

MEDICAL MALPRACTICE LIABILITY IN RWANDA: ALIGNING LEGAL THEORIES WITH JUDICIAL PRACTICES

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Abstract

Rwanda has achieved notable progress in enhancing the accessibility and quality of healthcare services. These advancements are supported by the establishment of a foundational legal framework designed to regulate health service delivery. Nevertheless, recurrent incidents of medical malpractice across the country underscore the pressing need for a more robust and coherent legal and regulatory regime. This paper critically examines the evolution and current state of medical malpractice liability in Rwanda, with particular emphasis on applicable legal doctrines, the protection of patient rights, and the jurisprudential trends in adjudicating medical malpractice claims. The analysis reveals that, in the absence of a specialized statutory framework, Rwandan courts often rely on outdated provisions from the abrogated Civil Code Book III, supplemented by general legal principles and considerations of equity. This paper advocates for the enactment of dedicated legislation to clarify standards of care, delineate liability, and strengthen avenues for redress—essential steps for ensuring accountability in the healthcare sector, protecting patient welfare, and fostering sustainable health system development in Rwanda.

Keywords

Medical malpractice, standard of care, negligence, damage, vicarious liability, patient rights, legal reform

Introduction

Medical malpractice refers to instances where a healthcare provider, through negligent action or omission, deviates from accepted medical standards and causes injury or death to a patient (Wane, 2014: 3). In this context, medical liability entails holding practitioners accountable for harm arising from the violation of established duties of care and widely recognized norms of medical practice.

Important to mention is that medical liability is not a modern construct. Its origins trace back to ancient Mesopotamia circa 2400 BC, where Babylon emerged as a center of medical scholarship. The Code of Hammurabi (circa 1900 BC) exemplifies early regulatory efforts, including Article 218, which prescribes severe penalties—such as amputation of the physician’s hands—for grave medical errors, stating that “if a physician kills a patient or destroys a patient’s eye during a major operation, the physician’s hands shall be cut off (Hammurabi, art. 218).

During the Middle Ages, Roman legal principles significantly influenced subsequent legal systems. The Lex Aquilia provided a remedy for injury caused by another’s fault, including by healthcare practitioners, while the Corpus Iuris Civilis contained rules punishing medical incompetencies (Treglia et al., 2021). For example, Digest 9.2.8.1 authored by Ulpian, established legal responsibility for medical negligence, stating that doctors who carelessly harm or kill patients can be held legally responsible (Scott, 1932). These doctrines shaped the western jurisprudence and contributed to the evolution of medical liability globally.

In Rwanda, the development of medical liability has mirrored the evolution of the country’s healthcare and legal systems. From German colonial rule (1897–1916) to Belgian administration (until 1962),

medical liability was governed by a blend of colonial and national laws. For instance, the Belgian Civil Code of 1958, notably Article 1382, provided the foundational basis for compensation arising from harm. For a number of reasons, including but not limited to eliminating colonial legacies and addressing the needs of the population, Rwanda has undertaken significant legal reforms and recently repealed all colonial legislation (Binagwaho & Freeman, 2021).

Even though, prior to the 1994 Genocide against the Tutsi, Rwanda's legal framework governing health and medical liability remained nascent. In its aftermath, systematic reform commenced. Key developments include the Law No. 10/98 of 28 October 1998 regulated the exercise of the art of healing, which established basic standards and penalties for violations of professional conduct. The Rwanda Medical Council, established in 2001, introduced oversight and standard enforcement, while Ministerial Instruction No. 20.53 of 5 April 2011 introduced continuous professional development (CPD) for doctors and dentists. Law No. 49/2012 of 14 January 2013, which established mandatory medical liability insurance, further codified patient rights and complaint procedures. In 2013, the Council's mandate expanded to include dental practitioners.

Nowadays, Rwanda continues to pursue reforms aimed at strengthening accountability and patient safety, such as the "4x4" initiative to quadruple the healthcare workforce in four years and the Health Sector Strategic Plan V (2024–2029), which seeks to enhance service quality, training, and regulatory mechanisms to prevent malpractice (Rwanda Ministry of Health, 2024).

Despite these commendable efforts, several challenges remain. There is currently no legally binding mechanism for amicable settlement of malpractice claims, making litigation the default—an often costly and protracted process. Furthermore, standards of liability and penalties are insufficiently defined. The continued emergence of medical malpractice cases underscores the need for a comprehensive legal framework addressing all aspects of medical liability.

