INCIDENT REPORTING AND CLAIMS HANDLING PROCEDURES – MEDICAL MALPRACTICE INSURANCE

THIS IS A VERY IMPORTANT DOCUMENT. WE URGE YOU TO READ IT CAREFULLY AND TO CONTACT US IF YOU NEED ANY CLARIFICATION OR ASSISTANCE

IMPORTANT CONDITIONS OF COVER CONTAINED IN YOUR POLICY

1) It is a condition of your medical malpractice/professional indemnity cover that you must report any **incident, circumstance or event** which you believe could lead to a claim or a complaint against you, to CFP Brokers, in writing, as soon as you become aware of it.

2) Insurers have a bad reputation of seeking to avoid claims. (This is not my experience as I have generally found most Insurers willing to accommodate claims.) However, this is the area in which I have seen more claims rejected than any other, namely failure by the Insured to timeously report incidents which could lead to possible claims or complaints that they were aware of or ought reasonably to have been aware of.

3) Do not wait for formal legal action to be taken against you or to receive an official notification from the HPCSA; AHPCSA or SANC, that a complaint has been lodged against you before you notify your insurers of a claim. In the balance of this document we will refer to the HPCSA, AHPCSA and SANC as "**Council**" for ease of reading.

4) Notify us, in writing, at claims@cfpbrokers.co.za and cc in Noleen at noleen@cfpbrokers.co.za

5) The first question that insurers ask us when we notify through a claim or a complaint to them is, "When did the insured (which would be you), first become aware that there might be a potential claim or complaint against them?"

6) Where it is established that you have known about a problem/incident for some time and that you have only notified us when you received a formal complaint from Council, or notification of a formal claim against you, insurers will bring up the issue of late notification which could result in their rejecting the claim or declining to assist you with the legal defence of the complaint.

7) You should **not** delay notifying us of a potential claim/complaint against you for any reason- regardless of whether:

   a) You and/or your employer have finalised your own internal investigations;

   b) Your employer tells you that it is not necessary to notify us of a potential claim, as their attorneys or insurance is handling the matter;

   c) You believe that the matter can be amicably resolved or that the patient or their family would never take legal action against you, because for example, they are family friends;

   d) You think that there is no merit in the potential complaint/claim and that the patient or their family is being unreasonable or making vexatious or unjustified allegations;

   e) Or not, a formal threat of litigation has been made against you;

   f) You think that there is no merit in an allegation that there has been criminal conduct;

   g) You have not yet had an opportunity to discuss allegations made against an employee or a locum in your practice;

   h) You don't intend to claim under the policy as you think that the amount in question is too small to warrant involving insurers and you plan on writing off or refunding the amount in question (often the amounts turn out to be much larger than we originally anticipated).

8) It is also a condition of your cover that you do not make any admissions of liability or enter into any kind of settlement negotiations without the prior written consent of your insurers.

9) If insurers establish that you have done something which could be construed as an admission of liability, without their prior authorisation, they will probably reject the claim or decline to assist you with the defence of a complaint, on the basis that by breaching this condition of cover, you have compromised your own defence.

10) It is therefore very important that no-matter how bad you might feel if there has been an incident at your practice, or how irate a patient or their family may be, and what demands they might make of you, that you do not admit any liability or offer to pay for any medical expenses or offer to write off your account or discount your account.

11) Likewise, you should under no circumstances make any payments to a Medical Aid who have written to you demanding payment/reimbursement with a simultaneous allegation that you have in some way been

guilty of wrongful conduct, e.g. billing for treatments that you have not rendered. You should first notify us in writing so that we can assist you and notify your insurers.

12) Making payments/discounting or writing off your accounts in the face of allegations made against you of any kind of wrongdoing, can be construed as admissions of liability, if you have not obtained insurer's prior written consent and assistance in making such payments in a manner which does not compromise your defence of the allegations.

Where do I notify potential claims/complaints and incidents?

13) Please address your claim/incident notifications to claims@cfpbrokers.co.za . Noleen Podrouzek is our Claims' Manager. If you don't receive a response within a couple of days and you wish to follow up, you can e-mail Noleen@cfpbrokers.co.za; Catherine at catherine@cfpbrokers.co.za or Kristy at kristy@cfpbrokers.co.za .

14) Although we require your notification in writing, you are very welcome to phone our office for advice and assistance with all claims Council complaints and incident reports. Our contact details are in the footer of this letterhead.

