

Recalibrating the Legal Risks of Cross-Border Health Care

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INTRODUCTION

Three patients leave the United States for surgery. The first is self-employed and has no health insurance. He needs life-prolonging heart surgery that would cost at least \$50,000 in the United States. On the Internet, he finds a cardiac surgeon at a private hospital in New Delhi, India, who can perform the surgery for no more than \$10,000.¹ Terms and conditions on the hospital's website require patients to resolve any complaints in Indian courts or in one of India's consumer dispute forums. Civil litigation in India can take fifteen to twenty years to resolve, and India's consumer forums cannot grant non-economic damages like pain and suffering.

The second patient works for a large, self-insured manufacturer. To compete with foreign manufacturers, his employer must cut jobs and benefits. After seeing a segment on medical tourism on the news, the manufacturer's benefits manager contacts a medical tourism facilitator in North Carolina.² Together, the companies craft a plan to outsource expensive surgeries by paying employees for travel expenses and offering them 25% of the cost-savings, up to \$10,000.³ The employee needs knee surgery, so the facilitator arranges for it at a famous private hospital in Bangkok, Thailand. The contract stipulates that the facilitator shall not be held responsible for any negligence committed by the Thai hospital or physicians. Moreover, the employee must sign a waiver agreeing not to hold the employer liable. The average malpractice payout in Thailand is less than \$2500.⁴

The third patient buys health insurance through her employer. The insurance company recently added to its provider network a private hospital in Monterrey, Mexico, and it now offers a plan with much lower premiums and deductibles to patients willing to visit Mexico for certain procedures. The patient visits Monterrey for cataract surgery. The insurance policy states that all network providers are independent contractors and are not agents of the insurer. Mexican law pegs tort compensation to very modest awards in its federal workers' compensation statute. Moreover, under Mexico's new medical arbitration system,

1. All amounts are in U.S. dollars, unless otherwise indicated. Though the legal details are hypothetical, I adapted this scenario from the highly publicized case of Howard Staab. See *The Globalization of Health Care: Can Medical Tourism Reduce Health Care Costs?: Hearing Before the S. Spec. Comm. on Aging*, 109th Cong. 1 (2006) [hereinafter Senate Hearing] (statement of Maggi Ann Grace).

2. Some argue that the label "medical tourism" trivializes the phenomenon. See, e.g., Michele Masucci & Scott Simpson, *Outsourcing Care: Medical Tourism Is the Globalization of the American Operating Room*, 238 N.Y. L.J. 11 (2007). Though I agree, I use "medical tourism" because it reflects the dominant nomenclature.

3. Though the legal details are hypothetical, I adapted this scenario from the highly publicized example of Blue Ridge Paper Products. See Senate Hearing, *supra* note 1 (statement of Bonnie Grissom Blackley).

4. See *infra* text accompanying notes 312-316.

the average malpractice recovery is roughly \$4800.⁵

These patients have three things in common. They are gainfully employed. They are leaving the United States to save money on medical expenses. And they have very little legal recourse should they fall victim to medical negligence.

These three scenarios reflect the essential tradeoff. The first patient, by agreeing to Indian jurisdiction, sacrifices potential legal remedies in exchange for life-prolonging medical care that he otherwise could not afford. The risks and benefits accrue directly to the patient. The second and third patients also sacrifice potential legal remedies, as jurisdiction likely resides in Thailand and Mexico. But the benefits accrue diffusely—outsourcing saves money for the patient, employer, and insurer alike.

Do these parties fully appreciate the tradeoff? Employers and insurers seem to—they use releases, waivers, disclaimers, and other contractual devices to limit their legal liabilities when sending patients abroad. And the medical tourism companies that facilitate these transactions use a similar combination of legal prophylaxes. However, it is unclear whether patients fully understand the legal risks. Patients may vaguely comprehend that they might not receive the same legal or regulatory protections overseas. But there is reason to suspect that they do not fully digest just how few legal remedies remain or what options they have if something goes awry.

More and more patients are accepting this tradeoff, wittingly or not. The patients diligent enough to investigate these legal disparities will not find much helpful information. Currently, the literature assumes that foreign jurisdictions provide lesser legal remedies, but until now, no one has tested or supported these assumptions.⁶ To date, there are no reliable, comprehensive sources for patients

5. See *infra* text accompanying note 601.

6. See, e.g., MILICA Z. BOOKMAN & KARLA R. BOOKMAN, MEDICAL TOURISM IN DEVELOPING COUNTRIES 156 (2007) (stating, without identifying jurisdictions for comparison, that other legal systems may not handle disputes as efficiently as U.S. courts); Nathan Cortez, *Patients Without Borders: The Emerging Global Market for Patients and the Evolution of Modern Health Care*, 83 IND. L.J. 71, 106-07 (2008) (briefly identifying problems with malpractice suits in Malaysia, Singapore, India, and Thailand); Michael Klaus, *Outsourcing Vital Operations: What if U.S. Health Care Costs Drive Patients Overseas for Surgery?*, 9 QUINNIPIAC HEALTH L.J. 219, 235-39 (2006) (stating, without citing authority, that malpractice laws “either do not exist or are not enforced” in Asia and that patients in India and Thailand “bear the full costs of the medical errors” by physicians); Masucci & Simpson, *supra* note 2 (stating, without citing authority, that “a medical malpractice plaintiff is unlikely to be made whole by a foreign judgment”); Nicolas P. Terry, *Under-Regulated Health Care Phenomena in a Flat World: Medical Tourism and Outsourcing*, 29 W. NEW ENG. L. REV. 421, 464 (2007) (asserting that medical tourists may experience “reduced legal outcomes (compensation)” overseas, but acknowledging the lack of information on this point); Marcia S. Wagner, *Medical Tourism and Group Health Plans*, J. COMP. & BENEFITS, Sept./Oct. 2006, at 26 (stating, without citing authority, that most host countries “have weak malpractice laws”); Kristen Boyle, *A Permanent Vacation: Evaluating Medical Tourism’s Place in*

to learn about legal recourse for malpractice committed in those jurisdictions.⁷

As such, it is highly doubtful that most U.S. patients fully appreciate the legal risks of medical travel.⁸ The three scenarios above reflect increasingly common arrangements. Patients are being asked to forego potential legal claims in U.S. courts, leaving them to rely on foreign judicial systems for compensation, venues where it is unlikely they will recover adequate compensation by U.S. standards. For example, the mean and median recoveries by malpractice victims in the United States (\$311,000 and \$175,000, respectively) dwarf the average recoveries in Thailand (\$2500) and Mexico (\$4800).⁹ Perhaps for this reason, industry observers and representatives warn patients not to travel overseas if they are at all concerned with their potential legal remedies.¹⁰

If patients travel overseas for less expensive health care (particularly if they are encouraged to do so), they should understand precisely what remedies they are sacrificing.¹¹

This Article recalibrates the legal risks of medical travel by assessing whether patients injured overseas have adequate legal recourse either in the

the United States Healthcare System, HEALTH LAW., June 2008, at 42, 46 (stating, without citing authority, that patients have more difficulty suing overseas); Howard D. Bye, *Shopping Abroad for Medical Care: The Next Step in Controlling the Escalating Health Care Costs of American Group Health Plans?*, HEALTH LAW., Apr. 2007, at 30, 31 (stating that lawsuits against foreign providers “can be severely limited by local law” and citing only Klaus, *supra*).

7. R.K. Nayak, *Medical Negligence, Patients’ Safety and the Law*, REGIONAL HEALTH F., Vol. 8, No. 2, 2004, at 15, 23 (noting that except for India, there is very little information on medical malpractice law in Southeast Asia). There are impressive comparative works on medical malpractice laws. See, e.g., DIETER GIESEN, *INTERNATIONAL MEDICAL MALPRACTICE LAW: A COMPARATIVE LAW STUDY OF CIVIL LIABILITY ARISING FROM MEDICAL CARE* (1988). But these tend to focus on highly developed countries rather than on the developing countries that patients increasingly visit.

8. Of course, medical travel presents non-legal risks as well. For example, traveling for surgery may complicate a patient’s recovery. See Cortez, *supra* note 6, at 103-04. This Article focuses on the legal element to these risks, particularly the risk that patients will not have adequate legal recourse if subject to medical malpractice.

9. See *infra* text accompanying notes 99, 317-320, 611.

10. See, e.g., Julie Davidow, *Thousands of ‘Medical Tourists’ Are Traveling Abroad To Save Money – And at Their Own Risk*, SEATTLE POST-INTELLIGENCER, July 24, 2006, at A1 (quoting the author of a medical tourism guide, who says, “My sort of blunt advice is that if your primary concern in going to a doctor, surgeon, or dentist is whether or not you’re going to have legal recourse if you don’t like the work you get, you shouldn’t go overseas”); Toby Manthey, *Surgery Costs Drive Americans Abroad: Arkansans Join Tourism Trend for Cheaper Meds*, ARKANSAS DEMOCRAT-GAZETTE, May 6, 2007, at 60 (“If someone is considering suing someone, for whatever reason, don’t [seek treatment abroad.] That’s all we have to say.”).

11. In Subsection III.B.3, *infra*, I discuss whether patients should be able to waive legal remedies in exchange for less expensive health care.

United States or in one of four common destinations: India, Thailand, Singapore, and Mexico. I conclude that U.S. medical tourists will struggle to obtain adequate compensation, either here or abroad. Patients looking to sue in U.S. courts for medical malpractice abroad will face difficulties locating a proper defendant, venue, and theory of liability. Patients suing overseas will also face obstacles recovering adequate, timely compensation in legal systems that use unfamiliar procedures, communicate in foreign languages, limit the remedies available, and impose more onerous burdens of proof. Moreover, I argue that patients cannot accurately appraise the legal risks because 1) no dispositive case law exists indicating whether medical tourists can recover in U.S. courts and 2) until now, there were no reliable resources that explained the remedies patients might have in foreign jurisdictions. In this Article, I attempt to fill this void. Given this information, I also discuss how policymakers might reallocate these risks more fairly and efficiently.

Part I begins by evaluating whether medical tourists can recover in U.S. courts. I use existing scholarship to outline the legal theories patients might use against certain defendants. I emphasize the term “theories” here because courts have yet to test these claims. First, I discuss how patients will struggle to prevail on issues of jurisdiction, venue, and choice of law if they sue foreign providers in U.S. courts. I then discuss how patients will face different obstacles if they attempt to recover from U.S.-based employers, insurers, and medical tourism facilitators. I evaluate several theories of liability, including corporate negligence, informed consent, vicarious liability, and negligent credentialing. Part I concludes by discussing how the industry uses releases, waivers, disclaimers, and other contractual prophylaxes to shift the legal risks in two directions—toward patients and toward foreign jurisdictions.

Part II proceeds on the assumption that patients will have difficulty suing in U.S. courts for malpractice committed overseas. I evaluate the means of redress available in four popular destinations: India, Thailand, Singapore, and Mexico.

In India, patients can sue in civil court or in one of India’s consumer forums. India also relies on criminal prosecution, self-regulation, and hospital accreditation to impose quality standards on providers. But none of these systems enforce much accountability. Civil litigation is an extremely long process, even by U.S. standards. India’s consumer forums provide an efficient alternative, but patients must contend with procedural hurdles and overcome difficulties securing medical records and expert testimony simply to recover rather modest compensation. Criminal prosecution is rare. Government regulation is virtually non-existent, and self-regulation by the medical councils is deeply flawed. Hospital accreditation is establishing some standards, but does not pretend to address negligence. India should be credited for acknowledging these shortcomings and attempting to mitigate them through its consumer forums. But given the relatively small size of malpractice recoveries reported by the Indian

media, it is doubtful that U.S. patients will be satisfied with the remedies offered by these forums.

In Thailand, patients also struggle to hold someone accountable for medical negligence. Few patients file any sort of complaint—either in civil court or with the Thai Medical Council, the Ministry of Public Health, or the Consumer Protection Agency. Those suing in civil courts face several obstacles. Thai malpractice law is underdeveloped. Patients often cannot access their medical records. Thai courts communicate solely in Thai, do not allow pretrial discovery, and seem hostile to tort claims in general. Finally, the average Thai patient recovers less than \$2500, which most U.S. patients would find unsatisfying. But like most countries, Thailand is searching for the appropriate balance and is considering several major reforms, including no-fault liability and a patient's compensation fund. Thus, the Thai system remains in flux.

In Singapore, patients face yet other obstacles. In negligence cases, Singapore adheres to the notorious *Bolam* rule, an English trial court opinion from 1957 that strongly favors physicians by instructing courts to use a deferential interpretation of the appropriate standard of care. Patients in Singapore also remain exceedingly reluctant to sue, in part because Singaporean law imposes costs on the losing litigant and prohibits contingency fee arrangements. Finally, compensation is modest not only by U.S. standards, but by standards we might expect for a nation with Singapore's wealth. Nonetheless, Singapore comprehensively regulates its health care providers, and the government seems to be committed to understanding and reducing the frequency of medical errors.

Finally, patients in Mexico must contend with a legal system that uses neither juries nor *stare decisis* and a civil code that pegs compensation to a formula used in workers' compensation cases. Tort litigation is virtually nonexistent in Mexico, and most U.S. tort victims injured there prefer to sue in the United States if they can. Although Mexico has implemented an innovative new medical arbitration system that is viewed favorably by both patients and physicians, the average recovery is only \$4800 per patient, which, again, most U.S. patients would find inadequate.

In addition to obstacles unique to each jurisdiction, suing overseas could discourage even the most resolute plaintiffs, who must retain local counsel, navigate a foreign legal system (most likely in a foreign language), travel to hearings, prove their cases, and perhaps even enforce judgments in their favor.¹² These factors may combine to effectively preclude legal recourse.

Part III concludes by exploring how the public and private sectors might

12. See Thomas R. McLean, *The Offshoring of American Medicine: Scope, Economic Issues and Legal Liabilities*, 14 ANNALS HEALTH L. 205, 247-55 (2005); Terry, *supra* note 6, at 465; Jorge A. Vargas, *Mexican Law and Personal Injury Cases: An Increasingly Prominent Area for U.S. Legal Practitioners and Judges*, 8 SAN DIEGO INT'L L.J. 475, 505 (2007).

reallocate—and perhaps mitigate—the legal risks of medical travel. In the private sector, an industry association recently began certifying medical tourism facilitators, and this process seems to encourage companies to disclose the legal remedies their customers might have, including remedies in foreign jurisdictions. Also, at least one insurance company now offers medical tourism insurance, and the American Medical Association has published industry guidelines. Part III examines the strengths and weaknesses of these approaches, and concludes by proposing ways the public sector could intervene. Legislatures could impose statutory strict liability on employers, insurers, and intermediaries that send patients overseas. Lawmakers could require these companies to insure against medical errors or pay for any pre-screening or post-operative care that may be necessary. They could invalidate any releases or waivers of liability. Or, policymakers might simply try to correct the information asymmetries that contribute to the current misallocation of legal risks. I propose a combination of these methods that would ease legal impediments to suing in the United States and inform patients of the risks of agreeing to assert claims in foreign courts. Even if these efforts do not generate precisely the same remedies as those available to patients treated in the United States, they should better spread the risks among the parties that benefit from these transactions.

This Article has two major goals, one descriptive and one prescriptive. First, the descriptive goal is to provide much-needed basic information about the legal systems in four countries that foreign patients increasingly visit. As I describe the medical malpractice compensation systems in India, Thailand, Singapore, and Mexico, I try to outline the basic mechanics of each system and the obstacles that might preclude foreign patients from receiving meaningful compensation.¹³ Hopefully, this information will be useful to patients, the industry, and policymakers alike.

The second, prescriptive goal of this Article is to suggest how both the public and private sectors might reallocate the legal risks more fairly and efficiently, so they do not fall solely, or even squarely, on patients. I scrutinize private-sector responses to the legal imbalance and recommend specific public sector options that would both eliminate impediments to hashing out these legal claims in the United States and better inform patients who agree to foreign jurisdiction just what they are sacrificing. Again, the goal is to guide this market toward a more optimal allocation of risks and responsibility.

13. I should note that this Article is not a traditional comparative work. I do not attempt to compare the malpractice systems of these countries to the American system, nor do I try to extract any policy lessons or identify the most fair and efficient method of compensating aggrieved patients. Rather, my goal is to fill a void in the literature by examining how patients might fare in select jurisdictions and whether U.S. patients will be satisfied with these remedies. Each jurisdiction deserves much closer scrutiny than anyone can provide in one article, and a pure comparative analysis would require better empirical data than is currently available.

I. SEEKING REDRESS IN THE UNITED STATES

Many believe cross-border medical treatment could be the next big trend in global health care. The phenomenon has triggered a torrent of media coverage and academic articles trying to predict what will come of it.¹⁴ Health economist Uwe Reinhardt says it “has the potential of doing to the U.S. health care system what the Japanese auto industry did to American carmakers.”¹⁵

Estimates vary widely on the precise number of U.S. patients that travel overseas for treatment each year. A 2008 report estimates that only 5000 to 10,000 Americans travel each year specifically for inpatient procedures.¹⁶ But a separate report estimated that 750,000 U.S. patients traveled overseas for medical care in 2007, and some predict that five or six million will do so in 2010.¹⁷ In either case, a mounting number of employers and insurers is garnering national media attention for adding foreign hospitals to their provider networks.¹⁸ Moreover, foreign hospitals and governments are intensifying their efforts to attract American patients.¹⁹ Because the industry remains embryonic, now may be the perfect time to influence how it allocates legal risks.

Before evaluating how aggrieved patients might fare abroad, I describe how they might fare in the United States. In this Part, I draw on existing scholarship to summarize whether U.S. patients who obtain treatment overseas might be able to recover from specific defendants in U.S. courts, including the legal theories they might use. I emphasize the word “theories” because these suits have not been tested. A major caveat in any legal analysis of medical tourism is the pervasive uncertainty over who might be liable for malpractice overseas. It remains entirely unclear whether medical tourists can recover in U.S. courts. My research found no reported opinions or test cases, and I suspect that providers and facilitators have strong incentives to settle complaints outside the public eye. Moreover, the

14. See, e.g., Cortez, *supra* note 6, at 72 n.5 (noting that the World Trade Organization, World Health Organization, World Bank, and U.S. Senate have all studied medical tourism).

15. Unmesh Kher, *Outsourcing Your Heart*, TIME, May 21, 2006, at 44 (quoting Reinhardt).

16. Tilman Ehrbeck, Ceani Guevara & Paul D. Mango, *Mapping the Market for Medical Travel*, MCKINSEY Q., May 2008, at 2-3, 6 (acknowledging that a substantial number of patients may travel for outpatient rather than inpatient procedures and distinguishing treatments given to medical tourists from those given to visitors and expatriates).

17. DELOITTE CTR. FOR HEALTH SOLUTIONS, MEDICAL TOURISM: CONSUMERS IN SEARCH OF VALUE 4 (2008), available at [http://www.deloitte.com/dtt/cda/doc/content/us_chs_MedicalTourismStudy\(3\).pdf](http://www.deloitte.com/dtt/cda/doc/content/us_chs_MedicalTourismStudy(3).pdf); Ann Tatko-Peterson, *Going Abroad for Health Care*, SAN JOSE MERCURY NEWS, Oct. 16, 2006, at A3.

18. See, e.g., Janet Fullwood, *Medical Tourism: Booming Trend is Standard Operating Procedure*, MIAMI HERALD, Nov. 2, 2008, at J4 (citing BlueCross BlueShield of South Carolina); Roni Caryn Rabin, *Insurer Offers Options for Surgery in India*, N.Y. TIMES, Nov. 21, 2008, <http://www.nytimes.com/2008/11/21/health/21abroad.html> (citing Wellpoint).

19. See Cortez, *supra* note 6, at 89-95.

industry is quickly formulating ways to avoid liability, and patients may not appreciate just how few legal remedies remain.²⁰

A. Suing Foreign Providers in the United States

Victims of medical malpractice overseas might logically seek recourse directly from the foreign hospital or medical professional that caused the injury. However, the most obvious defendants may also be the most difficult to haul into U.S. courts.

1. Personal Jurisdiction

The first obstacle to suing a foreign provider in the United States is establishing that a U.S. court has personal jurisdiction over the defendant.²¹ The law of personal jurisdiction generally requires that a defendant has “minimum contacts” with the forum state through some purposeful contacts or through substantial and continuous connection with the forum.²² Finding minimum contacts is never straightforward, but medical tourist arrangements complicate the analysis by involving foreign health care providers who communicate with patients to varying degrees over the Internet.²³

First, in the medical context, courts traditionally have been reluctant to assert jurisdiction over physicians who reside and practice even in another state, particularly if the physician does not make any “systematic or continuing effort” for his or her services “to be felt in the forum state.”²⁴ Although this analysis should differ if foreign providers systematically target U.S. residents through websites or other avenues, my research uncovered few cases on point.²⁵

20. See, e.g., Wagner, *supra* note 6, at 4 (recommending that health plans have patients release the plan from liability, noting that such a release “may or may not be valid in a court of law . . . but could have a chilling effect on potential plaintiff litigation”); Scott A. Edelstein, Partner, Squire, Sanders, & Dempsey, Addressing Liability Issues in Structuring Medical Tourism Programs: Address at the 2008 World Medical Tourism & Global Health Congress (Sept. 9, 2008) (slides on file with author).

21. Philip Mirrer-Singer, *Medical Malpractice Overseas: The Legal Uncertainty Surrounding Medical Tourism*, 70 LAW & CONTEMP. PROBS. 211, 212-15 (2007).

22. See *Helicopteros Nacionales de Colombia, S.A. v. Hall*, 466 U.S. 408, 414 nn.8-9 (1984) (distinguishing “specific” and “general” jurisdiction); *World-Wide Volkswagen Corp. v. Woodson*, 444 U.S. 286, 291-92, 297-98 (1980).

23. I use the term “Internet” here to denote contacts through cyberspace and other computer networks. See A. Benjamin Spencer, *Jurisdiction and the Internet: Returning to Traditional Principles To Analyze Network-Mediated Contacts*, 2006 U. ILL. L. REV. 71.

24. Mirrer-Singer, *supra* note 21, at 213 n.9 (quoting *Wright v. Yackley*, 459 F.2d 287, 290 (9th Cir. 1972)).

25. For example, a U.S. court has extended jurisdiction over a foreign website operator that targeted U.S. students as customers. *Graduate Management Admission Council v. Raju*, 241 F.

An aggrieved patient might also argue for jurisdiction based on a state's long-arm statute if the foreign provider transacts or solicits business in the state.²⁶ But courts have been reluctant to exert jurisdiction on this basis alone.²⁷ Even a steady stream of referrals from the United States may not establish personal jurisdiction.²⁸ However, courts have exercised personal jurisdiction over out-of-state health care providers that have ongoing relationships with referral sources in the forum.²⁹ Thus, a signed contract between a foreign provider and a U.S. referral source may establish jurisdiction,³⁰ even though, again, some courts have refused to find jurisdiction based solely on a contract—particularly if the contract does not pertain to conduct being challenged in the litigation.³¹ For example, in *Romah v. Scully*, a federal district court recently held that a Toronto hospital being sued for malpractice by a U.S. patient was not subject to the court's jurisdiction.³² Although the hospital had signed contracts with entities in the forum state, the contracts were executed in Canada, and the hospital performed the required work in Canada.³³

Pervasive contact via the Internet, however, could establish jurisdiction over a foreign provider that specifically targets U.S. patients.³⁴ At least one court has exercised jurisdiction over an Indian defendant based on a website that specifically targeted U.S. customers.³⁵ Moreover, in *Romah v. Scully*, part of the reason the court did not accept jurisdiction over the Toronto hospital was that the patient offered weak evidence that the hospital had targeted patients in the forum state.³⁶ Although many medical tourists may be able to muster more concrete evidence that the foreign entity solicited U.S. patients, these analyses are so fact-specific that it is difficult to predict whether any given U.S. court would assert

Supp. 2d 589, 599 (E.D. Va. 2003). See Spencer, *supra* note 23, for a thoughtful analysis of personal jurisdiction based on Internet contacts.

26. See Mirrer-Singer, *supra* note 21, at 213 (citing New York's long-arm statute, at N.Y. C.P.L.R. 302(a)(1), (a)(3)(i) (McKinney 2001 & Supp. 2007)); Kerrie S. Howze, Note, *Medical Tourism: Symptom or Cure?*, 41 GA. L. REV. 1013, 1031 (2007).

27. Mirrer-Singer, *supra* note 21, at 213 (citing cases).

28. *Id.* (citing cases).

29. *Id.* at 214 (citing cases).

30. *Id.*

31. *Romah v. Scully*, No. 06-698, 2007 WL 3493943, at *5-*6 (W.D. Pa., Nov. 13, 2007) ("The mere existence of a contract, standing alone, does not confer general jurisdiction over a defendant.").

32. *Id.* Importantly, the patient was not a medical tourist, but was treated while in the custody of Canadian law enforcement.

33. *Id.* at *7.

34. Howze, *supra* note 26, at 1032.

35. Graduate Management Admission Council v. Raju, 241 F. Supp. 2d 589, 599 (E.D. Va. 2003).

36. *Romah*, 2007 WL 3493943, at *8-*9.

personal jurisdiction over a foreign provider.³⁷ Recent critiques of Internet-based jurisdiction suggest ways courts might better balance concerns of fairness and the limits of state sovereignty,³⁸ which are particularly applicable in medical tourist arrangements.

Aggrieved patients might also argue for U.S. jurisdiction under a continuing tort theory if the patient continues to be affected in the forum state by the foreign provider's tortious conduct.³⁹ But U.S. courts may be reluctant to make this leap unless the patient has some sort of continuing relationship with the provider,⁴⁰ which is less likely in medical tourist arrangements.

Notwithstanding these hurdles, patients might be comforted to know that U.S. courts often provide remedies when Americans are tortiously injured in Mexico.⁴¹ In fact, U.S. courts decide far more tort cases arising in Mexico than Mexican courts do.⁴² One study found that Americans can sue in U.S. courts if the injury is egregious enough. For example, if a company with U.S. ties books a vacationer's travel and strongly recommends a particular hotel in Mexico, a hotel guest injured in the hotel can often sue in the United States.⁴³ This scenario suggests that U.S. courts might find ways to exercise jurisdiction in egregious medical tourism cases as well.

2. *Venue and Forum Non Conveniens*

Even if a patient can establish jurisdiction in the United States, most foreign defendants would move to dismiss under *forum non conveniens*—a doctrine that allows courts to dismiss cases that would excessively burden the defendant and when a more appropriate forum exists elsewhere.⁴⁴ For example, if the defendant resides overseas along with most of the witnesses and evidence, a court would likely dismiss the case. In *Jeha v. Arabian American Oil Co.*, a U.S. court dismissed a medical malpractice suit filed by an employee's wife against a Saudi Arabian-based employer because the critical evidence and witnesses were all located in Lebanon.⁴⁵ Courts considering a *forum non conveniens* motion must

37. Howze, *supra* note 26, at 1031-32.

38. See, e.g., Spencer, *supra* note 23.

39. Mirrer-Singer, *supra* note 21, at 214 (citing cases).

40. *Id.* (citing cases explaining that refilling a prescription or receiving "incidental" phone calls from a resident of the forum state did not establish personal jurisdiction over the out-of-state doctor).

41. Vargas, *supra* note 12, at 477.

42. *Id.* at 478.

43. *Id.* at 505.

44. Piper Aircraft Co. v. Reyno, 454 U.S. 235, 241 (1981).

45. 751 F. Supp. 122, 126-28 (S.D. Tex. 1990). Note that *Jeha* involved a particularly complicated fact pattern. The plaintiff was the wife of the employee and was treated by the employer's doctors in Saudi Arabia. Both the employee and his wife were Lebanese citizens, who

also consider which country's laws to apply and, more importantly, whether there is an adequate alternative forum.⁴⁶ Courts commonly invoke *forum non conveniens* if foreign rather than domestic law governs the conduct at issue.⁴⁷ Thus, for example, a U.S. court might be reluctant to accept venue and be forced to apply Thai law to malpractice allegedly committed in Bangkok.

Courts typically recognize *forum non conveniens* if an alternative forum can provide adequate legal redress, even if the remedies available are "substantially less than provided by U.S. laws."⁴⁸ Though courts are reluctant to find that a foreign forum is inadequate, some have.⁴⁹ For example, in *Bhatnagar v. Surrendra Overseas Ltd.*, the Third Circuit denied a motion to dismiss a personal injury case against an Indian shipping company on *forum non conveniens* grounds because the alternative forum in India (the Calcutta High Court) was beset by "extreme delays," lasting possibly even a quarter century.⁵⁰ The court held that the severe backlog in Indian courts rendered them inadequate.⁵¹ Testimony in the *Bhatnagar* case suggested that an "average" case before the Calcutta High Court would take fifteen to twenty years to resolve.⁵² Thus, the delayed remedies provided by Indian courts may be "so clearly inadequate or unsatisfactory" that they are "no remedy at all."⁵³ However, the availability of India's consumer forums for malpractice complaints might complicate this analysis, as consumer forums were designed to resolve cases much more expediently.⁵⁴ Nevertheless, medical tourists should know that plaintiffs have had difficulty convincing U.S. courts that even extremely small recoveries overseas amount to "no remedy at all."⁵⁵ For example, in *Gonzalez v. Chrysler Corp.*, the Fifth Circuit held that a \$2500 maximum recovery in Mexico did not prove that

sued in federal district court in Texas in part because she traveled to the United States for treatment, in part because the Saudi company had a Houston-based subsidiary, and most likely in part because Saudi law does not recognize vicarious liability. A U.S. court might be more sympathetic to a U.S. medical tourist injured overseas.