This paper aims to articulate the historical development of medical liability in Rwanda, emphasizing the role of courts and the protection of

patient rights. It also explores the prevailing legal theories and constituent elements of medical malpractice.

The production of this paper used a qualitative research methodology, relying primarily on doctrinal analysis. Defined as involving a systematic examination of legal rules to explore the relationship between rules and societal problems (Hutchinson, 2006), the choice of the doctrinal method was motivated by its dominance in legal research and involved systematic examination of legal rules and frameworks to assess their relationship with broader societal concerns (Hutchinson, 2015:131). Desk research was conducted through consultation of textbooks, academic journals, legal commentaries, and institutional reports. Although foreign jurisdictions were consulted, this was not intended for comparative legal analysis but rather to identify best practices and legal innovations that may inform Rwanda's evolving framework on medical liability.

The paper is organized into four substantive sections: after introduction, the first section introduces the concept of medical malpractice within the context of Rwanda's healthcare and legal systems, setting the stage for subsequent analysis. The second section explores the legal foundations of medical liability, including tort law, contractual principles, and other doctrines relevant to professional accountability in healthcare. In the third section, the analysis turns to the essential components of medical malpractice claims—breach of duty, causation, and harm—highlighting evidentiary and procedural requirements in adjudication. The fourth section consolidates insights from the preceding analysis and offers strategic recommendations to strengthen Rwanda's medical malpractice regime, improve patient protection, and align legal theory with practical enforcement. After that comes the conclusion.

Legal theories on medical malpractice

Medical liability constitutes a cornerstone of healthcare law. It serves dual purposes: on one hand, it ensures that medical professionals are held accountable for malpractice arising from errors or negligence, while on the other hand, it safeguards patient rights as enshrined in legal frameworks (Johnson, 2019: 10). While regulatory approaches vary across jurisdictions, medical liability is typically governed by statutory

provisions, judicial precedent, interpretative jurisprudence, and doctrinal legal theories. These theories are instrumental in determining whether a healthcare provider has breached a duty of care and the extent to which they bear legal responsibility.

For the sake of brevity and within the limits of this paper, the discussion focuses on four key legal theories: Informed Consent, Negligence, Vicarious Liability, and the Professional Standard of Care, with emphasis placed on the theories most relevant to Rwanda's practice of law.

Informed Consent theory

The theory of informed consent imposes a duty on healthcare professionals to disclose comprehensive information to patients before undertaking any medical procedure, diagnostic intervention, or clinical research (Party at el, 2024). This includes the potential risks, anticipated benefits, and available alternatives. Nowadays, informed consent embodies legal compliance, professional responsibility, and ethical integrity, making it inseparable from contemporary healthcare delivery (Schuck, 1994:18).

Valid informed consent is predicated on four cumulative elements: one is adequate Information—ensuring the patient is sufficiently informed. Second is Competence – confirming the patient's capacity to understand and decide. Third is Voluntariness – ensuring freedom from coercion or undue influence. Fourth is Dynamism – recognizing the ongoing nature of consent and the right to withdraw it. These elements are cumulative and the absence of any one element vitiates the validity of consent (Bowman at el, 2011: 6). Accordingly, the obligation lies with the healthcare provider to secure untainted and legally sound consent, encompassing all four components.

It is important to note that informed consent does not absolve a healthcare provider from liability arising from procedural negligence or medical error. Instead, it functions as a foundational safeguard for patient autonomy and legal accountability.

In Rwanda, medical professionals are obligated to honor a patient's decision to decline or withdraw consent for any procedure (Law No.

49/2012, 2013, art. 9(1). If a patient declines, rejects or refuses to undergo a procedure or treatment, or even withdraws his consent, healthcare professionals are obliged to honor their choice. This principle was underscored in *Case No. RCA 00094/2023/HC/KIG – CMB 00108/2023/HC/KIG*, where the High Court affirmed that it is completely allowed for a patient to change his/her mind, however, withdrawal of consent must be made in writing and stored in an accessible location to be legally enforceable (*MMA v. King Vaisal Hospital*, 2024. para. 94). Oral revocations or undocumented objections lack probative value in legal proceedings.