15) In instances where it is a condition of cover that you are a member of your voluntary Association / Society, we will then obtain the necessary proof from your Association or Society, that you are a paid-up member.

16) We will also check that you have paid for your Medical Malpractice Indemnity Insurance Policy and make contact with you to assist you further, after we receive your initial notification.

17) If you have not heard back from us within a couple of days after you have notified us, via e-mail of any incident/circumstance/claim/complaint please call us on 011 – 794 6484 or send a follow-up e-mail to ensure that your notification has been forwarded on to the Insurers. It is important that you have written confirmation from us, for your records, acknowledging receipt of your notification and confirming that we have forwarded your notification on to your Insurers.

What do you do if you have received a summons or a letter of demand from attorneys?

18) Please do not simply e-mail either of these through to us!

19) It is very important, if you have received a summons or a letter of demand, that you phone our office let us know that you have received a summons, etc and that you will be sending it through to us.

20) Time is of the essence when dealing with a summons, as there are certain time-frames that you have to respond in, otherwise the plaintiff can obtain default judgement against you.

21) We need to avoid any chance that a summons that is sent to us via e-mail is overlooked and not attended to timeously. The only way that we can ensure this, is if you have phoned us to alert us that you have received a summons, so that we are expecting the e-mail with the summons and can alert your insurers that they need to appoint an attorney to enter the appropriate response.

22) It is very important when you send us a copy of the summons that you let us know in the e-mail what date the summons was served on you or your practice, as Insurers need this information to calculate when the response is due by.

Some practical steps in handling incidents at your practice

23) Before you respond to any complaint or do anything else, notify us in writing, immediately when you become aware of an incident/circumstance/alleged criminal conduct which may give rise to a claim under this policy.

24) Contact us telephonically if you would like to discuss the matter and obtain guidance. Please also remember to contact us telephonically if you have not heard back from us within a couple of days of e-mailing us your written notification or submitting your notification via our App.

25) Show empathy to the patient and answer all queries as honestly as possible, without admitting liability.

26) If you refuse to speak to a patient or their family after an incident, this is often construed as your having something to hide and could lead to a complaint against you that could have been avoided with a more sympathetic and open handling of the matter.

27) Ensure that you keep a written record of your notification to us, including proof of the date of notification so that you can prove timeous notification should this ever be disputed by your Insurers (if you use our App., this will be automatically generated and sent to you via e-mail for your records).

28) Be especially careful regarding what you put in writing to us, as whatever you disclose in your correspondence with us is **not necessarily** protected by the legal privilege, that would protect correspondence between yourself and a legal representative. It is therefore possible (although it has never happened to us in the past), that we may be asked to disclose the contents of your communication, should the matter ever proceed to litigation, and be legally obliged to do so.

29) Secure the patient records and make sure that they are kept in a safe and accessible place for at least 5 years from the date of the incident. You need to keep the records for longer if you are still involved in the patient's on-going treatment or if the patient is a minor or mentally incapacitated or if Legislation requires you to keep the records for a longer period.

30) If you would like further guidance with regard to record keeping and how long you should be retaining your records, please refer to the MPS publication titled, *Medical Records in South Africa, An MPS Guide 2012,* and the HPCSA produced booklet, no. 14 titled, *Guidelines on the keeping of patient records, Pretoria, 2008.* You can find information regarding the recommended retention periods in Appendix 1 (which is titled *Retention and disposal of records)* on page 28 of the MPS Guide.

    Please note that the law is not static- so there may have been amendments to the legislation and regulations mentioned in the 2 documents cited above. You should therefore not rely on these documents as the final word as the information provided, while serving as a useful guide, may well be outdated.

31) Keep a record of all communications (telephonic or otherwise) with the patient, the patient's family, the patient's legal representatives, your employees or locum, other healthcare workers, ourselves, your insurers and anyone else who may be involved and make sure that you also keep this record for at least 5 years from the date of the incident (or longer as per 31 above).

32) It is often very useful to have a record that was written contemporaneously with the event, to refresh your memory from, should the event ever lead to litigation or a Council Enquiry. It is very difficult without a written record to remember, a few years down the line should the matter end up in court or at an Inquiry- who said and did what.

