November 25, 2010

Disputes Related to Healthcare Across National Boundaries: The Potential for Arbitration

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Available at: https://works.bepress.com/deth_sao/5/
DISPUTES RELATED TO HEALTHCARE ACROSS NATIONAL BOUNDARIES: THE POTENTIAL FOR ARBITRATION

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ABSTRACT

Trade in international health services has the potential to play a leading role in the global economy, but its rapid growth is impeded by legal barriers. Advances in technology and cross-border movement of people and health services create legal ambiguities and uncertainties for businesses and consumers involved in transnational medical malpractice disputes. Existing legal protections and remedies afforded by traditional judicial frameworks are unable to resolve the following challenges: (1) assertion of personal jurisdiction; (2) choice of forum and law considerations; (3) appropriate theories of liability for injuries and damages arising from innovations in medical care and delivery of health services; and (4) enforcement of foreign judgments. Such legal uncertainties and ambiguities call for a uniform means of redress that is more flexible and predictable than litigation in a court room. Given such needs, arbitration offers a potential solution, as it is a private streamlined adjudication process that has been successfully utilized on an international level to resolve several of the above mentioned legal quandaries. The voluntary, flexible, and legally binding nature of arbitration agreements across jurisdictions makes this form of dispute resolution more efficient and adaptive to changes in the health services industry than litigation. With careful construction of an approach that accounts for arbitration costs, reasonable recovery amounts, and complementary mechanisms such as no-fault compensation, international arbitration of medical malpractice disputes will reallocate the legal risks borne by businesses and consumers more fairly and efficiently.
I. INTRODUCTION

As one of the fastest growing sectors in the world economy, the international health services industry has been the focus of much attention and concern in business and legal circles. However, the potential of the health services industry to be a leading player in the global economy is impeded by several trade barriers, chief among them being legal liability risks and remedies for businesses and consumers. Earlier scholarship in international health services trade has analyzed legal barriers in this industry, and this paper attempts to build upon such existing scholarship by proposing the use of arbitration as a method of dispute resolution for transnational medical malpractice claims involving businesses and consumers.

International arbitration of these types of disputes would reallocate the legal risks borne by patients and foreign health care providers more fairly and efficiently. To build a case for such a proposal, part II of this paper will discuss the globalization and growth of the health services trade and its unmet potential. Part III will address the ways in which inefficiencies and inadequacies of current litigation systems contribute to such a gap between this industry’s present performance and potential. Part IV proposes the use of arbitration as a viable alternative dispute mechanism that more effectively resolves the uncertainties associated with legal liability risks and remedies of traditional medical malpractice litigation than national courts. Part V will examine how the features and processes of arbitration may be best applied to medical malpractice claims in the context of a business-to-consumer dispute. In particular, this section will address public policy considerations, potential allocation of costs and liabilities of all parties involved in the transaction, complementary dispute resolution mechanisms, and alternative forums and contract provisions to consider in arbitrating cross-border health services claims. Finally, Part VI will conclude with the observation that the proposal of an international
arbitration framework for cross-border health services disputes represents merely one of several feasible and potentially successful paths to pursue, including some that have yet to be thought of. This proposal seeks to continue the dialogue demonstrating the necessity to consider and act upon new solutions.

Just as with the Industrial Revolution in the Nineteenth Century and the Information Technology Revolution of the Twentieth Century, we are presented with another inevitable transformation of the global economy through the cross-border transfer of persons and technological advances for medical care. And, just as international business and legal practices adjusted to the two former global revolutions, so too must we develop flexible frameworks to accommodate the ambiguous and ever-changing nature of the health services industry.¹

II. GLOBALIZATION OF HEALTH SERVICES

While cross-border exchange in health services is not a new phenomenon, the industry’s scope and geographic reach has grown tremendously in the past twenty years.² In pre-historic times dating as far back as the Bronze Age, people traveled to spas throughout Europe in the belief that mineral water had curative powers.³ Notwithstanding this precedent, a historical overview reveals that until recent decades, health services were primarily local in nature, involving local parties and resources in all stages of such transactions.⁴ Several factors accounted for the industry’s circumscribed geographic scope, which include limitations in

medical knowledge, technology, and transportation. It was only within the past few decades that technological advances have catapulted trade in health services to an international level. In 2001, the World Health Organization (WHO) reported health services as one of the fastest growing global markets. In 2009, the health care industry ranked among the top twenty fastest growing global industries.

