

**ADDIS ABABA UNIVERSITY**  
**SCHOOL OF GRADUATE STUDIES**  
**SCHOOL OF LAW**

**LIABILITY OF MEDICAL INSTITUTIONS IN ETHIOPIA:  
INJURIES CAUSED BY INDEPENDENT CONTRACTORS AND  
NON-EMPLOYEE PHYSICIANS**

**BY**  
**BY HABTAMU SIMACHEW**

**September, 2011**

**ADDIS ABABA UNIVERSITY**  
**SCHOOL OF GRADUATE STUDIES**  
**FACULTY OF LAW**

**LIABILITY OF MEDICAL INSTITUTIONS IN ETHIOPIA:  
INJURIES CAUSED BY INDEPENDENT CONTRACTORS AND  
NON-EMPLOYEE PHYSICIANS**

**BY: HABTAMU SIMACHEW**

**ADVISOR: MAHARI REDAE (Asst. Prof.)**

**A Thesis Submitted to Addis Ababa University, the School of Graduate Studies, School of Law in Partial Fulfillment of the Requirements for the Degree of Master of Laws (LL.M) in Business Law**

October, 2011

### Declaration

I the undersigned, declare that this thesis is my original work and has not been presented for a degree in any form and in any other university, and that to the best of my knowledge and belief all source of material used for the thesis have been duly acknowledged.

Declared by:

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Confirmed by Advisor:

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Place and date of submission:

# Table of Contents

Acknowledgment.....	i
Abstract .....	ii
CHAPTER ONE	
1. INTRODUCTION.....	1
1.1. Background of the Study.....	1
1.2. Statement of the problem.....	3
1.3. Objectives of the study.....	4
1.4. Method/Approach.....	4
1.5. Significance of the Study.....	5
1.6. Limitation of the Study.....	5
1.7. Organization of the Study.....	6
CHAPTER TWO	
2. The Health Care System in Ethiopia.....	7
2.2. Medical Institutions and Services in Ethiopia.....	7
2.3. Health Care Relationships.....	11
2.3.1. Physician-patient Relationship.....	11
2.3.2. Patient-Medical Institutions Relationship.....	12
2.3.3. Physicians-Medical Institutions Relationships.....	12
2.4. The Regulation of Health Care in Ethiopia.....	13
2.3.1. The Regulation of Health Professionals.....	15

2.3.1.1.	Licensure of Health Professionals.....	17
2.3.1.2.	Requirements to Issue License.....	18
2.3.1.3.	Dealing with Problems Surrounding License.....	20
2.3.2.	The Regulation of Health Institutions.....	21
2.3.2.1.	Certification of Competence/ Institutional Licensure.....	22
2.3.2.2.	Requirements for the Issuance of Certificate of Competence.....	22
2.3.2.3.	Suspension and Cancelation of Institutional License.....	23
2.3.3.	Enforcement of Regulations.....	24

### CHAPTER THREE

3.	Medical Malpractice and Negligence.....	26
3.1.	Negligence.....	27
3.2.	Malpractice.....	27
3.3.	Establishing Medical Malpractice or Negligence.....	28
3.3.1.	Duty Owed the Patient.....	29
3.3.1.1.	Establishing Health Care Standards.....	30
3.3.1.2.	Crisis Standards of Care.....	32
3.3.2.	The Breach of Duty.....	34
3.3.3.	Causation.....	36
3.3.4.	Damages.....	38

### CHAPTER FOUR

4.	Liabilities of Health Institutions in General.....	41
----	--	----

4.1.	Liability of Medical Institutions in Tort.....	43
4.1.1.	The Doctrine of Ostensible Agency.....	47
4.1.2.	The Doctrine of Corporate Negligence.....	49
4.2.	Liability of Medical Institutions in Contract.....	52

## CHAPTER FIVE

5.	Liability of Health Institutions in Ethiopia.....	54
5.1.	Liabilities of Health Institutions Arising out of Contract of Hospitalization....	54
5.1.1.	Medical Treatment.....	56
5.1.2.	Board and Lodging.....	60
5.2.	Liabilities of Health Institutions Arising out of Tort.....	60
5.2.1.	Liability of Public Health Institutions in Ethiopia.....	61
5.2.2.	The Liability of For-profit Health Institutions.....	62
5.3.	Medical Malpractice Claims in Ethiopia.....	64
5.4.	Impact of Health Care relationships on the Liability of Health Institutions.....	67
5.5.	Case Report and Comment.....	71
5.5.1.	CASE ONE.....	71
5.5.2.	CASE TWO.....	75

## CHAPTER SIX

6.	Conclusions and Recommendations.....	79
	Bibliography.....	82

## **Acknowledgment**

I am heartily thankful to my advisor, Mahari Redae (Asst. Prof.), whose supervision and constructive comments enabled me to develop good understanding of the subject. I also would like to thank those who supported me in any aspect during the completion of this work.

## **Abstract**

*In most jurisdictions the liability of medical institutions for the injuries caused to its patients used to be conditional up on the employment relationship that may exist between the institution and the health professional that caused the injury. However, modern medical institutions started to avoid formal employment relationship with physicians to insulate themselves from medical malpractice claims that may arise due to the fault of the attending health professional. Given the modern set up of health institutions, where patients' reliance is placed up on the effectiveness of the institution- not individual physicians, some legal systems responded to this situation by adopting theories of corporate negligence and ostensible agency to establish the liability of such health institutions for medical malpractices and faults committed by non-employee physicians or independent contractors. This thesis therefore explores the Ethiopian legal framework towards the liability of medical institutions for medical malpractices and shows how the Ethiopian Civil Code of 1960 leaves untouched the liability of medical institutions when independent contractors or non-employee physicians cause injury to a sick person within the premises of the institution, and makes suggestions to update the law to cope with new developments in the health care relationships and medical service.*

# CHAPTER ONE

## 1. INTRODUCTION

### 1.1. Background of the Study

In the relationship between medical institutions\* and patients, a medical treatment is the central purpose of the relationship. Given that, the treatment may sometimes goes wrong and cause injuries or fail to bring the hoped-for beneficial outcome<sup>1</sup>. Depending on the type of relationship, the injured patient in principle claim compensation from the institution.

Historically, medical institutions used to render a charitable service<sup>2</sup>. Due to this non-profit purpose most legal systems provide immunity clauses for medical malpractice actions. The prime reason advanced to support this immunity was that one who seeks and accepts charity must be deemed to have waived any right to damages for injuries suffered.

When medical institutions started to charge patients for medical care and treatment, the charitable immunity for medical institutions began to disappear. Accordingly, society's attitude towards the health care industry has changed concurrently and the increased emphasis, on "consumerism" has led to increased demands by patients for extraordinary, if not perfect, results from the performance of medical professionals.

Consequently, medical institutions become parties in medical malpractice actions. In this regard, there are two different approaches to govern the liability of medical institutions, namely of tort and contract. The importance attached to these rules towards the liability of medical institutions is different in different countries.

First, the tort rules as basis for the liability of medical institutions is common in the Anglo-Saxon countries as the relationship between the patient and the institutions is often excluded from the

---

\*The author has used the term "medical institution" or "health care institutions" throughout the thesis to refer to institutions established to provide health care.

<sup>1</sup> Marc Stauce, *The Law of Medical Negligence in England and German: A Comparative Analysis*, Hart Publishing, Oregon, 2008, P 17.

<sup>2</sup>Mark E. Milsop, Corporate Negligence: Defining the Duty Owed by the Hospital to their Patients, *30 Duq. L. Rev.* 639, 640. (1991-1992.)

regime of contracts<sup>3</sup>. Before the 1950s, medical malpractice actions against medical institutions in such countries were essentially based on rules of vicarious liability or respondent superior. This doctrine dictates that medical institutions are liable for the faults committed by employee physicians.

In order to reduce their potential liability for negligent treatment, medical institutions made a deliberate arrangement to enter in to a contract with independent contractor or non-employee physicians. As such, the independent contractor or non-employee status of a particular treating physician has become a bar to the medical institution's liability for malpractice. This was a clear paradox with the set ups of modern health care institutions. In the first place, most modern for-profit medical institutions present themselves to the public as full-serviced health care facilities committed to excellence. Secondly, they seldom attempt to inform patients of the employment status of their physicians nor is it likely they could do so effectively. Consequently, these and other concrete facts have resulted change in the legal rules of some common law countries to expand the liability of medical institutions for the faults committed by independent contractor and non-employee physicians<sup>4</sup>.

Second, the liability of medical institutions in contract is usually favored in countries following the civil law legal system<sup>5</sup>. The contractual dimension of medical institutions' liability presupposes the existence of actual contract between the patient and the institutions for the purpose of treatment. As such, the provision of medical treatment becomes the obligation of the institution, and negligent treatments constitute a breach of contractual obligation that the institution owes the patient.

The 1960 Civil Code of Ethiopia recognized both contractual and non-contractual liabilities of medical institutions. In cases of extra contractual liabilities, the Civil Code provides no separate rules that specifically deal with medical malpractices or negligence, instead the general tort provisions become applicable for medical malpractice actions. Conversely, the Civil Code enumerates some provisions regarding the contractual dimension of medical institutions'

---

<sup>3</sup> see Mark Stauce, *supra* n. 1:17

<sup>4</sup> New doctrines like corporate negligence and ostensible agency become instruments to expand the liability of medical institutions.

<sup>5</sup> See Mark Stauce, *supra* n. 1: 18

liability<sup>6</sup>. Specifically, Article 2651 of the Civil Code provides that medical institutions shall be liable for the damage caused to a sick person if the fault is committed by physicians or auxiliary staffs which the institution employs. As such, it excludes liability of medical institutions for the damages caused by independent contractor or non-employee physicians.

## **1.2. Statement of the problem**

Before half a century ago, in the US and UK, the liability of medical institutions for the damages caused by physicians was conditional upon employment relationships. Given that, medical institutions deliberately entered in to contracts with non-employee physicians to supply some services to patients that had previously been supplied by salaried employees of the hospital so as to mitigate their potential liability arising out of negligent treatments. These changes in hospitals bear concomitant change in laws, and liability of hospitals has expanded to cover the damages caused by independent contractors and non-employee physicians who practice medicine within the premise of the hospital<sup>7</sup>.

Similarly, Article 2651 of the Civil Code of Ethiopia, which is the pillar legal provision to establish the liability of medical institutions provide that ‘medical institutions shall be liable if the damage is caused by the fault of the physician or auxiliary staff which the institution employs.’ As such, the liability of medical institutions in Ethiopia is also dependent upon the existence of employment relationship between the physician and the institution.

As it has been indicated above, if the liability of medical institutions is limited to the damage caused by employee physicians, such institutions can insulate themselves from liability through contractual arrangements. Specifically, medical institutions may allow independent contractor or non-employee physicians to render medical treatments within the premises of the institution. This could happen in Ethiopia any time. If it happens, there will not be any legal remedy for the injured patient to claim compensation from the medical institution that renderers the treatment.

---

<sup>6</sup> See Article 2639-2652 of Civil Code of the Empire of Ethiopia, Proclamation No. 165/1960, Negarit Gazeta, Year 19, No. 2, Addis Ababa, 5<sup>th</sup> May 1960(here in after cited as Civil Code.)

<sup>7</sup> Theories of Corporate negligence (direct liability of medical institutions’ to their patients) and the doctrine of ostensible agency (liability of medical institutions for the faults of independent contractor and non-employee physicians) were introduced to expand the liability of medical institutions.

Stated differently, the victim's remedy will be limited to resorting against the physician personally.

Having said that this study specifically attempts to provide answer to the following questions:

1. What is the liability of medical institutions in Ethiopia in tort and contract?
2. What is the liability of medical institutions for the damages caused to patients by the fault of independent contractor or non-employee physician:
3. To what extent does the existing legal rule serve to address medical malpractice actions?

### **1.3. Objectives of the study**

The main purpose of this study is to explore the grounds by which medical institutions should be held liable for the fault of independent contractor or non-employee physicians in Ethiopia. In dealing with this issue, the study has also:

- Discussed the liability of medical institution in Ethiopia;
- explored the issues surrounding medical malpractice claims in Ethiopia; and
- assessed the regulation of health professionals and health institutions in Ethiopia.

### **1.4. Method/ Approach**

The study is a multi-method in nature so as to explain clearly the issues of medical institutions' liabilities. Accordingly, the researcher has reviewed literatures, conducted interviews, and made observations. All sources have served to provide information on the research question.

- ❖ **Literature Review:** the literature review component of this study represents reading and analyzing library and on line resources such as those identified in the bibliography.
- ❖ **Interviews:** the researcher has conducted interviews with legal professionals, health institutions, health professionals, professional associations in the field of health care, and officials from the Federal Democratic Republic of Ethiopia Ministry of Health. The

interviews were aimed to gather information regarding the activities of medical institutions and their liabilities.

- ❖ **Case study:** the author of this thesis is of the opinion that the study of real cases on medical malpractices may create a great deal of convenience to relate the practice with the laws of the country. The case study is made with the intent of commenting very selected issues from the judgment of courts.

The study has also involved some aspects of comparative study as it relates Ethiopian legal rules with the legal rules of some countries that are usually considered to have a well developed medical malpractice laws. Generally, the aforementioned methods have been used in the study.

### **1.5. Significance of the Study**

The author is of the opinion that the research will contribute to the proper understanding of medical institutions' liability in general, and their liability for the damages caused by independent contractor and non-employee physicians in particular. This in turn helps patients and medical institutions to understand their potential claims and counterclaims whenever medical malpractices or negligence occur within the confines of the institutions. Moreover, this research will also give an insight to legislator to fill the legal lacuna seen in areas of medical institutions' liability. This research also serves as reference for future researchers that will be conducted in this area since scanty literature is available about medical malpractices and liability of medical institutions in Ethiopia.

### **1.6. Limitation of the Study**

The author of this work considers the following issues as limitations of the study;

- Limitations related with the very nature of case report and comment. The researcher analyzed and attached two cases in this work. In this regard, the arguments of parties and the decision of the court in the cases that the researcher has commented may not reflect the ruling of all medical malpractice cases in Ethiopia.

- Limitations related with quantified data: even though the FDRE Ministry of Health publish an organized health and health related indicators in every five years, the number of medical errors is not yet included in the report. There are not also other documents that show the number or occurrence of medical errors in Ethiopia. This in turn, has hindered the researcher to give a clear picture that the occurrence of medical malpractices caused in the socio-economic sphere of the country. However, the researcher has used the occurrence of medical errors estimated in developing countries to understand the situation in Ethiopia.
- Limitations related with cooperation in the collection of information: some for-profit medical institutions were not willing to disclose the form of relationship that they have with health professionals practicing medicine within the premises of the institution. This has hindered the researcher from making estimates as to the number of independent contractors and non-employee physicians practicing medicine within medical institutions.

### **1.7. Organization of the Study**

This study is organized in six chapters. The first chapter gives the general background of the study, statement of the problem, objective, method and significance of the study. Chapter two reviews the health care system of Ethiopia by giving emphasis on the service rendered by medical institutions along with the existing regulatory framework of Ethiopia. Chapter three is concerned with the theoretical aspects of medical malpractice and negligence. Chapter four explores the liabilities of health institutions in general, whereas chapter five specifically deals the liability of health institutions in Ethiopia by addressing both aspects of tort and contract. Finally, the last chapter presents the conclusion and recommendations.

## CHAPTER TWO

### 2. THE HEALTH CARE SYSTEM IN ETHIOPIA

#### Preview

*Medical institutions do not espouse the same purpose. Depending on their purpose and function, medical institutions may vary from governmental to purely private. This classification is believed to be an important consideration in determining liability.*

#### 2.1. Medical Institutions and Services in Ethiopia

Medical institutions in Ethiopia undergone through changes since the birth of the first modern government run hospital in 1906<sup>8</sup>. This hospital was built by Emperor Menelik and popularly known as “Menelik II Hospital.” The second hospital was built by an American Christian Missionary Dr. Thomas Lambie in 1922<sup>9</sup>. This was the first modern charitable hospital in Ethiopia.

When the Ministry of Health was established in 1948, most health care institutions were run by religious missions for charity purpose<sup>10</sup>.

Today, however, medical services in Ethiopia are provided by the public and the private sector. ‘Medical institutions as public health providers’ refers to those medical institutions under the ownership of the government that provide medical services to the public. The quantity of these

---

<sup>8</sup> Aynalem Adugna, Health Institutions and Services, Lesson 13, P 4.

<sup>9</sup> In 1964 this hospital becomes a central laboratory research institute (Pasture) and finally it was merged with the Ethiopian Nutrition Institute to become the Ethiopian Health and Nutrition Research Institute (ENHRI). See *ibid*.

<sup>10</sup> *Ibid*.

institutions and the quality of service they rendered are very much dependent upon the economic development of countries.

In Ethiopia, the public sector which is the major provider of health care in the country is structured in a three tier health service delivery system<sup>11</sup>.

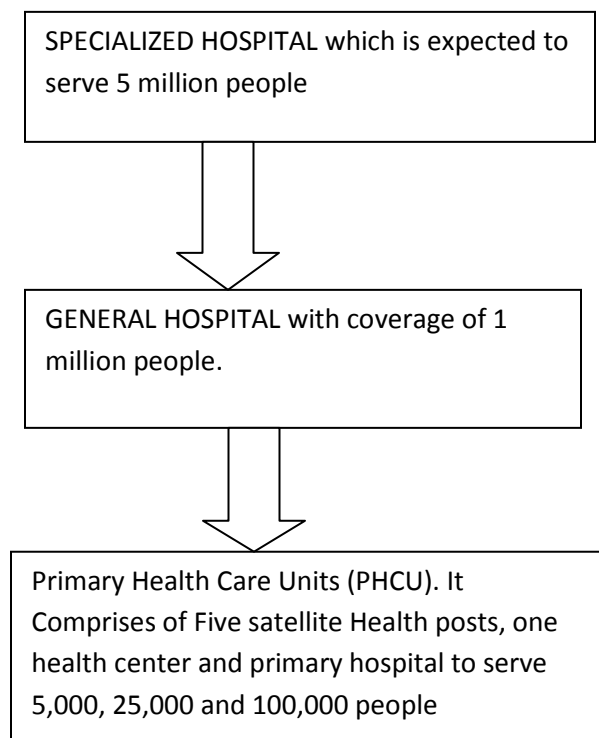


Fig. 1.2. A three tier health service delivery system in Ethiopia implemented after the late 1990s.

On the basis of ownership, medical institution might also be owned by private individuals and corporation. These institutions may be established to render medical services for profit or for-not-profit purpose. The profit oriented nature of these institutions in most jurisdictions triggered the imposition of a wide variety of liability for faults committed in its property or by its employees<sup>12</sup>.

<sup>11</sup> FDRE Ministry of Health & World Health Organization, Survey on Price of Medicines in Ethiopia, October 2005, Addis Ababa, Ethiopia. p 5

<sup>12</sup> Jim M. Perude, Direct corporate Liability of Hospitals: A Modern Day Legal Concepts of Liability for Injury occurring in the Modern Day Hospital, 21 S. Tex. L. J. 773, 776 (1983).

