

Understanding Medical Malpractice Insurance in South Africa

Donald Dinnie, March 2019



TABLE OF CONTENTS

Why the need for medical malpractice insurance? 3

Liability insurance and medical malpractice insurance in particular 6

The alternative to medical malpractice insurance 7

Occurrence-based and claims-made types of medical malpractice insurance..... 8

The tail10

Retroactive date.....12

Financial structure of the policies.....12

Notifications13

Other policy terms.....15

Donald Dinnie
March 2019
www.natmed.mobi

Why the need for medical malpractice insurance?

“If a physician makes a large incision with the operating knife and kill him, or open a tumour with the operating knife, and cut out the eye, his hands shall be cut off.”

Table 218 Code of Hammurabi

The Code of Hammurabi is the oldest medical handbook found buried in the Nupur ruins after more than 4000 years. They are a set of laws relating exclusively to certain surgical interventions fully explaining patient’s rights, imposing authoritarian surgical care, with the possibility of legal action to ensure justice and equity particularly to each social class of the kingdom at the time on a rough justice basis.¹

Today a healthcare practitioner who is negligent in treating a patient, while no longer exposed to threats to their physical safety, may suffer from severe reputational, professional and financial harm.

Our courts have long ago set out the test for medical negligence, the central principles of which have remain unchanged.

In Mitchell v Dixon² :

“A medical practitioner is not expected to bring to bear upon the case entrusted to him the highest possible degree of skill and care, he is bound to employ reasonable skill and care; and he is liable for the consequences if he does not.”³

The test is and remains that of the reasonable healthcare practitioner in the particular circumstances of the case. This is the same whether the practitioner is a doctor, nurse or allied healthcare practitioner.⁴ In other words, a layperson is held to the standard of the reasonable person, when testing for negligence. A doctor is held to the standard of the reasonable doctor (not merely the reasonable layperson), a nurse must meet the standard of the reasonable nurse, etc.

This test for liability is essentially the same whether the healthcare practitioner or facility is sued in contract or delict. Unless, of course, the practitioner has bizarrely contracted with the patient on a no-fault basis, for example, guaranteeing to heal the patient.⁵

A delict is a civil wrong, or blameworthy conduct that causes harm to a person. You do not need to have a contract with a person in order to claim from them in delict – if someone causes you harm, you have a claim in delict if you can prove all of the legal elements of the delict, which are: Conduct (an act or omission), wrongfulness, fault (intention or negligence), causation and harm.

Healthcare practitioners always have a liability for their negligence causing injury to a patient. If at that time they are employed by another party, for example a hospital, the hospital is also

vicariously liable for that causal negligent conduct where the practitioner acts in the course and scope of their employment with the hospital.

In general terms vicarious liability may be described as the strict liability by one person for the delict of another. It usually arises in the context of an employer and employee relationship.⁶

So, in such a case the employer (the hospital, for example) is liable to the patient for the negligent conduct of its employee, the doctor, although neither the hospital nor the MEC for health (in the case of a public hospital) is at fault, in their own right. A doctor who employs a nurse in their practice would be vicariously liable for the negligence of the nurse who, in the course and scope of their employment, causes harm to the doctor's patient.

In South Africa in the public health sector, the healthcare professionals attending to the patient at the hospital are all employed by the relevant provincial authority (usually the MEC for health) so that health authority has vicarious liability for negligent conduct of its healthcare employees. In the private sector, hospitals usually employ nurses and related staff but not the doctors. The doctors are independent contractors for whom the hospital as a general principle has no vicarious liability. However, the hospital and doctor may still share portions of the liability, depending on the circumstances of each case.

A public healthcare patient injured through the negligent conduct of their attending doctors and/or nurses will simply sue the MEC of the relevant province and does not need to sue the negligent healthcare practitioners themselves. They may do so if they wish to but that seldom occurs and there is little practical purpose to that because the resources for indemnifying the patient financially lie with the Province and not the employees.⁷ In the private sector, a patient who alleges they are injured because of the negligent conduct of both the nurses and the doctor, will sue the hospital on the basis of vicarious liability (seldom suing the nurse as well) and the doctor. In such a case there would be two defendants.

In complex medical malpractice litigation in the private sector, there may be a relatively long list of defendants. In a baby claim, for example, alleging causal negligence during the birth/delivery of the baby which resulted in the child suffering from cerebral palsy, the hospital, attending gynaecologist/obstetrician and attending paediatrician may all be sued.

The patient bears the onus on the balance of probabilities of establishing their claim. ⁸ A balance of probabilities is the civil standard for the burden of proof (as opposed to the criminal law standard, which is beyond a reasonable doubt).

Where there is more than one person responsible for the patient's injury, the patient can choose to sue all, one, or a combination of the wrong-doers. In those circumstances where, for example, the Hospital is sued, and judgment obtained against the Hospital, all liability conceded, the Hospital may, in turn, institute action against the doctor for a contribution to the damages awarded.⁹ In *S v Kramer*¹⁰ the Court held that each specialist performs a specialised function as part of a team and that one is not responsible for the conduct of the other in their field of expertise.

Where a hospital, for example, is negligent in their own right or is at fault in their own right causing harm to the patient, the hospital or MEC will be liable to the patient. The hospital, for example, may have negligently implemented ineffective infection procedures and protocols resulting in patient infection, or be negligent in appointing and employing an unqualified nurse, or granting a doctor they ought to know is incompetent surgical privileges at the hospital, or fails to maintain medical equipment as they should, which defective equipment subsequently injures the patient. The hospital (and other healthcare professionals) may also have a strict liability to the patient in appropriate circumstances under certain legislation such as the Consumer Protection Act ¹¹ regarding product liability. Strict liability is liability for which negligence or fault does not have to be proved by the claimant. The Consumer Protection Act also influences how the courts look at exclusionary clauses in contracts between patients, hospitals and doctors.¹² An exclusionary clause could try, for example, to exclude liability for certain actions or certain types of harm caused. However, legislation like the Consumer Protection Act may limit what liability can be excluded via contract.

