REPUBLIC OF KENYA

IN THE HIGH COURT OF KENYA

AT NAIROBI

CIVIL CASE NO. 118 OF 2013

ZACHARY MUMBO MOSOTI.....PLAINTIFF

VERSUS

THE AGA KHAN UNIVERSITY HOSPITAL NAIROBI.....1ST DEFENDANT

DR. ALIVIZA KITAZI.....2ND DEFENDANT

DR. MATIVO.....3RD DEFENDANT

JUDGEMENT

1. The plaintiff in this instance has brought a suit against the 1st, 2nd and 3rd defendants vide a plaint dated 15/3/2013. The 1st defendant is sued in its capacity as the hospital which the plaintiff received treatment at all material times whereas the 2nd and 3rd defendants are sued in their capacity as medical practitioners and employees of the 1st defendant at all material times.

2. The plaintiff pleaded in his plaint that on or about 10/1/2011 the plaintiff then aged 49 years was admitted at the Agha Khan University Hospital with a history of having fallen down and feelings of instability when walking. He informed the medical personnel attending to him which included the 2nd and 3rd defendant that, prior to his admission, he experienced jerky movements, general body stiffness and that the movements were unintentional, sudden, repetitive and only involved the upper part of the back. He further informed the medical personnel that no similar movements were noted in the limbs or hands and there was no history of altered mentation, loss of consciousness or convulsions but however he experienced episodes of pain on the back and hips.

3. When admitted at the 1st defendant the plaintiff was attended, advised and treated by the 2nd and 3rd defendant. The 2nd defendant a consultant psychiatrist diagnosed him with anxiety disorder while the 3rd defendant a consultant neurologist diagnosed him with somatoform disorder and proceeded to administer medication for both. The 2nd defendant further recommended that he would need systemic desensitization and cognitive behavior therapy.

4. The treatment and medication administered to the plaintiff made his condition worse by affecting him psychologically, physiologically and caused him to lose his mental capacity. He was therefore unable to perform his duties at his place of work and at home as a family man.

5. The condition worsened which led to the plaintiff seeking medical treatment at Liberty Health Jersey City Medical Centre Campus in the United States of America. While there, he went through various tests which revealed that he suffered a bilateral fracture of the hip whereafter he underwent surgery which involved a total hip replacement. The plaintiffs condition has since then improved tremendously and he no longer suffers from the symptoms he had before.

6. Consequently, the plaintiff sought the following reliefs from this court;

a. General Damages

b. Special Damages of Kshs. 1,615,000 and US $74,323 or its equivalent

c. Damages for loss earning capacity and or loss of income.

d. Costs of and incidental to this suit

e. Interest on (a), (b), (c) and (d) above at court rates.

f. Ant other relief that this court may deem fit.

7. The suit Is opposed by the defendants who filed the defence dated 22/5/2013 where they denied the averments by the plaintiff and put them to strict proof.

8. At the hearing, the plaintiff relied on the testimony of two witnesses while the defendants also summoned two witnesses.

9. PW1 ZACHARY MUMBO an associate professor at USIU Africa, told the court that sometime in 2004 while he was a resident at Minnesota USA he fell in a supermarket which prompted him to visit a nearby health facility where he was diagnosed with muscle sprain and was given medication and allowed to go home.

10. It was his testimony that in 2019 he started experiencing difficulty walking and he proceeded to the 1st defendant hospital. On 10/1/2011 he was admitted at the hospital and the 2nd and 3rd defendants attended to him. He said he experienced jerky movements, general body stiffness, unintentional movements which were sudden and repetitive that only involved the upper part of the back. He additionally experienced episodes of pain on the back and hips.

11. The 2nd defendant diagnosed him with anxiety disorder while the 3rd defendant stated he suffered somatoform disorder which he was given medication and put on treatment.