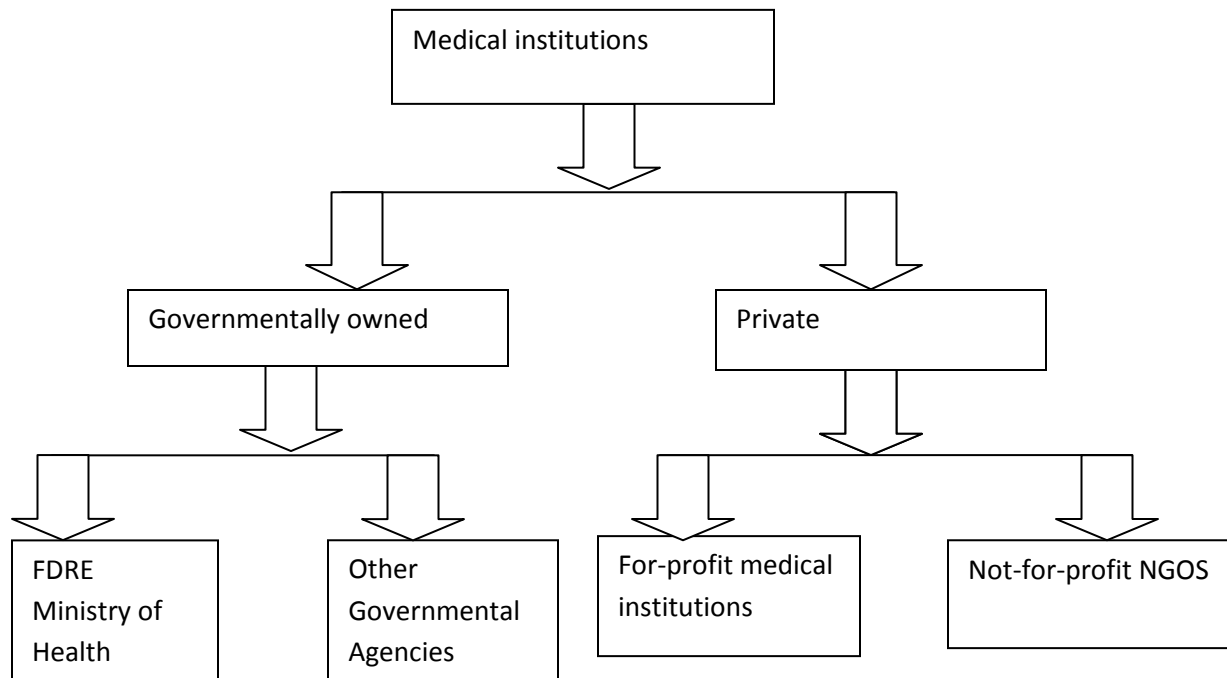


Fig. 1.1. Types of medical institutions in Ethiopia based on ownership

Normally, all medical institutions are not established to serve the same purpose. They may be established for profit, charity, maximization of utility or some other purposes. The Ethiopian health care system also encompasses a variety of medical institutions which have different purpose and organizational form. Understanding the organizational form of medical institutions is important for various reasons. Some of which that are relevant to the discussion include;

- A. Provision of Medical Services:** the provision of medical service is the common denominator of all for-profit, not-for-profit, and governmental medical institutions. However, there might be difference in their willingness to provide public services. Governmental and not-for-profit hospitals, for instance, are commonly known in the provision of public goods, while for-profit enterprises have very little or minimized involvements.
- B. Quality of Medical Services:** for-profit medical institutions have greater incentive on patient care than do not-for-profit medical institutions. Put it differently, greater pay in for-profit institutions may lead to better managerial ability which in turn bears better outcomes. In this regard, the empirical data collected by the USAID in 2009 shows that

the days and hours of operation of private facility and hospitals are better than public primary health care facilities<sup>13</sup>. Numerically, above 80 percent of private facilities operated daily; 18 percent operated every day except Sunday<sup>14</sup>. Conversely, the public primary health care facilities generally operate from 8:30 AM to 5:30 PM<sup>15</sup>.

**C. Liabilities:** the liability of medical institutions may arise either from contract or tort. When the relationship between the injured patient and the medical institution is formed on the basis of contract of hospitalization, the organizational form of medical institutions made no difference to establish liability in Ethiopia<sup>16</sup>.

However, the tort liabilities of private and governmental medical institutions are not identical. For instance, publically hold medical institutions in most jurisdictions are not subjected to tort claims by plaintiffs. The doctrine which precludes plaintiffs from lawsuits is commonly referred to as “governmental immunity.”<sup>17</sup> This doctrine has its origin in the English common law concept that the king could do no wrong; therefore, he and his subordinates could not be sued<sup>18</sup>.

Most jurisdictions have abandoned this doctrine in favor of permitting tort lawsuit with certain limitations and restrictions<sup>19</sup>. In Ethiopia, Article 2126(2) of the 1960 Civil Code provides that “where the fault is a professional fault, the victim may claim compensation from the state provided that the state may subsequently claim from the servant or employee at fault. If the fault is a personal fault, the state will not be held liable<sup>20</sup>. On the other spectrum, for-profit organization shall be liable under the law where one of their

---

<sup>13</sup> USAID, Assessing the Role of the Private Health Sector in HIV/AIDS Service delivery in Ethiopia, May 2009. P 28

<sup>14</sup> Ibid.

<sup>15</sup> Ibid.

<sup>16</sup> See Article 2651 of the Civil Code of Ethiopia. Broad discussion on the issue of liability of medical institutions will be made on chapter five of this paper.

<sup>17</sup> Dana C. McWay, Legal Aspects of Health Information Management, Delamar Publisher, 1997, p. 54

<sup>18</sup> In the US legal system it is adopted to mean that the government is immune from lawsuits arising out of the negligence of their officers, agents, and employees, unless the federal or state government expressly consented to the lawsuit. Federal Tort Claim Act in 1946 abolished US government’s immunity from tort liabilities and established certain conditions for suits and claims against the government. Acts within the scope of employment duties was among the conditions to sue the government. See Id. p 55.

<sup>19</sup> Ibid.

<sup>20</sup> Civil Code, Article 2126(3)

representatives, agents, or paid workers incurs a liability in the discharge of his employment duties<sup>21</sup>.

## 2.5. Health Care Relationships

The field of health care involves the interactions of different actors. The relationships formed between patients and medical institutions, patients and physicians, and physicians and medical institutions, however, are the usual and common ones. These relationships are decisive to determine liability in case of medical malpractices or negligence. A brief discussion of each relationship follows.

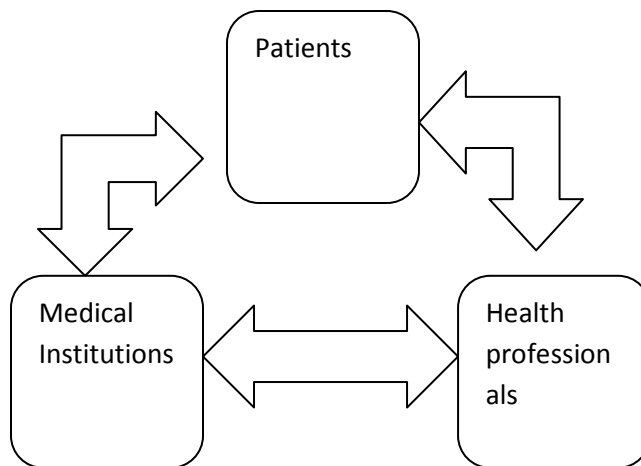


Fig 2.1. Health care relationships.

### 2.5.1. Physician-patient Relationship

The physician-patient relationship may be created in a variety of ways, but contract essentially serve as a basis for most relationships created between patients and physicians. As such it involves the basic elements in the formation of contracts like offer and acceptance. The initial offer is made by the patient when making a request for treatment; and acceptance is made by the physician when he expresses his agreement to render medical service or treatment.

The contractual relationship between physicians and patients might be an express or implied contract. In express contracts, parties agree on the terms of the contract either orally or in writing

---

<sup>21</sup> Ibid, Article 2129 & 2130.

or in any other form the law considers appropriate. An implied contract, on the other hand, is formed when the conduct of parties creates a tacit or implied understanding that an agreement has been reached. In the physician-patient relationships, an implied contract is created when a physician treats the patient prior to an agreement on the terms for payment and treatment.

The relationship created between the physician and the patient continues until such time that it has been properly terminated or the patient no longer requires treatment<sup>22</sup>. There are a variety of ways to terminate this relationship: 1) the physician may withdraw from the contract; 2) the patient may dismiss the physician; or 3) the physician and patient may mutually agree to end the relationship<sup>23</sup>. Termination of physician-patient relationship might also be attributed for the fact that the patient has either cured or died, or patient's failure to comply with the physician's order.

### **2.5.2. Patient-Medical Institutions Relationship**

The patient-medical institution relationship often begins when the patient is admitted to the medical institutions for treatment. At the time of admission, the patient's act of signing certain forms that demonstrate his agreement to pay the price for the treatment that will be rendered, might constitute an express contract to receive treatment. Unlike physician-patient relationships, express contracts are often used to create patient-medical institutions relationships.

Even though expressed contracts served as a basis for patient-medical institutions relationships, emergency care situations are exceptions to this rule. Normally, the emergency care situation influences medical institutions' ability to whether or not to create a relationship with the patient<sup>24</sup>. Accordingly, the emergency acts of most jurisdictions put a duty up on medical institutions to treat emergency patients. Thus the patient-medical institutions relationship might also be establish by the provisions of the law.

### **2.5.3. Physicians-Medical Institutions Relationships**

This relationship is essentially based on the contract between medical institutions and physicians. The contractual relationship may take different forms, interalia; a) employer-employee; b)

---

<sup>22</sup>See Dana C. McWay, supra n. 17: 37.

<sup>23</sup> Id. p 38

<sup>24</sup> Id. p 39

principal-agent; and c) independent contractor relationships (physicians may agree with medical institutions to provide medical service as independent contractors, without being employed.)

A physician-medical institutions relationship, in fact, does not directly involve patient care. However, the existence of this relationship is important to establish medical malpractice claims against medical institutions. Specifically, without this relationship, patient plaintiffs will not hold medical institutions liable for the damages caused by its staff physicians.

The liability issues along with the legal duties to maintain competent medical staffs, requires medical institutions to give due considerations before admitting and giving staff privileges to physicians. As such, medical institutions often look the educational backgrounds, experience, and license whether or not to admit a physician as its staff.

In sum, in the modern health care system, where patients/consumers demand quality and excellent medical services, medical institutions relationship with competent physicians is quite relevant. Because, this relationship, if not directly, indirectly has impact on the overall medical malpractice claims that patients plaintiffs may raise against medical institutions.

### **2.3. The Regulation of Health Care in Ethiopia**

Regulation may be defined as any government measure or intervention that seeks to change the behavior of individuals or groups by promoting the rights and liberties of citizens and restricting what they can do<sup>25</sup>. Governments have been often ready to introduce new regulation which has an important role in protecting the public, preventing fraud or ensuring minimum standards<sup>26</sup>.

Having said that, the regulation of health care, in simple terms, could be viewed as a body or sets of rules designed to secure good medical practices and services. In most countries, there is some sort of health field regulation, though there are important differences in the way the regulations are enacted. A number of factors could be listed for the difference in the health care regulatory framework of countries.

---

<sup>25</sup> Ellie Scrivens, Quality, Risk and Control in Health Care, Open University Press, Berkshire, 2005, p. 31

<sup>26</sup> Id. p 16

Presumably, the regulation of the health sector serves various purposes. Ensuring a better quality of medical services, and protecting patients from suffering harm are the most commonly invoked ones. Ellie Scrivens has written the following on the purpose of state regulation in general:

“...the main purpose of state regulation is to respond to and apply controls to minimize specific risks. Where individuals or businesses impose risks on others, government’s role is mainly as a regulator, setting the rules of the game. This suggests that the rules of the game are the controls imposed on the behavior of individuals or organizations, to reduce the risks that may be created for others<sup>27</sup>.”

Governments use a number of mechanisms to regulate the field of health care. However, the establishment and use of formal rules, procedures, and policies are very common in most jurisdictions. Accordingly, in Ethiopia, there are plenty of legislations that are relevant to regulate the field of health care. The following are some of the relevant legislations worth to be mentioned in this regard:

- Food, Medicine and Health Care Administration and Control Proclamation ( Proclamation No 661/2009);
- The Ethiopian Health and Nutrition research Institute Establishment Council of Ministers Regulation ( Regulation No. 26/1996);
- Public Health Proclamation ( Proclamation No. 200/2000);
- Ethiopian Health Professionals council Establishment Council of Ministers Regulation (Regulation No 76/2002);
- Social Health Insurance Proclamation ( Proclamation No. 690/2010);
- Food, Medicine, and Health Care Administration and control authority Establishment Council of Ministers Regulation (Regulation No. 189/2010);
- The Civil Code of Ethiopia; and

---

<sup>27</sup>Id. P. 61

➤ The Criminal Code of Ethiopia

An interesting point worth noting in the regulation of Ethiopian health care is that the federal structure of the country has produced systems of health care regulation organized at a state and federal levels. All the foregoing lists are produced by the federal government. As such, the federal government of Ethiopia played greater part in the regulation of the health sector. Conversely, in federal countries like US and Canada, the federal government has little or no part in health care regulation<sup>28</sup>.

### **2.3.1. The Regulation of Health Professionals**

The Greek physician Hippocrates who is generally regarded as the “father of medicine” produced major works on medical practice and medical law<sup>29</sup>. In the context of medical ethics, the so-called ‘Hippocratic Oath’ is still the basic ethical guide for the medical profession. As it is in most medical schools, graduating physicians in Ethiopia on taking the Hippocratic Oath, swears:

“... I will prescribe regimen for the good of my patients according to my ability and my judgment and never do harm to anyone. To please no one will I prescribe a deadly drug, nor give advice which may cause his death. Nor will I give a woman a pessary to procure abortion... in every house where I come I will enter only for good of my patients, keeping myself far from all intentional ill doing... all that may come to my knowledge in the exercise of my profession or outside of my profession or in daily commerce with men, which ought not to be spread abroad, I will keep secret and will never reveal....”

The aforementioned oath alone does not guarantee the proper application of medical practices. Accordingly, any government intervention or measure in the form of regulation which controls, directs or restricts the behavior of individuals or entities is very desirable. This takes us to the definition or meaning of the regulation of health professionals in Ethiopia.

---

<sup>28</sup> Kieran Walshe, Patient Safety First: Responsive regulation in Health care, (ed. Judith Health, & Paul Dugdale), Allen & Unwin, Australia, 2009, p. 58

<sup>29</sup> Lester A. Sobel, Medical Science and the Law: the life and death controversy, Facts on File Inc. United states, 1977, p. 2

Pursuant to Article 2(30) of FDRE proclamation No. 661/2009, the term “health professional” is defined as a physician who is licensed by the executive organ to examine and diagnosis human disease and treat them , by drug or surgical operation or any other health professional who is authorized to perform such activity. When we combine this definition of health professional with the definition of regulation provided above, it would give us a clue to understand what is meant by the ‘regulation of health professionals.’ As such, health professional’s regulation may be simply referred as the arrangements put in place to assure the quality of individual professional practice by health professionals<sup>30</sup>.

The regulation of health professionals is one of the mechanisms for protecting patients and the public against medical errors and for assuring and improving patients’ safety. In that case, it is basically meant to ensure that only qualified persons deliver health care. But, there are also other factors that need to be considered in the regulation of health professionals depending on the socio-economic realities of the countries. Jonathan Herring has listed certain principles that are important in the regulation of health professionals<sup>31</sup>:

- the overriding interest should be the safety and quality of care that patients receive from health professionals;
- The regulation needs to sustain the confidence of both the public and the professionals through demonstrable impartiality;
- Since health professionals’ regulation is about identifying and addressing poor practice or bad behavior, it should be as much about sustaining, improving and assuring the professionals standards of the overwhelming majority of health professionals; and
- Finally, it should not create unnecessary burdens.

Generally, the legal rules that are meant to regulate medical professionals fall in to two broad categories: preventive and disciplinary. Preventive rules have the primary purpose of preventing the occurrence of bad medical practice in advance by stipulating certain mandatory rules or minimum requirements that could distinguish qualified health professionals from unqualified

---

<sup>30</sup> See Kieran Walshe, *supra* n. 28: 144

<sup>31</sup> Jonathan Herring, Medical Law and Ethics, 3<sup>rd</sup> Edition, Oxford University Press: Oxford, 2010, pp. 91-92.

persons. On the other hand, disciplinary rules have the purpose of punishing those individuals who transgress the requirements provided by the law.

In Ethiopia, there are a number of legal rules that are meant to regulate the activities of health professionals. In this regard, the issuance, renewal, suspension and revocation of health professional's license are very critical and merit the discussion.

### **3.3.1.1. Licensure of Health Professionals**

License could be defined as the legal process by which an authorized authority grants permission to a qualified individual or entity to perform designated skills and services in a jurisdiction where practice would be illegal without a license<sup>32</sup>. Likewise, license of health professionals in Ethiopia is nothing more, nothing less than a certificate issued for a health professional to provide medical or other health related services<sup>33</sup>.

In most instances, licenses are issued by an authorized governmental authority. The Ethiopian Food, Medicine, and Health care Administration and Control Authority (here in after referred to as “the authority”) used to issue, renew, suspend and revoke all forms of license for medical professionals<sup>34</sup>. Today, however, the authority delegates some of its powers of issuing, renewing, suspending and revoking license to regional health bureaus, except licenses issued for insufficiently available health professionals, complementary and alternative medicine practitioners and health professionals coming privately or in group from abroad to deliver health services<sup>35</sup>.

Article 33 of proclamation No. 661/2009 provides the following guiding rules on the issuance of health professionals' license;

- No person shall practice as a health professional without having obtained a professional practice license issued by the appropriate organ;

---

<sup>32</sup> Ginny W. Guido, Legal Issues in Nursing, 2<sup>nd</sup> ed., Appleton & Lange Stamford, connecticus: USA, 1997, p 188.

<sup>33</sup> See Article 2 (31) of FDRE, Food Medicine and Health Care Administration and Control Proclamation, proclamation No. 661/2009; Negarit Gazeta, 16<sup>th</sup> Year, No. 9, ADDIS ABABA 13<sup>th</sup> January 2010 (here in after cited as proclamation no. 661/2009)

<sup>34</sup> Interview with Ato Henok who is the Licensing Officer in the Federal Democratic Republic of Ethiopia Food, Medicine and Health Care Administration and Control Authority on June 21, 2011.

<sup>35</sup> See Article 4(16) of Proclamation No. 661/2009

- Professional practice license given to any health professionals shall be renewed every five years upon ethical and competence evaluation;
- A health professional whose license has been suspended or revoked shall be prohibited to practice his profession; and
- The appropriate organ shall notify to the public the list of health professionals whose licenses have been suspended and revoked.

It is also worth noting that the proclamation under Article 46 provides license requisites regarding traditional or complementary or alternative medicine practitioner<sup>36</sup>. As such, obtaining a practice license issued by the appropriate organ is a prerequisite under the law to practice medicine as a traditional or complementary or alternative medicine practitioner. This license shall also be renewed every five years upon ethical and competence evaluations<sup>37</sup>.

### **3.3.1.2. Requirements to Issue License**

Usually, issuance of license is dependant up on the fulfillment of certain requirements provided by law. In the case of health professionals, license requirements centers on personal characteristics and educational backgrounds. These requirements are important to ensure that health professionals are at least minimally competent to practice medicine. Stated differently, the requirements of license often include academic and clinical performance, passing score on the licensing examination, and personal qualities<sup>38</sup>.