Exceptions to this rule arise in emergencies where the patient is incapacitated or unable to express consent. In such cases, consent may be obtained from a legally designated proxy or, where unavailable, another qualified healthcare provider or facility administrator may authorize the procedure. For minors and legally incapacitated individuals, consent must be provided by a parent or guardian unless exigent circumstances dictate otherwise (Law No 49/2012, 2013, art. 9(1,2,3&4)).

Although informed consent is legally significant, it remains an underutilized basis for liability claims in Rwanda's jurisprudence. In contrast, negligence is the predominant legal theory underpinning malpractice litigation.

The Bolam Test or Professional Standard of Care theory

The professional standard of care denotes the degree of skill, diligence, and prudence expected of a practitioner possessing comparable training and experience. It acts as a benchmark for evaluating professional conduct and service delivery. Failure to meet this standard may result in findings of negligence or malpractice (Vanderpool, 2021: 1-2).

The professional standard of care roots in consideration of the fact that medical practitioners must be proficient not only in traditional techniques but also in the medical devices they use including contemporary innovations and emerging medical technologies. The adoption of such tools entails an implied responsibility for adequate training and informed utilization.

The origin of this theory is traced to the United Kingdom's 1957 landmark case of *Bolam v. Friern Hospital Management Committee*. In this case, Mr. Bolam, a voluntary patient at Friern Hospital, consented to undergo electroconvulsive therapy. Unfortunately, during the procedure, he was not administered any muscle relaxants or physical restraints, leading to severe injuries, including fractures of the acetabula. He then sued the hospital arguing that they had negligently failed to provide relaxants, restrain him, and inform him of the potentially associated risks. The court held that a medical practitioner is not negligent if his/her actions align with a responsible body of medical opinion. This became the foundation for the Bolam Test, now widely applied across common law jurisdictions.

In Rwanda, the judiciary frequently relies on expert evidence to assess adherence to professional standards of care. This practice is enshrined in Article 61(1) of the Law regulating evidence in Rwanda that empowers competent organs to appoint experts for claim or a technical matter examination (Law No 062/2024, 2024, art. 61). Moreover, Article 78 of the same law clarifies the probative weight of expert reports, stating that while courts are not bound by expert opinions, they may attribute evidentiary value to their findings based on the case context.

This reliance is for instance evident in *Case No. RCA 00255/2022/HC/KIG*, where the High Court dismissed a malpractice claim after expert assessments failed to establish causation between the hospital's actions and the patient's incurable condition (*LA CROIX DU SUD v U.N*, 2024, para 55). Similarly, in *Case No. RCA 00094/2023/HC/KIG – CMB RCA 00108/2023/HC/KIG*, the Court based on the expert report to exonerate Dr. M was after determining that he had acted appropriately despite the tragic outcome. The hospital, however, was found liable for failing to exercise proper discretion in conjunction with abandoning the desperate patient untreated. The Court noted that Dr. M. was called to operate the patient when it was obvious that the claimant could not deliver her baby normally. The doctor made every effort to save the child's life, but it was too late (*M.G. v. King Faisal Hospital*, 2024, para 54-58).

These decisions underscore the Rwandan judiciary's commitment to evidence-based adjudication and its nuanced approach to distinguishing between individual practitioner fault and institutional accountability. The Court's methodology reflects a sound balance between protecting patient rights and recognizing the complex realities of medical practice, thereby shielding competent professionals from undue liability.

Negligence theory

Negligence, in general legal terms, refers to the failure to exercise the standard of care that a reasonable person would employ under similar circumstances (Cambridge Dictionary, 2020). In healthcare, medical negligence arises when a practitioner deviates from the expected professional standards, resulting in injury, harm, or adverse medical outcomes for the patient. To successfully claim compensation, the claimant must establish that the provider's breach of duty directly caused the alleged injury (Sonny et al, 2009).

Under Rwandan law, liability may arise not only from affirmative acts but also from omissions, carelessness, or lack of diligence (Civil Code Book III, art. 259). This principle has underpinned litigation in medical malpractice claims, with negligence emerging as a dominant ground for establishing liability over the past two decades.

From the existing cases, medical liability and negligence look intertwined to an extent that the two are mostly always discussed together. For instance, in *Case No. RCAA 00073/2018/CA (N.L. vs King Faisal Hospital)*, rendered on 19 July 2019, the Court of Appeal found that the hospital's negligence led to the claimant's prolonged illness and permanent infertility. The decision further acknowledged the social and emotional ramifications—namely abandonment by her spouse and diminished quality of life—thereby reinforcing the court's broad view of consequential harm in medical malpractice.

