



Aga Khan University Hospital v Disciplinary & Ethics Committee & 2 others (Civil Appeal E168 of 2022) [2025] KEHC 13004 (KLR) (19 September 2025) (Judgment)

Neutral citation: [2025] KEHC 13004 (KLR)

**REPUBLIC OF KENYA
IN THE HIGH COURT AT NAIROBI (MILIMANI LAW COURTS)
CIVIL APPEAL E168 OF 2022
JN NJAGI, J
SEPTEMBER 19, 2025**

BETWEEN

AGA KHAN UNIVERSITY HOSPITAL APPELLANT

AND

THE DISCIPLINARY & ETHICS COMMITTEE 1ST RESPONDENT

**THE MEDICAL PRACTITIONERS & DENTISTS COUNCIL 2ND
RESPONDENT**

**PROF KIAMA WANGAI & COMPANY ADVOCATES (ON BEHALF OF
CHARITY WAMAITHA KIBURU) 3RD RESPONDENT**

(Being an appeal from the decision of the Disciplinary and Ethics Committee of the Kenya Medical Practitioners and Dentists Council in PIC Case No.81 of 2019 delivered on 21/2/2022)

JUDGMENT

1. The 3rd Respondent herein, Prof. Kiama Wangai, filed a complaint before the Kenya Medical Practitioners and Dentists Council [herein referred to as 'The Council'] against the Appellant on behalf of the estate of the late Charity Wamaitha Kiburu [herein referred to as the deceased] who died while undergoing treatment at the Appellant's medical facility. The estate of the deceased blamed the doctors who attended the deceased at the Appellant's medical facility for poor treatment, care and management of the deceased during labour and delivery that led to her death. The Appellant denied the accusations. After a full trial before the Disciplinary Committee of the Council, the Committee found the Appellant liable for mismanaging the patient and consequently the Council thereupon ordered the Appellant to: pay a fine of Kshs. 350,000/= to the Council within 30 days from the date of the ruling; initiate mediation with the estate of the deceased patient with a view to compensating the latter and thereafter inform the Council within 120 days from the date of the ruling. In the event the Appellant



failed to comply with the said orders, the Council ordered that it was at liberty to suspend, withdraw or cancel the operating license for the Appellant.

2. The Appellant was dissatisfied with the decision of the council and lodged the instant appeal. The appeal raises 12 grounds of appeal which revolve on 4 issues:
 - [1] That the right to fair hearing of the Appellant was contravened in that one of the Committee members, Dr. Amiani I. Litswa, raised the issue concerning the Appellant's case before a scientific conference after the hearing of the case was concluded by the Committee and before the verdict in the case was delivered by the Council.
 - [2] That the Committee erred in making a finding on the procedure administered to the patient by the anesthetist, Dr. Lubega
 - [3] That the Committee erred in making a finding that the Appellant's staff, Dr. Sikolia, failed to inform the patient's family of the patient's situation.
 - [4] That the Committee erred in its medical findings on the care and management given to the patient.
 - [5] That the Committee erred in failing to take into account the autopsy report by Dr. Geoffrey Zambezi Mutuma dated 22nd February 2019.
3. The appeal was canvassed by way of written submissions of the counsels appearing for the respective parties.

Appellant's Submissions

4. The first ground of appeal is that before the delivery of the ruling, one of the Committee members addressed a scientific conference in which he addressed issues on the case that was pending before the Committee and made definite findings on pertinent issues concerning the case. That the Appellant made a complaint to the Council on the doctor's conduct which did not elicit a reply from the Council. The Appellant submitted that the conduct of the doctor was in violation of the Appellant's right to fair hearing and unbiased trial as stipulated under Article 50 of *the Constitution* of Kenya, 2010. That the Council did not address the issue in its ruling and for this reason, the ruling should be set aside.
5. The Appellant in its second ground of appeal faults the finding of the Council on the care and management given to the patient by Dr. Lubega, the anesthetist who attended to the deceased during CS operation. The Appellant faults the finding of the Council that Dr. Lubega administered a test dose of 6ml 0.25 bupivacaine which according to the Committee was four times the recommended dose, contrary to the evidence of Dr. Lubega that he used a test dose of 40mg lignocaine and a loading dose of 6ml of 0.25% bupivacaine and 200 micrograms of morphine. The Appellant faulted the Committee of misconstruing between the test dose and the loading dose administered by Dr. Lubega and thus arrived at a wrong finding.
6. The Appellant submitted that the Council erred in making a finding that Dr. Lubega ought to have used fentanyl during the operation rather than morphine as per the Appellant's Labour Epidural Guidelines. The Appellant submitted that use of morphine is recommended in international standards and that the amount used in this case was appropriate, yet that could not explain the complications or side effects experienced by the deceased patient.
7. It was submitted that the Committee in paragraph 41 of the Ruling reckoned that 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 – see *Herman Nyangala Tsuma v Kenya Hospital Association T/A The*