The Ethiopian Health Professionals Council is tasked with the supervision of the registration and licensure of health professionals. Pursuant to Article 15 of Council of Ministers Regulation Number 76/2002, it is provided that the council established a registration and licensing sub-committee which has the power to set the criteria for a professional license. This sub-committee

---

<sup>36</sup> Traditional practitioner means a person who is licensed by the appropriate body to provide traditional medication. (see Article 2(34) of proclamation no. 661/2009) ; Complementary or alternative practitioner means a person who is licensed by the executive organ to provide complementary or alternative medicine. (see Article 2(36)) of proclamation No. 661/2009.)

<sup>37</sup> See Article 46(2) of Proclamation No. 661/2009.

<sup>38</sup>See Ginny W. Guido, supra n.32:193

is also charged with the responsibility of verifying applications by health professionals for the issuance of license certificate.

When a health professional seeks to apply for the issuance of professional competence confirmation certificate, Article 21 of the health professionals' council establishment regulation provides the following as prerequisite;

- The application should be submitted in the form prepared in accordance with the direction of the FDRE Ministry of Health;
- The applicant should attach with his application the following original documents:
  - ✓ Credentials from institutions of training;
  - ✓ Documents given by the institute in evidence of completing an internship program;
  - ✓ Concerning professionals who, upon the decision of the Ministry of Health, are required to take professional competence confirmation examination, documents to the effect of testifying that one has passed such an examination;
  - ✓ Payment of required fees; and
  - ✓ Other documents that may be required by the Ministry of Health;

As indicated above, the certificate issued by the authority has to be renewed every five years<sup>39</sup>. The renewal process has also its procedures and requirements. These include submitting application, paying renewal fees, fulfilling professional ethics criteria, and passing score on the examination that would be given by the Council<sup>40</sup>.

---

<sup>39</sup> Article 22 (1) of the FDRE Ethiopian Health Professionals Council Establishment Council of Ministers Regulations No. 76/2002, Negarit Gazeta, 8<sup>th</sup> Year, No. 13, ADDIS ABABA 18<sup>th</sup> January 2002. (here in after cited as Regulation No. 76/2002)

<sup>40</sup> Ibid, Article 22.

### **3.3.1.3. Dealing with Problems Surrounding License**

After the issuance of license there might arise concerns about the activities of a licensed health professional. The concerns too often relates with the behaviors or performance of the individual practitioner. This will take us to the issue of suspension and revocation of license.

Where the holder of a license works in violation of health related proclamation, regulations or directives issued by the government, the license issued by the appropriate organ may be suspended or revoked<sup>41</sup>. If such license is revoked or suspended by the appropriate organ, the holder thereof shall no longer be allowed to practice his profession<sup>42</sup>.

The violation of some license provisions might also entail imprisonments and monetary penalties. For instance, a health professional cannot transfer the license issued to him to any person by way of any means without the permission of the authority<sup>43</sup>. If a person disregards this provision, and transferred his license to any person, the law makes the action punishable with imprisonment of not less than two years and not exceeding five years and a fine of not less than birr 50,000 and not exceeding Birr 100,000<sup>44</sup>.

Employees or officials of the appropriate organ might also be subjected to punishment, if they issues or renews or causes the issuance or renewal of license by taking bribes or through nepotism or other illegal relationships, and in violation of relevant laws<sup>45</sup>. In this regard, unless a higher penalty is provided under the Criminal Code, the punishment for such acts shall be with imprisonment of not less than seven years and not exceeding fifteen years and with a fine not less than Birr 30,000 and not exceeding Birr 50,000<sup>46</sup>.

It is important to note that the issuance, suspension, and revocation of license being a difficult task, it further needs an ongoing evaluation of government regulatory schemes. With regard to health professionals, the Health Professionals Council has taken the responsibility to follow up and supervise that the names of registered professionals and those who are cancelled from the

---

<sup>41</sup> Proclamation No 661/2009, Article 48(1).

<sup>42</sup> Ibid, Article 46(3).

<sup>43</sup> Ibid, Article 53(1)(a)(2).

<sup>44</sup> Ibid, Article 53(1)(a)(2).

<sup>45</sup> Ibid, Article 53(2)(a).

<sup>46</sup> Ibid, Article 53(2)(a).

registry due to various reasons are properly kept by the secretariat<sup>47</sup>. Given that, the federal government's delegation of parts of its power to regional organs makes the integration of the country's license information more difficult. In this regard Article 51 (2) of proclamation No. 661/2009 seems to have positive implication as it puts obligations on state regulatory or delegated organs to submit a periodic report about their activities.

Finally, if a person is aggrieved by the suspension or revocation of a license, he may lodge his complaints within 30 days from the date of decision to the grievance hearing body established by the appropriate government organ<sup>48</sup>.

### **2.3.2. The Regulation of Health Institutions**

The regulation of health institutions should start from the recognition that institutions have concerns in the conduct of their daily activities or business. Such recognition is important for governments not to waste time, if not impossible, to the difficult task of regulating each and every conduct or activity of health institutions. Institutions, therefore, have to have systems, in place to make sure that activities are carried out appropriately and to restrict actions that may pressure risks, that is actions which may directly or indirectly lead to harm or failure to achieve what the organization has set out it deliver<sup>49</sup>.

However, when an external review of the activities of organizations is made by the government, it would provide a relative assurance to others that effective control is in place. In this regard, governments' regulate the activities of (health) institutions by the use of formal rules, procedures and policies<sup>50</sup>. These externally generated controls by the government too often tend to use high level prescriptions.

On the part of the regulatory organ, the regulation of health institution is like an investment for quality assurance, the primary aim being to ensure that institutions are well-designed and well-

---

<sup>47</sup> Regulation No. 76/2002, Article 4(4).

<sup>48</sup> Proclamation No. 661/2009, Article 49 (1).

<sup>49</sup> Das and Teng 2001, cited in Ellie Scrivens, supra n. 25: 22.

<sup>50</sup> The establishment and use of formal rules procedures and policies to monitor and reward desirable performance is commonly referred as a formal external control. On the other spectrum, there is also an approach which relies on the establishment of organizational norms, values, culture, and internalization of goals to encourage desirable behavior and outcome. This approach is commonly known as informal control or normative control. See Ellie Scrivens, supra n. 25:23.

run facilities that provide good working environment for staff and quality health care for patients.

In Ethiopia, there are a number of rules and procedures in place to regulate health institutions. The regulatory process encompasses various activities. The setting of standards care and institutional licensure are, however, very important instruments in the context of Ethiopia. Detail discussion on the setting of standards of care will be made on the next chapter; but the discussion on institutional licensure follows.

### **2.3.2.1. Certification of Competence/ Institutional Licensure**

Certification of competence is one of the mechanism by which a government regulates health institutions. In broad terms, certification refers to a guarantee by a certification body, through an evaluation process that an organization has capacity or technology in a certain field and meets certain designed standards<sup>51</sup>. The certification of competence for health institutions in Ethiopia refers to a work license issued for the institution to carry out medicine, health or health related or trade in accordance with the standards set by the appropriate organ<sup>52</sup>.

Governments too often issue license to health institutions to grant permission for the facility to operate its activities within the scope provided. In Ethiopia, a person requiring to establish a health institution shall obtain certificate of competence from the appropriate organ<sup>53</sup>. If a health institutions is found practicing medicine without having certificate of competence, the appropriate authority will immediately close that institution<sup>54</sup>. As such, licensure of health institutions is the legal recognition of organization, the aim being to ensure basic standards of public health.

### **2.3.2.2. Requirements for the Issuance of Certificate of Competence**

The Council of Ministers Regulation on the Licensing and Supervision of Health Services Institutions (Council of Ministers Regulation No. 174/1994) is the most relevant law in Ethiopia

---

<sup>51</sup> See Kiera Walshe, *supra* n. 28: 275.

<sup>52</sup> Proclamation No. 661/2009, Article 2 (24).

<sup>53</sup> *Ibid*, Article 41 (1).

<sup>54</sup> *Ibid*, Article 47 (3).

towards the licensing of medical institutions. According to this regulation the power to issue license is given to the Ministry of Health or the Health Bureau of National/Regional self-governments depending on the nature of medical institutions<sup>55</sup>. Specifically, the Ministry of Health has the power to issue license for hospitals, radiological diagnostic centers and for any health institutions run by foreign organizations or by foreign investors, while health bureaus of the national/regional self governments retain the power to issue license for health centers, clinics and clinical diagnostic centers operated by domestic organizations and domestic investors<sup>56</sup>.

As it has been discussed above, any organ with juridical personality desiring to establish or operate a health service institutions is required to obtain a license for the appropriate licensing authority. In order to get the license, the person shall submit, to the licensing authority, an application which contains the necessary information<sup>57</sup>. In this regard, the directives issued by the Ministry of Health to implement Regulation No. 174/1994, provides information as to the minimum requirements to be met by each level of medical service institutions.

The licensing authority, upon examining the application submitted to it in line with the standards set by the country, may issue license or rejects the application<sup>58</sup>. If the licensing authority issues the license, the concerned health service provider shall renew the license every year up on payment of appropriate fees<sup>59</sup>.

### **2.3.2.3. Suspension and Cancellation of Institutional License**

Issuance of institutional license for health services institutions is conditional up on different obligations or duties. If the licensed institution failed to observe these obligations, the licensing authority may suspend, or at times may even cancel the license depending on the type of offence the institution found committed.

---

<sup>55</sup> TGE, Licensing and Supervision of Health Service Institutions Council of Ministers Regulation No. 174/1994; Negarit Gazeta, Addis Ababa, 53<sup>rd</sup> Year, No. 66, ADDIS ABABA 16<sup>th</sup> February 1994.(here in after cited as Regulation No. 174/1994)

<sup>56</sup> Ibid, Article 3(1) and (2).

<sup>57</sup> Ibid, Article 5(1).

<sup>58</sup> Ibid, Article 5 (1) and (2).

<sup>59</sup> Ibid, Article 8(1).

**A. Grounds of Suspension:** pursuant to Article 11 of regulation No. 174/1994, the licensing authority may suspend the license of medical institutions until such time as the shortcomings are corrected, on the basis of the following grounds:

- ✓ Where it fails to observe medical ethics;
- ✓ Where it renders medical services beyond the scope for which the license is obtained;
- ✓ Where it allows a practitioner, who is not registered, or who has been suspended, or who is addicted to alcohol or drug, to work within its confines;
- ✓ Where it fails to observe laws, regulations and directives relating to health services; or
- ✓ Where it fails to submit, accurately and on time, information required by Regulation No. 174/1994 and directives issued for its implementation.

**B. Grounds of Cancellation:** according to Article 12 of Regulation No. 174/1994, the licensing authority may cancel the license of medical institutions, where;

- ✓ the license is proved to have been obtained by submitting false information;
- ✓ the faults referred to in the suspension of license have been committed for the second time or more repeatedly depending on their gravity;
- ✓ the license is found transferred to another person;
- ✓ The license has not been renewed as required by the law.

### **2.3.3. Enforcement of Regulations**

Regulatory rules and legislations are meant to be enforced. In most instances, government bodies take the responsibility of ensuring the enforcement of these regulations. However, it was

increasingly recognized that it was difficult to give assurance that organizations were complying with the set of rules and regulations applied to them<sup>60</sup>.

In Ethiopia, different organs of the government could be mentioned in the regulation of the health sector. These includes, but not restricted to the Ministry of Health, the Health Professionals Council, the Ethiopian Food, Medicine and Health Care Administration and Control Authority and the Health Bureau of National/Regional self-governments.

In the field of health care, the opening up of the health sector to the private investors in the post 1991 period has resulted the proliferation of a significant number of private health institutions in Ethiopia. This in turn brings the need for governmental oversight to ensure citizens will not be harmed, exposed to hazards, or at risk of injury. Consequently, the government has established its own regulatory schemes to regulate for-profit health institution in particular and others in general. However, it is too often noted that the enforcement of such regulations is an expensive activity in poor countries like Ethiopia.

---

<sup>60</sup>see Ellie Scrivens, *supra* n. 25:33

## **CHAPTER THREE**

### **4. MEDICAL MALPRACTICE AND NEGLIGENCE**

This chapter aims to explore the rules of medical malpractice and negligence in general, and their treatment under the relevant Ethiopian laws.

At the very outset, it has to be made clear that medical treatment too often requires invasion of the patient's body. As such, though medical treatment is undertaken for positive purpose, the patient may find himself in a state of health less than that which ought to have been achieved after treatment. Stated differently, sometimes the treatment intended to cure the patient might bring risks that is additional to his underlying illness.

There are two popular approaches used by nations to provide compensation for patients who are injured by medical malpractice and negligence: "fault" approach, and the 'No-fault' approach. The "fault" approach requires the existence of fault on the part of the physician or health institutions to award compensation for injured patients. On the other hand, the "no-fault" approach deals about the appropriate compensation that should be awarded to the injured patient regardless of the existence of fault on the side of the physician or health institutions.

Negligence and malpractice, in general, fall under the legal division of tort law which essentially concerns legal wrongs committed by one person against another person or against the property of another person. In the context of medical or hospital contracts which require physicians and medical institutions due care and diligence, medical negligence or malpractice may also be considered as breach of contractual duty. Hence, medical negligence or malpractice may be treated under the law of contract or tort depending on the legal rules and policy preferences of countries. Before directly addressing the tort and contract aspects of the two terms, it would be better first to have a brief discussion on the fierce distinction between the term "negligence" and "malpractice" even though they are often used interchangeably.

### 3.1. Negligence

Negligence is a broad term that represents conducts lacking in due care. It may also denote doing something unreasonably in deviation from the standards of care. The reasonableness of the conduct is determined by what a similarly situated person would do.

In the context of health professionals and entities, negligence in essence says that something bad happened that the health professional did it, and based on training, knowledge and experience, the physician should have known that<sup>61</sup>. As such, it does not suggest that the physician did something intentionally or on purpose.

### 3.2. Malpractice

In simple terms, malpractice is negligence on the part of professional person<sup>62</sup>. It may also be defined as the failure of a professional person to act in accordance with the prevailing professional standards or the failure to foresee consequences that a professional person, having the necessary skills and education should foresee<sup>63</sup>. Given that, malpractice is a more specific term and looks at a professional standard of care as well as the professional status of the care giver.

In general, the foregoing definition asserts that a person liable for malpractice must be a professional. Thus, when a health professional lacks due care in the provision of medical services in accordance with the prevailing health care standards, the act might constitute the so called medical malpractice.

The foregoing discussion on the distinction between negligence and malpractice is important to establish liability as different level of diligence is expected from professionals and non-professionals. However, the same act may form the basis for negligence or malpractice.

---

<sup>61</sup> William T. Choctaw. Avoiding Medical Malpractice: A Physician's Guide to the Law, Springer, Los Angeles, 2008, p 26.

<sup>62</sup> See Ginny W. Guido, supra n. 32:67.

<sup>63</sup> Ibid.

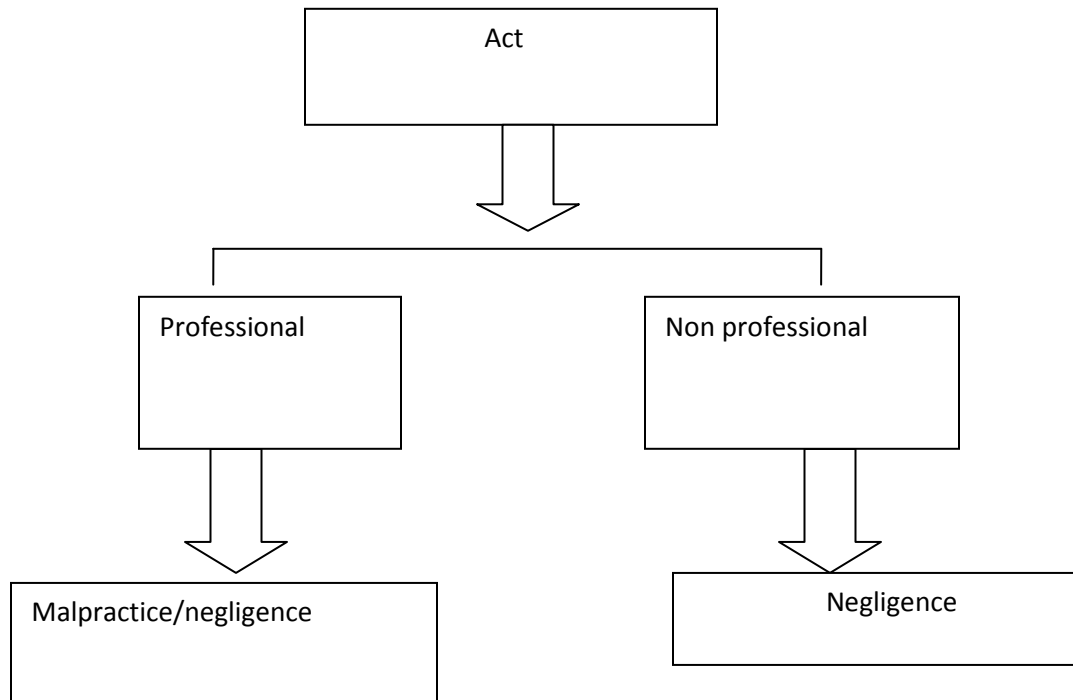


Fig. 3.1. The relationship between negligence and malpractice

### 4.3. Establishing Medical Malpractice or Negligence

As a result of faulty treatment by the physician and/or health institution, the patient might suffer an avoidable harm. This faulty treatment has the potential to bring the liability of physicians and/or health institutions. The patient plaintiff, however, need to construct certain elements to establish a successful medical malpractice or negligence claim.

As pointed out above the relationship between the patient and the physician/health institution might be either of tort or contract. Consequently, establishing claims based on the regime of tort and contract is not the same. However, the following elements are considered as crucial in most jurisdictions depending on the type of relationship which results the faulty treatment<sup>64</sup>:

<sup>64</sup> Some jurisdictions introduced the doctrine of “Res Ipsa Loquitur” meaning “the thing speaks for itself.” This doctrine allows the negligence of cause of actions in medical malpractices without requiring the fulfillment of the elements of malpractice/negligence provided above. The most typical example for the courts to allow this doctrine include those in which a foreign object has been left in the patient during surgery; infection was caused by unsterile instruments; burns occurred during surgery; or a surgical procedure was performed on the wrong limb or part of the body. Id. p 76.

- The Duty owed the patient;
- Breach of the duty owed the patient;
- Causation; and
- Damages.

### 4.3.1. Duty Owed the Patient

Duty owed the patient has frequently been defined to mean the applicable standards of health care. Standards of health care in turn are referenced in medical malpractice or negligence cases against health professionals to prove that they breached the duty of care owed the patient.

In simple terms the duty owed the patient under medical malpractice or negligence claims refers to the minimum accepted standards of health care. Whenever, medical institutions or health professionals render medical service, they are expected to obey these minimum standards of care. When the quality of care rendered by a particular professional is below the minimum accepted standards of care, and causes injury or inconvenience up on third parties, the injured party may sue the professional or the institution for lack of diligence. As such, standards of care are the key instruments by which the quality of care is measured<sup>65</sup>.