Internationally, jurisdictions such as the United States, Canada, Germany, Australia, and South Africa apply four core elements to establish medical liability: Existence of a duty of care; Breach of that duty; Causation linking the breach to the injury; and Actual damage warranting legal redress (Vera et al, 2022: 4). Rwandan jurisprudence

reflects a similar analytical framework, which is discussed further in the third section of this paper.

Vicarious Liability theory

Vicarious liability arises when an entity is held accountable for the wrongful acts of another—most commonly, an employer for its employees. In common law systems, this is often described as the master's liability for the servant's actions (Giliker, 2010: 1). Rwanda's sui generis legal system, blending civil law, common law, and customary principles, neither explicitly codifies nor excludes vicarious liability, yet the doctrine is frequently applied in judicial reasoning.

For instance in *Case No. RPA 0074/07/CS*, the Supreme Court articulated four conditions necessary to establish employer liability: (a) a principal-agent or employment relationship; (b) a fault committed by the employee; (c) resulting damage; and (d) a direct link between the fault and the execution of assigned duties (*Pte NIYOYITA Innocent v. NPPA*, 2008, para 32-37). For the sake of brevity, we will not go into details articulating these elements here, but it is worthy mentioning that this kind of liability falls under the category of strict liability for the torts of another. In practice, these factors have become the de facto test in Rwanda for establishing institutional responsibility, including in the healthcare sector.

Notably, hospitals are frequently the primary respondents, as individual practitioners are rarely sued in isolation. As illustrated in *RCAA 00073/2018/CA*, the Court of Appeal distinguished two circumstances under which hospitals may be held liable: for faults committed by employees in the execution of their duties; and for institutional negligence independent of individual conduct (*N.L v. King Faisal Hospital*, 2019, para 1). The doctrine was further cemented in *Case No. RCAA 00008/2020/CA*, wherein the Kibungo Medical Centre was held liable after one of its staff negligently injured a child during circumcision, resulting in 50% of disability. Despite successive appeals, the Court of Appeal upheld the original compensation award of Rwf 35,000,000, citing the employer's acknowledgement of fault and invoking vicarious liability (*N.D v. Kibungo Medical Centre*, 2021, para 25 & 26).

In *Case No. RADA 0054/12/CS*, the Supreme Court invoked the same doctrine to hold the Ministry of Health accountable for a disability caused by an unauthorized injection administered by a cleaner impersonating a nurse. The injection caused paralysis, resulting in the claimant's disability. Quoting the doctrine of vicarious liability, the ruling emphasized that an employer is liable for the actions of its agents, particularly when operating within the scope of employment, regardless of formal role designation (*KABAYIJUKA v. the Republic of Rwanda*, 2014, para 17 & 21).

The High Court applied this reasoning again in *Case No. RCA 00094/2023/HC/KIG – CMB RCA 00108/2023/HC/KIG*. The claimant suffered grievous harm due to delayed surgery during childbirth, resulting in having a child born with serious health issues, including brain damage, uncontrolled epilepsy, encephalomalacia, and fragile bones, assessed at 100% disability (*M.G. v. King Faisal Hospital*, 2024, para 79-103). The oversight was attributed to the attending physician and institutional failure. The court ordered the hospital to pay damages, and the appellate challenge was dismissed.

Collectively, these decisions affirm Rwanda's adoption of vicarious liability as a judicially accepted doctrine, even absent explicit statutory recognition. It underscores a critical accountability mechanism wherein employers—particularly healthcare institutions—must ensure that their employees uphold the requisite standard of care.

While employers are entitled to seek reimbursement from negligent employees under the principle of *Action de in Rem Verso*, this remedy is seldom exercised. Its limited invocation may reflect internal settlement practices or reluctance to pursue legal action against staff.

Constitutive elements of medical malpractice liability

In Rwanda, both public and private healthcare professionals and institutions may be held legally liable for patient harm when fault is established. Liability may be avoided if the provider can demonstrate that the damage resulted from unforeseen or inevitable circumstances beyond their control. Accordingly, medical professionals are required to

exercise due diligence and make all reasonable efforts to attain acceptable treatment outcomes.