So, healthcare practitioners and healthcare facility operators have liability exposure in their own right directly to the patient for their negligent conduct, and on appropriate facts a vicarious liability for the negligent conduct of their employees, and also have an exposure to a contribution to any damages awarded or agreed for injury to a patient where that person or entity is a joint wrong-doer.

The healthcare practitioner and healthcare facility operator's financial exposure in those circumstances for damages suffered by the patient may be extremely serious. Special and general damages are awarded in respect of past and future medical expenses, past and future loss of earnings, loss of earning capacity, pain and suffering and loss of amenities of life.¹³ In the *Life Healthcare and Suliman* judgment, the agreed damages were R20 million (excluding the Plaintiff's costs as taxed or agreed; and the various Defendants' own Attorney and Client costs). Financial exposure relates not only to the capital amount of the Plaintiff's award but to the cost of the litigation which may be very significant and run into millions of Rands.¹⁴ Special damages covers the more easily quantifiable aspects of loss, whereas general damages are awarded for things such as pain and suffering, which could be hard to quantify. The courts look to previous awards in similar circumstances, as well as the particular circumstances of each case, in deciding what amount to award as general damages.

Bear in mind, however that simply because something has gone wrong during surgery or medical treatment, does not automatically mean that there is negligence and accordingly liability of the healthcare practitioner to the patient. Our courts have repeatedly said that this would be to impermissibly reason backwards from reason to cause. South African courts have consistently cautioned against the natural human tendency to find fault when an innocent party is injured:

“... we should be doing a disservice to the community at large if we were to impose liability on hospitals and doctors for everything that happens to go wrong

... We must insist on due care for the patient at every point, but we must not condemn as negligence that which is only a misadventure.”¹⁵

Liability insurance and medical malpractice insurance in particular

Medical malpractice insurance is a special type of professional indemnity insurance. It is a form of liability insurance (also known as casualty insurance in some other jurisdictions). It is also indemnity insurance. In other jurisdictions, professional indemnity insurance may also be called Errors and Omissions Insurance or Malpractice Insurance.

Medical malpractice insurance provides insurance for healthcare professionals and healthcare facility operators for legal liability to a third party, for losses proximately caused by their negligence in the conduct of their professional business. Careful regard must be had to the insuring (or operative) clause of the policy to ensure that there is appropriate cover for the relevant profession and business,¹⁶ to ensure that the practitioners' ordinary activities, including the omission to provide their services, are covered.

The insurance does not absolve the practitioner or facility of liability to the third party. Like all insurance it is a way of shifting the financial burden. The healthcare practitioner or healthcare facility will always have the primary responsibility to indemnify the third party for their negligent conduct causing injury to that third party. If, for example, the third party obtains a judgment against the healthcare practitioner, in that regard, the judgment will always stand. The medical malpractice policy will assist the healthcare practitioner in whole or in part, discharging the judgment debt to the third party. Therefore, whether a claim is payable to the harmed person is determined by the court, as a separate issue to whether a healthcare practitioner's insurance will pay out (which is determined by the insurer – although if the insurer refuses to pay, this may also become a matter for a court to decide).

Medical malpractice insurance is implemented by the conclusion of a contract. In terms of the contract the insurer agrees to take over the risk to which the insured is exposed and the insured, in turn, agrees to pay a premium.¹⁷ It is governed by the law of obligations (contract law) and, of course, by the express wording of the policy. So, if there is no contract there is no insurance. The transference of the risk for which the insured is exposed is the main aim of the contract and is not incidental to it. The insurance contract is a mechanism to transfer and facilitate the spreading of risk. Whether or not the insured is to be indemnified is determined by the terms of the insurance contract and is not discretionary.

A contract of insurance is a contingent liability. There is a legal obligation to pay out if the incident is within the terms of the policy. There may be a debate as to the causal negligence as a matter of law, but the insurer does not have a discretion as to whether or not to pay out. The contract of insurance is a legally enforceable obligation to pay the specified benefit upon the occurrence of the events referred to in the policy, but which may be subject to limits of indemnity and exclusions. Therefore, the insurer has an obligation to pay the claim on the

happening of a covered, insured event and can only escape liability to the extent of its limit of indemnity (the maximum amount that the policy will pay), or if an exclusion applies.

While it is common sense for a healthcare practitioner or healthcare facility to have medical malpractice insurance in place in South Africa, there are no professional rules to hold such insurance or its equivalent.¹⁸ The National Healthcare Act does require every private health establishment to maintain insurance cover sufficient to indemnify a patient for damages that they may suffer by an act of a member of its staff or its employees. There is no further content as to what that insurance must look like and there have been no judgments on the issue to provide any guidance. A similar obligation is not imposed on public health establishments whose liability is governed by, amongst other things, the State Liability Act and the Public Finance Management Act.¹⁹

In various financial and treasury legislation²⁰ it is not permitted for public healthcare authorities to transfer their medical malpractice risks through insurance.

Medical malpractice insurance is usually obtained for the individual healthcare practitioner rendering the particular healthcare service (for example a doctor). Where the practitioner practices through some form of legal entity, cover should be obtained, usually through a separate malpractice policy, for that business. That would include all the employees working at the business including nurses employed by the doctor.

