REPUBLIC OF KENYA

KMPDC
Enhancing Quality Healthcare

KENYA MEDICAL PRACTITIONERS
AND DENTISTS COUNCIL

The Code of Professional Conduct and Ethics

7TH EDITION | FEBRUARY 2026

Cover page inlay

FOREWORD

Regulation is an important element in ensuring quality healthcare. A key role of regulatory bodies is to protect healthcare consumers from health risks, provide a safe working environment for healthcare professionals, and ensure that public health and welfare are served by health programs. Regulations are therefore necessary to standardise and supervise healthcare, ensure that healthcare bodies and facilities comply with the prescribed standards and that they provide safe care to all patients and visitors to the healthcare system.

Advances in healthcare are dynamic and thus the Kenya Medical Practitioners and Dentists Council reviewed *The Code of Professional Conduct and Discipline* so as to address emerging issues in the practice of medicine and dentistry within the confines of the Law.

This reviewed *Code* repeals some of the provisions of the 2012 edition to reflect the current position and reduce eminent obsolesce noted in the previous edition. Emerging current issues in the practice of medicine have also been discussed with a view of standardising and creating uniform standards that can be applied without bias and with tremendous clarity for all stakeholders.

The Code shall be observed by all medical and dental practitioners, community oral health officers and other health professionals registered or licensed under the Medical Practitioners and Dentists Act to practice in Kenya. Practitioners should familiarise themselves with this *Code* and any other regulations or circulars that may be issued by the Council from time to time.

This *Code* supersedes any other previous publication and is effective from **1st February 2026**.

PROF. FREDRICK N. WERE
CHAIRPERSON
KENYA MEDICAL PRACTITIONERS AND DENTISTS COUNCIL

PREFACE

The review of *The Code of Professional Code and Discipline, 2012* was inescapable and overdue. This is owing to the fact that the practice of medicine and dentistry is extremely volatile and ever evolving. Over the years, there have been tremendous changes in technology and technique of practice that if left unregulated would result in a crisis. Globally there has been a shift in the perception and outlook of codes of professional code of conduct and ethics.

The process of this review was thorough and rigorous noting to involve the key relevant stakeholders at various stages, culminating a document that will support the provision of quality and ethical healthcare. This document is not to be viewed from a punitive angle but from a progressive and supportive guidance viewpoint. It lays out globally accepted good practice in various circumstances while still observing basic ethical principles and professional values. This *Code* majorly lays focus on preventive, curative and rehabilitative care while giving special attention to preserve Human Rights Laws both locally and internationally.

The Code of Professional Conduct and Ethics 7th edition seeks to lay out the principles that ensure good clinical practice and minimise practices likely to bring the profession to disrepute. This *Code* is divided into nine chapters. Chapter One presents the legal basis and rationale for the *Code* while Chapter Two provides the basic ethical principles and professional values on which the *Code* is founded. Chapter Three addresses the conduct expected of a practitioner as a professional while Chapter Four tackles different elements of the practitioner-patient relationship. Chapter Five provides guidelines on establishing respectful and supportive relationships with other healthcare professionals while Chapter Six expounds on the role of the practitioner within the health system and society and Chapter Seven provides guidelines on tackling some of the emerging issues in healthcare. Chapter Eight focuses on the practitioners maintain a good relationship with the regulator while Chapter Nine provides international codes of professional practice that the practitioner can refer to for additional guidance.

It therefore goes without say that this *Code* is a document that every responsible practitioner within the Republic ought to acquire and abide to, so as to uphold the profession’s cachet.

DR DAVID G. KARIUKI
CHIEF EXECUTIVE OFFICER
KENYA MEDICAL PRACTITIONERS AND DENTISTS COUNCIL

ACKNOWLEDGEMENTS

On behalf of the Council, we take this opportunity to express our utmost gratitude to the following individuals for their exemplary contribution towards the review of this Code of Professional Conduct and Ethics:

The Council Member, namely Prof. Fredrick Were, Dr Patrick Amoth, Dr Elizabeth Gitau, Dr Timothy Theuri, Mr. Moses Kiptanui, Prof. Stephen Ogendo, Prof. Rose Kosgei, Hon. Sara Bonaya, Mr. Ashford Kathaara, Mr. Livingstone Bumbe and Ms. Vivianne Majani, for their leadership and strategic oversight.

The members of the Technical Working Group led by Dr Elizabeth Gitau and comprising of Prof. Elizabeth A. Bukusi, Dr Lydia Okutoyi, OGW, and Mr. Ndunu Chege, for their expert analysis and technical guidance in this review process,

Our esteemed stakeholders for giving invaluable insight, constructive feedback and participation into the review of the Code.

Special regards to the secretariat staff, led by Dr Margaret Mbugua, and comprising of Mr. Simon Kiraithe, CS Eunice Muriithi, CS Michael R. Onyango, Dr Wangechi King'ori, Dr Stella Kanja, CS Esther Mutheu, Mr. Maroko Ragwanda, Ms. Sarah Were, Mr. Duncan Mwai, Mr. Harun Liluma, Mr. Francis Chege, Mr. Bethuel Ekal, Mr. Hosea Muchiri, Mr. Joshua Muchui, Mr. Shadrack Mutua and Mr. Patrick Wawire, who provided technical and logistic support in undertaking the review of this *Code*.

The successful completion of *The Code of Professional Conduct and Ethics 7th edition* is evidence of the shared commitment to upholding ethical conduct within the regulated professions.

PROF. STEPHEN OGENDO
CHAIR, DISCIPLINARY AND ETHICS COMMITTEE
KENYA MEDICAL PRACTITIONERS AND DENTISTS COUNCIL

TABLE OF CONTENTS

ABBREVIATIONS AND ACRONYMS

BDS	Bachelor of Dental Surgery
BSc.OH	Bachelor of Science in Oral Health
Cap. 253	Medical Practitioners and Dentists Act, Chapter 253, Laws of Kenya
CEO	Chief Executive Officer
COHO	Community Oral Health Officer
CME	Continuous Medical Education
CPD	Continuing Professional Development
CPR	Cardiopulmonary Resuscitation
CRS	Department of Civil Registration Services
D&EC	Disciplinary and Ethics Committee of KMPDC
Dip.COH	Diploma in Community Oral Health
EAC	East African Community
KCSE	Kenya Certificate of Secondary Education
KMPDC	Kenya Medical Practitioners and Dentists Council
MBChB/ MBBS/ MBBCh	Bachelor of Medicine and Bachelor of Surgery
NACOSTI	National Commission for Science, Technology and Innovation
NCPWD	National Council for Persons with Disability
PEP	Post-Exposure Prophylaxis
PPE	Personal Protective Equipment
PWD	Person With Disability
TAR&HRC	Training, Assessment, Registration and Human Resource Committee of KMPDC
WADA	World Anti-Doping Agency
WHO	World Health Organization
WMA	World Medical Association

DEFINITION OF TERMS

Advertising	Promotion of services or products offered by a practitioner or health institution with the aim of attracting patients or clients
Age of majority	Section 2 of the Age of Majority Act (Cap. 33) states that "A person shall be of full age and cease to be under any disability by reason of age on attaining the age of eighteen years". Further, Section 3 of the Kenya Citizenship and Immigration Act (Cap. 170) states that "a person is considered not to have attained a given age until the commencement of the relevant anniversary of the day of his birth."
Artificial intelligence (AI)	The field of computer science that focuses on creating machines and computer systems capable of performing tasks that typically require human intelligence, e.g. learning, reasoning, problem-solving, perception and decision-making
Assent	Process in which minors (below the age of 18 years) are given information about a certain test, procedure or treatment in a manner that they are able to understand with the aim of helping them participate in decision making
Assisted reproduction	The use of medical techniques to bring about conception
Chaperone	A person, usually a healthcare professional, who is present during a patient's examination or procedure to act as a witness and ensure the patient's comfort, safety, and privacy
Clinical leader	An experienced healthcare professional who uses expertise, influence, and communication to guide teams; improve patient care quality and safety; foster innovation, and drive positive change in clinical settings, acting as a role model for best practices and person-centred care
Collegiality	A cordial and cooperative relationship between members of the same profession
Community	A group of people with shared characteristics, interests, location, or identity, forming social units from neighbourhoods to global groups, characterised by connection, mutual support, and common goals, whether physical or virtual
Community Oral Health Officers (COHOs)	Health professionals with a basic qualification of Diploma in Community Oral Health or Bachelor of Science in Oral Health that are registrable under Cap. 253
Comprehension	The ability to grasp the meaning, significance, or importance of information presented and using it to make a decision

Confidentiality	The practice of keeping sensitive information private, and protecting it from unauthorised access, use, disclosure, modification, loss or theft
Conflict of interest	A situation where there is a clash between public duty or professional responsibility and private interests
Consent	The act of giving permission for something to be done
Cosmetic intervention	An intervention, procedure or treatment carried out with the primary objective of changing an aspect of a patient's physical appearance, which includes surgical and non-surgical procedures, both invasive and non-invasive
Dental Practitioners/ Dentists	Health professionals with a basic qualification of BDS, DDS or its equivalent that are registrable under Cap. 253
Dependant	A person who relies on another for survival
Disability	Includes any physical, sensory, mental, psychological or other impairment, condition or illness that has or is perceived to have a substantial or long-term effect on an individual's ability to carry out ordinary day to day activities
Doping	The unlawful use of drugs and substances to enhance the performance of a sportsperson
e-Health	The use of information and communication technologies, (e.g. the internet, computers, mobile devices, applications and data systems) to deliver, support and enhance health and healthcare services
Emergency treatment	The necessary immediate healthcare that must be administered to prevent death or worsening of a medical situation
Euthanasia	The administration of a lethal substance to another person with the intention of ending their life so as to eliminate the patient's intolerable and incurable pain and suffering
Explicit consent	Voluntary, specific, clear and affirmative communication indicating a person's willingness to engage in a particular act
Fellow	A Medical or Dental Practitioner undertaking a subspecialty training programme.
Gamete	A mature reproductive cell which can fuse with another from the opposite sex in sexual reproduction (in this case, a human ovum or sperm, which can fuse with a human sperm or ovum respectively to form a zygote)
Gamete donation	Process through which an individual gives their sperm or ova for use by another person to assist them in achieving a pregnancy
Gender Based Violence (GBV)	Harmful acts directed at an individual based on their gender and inflicted in public or in private. This includes sexual, physical, mental and economic harm; threats of violence; coercion; manipulation, and other harmful acts.

Health facility/ Health institution	The whole or part of a public or private institution, building or place, whether for profit or not, that is operated or designed to provide in-patient or out-patient treatment, diagnostic or therapeutic interventions, nursing, rehabilitative, palliative, convalescent, preventative or other health service
Health system	An organisation of people, institutions and resources that deliver healthcare services to meet the health needs of the population, in accordance with established policies
Hippocratic Oath	An ancient Greek text outlining ethical duties for doctors, traditionally sworn by doctors upon graduation. Modern versions adapt its core principles, emphasising patient wellbeing, respect, and professional integrity reflecting evolving medical ethics and societal values, while removing some historical/ religious aspects like references to specific gods
Human research	Research involving human subjects, which includes both medical (clinical trials) and non-clinical (social science) studies
Impede	Deliberately delay or prevent someone or something by obstructing
Implicit consent	Consent that is not expressly granted but is inferred from the person's actions or surrounding circumstances.
Informed consent	Communication between a patient and practitioner leading to permission for care, services and treatment.
Internet	A global network of computers providing a variety of information and communication facilities, consisting of interconnected networks using standardised communication protocols
Intersex	A person who is conceived or born with a biological sex characteristic that cannot be exclusively categorised in the common binary of female or male due to their inherent and mixed anatomical, hormonal, gonadal or chromosomal patterns, which could be apparent prior to, at birth, in childhood, puberty or adulthood
Intimate examination	Examination of the genital, pelvic, rectal or breast regions, or any other part of the body where it is necessary for a practitioner to touch or be close to the patient, and that may be embarrassing or distressing to the patient
Junior doctor	A term that is generally used to refer to young doctors ranging from newly qualified up to ten years after qualification, and include doctors undertaking specialist training

Mature/ Emancipated minor	A person who is below 18 years of age but, due to specific circumstances, has reached a sufficient level of emotional and intellectual development and is considered legally capable of making their own healthcare decisions without involving their parent or guardian.
Medical or Dental Specialists/ Subspecialists	Medical or Dental Practitioners who have additional postgraduate qualifications in the recognised specialties or subspecialties that are registrable under Cap. 253
Medical Practitioners	Health professionals with a basic qualification of MBChB, MBBS or its equivalent that are registrable under Cap. 253
Medical proxy	A trusted person who is legally designated to make medical decisions for or on behalf of the patient, when the patient is incapacitated, unable to make decisions for themselves, or unable to communicate their decision
Mental health	A state of emotional, psychological and social wellbeing that enables people to cope with the stresses of life, realise their abilities, learn well and work well, and contribute to their community
Metadata	Data that provides context, structure and information to help find, manage, and understand other data, includes parameters like creation date and time, file size, location of recording, author, camera or device settings, etc.
Minor	A person who Is below the age of 18 years and is legally considered a child
Next of kin	A person's closest living relative
Organ donor	A person who agrees to give healthy cells, tissues or organs to someone else (a recipient) whose own cells/ tissues/ organs are failing or damaged, either while living or after their death in order to save lives or significantly improve quality of life
Organ trafficking	The illegal trade or exchange of human cells, tissues and organs for financial or other material gain, typically exploiting vulnerable individuals
Overcharging	Agreeing to or receiving payments for services rendered that are higher than those specified in the Medical Practitioners and Dentists (Professional Fees) Rules
Patient	A person requiring or receiving healthcare services
Physician-assisted suicide	Occurs when a physician facilitates a patient's death by providing the necessary means, information, prescription and/or drugs to enable the patient to perform the life-ending act
Policies	A set of rules governing various issues.

Practice of medicine or dentistry	Activities undertaken by any person, health professional or organisation involved in the prescription and/or administration of any procedure or treatment, with the aim of alleviating or preventing physical or mental ill health, restoring functionality, or promoting habits that prevent ill health.
Practitioner	Unless otherwise specified, where stated in this *Code of Professional Conduct and Ethics*, the term "practitioner" refers to a medical practitioner, dental practitioner, community oral health officer or any other health professional who is registered or registrable under the Medical Practitioners and Dentists Act (Cap. 253 Laws of Kenya)
Prohibited List	List of substances whose use by sportsmen/ sportswomen is banned by WADA
Prohibited substance	Drugs, medication and substances whose use is banned for purposes of sporting activities
Pseudoscience	Claims, beliefs, or practices presented as factual or scientific but lacking evidence and compatibility with the scientific method, often relying on vague statements, anecdotes, and resistance to scrutiny
Pseudotherapies	Practices, products, procedures or treatments whose effectiveness lacks scientific evidence, often presented as scientific but failing rigorous testing, relying heavily on placebo effects, and risking harm by leading people to abandon proven remedies
Referral	The act of directing a patient to another practitioner or health facility for further consultation, review or action
Registrar	1) An official responsible for keeping a register or official records. In KMPDC, this role assigned to the CEO. 2) A Medical or Dental Practitioner undertaking a postgraduate specialty training programme. Also referred to as a **Resident**.
Research	The structured, systematic and creative investigation to discover new knowledge or create new understanding by collecting, analysing, and interpreting data
Rights	Legal, social or ethical principles of freedom or entitlement inherent to all people, ensuring dignity, respect and fair treatment
Sanctions	A threatened penalty for disobeying the law
Sex selection	The deliberate attempt to control the sex of the offspring to achieve a desired sex

Social media	Technology that facilitates sharing of content and information for personal or business purposes through virtual internet-based platforms
Society	An organisation or grouping of people having common activities, traditions and institutions, and sharing collective interests
Sports Medicine	The branch of medicine that focuses on physical activity, treating and preventing injuries from sports or exercise, and enhancing fitness for all ages and abilities, not just elite athletes
Supervision	The act of watching, directing and supporting a fellow practitioner, an intern or a healthcare student to ensure that they learn and/or develop required professional skills
Surrogacy	An arrangement in which a woman (surrogate) carries a pregnancy for another person or couple (intended parents) who are unable to carry the pregnancy themselves, often due to infertility or medical reasons
Telemedicine	Use of electronic information and telecommunication technology to deliver healthcare services remotely
Termination of pregnancy	Deliberate actions that result in expulsion of an embryo or foetus
Therapeutic donor insemination	The injection of sperm from a woman's partner or third-party donor into her uterus to enable her to conceive
Third party reproduction	The introduction of a third party (including gamete donor and surrogate) into the process of reproduction, to enable an individual or couple to conceive
Transgender	A person whose gender identity does not correspond with their registered gender.
Transplant tourism	The movement of persons across jurisdictions for transplant services, which becomes unethical when it involves organ trafficking and commercialisation; trafficking in persons for the purpose of organ removal, or when the provision of transplants to foreigners undermines a country's ability to provide transplants for its own population
Undercutting	Charging for services rendered an amount that is lower than the minimum listed in the Medical Practitioners and Dentists (Professional Fees) Rules
Voluntary	Actions done out of one's own free will

THE HIPPOCRATIC OATH

Every Practitioner is required to take and sign the Hippocratic Oath at the time of admission into the medical or dental profession as follows:

"I, ... , solemnly pledge myself to consecrate my life to the service of humanity.
I will give to my teachers the respect and gratitude which is their due.
I will practice my profession with conscience and dignity.
The health of my patient will be my first consideration.
I will respect the secrets which are confided in me, even after the patient has died.
I will maintain, by all the means in my power, the honour and the noble tradition of the medical profession.
My colleagues will be my brothers and sisters.
I will not permit considerations of religion, nationality, race, ethnicity, gender, sexual orientation, party politics or social standing to intervene between me and my patient.
I will maintain the utmost respect for life from its beginning, even under threat, and I will not use my medical knowledge contrary to the laws of humanity.
I make these promises solemnly, freely and upon my honour.
So, help me God."

Signature: . . . .

Date: . . . .

1. INTRODUCTION

1.1. ABOUT KMPDC

The Kenya Medical Practitioners and Dentists Council (KMPDC) is a body corporate established under Section 3 of the Medical Practitioners and Dentists Act (Chapter 253, Laws of Kenya) enacted in 1977. The Council is mandated by Cap. 253 to regulate the training and practice of medicine, dentistry and community oral health, and to regulate health institutions within the Republic of Kenya.

Its corporate philosophy is as indicated below:

Vision

Excellence in regulation of training and practice of medicine and dentistry

Mission

To regulate the training and practice of medicine and dentistry through registration, licensing and inspections for provision of people-centred, quality and ethical healthcare

Core values

- Excellence
- Professionalism
- Integrity and Impartiality
- Collaboration and Partnerships

Goal

Enhancing quality healthcare

Functions

The functions of the Council as indicated in Section 4 of Cap. 253 are to:

a. establish and maintain uniform norms and standards on the learning of medicine and dentistry in Kenya;
b. approve and register medical and dental schools for training of medical and dental practitioners, and community oral health officers;
c. prescribe the minimum educational entry requirements for persons wishing to be trained as medical and dental practitioners, and community oral health officers;
d. maintain a record of medical, dental and community oral health students;

e. administer internship qualifying examinations, preregistration examinations, and peer reviews as deemed appropriate by the Council;
f. inspect and accredit new and existing institutions for medical, dental and community oral health internship training in Kenya;
g. license eligible medical, dental and community oral health interns;
h. determine and set a framework for professional practice of medical and dental practitioners, and community oral health officers;
i. register eligible medical and dental practitioners, and community oral health officers;
j. regulate the conduct of registered medical and dental practitioners, and community oral health officers, and take such disciplinary measures for any form of professional misconduct;
k. register and license health institutions;
l. carry out inspection of health institutions;
m. regulate health institutions and take disciplinary action for any form of misconduct by a health institution;
n. accredit continuous professional development providers;
o. issue certificate of status to medical practitioners, dental practitioners, community oral health officers and health institutions, and
p. do all such other things necessary for the attainment of all or any part of its functions.

1.2. LEGAL BASIS FOR *THE CODE OF PROFESSIONAL CONDUCT AND ETHICS*

The Code of Professional Conduct and Ethics is anchored on the Constitution of Kenya, the Health Act, the Medical Practitioners and Dentists Act and its subsidiary legislation, and other relevant Laws.

The Constitution of Kenya 2010 provides as follows:

a. Article 2 states that the “Constitution is the supreme law of the Republic and binds all persons and all State organs at both levels of government”. It further acknowledges that general rules of international Law shall be part of the Law in Kenya, as long as they are in conformity with the Constitution of Kenya.
b. Article 26 states that:
    (1) Every person has the right to life.
    (2) The life of a person begins at conception.
    (3) A person shall not be deprived of life intentionally, except to the extent authorised by this Constitution or other written law.

(4) Abortion is not permitted unless, in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the mother is in danger, or if permitted by any other written law.

c. Article 27 enshrines the right to equality and freedom from discrimination, including that:
   i. Every person has the right to equal protection and equal benefit of the law;
   ii. Equality includes the full and equal enjoyment of all rights and fundamental freedoms;
   iii. Women and men have the right to equal treatment, including the right to equal opportunities in political, economic, cultural and social spheres, and
   iv. The State or any other person shall not discriminate directly or indirectly against any person on any ground, including race, sex, pregnancy, marital status, health status, ethnic or social origin, colour, age, disability, religion, conscience, belief, culture, dress, language or birth.

d. Article 28 states that “Every person has inherent dignity and the right to have that dignity respected and protected.”

e. Article 31 (c) provides that “Every person has the right to privacy, which includes the right not to have information relating to their family or private affairs unnecessarily required or revealed.”

f. Article 41 enshrines the right of every person to fair labour practices, including the right to:
   i. fair remuneration;
   ii. reasonable working conditions;
   iii. form, join or participate in the activities and programmes of a trade union; and
   iv. go on strike.

g. Article 43 (1) (a) provides that “Every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care” while Article 43 (2) provides that “A person shall not be denied emergency medical treatment.”

h. Article 46 (1) enshrines the rights of consumers to:
   i. goods and services of reasonable quality;
   ii. the information necessary for them to gain full benefit from goods and services;
   iii. the protection of their health, safety, and economic interests; and

    - iv. compensation for loss or injury arising from defects in goods or services.
- i. Article 53 states the rights of every child, including the rights to:
    - i. a name and nationality from birth;
    - ii. basic nutrition, shelter and health care;
    - iii. be protected from abuse, neglect, harmful cultural practices, all forms of violence, inhuman treatment and punishment, and hazardous or exploitative labour;
    - iv. parental care and protection, and
    - v. not be detained, except as a measure of last resort
- j. Article 53 (2) states that "A child's best interests are of paramount importance in every matter concerning the child."
- k. Article 232 (1) provides the values and principles that should be upheld in the public service, including:
    - i. high standards of professional ethics;
    - ii. efficient, effective and economic use of resources;
    - iii. responsive, prompt, effective, impartial and equitable provision of services;
    - iv. involvement of the people in the process of policy making;
    - v. accountability for administrative acts;
    - vi. transparency and provision to the public of timely, accurate information;
    - vii. fair competition and merit as the basis of appointments and promotions;
    - viii. representation of Kenya's diverse communities, and
    - ix. affording adequate and equal opportunities for appointment, training and advancement, at all levels of the public service, of men and women; the members of all ethnic groups; and persons with disabilities.
- l. The Fourth Schedule provides for the distribution of functions between the national government and the county governments, with healthcare being a shared function between the two levels. The national government was left in charge of:
    - i. policy making;
    - ii. regulation and setting standards;
    - iii. key cross-cutting preventive services like immunisation and communicable disease control, and
    - iv. managing the national referral hospitals.

  while the county governments were assigned the responsibility for:
    - i. developing county health services, including the management of health facilities and pharmacies at the county level, and ambulance services

    ii. promotion of primary health care
    iii. licensing and control of undertakings that sell food to the public
    iv. cemeteries, funeral parlours and crematoria
    v. refuse removal, refuse dumps and solid waste disposal
    vi. the provision of community health services
    vii. provision of health education
    viii. implementation of preventative health programmes including vector control, and
    ix. reproductive health services.

The Health Act (Cap. 241) aims to establish a unified health system; to coordinate the inter-relationship between the national government and county government health systems, and to provide for regulation of healthcare service and healthcare service providers, health products and health technologies. The Health Act provides as follows:

a. Section 4 states that “It is a fundamental duty of the State to observe, respect, protect, promote and fulfil the right to the highest attainable standard of health including reproductive healthcare and emergency medical treatment” including the responsibility to:
    i. develop policies, laws and other measures necessary to protect, promote, improve and maintain the health and wellbeing of every person, and
    ii. ensure the prioritisation and adequate investment in research for health to promote technology and innovation in healthcare delivery.
b. Section 5 reiterates the right of every person to the highest attainable standard of health including progressive access for provision of promotive, preventive, curative, palliative and rehabilitative services, and the right to be treated with dignity, respect and have their privacy respected in accordance with the Constitution.
c. Part II of the Act unpacks the rights and duties for actualising the right to the highest standard of health. These include:
    i. Section 6 which enshrines the right of every person to reproductive healthcare, including access to appropriate health services, provided by qualified health professionals, and performed in recognised health facilities with an enabling environment;
    ii. Section 7 which enshrines the right of every person to emergency medical treatment, including pre-hospital care, stabilising the health

status of the individual, and arranging for referral to facilities that have the capacity to stabilise the health of the individual;

iii. Section 8 requires healthcare professionals, health facilities and other healthcare providers to provide to patients (or their guardians) and health system users, in a language that they understand, adequate information on:
    - their health status;
    - the range of promotive, preventive and diagnostic procedures and treatment options available;
    - the benefits, risks, costs and consequences generally associated with each option, and
    - the user's right to refuse recommended medical options; explaining the implications, risks and legal consequences of such refusal and formally document such refusal;

iv. Section 9 provides that no health service may be provided without the informed consent of the patient or health system user, and that a healthcare provider must take all reasonable steps to obtain the patient’s or user’s informed consent.

v. Section 11 provides that the information concerning a health system user “including information relating to his/her health status, treatment or stay in a health facility is confidential except where such information is disclosed under order of court or informed consent for health research and policy planning purposes”.

vi. Section 12 (1) provides the rights of healthcare professionals, including the rights to:
    - not to be unfairly discriminated against on account of any of the grounds set out in Article 27(4) of the Constitution;
    - a safe working environment that minimises the risk of disease transmission and injury or damage to the healthcare personnel or to their clients, families or property;
    - refuse to treat a user who is physically or verbally abusive or who sexually harasses him/her except in an emergency situation where no alternative healthcare personnel is available, and
    - apply for and accept a salaried post in the public service or the private sector.

vii. Section 12 (2) provides that healthcare providers, whether in public or private sector, shall have the duty to:
    - provide healthcare, conscientiously and to the best of their knowledge within their scope of practice and ability, to every person entrusted to their care or seeking their support;
    - provide emergency medical treatment as provided for under section 7(2), and
    - inform a user of the health system, in a manner commensurate with his or her understanding, of his or her health status.

viii. Section 13 lists the duties of health system users, in the absence of any observable incapacity, including the duty to:
    - adhere to the rules of a health facility when receiving treatment or using the health services provided by the establishment;
    - adhere to the medical advice and treatment provided by the establishment;
    - supply the healthcare provider with accurate information pertaining to his or her health status;
    - cooperate with the healthcare provider;
    - treat healthcare providers and health workers with dignity and respect, and
    - if so requested, to sign a discharge certificate or release of liability if he or she refuses to accept or implement recommended treatment.

ix. Section 14 provides that “any person has a right to file a complaint about the manner in which he or she was treated at a health facility and have the complaint investigated appropriately”. It also provides for the establishment of procedures and frameworks for filing and handling such complaints.

x. Section 15 expounds on the duties of the national government ministry responsible for health including:
    - to develop health policies, laws and administrative procedures and programmes in consultation with county governments and health sector stakeholders and the public for the progressive realisation of the highest attainable standards of health including reproductive healthcare and the right to emergency treatment;
    - to develop and promote application of norms and standards for the development of human resources for health including affirmative action measures for health workers working in marginalised areas;

- to develop, through regulatory bodies, standards of training and institutions providing education to meet the needs of service delivery;
- through respective regulatory bodies to develop and ensure compliance on professional standards on registration and licensing of individuals in the health sector, and
- to co-ordinate development of standards for quality health service delivery.

The Medical Practitioners and Dentists Act (Cap. 253) provides as follows:

a. Section 2 defines "professional misconduct" as a serious digression from established or recognised standards or rules of the profession, that includes a breach of such codes of ethics or conduct as may be prescribed for the profession from time to time.
b. Section 4 provides the functions of the Council, which include among others:
    - (h) determine and set a framework for professional practice of medical and dental practitioners, and community oral health officers;
    - (i) register eligible medical practitioners, dental practitioners and community oral health officers;
    - (j) regulate the conduct of registered medical and dental practitioners, and community oral health officers, and take such disciplinary measures for any form of professional misconduct;
    - (m) regulate health institutions and take disciplinary action for any form of misconduct by a health institution, and
    - (o) issue certificate of status to medical practitioners, dental practitioners, community oral health officers and health institutions.
c. Section 4A (1) (b) provides that the mandate of the Disciplinary and Ethics Committee includes, among others:
    - (ii) regulating professional conduct, and
    - (iii) ensuring fitness to practice and operate.
d. Section 5 provides that the CEO shall be the Registrar and a list of the registers that he/she shall maintain annually.
e. Section 6 provides the criteria for registration of medical and dental practitioners.
f. Section 12 provides for the Council to issue general, specialist and other practice licences to eligible medical and dental practitioners.

g. Section 15A states that every practitioner shall in each year take a professional indemnity cover and every health institution shall in each year insure the health institution against professional liability of its staff.

h. Section 16 states that the issue, cancellation, revocation or withdrawal of a licence shall be published in the Kenya Gazette.

i. Section 17 states that no person shall be entitled to recover a charge for medical or surgical advice or attendance, or for the performance of an operation as a medical or dental practitioner, or for medicine which he/she has prescribed and supplied as a medical or dental practitioner, unless he/she is at the time appropriately licensed.

j. Section 18 states that no certificate or other document required by Law to be signed by a duly qualified medical or dental practitioner shall be valid unless signed by a person registered as a medical or dental practitioner under the Act or, where the context so admits, by a person who is licensed by the Council, and

k. Section 22 provides the penalties for offences such as:
    - Practicing, professing to practice, or publishing one's name as practicing medicine or dentistry by a person who is not registered or licensed as a medical or dental practitioner under Cap. 253;
    - Any false or fraudulent representation or declaration either orally or in writing that a person is a medical or dental practitioner (and any person who aids or assists herein);
    - Falsely taking or using a name, title or addition implying a qualification to practice medicine or dentistry;
    - Using the title "doctor" when one is not a registered medical or dental practitioner, and does not hold doctoral or other qualifications that entitle him/her to use that title;
    - Any person who, while in charge of a health institution, employs or engages the services of another person as a medical or dental practitioner who is not registered and licenced under Cap. 253, and
    - A person who uses premises as a health institution which premises is not licensed as a health institution.

