. In this case, I have found that both the 1st and 3rd defendants were negligent in their actions. With respect to the 2nd defendant, no evidence was adduced by him in this case. Although I have been unable to attribute any negligence on his part I am unable to find that in the unique circumstances of this case the plaintiff was not justified in joining him in this case.

65.Nevertheless, despite the dismissal of the suit, I am required to assess the damages that would have been awarded had the plaintiff succeeded. In the plaintiff's view, he is entitled to Kshs. 10,000,000.00 while the defendant's position is that the plaintiff is entitled to Kshs. 300,000.00. In **Jimmy Paul Semenye vs. Aga Khan Health Services** (supra) **Angawa, J** awarded Kshs. 800,000.00 for amputated limbs on 6th April 2006. In **Alec Asutsa vs. Sammy Maina Ndei** (supra) **Khamoni, J** awarded Kshs. 5,000,000.00 on 27th March 2009. This was, however a road traffic accident in which the plaintiff suffered injuries leading to severe mental deterioration. In my view an award of Kshs. 700,000.00 would have been reasonable in the circumstances as general damages for pain and suffering. With respect to future medical expenses no sufficient evidence was adduced to merit an award in respect thereof.

66.In the result the order that commends itself is that the plaintiff's suit be and is hereby dismissed. Each party to bear his/its own costs.

Dated at Nairobi this 22nd day of October 2012

G V ODUNGA
JUDGE

Delivered in the presence of

Miss Ngeresa for Plaintiff

Miss Muthoga for the 1st and 2nd Defendants