46. Mirrer-Singer, *supra* note 21, at 223-24.

47. *Id.* at 223 (citing cases).

48. *Sector Navigation Co. v. M/V Captain P*, No. 06-1788, 2006 WL 2946356, at *4 (E.D. La. Oct. 13, 2006); Mirrer-Singer, *supra* note 21, at 223-24; Howze, *supra* note 26, at 1033.

49. Mirrer-Singer, *supra* note 21, at 223-24.

50. *Bhatnagar v. Surrendra Overseas Ltd.*, 52 F.3d 1220, 1226-29 (3d Cir. 1995) (noting that the experts "provided both statistical and anecdotal evidence documenting litigation delays" in India); Mirrer-Singer, *supra* note 21, at 224.

51. *Bhatnagar*, 52 F.3d at 1227.

52. *Id.* at 1228.

53. *Piper Aircraft Co. v. Reyno*, 454 U.S. 235, 254 (1981). *But see id.* at 265 n.22 (noting that alternative forums would be inadequate only in "rare circumstances"); Howze, *supra* note 26, at 1034.

54. See Section II.B, *infra*, for a description of India's consumer dispute redressal forums.

55. Howze, *supra* note 26, at 1035.

the Mexican court was inadequate under *forum non conveniens*.⁵⁶ Thus, although concerns about lengthy judicial delays abroad may be sufficient for medical tourists to gain access to U.S. courts, those same courts may not be sympathetic to patients' complaints about the meager damage awards available overseas.

3. Choice of Law

Patients that sue foreign providers in U.S. courts must establish not only jurisdiction and venue, but also may have to litigate complicated choice of law questions. Defendants no doubt will argue that the laws where the treatment was provided govern because, as I demonstrate in Part II, these laws tend to favor providers.

Choice of law questions could be dispositive in medical tourism disputes. Defeating a motion to dismiss for *forum non conveniens* may represent a Pyrrhic victory, as U.S. courts will frequently be obliged to follow the defendant-friendly laws of major medical tourism destinations. For example, in *Chadwick v. Arabian American Oil Co.*, a U.S. plaintiff sued a Saudi Arabian company incorporated in Delaware, arguing that the company was vicariously liable for medical malpractice committed by the company's physician in Saudi Arabia.⁵⁷ The court followed Delaware's conflict of law principles, governed by *lex loci delicti* (a choice of law rule that applies the law of the place where the tort was committed), and applied Saudi law because the physician allegedly misdiagnosed the plaintiff in Saudi Arabia.⁵⁸ But because Saudi law does not recognize vicarious liability, the court dismissed the case.⁵⁹ Similarly, a U.S. court applying the law of India to a malpractice case might leave the patient with very little compensation, yielding the same outcome as if the plaintiff had sued in India.⁶⁰

But the *Chadwick* case may be an unrepresentative and relatively simplistic example of how courts might resolve choice of law questions in medical tourism cases. First, very few American jurisdictions use *lex loci delicti*.⁶¹ Instead, modern choice of law approaches tend to rely on a multitude of "contacts, factors, and policies" that would require courts not only to examine the content of foreign laws, but their underlying policies as well.⁶² Second, choice of law

56. 301 F.3d 377, 383 (5th Cir. 2002); see also Howze, *supra* note 26, at 1035.

57. *Chadwick v. Arabian Am. Oil Co.*, 656 F. Supp. 857, 858 (D. Del. 1987).

58. *Id.*

59. *Id.*

60. Howze, *supra* note 26, at 1038.

61. Symeon C. Symeonides, Choice of Law in Cross-Border Torts 8 (Jan. 14, 2009), available at <http://ssrn.com/abstract=1328191> (unpublished manuscript) (noting how forty-two out of fifty-two U.S. jurisdictions have abandoned the more straightforward *lex loci delicti* rule, which applies the law of the place of injury). Note, however, that in Symeonides's article, "cross-border tort" refers to conduct that causes an injury in a different state. *Id.* at 3 n.1.

62. *Id.* at 9.

disputes will be challenging because medical tourism complicates the traditional analyses. U.S. patients might argue that because foreign providers market themselves as meeting Western standards of medical care, they should be held to those standards in court. Otherwise, divergent standards of care between jurisdictions can affect the choice of law analysis.⁶³ Moreover, courts assessing choice of law might consider patients' expectations and role in choosing the foreign provider.⁶⁴ For example, in a domestic cross-border malpractice case, a Pennsylvania court declined to apply Pennsylvania law and applied the more pro-defendant law of Delaware, noting that patients who travel out-of-state for care cannot carry with them the more protective laws of their domiciles, because such a rule would require providers to comply with the laws of all states that send them patients.⁶⁵ In a medical tourism case, the foreign provider could similarly argue that patients knowingly choose to receive health care in a foreign jurisdiction and that providers cannot be expected to comply with the laws of all of their patients' home countries.

Thus, although suing a foreign provider seems to be the most straightforward avenue for redress, it could be anything but. Patients not only would struggle to establish jurisdiction and venue in U.S. courts, but they may find that courts would apply foreign law. Moreover, these legal obstacles are only compounded by practical ones, such as the burden of properly serving process to a defendant overseas.⁶⁶ Combined, these obstacles could insulate foreign providers from liability in U.S. courts. But until courts are confronted with such cases, we are left to speculate.

B. Suing Intermediaries in the United States

Although medical facilitators located overseas can use many of the same defenses as foreign providers, facilitators located in the United States are not similarly shielded by questions of jurisdiction, venue, or choice of law, making

63. *Id.* at 30 (discussing *Kuehn v. Childrens Hospital, L.A.*, 119 F.3d 1296 (7th Cir. 1997), in which Judge Richard Posner held that a medical malpractice claim brought by a Wisconsin plaintiff against a California hospital was governed by Wisconsin law in part because the state laws differed primarily "in the scope of liability for negligence, not in the standard of care." 119 F.3d. at 1302).

64. Symeonides, *supra* note 61, at 31-32 (citing *Pietrantonio v. United States*, 827 F. Supp. 458 (W.D. Mich. 1993)). In *Pietrantonio*, the court held that a Michigan patient could sue a Wisconsin hospital under Michigan law because the patient "did not go to Wisconsin except by referral from his Michigan doctor" and thus "did not choose Wisconsin as the source of his medical care and . . . would not have expected Wisconsin law to determine [his and his family's] rights." *Pietrantonio*, 827 F. Supp. at 462.

65. *Troxel v. A.I. duPont Inst.*, 636 A.2d 1179, 1181-82 (Pa. Super. Ct. 1994).

66. *Romah v. Scully*, No. 06-698, 2007 WL 3493943 (W.D. Pa. Nov. 13, 2007) (noting difficulty plaintiff had serving process on a Toronto-based hospital defendant); Edelstein, *supra* note 20, at Slide 11.

them more convenient defendants.⁶⁷ U.S. facilitators could be liable under any of the following theories: corporate negligence, failure to obtain informed consent, and vicarious liability.

1. Corporate Negligence

Aggrieved patients may sue medical tourism facilitators for corporate negligence, just as hospitals have been held liable for negligently hiring, retaining, or supervising unfit or incompetent physicians.⁶⁸ However, courts might be reluctant to extend corporate negligence beyond hospitals, as shown by decisions absolving HMOs for torts committed by network physicians.⁶⁹

Moreover, medical tourists could encounter difficulty proving corporate negligence. For example, proving negligent retention would require demonstrating not only that the foreign physician was unfit or incompetent, but also that the U.S. company knew or should have known this based on some pattern of misconduct.⁷⁰ Patients might find it difficult to muster evidence that a foreign provider was unfit or incompetent, especially if the standards for credentialing and practice depart from U.S. standards. Further, courts may be reluctant to pass judgment on such matters.

2. Informed Consent

Patients may also sue medical tourism facilitators for failure to obtain informed consent if the company misrepresents the quality or qualifications of its foreign providers.⁷¹ Facilitators often boast about the quality of foreign providers, and it is not difficult to find marketing hyperbole on their websites.⁷² Of course, patients will face several hurdles proving not only that a facilitator had a duty to obtain informed consent, but that the facilitator also had failed to do so. Courts remain wary of extending informed consent liability beyond the treating physician.⁷³ And it would be difficult to prove that the misrepresentation was material because it must be shown to have caused the patient's injuries.⁷⁴ Most importantly, it would be difficult for U.S. courts to ascertain whether the statements were in fact misrepresentations, because this determination requires

67. Cortez, *supra* note 6, at 113-20; Mirrer-Singer, *supra* note 21, at 215-16.

68. Cortez, *supra* note 6, at 120; Mirrer-Singer, *supra* note 21, at 216.

69. Mirrer-Singer, *supra* note 21, at 216.

70. *Id.* at 216-17 (proving negligent hiring or supervision requires similar steps).

71. *Id.* at 217-19.

72. See, e.g., Global Med Network, Quality, <http://www.globalmednetwork.com/html/quality.html> ("All our network hospitals have success rates that are in many cases equal to or higher than their American counterparts.").

73. Mirrer-Singer, *supra* note 21, at 217.

74. *Id.* at 217-18 (citing cases).

courts to assess the quality and credentials of foreign health care providers—a thorny proposition.⁷⁵

3. *Vicarious Liability*

Finally, patients may argue that a medical tourism facilitator should be vicariously liable for malpractice committed overseas.⁷⁶ However, courts generally refuse to hold HMOs and similar entities vicariously liable for malpractice by a physician unless the physician is an employee or the agent of the company.⁷⁷ Even then, most medical tourism facilitators can safeguard against liability through a well-worded disclaimer.⁷⁸

C. *Suing Employers and Insurers in the United States*

Today, many patients venture overseas not on their own planning, but because an employer or insurer encourages it. In such cases, patients might assert yet additional theories of liability. In fact, patients sent overseas by an employer or insurer may have an easier path to redress in the United States than patients venturing overseas independently.⁷⁹ Some legal theories available to patients suing employers or insurers overlap with those that would hold facilitators liable. For example, patients might argue that an employer or insurer failed to obtain informed consent or exerted some control over a negligent foreign provider and should be vicariously liable.⁸⁰ If an HMO physician recommends a foreign surgeon, the U.S. physician would probably have some duty to disclose the risks of the procedure and obtain preliminary informed consent; at least one court has imposed such a duty on the referring physician in a domestic case.⁸¹ In spite of this domestic precedent, courts in medical tourism cases would still need to resolve complicated questions regarding the scope of the risks, disclosures, and consent required.⁸²

Like hospitals, insurers could be responsible for negligent credentialing if

75. *Id.* at 218-19.

76. Cortez, *supra* note 6, at 120; Mirrer-Singer, *supra* note 21, at 219-21.

77. Mirrer-Singer, *supra* note 21, at 219-20.

78. *Id.* at 221-22.

79. BOOKMAN & BOOKMAN, *supra* note 6, at 157.

80. Howze, *supra* note 26, at 1039-40, 1043-44. Note, however, that the Supreme Court's recent decision in *Aetna v. Davila*, 542 U.S. 200, 209 (2004), held that ERISA preempts state tort claims against covered HMOs.

81. Howze, *supra* note 26, at 1046-48 (citing *Kashkin v. Mount Sinai Med. Ctr.*, 538 N.Y.S.2d 686 (Sup. Ct. 1989), which held the referring physician liable for failure to obtain informed consent because the physician not only referred the patient to a second physician for a specific procedure rather than a second opinion, but also made hospital arrangements through the referrer's office).

82. Howze, *supra* note 26, at 1049-50.

the insurer negligently approved a foreign physician for treating its customers.⁸³ Some observers argue that if HMOs and other employer-sponsored health plans outsource surgeries to foreign providers, they may violate their fiduciary duties under the Employee Retirement Income Security Act of 1974 (ERISA).⁸⁴ Health plans covered by ERISA must act “solely in the interest” of plan beneficiaries and must at minimum avoid making any material misrepresentations about the plan.⁸⁵ Health plans that outsource surgeries risk violating both duties.⁸⁶ Even though an ERISA claim would not compensate victims of malpractice, it might encourage health plans to be more careful about the financial incentives they offer and perhaps the representations they make about foreign providers. Otherwise, insurers might be liable for civil damages as a result of the breach.⁸⁷

Overall, employers and insurers that send patients overseas may be the least sympathetic defendants because they generally save a significant amount of money without accepting much risk in return.⁸⁸ Some authors even suggest that offering financial incentives to patients may increase an insurer’s risk of liability.⁸⁹

But as with other defendants, there are real obstacles to proving these claims against employers and insurers. For example, a court would have to resolve several knotty questions outlined above to hold a U.S. employer or insurer liable for failing to obtain informed consent from medical tourists.⁹⁰ Vicarious liability is unlikely unless the employer or insurer exerted some control over the foreign provider,⁹¹ which would be relatively unusual. A complaint based on negligent credentialing may have some teeth but would require courts to scrutinize the credentials of foreign providers operating in vastly different environments.

D. Inoculating Against Liability

The medical tourism industry is well aware of its potential legal liabilities. Companies have identified these risks and are taking steps to minimize them.⁹² Lawyers are busy formulating ways to avoid liability, particularly in U.S.

83. *Id.* at 1040-42.

84. *See, e.g.*, Christopher J. Brady, *Offshore Gambling: Medical Outsourcing Versus ERISA’s Fiduciary Duty Requirement*, 64 WASH. & LEE L. REV. 1073 (2007); *see also* Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001-1461 (2006).

85. Brady, *supra* note 84, at 1081-87 (citing cases).

86. *See generally id.*

87. *Id.* at 1078-79; 29 U.S.C. § 1109(a) (2006) (describing the remedies available).

88. *See, e.g.*, Cortez, *supra* note 6, at 121-23; Wagner, *supra* note 6, at 7.

89. BOOKMAN & BOOKMAN, *supra* note 6, at 157.

90. Howze, *supra* note 26, at 1048-49.

91. *Id.* at 1039-40, 1043-44.

92. *See generally* Edelstein, *supra* note 20.

courts.⁹³ In fact, companies may be able to limit their exposure (or at least discourage lawsuits) by asking patients to acknowledge disclaimers or sign releases or waivers. For example, companies can try to use contracts to limit the remedies available, to cap damages, to allocate liability between suppliers, to require indemnification, to shift jurisdiction to foreign courts, and to designate alternative dispute resolution or other non-judicial methods of settling disputes.⁹⁴

As a practical matter, medical tourism companies can also reduce their exposure by limiting the representations they make about foreign providers, including any claims about surgical success rates or express comparisons to U.S. hospitals.⁹⁵ The industry might also discourage litigation by informing customers of medical malpractice accident insurance and other forms of protection,⁹⁶ which I explore further in Section III.A. Together, these safeguards may inoculate the industry against liability, particularly in U.S. courts.

Nevertheless, the unsettled legal questions raised by medical tourism introduce pervasive uncertainty for patients, providers, and facilitators in the market. These issues will be litigated eventually, and the first reported opinions will quickly set standards for the industry. Patients undoubtedly will assert creative legal theories, and defendants will devise even more creative defenses. Until then, we are left to speculate. In the meantime, companies that outsource health care to less expensive jurisdictions will continue to try to outsource potential legal disputes as well.

II. SEEKING REDRESS IN FOREIGN JURISDICTIONS

Medical tourists who do not have legal recourse in the United States will have to look elsewhere. In this Part, I evaluate the legal redress provided by four common destinations—India, Thailand, Singapore, and Mexico. I assess whether these countries provide adequate recourse to U.S. patients and the obstacles patients might face navigating various complaint mechanisms in each country.

To date, no scholars or policymakers have tackled these issues, even as employers and insurers increasingly outsource medical treatments. The current literature assumes, without scrutiny, that medical tourist destinations provide lesser remedies or even no remedies at all. In fact, most assume patients will be on their own. For example, the United Kingdom's National Health Service (NHS) warns that if patients seek treatment abroad and need to sue a treating provider, they must rely on the legal system in that country.⁹⁷ Industry

93. *Id.*

94. *Id.* Part III discusses the extent to which waivers of liability might be enforceable in medical tourist arrangements.

95. *Id.*

96. *Id.*

97. Cara Guthrie & Hannah Volpé, *Overseas Treatment for NHS Patients*, 2006 J. PERSONAL

representatives and observers often warn patients not to travel overseas if they are concerned with their potential legal remedies. That is, medical tourists are warned *caveat emptor*.

A. U.S. Expectations

Before scrutinizing malpractice regimes overseas, it is worth taking stock of how U.S. patients fare here. In 2006, the National Practitioner Data Bank (NPDB) received over 12,500 reports of medical malpractice payouts made on behalf of physicians, including both judgments and settlements.⁹⁸ The mean payout was \$311,965 per patient, with a median of \$175,000.⁹⁹ The NPDB also reported that patients waited an average of 4.88 years from the date of the incident to receive compensation.¹⁰⁰

Malpractice litigation in the United States is criticized as being a “lawsuit lottery.”¹⁰¹ The system is blamed for not only awarding windfall damages, but also for awarding damages to meritless claims and denying damages to claims with merit.¹⁰² The Institute of Medicine estimated that anywhere from 44,000 to 98,000 U.S. patients die in hospitals each year from preventable errors.¹⁰³ Yet the vast majority of U.S. patients injured by medical negligence do not sue.¹⁰⁴ Around 70% of those who file claims receive no compensation, and defendants win most cases that proceed to trial.¹⁰⁵ Although several studies conclude that

INJ. L. 12, 15-16; Terry, *supra* note 6, at 464. NHS’s program paying for certain medical treatments in fellow member states is known as E112. National Health Service, Going Abroad for Planned Treatment, Using E112, <http://www.nhs.uk/Treatmentabroad/Pages/E112.aspx> (last visited Nov. 22, 2009).

98. U.S. DEP’T OF HEALTH & HUM. SERVS., NAT’L PRACTITIONER DATA BANK, 2006 ANNUAL REPORT 27, 65 tbl.4 (2006), http://www.npdb-hipdb.hrsa.gov/pubs/stats/2006_NPDB_Annual_Report.pdf [hereinafter NPDB ANNUAL REPORT]. Congress created the NPDB in the Health Care Quality Improvement Act of 1986, Pub. L. No. 99-660, 100 Stat. 3784, codified at 42 U.S.C. § 11,101 (2006).

99. NPDB ANNUAL REPORT, *supra* note 98, at 8, 65 tbl.4.

100. *Id.* at 8. Although the NPDB requires reports in various circumstances (e.g., when state boards take disciplinary actions, or when hospitals, HMOs, and similar entities discipline physicians), *id.* at 14-15, the NPDB has been concerned about under-reporting, *id.* at 39-40. Note, however, that very few practitioners dispute reports about them, *id.* at 8, and false reports can trigger criminal punishment, *id.* at 17.

101. David M. Studdert, Michelle M. Mello & Troyen A. Brennan, *Medical Malpractice*, 350 NEW ENG. J. MED. 283 (2004).

102. David M. Studdert et al., *Claims, Errors, and Compensation Payments in Medical Malpractice Litigation*, 354 NEW ENG. J. MED. 2024, 2025 (2006); Studdert, *supra* note 101.

103. INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH CARE SYSTEM 1 (Linda J. Kohn, Janet M. Corrigan & Molla S. Donaldson eds., 1999).

104. Studdert et al., *supra* note 102, at 2024, 2025 (citing research).

105. Studdert et al., *supra* note 101, at 285.

“the tort system does a reasonably good job of directing compensation to plaintiffs with meritorious claims,” compensation can still be indiscriminate.¹⁰⁶ At the same time, stories are legion of U.S. physicians quitting practice due to skyrocketing malpractice insurance premiums.¹⁰⁷ Media reports of “mega awards” in states without damage caps further undercut the public’s faith in our medical malpractice compensation system.¹⁰⁸

Critics of our system are also quick to note that it is expensive and inefficient: “For every dollar spent on compensation, 54 cents went to administrative expenses (including those involving lawyers, experts, and courts).”¹⁰⁹ The consensus in the U.S. health care industry, of course, is that “malpractice litigation has long since surpassed sensible levels and that major tort reform is overdue.”¹¹⁰ Many states have responded by enacting some kind of tort reform, mostly focusing on capping damages.¹¹¹ Critics blame malpractice litigation for encouraging defensive medicine and raising the costs of health care, although “that canard has been exposed,”¹¹² as researchers have found that defending against medical malpractice litigation accounts for less than one percent of all health care spending in the United States.¹¹³ The U.S. Department of Health and Human Services under former President Bush also expressed its concerns with our system, noting that “Americans spend far more per person on the costs of litigation than any other country in the world.”¹¹⁴

106. *Id.* (citing five sources concluding that the system generally compensates valid claims filed, but citing two sources concluding that compensation is indiscriminate). Note also that Studdert et al., reviewing a random sample of closed malpractice claims from five liability insurers, found that 72% of malpractice claims not associated with medical errors did not result in compensation, while 73% of claims associated with medical errors did. Studdert et al., *supra* note 102, at 2028.

107. See U.S. DEP’T OF HEALTH & HUM. SERVS., ADDRESSING THE NEW HEALTH CARE CRISIS: REFORMING THE MEDICAL LITIGATION SYSTEM TO IMPROVE THE QUALITY OF HEALTH CARE 3-7 (2003), <http://aspe.hhs.gov/daltcp/reports/medliab.pdf> [hereinafter NEW HEALTH CARE CRISIS].

108. *Id.* at 13-14 (listing awards of \$94 million and \$100 million). Note, however, that appellate courts almost uniformly reduce such awards.

109. Studdert et al., *supra* note 102, at 2024. A separate study found that sixty cents of every dollar is spent on administrative costs. See Studdert et al., *supra* note 101, at 286.

110. Studdert et al., *supra* note 101, at 283.

111. See David A. Hyman et al., *Estimating the Effect of Damages Caps in Medical Malpractice Cases: Evidence from Texas*, 1 J. LEG. ANALYSIS 355, 356 (2009) (noting that thirty states cap non-economic or total damages); Studdert et al., *supra* note 101, at 283.

112. NEW HEALTH CARE CRISIS, *supra* note 107, at 7-8; Studdert et al., *supra* note 101, at 283; Terry, *supra* note 6, at 456-57 (describing the debate over the extent to which malpractice litigation contributes to defensive medicine and rising health care costs).

113. Gerard F. Anderson et al., *Health Spending in the United States and the Rest of the Industrialized World*, 24 HEALTH AFF. 903, 910 (2005).

114. NEW HEALTH CARE CRISIS, *supra* note 107, at 1.

Thus, there are obvious dangers in juxtaposing any malpractice system with ours. Our system has gained international notoriety for being excessive, inefficient, arbitrary, wasteful, and sometimes punitive.¹¹⁵ Virtually any comparison using U.S. awards as a baseline might conclude that the foreign system undercompensates patients. Moreover, scholars cannot say with any certainty that other systems are more or less adept at resisting meritless claims or compensating claims with merit, because these data elude us. The best we can do is to piece together disparate points of information to gauge how patients with legitimate claims fare in each jurisdiction.

Finally, while each of the four countries I examine seems to be struggling to make its malpractice system more efficient and just, each country has expressed grave concerns about the rise of malpractice complaints. Moreover, developing countries in particular worry about more pressing public health issues that might relegate patient compensation down the list of priorities. Needless to say, these tensions may magnify if foreign patients from more litigious jurisdictions begin suing local providers.

B. India

India has quickly become perhaps the leading new destination for foreign patients. In 2007, roughly 450,000 foreign patients visited India, up from roughly 150,000 in 2003 and second only to Thailand.¹¹⁶ By 2012, India may earn over \$2 billion per year from medical tourism.¹¹⁷ India possesses the perfect formula for attracting foreign patients. Its supply of physicians is world renowned,¹¹⁸ and its hospitals are gaining ground.¹¹⁹ India integrates new medical technologies relatively well. Widespread use of English makes its private hospitals and physicians accessible to U.S. patients. Most of all, health care in India is dramatically less expensive than in most countries that offer comparable services.¹²⁰

115. Robert B. Leflar, "Unnatural Deaths," *Criminal Sanctions, and Medical Quality Improvement in Japan*, 9 YALE J. HEALTH POL'Y L. & ETHICS 1, 3 (2009).

116. DELOITTE CTR. FOR HEALTH SOLUTIONS, *supra* note 17, at 6; Aaditya Mattoo & Randeep Rathindran, *Does Health Insurance Impede Trade in Health Care Services?* 2, 12 tbl.2 (World Bank, Policy Research, Working Paper No. 3667, 2005). Many in the industry believe that India will eventually attract more medical tourists than Thailand, although projecting the number of medical tourists that will visit any one country has proven notoriously difficult.

117. Ganapati Mudur, *Hospitals in India Woo Foreign Patients*, 328 BRIT. MED. J. 1338 (2004).

118. See, e.g., Fitzhugh Mullan, *Doctors for the World: Indian Physician Emigration*, 25 HEALTH AFF. 380 (2006).

119. Cortez, *supra* note 6, at 83-85.

120. See, e.g., Aaditya Mattoo & Randeep Rathindran, *How Health Insurance Inhibits Trade in Health Care*, 25 HEALTH AFF. 358, 359 (2006).

The Indian government aggressively promotes its medical tourism industry, following the lead of Thailand and Singapore.¹²¹ The Ministry of Tourism partners with the industry to promote medical tourism, and some state governments have followed suit.¹²² When U.S. health insurers consider outsourcing surgeries, Indian hospitals often top the list of candidates.

But when observers scrutinize India as a destination for U.S. patients, we often generalize about the extent to which its legal and regulatory systems fail to protect patients. In theory, Indian laws attempt not only to punish and deter medical malpractice, but also to compensate patients. Patients can file complaints both in civil courts and in India's Consumer Disputes Redressal Agencies (CDRAs).¹²³ India also relies on familiar mechanisms like criminal prosecution, self-regulation by medical councils, and hospital accreditation to enforce at least some quality standards and accountability.

In reality, India does not impose much accountability. Civil litigation in India is beset by maddening delays.¹²⁴ India's consumer forums were intended to provide a fair and efficient alternative but suffer from several deficiencies.¹²⁵ Criminal prosecution for medical malpractice is rare,¹²⁶ perhaps as it should be. Regulation by the government is virtually non-existent, and self-regulation by medical councils is deeply flawed.¹²⁷ Hospital accreditation is beginning to take hold among private hospitals that attract foreign patients, but the patchwork of accreditation bodies is immature and weak,¹²⁸ and accreditation does not pretend to address negligence. Notably, an executive with the Confederation of Indian

121. Cortez, *supra* note 6, at 91-93.

122. *Id.* at 91.

123. See Subsection II.B.1, *infra*.

124. See Subsection II.B.1, *infra*.

125. See Subsection II.B.1, *infra*.

126. See Subsection II.B.2, *infra*.

127. See Subsection II.B.2, *infra*.

128. There is no national hospital accreditation in India, and at least seven different groups have proposed accreditation systems, including 1) states, 2) the Bureau of Indian Standards, 3) the National Institute for Health and Family Welfare, 4) the Indian Hospital Association, 5) the Confederation of Indian Industry, 6) the National Accreditation Board for Hospitals and Health Care Providers, and 7) the Indian Ministry of Health and Family Welfare. The latter three efforts have emerged with international standards and commerce in mind. See Chandrima B. Chatterjee, *Accreditation of Hospitals: An Overview*, EXPRESS HEALTHCARE MGMT. (India), Sept. 2005, <http://www.expresshealthcaremgmt.com/20050915/accreditation01.shtml>; Rupa Chinai & Rahul Goswami, *Medical Visas Mark Growth of Indian Medical Tourism*, 85 BULL. WORLD HEALTH ORG. 164 (2007), available at <http://www.who.int/bulletin/volumes/85/3/07-010307.pdf>; Varsha Zende, *Dynamics of Accreditation of Private Hospitals*, EXPRESS HEALTHCARE MGMT. (India), Nov. 2006, <http://expresshealthcaremgmt.com/200611/accreditation01.shtml>; National Accreditation Board for Hospitals and Healthcare Providers (NABH), <http://www.qcin.org/nabh> (last visited Nov. 22, 2009).

Industry states that “[a]ny litigation launched against an Indian hospital will expose the poor system of justice that exists here.”¹²⁹

In short, India’s legal and regulatory systems impose few standards on the practice of medicine and do not hold providers accountable in any meaningful way. In fact, some feel the lack of standards and accountability has led the medical profession in India to become increasingly “recalcitrant.”¹³⁰ Finally, there remains a gap in India between several well-intentioned laws and how they operate in reality. As one medical malpractice expert observes, laws exist, but in practice the legal and regulatory systems are beset by delay and apathy.¹³¹ Ironically, the most concrete incentives to avoid injuring foreign patients derive from external sources, such as international accreditation, adverse publicity, and perhaps contracts with foreign payors.

Thus, my research largely confirms our intuition that U.S. patients will struggle to obtain adequate, timely redress in India. But my research also complicates this intuition. Recourse is inadequate in India not because of unreasonable delays or inaccessible tribunals—India’s consumer forums still resolve cases more quickly than most U.S. courts—but because compensation is several magnitudes lower than what U.S. patients might expect. Ironically, compensation is lower in India for largely the same reasons that medical care costs so little: everything is more expensive in the United States.¹³²

1. Redressal Options in India

Victims of medical negligence in India have two primary options: sue in a consumer forum under the Consumer Protection Act or sue in civil court under the tort theory of negligence. Although the government created consumer forums to avoid the burdens of civil litigation, they have come to suffer from some of the same deficiencies that plague civil courts. I discuss both venues and conclude that although consumer forums provide a much more efficient alternative to civil litigation, they present discrete challenges for aggrieved foreign patients, not the least of which is very modest compensation.

a. Consumer Forums

India’s Consumer Disputes Redressal Agencies have become the primary avenue of redress for patients. The forums are a quasi-judicial grievance system intended to create a fair, efficient alternative to civil courts. Although India

129. Chinai & Goswami, *supra* note 128, at 165. The Confederation is a not-for-profit industry organization, much like the U.S. Chamber of Commerce.