The nature and scope of international trade in health services may be best understood through the four modes of supply adopted by the General Agreement on Trade in Services (GATS) of the World Trade Organization (WTO): (1) cross-border delivery, where both supplier and consumer remain in different countries; (2) consumption abroad, where a consumer travels to a supplier’s country to consume a service; (3) commercial presence, where a foreign supplier establishes a commercial presence in a consumer’s country; and (4) presence of natural persons, where labor moves to a consumer’s country. In the context of international health services, mode one encompasses a variety of services, ranging from telemedicine to remote education to the purchase of health insurance. Mode two is broadly termed as medical tourism, where foreign patients travel abroad for specialized or more affordable medical care unavailable in their home countries. Mode three mainly encompasses foreign-ownership of medical practice and hospital activities in a patient’s country. For example, a foreign commercial presence would

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5 Id.
6 Herman, supra note 2, at 4.
9 Herman, supra note 2, at 2-3.
10 Id. at 4.
11 Deloitte Center for Health Solutions, Medical Tourism Consumers in Search of Value (2008), 7 Fig. 5, http://www.deloitte.com/assets/DeCom.UnitedStates/Local%20Assets/Documents/us_chs_MedicalTourismStudy(3).pdf [hereinafter Deloitte].
12 Herman, supra note 2, at 14.
arise if an Arizona hospital established a subsidiary in Mexico. Mode four commonly occurs when individual foreign health care providers move to a consumer’s country to offer their medical services.\textsuperscript{13} This paper will focus on modes one and two of international health services, as these cross-border transactions are most likely to involve the legal ambiguities and uncertainties that businesses and consumers face in the event of a health services dispute. As such, all future references to the health services industry and trade will only encompass these two modes.

Existing scholarship lacks comprehensive data on the extent of the health services trade,\textsuperscript{14} but an overview of the services trade in all sectors offers an instructive introduction to the nature and trends of this sub-sector. Contrary to public perception that services outsourcing only flows one way from industrialized countries to developing countries. For instance, foreigners have been seeking health care in US hospitals and facilities such as the Mayo Clinic for many decades as a matter of course.\textsuperscript{15} Gary Hufbauer and Sherry Stephenson cite studies demonstrating that trade in services is a two-way flow among many participating countries. \textsuperscript{16} These studies also reveal that what one uses as the basis for measurement determines a country’s ranking relative to others in terms of insourcing and outsourcing activities.\textsuperscript{17} In a 2002 study that used the share of GDP to measure the value of services offshoring, developing countries ranked among the top outsource.

\begin{footnotesize}
\begin{enumerate}
\item Herman, supra note 2, at 18.
\item Id. at 2.
\item Glenn Cohen, \textit{Protecting Patients With Passports: Medical Tourism And The Patient-Protective Argument}, 95 IOWA L. REV. 1467, 1471 (2010).
\item Id.
\item Id. Hufbauer & Stephenson cite examples such as Angola, Democratic Republic of Congo, and Mozambique. Significantly, the United States ranked 117\textsuperscript{th} among the countries examined in this study.
\end{enumerate}
\end{footnotesize}
States, United Kingdom, Germany, France, and the Netherlands among the top insourcers.\textsuperscript{19} To underscore the variance in and two-way flow of the services trade, it should be noted that India had a higher rate of insourced skilled work than call-center work in 2006.\textsuperscript{20}

Just as with services trade in general, the sub-sector of health services flows back and forth at varying levels among its country participants.\textsuperscript{21} The present information available and offered below affirms the health services industry's emergence in the international market place and its potential to be one of the leading players in the global economy.

\textbf{A. Cross-border Delivery of Health Services}

As discussed above, cross-border delivery of health services encompasses a wide range of activities.\textsuperscript{22} Telemedicine constitutes the bulk of these cross-border activities,\textsuperscript{23} and is itself a sub-category covering a plethora of services. Defined as “the use of medical information exchanged from one site to another via electronic communications to improve patients' health status,”\textsuperscript{24} telemedicine has the potential to perform essentially any medical service across distances.\textsuperscript{25} Presently, trade in telemedicine includes a wide range of applications, including but not limited to: two-way video conferencing;\textsuperscript{26} electronic communications of diagnoses, second

\begin{itemize}
\item \textsuperscript{19} Id.
\item \textsuperscript{20} Id.
\item \textsuperscript{21} Herman, supra note 2, at 4-7.
\item \textsuperscript{22} Id. at 4.
\item \textsuperscript{23} Mclean, supra note 4, at 593 (2008) (“The global market for health care services is composed of medical tourism and telemedicine”).
\item \textsuperscript{25} Mclean, supra note 4, at 605 (2008).
\item \textsuperscript{26} AMERICAN TELEMEDICINE ASSOCIATION, WHAT IS TELEMEDICINE & TELEHEALTH?, http://www.americantelemed.org/files/public/abouttelemedicine/What_Is_Telemedicine.pdf.
\end{itemize}
opinions, and consultations; and telehealth services such as telepathology, teleradiology, and
telepsychiatry.\(^{27}\)