The alternative to medical malpractice insurance

Healthcare professionals but not healthcare facility operators may, in certain jurisdictions, including South Africa, obtain an indemnity for medico-legal exposures through medical defence organisations.²¹ They are mutual organisations with Articles of Association which set out their responsibilities in respect of their members. There is no regulatory framework for members to raise a complaint should they consider their conduct unfair and members would be required to take legal action through the Courts should they seek relief. Such organisations are not insurers and say so expressly and the benefits of membership are discretionary.²² Accordingly, there is no contractual obligation to meet the cost of any claim of any practitioners they cover. Unlike insurers, which are governed by a complex set of insurance laws and regulations including obligations on reserving, mutual organisations have no legal obligation to ensure that they have a reserve to cover the cost of claims. Such membership does have the potential benefit that it may allow the organisation to exercise its discretion in such circumstances where the practitioner or facility may not have been ordinarily covered had they held insurance due to limitations of liability or exclusions.

There is an ongoing debate as to whether the discretionary indemnity offers less certainty to healthcare practitioners than a contract of insurance. The rules of membership usually provide that the organisations' discretion is absolute, any assistance offered is at the organisation's sole discretion and that they are, therefore, not obliged to pay out in any circumstances.²³ Healthcare professionals accordingly have less certainty and assurance of incidents where

they may not be covered under a discretionary indemnity. In South Africa there is no regulatory oversight by the Financial Services Conduct Authority of the provision of discretionary indemnities in the circumstances.

Occurrence-based and claims-made types of medical malpractice insurance

Traditionally medical malpractice cover has been provided through a claims-made policy. That covers claims, as defined, arising after the start and retroactive dates of the policy in force, first brought against the insured whilst the policy is in force. Various claims-made policies may provide for extended reporting periods and deeming provisions where an event is first notified whilst the policy is in force, but the claim is made against the insured after the policy has ended.

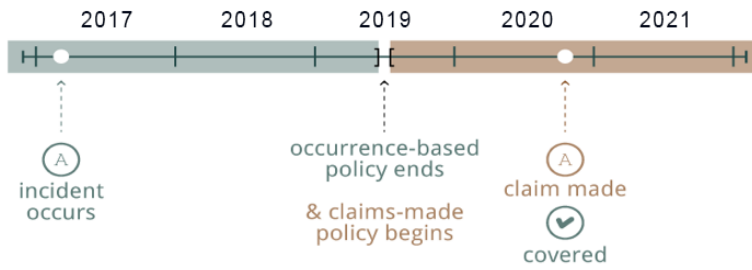
An occurrence-based policy provides cover for events that occurred during the period of insurance even though the claim is made after the end of the insurance.

In very broad terms, an occurrence-based policy protects against claims arising from incidents occurring while the policy is in force no matter when they are reported even if the claim occurs years after the end of the insurance. Whilst under a claims-made policy, the insured is protected for incidents which both occur, and are reported, whilst the policy is in force. A significant benefit of an occurrence-based insurance is, however, the protection in respect of claims relating to incidents occurring during the life of the policy of which the healthcare practitioner was unaware of and could, therefore, not have notified their insurer of.

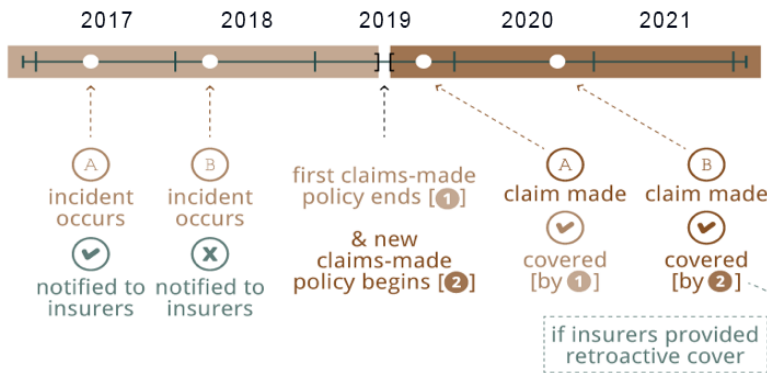
Under both types of policies, whether or not there is or may be a gap in cover, will be informed by the terms of the policy, the retroactive date, the notification by the insured to the insurer of its obligations and any deeming provisions, and any extended notification periods. The following diagram demonstrates and allows for a discussion regarding any claim exposure.



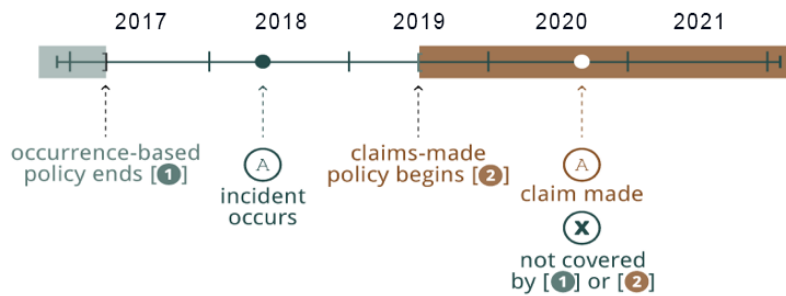
occurrence-based cover:

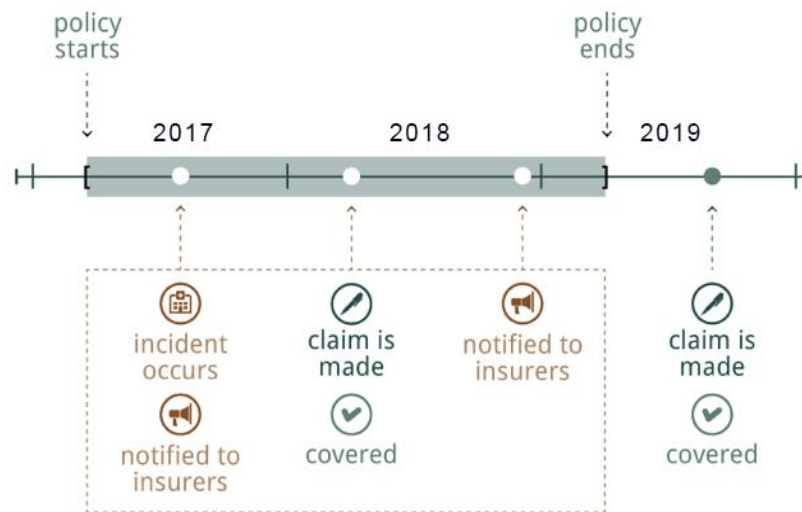


claims-made cover:



no cover:





In an occurrence-based policy the limits which are available to pay a claim are the limits which were in place during the policy term that the medical treatment was provided. In a claims-made policy, unless there are deeming provisions regarding the notification of the incident, the limits that apply to a claim are the limits that are in place at the time that the claim is made, and not at the time that the medical treatment was provided.

The tail

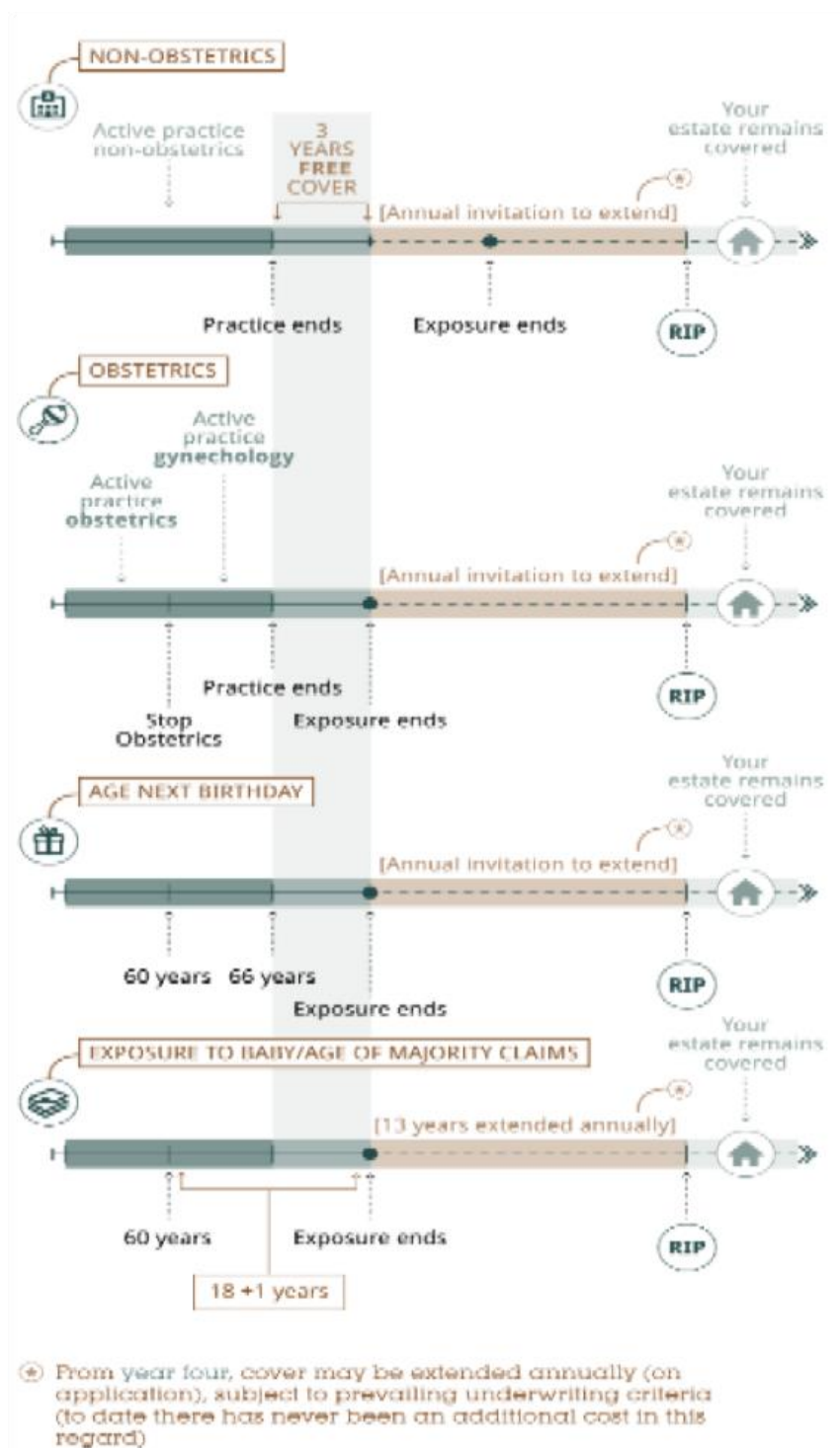
Claims are usually made by a patient against the healthcare practitioner or healthcare facility some time after the treatment is provided. The "Tail" refers to the time period between the adverse incident occurring and it being reported, and/or a claim made. There may be a delay between the incident occurring and the patient becoming aware that they have suffered harm and have a claim. Adult patients have three years within which to institute a claim. The running of the three years commences on the date on which the patient becomes aware that they have suffered harm.²⁴