It is noted that the term “standards of care” actually comes from a legal setting, not a medical setting. This makes an apparent distinction between the legal and medical standards of care. Medical standards of care refer to the type and level of medical care required in specific circumstances by professional norms, accreditation or other requirements<sup>66</sup>. On the other hand, legal standards of care imply the amount of skill that a medical practitioner should exercise in particular circumstances based on reasonable and common practice.<sup>67</sup> The former provides the minimum acceptable standard of care or the level or degree of quality considered adequate by a

---

<sup>65</sup>Some literatures make a distinction between the term standard and criteria. One author defined criteria as an attribute of structure, process, or outcome that is used to draw an inference about quality. For instance, in the health care context, criteria of structure could be the staffing of the intensive care unit; a criterion of process could be whether or not blood transfusion has been used during surgery; and a criterion of outcome could be case fatality. On the other hand, he defines the term standard as to mean a specified quantitative measure of magnitude or frequency that specifies what is good or less so. See Avedis Donabedian, An introduction to Quality Assurance in Health Care, (ed. Rashid Bashshur), Oxford University Press, Oxford, 2003, p 60.

<sup>66</sup> IOM, Crisis standards of Care: Summary of a Workshop Series, The National Academies Press, Washington DC., 2010, P 55.

<sup>67</sup> Ibid.

specific profession. In the context of medical practice, the legal standards of care refer to the minimum quality of medical service that a medical professional delivered to the patient.

#### **4.3.1.1. Establishing Health Care Standards**

Normally, [health service] standards of care may be established in a variety of ways. Based on the institution in which they are published, standards of care could be generally classified in to two: internal and external standards of care<sup>68</sup>. Internally set standards of care refer to those standards established by individual medical institutions. Externally set standards, on the other hand, constitutes those standards set by government agencies, professional organizations, and specialty practice groups like nurses associations or medical doctors associations<sup>69</sup>.

Externally set standards are different from internal standards of care because they are above individual physicians and single medical institutions. In most instances externally set standards resembles with national standards of care<sup>70</sup>. Medical professionals, however, are responsible for both categories of standards.

On the other hand, based on the geographical area in which they are meant to apply, standards of care in the health service sector could also be classified in to two: national and local standards of care.

**A. National Standards of Care:** National standards of care illustrate the average degree of care, skill and diligence exercised by the medical community across the nation. National standards make no distinction between medical services rendered in different levels. For instance, a physician practicing medicine in remote rural area is expected to meet the same minimum standards of care with that of a physician practicing in large urban areas.

The trend today is toward national standards of health care. There are two reasons that support the adoption of national standards of health care. First, all patients have the right to quality health care, whether they are in a small community or in big urban cities.

---

<sup>68</sup>See Ginny W. Guido, *supra* n. 32: 54

<sup>69</sup>*Id.* p. 55.

<sup>70</sup> *Id.* p. 56

Second, with the advent of Information Communication Technology, it is possible to disseminate the same information to all areas with health care delivery systems<sup>71</sup>.

**B. Local Rules:** based on the locality rule standards of health care will be viewed from the perspective of care within a given geographic area or a “similar community.”<sup>72</sup> Put it differently, the skill, care, and diligence of members of the profession is assessed and evaluated within that specific geographic area. For instance, if a local standard of care is formulated for urban areas in Ethiopia, physicians or health institutions in rural setting are not bound to meet the same standards of health care.

In Ethiopia, almost all standards of care fall under the category of national standards of care. As such, the law presumes the same quality of health care in urban and remote rural areas. However, studies show that there is an apparent difference in the quality of service rendered by different medical institutions based on the geographic area they situated and their organizational form. For instance, the study conducted by the US AID revealed that the distinction between for-profit and not-for-profit medical institutions has impacted patient’s expectation of the quality of service rendered by those institutions<sup>73</sup>.

Generally, the duty of care to be established in medical malpractice claims has two important aspects: a) it must first be shown that a duty was indeed owed the patient, and b) the scope of the duty must be proven.

➤ **Showing the existence of duty owed the patient:** In most malpractice claims showing the existence of duty owed the patient is not a difficult task. The health care relationships discussed in the previous section are very critical in this regard. For instance, the physician-patient, physician-health institutions, and patient-health institutions relationships created through contract or implied terms potentially form the duty owed concept.

---

<sup>71</sup> The availability of communication facilities, however, are very much dependent upon the level of economic development of countries. See Id. 58.

<sup>72</sup> Ibid. p. 58.

<sup>73</sup> USAID, Assessing the Role of the Private Health Sector in HIV/AIDS Service Delivery in Ethiopia, 2009, p. 17

- **The scope of duty owed the patient/the duty to provide a standard care:** showing the standards of care to be delivered is the benchmark to determine whether or not a health professional or/and health institution undertakes its activities as provided by the set of standards made for that specific sort of medical treatment.

In countries like Ethiopia where the judges are generalists in the field of law, the court would not be in a position to determine the adequate quality of care that should be rendered in a certain medical treatment. As such, the standards of care ruling in medical malpractice cases did not set firm quality standards; rather, it set forth a system for retrospectively determining the quality of a given physician care<sup>74</sup>.

The most important element in this regard comes in how the standard of care is determined. In medical malpractice cases the standards of care is the degree of care that a reasonable physician would exercise in the circumstances. Judges in civil courts are not doctors, so they are not ordinarily able to evaluate whether the physician conduct met that standard of care without hearing evidence from the person in the medical profession. Given that, a medical malpractice case almost always requires expert testimony from health professionals. The expert testimony is supposed to explain what physicians expect other physicians to do in similar circumstances. Stated differently, the determination of the adequate standards of care in medical malpractice case took a reasonable-physician standard of care as a reference. Details of the testimony given by expert witness will be discussed on chapter five of this thesis.

#### **4.3.1.2. Crisis Standards of Care**

There are certain circumstances by which fulfilling the minimum standards of care become difficult. In times of emergency, for instance, the ordinary local or national standards of health care might fall beyond the actual emergency relief measures. Taking in to account the unique situation of emergencies, some states provide a separate “crisis standards of care” that subtracts medical professionals and institutions from the liability resulted by the delivery of medical services below the quality set by the ordinary standards of health care. Stated differently,

---

<sup>74</sup> Neal C. Hogan; Law and Society, Unhealed Wounds: Medical Malpractice in the Twentieth Century; (edited by Eric Rise); LFB Scholarly Publishing PLC; New York 2003, p. 14

outlining standards of care clearly helps jurisdiction to limit medical malpractice liability during emergency situations<sup>75</sup>.

It is noted that crisis standards of care by and large immunize ordinary act of negligence while not immunizing gross negligence or willful disregard of standards of care<sup>76</sup>. A disagreement abounds concerning this exclusion of gross negligence and willful disregard of standards of care from the immunity clause provides by “crisis standards of care.” Some viewed the exclusion as a drawback as it puts limits on emergency activities. On the other hand, some contends that the exclusion is a creative approach to the issue as it discourages harmful behaviors and protects patients from those who do not act in good faith during emergencies.

In Ethiopia, any health professional shall be required to render emergency medical treatment within the scope of his professional practice<sup>77</sup>. Where a health professional is not capable of providing the necessary emergency medical treatments in accordance with the health institution’s standard, the law requires him to immediately refer the patient, in accordance with the referral system to an appropriate health institution which is capable of providing the necessary treatment<sup>78</sup>.

It doesn’t seem that the emergency situation that the law refers is the mass emergency situations that may arise during disasters and crisis, even if considered to be so; the requirement of the law to maintain the institution’s ordinary standards of care during emergency treatment is a bit absurd for emergency care during disasters and crisis. As such, the foregoing provisions are implicit expressions of the absence of emergency or crisis standards of care in Ethiopia.

This issue can make health care providers uncertain about the legal liabilities that may emerge during emergencies and crisis. The uncertainties in turn may result unwillingness of medical

---

<sup>75</sup> South Carolina, for instance, has certain legal rules that limit legal liabilities during emergencies. These include; a) Emergency Health Power Act (44-5-570(c) (1): “ any health care provider appointed by [the south Carolina Department of health & Environment control]... must not be held liable for civil damages as a result of medical care... unless the damages result from... circumstances demonstrating a reckless disregard for the consequences.” b) Medical Malpractice Act (38-79-30): ( Volunteer (non-Compensated) health care provider... not liable for any civil damage for any act or omission resulting from the rendering of the (medical)services unless... act or omission was the result of ... gross negligence or willful misconduct. See IOM, supra n. 66: 54.

<sup>76</sup> Ibid.

<sup>77</sup> Proclamation No. 661/2009, Article 38(1).

<sup>78</sup> Ibid, Article 38 (2),

professionals and institution to act during emergencies. Hence, solving the legal liability issues related with medical malpractices during emergencies should be dealt in clear terms, so that all stakeholders become willing to participate in emergency relief measures. Besides, if the legal issues are not dealt explicitly, there will not be a sound ground to disregard the national and local standards of health care for the medical malpractices during emergencies.

In order to build quality and competent health care system, drawing standards of care that sets out a minimum level of expertise is very much desired as it serves multiple purposes. First, it enables the health care recipient the knowledge to avoid a substandard care. Second, it gives guidance to the health care providers to provide a medical service that meets at least the minimum standard. Third, it also serves courts in the adjudication of medical malpractice cases. In the later case, patient plaintiff often sues medical institutions and professional for the breach of certain duty. In order for the court to determine the breach of a duty by the medical professional, it needs certain references like “standards of care” which is accepted by the profession as a reasonable and average quality of care.

### **4.3.2. The Breach of Duty**

Once duty owed to the patient is established, the next question is whether the health professional breached that duty. Of course, the essence of a successful malpractice case is for the patient plaintiff to prove that the physician has breached his duty of care owed the patient. The test used to establish such breach is whether the health professional or/and institution has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art<sup>79</sup>.

Normally, breaches one’s duty is to act below the standards of care. In this regard, Jonathan Herring has written the following:

---

<sup>79</sup> See Jonathan Herring, *supra* n. 31: 106.

*“...the question is not whether the defendant was acting in the ideal way but that their actions were above the minimum acceptable practice. Therefore, even if it is shown that the professional made a misdiagnosis, this does not mean it was negligent.”<sup>80</sup>*

In medical malpractice cases the breach of duty is established by the production of documentary evidences and testimony of witnesses. The witness appeared before the court could be an expert or a lay witness. Lay witness is important to establish facts at the trial level, by simply defining what happened since he has direct connection with the case in controversy<sup>81</sup>. Specifically, the lay witness is allowed to testify only to facts and may not draw conclusions or form opinions<sup>82</sup>.

On the other hand, the second type of witness, the expert witness, is required to explain highly specialized opinion to the court<sup>83</sup>. Expert witness is often involved in court proceedings, if the case has elements special to a certain profession, the determination of which is beyond the common knowledge of the parties or the judge. Expert witnesses might not have direct connection with the case in controversy, unlike lay witnesses.

In medical malpractice and negligence cases, the importance of expert witness is paramount. Patient plaintiffs and judges in the judicial system are not familiar with sophisticated health care procedures to establish the breach of duty by medical professionals and/or medical institutions. Consequently, when medical malpractice claims brought before the court, judges seek expert's assistance to determine the breach of certain professional duty. The testimony is often related with the prevailing standards, the adherence to which ensures quality, competent health care. Thus, standards of care in medical services are determined for the judicial system by expert witnesses.

In most medical malpractice cases, expert witness is needed to testify that the acts or omissions of the defendant fell below medical standards or were unreasonable under the circumstances<sup>84</sup>.

---

<sup>80</sup> Ibid.

<sup>81</sup> See Ginny W. Guido, supra n. 32: 44

<sup>82</sup> Ibid.

<sup>83</sup> Ibid.

<sup>84</sup> Avedis Donabedian, An Introduction to Quality Assurance in Health Care; (edited by Rashid Bashur), Oxford University Press, New York, 2003, p.75.

This testimony usually helps the court to construct whether the acts of a medical professional deviated from those standards and whether deviation caused the patient plaintiff's injury<sup>85</sup>.

Stated differently, courts too often establish the breach of duty owed the patient by the testimony of expert witnesses who has the knowledge and experience in the same clinical area. The expert witness will be asked to review the case and determine the level of standard of care taken by the defendant in a medical malpractice suit<sup>86</sup>. The following few points should at least be considered in the determination of breach of duty owed the patient<sup>87</sup>;

- A health professional is to be judged on the state of knowledge at the time of the incident;
- The defendant's course of action was approved of by a responsible body of medical opinion that was enough to show that there was no negligence. It does not need to be a substantial body of opinion;
- The standard of care a professional is expected to exercise is that of those in the specialty or profession involved. For instance, a general practitioner is to be assessed by the skills expected of a general practitioner not a specialist consultant; and
- The situation in which health professionals find themselves has to be taken in to account. For instance, emergency situations.

### 4.3.3. Causation

Showing causation in medical malpractice cases refers to the link that may exist between the unreasonable action of the health professional and the patient's injury. To be successful in a malpractice claim patient plaintiff must show that the unreasonable action of the physician was the actual and proximate cause of the patient's injury.

Causation could be subdivided in to two: a) cause-in-fact, and b) proximate cause<sup>88</sup>.

**A. Cause-in-fact:** it refers that the breach of duty owed caused the injury.

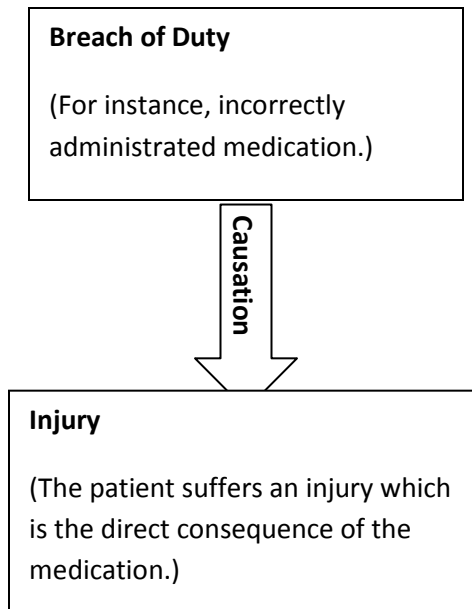
---

<sup>85</sup> Ibid.

<sup>86</sup> See William T. Choctaw, supra n. 61: 20.

<sup>87</sup> See Jonathan Herring, supra n.31: 106-110

<sup>88</sup> See Ginny W. Guido, supra n.32: 69.



There are certain established tests used frequently to determine ‘cause-in-fact.’ These include the ‘but-for test’, the substantial factor test, and the alternate cause approach. First, the “but-for test” aims to answer the question if the act or omission of a health professional is a direct cause of the injury or harm sustained by the patient<sup>89</sup>.

Second, the substantial factor test developed to determine cause-in-fact when several factors or causes occur to bring about a given injury<sup>90</sup>. It is important to note that the “but-for test” is inadequate if the injury is the result of several possible causes. As such, the substantial factor test is used to establish a causal link between actions and, injury by asking whether or not the defendant’s act or omission was a substantial factor in causing the ultimate harm or injury. If the answer is in the affirmative, then there is cause-in-fact.

Finally, the alternate cause approach deals with the problem in which two or more persons have been accused of negligence<sup>91</sup>. According to this approach the plaintiff must

---

<sup>89</sup> Would the injury have occurred, but for the act or omission by the defendant is the question that this test tries to answer. See id. p 70.

<sup>90</sup> Ibid.

<sup>91</sup> Id. p. 71.

show that the harm or injury was caused by one of the multiple defendants, and the burden of proof then shifts to the defendant to show who actually caused the harm or injury at issue.

**B. Proximate Cause:** this type of causation helps to determine how far the liability of the defendant extends for consequences following negligent activity<sup>92</sup>. Thus, the foreseeability of the extent to which consequences will follow a negligent action is a critical element in the proximate cause.

Normally, it is not difficult to establish the proximate cause if the result is directly related with the negligent act. However, the determination of proximate cause becomes less clear when intervening variables are present. Intervening variable in this context refers to those factors that may combine with the original negligent action to cause the resultant injury.

In medical malpractice cases, the health care provider is frequently liable for intervening forces when they are foreseeable<sup>93</sup>. Ginny W. Guido has written the following illustration to describe the nature of intervening variables:

*“...a patient hurt in an automobile accident, sued the driver’s physician, alleging that the driver was given an excessive amount of valium by the physician and the physician failed to adequately evaluate his patient’s psychiatric and drinking history before prescribing valium... a foreseeable consequence of prescribing valium is that the patient with psychiatric problems will drink, and such a patient, high on alcohol and valium, may injure others.”<sup>94</sup>*

#### 4.3.4. Damages

The foregoing discussion that shows the duty owed the patient, its breach and causal link is not sufficient to establish the liability health professionals or medical institutions on the basis of malpractice or negligence. The outcome of the negligent act is also equally important, since there is no malpractice in the absence of injury or damages. More specifically, when tort law becomes

---

<sup>92</sup> Ibid.

<sup>93</sup> Id. p.72.

<sup>94</sup> Ibid.

the basis for medical malpractice claims, the significance of establishing the final outcome or injury is paramount.

	Conduct	Outcome	Liability
1	No negligence	Satisfactory outcome	No legitimate liability
2	No negligence	Bad outcome	No legitimate liability
3	Negligence	Satisfactory outcome	No legitimate liability
4	<b>Negligence</b>	<b>Bad outcome</b>	<b>Legitimate liability</b>

Table 3.1. The impact of injuries to establish the liability of physicians or medical institutions under tort rules

Even though the foregoing combinations demonstrated in the table essentially reflects the rule of tort law, *mutatitmutandis*, they could also be used in the case of medical malpractice claims arising out of contract. As has been discussed in the previous chapter, medical negligence or malpractice in tort law is equivalent to the breach of contractual duties in contract law regime. As such, breach of contractual duties or non-performance by the medical professional and/or institutions and its outcome is vital for patient plaintiffs to establish legitimate claims in the court of law. For instance, a certain medical treatment rendered by a particular medical institution or physician may have a bad outcome even though there is no breach of contractual duty on the part of the institution or physician. The same bad outcome might be resulted when the institution or the physician failed to discharge his contractual duties. The following table summarizes some combinations of conduct and outcome on the liability of medical institutions or physicians for medical treatments arising out of contract.

	Conduct	Outcome	Liability
1	No breach of contractual duty	Satisfactory outcome	No legitimate liability
2	No breach of contractual duty	Bad outcome	No legitimate liability*
3	Breach of contractual duty	Satisfactory outcome	No legitimate liability**
4	Breach of contractual duty	Bad outcome	Legitimate liability

\*if the physician or the medical institution guarantees the success of its medical treatment, there might be the possibility to establish legitimate liability under the same combination.

\*\*Article 2647 and 2651 of the 1960 Civil Code of Ethiopia require damage on the part of the patient to establish the liability of physicians and medical institutions.

Table 3.2. The impact of injuries to establish the liability of physicians or medical institutions under contract law regime

## CHAPTER FOUR

### 4. Liabilities of Health Institutions in General

#### *PREVIEW*

*Patients too often approach medical institutions for medical treatment. The medical institutions may be either public institutions (run by the government) or private and/or charitable in nature. Regardless of the nature of medical institutions, where something goes wrong, the injured patient may be disposed to regard himself as the victim of a fault perpetrated by a given medical institution or a doctor practicing within it.*

This chapter deals about the civil liability issues surrounding medical institutions in general. Specifically, the liability of medical institutions in contract and tort will be the prime focus of the discussion.

Historically, hospitals were considered to be charitable institutions, unaccountable for the service rendered<sup>95</sup>. Two reasons were forwarded to support the charitable immunity of medical institutions. First, if the money contributed for charity used to pay claims for medical malpractices, it might have the effect of discouraging donors from additional contribution to charities. Second, charity recipients waived their right to recover damage since their medical services were rendered gratuitously<sup>96</sup>.