Nairobi Hospital & 2 Others [2012] eKLR. It was submitted that despite that finding the Committee proceeded to castigate Dr. Lubega for exercising his discretion to use morphine. In this respect the appellant cited the case of BS v Jonardan D. Patel [2019] eKLR wherein the court opined that: “In the course of treatment, some discretion must be left to the judgment of the doctor on the spot so that he uses his common sense, his experience and judgment as far as it suits to the situation of the case”.

8. The Appellant submitted that the Committee erred in finding that the administration of the epidural at the L3/4 level of the lumbar spine following the failure to the site catheter at the L4/L5 increased the patient’s risk of developing a high spinal. It was submitted that the Appellant’s Labour Epidural Guideline provided that the Epidural Catheter should be sited in L3-4 space or below. Therefore, that the administration of the epidural at the L3/4level of the lumbar spine was appropriate and within the accepted and well-known medical procedures. That the finding by the Committee that the complications seen on the deceased’s case is associated with intrathecal administration of bupivacaine and long-acting opioids is speculative as no reasoned basis was provided in the ruling.
8. The Appellant submitted that the standard of care in medical claims is as was stated in Bolam v Friern Hospital Management Committee [1957] 1 WLR 583 which established that if a doctor acts in accordance with a responsible body of medical opinion, he or she was not negligent. Further, the case of Bolitho v Hackney Health Authority [1977] was cited where the Bolam test was modified to include the requirement that the opinion by the responsible medical body establishing negligence ought to be reasonable and/responsible such that it is able to withstand logical analysis.
9. It was submitted that the Council erred in finding that the care and management provided by Lubega was wanting despite the doctor having acted within the known and accepted parameters of conducting epidural analgesia procedure.
10. In regard to the finding on Dr. Sikolia Wanyonyi, who was the leader of Obstetrics Gynecology and who was indicted for not debriefing the family of the Deceased with the situation and the possible outcomes of the procedure, the Appellant submitted that the finding of the Committee cannot be accurate since the doctor on various occasions as captured in his notes on the patient’s file shows that the staff had various debriefs with the family of the deceased.
12. On the care given by Dr. Misango, the Committee noted that the patient suffered two documented episodes of cardiac arrest but that there was no documented review of the patient by a cardiologist and the care management instituted did not include enzyme analysis, as a result of which the Committee made a finding that the cardiac arrest care given was wanting. The Appellant submitted that the Committee disregarded Dr. Misango’s medical report dated 14th November 2019 that he indicated that he sought the opinion of Dr. Hasham, a cardiologist who was of the opinion that the patient had not suffered a myocardial infarction thus no need for enzyme test.
13. It was submitted that the 1st Respondent’s Committee members erred in fact and law by failing to appreciate the entire evidence of Dr. Misango in respect to the critical care and management given to the patient.
14. The Appellant made submissions on the autopsy report urging that had the 1st Respondent analyzed the report fully, probably a different finding would have been made showing that the cause of death was acute anaphylactic reaction to drugs and not any other cause attributable to the Appellant. It was submitted that the Committee disregarded Dr. Misango’s medical report that

The Appellant concluded its submissions by citing the decision of the Justice Aburili in P.B.S & Another v Archdiocese of Nairobi Kenya Registered Trustees & 2 others [2016] eKLR while citing the decision of Justice Aburili in John Paul’s Hospital & Another v Baby Kasosi [1974] EA 221 that



in medical cases the fact that something has gone wrong is not in itself any evidence of negligence and that the court ought to be careful not to construe everything that goes wrong in the cause of medical treatment as amounting to negligence.