Several reasons account for the emergence and proliferation of cross-border delivery of health services. One major motivator is the lack of access to health care suffered by many patients in different parts of the world.\(^ {28}\) In both developing and industrialized countries, patients in rural areas are often deprived of medical care, as hospitals and health care providers are located in urban areas.\(^ {29}\) Additionally, cross-border delivery of health services helps to alleviate the stresses and shortages of medical professionals associated with providing round-the-clock medical care.\(^ {30}\) The WHO and American Cancer Society have linked health hazards to the graveyard shift that medical professionals must work as a consequence of such circumstances.\(^ {31}\)

Spurred by these societal concerns and the economic benefits from expansion into new markets, many countries are participants in cross-border delivery of health services.\(^ {32}\) These countries are at varying levels of economic development, and experience different degrees of involvement as importers and/or exporters.\(^ {33}\) Trade pattern studies of several OECD countries conducted by Lior Herman indicate no clear categorization of export or import countries (with

\(^{27}\) CHANDA, supra note 7, at 158. Because much has been written about current and potential applications of telemedicine and its benefits, and such in-depth analysis is beyond the scope of this paper, see the following for more information: John D. Blum, The Role of Law in Global E-Health: A Tool for Development And Equity In A Digitally Divided World, 46 ST. LOUIS U. L.J. 85 (2002); P. Greg Gulick, E-Health and the Future of Medicine: The Economic, Legal, Regulatory, Cultural, and Organizational Health Obstacles, 12 ALB. L.J. SCI. & TECH. 351 (2002); Thomas R. McLean, The Future of Telemedicine & its Faustian Reliance on Regulatory Trade Barriers for Protection, 16 HEALTH MATRIX 443, 462 (2006); Susan E. Volkert, Telemedicine: RX for the Future of Health Care, 6 MICH. TELECOMM. & TECH. L. REV. 147, 153 (2000).

\(^{28}\) Herman, supra note 2, at 4

\(^{29}\) Id.

\(^{30}\) Id.

\(^{31}\) Id.\(^ {31}\)

\(^{32}\) Id.\(^ {31}\)

\(^{33}\) Id.
few exceptions); instead, most countries alternate between trade surpluses and deficits.\footnote{Herman, supra note 2, at 5. OECD refers to countries who are members of the multinational institution, Organization for Economic Cooperation and Development, most of which have high-income economies.} For instance, the US engages in both offshoring and insourcing activities. In 2004, the nation’s telemedicine market had an estimated worth of $380 million and grew at more than fifteen percent annual rate.\footnote{Id. at 4.} This is likely a conservative estimate, as a 2006 federal report observed underreporting of offshoring activities by US health institutions.\footnote{Sanjiv N. Singh & Robert M. Wachter, Perspectives on Medical Outsourcing and Telemedicine — Rough Edges in a Flat World? 358 NEW ENG. J. MED. 1622, 1623 (2008), available at http://nejm.highwire.org/cgi/reprint/358/15/1622.pdf.} Due to the domestic shortage of several physician specialties, offshoring is a necessitous practice.\footnote{Nicholas P. Terry, Under-Regulated Health Care Phenomena in a Flat World: Medical Tourism and Outsourcing, 29 W. NEW ENG. L. REV. 421, 444 (2007).} Approximately 300 US hospitals offshore outsource imaging services to cover for the shortage in radiologists.\footnote{Id. at 445.} Approximately 100 US hospitals use foreign health care providers for remote monitoring of Intensive Care Units (ICUs) to cover for the shortage in intensivists.\footnote{Id.} With regards to insourcing, US hospitals provide the following medical services to countries in Central America and the Eastern Mediterranean: telediagnoses, surveillance, and consultations.\footnote{CHANDA, supra note 7, at 158.}