Eventually, with the commercialization of medical practice and changes in the nature of medical institutions, the charitable immunity of hospitals started to be abolished even in countries like US

---

<sup>95</sup> Earlene P. Weiner, Independent Duty of a Hospital to prevent Physicians Malpractice, 15 ARIZ. L. REV. 953, 954 (1973)

<sup>96</sup> Note, Theories for imposing liability upon Hospitals for Medical Malpractice: Ostensible Agency and Corporate Liability, 11 Wm. Mitchell L. Rev. 561, 568 (1985)

and UK where the doctrine was very prevalent<sup>97</sup>. Consequently, the resurgence of different rules to establish the liability of medical institutions for medical malpractices was witnessed up on the death of charitable immunity.

In so far as the legal rules that apply between the relationship between injured patients and medical institutions concerned the rules of tort and contract are very common<sup>98</sup>. A contractual liability refers to the liability of a person that arose from the breach of an obligation created through contractual relationships between parties. Tort liabilities, on the other hand, represents a legal wrongs in which responsibility for damages may arise.

With respect to claims in general, and medical malpractice claims in particular, the rules of tort and contracts enjoy a fierce distinction. As Tony Weir has written<sup>99</sup>:

*“...human good, for which the law exists, depends upon the maintenance and development of human goods- life, health, property, and wealth... to ensure their maintenance we have the law of tort, and to promote their development we have the law of contract. Contract is productive, tort law is protective. In other words, tortfeasors are typically liable for making things worse, contractors for not making them better...”*

As indicated above, the civil liability of medical institutions involving the alleged default of a health professional or medical institution fall within the framework of contractual and tortious dimensions. As will be discussed in the subsequent sections, there is significant difference in the position of countries to establish the liability of medical institutions for injuries occurring within their confines. Some countries prefer tort provisions or doctrines to establish medical malpractice actions against medical institutions. Others, on the other hand, favor contract law over tort. This distinction concerns the source of the relevant law in the liability of medical institutions. As such, details of the discussion regarding the liability of medical institutions in tort and contract follow.

---

<sup>97</sup> Ibid.

<sup>98</sup> See Marc Stauch, supra n. 1: 7

<sup>99</sup> Ibid.

## 4.1. Liability of Medical institutions in Tort

Tort rules as a primary rule of medical malpractices actions against medical institutions is common in common law countries<sup>100</sup>. These rules require no contractual relationship between the patient and the health institutions to hold the institution liable for medical negligence or malpractices.

There are different schemes of tortious liabilities recognized in a number of jurisdictions. These include interalia; fault liability, strict liability and no fault liability<sup>101</sup>. In broader terms the no fault liability scheme usually refers to the liability of a given person for the acts or omissions of another person that entails damage to third parties. In the context of medical institution, the no fault liability which is commonly cited as “vicarious liability” refers to the liability of medical institutions for a wrongful act or omission of their employee nurses and physicians<sup>102</sup>.

The application of the rule of vicarious liability, however, depends on the satisfaction of certain tests. First, there has to be certain kind of relationship between the person who causes an injury and the person who assumes the responsibility of compensating the injured party. In this regard, there are a variety of relationships in different legal systems that may serve as basis for the rule of vicarious liability<sup>103</sup>. The liability of employer for the wrongdoing of his/her employee is the most commonly raised instance of vicarious liability.

However, it is important to note that vicarious liability does not exonerate the employee from the scope of liability, but adds employers to the option of plaintiffs. Put it differently, the plaintiff or the injured party may sue the employer directly for the wrongdoing of the employee, or he may sue both the employer and employee jointly in order to recover the damages.

---

<sup>100</sup> Ibid.

<sup>101</sup> Fault liability dictates the need to proof the existence of fault to claim compensation, while strict liability only requires failure to meet a required standard of law without a need to show that the defendant was at fault. See Chris Turner, & Sue Hodge, Unlocking Torts, 2<sup>nd</sup> ed., Hodder Arnold, UK, 2007, pp. 12-13.

<sup>102</sup> Clair G. Combs, Hospital Vicarious Liability for the Negligence of Independent Contractors and Staff Physicians: Criticisms of Ostensible Agency Doctrine in Ohio, 56 U. Cin. L. Rev 711, 711(1987-1988)

<sup>103</sup> In the Ethiopian case, a person relationship with a minor child, employer-employee relationships, authors' relationship with an editor, and agent-principal relationships could be mentioned, among others as basis for the rule of vicarious liability.

The liability of the employer is generally appropriate where there is a significant connection between the creation or enhancement of a risk and the wrong that results there-from, even if unrelated to the employer's desire<sup>104</sup>. Hence, any form of connections and relations to the employment enterprise will not suffice to invoke vicarious liability. In principle, employers or principals, for instance, are not vicariously liable for the tortuous acts of independent contractors though they have an apparent relationship with the hiring enterprise.

Second, the tort alleged to be committed by the employee has to be during the discharge of duties with the relationship in questions<sup>105</sup>. Since the rule of vicarious liability imposes liability on the "innocent employer," the liability is strictly limited and the employer will only be liable for those torts committed while the employee is in the course of the employment.

It is not a simple task for courts to determine what is and is not in the course of employment. In most instances a wrongful act that has been authorized by the employer; or an act that , while authorized, was carried out in unauthorized way has appeared to be a suggested test for conducts 'in the course of employment'<sup>106</sup>.

This rule of "vicarious liability" is an exception to the general rule of extra-contractual liability where a given plaintiff resorts against an "innocent defendant." In this regard, there are a number of theoretical justifications for the imposition of vicarious liability on employers/medical institutions. The following could be mentioned as reasons for the development of the doctrine;

- It is increasingly likely to be efficient. Consider for instance, the situation when employees are insolvent but employers are not. Under such circumstances the absence of vicarious liability results personal liability which gives insolvent employees insufficient incentives to take care, since they lack the wealth to pay tort damages<sup>107</sup>.

---

<sup>104</sup> Paul T. Rose, The Evolution of Vicarious Liability in Tort in respect of Deliberate Wrongdoing, 9Journal of Personal Injury Law 179, 182(2009)

<sup>105</sup> J. A . Jolowicz, Winfield and Jelewicz on Tort; 9<sup>th</sup> ed., Sweet and Maxwell; UK, 1971, p 527.

<sup>106</sup> The vicarious liability of employers for the wrongful act that has been authorized by him is self-explanatory. However, his liability for an act that has been authorized but carried out in an unauthorized way seems a bit rough. The significant point is that the employee is actually still engaged in the work for which he/she is employed and the tort arises out of this work. See Chris turner and Paul Hodges, supra n. 101: 522-3. For further discussion regarding torts committed outside of the course of employment, see *infra* text accompanying note 527-30.

<sup>107</sup> Reinier H. Kraakman, Vicarious and Corporate Civil Liability; 1999, p 670.

- It provides a just and practical remedy for the resulted harm<sup>108</sup>. With this, the employer puts in to the community an enterprise which carries with it certain risks. According to the rule of vicarious liability, it is fair that the person/employer who creates a risk bears the loss when those risks materializes and causes injury to a member of the public despite the employer's reasonable efforts<sup>109</sup>.
- It is believed to contribute in the deterrence of future harm. By this, if the employer assumes the responsibility for the employee's act or omission which resulted harm, even when the employer is not negligent, then it may have a deterrent effect by putting the employer in a position to take all precautionary measures in the hiring and supervising its staff. Put it differently, the employer is supposed to hire, fire, and discipline its staff. If employees are either careless or prone to causing harm, the employer needs to do something about it, ultimately to the extent of dismissing staff.
- The employee is supposed to render service to his/her employer by accepting certain instructions and commands. Had the employer not employed others to do the work, he was supposed to carry the work out by himself. Consequently, he should not escape from the liabilities emanated from the acts and omissions in the discharge of employment duties.
- The risk bearing ability of employers/principals over employees could be another addition to the rule of vicarious liability. It is not odd to assume that the employers/principals are financially in a better position and thereby, with a least disturbance to themselves and their family, are able to satisfy the claims of the victim<sup>110</sup>.

The theoretical justifications of vicarious liability mentioned here in above towards the liability of medical institutions for medical injuries caused by their staff health professionals is basically emanated from the control/supervision which is expected to be exercised by institutions. However, the practice of medicine, by its nature, requires a high level of skill and specialization

---

<sup>108</sup> See Paul T. Rose, *supra* n. 104: 182

<sup>109</sup> *Ibid.*

<sup>110</sup> Desalegn Mesfin, *The Doctrine of the Respondent Superior Under Ethiopian Civil Law*; Research Paper in Fulfillment of the Requirement for the Degree of Bachelor of Laws at the Faculty of Law. AAU (unpublished), 1986, p 71.

that hospitals' administrators could not easily control the acts of medical professionals. Accordingly, in the early times there was a difficulty to impose the doctrine of vicarious liability upon medical institutions even if the medical malpractice is committed by a salaried physician. In discussing this issue and the viability of the doctrine of vicarious liability on medical institutions, one author has stated:

*When applying the doctrine of [vicarious liability] to the hospital-physician relationship it is important to recognize that the traditional "right of control test" is unworkable. Central to the control test is the master's [employer's] right of physical control over the details of the servant's [employee's] work. The lay board of directors or lay administrators of hospitals obviously do not exercise any control over the medical treatment rendered by physicians.... Moreover, it would be a violation of most state medical practices acts for directors to attempt to exercise such control. Thus although courts still frame the issue in terms of the right of control, they necessarily ignore it whenever they hold a hospital liable for the malpractice of a physician<sup>111</sup>.*

Besides, there was a tendency of viewing the activities of medical professionals in to administrative and medical to determine the liability of medical institutions for its employees. By this, medical institutions were liable to the torts of their employee physicians and nurses, if the alleged conduct is administrative<sup>112</sup>. Most jurisdictions abandoned this administrative-medical act distinction towards the liability of medical institutions due to the difficulty of drawing a clear line between the two.

Generally, in some countries like US and UK, medical institutions which used to enjoy tort immunity were highly frustrated by the rule of vicarious liability for the negligence of its employees and started to devise a new arrangement to escape liability. Accordingly, they have entered in to a contract with non-employee physicians to supply medical services. This deliberate arrangement reduces medical institutions' liabilities for negligent treatment attributed to medical professionals working as independent contractors. This in turn reduced the probability of indemnification claimed by injured patients. This factor coupled with the virtual metamorphosis of the hospitals' role in the provision of medical services witnessed in some jurisdictions after

---

<sup>111</sup> Comment, The Hospital- Physician Relationships: Hospital Responsibility for Malpractice of Physicians; 50WASH. L. Rev. 385, 392(1975)

<sup>112</sup> Unless we consider medical institutions as facilities where nurses and physicians practice, the medical-administrative distinction to impose liability gives no sense.

mid 20<sup>th</sup> century, has resulted a concurrent increase in hospitals' responsibility and in the potential for liability<sup>113</sup>. In this regard the doctrine of “ostensible agency” and “corporate negligence” could be mentioned as additions to the regime of medical institutions' liability for medical malpractices.

#### **4.1.1. The Doctrine of Ostensible Agency**

An ostensible or apparent agency is one form of agency relationship imposed by the law. In simple terms, the doctrine of ostensible agency could be defined as the situation of a person who represents that another is his servant or agent and thereby causes a third person justifiably to rely upon the care or skill of such apparent agent<sup>114</sup>. If a person appearing to be a servant causes harm against third party, the person assumed to be represented by “the apparent agent” will be liable to third parties as if there is agency relationship<sup>115</sup>.

The determinative issues necessary to establish ostensible agency includes: a) whether the entity, through its acts created the appearance that an agency relationship existed between the entity and the alleged agent; and b) whether third parties reasonably relied upon that appearance<sup>116</sup>.

Unlike the rule of vicarious liability, the actual control of principals or employers over employees does not matter for the application of ostensible agency-what matters is the appearance of the relationship between the entity and the person claimed to be an agent.

In relation to medical malpractice claims, the doctrine of ostensible agency might be raised by patient-plaintiff against medical institutions when physicians cause injury. In general, establishing an ostensible agency case against medical institutions requires the existence of certain essential elements. First, it requires that the patient reasonably believes that a non-employee or an independent contractor physician is an employee of the institution. Second, the patient's belief has to be generated by some act or omission of the medical institution that led

---

<sup>113</sup>Judith M. Kinney, Tort Law-Expansion of Hospital Liability under the Doctrine of “Corporate Negligence”-Thompson V. Nason Hospital, 591 A. 2d 703 (pa. 1991.), 65 Tample L. Rev. 787, 787 (1992).

<sup>114</sup> Earlene P. Weiner , Managed Health Care: HMO Corporate Liability, Independent Contractors, and the Ostensible Agency Doctrine, 15 Journal of Corp. L. 535, 546 (1989-1990).

<sup>115</sup>Ibid.

<sup>116</sup> Keith Phoenix, & Anne L. Schlueter, Hospital Liability for the Acts of Independent Contractors: The Ostensible Agency Doctrine, 30 St. Louis U. L. J. 875, 879 (1986)

him to believe the physician was an employee. Third, the medical services rendered should constitute inherent functions of medical institutions<sup>117</sup>.

Stated differently, to get compensation on the basis of this theory, the patient is only required to show an actual belief in his side that the physician was an employee of the hospital and that he sought the physician's care based on that belief<sup>118</sup>.

It is noteworthy that the doctrine of ostensible agency is frequently cited if the physician who causes an injury is not an employee, but has certain kind of relationship with the medical institutions. Independent contractors, for instance, are not employees and there by medical institutions won't be vicariously liable for the medical malpractice of those persons. The absence of the principals' control over the activities of independent contractor is the prime reason for the exclusion. However, such institutions might be liable to the conduct of independent contractor physician on the basis of ostensible agency as long as the patient-plaintiff show the fulfillment of the tests provided above<sup>119</sup>.

The adoption of the doctrine of ostensible agency in the context of medical institutions is basically attributed to the sophisticated set up of modern medical institutions. It is apparent that modern medical institutions are quite different from their predecessor of long ago. As has been discussed in the first section of this chapter, in the mid 20<sup>th</sup> century medical institutions become more than the provider of bed and board for patients. In most societies these modern set up of medical institution creates a likelihood that patients will look to the entity rather than the individual physician for care<sup>120</sup>. Moreover, medical institutions today present themselves as fully fledged service providers to their patients or consumers. Thus, the fact that a physician is an independent contractor not subjected to the control of the institution should not be raised as a

---

<sup>117</sup> Patients' involvement in the selection of physicians is considered as a basic factor to determine the existence of ostensible agency. See Bradford C. Kendall, *The ostensible agency doctrine: In Search of the Deep Pocket*, 5UMKC L. REV. 917, 924(1988-1989)

<sup>118</sup> See Earlene P. Weiner, *supra* n. 114: 547.

<sup>119</sup> The increasing frequency with which medical institutions enter into contracts with independent contractor physicians has resulted the frequent application of ostensible agency in some jurisdictions. See *Ibid*.

<sup>120</sup> *Ibid*.

defense against the patient who is the ultimate victim of that physician's malpractice, as long as the patient relied up on the institution to provide care<sup>121</sup>.

In general, the use of ostensible agency doctrine against medical institutions is meant to pierce the traditional rules of vicarious liability<sup>122</sup>. The Application of the doctrine is particularly significant in those jurisdictions that hospitals do not employ physicians, but instead contract with physicians as independent contractors<sup>123</sup>. The adoption of this rule exposes medical institutions to face much greater liability since their liability is not only limited to the negligence of their employees as provided in the rule of vicarious liability. In order to describe this situation one author said that:

*“The plaintiff in a medical malpractice action is the beneficiary of the ostensible agency doctrine which represents another weapon in a plaintiff's arsenal of theories of recovery, and consequently, another chink in a [m]edical institution's armor against increased exposure to liability<sup>124</sup>.”*

#### **4.1.2. The Doctrine of Corporate Negligence**

In broader terms, the doctrine of corporate negligence which is often referred to as corporate liability encompasses the meaning that “the hospital is liable if it fails to uphold the proper standard of care owed to its patient.<sup>125</sup>” By this, the hospital has a distinct duty of care which it owes directly to the patient<sup>126</sup>. Stated differently, the doctrine of corporate negligence attaches

---

<sup>121</sup>It would be unreasonable to expect the patient to enquire who is who in the institution before getting treatment. Besides, it would be uneconomical for the hospital to disclose physicians' contract with the institution to each patient.

<sup>122</sup> See Bradford C. Kendall, supra n. 117: 917

<sup>123</sup> Ibid.

<sup>124</sup> Ibid.

<sup>125</sup> Ibid.

<sup>126</sup> Illinois Supreme Court Decision in Darling Vs. Charleston Memorial Hospital marked the origin of the doctrine of Corporate Negligence in the United States. A plaintiff who broke his leg in a football game was awarded \$150,000 by a jury after his leg was amputated due to the negligence of Dr. Alexander, the attending physician. Dr. Alexander was an independent contractor physician. The Defendant argued that the hospital only owes a duty to furnish facilities for treatment, but does not undertake to treat its patients. On the other hand, Darling, the victim argued that the hospital's failure to review negligent medical care rendered by an independent contractor physician or to require consultation amounted to direct negligence of the hospital. Considering both arguments, the court finally stated that “present day hospitals, as their manner of operation demonstrates do far more than furnish facilities for treatment as the limited view of a hospitals duty no longer reflected the fact. See darling, 211 NE2d at 257 and see also Mark E. Milsop, Corporate Negligence: Defining the Duty Owed by Hospitals to their Patients, 36

liability directly to the medical institutions as a form of institutional or independent negligence<sup>127</sup>.

It is noteworthy that the doctrine of corporate negligence differs from the rule of vicarious liability as it imposes an independent non-delegable duty upon a medical institution to the care of the patient. This doctrine gives priority for patient's safety. For instance, it requires medical institutions; a) to use reasonable care in the maintenance of buildings and grounds for the protection of its patients; b) to maintain medical equipments free of defects; c) to use reasonable care in the selection of its employees; and d) to supervise all persons who practice medicine within its vicinity<sup>128</sup>.

Even though, the doctrine of corporate negligence requires medical institutions to assume a wide variety of care towards their patients, it is not meant to hold medical institutions as guarantors for all sorts of care. Hence, defining the parameters or boundaries of the corporate duties is a very crucial element in the application of the doctrine. In this regard, the rationales and justifications of the doctrine are believed to give insight as to its boundaries.

Jurisdictions that applied the doctrine of corporate negligence forwarded different rationales for its adoption. The changing role of medical institutions within a society is the first justification for corporate negligence<sup>129</sup>. This rationale is also commonly referred to as "policy rationale."<sup>130</sup> On the basis of this justification, corporate negligence is meant to serve the purpose of enforcing the legitimate expectation of patients who are members of the general public<sup>131</sup>. Because, as early as the adoption of this doctrine, it has been recognized that a patient who avails himself of hospital facilities expects that the hospital will attempt to cure him. However, modern medical institutions enter in to a contract with outside entities and individuals to provide (medical) services to patients. Sometimes, they even grant staff privileges to physicians who are neither independent contractors nor employees. Thus, these deliberate arrangements of medical

---

Duq. L. Rev. 639, 641 (1991-1992). See also Diane M. Janulis, & Alan d. Honstein, Damned If you Do, Damned If You Don't: Hospitals liability for Physicians Malpractice, 64 Neb. L. Rev. 689, 704 ( 1985).

<sup>127</sup> See Earlene P. Weiner, *supra* n. 114:544

<sup>128</sup> See Bradford C. Kendall, *supra* n. 117:922, and see also Judith M. Kinney, *supra* n. 113:792.