So, the date when the patient actually claims may even be longer than the three years if the patient can justifiably demonstrate that the date on which they became aware that they had suffered harm was outside the three-year period.²⁵

It is rare that claims are made soon after an adverse event occurs. A review of the medico-legal judgments in 2018 indicate an average eight-year period from date of incident to date of judgment.²⁶

To protect the insured under a claims-made policy, this is dealt with by way of "Tail" cover or "run-off" cover or under extended reporting provisions in the event of the insured's death, permanent retirement, immigration or ceasing to work due to permanent ailment or ceasing

to practice as a healthcare practitioner. Often an extended reporting period may be obtained for a limited period without an additional premium. Further extended reporting periods may be obtained on application and such terms and conditions as the insurer determines. Under a "Tail" policy there is the benefit of protection in perpetuity for claims arising from that particular period of insurance's practice without the need to acquire (with or without an additional charge) the run-off cover. The following demonstrates the application of run-off cover where there is three years free extended reporting period:



It is possible to move between claims-made insurers without purchasing a tail. The new insurer will take over the predecessor insurer's responsibility by writing the policy retroactively over the previous insurer. It picks up the retroactive date offered by the previous insurer and may charge a premium based on the number of years previous cover needed²⁷. Where the new insurance provides protection for a former practice it is known as nose coverage. Tail coverage refers to claims-made medical malpractice insurance coverage for a claim that may arise a given number of years after the practitioner discontinues their medical malpractice insurance policy. Tail coverage does not cover the practitioner for active practice but for events that occurred while the policy, since discontinued, was active. Tail coverage is usually a built-in feature of occurrence-based policies.

Retroactive date

The retroactive date is the date from which the insured has held uninterrupted indemnity insurance (even if the insured has changed insurers in that time) or from the date where the insurer has agreed to cover the insured. Any claim that arises prior to the retroactive date would not be covered by the retroactive insurance. For professional indemnity insurance the retroactive date should normally be from the first day the healthcare practitioner started practising or if the insurer has changed and there is an existing professional indemnity policy in place, the date that the existing policy started. The start date of the new policy would be the inception date, but work done by the healthcare practitioner before the inception date of the new policy with the insurer, right back to the first date of the retroactive period would be included.

The retroactive date is a key term included in every professional indemnity policy written on a claims-made policy basis, since such policy would, as a general proposition, not include claims made before or after the policy period no matter when the claim occurred. Under the claims-made policy, the retroactive date serves to exclude claims for events which occur prior to that date even if the claim is first made during the policy period. The retroactive date may be used to eliminate coverage for events which give rise to claims in the future and to prevent obsolete claims which arise from events far in the past. Where a healthcare practitioner renews a claims-made policy or changes insurers, it is important to preserve the policy's original retroactive date.

Financial structure of the policies

There is a significant difference between the pricing structure of an occurrence-based and claims-made policy. Both policies will determine a premium based on, amongst other things, the speciality of the healthcare practice, place of practice, size of the practice and claims experience and is reviewed annually. The occurrence-based policy premium provides protection from all future claims occurring within the insurance year. That premium has to factor in, up front, the "Tail" referred to above. Because there is generally a long delay between the incidents of medical negligence, the claim being reported and the resolution of

the claim, this places great pressure on the insurer to provide sufficient cover for such claims and is subject to considerable uncertainty. Insurers are under regulatory requirements to hold and reserve sufficient capital in respect of such claims and, in the event of the possibility of such claims.

Claims-made policies use the same variables as above but are structured differently and are cheaper than occurrence-based policies. A claims-made premium may rise in price and then usually even out at 20 to 25% less than the occurrence-based premiums over a 10 year period, because of the changing nature of the protection obtained.

For example, in year one of claims made in the year of the insurance purchased, (and let's assume that the healthcare practitioner begins practising in that year too) cover needs to be provided for claims both made and reported in that year. Incrementally, as the healthcare practitioner continues to practice, premiums need to provide for notifications during subsequent years of practice and the likelihood of a claim increases both because of the increasing length of practice and the need for the patient to claim before prescription intervenes (prescription is the three-year period in which the patient has to claim, discussed above). The longer the indemnity is in force, the further back it must reach to protect the healthcare practitioner. The claims-made risk will mature when most of the claims from practice from early years are notified or have been made. An occurrence-based policy provides both protection from recognised incidents of which the healthcare practitioner is aware of and from events which may give rise to a claim, which the healthcare practitioner is not aware of and therefore, has not reported to the insurer. Because the claims-made policy protects only against recognised events, the premium is, as a matter of principle, cheaper than an occurrence-based policy.

Notifications

Both occurrence-based policies and claims made policies²⁸ require the practitioner to give notice of occurrence of the event which may give rise to a claim on the policy or the claim itself. The extent, timing, and nature of what should be notified are subject to the particular terms of each policy. Examples of the types of notifications required are seen in clauses 11.15 to 11.17 of the claims-made policy attached, clause 7.5 of the occurrence-based policy attached and clauses 11.12 to 11.14 of the Healthcare Facilities Liability Policy attached. Such notice allows the insurer to investigate circumstances of the claim under the most favourable circumstances, to ensure that it minimises its and its healthcare practitioner's liability in the event of a claim.²⁹ The precise content of the notice required depends on the terms of the policy in question and of course the context in which it is acquired³⁰. The notice needs to be sufficient to enable the insurer to ascertain when the claim occurred and whether it may incur liability.³¹

Claims-made policies usually provide for "incident" or "demand" reporting. These are referred to as the claims trigger. Where incident reporting is required, the claims-made insurer is responsible for any incident reported to it during the time that the policy is in force even if it