130. ANOOP K. KAUSHAL, *MEDICAL NEGLIGENCE AND LEGAL REMEDIES* 2 (2004).

131. *Id.* at 5.

132. See, e.g., Gerard F. Anderson et al., *It’s the Prices, Stupid: Why the United States Is So Different from Other Countries*, 22 *HEALTH AFF.* 89 (2003).

should be commended for creating these forums, in practice, medical negligence suits in consumer forums now impose many of the same burdens as civil litigation: delays, difficulty securing medical records and expert testimony, low success rates, and very modest compensation. In this section, I describe how the consumer forums function and the obstacles U.S. patients might encounter.

i. Creating an Alternative to Civil Litigation

In 1986, the Parliament of India passed the Consumer Protection Act,¹³³ implementing the United Nations' 1985 Consumer Protection Resolution.¹³⁴ The Act was hailed as a "remarkable piece of legislation" because it created an economical, quasi-judicial alternative for resolving consumer grievances in a country that sorely needed it.¹³⁵ Although it took several years to clarify that the Act applied to medical malpractice cases,¹³⁶ it has since become the most well-known law among medical practitioners in India.¹³⁷ Indeed, the Act is a source of anxiety for physicians precisely because it supplants India's notoriously protracted civil litigation system, in which plaintiffs might have to wait well over ten years for a case to be resolved.¹³⁸

The Act established three tiers of consumer forums—district, state, and national.¹³⁹ States have established at least 604 District Forums and 34 State Commissions.¹⁴⁰ The Parliament structured these forums to be "quicker and less costly" alternatives to civil litigation.¹⁴¹ None of the forums utilize juries; decisions are made by panels of "members" and a president. Each tier generally appoints members with both judicial and non-judicial backgrounds, in line with

133. The Consumer Protection Act, 1986, No. 68, Acts of Parliament, 1986.

134. G.A. Res. 39/248, U.N. Doc. A/RES/39/248 (Apr. 16, 1985). This resolution asked signatories, particularly developing countries like India, to improve consumer protection laws, including "measures enabling consumers to obtain redress." *Id.*

135. Bharat Jayaraj, *A Forum for Redressal*, HINDU FOLIO, Oct. 31, 1999, available at <http://www.hinduonnet.com/folio/fo9910/99100100.htm>.

136. Consumer forums began operating in 1987. In 1992, the National Consumer Disputes Redressal Commission announced that the Act applied to medical services, and in 1995 the Indian Supreme Court affirmed. *See Indian Med. Ass'n v. V.P. Shantha*, A.I.R. 1996 S.C. 550.

137. Ramesh Bhat, *Regulation of the Private Health Sector in India*, 11 INT'L J. HEALTH PLAN. & MGMT. 253, 262 (1996).

138. Sanjay Kumar, *India: Doctors Dispute Trader Role*, 340 LANCET 1400 (1992).

139. The Consumer Protection Act, 1986, No. 68, Acts of Parliament, 1986.

140. National Consumer Disputes Redressal Commission, Addresses of the State Consumer Disputes Redressal Commissions, <http://www.ncdrc.nic.in/sDetails.html>; National Consumer Disputes Redressal Commission, District Forums, <http://www.ncdrc.nic.in/districtforums.html> (the database does not include information for the state of Manipur).

141. Bhat, *supra* note 137, at 264.

the forum's quasi-judicial nature.¹⁴² And each tier has original jurisdiction to hear complaints based on the damages claimed.¹⁴³ For example, District Forums may hear complaints claiming compensation up to two million rupees (roughly \$43,500).¹⁴⁴ State Commissions hear complaints seeking compensation between two million and ten million rupees (between \$43,500 and \$217,700).¹⁴⁵ The National Commission hears complaints seeking more than ten million rupees (\$217,700).¹⁴⁶ These ranges were raised significantly in 2002.¹⁴⁷ Both the State and National Commissions also have appellate jurisdiction to hear appeals from subordinate forums.¹⁴⁸

In structuring these forums, the Indian Parliament tried to balance the convenience of non-judicial forums with the legitimacy of courts. For example, the Act vests consumer forums with the power to summon witnesses, receive affidavits, request laboratory tests, and review other documentary and material evidence.¹⁴⁹ In fact, the Act deems each consumer forum to be a "civil court"¹⁵⁰ and every proceeding is a "judicial proceeding" under the Indian Code.¹⁵¹ Despite these grants, National Commission regulations recognize that a consumer forum is "not a regular court."¹⁵²

ii. Causes of Action

The Act empowers consumers in India to bring six different causes of

142. For example, the president of each District Forum must be a current or former District Judge, or someone who is "qualified" to be one. *See* The Consumer Protection Act § 10(1)(a), No. 68 of 1986, *available at* http://ncdrc.nic.in/1_1.html.

143. The Consumer Protection Act §§ 9-27A, No. 68 of 1986, *available at* http://ncdrc.nic.in/1_1.html.

144. *Id.* § 11(1). I calculated the U.S. dollar equivalents using the Federal Reserve Bank's historical foreign exchange rates for the Indian rupee as of September 15, 2008. *See* Federal Reserve Statistical Release H.10, Foreign Exchange Rates (Weekly), Historical Rates for India, http://www.federalreserve.gov/releases/h10/hist/dat00_in.htm.

145. The Consumer Protection Act § 17(1)(a)(i), No. 68 of 1986, *available at* http://ncdrc.nic.in/1_1.html.

146. *Id.* § 21(a)(i).

147. The Consumer Protection (Amendment) Act, 2002, No. 62, Acts of Parliament, 2002.

148. The Consumer Protection Act §§ 17(1)(a)(ii), 21(a)(ii), No. 68 of 1986, *available at* http://ncdrc.nic.in/1_1.html.

149. The Consumer Protection Act § 13(4), No. 68 of 1986, *available at* http://ncdrc.nic.in/1_1.html.

150. *Id.* § 13(5).

151. *Id.*

152. National Consumer Disputes Redressal Commission, Consumer Protection Regulations, 2005, § 3(1), *available at* <http://ncdrc.nic.in/Regulations2005.html> [hereinafter Consumer Protection Regulations].

action.¹⁵³ The most common cause of action used by patients is that medical services “suffer from deficiency in any respect.”¹⁵⁴ The Act defines “deficiency” broadly to mean “any fault, imperfection, shortcoming or inadequacy in the quality, nature and manner of performance.”¹⁵⁵ Of course, the trick for consumer forums is determining whether a physician provided services that were indeed faulty, imperfect, or inadequate. This language is widely considered to be a negligence standard, even though a separate provision in the Act awards damages for any loss or injury due to “negligence.”¹⁵⁶

The Act exempts complaints for services provided “free of charge or under a contract of personal service.”¹⁵⁷ Despite longstanding arguments by physicians that this exemption excluded medical services from the Act, the Indian Supreme Court held that the Act allows consumers to sue private (and sometimes public) physicians.¹⁵⁸ Of course, physicians criticized the Supreme Court’s opinion.¹⁵⁹ In response, one physician castigated his colleagues for their “God complexes” and implored them to embrace the Act for the sake of patients.¹⁶⁰

iii. Truncated Procedures, But Delays

Parliament created truncated procedures so consumer forums could dispose of cases quickly. The Act gives consumers two years to file a complaint from when the cause of action arose.¹⁶¹ Forums must hear complaints “as expeditiously

153. *Id.* § 2(c).

154. *Id.* § 2(c)(iii).

155. *Id.* § 2(g).

156. *Id.* § 14(d); see, e.g., Bhat, *supra* note 137, at 265; K.K.S.R. Murthy, *Medical Negligence and the Law*, INDIAN J. MED. ETHICS, Jul.-Sept. 2007, available at <http://www.issuesinmedicalethics.org/153oa116.html>; Talha Abdul Rahman, *Medical Negligence and Doctors’ Liability*, INDIAN J. MED. ETHICS, Apr.-June 2005, available at <http://www.issuesinmedicalethics.org/132hl060.html>.

157. National Consumer Disputes Redressal Commission, *supra* note 152, § 2(1)(o) (defining “service”); Bhat, *supra* note 137, at 264.

158. *Indian Med. Ass’n v. V.P. Shantha*, A.I.R. 1996 S.C. 550, 567-68 (holding that service rendered to a patient by a doctor qualifies as “service” under the Consumer Protection Act and that patients in Employee State Insurance hospitals and dispensaries could sue under the Act because patients partially pay for treatments); Khomba Singh, *Government Working on Framing Clinical Guidelines for Doctors*, ECON. TIMES (India), May 2, 2008, available at 2008 WLNR 8113374.

159. Bhat, *supra* note 137, at 265.

160. Mangesh Jalgaonkar, *Consumer Protection Act: An Introspection by a General Practitioner*, INDIAN J. MED. ETHICS, Nov. 2007, available at <http://www.issuesinmedicalethics.org/022mi012.html> (“Patients used to consider us as Gods. We still believe ourselves so.”).

161. The Consumer Protection Act § 24A(1), No. 68 of 1986, available at http://ncdr.nic.in/1_1.html. Forums may accept complaints beyond two years if the party shows “sufficient cause.” *Id.* § 24A(2).

as possible” and must attempt to resolve them within three months from receiving the defendant’s response.¹⁶² The Act anticipates that, from start to finish, complaints should be resolved within five-and-a-half to six months of being filed, subject to limited “adjournments.”¹⁶³

In reality, very few cases resolve this quickly. Critics complain that delays cripple India’s consumer forums because forums rarely resolve cases within the recommended deadlines.¹⁶⁴ Although the Act calls for forums to resolve complaints within three months of hearing arguments, “cases are likely to take two or three years.”¹⁶⁵ The Department of Consumer Affairs estimated that only 27% of cases were resolved within the three-month period required by the Act.¹⁶⁶ Although these delays may not be what Parliament envisioned, the timeframes still compare favorably to the 4.88 years it takes on average for payouts in the United States.¹⁶⁷

The forums have tried to mitigate delays, with minimal success. Regulations require each District Forum to resolve “at least 75 to 100 matters every month.”¹⁶⁸ The National Commission boasts that all three tiers of consumer forums have disposed of a large portion of their cases.¹⁶⁹ Yet delays remain a concern in India, as shown by the sheer number of pending cases. For example, in September 2007, there were 723 pending cases in Chennai (North) District Forums and 1,372 in Chennai (South).¹⁷⁰ Karnataka boasted that its State Commission had resolved 95.4% of cases and that its District Forums had resolved 96.9%.¹⁷¹ But these clearance percentages may be misleading because it appears that states and districts are calculating the number of cases resolved against every complaint that the forums have *ever* entertained—meaning that

162. *Id.* § 13(3A). The Act gives a five-month timeframe for cases that require products to be tested by laboratories, but it is not clear if this would apply to many malpractice cases.

163. *Id.* §§ 12-14.

164. Jayaraj, *supra* note 135; *Consumer Laws Implementation*, HINDU (India), Nov. 6, 2007, available at 2007 WLNR 21848658.

165. See Tim Ensor & Sabine Weinzierl, *Regulating Health Care in Low- and Middle-Income Countries: Broadening the Policy Response in Resource Constrained Environments*, 65 SOC. SCI. & MED. 355 (2007) (noting that in the state of Andhra Pradesh, cases typically take three to four years); *Consumer Laws Implementation*, *supra* note 164.

166. K. Srinivasan, *A New Era in Consumerism*, HINDU FOLIO (India), Oct. 31, 1999, available at <http://www.hinduonnet.com/folio/fo9910/99100060.htm>.

167. See NPDB ANNUAL REPORT, *supra* note 98, at 8.

168. Consumer Protection Regulations, *supra* note 152, § 19(1).

169. NCDRC, Total Number of Consumer Complaints Filed/Disposed Since Inception Under Consumer Protection Law, http://ncdrc.nic.in/statistics_files/sheet006.html (posting cases resolved as of Nov. 13, 2009) (last visited Nov. 22, 2009).

170. *Consumer Laws Implementation*, *supra* note 164.

171. *Consumer Forums Clear 95 Per Cent of Cases*, HINDU (India), Dec. 24, 2006, available at 2006 WLNR 23781013.

over time, the clearance rates will naturally inflate. To illustrate, despite 95% to 97% clearance rates in Karnataka, 977 cases were still pending before its State Commission, and 2982 cases were pending in its District Forums.¹⁷² Observers argue that these delays deter consumers from filing complaints in the first place,¹⁷³ though it is not clear whether a three to four year delay would deter U.S. patients.¹⁷⁴

iv. The Obstacles to Proving Negligence

Delays may deter claims, but patients in India might be even more disheartened by other obstacles to proving malpractice in consumer forums. As in most countries, patients in India alleging medical negligence must bear the burden of proving it.¹⁷⁵ This burden does not seem unreasonable until we account for two major obstacles. First, it is extremely difficult for patients to find a qualified medical expert willing to testify that a colleague was negligent. Second, physicians and hospitals make it difficult for patients to obtain medical records and other information about the services in dispute.

First, physician defendants easily find experts to testify on their behalf, but plaintiffs have “faced problems in getting qualified medical practitioners to testify on their behalf,” and most have been “ultimately unable to furnish qualified witnesses to support their claim.”¹⁷⁶ A plaintiff’s lawyer who has tried more than 1,000 consumer forum cases said that malpractice cases often fail because “[i]n most of these cases, the expert opinion provided by the Indian Medical Association are always in favour of doctors and hospitals, even if they have erred.”¹⁷⁷ Thus, patients claiming damages for medical negligence in consumer forums are often unable to prove their allegations because physicians are unwilling to testify against other physicians.¹⁷⁸ One observer notes that “patients are clearly at a disadvantage because of lack of on-the-record testimony

172. *Id.*

173. *Consumer Laws Implementation*, *supra* note 164.

174. American patients suing in U.S. courts might be more patient waiting for judgment or settlement because they anticipate a relatively large recovery; American patients suing in India’s consumer protection forums may be less patient if they anticipate relatively small recoveries by U.S. standards.

175. KAUSHAL, *supra* note 130, at 12, 26.

176. Bhat, *supra* note 137, at 265.

177. *His Brief Is Different*, HINDU (India), Sept. 17, 2005, available at 2005 WLNR 14689221.

178. Ganapati Mudur, *Indian Doctors Not Accountable, Says Consumer Report*, 321 BRIT. MED. J. 588 (2000). Although securing expert medical testimony can be a challenge in most jurisdictions, including the United States, it is especially so in India, where there are many fewer physicians per capita.

by doctors and also a lack of relevant medical documents.”¹⁷⁹ In 2003, the President of the Consumer Information Center said that “it is very difficult to prove an act of negligence” because “[m]ost doctors never speak against their fellow medical practitioners even if they are guilty.”¹⁸⁰

Some observers worry that consumer forums do not have the requisite expertise or resources to handle complex medical cases.¹⁸¹ A State Consumer Affairs Minister agreed that consumer forums need outside medical experts in negligence cases—possibly an independent advisory panel.¹⁸² Currently, civil courts can ask experts from government medical colleges to testify, but consumer courts lack this authority.¹⁸³ Others have echoed this recommendation, proposing that a panel convene monthly to hear all the medical negligence cases on a forum’s docket, or alternatively, proposing that forums assign an additional medical expert to each two-member panel.¹⁸⁴ One malpractice expert in India even suggested that forums could require complaints to append a supporting expert opinion affidavit.¹⁸⁵ Such a recommendation would likely preclude many legitimate complaints, given the widely-acknowledged difficulty that patients have securing expert testimony of any kind. At least one high court has urged courts not to speculate about medical practices, concluding that court opinions must be supported by some expert evidence.¹⁸⁶

Second, patients have difficulty proving medical negligence in India’s consumer forums because hospitals and physicians often refuse to provide medical records or other information about the services in dispute. Providers regularly fail to give patients written records of the diagnoses they receive, the medicines they consume,¹⁸⁷ or their course of treatment.¹⁸⁸ Historically, no laws in India have required medical professionals to provide such information to patients or their families.¹⁸⁹ It was not until 2002 that Indian Medical Council

179. *Id.* at 588.

180. *Straight Answers*, ECON. TIMES (India), Oct. 1, 2003, *available at* 2003 WLNR 4449878.

181. Bhat, *supra* note 137, at 265.

182. Debashis Konar, *Courting Crisis: Medico Cases in the Docks*, TIMES INDIA, Apr. 23, 2005, *available at* 2005 WLNR 6358838.

183. *Id.* Dr. K. Mathihran doubts that many civil courts actually exercise this option. Letter from K. Mathihran, Professor, Institute of Legal Medicine (Chennai, India), to Nathan Cortez, Assistant Professor, Southern Methodist University, Dedman School of Law (Jan. 4, 2009) (on file with author).

184. KAUSHAL, *supra* note 130, at 6-7.

185. *Id.* at 66.

186. Dr. C.J. Subramania v. Kumarasamy, I (1994) C.P.J. 509, ¶ 28; KAUSHAL, *supra* note 130, at 67.

187. Bhat, *supra* note 137, at 265.

188. Nayak, *supra* note 7, at 22.

189. *Id.* at 22; KAUSHAL, *supra* note 130, at 24. Note, however, that in 1996, the Bombay High Court held that physicians and hospitals must provide medical records to patients or their close

regulations required physicians to maintain patient records for three years and provide them upon request.¹⁹⁰ However, it is unclear whether the Medical Council has enforced these new requirements. Thus, access to basic information about one's course of treatment remains alien to most patients in India.¹⁹¹

This unfortunate reality only compounds plaintiffs' burden of persuasion, because most patients will find it nearly impossible to convince an expert to testify that a physician was negligent without the benefit of at least some written records describing the procedure and its outcome.¹⁹² Notably, the National Commission has held that a hospital's failure to supply medical records is not actionable as a "deficiency in service" under the Consumer Protection Act because no law in India created a legal duty to provide these records.¹⁹³ However, the 2002 Medical Council regulations that require physicians to keep patient records and provide them upon request might enable such a cause of action.¹⁹⁴ The Medical Council may remove physicians from the Indian Medical Register if a physician refuses to maintain or provide records,¹⁹⁵ but this is a punishment the Council rarely employs.¹⁹⁶ Even though India's Central Consumer Protection Council "has periodically urged the Indian health ministry to make it mandatory for all hospitals to provide medical records to patients," in practice, hospitals still refuse such requests.¹⁹⁷ In 2003, the Medical Council in the state of West Bengal passed its own new Code of Medical Ethics requiring physicians to keep records for every patient for at least three years.¹⁹⁸ Interestingly, one of the putative purposes of the new Code was to speed up decisions in medical negligence

relatives when requested. *Raghunath G. Raheja v. Maharashtra Med. Council*, A.I.R. 1996 Bom. 198, 203; K. Mathiharan, *Medical Records*, INDIAN J. MED. ETHICS, Apr.-Jun. 2004, available at <http://www.issuesinmedicalethics.org/122hl059.html>

190. Medical Council of India, Code of Ethics Regulations, 2002, § 1.3, Apr. 6, 2002, <http://www.mciindia.org/know/rules/ethics.htm> [hereinafter Code of Ethics Regulations].

191. Nayak, *supra* note 7, at 22.

192. KAUSHAL, *supra* note 130, at 27 (citing *Dr. Shyam Kumar v. Rameshbhai, Harmanbhai Kachhiya*, 2002 (1) C.P.R. 320).

193. *Poona Medical Foundation v. Maruttrao Tikare*, 1995 (1) C.P.R. 661 (NC); KAUSHAL, *supra* note 130, at 27; Mathiharan, *supra* note 189.

194. Code of Ethics Regulations, *supra* note 190, § 1.3.

195. *Id.* §§ 7.2, 8.3. The Register is a nationwide registry of physicians with recognized credentials. See The Indian Medical Council Act §§ 21, 23, No. 102 of 1956, available at <http://www.mciindia.org/know/acts/acts.htm>; Medical Council of India, MCI Regulations, 2000, §§ 61-67, Nov. 15, 2000, <http://mciindia.org/know/rules/regulate2000.htm> [hereinafter MCI Regulations].

196. Bhat, *supra* note 137, at 270.

197. Mudur, *supra* note 178, at 588.

198. Aditya Ghosh, *Negligence Cases Pile Up at Medical Council*, ECON. TIMES (India), Feb. 17, 2004, available at 2004 WLNR 7027823.

cases.¹⁹⁹ But the West Bengal Medical Council seemed to be looking out for its own constituents—an officer with the Council said that doctors were disadvantaged in negligence cases because most of the documentary evidence was produced by patients.²⁰⁰ By mandating that doctors keep better records, the West Bengal Medical Council is trying to ensure that physicians control more of the evidence instead of relying on the documentation of patients. There may be a move toward more disclosure in India, but this move is by no means a revolution motivated solely by an interest in protecting patients.

Some patients have sued for alleged manipulation of their medical records,²⁰¹ but these cases seem to be rare. Thus patients in India “are not in a position to build a case with the necessary information and documents as evidence.”²⁰² Although consumer forums recognize the doctrine of *res ipsa loquitur*²⁰³—which allows a forum to presume negligence when the injury could not have occurred otherwise—this does not compensate for the significant hurdles that often preclude patients from accessing expert witnesses and medical records.

v. Limited Compensation

Perhaps the biggest practical obstacle for U.S. patients seeking recourse in India is the very modest compensation awarded. Not only does the Consumer Protection Act not recognize non-economic damages like pain and suffering²⁰⁴ that often amplify recoveries in U.S. courts, but the awards themselves are simply magnitudes lower.

As a structural matter, the Act allows consumer forums to award several forms of compensation. In medical malpractice cases, the most common form is damages “for any loss or injury suffered by the consumer due to the negligence of the opposite party.”²⁰⁵ The Act also allows forums to grant punitive damages “in such circumstances as it deems fit.”²⁰⁶ Finally, the Act empowers forums to “provide adequate costs to parties.”²⁰⁷ It is unclear how often consumer forums actually grant punitive damages or costs. Recently, the Indian Supreme Court

199. *Id.*

200. *Id.*

201. KAUSHAL, *supra* note 130, at 27-28; Mathiharan, *supra* note 189.

202. Bhat, *supra* note 137, at 265.

203. Janak Kantimathi Nathan v. Murlidhar Eknath Masane, 2002 (2) C.P.R. 138, *available at* <http://ncdrc.nic.in/fa7391994.html>.

204. Harjol Ahluwalia v. Spring Meadows Hosp., 1986-1999 Consumer 4457 (NS); Spring Meadows Hosp. v. Harjol Ahluwalia (1998) 4 S.C.C. 39.

205. The Consumer Protection Act § 14(1)(d), No. 68 of 1986, *available at* http://ncdrc.nic.in/1_1.html.

206. *Id.*

207. *Id.* § 14(1)(i).

held that awards in consumer forums should not only compensate patients but should aim to do justice by changing the attitudes of deficient service providers.²⁰⁸ Nevertheless, forums are not explicitly authorized to grant damages for pain and suffering or most other forms of non-economic damages.²⁰⁹ Indian consumer forums have discretion to “serve ends of justice,”²¹⁰ but non-economic damages are not widely accepted.

As a practical matter, India’s consumer forums simply award much lower compensation than U.S. courts do. There is no reliable data of recovery amounts as there is in the United States, but anecdotal evidence in cases and media reports suggest much lower compensation. In fact, major national newspapers in India report malpractice awards that would barely warrant local media coverage here in the United States. For example, the Times of India, the highest circulating English language newspaper in the world,²¹¹ reported that a consumer forum awarded 250,000 rupees (\$5443) to the family of a patient who died during an appendicitis operation.²¹² My review of other media reports shows similarly modest awards making national news: 80,000 rupees for a faulty eye operation (\$1742),²¹³ 100,000 rupees for an eye operation that resulted in death (\$2177),²¹⁴ and 80,000 rupees for leaving a needle inside the body after surgery (\$1742).²¹⁵ Other publications also report awards in these ranges, indicating that payouts of this magnitude are considered newsworthy.²¹⁶ There have been significantly higher awards, but these appear to be the exception rather than the rule.²¹⁷

Importantly, compensation is modest in India compared to the United States for largely the same reasons that medical care costs so little. The basic inputs

208. Charan Singh v. Healing Touch Hosp., A.I.R. 2000 S.C. 3138, 3142.

209. *Id.*

210. *Id.*

211. *Times Now Masthead of the World*, TIMES INDIA, June 27, 2005, available at 2005 WLNR 10154745.

212. *Dead Patient’s Kin Get Rs. 2.5 Lakh*, TIMES INDIA, May 24, 2006, available at <http://timesofindia.indiatimes.com/city/delhi/Dead-patients-kin-get-Rs-25-lakh/articleshow/1549786.cms> (last visited Nov. 22, 2009). For an explanation of how I calculated the U.S. Dollar equivalents, please see note 144, *supra*.

213. Konar, *supra* note 182.

214. *Id.*

215. *His Brief Is Different*, *supra* note 177.

216. See, e.g., KAUSHAL, *supra* note 130, at 71-72 (reporting awards of \$2612 for negligent death, \$2721 for an injury resulting in an amputated leg, and \$2177 for negligent death). Kaushal reports similar awards in a digest of cases. *Id.* at 120-216.

217. For example, in *Harjol Ahluwalia v. Spring Meadows Hospital*, 1986-1999 Consumer 4457 (NS), the National Commission awarded Rs.1,250,000 for medical negligence by a nurse, a physician, and a hospital. The National Commission further awarded Rs.500,000 for mental agony suffered by the parents of the minor. On appeal, the Supreme Court upheld the order. *Spring Meadows Hosp. v. Harjol Ahluwalia*, (1998) 4 S.C.C. 39.

contributing to the cost of medical care are higher in the United States than in other countries.²¹⁸ Thus, it is unrealistic for U.S. patients to expect to pay third world prices for medical care, but receive first world compensation if something goes wrong. The prices of wages and other inputs simply do not support U.S.-like compensation. Yet, even some Indian consumers are not happy with the compensation awarded by consumer forums, ironically in part because they hope to receive a huge, “American-like compensation.”²¹⁹

vi. Few Patients Succeed

There are no reliable, comprehensive, and recent estimates of how medical malpractice complaints fare in India’s consumer forums, but the best available sources suggest they do not fare well. Between 1988 and 1998, only 73 out of 302 cases (24%) reported by the State Commissions, the National Commission, and the Supreme Court awarded compensation.²²⁰ Another report estimated that 71% of malpractice cases resolved by the Gujarat State Commission between 1990 and 1994 were resolved in favor of the physician.²²¹ In 1998, even the Indian Medical Association estimated that district forums dismissed more than 90% of the 10,000 medical malpractice cases filed in a two year period.²²² This data does not, on its face, support the contention by physicians that the Consumer Protection Act treats them unfairly.²²³

The final barrier to efficient and effective recourse as envisioned under the Consumer Protection Act derives from the difficulty of enforcing judgments. Indian consumers used to face “enormous difficulty” enforcing orders by the consumer forums,²²⁴ and recovery could be “tedious.”²²⁵ Even though the original Act empowered forums to enforce judgments as if they were courts,²²⁶ it did not

218. See, e.g., Anderson et al., *supra* note 132 (using OECD data to compare health spending in the United States and twenty-nine other countries, not including India).

219. *His Brief Is Different*, *supra* note 177.

220. Letter from K. Mathiharan, Professor, Institute of Legal Medicine (Chennai, India), to Nathan Cortez, Assistant Professor, Southern Methodist University, Dedman School of Law (Jan. 4, 2009) (on file with author).

221. Ramesh Bhat, *Regulating the Private Health Care Sector in India: The Case of the Indian Consumer Protection Act*, 11 HEALTH POL’Y & PLAN. 266, 275 (1996); Bhat, *supra* note 137, at 265.

222. Ganapati Mudur, *Indian Doctors Call for Protection Against Patients’ Complaints*, 316 BRIT. MED. J. 1558 (1998); see also Howze, *supra* note 26, at 1034 (estimating that 95% of medical malpractice cases are dismissed).

223. Bhat, *supra* note 221, at 269; Bhat, *supra* note 137, at 265.

224. Jayaraj, *supra* note 135.

225. *Id.*

226. The Consumer Protection Act § 25, 1986, No. 68, Acts of Parliament, 1986.

allow forums to attach the property of non-complying parties.²²⁷ To attach a property, consumer forums had to transfer the case to civil court, creating another procedural hurdle.²²⁸ However, recent amendments vest consumer forums with new enforcement powers. For example, the forums may attach the property of non-complying parties or may even impose criminal penalties, such as imprisonment up to three years or a fine up to ten thousand rupees (\$217).²²⁹ Nevertheless, it remains to be seen whether consumer forums will use these new powers or if the gap between the well-intentioned language of the Act and reality will persist. One physician summarized the recent atmosphere in India as “absolute chaos.”²³⁰

In summary, India’s consumer forums serve as an efficient alternative to civil litigation, although medical malpractice cases can bog down as they do in civil courts. Nevertheless, they still provide a crucial alternative to India’s notoriously protracted civil litigation system. And though both domestic and foreign patients may struggle to secure expert testimony or access their own medical records, the biggest impediment to U.S. patients recovering satisfactory compensation in India’s consumer forums is the comparatively small recoveries they award. Thus, patients visiting India should know that although consumer forums provide a palatable alternative to civil litigation, this alternative provides understandably modest compensation.

b. Civil Courts

Civil courts in India have morphed into a depository for malpractice cases that cannot or will not be entertained by consumer forums. For example, tort law in India allows patients to sue for medical negligence even if the service was provided free of charge, which would disqualify it from consumer forum jurisdiction.²³¹ More importantly, consumer forums sometimes transfer complex medical negligence cases to civil courts.²³² In *Herambalal Das v. Dr. Ajoy Paul*, a consumer forum declined to hear a complaint arising from an allegedly

227. *Id.*; Jayaraj, *supra* note 135.