33) If a patient or their family start to put pressure on you to pay medical accounts which they allege have been necessitated by your negligence, write off accounts or discount accounts- please do not do so as doing so would be construed as an admission of liability. If the patient then decided to proceed against you- your insurers would reject your claim, or decline to assist you with a complaint made against you to your regulatory Council, on the basis that you had already done something which could be construed as an admission of liability, and consequently breached a condition of the cover and compromised any defence.

34) What we recommend that you do in these circumstances, is to ask the patient or their family to please put their request or complaint in writing, if they feel that you are responsible for any loss or injury that they have suffered, so that you can submit their communication to your insurers to investigate.

What information should you include in your e-mail/s when you are first notifying us of a potential claim/incident/complaint (please note that if you notify us using our App. then you will be prompted by the App. to provide all the information we need. However, you will not be able to upload any of your documents and you will need to e-mail all relevant documents to us):

35) In order for us to give your notification the necessary priority, it is very important that the subject line of your e-mail makes it clear that your e-mail is in respect of:

a) An incident notification which may lead to a claim or a complaint against you; or

b) That you have received a summons or a letter of demand; or

c) That a medical aid has contacted you and has requested a meeting relating to allegations of irregular billing, etc.; or

d) That you have received a Council complaint from the AHPCSA/HPCSA/SANC

For example: Name of your Association (if applicable)/Your Full Name/A brief description such as "HPCSA Complaint"

We always try to prioritise the handling of any e-mail which is related to the notification of a claim/complaint/incident- so an e-mail which does not make it clear from its subject line what the e-mail is about or that it relates to the notification of a potential claim- may be overlooked- resulting in delays in your receiving a response from us.

36) Please also include the following important information in the body of your notification e-mail:

a) All your contact details and contact details of anyone else in your practice who was involved in treatment.

b) If you are an employee of the practice, please also provide your employer's name and Association/Society membership number if they are also covered under the Association or Society's Medical Malpractice Indemnity Insurance Scheme, as we will need to report the matter through under their name as well, as they may be sued or a complaint may come in against them as the practice owner, as employers are vicariously liable for the negligent actions and omissions of their employees in the conduct of employment-related duties.

c) Confirmation that you are a paid-up member of your Association/Society and your membership number.

d) A narrative of the matter which should include at least the following:
   i) Date of Incident
   ii) Patient's name (If you are not comfortable supplying the patient's full name you can supply just the first name or the surname for notification purposes)
   iii) Brief description of incident
   iv) Date of first demand / correspondence indicating the events that may lead to a claim/complaint
   v) Current status, e.g. whether or not the patient has made a formal complaint or threatened litigation
   vi) Available details of Third Party (i.e. the person who may sue you or lodge a complaint against you)
   vii) Copies of all available / relevant documents relating to the matter.

<u>Where you have received notification from the HPCSA/SANC/AHPCSA of a complaint made against you, please include the following in addition to the above:</u>

   viii) Confirmation of date that you received the letter from your Regulatory Council/Body.
   ix) Confirmation of the due date for response / appearance to Council should it not be mentioned on the letter of complaint sent to you by your Regulatory Council/Body.

37) Please attach a copy of the letter of complaint and the covering letter that you have received from the HPCSA/SANC/AHPCSA.

38) Please attach any other relevant documents.

39) Insurers will appoint an attorney, without prejudice to their rights, to assist you with a response to the HPCSA/SANC/AHPCSA should all of the above be received in order together with our confirmation from your Association/Society that you are a paid-up member (this only applies to certain policies) and that you have paid for medical malpractice insurance.

Requirement that you are a paid-up member of your Association/Society. ***This requirement applies to members of the SASP, BASA, SASOHN, SAOA and the SAAA***

40) It is a condition of cover, under the SASP, BASA, SASOHN, SAOA and SAAA schemes that you are a paid-up member of your Association/Society and in good standing when you first become aware of a potential or actual claim or complaint against you.

    Please note that you will not be covered if it is established that you were not a paid-up member in good standing with your Association/Society at the time that the services giving rise to the complaint or claim were rendered, <u>and</u> if you were not a paid-up member in good standing with your Association/Society, at the time that you first became aware of the complaint/claim/incident <u>and</u> if you have not maintained the cover in place between the date that you rendered the service and the date that you became aware of the potential or actual claim or complaint.

What happens when I notify insurers of a potential or actual claim against me for medical malpractice or professional negligence?