In this regard, Rwandan courts adhere strictly to the principle that the burden of proof lies with the claimant. This principle is codified in Article 12(1) of *Law No. 22/2018 of 29 April 2018* governing civil, commercial, labor, and administrative procedures. It provides that the party asserting a right bears the responsibility of proving their claim, failing which the respondent prevails by default. This rule is reinforced by Article 4 of *Law No. 062/2024 of 20 June 2024* on evidence, which affirms that while the claimant must substantiate their assertions, the respondent may challenge those claims through rebuttal arguments.

One example exemplifying this is the *Case No. RCAA 00073/2018/CA (N.L. v. King Faisal Hospital)*, in which the Court of Appeal held that to establish medical negligence, the claimant must demonstrate three fundamental elements: the duty of care, the breach of that duty, and the causation, i.e. the causal nexus between the breach and the resulting harm. Each of these elements is examined below.

Duty of Care

Duty of care refers to the legal and professional obligation of healthcare providers to deliver medical services with reasonable competence, prudence, and skill (Simon Law PC, 2024). This duty extends to all clinical professionals—including physicians, nurses, and medical institutions—and forms the bedrock of medical accountability.

In *Case No. RCAA 00073/2018/CA*, the Court invoked the well-known doctrine of *Res Ipsa Loquitur* (“the thing speaks for itself”) to assert that a hospital assumes responsibility when it accepts a patient. This responsibility includes not only the provision of appropriate medical personnel but also access to adequate equipment and continuous monitoring throughout treatment. The ruling affirmed that healthcare institutions must ensure the qualifications of their practitioners and the capacity to deliver quality care, alongside the provision of the necessary equipment to deliver proper care (*N.L. v. King Faisal Hospital*, 2019, para 23).

Breach of duty

A breach of duty arises when a medical provider fails to meet the expected professional standards, resulting in patient injury. This may include diagnostic errors, failure to conduct necessary examinations, improper treatment, or neglecting to provide sufficient information for informed decision-making. In medical malpractice litigation, breach of duty is established by comparing the healthcare provider's conduct to that of a reasonably competent practitioner under similar circumstances (McMichael, 2020).

In the aforementioned case (*Case RCAA 00073/2018/CA*), the Court of Appeal found that the hospital's failure to perform timely surgical intervention during cesarean delivery, which resulted in the patient experiencing pain and ultimately led to an incurable disability, constituted a breach. The patient sustained a vesico-vaginal fistula due to delayed and improperly managed surgery. Expert testimony confirmed that the injury stemmed from a failure to promptly identify and respond to intraoperative complications—suggesting that the responsible physician lacked sufficient expertise in handling such emergencies. This indicates that the hospital may have employed an inexperienced or unskilled doctor who was inadequate for handling cesarean deliveries.

Damage

Under tort law, liability requires proof of actual harm. In medical malpractice, the harm may be physical, emotional, or financial, and its assessment can be complex, especially when the damage lacks a clear monetary value. Rwandan courts thus retain discretion in awarding compensation, taking into account the severity of injury and its long-term implications.

In *Case No. RCAA 00019/2017/SC*, the claimant underwent a procedure at King Faisal Hospital during which her uterus ruptured, resulting in the loss of reproductive organs and the unborn child. She filed a claim against the hospital and the Court recognized the profound impact of the injury and awarded compensation of Rwf 50 million. This decision exemplifies the growing sophistication of Rwandan jurisprudence in

addressing medical harm and signals a strengthened commitment to patient protection and healthcare accountability.

Overview of other jurisdictions

Medical malpractice liability varies significantly across jurisdictions, reflecting distinct legal traditions and regulatory architectures. In the United Kingdom, medical liability is principally governed by common law doctrines, notably the Bolam Test, which assesses whether a practitioner's conduct aligns with accepted medical standards. Claims against the members of the National Health Service (NHS) are administered by the NHS Resolution under the auspices of the Department of Health and Social Care, whereas private practitioners are covered by professional indemnity insurance. Although litigation remains the primary mechanism, alternative dispute resolution, particularly mediation, has gained prominence for resolving medical malpractice disputes (Richard Goldberg, 2012: 3).