228. The Consumer Protection Act § 25, 1986, No. 68, Acts of Parliament, 1986; Jayaraj, *supra* note 135.

229. Consumer Protection Act § 27(1). For the methodology I used to calculate exchange rates, see *supra* note 144.

230. George Thomas, *Consumate Justice or Complete Folly? Doctors and Consumer Protection Act*, ISSUES MED. ETHICS, Apr.-June 2002, at 28, available at <http://www.issuesinmedicalethics.org/102le028.html>.

231. Rahman, *supra* note 156.

232. See *Herambalal Das v. Dr. Ajoy Paul*, 2001 (2) C.P.R. 498, 498 (dismissing medical malpractice claim while granting liberty to complainant “to seek remedy before the appropriate Forum”).

deficient cataract surgery,²³³ referring the case to civil court because the physicians may have manipulated and fabricated the medical records, which required the consumer forum to take elaborate oral and documentary evidence beyond the forum's expertise.²³⁴ Another consumer forum referred a case to civil court because the dispute would have taken too long to resolve.²³⁵ There does not appear to be any predictable doctrinal framework that guides the decisions of consumer forums to transfer cases to civil courts.

Liability for medical negligence in civil courts derives in part from India's Fatal Accidents Act, which compensates the heirs of those killed by an actionable wrong.²³⁶ Liability also derives from the common law. Indian courts seem to use the same formula that U.S. courts generally use in malpractice cases, looking at duty, breach, causation, and damages.²³⁷ But India's legal system derives from the English system, and as a result, Indian courts generally follow the decisions of English courts.²³⁸ In medical negligence cases, Indian courts adhere to the controversial *Bolam* and *Bolitho* decisions.²³⁹ *Bolam v. Friern Hospital Management Committee*, a 1957 English trial court opinion, and *Bolitho v. City & Hackney Health Authority*, a 1998 House of Lords opinion, altered the standards for proving medical negligence, requiring a judgment for the defendant if any "expert" concludes the physician's actions were appropriate. These rulings have been criticized for making courts overly reliant on medical testimony and permitting negligent doctors to escape liability if they can find one expert to testify on their behalf.²⁴⁰

Perhaps the most significant hurdle for patients in civil courts is their infamous delays. Plaintiffs may wait well over ten years for a case to conclude.²⁴¹

233. *Id.*; KAUSHAL, *supra* note 130, at 27-28.

234. *Herambalal Das*, 2001 (2) C.P.R. at 498-99.

235. *See Basudev Goswami v. Dr. Bhaskar Das*, 2001 (2) C.P.R. 501, 503 (agreeing with decision of Consumer Forum to dismiss case where "adjudication of the dispute in hand cannot be done within a time frame"); KAUSHAL, *supra* note 130, at 28.

236. The Fatal Accidents Act § 1A, No. 13 of 1855, available at <http://indiacode.nic.in/fullact1.asp?tfnm=185513>. The Act does not specify that it applies to medical negligence cases, but courts have interpreted the statute broadly and have awarded damages to the heirs of deceased patients. *See Dr. Laxman Balkrishna Joshi v. Dr. Trimbak Bapu Godbole*, A.I.R. 1969 S.C. 128; *Amalgamated Coal Fields Ltd. v. Mst. Chhotibai*, (1973) 18 M.P.L.J. 389.

237. KAUSHAL, *supra* note 130, at 11-12; *see W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS* (5th ed. 1984); Nayak, *supra* note 7, at 22.

238. Nayak, *supra* note 7, at 20; Sidhartha Satpathy & Sujata Satapathy, *Medical Negligence or Diagnostic Conundrum? – A Medico-Legal Case Study*, 21 MED. & L. 427, 428 (2002).

239. *Bolitho v. City & Hackney Health Auth.*, [1998] A.C. 232 (H.L.); *Bolam v. Friern Hosp. Mgmt. Comm.*, [1957] 1 W.L.R. 582 (Eng.).

240. *See* Section II.D, *infra*, for a fuller discussion of the criticisms of *Bolam* and its progeny.

241. Kumar, *supra* note 138.

In fact, as noted above, a U.S. court refused to dismiss a case on *forum non conveniens* grounds because the courts in India have such severe delays, possibly even “up to a quarter century.”²⁴² Testimony in that case revealed that an “average” case before the Calcutta High Court would take fifteen to twenty years.²⁴³

Aside from the burdens of civil litigation, there are other reasons patients might prefer India’s consumer forums to its civil courts. First, when litigating a complaint in civil court, the plaintiff cannot file a parallel claim in a consumer forum.²⁴⁴ Thus, the choice to litigate in civil court effectively precludes a consumer complaint, given the two-year statute of limitations under the Consumer Protection Act. Perhaps more importantly, some Indian courts have expressed unabashed hostility toward medical negligence cases. In 2004, a justice of the Calcutta High Court criticized the rise in medical negligence cases, claiming that the entire medical system would collapse if physicians were harassed by lawsuits.²⁴⁵ Though such hostility certainly is not limited to judges, criticisms of medical negligence claims by judicial officers indicates the type of legal environment medical tourists must be prepared to encounter.

c. Self-Regulation by Medical Councils

India’s medical councils ostensibly govern medical practice in India. The primary professional organization for physicians is the Medical Council of India.²⁴⁶ On several occasions, the Indian Parliament has granted more statutory powers to the Medical Council to “make it an effective regulatory body.”²⁴⁷ The Medical Council sets and maintains standards for medical education and credentialing²⁴⁸ and runs the Indian Medical Register of physicians with recognized credentials.²⁴⁹ As health regulation is decentralized in India, several

242. *Bhatnagar v. Surrendra Overseas Ltd.*, 52 F.3d 1220, 1226-27 (3d Cir. 1995) (reporting that experts who testified about India’s legal system “provided both statistical and anecdotal evidence documenting litigation delays” there); *Mirr-Singer*, *supra* note 21, at 224.

243. *Bhatnagar*, 52 F.3d at 1228.

244. KAUSHAL, *supra* note 130, at 69.

245. *Hasty Negligence Pleas Annoy High Court*, *ECON. TIMES* (India), Jan. 23, 2004, available at 2004 WLNR 6999762.

246. The Indian Medical Council Act, 1933, No. 27, Acts of Parliament, 1933, *repealed by* Indian Medical Council Act, 1956, No. 102, Acts of Parliament 1956 (amended by the Indian Medical Council (Amendment) Acts of 1964, 1993, and 2001).

247. Bhat, *supra* note 137, at 269.

248. Medical Council of India, Introduction, http://www.mciindia.org/know/mci/mci_intro.htm (last visited Nov. 22, 2009).

249. *Id.*; The Indian Medical Council Act §§ 21, 23, 1956, No. 102, Acts of Parliament, 1956; MCI Regulations, *supra* note 195, §§ 61-67.

states have parallel state medical councils that also register physicians.²⁵⁰ However, India's medical councils are more useful in theory than in practice. The councils have lost their influence because few physicians are active members, and most ignore the councils' guidelines.²⁵¹ Unsurprisingly, Indian patients do not trust the medical councils to regulate physicians.²⁵²

First, the councils are intended to regulate members and promote compliance,²⁵³ but the Medical Council of India is often criticized for protecting its members rather than the public.²⁵⁴ Critics note that "the Medical Council of India has a poor record in dealing with malpractice, and it cannot award compensation or pass criminal sentences."²⁵⁵ Council regulations identify forms of misconduct that can trigger disciplinary action.²⁵⁶ For example, the Council can punish physicians by removing their names from the register.²⁵⁷ Nevertheless, the list of actionable offenses is generally incomplete, outdated, and does not identify a range of punishments to fit offenses of vastly different severity.²⁵⁸

Of course, the most glaring weakness with self-regulation by medical councils is the conflict of interest created when the foxes guard the henhouse. The Council's Code of Ethics Regulations requires disciplinary cases to be judged by "peers."²⁵⁹ One critic of the Medical Council's oversight explains:

There have been few instances of medical councils intervening and initiating disciplinary action against members of their profession even when there is a formal complaint of negligence. Informal discussions with one of the council members revealed that not many councils have suspended the registration of any member even though many complaints are received by the council. In the case of one council, inquiry was initiated in only three cases and, in those, no disciplinary action has been taken."²⁶⁰

In 1996, the Supreme Court handed down its landmark decision, *Indian Medical Ass'n v. V.P. Shantha*, which ruled in favor of those who had criticized the self-regulation of the medical profession by clarifying that the Consumer

250. Bhat, *supra* note 137, at 269.

251. *Id.* at 264.

252. Ensor & Weinzierl, *supra* note 165, at 359.

253. Bhat, *supra* note 137, at 269.

254. *Id.* at 270.

255. Kumar, *supra* note 138; Bhat, *supra* note 223, at 269.

256. Code of Ethics Regulations, *supra* note 190, § 7.

257. Indian Medical Council Act § 24(1), 1956, No. 102, Acts of Parliament, 1956.

258. Code of Ethics Regulations, *supra* note 190; Bhat, *supra* note 137, at 270.

259. Code of Ethics Regulations, *supra* note 190, § 8.6.

260. Bhat, *supra* note 137, at 270.

Protection Act applies to medical services.²⁶¹ The Medical Council of India has been castigated by consumer groups, the Supreme Court, and even physicians for being corrupt and for not punishing its own members.²⁶² A neurosurgeon declared at a public meeting on medical ethics that the national and state councils “are inefficient and corrupt.”²⁶³ The medical councils in India are subject to minimal, if any, government oversight,²⁶⁴ and the government will intervene only if the councils do not follow the Medical Council Act.²⁶⁵

In short, the medical councils of India do not regulate the practice of medicine in any meaningful way.²⁶⁶ The councils may fail patients more than anyone, given their unique position to influence practice standards and ethics.²⁶⁷

d. Criminal Prosecution

Physicians in India may be prosecuted criminally, though it is doubtful this deters ordinary negligence. The most common provision used against physicians is section 304A of the Indian Penal Code, which prohibits “causing death by negligence.”²⁶⁸ The Code punishes “[w]hoever causes the death of any person by doing any rash or negligent act” with imprisonment up to two years, or a fine, or both.²⁶⁹ Although this appears to create culpability from simple negligence, the Indian Supreme Court has held that physicians committing a mere error of judgment are not criminally liable under section 304A.²⁷⁰ Rather, the Supreme Court read into section 304A a standard of gross negligence or recklessness.²⁷¹ The Court found a heightened standard in light of two other sections in the Penal Code that absolve accidents resulting from lawful activities performed in good faith, which would cover most medical care.²⁷² Physicians in India obviously

261. *Indian Med. Ass’n v. V.P. Shantha*, A.I.R. 1996 S.C. 550, 567-68. Note that this case originated in part from consumer frustration with the Medical Council’s poor record in disciplining its members. See Lilani Kumaranayake, *The Role of Regulation: Influencing Private Sector Activity Within Health Sector Reform*, 9 J. INT’L DEV. 641, 647 (1997) (noting that consumer groups initiated the litigation in response to the Medical Council’s failures to discipline its members).

262. *Straight Answers*, *supra* note 180; Thomas, *supra* note 230.

263. *Lack of Medical Ethics Deplored*, ECON. TIMES (India), June 25, 2003, available at 2003 WLNR 4399683.

264. Bhat, *supra* note 137, at 270.

265. *Id.*

266. *Id.*

267. *Id.*

268. Indian Penal Code § 304A, 1860, No. 45, Acts of Parliament, 1860.

269. *Id.*

270. *Dr. Suresh Gupta v. Government of N.C.T. of Delhi*, A.I.R. 2004 S.C. 4091; *Mahadev Prasad Kaushik v. State of Uttar Pradesh*, 2008 Criminal Appeal No. 1625.

271. *Dr. Suresh Gupta*, A.I.R. 2004 S.C. 4091.

272. *Id.* Indian Penal Code section 80 absolves any “accident” that results from a lawful act.

were relieved by the Court's opinion.²⁷³

Other provisions in the Indian Penal Code may also punish medical malpractice that does not result in death.²⁷⁴ Although it is not immediately clear how frequently physicians are prosecuted under these latter provisions, they have been invoked in some cases.²⁷⁵

Of course, proving criminal negligence against medical professionals is difficult. In 2005, the Supreme Court held that courts should not hear criminal complaints against physicians without *prima facie* evidence supporting the charge from a competent medical expert.²⁷⁶ As noted earlier, finding such an expert is difficult. The Court also encouraged investigators, often police, to secure an independent medical opinion, preferably from a government physician.²⁷⁷ Most importantly, Indian law departs from most jurisdictions in placing the burden to *collect* evidence of criminal liability on the complainant, even though prosecutors must still prove the case.²⁷⁸ Given weak access to medical records, this evidentiary demand may preclude many prosecutions.²⁷⁹

2. Foreign Patients in India

Although India ostensibly regulates medical practice through consumer forums, civil and criminal liability, and self-regulation by medical councils, each of these systems is flawed. Civil litigation is fraught with delay. Consumer forums present several obstacles. Government regulation is virtually non-existent, and self-regulation by medical councils is inherently problematic. In

Section 88 absolves actions that were not intended to cause death and were performed with consent in good faith for the person's benefit. No. 45 of 1860, INDIAN PEN. CODE §§ 80, 88 (2002); Murthy, *supra* note 156, at 117.

273. Nayak, *supra* note 7, at 21; *Docs Can't Be Culpable*, ECON. TIMES (India), Aug. 6, 2004, available at 2004 WL 7387190.

274. No. 45 of 1860, INDIAN PEN. CODE § 337 (2002) (punishing those who cause "hurt to any person by doing any act so rashly or negligently as to endanger human life, or the personal safety of others"); *id.* § 338 (punishing those who cause "grievous hurt to any person by doing any act so rashly or negligently as to endanger human life, or the personal safety of others").

275. M.R. Hariharan Nair, *Supreme Court Judgment on Criminal Medical Negligence: A Challenge to the Profession*, INDIAN J. MED. ETHICS, Oct.-Dec. 2005, available at <http://www.issuesinmedicalethics.org/134ed110.html>.

276. Jacob Mathew v. State of Punjab, A.I.R. 2005 S.C. 3180; Murthy, *supra* note 156; Nair, *supra* note 275.

277. Nair, *supra* note 275.

278. *Id.*

279. Overall, my research did not reveal much interplay between criminal actions and civil or consumer forum actions. Physicians acquitted in criminal cases may not use the acquittal as evidence in a consumer forum, because the standard in consumer forums is mere negligence rather than gross negligence or recklessness. *Dead Patient's Kin Get Rs. 2.5 Lakh*, *supra* note 212.

short, India's legal and regulatory systems impose few standards on medical practice and generally fail to hold health care providers accountable in any meaningful way.

Notably, the best mechanisms for regulating Indian providers that treat foreign patients may be external sources, such as international accreditation, adverse publicity that might encourage foreign patients to go elsewhere, and contracts with foreign payors that might impose some accountability. That said, all patients in India would benefit from locally-grown oversight. India's state and local governments could do much more to regulate medical practice. However, increased regulation does not seem to be a high priority. India is plagued by extremely pressing public health issues like HIV/AIDS, malaria, a severe shortage of resources, and extreme poverty.²⁸⁰ In a country where someone dies every minute from tuberculosis,²⁸¹ other health priorities obviously loom.

C. Thailand

Thailand is a primary destination for foreign patients. In 2006, it treated an estimated 1.2 million foreigners, more than any other developing country.²⁸² Thailand's Bumrungrad International Hospital itself claims to host some 500,000 foreign patients annually,²⁸³ and the country boasts at least 450 hospitals with internationally trained health care professionals.²⁸⁴ In 2006, Thailand generated roughly \$2.3 billion from treating foreign patients, and revenues grow 40% each year.²⁸⁵ Thailand has also been one of the more aggressive countries courting foreign patients. After the 1997 Asian economic crisis, the Ministries of Public Health and Commerce began coordinating with the Private Hospitals Association to promote Thai hospitals overseas.²⁸⁶ More recently, the government has planned to develop and promote health care centers in Bangkok, Phuket, and

280. WORLD HEALTH ORG., INDIA: NATIONAL HEALTH SYSTEM PROFILE 10, 13 (2002), available at http://www.searo.who.int/LinkFiles/India_CHP_india.pdf.

281. Reuben Granich et al., *Tuberculosis Control in India*, 3 LANCET INFECTIOUS DISEASES 595, 595 (2003).

282. DELOITTE CTR. FOR HEALTH SOLUTIONS, *supra* note 17, at 6 (defining this population as anyone "traveling to another country to seek specialized or economical medical care" as distinct from emergency or unplanned services provided to foreign tourists or expatriates).

283. *Bumrungrad Keeps on Target*, NATION (Thail.), Jan. 14, 2009, available at 2009 WLNR 775459.

284. Arthur Saniotis, *Changing Ethics in Medical Practice: A Thai Perspective*, 4 INDIAN J. MED. ETHICS 24, 24 (2007), available at <http://www.issuesinmedicalethics.org/151ie24.html>.

285. *Id.*

286. Cha-aim Pachanee & Suwit Wibulpolprasert, *Incoherent Policies on Universal Coverage of Health Insurance and Promotion of International Trade in Health Services in Thailand*, 21 HEALTH POL'Y & PLAN. 310, 311-12 (2006).

Chiang Mai.²⁸⁷

But Thailand struggles with an emergent dichotomy, part of which embraces medical tourism and part of which remains uneasy with the drive toward more commercialized, profit-driven medicine.²⁸⁸ Though medical tourism draws new revenues to Thailand, critics argue that it crowds out the medical care available to ordinary Thais.²⁸⁹ There is widespread fear of both a brain and resource drain from the public to the private sector,²⁹⁰ although some dispute the severity of the drain.²⁹¹ Indeed, officials from the Ministry of Public Health have estimated that “the resources needed to provide services to one foreigner may be equivalent to those used to provide services to 4-5 Thais.”²⁹² While the medical tourism industry booms, several provincial public hospitals have closed from lack of resources.²⁹³ There remains a severe shortage of physicians in public hospitals²⁹⁴ because physicians can earn five to ten times as much in private ones.²⁹⁵

287. Joan C. Henderson, *Healthcare Tourism in Southeast Asia*, 7 TOURISM REV. INT’L 115 (2004).

288. Saniotis, *supra* note 284.

289. *See id.* at 25.

290. *Id.*

291. Professor Eungprabhanth notes that the brain drain from the public to the private health care sector in Thailand is not as severe as reported. He offers two possible reasons: first, public hospitals receive a steady stream of new medical graduates who are obligated to work in public hospitals for three years (with very few opting to pay a hefty fine to exempt themselves); and second, provisions in Thai law exempt public but not private hospital physicians from legal liability, allowing public patients to sue the government instead of individual physicians. Memorandum from Prof. Vithoon Eungprabhanth, Consultant for Health Laws and Ethics Ctr., Thammasat Univ., Thailand to Prof. Nathan Cortez, Assist. Prof. of Law, SMU Dedman School of Law (June 14, 2009) (on file with author) [hereinafter Memorandum from Prof. Eungprabhanth].

292. Suwit Wibulpolprasert et al., *International Service Trade and Its Implications for Human Resources for Health: A Case Study of Thailand*, HUM. RESOURCES FOR HEALTH, June 2004, <http://www.human-resources-health.com/content/2/1/10>. Note, however, contrary data from Australian officials, who claim that revenue from one foreign patient can be used to treat two or three Australian patients on waiting lists. *See* David D. Benavides, *Trade Policies and Export of Health Services: A Development Perspective*, in TRADE IN HEALTH SERVICES: GLOBAL, REGIONAL, AND COUNTRY PERSPECTIVES 65 (Nick Drager & Cesar Vieira eds., 2002). Note also that according to Professor Eungprabhanth, many of the large, private hospitals that cater to foreign patients have chosen not to participate in Thailand’s universal health insurance system. *See* Memorandum from Prof. Eungprabhanth, *supra* note 291.

293. Saniotis, *supra* note 284. Note, however, that Professor Eungprabhanth disputes that provincial public hospitals have had to close because of resource constraints. *See* Memorandum from Prof. Eungprabhanth, *supra* note 291.

294. *Id.*; Songphan Singkaew & Songyot Chaichana, *The Case of Thailand*, in INTERNATIONAL TRADE IN HEALTH SERVICES: A DEVELOPMENT PERSPECTIVE 237, 238 (Simonetta Zarrilli & Colette Kinnon eds., 1998).

295. Wibulpolprasert et al., *supra* note 292.

Meanwhile, Thailand recently created a universal health care system by extending coverage to 18.5 million previously uninsured Thais,²⁹⁶ and researchers report that the system “has greatly increased demand for health care.”²⁹⁷ As in other developing countries, Thailand’s public and private sectors wrestle for finite health care resources.

What do these domestic challenges mean for foreign patients? First, the struggle for finite resources exacerbates Thailand’s two-tiered health care system, and Thais may view foreign patients as a drain on health care resources rather than as a source that might replenish them. Second, Thai courts and the legislature might be more concerned about local public health issues and could have little sympathy for foreign patients seeking relatively large malpractice awards. As in India, other health priorities beckon. In short, Thailand’s health care system remains in flux. Not only is there tension between the public and private sectors, but several legislative proposals may dramatically change the way Thailand’s legal and regulatory systems resolve medical malpractice cases. In this section, I explain the avenues of redress in Thailand, how those avenues may change, and what these changes could mean for foreign patients.

1. Avenues of Redress in Thailand

Bumrungrad International, perhaps Thailand’s most famous hospital, explains on its website that Thailand protects patients in several ways:

All patients in Thailand are protected by Thai law, codes of medical conduct, and a Patient Bill of Rights enforced by the Kingdom’s Medical Council Patients may complain directly to the Thai Medical Council, or the Ministry of Public Health You may also complain to the Thai Consumer Protection Agency or the police, or take legal action in a Thai court.

When considering any overseas treatment it is important to understand that any legal disputes . . . will be decided in the country of treatment, not your country of origin or citizenship.²⁹⁸

Bumrungrad International assures foreign patients that they are protected by several legal and regulatory authorities in Thailand. Although Bumrungrad warns

296. David Hughes & Songkramchai Leethongdee, *Universal Coverage in the Land of Smiles: Lessons from Thailand’s 30 Baht Health Reforms*, 26 HEALTH AFF. 999, 1000 (2007); Pachanee & Wibulpolprasert, *supra* note 286, at 310; Adrian Towse et al., *Learning from Thailand’s Health Reforms*, 328 BRIT. MED. J. 103, 103 (2004). Thailand’s reform was called the “30 baht treats all diseases project” because it provided a generous benefit package for a 30 baht copayment (around \$0.80) per chargeable episode. Hughes & Leethongdee, *supra*, at 999-1000.

297. Pachanee & Wibulpolprasert, *supra* note 286, at 311-12.

298. Bumrungrad International, FAQs, <http://www.bumrungrad.com/overseas-medical-care/faq-s.aspx#Q10> (last visited Nov. 22, 2009).

that complaints will be governed by Thai rather than foreign law, the hospital conveys the unmistakable message that Thai authorities protect foreign patients and give them adequate legal recourse. But a fuller understanding of Thailand's legal and regulatory systems calls these claims into question.

a. Civil Litigation in Thailand

Aggrieved patients in Thailand may sue health care providers in trial court and may appeal unfavorable decisions to appellate courts and ultimately to Thailand's Supreme Court.²⁹⁹ Although Thailand is a civil code country, no Thai statutes specifically address medical malpractice. Thus, patients most frequently claim damages under Section 420 of Thailand's Civil and Commercial Code, which requires any "person who, willfully or negligently, unlawfully injures the life, body, health, liberty, property, or any right of another person" to pay remuneration.³⁰⁰ Thus, health care providers in Thailand may be sued for simple negligence, though the plain language of the statute allows plaintiffs to allege more creative grounds. As in most countries, medical negligence in Thailand is defined as deviating from "a degree of care and skill that could reasonably be expected of a normal, prudent practitioner of the same experience and standing."³⁰¹ Patients bear the burden of proving negligence in Thai courts.³⁰² As in India, patients face enormous practical difficulties proving negligence and recovering meaningful compensation.³⁰³ These burdens are magnified for foreign patients.

First, aggrieved patients frequently fail to recover satisfactory compensation for medical negligence because Thai malpractice law is underdeveloped. No significant body of jurisprudence exists governing medical malpractice cases, and there are few standards to guide courts in granting remuneration.³⁰⁴ In addition to the lack of malpractice statutes, there are very few reported cases, legal periodical articles, and books that discuss malpractice law there.³⁰⁵

Second, Thais perceive that medical negligence suits languish in courts,

299. S. Saithanu et al., *Management of Medical Liability in Thailand*, 12 J. HEALTH SCI. 876 (2003) (Thail.).

300. THAIL. CIVIL & COMMERCIAL CODE § 420.

301. Sukhit Phaovasasdi et al., *Physician's Weak Points at Court*, 89 J. MED. ASS'N THAIL... 401, 401 (2006).

302. Saithanu et al., *supra* note 299.

303. *Id.*

304. *Id.*

305. Yot Teerawattananon et al., *Health Sector Regulation in Thailand: Recent Progress and the Future Agenda*, 63 HEALTH POL'Y 323 (2003). Two well-known books are DR. VITHOON EUNGPRABHATH, *MEDICAL LAW: LIABILITY OF MEDICAL AND HEALTH SERVICE PROVIDERS* (2004); and SAWANG BOONCHALERMVIPAS, *LAWS AND CAUTIONS FOR MEDICAL PRACTITIONERS* (2002), both in Thai.

bogged down in procedure.³⁰⁶ Malpractice suits generally take five to seven years to resolve,³⁰⁷ although like India, this timeframe does not necessarily compare unfavorably to the United States.³⁰⁸ However, there are no official, comprehensive estimates of how long the average malpractice case in Thailand takes to resolve, and it is unclear whether these delays would deter U.S. patients.

Third, as in India, patients face enormous difficulty proving medical negligence because many cannot access their own medical records. Some in Thailand worry that “patients are systematically being denied access to hospital medical records” when preparing malpractice complaints.³⁰⁹ Preeyanan Lorsermvattana, director of the Thai Iatrogenic Disease Network and herself a malpractice plaintiff on behalf of her son, says that “[i]n many cases, the hospitals simply claim that the records have disappeared.”³¹⁰ Although Thailand’s professional councils helped promulgate a Declaration of Patients Rights in 1998, physicians are still reluctant to provide patients with information, even before treatment.³¹¹ Thus, as in India, lack of access to medical records may effectively preclude many legitimate complaints.

Fourth, even if plaintiffs can prove negligence, compensation is modest both in judgment and in settlement.³¹² For example, one author suggests that the largest award ever issued was around \$100,000.³¹³ A Thai newspaper reported that “about 36.5 million baht in total was paid to 443 victims of medical malpractice between 2005-2006”³¹⁴—about 82,393 baht (\$2463) per person.³¹⁵ Thus, as in India, compensation in Thailand is dwarfed by the mean (\$311,965) and median (\$175,000) payouts in the United States.³¹⁶

Fifth, of immediate practical significance to foreign patients is the Thai court system itself, which utilizes judges rather than lay juries, and is conducted

306. Saithanu et al., *supra* note 299.

307. *Health Forum To Debate Medical Malpractice Law*, NATION (Thail.), Feb. 21, 2008, available at 2008 WLNR 3415529.

308. See NPDB ANNUAL REPORT, *supra* note 98.

309. Tunya Sukpanich, *The ‘Doctor’s Devil,’* BANGKOK POST, Jan. 6, 2008, available at 2008 WLNR 297194.

310. *Id.*

311. Teerawattananon et al., *supra* note 305, at 336.

312. Saithanu et al., *supra* note 299.

313. Mark Roth, *A Cheaper Medical Alternative; For Those with Minimal Health Insurance, Getting Surgery Abroad May Be a Sound Option*, PITTSBURGH POST-GAZETTE, Sept. 10, 2006, at G1.

314. *Thailand: The Public Health Ministry Drafts New Laws on Compensation for Victims of Medical Malpractice*, THAI PRESS REPS., Apr. 26, 2007, available at 2007 WLNR 7811849.

315. See Federal Reserve Statistical Release H.10 (Thailand) (calculated exchange rate on January 1, 2006), available at http://federalreserve.gov/RELEASES/H10/Hist/dat00_th.htm.

316. NPDB ANNUAL REPORT, *supra* note 98, at 8, 65 tbl.4.

exclusively in Thai.³¹⁷ All oral and documentary evidence in foreign languages must be translated into Thai.³¹⁸ Moreover, Thai courts do not permit pre-trial discovery of documents; instead, courts subpoena parties to present documents at trial,³¹⁹ which disadvantages plaintiffs. Consequentially, navigating the Thai legal system may present an incredible challenge for a foreign plaintiff.³²⁰

Finally, as in India, there is some hostility in Thailand toward medical malpractice lawsuits and the legal system in general. New malpractice cases still make national news in Thailand.³²¹ And as in most jurisdictions, physicians openly lament malpractice litigation. The Medical Association of Thailand decries litigation as “a win at all costs game that we [find] dishonorable,” and has called for a national discussion “to restore sanity to a system that right now severely inhibits physicians’ efforts to learn from mistakes and make health care safer for everyone.”³²² Physicians complain that litigation can last “many years” and that they often have no choice but to settle.³²³ These lamentations are sometimes published as invective toward patients.³²⁴ On the other hand, some physicians in Thailand believe that a small minority of “egotistic,” “selfish,” and “merciless” physicians ruin the profession’s reputation.³²⁵

On a more basic level, Thais generally distrust the legal system and rarely

317. Interview with Yuthana Srisavat and Pongwut Bamrungsuksawat, L.L.M. Candidates, Southern Methodist University, Dedman School of Law, in Dallas, Tx (Mar. 18, 2009) (citing Civil Procedure Code, Articles 13, 46, procedural rules that require the translation of court documents into Thai). The Thai Constitution does not mention a right to jury trials, and section 197 ascribes judicial powers to judges. Constitution of the Kingdom of Thailand, B.E. 2550 (2007).