Elsewhere, suppliers employ physicians in India at costs below foreign physicians’ wages.\footnote{Mclean, supra note 4, at 606 (2008).} Researchers estimate that India already serves two percent of the US health care market.\footnote{Singh & Wachter, supra note 36, at 1623.} Health care institutions in Bangladesh and Nepal outsource telepathology services to India.\footnote{CHANDA, supra note 7, at 158.} Similar to India’s relationship with its neighbors, China-based health providers offer telediagnoses to patients in Macao and several south-east Asian countries.\footnote{Id.}
B. Consumption of Health Services Abroad

As discussed above, the consumption of health services in foreign countries is broadly termed as medical tourism, which involves “the act of traveling to another country to seek specialized or economical medical care, well being and recuperation of acceptable quality with the help of a support system.” Operating as an unregulated industry, the global medical tourism market reached approximately $60 billion in 2008, and was expected to grow to $100 billion by 2010. Over 35 countries serve more than one million medical tourists annually.

Patients seek medical care abroad because of lack of domestic access to a particular treatment and/or affordability of a treatment relative to their own countries. These patients fall under the following categories: (1) patients in developing countries seeking specialized and/or high-quality care in other developing or industrialized countries; (2) patients from industrialized countries seeking affordable or alternative care in developing countries; (3) patients seeking medical services not offered in their home countries due to moral and/or ideological reasons (e.g. abortion, fertility treatments, and euthanasia). Most destination hospitals provide greater incentives for foreign patients to choose them by attaining accreditation of quality care from the US-based Joint Commission on Accreditation of Healthcare Organizations’ (JCAHO) international arm, the Joint Commission International (JCI). Such accreditation means that the

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45 DELOITTE, supra note 11, at 7, Fig. 5.
46 Dana A. Forgione & Pamela C. Smith, Medical Tourism And Its Impact On The Us Health Care System 34 J. HEALTH CARE FIN. 27, 32 (2007).
47 DELOITTE, supra note 11, at 7, fig. 5.
48 Id.
50 CHANDA, supra note 7, at 158.
51 Dr. Puteri Nemie J. Kassim, Medicine Beyond Borders: The Legal And Ethical Challenges, 28 MED. & L. 439, 443 (2009); Levi Burkett, Medical Tourism Concerns, Benefits, and the American Legal Perspective, 28 J. LEGAL MED. 223, 229 (2007).
hospital in question meets uniform requirements established by international health care experts.\textsuperscript{53} Additionally, to compete with the US reputation for top quality care, many foreign hospitals advertise that their physicians are US board certified or are trained at highly regarded US medical schools.\textsuperscript{54}

Just as with cross-border delivery of health services, many countries engage at varying levels of offshoring and insourcing activities related to medical tourism. With respect to the US, foreign patients are drawn to the high-quality and specialized approach of its health care system while many domestic patients are driven away because of the system’s high-costs relative to other countries.\textsuperscript{55} A 2008 Deloitte study estimated that by the end of 2010, the US will have treated approximately 456,000 foreign patients.\textsuperscript{56} By the end of 2017, this number is estimated to increase to 561,000 foreign patients.\textsuperscript{57} In comparison, approximately 750,000 US patients would have traveled abroad for treatment during that same time period.\textsuperscript{58} These cost-conscious consumers are drawn to countries such India, Thailand, and Singapore, which offer comparable care for much lower prices – even as low as one-tenth of US prices.\textsuperscript{59}

Similar to the United States, other countries capitalize on their medical areas of specialty and/or market their services to attract foreign patients. Latin American countries such as Brazil, Cuba, and Mexico provide instructive examples. Brazil offers cosmetic surgeries at 40 to 50 percent of US prices.\textsuperscript{60} Cuba focuses on specialized hospitals offering high-quality care at

\textsuperscript{53} Id.
\textsuperscript{54} Burkett, supra note 51, at 230.
\textsuperscript{55} DELOITTE, supra note 11, at 5, 20.
\textsuperscript{56} Id. at 20.
\textsuperscript{57} Id.
\textsuperscript{58} Id. at 5, fig. 3.
\textsuperscript{59} Id. at 5.
\textsuperscript{60} Id. at 7, fig. 5.
competitive prices to target markets such as Latin America, the Caribbean, Europe, and Russia. Mexico provides dental and cosmetic surgery at 25 to 35 percent of US prices, and otherwise draws US patients due to its proximity.