In the United States, most medical malpractice claims are predominantly resolved out of court, through settlements negotiated between claimants, respondents, and insurance carriers. If this fails, for a claim to succeed in litigation, four cumulative elements must be established: the duty of care, the breach of that duty, the causation, and the damage. The burden of proof lies with the claimant, and failure to demonstrate any of these elements results in dismissal. As far as the procedure is concerned, medical malpractice petitions must be filed within prescribed statutory limits (Sonny et al, 2009: 4 & 60).

In Germany, Germany's medical liability framework is governed by the German Civil Code and the Patient Rights Act (2013), providing robust protections for patients. Claims can be pursued through civil courts or resolved via medical arbitration boards, the latter being a widely preferred mechanism that reduces judicial burden. Physicians are required to carry professional liability insurance, and public hospitals are liable under regional state legislation. It is worth emphasizing that Germany is among the few jurisdictions with a comprehensive codified structure facilitating medical malpractice adjudication and alternative remedies (Sommer et al, 2015: 1-2).

In Australia, the system follows common law principles complemented by statutory frameworks, such as the Civil Liability Acts in various states. Medical professionals must maintain professional indemnity insurance. Unlike Germany and the UK, disputes in Australia are more frequently resolved through litigation. Negligence is assessed based on duty, breach, causation (including remoteness), and damage. Regarding the duty of care, the courts recognize a unified duty of care encompassing diagnosis, treatment, and risk advisement (Lucia et al, 2022). The Bolam Test remains relevant in evaluating whether professional standards were observed. Last but not least, damages and compensation are crucial for any medical liability action (Cheluvappa, 2020).

In South Africa, the medical liability regime incorporates common law traditions and legislative enactments, notably the Consumer Protection Act 68 of 2008. Claims may be directed at public hospitals—covered by the State Liability Act—or private practitioners, who are mandated to hold professional indemnity coverage. While litigation remains common, the system actively promotes alternative dispute resolution to mitigate costs and expedite settlements (Coetzee et al, 2021: 1-3).

CONCLUSION AND RECOMMENDATIONS

From a legal and regulatory perspective, this paper examined Rwanda's evolving framework for medical malpractice liability, revealing both significant legal progress and persistent gaps. Through doctrinal and jurisprudential analysis, it highlighted Rwanda's reliance on general tort principles, judicial interpretation, and fragmentary statutory instruments, such as Law No. 49/2012 on medical professional liability insurance. While this law lays foundational provisions, it does not constitute a comprehensive regime for managing medical harm. Courts have played an instrumental role in shaping liability norms, particularly in recognizing causation, expert evidence, and institutional accountability.

While in Rwanda most medical malpractice claims are settled through litigation, comparative insights from jurisdictions such as Germany, South Africa, and the United States underscore the importance of

dedicated legislation, structured arbitration mechanisms, and mandatory insurance coverage. Rwanda stands at a crucial juncture where strategic reform can enhance legal certainty, reduce procedural inefficiencies, and reinforce patient protections. Thus, in light of the findings, this paper makes the following practical recommendations.

One is about legislative Action. The Rwandan Parliament should enact a comprehensive Medical Liability Act to consolidate standards of care, define institutional and individual responsibilities, and outline procedural remedies. This would address the limitations in the existing scattered legislation and provide a coherent legal framework.

Second, is about mandatory alternative dispute resolution. The Ministry of Justice and the Rwanda Medical Council should introduce compulsory pre-litigation mediation for malpractice claims. This would reduce costs, expedite resolution, and mirror successful practices in Rwanda's labour dispute system (Sage, 2003:7).

Third is about healthcare staffing regulation. The Ministry of Health should enforce stricter recruitment and credentialing standards for healthcare practitioners and paramedical staff. Institutions must avoid employing underqualified personnel whose misconduct may result in harm and reputational damage.

Fourth is about insurance compliance and monitoring. All registered healthcare facilities should be required to subscribe to professional liability insurance, monitored by the Rwanda Medical and Dental Council. This would ensure financial cover for malpractice claims and strengthen accountability.

While this paper provides a foundational analysis, it does not purport to be exhaustive. Medical malpractice liability remains under-researched in Rwanda and presents a fertile ground for further inquiry. Some of the emerging themes to be further explored included artificial Intelligence and medical liability, the evidentiary weight of expert opinion in medical malpractice litigation, preventive strategies for diagnostic error and corresponding liability, etc.

We, therefore, call upon legal scholars and practitioners to investigate these areas and contribute to a growing body of literature that will inform judicial practice and regulatory reform.

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