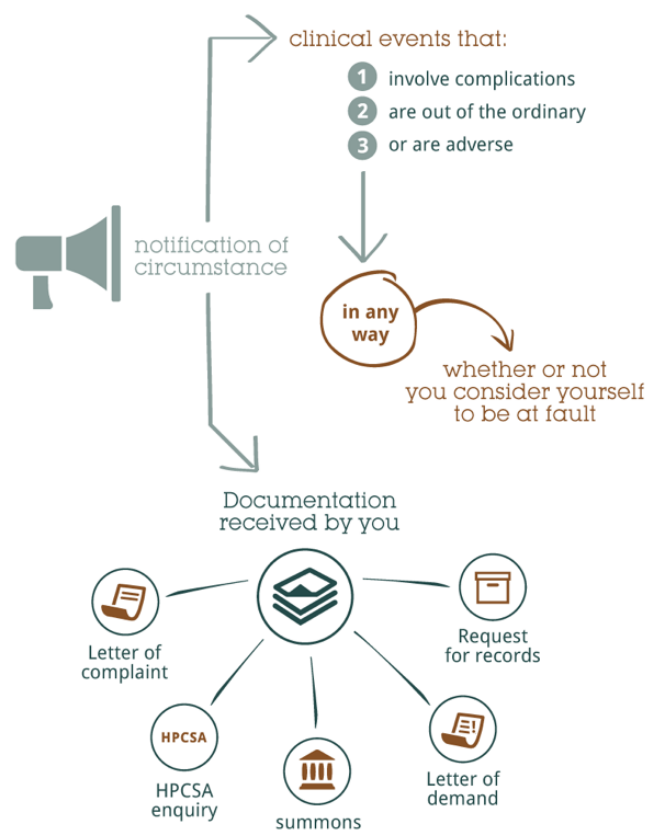
does not ripen into a claim until after the policy has ended. In demand reporting the insurer is only liable for claims made during the policy term. That would require the incident reported to become a claim during the same period of insurance.

Compliance with the notification obligations is usually a condition precedent for the insurer's liability under the provisions of the policy.³²

An insurer who wants to deny liability for non-compliance with the notice obligations must allege and establish the absence of a proper notice.³³

A policy may contain to the benefit of the insured healthcare practitioner the provision that where notice is given of occurrences and circumstances that *may* give rise to a claim as compliance with the notification obligations during the period of insurance, then for the purposes of the relevant operative clauses and any extensions, the claim which eventuates therefrom will be deemed to be made during the period of insurance. This is the form of incident reporting referred to above. So, where for example, notification is given of an event which may give rise to the claim during the period of insurance, but the claim only eventuates ten years later and after the insurance has ended the practitioner would be covered for that claim but of course on the terms and subject to the limited liability of the policy in force during the period of insurance in which the event was first notified. It would also mean that if the healthcare practitioner has maintained their claims-made insurance until year ten, the indemnity period applicable in the first year applies and not that applicable in year ten.

Here is an example of the practical application of the notification obligations:



Other policy terms

The attached schedules are for occurrence-based and claims-made policy wordings for healthcare practitioners and healthcare facilities current in the market. All have features common to the type of insurance offered.

The limit of indemnity is the maximum amount which the insurer will pay in respect of any one claim. There is usually also the aggregate indemnity limit per annum. The individual limit is the amount that the insurer will pay for a single claim. The aggregate limit is the total amount that the policy will pay during an established period of time. The aggregate can cover multiple claims. The two limits are usually written together. The policy may also provide for a specified number of reinstatements of the cover annually. The indemnity limit is usually inclusive of claimant's costs and defence costs, interest and VAT.

A deductible, also known as an excess or first amount payable, may apply. If a deductible is payable, the amount may vary depending on the nature of the practice and the claim. For example, there may be a significant deductible for cerebral palsy baby claims. It is an option to include a deductible to obtain a premium discount. There may be an indemnity deductible or indemnity and defence deductible. An indemnity deductible requires payment of a sum of money to the insurer only when there is an indemnity judgment. In the case of an indemnity and defence deductible the insured must pay the deductible as soon as expenses are incurred in defending the medical malpractice claim whether there is an indemnity payment or not. The policy wording may also require payment of the deductible before any defence steps are taken by the insurer.

Therefore it is very important that when an indemnity limit is chosen, and any deductible agreed, the healthcare practitioner has regard to their risk exposure and not only the type of capital awards which are made against healthcare practitioners in that same field where there is negligence but also all the legal costs involved.³⁴ In the *Suliman* judgment example, agreed damages were R20 million which excluded the claimant's costs which would have to be paid and the hospital and doctor's own legal costs. Those costs in the context of the case would have been significant, probably between R3 million to R5 million so if, for example, the hospital's indemnity limit was R20 million for any one claim and the hospital did not succeed in obtaining the contribution from the doctor, the hospital would be out of pocket in respect of all those costs.

Professional indemnity policies usually cover not only the medical malpractice claim itself but would include cover in respect of HPCSA, legal and medical costs but usually to a sub-limited extent and would exclude liabilities in respect of penalties or fines payable.

Claims-made policies may then have various extensions including public liability, product liability, and/or employer's liability.

There are various exclusions in respect of the cover which include exclusions regarding:

Any deliberate, conscious or intentional disregard by the practitioner to take reasonable precautions to prevent loss, injury or damage;

Conduct whilst under the influence of drugs or alcohol;

Dishonest, fraudulent, illegal or criminal conduct;

Clinical trials: clinical trial insurance is obtainable and obligatory in terms of the ethical rules of the sponsoring institution and is a specialised form of insurance;

Events or claims which are, or ought to be notified under any other insurance or the equivalent or in respect of which the insured is entitled to indemnity under any other insurance or its equivalent (which highlights the importance of notifications);

Punitive or aggravated damages;

There are usually territorial exclusions, for example, for claims made within the United States of America or Canada.

