In December 2010, my mother was admitted to an established private hospital in Nairobi for what we considered a routine surgery. This surgical procedure was the culmination of a series of medical tests that began in July that year in Kisumu where she lived and ended up in a referral to a sister hospital in Nairobi. After several tests and doctor consultations, the second doctor confirmed that she was in the early stages of cervical cancer and the best course of action for a woman her age – 64 years – was a hysterectomy.

It all seemed straightforward really. Armed with health insurance, we accompanied my mother through hospital admission procedures a day before her surgery. What was intended as a three-hour surgery ended up with my mother being wheeled out of recovery at 11 p.m. It turned out that the surgeons had found a hernia, chose to repair it and then conduct the hysterectomy. On the third-day post operation – the day she began to eat solid foods – my mother developed complications in the night. These complications included difficulty breathing, reduction in urine output, low blood pressure for a high blood pressure patient. All of these symptoms were red flags.

Thirty-six hours later, my mother died of an acute bacterial infection. The doctors told us they did not know the cause of the bacterial infection. We were told infections can be picked up anywhere, we were after all in a hospital. When we asked for a post-mortem, it was suggested that it was
unnecessary. To cite one doctor – we would find nothing except a missing uterus. We went ahead and conducted a post-mortem. A relative had the presence of mind to encourage us to get an independent pathologist to observe the procedure. It is the results of the post-mortem that pointed us to the cause of the bacterial infection (septicaemia) tiny punctures to her large intestines that occurred during surgery. In essence the minute she started eating food, the contents of her large intestines leaked into her bloodstream and poisoned her.

The admitting doctor quickly vacated the scene and left us in the hands of the ICU doctors, only offering a full medical report in mid-January 2011, despite our requests for said report in December 2010. She went on holiday. It is both treatment and responses we received to our questions about whether anything could have been done to avoid my mother’s death that set us on a six-year-long process of looking for accountability.

In 2011, we returned to demand answers from the hospital management. At this stage, we were slightly more than angered by the callous treatment we were receiving from the hospital. Yet, even in this anger, all we wanted was an admission that they had failed in their duty of care and an apology. We had proof of the cause of death. We wanted an apology that would for us acknowledge my mother as a person whose life mattered. She was not simply a 64-year-old African woman in bed X. We wanted my mother to be seen and our grief acknowledged.

Instead, we met a management team that was preparing for the possibility of legal action. In that meeting, the two surgeons who had operated on my mother were missing. We were told they were busy. The head of obstetrics confirmed that the case was internally investigated and the outcome of said investigation revealed that a crucial window had been missed. The window being the moment between the observation of changes in my mother’s vitals by the nurses and the time the doctors offered a proper medical response, which was mid-morning the next day. I am familiar with the missed opportunity referred to because I became intimately acquainted with my mother’s hospital records in the months that followed.

By the time the doctors begun accelerating their medical response, the opportunity to take her back into theatre had passed and no surgeon would have risked such a move because she would have died on the table. They made her comfortable and waited for her to die. He also hinted at my mother’s weight and pre-existing medical conditions such as high blood pressure and old age onset of diabetes as factors that did not help her situation. They were not fully to blame, the now deceased patient had to take responsibility for being “unhealthy”. The hospital after discussion agreed to transfer a copy of the medical file to a doctor in a sister hospital in Kisumu for review. They would not hand over a copy of the file to us without a court order. It is the outcome of that review that led us to the Kenya Medical Practitioners and Dental Board (KMPDB) to file a malpractice case.

**Pursuing Accountability: Some Lessons**

There is often that one case that hits the Kenyan media that reignites public concern about the state of medical care in Kenya. In the recent past, most of these cases have been located at Kenyatta National Hospital (KNH), such as the case of Alex Madaga[1], the rape allegations at KNH[2] which are about institutional care and most recently the patient who had brain surgery for no apparent reason[3]. These cases have occurred in the largest referral public hospital in Kenya, which often leads to the assumption that medical malpractice is a problem confined to public hospitals and that this is a class question. It is not.

To be clear medical malpractice is not unique to Kenya. The scale is accelerated by weaknesses in accountability channels that limit remedial measures taken to address gaps in medical procedures and implementing personnel. Of course, medical malpractice cannot be understood outside the
larger training and labour issues associated with the health sector in Kenya. Nonetheless, I want to focus on accountability as a critical pillar to medical practice that does not necessarily disappear or reduce when better labour conditions are put in place. There is a general “utado” attitude that sits at the heart of accountability questions everywhere. It is that daring people to act – a dare that is located in an acknowledgement of structural powerlessness – that must be dealt with.