41) Depending on the seriousness of the claim or possible claim, insurers will either ask you to let them know if there are any further developments, see whether they can resolve the matter internally or appoint attorneys.

42) If attorneys are appointed, they are usually required to:

a) Enter a notice of appearance to defend if a summons has already been served on you. This is a standard document that needs to be filed at court, within a certain time period, specified in the summons. This will notify the claimant that you intend to defend the matter, although, this is usually done as a formality, to buy more time for insurers to investigate your liability;

b) Determine whether or not your claim falls within the policy and whether or not there is in fact cover under the policy (for example whether you have breached a condition of cover or there is an exclusion in the policy which would exclude the claim).

Once the formality of entering a notice of intention to defend is out of the way (usually the attorney's first task), the issue of coverage is usually addressed in the attorney's first letter providing his/her legal 'opinion' to the insurers.

Bear in mind that the insurers will generally not allow the attorneys to release a copy of this "opinion" to us or yourselves as the report is to establish their own position in relation to your claim. There is the further consideration that privilege (i.e. protection against having to disclose it to the other side) could be lost as soon as a copy of that opinion is released to ourselves and the opinion may contain information that could compromise a defence if revealed to the other side.

43) Once the attorneys have satisfied themselves that the policy should respond to cover the claim, they will then usually provide insurers with a preliminary opinion with regard to your liability, drawing on any relevant legislation, regulations and case law precedents which deal with the same, or similar issues. They will also usually advise the insurers as to how they should proceed with the matter (for example, they will seek insurer's consent to appoint expert witnesses they feel may be necessary and will advise the insurers which witnesses they need to interview).

They will also provide insurers with an indication of what amount they consider the insurers should be reserving to cover a potential payment of damages/settlement offers, as well as legal costs that they anticipate will be incurred in the finalisation of the matter.

44) A number of subsequent opinions will be sent to insurers until the matter proceeds to court, or is settled, or otherwise resolved. These opinions will cover aspects such as what the experts have said and the testimony provided by various witnesses.

45) Bear in mind that the whole process of litigation can be notoriously slow and laborious. It is not uncommon to hear of a matter dragging on for 5 years from service of summons on you, to finalisation.

46) Sometimes a decision may be made to '*split*' the trial, i.e. to determine the issue of liability first, and only in the event that it is agreed that you are liable to the plaintiff, to then determine the quantum of damages (i.e. the amount of compensation due to the plaintiff arising out of your liability to them). This is referred to as "splitting quantum and merits".

47) In some instances, "merits" may be conceded up-front , i.e., both parties will agree that you are liable to compensate the plaintiff, and the parties will only proceed to trial to argue the issue of quantum (the amount of the compensation to be paid to the plaintiff).

48) There is a set process that both parties must follow to bring the matter to finality. There are time periods within which both parties are required to file certain documents e.g. notice of intention to defend, a plea, summaries of expert evidence that they intend to lead at trial, etc.

49) There is also a process called '*discovery*'. In this process, each party is required to compile a document listing all the documents relating to the matter, which they have in their possession which relate to the matter, and reflecting which of them are 'privileged' (i.e. not subject to disclosure to the other side). The other party is entitled to copies of all the documents listed in this 'discovery notice' except those in respect of which the other party has claimed privilege. Sometimes there may be disputes over whether or not legal privilege attaches to a document.

50) Many matters are settled on the steps of court after substantial legal costs have been incurred.

Payment of the excess

51) Even if no damages' award or settlement amount is paid by insurers, or even if you successfully defend your case, or Council finds in your favour where a complaint has been lodged against you, or where there

has been an inquiry into your conduct, you will still be required to pay the relevant excess as set out in the policy schedule, because insurers will have incurred legal costs in your defence.

52) Insurers require payment of the excess upon their request and this is usually as soon as they need to incur any legal costs in the investigation or defence of the claim and/or Council complaint made against you.

Excesses payable

53) There are different excess amounts payable under the various sections and extensions under the policy. Please refer to your policy schedule for details of the different excesses payable under the different sections and extensions of the policy, or alternatively, please contact us for assistance.

I hope that this document will prove helpful but please do not hesitate to contact Noleen (noleen@cfpbrokers.co.za), Catherine (catherine@cfpbrokers.co.za) or Kristy, at CFP Brokers (all contact details in the footer) if you need any assistance or clarification.