Malpractice policies usually contain some form of a consent-to-settle clause. This requires the insurer to obtain the insured's agreement before settling and provide a mechanism for resolution of any disagreement regarding a settlement.³⁵

Policies may also have a "hammer" clause instead of a consent-to-settle clause. This takes effect if the insured refuses the insurer's settlement recommendation, chooses to go to trial instead, and ends up with an award higher than the settlement.

A healthcare practitioner or anyone on their behalf, must not admit liability, accept a claim, or settle a claim without the insurer's prior written consent. Healthcare practitioners must be conscious of the balance between acting with compassion and sympathy, where there is an adverse health event, and breaching their contractual obligation with their insurer in terms of acting without their insurer's consent.³⁶

Donald Dinnie
March 2019
www.natmed.mobi

End notes

- ¹ Halwani, T and Takroui M: Medical laws and ethics of Babylon as read in Hammurabi's code (History). The Internet Journal of Law, Healthcare and Ethics, Volume 4, Number 2
www.ispub.com

Violato, Claudio: Doctor-patient relationships, laws, clinical guidelines, best practices, evidence-based medicine, medical errors and patient safety. Can Med Educ J. 2013; 4(1): e1-e6.
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4563658/>
- ² 1914 AD 419

See also the classic formulation for medical negligence in *Van Wyk v Lewis*, 1924 AD 438; *Goliath v MEC for Health, Eastern Cape*, 2015 (2) SA 97 (SCA)
- ³ See, for example, *Masuku v Mdlalose* 1998 (1) SA 1 (SCA) but also see *Metewa v Minister of Health* 1989 (3) SA 600 D and *Esterhuizen v Administrator, Transvaal*; *Dube v Administrator Transvaal* 1963 (4) SA 260 (T) and *Buls v Tsatsarolakis* 1976 (2) SA 891 (T)
- ⁴ SA law reform commission, Issue paper 33, Project 141 – Medico legal claims, 20 May 2017, 29
- ⁵ C. Coetzee & Pieter Carstens, *Medical Malpractice and Compensation in South Africa*, 86 Chi.-Kent L. Rev. 1263 (2011).
- ⁶ SA law reform commission, Issue paper 33, Project 141 – Medico legal claims, 20 May 2017, 35
- ⁷ See Regulation 12.2.1 of the Public Finance Management Act, 1999 as read with Section 76 (1)(h): An institution must accept liability for loss or damage suffered by another person, as for a claim against the state, which arose from an act or omission of an official. There are some limited exceptions to this. Those provisions make it unnecessary for a doctor or nurse employed by a province to obtain medical malpractice insurance since they are indemnified for their conduct by the state.
- ⁸ Since this announcement, the Courts have moved with the times to acknowledge that the test is that of a reasonable person and not the reasonable man.
- ⁹ In the recent judgment of *Life Healthcare Group (Pty) Ltd v Dr Suliman* 2018 (SCA) the Court allowed the Hospital to recover a contribution from the negligent doctor on the basis of a 40-60 apportionment in favour of the Hospital. The hospital conceded liability to the patient and was liable for R20 million. The hospital then sued the attending doctor for a contribution to the amount, and the court found that the doctor was contributorily negligent and therefore should make a contribution to the payment – in fact, the doctor's portion of the liability was higher than that of the hospital's in this case. A hospital (or its subrogated medical malpractice insurer) could in law also recover damages, or a contribution to damages, for which the hospital was vicariously liable from, for example, its negligent nurses. For various reasons that is never done.
- ¹⁰ *S v Kramer* 1987 (1) SA 877 (W)
- ¹¹ See Section 61 of the Consumer Protection Act 68 of 2008 which provides that suppliers of goods may be held liable for any harm caused as a result of the supplier of unsafe goods, product failure, a defect or hazard in the product, inadequate instruction for the use of goods or warnings related to any possible hazard which might be associated with the product whether or not there was fault

on the part of the supplier. So, negligence and foreseeability is no longer required for liability. There are some defences to this modified liability which include if it is unreasonable to expect for a distributor or retailer to have discovered the defect or hazard.

¹² Exclusionary clauses also known as “exemption clauses”, “indemnity clauses” “exculpatory clauses” and “waivers”. See *Afrox Healthcare Bpk v Strydom* 2002 (6) SA 21 (SCA) see *Strydom* now in the context of Sections 2(2), 48, 51 and 54 of the Consumer Protection Act.

¹³ Pepper and Slabbert 2011 *SAJBL* 29, where it is pointed out that there has been a 900% increase in claims of over R5 million, compared to approximately 10 years ago.

¹⁴ Reference to the agreed damages of R20 million – this was a cerebral palsy baby claim which claims are notorious for the quantum of damages claimed and awarded. An award of R20 million for a cerebral palsy claim is “run of the mill”. There have been awards and/or settlements far in excess of that and it is not unusual now to find claims in the pleadings in excess of R50 million with some exceeding R100 million.