12. The plaintiff further stated that the treatment and medication that were given to him by the defendants made his condition worse. He was affected mentally psychologically and caused him lose his mental capacity. He became ruthless, angry, uncooperative to his family members, his employer, workmates and students. His condition worsened and eventually he was unable to stand or walk and was subsequently put on a wheel chair

13. He sought medical treatment at Liberty Health Jersey City Medical Centre in the USA and various tests were conducted and revealed that he suffered a bilateral fracture of the hip. He went for surgery which involved a total hip replacement. His condition thereafter improved tremendously and he no longer exhibits the aforementioned symptoms

14. PW2 DR OMONDI AFULO an orthopedic surgeon working at the Kenyatta National Hospital in his testimony told the court that he examined the plaintiff on 8/11/2012 and found him to have had a hip injury that was operated in the USA. He reiterated the experience the plaintiff had at the 1st defendant hospital.

15. It is **PW2's** testimony that when he saw the plaintiff in 2012 he was able to bear his weight but was unable to walk for long distances therefore had a limitation on walking. He therefore found that the plaintiff had a permanent disability of 75%.

16. During cross examination, **PW2** noted that there was nothing wrong with diagnosing someone with anxiety disorder. He further indicated that a patient can have a bilateral femoral neck fracture and the patient could still walk but with difficulty.

17. He indicated that the plaintiff did not receive treatment on the fractures even after complaining of pain in the lower limbs and it was possible that the fractures could have caused the plaintiff to have anxiety disorder.

18. DW1 DR NELLY ALIVISA KITASI, a consultant psychiatrist told the court that that from the records of the 1st defendant hospital, the plaintiff had visited the hospital several times. Several tests were done and when they came back normal he was referred to her.

19. It is DW1's evidence that on 8/12/2010 that she first attended to the plaintiff. She observed him to have low moods, emotional and had extreme anxiety. When asked to stand unaided the plaintiff clutched the table for fear of falling which made her diagnose him with post traumatic disorder. She followed by prescribing medications used to treat severe anxiety.

20. One month later, on 10/11/2011 the plaintiff returned to the 1st defendant hospital complaining of tremors and jerky movements which worsened in strange or new environments. The plaintiff revealed to her that he had a fall whilst in the USA. She reviewed him the following day and took him through a desensitization procedure by walking with him in the ward. On 13/1/2011 the plaintiff improved and from the hospital record by the other doctors he had not experienced any stiffness or jerky movements. He was later discharged on 15/1/2011 and when he left the hospital he was walking with the aid of a walking cane.

21. It was her testimony therefore that as per the hospital records the plaintiff visited the 1st defendant hospital several times after discharge but neglected to visit the psychiatry and Psychology clinic despite advice. The plaintiff condition improved tremendously during the cause of his treatment and had there been any mental, psychological or physiological effects as alleged it would have manifested in the EEG report and detected by the doctors. She therefore maintained that she did not misdiagnose the plaintiff and that he got the best care.

22. DW2 DR MATIVO a neurologist testified and told the court that he only attended to the plaintiff on 12/1/2011 when, he described to him that he had a fear of walking on tiled surfaces after a fall he had sustained. The plaintiff further complained of jerky movements that had

been happening involuntarily for about three months and that also his wife had informed him that the movements would sometimes occur while he was asleep.

23. He proceeded to request for an EEG to be conducted which is a test performed to diagnose seizures and/or abnormal electrical changes which occur in the brain when having true seizures. The EEG finding were normal despite the jerky movements reported while doing EEG

24. The next day he examined the plaintiff and noted that he was stable and had been taking valium. His condition had improved and since the EEG findings were normal, the plaintiff was advised to continue with the psychiatric management.

25. DW2 examined the plaintiff before discharge on 14/1/2011 and made a determination that his condition was stable. He was able to attend physiotherapy and walk about free of pain. He opined that if the plaintiff had been suffering from a bilateral hip fracture as alleged he would have been completely immobilized, in excruciating pain and unable to place any weight on his legs. DW2 was therefore not negligent during treatment and care of the plaintiff.

26. At the close of evidence parties were directed to file and exchange written submissions which they filed.

27. On his part, the plaintiff submitted that the defendants were guilty of negligence and that they failed to use reasonable care, skill and diligence while giving the plaintiff treatment. He was of the view that with his history and symptoms, the defendants failed to conduct any radiological examinations and CT scans of the plaintiff's skeletal structure and subsequently failed to accurately diagnose the plaintiff's condition and resulted in the issuance of medication and treatment that adversely affected the plaintiff.