318. *Id.*

319. *Id.*

320. The U.S. Embassy in Bangkok maintains a list of attorney referrals should Americans need legal assistance. Email from American Citizen Services (ACS), U.S. Embassy Bangkok, to Prof. Nathan Cortez (Dec. 22, 2008, 09:46 p.m. CST) (on file with author). Because the Embassy does not ask why U.S. citizens are asking for attorney referrals, it was unable to estimate how many seek an attorney to handle medical malpractice cases.

321. *See, e.g., Couple May Sue Hospitals*, THE NATION (Thail.), Dec. 29, 2007, available at 2007 WLNR 25643974.

322. Phaosavasdi et al., *supra* note 301, at 401.

323. *Id.*

324. Members of the Medical Association of Thailand complained that physicians “must always remain calm even when the other party’s temper[s] flair, they do not listen to reason, they always complain about the doctor’s privilege, they question everything but do not listen to the answers and they keep talking nonsense, even when they are wrong.” *Id.* at 402. Despite such public condescension, the authors recommend that Thailand “actively pursue patient safety initiatives that prevent medical injury, promote open communication between patients and doctors and create a just compensation system without hindering the doctor’s ability.” *Id.*

325. Sukhit Phaosavasdi et al., *Medical Ethics and the Survival of the Medical Profession*, 88 J. MED. ASS’N THAIL. 563 (2005).

pursue formal recourse in part because of Buddhist principles like karma, which warn that “the assertion of [legal] rights may ultimately prolong conflict and may in the long run contribute to suffering, misfortune, and distress.”³²⁶ In surveying Thai citizens over several years, Professor David Engel found “diminished regard for and use of law and legal institutions,”³²⁷ quoting a Thai aphorism that “It is better to eat dog shit than to go to court.”³²⁸ Although litigation rates have always been low in Thailand,³²⁹ rates of tort litigation in certain provinces have dramatically decreased per capita over the last twenty-five to thirty years,³³⁰ which may suggest an unfriendly atmosphere for plaintiffs.

Perhaps reflecting these aggregate difficulties, malpractice complaints in Thailand seem to be extremely rare,³³¹ and those that exist are not often successful. Roughly half of the 2726 complaints submitted to the Medical Council between 1988 and 2006 alleged medical malpractice, but only twenty-two of those cases went to court.³³² At the same time, some researchers have found a decisive uptick in malpractice complaints in various forums.³³³ The Ministry of Public Health found that the rate of malpractice complaints submitted to the Thai Medical Council increased sevenfold between 1980 and 2004.³³⁴ The

326. See generally David M. Engel, *Globalization and the Decline of Legal Consciousness: Torts, Ghosts, and Karma in Thailand*, 30 LAW & SOC. INQUIRY 469, 506 (2005).

327. *Id.* at 471-72.

328. *Id.* at 493.

329. *Id.* at 502, n.22.

330. *Id.* at 497. Note that this seems to counter the assertion by the National Health Commission Office that Thai patients increasingly assert legal rights. NAT'L HEALTH COMM'N OFFICE OF THAIL., DOCTOR-PATIENT RELATIONSHIPS: A CHRONIC PROBLEM WHICH MUST BE “CURED” WITHOUT PREJUDICE 2 (2008), http://www.nhcthailand.com/admin/data/Factsheet_D-P.pdf.

331. *Id.*; Kumaranayake, *supra* note 261, at 644.

332. *Thailand: Public Health Minister Wants Doctors To Contribute to Fund To Help Patients Affected by Medical Malpractice*, THAI PRESS REP., Dec. 21, 2007, available at 2007 WLNR 25204659. Patients may sue directly in civil courts, but most Thais prefer to avoid court and attempt to resolve the dispute via the Medical Council.

333. NAT'L HEALTH COMM'N OFFICE OF THAIL., *supra* note 330, at 1-2; Phaosavasdi et al., *supra* note 301, at 401; Saithan et al., *supra* note 299; Teerawattananon et al., *supra* note 305, at 323; *Groups Divided over Bill on Compensation for Medical Errors*, NATION (Thail.), May 26, 2008, available at 2008 WLNR 9951397; *President of Thailand Medical Council Works To Stop Malpractice Lawsuits*, THAI PRESS REP., Jan. 17, 2006; Pongphon Sarnsamak, *New Panel To Resolve Medical Disputes*, NATION (Thail.), Dec. 15, 2007, available at 2007 WLNR 24808537. Note, however, that Professor Eungprabhanth believes that the Thai press sometimes overestimates the number of complaints, and he believes that the number of malpractice complaints made against private facilities has definitely not increased. See Memorandum from Prof. Eungprabhanth, *supra* note 291.

334. Wibulpolprasert et al., *supra* note 292. The Thai Medical Council claims that negligence suits jumped from 250 in 2004 to more than 300 in 2005. *President of Thailand Medical Council*

Thai Medical Association claims that from 1973 to 2003, medical malpractice lawsuits rose from 250 per year to over 500 per year,³³⁵ although, proportionally, the amount of medical services provided during that period has probably risen at least as much. The National Health Commission Office observed sharper rises in complaints to the Medical Council in 1999 and 2005 but reported fewer complaints in 2006 and 2007.³³⁶ There are caveats, however, when attempting to extract any conclusions from these data. There are no official, reliable, and comprehensive estimates of the number of medical malpractice complaints filed in Thailand,³³⁷ and many sources conflate separate complaint venues, for example by failing to distinguish lawsuits filed in civil courts from complaints made to the Medical Council.³³⁸ Nevertheless, even if the Medical Association is correct that malpractice suits have risen to 500 per year, this seems like a relatively minuscule number for a population of over 66 million.³³⁹

One anecdote demonstrates the difficulties aggrieved patients might face in Thailand. Preeyanan Lorsermvattana, director of the Thai Iatrogenic Disease Network, filed suit on behalf of her son, who suffered injuries after being born at “a famous private hospital.”³⁴⁰ In January 1996, she sued the hospital for 57 million baht (\$1.5 million).³⁴¹ In 2000, the trial court dismissed the case because she filed it past the one-year statute of limitations.³⁴² Moreover, the court ordered her to pay the hospital 200,000 baht (\$5420) in court fees and 100,000 baht (\$2710) in lawyers’ fees.³⁴³ In 2002, Lorsermvattana sought help from the National Human Rights Commission, which asked the hospital to compensate her family and pay for future medical treatments.³⁴⁴ The Commission also asked the

Works To Stop Malpractice Lawsuits, supra note 333.

335. Phaosavasdi et al., *supra* note 301, at 401.

336. NAT’L HEALTH COMM’N OFFICE OF THAIL., *supra* note 330, at 2.

337. Professor Eungprabhanth explains that it is extremely difficult to quantify the number of medical malpractice cases filed in civil courts each year in Thailand. However, he estimates that the number of cases filed is “not more than 100 cases per year.” See Memorandum from Prof. Eungprabhanth, *supra* note 291.

338. See, e.g., Phaosavasdi et al., *supra* note 301, at 401; *Thailand: Public Health Minister Wants Doctors To Contribute to Fund To Help Patients Affected by Medical Malpractice, supra* note 332. The Medical Council governs only professional disciplinary rules, not tort claims. See Memorandum from Prof. Eungprabhanth, *supra* note 291.

339. U.S. Department of State, Background Note: Thailand, July 2009, <http://www.state.gov/r/pa/ei/bgn/2814.htm>.

340. Sukpanich, *supra* note 309.

341. *Id.*; see Federal Reserve Statistical Release H.10 (Thailand), available at http://federalreserve.gov/RELEASES/H10/Hist/dat00_th.htm (using the earliest exchange rate available, January 3, 2000).

342. Sukpanich, *supra* note 309.

343. *Id.* (using the exchange rate on January 3, 2000).

344. *Id.*

Medical Council of Thailand to reconsider her son's case and requested that the Ministry of Public Health set better standards for medical care, though these requests were not legally binding.³⁴⁵ Meanwhile, the hospital sued Lorsermvattana for 100 million baht (\$3.1 million) for defamation, though the Supreme Court dismissed this claim.³⁴⁶

In sum, aggrieved patients face obstacles to securing compensation nearly everywhere, but there are significant obstacles in Thailand. Foreign patients may find Thailand's redressal system to be an unrealistic option. Malpractice suits are rare. Compensation is meager, especially by Western standards. Litigation is long and expensive, and generally disfavors patients in fundamental ways. Proving negligence is exceedingly difficult with lack of access to medical records. Court proceedings are conducted exclusively in Thai. And the general atmosphere is hostile to medical malpractice complaints. There have even been reports of violence—both real and threatened—against those who have brought malpractice complaints.³⁴⁷ A medical tourism company in the United States states bluntly: "If someone is considering suing someone, for whatever reason, don't [seek treatment abroad] . . . That's all we have to say."³⁴⁸

b. Pending Reforms in Thailand?

Aware of these hurdles, the government is considering several legislative proposals that may fundamentally change how Thailand handles medical malpractice complaints. Policymakers are considering no-fault compensation and mediation committees, and they may amend legal burdens of proof, criminal liability, and other devices that can hold health care providers accountable.

Currently, Thai law provides a limited safety net for some malpractice victims. The National Health Security Fund compensates victims of medical errors if the patient does not receive any compensation from the health care provider within a reasonable time frame.³⁴⁹ Although the National Health

345. *Id.*

346. *Id.* (using the exchange rate on October 1, 2007).

347. A member of the Thai Iatrogenic Disease Network was shot dead in front of her house in 2007 after suing a physician who allegedly left her face disfigured after cosmetic surgery. The police suspect her murder might have been related to her complaint. Sukpanich, *supra* note 309. Moreover, the father of a 23 year-old American who died during surgery at Bumrungrad International hospital has reported receiving death threats after publicizing the death on a website. See Bumrungrad Hospital Death 2006, <http://www.bumrungraddeath.com> (last visited Nov. 22, 2009).

348. Manthey, *supra* note 10 (quoting a MedRetreat spokesperson) (internal quotation marks omitted).

349. National Health Security Act B.E. 2545, § 41 (2002) (Thail.), available at http://www.nhso.go.th/eng/content/uploads/files/Thailand_NHS_Act.pdf; Saithanu et al., *supra* note 300. A committee of five to seven reviewers determines whether an application for

Security Act caps medical malpractice compensation provided under the Fund to 200,000 baht (\$5764), legislation may raise the cap to two million baht (\$57,636).³⁵⁰ The National Health Security Office can then seek indemnification from the health care provider.³⁵¹ The Committee of National Health Security replenishes the Fund by withholding 1% or less from hospital budgets.³⁵² Article 38 of the Act suggests that the Fund applies to both public and private hospitals,³⁵³ but it is not clear how often patients treated at private hospitals turn to the Fund for compensation.

In 2008, the Ministry of Health proposed legislation to handle malpractice complaints through a “no fault” system, utilizing a national fund to compensate victims of medical errors.³⁵⁴ Former Health Minister Mongkol na Songkhla wanted state physicians to contribute 3000 to 5000 baht to the fund each year, but some doubt physicians would willingly do so.³⁵⁵ Others have called for the government to standardize criteria for awarding compensation.³⁵⁶

Whatever reforms materialize, Thailand seems to be following the recommendation of health policy researchers who urge it to move further away from the U.S. medical malpractice system:

There is a risk of creating the environment of the US where fear of litigation generates unnecessary investigations, overdiagnosis and overtreatment and hence higher health care costs, and there is a vicious cycle of rising insurance premia and rising health-care costs.³⁵⁷

The researchers support a “no fault” compensation system not only because it removes the time and expense spent proving fault, but because it should

compensation complies with the criteria in the regulations, the most important of which is that the patient suffered damages that would not normally occur and has not yet received compensation. See Regulation of National Health Security Office on Criteria, Methods and Conditions for Primary Compensation for Damages from Medical Services, B.E. 2549 (2007).

350. Regulation of National Health Security Office on Criteria, Methods and Conditions for Primary Compensation for Damages from Medical Services, B.E. 2549 (2007); Samsamak, *supra* note 333. For exchange rate methodology, see Federal Reserve Statistical Release H.10, Foreign Exchange Rates (Weekly), Historical Rates for Thailand, http://www.federalreserve.gov/releases/h10/Hist/dat00_th.htm.

351. National Health Security Act B.E. 2545, § 42.

352. National Health Security Act B.E. 2545, § 41.

353. National Health Security Act B.E. 2545, § 38.

354. Pongphon Samsamak, *A Challenge To Improve Quality of Life*, NATION (Thail.), Jan. 1, 2008, available at 2008 WLN 49326.

355. Thailand: Public Health Minister Wants Doctors To Contribute to Fund To Help Patients Affected by Medical Malpractice, *supra* note 332.

356. Saithanu et al., *supra* note 299.

357. Teerawattananon et al., *supra* note 305, at 336.

improve physician-patient relationships.³⁵⁸

Thailand may be moving precisely in this direction. In early 2008, Thailand's Health System Research Institute (HSRI) reignited earlier efforts by proposing more expansive legislation to establish a "Medical Malpractice Victim Fund,"³⁵⁹ which would compensate patients within one month of suffering "damage" from medical malpractice and provide additional compensation shortly thereafter depending on the type and severity of damages.³⁶⁰ The bill would compensate only "serious cases,"³⁶¹ although it is not clear how the government would distinguish serious cases from minor ones. The legislation aims to compensate patients quickly—within five months of being injured.³⁶² To build support for the bill, HSRI noted that five months compared very favorably to civil litigation, which generally takes between five and seven years.³⁶³

Of course, establishing a convenient compensation system comes with a price. The legislation has hit some political snags, and the Ministry of Public Health is trying to reconcile several conflicts.³⁶⁴ First, an early analysis of the bill predicts that the Thai government might spend one billion baht per year (\$28.8 million) to compensate malpractice in public hospitals.³⁶⁵ Private hospitals would have to contribute to the fund separately to be covered.³⁶⁶ The bill would effectively render the system a form of government-sponsored malpractice insurance.

Second, a proposal would require patients to forego suing in civil court once they pursue compensation through the fund.³⁶⁷ This provision has become an obvious point of contention. Previously, Thailand's Iatrogenic Disease Network supported the legislation, but it later opposed this new wrinkle and proposed its own reformulation.³⁶⁸ A separate proposal by the National Health Commission would require patients and providers to negotiate before patients could receive compensation.³⁶⁹

Finally, physicians groups have used these legislative efforts as an

358. *Id.*

359. *Health Forum To Debate Medical Malpractice Law*, *supra* note 307.

360. *Id.*

361. *Id.*

362. *Id.*

363. *Id.*

364. *Groups Divided Over Bill on Compensation for Medical Errors*, *supra* note 333.

365. *Health Forum To Debate Medical Malpractice Law*, *supra* note 307 (using exchange rates on Dec. 31, 2008).

366. *Id.*

367. *Id.*; *Groups Divided Over Bill on Compensation for Medical Errors*, *supra* note 333.

368. *Groups Council Urged to Seek Outside Help*, BANGKOK POST, Mar. 12, 2008, available at 2008 WLNR 4790095; *Divided Over Bill on Compensation for Medical Errors*, *supra* note 333.

369. *Groups Divided Over Bill on Compensation for Medical Errors*, *supra* note 333.

opportunity to limit criminal and possibly even civil liability for malpractice. The Medical Council has asked the National Legislative Assembly to revise the Criminal Code to limit criminal punishment for physicians unless they intentionally injure a patient.³⁷⁰ The Council has even proposed eliminating both criminal and civil liability unless the plaintiff proved that the malpractice was intentional or grossly negligent.³⁷¹ Though some recommended that the legislature focus on amending the National Health Security Act rather than the Criminal Code,³⁷² it seems likely that the Medical Council will achieve at least some concessions on this point.

There have been separate but related efforts in Thailand to enhance the medical expertise available to tribunals that hear malpractice cases. Former Health Minister Mongkol na Songkhla proposed establishing a mediation committee to help patients and physicians negotiate settlements.³⁷³ As noted above, the legislation would have increased the maximum medical malpractice compensation from 200,000 baht to two million baht (from roughly \$5700 to \$57,000).³⁷⁴ Although the mediation committee would decide compensation in each case, the legislation would still give victims the chance to sue in court.³⁷⁵ It was not clear whether or when the legislation would be considered formally,³⁷⁶ but the mediation idea seems to be gaining support.³⁷⁷

In a similar vein, the Thai Medical Council proposed legislation to ensure that judges hearing malpractice cases would have access to medical experts.³⁷⁸ But the Council again combined this proposal with a provision that would eliminate both civil and criminal liability for physicians unless the malpractice was intentional or grossly negligent.³⁷⁹

Thus, the medical malpractice system in Thailand remains very much in transition. The government is considering several different legislative proposals, and even with ongoing political upheaval, the compensation system available to patients may look very different, very soon. Of course, this change could be a

370. Sarnsamak, *supra* note 333; *Medical Council Wants New Law To Protect Doctors*, BANGKOK POST (Thail.), Dec. 15, 2007, available at 2007 WLNR 24755523; *Thailand: The Public Health Ministry Drafts New Laws on Compensation for Victims of Medical Malpractice*, *supra* note 314.

371. Sarnsamak, *supra* note 354.

372. *Jarun: Plan to Protect Doctors Needs Review*, BANGKOK POST, Dec. 20, 2007, available at 2007 WLNR 25050574.

373. Sarnsamak, *supra* note 354.

374. Sarnsamak, *supra* note 333.

375. *Id.*

376. *Id.*

377. *Calls for Law To Protect Doctors*, BANGKOK POST, Feb. 12, 2008, available at 2008 WLNR 2651367.

378. Sarnsamak, *supra* note 354.

379. *Id.*

good thing. But it also compounds the uncertainty for foreign patients traveling to Thailand.

c. Consumer Complaints

In February 2008, the Thai government enacted the Consumer Case Procedure Act, B.E. 2551, which creates a streamlined procedure for “consumers” to file complaints against “business operators,”³⁸⁰ which presumably includes private hospitals.³⁸¹ Like India’s consumer forums, the intent seems to be to offer a less costly and more convenient alternative forum to resolve consumer complaints. In fact, the new procedures resemble those in India’s consumer forums, particularly their informality (consumers do not need to be represented by counsel), their quasi-judicial nature (judges are supported by judicial officers who try to mediate), and their truncated procedures (cases are meant to be resolved much more quickly than civil litigation).³⁸² However, because the law took effect in August 2008, it remains unclear what impact it will have on medical malpractice cases.³⁸³

d. Thai Ministry of Public Health

Thailand’s Ministry of Public Health is the Prime Minister’s central cabinet-level department responsible for regulating health care.³⁸⁴ The Ministry not only registers and licenses medical professionals³⁸⁵ but also investigates and reviews patient complaints.³⁸⁶ Most importantly, Thai law authorizes the Ministry to act as a safety net for aggrieved patients by allowing it to order compensation for any damages resulting from inappropriate medical services,³⁸⁷ although it is not clear the Ministry actively exercises this authority.

In spite of its authority, researchers found that the Ministry plays virtually “no role” in regulating the quality or safety of medical services as a practical

380. Consumer Case Procedure Act B.E. 2551 (2008) (English translation on file with author).

381. See Memorandum from Prof. Eungprabhanth, *supra* note 291.

382. *Id.*

383. *Id.* Professor Eungprabhanth predicts that medical malpractice complaints will increase through these new consumer procedures. Memorandum from Prof. Eungprabhanth, *supra* note 291. But to date, the most notable complaint involved the failure of an airport to use a metal detector. See *Airport Fined for Lack of Metal Detector*, NATION (Thail.), Dec. 18, 2008, available at 2008 WLNR 25048009.

384. See Ministry of Public Health: Thailand, <http://eng.moph.go.th> (last visited Nov. 22, 2009).

385. Singkaew & Chaichana, *supra* note 294, at 241.

386. National Health Security Act B.E. 2545, § 50 (2002) (Thail.), available at http://www.nhso.go.th/eng/content/uploads/files/Thailand_NHS_Act.pdf.

387. National Health Security Act B.E. 2545, §§ 50(5), 50(8), 59.

matter.³⁸⁸ Although the Ministry's laws seem to be comprehensive, reviews of discipline in the 1990s show that "enforcement is poor" and "few severe penalties were awarded."³⁸⁹ This comports with a recent analysis of health care regulation in low- and middle-income countries, which found that "traditional methods such as licensing and certification frequently fail to control behavior because of the limited resources available to government [for enforcement] in low- and middle-income countries, and because of the powerful countervailing incentives that encourage deviant behavior to continue."³⁹⁰ Thus, even in more prosperous low- and middle-income countries like Thailand, enforcement lags due to lack of resources.³⁹¹

e. Thai Medical Council

The Thai government entrusts the Medical Council, a quasi-governmental self-regulatory body, to oversee medical professionals by licensing them and enforcing rules of professionalism and ethics.³⁹² The Council may also sanction members, for example by placing them under probation for mild violations or by suspending or revoking licenses for more severe ones.³⁹³ The Council uses an Ethical Committee to handle medical malpractice and ethical complaints against members.³⁹⁴ The Committee investigates each complaint and then recommends penalties.³⁹⁵

Complaints to the Council seem to be rising. Between 1990 and 2006, around 2800 patients filed complaints, more than half alleging malpractice.³⁹⁶ Council records claim that malpractice complaints jumped from 250 in 2004 to more than 300 in 2005.³⁹⁷ Also, the ratio of claims seems to be rising, from 88 complaints per 100,000 physicians in 1975³⁹⁸ to 869 complaints per 100,000

388. Teerawattananon et al., *supra* note 305, at 331 tbl.3.

389. *Id.* at 332.

390. Ensor & Weinzierl, *supra* note 165, at 355.

391. Kumaranayake, *supra* note 261, at 645.

392. Teerawattananon et al., *supra* note 305, at 325.

393. *Id.*

394. *Id.* at 334.

395. *Id.* at 330.

396. Media reports conflict on the precise time frame and number of complaints. *See Thailand: Public Health Minister Wants Doctors To Contribute to Fund To Help Patients Affected by Medical Malpractice*, *supra* note 332 (reporting that between 1988 and 2006, 2726 complaints were filed with the Council). *But see Thailand: The Public Health Ministry Drafts New Laws on Compensation for Victims of Medical Malpractice*, *supra* note 314 ("More than 2,800 complaints were submitted to the Medical Council between 1990 and 2006 . . .").

397. *President of Thailand Medical Council Works To Stop Malpractice Lawsuits*, *supra* note 333.

398. Note again that media reports differ on the precise number. *Compare* Teerawattananon et

physicians in 2003.³⁹⁹ Nonetheless, researchers report that despite widespread problems with physicians in Thailand, the Medical Council still receives relatively few complaints.⁴⁰⁰

Of course, the Medical Council is vulnerable to the same criticisms that plague other professional medical organizations responsible for regulating their own members. For example, a study found that the Council and other professional medical organizations in Thailand “react passively to complaints made directly by consumers and to reports of ethical misconduct from fellow professionals,” even though most complaints allege negligent or substandard care.⁴⁰¹ The same study found that “punishments of the guilty were mostly mild with 53% being reprimanded, 23% placed on probation, 22% ha[ving] their licenses suspended, and 1% ha[ving] their licenses revoked.”⁴⁰² As in India, professional medical organizations in Thailand seem to lack any real incentive to actively investigate their members and resolve complaints.⁴⁰³ One study concluded that the Council only disciplined its members when the Thai media publicized potential violations.⁴⁰⁴

The Medical Council receives many more complaints than it is able or perhaps willing to handle.⁴⁰⁵ In 1999, it resolved only thirty-eight of the 173 complaints filed, and the gap grows over time.⁴⁰⁶ The backlog has provoked even more public criticism of the Council and has raised questions whether the Council is more concerned with protecting patients or its members.⁴⁰⁷

Unsurprisingly, there is widespread public distrust of the Council.⁴⁰⁸ As noted above, plaintiffs criticize it for protecting its members in complaints.⁴⁰⁹ Its investigations are slow and operate under no deadlines.⁴¹⁰ One study notes that “plaintiffs have little confidence that their cases will be handled fairly.”⁴¹¹ Observers have urged the Council to seek assistance from neutral, outside experts

al., *supra* note 305, at 330, 332 (identifying 687 complaints per 100,000 physicians in 1999), with Wibulpolprasert et al., *supra* note 292 (identifying 114.6 complaints per 10,000 physicians in 1999, which is equivalent to 1146 complaints per 100,000 physicians).

399. Wibulpolprasert et al., *supra* note 292 (identifying 86.9 complaints per 10,000 physicians in 2003, is equivalent to 869 complaints per 100,000 physicians).

400. Kumaranayake, *supra* note 261, at 644.

401. Teerawattananon et al., *supra* note 305, at 335.

402. *Id.* at 327 (based on records from the Medical Council between 1995 and 1999).

403. *Id.* at 334.

404. Ensor & Weinzierl, *supra* note 165, at 359.

405. Teerawattananon et al., *supra* note 305, at 335.

406. *Id.* at 333 fig.4.

407. *Id.* at 330.

408. *Council Urged To Seek Outside Help*, *supra* note 368.

409. Saithanu et al., *supra* note 299.

410. *Id.*

411. Teerawattananon et al., *supra* note 305, at 335.

to handle malpractice complaints.⁴¹² One respected scholar recommended that the Council avoid handling any malpractice complaints to avoid conflicts of interest and to restore the public's faith in the profession.⁴¹³ Of course, the Council's president claims that the Council already asks neutral experts to help investigate complaints, noting skeptically that some patients file complaints simply because "they want to get money and take revenge."⁴¹⁴

Meanwhile, it is becoming even more crucial that the Medical Council and other regulators hold physicians in Thailand accountable. In 2004, the Ministry of Public Health wrote that "[w]ith more international trade in health services, professional ethics may erode," and "[m]ore malpractice lawsuits can be envisaged if professional councils are not strong enough."⁴¹⁵ The Ministry thus recommended that the government strengthen regulatory oversight by professional councils and associations.⁴¹⁶

In short, as in India, foreign patients visiting Thailand cannot rely on physician self-regulation to provide any meaningful constraints on medical practice.

f. Criminal Prosecution in Thailand

Physicians in Thailand can also be prosecuted for extreme cases of medical malpractice, but as in most countries, such prosecutions are quite rare. In fact, only one physician has been sentenced to prison for malpractice in Thailand, and this case ignited a firestorm of debate.⁴¹⁷ A rural doctor was sentenced to three years in prison after injecting anesthetic into a patient during a fatal appendicitis operation.⁴¹⁸ According to press reports, the case has intensified tensions between physicians and patients in Thailand, and many surgeons have expressed more reluctance to operate.⁴¹⁹ For example, in response to the case, the Rural Doctors Society threatened to stop operating at rural hospitals.⁴²⁰ The Ministry of Public

412. Sukpanich, *supra* note 309.

413. *Calls for Law To Protect Doctors*, *supra* note 377.

414. Sukpanich, *supra* note 309.

415. Wibulpolprasert et al., *supra* note 292.

416. *Id.*

417. *Medical Council Wants New Law To Protect Doctors*, *supra* note 370; Sarnsamak, *supra* note 354; *Thailand: Public Health Minister Wants Doctors To Contribute to Fund To Help Patients Affected by Medical Malpractice*, *supra* note 332; see also Engel, *supra* note 326, at 500 (noting the drop in private criminal cases arising out of personal injuries). Note, however, that physicians and nurses have been convicted for non-malpractice-related offenses. NAT'L HEALTH COMM'N OFFICE OF THAIL., *supra* note 330, at 1 (reporting what appears to be a case of physician-assisted suicide).

418. *Medical Council Wants New Law To Protect Doctors*, *supra* note 370.

419. Sarnsamak, *supra* note 354.

420. *Medical Council Wants New Law To Protect Doctors*, *supra* note 370.

Health paid the patient's family 600,000 baht (\$15,267) after a civil court ordered the remuneration.⁴²¹ However, the Ministry is appealing the three-year sentence.⁴²² This example might suggest that criminal prosecution in Thailand incites more anger than self-reflection by physicians.

2. Foreign Patients in Thailand

Thailand remains a popular destination for patients, and as in India, most patients visiting will receive competent medical care. Health care regulation in Thailand is fairly comprehensive,⁴²³ but enforcement lags because Thai regulators dedicate insufficient personnel and resources to monitor and enforce compliance.⁴²⁴ A study by the World Health Organization and the United Nations Conference on Trade and Development found that Thailand uses "a passive regulatory system for health-care."⁴²⁵ The study concluded that "[a]lthough some mechanisms for health care supervision and monitoring in public facilities are implemented, there is a lack of continuous, formal appraisal of the quality and appropriateness of care in public and private hospitals as well as private clinics."⁴²⁶ In general, researchers have found that middle-income countries like Thailand lack the resources to adequately regulate health care.⁴²⁷ Even the scholars that praise Thailand's relatively comprehensive regulatory system recommended several fundamental reforms.⁴²⁸ Thus, as in India, lawmakers have the best intentions, but their efforts thus far have been mostly cosmetic due to lax enforcement.

Moreover, medical malpractice is a matter of *when*, not *if*. Foreign patients unlucky enough to be injured by malpractice will not, as a practical matter, have much recourse if left to navigate Thailand's many redressal systems. And though Thailand's health care regulatory system is fairly broad, it does not promote much accountability.