¹⁵ See *Goliath v MEC for Health, Eastern Cape*, 2015 (2) SA 97 (SCA) and also *MEC for Health, Western Cape v Q*, Supreme Court of Appeal September 2018; *AZ v Member of the Executive Council for Health, Eastern Cape*; Eastern Cape High Court 14 August 2018; and *Clarke v MEC for Health, Western Cape and Another*, Western Cape High Court 28 March 2018 2015 (2) SA 97 (SCA)

¹⁶ In *AAI Limited (t/as Vero Insurance) v GEO Group Australia Pty Limited* [2017] NSWCA 110 the insuring clause provided:

“The insurer will indemnify the Insured against civil liability for compensation and the claimant’s costs and expenses in respect of any Claim or Claims first made against the Insured and notified to the Insurer during the Period of Insurance resulting from the conduct of the Health Care Services.”

The insured was a private operator of a correctional centre contractually required to provide psychological and psychiatric services to inmates. A disturbed inmate jumped off a landing and suffered serious brain injuries and successfully claimed against, amongst others, the insured for damages suffered. The allegations were that the insured failed to provide him with adequate healthcare services as it ought to have done. The insured sought an indemnity under its medical malpractice policy. The insurer argued that the non-provision of counselling and psychological services to the inmate did not fall within the cover provided by the policy. Both the trial and appeal courts disagreed and found that the cover extended to claims concerning acts and also omissions in the conduct of the healthcare services which were defined as the provision of medical services and treatment including services and treatment provided by psychologists and counsellors. The insurer had unsuccessfully argued that the non-provision of the services related to the provision of the insured operational custodial services, which it did not insure, rather than its healthcare services. The appeal court held that an objective observer would conclude that the parties to the insurance policy intended that the “conduct” of the healthcare services include an omission by the insured to provide healthcare services. The court applied a broad interpretation of the insuring clause so that the cover applied.

¹⁷ For a working definition, and as point of departure, see *Lake v Reinsurance Corporation Ltd* 1967 (3) SA 124 (W) 127-128

¹⁸ Section 46 of The National Health Act 61 of 2003

For a discussion on the aborted attempt to require doctors to obtain medical malpractice insurance see the short-lived regulations discussed in "Medical practitioners must be insured" Donald Dinnie, 13 September 2010, Mondaq www.mondaq.com

¹⁹ State Liability Act 20 of 1957

²⁰ See, for example, the Public Finance Management Act, Act No 1 of 1999

²¹ See, for example, the Medical Protection Society Limited www.medicalprotection.org

²² In the *Medical Defence Union Limited v The Department of Trade* [1979] [1] Lloyds Rep 499 Chancery Division the Court, in considering the business of the Union and the contract between a member and the Union at the time, held that the Union was not an insurance company carrying on insurance business within the meaning of the relevant insurance legislation.

²³ MDU Memorandum and Articles of Association <https://www.themdu.com/about-mdu/memorandum-and-articles-of-association>; MPS Memorandum and Articles of Association https://www.medicalprotection.org/docs/default-source/pdfs/financial-information/mps_memoarts.pdf?sfvrsn=14; MDDUS Articles of Association <https://www.mddus.com/about-us/corporate-governance/mddus-corporate-documents>

²⁴ See Spies, Dominique: Best before date of litigation. May 2018. www.medicaldefence.mobi

²⁵ See, for example, the discussion regarding prescription in *Loni v Member of the Executive Council, Department of Health, Eastern Cape, Bisho*, Judgment of the Constitutional Court, February 2018 and the earlier judgment of *Links v The Member of the Executive Council, Department of Health, Northern Cape Province* (2016) CC. The law allows the start of the three-year period to run from when the claimant ought to have become reasonably aware of the harm and the identity of the debtor. There are also further exceptions to the three-year period relating to minors and persons who are mentally incompetent. In South Africa the age of majority is 18 years. If on the age of majority, the three-year period in respect of the minor's claim would have already run, the minor has an additional one year within which to institute the claim. So, for an example, in the case of a child injured at birth that child would have until the age of 19 to institute any claim. If a child is injured at age 17 they will have, in the normal cause of events until age 22 to institute the claim.

²⁶ See the cases surveyed in Natmed's Annual Survey of Medical Malpractice Judgments of 2018, www.medicaldefence.mobi; also see: SA law reform commission, Issue paper 33, Project 141 – Medico legal claims, 20 May 2017, 20 - 22

²⁷ It is unusual for an insurer to charge for retroactive cover.

²⁸ This is new for occurrence-based premiums for obstetricians only.

²⁹ See *Trollip v Southern Life Association* (19) 17 CTR 490; *Norris v Legal and General Assurance Society Limited* [1962] 4 SA 422 C

³⁰ When notification is required, can be the source of some angst to an insured. The judgment of *Jacobs v Coster & Avon Insurance* [2000] Lloyds Rep IR 506

³¹ See, for example, *Russell and Loveday v Collins Submarine Pipelines Africa (Pty) Ltd* 1975 (1) SA 110 (A) 149-151

³² See, for example, *Carli v Incorporated General Insurances Limited* [1976] 2 ALL SA 443 (D)

- ³³ See, for example, *Russell and Loveday* above; *Johnson v Incorporated General Insurances Limited* 1983 (1) SA 318 (A)
- ³⁴ See *Naidoo v MEC for Health, KwaZulu-Natal*, *Naidoo v MEC for Health, KwaZulu-Natal*, *Phewa v MEC for Health, KwaZulu-Natal*, *Govender v MEC for Health, KwaZulu-Natal*, *Nthombela v MEC for Health, KwaZulu-Natal* Judgment of 14 March 2018 as reviewed in Natmed's Annual Survey of Medico-Legal Malpractice Judgments 2018
- ³⁵ There may be good reasons to settle a claim. A settlement may allow a resolution which avoids exceeding the insurance coverage and exposure to an adverse judgment.
- ³⁶ See Dinnie, Donald: "When Sorry is the Hardest Word"
<https://www.bizcommunity.com/Article/196/148/177114.html>