The Medical Practitioners and Dentists (Inquiry and Disciplinary Proceedings) (Procedure) Rules, 2022 further unpack the provisions in Cap. 253, including:

a. Rule 2 provides defines "unprofessional conduct" to mean conduct that falls short of what is reasonably expected of a professional in the course of their practice, and
b. Rule 4 expounds on the functions of the D&EC including:
    - (c) develop and regularly review the code of professional conduct for ethical and good practice for persons registered under the Act, and
    - (d) constitute as required subcommittees to inquire into and determine the fitness to practice and operate of persons registered under the Act.

1.3. RATIONALE FOR *THE CODE OF PROFESSIONAL CONDUCT AND ETHICS*

T*he Code of Professional Conduct and Ethics* aims to promote good relationships between medical and dental practitioners and community oral health officers, and their patients, other health professionals, health institutions, the public and the communities they serve. The goal of *The Code* is to provide guidance that promotes ethical professional behaviour among the practitioners regulated under Cap. 253 and thus protect the public, uphold human dignity and ensure patient safety.

The Code was last reviewed in 2012, and, in the intervening decade, changes witnessed in the demographic, epidemiologic, technological, environmental, sociocultural, legal and political spheres within the country, region and globally have led to emerging challenges in the practice of medicine and dentistry. This reviewed *Code* seeks to provide guidance that addresses these challenges, and its application will enhance the provision of ethical and quality healthcare.

1.4. PROCESS OF REVIEW OF *THE CODE OF PROFESSIONAL CONDUCT AND ETHICS*

This section elucidates the process undertaken in the review of *The Code of Professional Conduct and Ethics* as summarised in Figure 1:

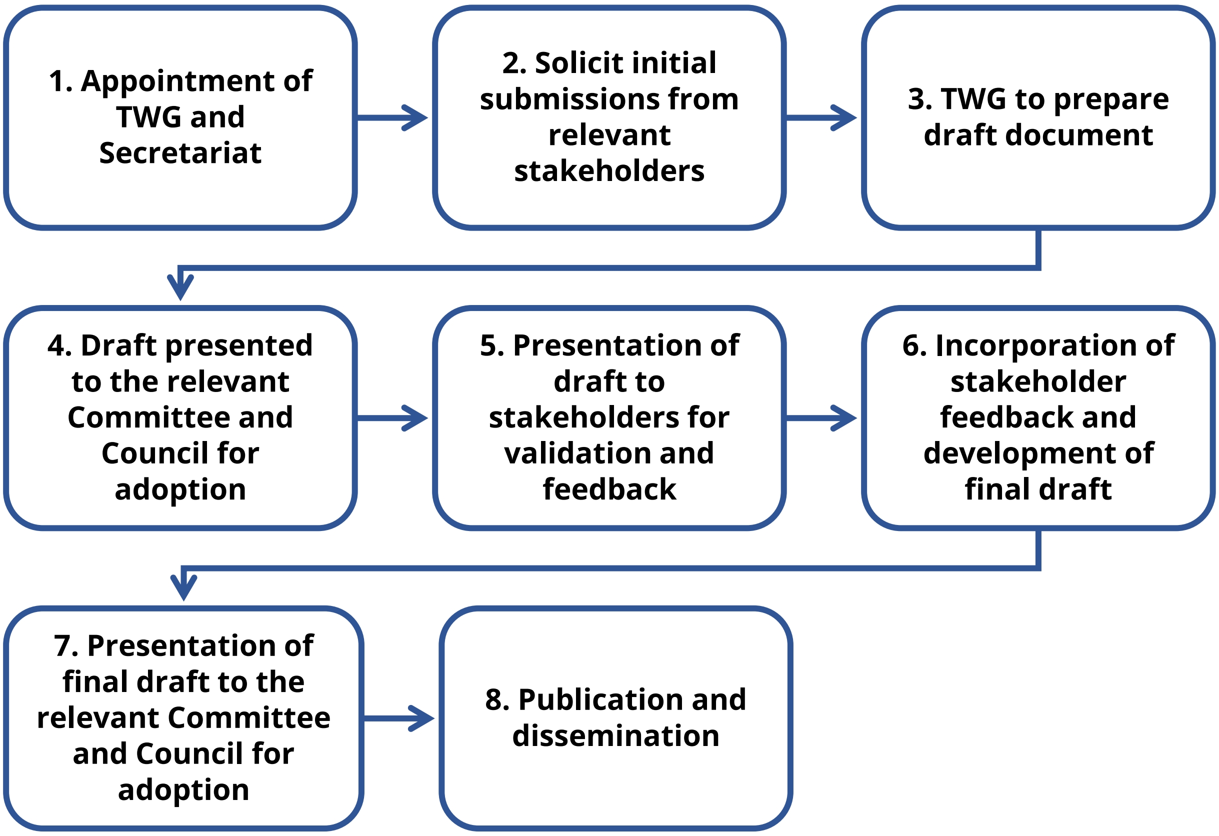

Figure 1: Process flow for review of The Code of Professional Conduct and Ethics

a. The process began with the appointment of a Technical Working Group (TWG) to spearhead the process of review, and a Secretariat team to provide technical and logistic support to the TWG in this review.
b. Stakeholders were then requested to submit their feedback on *The Code of Professional Conduct and Discipline* 6th edition and inputs for consideration in the revised *Code*. These stakeholders included individual practitioners, professional associations and healthcare providers.
c. The TWG then convened to consider these submissions and produced a Draft Zero of the revised Code.
d. The Draft Zero was then presented to the Council through the relevant Committee, the Disciplinary and Ethics Committee (D&EC).
e. After adoption by the Council, the Draft Zero was then subjected to stakeholder validation at a workshop.

f. The TWG then considered the feedback received orally or in writing from the stakeholders and incorporated the feedback to produce a Draft One of the revised Code.
g. The Draft One was then presented to the D&EC, which validated and adopted the Final Draft.
h. The final draft *Code of Professional Conduct and Ethics* 7th edition was then presented to the Council and adopted for publication and dissemination.

1.5. SCOPE OF APPLICATION AND DISSEMINATION

The Code of Professional Conduct and Ethics 7th edition applies to all medical practitioners, dental practitioners, community oral health officers, health institutions and any other health professionals regulated under the Medical Practitioners and Dentists Act (Cap. 253, Laws of Kenya).

The Code of Professional Conduct and Ethics 7th edition is available on the KMPDC website under the Publications section.

1.6. EFFECTIVE DATE, FEEDBACK AND REVIEW

This *Code* supersedes any other previous publication and is effective from **1st February 2026**.

Feedback on *The Code* is welcome. It should be addressed to the CEO/ Registrar, KMPDC and can be submitted through standards@kmpdc.go.ke.

The Code of Professional Conduct and Ethics will be reviewed at least once every five (5) years or when need arises.

2. BASIC ETHICAL PRINCIPLES AND PROFESSIONAL VALUES

Practitioners are required to maintain good professional practice, which is grounded in basic ethical principles and professional values, which are explored further in the subsequent chapters.

2.1. THE FUNDAMENTAL PRINCIPLES OF MEDICAL ETHICS

The fundamental principles of medical ethics include:

a. **Respect for persons**

This principle acknowledges that all patients are persons who have intrinsic worth, dignity, and sense of value. Practitioners should recognise that patients are persons and treat them as such.

b. **Beneficence**

This principle is based on the goals "to do good" and "to maximise benefits". Practitioners have a moral duty to act in the best interests of their patients, even when these interests are in conflict with their own personal interests.

c. **Non-maleficence**

This principle is based on the Hippocratic maxim "to do no harm". Practitioners have a duty to do no harm and to not allow harm to be caused to their patient through neglect or by acting against the best interests of their patients, even when these interests conflict with their own personal interests.

d. **Autonomy**

This principle incorporates two ethical convictions when dealing with patients:

i. That patients are individuals capable of making their own informed choices and, acting under the direction of such deliberation, to live their lives by their own beliefs, values, and preferences.
ii. That not every human being is capable of self-determination, and that such individuals with diminished autonomy are entitled to protection.

Practitioners should acknowledge and respect the right of patients to self-determination or make their own informed choices.

e. **Justice**

This principle is based on the right of all individuals to be treated in a just, fair and impartial manner. Practitioners should ensure that they treat patients, clients and colleagues in a manner that is fair, balanced, compatible with the law and respectful of the patient's rights, and that does not unfairly disadvantage the patient, client or colleague. Practitioners should be ready to serve all patients and clients equally without discrimination based on either age, ethnicity, race, gender, disability, marital status, sexual orientation, socioeconomic status, religious or spiritual beliefs, lifestyle, political affiliation, social standing, or any condition of vulnerability.

2.2. OTHER PRINCIPLES AND PROFESSIONAL VALUES

Other general principles that a Practitioner should be aware of and uphold include:

a. **Human rights**

Chapter 4 of The Constitution of Kenya, 2010 provides for the Bill of Rights, which serves to preserve the dignity of individuals and community. Practitioners should recognise and respect the basic human rights of all individuals.

b. **Confidentiality**

In the course of patient care, practitioners are routinely made privy to patient's personal information by virtue of the trust that emanates from practitioner-patient relationship. Practitioners are required to keep a patient's personal health information private, unless the consent to release the information is provided by the patient, and/or there are overriding reasons which confer a moral or legal obligation for the disclosure.

c. **Professional competence and self-improvement**

Practitioners are expected to maintain the highest level of competence in all aspects of their work; to keep their knowledge and skills up to date; to regularly participate in activities that maintain and develop their competence and performance, and to be familiar with guidelines and developments that affect their work.

d. **Integrity**

Practitioners should regard truthfulness as the foundation of their professional relationships. They should incorporate basic ethical principles and values into the foundation for their character and practice as responsible health professionals.

e. **Compassion and Empathy**

Practitioners are required to incorporate compassion and empathy in their practice, which involves acknowledging their patient's suffering, feelings and experience while remaining detached from them and maintaining a level-headed approach to their care.

f. **Tolerance**

Practitioners should acknowledge that individuals can have ethical values and principles based on their cultural, religious and educational background that are different from the practitioner's own and make reasonable effort to accommodate these differences.

g. **Contribution to the Community**

Practitioners have a responsibility to promote the health and improve the quality of life of the community through health education, screening, disease prevention and control, and limiting the spread of false information, pseudoscience and pseudotherapies. Additionally, practitioners should interact with society in accordance with their professional abilities and standing in the community.

3. PRACTITIONERS’ PROFESSIONAL CONDUCT

The health professions are governed by a code of ethics and a duty of service that places patient care above self-interest, and by the privilege of self-regulation granted by society. Professionalism is defined as a set of values, behaviours and relationships that underpins the trust that the public places in health professionals. It focuses on health professionals’ partnerships with patients and with each other. Health professionals are central to the delivery of high-quality healthcare services. Extensive training, education, and skills are essential in meeting the needs and demands of the population for safe, competent healthcare. This chapter expounds on the characteristics, values, standards and qualities expected of a health professional registered under Cap. 253.

3.1. PROFESSIONAL VALUES AND QUALITIES OF PRACTITIONERS

While there are professional values that underpin good medical practice, all practitioners have a right to have and express their personal views and values. However, the boundary between a practitioner’s personal and public profile can be blurred. Hence, practitioners need to consider the effect of their public comments and their actions outside of work (including engagements on social media) relate to medical and clinical issues, and how these actions reflect on their role as a practitioner and on the reputation of the profession.

In all aspects of their lives, all Practitioners are expected to uphold the following values and qualities:

a. Abide with all the laws of the country;
b. Be respectful of all persons and their choices, lifestyle, culture and religion;
c. Maintain the highest standards of integrity;
d. Conduct themselves in a manner that upholds the dignity of the profession;
e. Ensure that their professional practice is knowledge-led and evidence-based;
f. Ensure good communication;
g. Foster a culture of timeliness in all professional dealings;
h. Be reliable and dependable;
i. Be aware of their own strengths and limitations;
j. Maintain a healthy lifestyle;
k. Contribute to the advancement of their profession and science, and
l. Contribute to the betterment of the community.

3.2. RESPONSIBILITIES OF PRACTITIONERS

At the minimum, every Practitioner shall at all times:

a. Keep his/her professional knowledge and skills up to date;
b. Observe the laws of the country, especially in relation to his/her professional practice;
c. Maintain the highest standards of personal conduct and integrity;
d. Take care of their own health, safety and wellness, and encourage their colleagues to do the same;
e. Act in the best interests of his/her patients;
f. Respect patient confidentiality, privacy, choices and dignity;
g. Provide adequate information about the patient's diagnosis, treatment options and alternatives, costs associated with each such alternative and any other pertinent information to enable the patient to exercise a choice in terms of treatment and informed decision-making pertaining to his or her health and that of others;
h. Maintain proper and effective communication with his/her patients and other healthcare professionals;
i. Obtain informed consent from a patient or, in the event that the patient is unable to provide consent for treatment himself or herself, from his/her next of kin, guardian or medical proxy;
j. Maintain complete, accurate and up to date patient records;
k. Participate in activities that contribute to the improvement of the community and the betterment of public health;
l. Expose without fear or favour, any incompetent, corrupt, dishonest or unethical conduct by members of the profession;
m. Safeguard the profession against admission to it of persons who are deficient in moral character, education or skill; and
n. Not permit unqualified, unlisted or unregistered persons to attend to, treat or perform procedures on patients whenever professional skill or discretion is required.

3.3. KNOWLEDGE, SKILLS AND PERFORMANCE

All medical practitioners, dental practitioners and community oral health officers should:

a. Be competent in all aspects of their work, including management, research and teaching;

b. Update their professional knowledge and skills by regularly participating in activities that maintain and develop their skills and performance e.g. Continuing Professional Development (CPD) activities, quality improvement initiatives, research, etc;
c. Be familiar and keep up to date with laws, guidelines and regulations that are relevant to their work;
d. Find and participate in structured support opportunities where available (e.g. mentorship, active membership in professional associations);
e. Regularly reflect on their practice and its effectiveness, and their relationships with patients and other health professionals, and learn from what has worked and what has not;
f. Routinely engage in activities or processes that assess, monitor, evaluate and appraise their performance (e.g. clinical audits, self-assessments);
g. Continue to study, apply, and advance scientific knowledge;
h. Commit to and be available to offer medical training and mentorship, and
i. Make relevant information available to patients, colleagues, and the public.

3.4. SCOPE OF PRACTICE

Scope of practice refers to the activities, the extents and limits of medical interventions, or the range of responsibility that a practitioner may be involved in or perform within their profession. This is based on the individual practitioner's training, credentials, competence, performance and professional suitability.

In keeping with the expected standards of practice and care:
a. All practitioners must recognise and work within the limits of their competence;
b. All practitioners must confine themselves within the defined scope of practice for their field of practice as published by KMPDC, and
c. When needed, practitioners shall provide or arrange for suitable advice and prompt referral to another practitioner who has the skill or competence required by the patient.

The Scopes of Practice for the regulated cadres are published on the KMPDC website under the Downloads section.

3.5. REGISTRATION AND LICENSING

Every Medical Practitioner, Dental Practitioner and Community Oral Health Officer in Kenya must ensure that he/she:

a. complies with the registration and licensing requirements as stated in Cap. 253 and the Rules thereunder;
b. is duly registered to practice medicine, dentistry or community oral health in the country;
c. holds a valid practice licence and is duly indemnified for the year and his/her field of practice, and
d. only practices in premises that are duly registered and licensed to provide healthcare as stated in Cap. 253 and the Rules thereunder.

3.6. PROFESSIONAL INDEMNITY COVER

Professional indemnity cover, also known as professional liability insurance, is a form of liability (third party or risk) insurance cover that protects persons or institutions involved in offering professional advice and services from bearing the full costs of defending against a negligence claim or damages awarded in such a lawsuit. In healthcare, professional indemnity provides financial protection for practitioners, health institutions and patients in circumstances where a patient suffers an adverse outcome caused by errors, accidents, negligence, malpractice or any unlawful act.

Section 15A of Cap. 253, provides that: "*Every practitioner shall in each year take a professional indemnity cover and every health institution shall in each year insure the health institution against professional liability of its staff.*"

It is the responsibility of each individual practitioner to ensure that his/her practice is appropriately covered by a valid professional indemnity cover, and that he/she practices in health institutions that are duly indemnified.

3.7. DISHONEST BEHAVIOUR BY PRACTITIONERS

The community trusts the medical profession. Every practitioner has a responsibility to behave ethically and to ensure that their conduct justifies the patients' trust in them and the public's trust in the profession.

Dishonesty by Practitioners can be divided into three categories:

- Dishonest acts occurring outside the workplace or working hours and not involving patients or service users.
- Dishonest acts occurring in the workplace or during working hours, which may involve patients and service users, and which are recognised as dishonest by the perpetrator and/or colleagues.
- Dishonest acts occurring in the workplace or during working hours, which may involve patients and service users, but the dishonest act involved has been "normalised" at either individual, team, organisation or other level, and therefore is not recognised as dishonest.

Arising from these categories, six types of dishonest practices by Practitioners can be identified, as follows:

- **Dishonesty by omission** i.e. not disclosing the truth, where relevant information is withheld;
- **Dishonesty by commission** i.e. lying, where a practitioner tells an untruth;
- **Impersonation** i.e. a practitioner assuming the identity of another person or encouraging another person to assume their identity;
- **Theft** i.e. stealing, taking another person's money or property without permission or legal right and without intending to return it;
- **Fraud** i.e. deceiving for financial or other gain, and
- **Academic dishonesty** i.e. cheating in academia, fabrication of research findings, plagiarism, etc.

Every Practitioner should avoid engaging in dishonest practices and should always conduct him/herself in an honest and trustworthy manner that upholds the dignity of the profession. At the very least, every practitioner should:

a. Be honest about their experience, qualifications and current role;
b. When providing curriculum vitae:
    i. provide accurate, truthful and verifiable information about their education, professional qualifications, licensure and experience;
    ii. not misrepresent, by misstatement or omission, their education, professional qualifications, experience, licensure or position, and
    iii. omit or redact identifiable patient information from their CV and/or documents submitted along with it;
c. Be honest and trustworthy in all their communication with patients and colleagues. This means that they must make the limits of their knowledge

clear and make reasonable checks to make sure that any information they give is accurate;

d. Be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents. In this regard:
   i. they must make sure that any documents that they write or sign are not false or misleading;
   ii. they must take reasonable steps to check that the information is correct, and
   iii. they must not deliberately leave out relevant information;

e. Ensure that the information that they publish in advertisements is factual, can be checked, and does not exploit patients' vulnerability or lack of medical knowledge;

f. Be honest in financial and commercial dealings with patients, employers, insurers and other organisations or individuals;

g. Pay and file their registration and licence fees, taxes, rates, penalties and other dues promptly as prescribed by Law;

h. Promptly compensate, within the prescribed and agreed rates, other practitioners and employees working with or for them;

i. When faced with a conflict of interest, be open about the conflict, declaring their interest formally, and be prepared to exclude themselves from decision making;

j. Act with honesty and integrity when designing, organising or carrying out research, and follow national and international research governance guidelines, and

k. Be honest and trustworthy when giving oral, written, documentary or any other evidence to courts, inquests, tribunals or inquiry committees; they must take reasonable steps to check that the information is correct, and they must not deliberately leave out relevant information.

3.8. WORKING HOURS

Generally, the training and practice of medicine and dentistry occurs in strenuous high-stress environments and takes a significant toll on the physical, mental and social wellbeing of interns, registrars, fellows and practitioners. Physical and emotional fatigue impacts negatively on the safety and effectiveness of the healthcare provided by practitioners and poses a risk to their patients and colleagues. In this regard:

a. Practitioners should recognise the impact of fatigue on their health, the quality of their decisions, and their performance;
b. In calculating their work hours, Practitioners are advised to consider all aspects of their professional practice, including their primary practice, locum hours and class or study time, and
c. Practitioners are advised to work safe hours and allocate enough time in their schedule for adequate rest and rejuvenation.

3.9. SELF-CARE AND WELLNESS

Practitioners have a responsibility to maintain their health and wellbeing by:

a. Being aware of their own risk status;
b. Being aware of the risks of self-diagnosis, self-treatment and self-prescribing;
c. Retaining the services of practitioners outside of their own family;
d. Seeking independent and objective advice when they need medical care;
e. Taking measures to promote their own health and to protect themselves from illness, including:
    i. Ensuring that their work and/or study hours allow them to get enough rest and to avoid fatigue, stress and burnout;
    ii. Using appropriate personal protective equipment (PPE) during patient care and work activities;
    iii. Being vaccinated against common communicable diseases (unless otherwise contraindicated);
    iv. Maintaining an appropriate work-life balance;
    v. As far as possible, maintaining a healthy diet, a regular physical exercise regimen and sleep schedule, and
    vi. Participating in regular physical and mental wellness check-ups.
f. Taking into account their own safety;
g. Seeking help when they are suffering stress, burnout, anxiety or depression;
h. Adhering to treatment regimens and advice received from their doctors or caregivers, including modifying their practice;
i. Being aware and partaking of the available employee assistance, employee wellness, health advisory or referral programmes;
j. Alerting their supervisor, employer and/or regulator as soon as they are aware that they have a condition:
    i. That could be passed on to patients or colleagues;
    ii. That could, or whose treatment could, impair their judgement and performance, and/or

    iii. For which they have been advised to modify their practice, and

k. Registering with appropriate care or support groups and organisations, such as the National Council for Persons with Disability (NCPWD).

Health and training institutions are required to support the health and wellbeing of Practitioners and other health professionals by providing psychosocial support, employee wellness and assistance programmes.

3.10. PRACTITIONERS PROVIDING CARE TO THEMSELVES OR TO FAMILY MEMBERS

Practitioners are often their relatives' first point of call for medical and emotional support. Their interaction starts with asking for simple advice, consultation for minor ailments, and general questions about healthcare and health promotion, and can escalate to seeking medical care and even surgery.

Other than in emergencies or isolated settings where there is no other qualified practitioner available, offering general health information and for minor health problems, practitioners should avoid treating and/or acting as the primary physician for their family and those close to them.

In the event that practitioners offer medical care to their family members, they must be keen to uphold patient rights as they would any other patient.

3.11. RESPONDING TO QUERIES, COMPLAINTS, AND LEGAL OR DISCIPLINARY PROCEEDINGS

Even in the best circumstances, practitioners are bound to receive queries from patients, their relatives, other health professionals, employers, and/or regulatory bodies during the course of their practice. Some of these queries or complaints arise from:

- the care offered to patients;
- the practitioner's conduct during patient care;
- communication with patients or their relatives;
- the practitioner's conduct with other health professionals;
- requirements for mandatory reporting, and
- regulatory requirements.

All practitioners are expected to:

a. Provide patients (and where applicable, their legal guardian, medical proxy or next of kin), the information that they need to know, in a manner and language that they can understand;
b. Be honest and trustworthy in all their communication with patients, the persons close to them, other healthcare professionals, employers and regulatory bodies, by:
    i. Making the limits of their knowledge clear;
    ii. Making reasonable checks to ensure that the information that they give is accurate, and
    iii. Not leaving out any relevant information deliberately;
c. Be open and honest with patients (and persons close to them) when something goes wrong with their treatment or care, especially if it causes, or has the potential to cause, harm or distress;
d. Acknowledge that the patient and their relatives have a right to complain;
e. Provide information about the complaints system;
f. Work with the patient to resolve the issue locally or internally where possible;
g. Ensure that the complaint does not compromise the patient’s continued care, e.g. by referring the patient to another suitably qualified practitioner where possible;
h. Cooperate fully with any legitimate inquiries and complaints procedures, even when they have since left or are no longer affiliated with the institution where the incident took place, and promptly disclose all relevant information;
i. Take part in reviews and investigations when requested in an honest and trustworthy manner;
j. Support and encourage each other to be open and honest, and not stop someone from raising concerns where appropriate, and
k. Reflect on and learn from these incidents.

3.12. PERSONAL BELIEFS AND CONSCIENTIOUS OBJECTION

Practitioners have personal beliefs, religious or cultural practices and personal values that are central to their lives and that may affect their day-to-day practice.

Practitioners have a right to practice their profession in line with their personal beliefs and values, provided that they:

a. Act within the confines of the Law and relevant legislation;
b. Do not treat patients unfairly;

c. Do not deny patients access to appropriate medical treatment or services, and
d. Do not cause patients unnecessary distress.

Likewise, practitioners are entitled to exercise conscientious objection to providing certain care, treatments or procedures. A practitioner may opt out of providing care because of their personal beliefs and values as long as this does not result in direct or indirect discrimination against or harassment of individual patients or groups of patients. This means that practitioners must not refuse to treat a particular patient or group of patients because of their personal beliefs or views about them. Also, practitioners must not refuse to treat the health consequences of patients' lifestyle choices to which they object because of their beliefs.

When practitioners have a conscientious objection to a particular procedure or treatment, they must do the following:

a. Explain to the patients that they do not provide that treatment or procedure, being careful not to cause distress. They may explain to the patient the reason for their objection while being careful not to imply any judgement of the patient or be seen to influence to patient to change their mind;
b. Be respectful of the patient's dignity and views. In providing the necessary information, the practitioner must not imply or express disapproval of the patient's lifestyle, choices or beliefs;
c. Inform the patient that they have a right to be seen by and discuss the options of treatment with another practitioner who does not hold the same objection;
d. Make sure that arrangements are made, without unreasonable delay, for the patient to be seen by a suitably qualified and skilled practitioner who can take over their care;
e. Not obstruct the patient from accessing services in a timely fashion, or leave them with nowhere to turn to;
f. Bear in mind the patient's vulnerability and act promptly to make sure that they are not denied appropriate treatment or services, and
g. Not deny continued or further care to the patient after this objected treatment or procedure, unless by mutual agreement with the patient.

This notwithstanding, Practitioners must not refuse to provide the treatment necessary to save the life or prevent serious deterioration in the health of a person because that treatment conflicts with their personal beliefs.

3.13. INVOLVEMENT IN RESEARCH

Research involving human subjects, their tissue samples or their health information is vital to the development of treatments; the furthering of scientific knowledge; improving the quality of healthcare; reducing uncertainty for patients now and in the future, and improving the health of the wider population. Practitioners involved in the design, organisation, conduct or reporting of human research must follow national and institutional research governance guidelines. At the minimum, these practitioners have a responsibility to:

a. Act with honesty and integrity;
b. Ensure that the research has been approved or licensed by the relevant research authority, such as the National Commission for Science, Technology and Innovation (NACOSTI);
c. Ensure that any protocol for human research has been approved by a human research ethics committee;
d. Disclose all the sources and amounts of funding for research to the relevant ethics committee;
e. Disclose any potential or actual conflicts of interest to the relevant ethics committee;
f. Respect and protect participants, by:
    i. Ensuring that the safety, dignity and wellbeing of participants take precedence over the outcome of the research;
    ii. Ensuring that participation in human research is voluntary and based on an adequate understanding of sufficient information about the purpose, methods, demands, risks and potential benefits of the research;
    iii. Respecting the right of research participants to withdraw from any research at any time and without giving reasons;
    iv. Ensuring that foreseeable risks to participants are kept as low as possible. In addition, they must be satisfied that:
        - the anticipated benefits to participants outweigh the foreseeable risks, or
        - the foreseeable risks to participants are minimal if the research only has the potential to benefit others more generally;
    v. Respect participants' right to confidentiality, and make sure that any data and products of human origin (cells/ tissues/ organs/ fluids) collected as part of a research project are stored securely and in accordance with data protection laws and other requirements, and

    vi. Closely monitor the progress of the research and promptly report adverse events or unexpected outcomes;

g. Ensure that any dependent relationship between doctors and their patients is taken into account in the recruitment of patients as research participants by:
    i. respecting the patient's right to withdraw from a study without prejudice to their treatment, or
    ii. ensuring that the patient's decision to not participate or withdraw does not compromise the doctor–patient relationship or their care;
h. Ensure that appropriate safeguards are in place when the research involves children or adults who are unable to give informed consent;
i. Take reasonable steps to ensure non-discrimination and diversity of research participants;
j. Adhere to the approved research protocol;
k. Report research results accurately, objectively, promptly and in a way that can be clearly understood. They must make sure that research reports are properly attributed and do not contain false or misleading data, including adverse findings;
l. Adhere to the prevailing guidelines on the registration of the research project, publication of findings, authorship, peer review and conflicts of interest;
m. Make research findings available to those who might benefit. They should make reasonable efforts to inform participants of the outcome of the research, or make the information publicly available if it is not practical to inform participants directly;
n. Ensure that personal, financial, political or other interests do not influence, stop or adversely affect the conduct, completion or outcome of research, and
o. Report possible fraud or misconduct in research to the relevant ethical committee and relevant regulatory body.

3.14. CAREER TRANSITIONS

Medical Practitioners, Dental Practitioners and Community Oral Health Officers may work in multiple roles and fields over the span of their career. These include roles in clinical practice, health leadership and governance, academia, research and innovation, among others. All practitioners should:

a. Recognise that changing roles, reducing practice load or considering retirement can be challenging;

b. Be conscious that their professional performance may be affected by multiple factors, including changes in practice scope or context, increasing age, illness or acquired disability status;
c. Be mindful of how these factors may affect their performance;
d. Participate in periodic assessments of their knowledge, skills and/or health, as these may help detect or monitor declining performance;
e. Acknowledge that successful transition into different scopes of practice, different roles and retirement requires active forward planning and management;
f. Actively plan for a successful transition to different roles or retirement, and
g. Be open to seeking help from colleagues, peers and supervisors, and psychosocial support where needed.

3.15. RIGHTS OF PRACTITIONERS AS HEALTHCARE PROFESSIONALS

All Practitioners are entitled to the rights and freedoms of Kenyan citizens as enshrined in Chapter 4 of The Constitution of Kenya, 2010. Also known as the Bill of Rights, it states that “the purpose of recognising and protecting human rights and fundamental freedoms is to preserve the dignity of individuals and communities and to promote social justice and the realisation of the potential of all human beings”.

As workers, Practitioners are entitled to work in safe and conducive working environments as provided by the Occupational Safety and Health Act (Cap. 236A) whose purpose Is to “secure the safety, health and welfare of persons at work, and protect persons other than persons at work against risks to safety and health arising out of, or in connection with, the activities of persons at work”.