28. It was their submission that the plaintiff sought further treatment at Jersey City Medical Centre where the proper tests were carried out and the plaintiff was properly diagnosed, went through hip surgery and his condition improved tremendously.

29. The defendants on the other hand argued in their submissions that they stand by their diagnosis of somatoform disorder. They contended that they conducted comprehensive investigations of the plaintiff between the year 2008 and 2011 therefore they used appropriate care and skill in the way they managed the patient and in summary the treatment accorded to the plaintiff was consistent with the complaints he presented.

30. Having considered the evidence presented before the court I think the following issues arise for the determination:

a. Whether or not there was breach of duty of care and negligence attributed to the defendants?

b. What is the quantum of damages payable?

31. On the first issue as to whether or not there was a breach of duty of care and negligence, in **Stroud's Judicial Dictionary 5th edition**, medical negligence is defined as follows: -

"In relation to professional negligence I regard the phrase "gross negligence" only as indicating so marked a departure from the normal standard of conduct of a professional man as to infer a lack of that ordinary care which a man of ordinary skill would display.

A Doctor is not guilty of negligence if he has acted accordance with a practice accepted by a responsible body of medical men skilled in that particular form of treatment."

32. In the case of **Ricarda Njoki Wahome Vs Attorney General & 2 Others (2015) eKLR**, the court stated as follows: -

"A doctor can be held guilty of medical negligence when he falls short of the standard of reasonable medical care and not because in a matter of opinion he made an error of judgment. For negligence to arise there must have been a breach of duty and the breach of duty must have been the direct or proximate cause of the loss, injury or damage. By proximate is meant a cause which is a natural and continuous chain un broken by any intervening event, produces injury and without which injury would not have occurred. The breach of duty is one equal to the level of a reasonable and competent health worker. The plaintiff in her case must prove the following in order to show deviation on the part of the second and third defendants.

1) That it was a usual and normal practice

2) That a health worker has not adopted that practice

3) That the health worker instead adopted a practice that no professional or ordinary skilled person would have taken."

33. It is the plaintiff's case in brief that the defendants gave a wrong diagnosis on him which in turn worsened his condition. He argued that with the symptoms he presented the defendants should have examined his lower limbs by requesting x rays or CT scans for the area but failed to do so. He added that he sought for further treatment in the USA due to his deteriorating condition and is in the US that he was correctly treated after which his condition improved.

34. The plaintiffs list of produced a medical report by the 1st defendant dated 2/4/2011 in which it is indicated that the plaintiff was **"on follow up by the 2nd defendant he, as of that time presented with jerky movements, general body stiffness, unintentional movements that were sudden repetitive and only involved the upper back."**

35. However, in another report by liberty health dated 3/4/11 and confirmed in the plaintiff's submissions the plaintiff was admitted with **"a history of back pain for the last six months which was getting worse over the course of six months. The plaintiff visited the emergency room one week ago when he was found to have multiple disc bulging and protrusion and was discharged on pain management. Now for the last one day he has lower back pain, 10/10 intensity located in the lower lumbar area, radiates to both legs till knee joint, sharp pains, no history of back trauma, back surgery. Complaint of difficulty walking on and off"**

36. From the above, one can therefore infer that the plaintiff exhibited different symptoms while he was in the 1st defendant hospital as opposed to when he was at Liberty health Jersey City. So the questions that this court need to address is whether the defendants' treatment was usual and normal? Whether the defendants adopted the said treatment? and whether the health workers instead adopted a practice that no professional or ordinary skilled person would have taken?

37. It was explained by DW2 that from the symptoms of the Plaintiffs he requested a head CT scan and EEG and both tests came out normal. The plaintiff then did not have lower back pain nor 10/10 pain intensity located in the lower lumbar area radiating in both legs.

38. The plaintiff only indicated that he had fear of walking on tiled surfaces or new areas. Indeed, it was opined by DW2 at trial that if the plaintiff had been suffering from a bilateral hip fracture as alleged, he would have been completely immobilized, in excruciating pain and unable to place any weight on his legs. It would seem to this court that these excruciating symptoms occurred to the plaintiff whilst he was receiving treatment in the USA but not when he visited the 1st defendant hospital.