In addition to Latin American countries, several Asian countries have emerged as pioneers in medical tourism. Thailand is currently regarded as the industry leader, successfully marketing its hospitals to expatriates and foreign patients abroad. In 2006, Thailand treated 1.2 million foreign patients at an average of 30 percent of US prices. Close on Thailand’s heels is India, which is reportedly the fastest growing medical tourist destination. Patients from developed and developing countries are attracted to India for several reasons: specialty areas including neurology, cardiology, endocrinology, nephrology, and urology; surgical expertise; highly qualified medical professionals; and affordable treatment averaging at about 20 percent of US prices. In Malaysia, foreign patients primarily visit for cosmetic surgery and alternative medical care with treatment averaging at 25 percent of US prices.

Recognizing the potential and profitability of medical tourism, several Asian governments have implemented new policies designed to promote growth in this industry. In Korea, the government is involved in the planning stages of new medical facilities with

61 CHANDA, supra note 7, at 158.
62 DELOITTE, supra note 11, at 7, fig. 5.
63 Burkett, supra note 51, at 226.
64 Id. at 228.
65 DELOITTE, supra note 11, at 7, fig. 5.
67 CHANDA, supra note 7, at 159.
68 DELOITTE, supra note 11, at 7, fig. 5.
69 Id. at 7, fig. 5.
international patients in mind. In Taiwan, the government pledged $318 million towards the development of medical services.

European countries also target their medical services to patients in neighboring and distant countries. Hungary attracts European patients by offering dental and cosmetic surgery at 40 to 50 percent of US prices. Several nations are attractive destinations because they offer certain procedures unavailable in several surrounding European countries for moral reasons. For instance, Norway permits euthanasia and Slovenia performs fertility treatments.

III. THE LEGITIMACY OF LITIGATION IN RESOLVING CROSS-BORDER MALPRACTICE CLAIMS ON GLOBAL LEVEL

Notwithstanding the global reach of health services and the industry’s accompanying social and economic benefits, the industry is far from reaching its full potential. Herman’s study of OECD countries’ trade in health services noted the discrepancy between national and private health care expenditures and the relatively low trade in health services in relation to GDP. While the average ratio of total trade to GDP is 0.01 percent of total GDP, the average ratio of national and private health expenditures to GDP rises well above 20 percent. Furthermore, Herman notes that while 80 percent of European-based health providers utilize advanced e-health infrastructures to store patients’ data, only 0.7 percent of such data is transferred across national borders. Thus, the lack of correspondence between these figures

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70 DELOITTE, supra note 11, at 7.
71 Id.
72 DELOITTE, supra note 11, at 7, fig. 5.
73 Kassim, supra note 51, at 443; Burkett, supra note 51, at 230.
74 Kassim, supra note 51, at 443.
75 Burkett, supra note 51, at 230.
77 Herman, supra note 2, at 6.
78 Id.
79 Id., at 7-8.
and underutilization of e-health infrastructures points to the unmet capacity for international trade in health services.\textsuperscript{80}

To account for such shortfalls, earlier scholarship in this area has identified several trade barriers in the health services industry. These works note that the chief challenges for cross-border delivery of health services include dissimilar licensing requirements for medical professionals and differing national and sub-national legal liability and regulatory regimes.\textsuperscript{81} Similar to the problems encountered with cross-border delivery of goods and other types of services, the legal uncertainties of malpractice liability presents one of the major obstacles to medical tourism.\textsuperscript{82} Such legal limbo merits closer examination, as health providers and consumers are hard pressed to find legal recourse resulting from differences in legal and regulatory regimes, and diverse cultural expectations.\textsuperscript{83} Because the nationalities of the parties and the place of contract breach and/or injury necessarily share no common situs, ambiguities abound surrounding appropriate jurisdiction, choice of law, and enforceability of foreign awards.\textsuperscript{84} In order to understand the nature and scope of these legal barriers, this section will separately examine the challenges for dispute resolution for (1) cross-border delivery of health services and (2) consumption of health services abroad.

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\textsuperscript{80} Id.

\textsuperscript{81} Kassim, \textit{supra} note 51, at 448. It should be noted that in addition to trade barriers, resistance to the globalization of health services may result from public policy considerations. Such a discussion is beyond the scope of this paper, but arguments against globalization include ethical considerations surrounding seeking treatment abroad for procedures deemed illegal in one’s home country, and unequal access to health care in developing countries as a result of a preference for foreign patients because of their ability to pay more for services. \textit{Id.} at 442 – 443.