<sup>129</sup> See Mark E. Milsop, *supra* n.2: 643

<sup>130</sup> *Ibid.*

<sup>131</sup> *Ibid.*

institutions won't affect the expectation of members of the public if institutions owe direct duties to the care of their patients based on the rule of corporate negligence. In explaining this situation, justice Zappala noted that:

*“[Medical Institutions] have evolved highly sophisticated corporations operating primarily on a fee-for-service basis. The corporate hospital of today has assumed the role of comprehensive health center with responsibility for arranging and coordinating the total health care of its patients.”<sup>132</sup>*

The second justification which is, in fact, frequently proffered for corporate negligence is related with the economic arguments of the so called efficiency<sup>133</sup>. According to the rule of efficiency, among other things a certain rule is said to be efficient if it maximizes societal wellbeing. For a business to adopt a rule that maximizes societal wellbeing it has to make a cost benefit analysis.

As it is for other business entities, decisions within medical institutions also entail a cost benefit analysis. For instance, in order to fill a vacancy, a particular hospital may admit a number of young inexperienced physicians to its staff, or increase the workload of existing staff member. If the hospital hires an inexperienced doctor, there might be a higher probability of malpractice. On the other hand, hiring inexperienced doctor may have a benefit for the hospital as it pays a relatively lower salary. Thus, save other things remaining constant, a hospital may hire an inexperienced physician as long as its benefit is greater than the probable cost of medical malpractice.

Based on the example provided above if a medical institution owes a direct duty to use a reasonable care in the selection of employees, the decision-maker of the health care provider will take efficient level of precaution in the hiring of physicians. This shows how the rule of corporate liability will create circumstances conducive to efficient decision-making by health care providers. By utilizing the rule of corporate negligence, medical institutions are expected to reduce liability by taking precautions in their decision making.

---

<sup>132</sup> Ibid.

<sup>133</sup> Ibid.

In sum, this doctrine could be considered as the latest twist in hospital law as it vividly exposed those institutions to liability in almost all aspects of patient care<sup>134</sup>.

## 4.2. Liability of Medical Institutions in Contract

Contractual rules as basis of medical malpractice claims against medical institutions is common in civil law countries. In these countries there is a tradition to incorporate contractual rules in to legislative codes, which aim to present the rules in a systematic way. Accordingly, contractual rules dealing liabilities of medical institutions may be formulated within the general framework of contract law or it may be treated as a separate part.

It is noteworthy that medical or hospital contracts are concluded for the performance of medical services; and such contracts too often do not require the contractor to guarantee the success of the medical treatment unless the institution bounds itself in the contract to do so. The patient sought the institutions to do something positive, i.e. cure or palliate his illness. What is normally required of the medical institution or physician practicing within the premises of the institution is to render the service with due care and diligence in respect of the quality of care required by the medical profession and the relevant laws of that specific country. As such, the contractor is answerable for medical malpractices or negligent performance as breach of contractual obligations<sup>135</sup>.

Due to the complex nature of medical malpractice claims, contractual rules dealing such matters failed to foresee all combinations that result the injury. As such, these legal rules too often require further interpretation in the course of its application to settle a given case. Moreover, the interpretation is desired to define the application in unforeseen situation<sup>136</sup>. Stated differently, fact-situations raising potential liability for accidental harm are too varied to be made the subject of detailed *ex ante* contractual rules; and HLA Hart has written the following in favor of this assertion<sup>137</sup>:

---

<sup>134</sup>See Bradford C. Kendall, supra n. 117: 922, and see also Keith P., & Anne L. Schlueter, supra n. 116: 10

<sup>135</sup> See section 3.3 of Chapter Three for the details of determining negligence or malpractice during medical treatments.

<sup>136</sup> See Marc Stauce, supra n. 1: 7

<sup>137</sup> HLA Hart, The concept of Law (1994) p.133 cited in Id. p 8.

*“...owing to the immense variety of possible cases where care is called for, we cannot ab initio foresee what combination of circumstances will rise nor foresee what interests will have to be sacrificed or to what extent, if precaution against harm is to be taken... our aim of securing people against harm is indeterminate till we put it in conjunction with or test it against, possibilities which only experience will bring before us.”*

## Chapter Five

### 5. Liability of Health Institutions in Ethiopia

#### *Preview*

*In Ethiopia, the liability of health institutions for the injuries caused to its patients might also arise either from the breach of contractual obligations or torts. With respect to liabilities arising out of contract, it would be rare for there to exist an explicit term of such a contract guaranteeing the patient's confidences in most medical treatments rendered in Ethiopia. Such a term, however, is implied by the 1960 Civil Code of Ethiopia dealing with contracts in general, and hospital or medical contracts in particular.*

The discussion made in the previous chapter made clear that the liability of medical institutions involving the alleged medical errors committed within their premises is subjected to the framework of contract or tort depending on the approach taken by specific legal system. As far as the Ethiopian legal system concerned, both contract and tort regimes could be taken as sources for the liability of medical institutions. This chapter then will discuss the liability of Ethiopian medical institutions in tort and contract, and those instances where independent contractors and non-employee health professionals commit medical errors within the vicinity of such medical institutions.

#### **5.1. Liabilities of Health Institutions Arising out of Contract**

Book V of the Ethiopian Civil Code enumerates some provisions that govern the contractual relationship between medical institutions and patients. More specifically, in Ethiopia, medical or hospital contracts are dealt under Title XVI, Chapter 5 (Article 2639-2652) of the Civil Code. These provisions are meant to supplement parties' agreements.

The 1960 Civil Code of Ethiopia provided two forms of medical or hospital contracts: a) medical contract, and b) contract of hospitalizations. Medical contract refers to a contract where a physician undertakes to provide a person with medical care and to do his best to maintain him in

good health or cure him, in consideration of payment of fee<sup>138</sup>. As such, this could be taken as the source of physician-patient relationship in Ethiopia.

Second, the contract of hospitalization, on the other hand, refers a contract whereby a medical institution undertakes to provide a person with medical care from one or several physicians, in connection with a given illness<sup>139</sup>. This contract may be formed directly between the person in need of medical care and the medical institution, or it may also be made between the medical institution and a third party on behalf of the person in need of treatment<sup>140</sup>.

The contract of hospitalization being a contract that creates parties' respective obligations, the patient assumes the obligation of payment of the required fees; and the medical institution obviously assumes the obligation to provide the patient with medical care<sup>141</sup>. This information is usually recorded in the patients' card and could be used as an evidence for the conclusion of contract between the health institution and the patient<sup>142</sup>.

In principle, medical or hospital contracts require no special form. In that case, Article 1719 of Civil Code provides that 'a contract shall be valid where the parties agree.' Thus, the contract between medical institutions and patients could be drawn in writing or any other form as long as parties agree to their respective obligations.

Normally, the contract of hospitalization ultimately aims at maintaining the patient in good health or cures him. At times, however, the activities of the medical institution to cure the patient may go wrong and bring liabilities. In this regard the Civil Code of Ethiopia provides two sources for the liability of medical institutions: 1) medical treatment, and 2) board and lodging<sup>143</sup>.

---

<sup>138</sup> Civil Code, Article 2639 Civil Code.

<sup>139</sup> Ibid. Article 2641.

<sup>140</sup> Ibid. Article 2642.

<sup>141</sup> Ibid, Articles 2643-2646, and Article 2641.

<sup>142</sup> See Annex Two, the case between Senait Alemayehu v. Mari Stops International Clinic.

<sup>143</sup> Civil Code, Article 2651 and 2652.

### 5.1.1. Medical Treatments

As indicated above, contract of hospitalization puts the medical institution under the obligation of providing medical care. As such, the institution organizes and coordinates the overall medical treatment given to the patient. This is a direct duty the institution owes the patient. Accordingly, Article 2651 of the Civil Code of Ethiopia explicitly provides that ‘the medical institution shall be civilly liable for the damage caused to a sick person by the fault of the physician or auxiliary staff which it employs.’

It is noteworthy that the contract of hospitalization between the institution and the patient is the source of this liability, and the fault which caused the injury is failure in the discharge of contractual duties by the institution. In that case, patient plaintiff claims damage on the basis of non-performance of contract. According to Article 1790 of the Civil Code, it is clearly stipulated that a party may require that the damage caused to him by the other party failing to perform his obligations be made good.

In principle, the liability of the party who fails to perform his obligations is not conditional up on the existence of fault<sup>144</sup>. Exceptionally, however, the Civil Code requires proof of fault to claim damage arising out of non-performance of the contract. In this regard, Article 1795 of the Civil Code explicitly provides that ‘a party may not claim damages on the ground of non-performance of the contract by the other party, unless he can show that the other party is at fault, where:

- The debtor has undertaken to do his best to procure something to the other party without guaranteeing that he would succeed; or
- Such an exception is expressly provided by law in respect of certain contracts.

The foregoing provision has tremendous significance for liabilities arising out of medical or hospital contracts. In case of medical contracts, the law explicitly provides that ‘a physician shall not guarantee the success of his treatment unless he has expressly assumed this obligation in writing<sup>145</sup>.’ The fact the medical treatment failed to bring good result or cure the patient does not constitute a breach of the duty by the physician. Consequently, patient plaintiff who seeks to sue

---

<sup>144</sup> Ibid, Article 1791.

<sup>145</sup> Ibid, Article 2648.

and claim compensation from a physician on the basis of non-performance need to show the existence of fault on the part of the physician.

Unfortunately, as has been pointed out above, such express provision is not provided by the law in respect of contract of hospitalization. In fact, the concerned health institution is free to disown this obligation by expressly mentioning it in the contract of hospitalization. In the absence of such contractual provision, the issue then will be whether or not medical institutions guarantee the success of medical treatment given to the patient. The author is of the opinion that if we do not employ the legally accepted principle of analogy to use Article 2648 of the Civil Code which deals with guarantee of cure in case of medical contracts for the purpose of contract of hospitalization, the patient plaintiff might legitimately consider the medical institution as a guarantee for the success of the medical treatment.

From the foregoing discussion it can be easily discerned that the law provides no extra requirements to establish the liability of medical institutions bound by contract of hospitalization for medical injuries as long as the fault is committed by physician or auxiliary staff which the institution employees.

For the proper and good understanding of this issue, it would be better to have a look at the liability of physicians bound by medical contracts as provided under Article 2647 of the Civil Code. This provision prescribes that a physician shall not be liable to the person towards whom he is bound under the medical contract unless he commits a fault, having regard to the rules of his profession<sup>146</sup>. By this, the liability of physician is conditional upon the rules of his profession. The law also further prescribes that the liability of physicians for the faults committed by assistants whom he employs shall be governed by the Chapter of the Civil Code relation to “Extra-contractual Liability” (Art. 2130-2133)<sup>147</sup>. This part deals about employer’s vicarious liability for the damage caused by an employee, which is also very much dependent up on the occurrence of the fault in “the discharge of employment duties.” However, the provision dealing the liability of medical institutions bound by contract of hospitalization provides no condition except the employment relationship between the person causing the harm and the institution.

---

<sup>146</sup> Ibid, Article 2647(1).

<sup>147</sup> Ibid, Article 2649.

As such, it leaves many issues open for interpretation or discussion; but the following two are very decisive and worth mentioning: a) it makes no distinction between public and private health institutions; and b) it gives no information as to the nature of faults committed by the employee which is very relevant to determine the liability of the employer for the faults of its employees.

**A. No Distinction between Public and Private Medical Institutions:** there are different forms of medical institutions in Ethiopia. As discussed under chapter two of this thesis medical institution could be broadly categorized in to public and private. It is true that both public and private medical institution enter in to contract with patients for the provision of medical services. However, it is noteworthy that there is an apparent difference in the purpose pursued by these institutions. Public and for-not-profit medical institutions are too often established as utility maximizes, while for-profit medical institutions targets maximization of profit. Even, sometimes some for-not-profit health institutions render charitable medical service free of charge.

As such, the legislator has used an elegant approach when it defines contract of hospitalization. According to the definition provided under Article 2641 of the Civil Code, contract of hospitalization is just a contract where a medical institution undertakes to provide a person with medical care. This definition makes payment of fees on the part of the patient as a condition for the formation of contract of hospitalization. Hence, the contract of hospitalization might be formed with payment of fees on the part of the patient, or it might be formed for free.

Conversely, the definition of medical contract provides payment of fee as one element in the formation of the contract<sup>148</sup>. In that case, if a physician undertakes to provide a person with medical care with no consideration of payment of fee, the physician-patient relationship created will automatically be outside the scope of the section of the Civil Code dealing medical or hospital contracts.

From the foregoing discussion, it can be easily construed that the definition of hospitalization is too broad as it refers all contracts between health institutions and

---

<sup>148</sup> Ibid, Article 2639.

patients for medical care. The implication is, however, tremendous. It puts all medical institutions, be it public, for-profit, or for-not-profit under the same status when it comes to liabilities for damages caused to sick persons. In the regime of medical institutions liability, this provision tells us the non-existence of charitable immunity in the Ethiopian legal system<sup>149</sup>.

**B. Nature of the Fault which caused the Injury:** to establish the liability of medical institutions pursuant to Article 2651 of the Civil Code, the fault of the physician or auxiliary staff which the institution employs is very critical. As indicated in the discussion of medical malpractices and negligence, patient plaintiff must show that the fault of the physician was the actual and proximate cause of the patient's injury.

However, all faults are not the same. It might consist in intentional act or mere negligence. It might also be a professional or personal fault. These classifications significantly affect theories of liability and the extent of damages. For instance, under Article 2126 of the Civil Code, the state shall not be vicariously liable for the damages caused by its employees where the fault is a personal fault; but if the fault is a professional one, the victim may claim compensation from the state.

In case of non-performance of contractual obligations, sometimes the nature of fault matters to determine liability. Article 1796 of the Civil Code, for instance, provides that 'where the contract is made for the exclusive advantage of one party, the other party shall not be liable to pay damages in case of non-performance unless he has committed a grave fault. The contract of hospitalization between for-not-profit health institutions and patients is too often made for the exclusive advantage of the patient. In case of injuries, however, these institutions get no privilege and the fault of the physician need not to be a grave one to establish liability.

In sum, regardless of the type of medical institutions and nature of faults, medical institutions bound by contract of hospitalization in Ethiopia shall be held liable for the

---

<sup>149</sup> Note that a large number of hospitals in the US used to enjoy charitable immunity until mid 20<sup>th</sup> century.

injuries caused to a patient by the fault of the health professional or auxiliary staff which it employs.

### **5.1.2. Board and Lodging**

Board and lodging refers to the situation where the sick person is lodged and fed by the medical institution. When the medical institution bound by contract of hospitalization undertakes to lodge and fed the patient, there are certain responsibilities and obligations arising out of it. In Ethiopia, ‘where the sick person, for purpose of his treatment, is lodged and fed by the medical institution, such institutions shall, as regards its obligations and responsibility arising from that lodging and feeding concerned, be subject to the provisions of the 1960 Civil Code dealing innkeepers’ contracts (Art. 2653-2671)<sup>150</sup>.

As such, medical institutions are responsible to make sure that the rooms engaged by the patient and those parts of the room used in common, the food or drink provided by the institution are healthy and safe<sup>151</sup>. However, the medical institution shall not be liable if the damage is caused due to force majeure or the client’s [patient’s] fault<sup>152</sup>.

The liabilities arising out of contract of innkeepers give emphasis to the loss or retention of the property brought into the innkeeper by the client. For instance, persons who want occupy hotel rooms too often come with their own luggage. As such, it is reasonable for the law to impose obligation upon the innkeeper to look after the client’s luggage without any additional payment.

Unless the loss of the thing brought to the hotel is due to the fault of the innkeeper or a member of his family, or member of his staff; or occurs to the thing which the client has especially deposited with the innkeeper, the innkeepers’ liability shall be limited to a total sum of five hundred Ethiopian dollars<sup>153</sup>. Analogously, medical institutions which retain the property of the patient on the basis of innkeepers’ contract will also be liable to the aforementioned amount.

---

<sup>150</sup> Under Article 2653 of the Civil Code, an innkeepers’ contract is defined as a contract whereby a person who exercises the occupation of innkeeper undertakes to lodge a client during one or several nights.

<sup>151</sup> Civil Code, Article 2658.

<sup>152</sup> Ibid, Article 2658(3).

<sup>153</sup> Ibid, Article 2664 and 2665.

## **5.2. Liabilities of Health Institutions Arising out of Tort**

In Ethiopia, the liability of medical institutions may also arise out of extra-contractual relationships. This situation represents all instances that medical institution render medical service to their patients without entering in to contract of hospitalization. There could be various instances of extra-contractual relationships between medical institutions and patients; but the emergency medical treatment as provided under Article 34(2) of Proclamation No. 559/2010 is worth mentioning in this regard. Pursuant to this provision, ‘any medical institution shall have the duty to provide emergency medical treatment to a victim of a vehicle accident when approached by such victim.’

If however, liabilities arise out of such extra-contractual relationships, the general provisions of tort provided under the 1960 Civil Code Ethiopia will come in to the center to govern the relationship between parties. These provisions are not specifically meant for the liability of medical institutions; instead, they are crafted to address the liability that may arise out of various sorts of relationships.

More specifically, the Civil Code mentions employer-employee or principal-agent kind of relationships as sources of tort liabilities. In the employer-employee kind of relationship, the liability of the employer is essentially based on the rule of vicarious liability<sup>154</sup>. In the context of health institutions, the institution will be vicariously liable for the damages caused by its employee physicians.

Generally, regardless of the nature of relationships mentioned above, all health institutions, be it private or public would be liable for the acts of their employees. However, the vicarious liability regime makes a slight distinction between the liability of public and private medical institutions. Details of this discussion follow.

### **5.2.1. Liability of Public Health Institutions in Ethiopia**

As per Article 2126(1) of Civ. Code, ‘any civil servant or government employee shall make good any damage he causes to another by his fault. However, the victim may claim compensation

---

<sup>154</sup> Refer section 4.1 of Chapter four for the details of the rule of vicarious liability.

from the state, if the fault committed by the civil servant or government employee is a professional fault<sup>155</sup>.

In this regard, what is meant by “professional fault” is very critical to determine the liability of state. As such, Article 2127 Civ. Code, defined professional fault as a fault where the person who committed it believed in good faith that he acted within the scope of his duties and in the interest of the state. In the context of health care, public health institutions become liable when an employee health professional commit a professional fault and causes injury to another party/patient.

However, if the injured patient plaintiff succeeded and got compensation from the public health institution, the law provided that the institution may ultimately claim from the tort feisor (health professional)<sup>156</sup>. In case of professional faults committed by a civil servant or employee, Article 2157 of the Civil Code neutralizes the rigidity of this rule by giving discretion to the court to decide the division of liability<sup>157</sup>.

It is noteworthy that the law, at times, does not impose liability on third party or entity, and allow the person primarily at fault to avoid responsibility and accountability. In this regard, Article 2126(3) of the Civil Code exonerates the state from the liability where its civil servants or employees commit a personal fault. The definition of personal fault under the Civil Code referred all faults except professional faults as defined above. Stated simply, the regime of personal fault for the purpose of state liability in Ethiopia is like a big basket where you can put every fault of the employee, save professional faults.

### **5.2.2. The Liability of For-profit Health Institutions**

The Civil Code under Article 2129 provides the vicarious liability aspect of bodies corporate. This provision is relevant to establish the vicarious liability of private health institutions for the damage caused to a patient by the fault of a third party whom the institution is answerable. In

---

<sup>155</sup> The state may subsequently claim the amount paid from the civil servant or employee at fault. See Civil Code, Article 2126(2).