As a complicating factor, many in Thailand are uneasy with the growth of medical tourism and private, commercialized health care. Citizens distrust the private health care sector,⁴²⁹ and "[s]ocial attitudes towards the medical

421. *Id.* (using the exchange rate on Dec. 14, 2007).

422. *Thailand: Public Health Minister Wants Doctors To Contribute to Fund To Help Patients Affected by Medical Malpractice*, *supra* note 332.

423. Teerawattananon et al., *supra* note 305, at 323.

424. Kumaranayake, *supra* note 261, at 644.

425. Singkaew & Chaichana, *supra* note 294, at 240.

426. *Id.*

427. Ensor & Weinzierl, *supra* note 165, at 355; Kumaranayake, *supra* note 261, at 645.

428. Teerawattananon et al., *supra* note 305, at 335-37.

429. *Id.* at 292. Note, however, that Professor Vithoon Eungprabhanth suggests that Thais generally trust the private sector more than the public sector, except for university hospitals. See Memorandum from Prof. Eungprabhanth, *supra* note 291.

profession have changed drastically since much of the health care service is now done by the private sector and it has become a business.”⁴³⁰ As a result, aggrieved foreign patients treated in private hospitals may not find much sympathy in Thailand.

D. Singapore

Singapore has long been a regional hub for patients, and like India and Thailand, it has grand ambitions for its medical tourism industry. Roughly 348,000 foreign patients visited Singaporean hospitals in 2007, up from 200,000 just four years earlier.⁴³¹ Singapore is being pressured by competition from less expensive destinations like Malaysia, Thailand, and India.⁴³² And, perhaps as only Singapore can do, its government has mustered a coordinated, centralized effort to promote its medical tourism industry and retain its status as Asia’s health care hub.⁴³³ Indeed, the government announced that it hopes to attract one million foreign patients annually by 2012.⁴³⁴

Singapore as a medical destination is a study in contrasts. On one hand, Singapore is far and away the richest, most developed country I examine in this Article.⁴³⁵ Its average income resembles the United States more than India, Thailand, or Mexico.⁴³⁶

But similarities with the United States do not extend much further. Unlike the United States, Singapore’s system for compensating patients is much more limited, veering more toward India and Thailand. Medical malpractice lawsuits

430. *Jarun: Plan to Protect Doctors Needs Review*, *supra* note 372.

431. Maria Almenoar, *Stats at Odds: More or Fewer Medical Tourists?*, STRAITS TIMES (Sing.), Jan. 23, 2009, available at 2009 WLNR 1270475; Mattoo & Rathindran, *supra* note 116, at 2, 12 tbl.2; Singapore Ministry of Health, Medical Travelers Update, Jan. 22, 2009, <http://www.moh.gov.sg/mohcorp/parliamentaryqa.aspx?id=20836>. Note, however, that the Singapore Tourism Board estimates elsewhere that 571,000 medical tourists visited in 2007. See Wong Mei Ling, *Medical Tourism Hit by Global Downturn*, STRAITS TIMES (Sing.), Jan. 11, 2009, available at 2009 WLNR 527972.

432. See Cortez, *supra* note 6, at 89-93.

433. See *id.* at 92-93; SingaporeMedicine, Welcome to SingaporeMedicine, <http://www.singaporemedicine.com> (last visited Nov. 22, 2009).

434. Mattoo & Rathindran, *supra* note 116, at 2, 12 tbl.2.

435. In 2006, the gross national income per capita was \$2460 in India, \$7440 in Thailand, \$11,990 in Mexico, \$43,300 in Singapore, and \$44,070 in the United States. See WHO, WHO Statistical Information System (WHOSIS), <http://www.who.int/whosis/en/index.html> (last visited Nov. 22, 2009) (perform a “Customized Search,” selecting India, Mexico, Singapore, Thailand, and United States, then select “Gross national income per capita (PPP international \$),” then select “2006,” the latest date for which data is available).

436. *Id.*

are rare.⁴³⁷ Awards are modest not only by U.S. standards but by standards appropriate for a country with Singapore's wealth.⁴³⁸ Patients in Singapore remain reluctant to file suit, partly due to a cultural aversion to challenging medical authority, partly due to modest awards, and partly due to the risks of unsuccessful litigation in a system that imposes costs on the losing party and does not allow contingency fee arrangements.⁴³⁹ As in India and Thailand, patients have trouble finding medical experts willing to testify against colleagues.⁴⁴⁰ And like India, Singapore is one of the former British colonies saddled with the *Bolam* decision, the 1957 English trial court opinion that has made proving medical negligence exceptionally difficult.⁴⁴¹ Finally, Singapore is a relatively non-litigious society, and the medical profession is winning the public relations battle against malpractice suits, warning the country that it is sliding further toward a medical malpractice crisis like that in the United States.⁴⁴² All these factors create a general atmosphere that both discourages malpractice suits and makes them unlikely to achieve much.

My goal in this section is to describe this atmosphere and explain how Singapore's redressal system operates. Allegations of medical malpractice in Singapore can trigger several distinct legal procedures, including criminal sanctions, actions by the Singapore Medical Council, and civil liability. Here I outline these procedures and assess whether they might provide adequate recourse to foreign patients.

1. Civil Liability in Singapore

Physicians in Singapore may be civilly liable for medical malpractice under theories of both contract and tort—though the most common allegation is simple

437. See, e.g., Kumaralingam Amirthalingam, Book Review, 2005 SING. J. LEG. STUD. 471, 472 (reviewing YEO KHEE QUAN ET AL., *ESSENTIALS OF MEDICAL LAW* (2004)) (noting that Singapore cases "account for well below 10% of the cases mentioned in the book").

438. See Kumaralingam Amirthalingam, *Judging Doctors and Diagnosing the Law: Bolam Rules in Singapore and Malaysia*, 2003 SING. J. LEG. STUD. 125, 143-44.

439. See Terry Kaan, *Singapore*, in INTERNATIONAL ENCYCLOPAEDIA OF LAWS: MEDICAL LAW 89-90 (Herman Nys ed., 1994 & Supp. 1998); D. Kandiah, *Comparisons of the Interactions of Health Care Delivery and Medico-Legal Practice Between Australia and Singapore*, 25 MED. & L. 463, 467 (2006). Of course the decision to file a complaint is complex. Physicians and patients in Singapore often prefer to use mediation and arbitration—or simply prefer to settle—to avoid legal confrontations. Letter from Kumaralingam Amirthalingam, Professor, National University of Singapore Faculty of Law, to Nathan Cortez, Assistant Professor, Southern Methodist University, Dedman School of Law (Jan. 27, 2009) (on file with author).

440. See Liu Chun Fai, *A Functional Review of Medical Negligence Law*, 6 SING. L. REV. 188, 195 (1985).

441. *Bolam v. Friern Hosp. Mgmt. Comm.*, [1957] 1 W.L.R. 583 (Eng.).

442. See Amirthalingam, *supra* note 438, at 143-44.

negligence in tort.⁴⁴³

As a foundational matter, Singapore inherits its common law from England, and to this day, Singaporean courts often apply judicial precedents from English courts.⁴⁴⁴ Courts tend to treat English decisions as “highly persuasive if not practically binding,” although the Singapore High Court has held that courts need not follow English common law.⁴⁴⁵ In addition, a 1993 statute allows courts to reject English precedents if applying them would be inappropriate.⁴⁴⁶ Thus, courts in Singapore have shown increased willingness to depart from English common law and follow more patient-friendly precedents from Australian or Canadian courts (though Singaporean courts remain reluctant to adopt U.S. precedents).⁴⁴⁷ The Parliament of Singapore has grown more assertive in regulating medical professionals, but medical practice remains governed almost exclusively by the common law of contract and tort.⁴⁴⁸

Courts in Singapore continue to adhere to the infamous *Bolam* rule, the standard for finding medical negligence that has been widely criticized for unduly favoring physicians.⁴⁴⁹ In *Bolam v. Friern Hospital Management Committee*,⁴⁵⁰ the court explained that it would not find medical professionals to be negligent if they “acted in accordance with a practice accepted by a responsible body of medical men skilled in that particular art.”⁴⁵¹ This famous test simply states that the standard of care for physicians is not that of the ubiquitous “reasonable man,” but of a reasonable physician possessing roughly the same special skills and competencies.⁴⁵²

On its face, the *Bolam* rule seems to be innocuous, even bland. But most courts have interpreted *Bolam* to create almost insurmountable hurdles for patients. First, if the standard of care is that of “a responsible body of medical men skilled in that particular art,”⁴⁵³ who else but those same “medical men”

443. Kaan, *supra* note 439, at 70. As with most common law jurisdictions, Singaporean courts apply the familiar duty-breach-causation formula in medical negligence claims at tort. Fai, *supra* note 440, at 195; Margaret Fordham, Singapore Academy of Law, The Law of Negligence § 20.1.3, <http://www.singaporelaw.sg/content/Negligence1.html> (last visited Nov. 22, 2009).

444. Kaan, *supra* note 439, at 15-18.

445. *Id.* at 88 (citing *Pang Koi Fa v. Lim Djoe Phing*, [1993] 3 S.L.R. 317, 323D-E (Sing.)).

446. Application of English Law Act, Ch. 7A, Act 35 of 1993 (Sing.), available at <http://policy.mofcom.gov.cn/resource/flaw/f970eb0f-21ba-46d2-9014-025ef1ab5d09.pdf>; see also Kaan, *supra* note 439, at 18.

447. Kaan, *supra* note 439, at 18.

448. *Id.* at 16-18.

449. See, e.g., Amirthalingam, *supra* note 438; Fai, *supra* note 440; Fordham, *supra* note 443, § 20.4.10.

450. *Bolam v. Friern Hosp. Mgmt. Comm.*, [1957] 1 W.L.R. 582 (Eng.).

451. *Id.* at 587.

452. *Id.*

453. *Id.*

could identify what practices were appropriate in each case? *Bolam* requires courts to refer to expert testimony to help determine the standard of care—as do courts in most common law jurisdictions—but courts in Singapore rely overwhelmingly on such testimony with very little independent, critical assessment.⁴⁵⁴ In fact, courts applying *Bolam* do not grant themselves much leeway to decide between conflicting medical experts.⁴⁵⁵ Most courts applying *Bolam* prohibit non-experts like judges from independently determining whether the physician was negligent as long as *some* evidence supports the defendant's conduct.⁴⁵⁶ Courts have even held that the testimony of a single expert defense witness can represent a “responsible body” of medical opinion, even if it contradicts a larger body of opinion.⁴⁵⁷ Thus, courts applying *Bolam* often refrain from finding negligence if only one expert finds the defendant's conduct reasonable—even if multiple competent experts find it unreasonable.⁴⁵⁸

As a practical matter, therefore, medical negligence under *Bolam* is often “determined by the lowest standard of care (accepted by the medical profession) rather than reasonable contemporary standards.”⁴⁵⁹ One lawyer notes that “barring a truly exceptional case, there will invariably be a body of medical opinion that supports the allegedly negligent physician's practice.”⁴⁶⁰ Essentially, courts in Singapore enforce standards that the medical profession set for itself without independently assessing those standards.⁴⁶¹ Scholars in Singapore bemoan that courts have forgotten the normative interpretation required when determining whether a physician acted in accordance with a “responsible body” of professional medical opinion.⁴⁶² Indeed, courts in Singapore seem quicker to chastise themselves than physicians. For example, in one highly-publicized case, the Singapore Court of Appeal fumed that:

It would be pure humbug for a judge, in the rarified atmosphere of the courtroom and with the benefit of hindsight, to substitute his opinion for that of the doctor in the consultation room or operating chamber. We often enough tell doctors not to play God; it seems only fair that, similarly, judges and lawyers

454. See Amirthalingam, *supra* note 438, at 129.

455. See, e.g., *Dr. Khoo James v. Gunapathy d/o Muniandy*, [2002] 2 S.L.R. 414 (Sing.); Amirthalingam, *supra* note 438, at 129.

456. Amirthalingam, *supra* note 438, at 129.

457. *Id.* at 129 (citing *Gerrard v. Royal Infirmary of Edinburgh NHS Trust* [2002] ScotCS 11 ¶ 89).

458. *Id.* at 129-30 (citing cases).

459. *Id.* at 129.

460. Paul Tan, *The Doctrine of Informed Consent – When Experts and Non-Experts Collide*, 2006 SING. J. LEG. STUD. 148, 153.

461. Fai, *supra* note 440, at 189.

462. Amirthalingam, *supra* note 438, at 129.

should not play at being doctors.⁴⁶³

A recent trend suggested that courts might retreat from *Bolam* or at least domesticate it, but this proved not to be much of a revolution. In 1998, the English House of Lords left room for courts to depart from *Bolam* in its well-known *Bolitho* opinion,⁴⁶⁴ where it held that courts should depart from *Bolam* when the professional medical opinion “is not capable of withstanding logical analysis.”⁴⁶⁵ *Bolitho* seemed to give judges an opportunity—albeit a narrow one—to reassert themselves and critically weigh expert opinions in medical negligence cases.⁴⁶⁶ Although several courts did use *Bolitho* to appraise expert medical testimony more critically, Lord Browne-Wilkinson warned lower courts in his House of Lords opinion in *Bolitho* to apply the case only in exceptional circumstances.⁴⁶⁷ Thus, many observers view *Bolitho* as only slightly altering *Bolam*’s status quo.⁴⁶⁸

In 2002, in the case of *Dr. Khoo James v. Gunapathy d/o Muniandy*, the Singapore Court of Appeal systematically reviewed the common law in this area.⁴⁶⁹ Reacting to public backlash against a S\$1.4 million trial court award, the Court of Appeal announced that judges should not determine the reasonableness of medical opinions but should merely determine whether the expert medical testimony is logically defensible.⁴⁷⁰ Indeed, the Singapore High Court noted in a 2002 case predating *Gunapathy* that *Bolam* and its progeny prevent courts from finding negligence “even if the diagnosis or treatment were wrong.”⁴⁷¹ As such, the *Gunapathy* opinion represents the current law in Singapore,⁴⁷² cementing the near sancrostat status of the *Bolam* rule. One scholar has interpreted *Gunapathy* as rendering malpractice cases more hostile to plaintiffs in Singapore than in England.⁴⁷³

Professor Amirthalingam has called for courts to “reassert their role as the

463. *Dr. Khoo James v. Gunapathy d/o Muniandy* [2002] 2 S.L.R. 414, ¶ 3 (Sing.), available at <http://www.singaporelaw.sg/rss/judg/8318.html> (English translation).

464. *Bolitho v. City & Hackney Health Auth.*, [1998] A.C. 232 (H.L.).

465. *Id.* at 243.

466. Amirthalingam, *supra* note 438, at 132-33.

467. *Bolitho*, [1998] A.C. at 243.

468. *See, e.g.*, Amirthalingam, *supra* note 438, at 132-33.

469. *Dr. Khoo James v. Gunapathy d/o Muniandy* [2002] 2 S.L.R. 414, ¶ 52 (Sing.), available at <http://www.singaporelaw.sg/rss/judg/8318.html> (English translation); Amirthalingam, *supra* note 438, at 135.

470. *Gunapathy*, [2002] 2 S.L.R. ¶ 63, 65; Amirthalingam, *supra* note 438, at 137.

471. Amirthalingam, *supra* note 438, at 137 (quoting an unreported opinion from 2002).

472. *Id.* at 137.

473. *See* Margaret Fordham, *A Life Without Value? JV and Another v. See Tho Kai Yin*, 2005 SING. J. LEGAL STUD. 395, 404.

final arbiters in determining medical negligence.”⁴⁷⁴ He criticizes *Bolam* for allowing the medical profession to self-regulate and for allowing judges to abdicate their responsibility to determine the *legal* standards of care and negligence.⁴⁷⁵ Professor Amirthalingam also recommends that Singaporean courts abandon the English approach in *Bolam* and embrace the more neutral Australian approach enunciated in *Rogers v. Whitaker*, which reasserted the role of courts in determining the standard of care.⁴⁷⁶ As it is under *Bolam* in India and Thailand, expert medical testimony in Singapore enjoys almost talismanic power, which of course lowers the chance that patients will successfully recover damages.⁴⁷⁷

But *Bolam* is only one part of the medical malpractice atmosphere in Singapore. As in India and Thailand, patients in Singapore face other obstacles in proving negligence.⁴⁷⁸ Indeed, a full assessment of Singapore’s medical malpractice system shows why patients remain so reluctant to sue.

First, lawyers in Singapore cannot accept contingency fees, thus guaranteeing that litigation will be a sunk cost for patients.⁴⁷⁹ And those brave enough to file suit have a strong incentive to settle because a court can impose costs if the case goes to trial and the court finds that an original settlement offer was reasonable.⁴⁸⁰ Perhaps more importantly, patients are deterred from filing all but the strongest medical negligence claims because a court may order the plaintiff to pay the defendant’s costs if the patient fails to prove negligence.⁴⁸¹ Singapore also does not provide jury trials in medical malpractice cases,⁴⁸² which may further disadvantage patients.⁴⁸³

Perhaps unsurprisingly, patients in Singapore seem to be among the least litigious of wealthy, industrialized countries.⁴⁸⁴ Patients there historically have

474. Amirthalingam, *supra* note 438, at 125.

475. *See id.* at 130.

476. [1992] 175 C.L.R. 479 (Austl.); *see* Amirthalingam, *supra* note 438, at 127, 136; Margaret Fordham, *Doctor Does Not Always Know Best: Foo Fio Na v. Dr. Soo Fook Mun*, 2007 SING. J. LEGAL STUD. 128, 132.

477. Fai, *supra* note 440, at 189; Fordham, *supra* note 473, at 406.

478. *See* Kaan, *supra* note 439, at 89; *supra* Sections II.A-B.

479. Kaan, *supra* note 439, at 89-90.

480. *Id.* at 89.

481. *Id.* at 90; Kandiah, *supra* note 439, at 467.

482. Kandiah, *supra* note 439, at 468 tbl.1.

483. For a look at the complicated role of juries in medical malpractice cases, *see*, for example, Nancy S. Marder, *The Medical Malpractice Debate: The Jury as Scapegoat*, 38 LOY. L.A. L. REV. 1267 (2005).

484. *See, e.g.*, M.K. Lim, *Quest for Quality Care and Patient Safety: The Case of Singapore*, 13 QUALITY & SAFETY HEALTH CARE 71, 74 (2004), available at <http://www.who.int/management/questqualitysingapore.pdf>.

been very reluctant to sue,⁴⁸⁵ and very few medical negligence cases in Singapore proceed to trial.⁴⁸⁶ Court records in Singapore show that the number of medical negligence lawsuits has been trivial: three in 1998, seven in 1999, and ten in 2000.⁴⁸⁷ In 2007, medical malpractice cases in the public health sector had fallen from roughly fifteen cases per year in the late 1990s to around eleven per year, counter to the international trend.⁴⁸⁸ In a comprehensive review of initiatives to improve health care quality in Singapore, Professor Lim emphasizes that most of these quality initiatives were pressed by the government rather than the public, “and certainly not the medical profession.”⁴⁸⁹ By attracting patients from the United States and other more litigious societies, Singapore may be inviting a group of patients that is more aware of and ready to assert its legal rights.

Second, as in other jurisdictions, patients may encounter resistance securing an expert medical witness to testify against a colleague—the so-called “conspiracy of silence.”⁴⁹⁰ One possible solution would be for courts to rely more liberally on the doctrine of *res ipsa loquitur*, which allows a plaintiff to establish prima facie evidence of negligence without relying heavily or exclusively on expert medical testimony.⁴⁹¹ However, courts in Singapore historically have been less willing to apply this doctrine than courts in the United States,⁴⁹² and it logically applies only in the most unequivocal cases.

Third, as in most jurisdictions, physicians are winning the public relations battle against medical malpractice suits, which generally creates a more hostile atmosphere for aggrieved patients. Many countries claim to be on the cusp of a malpractice litigation crisis that will drive up health care spending. *The Straits Times* reported that malpractice insurance premiums rose almost 300% for cosmetic and aesthetic surgeons in Singapore between 2002 and 2007.⁴⁹³ Some medical practitioners have used litigation statistics from the United States, the United Kingdom, and Australia to warn that there is a crisis in Singapore.⁴⁹⁴

485. See Fai, *supra* note 440, at 199.

486. Amirthalingam, *supra* note 438 (noting that most cases settle and the details are kept confidential, which precludes public scrutiny of the merits of the claims); Kaan, *supra* note 439, at 70.

487. Lim, *supra* note 484, at 74 (citing the 2002 Singapore High Court Registry).

488. Salma Khalik, *Fewer Suits Filed Against Public Hospitals; S'pore Bucks Rising Global Trend; Yearly Figures Here Fall from 15 Cases to About 11*, STRAITS TIMES (Sing.), Oct. 20, 2007, available at 2007 WLNR 20585394.

489. Lim, *supra* note 484, at 74.

490. Fai, *supra* note 440, at 195.

491. The doctrine was first enunciated in the 1863 English case, *Byrne v. Boadle*, [1863] 159 Eng. Rep. 299, in which the court presumed that a barrel of flour falling out of a second-story window was prima facie evidence of negligence.

492. Fai, *supra* note 492, at 197-99.

493. Khalik, *supra* note 488.

494. Amirthalingam, *supra* note 438, at 143.

Physicians groups like the Singapore Medical Association publish critiques of patient complaints and malpractice litigation.⁴⁹⁵ Medical commentators propagate these claims, contributing to the general atmosphere.⁴⁹⁶

This public relations campaign has driven a fear of a pending medical malpractice crisis that has probably contributed to courts' reluctance to relax the *Bolam* rule.⁴⁹⁷ Indeed, Professor Amirthalingam criticizes these tactics and argues that providers in Singapore already enjoy low malpractice costs:

All first world countries have far higher medical indemnity and general insurance costs, as well as higher compensatory awards. We cannot have our cake and eat it; the move to first world status also means embracing an advanced citizenry that is aware of its rights and desires to assert them.⁴⁹⁸

Fourth, even though Singapore enjoys a relatively high standard of living and is the most developed among major medical tourist destinations,⁴⁹⁹ malpractice awards can still be quite modest. For example, in 2001 *The Straits Times* published an article describing a S\$2.55 million medical negligence judgment by the Singapore High Court (\$1.4 million).⁵⁰⁰ The full-page article describing this “astronomical sum” triggered a “torrent of letters to the newspaper” and “terrified” local physicians.⁵⁰¹ The Court of Appeal swiftly overturned the decision and reaffirmed *Bolam*'s highly deferential standard.⁵⁰² Before this record award, the previous record in a medical negligence case in Singapore appears to have been only S\$356,000 (\$200,000).⁵⁰³ However, in 2007, *The Straits Times* reported a medical malpractice award of S\$2 million

495. P.Y. Cheong, *Handling of Patients' Complaints*, 39 SING. MED. J. 386 (1998), available at <http://www.sma.org.sg/smj/3909/articles/3909e1.html>. To be fair, some physicians do publish honest self-assessments of their role in malpractice. See, e.g., S.Y. Tan, *Blame the Pilots, Blame the Doctors: Lessons from SQ 006*, 43 SING. MED. J. 276 (2002), available at <http://www.sma.org.sg/smj/4306/4306e2.pdf>.

496. See, e.g., Amirthalingam, *supra* note 437, at 471 (noting that the authors of the book he is reviewing show “almost reverent support” for the negligence test in *Bolam* and issue “dire warnings against any dilution of it”).

497. See Amirthalingam, *supra* note 438, at 143-144.

498. *Id.* at 144-45.

499. Lim, *supra* note 484, at 71.

500. H.T. Liang, *When Medical Experts No Longer Hold Sway*, STRAITS TIMES (Sing.), July 21, 2001, at H12. Using the exchange rate on July 2, 2001, this calculates to \$1.37 million. See Federal Reserve Statistical Release H.10, Foreign Exchange Rates, Historical Rates for Singapore, http://www.federalreserve.gov/releases/h10/hist/dat00_si.htm (last visited Nov. 22, 2009).

501. Amirthalingam, *supra* note 438, at 125.

502. *Id.* at 125 (citing *Dr. Khoo James v. Gunapathy d/o Muniandy* [2002] 2 S.L.R. 414, 419 (Sing.)).

503. See Amirthalingam, *supra* note 438, at 143.

(\$1.3 million)⁵⁰⁴ and the resulting increase in malpractice insurance rates.⁵⁰⁵ Thus, aggrieved patients in Singapore may be faring better than they have historically, which could signal a better legal atmosphere for foreign patients.

2. The Singapore Medical Council

All physicians in Singapore must register with the Medical Council, a component of the Ministry of Health.⁵⁰⁶ The Council has statutory authority to discipline physicians for unprofessional conduct or other ethical transgressions, usually by removing them from the registry, restricting their practice, levying fines up to S\$10,000, or censuring them.⁵⁰⁷ Although more severe cases of medical malpractice may rise to the level of an ethical transgression, this is rare. Further, the Council cannot compensate patients, nor can it compel physicians to provide patients their medical records, which are necessary to support a malpractice suit.⁵⁰⁸

The overall number of complaints made to the Council is rising, from 84 in 2004 to 138 in 2008,⁵⁰⁹ although there has been no upward trend in the number of complaints filed per physician.⁵¹⁰ Around 20% of complaints allege medical negligence, though a higher number could be categorized as such.⁵¹¹ The Council's complaint form notes that investigations may take between six and nine months, if not longer.⁵¹²

The Ministry of Health is considering proposals to amend the Council's

504. Khalik, *supra* note 488. I used the exchange rate on January 2, 2007. See Federal Reserve Statistical Release H.10, *supra* note 503.

505. Khalik, *supra* note 488.

506. Kaan, *supra* note 439, at 43, 47-49; Singapore Medical Council, Home, http://www.smc.gov.sg/html/SMC_Home.html (last visited Nov. 22, 2009).

507. See Medical Registration Act § 40, Ch. 174 (Sing.); Kaan, *supra* note 439, at 43, 47-49, 51-52.

508. Singapore Medical Council, Frequently Asked Questions, http://www.ifaq.gov.sg/smc/apps/fcd_faqlmain.aspx (last visited Nov. 22, 2009).

509. Jessica Jaganathan, *Quicker Action on Complaints: Higher Maximum Fines Proposed in Changes to Medical Registration Act*, STRAITS TIMES (Sing.), Jan. 15, 2009, available at http://www.straitstimes.com/Breaking%2BNews/Singapore/Story/STISStory_326369.html.

510. SING. MED. COUNCIL, ANNUAL REPORT 2007, at 16 tbl.1, available at <http://www.smc.gov.sg/html/MungoBlobs/629/548/Annual%20Report%20v06.pdf>.

511. *Id.* at 16-17 tbl.2. The Council categorized the "nature" of each complaint. In addition to "professional negligence/incompetence," other categories could qualify as negligence as a legal matter, including for example "excessive/inappropriate prescription of drugs," "misdiagnosis," and "over/unnecessary/inappropriate treatment."

512. Singapore Medical Council, Instructions on Putting Up a Statutory Declaration, http://www.smc.gov.sg/html/SMC_DownloadForms.html (follow link for "complaints/disciplinary proceedings forms") (last visited Nov. 22, 2009).

grievance procedures.⁵¹³ For example, the proposals would 1) increase maximum fines from S\$10,000 to S\$100,000, 2) speed up the complaint process, 3) broaden the Council's powers to recommend outside mediation, and 4) allow patients to appeal decisions to the Singapore High Court.⁵¹⁴ Currently, patients can appeal decisions by the Council's complaints committee to the Health Minister, but only physicians can further appeal those decisions to the High Court.⁵¹⁵ Singapore may try to use these proposed reforms to shift complaints away from civil tort litigation.

3. *Criminal Sanctions in Singapore*

When a patient dies, Singapore's Criminal Procedure Code requires a public coroner's inquiry to determine the precise cause of death.⁵¹⁶ The coroner does not initiate formal charges or recommend sanctions, but the coroner may identify specific medical professionals as defendants for potential prosecution.⁵¹⁷ Yet the coroner's inquiry does not obligate the Attorney General to prosecute, nor can plaintiffs use it as evidence in civil suits.⁵¹⁸ Given that only a patient's death can trigger criminal action as well as the limited impact of coroners' reports, criminal proceedings against physicians remain exceedingly rare.⁵¹⁹

4. *Foreign Patients in Singapore*

Singapore is an established medical destination whose hospitals have experience handling foreign patients. However, Singapore's medical malpractice system generally favors providers and disfavors patients, and the few patients that win judgments receive compensation that is modest not only by U.S. standards, but by standards appropriate for a country with Singapore's wealth. Scholars have called for courts in Singapore to reassert themselves in medical negligence cases, but the common law remains a significant obstacle. The general atmosphere also tends to encourage mediation and settlement over full-blown litigation.

The bright spot for patients is that, overall, Singapore's health care system

513. See Medical Registration Amendment Bill, 2009 (Sing.), available at [http://www.moh.gov.sg/mohcorp/data/EConsult/752/draft_mra%20\(amendment\)_bill140109.pdf](http://www.moh.gov.sg/mohcorp/data/EConsult/752/draft_mra%20(amendment)_bill140109.pdf); Jaganathan, *supra* note 509; Singapore Ministry of Health, Legislation: E-Consultation, <http://www.moh.gov.sg/mohcorp/econsultationpast.aspx?ecid=752>.

514. Jaganathan, *supra* note 509.

515. *Id.*

516. Singapore Criminal Procedure Code, §§ 273-277, Ch. 68, Rev. Ed. 1985 (Sing.); see also Kaan, *supra* note 439, at 68-69.