Drawing from these, Practitioners as healthcare professionals are entitled to:

a. Not to be threatened, harassed, bullied or exploited in any manner by any person or institution;
b. Reasonable skill to duties match;
c. Be involved in the continuous improvement of their knowledge, skills and competence through training, CPD/ CME and access to information, in order to perform the tasks required of them;
d. Be paid a fair remuneration for services rendered in a timely manner and in compliance with the prevailing regulations;

e. Fair labour practices including fair dispensations of working hours, overtime, leave, working conditions and other benefits, and the right to have their grievances taken up at appropriate forums;
f. A safe working environment that is not harmful to their health and well-being including the provision of personal protective equipment, post-exposure prophylaxis, medical management to prevent or control their own illness, protection from violence, and appropriate psychosocial support to manage stressful situations;
g. Clinical independence, including the right to make decisions about their professional practice, and the right not to be compelled to offer or perform any unnecessary, unscientific, unproven, harmful, cruel, inhumane, demeaning, derogatory and/or humiliating examinations, tests or treatments;
h. Have access to appropriate physical facilities and equipment and receive adequate and appropriate supplies and materials in order to provide services at an acceptable level of quality;
i. Be assured that whatever the level of care at which they are working, they will receive supportive supervision and back up from other individuals or units, and
j. Reasonable accommodation of their personal religion, beliefs and opinions, provided that they respect the religions, beliefs and opinions of others, and do not cause undue distress to others.

4. THE PRACTITIONER-PATIENT RELATIONSHIP

The practitioner–patient relationship is the cornerstone of clinical care. It is essential that the relationship is based on respect, openness, trust and good communication in order to enable the practitioner to work in partnership with the patient to address their needs.

4.1. PATIENTS' RIGHTS AND RESPONSIBILITIES

In October 2013, the Ministry of Health published *The Kenya National Patients' Charter 2013*, which "is meant to inform clients and patients of their rights and responsibilities thus empowering them to demand quality services from healthcare providers". Practitioners should be aware of and uphold the rights and responsibilities of patients as provided for in the *Charter* and summarised in this section.

Every patient or client has a right to:

a. access healthcare;
b. the highest attainable quality of healthcare products and services;
c. receive emergency treatment;
d. be treated with respect and dignity;
e. choose a healthcare provider;
f. confidentiality;
g. informed consent to treatment;
h. information;
i. second medical opinion;
j. refuse treatment;
k. complain;
l. insurance coverage without discrimination on the basis of age, pregnancy, disability or illness including mental disorders;
m. be informed all the provisions of one's medical scheme or health insurance policy, and
n. donate his/her organs and/or any other arrangements or wishes upon one's demise.

Every patient has the following responsibilities:

a. To take care of his/her health by adopting a healthy lifestyle;

b. If the patient is a minor, protection, care and healthy lifestyle of the minor shall be the responsibility of the parent or guardian of the minor;
c. To adopt a positive attitude towards their health and life;
d. To protect the environment;
e. To respect the rights of others and not endanger their life and health;
f. To be aware of the available healthcare services in his/her locality and to make informed choices when utilising such services responsibly;
g. When an adult patient is not competent to make decisions on healthcare services, the spouse, next of kin and/or guardian, where applicable, shall accord protection and care to the patient;
h. To seek treatment at the earliest opportunity;
i. To keep scheduled appointments, observe time and, if not possible, communicate to the healthcare provider;
j. To give healthcare providers relevant and accurate information to facilitate diagnosis, treatment, rehabilitation and/or counselling while being truthful and honest about past healthcare;
k. To follow instructions, adhere to and not abuse or misuse prescribed medication or treatment and/or rehabilitation requirements;
l. To enquire about the costs of treatment and rehabilitation and to make appropriate arrangements for payments;
m. To take care of the health records in his/her possession and produce them if and when required by the healthcare provider;
n. To inform the healthcare providers, where necessary, when one wishes to donate his/her organs and/or any other arrangements or wishes upon one's demise, and
o. To express any concerns and preferences through the right channels confidentially.

4.2. RESPONSIBILITY/DUTY FOR PATIENT CARE

The duty of care begins when a Practitioner or other health professional first engages with a patient and continues until one or other party ends the relationship. It involves prioritising the patient's best interest, acting with reasonable skill, and following the expected standards and best practices in all healthcare delivery.

Legally, Practitioners have a duty of care when they assume some responsibility for a patient. This can be once they know of the person's need for medical services from them, or when they interact with the person in a professional capacity. In health facilities, the duty of care begins as soon as the patient presents themselves for treatment.

Practitioners are not under any obligation to treat a “stranger”, except in emergencies when no other health professional is available and where first aid is urgently needed. Even in such cases, the Practitioner’s duty of care is only established once he/she offers any kind of medical care to the patient. Further, a Practitioner is not under any legal or moral obligation to accept a patient. Likewise, a patient cannot legally force a Practitioner to take care of them.

The duty of care can vary, depending on the type and duration of the contact. Some aspects of the duty of care extend beyond the patient-practitioner interaction, e.g. the duty of confidentiality which extends even after the patient’s death.

4.3. PRACTITIONER’S CONDUCT DURING PATIENT CARE

In clinical practice, the care of the patient is the practitioner’s primary concern. Maintaining a high level of medical competence and professional conduct is essential for good patient care. All practitioners must:

a. Recognise and work within the limits of their competence and scope of practice;
b. Recognise and respect patients’ rights to make their own decisions;
c. Be courteous, respectful, compassionate and honest;
d. Communicate effectively with patients;
e. Assess the patient, taking into account the history, the patient’s views, and an appropriate physical examination. The history includes relevant psychological, social and cultural aspects;
f. Ensure that they have informed consent or other valid authority before they carry out any examination or investigation, provide treatment or involve patients or volunteers in teaching or research;
g. Consider the balance of benefit and harm in all clinical-management decisions;
h. Formulate and implement a suitable management plan (including arranging investigations and providing information, a diagnosis, treatment and advice);
i. Provide evidence-based treatment options;

j. Prescribe drugs or treatment, including repeat prescriptions, only when they have adequate knowledge of the patient's health and are satisfied that the drugs or treatment will serve the patient's needs;
k. Check that the care or treatment that they provide for each patient is compatible with any other treatments the patient is receiving, including (where possible) self-prescribed over-the-counter formulations;
l. Take steps to alleviate patient symptoms and distress, whether or not a cure is possible;
m. Consult and take advice from colleagues, when appropriate;
n. Support the patient's right to seek a second opinion;
o. Facilitate the coordination and continuity of care;
p. Refer a patient to another practitioner when this is in the patient's best interests or as required by legislation;
q. Inform the patient when the practitioner's personal opinion (in the context of practice) does not align with the profession's generally held views;
r. Recognise individual bias and take appropriate action, and
s. Recognise that there is a power imbalance in the doctor–patient relationship, and not exploit (or act in a manner that may be seen to exploit) patients, including physically, emotionally, sexually or financially.

4.4. COMMUNICATION WITH PATIENTS AND THEIR RELATIVES OR GUARDIANS

Communication is the process of exchanging ideas, thoughts, opinions, knowledge, and data so that the message is received and understood with clarity and purpose. It occurs in both verbal and non-verbal modes and includes verbal, written, visual and non-verbal cues.

Effective communication is an important part of patient care and the doctor–patient relationship. It involves:
a. Being courteous, respectful, compassionate and honest;
b. Listening to patients, asking for and respecting their views about their health, and responding to their concerns and preferences;
c. Establishing who the persons close to them are (next of kin/ guardians), and what information the patient feels comfortable sharing with them;
d. Giving patients the information that they need to know by:

    i. informing patients of the nature of, and need for, all aspects of their clinical management, including examinations, investigations and treatments;
    ii. discussing with patients their condition and the available management options, including their potential benefit and harm, and material risks of each;
    iii. encouraging patients to speak about how they are currently managing their condition, including any other health advice they have received, any prescriptions or other medication they have been taking, and any other conventional, complementary or alternative therapies they are using;
    iv. giving them adequate opportunity to question or refuse intervention and treatment, and
    v. endeavouring to confirm that the patient understands what the practitioner has said;
e. Taking all practical steps to ensure that arrangements are made to meet patients' specific language, cultural and communication needs, and being aware of how these needs affect patients' understanding;
f. Responding to patients' questions and keeping them informed about their clinical progress;
g. Being considerate of those close to the patient and being sensitive and responsive in giving them information and support;
h. Being readily accessible to patients and colleagues seeking information, advice or support while they are on duty, and
i. Documenting any relevant communication between the practitioner, patient and persons close to them, and with other healthcare professionals.

4.5. PATIENT PARTICIPATION IN THEIR OWN CARE (SHARED DECISION-MAKING)

Making decisions about healthcare is the shared responsibility of the practitioner and the patient. Patients may wish to involve their family, caregiver or other persons close to them as complementary or substitute decision-makers. Shared decision making is a key component of person-centred care.

In establishing and maintaining partnerships with patients, Practitioners must:

a. Work in partnership with patients, providing them with the information that they will need to make informed decisions about their care, including:

    i. their condition, its likely progression and the options for treatment, including associated risks and uncertainties;
    ii. the roles and responsibilities of the practitioner in the team;
    iii. the progress of their care;
    iv. who is responsible for each aspect of patient care;
    v. how information is shared within teams and among those who will be providing their care, and
    vi. any other information patients need to know, including possible involvement in teaching and/or research;
b. Treat information about patients as confidential, even after the patient has died;
c. Support patients in caring for themselves by empowering them to improve and maintain their health, e.g. by:
    i. advising patients on the effects of their life choices and lifestyle on their health and well-being, and
    ii. supporting patients to make lifestyle changes where appropriate;
d. Inform and explain to patients when there is a need to refer, consult or delegate their care to another practitioner, and facilitate the transfer of their care, and
e. Explain to patients when the practitioner has a conscientious objection to a particular treatment or procedure, and make arrangements to transfer their care to a suitably qualified practitioner who can offer that care.

4.6. INFORMED CONSENT

The concept of informed consent is a legal and moral requirement rooted in the principles of respect for persons and their autonomy, requiring that individuals be given the opportunity to choose what should and should not be done to them. There are two types of consent:

a. **Implicit consent** (or implied consent) is consent that is not expressly granted but is inferred from the person's actions or surrounding circumstances. It may arise when a patient presents him/herself to the health facility and accepts to undergo routine procedures or processes suggested by the doctor during consultations. Such routine procedures include taking clinical history, physical examination, carrying out investigations and treatment.

b. **Explicit consent** is a voluntary, specific, clear and affirmative communication indicating a person's willingness to engage in a particular act based on the information that they have been given. It must be obtained for special, sensitive or invasive procedures, where the various options of the management highlighting the merits, demerits, risks involved, and outcome must be explained. This consent may be offered verbally or in writing, and must be appropriately documented.

4.6.1. ELEMENTS OF INFORMED CONSENT

Consent has four key elements: information, comprehension, voluntariness and capacity.

a. **Information** seeks to ensure that the patient receives sufficient information on:
    i. The medical condition for which the test, treatment or procedure is required;
    ii. The purpose and intended benefits of the proposed test, treatment or procedure;
    iii. Detailed explanation, with illustration or documentation, of conducting the intended test, treatment or procedure;
    iv. The risk of complications and adverse events which may arise during or following the test, treatment or procedure, including the risk of death;
    v. Any additional measures that may be warranted (e.g. blood transfusion), and their possible complications or adverse events;
    vi. The alternative treatments, tests or procedures, if any, that are available, and their relative benefits and risks;
    vii. The consequences of not accepting to have the test, treatment or procedure done;
    viii. The post-procedure care;
    ix. An opportunity to ask questions, and
    x. An opportunity to give, withhold or withdraw consent.

b. **Comprehension** requires that the information is presented in a manner that allows the patient to understand prior to making any decision. Hence, the information should be packaged and presented calmly in a manner that is adapted to the patient's capacities e.g. in a language that they understand, using very little (if any) medical jargon.

c. **Voluntariness** – Consent is only valid if it is voluntarily-given under conditions that are free of coercion or undue influence. Practitioners must clearly explain to the patient that they are free to accept or refuse a test, treatment or procedure, and that they can do so at any time, not just at the time of giving initial consent.

d. **Capacity to consent** – For consent to be valid, it must be given by a person with the legal capacity or competence to make decisions. A person is deemed to have the **capacity to consent** if they are able to understand the information provided, weigh the available options, make a decision, and communicate the decision made**. Competence** is a legal term that refers to a person's ability to make decisions about all aspects of life. Special consideration should be given to ensure the individual giving consent is mentally competent as determined by the practitioner and has attained the age of majority. All adults (aged 18 years or older) are presumed to have sufficient capacity and competence to consent, unless there is significant evidence to suggest otherwise (e.g. when a person's brain or mind is impaired)**.**

4.6.2. PROCESS OF OBTAINING INFORMED CONSENT

Obtaining informed consent is a process and not just a signature. It involves:

a. Preparing, in a clear and understandable language, information on the nature of the condition, the proposed test, treatment or procedure, its intended benefits, potential risks of complications or adverse events, alternative options and their relative benefits and risks, and the consequences of not accepting the intervention;
b. Establishing rapport with the patient, their parent, guardian or medical proxy, the persons close to them, and the witness;
c. Assessing the individual's capacity to consent;
d. Establishing that the individual has understood the information provided, such as by asking them to explain what they have understood in their own words and giving them an opportunity to ask questions;
e. Where possible, giving the patient/ medical proxy/ guardian time to consider the available options and/or seek a second opinion prior to making the decision;
f. Confirming that the decision is made voluntarily, without coercion and undue influence, and that the patient is aware that they are free to refuse or withdraw consent, and
g. Documenting the conversation that took place.

4.6.3. DOCUMENTATION OF INFORMED CONSENT

Ideally, informed consent should be obtained by the person(s) undertaking the test, procedure, or treatment. Documentation of explicit informed consent should include seven (7) vital components:

a. An explanation of the medical condition that warrants the test, procedure, or treatment;
b. An explanation or description of the proposed test, procedure, or treatment; its intended purpose and benefits, and the potential risks of complications or adverse events, including death;
c. An explanation of any additional measure that may be warranted and potential risk of complications or adverse events;
d. A description of alternative treatments, procedures, or tests, if any, and their relative benefits and risks;
e. A discussion of the consequences of not accepting the test, procedure, or treatment;
f. A discussion on post-procedure care, and
g. A statement offering the patient the opportunity to ask questions and that they are free to withdraw consent at any time.

Additionally, the informed consent forms should clearly indicate:

- Name, title and signature of the person(s) obtaining the consent;
- Name and signature of patient, or the guardian or medical proxy of patient (indicate relationship);
- Name and signature of the person who witnessed the consent being obtained, and
- Date and time of consent.

4.6.4. VALIDITY OF CONSENT

Practitioners must note that consent is procedure-specific and expires upon completion of the procedure or when consent is withdrawn. For ongoing or long-term treatments (e.g. dialysis, chemotherapy), written consent should be renewed at least once every fourteen (14) days, provided that the patient is required to give verbal consent and offered an opportunity to withdraw consent before each procedure.

4.6.5. SPECIFIC CONSIDERATIONS FOR INFORMED CONSENT

4.6.5.1. Informed financial consent

Between 2019 and 2024, concerns about medical bills accounted for approximately 7% of all complaints received by KMPDC. This shows that the cost of healthcare is not just a financial issue but also a source of conflict between healthcare providers and patients, the persons close to them or third-party payers. Understanding the costs of receiving healthcare services and the implications of meeting them forms a crucial component of patient management.

Informed financial consent ensures that patients are fully informed about the costs of the healthcare service and agree to those costs **before** that treatment, test or procedure is performed. This allows patients to make a fully informed decision by understanding the financial implications, empowering them to choose treatment options that align with their financial situation and personal preferences.

Information that should be provided when seeking financial consent includes but is not limited to:

a. A breakdown of the expected costs, such as:
    i. fees charged by the health facility including admission, hospitality, etc;
    ii. fees charged for specific facilities, e.g. theatre charges;
    iii. consultation fees for all healthcare professionals involved in caring for the patient;
    iv. charges for all diagnostic tests, procedures and medication used;
    v. cost of follow up care, and
    vi. any other potential costs that may arise;
b. Information on how and where the payments will be made, e.g. is the full amount to be paid to the health facility, or are some healthcare professionals to be paid separately?
c. Identification of which costs will be covered by a third-party payer on behalf of the patient, e.g. insurance, medical scheme or health fund;
d. Identification of expected out-of-pocket expenses that will be paid for by the patient.

While obtaining informed financial consent for healthcare is not a legal requirement, its use promotes trust and transparency between patients and healthcare providers, and thereby strengthens the practitioner-patient relationship.

At the very minimum, **documentation** of informed financial consent should include the following:

a. Details of the patient;
b. Name of the procedure or treatment that the patient will be receiving;
c. An itemised list of all expected costs during the hospital stay and follow up period;
d. A breakdown of which costs will be covered by the third-party payers and the expected out-of-pocket expenses;
e. A statement noting that the costs indicated are estimates, and the final bill may vary due to some circumstances (these should also be listed);
f. A statement reminding the patients to confirm with the third-party payer about their commitment to meet the costs;
g. An opportunity for the patient to ask questions;
h. The signature of the patient/ guardian/ medical proxy, and the witness.

4.6.5.2. Consent for use of anaesthesia

Consent for the use of anaesthesia should be obtained by the anaesthesia provider and documented separately from the consent for the test, treatment or procedure. The anaesthesia provider should take an appropriate clinical history (including allergies and medication history), undertake a pre-anaesthesia examination and document the findings prior to obtaining consent for the use of anaesthesia. The information provided and documented for this consent must include:

a. the type of anaesthesia to be administered;
b. its intended benefit;
c. the risk of complications and adverse events which may arise during or following the anaesthesia, from the anaesthetic agent and from the route of administration, including the risk of death;
d. other viable options along with their relative benefits and risks;
e. the consequences of not accepting to have anaesthesia;
f. the post-anaesthesia care;
g. an opportunity to ask questions, and
h. an opportunity to give, withhold or withdraw consent for anaesthesia.

4.6.5.3. Consent for additional procedures

Ideally, all foreseeable complications and the additional measures required to manage them should be discussed when obtaining the initial informed consent for the test, treatment or procedure. In the event that unforeseen circumstances arise during the procedure, and unexpected measures are required, additional consent should be obtained for these unexpected procedures that are in the interest of the patient but were not mentioned in the preceding consent. In the process of obtaining additional consent, a witness must be present.

Where additional consent is required for a patient who is unconscious/ incapacitated or in the case of a life-threatening condition, the provisions in the sections below on Consent for emergency treatment and Consent for patients with diminished capacity apply.

4.6.5.4. Consent for emergency treatment

The Health Act (Cap. 241) defines a medical emergency as “an acute situation of injury or illness that poses an immediate risk to life or health of a person or has potential for deterioration in the health of a person or if not managed timely would lead to adverse consequences in the well-being”, and emergency treatment as “the necessary immediate healthcare that must be administered to prevent death or worsening of a medical situation”. In many cases, emergency treatment is initiated away from health facilities.

It may be difficult to obtain and document explicit consent in such situations, especially if the patient is unconscious and in need of life-saving healthcare. As such, the patient’s immediate need is presumed to be implied consent for emergency treatment and diagnostic tests to be initiated. Where invasive procedures are required, explicit consent should be obtained from the patient’s next of kin/ guardian/ medical proxy , or an independent senior practitioner who is not directly involved in the management of the patient.

Nevertheless, explicit consent must be obtained and documented soonest possible after the patient regains his/her capacity to consent.

4.6.5.5. Consent in outpatient settings

A patient who presents themselves to a practitioner or health facility is assumed to have given implicit consent to receive certain aspects of care, such as providing a clinical history, undergoing physical examination and some routine investigations.

Despite this, the practitioner should seek explicit verbal consent before proceeding, for example by asking the patient if they agree to be asked some questions, examined and undergo routine tests so that the practitioner can determine what is ailing the patient.

Explicit consent must be sought for intimate examinations, use of anaesthetic agents, administration of treatment, and any invasive tests, procedures and treatments. This consent should be documented in the patient's outpatient card or file.

4.6.5.6. Consent by patient with impaired hearing or language barrier

Where communication barriers exist and translation or sign-language interpretation is required, consent for use of an interpreter should be sought from the patient/ parent/ guardian/ medical proxy prior to obtaining the consent for the test/ procedure/ treatment/ anaesthesia. The documentation of informed consent in such cases should in addition indicate that an interpreter was involved in the conversation between the health professional obtaining the consent and the patient/ parent/ guardian/ medical proxy, as some things may be lost in translation.

4.6.5.7. Consent for patients with diminished capacity

A person is deemed to have sufficient capacity to consent if they are able to:

a. understand and remember the information provided;
b. weigh the available options;
c. make a decision based on the information provided, and
d. communicate the decision made.

A person is deemed to have **diminished capacity to consent** if they unable to make a decision at that time, as evidenced by the person not being able understand the information provided; remember that information; use that information to make a decision, and/or communicate the decision made.

Generally, all adults (aged 18 years or older) are presumed to have sufficient capacity and competence to consent, unless there is significant evidence to suggest otherwise. Conditions that may impair one's capacity to consent include but are not limited to:

- intoxication by alcohol, licit and illicit drugs;
- physical or mental conditions that cause confusion, drowsiness or loss of consciousness;
- injury or illness affecting the brain;
- dementia, Alzheimer's disease and other conditions that cause cognitive impairment;
- mental illnesses (where the ability to perceive reality is distorted);
- conditions that cause severe learning disability.

Where a patient is found to have diminished capacity to consent, explicit consent should be obtained from the patient's next of kin/ guardian/ medical proxy, or an independent senior practitioner who is not directly involved in the management of the patient.

4.6.5.8. Consent for minors

The Age of Majority Act (Cap. 33) provides that "A person shall be of full age and cease to be under any disability by reason of age on attaining the age of eighteen years". As such, persons below the age of 18 years (referred to as minors) do not have the legal competence to make decisions about all aspects of their life, and as such cannot be held accountable for these decisions.

Informed consent for minors to receive healthcare services should be sought from their parents or legal guardians, noting to preserve the best interests of the child. It is advisable that children are provided with age-appropriate information and be incrementally involved in the decision-making process.

Assent by minors refers to the explicit expression of a child's agreement or willingness to receive medical treatment or participate in research. It shows respect for the child's individuality, considers the child's ability to understand the information provided, and provides them an opportunity to participate in the decision-making process. The child should also be allowed to ask questions about the care that they are receiving, be explained to what to expect, and be able to give permission for the care that they are to receive. Typically, assent is sought from children aged 13 years or older. Assent by minors should be sought in addition to the informed consent given by the parent or legal guardian (and not as a replacement of informed consent by a parent or guardian).

The term **mature minor** (also referred to as emancipated minor) refers to an individual aged less than 18 years who, due to specific circumstances, is considered legally capable of making informed decisions about their health and well-being, similar to an adult. This includes a minor who is married, pregnant, a mother, a head of household, or financially self-sufficient. It may be extended to include a minor who has a drug dependency or sexually transmitted infection. Mature minors are granted the legal capacity to make decisions and give informed consent for medical procedures and to participate in research, even without parental consent.

4.6.5.9. Consent for reproductive health services

All women and men have equal rights to access healthcare of the highest possible standard and these includes reproductive health services and family planning. Each party can independently consent to various family planning methods, provided that they are given adequate information to make informed decisions. Explicit informed consent for reproductive health services should be documented appropriately and a copy retained in the patient's medical record.

4.6.5.10. Consent for cell/ tissue/ organ donation and transplantation

Cell/ tissue/ organ transplantation involves the removal of cells, tissues or organs from one body (the donor) and their placement in the body of a recipient to replace damaged or missing cells/ tissues/ organs. The donor may be alive or deceased at the time of retrieval of the cells/ tissues/ organs.

Explicit informed consent must be sought before offering a transplant service. This includes consent to undergo:

- laboratory or radiological testing;
- surgical procedure to donate or receive cells, tissue or organ;
- use of anaesthesia;
- blood transfusion, and
- any other procedures necessary to support donation or transplantation.

Considerations on consent for cell/ tissue/ organ donation and transplantation include:

a. As with other informed consent, consent for cell/ tissue/ organ donation and transplantation must be witnessed.
b. The witness for the donor should preferably be a person related to or identified by the donor. For example, the recipient or the persons close to them (recipient's parent/ spouse/ sibling/ guardian) would not be an ideal choice as a witness for the donor.
c. Informed consent for donation of tissues and organs after one's death must be sought and documented while the donor is still alive.
d. Where the donor is a minor or is dependent on the recipient, utmost care should be taken to protect the donor from coercion, inducement and undue influence.
e. All living donors should be assigned an **independent living donor advocate**. This is a healthcare professional whose primary role is to support and protect the rights of living organ donors. They ensure that:
    i. donors are fully informed about the donation process;
    ii. donors understand the risks and benefits, and
    iii. that their decision to donate is voluntary and free from coercion.

4.6.5.11. Consent for research

Explicit informed consent should be sought from all research participants. Measures must be taken to ensure that minors, vulnerable persons, and persons with diminished capacity are adequately protected from exploitation. The participants should be made aware that they can withdraw their consent and refuse to participate in the research at any time, even after the study has begun. When seeking consent for research from patients, it should be emphasised that participation or refusal to participate in research will not jeopardise the practitioner-patient relationship or the continued care for the patient.

In obtaining consent for research, the researcher must adhere to:

a. Institutional research ethics committee procedures;
b. The national research ethics guidelines such as those issued by NACOSTI;
c. The WMA Declaration of Helsinki;
d. Good Clinical Practice (GCP);
e. Prevailing Laws and regulations including the Health Act (Cap. 241), and the Medical Practitioners and Dentists Act (Cap. 253), among others.

Further, it should be acknowledged that consent is a process, not a form. It must be revisited and reaffirmed, especially in long-term or multiphase studies, and if there are changes in the study or its risks.

4.6.5.12. Consent in health institutions that also serve as training institutions

These training institutions include teaching hospitals, internship training centres and/or collegiate training sites. Such institutions should inform the patients or clients who seek health services there that they are training institutions and obtain their consent for the involvement of students/ interns/ registrars/ fellows in their care.

4.7. PATIENTS' REFUSAL OF TREATMENT AND DISCHARGE AGAINST MEDICAL ADVICE

Patients have a right to make informed decisions about what can be done or not done to their bodies. This includes the right to refuse recommended treatment, hospital stay or other intervention, even when there is risk that such a refusal may cause harm to the patient.

Where the decision to refuse treatment or be discharged against medical advice is being made by a parent/ guardian/ medical proxy on behalf of a child or an incapacitated or vulnerable adult, the best interests of the patient must take precedence, and care must be taken to secure them.

When a patient expresses the desire to refuse treatment or be discharged against medical advice, a Practitioner should:

a. Assess the patient's capacity to make a voluntary informed decision and competence to be held accountable for their decision;
b. Ask open-ended questions to understand the fears, beliefs, goals or reasons behind the refusal. Such reasons may include fears about side effects or diminished quality of life, financial constraints, or family responsibilities;
c. Clearly provide information to alleviate their fears, e.g. about potential negative outcomes;
d. Provide information on viable alternatives;
e. Offer to seek another medical opinion;
f. Offer supportive compassionate care, even when treatment is refused, and

g. Clearly and comprehensively document the refusal, information discussed and capacity assessment.

The discission on refusal of treatment or discharge against medical advice should take place in the presence of two witnesses.

Documentation of a patient’s refusal of treatment or discharge against medical advice should include the following:

i. Details of the patient;
ii. The diagnosis and the proposed treatment or intervention;
iii. Date, time and venue of the discussion;
iv. Record of assessment of the patient’s capacity to consent;
v. A record on the information provided to the patient, regarding the proposed treatment or intervention, and alternative options, including the respective intended benefits, risks and complications;
vi. A discussion on the consequences of refusing treatment or discharge against medical advice;
vii. A signed statement by the patient (or guardian/ medical proxy) declaring their decision to refuse treatment or be discharged against medical advice including what they have understood during the discussion; the reasons for the decision made and that they take full responsibility for their actions;
viii. The signature and identification document number of the patient (or guardian/ medical proxy);
ix. The name, designation and signature of the practitioner involved in the assessment, and
x. The names and signatures of two witnesses.

The documentation of the patient’s refusal of treatment or discharge against medical advice must be retained in the patient's medical record.

4.8. MEDICAL RECORDS

A medical record is “any relevant record made by a health practitioner at the time of, or subsequent to, a consultation and/or examination or the application of health management”. It covers an array of documents that are generated as a result of patient care, including but not limited to:

a. Handwritten or typed notes taken by the health practitioner during or immediately after the patient encounter;

b. Notes taken by previous practitioners who attended to the patient, including the handwritten or typed medical reports and patient discharge summaries;
c. Informed consent forms;
d. Prescriptions;
e. Referral letters to and from other health professionals or health facilities;
f. Evidence of diagnostic tests including request forms, laboratory reports, histology sections, cytology slides, printouts from automated analysers, imaging films and reports, ECG traces, etc.;
g. Audio-visual records such as photographs, videos and voice recordings;
h. Clinical research forms and clinical trial data;
i. Other forms completed during the health interaction e.g. insurance forms, disability assessments, documentation of injury on duty, etc., and
j. Death certificates and autopsy reports.

Complete and well-organised medical records are essential for good medical practice, continuity of care, aiding clear communication between professionals, and demonstrating that best practice has been followed. Medical records are necessary for a health practitioner's defence against a claim or complaint and can be seen to reflect the quality of care provided. Appropriate record-keeping is recognised as an important component of professional standards.

4.8.1. DOCUMENTATION

Practitioners should make and keep comprehensive medical records. For documentation, a practitioner should ensure that:

a. They record their work in a clear, accurate and **legible** manner;
b. They make the records at the same time as the events that they are recording or soonest possible thereafter;
c. Records containing personal information about patients, colleagues or others are kept securely, and in line with the requirements of the prevailing data protection laws;
d. All clinical records include:
    i. relevant clinical history and examination findings;
    ii. diagnostic investigations and results;
    iii. the decisions made and actions agreed, and who is making the decisions and agreeing the actions;
    iv. the information discussed with patients;
    v. any drugs or other treatment prescribed;

    - vi. informed consent;
    - vii. consultations and referrals;
    - viii. name and signature of the person making the record, and
    - ix. date and time of patient encounter and of making the record (if different);
- e. Clinical records are not changed. However, where a practitioner later realises that the record is factually inaccurate, they should add an amendment. Any correction must be clearly shown as an alteration and be clearly signed and dated;
- f. Clinical records include adequate information to facilitate continuity of care;
- g. Clinical records only include information that is necessary for the medical record, and
- h. Clinical records do not include offensive or derogatory remarks about the patient e.g. demeaning, sexist, racist or insensitive remarks.

Practitioners should always remember that patients have a right to access their own medical records and facilitate such access.

4.8.2. ISSUING PRESCRIPTIONS

As with other aspects of practice, practitioners must keep up to date and comply with regulations and guidelines relevant to their practice.