1st and 2nd Respondents` Submissions

15. On the issue of violation of right to fair trial, the 1st and 2nd Respondents submitted that the presentation of the scientific paper by Dr. Amiani was delivered in August 2021 which was way after the proceedings before the Committee had been concluded. It was submitted that the presentation by Dr. Amiani did not make reference to the proceedings that were before the Committee in case PIC No.18 of 2019. That the Appellant did not demonstrate how the discussion of the conference adversely impacted the right to fair trial of the Appellant or even influenced the Committee's decision. That it was not shown that the said doctor was biased against the Appellant. That both sides were given an opportunity to present their evidence. That the process undertaken by the committee or the manner the inquiry was conducted has not been challenged and cannot be faulted.
16. On the issue of care and management of the patient, the referred to Respondents submitted that the Appellant owed the deceased a duty of care as was defined in the case of Herman Nyangala Tsuma v Kenya Hospital Association T/A The Nairobi Hospital 2 others [2012] eKLR where negligence was described as follows:

“In the case of law of Blythv Birmingham Co. [1856] 11exch.781.784, Negligence was defined as the omission to do something which a reasonable man, guided upon those considerations which regulate the conduct of human affairs would do, or doing something which a provident and reasonable man would not do. In strict legal analysis, negligence means more than needless or careless conduct, whether in omission or commission, it properly connotes the complex concept of duty, breach and damage thereby suffered by the person to whom the duty was owing....A duty of care arises once a doctor or other health care professional agrees to diagnose or treat patient. That professional assumes a duty of care towards that patient.”

17. It was submitted that the Council and the attendant Committee are comprised of qualified experts, professionals and specialists in various fields of medicine or dentistry and are thus equipped with the necessary knowledge, experience and expertise to justly and fairly determine complaints against medical institutions and practitioners through peer review, consultation and best practice. Therefore, that this court cannot be called upon to consider the professional issues or manner the Appellant treated or managed the patient as those issues can only be handled by peers of the medical professionals who handled the patient.
18. It was submitted that the listed grounds of appeal comprised of matters within the scope of the qualifications, expertise and experience of the Committee and the Council as they relate to medical and scientific procedures and protocols that are best dealt with by the Committee and the Council. That the issues should have been raised before the inquiry but not in this appeal as this court has no expertise to consider aspects on the practice of medicine, breach of protocols or professional misconduct by medical practitioners. Reliance on this proposition was placed in the case of JOO & 2 Others v Praxedes P. Mandu Okutoyi & 2 others [2018] eKLR where the court stated that:

“Courts, the world over have recognized the bodies such as the MPDB are particularly and uniquely well qualified, by virtue of their calling and experience, to determine the issue of responsibility for an incident such as in this case. Reference was made to Evans vs.



General Medical Council, where the Board of the Privy Council stressed the importance of the findings of a professional body such as the General Medical Council to a court when considering cases of professional conduct and *Atsango Chesoni vs. Davis Mortons Silvesterin*.”

19. Further reliance was placed in the case of *Atsango Chesoni v David Morton Silversten* [2005] eKLR where it was held that:

“The matter in issue is pecuniary matters relating to the practice of a medical practitioners of which the members for the tribunal are particularly acquainted as it involves their everyday business. They are in the best position to judge such matters....”

20. It was submitted that the Appellant was heard by experts whose recommendation was submitted to the Medical Council which independently reassessed the Committee’s decision and ratified it before delivering it to the parties. It was submitted that the findings of the Council on the failure to adhere to the protocols on administration of the epidural analgesia; failure to document review of the patient by a cardiologist and failure to include enzyme analysis; failure to document evidence of pulmonary oedema and failure to institute continuous renal replacement [CRRT]; gaps in the management of fluid overload and gaps in the management of hypoxia as well as failure by Dr. Sikolia to brief the deceased’s relatives, all showed that the Appellant failed to meet the standard of care required of them. It was submitted that the decision of the Committee was well reasoned, fair and merited. The 1st and 2nd Respondents urged the court to uphold the decision and dismiss the appeal.

3rd Respondent’s Submissions

21. The 3rd Respondent submitted that the appeal raised an issue on the biasness of one Dr. Amiani Litswa. That doctor cannot be faulted for the decision made by the 1st Respondent and ratified by the 2nd Respondent.

22. It was submitted that the Appellant has no capacity professionally to challenge the decision of the 1st and the 2nd Respondents if the procedure followed accorded them a fair trial. It was submitted that the matters of facts were adequately dealt with by the Committee which has the wherewithal and expertise to receive complaints, investigate and appraise the evidence and finally make a finding.

23. The 3rd Respondent submitted that for an appellant to succeed in a case of professional negligence, it has to be shown that the tribunal’s decision was wrong in the sense referred in the case of *Fox v General Medical Council* [1960] 3 All E.R. 225 where Lord Radcliffe stated that:

“The tribunal was therefore, fully entitled to make the finding that it did on the evidence before it, and it would be impossible for an appellate court to reverse the finding on any contrary view of the facts. It follows that the appeal must fail unless here was some defect in the conduct of the inquiry, by way of admission or rejection of evidence or otherwise, that may fairly be thought to have been sufficient significance to the result to invalidate the committee’s decision. It is to this that their Lordship now turn.”