517. Kaan, *supra* note 439, at 69.

518. *Id.* at 69.

519. *Id.* at 70-71.

enjoys a relatively strong regulatory environment,⁵²⁰ contrary to many other medical tourist destinations. The Ministry of Health and the Singapore Medical Association have initiated programs to study the incidence of medical errors and reduce them.⁵²¹ Moreover, practitioners have embraced evidence-based medicine to guide clinical practice, which some believe may frame standards of care in more concrete terms.⁵²² These developments should only help patients.

E. Mexico

Mexico has long been a medical destination for U.S. residents,⁵²³ and thousands on both sides of the border cross each day to purchase medical care, dental care, or pharmaceuticals.⁵²⁴ More recently, Mexican hospitals in cities like Monterrey are earning stellar reviews from U.S. patients,⁵²⁵ and health care providers in Mexico now actively compete for medical tourists.⁵²⁶ Private medicine is one of Mexico's most profitable industries,⁵²⁷ and cross-border health care between the United States and Mexico is a ripe market. At least 11.5 million people reside along the border.⁵²⁸ Many U.S. residents seek health care in Mexico because they are uninsured, have low incomes, or might prefer Spanish-speaking providers.⁵²⁹ Though prices may not be as low as in some Asian countries, Mexico's competitive advantage is its proximity to the United States.⁵³⁰

520. See Lim, *supra* note 484, at 72-75.

521. See *id.* at 74 (noting that "no one knows what the true incidence of medical errors is, but everyone knows it is certainly not zero").

522. See Kandiah, *supra* note 439, at 476-77 (noting, however, the complications of relying on evidence-based medicine both in guiding clinical practice and in determining legal standards of care).

523. BOOKMAN & BOOKMAN, *supra* note 6, at 49.

524. *Id.* at 49; Núria Homedes, *Globalization and Health at the United States-Mexico Border*, 93 AM. J. PUB. HEALTH 2016, 2017 (2003); David C. Warner & Pablo G. Schneider, *Cross-Border Health Insurance: Options for Texas*, at xxiv, xxv (2004) (unpublished manuscript, on file with author).

525. See, e.g., Alfredo Corchado & Laurence Iliff, *Good Care, Low Prices Lure Patients to Mexico*, DALLAS MORNING NEWS, July 28, 2007, at 1A.

526. *Id.*

527. BOOKMAN & BOOKMAN, *supra* note 6, at 3 (citing Jorge Augusto Arredondo Vega, *The Case of the Mexico-United States Border Area*, in INTERNATIONAL TRADE IN HEALTH SERVICES: A DEVELOPMENT PERSPECTIVE, *supra* note 294, at 161, 166.

528. Homedes, *supra* note 524, at 2016.

529. Cortez, *supra* note 6, at 101; Marissa Paul Walker & Robert Guerrero, *Cross-Border Health Insurance Initiatives in California, Texas and Arizona* 5, 8 (Jan. 30, 2003), available at <http://econdev.web.arizona.edu/pubs/az-mexico/pubs/Cross-BorderInsurance.pdf> (slides only).

530. BOOKMAN & BOOKMAN, *supra* note 6, at 58 (noting that proximity is an important factor for elderly and ill patients traveling from the United States and Canada to Mexico); Corchado & Iliff, *supra* note 525 (noting that surgeries are 40% less expensive in Mexico than in the United

Providers are using a combination of proximity, improved quality, and comparatively low prices to target not only individual patients, but also U.S. employers and insurers willing to outsource expensive surgeries or even routine checkups.⁵³¹

But Mexico's geographic proximity, shared demography, and cross-border commerce with the United States do not translate into many similarities between the countries' health care systems.⁵³² Providers along the border collaborate much less than we might expect, which some attribute to dramatically different systems for organizing, financing, delivering, and regulating health care.⁵³³

Moreover, although Mexico is geographically closer to the United States than India, Thailand, or Singapore, its malpractice compensation system may be the most distant. Like Thailand, Mexico is a civil law country, and its courts do not utilize juries or *stare decisis*.⁵³⁴ Tort litigation in Mexico is virtually non-existent, and medical malpractice cases are even rarer.⁵³⁵ Mexican law does not allow non-economic damages like pain and suffering, and its economic damages are deflated from being pegged to Mexico's workers' compensation statute.⁵³⁶ Mexican tort law is perhaps the most arcane, alien, and "contrastingly different" body of law between Mexico and the United States.⁵³⁷ As with India's consumer forums, Mexico's new National Commission for Medical Arbitration provides a more efficient alternative to civil litigation, but the compensation it awards would probably not satisfy most U.S. plaintiffs.

In short, U.S. patients traveling to Mexico for medical care should not assume that its legal or arbitration systems will provide satisfactory recourse. On the bright side, U.S. courts have demonstrated a willingness to hear complaints by U.S. residents arising in Mexico,⁵³⁸ which may be the best option for most American patients. In this section, I evaluate how Mexico handles malpractice

States); Kelly Arthur Garrett, *Prices of Medical Services Are at Least 30% Lower in Mexico than in U.S.*, EL UNIVERSAL (Mex.), Dec. 27, 2004, available at 2004 WLNR 14869899.

531. Jason Beaubien, *Mexican Hospitals Aim to Attract More Americans*, NPR WEEKEND EDITION SATURDAY, Jan. 3, 2009, available at 2009 WLNR 135025; Corchado & Iliff, *supra* note 525; Gabriela Rico, *U.S. Patients Turn for Care to Mexico*, ARIZ. DAILY STAR, Apr. 13, 2008, at A1.

532. See Homedes, *supra* note 524, at 2017.

533. *Id.*

534. Vargas, *supra* note 12, at 486.

535. Jorge A. Vargas, *Tort Law in Mexico*, in 2 MEXICAN LAW: A TREATISE FOR LEGAL PRACTITIONERS AND INTERNATIONAL INVESTORS § 21.5 (West 1998) [hereinafter Vargas, *Tort Law in Mexico*] (noting that very few Mexican attorneys handle tort cases, partly due to cultural preferences for resolving these disputes informally, and partly due to Mexico's relatively simple and limited compensation system); Garrett, *supra* note 530; Vargas, *supra* note 12, at 488.

536. Vargas, *supra* note 12, at 479, 484.

537. *Id.* at 484.

538. *Id.* at 476.

complaints, beginning with a brief case study evaluating how cross-border health insurers have handled the legal risks of relying on providers in Mexico.

1. The New Market for Cross-Border Health Insurance

Cross-border health insurance covering treatments in Mexico is becoming increasingly popular. In California, HMOs offer less expensive insurance plans to California residents willing to be treated in Mexico.⁵³⁹ For example, HealthNet, Blue Shield, and SIMNSA are selling plans with lower premiums and deductibles to U.S. citizens in California,⁵⁴⁰ and SIMNSA is selling similar plans to Mexican nationals residing in California.⁵⁴¹ These cross-border health plans generally cost 40-50% less than those that utilize U.S. providers only.⁵⁴²

The cross-border insurance trend emerged primarily after legislation in California legitimized these plans by establishing specific requirements to regulate them.⁵⁴³ Texas and Arizona have considered similar legislation, but concerns remain over legal liabilities and other practical impediments.⁵⁴⁴ Interestingly, California decided to regulate cross-border health plans in substantial part to protect consumers already using unregulated plans and to provide legal recourse in the United States should patients need to sue.⁵⁴⁵ California was concerned that U.S. nationals would find it difficult to seek redress in Mexican courts. In fact, California's statute prevents cross-border HMOs from forcing U.S. residents to rely on the unfamiliar Mexican legal

539. David Warner and Pablo Schneider have published a comprehensive analysis of these plans. See Warner & Schneider, *supra* note 524; see also Cortez, *supra* note 6, at 99-100; Ly Tran, *Sick and Tired of the Knox-Keene Act: The Equal Protection Right of Non-Mexican Californians to Enroll in Mexico-Based HMO Plans*, 14 SW. J.L. & TRADE AM. 357, 357-63 (2008).

540. Cortez, *supra* note 6, at 100.

541. Tran, *supra* note 539.

542. Sonya Geis, *Passport to Health Care at Lower Cost to Patient; California HMOs Send Some Enrollees to Mexico*, WASH. POST, Nov. 6, 2005, at A3; Tran, *supra* note 539, at 358.

543. Knox-Keene Act Health Care Service Plan Act of 1975, CAL. HEALTH & SAFETY CODE §§ 1340-1399 (West 2008) (regulating cross-border health plans sold to U.S. nationals); Warner & Schneider, *supra* note 524, at xix.

544. The Texas legislature considered several bills that would legalize cross-border health insurance. A 1999 bill would have legalized cross-border insurance, but the legislature instead only monitors the trend and has created an Interim Committee on Binational Health Benefit Plan Coverage to study the issue. Additionally, the Texas Department of Insurance studies cross-border insurance but remains concerned about the outstanding legal issues. Warner & Schneider, *supra* note 524, at xxi, 83-87, 89, 117-118 (citing various Texas House and Senate bills); see also Corchado & Iliff, *supra* note 525 (describing proposed legislation in Texas introduced in 2007 that "would have allowed U.S.-based insurers to cover health services in Mexico"); Walker & Guerrero, *supra* note 529.

545. See Tran, *supra* note 539, at 361.

system, even if care was provided in Mexico.⁵⁴⁶

The California statute protects U.S. residents in other ways. First, HMOs offering cross-border plans not only must establish grievance procedures in the United States but also must submit to California's jurisdiction.⁵⁴⁷ For example, SIMNSA maintains offices in San Diego to receive member complaints.⁵⁴⁸ Licensure by the California Department of Managed Health Care (DMHC) also triggers jurisdiction by U.S. courts.⁵⁴⁹ The DMHC has received very few complaints about cross-border health plans to date,⁵⁵⁰ though these grievance procedures may be a poor proxy for measuring the frequency of medical errors by Mexican providers.

Second, HMOs offering cross-border plans in California must regularly review the quality of Mexican providers⁵⁵¹ and must publish an advisory statement on health care in Mexico.⁵⁵² For example, Blue Shield's "Access Baja" plan states that both legal and medical standards differ in Mexico:

Legal requirements for and generally accepted practice standards of medical care in Mexico are different than those of California or elsewhere in the United States. . . . Any member who is not completely comfortable with the standards of care for the practice of medicine in Mexico should not enroll in the Access Baja HMO Health Plan.⁵⁵³

Unsurprisingly, Blue Shield disclaims liability for negligence committed by physicians, hospitals, or other providers in Mexico and classifies them as independent contractors.⁵⁵⁴ Blue Shield's plan also requires Mexican physicians to have their own malpractice insurance.⁵⁵⁵

In short, California addressed the problem of U.S. patients having to sue in Mexican courts by requiring health insurers to submit to U.S. jurisdiction.

546. Tran, *supra* note 539, at 365; Warner & Schneider, *supra* note 524, at 23.

547. CAL. HEALTH & SAFETY CODE § 1351.2(a)(10) (West 2008); Tran, *supra* note 539, at 371-72.

548. Warner & Schneider, *supra* note 524, at 54-55.

549. CAL. HEALTH & SAFETY CODE § 1351 (West 2008); Warner & Schneider, *supra* note 524, at 20, 23.

550. Tran, *supra* note 539, at 364 (citing Sarah Skidmore, *The Mexico Option: Cross-Border Health Insurance Is a Hit with Employers and Workers*, SAN DIEGO UNION-TRIBUNE, Oct. 16, 2005, at H1).

551. CAL. HEALTH & SAFETY CODE § 1370 (West 2008).

552. TEX. INTERIM COMM. ON BINATIONAL HEALTH BENEFIT PLAN COVERAGE, BINATIONAL HEALTH BENEFIT PLAN REPORT PURSUANT TO HB 2498 AND SB 496, at 7, 53 (2003), *available at* <http://www.senate.state.tx.us/75r/senate/commit/c1000/downloads/binational.pdf>.

553. *Id.*

554. *Id.* at 57.

555. Warner & Schneider, *supra* note 524, at 37.

Nevertheless, as in Blue Shield's case, insurers have shielded themselves from liability for malpractice committed by Mexican providers. Patients may still be able to sue these providers in U.S. courts, but they will have to establish personal jurisdiction, which is by no means certain. Otherwise, patients will be left to navigate Mexico's civil courts.

2. Civil Litigation in Mexico

Patients injured by medical malpractice in Mexico may sue in Mexico's civil courts. Some contend that U.S. citizens have adequate legal recourse in Mexico because patients are not only free to sue in Mexican courts but also to file claims with Conamed, Mexico's new medical arbitration board.⁵⁵⁶ However, as in India, Thailand, and Singapore, U.S. patients are likely to find these avenues of redress to be inadequate. There are serious concerns that Mexican courts do not provide any real recourse to victims of medical malpractice. First, most U.S. patients will find the Mexican legal system to be unfamiliar, and Mexican tort law is perhaps the most arcane and distinctive body of law between Mexico and the United States.⁵⁵⁷ Mexico's tort cases are governed primarily by the Federal Civil Code or a corresponding state code.⁵⁵⁸ Mexico's Civil Code has been described as "scant," "skeletal," "obsolete," and "simplistic"—and remains so because the Mexican legislature has not modernized it.⁵⁵⁹ In fact, tort law does not really exist in Mexico;⁵⁶⁰ instead, Mexico characterizes tort law as extra-contractual liability,⁵⁶¹ based on obligations arising from illegal acts.⁵⁶² The legislature has

556. Tran, *supra* note 539, at 371; Warner & Schneider, *supra* note 524, at 24. Note, however, that Tran acknowledges that the Mexican legal system differs from the U.S. legal system and suggests that U.S. citizens try to avoid Mexican courts. Tran, *supra* note 539, at 374-76.

557. Ryan G. Anderson, *Transnational Litigation Involving Mexican Parties*, 25 ST. MARY'S L.J. 1059, 1060 (1994); Vargas, *supra* note 12, at 484.

558. Vargas, *Tort Law in Mexico*, *supra* note 535, § 21.2; Vargas, *supra* note 12, at 478 (citing Articles 1910-1934 of the Federal Civil Code and noting that the thirty-one state codes overwhelmingly adopt these articles).

559. Vargas, *supra* note 12, at 478, 487-88, 499 ("[T]he legal principles that control personal bodily injuries and wrongful deaths in [Mexico] have been kept in isolation and virtually untouched in a legal time capsule that is today legally obsolete and completely out of sync with Mexico's economic and industrial realities."); *see also* Vargas, *Tort Law in Mexico*, *supra* note 535, § 21.41.

560. Vargas, *Tort Law in Mexico*, *supra* note 538, § 21.2.

561. Código Civil Federal [C.C.F.] [Federal Civil Code], *unamended*, Art. 1910, Diario Oficial de la Federación [D.O.], 26 de Mayo de 1928 (Mex.).

562. Jorge Mario Magallón Ibarra, *La Responsabilidad Profesional De Los Medicos*, 1 MEXICAN L. REV. 46, 54 (2004) ("[L]a conducta del que obrando ilícitamente o contra las buenas costumbres cause daño a otro, resulta obligado a repararlo, a menos que demuestre que el daño se produjo como consecuencia de culpa o negligencia inexcusable de la víctima."), *available at* <http://www.juridicas.unam.mx/publica/librev/rev/derpriv/cont/1/dtr/dtr4.pdf>; Vargas, *Tort Law in Mexico*, *supra* note 535, §§ 21.11-21.13; Vargas, *supra* note 12, at 496-98.

not clarified when courts should find fault, negligence, or causation.⁵⁶³ As a result, such questions are left almost entirely to the discretion of individual judges.⁵⁶⁴ Tort law and its attendant concepts are “alien to Mexican legal thinking.”⁵⁶⁵ Mexican courts do not use juries, nor do they use *stare decisis* to establish binding judicial precedents.⁵⁶⁶ Moreover, Mexican courts do not utilize pretrial discovery, instead relying on courts to conduct discovery during trial.⁵⁶⁷ Together, these features suggest that medical malpractice litigation in Mexico’s civil courts will present foreign patients with significant burdens.

Second, and perhaps most importantly, foreign patients will be underwhelmed with malpractice awards in Mexico. Mexican law does not award punitive or exemplary damages, damages for pain and suffering, or damages for loss of consortium.⁵⁶⁸ Even tort actions involving death only generate an amount around \$17,880 pursuant to the Civil Code’s formula for calculating damages.⁵⁶⁹ Such paltry compensation undoubtedly encourages Americans injured in Mexico to sue in U.S. courts.⁵⁷⁰

Courts in Mexico calculate tort compensation by referring to the workers’ compensation formula.⁵⁷¹ Mexico’s Federal Civil Code directs courts to calculate economic recoveries in tort under the Federal Labor Act, as if the victim were a Mexican laborer injured at work.⁵⁷² Courts may award patients the costs of medical care and rehabilitation, but economic losses are limited to four-times the prevailing minimum wage in the state, multiplied by the number of days assigned to the specific disability claimed under the Federal Labor Act.⁵⁷³ As a result, tort damages have been described as “outdated and less than frugal,”⁵⁷⁴ and very few attorneys even handle—let alone specialize in—personal injury cases.⁵⁷⁵

Third, tort cases are extremely rare in Mexican courts. Americans injured

563. Vargas, *supra* note 12, at 499-500. The Mexican Supreme Court refers briefly to negligence and custom in its *Jurisprudencias*, but merely to emphasize that judges should use their discretion. Vargas, *Tort Law in Mexico*, *supra* note 538, § 21.23.

564. Vargas, *supra* note 12, at 499-500.

565. Vargas, *Tort Law in Mexico*, *supra* note 535, § 21.7.

566. Vargas, *supra* note 12, at 486.

567. Anderson, *supra* note 557, at 1060.

568. Vargas, *supra* note 12, at 484; Vargas, *Tort Law in Mexico*, *supra* note 535, § 21.2.

569. Vargas, *supra* note 12, at 503.

570. Vargas, *Tort Law in Mexico*, *supra* note 535, § 21.2; Vargas, *supra* note 12, at 503. See generally Anderson, *supra* note 557, at 1100-03; Kozolchik & Ziontz, *supra* note 566.

571. Vargas, *supra* note 12, at 479.

572. Vargas, *supra* note 12, at 478 (citing Ley Federal del Trabajo [L.F.T.] [Federal Labor Law], *as amended*, Diario Oficial de la Federación [D.O.], Title IX, arts. 477-80, 487, 491-93, 495-97, 500-02, 1 de Agosto de 1971 (Mex.)).

573. Vargas, *supra* note 12, at 479.

574. *Id.* at 488.

575. *Id.* at 501-02; Vargas, *Tort Law in Mexico*, *supra* note 535, § 21.5.

while visiting Mexico greatly prefer to sue in the United States.⁵⁷⁶ In fact, U.S. courts decide a far larger number of tort cases arising in Mexico than Mexican courts do.⁵⁷⁷ Professor Vargas states bluntly that “the practice of tort law in Mexico is simply non-existent” and proposes modernizing the framework by borrowing principles from Europe and the United States.⁵⁷⁸ Adding to the danger for patients, there is almost no product liability law in Mexico,⁵⁷⁹ leaving patients exposed should they be injured by faulty pharmaceuticals or medical devices.

Fourth, as in India, Thailand, and Singapore, Mexican culture fundamentally differs from U.S. culture on its desire and tolerance for adversarial litigation.⁵⁸⁰ Mexicans remain pointedly distrustful that courts will resolve disputes fairly.⁵⁸¹ Of course, as in the other countries I examine, observers in Mexico firmly believe that more and more tort cases are being filed, spurred in part by growing consumer awareness.⁵⁸² Mexico claims to be beset by a surge of medical malpractice suits, which observers attribute to “poor personal communication, unrealistic expectations of performance, the high costs of medical attention, and better informed and more critical patients.”⁵⁸³ Some lament that the growing number of lawsuits creates a “vicious circle” of rising insurance premiums, defensive medicine, and rising health care costs.⁵⁸⁴ Unfortunately, as is common in other jurisdictions, the critics decry the situation in Mexico but only cite as support articles describing malpractice litigation in the United States and the United Kingdom.⁵⁸⁵

Thus, foreign patients will likely find that Mexico’s civil litigation system provides inadequate redress for medical negligence. Tort litigation is almost non-existent; damages are modest by U.S. standards and are limited by law. Further, the legal system is arcane, costly, and not trusted by its own citizens.

3. Mexico’s New National Commission for Medical Arbitration

As in India, the Mexican government confronted its flawed civil litigation system by creating an alternative. Malpractice victims in Mexico now have access to a new medical arbitration system, formed to provide a less formal and

576. Vargas, *supra* note 12, at 477.

577. *Id.* at 478.

578. *Id.* at 488.

579. *Id.* at 494-96.

580. *Id.* at 502.

581. *Id.* at 502.

582. *Id.* at 506-07, 519.

583. See, e.g., Carlos Tena-Tamayo & Julio Sotelo, *Malpractice in Mexico: Arbitration Not Litigation*, 331 BRITISH MED. J. 448 (2005).

584. *Id.* at 448.

585. *Id.* at 448 (citing five articles, none of which address Mexico).

costly alternative to civil litigation.⁵⁸⁶ In 1996, President Ernesto Zedillo created by decree the National Commission for Medical Arbitration (Comisión Nacional de Arbitraje Médico, or “Conamed”), residing within the Ministry of Health, and composed entirely of government-paid employees.⁵⁸⁷ Zedillo’s decree gave Conamed jurisdiction to advise parties of their legal rights and obligations and to investigate, hear, and resolve complaints concerning medical care.⁵⁸⁸

Conamed has had some success with its efforts to resolve disputes promptly by having a specialized consultant contact the parties. Between 2001 and 2003, Conamed resolved 73% of nearly 15,000 cases within forty-eight hours of being filed.⁵⁸⁹ If the special consultant fails and a complaint is filed, Conamed will assemble the parties to negotiate during an initial, conciliatory phase.⁵⁹⁰ Fourteen percent of cases filed are resolved by conciliation,⁵⁹¹ in an average of three to six months.⁵⁹²

If the parties do not settle, the case continues to a Conamed arbitrator.⁵⁹³ Conamed then gathers expert medical opinions, including the opinion of the treating physician.⁵⁹⁴ Arbitration generally takes an average of fifteen months.⁵⁹⁵ Conamed has a major advantage over courts because it enjoys credibility in medical disputes.⁵⁹⁶ For example, when selecting physicians and lawyers to handle each dispute, Conamed “consider[s] their expertise, academic background, impartiality in the specific case, and up to date knowledge in the particular branch of the medical specialty involved.”⁵⁹⁷

586. Vargas, *supra* note 12, at 519-20.

587. Magallón Ibarra, *supra* note 562, at 47-48 (describing the purposes and promise of Conamed); Tena-Tamayo & Sotelo, *supra* note 583, at 449; Comisión Nacional de Arbitraje Médico, <http://www.conamed.gob.mx/index.php> (last visited Nov. 22, 2009).

588. Magallón Ibarra, *supra* note 562, at 47-48 (“[L]a Comisión Nacional de Arbitraje Médico . . . puedan contribuir de manera imparcial, al análisis, dictamen y resolución de las quejas y controversias que surjan entre ellos, con motivo de lo que se consideren irregularidades en las prestación o negativa a la prestación de los servicios médicos.”); Jorge Fernández Ruiz, *La Comisión Nacional De Arbitraje Médico y La Responsabilidad De Los Servidores Públicos* [*The National Commission of Medical Arbitration and the Responsibility of Civil Servants*], 3 MEXICAN L. REV. 311, available at <http://www.juridicas.unam.mx/publica/librev/rev/boletin/cont/92/art/art1.pdf>; Tena-Tamayo & Sotelo, *supra* note 583, at 449.

589. Tena-Tamayo & Sotelo, *supra* note 583, at 449, 450.

590. *Id.* at 449.

591. *Id.* at 449, 450.

592. *Id.* at 450.

593. *Id.* at 449 (citing Comisión Nacional de Arbitraje Médico, <http://www.conamed.gob.mx/index.php> (last visited Nov. 22, 2009)).

594. *Id.*

595. *Id.*

596. *Id.*

597. *Id.* at 450.

If Conamed arbitrators find that the physician committed malpractice (usually negligence), then it can award monetary damages under the same criteria used in civil litigation, relying on Mexico's workers' compensation formulas.⁵⁹⁸ However, Conamed's National Commissioner acknowledged that the amount awarded in arbitration is usually lower than that awarded by courts.⁵⁹⁹ In fact, data from Conamed show that cases resolved through conciliation or arbitration typically result in the health care provider solely agreeing to assume responsibility for providing ongoing medical care.⁶⁰⁰ Only 28% of the complaints resolved through conciliation or arbitration resulted in damage awards, paying an average of only \$4841 to each patient.⁶⁰¹

In addition to the limited damages, Conamed has other limitations. Both patients and health care providers must agree to resolve the dispute via Conamed. Although either party may withdraw from Conamed at any time prior to signing the arbitration agreement,⁶⁰² once the arbitration contract has been signed, neither party may take the case to court.⁶⁰³ Similarly, Conamed cannot resolve disputes already being heard by courts.⁶⁰⁴ Moreover, "Conamed is not a judicial authority" and cannot enforce its own judgments,⁶⁰⁵ though it is not clear if lack of enforcement has been a problem.

Conamed maintains comprehensive data of its complaints and resolutions, which aids potential medical tourists in understanding their likelihood of success in Conamed.⁶⁰⁶ As noted above, almost three-quarters of all cases are resolved by special consultants before a formal complaint is filed.⁶⁰⁷ Of the cases that proceeded to conciliation or arbitration, 47% were not resolved, either because a party withdrew or the parties went to court.⁶⁰⁸ Of all the cases filed with Conamed, approximately 12% were left unresolved.⁶⁰⁹

The data also show that of the complaints Conamed resolved through conciliation or arbitration, 66% concluded that no medical malpractice occurred, while 34% found evidence of malpractice.⁶¹⁰ A separate analysis of randomly

598. *Id.* 449, 450.

599. *Id.* at 449.

600. *Id.* at 449-50.

601. *Id.* at 450 (stating that Conamed awarded a total of \$2.9 million to 599 patients).

602. *Id.*

603. *Id.* at 449.

604. *Id.*

605. *Id.*

606. Maria-Eugenia Jimenez-Corona et al., *Epidemiology of Medical Complaints in Mexico: Identifying a General Profile*, 18 INT'L J. QUALITY IN HEALTH CARE 220, 221 (2006).

607. See text accompanying note 588.

608. Tena-Tamayo & Sotelo, *supra* note 583, at 449 box 1, 450.

609. *Id.*

610. *Id.* at 450.

sampled cases found evidence of malpractice in 36.5% of cases.⁶¹¹ Thus, this study corroborated the outcomes reached in Conamed's arbitrations. Additionally, this study found that 67% of the malpractice cases were attributable to the provider's lack of skill rather than negligence.⁶¹²

To date, patients and health care providers seem to be highly satisfied with Conamed. In a survey of over 5500 patients and physicians that used Conamed, 97% of respondents rated the process as good or excellent.⁶¹³

Before Conamed was created, there had been "no systematic review of the annual trends of medical complaints and litigation in Mexico."⁶¹⁴ Thus, Conamed has provided not only an accessible alternative to civil litigation, but also a glimpse into trends surrounding malpractice complaints in Mexico. Unfortunately, even a more efficient, neutral alternative like Conamed is unlikely to provide much recourse to foreign patients if recoveries average only \$4841 per patient.⁶¹⁵

4. Foreign Patients in Mexico

Under almost any scenario, Mexico will continue to compete for U.S. patients. However, patients that visit Mexico to avoid wandering too far from the United States should know that Mexico's legal system does not share the same proximity. As in India, Thailand, and Singapore, seeking recourse in Mexico's civil courts remains fraught with difficulties. And though Conamed provides a relatively neutral, efficient alternative, compensation is still extremely modest by U.S. standards. Moreover, it is telling that California, one of the only legislative bodies to have addressed cross-border health insurance, took several steps to minimize patients' exposure to Mexico's legal system.

Patients should also know that health care in Mexico differs from health care in the United States much more than one might expect, given the countries' shared border, demography, and commerce. The Mexican government approves credentials for physicians and hospitals and provides legal recourse to patients,⁶¹⁶ but these systems are evolving and are in some cases relatively new.⁶¹⁷ Moreover,

611. Jimenez-Corona et al., *supra* note 606, at 221.

612. *Id.* at 221. The authors sorted the "malpractice" cases into lack of skill (67.4% of cases), negligence (30.0%), and deceit (2.6%).

613. Tena-Tamayo & Sotelo, *supra* note 583, at 451 (citing an anonymous Conamed survey conducted in 2002 and 2003).

614. *Id.*

615. *Id.* at 449, 450 (stating that Conamed awarded a total of \$2.9 million to 599 patients, an average of \$4841 per patient).

616. Warner & Schneider, *supra* note 524, at xxv.

617. See TEX. STATE SENATE, REPORT OF THE INTERIM COMM. ON BINATIONAL HEALTH BENEFIT PLAN COVERAGE 8-11 (2003), available at <http://www.senate.state.tx.us/75r/senate/commit/c1000/downloads/binational.pdf>.

Mexico generally does not regulate medical services or impose quality controls to the same extent as the United States.⁶¹⁸ Although these differences may wane as more private hospitals in Mexico cater to foreign patients, Mexican health care providers, insurers, and institutions remain distinct from their U.S. counterparts. For example, researchers have found “profound distrust between decisionmakers and health care workers on both sides of the border.”⁶¹⁹ Patients visiting Mexico should thus consider how they might establish jurisdiction to sue negligent providers in U.S. courts, as U.S. residents have done in other personal injury contexts.