In issuing prescriptions, practitioners must:

- a. Recognise and work within the scope and limits of their practice licensure;
- b. Prescribe effective treatments based on the best available evidence;
- c. Prescribe drugs or treatments, including repeat prescriptions, only when they have adequate knowledge of the patient's health and are satisfied that the treatment will serve the patient's needs;
- d. Confirm that the patient does not have a known allergy to the medication or any component within the treatment prescribed;
- e. Check that the treatment that they provide or prescribe is compatible with any other treatment(s) that the patient may be receiving, including (where possible) self-prescribed formulations;
- f. Explain to the patient:
    - i. the likely benefits, risks and adverse effects of the treatment, including both common and serious side effects;
    - ii. the likely duration of the treatment;
    - iii. instructions on how and when to take the medication;

    iv. lifestyle modification required while on the treatment;
    v. what to do when they experience a side effect or recurrence of the condition, and
    vi. arrangements for monitoring, follow up, review and dose adjustments for long-term medication;
g. Reach an agreement with the patient on their consent and adherence to the treatment prescribed;
h. Document the prescription clearly, legibly and accurately, including:
    i. the name and details of patient;
    ii. the date of prescription;
    iii. the treatment(s) prescribed and duration of each – preferably using generic names rather than brand names;
    iv. the prescribing practitioner's full name, registration number, signature and contact details, and
    v. the health facility from which the prescription is given to the patient.

4.8.3. AUDIO-VISUAL RECORDINGS AND IMAGES

For the purposes of this guideline, "audio-visual recordings" and "recordings" includes all images, photographs, voice and video recordings made in any format and/or recorded on any devices.

Practitioners may need to make audio and visual recordings of or showing patients in the course of their professional duties. Such recordings include but are not limited to:

- Any recordings made within and around health facilities or premises where healthcare is provided (e.g. a medical camp or outreach);
- Recordings made as part of assessment, diagnostic investigation or treatment of a patient's condition;
- Recordings made for purposes of teaching, training, research, assessment of health professionals and students, or any other health related uses which are not designed to benefit the patient directly;
- Recordings made for public health education, promotion or advocacy purposes, and
- Recordings made for publicity purposes.

When making recordings, practitioners and administrators of health facilities are legally and morally required to respect patients' rights, dignity and autonomy to make or participate in decisions that affect them. Thus, Practitioners and facility administrators must:

a. give patients all the information including information about the purpose of the recording, the intended audience, the expected duration of the recording, the potential benefits and harms of participating, and any other concerns they may have prior to recording;
b. make recordings only where they have appropriate written consent or other valid authority for doing so;
c. ensure that patients are under no pressure to give their consent for the recording to be made;
d. not make or participate in making recordings against a patient's wishes;
e. where practicable, stop the recording if the patient asks them to, or if it is having an adverse effect on the consultation or treatment;
f. not make or participate in making recordings where such a recording may cause the patient harm;
g. ensure that the metadata of the record files are correct and correspond to the recorded event;
h. anonymise or code recordings before using or disclosing them for a secondary purpose;
i. disclose or use recordings from which patients may be identifiable only with consent or other valid authority for doing so;
j. make appropriate secure arrangements for storing recordings;
k. handle recordings made as part of the medical record in the same manner as other clinical records;
l. ensure that all non-clinical personnel present during the recording and involved in processing the recording understand and agree to adhere to medical standards of privacy and confidentiality;
m. be familiar and comply with the requirements of the prevailing data protection law, and
n. not disclose or use recordings for purposes outside the scope of the original consent without obtaining further consent.

As with other medical records, the duty of confidentiality of audio-visual recordings continues even after the patient has died.

4.8.4. CONFIDENTIALITY

Trust is an essential part of the practitioner-patient relationship and confidentiality is central to this. Patients may avoid seeking medical help, or may under-report symptoms, if they think that their personal information will be disclosed by practitioners without consent, or without the chance to have some control over the timing or amount of information shared. Practitioners and healthcare providers are required to keep a patient's personal health information private, unless the consent to release the information is provided by the patient and/or there are overriding reasons which confer a moral or legal obligation for the disclosure. The duty of confidentiality extends even after the patient has died.

The principles of confidentiality include:

a. Use of only necessary personal information. Where it is practicable, anonymised information to be used.
b. Manage and protect information. Practitioners and healthcare providers should ensure that any personal information that they hold or control is effectively protected at all times against improper access, disclosure or loss.
c. Control access to patient information. Practitioners and healthcare providers should develop and maintain an understanding of information governance that is appropriate to their role whether clinical or non-clinical.
d. Comply with the Law. Practitioners and healthcare providers should ensure that they are handling personal information lawfully and comply with the prevailing laws on data protection and management of health records.
e. Share relevant information, to other practitioners, for direct care unless the patient has objected.
f. Ask for and document explicit consent to disclose identifiable information about patients for purposes other than their care or local clinical audit, unless the disclosure is required by law or can be justified in public interest.
g. Tell patients about any disclosures of personal information made that they would not reasonably expect, or check they have received information about such disclosures, unless that is not practicable or would undermine the purpose of the disclosure. Practitioners and healthcare providers should keep records of their decisions to disclose or not to disclose information.
h. Support patients to access their information. Respect, and help patients exercise, their legal rights to be informed about how their information will be used and to have access to, or copies of, their health records.

4.8.5. RECORD KEEPING

Medical records contain valuable patient information and provide documentary evidence of the healthcare given. Hence, in addition to their clinical purpose, medical records also serve as legal documents. Practitioners and health providers are required to ensure that the medical records that they hold or control:

a. are kept securely and protected against unauthorised access;
b. are accessible to other health professionals and providers involved in the patients care;
c. are transferrable in a prompt manner that does not obstruct continuity of care;
d. should be retained for the period required by Law;
e. should be destroyed securely when deemed no longer necessary, and
f. can be accessed by patients, who have a right to access their own medical information.

Physical medical records are bulky. The security and storage requirements for keeping them pose significant challenges to practitioners and health institutions. The Council recommends as follows:

i. General medical records, including records of pregnancy and birth

- Physical paper files should be kept for a minimum of ten (10) years after the last encounter while the patient is presumed alive, and for at least six (6) years after the death of the patient.
- Digital records should be kept for a minimum of twenty (20) years after the last encounter while the patient is presumed alive, and for at least six (6) years after the death of the patient.

ii. Occupational health records and medical records on work-related injury

- Both physical paper files and digital records should be kept throughout the duration of employment and for at least six (6) years after exit or the last encounter, whichever comes later.
- Where these records are likely to be used in a court case, they should be kept until the statute of limitations is exhausted.

iii. Medical records on cases of assault or injuries

- These records should be treated like general medical records.
- Where a criminal element is suspected, they should be kept for as long as the data subject is presumed to be alive as there is no statute of limitations for criminal prosecutions.

iv. **Medical records on cases of rape, defilement and sexual assault**
These records should be kept for as long as possible, or the data subject is presumed to be alive as there is no statute of limitations for criminal prosecutions.

4.8.6. DISSEMINATION AND DISCLOSURE

Confidentiality is an important ethical and legal duty; however, it is not absolute. Practitioners and healthcare providers are required to share information about a patient to facilitate patient care and for the overall benefit of the patient. In such cases, patients give implicit or explicit consent for the disclosure. However, a patient may object to disclosure of their information (or a part of it) even when that disclosure is for their own care and benefit. In other cases, the patient may not have the capacity to give consent (e.g. unconscious patients), but the practitioner needs to disclose the information to facilitate their care.

Outside of their clinical care, practitioners and health providers can divulge information regarding a patient if:

a. The disclosure is under a statutory provision e.g. mandatory reporting, clinical audit;
b. The disclosure is in the public interest e.g. situations where contact with the patient would expose other people to an infection and considerably increase their risk of contracting it;
c. The disclosure is in response to instructions issued by a court of law or quasi-judicial tribunals and committees;
d. The disclosure is under the express written or verbal consent of the patient (or their guardian or medical proxy, if the patient is a minor or an adult who is unable to give informed consent);
e. The disclosure is under the written consent of a deceased patient's next of kin or the executor of their estate, and
f. The disclosures are kept to the minimum necessary for the purpose.

Practitioners and health providers are required to keep a record of their decision to disclose or not to disclose the patient's information.

Requests for records by patients or their next of kin or guardians should be made in writing and such requests filed in the patient's medical records.

People that play a significant role in supporting and caring for the patient, may need information about the patient's diagnosis, care and treatment. Where the patient has the capacity to decide, the practitioner should establish with the patient what information they want to be shared, with whom, and in what circumstances; and to clearly state what they would not like to be shared under whatever circumstances.

4.8.7. HEALTH DATA PROTECTION COMPLIANCE

The Data Protection Act (Cap. 411C) provides the following definitions:

- "data subject" means an identified or identifiable natural person who is the subject of personal data;
- "health data" means data related to the state of physical or mental health of the data subject and includes records regarding the past, present or future state of the health, data collected in the course of registration for, or provision of health services, or data which associates the data subject to the provision of specific health services;
- "personal data" means any information relating to an identified or identifiable natural person, and
- "sensitive personal data" means data revealing the natural person's race, health status, ethnic social origin, conscience, belief, genetic data, biometric data, property details, marital status, family details including names of the person's children, parents, spouse or spouses, sex or the sexual orientation of the data subject.

The *Guidance Note on Processing of Health Data* issued by the Office of the Data Protection Commissioner (ODPC) states that healthcare providers in Kenya are required to comply with the Data Protection Act when processing personal data. This includes:

a. being duly registered by the ODPC as data controllers or data processors;
b. ensuring that data is processed on reliance on a proper lawful basis from individuals before collecting their data;
c. ensuring that the data that they hold is accurate and up to date;
d. protecting data from unauthorised access, use, and disclosure;
e. carrying out data protection impact assessments;
f. reporting to the ODPC within 72 hours of becoming aware of a personal data breach and notifying the affected data subjects;

g. only engaging data processors (e.g. electronic health records providers) that have experience in handling health data and are compliant with all relevant laws and regulations related to data protection and confidentiality;
h. ensuring that data transfer to other healthcare providers and data sharing for mandatory reporting obligations are done in an ethical manner that protects the data subjects' privacy and confidentiality.

The *Guidance Note* further provides that the **rights of a data subject** include:
i. right to be informed of the use to which their personal data is to be put;
ii. right to access their personal data in custody of a data controller or data processor (i.e. the healthcare provider);
iii. right to rectification of inaccurate or incomplete personal data;
iv. right to object to the processing of all or part of their personal data;
v. right to not be subjected to automated decision making;
vi. right to erasure of their personal data by healthcare providers, and
vii. right to data portability (i.e. right to receive a copy of their personal data in a structured, commonly used, machine readable format, and to transmit or transfer that data to another data controller without hindrance).

The Data Protection Act provides that the rights conferred on a data subject may be exercised by the data subject themselves, by a person authorised to act on behalf of the data subject, or by a person who has the authority to make decisions on behalf of the data subject (such as a parent, guardian or legally appointed administrator).

4.9. MEDICAL CERTIFICATES AND REPORTS

A medical certificate includes any written statement by a health professional that attests to the result of a clinical or diagnostic examination of a patient and serves as the evidence of the patient's health condition. They include sick sheets, off duty forms and death certificates.

A medical report is a comprehensive statement that covers a person's medical history, examination findings, results of diagnostic tests, treatment prescribed and given, response to the treatment, procedures done and any other relevant information or documentation, issued by a duly registered and licensed practitioner.

Practitioners shall only sign medical certificates, reports or statements that they know to be true. When communicating with patients, writing reports, completing or signing forms, reports, certificates and other documents, practitioners must:

a. Be honest and trustworthy;
b. Make the limits of their knowledge clear and not give opinions beyond those limits;
c. Make reasonable checks to ensure that any information they give is accurate;
d. Ensure that any documents that they write or sign are not false or misleading;
e. Not sign any documents that imply that they performed an examination, test, treatment or procedure that they did not;
f. Not deliberately leave out any relevant information;
g. Prepare or sign documents and reports that they have agreed or are required to do promptly, within a reasonable and justifiable timeframe, and
h. Not sign, or permit their name signature, registration or licence number to be used, to indicate that they offered a consultation; performed an examination, test, treatment or procedure, or issued a prescription that they did not.

A practitioner shall grant a **certificate of illness** only if the certificate contains the following information:

i. the name of the patient;
ii. the employment number of the patient (if applicable);
iii. the date and time of the examination;
iv. whether the certificate is being issued as a result of personal observations by the practitioner during an examination, or as a result of information which has been received from the patient and which is based on acceptable medical grounds;
v. a description of the illness, disorder or malady in layman's terminology with the informed consent of the patient (provided that if the patient is not prepared to give such consent, the practitioner shall merely specify that, in his/her opinion based on an examination of the patient, the patient is unfit to work);
vi. whether the patient is totally indisposed for duty or is able to perform less strenuous duties in the work situation;
vii. the exact period of recommended sick leave as provided by the prevailing guidelines issued by the Ministry of Health;
viii. the date of issue of the certificate of illness, and

ix. the name (in block letters), the registration number, qualification and signature of the practitioner who issued the certificate.

When using pre-printed stationery, the practitioner should delete or cross out the words which are not applicable.

4.9.1. REQUIREMENTS FOR THE MEDICAL CERTIFICATION OF CAUSE OF DEATH

The Births and Deaths Registration Act (Cap. 149) provides for the creation of the Department of Civil Registration Services (CRS), and that all births and deaths within the country must be registered within six (6) months of the occurrence. It also provides for who is mandated to certify deaths, as follows:

- deaths in health facilities should be certified by Medical Officers using Form D1, while
- deaths at home or in the community should be certified by Chiefs and Assistant Chiefs using Form D2.

Further, it stipulates that deaths reported after six (6) months can only be registered by the Civil Registration Officers.

In mortality coding, both underlying cause and multiple causes should be recorded following correct application of the International Classification of Diseases (ICD) instructions for selection and modification of the underlying cause of death.

When filling in the Form D1, Medical Practitioners are advised to observe the following rules:

a. Do not use abbreviations of the causes of death;
b. Use legible handwriting;
c. Avoid cancellation. Where inevitable, all cancellations should be countersigned or initialled against;
d. Write only one cause of death per line;
e. Always start at line “a” (Immediate cause), then “b” and “c” (intermediate causes), then “d” (underlying cause);
f. Always include the duration of each condition;
g. Do not leave any intervening line empty;
h. The lowest used line (b, c or d) should explain all conditions listed above it;
i. Ensure that the pathological and chronological sequence makes sense;

j. Remember to fill in all other significant conditions that may have contributed to the death, including mental illness;
k. Avoid ill-defined causes, and
l. Avoid filling in modes of dying as causes of death.

Further, Medical Practitioners are reminded to indicate their role in the certification, and to write their names, designation and date when signing the Form D1.

Health institutions are required to retain photocopies or scanned copies of the Form D1 issued in the patient file, as this completes the medical record.

4.10. REFERRAL OF PATIENTS

Referral of patients occurs when a practitioner sends a patient to obtain medical opinion, care or treatment from another health professional, usually for a particular purpose and a defined duration.

When referring patients, practitioners must:

a. Ensure that there are arrangements in place for continued care of patients. Whenever possible, these arrangements should be made in advance and communicated to the patient, other practitioners managing the patients and relevant health facilities;
b. Explain to the patient (or their parent/ guardian/ medical proxy) that they plan to transfer part or all of their care to another practitioner or health facility and why;
c. Inform the patient about who is responsible for their overall care, and if the transfer is temporary or permanent;
d. Confirm that the patient understands that part or all of their health information will be shared with the new practitioner or team, and why it is necessary to do so, and that the patient has a right to request that some of their information is withheld;
e. Ensure that sufficient relevant information about the patient (including clinical history, condition, investigation results, reason for referral, subsequent plan of management) is passed on to the health practitioner, team or health facility that they are referring the patient to, to enable continuing care for the patient;
f. Take reasonable steps to ensure that the health professional that they refer the patient to has the qualifications, experience, knowledge and skills to

provide the care required. This includes confirming that the health professional or health facility that they refer the patient to is registered with and licensed by the relevant regulatory body;

g. Within reasonable limits, confirm that a named health professional or team has taken over responsibility for the patient's care, and
h. Document the referral process.

When referring patients outside the country, Practitioners should adhere to the provisions of The Medical Practitioners and Dentists (Referral of patients abroad) Rules. Shipping or referral of samples outside the country must be done in compliance with prevailing Laws.

4.11. RETENTION OF HUMAN ORGANS AND TISSUES

A practitioner or healthcare provider may retain the organs or tissues taken from a deceased person at autopsy for research, educational, training or prescribed purposes, if:

a. The person during his/her lifetime gave express written consent for the practitioner to do so;
b. In case the person is a minor, written consent was given by the parent or legal guardian, or
c. Where the deceased person had not given such consent in his/her lifetime, the person's next of kin or executor of his/her estate gives such express written consent.

Retained organs and tissues should only be used for the purposes for which consent was given. Should the organs or tissues be required for a purpose other than that for which consent had been given, the practitioner or healthcare provider should seek written consent from the patient, or their guardian, medical proxy next-of-kin or executor, prior to doing so.

Donation of bodies for educational purposes should be done as stipulated in the Anatomy Act (Cap. 249).

4.12. FINANCIAL ARRANGEMENTS AND CONFLICT OF INTEREST

Practitioners work within healthcare systems that increasingly determine the models of healthcare delivery, reimbursement mechanisms, restrictions on referrals or use of services, clinical practice guidelines, and limitations on benefit packages, all of which put the practitioner's independence and ability to uphold professional standards at risk.

All Practitioners have a fundamental ethical obligation to put the welfare of the patient ahead of all other considerations, including the expected reward or financial gain for the services rendered. The expectation is that practitioners are free to exercise independent professional judgement in recommending investigations, treatments and care that are necessary, based on the needs of individual patients.

4.12.1. CONFLICTS OF INTEREST

Every practitioner has a responsibility to behave ethically and to ensure that their conduct justifies the patients' trust in them and the public's trust in the profession. This trust may be damaged if either the practitioner's financial, professional or personal interests; interests of the practitioner's family and those close to them, or the practitioner's relationships with third parties, compromise (or are seen to compromise) his/her professional judgement.

Conflicts of interest are common and may arise in a range of situations. They require identification, careful consideration, appropriate disclosure and accountability. Conflicts of interest are not always avoidable, and whether a particular conflict creates a serious concern will depend on the circumstances and what steps have been taken to mitigate the risks e.g. by following established procedures for declaring and managing a conflict.

Every Practitioner should:

a. Always use his/her professional judgement to identify potential conflicts of interest that may arise in relation to their professional relationship with a patient;
b. Always avoid conflicts of interest wherever possible;
c. Always act in the patients' best interests when recommending tests and treatments, when making referrals, and when providing or arranging treatment or care;

d. Always be aware of the ways in which his/her practice may be influenced, or be seen to be influenced, by marketing of pharmaceuticals, medical devices, and other medical products and services;
e. Not ask for or accept any inducement, kickback, gift, hospitality or other non-financial benefit such as academic or research from companies that produce, provide, market or sell pharmaceuticals, medical devices, and other medical products and services, that may influence, or be seen to influence, the way that he/she manages and refers patients;
f. Not offer such inducements or enter into arrangements that could be perceived to provide such inducements;
g. Not ask for or accept any fees for meeting sales representatives from companies that produce, provide, market or sell pharmaceuticals, medical devices and other medical products and services;
h. Not allow any financial or commercial interest in a health facility, healthcare organisation or company providing or manufacturing healthcare devices, products or services to adversely affect the way that he/she manages and refers patients;
i. Promptly, formally and in line with the health facility's or organisation's policies, declare any conflict of interest to anyone affected. If the practitioner is in doubt about whether or not there is a conflict of interest, he/she should act as though there is;
j. Always inform patients and clearly document in the patient's file when he/she has an interest that could affect, or could be perceived to affect, patient care, and
k. Always make sure that arrangements are made, if need be, for the patient to be seen by a suitably qualified and skilled practitioner who can take over their care without unreasonable delay.

4.12.2. BILLING/ FEES FOR PROFESSIONAL SERVICES

The primary objective of the medical profession is to render service to humanity; any anticipated reward or financial gain is a subordinate consideration. The Medical Practitioners and Dentists (Professional Fees) Rules, 2016 specifies fees that should be charged by practitioners offering medical and dental services. These fees should be adhered to by all practitioners and health institutions registered under the Act. Subsequently, both **undercutting** (offering services at a lower cost than the minimum listed in the Rules) and **overcharging** (agreeing to or receiving amounts higher than those specified in the Rules) are considered to be professional misconduct. Further, prescribing or providing unnecessary treatments, tests, services, procedures, devices or hospitalisation for the sole purpose of financial or commercial gain constitutes unethical practice.

Medical, Dental and Community Oral Health Practitioners, and the health institutions that they practice in, should:

a. Not exploit patients' vulnerability or lack of medical knowledge when charging professional fees;
b. Solely rely on their professional judgement and the accepted standards of practice to prescribe, administer or perform only those treatments, tests, services, procedures, devices or hospitalisation that are necessary for the management of their patients;
c. Inform patients about the fees that they will charge for the services rendered, preferably before seeking the consent for treatment/ management;
d. Disclose to the patients if any part of the fee goes to another healthcare professional or to the facility (e.g. the total fee billed for a surgical procedure will include fees for the procedure itself, anaesthesia and hospital stay);
e. Adhere to the minimum and maximum professional fee limits stated in The Medical Practitioners and Dentists (Professional Fees) Rules, regardless of the payer (i.e. the person or organisation that pays for the services rendered to the patient);
f. Itemise separately charges for diagnostic, laboratory, pharmacy, clinical, non-clinical and administrative services provided by other healthcare professionals or the health facility;
g. Clearly indicate who provided the service when fees for services delivered by other professionals cannot be billed directly to the patient, in addition to charges for the practitioner's own professional services;
h. Disclose the itemised bill to the patient and the payer;
i. Ensure prompt that they pay to the respective healthcare professional any amounts received on their behalf;
j. Not charge fees or receive payment for consultation or services not rendered;
k. Promptly refund any professional fees paid in advance if the service is not rendered;
l. Promptly refund any excess professional fees that are charged erroneously, as soon as they notice or are made aware of such errors, and
m. Submit contributions to inform the review and revision of the prescribed professional fees.

4.12.3. FINANCIAL AND COMMERCIAL DEALINGS

Practitioners must be honest and transparent in financial arrangements with patients and shall:

a. Not exploit patients' vulnerability or lack of medical knowledge when providing or recommending treatment or services and setting fees;
b. Avoid financial involvements, such as loans and investment schemes, with patients;
c. Not encourage or coerce patients to give, lend or bequeath money or gifts that will benefit the practitioner directly or indirectly, and
d. Not pressure patients or their families to make donations to other people or organisations.

4.12.4. FINANCIAL ARRANGEMENTS THAT MAY AFFECT PRACTITIONERS' DECISIONS ABOUT PATIENT CARE

Professional autonomy and clinical independence are essential for the delivery of high-quality healthcare to the benefit of patients and the community. It is limited by adherence to professional rules, standards and the evidence base.

Practitioners' clinical independence may be constrained by factors that affect availability of resources and limitations on healthcare coverage. Such limitations are usually based on financial considerations and may not reflect the fundamental principles of: (1) the best interests of the patient/ community, (2) the practice of evidence-based medicine, (3) cost-effectiveness, and (4) the prudent use of available resources.

Practitioners should not be compelled to provide care that is excessive or that is inadequate in relation to what the patient needs. Where the economic interests of the health facility, healthcare funder, health management organisation, or other entity are in conflict with patient welfare, the welfare of the patient takes priority.

Financial arrangements that may affect practitioners' decisions about patient care include health insurance (also known as medical/ healthcare insurance) and incentives.

Challenges arising from financial arrangements that affect Practitioners' decisions about patient care include:

a. **Underservicing and Over-servicing**

Over-servicing refers to the supply, provision, administration, use or prescription of any treatment or care which is medically and clinically not indicated, unnecessary or inappropriate under the circumstances, or which is not in accordance with the recognised treatment protocols and procedures, without due regard to both the financial and health interests of the patient.

Underservicing refers to the failure to provide a patient with the standard of care that a reasonably competent doctor in a similar situation and in the same field of medical practice would be expected to provide, usually due to the financial capability of the patient.

In this regard, Practitioners should never provide care that is excessive, wasteful and unnecessary in relation to what the patient needs. Likewise, Practitioners should not be compelled to provide care that is inadequate in relation to what the patient needs based on restrictions placed by the health facility or healthcare funder.

b. **Practitioner/ supplier-induced demand**

The practice of medicine and dentistry occurs in an environment where there is asymmetry of information between the supplier (healthcare professional, health facility, healthcare organisation) and the patient who is the consumer.

Supplier-induced demand refers to the notion that practitioners, in acting as agents for their patients, can use their discretionary power to engage in demand-shifting or inducement activities such that their recommended care differs from that which an informed patient would deem appropriate. The induced demand may take the form of an increase in the number of services or a change in the service mix provided to patients, and usually results from actions related to the Practitioners'/ health organisations' interests. That is, the Practitioner exploits the patient's lack of knowledge to recommend interventions that the patient does not require for the sole purpose of benefitting him/herself, or the health organisation that he/she is affiliated with.

In this regard, practitioners and health facilities are reminded that any treatment or hospitalisation that is wilfully excessive constitutes unethical practice.

4.13. SEXUAL BOUNDARIES BETWEEN PRACTITIONERS AND PATIENTS

Sexual relationships and/or contact between the practitioner and patient in their care are unacceptable and unethical. The following guidelines apply regardless of who initiates the relationship and take no account of gender or sexual orientation:

a. Sexual contact between a practitioner and a patient under their care is prohibited;
b. The practitioner must never pursue a personal or intimate relationship with a patient;
c. Practitioners must never make sexual advances or display sexual behaviour (including inappropriate touch and sexual comments) towards a patient;
d. A practitioner and patient must mutually agree to end the formal professional practitioner-patient relationship. However, a practitioner must not end a professional relationship with a patient for the sole purpose of pursuing a personal relationship with them;
e. A practitioner must not use their professional relationship with a patient to pursue a personal relationship with someone close to the patient. For example, they must not use home visits to pursue a relationship with a member of a patient's family;
f. If a patient pursues a sexual or improper emotional relationship with a practitioner, the practitioner should refuse them politely and considerately, and try to re-establish a professional boundary;
g. If trust has broken down, the practitioner may find it necessary to terminate the professional relationship and hand the patient's care over to a suitably qualified practitioner;
h. Personal and/or sexual relationships with former patients may also be inappropriate, depending on the following factors:
    i. The **timing**: The more recently a professional relationship with a patient ended, the less likely it is that beginning a personal relationship with that patient would be appropriate. In determining the timing, the duration of the professional relationship is relevant;
    ii. The **vulnerability** of the patient at the time of the professional relationship, and whether they are still vulnerable: Some patients may

    be more vulnerable than others because of their age, illness, disability, frailty, or current circumstances e.g. bereavement. The more vulnerable the patient is, the more likely it is that a practitioner having a relationship with them would be an abuse of their power and position. Where a practitioner is a psychiatrist or a paediatrician, pursuing a relationship with a former patient is more likely to be perceived as an abuse of their position;
    iii. The **nature** of their previous relationship prior to the professional relationship, and
    iv. Whether or not the practitioner will be caring for other members of the patient's family;

i. Practitioners are duty bound to report breaches of sexual boundaries by their colleagues as soon as they become aware of such breaches. For example:
    i. if a patient reports a breach of sexual boundaries to the practitioner;
    ii. if the practitioner has reason to believe that a colleague may have displayed sexual behaviour towards a patient;
    iii. if a practitioner suspects or is aware that a colleague has committed a sexual assault, etc.

    Such reports should be made in a manner that upholds the patient's autonomy, dignity, confidentiality and safety.

4.14. USE OF CHAPERONES DURING INTIMATE EXAMINATIONS AND CARE

Intimate examinations include those of the genital, pelvic, rectal, breast or facial regions, and may also include any examination where it is necessary for a practitioner to touch or be close to the patient. These examinations can be embarrassing and/or distressing for patients, and practitioners should be sensitive to what the patient may think of as intimate.

Before conducting an intimate examination, practitioners should:

a. Explain to the patient why the examination is necessary and give the patient an opportunity to ask questions;
b. Explain what the examination will involve, in a way the patient can understand, so that the patient has a clear idea of what to expect, including any pain or discomfort;
c. Get the patient's (or the patient's guardian or medical proxy) permission or consent before conducting the examination and record that the consent has been given;

d. Explain to the patient that they are at liberty to ask the practitioner to stop the examination, even after initially agreeing to it;
e. Offer the patient a chaperone and document the patient's acceptance or refusal, and
f. Give the patient privacy to undress and dress, and keep them covered as much as possible to maintain their dignity. Practitioners are reminded that they should not help the patient to remove clothing.

When examining a **minor**, even after receiving consent to perform the examination from the patient's guardian, the practitioner should inform the minor about what the examination would entail and get permission from the minor for the parent/guardian to uncover them or help them undress where applicable.

Before carrying out an intimate examination on a **sedated or anaesthetised patient**, the practitioner must make sure that the patient has given explicit consent for the examination in advance, preferably in writing.

During the examination, the practitioner should keep discussion relevant and not make unnecessary personal comments.

A **chaperone** is an impartial observer present during an intimate examination of a patient. He or she will usually be a health professional who is familiar with the procedures involved in the examination. The chaperone should:
a. Be sensitive and respect the patient's dignity and confidentiality, including avoiding inappropriate remarks and gestures;
b. Reassure the patient if they show signs of distress or discomfort;
c. Be familiar with the procedures involved in a routine intimate examination;
d. Stay for the whole examination and be able to see what the practitioner is doing, if practical, and
e. Be prepared to raise concerns if they are apprehensive about the practitioner's behaviour or actions.

A relative or friend of the patient is not an impartial observer and would not usually be a suitable chaperone, but the practitioner should comply with a reasonable request to have such a person present as well as a chaperone.

In the patient's medical record, the practitioner should record the following:
i. Any discussion about chaperones and the outcome of the discussion, and

ii. The fact that a chaperone is present and their identity, or
iii. That the patient does not want a chaperone, and that the offer was made and declined.

If either the practitioner or the patient does not want the examination to go ahead without a chaperone present, or is uncomfortable with the choice of chaperone, the practitioner may offer to delay the examination to a later time when a suitable chaperone will be available, as long as such a delay would not adversely affect the patient's health.

If the practitioner does not want to go ahead with the examination without a chaperone present but the patient has said no to having one, the practitioner must explain clearly why they want a chaperone present. Ultimately, the patient's clinical needs must take precedence. The practitioner may wish to consider referring the patient to another suitably qualified practitioner who would be willing to examine the patient without a chaperone, as long as such a delay would not adversely affect the patient's health or cause undue distress.