24. Reference was also made to the case of *Sivarajah v General Medical Council* [1964] 1 ALL E.R. 504 at page 507 where Lord Guest stated that:

“The committee are masters both of the law and of the fact. Thus what might amount to a misdirection in law by a judge to a jury of a criminal trial does not necessarily invalidate



the committee's decision. The question is whether it can "fairly be thought to have been sufficient significance to the result to invalidate the committee's decision."

25. The 3rd Respondent urged the court to dismiss the appeal.

Analysis and Determination

26. This is an appeal as contemplated by section 20[9] of the *Medical Practitioners and Dentists Act*. It is the duty of this Court to evaluate afresh the evidence adduced before the Disciplinary Committee of the Medical Council and satisfy itself that the decision of the Council was well-founded. This principle is well elucidated in the case of *Selle & Another v Associated Motor Boat Co. Ltd & Others* [1968] EA 123, where the court held as follows:

"...this court is not bound necessarily to accept the findings of fact by the court below. An appeal to this court is by way of retrial and the principles upon which this court acts in such an appeal are well settled. Briefly put they are that this court must reconsider the evidence, evaluate it itself and draw its own conclusions though it should bear in mind that it has neither seen nor heard the witnesses and should make due allowance in this respect..."

27. Having gone through the record of appeal and the rival submissions of the parties herein, the issue for determination is whether the the Appellant through its servants and/or agents who attended to the deceased, were negligent in the treatment and management accorded to the deceased.

The test to determine whether there was medical negligence or not is that found in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 wherein McNair J. stated that:

"The test of whether there has been negligence or not is not the test of the man on top of the Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill."

28. In the case of *PBS and INS v Archdiocese of Nairobi Registered Trustees* [2016] eKLR, Aburili J. cited the High Court of Northern Ireland in *Magil v Royal Group Hospital* [2010] N.1 QB 1 where the court stated the following on the subject:

There is to be applied the standard of the ordinary skilled consultant, doctor or nurse as the case may be. They must act in accordance with the practice accepted at the relevant time as preferred by a responsible body of medical and nursing opinion. The standard of care must reflect clinical practice which stands up to analysis and is not unreasonable. It is for the court, after considering the expert evidence [?] whether the standard of care afforded to the deceased put him at risk.

29. Therefore, what was expected of the Respondents and especially the 3rd Respondent was to adduce evidence before the Committee showing that the doctors who attended the Deceased acted outside the boundaries of skilled professionals.

30. It is on record that Dr. Amiani presented a paper at the KSA and CCSK Annual Scientific Conference in August 2021 titled "Medical Legal Aspects in Obstetrics", consequent to which the Appellant addressed a letter to the Committee dated 24/8/2021 wherein they complained that the presentation discussed matters incidental to "Epidural Analgesia" in a "manner that we [the Respondent] are exceedingly convinced that one of the complaint that is under discussion thereat was PIC No.18 of 2019." The council on its part argued that the presentation did not make reference to the Appellant's proceedings that were before the Committee in PIC No.18 of 2019.