III. REALLOCATING THE LEGAL RISKS OF CROSS-BORDER HEALTH CARE

Medical tourists face real obstacles seeking recourse for medical errors. In Part I, I described how aggrieved patients might struggle in U.S. courts not only to resolve issues of jurisdiction, venue, and choice of law in their favor, but to prove sometimes attenuated theories of liability. In Part II, I explained how patients visiting India, Thailand, Singapore, and Mexico might not recover adequate, timely compensation in those jurisdictions. Two themes join Parts I and II: there are very real obstacles for patients seeking legal recourse for medical errors committed overseas, and patients may not fully appreciate these obstacles. As a result of patients’ lack of understanding, these transactions might not reflect the true risk tolerance of patients. This information deficiency may generate not only inefficient, suboptimal outcomes, but also injustice if patients agree to have surgery overseas based in part on assumptions that foreign legal systems will provide adequate recourse.

It is difficult to predict how destination countries or the medical tourism industry will respond. Some jurisdictions might “race to the top” by shoring up relatively weak systems for regulating local providers and compensating aggrieved patients, recognizing that inadequate legal protections might dissuade patients from visiting.⁶²⁰ Or jurisdictions might “race to the bottom” (or remain there) to keep prices low or offer treatments that are banned elsewhere.⁶²¹ Either way, it is probably unrealistic to expect countries that are strapped for resources and struggling with more pressing public health concerns to bolster legal remedies for patients—and perhaps ignore protectionist impulses.

Thus, in Part III, I evaluate how other parties might respond. First, I evaluate several private sector responses that have emerged, including certification, malpractice insurance, and industry guidelines. After evaluating the promise and weaknesses of these approaches, I suggest several methods the public sector

618. *Id.* at 12.

619. Homedes, *supra* note 524, at 2020.

620. Cortez, *supra* note 6, at 91 n.178; Terry, *supra* note 6, at 466.

621. Cortez, *supra* note 6, at 105; Terry, *supra* note 6, at 466.

might use to reallocate the legal risks of medical travel. I evaluate each response by its ability to both inform patients and improve their chances of obtaining adequate redress.

A. Private Sector Responses

The interests of patients and the medical tourism industry are not necessarily incompatible. Poor quality care and inadequate legal recourse can deter many would-be medical tourists, and defending litigation is burdensome and expensive for providers and insurers. Moreover, legal uncertainties may be discouraging both patients and insurers that would otherwise consider using foreign providers. Thus, companies have some incentives to reallocate the legal risks of medical travel more fairly. In this section, I analyze three different responses by the private sector to date, and I comment on how these responses may not accomplish their stated objectives.

1. Certification

Demand for reassurance in the chaotic medical tourism market has led the industry to respond. A newly-formed industry group, the Medical Tourism Association (MTA), recently began offering a pilot “Medical Tourism Facilitator Certification Program.”⁶²² The MTA intends to use certification to create “best practices” among medical tourism “facilitators” and to assure patients, insurers, and providers that certified facilitators meet certain minimum standards.⁶²³ The form asks applicants to answer over 200 questions regarding how they do business—including how they select foreign providers, handle patients, and earn revenues.⁶²⁴ Approved facilitators receive a renewable, two-year certification for \$2500.⁶²⁵

Because the certification program is new, it is unclear how it will operate, and more importantly, whether it will achieve the MTA’s stated goals. For example, the MTA claims that certification will generate “confidence, trust, and . . . credibility” for medical tourism companies in the eyes of both patients and insurers.⁶²⁶ However, as I have noted, industry self-regulation can be problematic and could be a mediocre substitute for government oversight here.⁶²⁷ Thus, it

622. Medical Tourism Association, Medical Tourism Facilitator Certification Program, 2008-2009, <http://medicaltourismassociation.com/certification.html> (last visited Nov. 22, 2009).

623. *Id.*

624. Medical Tourism Association, Medical Tourism Facilitator Certification 2009-2010, <http://medicaltourismassociation.com/Certification%20Evaluation%20Form.PDF> (last visited Nov. 22, 2009).

625. Medical Tourism Association, *supra* note 622.

626. Medical Tourism Association, *supra* note 622.

627. See Sections II.B (India), II.C (Thailand), II.D (Singapore), *supra*.

remains unclear whether the MTA's certification program will succumb to the same problems that plague the other self-regulatory bodies I discuss in this Article.

The MTA also claims that its certification program can help ensure patient safety.⁶²⁸ For example, the certification form asks whether the applicant: 1) verifies that its foreign providers are accredited and/or certified; 2) personally inspects foreign facilities and meets foreign surgeons; 3) tracks patient outcomes; 4) coordinates follow-up care; 5) validates the need for non-elective surgeries; 6) uses a medical advisor; and 7) uses a process to handle patient complaints.⁶²⁹

However, the MTA does not explain how it will tally or weigh answers to the application, nor does it explain the criteria it will use to grant or deny applications. For example, will the MTA deny applications that answer "no" or "not applicable" to some of these questions? The MTA also does not explain the criteria it will use to revoke certifications or renew applications or whether it would make such decisions public.

Notably, the MTA's application form also asks what information companies convey to patients about their potential legal recourse. For example, the form asks whether the company "adequately explains" the recourse available against the surgeon or hospital, including the "specific legal recourse options for each country" to which it sends patients.⁶³⁰

But what do these companies really know about the medical malpractice systems overseas? As I emphasized in Part II, it is difficult to navigate the medical malpractice systems in these countries, and there are no comprehensive and reliable sources of information. Most intermediaries disclose the legal risks in densely worded legalese, if at all. Moreover, what explanations will the MTA deem "adequate"? For example, must the company explain how Singaporean courts use a strict burden of proof that defers greatly to medical experts? Must companies explain how the civil code in Mexico calculates and caps damages? Do companies have to disclose the limited universe of remedies in India? Or would a general statement listing the possible avenues for recourse in each country suffice, without any analysis of whether the patient might find such recourse difficult to obtain or inadequate? Intermediaries may warn buyers to beware of foreign legal systems without either highlighting specific deficiencies with each system or demonstrating how such systems compare with U.S. courts. Thus, although it appears that the MTA wants facilitators to disclose the legal risks of medical travel, I remain skeptical that facilitators will disclose the critical details that patients may desire to know—such as the average medical malpractice award or the average length of time to recover. Moreover, even if facilitators disclose these details, patients might not fully understand how to

628. Medical Tourism Association, *supra* note 622.

629. Medical Tourism Association, *supra* note 624.

630. *Id.* (Section C, "Legal Recourse").

interpret and use such information.

Notwithstanding these criticisms, the certification program could live up to the MTA's aspirations of creating at least some standards and transparency in a market that currently lacks both. In fact, if the MTA made its data public, the program could achieve many of the objectives I have called for elsewhere, such as: 1) certification or licensure for medical tourism intermediaries, with the threat of decertification; 2) increased transparency in their business practices (to the extent the MTA makes this information public); and 3) gathering more data revealing what types of patients visit which countries for which procedures, including outcomes data.⁶³¹ Moreover, the MTA's certification program seems to encourage companies to think critically and creatively about patient safety, for example, by asking whether facilitators offer patients "complications insurance."⁶³²

Ultimately, however, the MTA is a trade organization, and its certification program—however well-intentioned—may be susceptible to the same pitfalls that plague other self-regulatory bodies. The companies applying for certification are the same companies whose fees fund the program and whose membership dues and advertising dollars fund the MTA itself.⁶³³ Can we trust the industry to regulate itself? At this point, we have no other choice, although elsewhere I have sketched out what government oversight of the industry might look like.⁶³⁴

2. Medical Malpractice Insurance for Patients

Companies that arrange for U.S. patients to travel overseas might consider offering patients insurance that covers any resulting injuries or complications, including the cost of any remedial care required back home.⁶³⁵

To date, there are few such products. Recently, AOS Assurance Company began offering "Patient Medical Malpractice Insurance" to medical tourists.⁶³⁶ Patients can purchase a policy that compensates them for lost wages, medical expenses, rehabilitation expenses, disfigurement, and death from "negligent injury or error" committed during a covered procedure.⁶³⁷ Policy coverage ranges

631. Cortez, *supra* note 6, at 123-27.

632. Medical Tourism Association, *supra* note 624 (Question E3, "Insurance").

633. Note that government regulators sometimes rely on "user fees" by regulated parties and may be criticized for such. See, e.g., James L. Zelenay, Jr., *The Prescription Drug User Fee Act: Is a Faster Food and Drug Administration Always a Better Food and Drug Administration?*, 60 FOOD & DRUG L.J. 261, 288, 330-34 (2005) (noting criticisms of the FDA for relying on user fees paid by pharmaceutical companies).

634. Cortez, *supra* note 6, at 123-27.

635. Terry, *supra* note 6, at 466.

636. AOS Assurance Company Ltd., Patient Medical Malpractice Insurance, <http://www.aosassurance.bb/PublicHtml/readmore.htm> (last visited Nov. 22, 2009).

637. *Id.* at 4; AOS, Patient Medical Malpractice Product Sheet, <http://www.aosassurance.bb/>

from \$100,000 to \$1 million.⁶³⁸ Companies can also purchase group policies.⁶³⁹

The policies cover only certain procedures performed by certain surgeons. The application form requires the patient to select among several dozen procedures and practitioners, though Aos may cover others not specifically listed.⁶⁴⁰ However, Aos does require that all procedures be performed at a facility accredited by Joint Commission International, by a board-certified physician or equivalent.⁶⁴¹

Aos markets this insurance as a way for patients to reduce the legal uncertainty of traveling overseas for surgery. For example, Aos notes in a brochure that “patients face dramatically increased liability exposure if a negligent injury should occur” overseas, because destination countries “have weak malpractice laws resulting in little to no recourse for the patient should something go wrong.”⁶⁴² Aos also advertises that it will settle claims 80% faster than patients would recover in U.S. courts.⁶⁴³ Finally, Aos promises that it will “handle and settle claims in accordance with the norms of the employee[’]s home country with local claim adjusters who understand the particular country customs and standards.”⁶⁴⁴ This could mean, for example, that Aos will provide greater reimbursement to patients from countries with higher standards of living, higher wages, and more expensive remedial care—though Aos does not clarify.

This type of insurance should improve as other companies begin offering competing products. For example, Aos charges policyholders \$1000 simply to file a claim and only refunds the fee if the claim prevails.⁶⁴⁵ Also, the prices quoted on Aos’s website show that purchasing a policy may add significantly to the overall cost of the venture.⁶⁴⁶ Such prices and terms may become more

PublicHtml/Documents/PMMI/PMMI%20Product%20Sheet.pdf (last visited Nov. 22, 2009).

638. *Id.*

639. Aos Assurance Company, *supra* note 636.

640. Aos Assurance Company, *supra* note 636 (Application Step 3).

641. *Id.*

642. AOS, EXECUTIVE SUMMARY: MITIGATING NEGLIGENT INJURY RISK: MEDICAL TOURISM 3, available at <http://www.aosassurance.bb/PublicHtml/Documents/PMMI/Executive%20Summary%20PMMI.pdf>.

643. AOS, Group Medical Malpractice Insurance (GMMI) Coverages, http://www.aosassurance.bb/PublicHtml/GMMI_Coverages.htm (last visited Nov. 22, 2009).

644. *Id.*

645. See AOS, Group Medical Malpractice Insurance (GMMI™) Product Sheet, <http://www.aosassurance.bb/PublicHtml/Documents/GMMI/GMMI%20Product%20Sheet.pdf> (last visited Nov. 22, 2009). Note, however, that Aos does not charge deductibles or copayments.

646. For example, purchasing the median policy with \$500,000 of coverage for arthroscopic surgery on an anterior cruciate ligament (ACL) would cost approximately \$948. See AOS, AOS Quick Quote, <https://www.aosassurance.bb/Reaktor2K7/application/quickquote/quickquote.aspx> (last visited Nov. 22, 2009) (select “Arthroscopic Surgery – Anterior Cruciate Ligament” from the “Procedure” menu and \$500,000 from the “Amount of insurance coverage in

favorable as more companies enter the market. Most importantly, these competition-driven policies are likely to offer peace of mind to patients venturing overseas. Intermediaries might even consider packaging these insurance products into the menu of services they offer.

3. Industry Guidelines

Demand for standards in the medical tourism industry has also prompted a response from the American Medical Association (AMA), which recently published what it calls the “first ever guidance on medical tourism.”⁶⁴⁷ The guidelines implore “employers, insurance companies, and other entities that facilitate or incentivize medical care outside the U.S.” to follow nine principles.⁶⁴⁸ For example, the AMA calls for all travel to be voluntary and instructs that financial incentives for patients “should not inappropriately limit the diagnostic and therapeutic alternatives that are offered to patients, or restrict treatment or referral options.”⁶⁴⁹

Like the MTA’s certification program, the AMA’s guidelines aspire to “ensure the safety of patients considering traveling abroad for medical care.”⁶⁵⁰ The guidelines, of course, bind no one. But the AMA says that it will try to codify these guidelines by introducing model legislation to state legislators.⁶⁵¹

Of course, like the MTA, the AMA is not exactly an objective bystander. U.S. physicians may lose business to foreign providers, and the AMA has publicly cautioned medical tourists about the quality of care overseas.⁶⁵² Nonetheless, the AMA has been a valuable counterpoint to the chorus of industry voices in the media that tend to downplay the risks of medical travel.

Finally, like the MTA’s certification program, the AMA’s guidelines are somewhat aspirational. For example, the AMA calls for companies to inform patients of “their rights and legal recourse prior to agreeing to travel outside the U.S. for medical care.”⁶⁵³ However, as I demonstrate throughout this Article, it is highly doubtful that most U.S. employers, insurers, or intermediaries know much about the medical malpractice systems in destination countries, as this information is elusive. Moreover, companies that try to inform patients of their

US\$” menu).

647. Press Release, Am. Med. Ass’n, *AMA Provides First Ever Guidance on Medical Tourism*, (June 16, 2008), available at <http://www.reuters.com/article/pressRelease/idUS38122+17-Jun-2008+PRN20080617>.

648. American Medical Association, *New AMA Guidelines on Medical Tourism*, <http://www.ama-assn.org/ama1/pub/upload/mm/31/medicaltourism.pdf> (last visited Nov. 22, 2009).

649. *Id.*

650. Press Release, Am. Med. Ass’n, *supra* note 647.

651. *Id.*

652. Edward R. Langston, Letter to the Editor, *CHI. TRIB.*, Apr. 8, 2008, at 20.

653. American Medical Association, *supra* note 648.

legal rights in the United States cannot speak with much authority, given the uncertainty surrounding these issues and the lack of test cases. Nonetheless, as more and better information becomes available, parties should follow the AMA's guidelines and disclose to patients the very real legal risks of having surgery overseas.

4. *Other Responses*

The private sector undoubtedly will conceive more creative ways to introduce standards and certainty to the medical tourism market, including ways for patients to mitigate their legal risks. Hopefully, these attempts move us toward a more equitable allocation of the legal risks and away from the current market allocation that shifts most of the risks to patients.⁶⁵⁴

For example, patients and intermediaries might agree contractually to resolve disputes through alternative dispute resolution, which could assure patients access to at least some realistic forum for redress. Intermediaries might also convince foreign providers to share the burdens of insuring against malpractice, contributing to a patient compensation fund, or perhaps funding alternative grievance procedures. Foreign providers might agree, for example, to compensate for specified losses, such as medical expenses, lost wages, and perhaps even limited payments for pain and suffering that are not available in some jurisdictions. These contributions would obviously raise the cost of medical tourism. But if foreign providers are going to avail themselves of patients from wealthier countries, they should understand that these patients probably expect larger recoveries.

Finally, a powerful tool may be negative publicity. As I have noted, negative publicity generated by medical malpractice suits could be catastrophic for foreign providers,⁶⁵⁵ especially if it jeopardizes contracts with U.S. insurers. In fact, demand for medical tourism services should be sensitive to perceptions of quality. High profile malpractice cases could discourage patients from going overseas.⁶⁵⁶ Unfortunately, there are few incentives in the industry that would encourage companies to publicize substandard quality care.⁶⁵⁷ Currently, we must rely on anecdotal media reporting and academic inquiries.

B. *Public Sector Responses*

Can the government respond to a medical tourism market that

654. Cortez, *supra* note 6, at 119.

655. *Id.* at 101.

656. BOOKMAN & BOOKMAN, *supra* note 6, at 60.

657. Note, however, that medical tourism intermediaries do have a significant incentive to avoid or cease contracting with substandard foreign providers, even if they probably would not publicize substandard care already provided to their customers.

disproportionately allocates legal risks to patients? Before answering, we must note some limits to what the government might reasonably achieve. First, as I note elsewhere, the government would have a difficult time restricting patient travel (an admittedly unlikely option),⁶⁵⁸ or targeting advertising or other commercial speech by medical tourism companies.⁶⁵⁹ Legislatures might consider extending long-arm jurisdiction over providers or intermediaries located overseas, but the federal Due Process clause would limit its reach.

Elsewhere I have called for a variety of government efforts that would provide greater oversight of the employers, insurers, and intermediaries that arrange for patients to travel overseas.⁶⁶⁰ Rather than repeating those recommendations here, I focus solely on fairly reallocating the legal risks. I propose a combination of methods below that would ease legal impediments to suing in the United States and inform patients of the risks of agreeing to assert claims in foreign courts. Importantly, these options need not replace private sector efforts; public and private efforts should operate in tandem.

1. Impose Strict Liability

Governments could create vicarious, strict liability by statute for U.S. employers, insurers, or intermediaries that send patients overseas.⁶⁶¹ For example, a medical tourist injured overseas could receive predetermined compensation based on the injury suffered, without needing to prove whether the provider or the intermediary was somehow negligent.

A vicarious strict liability regime could address several problems. First, vicarious liability would allocate legal responsibility to a U.S. company and thus avoid the burdens of suing in foreign jurisdictions or trying to sue foreign defendants here. Second, imposing strict liability would sidestep thorny legal questions of how to prove that either the provider or intermediary was negligent.⁶⁶² Third, strict liability might also encourage employers, insurers, and intermediaries to choose foreign providers more carefully, monitor quality, and perhaps purchase insurance to cover injuries—these companies are also in a better position to regulate, confront, and negotiate with foreign providers. Thus, vicarious strict liability would not only reallocate the legal risks more fairly, but would more closely align the interests of patients and intermediaries. Currently, employers and insurers save money sending patients overseas without bearing many of the risks.

Though statutory strict liability might appeal here in theory, governments

658. Cortez, *supra* note 6, at 114-18.

659. *Id.* at 119.

660. *Id.* at 118-27.

661. *Id.* at 122.

662. *Id.*

could find the system difficult to create and administer.⁶⁶³ Strict liability would require the government to administer a no-fault compensation system, much like our workers' compensation system or the no-fault system used to compensate for medical errors in New Zealand.⁶⁶⁴ The government would have to assign a range of remedies for a range of injuries, and most governments may be reluctant to devote the time and energy required to do so. Finally, as I have noted elsewhere, such heavy-handed approaches might have the perverse effect of driving medical tourism intermediaries overseas to less regulated jurisdictions.⁶⁶⁵

2. *Mandate or Encourage Insurance*

Governments should consider requiring employers, insurers, or other intermediaries to insure patients against medical errors or other complications arising from surgery overseas. Such insurance might take several forms. First, the government could require intermediaries to purchase (or at least offer) individual insurance policies covering each medical tourist, much like the policies offered by AOs. For example, a U.S. insurer that contracts with a foreign hospital might purchase accident insurance covering each patient sent to that hospital. Patients could even select the precise coverage they desire, similar to the AO policies. The government could mandate minimum coverage just as states mandate minimum automobile insurance. In the United Kingdom, the National Health Service encourages (but does not require) patients that travel to another EU member state for health care services under its E112 program to purchase insurance "to ensure any unforeseen emergencies are covered."⁶⁶⁶ Second, the government could require intermediaries to pay for all pre-screening or post-operative care that might be required in the United States, including any corrective treatments.⁶⁶⁷ This requirement would be a form of de facto insurance for patients injured overseas.

Although a mandate of either kind would increase the overall costs of the venture, it would better approximate the true risk tolerance of patients and would force suppliers of medical tourism services—both providers and intermediaries—to internalize more of the risks inherent in these transactions. Policymakers can require U.S. employers, insurers, or other intermediaries to pay for prescreening and post-operative care in the United States unless the company is able to procure an insurance policy meeting minimum standards.

663. *Id.*

664. Marie Bismark & Ron Paterson, *No-Fault Compensation in New Zealand: Harmonizing Injury Compensation, Provider Accountability, and Patient Safety*, 25 HEALTH AFF. 278 (2006).

665. Cortez, *supra* note 6, at 120.

666. National Health Service, *Going for Planned Treatment, Entitlement*, <http://www.nhs.uk/Treatmentabroad/Pages/Entitlement.aspx> (last visited Nov. 22, 2009).

667. Cortez, *supra* note 6, at 122.

3. Invalidate Liability Waivers

Legislatures might also consider prohibiting releases and waivers of liability, thus allowing courts to iron out complicated questions of duty, fault, and causation raised by medical tourist arrangements. For example, in the clinical research context, Food and Drug Administration regulations prohibit informed consent documents from including “any exculpatory language through which the subject or the representative is made to waive or appear to waive any of the subject’s legal rights.”⁶⁶⁸ Some state laws also broadly prohibit contracts that exempt one party from responsibility for negligence or violations of law.⁶⁶⁹ Likewise, legislatures may simply decide that courts should resolve liability in medical tourist arrangements by removing the legal obfuscation created by releases and waivers.

Without such legislation, it is not clear whether releases and waivers of liability in medical tourism transactions are valid. In general, liability releases for medical negligence are invalid as being contrary to public policy.⁶⁷⁰ Under the seminal case, *Tunkl v. Regents of the University of California*, the California Supreme Court refused to enforce a release signed by a patient that absolved UCLA Medical Center from liability for negligence, on the basis of a state statute prohibiting such agreements.⁶⁷¹ Releases in California are invalid only if they affect the public interest, and the court applied numerous factors to find that hospital-patient contracts do indeed affect the public interest.⁶⁷² But because the public interest is an amorphous concept, and because the freedom to contract between patients and providers varies by circumstances, several jurisdictions have departed from *Tunkl*.⁶⁷³ Medical tourist arrangements also complicate this analysis because releases and waivers are being sought not only by foreign providers who may not be subject to U.S. jurisdiction, but by intermediaries who do not provide medical care and do not factor neatly into the *Tunkl* criteria.⁶⁷⁴ Legislation could render moot these uncertainties.

Such legislation would also respond to normative arguments that patients

668. 21 C.F.R. § 50.20 (2007).

669. See, e.g., CAL. CIV. CODE § 1668 (West 2009).

670. MARK A. HALL, MARY ANNE BOBINSKI & DAVID ORENTLICHER, MEDICAL LIABILITY AND TREATMENT RELATIONSHIPS 419 (2005).

671. *Tunkl v. Regents of the Univ. of Cal.*, 383 P.2d 441 (Cal. 1963) (striking down the release under CAL. CIV. CODE § 1668).

672. *Id.* at 444-47.

673. See Maxwell J. Mehlman, *Fiduciary Contracting: Limitations on Bargaining Between Patients and Health Care Providers*, 51 U. PITT. L. REV. 365, 401-03 (1989-1990) (discussing alternative approaches adopted by courts).

674. It is not clear whether the factors enunciated in *Tunkl*, 383 P.2d at 445-46, would support invalidating releases of liability in medical tourist arrangements. In fact, application of each of the factors raises interesting policy questions.

should be free to waive legal rights in exchange for less expensive health care. For example, in their new book, *Nudge*, Richard Thaler and Cass Sunstein argue that patients should be allowed to waive the right to sue for medical malpractice, which would free them to negotiate for lower physician fees.⁶⁷⁵ Other scholars have also argued that in lieu of complete waivers, courts should enforce agreements by patients to lower providers' ordinary standard of care.⁶⁷⁶

However, even proponents of more moderate liability standards acknowledge that few courts currently support this position.⁶⁷⁷ And other scholars are poking holes in the wisdom of allowing patients to waive liability for malpractice, and even whether patients can or want to make these complex tradeoffs.⁶⁷⁸ Moreover, medical tourism complicates even this debate. Medical tourists do not exactly accept a lower standard of medical care by going overseas, but the standard might differ in tangible ways. Moreover, medical tourists may not be asked to waive liability completely, but simply agree to resolve disputes in foreign jurisdictions. This choice further complicates the question of whether medical tourists can make fully informed, rational, utility-maximizing decisions to waive legal recourse in the United States in exchange for less costly health care overseas. Again, legislation prohibiting such waivers or imposing strict, vicarious liability could render these difficult questions moot. Combined with a mandatory insurance requirement, the facilitators and suppliers in the medical tourism industry would also have to share the risks.

675. RICHARD H. THALER & CASS R. SUNSTEIN, *NUDGE: IMPROVING DECISIONS ABOUT HEALTH, WEALTH, AND HAPPINESS* 207-14 (2008).

676. See, e.g., Clark C. Havighurst, *Private Reform of Tort-Law Dogma: Market Opportunities and Legal Obstacles*, 49 *LAW & CONTEMP. PROBS.* 143 (1986). Note that Thaler, Sunstein, and Havighurst do not contemplate waivers in cross-border medical care arrangements and thus focus on advantages to be gained from bargaining within the U.S. health care system and its web of protective regulations.

677. Mark A. Hall, *Paying for What You Get and Getting What You Pay For: Legal Responses to Consumer-Driven Health Care*, 69 *LAW & CONTEMP. PROBS.* 159, 177 (2006) (noting the distinction between patients agreeing to reduce the level of resources used versus the level of skill used by the provider).

678. See, e.g., TIMOTHY STOLTZFUS JOST, *HEALTH CARE AT RISK: A CRITIQUE OF THE CONSUMER-DRIVEN MOVEMENT* 86-118 (2007) (critiquing the application of traditional neoclassical microeconomic theory to health care and patient decisionmaking); Jennifer Arlen & W. Bentley MacLeod, *Malpractice Liability for Physicians and Managed Care Organizations*, 78 *N.Y.U. L. REV.* 1929, 1998-2005 (2003) (arguing that waivers of liability for medical malpractice are suboptimal even when patients accurately anticipate the risks); Tom Baker & Timothy D. Lytton, *Allowing Patients to Waive the Right To Sue for Medical Malpractice: A Response to Thaler and Sunstein* (Univ. of Pa. Inst. for L. & Econ. Research, Paper No. 09-06, 2009), available at <http://ssrn.com/abstract=1349836>.

4. *Correct Information Asymmetries*

Finally, perhaps the least ambitious but most realistic way to begin to reallocate the legal risks is to correct specific information asymmetries that contribute to the current misallocation of risks. Patients should know what legal recourse they will have under different medical tourism arrangements, particularly those that ask patients to waive various legal rights or litigate in a foreign jurisdiction. Patients should remain free to have surgery overseas—either of their own volition or at the behest of an employer or an insurer—but patients should fully appreciate what legal and regulatory protections they might be sacrificing.

In this spirit, the public sector could try to correct specific information asymmetries in the medical tourism market. For example, a government agency, commission, or perhaps even a multilateral organization like the WHO, might provide information to medical tourists and other payors regarding the legal and regulatory systems in destination countries. These groups could publish country-specific studies comparing foreign legal and regulatory systems and might disseminate the findings through websites, press releases, ad campaigns, targeted announcements, or other methods. For example, some news outlets have provided checklists and answers to frequently asked questions to potential medical tourists.⁶⁷⁹ The government might do the same, except that it could commission more robust data. Governments might even encourage companies that arrange for surgery overseas to disseminate these materials as part of a campaign to encourage full disclosure of the risks.

This method would preserve the status quo that allows patients to forego potential legal recourse in exchange for lower prices, except that it helps patients understand precisely what additional legal risks they are bearing. The current market discloses the legal risks in vague disclaimers loaded with legalese and potentially misleading reassurances that patients, ultimately, do have some legal recourse, somewhere. The government should provide this information because it is doubtful that the market alone will encourage companies to generate or disseminate complete and accurate information.

Under the status quo, some patients may fully appreciate the tradeoffs they are making. However, considering the minimal information available to them, I suspect the majority do not. And those that do not would benefit considerably from the prophylactic measures I propose. The government might supplement these measures with existing regulatory tools, such as consumer protection regulations, bans on unfair or deceptive trade practices, and the like.⁶⁸⁰ Requiring

679. See Greg Allen, *Employers, Insurers Considering Overseas Health Care*, NPR ALL THINGS CONSIDERED, Nov. 14, 2007, available at <http://www.npr.org/templates/story/story.php?storyId=16294182>.

680. Cortez, *supra* note 6, at 119-20.

insurance and banning liability waivers would provide immediate protection for patients in these potentially unbalanced contractual relationships. Collectively, these measures could begin to reallocate more fairly the legal risks of medical travel.

CONCLUSION

This Article began with an ambitious but straightforward goal: to recalibrate the legal risks of cross-border health care by evaluating whether U.S. patients injured overseas have adequate legal recourse, either here or in one of four common destinations: India, Thailand, Singapore, and Mexico. The value, I hope, in covering these four separate jurisdictions is to fill a major void in the literature and give patients a sense of the variety of obstacles they might encounter when seeking legal recourse overseas. The decision to travel for medical care should accurately reflect patients' true risk tolerances, and providers and intermediaries in the industry should share the risks of these transactions. I also hope to encourage the industry to think more critically and creatively about how it might reallocate the legal risks, so they do not fall squarely on patients. In the long run, the industry would benefit from confronting these risks, rather than simply deflecting them to patients. Finally, for the policymakers, I hope to demonstrate how targeted intervention can fairly and efficiently redistribute the legal risks or at least enable patients to make more informed choices about traveling overseas.