4.15. DISCLOSURE AFTER INCIDENTS AND ADVERSE EVENTS (PROFESSIONAL DUTY OF CANDOUR)

All healthcare professionals have a duty of candour – a professional responsibility to be honest with patients (or their parent/ guardian/ medical proxy) – when things go wrong with the care that they provide, and the patient suffers harm or distress as a result. It does not include a patient's condition getting worse due to the natural progression of illness. This duty begins even before the care is provided, when patients are informed about their care and the expected benefits, possible risks or complications, expected outcomes, and alternative options to the care, if available.

A **medical error** is an adverse event or near miss related to the management of a patient that is preventable with the current standard of medical knowledge. A **near miss** is an incident that had the potential to result in harm but did not do so. The process of addressing a medical error involves:

a. Identifying that the error has happened;
b. Ameliorating or salvaging the harm to protect the patient;
c. Documenting that harm has happened in the patient's record and in any other relevant records, and

d. Reviewing the incident by the health professionals and the health facility for quality improvement and learning purposes.

Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. This means that healthcare professionals must:

i. As soon as possible after they realise, tell the patient (or their parent/ guardian/ medical proxy) when something has gone wrong;
ii. Ensure that the patient has someone to support them during this disclosure, if this is acceptable to them;
iii. Speak to the patient (or their guardian or medical proxy) in a place and at a time when they are best able to understand and retain the information;
iv. Give the information to the patient (or their guardian or medical proxy) in a considerate and respectful manner, taking into account their right to privacy and dignity;
v. Be clear about what has been established, what is pending investigation, and when the possible outcome of this investigation will be made known;
vi. Express regret to the patient (or their parent/ guardian/ medical proxy) for what has happened without admitting or accepting legal liability;
vii. Offer an appropriate remedy or support to put matters right (if possible);
viii. Explain fully to the patient (or their guardian or medical proxy) the short- and long-term effects of what has happened;
ix. Ensure that the patient (or their guardian or medical proxy) knows who to contact in the healthcare team to ask further questions or raise concerns, and
x. Respect, support and facilitate the patient's wishes to terminate their professional relationship and appropriately transfer their care to another suitably qualified healthcare professional, team or facility.

Healthcare professionals must also be open and honest with their colleagues, employers and relevant organisations, and take part in reviews and investigations when requested. They must support and encourage each other to be open and honest, and not stop someone from raising concerns. Senior practitioners have a responsibility to set a good example by encouraging openness and honesty in reporting adverse incidents and near misses. Clinical leaders should actively foster a culture of learning and improvement.

Further, healthcare professionals are required to respond promptly, openly and honestly to all queries raised by the regulators about the care provided to patients, and to encourage their colleagues to do the same.

4.16. WITHHOLDING AND WITHDRAWING TREATMENT

Practitioners are duty bound to make the care of their patients their first concern. All persons have the right to high-quality, evidence-based, and humane healthcare. Patients who are approaching the end of their life need high-quality treatment and care that support them to live as well as possible until they die in a dignified manner. Providing treatment and care towards the end of life will often involve decisions that are clinically complex and emotionally distressing; and some decisions may involve ethical dilemmas and uncertainties about the law that further complicate the decision-making process.

The most challenging decisions in this area are generally about withholding or withdrawing treatment when it has the potential to prolong the patient’s life. This may involve treatments such as antibiotics for life-threatening infection, cardiopulmonary resuscitation (CPR), mechanical ventilation, renal dialysis, and artificial/clinically assisted nutrition and hydration.

The evidence of the benefits, burdens and risks of these treatments is not always clear cut, and there may be uncertainty about the clinical effect of a treatment on an individual patient, or about the benefits, burdens and risks for that particular patient. In some circumstances, these treatments may only prolong the dying process or cause the patient unnecessary distress. Given the uncertainties, everyone involved in the decision-making process may need reassurance about what is ethically and legally permissible, especially when deciding whether to withdraw a potentially life-prolonging treatment. Whenever possible, the hospital ethics committee should be involved in making the decision to withhold or withdraw treatment, especially where such an action is likely to hasten the patient’s death.

The existing laws in Kenya prohibit killing, euthanasia and assisted suicide. The laws take into account a patient’s right to autonomy, dignity and to refuse treatment. Hence, they allow for a living will or advance care directive, in which a patient states their wishes in regard to future medical treatment, resuscitation or the use of artificial means to prolong their life, in circumstances when they are no longer able to give informed consent.

All healthcare practitioners:

a. Have a duty to give priority to patients on the basis of clinical need, while using up to date evidence about the clinical efficacy of treatments;
b. Must not allow their own views about, for example, a patient's age, disability, race, ethnicity, culture, beliefs, sexuality, gender, lifestyle, socioeconomic status or other irrational grounds, to prejudice the choices of treatment offered or the general standard of care provided to their patients;
c. Must abide with the prevailing laws and regulations in the country;
d. Shall respect the patient's wishes regarding continuing treatment, resuscitation or the use of artificial means to prolong their life, including those contained in a living will or advanced care directive, when they become aware of them, and
e. Should ensure that patients in their care are treated in a compassionate manner that preserves their dignity, even in dying and death, for example by ensuring that their hygiene needs are taken care of.

Further guidance on End-of-Life Issues is provided in section 7.7.

4.17. TERMINATING PROFESSIONAL RELATIONSHIPS WITH PATIENTS

It is much more difficult to end a practitioner-patient relationship than it is to enter into one, especially where this professional relationship is long-term. Either the patient or the practitioner may make the decision to end the practitioner-patient relationship.

Circumstances which lead to termination of practitioner-patient relationships include but are not limited to:

- The patient's choice (a patient is free to terminate a practitioner-patient relationship at any point);
- The Practitioner is either relocating or closing down their practice;
- The Practitioner has identified conflict of interest which may compromise or be seen to compromise their judgement;
- The practitioner-patient relationship has irredeemably broken down, e.g. due to:

  - disruptive behaviour by a patient (such as theft, violence, sexual harassment or use of threatening/ derogatory/ disrespectful language);
  - where a patient poses a safety risk to the practitioner, his/her colleagues or other patients, or
  - where a patient refuses to follow the treatment, regimen prescribed by the Practitioner, thus undermining their own recovery;
- The patient needs care beyond the Practitioner's scope;
- The Practitioner is permanently deregistered by the Council, or has their license temporarily restricted, withdrawn or suspended by the Council;
- The Practitioner suffers temporary or permanent incapacitation rendering him/her unable to continue offering services, and
- The Practitioner's death.

Whatever the circumstances, Practitioners should always be aware of:

i. their fundamental duty of patient care, and that they must maintain the care of the patient until a suitable alternative is found;

ii. the possibility of the patient to feel discriminated against, should they deem the reason for the termination of the relationship to be unfair or unjustifiable, and

iii. the potential liability of patient abandonment if the relationship is not properly terminated.

Where the practitioner-patient relationship breaks down, the Practitioner should:

1) Try to find a mutually acceptable solution, taking into account the patient's needs and circumstances, and the safety risk to the Practitioner, their colleagues and other patients, and
2) Only end the practitioner-patient relationship if attempts to resolve the situation have not been successful.

When considering whether to end a practitioner-patient relationship, the practitioner should:

(i) Explain his/her concerns or change in circumstances to the patient and the reasons why they are considering ending the relationship;

(ii) Assess the impact on the patient, where treatment may be incomplete, acute, or ongoing unless their treatment has been transferred to another suitably qualified practitioner;

(iii) Use the most appropriate and culturally-acceptable way to end the relationship, including helping to transfer the patient's care to another suitably qualified practitioner;
(iv) Consider discussing this decision with a colleague, supervisor, the facility manager/administrator, or their professional indemnity provider, while protecting the patient's dignity and privacy, and seek their support, and
(v) Be prepared to justify their decision.

When the Practitioner has decided to end their professional relationship with a patient, they should:

a. Do so in a respectful and professional manner;
b. Respectfully inform the patient and their caregiver in person and in writing that the practitioner-patient relationship has ended and the reasons for this;
c. Continue providing necessary acute or ongoing care until the transfer of care to a suitably qualified practitioner is completed;
d. Document the termination of the practitioner-patient relationship in the patient's records in a factual and objective manner that would not unfairly prejudice the patient's future treatment;
e. Allow the patient to access and review their patient records and request their consent to transfer the records, along with transferring their care, to another suitably qualified practitioner;
f. Document this consent to transfer the patient records, and
g. Ensure transfer of the patient's records. The practitioner may retain a copy of the records for use in case there are any queries in the future.

4.18. PRACTITIONERS' RESPONSIBILITY TOWARDS PATIENT CARE DURING INDUSTRIAL ACTIONS

Practitioners have the right to freedom of association, including the right to join trade unions and to participate in lawful union programmes and activities, such as industrial action. This right is recognised and protected in law and forms an important component of collective bargaining and the promotion of fair and safe working conditions.

At the same time, practitioners owe a continuing professional and ethical duty to safeguard patient welfare. This includes an obligation to provide emergency and life-saving care and to take reasonable steps to prevent foreseeable harm to patients, even in the context of a strike or go-slow.

Where industrial action occurs, health institutions and employers bear a corresponding responsibility to plan and implement appropriate contingency measures. Such measures should ensure continuity of essential and emergency services and the delivery of care of the highest possible standard in the prevailing circumstances, so as to meet patients’ fundamental healthcare needs and to minimise the risk of harm.

5. THE PRACTITIONER'S RELATIONSHIPS WITH OTHER HEALTHCARE PROFESSIONALS

Respectful relationships are essential for safe patient care. Practitioners should endeavour to cultivate respectful relationships with colleagues, other healthcare professionals, team members, support staff, administrative staff, interns and students.

5.1. RELATIONSHIPS WITH COLLEAGUES, TEACHERS, INTERNS AND STUDENTS

It is essential for good and safe patient care that doctors work effectively with colleagues from other health and social care disciplines, both within and between teams and organisations.

5.1.1. COLLEGIALITY

Collegiality refers to the existence of a friendly relationship between people who work together, which can be described using positive terms such as supportive, cordial, rewarding, equal or democratic.

A practitioner should foster collegiality through:

a. Acknowledging and respecting the contribution of all healthcare professionals involved in the care of the patient;
b. Addressing colleagues and other healthcare professionals respectfully and courteously;
c. Communicating clearly, effectively, courteously, respectfully, and promptly with other healthcare professionals;
d. Where conflict arises, resolving such conflict without using disparaging words or references to colleagues and other healthcare professionals,
e. Not making comments to a patient that may cast aspersions on a colleague's knowledge, skills or experience which cannot be fully justified;
f. Supporting colleagues to uphold the core values and standards embodied in these guidelines;
g. Advising colleagues who are impaired to seek professional assistance;
h. Supporting colleagues who have problems with their performance or health, putting patient safety first;
i. Being receptive towards challenges to their professional opinion including management of specific patients where they view themselves as authorities;

j. Behaving professionally and courteously to colleagues and other health workers, including on mass media and when using social media, and
k. Ensuring that they promptly and fully compensate any healthcare professional working with or for them, or for whom they have received payment for services that they delivered as per the agreed terms.

5.1.2. TEACHING, SUPERVISING, MENTORING, COACHING AND ASSESSING

Practitioners are expected to contribute to the training of students, interns and junior colleagues. This role encompasses teaching, supervising, mentoring, coaching and assessing their performance.

Practitioners should;

a. Take on a mentoring role for students, interns, junior doctors and other healthcare professionals;
b. Take part in the induction offered by the employer upon joining an organisation, moving into a new role, and also contribute to the induction of colleagues when requested;
c. Where formally involved in teaching, develop the skills, attitudes, and practices of a competent teacher. This includes respecting cultural diversity and making reasonable adjustments for those with a disability without affecting patient safety or educational outcomes;
d. Ensure that patients are aware that students, interns, registrars or fellows may participate in their care and that they can object to receiving care from students/ interns/ registrars/ fellows;
e. Support any colleagues that they supervise to develop their skills by appropriately delegating tasks and responsibilities;
f. Ensure that the junior colleagues that they supervise have the necessary skills and training to carry out their roles;
g. Where responsible for managing teaching and training in their organisation, ensure that:
    i. Only people with the appropriate knowledge, skills and attitudes carry out any teaching and training;
    ii. There are enough staff members from appropriate disciplines, and with the necessary skills and experience, to deliver teaching and training and to support the learning and development of trainees and students;
    iii. Systems are in place to identify and record the educational and training needs of students, trainees, and staff, including locums, so that the best

use is made of the time, and resources available for keeping knowledge and skills up to date;

iv. An appropriate environment for training is provided, including implementing reasonable adjustments to meet individual trainees' needs;
v. Ensure that there are governance structures, feedback and review mechanisms for the teaching programmes;
vi. Opportunities are available for teachers, trainers and supervisors to keep up to date and develop their knowledge and skills, and make sure that there are systems in place for regular feedback and appraisal of those skills, and
vii. Any new practitioner or healthcare professionals is offered relevant induction and that induction policies and procedures contain information that is relevant, accessible, and proportionate to their role and length of employment within the organisation.

5.1.3. DISCRIMINATION, HARASSMENT AND BULLYING

Discrimination, bullying, violence and harassment (including sexual harassment) adversely affect individual practitioners, increase risk to patients and compromise effective teamwork in healthcare teams.

Practitioners should not engage in any form of discrimination, harassment, bullying or violence against other health workers, be they students, interns, junior or senior practitioners, other health professionals, non-clinical staff or support staff.

Further, Practitioners should speak up when they witness any form of discrimination, harassment, bullying or violence by others, and report it to the appropriate authorities (including KMPDC) through the provided mechanisms.

5.1.4. WRITING REFERENCES OR TESTIMONIALS

When writing references or testimonials about the performance of a student, intern, other practitioner or other health professional, every practitioner should;

a. Be cognisant of the fact that they will be held responsible for any reference given;
b. Ensure that the references include all information relevant to the person's competence, performance and conduct, and

c. Take reasonable steps to confirm that the information provided is accurate.

5.2. COORDINATING PATIENT CARE

In coordinating a patient's care, a practitioner should ensure that it is clear to the patient, the persons close to them and the other health professionals who is ultimately responsible. It is prudent for a Practitioner to:

a. Understand their role as part of the team and fulfil the responsibilities associated with that role;
b. Communicate effectively with other team members and with the patients, and
c. Advocate for a clear delineation of roles and responsibilities, including that there is a recognised team leader or coordinator.

5.2.1. COMMUNICATION WITH COLLEAGUES

Multidisciplinary teams (the expected norm) bring benefits to patient care when communication is timely and relevant. However, problems may arise when communication is poor or responsibilities are unclear. In communicating with colleagues, Practitioners should always:

a. Ensure that they communicate relevant information clearly to colleagues in the team and colleagues in other services with which they work;
b. Not assume that someone else in the team will pass on information needed for patient care, and
c. Encourage team members to cooperate and communicate effectively with each other and other teams or colleagues with whom they work.

5.2.2. CONSULTATION, DELEGATION, HANDING OVER AND REFERRAL

Where the situation or circumstances warrants, a practitioner may, consult, delegate, refer or hand over patients to another practitioner.

- **Consultation** occurs when a health professional requests another health professional for their opinion, advice or service to assist in patient care. In this case, the responsibility/duty of care remains with the primary physician.
- **Delegation** occurs when a health professional asks another health professional to provide care or treatment on their behalf. In this case, the responsibility/duty of care is shared between the two health professionals.
- **Handing over** occurs when care is temporarily transferred to another health professional or service, usually within the same clinical team and/or health institution, e.g. as happens at the end/beginning of each shift. In this case,

each health professional is responsible for their own acts or omissions with regard to patient care, e.g. during the time that they were on duty.

- **Referral** occurs when a health professional or institution asks another health professional or institution to take over part or all of the patient's care. In this case, the responsibility/duty of care is transferred to the other health professional or institution.

In such circumstances, the practitioner should:

a. Ensure that arrangements are in place for continued care of patients when they are not available. These arrangements should be made in advance whenever possible, and communicated to the patient, the other treating practitioners and any relevant facilities;
b. Take reasonable steps to ensure that the person to whom they delegate, refer or handover has the qualifications, experience, knowledge and skills to provide the care required and to safeguard the best interests of the patient;
c. Understand that when they delegate, they remain responsible for the overall management of the patient, and for their decision to delegate;
d. Always communicate sufficient information about the patient and the treatment they need in order to facilitate their continued care;
e. Not supersede or take over a patient from another practitioner if he or she is aware that such patient is in active treatment of another practitioner, unless he/she:
    i. takes reasonable steps to inform the other practitioner that he/she has taken over the patient at such patient's request, and
    ii. establishes from the other practitioner what treatment such patient previously received, especially what medication, if any, was prescribed to such patient and in such case the other practitioner shall be obliged to provide such required information;
f. Not impede a patient from obtaining the opinion of another practitioner or from being treated by another practitioner, and
g. Only give a second opinion when they feel competent and safe enough to do so.

5.3. REPORTING UNSAFE AND UNETHICAL PRACTICES AND/OR BEHAVIOUR

Every practitioner has a duty to institute appropriate measures to safeguard the patient’s best interests and report unsafe and unethical practices.

A practitioner should report:

a. violations where they have a good or persuasive reason to believe that the rights of patients are being violated;
b. incompetent and impaired colleagues who are a danger to the health of their patients, and
c. directly to the Council when the conduct in question poses an immediate threat to the health and safety of patients or violates the licensing provisions.

A practitioner should comply with any statutory reporting requirements, including mandatory reporting requirements under the Law as they apply in their jurisdiction.

6. PRACTITIONERS', THE HEALTH SYSTEM AND SOCIETY

Practitioners ply their trade within a defined health system. As members of communities, Practitioners have a responsibility to contribute to the betterment of the communities that they serve and society as a whole. This section provides guidelines for best practice on some key crosscutting issues in healthcare.

6.1. LEADERSHIP, MANAGEMENT AND GOVERNANCE

Practitioners are leaders of clinical teams. In addition to this, they are expected to provide leadership within the organisations and systems in which they work; in the profession, and in society as a whole.

Leadership, management and governance is a core pillar of the health system framework. Practitioners are encouraged to continuously equip themselves with the necessary information, knowledge and skills in order to effectively articulate their role in leadership, management and governance.

6.2. OCCUPATIONAL HEALTH AND SAFETY

Compared to the general public, Practitioners and other health professionals in the course of their work have a higher risk of exposure to a combination of biological (e.g. infectious agents), physical (e.g. radiation, noise, violence, ergonomic, slips and falls), chemical (e.g. drugs , reagents), and psychological (e.g. long working hours, inadequate rest, harassment, burnout) hazards, leading to higher incidence of infectious diseases, chronic conditions and mental illness.

Practitioners should be aware of the provisions of the Occupational Safety and Health Act (Cap. 236A), the Work Injury Benefits Act (Cap. 236), the *National Policy on Patient Safety, Health Worker Safety and Quality of Care*, and other relevant legislation. These documents secure the Practitioners' rights to a safe working environment that is not harmful to their health and wellbeing, including the provision of:

- personal protective equipment;
- postexposure prophylaxis;
- medical management to prevent or control their own illness;
- protection from violence;
- appropriate psychosocial support to manage stressful situations, and
- compensation for injuries sustained at work.

Practitioners should be involved in and advise on their organisation's workplace occupational safety and health programmes. Further, they should be cognisant of their duty to self and must prioritise their wellbeing and working conditions.

Practitioners working in occupational health services are required by the Occupational Safety and Health Act and Work Injury Benefits Act to:

a. ensure that a safety and health audit of the workplace is conducted at least once every twelve (12) months, and the implementation of corrective measures;
b. undertake routine medical examinations of employees, including temporary workers, interns and attachés;
c. undertake medical surveillance on the health of all employees;
d. establish measures to identify, report, investigate, manage, control and prevent any dangerous incidents, accidents or occupational poisoning occurring in the workplace;
e. investigate any dangerous incidents, accidents or occupational poisoning occurring in the workplace, regardless of whether they result in fatal or non-fatal injuries;
f. notify the Directorate of Occupational Safety and Health Services, within the stipulated period, of the occurrence of any disease, injury or death occurring in the workplace;
g. comply with requests for information and participate in inquiries related to occupational health incidents while observing the principle of confidentiality, and
h. undertake any other activities related to the identification, reporting, management, investigation and prevention of occupational health incidents in compliance with the prevailing Laws, regulations, policies and guidelines .

6.3. PATIENT SAFETY AND QUALITY OF CARE

Practitioners should be dedicated to continuous improvement in the quality of healthcare, whether in clinical or nonclinical roles. This entails:

a. maintaining professional competence through lifelong study;
b. advise and lobby for a safe, efficient, reliable working environment to provide quality care within the institutions that they work;

c. exercising independent professional judgement in recommending the necessary investigations, treatments and care that are evidence-based and responsive to the needs of the patients;
d. working collaboratively with other professionals to enhance patient safety, optimise outcomes of care;
e. ensuring the proper allocation and use of healthcare resources, and
f. being actively involved in the development and implementation of quality improvement measures addressing patient safety, care effectiveness and patient-centred care.

6.4. PRUDENT USE OF AVAILABLE HEALTHCARE RESOURCES

Practitioners have a duty to provide quality healthcare based on the best available scientific evidence, placing the best interest of the patient above all other interests, including the practitioner's own. Practitioners should place paramount consideration on the need for and the cost of diagnostic tests and procedures, and of management and treatment modalities recommended.

In this regard, Practitioners shall:

a. prescribe tests, procedures, treatment regimens and medical services that are justifiable and of benefit to the patient;
b. use proven and evidence-based remedies;
c. utilise available resources appropriately to provide the best possible care to the patients
d. avoid unjustifiable additional expenses.

6.5. RESPONSIBILITIES OF PRACTITIONERS IN COMMUNITIES

Every Practitioner has the responsibility to contribute to the betterment of their community. Practitioners should:

a. Participate in formulation and implementation of health policies towards the prevention of injury and disease, and the promotion of healthy living;
b. Advocate for service provision and improvement of the health system to address healthcare inequity, and to protect and advance the health and wellbeing of individual patients, communities and populations;
c. Assist in promotion of health and safety, including countering misinformation and disinformation;
d. Protect the profession against practise by unqualified and unlicensed persons;

e. Be sensitive to the religious and cultural beliefs and preferences of the people and communities that they serve; the ethical dilemmas that such preferences may pose to their professional duties, and take reasonable steps to accommodate these preferences while safeguarding the best interests of the patients and communities they serve;
f. Be open to respond to the call to action in the event of disasters and emergencies;
g. Promptly report all notifiable diseases or illnesses to relevant authorities;
h. Act as expert witnesses in regulatory, legal and criminal proceedings;
i. Participate in court-initiated/ mandated medical treatments keeping in mind the patients' rights and safeguarding their best interests;
j. Not participate, be seen to participate or compel others to participate, in offering or performing any harmful, cruel, inhumane, demeaning, derogatory and/or humiliating examinations, tests, treatments or procedures whether the people subjected to such examinations, tests, treatments or procedures are free, detained or imprisoned;
k. Recognise, treat and document signs of abuse, torture or degrading treatment in patients and clients, especially in vulnerable populations; report such incidents to the relevant authorities, and provide expert witness in the investigations of such incidents;
l. Be cognisant of the impact of climate change and changes in the environment on the health of the population, and
m. Be cognisant of the impact of the practice of medicine and dentistry on the environment, including environmentally-safe management of healthcare waste.

6.6. PUBLIC HEALTH EMERGENCIES

A public health emergency is a serious threat to the health of a population, often due to natural or human-made hazards, which can or has the potential to cause many illnesses, injuries, impairments or deaths; disrupt health systems; hinder economic and social development, and significantly reduce community resilience. It becomes a Public Health Emergency of International Concern (PHEIC), and can be declared as such by the World Health Organization (WHO), when it poses a risk to other countries through international spread of disease and potentially requires a coordinated international response.

The combination of urgency, uncertainty, and dwindling health resources presents severe challenges and ethical dilemmas to the healthcare professionals, health institutions and health authorities involved in the response to public health emergencies.

Practitioners, health institutions and health authorities involved in response to public health emergencies should:

a. Bear in mind that the fundamental ethical principles of respect for persons, beneficence, non-maleficence, autonomy and justice remain unchanged;
b. Aim to maximise benefits and minimise harms at population level;
c. Preserve the confidentiality of patient information, and disclose only the information that is necessary for managing the emergency in accordance with prevailing Laws and regulations, such as mandatory reporting requirements;
d. Remember that while patients have a right to consent to or refuse treatment, refusal of treatment may pose serious harm to others, and as such, some compulsory measures that do not amount to treatment (e.g. confinement) may be instituted, provided that there is a legal and ethical mandate supporting them;
e. Ensure that any interference with fundamental rights, including restrictions of liberty, is:
    i. necessary, proportionate and justified by public good;
    ii. based on lawfully-provided powers and authority, and
    iii. only imposed for as long as is necessary based on scientific evidence, and
    iv. that the basic needs of confined persons are met at all times;
f. Clearly inform individuals and communities what interventions are being taken to mitigate the public health emergency; their intended purpose and duration, and how these measures will affect them;
g. Maintain clear communication with individuals and communities of evidence-based and scientifically sound information; and take steps to counter misinformation and disinformation, especially when it is coming from health professionals;
h. Ensure that allocation of limited health resources is ethical and aims to maximise benefits by prioritising those with the greatest need and those who are most likely to benefit from an intervention;
i. Be aware of the rights of health professionals, other responders and volunteers involved in the public health emergency response;

j. Take measures to protect health professionals, other responders and volunteers involved in the response from harm, such as by minimising risk exposure, and providing them with vaccines, personal protective equipment (PPE), psychosocial support, legal protection, and adequate remuneration, among others;
k. Ensure that the interventions instituted during public health emergencies consider the religious and cultural practices of the community they serve and make reasonable adjustments to accommodate these whenever possible, e.g. funeral rites, and
l. Ensure that any research undertaken during a public health emergency is done in accordance with prevailing Laws, regulations and human research ethics, and does not jeopardise the care given to patients.

6.7. ADVERTISING

Advertisements for medical services can be useful in providing information for patients and clients. A practitioner or health institution may advertise the health services which they offer provided that they abide with the provisions in The Medical Practitioners and Dentists (Practitioners and Health Facilities) (Advertising) Rules. Rule 3 (4) provides that an advertisement made under these Rules shall:

a. be objective, true and dignified;
b. be respectful of the professional ethics of the profession;
c. not attempt to denigrate other practitioners or health institutions or the profession, and
d. not infringe on patient confidentiality.

In addition, Practitioners and health institutions must abide with any other relevant laws and regulations, including but not limited to the Health Act (Cap. 241), the Data Protection Act (Cap. 411C), the Consumer Protection Act (Cap. 501), and the Computer Misuse and Cybercrimes (Cap. 79C). Further, Practitioners are required to abide by the provisions in this *Code* on preserving the dignity, confidentiality and respect for patients as detailed in Chapter 4,

In advertising the healthcare services that they offer, regardless of the medium of advertisement, Practitioners and health institutions should:

a. Ensure that any information that they publish or disseminate about their facilities and services is factual and verifiable;

b. Make only justifiable claims about the quality and outcomes of their services;
c. Not guarantee cures or raise unrealistic expectations;
d. Not exploit patients’ vulnerability and concerns about their current or future health;
e. Not coerce or offer inducements to current or former patients to give testimonials, and
f. Not make inaccurate, unfair or disparaging comparisons between their services and those provided by other practitioners or health institutions.

6.8. DISABILITY

The Persons with Disabilities Act (No. 4 of 2025) states that disability “includes any physical, sensory, mental, psychological or other impairment, condition or illness that has or is perceived to have a substantial or long-term effect on an individual's ability to carry out ordinary day to day activities”.

Practitioners who are involved in the assessment and/or certification of disability should be aware of:

a. Advancements in the categorisation of different types of disability;
b. The regulations governing assessment and certification of disability, such as the *Disability Medical Assessment and Categorisation Guidelines 2022* published by the Ministry of Health;
c. The requirements and implications of such certification, and
d. The practitioner’s role in such certification.

Further, Practitioners should be aware of available support services for persons with disability and be involved in disability mainstreaming programmes in their organisations.

6.9. MENTAL HEALTH

Mental health is a key determinant to the overall health and socio-economic development. Mental illnesses are largely due to interplay and pathways of multiple factors including; biological, psychological, social and environmental. It is the responsibility of the practitioner, other health professionals in the team, the management to create an enabling environment for joy at work.

The Mental Health Act (Cap. 248) enshrines the right to mental healthcare as a constitutional imperative, emphasising dignity, autonomy and community-based interventions. Section 3 provides the rights of persons with mental illness, including the right to:

i. fully participate in the affairs of the community in any position suitable and based on the person's interests and capabilities;
ii. access medical, social and legal services for the enhancement of the protection of the rights of the person under the Constitution;
iii. protection from physical and mental abuse and any form of discrimination and to be free from exploitation;
iv. take part in activities that promote the person's social, physical, mental and emotional well-being, and
v. receive reasonable care, assistance and protection from their family and the State.

The Act further expounds on the rights of persons with mental illness to:

a. the highest attainable standard of mental health services;
b. informed consent to treatment;
c. participate in treatment planning;
d. access to medical insurance for mental health services;
e. protection of persons with mental illness from physical, economic, social, sexual and other forms of exploitation;
f. exercise all civil, political, economic, social and cultural rights;
g. access to information, including information about their health status;
h. confidentiality;
i. appoint a supporter and decisions that the supporter can make, and
j. legal capacity of a person with mental illness.

Section 14 of the Mental Health Act provides for involuntary admission of persons with mental illness:

- when, because of the mental illness, there is a serious likelihood of immediate or imminent harm to the person or to other persons, or
- in the case of a person whose mental illness is severe or whose judgement is impaired, failure to admit such a person may lead to serious deterioration in their condition or hinder the provision of appropriate treatment.

Further, sections 15A and 16 of the Act provide for emergency admission of persons with mental illness, including those in police or administrative custody. A person admitted under these provisions shall only be detained for the period necessary to stabilise and provide mental healthcare services to them.

Practitioners are required to:

a. Uphold the Mental Health Act's guiding principles, including the promotion of the highest attainable standard of mental health, protection from discrimination, and transparency in service delivery;
b. Take cognisance of emerging, pervasive and prevalent issues of mental health and wellbeing;
c. Keep abreast with diagnostic and management practices on mental health;
d. Advocate for the patients and their needs, and highlight both: the impact of social inequalities on mental health and the resulting inequities of mental illness;
e. Ensure that they safeguard their own mental health and wellbeing and when need be, seek relevant psychosocial support, treatment and care;
f. Link patients with mental illness to appropriate multidisciplinary services, including psychosocial support, and
g. Keep abreast with the Laws, regulations and policies governing mental healthcare, including substance use and suicide.