31. I have gone through the presentation. The same appears to be a scientific paper on the stated subject and did not directly refer to the Appellant's case. I am not persuaded that the paper influenced the decision of the committee. The Appellant has not shown that its right to fair trial was violated.
32. On the management given to the patient, the Committee found that the deceased reacted to the test dose of epidural anesthesia immediately it was given and perimortem CS was performed to deliver the baby. The patient subsequently developed complications of pulmonary oedema and fluid overload.
33. On the administration of epidural analgesia, the Committee noted that the Appellant's Hospital protocols provided for a test dose of 3ml of 0.125% bupivacaine but that Dr. Lubega administered a test dose of 0.25% bupivacaine which the Committee found was 4 times the recommended dose. That the protocols recommended the use of fentanyl for induction but that the doctor administered morphine.
34. Contrary to the finding by the Committee, the medical report of Dr. Lubega indicated that he administered a test dose of 40mg Lignocaine and that after establishing a negative epidural dose, he went on to perform the loading of the epidural with the loading dose of 6ml bupivacaine 0.25 % and lidocaine 0.5 and morphine 200 microgram. Going through the record of appeal, it is clear that the Committee got it wrong in making a finding that the test dose administered by Dr. Lubega was 0.25% bupivacaine when the same was 40mg Lignocaine. Indeed, the Committee in paragraph 24 of its ruling captured the test dose given by the doctor as 40mg lignocaine. Consequently, I find that the Committee erred in its finding as to the test dose given to the deceased by Dr. Lubega. No evidence was led to indicate that the test dose of 40 mg lignocaine was not appropriate or within the well-known and accepted procedures in medicine.
35. The Committee faulted Dr. Lubega for using morphine for induction instead of using fentanyl as recommended by the Appellant's protocols. The Committee however did not give a reason why it was not appropriate to use morphine in this case. It was not shown that morphine is not recommended in international standards or that the amount administered was not appropriate. In the case of *BS v Jordan D. Patel [supra]*, the court stated that in the course of treatment some discretion must be left to the judgment of the doctor so that he uses his common sense, experience and judgment as suits the situation of the case. The Committee did not show that the discretion by Dr. Lubega to use morphine was not appropriate in the circumstances of this case.
36. The Committee further faulted Dr. Lubega for administering analgesia at the L3/L4 of the lumbar spine following the failure to site the catheter at L4/L5 as the same increased the risk of developing a high spinal. It is to be noted that the Appellant's Labour Epidural Guidelines at page 200 of the Record of Appeal provided that the Epidural Catheter should be cited at L3-4 or below. The doctor did not thereby commit any wrong in siting the catheter at L3/L4.
37. The Committee faulted Dr. Sikolia for not debriefing the family of the deceased of the situation at the hospital as concerned the deceased. The doctor told the Committee that he briefed the relatives of the deceased on two occasions, the first time immediately after the events and later after the patient was admitted at HDU. He in his medical notes indicated that the staff had severally briefed the relatives of the deceased. On the other hand, the witness who testified on behalf of the estate of the deceased, Lydia Kiburu, confirmed that the family was on several occasions briefed by the hospital and at one time by a Ugandan doctor. She however complained that the briefing was not adequate. It is then clear that the family of the deceased was severally briefed of the situation as confirmed by Lydia Kiburu. Whether the same was adequate or not is neither here nor there. There was no basis on the finding that Dr. Sikolia did not brief the relatives of the deceased.



38. Though the Committee found that post -cardiac arrest management was wanting, it quoted Dr. Misango, the third witness called by the Appellant, to the effect that the patient was seen by a cardiologist Dr. Hashim, who however did not agree with the preliminary diagnosis of myocardial infarction and hence did not recommend troponins. The Committee did not summon the said doctor to hear from him before making an adverse finding that the management given on post-cardiac arrest was wanting. In my view, the finding was not supported by the evidence.
39. The Committee further found that the patient developed complications of pulmonary oedema and fluid overload but that the critical care team did not institute Continuous Renal Replacement Therapy [CCRT]. The Committee however seems not to have considered the evidence of Dr. Misango that the patient was seen by a nephrologist, Dr. Sokhwala who advised against CCRT. The Committee did not hear the said doctor before reaching a contrary opinion to that taken by the said doctor. In my view, the opinion of the Committee could not have overridden that of the doctor who saw the patient. It was incumbent upon the Committee to hear the said doctor and the reasons behind his advice. I find the finding of the committee on the issue not to have been founded on strong grounds.
40. A post mortem report was filed in the case which indicated that the cause of death could have been attributable to:
- [1] Anesthetics drugs reaction following spinal anesthesia
 - [2] Lung oedema
41. The Committee did not comment anything on the findings as contained in the post mortem report. Neither did it summon the pathologist who prepared the report to hear his opinion. It was not professional for the Committee to dismiss the pathologist's report without giving reasons why they thought the report was wrong.
42. From the foregoing, I do not find evidence to indicate that the procedure adopted in the care and management of the deceased was contrary to the generally accepted medical standards. It was not shown that the standard of care accorded to the deceased put her at risk. It was not shown that the death of the deceased was attributable to medical negligence on the part of the Appellant. The mere fact that the deceased died in the cause of treatment by the Appellant does not proof negligence on the part of the appellant. Negligence has to be proved which I find not to have been done in this case.
42. The upshot is that this court does not find any merit in the Complaint by the 3rd Respondent. Consequently, the appeal succeeds and the decision of the Committee [the 1st Respondent] as ratified by the 2nd Respondent is hereby set aside.
43. The Appellant to have the costs of the appeal.

DELIVERED, DATED AND SIGNED AT GARSEN THIS 19TH DAY OF SEPTEMBER 2025.

J. N. NJAGI

JUDGE

In the presence of:

Mr. Chenge for Appellant

Miss Diru HB for Mr. Munge for 1st and 2nd Respondents

Court Assistant -