<sup>156</sup> Ibid, Article 2126 (2); emphasis added.

<sup>157</sup> The court may decide that the debt shall finally be borne, either wholly or partly, by the State or its territorial subdivision or the public service concerned. Ibid, Article 2157(2).

this regard, health institutions shall be liable under the law where one of their representatives, agents or paid workers incurs a liability in the discharge of his duties.

Similarly, Article 2130 of the Civil Code also held employers liable where one of his employees incurs a liability in the discharge of his duties.

To invoke the vicarious liability of private health institutions on the basis of the foregoing provision is very much dependent up on the meaning as to what constitutes “discharge of duties.” As such, a liability shall be deemed to have been occurred in the discharge of duties where the wrongful act or the abstention was committed for the purpose of caring out the duties<sup>158</sup>. Pursuant to Article 2132(1) of the Civil Code, if the damage is caused at the place where or during the time when the agent or paid worker is normally employed, the law takes the presumption that the damage shall be deemed to have been caused in the discharge of duties<sup>159</sup>. In that case, the body corporate [health institutions] may proof it to the contrary to rebut such presumption of the law<sup>160</sup>.

The law also tries to define what is meant by the “non-discharge of duties.” By this, the liability shall not be deemed to have been incurred in the discharge of duties where such duties have merely provided their author with an opportunity of committing the wrongful act or abstention which caused the injury. This excludes a plenty of employees’ conducts from the scope of “discharge of duties” which in turn saves bodies corporate or employers from liabilities arising out of the actions of its employees, agents or representatives.

Even though the law provides the definitions and presumptions as to the liabilities incurred in the discharge of duties, it is sometimes difficult for courts to establish this element. The common law courts too often consider the following factors to determine whether or not intentional torts as well as negligent torts occurred in the course of employment:

- Usual place of employment;

---

<sup>158</sup> Ibid, Article 2131(1).

<sup>159</sup> Ibid, Article 2132(1).

<sup>160</sup> Ibid, Article 2132(2).

- Whether the act's purpose, in whole or in part, was in furtherance of the employer's business;
- The extent to which the act was similar or different from authorized acts of the employer;
- The extent to which the act was a departure from the employer's customary methods; and
- Foreseeability or the extent to which the employer should have expected such an act to occur<sup>161</sup>.

The consideration of the foregoing factors would also be relevant in Ethiopian courts when the judges face difficulty in determining the occurrence of liability in the discharge of employment duties

### **5.3. . Medical Malpractice Claims in Ethiopia**

Medical malpractice claim fall within the general ambit of private law. Medical malpractice claims might be raised based on the law of contract or extra-contractual liability. Common law countries have tended to deal medical malpractices in tort. In England, for instance, the fact that treatment is free at the point of delivery has been held to militate against the existence of a contract<sup>162</sup>. Countries that are essentially influenced<sup>163</sup> by the continental legal system, on the other hand, favor contract to deal with medical malpractice cases.

In Ethiopia, medical malpractice claims might be raised based on the law of contract or tort<sup>163</sup>. As discussed in the previous section, the patient will almost invariably be in a contract with the medical institution. All that is required to form contractual relationship between the patient and the medical institution is that the institution indicates willingness to treat, and the patient to be treated. As such, the obligation of medical institutions to the patient arises primarily in contract.

Given that, if the patient injured during the course of treatment, he may bring a claim for breach of contract by alleging that the error constitutes a breach of the institution's contractually assumed obligations. This raises the question of what is meant by the breach of duties in the

---

<sup>161</sup> American Jurisprudence, 1992, cited in Ginny W. Guido, supra n. 32:189

<sup>162</sup> There is strict application of consideration (exchange of benefits between contracting parties) in England contract law. See Mark Stauce, supra n. 1: 9.

<sup>163</sup> Medical malpractice claims in Ethiopia may also be pursued under the criminal code.

contract of hospitalization. It is noted that the 1960 Civil Code of Ethiopia has classified medical or hospital contracts as contracts for the performance of services. Under such contracts, it is too often difficult to warrant a particular result; instead a contractor is expected to exercise due care and skill unless he has expressly assumed this obligation.

Medical malpractice claims against medical institutions in Ethiopia may also be pursued under tort law. However, as has been pointed out above, contract law represents a large number of medical institutions-patients relationships, and medical malpractice claims on the basis of tort is secondary.

Generally, a claim for medical malpractice in Ethiopia is adjudicated based on the determination of fault which caused the injury<sup>164</sup>. For the claimant or the court, however, it is not easy to construct the occurrence of fault or breach of duty during medical treatments. There is no doubt that cases of medical malpractice claims are a little different from normal claim since they require the judge or the plaintiff to measure the reasonableness of medical activity about which the judge or the plaintiff has no great level of understanding. Moreover, it is for the medical profession rather than the court or the plaintiff to determine whether or not a particular medical treatment rendered by a medical institution has achieved the required standards of care. As such, the reasonableness of a particular medical treatment is not, generally speaking, within judicial knowledge, and this has led to a suggestion that in case of medical malpractice claims judges or claimants should seek the testimony of expert witnesses or professionals from the relevant field of study.

Unfortunately, expert witnesses in Ethiopia are biased in favor of the defendant, and they are often reluctant to testify on behalf of the patient plaintiff<sup>165</sup>. However, there are other schemes established by the government to evaluate the level of standards of care taken by physicians or medical institutions when patients or third parties on behalf of the patient allege the occurrence of medical malpractices. In this regard, the Ethiopian Health Professional Council established by FDRE Council of Ministers Regulations Number 76/2002 has played crucial role. The council

---

<sup>164</sup> There are two popular approaches to brought medical malpractice claims: fault-based and no-fault based approach.

<sup>165</sup> Interview with Ato Girma Negash who is a judged in First Instant Court of the Amharan Regional State, on June 20, 2011.

has a “Professional Ethics Sub-Committee” which has the capacity to determine whether or not the treatment given by physicians or medical institutions has achieved the required standards of care and professional ethics when a patient who alleges the existence of medical malpractice makes a complaint to the Council<sup>166</sup>.

In sum, studies have shown that the number of medical malpractice claims in the international arena, had increased more rapidly than anyone had expected<sup>167</sup>. By contrast, relatively very few medical malpractice claims have been pursued in Ethiopia. In the electronic database of the Federal High Court of Ethiopia, for instance, they are not more than a handful per year. But this does not mean that medical errors in Ethiopia are small in number.

In developing countries it is estimated that as many as one in 10 patients is harmed while receiving hospital care, and the probability of patients being harmed in hospitals of developing countries is higher than in industrialized nations<sup>168</sup>. For instance, the risk of health care-associated infection in some developing countries is as much as 20 times higher than in developed countries. As far as Ethiopia concerned, it is difficult to find a concrete data regarding the number of medical errors. However, it would not be illogical to expect a higher number of medical errors in Ethiopia, since the country is grouped within the Least Developed Countries of the world<sup>169</sup>.

---

<sup>166</sup> Regulation No. 76/2002, Article 16. For a better understanding of the function of the Council, some cases ruled by the profession ethics sub-committee are annexed. Please see Annex Three.

<sup>167</sup> In England, for instance, the number of medical malpractice claims is estimated in tens of thousands. See Neal C. Hoga, *supra* n. 74: 49.

<sup>168</sup> WHO, 10 Facts on Patient Safety, available at [http://www.who.int/features/facctfiles/patient\\_safety/en/index.html](http://www.who.int/features/facctfiles/patient_safety/en/index.html). Accessed on 23/08/11.

<sup>169</sup> Even though the occurrence of medical errors in Ethiopia is believed to be high, only few patients seek indemnity for an injury resulted during medical treatments. Why medical malpractice claims are small in number in Ethiopia needs further research, but the fact that injured patients remain without compensation is a big problem that legal rules of the country should give an answer. The author of this work is of the opinion that the introduction of “compulsory medical malpractice insurance” for the benefit of patients may ultimately give solution for this problem. This scheme of insurance would not be strange to the Ethiopian legal system as a similar ‘Mandatory Vehicle Insurance against Third Party Risk’ is introduced by Proclamation No, 559/2008. According to Article 4(1) & (2) of this proclamation, a third party insurance policy shall cover the compensation payable in the case of loss of life, bodily injury, damages to property and emergency medical treatment caused by the insured vehicle. If the accident is caused by uninsured or unidentified vehicle, the victim can get his compensation form the insurance fund operated by the government as provided under Article 20(2) of Proclamation No, 559/2008. Hence, if we could adopt a similar “compulsory insurance” for medical malpractices, it would enable most, if not all, patients to be indemnified for losses or injuries caused during medical treatments.

## **5.4. Impact of Health Care Relationships on the liability of Health Institutions**

In almost all forms of liabilities of health institutions for the damages caused to patients, be it contractual or tort, the type of relationship formed between health professionals and institutions is very decisive. As has been discussed on chapter two, this relationship is essentially established through various forms of contracts which includes, inter alia; employment contract, agency contract, contract for voluntary work, contract of apprenticeship and contract of work and labor.

In Ethiopia the typical contract of employment represents most of health institutions-physicians relationships. This contract of employment might require the health professional to work on a permanent or a part-time basis. Whatever the case, this employment relationship serves as the basis for the application of vicarious liability doctrine in Ethiopia when an employee incurs liability in the discharge of his employment duties. Once again, the liability of medical institutions bound by contract of hospitalization for the damage caused to a patient by the fault of the physician or auxiliary staff is also conditional up on employment relationship between the person who commit the fault and the institutions.

As indicated above, medical institutions-physicians relationship might also be established through the rules of agency. As such, the agent or representative of medical institution might cause injuries to the patient. The question then will be whether or not the injured patient could sue the institutions for compensation.

In the absence of contract of hospitalization between the patient and the medical institution, we could possibly invoke the provisions of the Civil Code dealing with extra-contractual liability and agency to hold medical institutions liable for the damage caused by an agent. In this regard it is expressly provided under Article 2129 of the Civil Code that ‘bodies corporate shall be civilly liable where their representatives or agents incur a liability in the discharge of his duties.’

In addition, the health institution-physician relationship might also be established through a contract which gives the physician an independent contractor status. In Ethiopia, medical institutions might allow health professionals to practice medicine as independent contractors. With regard to liability, Article 2134 provides that a person [medical institution] shall not be

liable for the faults or offences committed by another [health professional] while carrying out work which he has asked him to do, where the author of the offence is independent contractor. What matters most to determine liability on the basis of this relationship is the autonomy of the author who commits the offence, and medical institutions may legitimately raise this instance as a defense against injured patients.

As indicated in the discussion made under chapter four of this thesis, the introduction of the independent contractor status of health professionals has impacted the theories of liability in the field of health care. In those jurisdictions that employ tort law as a basis for medical malpractice claims, hiring independent contractor physicians was a deliberate arrangement of medical institutions to beat the requirements of the vicarious liability doctrine during malpractices or negligence. This deliberate arrangement which absolves medical institutions from liabilities arising out of negligence and malpractice, catch the attention of courts and legislators. Consequently, as has been pointed out in the introductory part of chapter four, some jurisdictions introduced new doctrines that hold for-profit health institutions liable for the faults committed by independent contractor and non-employee health professionals.

In Ethiopia, though the greatest part of medical institutions-health professionals' relationship is dominated by formal employer-employee contracts, there are also instances where these institutions hire independent contractor health professionals. More specifically, in some for-profit health institutions established in Ethiopia, there is a tendency to allow physiotherapists, neurologists and radiologists to render their medical services as independent contractors<sup>170</sup>.

However, independent contractor or non-employee physicians are not common in the public health service institutions. In fact, there are certain instances where public health institutions allow the institution's facility for non-employee physicians. For instance, according to the information that the author of this paper got from the Human Resource Department of Black Lion Specialized Hospital, there are numerous circumstances by which the hospital allow groups

---

<sup>170</sup> Interview with wro Abaynesh Mekonen who is the General Manager of Addis Cardiac Hospital on June 10, 2011.

of voluntary health professionals coming from abroad to practice medicine within the premises of the institution by way of charity or other arrangements without being formally employed<sup>171</sup>.

The prime issue then will be how far the Ethiopian legal rules address the instance where independent contractor or non-employee physicians cause injuries within the vicinity of medical institutions.

First, if the claim for compensation is based on the provisions of extra contractual liabilities, there will not be a possibility to recover damages from medical institutions for injuries caused by independent contractor physicians as the Civil Code under Article 2134 explicitly exonerates the person who hires independent workers from liabilities for the faults or offences committed by such workers.

However, there is a possibility to claim compensation against medical institution for the faults caused by non-employee physicians based on Article 2129 of the Civil Code. Pursuant to this provision, bodies corporate shall be liable under the law where one of their representatives, agents or paid workers incur a liability in the discharge of his duties. Given that, non-employee physicians providing medical service within medical institutions might be considered as representatives of the institutions.

Stated differently, a medical institution in Ethiopia could be held liable for the acts of non-employee physicians who appear to be representatives of the institution to the patient. However, these ways of endorsing the doctrine of vicarious liability through interpretation is just a possibility which do not guarantee its application in the liability of medical institutions arise out of tort.

Second, if patient plaintiff's claim for medical malpractice arises out of contract of hospitalization, Article 2651 of the Civil Code explicitly provides that medical institution's liability for the faults of physicians or auxiliary staff is limited to its employees. If the patient plaintiff sustains injuries due to the fault of independent contractor or non-employee physician, however, the institution might raise its relationship with the physician as a defense against the

---

<sup>171</sup> Despite the relentless efforts that the author of this work made in the interviews, there was no organized quantified data in Black Lion Specialized Hospital that shows the estimated number of these non-employee physicians over the years.

plaintiff. This might ultimately impede the injured patient from claiming compensation from the institution.

It is noteworthy that patients often enter in to a health institution with the assumption of receiving treatment from the entity as an institution, and often do not know or seek to know the identity of the health professional who will supply that treatment. As such, it would be absurd to allow the medical institution to raise its relationship with a particular independent contractor or non-employee physician as a defense against the patient. It is also unreasonable to expect the patient to distinguish the employment status of the physician who renders the treatments.

As indicated above, medical malpractices or negligence committed by independent contractors or non-employee health professionals, especially, within the premise of for-profit medical institutions results the desire to expand the liability of institutions in some jurisdictions. Accordingly, in those countries that use tort rules to establish medical malpractice claims, the doctrines of corporate negligence and ostensible agency were emerged to expand the liability of medical institutions to the faults of independent contractors or non-employee health professionals.

The desire to expand the liability of medical institutions is quite likely motivated by the demand to find a “deeper pocket” from which to compensate those injured by medical malpractices<sup>172</sup>. Besides, the way modern for-profit health institutions present themselves to the public has shifted the reliance of patients from health professionals to health institutions. Today, patients expect medical institutions to organize the overall medical treatments. As such, the relationship between the institution and physicians which is beyond the knowledge of patients should not ultimately be raised as a defense against them.

## **5.5. Case Report and Comment**

The study of cases on a certain subject matter is important to have a proper understanding on the prevailing practice in any one field of study. Accordingly, the author of this thesis has made efforts to collect medical malpractice cases rendered by Ethiopian courts. However, the task of

---

<sup>172</sup> see Keth Phoneix, & Anne L. Schlueter, supra n. 116: 877.

identifying medical malpractice cases has appeared to be difficult due to various reasons. These include, inter alia;

- a. There are very limited numbers of medical malpractice cases in Ethiopia.
- b. In the classification of cases there is no category especially made for medical malpractice cases, and
- c. The confusion surrounding medical malpractice claims as tort and contract affects the uniformity of classifying such cases in court registrars.

Nonetheless, the author was finally able to get some medical malpractice cases entertained by the Federal High Court and Federal Supreme Court of Ethiopia. Below, two cases will be discussed briefly so as to relate the practice with some of the points raised in this work..

## **5.1. CASE ONE**

Senayit Alemayehu V. Mary Stops International Clinic

Federal High Court, Addis Ababa

Civil Case No. 83/09

In the case, Senayit Alemayehu (here in after referred as the plaintiff) approached Mary Stops International Clinic (here in after cited as the defendant) to get a birth control medical treatment. Having made the necessary medical examination, the defendant inserted a medicine called Norplant in the upper arm of the plaintiff. After a while the plaintiff notified the defendant the fact that she is experiencing pain in the area where the birth control (Norplant) was inserted. Consequently, health professionals of the defendant made a decision and removed all inserted Norplant from the patient's arm.

Nonetheless, the pain that the plaintiff complained of has worsened and cause unceasing back pain and the swelling of the breast even after the removal of the Norplant.

## **A. Remedies Sought by the Plaintiff:**

The plaintiff in her statement of claim argued that the pain she has suffered is caused due to the medical fault committed in the removal of the Norplant by the employee of the defendant. Consequently, she sought the following two remedies from the court.

1. The court to declare the defendant as liable for the injuries caused to the patient on the basis of Article 2130(employer's liability), 2088, and 2651 of the Civil Code.
2. The court to order the defendant to pay 694,918 Ethiopian Birr to make good the damage sustained by the plaintiff.

## **B. Defenses Made by the Defendant:**

The defendant in his statement of defense deal specifically all the allegation made by the plaintiff as follows;

- i. Preliminary objections:** the defendant made a preliminary objection by claiming that the suit is barred by the two years period of limitation as provided under Article 2143(1) of the Civil Code<sup>173</sup>.
- ii. Other defenses:** the defendant in his statement of defense expressly denied the allegation that the injury sustained by the plaintiff is caused by the fault of the defendant's medical professionals. As far as the cause of action concerned the defendant asserted that the governing rules for the relationship between the plaintiff and the defendant should be the provisions of the Civil Code of Ethiopia dealing with medical or hospital contracts. As such, the defendant required the application of Article 2647 (1) of the Civil Code which consider "rules of profession" as a guideline to establish liability for the faults committed by physicians. In this regard the defendant also complained of the following points as defense for the allegation made by the plaintiff:

- The plaintiff failed to proof the actual cause that has resulted the injury

---

<sup>173</sup> According to Article 2143(1) of the 1960 Civil Code of Ethiopia, the action [for damages arising out of extra-contractual relationships] shall be brought by the victim within two years from the time at which he suffered the damage for which he is claiming compensation.(emphasis added)

- The plaintiff didn't show the cause and effect relationship between the insertion/removal of the Norplant and the injury sustained
- The plaintiff didn't proof her claim as provided under Article 2141 of the Civil Code.
- The plaintiff exaggerated the amount of compensation.

### **C. Decision of the court on the preliminary objection raised by the defendant:**

The Federal High Court of Ethiopia rejected the two years period of limitation taken by the defendant. The court's decision on the preliminary objection made clear that the relationship between the plaintiff and the defendant is contractual and as such the two years period of limitation provided under Article 2143(1) of the Civil Code for damages arising out of extra-contractual relationships could not be used as a defense against the plaintiff.

### **D. Issues Framed by the Court:**

The Federal High Court in its judgment frames two relevant issues in the settlement of the case.

- i. Whether the defendant is responsible for the injuries caused to the patient; and
- ii. Extent of liability in case the defendant is liable.

### **E. Decision Given by the Court:**

With regard to the first issue, the court holds the defendant liable for the injuries caused to the plaintiff. In the decision, the court mentioned the testimony given by the lay witnesses of the plaintiff as one ground to hold the defendant responsible for the injuries caused to the patient. In addition, even though the defendant expressly denied the occurrence of medical malpractice in its statement of defense, the court found the allegation made by the plaintiff in her statement of claim, i.e. the fact that the defendant admits the fault during the time the medical treatment was rendered, as sound to declare the defendant liable for the injuries.