6.10. GENDER BASED VIOLENCE

Gender based violence (GBV) is defined as harmful acts directed at an individual based on their gender, usually stemming from gender inequality and power imbalances and inflicted in public or in private. This includes sexual, physical, mental and economic harm; threats of violence; coercion; manipulation, and other harmful acts. The harmful acts may be perpetrated by persons known to the victim or by strangers.

Types of GBV include but are not limited to:

- **Physical violence** i.e. Any act that causes physical harm, such as beating, strangling, pushing, use of weapons, confinement/ restriction of free movement, or killing.
- **Sexual violence** i.e. Any sexual act, attempt to obtain a sexual act, or other act directed against a person's sexuality using coercion or without consent. This includes rape (including spousal and corrective rape), sexual assault, sexual harassment, and forced prostitution.
- **Psychological/ Emotional violence** i.e. Abusive behaviours such as coercion, threats, intimidation, humiliation, name-calling, stalking, and isolating a person from friends and family.

- **Economic violence** i.e. Acts that cause economic harm, such as restricting access to financial resources, education or the labour market, or damaging property.
- **Socio-economic violence** i.e. Acts that exclude a person from participating in society, such as denying access to health services, education, work, and civil or political rights.
- **Online/ Digital violence** i.e. Harmful behaviours in the online space, such as cyberbullying, cyberstalking, non-consensual sharing of intimate images (image-based abuse), and online harassment.
- **Harmful practices** i.e. Traditional or cultural practices that violate human rights, including female genital mutilation (FGM), child marriage, virginity testing, forced marriage, forced male circumcision, and so-called "honour killings".
- **Human trafficking** i.e. The illegal trade of people for exploitation, often involving physical and sexual abuse, blackmail, and control tactics.

In the course of their duties, Practitioners and health institutions may encounter survivors and perpetrators of GBV. Practitioners should:

a. Be aware of the different forms of GBV;
b. Routinely elicit signs and symptoms of GBV in patients;
c. Undertake and document the required assessments including appropriate examinations for survivors and suspects of GBV;
d. Observe the legal requirements for sample collection, chain of custody, and documentation for survivors and suspects of GBV;
e. Undertake the mandatory reporting procedures for GBV;
f. Participate in the management and rehabilitation of survivors of GBV;
g. Be aware of available support services and structures for survivors of GBV within their organisations or jurisdiction, and refer them appropriately;
h. Act as expert witnesses in cases of GBV, and
i. Be involved in GBV prevention programmes.

Further, Practitioners must never be perpetrators or abettors of gender-based violence.

6.11. PROTECTING CHILDREN

Children are vulnerable and require protection from abuse, neglect or exploitation as provided for by the Children Act (Cap. 141). The Act places the responsibility of safeguarding the rights and best interests of a child on the State, including the right to:

- life, survival, wellbeing, protection and development;
- a name and nationality;
- have the best interests of the child as the primary consideration;
- not be discriminated against on the grounds of age, origin, sex, religion, creed, custom, language, opinion, conscience, colour, birth, health status, pregnancy, social, political, economic or other status, race, disability, tribe, residence or local connection or any other status;
- parental care and protection;
- social security;
- basic education;
- leisure, recreation and play;
- religion and religious education;
- the highest attainable standard of healthcare services;
- inheritance;
- protection form child labour, domestic servitude, economic exploitation or any work or employment which is hazardous, interferes with the child's education or is likely to be harmful to the child's health or physical, mental, moral or social development;
- protection from armed conflicts, including hostilities, social strife or recruitment in armed conflict;
- protection from any form of abuse or neglect, including physical, sexual or psychological harm;
- protection from harmful practices including female genital mutilation, forced male circumcision, child marriage, virginity testing, girl-child beading, and except with the advice of a multidisciplinary team, organ change or removal in intersex children;
- protection from drugs and substance abuse;
- freedom from torture and cruel, inhuman or degrading treatment or punishment;
- unlawful detention;
- privacy, and
- assemble, demonstrate, petition and participate in public life.

Practitioners should consider the rights, needs and wellbeing of children in their care. Decisions made about children should always be made in the best interests of the child. In the event that the wishes, actions or inactions of a parent or guardian are not in line with the best interest of a child or amount to failure to provide necessary healthcare to a child in need, the practitioner shall:

a. admit the child to separate him/her from the parents/ legal guardian;
b. within the shortest time possible report this event to the officers in charge of the health institution and the authorised officers who will assume responsibility for the child, and
c. obtain informed consent for tests, treatment or procedures from a senior practitioner who is not directly involved in the management of the child.

Where practicable and there is no immediate risk to life of the child, such a case should be discussed and the management plan formulated by a multidisciplinary team.

Further, Practitioners have an obligation to report any finding of child abuse or an offence committed against a child to the authorised officers within 48 hours of such finding or as otherwise prescribed by the Children Act.

6.12. PROTECTING VULNERABLE ADULTS

A vulnerable adult is a person aged 18 years or older who is dependent on others to care for them or meet their daily needs, and/or who may be unable to protect him/herself from abuse, harm, neglect or exploitation. This includes but is not limited to:

- an elderly person, especially if they are frail (i.e. having a combination of physical, cognitive, social or resource deficits that render them weak);
- a person with a severe physical illness;
- a person with disability, especially where they are significantly dependent on others to look after themselves;
- a person with mental illness, cognitive deficit, dementia, personality disorder or learning disability;
- a person who misuses substances or alcohol to the extent that it affects their ability to look after themselves;
- a homeless person;
- a person living with a person who abuses substances or alcohol;
- an unpaid carer;

- a victim of slavery, domestic violence, sexual exploitation or human trafficking, and
- refugees and migrants.

When attending to patients, Practitioners should:

a. Identify vulnerable adults;
b. Safeguard the best interests of vulnerable adults, including taking reasonable measures to ensure that their wishes regarding what care they wish or do not wish to receive are heard and respected;
c. Recognise, treat and document signs of neglect, abuse, or exploitation in patients and clients;
d. Where possible, withdraw the vulnerable from harm or prevent access to the abuser;
e. Protect vulnerable persons from coercion and exploitation in healthcare services, e.g. in research, blood donation, gamete donation, surrogacy, cell/tissue/organ trafficking, and other circumstances;
f. Report such cases to the relevant authorities such as the Police and social services, and provide expert witness in the investigations of such incidents;
g. Be aware of the available support services and structures, and link vulnerable adults to these services, and
h. Participate in policy making and development of structures for protection of vulnerable adults.

7. GUIDELINES ON EMERGING ISSUES IN HEALTHCARE

This chapter provides guidelines for best practice on some key emerging issues in healthcare. Advances in healthcare are dynamic and ever evolving and thus these guidelines must be applied with necessary modifications within the confines of the Law.

7.1. BLOOD TRANSFUSION

Blood transfusion is a procedure in which whole blood or blood products are introduced into a patient's bloodstream. As with other treatments:

a. Blood transfusion should be prescribed and administered to a patient only if it will be of benefit to the patient, and
b. Informed consent for blood transfusion should be sought from the recipients and documented appropriately.

In giving consent for blood transfusion, patients (or their parent/ guardian/ medical proxy) should be adequately informed of the attendant risks and complications of the transfusion, and the consequences of their refusal, including the refusal by the Practitioner to institute further management on the patient (e.g. a surgeon may refuse to perform a surgery on patient who has refused a blood transfusion).

Practitioners should be aware of cultural and religious practices that may influence a patient’s (or their parent/ guardian/ medical proxy) decision to consent to or decline the administration of blood and blood products.

a. Where applicable, reasonable accommodations should be made for such patients;
b. Where available, alternatives can be used instead of blood, and
c. Where possible, clinical strategies that pre-empt blood transfusion instituted.

Health authorities and institutions have a responsibility to ensure management and oversight of blood and blood products. They should institute strict quality management systems to assure the safety of blood and blood products. Further, they management of blood and blood products should institute ethical consideration for both donors and recipients. The health institutions should uphold the principle of voluntary nonremunerated donation, while care should be taken to ensure that blood and blood products are not provided at a profit.

The Health Act (Cap. 241) at Section 85 established the Kenya National Blood Transfusion Service, which is mandated to develop a comprehensive and coordinated national blood service based on voluntary non-remunerated blood donations so as to guarantee availability of adequate and safe blood.

7.2. CELL/TISSUE/ORGAN DONATION AND TRANSPLANTATION

Organ transplantation is a medical procedure in which cells, tissues or organs are removed from one body (the donor) and placed in the body of a recipient to replace damaged or missing cells/tissues/organs. The donor and recipient may be at the same location, or organs may be transported from a donor site to another location.

Practitioners should adhere to local regulations governing cell/ organ/ tissue donation and transplantation, keeping in mind that the need to uphold patient's rights applies to both the donor and the recipients, even in death. The Health Act (Cap. 241) at Part XI stipulates the requirements for transplantation of human cells, tissues and organs in Kenya. In the absence of local guidelines, Practitioners are required to abide with internationally accepted guidelines, which include the *WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation*; *The Declaration of Istanbul on Organ Trafficking and Transplant Tourism*; the *WMA Statement on Organ and tissue donation*, and the *Organ Procurement and Transplantation Network Policies*.

Globally, the supply of organs has always been inadequate to meet the clinical need. This has led to the rise of transplant tourism, organ trafficking, and related criminal activities. *The Declaration of Istanbul on Organ Trafficking and Transplant Tourism*, first published in 2008 and revised in 2018, defines **organ trafficking** as consisting of any of the following activities:

a. removing organs from living or deceased donors without valid consent or authorisation, or in exchange for financial gain or comparable advantage to the donor and/or a third person;
b. any transportation, manipulation, transplantation or other use of such organs;
c. offering any undue advantage to, or requesting the same by, a healthcare professional, public official, or employee of a private sector entity to facilitate or perform such removal or use;

d. soliciting or recruiting donors or recipients, where carried out for financial gain or comparable advantage, and/or
e. attempting to commit, or aiding or abetting the commission of, any of these acts.

The *Declaration* further defines:

- **Trafficking in persons for the purpose of organ removal** as "the recruitment, transportation, transfer, harbouring, or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability, or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of the removal of organs".
- **Travel for transplantation** as the movement of persons across jurisdictional borders for transplantation purposes. Travel for transplantation becomes **Transplant tourism**, and thus unethical, if:
    i. it involves trafficking in persons for the purpose of organ removal or trafficking in human organs, or
    ii. the resources (organs, professionals, and transplant centres) devoted to providing transplants to non-resident patients undermine the country's ability to provide transplant services for its own population.

7.3. COSMETIC INTERVENTIONS

Cosmetic interventions refer to any intervention, procedure or treatment carried out with the primary objective of changing an aspect of a patient's physical appearance. This includes surgical and non-surgical procedures, both invasive and non-invasive.

Practitioners offering these cosmetic services shall:

a. Practice within their defined scope to provide the services;
b. Ensure that the products used are safe prior to performing any cosmetic intervention;
c. Ensure that the procedures are undertaken in a health facility where emergency services and appropriate referral mechanisms are available;
d. Work with each individual patient to make sure their expectations about the outcomes that can be achieved for them are realistic;

e. Consider the psychological needs of their patients prior to each cosmetic intervention;
f. Provide patients with all the information they need to make an informed decision, including risks, investigational techniques, post procedure care, long term effects, etc. prior to any cosmetic intervention;
g. Follow current guidelines or protocols for the provision of safe and effective cosmetic interventions;
h. Keep updated with the current treatment modalities, and
i. Ensure that they practice within the confines of the Law.

7.4. BEGINNING-OF-LIFE ISSUES

The Constitution of Kenya, 2010 states that every person has the right to life and that the life of a person begins at conception.

7.4.1. ASSISTED REPRODUCTION

Assisted reproduction is the use of medical techniques to bring about conception, usually offered to manage fertility issues, to prevent transmission of infectious and genetic conditions, or to assist people circumvent the fertility limitations imposed by illness and/or their management.

Assisted reproductive technology refers to all treatments or procedures involving the manipulation of sperm, ova or embryos *in vitro* with the goal of producing a pregnancy. It may involve multiple parties and includes procedures like Gamete donation and retrieval; Intracytoplasmic sperm injection (ICSI); In vitro fertilisation (IVF); Gamete intrafallopian tube transfer (GIFT); Intrauterine insemination (IUI); Embryo transfer; Pre-implantation genetic screening and diagnosis, and Procedures used for gamete or embryo processing, storage and transportation.

Currently, there is no legislation that comprehensively addresses the delivery of assisted reproductive services in Kenya. There are fragmented provisions in the Constitution of Kenya 2010, the Health Act (Cap. 241), the Children Act (Cap. 141), and the Medical Practitioners and Dentists Act (Cap. 253). The Assisted Reproductive Technology Bill 2022 seeks to fill this void by providing a unified legal framework for the provision of assisted reproductive technology services; to prohibit certain practices in connection with assisted reproductive technology; to regulate surrogacy arrangements; to protect the rights of parents, surrogate mothers, donors and children born through assisted reproductive technology, and to establish an institutional framework for the licensing and oversight of assisted reproductive technology facilities. The Bill sets out the rights and obligations of all parties involved in the use of assisted reproductive services, including:

i. the right to:
    - access assisted reproductive services by everyone including intersex persons;
    - information about assisted reproduction and assisted reproductive services;
    - confidentiality, and
    - maternity and paternity leave for surrogate mothers and intended parents;
ii. the rights of children born out of assisted reproductive services;
iii. informed consent;
iv. surrogacy arrangements, and
v. surrogacy agreements.

The Bill seeks to prohibit:

1) creating, keeping or using embryos except as provided for under the subsequent Act;
2) providing assisted reproductive services without valid licensure;
3) use of human reproductive material without written informed consent;
4) providing assisted reproductive services to a person without their written consent;
5) posthumous use of reproductive material without prior written consent;
6) obtaining gametes from children except for medical reasons with informed consent from their parent or guardian;
7) undertaking assisted reproduction for purposes other than human procreation;
8) undertaking assisted reproduction for experimental purposes aimed at modifying the human race;
9) placing non-human embryos or gametes in a woman;
10) keeping or using non-human embryos;
11) placing human embryos in animals;
12) any form of human cloning;
13) mixing human gametes with live animal gametes;
14) donating gametes or embryos more than ten times;

15) a surrogate mother entering into surrogacy agreements more than three times;
16) sex selection through assisted reproductive technology;
17) sale of human gametes, zygotes and embryos, and
18) commercial surrogacy and related practices.

Practitioners shall refer patients in need of assisted reproductive services to fertility centres that are accredited by the Council. Patients in need of assisted reproductive services shall, where practicable, be attended to by a multi-disciplinary team of specialists.

A practitioner who offers assisted reproductive services shall:

a. Provide patients with all of the information that they need to make an informed decision, including investigational techniques to be used (if any); risks, benefits, and limitations of treatment options and alternatives, for the patient and potential offspring; accurate, clinic-specific success rates; and costs;
b. Provide patients with psychological assessment, support and counselling, or a referral to such services;
c. Value the well-being of the patient and potential offspring as paramount;
d. Keep accurate and up to date records;
e. Ensure that all advertising for services and promotional materials is accurate and not misleading;
f. Not discriminate against patients;
g. Keep updated with the current treatment modalities;
h. Establish quality management systems to ensure the safety of patients, gametes and embryos, and quality of the services that they provide;
i. Participate in the development of peer-established guidelines and self-regulation;
j. Undertake research in line with the prevailing legal requirements, and
k. Ensure that they practice within the confines of the Law.

7.4.1.1. Gamete donation

Gamete donation is the process through which an individual gives their sperm or ova for use by another person to assist them in achieving a pregnancy. Practitioners who participate in gamete retrieval and storage shall:

a. Inform prospective gamete donors:

    - i. about the clinical risks of gamete donation;
    - ii. about the need for full medical disclosure and that they will be tested for infectious disease agents and genetic disorders, and informed of the findings;
    - iii. under what circumstances and with whom personal information, including identifying information, will be shared for clinical purposes;
    - iv. how donated gametes will be stored and policies and procedures governing the use of stored gametes, and
    - v. whether and how the donor will be compensated;
- b. Exclude prospective donors for whom testing reveals the presence of infectious disease agents and/or genetic disorders, and refer them for management;
- c. Obtain and document the prospective donor's informed consent for gamete retrieval;
- d. Counsel gamete donors on the need to involve their partner (if married) in the decision making;
- e. Discuss, document, and respect the prospective donor's preferences for how gametes may be used, including whether they may be donated for research purposes;
- f. Discuss, document, and respect the prospective donor's preferences regarding release of identifying information to any child (or children) resulting from use of the donated gametes;
- g. Adhere to good clinical practices, including ensuring that identifying information is maintained indefinitely so that:
    - i. donors can be notified in the event a child born through use of his/her gametes subsequently tests positive for infectious disease or genetic disorder that may have been transmitted by the donor, and
    - ii. the number of pregnancies resulting from a single gamete donor is limited, and
- h. Ensure that they practice within the confines of the Law.

7.4.1.2. Therapeutic Donor Insemination

Therapeutic donor insemination involves the injection of sperm from a woman's partner or third-party donor into her uterus to enable her to conceive.

A Practitioner who provides therapeutic donor insemination services shall:

- a. Provide therapeutic donor insemination in a non-discriminatory manner;

b. Not withhold or refuse services on the basis of nonclinical considerations, such as a patient’s marital status;
c. Obtain informed consent for therapeutic donor insemination, after informing the patient (and partner, if applicable) about:
    i. the risks, benefits, likelihood of success, and costs of the intervention;
    ii. the need to screen donated semen for infectious disease agents and genetic disorders when an individual proposes to donate sperm specifically for the patient's use in therapeutic donor insemination, and
    iii. the need to address in advance what will be done with frozen sperm (if any) from a known donor in the event that the donor dies;
d. When sperm is collected specifically for use by an identified patient, obtain informed consent from the prospective donor, after informing the individual:
    i. about the need to test donated semen for infectious disease agents and genetic disorders;
    ii. whether and how the donor will be informed in the event the semen tests positive for infectious disease or genetic disorder, and
    iii. in the event of such a condition, advise on available treatment options and refer accordingly;
e. Counsel patients who choose to be inseminated with sperm from an anonymous donor to involve their partner (if any) in the decision, and
f. Conduct all the necessary tests to screen the donated samples for infectious disease agents and genetic disorders, including sex-linked inheritable disorders.

7.4.1.3. Third Party Reproduction

Third party reproduction is a form of assisted reproduction in which a third party (such as a designated gamete donor or surrogate) is introduced into the process of reproduction, with the aim of enabling an individual or couple to conceive. The introduction of a third party poses ethical and legal challenges, especially in terms of identity, family structure, and parental rights and responsibilities.

Surrogacy is an arrangement in which a woman (surrogate or gestational carrier) carries a pregnancy for another person or couple (intended parents) who are unable to carry the pregnancy themselves, often due to infertility or medical reasons.

Practitioners who care for patients in the context of third-party reproduction shall:

a. Establish a patient-physician relationship with the surrogate to avoid situations of dual loyalty or conflict of interest, and to safeguard the best interests of the surrogate;
b. Ensure that the patient undergoes appropriate medical screening and psychological assessment;
c. Inform the patient about the risks of third-party reproduction for that individual(s), possible psychological harms to the individual(s), the resulting child, and other relationships;
d. Satisfy themselves that the patient's decision to participate in third-party reproduction is free of undue influence for commercial benefit or coercion before agreeing to provide assisted reproductive services;
e. Ensure that the surrogate is fully aware that their role will expire when the baby is born, at which point they will relinquish all parenting rights and responsibilities to the intended parents;
f. Establish a cordial relationship with the gamete donor(s) and intended rearing parent(s);
g. Ensure that the parties involved have entered into a legally binding agreement in advance on the terms of the agreement, including identifying possible contingencies and deciding how they will be handled, and
h. Ensure that they practice within the confines of the Law.

Collectively, the profession should advocate for public policy that will help ensure that the practice of third-party reproduction does not exploit disadvantaged women or commodify human gametes or children.

7.4.2. TERMINATION OF PREGNANCY

The Constitution of Kenya and the Laws of Kenya do not permit termination of a viable pregnancy on demand. Article 26 (4) of the Constitution of Kenya provides that "Abortion is not permitted unless, in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the mother is in danger, or if permitted by any other written law."

In applying this article, Practitioners and health institutions shall:

a. Offer nonjudgmental and nondirective counselling. In counselling, the practitioner shall consider health broadly also in line with the right to health,

consumer rights and right to information as provided in the Constitution of Kenya 2010;
b. Provide appropriate services in a safe manner including addressing any complications that arise and referral if necessary;
c. Where appropriate services are unavailable for whatever reason, the practitioner or health facility shall refer patients appropriately, and
d. Maintain a complete and accurate record of each case.

7.4.3. SEX SELECTION

Sex selection is the attempt to control the sex of the offspring so as to achieve a desired sex. This is achieved by practices such as termination of pregnancy of undesired sex, or preimplantation selection of embryos of desired sex. It is a harmful practice which reinforces gender-based discrimination.

It is unethical for Practitioners to engage in, support or encourage the practice of sex selection.

7.5. GENETICS

Technological advancements have led to the realisation of the role of individuals' genetic make-up in disease progression. These advancements have and will continue to revolutionise the study, prediction, screening, diagnosis, treatment and prevention of disease.

7.5.1. GENETIC TESTING AND COUNSELLING

Genetic testing is most appropriate when the results of testing will have a meaningful impact on the patient's care. Practitioners should not encourage testing unless there is effective therapy available to prevent or ameliorate the condition tested for. Whether a genetic test is performed to help diagnose an existing health condition, predict future health risks or provide information for managing a disease, it is important that the patient receives appropriate counselling.

Practitioners who order genetic tests (individually or as part of a multi-test panel or large-scale sequencing) or who offer clinical genetic services should:

a. Have appropriate knowledge and expertise to counsel patients about heritable conditions, risks for disease, and implications for health management, and to interpret findings of individual genetic tests or collaborate with other healthcare professionals who can provide these services, such as licensed genetic counsellors;

b. Adhere to standards of nondirective counselling and avoid imposing their personal moral values or judgment on the patient;
c. Discuss with the patient:
    i. what can and cannot be learned from the proposed genetic test(s) and reasons for and against testing, including the possibility of incidental findings. Practitioners should ascertain whether the patient wishes to be informed about findings unrelated to the goal of testing;
    ii. medical and psychological implications for the individual's biological relatives, and where appropriate communication with potentially affected parties; and
    iii. that the practitioner or collaborator will be available to assist in communicating with relatives;
d. Obtain and document the individual's informed consent for the specific test or tests to be performed;
e. Obtain and document the individual's consent to disclosure of the results of the genetic test to other people who may be affected by the outcome, e.g. siblings or offspring in the case of an inheritable condition, and
f. Ensure that appropriate measures are taken to protect the confidentiality of the patient's and their biological relatives' genetic information.

7.5.2. GENETIC TESTING FOR PROOF OF PARENTAGE

Genetic testing plays a vital role in establishing parentage and resolving disputes related to parental responsibility, access, custody and inheritance rights. Section 53(1)(e) of the Constitution of Kenya 2010 states that "Every child has the right to parental care and protection, which includes equal responsibility of the mother and father to provide for the child, whether they are married to each other or not. Section 7(1) of the Children Act (Cap. 141) states that "Every child shall have a right to a name and nationality and, as far as possible, the right to know and be cared for by their parents". The Evidence Act (Cap. 80) provides for the admissibility of genetic test results as evidence in court proceedings, provided that such tests are conducted by accredited laboratories and under legally acceptable conditions to ensure the reliability and admissibility of the results for use by the court in making decisions.

Practitioners and health institutions that provide genetic testing services for proof of parentage shall:

a. Ensure that the parties being tested are provided with non-judgemental and non-directive counselling prior to making any decisions about the test. In this counselling, the intended use of the results and the implications of the outcome of the test (e.g. decisions about parental responsibility and inheritance rights) should be discussed and the best interests of the child upheld;
b. Obtain and document informed consent from all parties being tested. In this case, consent should be sought from both parents (unless one is dead), and the child or offspring. Consent for children may be given by either parent (as registered on the birth certificate) or legal guardian;
c. Where a test is being carried out pursuant to a court order, ensure that the court order has been verified by an officer of the court and a copy retained in the medical record;
d. Ensure that the chain of custody is maintained so as to assure of integrity of the samples and results;
e. Ensure that appropriate measures are taken to protect the confidentiality of all parties involved;
f. Maintain complete and accurate records of each case, and
g. Limit disclosure of results to the parties tested and to the court as ordered.

7.5.3. ACCESS TO GENETIC INFORMATION BY THIRD PARTIES

Patients who undergo genetic testing have a right to have their information kept in confidence.

Practitioners who provide, and interpret genetic tests, or who maintain patient records that include the findings of genetic tests, have professional ethical obligations to:

a. Maintain the confidentiality of the patient’s health information, including genetic information;
b. Release a patient’s genetic information to third parties only with documented patient’s informed consent or in compliance with court orders, and
c. Decline to participate in genetic testing at the request of third parties (for example, for purposes of establishing healthcare or other benefits or coverage for the individual) except when at the patient’s request and with their informed consent.

7.5.4. FORENSIC GENETICS

Practitioners from whom genetic information is sought for purposes of criminal justice:

a. May ethically carry out DNA analysis on stored tissue samples or release genetic information without the consent of a living or deceased patient (through their authorised representative) in response to a warrant or court order;
b. Shall release only the minimum information necessary for the specific purpose;
c. Shall not be required to provide genetic information when:
    i. a suspect whose location is known refuses to provide a tissue sample for genetic analysis, or
    ii. a tissue sample for the suspect can be obtained from other sources (such as the body of a deceased suspect), and
d. Should decline to participate in the use of information from a genetic database created exclusively for criminal justice for any purpose other than identification.

7.6. GENDER AFFIRMING TREATMENTS

An intersex person is one “who is conceived or born with a biological sex characteristic that cannot be exclusively categorised in the common binary of female or male due to their inherent and mixed anatomical, hormonal, gonadal or chromosomal patterns, which could be apparent prior to, at birth, in childhood, puberty or adulthood.”

Decisions to institute gender affirming treatments to intersex persons should be taken in the best interests of the patient, keeping in mind their inalienable rights to be treated with respect and dignity, and to be protected from cruel and inhumane treatment.

Gender affirming treatments may be offered to intersex persons upon confirmation by a multidisciplinary team of medical specialists that the intersex person has been found to have anatomical, hormonal, gonadal or chromosomal patterns that lean towards one gender more than the other or has developed secondary sexual characteristics that are typical of one gender rather than the other.

The practitioners should provide the parents or guardians with the necessary guidance in a timely manner, keeping in mind the best interest of the minor.

7.7. END-OF-LIFE ISSUES

Practitioners have a vital role in assisting the community to deal with the reality of death and its consequences.

In caring for patients towards the end of their life, Practitioners should:

a. Take steps to manage a patient's symptoms and concerns in a manner consistent with the patient's values and understanding that practitioners do not have a duty to try to prolong life at all costs;
b. Provide or arrange for appropriate palliative care, including a multi-disciplinary approach whenever possible;
c. Encourage advance care planning and facilitate the appropriate documentation, such as an advance care directive;
d. Accept that patients have the right to refuse medical treatment or to request the withdrawal of treatment already started;
e. Respect different religious and cultural practices related to death and dying;
f. Strive to communicate effectively with patients and their families so that they are able to understand the outcomes that can and cannot be achieved;
g. Take reasonable steps to ensure that support is provided to patients and their families, even when it is not possible to deliver the outcome that they seek, and
h. Ensure that they practice within the confines of the Law.

Health institutions should establish clinical ethical committees to offer support to patients, families, and healthcare workers when addressing ethical dilemmas of patient care, including end-of-life issues.

7.7.1. EUTHANASIA AND PHYSICIAN-ASSISTED SUICIDE

Euthanasia is the practice of administering a lethal substance to another person with the intention of ending their life, so as to eliminate the patient's intolerable and incurable pain and suffering. **Physician-assisted suicide** occurs when a practitioner facilitates a patient's death by providing the necessary means, information, prescription and/or drugs to enable the patient to perform the life-ending act.

Both Euthanasia and Physician-assisted suicide (described as aiding suicide in Section 225 of the Penal Code (Cap. 63)) are illegal.

7.8. PSEUDOSCIENCE AND PSEUDOTHERAPIES

Pseudoscience refers to the set of statements, assumptions, methods, beliefs or practices that, without following a valid and recognised scientific method, are falsely presented as scientific or evidence based. On the other hand, **Pseudotherapies** are those practices that are intended for curing diseases, alleviating symptoms or improving health with procedures, techniques, products or substances which are not supported by available up-to-date scientific evidence, and which may have significant potential risks and harms. Practitioners must refrain from participating in and/or disseminating information that is not scientifically valid or evidence based.

The practice of medicine and dentistry must be based on the best available up-to-date scientifically proven evidence. To this end, Practitioners should:

a. Ensure that all new diagnostic, preventive and therapeutic methods they use, are those that are tested in accordance with scientific methods and ethical principles in order to assess their safety, efficiency, efficacy and scope of application. Where applicable, the health products and technologies should be duly registered and/or licensed by the relevant authorities;
b. Practice medicine and dentistry based on the application of critical scientific current knowledge, specialist skills, ethical behaviour and to maintain their skills on developments in their professional field;
c. Report any pseudoscience and pseudotherapy activities that put public health at risk to the competent authorities, and
d. Counter misinformation and disinformation by providing information that is accurate, scientifically proven and up to date.

7.9. SPORTS MEDICINE AND DOPING

Ethical codes of conduct in sports medicine should address emerging issues such as performance-enhancing substances, technology use, mental health, gender identity and inclusion, and financial or other conflicts of interest. By providing clear guidelines on these matters, ethical codes help promote the well-being of athletes and ensure fairness in the field of sports medicine.

The Anti-Doping Act (Cap. 245B) defines **doping** as the use of prohibited substances and methods in any sporting activity whether competitive or recreational in order to artificially enhance performance. Further, the Act defines the following:

- **Prohibited List** as the list developed by the World Anti-Doping Agency for purposes of identifying the prohibited substances and prohibited methods;
- **Prohibited method** as any method so described on the Prohibited List;
- **Prohibited substance** as any substance, or class of substances, so described on the Prohibited List, and
- **Therapeutic Use Exemption** as an exemption that allows an athlete with a medical condition to use a prohibited substance or prohibited method, but only if the conditions set out in Article 4.4. of the *World Anti-Doping Code* and the *International Standard for Therapeutic Use Exemptions* are met.

A Practitioner shall not:

a. prescribe or dispense prohibited substances or methods to an athlete with the intent of doping;
b. acquire, stock or be in unlawful possession of prohibited substances;
c. be found to be aiding or abetting the unlawful use of prohibited substances in sport, and
d. not hinder investigations into allegations of doping by the relevant national or international sporting authorities.