39. To this court, the balance of probability tips in favour of the defendants as it does appear that the defendants did provide treatment that was normal and adopted a treatment that any professional would have given. PW2 confirmed this in his testimony when he indicated that there was nothing wrong with diagnosing a patient with an anxiety disorder and that it was likely that the fractures would have caused it.

40. In the case of **Wahome** cited herein above, the court referred to the case of **Hunter Versus Harley 1955 Sc 200** where the court held as follows: -

> **"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 other men…. The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved guilty of such failure and no doctor of ordinary skill will be guilty of it in acting in ordinary care."**

41. The plaintiff herein alleged that the treatment that was rendered to him caused him to lose him mental capacity but in turn did not produce any evidence to prove so. It is DW1's testimony's that when the plaintiff was released from the 1st defendant hospital he did not visit the psychology or psychiatry clinic. This fact was never denied by the plaintiff and goes to show that he did not even adhere to the advice that he was given by the defendants.

42. In light of the above, I find that the plaintiff did not prove

His case as against the defendants on liability to the required stands in civil cases. This case is therefore found to be without merits.

43. On quantum, though the suit has been dismissed this court is bound to assess and award damages the court could have made had the plaintiffs suit succeeded.

44. On general damages the plaintiff pleaded to be awarded Ksh. 6,000,000/=. He cited several cases including the cased **of JOO & 2 Others v. Dr Praxedes P Maundu Okuyoti [2018] eKLR** where the Plaintiff was awarded Ksh. 5,000,000 for general damages where the plaintiff suffered brain damage after a botched surgery. T

45. The defendants on the other hand proposed an award of Ksh. 2,000,000 and cited the case of **BS v. Jonardon Patel [2019] eKLR** in which the court made an award of Ksh. 2,000,000 as general damages in a similar case where the plaintiff proved medical negligence. Having considered the rival proposals plus the authorities cited, I am convinced that an award of Ksh. 2,000,000 would have been reasonable as general damages.

46. The plaintiff has pleaded to be awarded special damages of Kshs. 1,615,000 and US$ 74,323 which amounts are in respect to his travel and treatment abroad. The defendants on the other hand contended that the plaintiff did not produce any receipts as evidence of the same. On perusal of the plaintiff's evidence this court notes that the receipts provided by the plaintiff did not sum up to the amounts pleaded. They however provided receipts proving the following amounts;

i. Dr Omondi Consultation - Ksh. 5,000

ii. X ray charged - $ 184

iii. Visit to University Hospital - $ 1707

iv. Medication bought at Walgreens- $70.69

v. Minneapolis Air Ticket -$ 1317

Total $ 3338.69 and Ksh 5,000

This court would therefore have awarded Ksh 5,000 and $ 3338.69 as special damages.

47.On damages for loss of earning capacity the plaintiff asked this court to award Ksh. 1,314,660.60 for loss of earnings at United States International University, Nairobi; Ksh 5,544,000 for loss of earnings at Jomo Kenyatta University of Agriculture and Technology; Ksh. 8,184,000 for loss of earnings at African Nazarene University. On perusal of the plaintiff's evidence, it only indicated the amount he earned in the different universities where he worked but failed to indicate the amount he lost while he was receiving treatment.

48. The plaintiff also failed to prove that he lost his earnings as a result of his medical condition and that he is incapable of getting gainful employment.

49. Loss of earnings is claimed as special damages and must be specifically pleaded and strictly proved. It is a specific figure based on the claimant's rate of monthly salary and the years expected to continue working and because of the plaintiff's failure to prove the same, this court would not have made any orders on loss of earning.

50. In the end, the suit is dismissed with cost to the defendants.

DATED, SIGNED AND DELIVERED ONLINE VIA MICROSOFT TEAMS AT NAIROBI THIS 11TH DAY OF JUNE, 2021

…….……

J. K. SERGON

JUDGE

In the presence of:

…… for the Plaintiff

…….. for the Defendant