This is Kenya

When we arrived at the decision to file a malpractice case, we received many responses from friends, the most common being “this is Kenya nothing will come of it”; “she is dead, this will not bring her back”. However, the most disturbing in my view, were the litany of medical malpractice examples recalled with ease, as though they were describing the decision to use Vaseline and not spirit on a wound. The casualness with which people spoke about patients who were given wrong medicine thus ending up dead, surgical items left in patient’s bodies and misdiagnosis was disturbing to say the least. In all the cases I heard, no one took any action, because either the patient had survived or they were dead. Beyond the costs – both emotional and financial – associated with pursuing accountability for medical malpractice, we are resigned to the fact that systems will fail us and if “you don’t know someone” why put yourself through the process of looking for justice. The number of medical malpractice cases that go unreported are anecdotally high, the number of cases reported at the board with limited response is equally high. However, the failure to address these cases and therefore improve the system is deeply reliant on an unholy alliance between our silence and the collusion of legal and health systems to protect “their own”. Our experience with the KMPDB points to this unholy alliance.

Professional Accountability

In the KMPDB, the body charged with the responsibility of holding medical professionals accountable to the highest standards of service, we find a manifestation of all weaknesses of the medical sector in Kenya. The slow responses by KMPDB to cases filed before it is indicative of the lethargy that accompanies a real commitment to hold medical professionals ethically accountable. This lethargy is evident in the speed with which KMPDB will deal with cases that attract public attention such as the death of former IEBC commissioner Letangule’s wife or Mugo wa Wairimu, while keeping non-high profile cases waiting for six months to a year for a hearing date, if you are lucky.

Second, in most jurisdictions outside Kenya, institutions such as KMPDB are considered independent professional bodies. This means that legal orders cannot be used to stop proceedings within the board. However, if someone is dissatisfied with the outcome of the board’s process, they can file a civil suit. Even if there is a concurrent matter before a court of law, the two processes are considered independent. This is not the case in Kenya. The medical malpractice case we filed at the medical board was stopped twice by the hospital asking to be de-linked from the case, yet they were the admitting hospital. My mother did not have her surgery on the highway. Every time the hearing was stopped it meant that we spent time and financial resources fighting court orders that went unchallenged by the very hospital that had filed them. It also meant that we went into a longer waiting period for another hearing date at the KMPDB.

It is clear this was a tactic used by the hospital to frustrate us. Most disturbing though was what appeared to be a collusion between the hospital and the board. This was apparent on one occasion when the director of the board, shouted into the corridor where we sat: “the case of the woman who died at X hospital. We will not hear your case today because there is a court order on the way to stop the proceedings”. Our hearing was being halted by a court order that had not been served to anyone. The board members then took an extended tea break ostensibly to buy time for this court
order to arrive so that they did not have to begin hearing the case. When we questioned board officials about this apparent collusion, they as would be expected denied that they had engaged in a stalling game designed to benefit the hospital and ostensibly the doctor.

Third, procedures at KMPDB remain opaque, which means that for families who do not have the requisite understanding of evidence collection and most importantly the resources to do so, most cases will not see light of day. On one occasion as I sat outside the KMPDB hearing venue, I spoke to a family whose case involved a deceased family member’s organs being harvested. This case was eight years in the making. I knew that case was not going anywhere because they were predictably asked for evidence. The family member had long since been buried, no post-mortem was ever conducted and all they had was a story.

Finally, the opacity surrounding institutional procedures is aided by the unwillingness of medical practitioners to hold each other accountable. Where malpractice cases require expert witnesses, finding doctors willing to offer evidence remains difficult. In our case, we found a doctor who agreed to provide an expert opinion not because his own medical record is squeaky clean because the assumption is that those testifying have never made any errors. He recognised that there was a major lapse in the duty of care and he knew the deceased – my mother. His motivation was therefore personal.

On collective accountability

Ours is not a tale that ends in triumph. After six years of running through the courts, lawyers and poring over medical evidence we chose to halt the process. As a family, we were suspended in grief for six years. Every time there was a court or board hearing, we were transported to those traumatic two days in December 2010 when we watched our mother’s body shut down one organ after the next. We decided that sending the message had been important and we stood up for her.

Accountability for medical malpractice is fundamentally a question of attitude. An attitude that recognises patients as human beings whose lives matter and that one mistake is a mistake too many. From my experience, the cycle of collusion that surrounds hospitals and medical personnel doing what is no doubt a difficult job, does not build any confidence in health institutions. There is need for collective accountability for medical malpractice in Kenya that goes beyond looking at individual hospitals and cases. There is a larger system based question that should generate a change process that targets all the actors responsible for medical care and ethics. A critical actor in this conversation is the patient. No one files a medical complaint because they are out to get doctors. Grief is too painful a process to prolong by choice.


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