All Practitioners should familiarise themselves with the prevailing Anti-Doping Act, the *World Anti-Doping Code* and the *World Anti-Doping Agency (WADA) Prohibited List*.

7.10. USE OF THE INTERNET AND SOCIAL MEDIA

Practitioners need to maintain high professional and ethical standards when using the internet and social media. The professional standards expected of practitioners do not change when they are communicating through social media. While using social media, practitioners should:

a. Be aware that there are potential risks in the sharing of information via social media;
b. Be cognisant of moral and professional obligations and laws regarding privacy, confidentiality, defamation, hate speech and copyright;

c. When interacting with patients via social media, be cautious of acting in a manner that may lead to failure in maintaining a strictly professional relationship with patients;
d. Politely establish and maintain professional boundaries if they receive inappropriate messages from a patient via social media;
e. Not provide treatment or prescriptions over the internet or social media to individuals with whom they do not have a practitioner-patient relationship. Where treatment is provided via social media, it must be documented in appropriate records as soon as possible;
f. Only share health advice that is evidence-based and scientifically sound;
g. Avoid internet and social media activities that include but are not limited to:
    i. Inappropriately sharing of identifiable person information, photographs, images, or videos taken during performance of procedures, treatments or other forms of care;
    ii. Making unsubstantiated negative comments about individuals or organisations;
    iii. Posting opinions that cast aspersions on the skills or professional reputation of other practitioners, and
    iv. Advertising, endorsing or encouraging the use of any health institution, medicine or health-related product with the aim of benefitting financially;
h. Ensure that they have explicit written consent to generate and use patient information, images or videos on the internet or social media keeping in mind to preserve patient dignity;
i. Familiarise themselves with the relevant internet and social media guidelines set by the institutions they practice in, and
j. Comply with the relevant legislation including the Health Act (Cap. 241), the Medical Practitioners and Dentists (Practitioners and Health Facilities) (Advertising) Rules, the Digital Health Act (No. 15 of 2023), the Data Protection Act (Cap. 411C), the Consumer Protection Act (Cap. 501), and the Computer Misuse and Cybercrimes (Cap. 79C).

7.11. E-HEALTH, TELEMEDICINE AND TECHNOLOGY-BASED HEALTHCARE SERVICES

The scope of technology-based healthcare services is vast and involves the use of information and telecommunication infrastructure and devices in the delivery of healthcare services over distance. Its extent includes but is not limited to telemedicine, e-health, m-health, robotic medicine, self-monitoring wearable devices, and artificial intelligence. The use of technology allows practitioners to manage patients remotely, and therefore has the potential to improve access to healthcare services in rural and resource limited settings.

Practitioners and health institutions providing technology-based healthcare services must:

a. Ensure compliance with the prevailing legislative and regulatory framework, including the Health Act (Cap. 241), Digital Health Act (No. 15 of 2023), the Medical Practitioners and Dentists Act (Cap. 253), the Data Privacy Act (Cap. 411C), the Civil Aviation (Unmanned Aircraft Systems) Regulations, 2020, and *The Kenya National Patients' Charter 2013*;
b. Only provide services that are within their defined scope of practice;
c. Keep in mind that artificial intelligence is a tool to support delivery of services, and not a replacement for human decision-making and oversight;
d. Keep in mind that they bear full responsibility for the treatment, decisions and other recommendations given to the patient, even when such clinical decisions made and care given through technology-based healthcare services is powered by artificial intelligence systems;
e. Ensure that they only use tools and systems that meet the highest standards of quality, data security and breach prevention;
f. Not prescribe to persons whose condition they do not know and/or have not ascertained;
g. Maintain accurate and complete records of all services provided;
h. Ensure that the records are kept securely, in a manner that protects the patient's confidentiality without hindering the patient's continued care;
i. Facilitate patient's access to their own medical records in an accessible and portable format, and
j. Not sign or permit their name, signature, registration or licence number to be used to indicate that they offered a service or issued a prescription that they did not.

8. THE PRACTITIONER AND THE REGULATOR

This chapter expounds on the Practitioner's relationship with KMPDC as the regulator of the training and practice of medicine, dentistry and community oral health in Kenya.

8.1. REGISTRATION AND LICENSING OF PRACTITIONERS

Medical, Dental and Oral Health Practitioners aspiring to practice or practicing in Kenya must comply with the statutory requirements for registration and licensing. Failure to obtain the necessary documentation constitutes an offence under Section 22 of the Medical Practitioners and Dentists Act. Detailed information on documentation can be accessed via the Council's website and from the Council's offices.

8.1.1. MINIMUM ENTRY REQUIREMENTS

The criteria for admission to the MBChB and BDS programmes are detailed in Rule 5, while the criteria for admission into Diploma COH and BSc.OH are detailed in Rule 6 of The Medical Practitioners and Dentists (Training, Assessment and Registration) Rules, 2022.

The minimum entry requirements for admission into **Bachelor of Medicine and Bachelor of Surgery (MBChB)** or **Bachelor of Dental Surgery (BDS)** programmes in Kenya are as follows:

a. For **Kenya Certificate of Secondary Education (KCSE)** holders:
   Minimum grade required for university admission is **C+ (plus)** and in addition, a minimum of **B plain** in each of the following cluster subjects:
   i. Biology
   ii. Chemistry
   iii. Physics or Mathematics, and
   iv. English or Kiswahili.

b. For **Kenya Advanced Certificate of Education (KACE)** holders:
   i. a minimum of two **principal passes** in Biology and Chemistry, and
   ii. a **subsidiary pass** in either Mathematics or Physics.

c. For **International General Certificate of Secondary Education (IGCSE)** holders:
   i. at Advanced (A) Level, an equivalent of C or above in the cluster subjects:
      (1) Biology as a principal subject;
      (2) Chemistry as principal subject, and
      (3) Physics or Mathematics as a subsidiary subject.
   AND
   ii. at Ordinary (O) Level, a minimum of C in English or Kiswahili.
d. For **International Baccalaureate (IB)** diploma holders:
   Minimum of **grade 5** or above in the following cluster subjects:
   i. Biology at high level;
   ii. Chemistry at high level;
   iii. Physics or Mathematics at standard level, and
   iv. English or Kiswahili at standard level.
e. For holders of a **Diploma in the medical sciences**:
   i. a minimum "O" level Division II pass in KACE,
      OR
      KCSE minimum mean grade of C+ (plus),
      AND
      minimum of Credit or C+ pass in the cluster subjects of Biology, Chemistry, Physics or Mathematics, and English or Kiswahili;
   AND
   ii. a three-year diploma in the medical sciences with a final grade of at least a **Credit** from a medical training institution recognised by the Council.
f. For holders of any **degree in Biological Sciences or equivalent** qualifications from a recognised university: subject to passing Graduate Record Examination (GRE).

The minimum entry requirements for admission into **Diploma in Community Oral Health** (Dip. COH) programme in Kenya are as follows:

a. For **KCSE** holders:
   The minimum college admission requirement, and in addition a minimum of **C plain** in each of the following cluster subjects:
   i. Biology;
   ii. Chemistry;
   iii. Physics or Mathematics, and
   iv. English or Kiswahili.

b. For **International General Certificate of Secondary Education (IGCSE)** holders:
   - i. at Advanced (A) Level, an equivalent of D or above in the cluster subjects:
     - (1) Biology as a principal subject;
     - (2) Chemistry as principal subject, and
     - (3) Physics or Mathematics as a subsidiary subject.

   AND
   - ii. at Ordinary (O) Level, a minimum of C in English or Kiswahili.

The minimum entry requirements for admission into **Bachelor of Science in Oral Health** (BSc.OH) programme in Kenya are as follows:

a. For **KCSE** holders:

   The minimum university admission requirement of overall grade of **C+ (plus)** and above, and in addition a minimum of **C+ (plus)** in each of the following cluster subjects:
   - i. Biology;
   - ii. Chemistry;
   - iii. Physics or Mathematics, and
   - iv. English or Kiswahili.

b. For **International General Certificate of Secondary Education (IGCSE)** holders:
   - i. at Advanced (A) Level, an equivalent of C or above in the cluster subjects:
     - (1) Biology as a principal subject;
     - (2) Chemistry as principal subject, and
     - (3) Physics or Mathematics as a subsidiary subject.

   AND
   - ii. at Ordinary (O) Level, a minimum of C in English or Kiswahili.

c. For **International Baccalaureate (IB)** diploma holders:

   Minimum of **grade 5** or above in the following cluster subjects:
   - i. Biology at high level;
   - ii. Chemistry at high level;
   - iii. Physics or Mathematics at standard level, and
   - iv. English or Kiswahili at standard level.

Further details on the minimum entry requirements are available in The Medical Practitioners and Dentists (Training, Assessment and Registration) Rules, 2022, and on the KMPDC website.

NOTE

Candidates who do not meet these minimum entry requirements are not eligible for registration as Medical Practitioners, Dental Practitioners or Community Oral Health Officers in Kenya, despite holding valid MBChB, BDS, Dip.COH, BSc.OH or equivalent qualifications from recognised training institutions.

8.1.2. INTERNSHIP TRAINING

Internship is a prescribed period of employment during which a Medical, Dental or Community Oral Health graduate works under supervision to fulfil registration requirements. During this period, the graduates have an opportunity to consolidate their knowledge, skills and attitudes to enable them to become competent practitioners.

All Medical, Dental and Community Oral Health graduates are required to undergo internship training. All interns are required to apply for an Internship Licence from the Council, which is only valid for the internship period and permits them to practise under direct supervision at a specific health facility that is approved and accredited as an Internship Training Centre.

Further details on internship training can be found in The Medical Practitioners and Dentists (Training, Assessment and Registration) Rules, 2022 and the *National Guidelines and Logbooks for Internship Training* available on the KMPDC website. The list of accredited Internship Training Centres is also available on the KMPDC website.

8.1.3. REGISTRATION OF PRACTITIONERS

The Council is required to maintain an updated register of Medical Practitioners, Dental Practitioners and Community Oral Health Officers in the country.

A Kenyan citizen who holds a qualification obtained from a university or college within Kenya or the East African Community which is recognised by the Council as making him/her eligible for registration; who presents proof of completion of internship, and satisfies the Council that he/she is a person of good moral standing, may apply to the Council for Registration as a Medical, Dental or Oral Health Practitioner under Cap. 253. These include foreign-trained Kenyan citizens who undertake their internship training in Kenya.

Kenyan citizens who hold qualifications equivalent to MBChB, BDS, Dip.COH or BSc.OH from universities and colleges outside the East African Community region, and have undertaken the internship training in those countries, are required to sit and pass a Pre-Registration Examination (PRE) set by the Council, prior to registration as Medical, Dental or Oral Health Practitioners.

Further details on the requirements for registration are available in the Medical Practitioners and Dentists Act (Cap. 253), The Medical Practitioners and Dentists (Training, Assessment and Registration) Rules, 2022, and on the KMPDC website.

8.1.4. ANNUAL PRACTICE LICENCES

It is the responsibility of every practitioner registered under Cap. 253 to ensure that his/her practice is duly licensed for the practice year and field of specialty. The requirements for application for Annual Practice Licence are as follows:

a. Valid registration as a Medical Practitioner, Dental Practitioner or Community Oral Health Officer;
b. (where applicable) Duly recognised in their field of specialty or subspecialty as recognised by the Council;
c. Valid professional indemnity for the field of practice and the practice year (as stipulated in Section 15A of Cap. 253);
d. Having achieved a minimum of 50 CPD points in the preceding practice year;
e. Inform the Council of any changes in their contact information or places of practice, and
f. Pay the prescribed annual practice licence fee and obtain a receipt.

While the practice year runs from 1st January to 31st December every year, practitioners are required to apply for the practice licences at least 30 days before the start of the practice year, as stated in Section 14 (1) of Cap. 253. Section 14 (2) further stipulates that practitioners who fail to apply for renewal of licences before the start of the licence period shall be liable to pay a penalty for late application (which currently stands at 50% of the licence fee). Further, Section 14

(3) states that “The Council may refuse to renew, or suspend, withdraw or cancel any practising licence, if satisfied that the medical, dental or oral health practitioner is guilty of professional misconduct or is in breach of any provisions of this Act or any regulations made thereunder, within a period of twelve months immediately preceding the date of the application for renewal.”

At least once every year at a convenient time after 1st January but not later than 31st March, the Registrar of the Council is required to publish the list of registered and licensed medical practitioners, dental practitioners and community oral health officers in the Kenya Gazette and in the print and electronic media. In addition, the Council is required from time to time to share information on practitioners’ registration, licensure and practice status with regulatory authorities in other jurisdictions.

8.1.5. SPECIALIST AND SUBSPECIALIST RECOGNITION

The Council may recognise a medical or dental practitioner as a Specialist or Subspecialist in any of the prescribed recognised specialties and subspecialties. Specialist and Subspecialist Recognition is usually awarded to Medical or Dental Practitioners who have acquired post-graduate qualifications in various disciplines/ specialities that are listed in the Council’s *List of Recognised Specialities and Subspecialties* available from https://kmpdc.go.ke/specialities/.

Specialist Recognition is awarded to only those who have undergone postgraduate training equivalent to Master of Medicine or Dental Surgery at a recognised training institution for the minimum prescribed period and have worked for a minimum of two (2) years under the supervision of a recognised Specialist in the same discipline.

Subspecialist Recognition is awarded to only those who have undergone postgraduate training for the minimum prescribed period and have worked for a minimum of one (1) year under the supervision of a recognised Subspecialist in the same discipline.

Practitioners applying for Specialist/Subspecialist recognition should ensure that the speciality/subspecialty appears on the *List of Recognised Specialties and Subspecialties* and are required to submit the following:

a. duly filled and signed Council *Form VIA: Application for Recognition of Specialist/ Sub-Specialty* form;
b. recent coloured passport size photo;
c. copy of their current Practice Licence;
d. certified copies of postgraduate qualification/degree certificate and official transcripts – certificates and transcripts in languages other than English should be accompanied by translations verified by the Embassy;
e. evidence of successful completion of the prescribed rotation period at a recognised facility and under supervision i.e. two (2) years after completion of training programme for Specialist Recognition, and one (1) year after completion of training programme for Subspecialist Recognition, and
f. supportive recommendation letters from two (2) professional referees who are recognised specialists/ subspecialists in the speciality/ subspecialty applied for. Where the specialty/ subspecialty is new, at least one of the referees should come from the institution where the Practitioner trained.

8.2. PROFESSIONAL SELF-REGULATION

The regulation of medicine and dentistry plays an essential role in ensuring that the professional practice is in the best interests of the citizens and maintaining public confidence in the standards of care. Practitioners have an obligation to participate in the activities undertaken by the regulatory authorities in carrying out the mandate in their areas of expertise and to maintain strong professional oversight.

To this end, and in keeping with the goal of professional self-regulation, the Council may call upon any General, Specialist or Subspecialist Medical Practitioner, Dental Practitioner and Community Oral Health Officer of good standing with the necessary knowledge, skills and expertise to aid the Council in carrying out its mandate. These activities may include:

a. Review of curricula for undergraduate, specialist and subspecialist Medical, Dental and Community Oral Health training programmes, including collegiate training programmes;
b. Inspection and accreditation of schools, universities and colleges offering training programmes in Medicine, Dentistry and Community Oral Health;
c. Inspection and accreditation of teaching hospitals, internship training centres and collegiate/ fellowship training sites;

d. Conducting pre-internship and pre-registration examinations, and peer reviews;
e. Review of Continuous Professional Development guidelines and programmes;
f. Undertaking fitness-to-practise assessments of Medical, Dental and Oral Health Students/ Interns/ Practitioners, and support programmes;
g. Assisting the Council in conducting disciplinary and ethics matters, including but not limited to:
    i. Conducting inquiries into complaints submitted to the Council;
    ii. Regulating professional conduct;
    iii. Ensuring fitness to practice and operate;
    iv. Promoting mediation and arbitration between the parties;
    v. Inspecting health facilities and training institutions, and
    vi. Reviewing *The Code of Professional Conduct and Ethics*, Cap. 253 and the Rules thereunder;
h. Submitting any reports or expert opinion as may be required from time to time, and
i. Any other functions for which the Council finds that they are suitably qualified to perform.

Further, all Practitioners are encouraged to be active members of professional associations, which advocate for members and support self-regulation through setting standards, and providing CPD, peer-to-peer support supervision and networking opportunities.

8.3. SELF-REPORTING

Practitioners shall, where applicable and as soon as possible, inform the Council of:

a. Acquisition of additional qualifications;
b. Changes in contact information and places of practice;
c. Changes in jurisdiction of practice;
d. Changes in nature of practice (e.g. from clinical to non-clinical, due to retirement, etc);
e. When they have a condition (including illness or acquired disability status):
    i. that could, or whose treatment could, impair their judgement, performance and fitness to practice, and/or
    ii. for which they have been advised to modify their practice;

f. Restrictions placed on their practice by other regulatory bodies or in other jurisdictions, and
g. Any other information that is relevant to the Council.

8.4. DISCIPLINARY PROCEEDINGS

Disciplinary powers are conferred upon the Council by Section 20 of the Medical Practitioners and Dentists Act (Cap. 253) as read together with The Medical Practitioners and Dentists (Disciplinary Proceedings) (Procedure) Rules under the Act.

8.4.1. THE DISCIPLINARY AND ETHICS COMMITTEE (D&EC)

The Disciplinary and Ethics Committee (D&EC) of the Council replaced the Preliminary Inquiry Committee established in the previous version of Cap. 253.

The D&EC is established pursuant to Section 4A (1) (b) of Cap. 253, which provides that the mandate of the Committee shall include:

a) Conducting inquiries into complaints submitted to it;
b) Regulating professional conduct;
c) Ensuring fitness to practice and operate;
d) Promoting mediation and arbitration between the parties, and
e) At its own liberty, recording and adopting mediation agreements or compromise between parties, on the terms agreed.

As stated in Rule 3 (1) of the Medical Practitioners and Dentists (Inquiry and Disciplinary Proceedings) (Procedure) Rules, the D&EC is constituted by the Council and comprises of three members of the Council, one of whom is the Chairperson, and two other persons whose knowledge and skills are necessary for the proper determination of any matter before it. Thus, the D&EC has the power to co-opt members whose knowledge and skills are necessary for the determination of any matter before it. To this end and in keeping up with the goal of professional self-regulation, any General, Specialist or Subspecialist Medical, Dental and Oral Health Practitioners of good standing may be called upon from time to time to serve on the Committee in the deliberation of matters within their fields of expertise.

In conducting proceedings under Cap. 253 and the Rules thereunder, the D&EC has the powers to:

a. conduct inquiries into and hearings over complaints submitted to it at such times and places as the Council shall determine;
b. ensure that the necessary administrative and evidential arrangements have been met;
c. develop and regularly review the code of professional conduct for ethical and good practice for persons registered under the Act;
d. constitute as required sub-committees to inquire into and determine the fitness to practice and operate of persons registered under the Act;
e. administer oaths;
f. summon persons to attend and give evidence; and
g. order for the production of relevant documents.

As stated in Rules 12 and 23 of the Medical Practitioners and Dentists (Inquiry and Disciplinary Proceedings) (Procedure) Rules, *2022*, when the Respondent fails to respond to a notice of inquiry, or, without reasonable excuse, fails to appear either personally or by his/her representative at the time and place fixed in the notice of hearing served on him/her:

- the inquiry may proceed in his/her absence; and
- the Respondent commits an act of professional misconduct.

8.4.2. THE DISCIPLINARY AND ETHICS CASES

8.4.2.1. Overview of Medicolegal Cases

Broadly, a medicolegal case is defined as any "medical case with legal implications". This discussion is confined to acts or omissions by healthcare providers that deviate from the expected standard of care which a patient should receive, and that result in harm, injury or death.

Even in the best circumstances, practitioners and health institutions are bound to receive queries from patients, their relatives, other health professionals, employers, and/or regulatory bodies during the course of their practice. Most complaints arise from the care given (especially when the outcome is not good) and the conduct of the healthcare professionals when interacting with the patients and/or the persons close to them.

8.4.2.2. Who can lodge D&EC complaints?

Any person who is dissatisfied with any professional service offered or alleges a breach of standards by a person or health institution registered and/or licensed under Cap. 253 may lodge a complaint in the prescribed manner to the Council. Persons lodging complaints (i.e. Complainants) may include the patients, their relatives or guardians, other health professionals, health facilities, professional associations, civil society organisations, government officers, and any member of the public. The Complainant may be represented by a lawyer, if they so wish.

The Council may also investigate complaints forwarded to it by other government bodies or raised in the media.

8.4.2.3. Common complaints

Most complaints arise from the care given and the conduct of the healthcare professionals when interacting with the patients and/or their relatives. They include:

a. Complaints about the standard of care given (or not given), especially when the outcome is not good, including misdiagnosis, mismanagement, negligence, patient abandonment;
b. Lack of informed consent;
c. Referral, transfer, consultation and delegation;
d. Communication between practitioners and the patients, i.e. what is said against what is understood;
e. Feedback to patients, e.g. results for samples taken for testing;
f. Follow up of patients;
g. Documentation, and
h. Billing, including over-servicing, overcharging, billing for services not rendered.

8.4.2.4. The D&EC case handling process

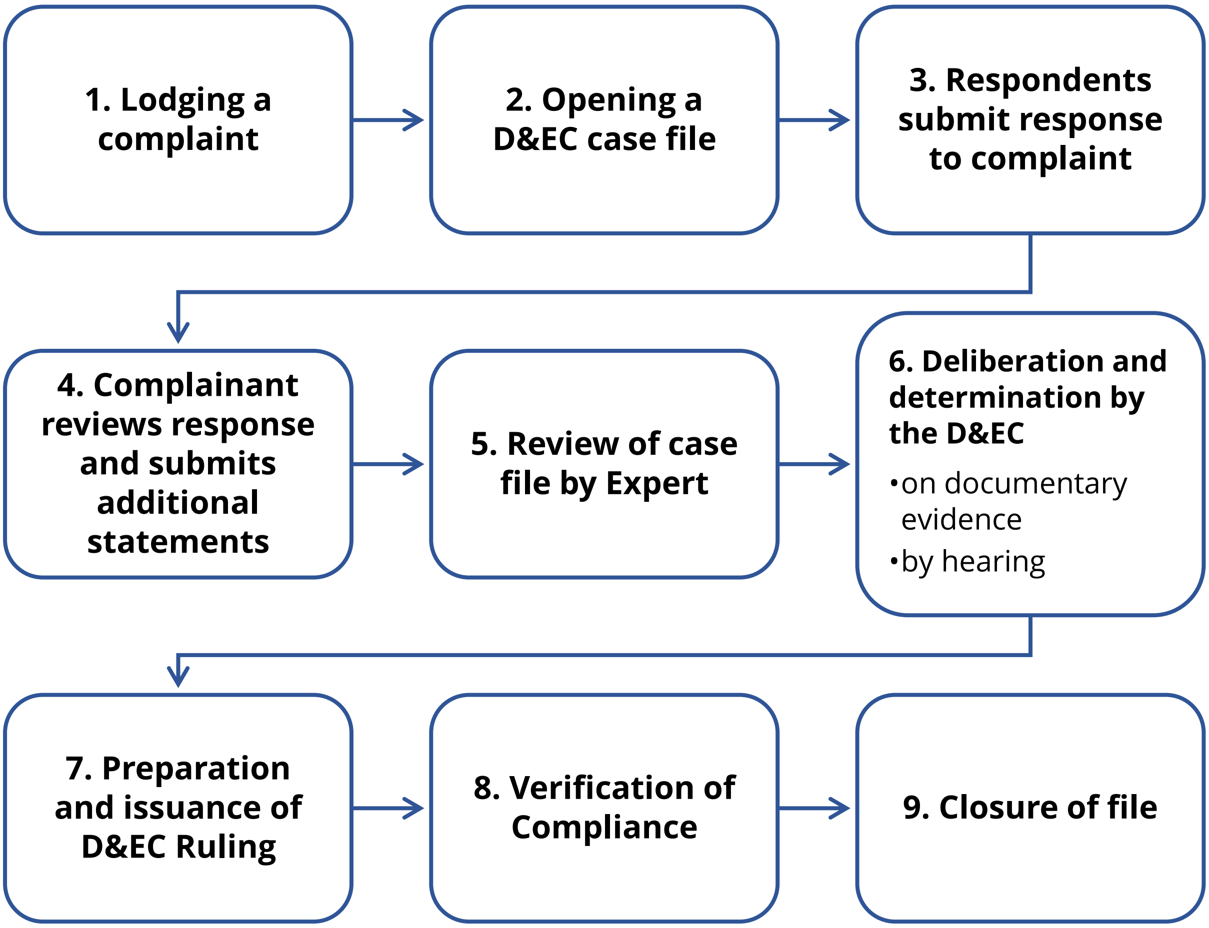

Figure 2: The D&EC case handling process

The D&EC case handling process can be summarised as follows:

a. The Complainant is required to fill the Council's *Application for Lodging a Compliant* form and attach:
    i. A statement narrating in detail the events leading to the complaint
    ii. Any documents relevant to the case that are in their possession

b. Once the Complaint documents are received at the Council offices, a case file is opened.

c. The Council then writes to the Respondent (i.e. the person or institution against whom the Complaint is lodged) requiring them to respond by submitting:
    i. A comprehensive statement addressing the allegations raised in the Complaint

    ii. A medical report on the management of the patient in question
    iii. A certified and paginated copy of the entire patient file
    iv. Detailed statements of all the medical personnel who managed the patient
    v. Any other relevant document(s) or information that will assist the D&EC to carry out its investigations

d. The documents submitted by the Respondent are forwarded to the Complainant, who may submit further statements.

e. The Council may require additional documents from other health professionals or institutions where the patient has been managed i.e. Third Party. Documents submitted by these third parties are also shared with the Complainant for their review and comments.

f. Once all the documents are submitted, the case file is examined for completion.

g. If deemed complete, the case file is forwarded to an Expert in that field of medicine or dentistry for review.

h. Reviewed case files are presented and discussed during the next D&EC meeting.

i. The D&EC first decides which of the matters presented are within the Council's jurisdiction. Cases found to be not within the Council's jurisdiction are then referred to the relevant institution.

j. For the cases found to be within Council jurisdiction, the D&EC then decides on the merits of each case.
    i. Some cases are found to have no merit (e.g. the care provided to the patient was within the expected standards of care) and the Respondents are found not culpable. These are dismissed and the case files closed.

    ii. Some cases are found to have merit but that they can be determined based on written submissions, i.e. without requiring an oral interview or hearing. For these, the parties involved are required to submit their written statements, which are reviewed by the D&EC and rulings issued.

iii. Some cases are found to have merit but cannot be determined without an oral interview or hearing. For these, all the parties involved (and their legal representatives where applicable) are required to attend the hearing in person and present their case. The D&EC then considers the evidence presented and issues the rulings.

Investigation of a D&EC case can be a lengthy process. The Council does everything within the Law to ensure that every matter is determined in the shortest time possible.

8.4.3. PENALTIES AND SANCTIONS

Where Respondents are found culpable (guilty), the D&EC can recommend that the Council institute sanctions as prescribed in Section 20 of Cap. 253 as follows:

a. The Council can issue **a caution or reprimand** in writing to the medical, dental or oral health practitioner, and/or health institution;

b. The Council can direct that the medical, dental or oral health practitioner undergoes **remedial training** for a period not exceeding twelve (12) months – *remedial training includes repeating undergraduate or postgraduate training; engaging in CPD accredited short courses, etc*;

c. The Council can direct that the medical, dental or oral health practitioner be **placed on probation** for a period not exceeding six (6) months – *during which period, he/she will be required to work under the direct supervision of a recognised Specialist/ Subspecialist in the field*;

d. The Council can **suspend, withdraw or cancel the practising licence of a practitioner** for a period not exceeding twelve (12) months – *the practitioner will surrender his/her practice licence to the Council and be barred from engaging in clinical duties for the duration of the suspension*;

e. The Council can **suspend, withdraw or cancel the licence of a health institution** or a section of the health institution for a period not exceeding twelve (12) months – *the health facility will surrender the withdrawn operating licence to the Council for the duration of the suspension*;

f. The Council can direct that the Respondent enter into a **mediation agreement** with the Complainant with a view of compensating the latter within a specified period;

g. The Council **permanently remove the name** of a medical, dental or oral health practitioner, or a health institution from the registers listed under Section 5(3) of Cap. 253 – *the Council shall not remove the name of a person from the register unless at least seven members of the Council are present in the inquiry*; and/or

h. The Council may, in addition to the penalties stipulated above, **impose a fine** (to be paid by the Respondent) which the Council deems appropriate in the circumstance.

Further, where necessary, the Council may recommend to the Director of Public Prosecutions to initiate criminal proceedings against persons found guilty.

9. INTERNATIONAL CODES OF PROFESSIONAL ETHICS AND CONDUCT

The Constitution of Kenya (2010) acknowledges that general rules of international Law shall be part of the Law in Kenya, as long as they are in conformity with the Constitution of Kenya. Thus, practitioners in Kenya are governed by the relevant international declarations, which include but are not limited to:

a. Hippocratic Oath
b. WMA Declaration of Geneva – The Physician's Pledge
c. WMA International Code of Medical Ethics
d. Universal Declaration of Human Rights
e. Nuremberg Code on Permissible medical experiments
f. WMA Declaration of Helsinki – Ethical principles for medical research involving human subjects
g. WMA Declaration of Sydney on the Determination of death and the Recovery of organs
h. WMA Declaration on Medically-indicated termination of pregnancy
i. WMA Declaration of Tokyo – Guidelines for physicians concerning torture and other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment
j. Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research, Report of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research
k. WMA Declaration of Lisbon on the rights of the patient
l. WMA Declaration of Venice on terminal illness
m. WMA Declaration on Principles of health care for Sports Medicine
n. WMA Declaration of Hamburg concerning Support for Medical Doctors refusing to participate in, or to condone, the use of torture and other cruel, inhuman or degrading treatment
o. WMA Declaration on Patient safety
p. WMA Declaration of Taipei on Ethical considerations regarding health databases and biobanks
q. WMA Declaration of Reykjavik – Ethical considerations regarding the use of genetics in health care
r. UNESCO Universal Declaration on Bioethics and Human Rights
s. WMA Declaration of Seoul on Professional autonomy and Clinical independence
t. WMA Declaration of Madrid on Professionally-led Regulation

u. WMA Statement on Assisted Reproductive Technologies
v. WMA Resolution on Organ donation in prisoners
w. WMA Declaration on End-of-life medical care
x. WMA Declaration on the protection of health care workers in situations of violence
y. Ethical principles of health care in times of armed conflict and other emergencies
z. WMA Declaration on euthanasia and physician-assisted suicide
aa. WMA Declaration of Cordoba on Patient-Physician relationship
bb. WMA Declaration on Pseudoscience and Pseudotherapies in the field of health
cc. WMA Declaration on Discrimination against Elderly Individuals within Healthcare Settings
dd. WMA Statement on Physicians treating relatives
ee. WMA Regulations in times of armed conflict and other situations of violence
ff. WMA Statement on Armed Conflicts
gg. WMA Statement on Primary Health Care
hh. WMA Statement on Medical Ethics during Public Health Emergencies
ii. WMA Resolution on the Abuse of Psychiatry
jj. WMA Statement on Conflict of Interest
kk. WMA Statement on Ageing
ll. WMA Statement on Aesthetic Treatment
mm. WMA Statement on Scope of Practice, Task Sharing and Task Shifting
nn. WMA Statement on Artificial and Augmented Intelligence in Medical Care
oo. WMA Statement on Physician Mental Health Care

9.1. THE DECLARATION OF GENEVA – THE PHYSICIAN'S PLEDGE

The World Medical Association (WMA) at its Second General Assembly held in Geneva, Switzerland in September 1948, adopted the Declaration of Geneva as a modern ethical physician's oath. This was in response to the Nazi-led atrocities carried out during the Second World War. The Declaration was intended to serve as a modern successor to Hippocratic Oath, upholding medical ethics and emphasising service to humanity, patient welfare and dignity. The Declaration is meant to be read together with the International Code of Medical Ethics.