From the decision of the court on the preliminary objection, it can be easily construed that the court chooses contract law as a governing law for the relationship of parties. If that is the case, the part of the Civil Code dealing with medical or hospital contracts should be at the center in the settlement of the case.

Nonetheless, the court failed to address the most critical argument raised by the defendant on the interpretation of Article 2647(1) of the Civil Code. Because, if the rule provided under Article 2647(1) of the Civil Code works for the liability of medical institution, the fault alleged to result the injury has to be considered in line with the “rules of medical profession.” In this regard, it is important to note that determining the existence of medical malpractice based on the accepted practice of medical profession usually requires expert witnesses from the relevant field of study. However, in the case at hand, the plaintiff called no expert witness that testifies the fact that the insertion/removal of the Norplant by the health professional of the defendant was actually below the required medical standards of care.

In addition the cause and effect relationship between the insertion/removal of the Norplant by the defendant and the injury sustained by the plaintiff should have been also considered critically by the court before declaring the defendant liable for the injuries caused to the patient<sup>174</sup>.

With regard to the amount of the compensation, the court awarded the plaintiff with 300,000 Ethiopian Birr for medical expenses on the basis of equity as provided under Article 2102(1) of the Civil Code.

The decision of the Federal High Court was taken on appeal by both parties to the Federal Supreme Court of Ethiopia. The appeal lodged by the defendant was made on the decision of the court regarding the amount of compensation and the preliminary objection<sup>175</sup>. The appellate court, however, found the decision given by the lower court appropriate and rejected the appeal lodged by the defendant.

On the other hand, plaintiff of the lower court also appealed on the amount of compensation claiming that the amount awarded by the court is not enough to cover the medical expenses to

---

<sup>174</sup> Civil Code, Article 1771(2) and 1791(1).

<sup>175</sup> Mary Stops International Clinic V. Senayit Alemayehu, Federal Supreme Court Civil File Number 57430.

make good the injury sustained by the plaintiff<sup>176</sup>. Accordingly, the appellate court vary the judgment given by the lower court and made a decision to award the appellant with an additional 394, 918 Ethiopian Birr which makes the total amount of compensation 694,918 Ethiopian Birr<sup>177</sup>.

## 5.2. CASE TWO

Plaintiff- Ato Abreham Desalgne

Defendant-1 Kagnawu Wubshet (MD)

2. Elias Ahmed (MD)
3. Mulugeta Tena (MD)
4. Zelalem Mola (MD)
5. Black Lion Specialized Hospital

Civil File No. 69219

In this case, the plaintiff has sustained injury in a car accident and admitted to Black Lion Specialized Hospital for the medical treatment of his broken left leg. Unfortunately, defendants mentioned 1-4, who are the employees of the 5<sup>th</sup> defendant, improperly applied a surgical procedure on the leg other than the plaintiff admitted for medical treatment.

### **A. Remedies Sought by the Plaintiff:**

The plaintiff alleged that he has sustained a 65% permanent bodily injury due to the improper medical treatment rendered by the defendants and sought a compensation of 2,550,752 Ethiopian Birr.

---

<sup>176</sup> Senayit Alemayehu V. Mary Stops International Clinic, Federal Supreme Court Civil File Number 58732

<sup>177</sup> The respondent of the appellate court made an application to the Cassation Bench of the Federal Supreme Court of Ethiopia by claiming error of law in the decision of the Federal High Court and Federal Supreme Court. However, the Cassation Bench confirmed the decision given by the Federal High Court. See Mary Stops International Clinic V. Senayit Alemayehu, Federal Supreme Court Cassation Bench, File No. 64590, and Mary Stops International Clinic V. Senayit Alemayehu, Federal Supreme Court Cassation Bench, File No.58041.

## **B. Defenses Raised by Defendants:**

Even though defendants mentioned 1-4 admit the fact that they have conducted a surgical procedure on the right leg, they contended that the medical treatment was necessary due to the disease called TB Aptrayites diagnosed in the right leg which is claimed by the defendant as healthy and normal. As such, defendants argued that the surgery was made in good faith to the benefit of the patient. The 5<sup>th</sup> defendant on its part argued that the fault alleged to be committed by the defendants mentioned 1-4 is a personal fault. As such, “Black Lion Specialized Hospital” being a public health institution should not be held liable for the personal faults committed by its employees since the Civil Code under Article 2126(3) expressly exonerate the state from liability for its employee where the fault is a personal fault.

## **C. Issues Framed by the Court**

The Federal High Court of Ethiopia, having considered the overall arguments of the parties has framed the following three issues;

1. Whether the injury sustained by the plaintiff is caused by the surgical procedure applied by defendants mentioned 1-4;
2. Whether the 5<sup>th</sup> defendant is responsible for the alleged medical malpractice committed by its employees; and
3. Extent of liability if defendants found to be liable for the injury complained by the plaintiff.

## **D. Decision of the Court**

With respect to the first issue mentioned above, the court held defendants listed 1-4 liable for the injury caused to the patient, but mentioned nothing as to the form of relationship between the plaintiff and defendants that gives rise to the liability.

With regard to the second issue, i.e. whether the 5<sup>th</sup> defendant is liable for the damage caused by the fault of physicians which the institutions employs, the court held the defendant liable on the basis of Article 2126(2) and 2127(1), & (2) of the Civil Code. The author of this thesis is of the

opinion that the application of Article 2126 and 2127 of the Civil Code is erroneous in point of law as these provisions talk about liabilities arising out of extra-contractual relationships, while the relationship between the plaintiff and the defendant is formed by contract of hospitalization.

Hence, the court must have at least made clear the governing law for the relationship that creates the respective obligations of the plaintiff and the defendants. In the case at hand, there is an apparent contract of hospitalization between the patient plaintiff and the 5<sup>th</sup> defendant (Black Lion Specialized Hospital.) Consequently, the Civil Code provisions dealing Medical or Hospital Contracts are the most appropriate ones in the settlement of this case even if the Federal High Court mentions nothing about its applicability in its judgment.

This case was taken on appeal to the Federal Supreme Court of Ethiopia by the defendants. In the appeal the defendants were contesting the decision of the Federal High Court which establishes their joint and several liabilities. The appellate court, however, rejected the argument of the appellants, and confirmed the decision of the lower court.

Though the appellate court confirmed the decision of the Federal High Court, it has made its judgment on the basis of different analysis. With regard to the liability of defendants mentioned 1-4, the court cited Article 2639 and 2647 of the Civil Code. These provisions talk about the definition of medical contracts and the liability of physicians bound by medical contracts respectively. However, in the case at hand, there is no direct medical contract between the patient plaintiff and defendant physicians mentioned 1-4; instead the contract is formed between the patient plaintiff and the medical institution. Hence, the application of these provisions for the liability of physicians by the Federal Supreme Court is once again erroneous in point of law. The author of this work is of the opinion that the relationship between the patient and the physicians/defendants mentioned 1-4 has to be governed by the provisions of the 1960 Civil Code of Ethiopia dealing with extra-contractual relationships. More specifically, the liability of defendants mentioned 1-4 has to be seen in line with professional fault as provided under Article 2031 of the Civil Code.

In relation to the liability of the 5<sup>th</sup> defendant, the court neither mentioned contract of hospitalization nor cited other provisions to show how the Black Lion Specialized Hospital is

liable for the injuries of the patient. Indeed, the court provided the administrative responsibilities of the institution towards the patient as means to justify the liability. “Where do these administrative duties of the hospital arise from?” They arise from the contract of hospitalization as provided in the Civil Code. This is the questions that the court should have asked and given an answer. Besides, one may also wonder why the appellate court failed to mention the provision of the Civil Code dealing about contract of hospitalization for the liability of the 5<sup>th</sup> defendant while citing the provisions of medical contracts for the liability of physicians as has been discussed above.

## CHAPTER SIX

### 6. Conclusion and Recommendation

Health care in Ethiopia is provided by a hybrid private and public system. In the past two decades this sector is becoming a big business in Ethiopia, and today a significant number of medical institutions are run increasingly for-profit by the private sector. Even though the sector has shown dramatic increase, the quality and distribution of medical institutions and health professionals is still questionable.

A large segment of Ethiopian population has no personal physician, and a patient often seeks treatment from medical institutions and those who practice within it. However, the medical treatments rendered by these institutions may sometimes go wrong and entail injuries on patients. This in turn brings the issue of liability of medical institutions for injuries sustained by its patients.

Normally, determining the liability of medical institutions for injury occurring within its premise is very much dependent up on the legal relationship that brings the patient and the institution together. Some common law jurisdictions consider this relationship as extra-contractual, and use the tort law regime to determine the liability. On the other hand, jurisdictions following the civil law legal system often tend to classify the relationship between medical institutions and patients within the domain of contracts for the performance of services. In Ethiopia too, the medical institution-patient relationship is essentially formed through contract even though there is a very slim possibility to apply tort law in the liability of medical institutions.

In Ethiopia, if the relationship between the patient and the medical institutions is formed through contract, the liability of the medical institution for injuries sustained by its patients is limited to faults committed by physicians or auxiliary staffs which the institution employs. This implies that medical institutions are not going to be liable for the fault of independent contractor or non-employee physicians even if the injury occur within the confines of the institution. As such, in the existing legal framework, medical institutions in Ethiopia can use contractual arrangements to insulate themselves from liability for acts of medical malpractice or negligence committed up on its premises.

As has been pointed out, the first two decades in the second half of the 20<sup>th</sup> century were remarkable in the development of different theories towards the liability of medical institutions for injuries occurring within their confines. The idea that a medical institution is only liable to the faults of its employees has steadily eroded during that time, and novel approaches to expand the liability of medical institutions for the faults committed by independent contractor or non-employee physicians were introduced. Specifically, it was from that time onwards that modern day health institutions which have been used to considered as employers, have come to be recognized as employers, contractors and evaluators for the purpose of establishing liability. The health institutions as employers suggest the vicarious liability theory. The health institutions as contractor bring the liability of such institutions for the acts of independent contractor or non-employee health professionals who may be viewed as ostensible agents of the institutions. As evaluator, the health institution may subject to liability for corporate negligence arise out of direct duties that the institutions owe to the patient.

Given its age, the 1960 Civil Code of Ethiopia seems to be out of touch with the aforementioned modern developments in the liability of medical institutions.

The author, therefore, forwards the following points by way of recommendation;

First, the law maker should think seriously about expanding the liability of medical institutions for injury occurring within its confines. It is worth mentioning that the expansion of liability meshes with the organizational realities of modern day medical institutions. This is due to the fact that modern day medical institutions, especially for-profit ones present themselves as institutions committed for excellence, and the patient expects medical institutions to organize the overall medical treatment. These changes in the service and organizational structure of medical institutions require a concomitant change in the legal climate since solving current and future problems is one purpose of legislating rules. As such, there should be a mechanism for the law to allow patients to rely on the health institutions as a guarantor of compensation if something goes wrong within its premise during medical treatments.

The expansion of liability, however, should not be a kind which results financial loss in medical institutions. The ultimate economic burden to indemnify the medical institution should fall on the

person who was at fault. In that case, to be sure that the rule of indemnification will effectively shield medical institutions from financial loss, the scheme of professional liability insurance, which is in fact rare in Ethiopia will be decisive.

Moreover, expanding the liability of medical institutions essentially serves two purposes. First, it would better protect the likelihood of patient's compensation for injuries caused by any physicians practicing medicine within the premises of the institutions. Second, it has a preventive role as it puts medical institutions under pressure in the selection and supervision of all physicians who provide service within its premise.

Second, a medical malpractice claim is not like other civil claims. The production of evidences, determination of negligence or malpractice, the relationship of parties, the interest of the general public on the issue of health care, at least could be mentioned in this regard. There is -`no doubt that medical malpractice cases are complex by their nature. As such, the legislator should also consider in codifying medical malpractice law as a separate law. If the legislators find this recommendation appropriate, the malpractice law should not be formulated in a rigid way as they can't foresee all possible circumstances or combinations in each medical malpractices case.

## **Bibliography**

### **Books and Articles**

- Choctaw, Willa T., (2008). Avoiding Medical Malpractice: A Physician Guide to the Law. Springer: Los Angeles
- Combs, Clair G., (1987-1988). Hospital Vicarious Liability for the Negligence of Independent Contractors and Staff Physicians: Criticisms of Ostensible Agency Doctrine in Ohio; 56 U. Cin. L. Rev., pp. 711-738
- Donabedia, Avedis (2003). An Introduction to Quality Assurance in the Health Care; (ed. Rashid Bashear). Oxford University Press: New York
- Guido, Wacker G. (1997). Legal Issues in Nursing; 2<sup>nd</sup> ed. Appleto & Large Stamford: USA
- Herrig, Jonathan (2010). Medical Law and Ethics; 3<sup>rd</sup> ed. Oxford University Press: Oxford
- Hoga, Neal C., (2003). Law and society, Unhealed Wounds: Medical Malpractice in the Twentieth Century; (ed. Eric Rise). LFB Scholarly Publishing PLC: New York
- IOM, (2010). Crisis Standards of Care: Summary of a Workshop Series. Washington, DC; The National Academic Press
- Janulis, Diane M., & Hornson A., (1985). Damed If You Do, Damned If You Don't: Hospital's Liability for Physicians' Malpractice; 64 Neb. L. Rev., pp. 689-717
- Jolowicz, J. (1971). Winfield and Jelewicz on Tort; 9<sup>th</sup> ed. Sweet and Maxwell: UK
- Kendall, Bradford C., (1988-1989). The Ostensible Agency Doctrine: In search of the Deep Pocket; 5 UMKC L. Rev., pp. 917-830
- Kinney, Judith M., (1992). Tort Law Expansion of Hospital Liability Under the Doctrine of "Corporate negligence". Thompson v. Nason Hospital 591A. 2d 703(pa. 1991); 65 Tample L. Rev., pp. 787-802
- Kraakma, Reinier H. (2009). Vicarious and Corporate Civil Liability; (ed. Michalel Faure); 2<sup>nd</sup> ed., Volume 1, Encyclopedia of Law and Economics. Edward and Elgar: Northampton
- McWay, Dana C., (1997). Legal Aspects of Health Information Management. Delamar Publisher
- Mesfin, Desalegn (1986). The Doctrine of the Respondent Superior Under Ethiopia Civil Law; research Paper in Fulfillment of the Requirement for the Degree of Bachelor of Laws at the Faculty of Law; AAU (Unpublished.)

- Milsop, Mark E. (1991-1992). Corporate Negligence: Defining the duty Owed by the Hospital to their Patients; 30 Duq. L. Rev., pp. 639-660
- O'Neil, Terrence B. Civil Liability: Implications for Corporation Officers; Appendix B.
- Perdue, Jim M., (1983). Direct Corporate Liability of Hospitals: A Modern Day Legal Concepts of Liability for Injury Occurring in the Modern Day Hospital; 21 S. Tex. L. J., pp.141-164
- Phoenix, Keith and Schlueter A., (1986). Hospital Liability for the Acts of Independent Contractors: The Ostensible Agency Doctrine; 30 St. Louis U. L. J., pp. 975-894.
- Rose, Paul T. (2009). The Evolution of Vicarious Liability in Tort in Respect of Deliberate Wrongdoing; 3Journal of Personal Injury Law and Economics 9: 179-191
- Scrivens, Ellie, (2005). Quality, Risk and Control in Health Care. Open University Press: Berkshire
- Sobel, Lester A., (1977). Medical Science and the Law: the Life and Death Controversy. Facts on File Inc: United States
- Stauce M., (2008). The Law of Medical Negligence in England and Germany: A Comparative Analysis. Hart Publishing: Oregon.
- Turner, Chris & Hodge S., (2007). Unlocking Torts; 2<sup>nd</sup> ed. Hodoer Arnold: UK
- USAID, (2009). Assessing the Role of the Private Sector in HIV/AIDS Service Delivery in Ethiopia
- Walshe, Kiera (2009). Patient Safety First: Responsive Regulation in Health Care; (eds. Judith Health, & Paul Dugdale). Allen & Unwin: Australia.
- Weiner, Earlene P., (1973). Duty of A Hospital to Prevent Physician Malpractice; 15 Ariz. L. Rev., pp. 953-967
- Weiner, Earlene P., (1989-1990). Managed Health Care: HMO Corporate Liability, Independent Contractors, and the Ostensible Agency Doctrine; 15 Journal of Corp. L., pp. 535-572
- \_\_\_\_\_, (1975). The Hospital-Physician Relationship: Hospital Responsibility for Malpractice of Physicians; 50 WASH. L. Rev., pp. 385-402
- \_\_\_\_\_, (1985). Theories of Imposing Liability Upon Hospital for Medical Malpractice: Ostensible Agency and Corporate Liability; 11 Wm. Mitchell L. Rev., pp. 561-584

WHO, 10 facts on patient safety, available at [http://www.who.int/features/factfiles/patient\\_safety/en/index.html](http://www.who.int/features/factfiles/patient_safety/en/index.html). Accessed on 23/08/11).

## **Laws**

FDRE Ethiopian Health Professionals Council Establishment Council of Ministers Regulations No. 76/2002, Negarit Gazeta, 8<sup>th</sup> Year, No. 13, ADDIS ABABA 18<sup>th</sup> January 2002

FDRE, Food Medicine and Health Care Administration and Control Proclamation, proclamation No. 661/2009; Negarit Gazeta, 16<sup>th</sup> Year, No. 9, ADDIS ABABA 13<sup>th</sup> January 2010

FDRE, the Criminal Code of Ethiopia; Proclamation No. 404/2003.

IGE, Civil Code of the Empire of Ethiopia, Proclamation No. 165/1960, Negarit Gazeta, Year 19, No. 2, Addis Ababa, 5<sup>th</sup> May 1960

TGE, Licensing and Supervision of Health Service Institutions Council of Ministers Regulation No. 174/1994; Negarit Gazeta, Addis Ababa, 53<sup>rd</sup> Year, No. 66, ADDIS ABABA 16<sup>th</sup> February 1994

## **Cases**

The case between Ato Abrham Desalgne v. Dr. Kagnawu Wubshet, et al; Ethiopian Federal High Court; Civil File Number, 69219.

The case between Dr. Kagnawu Wubshet, et al v. Ato Abrham Desalgne; Ethiopian Federal Supreme Court; Civil File Number, 52471.

The case between Wro. Senayit Alemayehu v. Mari Stops International Clinic; Ethiopian Federal High Court; 9<sup>th</sup> Civil Bench; Civil File Number, 83109.

## **Interviews**

Interview with Wro Abaynesh Mekonen who is the General Manager of Addis Ababa Cardiac Hospital on June 10, 2011

Interview with Sr. Woyneshet Mamo who is the vice President of Ethiopian Nurses' Association (ENA) on June 10, 2011

Interview with Ato Girma Negash who is a judge in a first instance court in the Amharan Regional State on June 18, 2011

Interview with Wro Ayida who is the legal advisor of Black Lion Specialized Hospital

Interview with Ato Henok who is the licensing officer in the FDRE Food Medicine and Health Care Administration and Control Authority on June 21, 2011

Interview with Ato Esayas who is the legal department head of FDRE Ministry of Health on June 21, 2011

Interview with Ato Hailye Sahle who is a legal consultant and attorney at law on September, 25, 2011