The Declaration has been adopted by many regulatory authorities, training institutions and medical associations around the world and is recited by doctors as a demonstration of their commitment to these principles and their dedication to the highest standards of ethical practice in the delivery of healthcare.

The latest amendment of the Declaration was adopted by the 68th WMA General Assembly held in Chicago, United States in October 2017.

The Physician's Pledge

As a member of the medical profession:
I solemnly pledge to dedicate my life to the service of humanity;
The health and well-being of my patient will be my first consideration;
I will respect the autonomy and dignity of my patient;
I will maintain the utmost respect for human life;
I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient;
I will respect the secrets that are confided in me, even after the patient has died;
I will practise my profession with conscience and dignity and in accordance with good medical practice;
I will foster the honour and noble traditions of the medical profession;
I will give to my teachers, colleagues, and students the respect and gratitude that is their due;
I will share my medical knowledge for the benefit of the patient and the advancement of healthcare;
I will attend to my own health, well-being, and abilities in order to provide care of the highest standard;
I will not use my medical knowledge to violate human rights and civil liberties, even under threat;
I make these promises solemnly, freely, and upon my honour.

9.2. THE WMA INTERNATIONAL CODE OF MEDICAL ETHICS

Adopted by the 3rd General Assembly of the World Medical Association, London, England, October 1949 and revised by the 73rd WMA General Assembly, Berlin, Germany, October 2022

PREAMBLE

The World Medical Association (WMA) has developed the *International Code of Medical Ethics* as a canon of ethical principles for the members of the medical profession worldwide. In concordance with the *WMA Declaration of Geneva: The Physician's Pledge* and the WMA's entire body of policies, it defines and elucidates the professional duties of physicians towards their patients, other physicians and health professionals, themselves, and society as a whole.

The physician must be aware of applicable national ethical, legal, and regulatory norms and standards, as well as relevant international norms and standards.

Such norms and standards must not reduce the physician's commitment to the ethical principles set forth in this Code.

The International Code of Medical Ethics should be read as a whole and each of its constituent paragraphs should be applied with consideration of all other relevant paragraphs. Consistent with the mandate of the WMA, the Code is addressed to physicians. The WMA encourages others who are involved in healthcare to adopt these ethical principles.

GENERAL PRINCIPLES

1. The primary duty of the physician is to promote the health and well-being of individual patients by providing competent, timely, and compassionate care in accordance with good medical practice and professionalism.
   The physician also has a responsibility to contribute to the health and well-being of the populations the physician serves and society as a whole, including future generations.
   The physician must provide care with the utmost respect for human life and dignity, and for the autonomy and rights of the patient.

2. The physician must practise medicine fairly and justly and provide care based on the patient's health needs without bias or engaging in discriminatory

conduct on the basis of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, culture, sexual orientation, social standing, or any other factor.

3. The physician must strive to use health care resources in a way that optimally benefits the patient, in keeping with fair, just, and prudent stewardship of the shared resources with which the physician is entrusted.

4. The physician must practise with conscience, honesty, integrity, and accountability, while always exercising independent professional judgement and maintaining the highest standards of professional conduct.

5. Physicians must not allow their individual professional judgement to be influenced by the possibility of benefit to themselves or their institution. The physician must recognise and avoid real or potential conflicts of interest. Where such conflicts are unavoidable, they must be declared in advance and properly managed.

6. Physicians must take responsibility for their individual medical decisions and must not alter their sound professional medical judgements on the basis of instructions contrary to medical considerations.

7. When medically appropriate, the physician must collaborate with other physicians and health professionals who are involved in the care of the patient or who are qualified to assess or recommend care options. This communication must respect patient confidentiality and be confined to necessary information.

8. When providing professional certification, the physician must only certify what the physician has personally verified.

9. The physician should provide help in medical emergencies, while considering the physician's own safety and competence, and the availability of other viable options for care.

10. The physician must never participate in or facilitate acts of torture, or other cruel, inhuman, or degrading practices and punishments.

11. The physician must engage in continuous learning throughout professional life in order to maintain and develop professional knowledge and skills.

12. The physician should strive to practise medicine in ways that are environmentally sustainable with a view to minimising environmental health risks to current and future generations.

DUTIES TO THE PATIENT

13. In providing medical care, the physician must respect the dignity, autonomy, and rights of the patient. The physician must respect the patient's right to freely accept or refuse care in keeping with the patient's values and preferences.

14. The physician must commit to the primacy of patient health and well-being and must offer care in the patient's best interests. In doing so, the physician must strive to prevent or minimise harm for the patient and seek a positive balance between the intended benefit to the patient and any potential harm.

15. The physician must respect the patient's right to be informed in every phase of the care process. The physician must obtain the patient's voluntary informed consent prior to any medical care provided, ensuring that the patient receives and understands the information needed to make an independent, informed decision about the proposed care. The physician must respect the patient's decision to withhold or withdraw consent at any time and for any reason.

16. When a patient has substantially limited, underdeveloped, impaired, or fluctuating decision-making capacity, the physician must involve the patient as much as possible in medical decisions. In addition, the physician must work with the patient's trusted representative, if available, to make decisions in keeping with the patient's preferences, when those are known or can reasonably be inferred. When the patient's preferences cannot be determined, the physician must make decisions in the patient's best interests. All decisions must be made in keeping with the principles set forth in this Code.

17. In emergencies, where the patient is not able to participate in decision making and no representative is readily available, the physician may initiate an intervention without prior informed consent in the best interests of the patient and with respect for the patient's preferences, where known.

18. If the patient regains decision-making capacity, the physician must obtain informed consent for further intervention.

19. The physician should be considerate of and communicate with others, where available, who are close to the patient, in keeping with the patient's preferences and best interests and with due regard for patient confidentiality.

20. If any aspect of caring for the patient is beyond the capacity of a physician, the physician must consult with or refer the patient to another appropriately qualified physician or health professional who has the necessary capacity.

21. The physician must ensure accurate and timely medical documentation.

22. The physician must respect the patient's privacy and confidentiality, even after the patient has died. A physician may disclose confidential information if the patient provides voluntary informed consent or, in exceptional cases, when disclosure is necessary to safeguard a significant and overriding ethical obligation to which all other possible solutions have been exhausted, even when the patient does not or cannot consent to it. This disclosure must be limited to the minimal necessary information, recipients, and duration.

23. If a physician is acting on behalf of or reporting to any third parties with respect to the care of a patient, the physician must inform the patient accordingly at the outset and, where appropriate, during the course of any interactions. The physician must disclose to the patient the nature and extent of those commitments and must obtain consent for the interaction.

24. The physician must refrain from intrusive or otherwise inappropriate advertising and marketing and ensure that all information used by the physician in advertising and marketing is factual and not misleading.

25. The physician must not allow commercial, financial, or other conflicting interests to affect the physician’s professional judgement.

26. When providing medical care remotely, the physician must ensure that this form of communication is medically justifiable and that the necessary medical care is provided. The physician must also inform the patient about the benefits and limitations of receiving medical care remotely, obtain the patient’s consent, and ensure that patient confidentiality is upheld. Wherever medically appropriate, the physician must aim to provide care to the patient through direct, personal contact.

27. The physician must maintain appropriate professional boundaries. The physician must never engage in abusive, exploitative, or other inappropriate relationships or behaviour with a patient and must not engage in a sexual relationship with a current patient.

28. In order to provide care of the highest standards, physicians must attend to their own health, well-being, and abilities. This includes seeking appropriate care to ensure that they are able to practise safely.

29. This Code represents the physician’s ethical duties. However, on some issues there are profound moral dilemmas concerning which physicians and patients may hold deeply considered but conflicting conscientious beliefs.
    The physician has an ethical obligation to minimise disruption to patient care. Physician conscientious objection to provision of any lawful medical interventions may only be exercised if the individual patient is not harmed or discriminated against and if the patient’s health is not endangered.
    The physician must immediately and respectfully inform the patient of this objection and of the patient’s right to consult another qualified physician and provide sufficient information to enable the patient to initiate such a consultation in a timely manner.

DUTIES TO OTHER PHYSICIANS, HEALTH PROFESSIONALS, STUDENTS, AND OTHER PERSONNEL

30. The physician must engage with other physicians, health professionals and other personnel in a respectful and collaborative manner without bias,

harassment, or discriminatory conduct. The physician must also ensure that ethical principles are upheld when working in teams.

31. The physician should respect colleagues' patient-physician relationships and not intervene unless requested by either party or needed to protect the patient from harm. This should not prevent the physician from recommending alternative courses of action considered to be in the patient's best interests.

32. The physician should report to the appropriate authorities conditions or circumstances which impede the physician or other health professionals from providing care of the highest standards or from upholding the principles of this Code. This includes any form of abuse or violence against physicians and other health personnel, inappropriate working conditions, or other circumstances that produce excessive and sustained levels of stress.

33. The physician must accord due respect to teachers and students.

DUTIES TO SOCIETY

34. The physician must support fair and equitable provision of health care. This includes addressing inequities in health and care, the determinants of those inequities, as well as violations of the rights of both patients and health professionals.

35. Physicians play an important role in matters relating to health, health education, and health literacy. In fulfilling this responsibility, physicians must be prudent in discussing new discoveries, technologies, or treatments in non-professional, public settings, including social media, and should ensure that their own statements are scientifically accurate and understandable.
    Physicians must indicate if their own opinions are contrary to evidence-based scientific information.

36. The physician must support sound medical scientific research in keeping with the WMA Declaration of Helsinki and the WMA Declaration of Taipei.

37. The physician should avoid acting in such a way as to weaken public trust in the medical profession. To maintain that trust, individual physicians must hold

themselves and fellow physicians to the highest standards of professional conduct and be prepared to report behaviour that conflicts with the principles of this Code to the appropriate authorities.

38. The physician should share medical knowledge and expertise for the benefit of patients and the advancement of health care, as well as public and global health.

DUTIES AS A MEMBER OF THE MEDICAL PROFESSION

39. The physician should follow, protect, and promote the ethical principles of this Code. The physician should help prevent national or international ethical, legal, organisational, or regulatory requirements that undermine any of the duties set forth in this Code.

40. The physician should support fellow physicians in upholding the responsibilities set out in this Code and take measures to protect them from undue influence, abuse, exploitation, violence, or oppression.

APPENDICES

APPENDIX I: LAWS AND REGULATIONS AFFECTING THE PRACTITIONER

Regulations that affect the Practitioner as a health professional, including but not limited to:

a. The Constitution of Kenya (2010)
b. Health Act (Cap. 241)
c. Medical Practitioners and Dentists Act (Cap. 253), and its subsidiary legislation including:
    i. The Medical Practitioners and Dentists (Fitness to Practice) Rules, 2016
    ii. The Medical Practitioners and Dentists (Medical Camp) Rules, 2016
    iii. The Medical Practitioners and Dentists (Practitioners and Health Facilities) (Advertising) Rules, 2016
    iv. The Medical Practitioners and Dentists (Professional Fees) Rules, 2016.
    v. The Medical Practitioners and Dentists (Referral of Patients Abroad) Rules, 2017
    vi. The Medical Practitioners and Dentists (Medical Institutions) (Amendment) Rules, 2021
    vii. The Medical Practitioners and Dentists (Forms and Fees) (Amendment) Rules, 2021
    viii. The Medical Practitioners and Dentists (Inspections and Licensing) Rules, 2022
    ix. The Medical Practitioners and Dentists (Inquiry and Disciplinary Proceedings) (Procedure) Rules, 2022
    x. The Medical Practitioners and Dentists (Training, Assessment, and Registration) Rules, 2022
    xi. The Medical Practitioners and Dentists (Mental Health Treatment and Rehabilitation Institutions) Rules, 2022
d. Public Health Act (Cap. 242)
e. Pharmacy and Poisons Act (Cap. 244)
f. Narcotic Drugs and Psychotropic Substances (Control) Act (Cap. 245)
g. Anti-Doping Act (Cap. 245B)
h. National Authority for the Campaign Against Alcohol and Drug Abuse Act (Cap. 122)
i. National Coroners Service Act (Cap. 89)
j. Anatomy Act (Cap. 249)
k. Human Tissue Act (Cap. 252)
l. Biosafety Act (Cap. 320)
m. HIV and AIDS Prevention and Control Act (Cap. 246A)
n. Cancer Prevention and Control Act (No. 15 of 2012)
o. Mental Health Act (Cap. 248)
p. Data Protection Act (Cap. 411C)

q. Primary Health Care Act (No. 13 of 2023)
r. Digital Health Act (No. 15 of 2023)
s. Social Health Insurance Act (No. 16 of 2023)
t. Facilities Improvement Financing Act (Cap. 277)
u. Social Assistance Act (Cap. 258A)
v. Births and Deaths Registration Act (Cap. 149)
w. The Children Act (Cap. 141)
x. Age of Majority Act (Cap. 33)
y. Persons with Disabilities Act (Cap. 133)
z. Protection Against Domestic Violence Act (Cap. 151)
aa. Protection of Traditional Knowledge and Cultural Expressions Act (Cap. 218A)
bb. Penal Code (Cap. 63)
cc. Sexual Offences Act (Cap. 63A)
dd. Universities Act (Cap. 210)
ee. Companies Act (Cap. 486)
ff. Competition Act (Cap. 504)
gg. Consumer Protection Act (Cap. 501)
hh. Computer Misuse and Cybercrimes Act (Cap. 79C)
ii. Food, Drugs and Chemical Substances Act (Cap. 254)
jj. Science, Technology and Innovation Act (Cap. 511)

Regulations that affect to the Practitioner as an employee or public officer, including but not limited to:
a. Employment Act (Cap. 226)
b. Labour Relations Act (Cap. 233)
c. Work Injury Benefits Act (Cap. 236)
d. Occupational Safety and Health Act (Cap. 236A)
e. Public Service Commission Act (Cap. 185)
f. Public Service (Values and Principles) Act (Cap. 185A)
g. Leadership and Integrity Act (Cap. 185C)
h. Conflict of Interest Act (No. 11 of 2025)
i. Official Secrets Act (Cap. 187)
j. Public Finance Public Finance Management Act (Cap. 412A)
k. Public Procurement and Asset Disposal Act (Cap. 412C)

APPENDIX II: MEMBERS OF THE TECHNICAL WORKING GROUP FOR REVIEW OF *THE CODE OF PROFESSIONAL CONDUCT AND DISCIPLINE* 6TH EDITION

In 2023, the CEO/Registrar of the Council appointed a Technical Working Group (TWG) to spearhead the process of reviewing *The Code of Professional Conduct and Discipline* 6th edition which comprised of the following:

Name	Role	Affiliation
Dr Elizabeth Gitau	TWG Chairperson	KMPDC Council Member/ Kenya Medical Association
Prof. Elizabeth Bukusi	TWG Member	Kenya Medical Research Institute/ Bioethics Society of Kenya
Dr Lydia Okutoyi, OGW	TWG Member	Kenyatta National Hospital/ Society for Quality Healthcare Kenya
Mr. Ndunu Chege	TWG Member	Oral Health Association of Kenya
Dr Margaret Mbugua	TWG Secretariat	KMPDC
Adv. Eunice Muriithi	TWG Secretariat	KMPDC
Mr. Simon Njagi	TWG Secretariat	KMPDC
Adv. Michael Onyango	TWG Secretariat	KMPDC
Dr Wangechi King'ori	TWG Secretariat	KMPDC
Dr Stella Kanja	TWG Secretariat	KMPDC
Adv. Esther Mutheu	TWG Secretariat	KMPDC
Mr. Maroko Ragwanda	TWG Secretariat	KMPDC
Ms. Sarah Were	TWG Secretariat	KMPDC

The Council acknowledges the invaluable efforts of the Team that spearheaded the review of *The Code of Professional Conduct and Discipline* 6th edition, which formed the basis for this review, comprising of:

Prof. George Magoha	Dr Josephine Omondi	Mr. John Kariuki
Dr Francis Kimani	Dr Loice Mutai	Mr. Philip ole Kamwaro
Prof. Alice Mutungi	Dr Fatmah Abdalla	Ms. Rose Wafukho
Prof. Jacob Kaimenyi	Dr Tom Ochola	Mr. Sospeter Oyano
Dr Judith Bwonya	Dr Samson Wanjala	Ms. Anne Ondieki
Prof. Barasa Khwa Otsyula	Dr Jane Kabutu	Mr. Reuben Makasi
Prof. Zipporah Ngumi	Dr Stephen Ochiel	Ms. Christine Muriu
Dr Elly Nyaim Opot	Dr Mahendra Pancholi	Ms. Sarah Were
Dr Joel ole Kiyiapi		

APPENDIX III: LIST OF CONTRIBUTORS

The Council is grateful to the following stakeholders who submitted input and feedback on *The Code of Professional Conduct and Discipline* at various stages:

S/No.	Name	Designation/ Affiliation
1.	**Dr Benjamin Wachira**	Emergency Medicine Kenya Foundation
2.	**Dr Ramadan Marjan**	Kenya Association of Muslim Medical Professionals
3.	**Dr Gladys Mwango**	Kenya Association of Radiologists
4.	**Dr Beryl Okose**	Kenya Hospices and Palliative Care Association
5.		Ophthalmological Society of Kenya
6.	**Dr Phoebe Wamalwa**	Pediatric Endocrine Society of Kenya
7.	**Ms. Fiona Malonza**	The Metro Group
8.	**Dr Abdi Osman Isse**	Medical Practitioner
9.	**Dr Abdirahman Mohamed Osman**	Medical Practitioner
10.	**Dr Abraham Masunde Espira**	Obstetrician and Gynaecologist
11.	**Prof. Adam Mohamed Adam**	Neurologist
12.	**Dr Ahmed Bashir Ali**	Medical Practitioner
13.	**Dr Alwiya A. A. Al-Hindwan**	Medical Practitioner
14.	**Dr Anastasia Ngumuta**	Physician
15.	**Dr Andrew Kanyoni**	Medical Practitioner
16.	**Dr Asma Ali Awadh**	Medical Practitioner
17.	**Dr Barry R. Ayumba**	General Surgeon
18.	**Dr Blasio Osogo Omuga**	Obstetrician and Gynaecologist
19.	**Dr Brian Orina**	Medical Practitioner
20.	**Dr Buoga Simon Peter**	Medical Practitioner
21.	**Ms. Caroline Kiruja**	COHO
22.	**Ms. Charity Nkirote Marete**	COHO
23.	**Dr Cyprianus Okoth**	Physician
24.	**Dr David Oyugi**	Dental Practitioner
25.	**Dr David Theuri**	Medical Practitioner
26.	**Dr Deborah Omeddo**	Paediatric Haemato-Oncologist
27.	**Ms. Delfina Gaiteng’a Mutaruchiu**	COHO
28.	**Dr Doris Muthomi Vincent**	Medical Practitioner
29.	**Ms. Elizabeth Gachini**	COHO

S/No.	Name	Designation/ Affiliation
30.	**Dr Esther Benjamin Mtinangi**	Medical Practitioner
31.	**Dr Faith Kwekwe**	Medical Practitioner
32.	**Dr Farida Said Elbuali**	Medical Practitioner
33.	**Dr Gesora Mosambaria**	Medical Practitioner
34.	**Dr Gilbert Ndayishimiye**	Medical Practitioner
35.	**Dr Ismael Atako**	Medical Practitioner
36.	**Dr Jeff Kitheka**	Medical Practitioner
37.	**Dr Joan Nangekhe**	Medical Practitioner
38.	**Dr Joel Mathenge**	Medical Practitioner
39.	**Dr John Omondi Amollo**	Medical Practitioner
40.	**Dr Jonathan Katana Wa Yaa**	Medical Practitioner
41.	**Prof. Joseph M. Abuya**	Radiologist
42.	**Dr Kimani Ndung'u**	Medical Practitioner
43.	**Dr Kizito Shisanya**	General Surgeon
44.	**Dr Kuloba Burudi**	General Surgeon
45.	**Dr Lenrod Kawa**	Medical Practitioner
46.	**Dr Lina Karimi**	Medical Practitioner
47.	**Dr Lucy Wainaina**	Paediatric Endocrinologist
48.	**Dr Mahendra B. Pancholi**	Dermatologist
49.	**Dr Mahesh Kumar**	Medical Practitioner
50.	**Dr Majid Warshow**	Cardiologist
51.	**Dr Malyun Sheikh**	Medical Practitioner
52.	**Mr. Martin Ngari Mitaru**	COHO
53.	**Dr Mbito C. Mongo**	Medical Practitioner
54.	**Dr Nadira Abdirahman Musa**	Medical Practitioner
55.	**Dr Ndiwa Martin**	Medical Practitioner
56.	**Dr Odoyo Mike Onyango**	Medical Practitioner
57.	**Dr Omar Mdoe Omar**	Medical Practitioner
58.	**Dr Priscilla Nyakundi**	Paediatric Immunologist
59.	**Dr Ratilal S. Shah**	Medical Practitioner
60.	**Dr Rosaline Muruakithi**	Dental Practitioner
61.	**Dr Roy Githui**	Medical Practitioner
62.	**Dr Said Mohamed Omar**	Medical Practitioner
63.	**Dr Said Muruu Hassan**	Dental Practitioner
64.	**Dr Samwel O. Adongo**	Anaesthesiologist
65.	**Dr Shohra Alwi Al-Hindwan**	Medical Practitioner
66.	**Dr Simon Mueke**	Obstetrician/ Urogynaecologist
67.	**Dr Sophie Mwaniki**	Medical Practitioner

S/No.	Name	Designation/ Affiliation
68.	**Dr Ssejjanzi Valanta**	Dental Practitioner
69.	**Dr Stephen Nzai**	Medical Practitioner
70.	**Dr Teresia Njoroge**	Medical Practitioner
71.	**Dr Wangari L. T. Ndwiga**	Medical Practitioner

APPENDIX IV: LIST OF PARTICIPANTS AT THE STAKEHOLDERS WORKSHOP

The Council appreciates the contributions of the following participants who attended the Stakeholders Workshop for the Validation and Adoption of the revised *Code of Professional Conduct and Discipline* held at the A & L Hotel, Machakos from 24th to 26th March 2025:

S/No.	Name	Affiliation
1.	**Dr Margaret Ndungu-Mwasha**	Association of Prosthodontists of Kenya
2.	**Prof. Stephen Muhudhia**	Bioethics Society of Kenya
3.	**Prof. Violet Naanyu**	Bioethics Society of Kenya
4.	**Dr Benjamin W. Wachira**	Emergency Medicine Kenya Foundation
5.	**Dr Samuel Kadivane Kazi**	Field Epidemiology Society of Kenya
6.	**Dr Catherine Nduku Kiama**	Field Epidemiology Society of Kenya
7.	**Dr Lilian Kerubo Bosire**	Kenya Association of Clinical Pathologists
8.	**Dr Roopkamal Kaur Saini**	Kenya Association of Dermatologists
9.	**Dr Winnie Njenga**	Kenya Association of Dermatologists
10.	**Dr Jonathan Nthusi**	Kenya Association of Family Physicians
11.	**Dr Ahmed Kalebi**	Kenya Association of Muslim Medical Professionals
12.	**Dr Nduguyu Kerre**	Kenya Association of Paediatric Dentists
13.	**Dr Erick Njenga**	Kenya Association of Physicians
14.	**Dr Joan Osoro-Mbui**	Kenya Association of Private Hospitals
15.	**Dr Kevin Onyinkwa Ombati**	Kenya Association of Radiologists
16.	**Dr Issack Sheikh**	Kenya Association of Urological Surgeons
17.	**Dr Daniel Kiura**	Kenya Conference of Catholic Bishops
18.	**Dr Timothy Theuri**	Kenya Dental Association
19.	**Dr Anne Wanjiru Wairagu**	Kenya Diabetes Study Group
20.	**Dr Maria Muthoka**	Kenya Ear, Nose and Throat Society
21.	**Dr Simon Kigondu**	Kenya Medical Association
22.	**Dr Daniel Oluoch Oduor**	Kenya Obstetrical and Gynaecological Society
23.	**Prof. Parmenas Oroko**	Kenya Orthopaedic Association
24.	**Dr Peter Kilonzo**	Kenya Orthopaedic Association
25.	**Dr Mercy Karanja**	Kenya Psychiatric Association
26.	**Dr Nidhi Leekha**	Kenya Society for Ultrasound in Medicine and Biology
27.	**Dr Patricia Othieno**	Kenya Society for Ultrasound in Medicine and Biology
28.	**Dr Rachael Kimani**	Kenya Society of Anaesthesiologists

S/No.	Name	Affiliation
29.	**Dr Peter Kamau Wanyoike**	Neurological Society of Kenya
30.	**Dr Lazarus Wambua Mutinda**	Ophthalmological Society of Kenya
31.	**Ms. Beatrice Achieng**	Oral Health Association of Kenya
32.	**Dr Paul Laigong**	Pediatric Endocrine Society of Kenya/ Kenya Paediatric Association
33.	**Dr George Nyale**	Respiratory Society of Kenya
34.	**Ms. Grace Kaluki**	Rural and Urban Private Hospitals Association
35.	**Dr Carolyne Mukuha**	Society for Quality Healthcare Kenya/ Telecare HealR
36.	**Ms. Wijdaan Wayua**	Telecare HealR
37.	**Dr Hussein Iman**	Supreme Council of Kenya Muslims
38.	**Prof. Paul Odula**	Surgical Society of Kenya
39.	**Dr Winnie Kemunto**	Surgical Society of Kenya
40.	**Dr David G. Kariuki**	KMPDC
41.	**Prof. Stephen Ogendo**	KMPDC
42.	**Dr Elizabeth Gitau**	KMPDC
43.	**Prof. Elizabeth Anne Bukusi**	KMPDC
44.	**Mr. Ndunu Chege**	KMPDC
45.	**Dr Lydia Okutoyi, OGW**	KMPDC
46.	**Dr Margaret Mbugua**	KMPDC
47.	**Mr. Simon Kiraithe**	KMPDC
48.	**Dr Wangechi King'ori**	KMPDC
49.	**Mr. Duncan Mwai**	KMPDC
50.	**Dr Stella Kanja**	KMPDC
51.	**Ms. Esther Mutheu**	KMPDC
52.	**Mr. Maroko Ragwanda**	KMPDC
53.	**Mr. Jerry Wamulla**	KMPDC
54.	**Mr. Harun Liluma**	KMPDC
55.	**Mr. Ekal Bethuel**	KMPDC

REFERENCES

Gallagher, A., & Jago, R. (2016). *A Typology of Dishonesty: Illustrations from the s29 Database*. Professional Standards Authority.

International Society of Blood Transfusion. (2017) *Code of Ethics relating to Blood Transfusion Medicine*. Amsterdam.

Kenya Dental Association. (2012). *Principles of Ethics and Code of Professional Conduct*.

Kenya Law Reform Commission. (2018) *Report of Taskforce on Policy, Legal, Institutional and Administrative Reforms regarding Intersex Persons in Kenya*.

Kenya Medical Association. (2021) *Professional Code of Conduct*.

Medical Council of Hong Kong. (2022) *Code of Professional Conduct for the guidance of registered medical practitioners*.

Organ Procurement and Transplantation Network. (2025) *Policies*.

Organización Médica Colegial de España. (2022) *Code of Medical Ethics and Deontology*.

Philippine Medical Association and Professional Regulation Commission. (2019) *Code of Ethics of the Medical Profession*.

South African National Department of Health. (2020) *National Clinical Guidelines for safe conception and fertility*.

The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. (1979) *Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research*.

The Nuremberg Code (1947) as published in the British Medical Journal No. 7070 Volume 313 on 7 December 1996.

The Transplantation Society. (2018) *The Declaration of Istanbul on Organ Trafficking and Transplant Tourism*.

United Nations Office on Drugs and Crime. (2015) *Assessment toolkit – Trafficking in persons for the purpose of organ removal*.

The Technical Working Group also referred to multiple documents published by the following:
- National Council for Law Reporting (Kenya Law)
- Ministry of Health (MOH)
- Kenya Medical Practitioners and Dentists Council (KMPDC)
- Office of the Data Protection Commissioner (ODPC)

- Medical Council of Tanganyika
- Uganda Medical and Dental Practitioners Council (UMDPC)

- Association of Medical Councils of Africa (AMCOA)
- Health Professions Council of South Africa (HPCSA)
- South Africa Medical Association (SAMA)

- General Medical Council (GMC)
- General Dental Council (GDC)
- British Medical Association (BMA)
- Human Fertilisation and Embryology Authority (HEFA)
- Royal College of Surgeons (RCS)

- Australian Health Practitioner Regulation Agency (AHPRA)
- National Health and Medical Research Council (NHMRC)
- Medical Board of Australia
- Medical Council of New Zealand
- Fertility Society of Australia and New Zealand

- Medical Council of India (now known as the National Medical Commission)
- Indian Council of Medical Research (ICMR)

- American Medical Association (AMA)
- American Dental Association (ADA)
- American Public Health Association (APHA)
- American Society for Reproductive Medicine (ASRM)

- United Nations
- World Health Organization (WHO)
- World Medical Association (WMA)
- FDI World Dental Federation
- World Anti-Doping Agency (WADA)

Back cover inlay

KENYA MEDICAL PRACTITIONERS AND DENTISTS COUNCIL

KMPDC

Enhancing Quality Healthcare

Talk To Us

KMPDC Complex, Woodlands Road,
off Lenana Road, Hurlingham

+254 111 052 222
+254 727 666 444

P. O. Box 44839 - 00100, Nairobi

@KmpdcOfficial

Kenya Medical Practitioners
and Dentists Council

info@kmpdc.go.ke
www.kmpdc.go.ke