\textsuperscript{82} Id. at 445; Mclean, \textit{supra} note 76, at 164 (2007); Kassim, \textit{supra} note 51, at 441.


\textsuperscript{84} \textit{See, generally, id.;} Kassim, \textit{supra} note 51, at 446- 447.
A. Legal Barriers to Cross-border Delivery of Health Services

The use of telemedicine across different national legal and regulatory regimes raises a variety of legal dilemmas. The following scenarios demonstrate the difficulty in deciding which party should be held liable, which judicial system has jurisdiction over the claim, which laws and/or regulations apply, and whether the selected laws and/or regulations adequately define the telemedicine transaction in question as medical malpractice: 85 (a) misdiagnosis or other injury by a health care provider performing the telemedical service in a different jurisdiction than where the patient is located; and (b) misdiagnosis or other injury resulting from technological error by telemedical device, and not by human error. 86 These matters are further complicated when including sub-national legal and regulatory regimes as part of the analysis. For instance, many of the same issues also arise when health services are delivered across state lines in the United States, as each state has the authority to regulate health professionals who practice in their territories and differing procedural and substantive laws governing health care disputes. 87

The issues listed above and addressed in greater detail below have no definitive answers because no international agreements or protocols concerning telemedicine exist. 88 Some scholars also speculate that the reason for such uncertainty is because telemedicine is still too small and new an industry to attract international attention and action. 89 Irrespective of the reasons behind such neglect, businesses and consumers suffer from higher transaction costs or forgo...

85 Singh & Wachter, supra note 36, at 1624.
86 Kassim, supra note 51, at 448.
participation in cross-border trade of health services for lack of reliable legal remedies and protection.\textsuperscript{90}

1. Potentially Liable Parties

In either of the liability scenarios described above, potential liable parties may include a remote health care provider, any affiliated local health care provider working in consultation and/or contracting with that remote health care provider,\textsuperscript{91} and supplier of the telemedical device.\textsuperscript{92} The ability of telemedicine to involve several parties in different locations and at varying capacities in the course of medical treatment complicates the nature and scope of a defendant’s liability in malpractice claims.\textsuperscript{93} For instance, a plaintiff pursuing a malpractice claim in the US must prove, among other elements, that the defendant had a duty to a patient arising out of a physician-patient relationship.\textsuperscript{94} The departure from the traditional face-to-face physician-patient relationship in telemedical care makes it difficult to determine when such duty arises and whether the standard of care is violated.\textsuperscript{95} US state case law has established that a physician-patient relationship begins “[w]hen the professional services of a physician are accepted by another person for the purposes of medical or surgical treatment.”\textsuperscript{96} This is interpreted to mean that such a relationship is mainly based on implied or express contract.\textsuperscript{97} If a patient goes to a local hospital for treatment, and that hospital outsources pathology services to an offshore health care provider, it is unclear which party or both parties have formed a

\textsuperscript{90}Kassim, supra note 51, at 441, noting that “countries, like the United States, have not been able to benefit as greatly from medical tourism because of increased legal liability and policy.”
\textsuperscript{91}Heather L. Daly, \textit{Telemedicine: The Invisible Legal Barriers To The Health Care Of The Future}, 9 ANNALS HEALTH L. 73, 99-100 (2000).
\textsuperscript{92}Id. at 100.
\textsuperscript{93}Id.
\textsuperscript{94}Id.
\textsuperscript{95}Id.
\textsuperscript{96}STEVEN E. PEGALIS & HARVEY F. WACHSMAN, AMERICAN LAW OF MEDICAL MALPRACTICE, 24 (2d ed. 1992).
\textsuperscript{97}Id. at 25.
Another similar dilemma may occur where a local hospital utilizes a telemedical device that may or may not be supplied by an offshore entity, which treats a patient without the aid of any human assistance. While some scholars surmise that in the US, the “ostensible agency” doctrine would apply and make the hospital liable for acts of offshore health care providers, the lack of well established case law leaves this question unanswered. The above considerations in determining an appropriate liable party likewise applies to health care providers seeking to minimize their liability while engaging in cross-border telemedicine. In addition to facing such legal uncertainties, these health care providers have the additional burden of finding malpractice insurers willing to cover such activities with unknown risks.

2. Determining Appropriate Jurisdiction to Litigate and Enforce a Claim

In addition to determining which parties are liable, the injured party has the challenge of selecting the appropriate forum that will litigate and enforce the claim. The selected court must have jurisdiction over the claim, as jurisdiction grants the court authority to prescribe, adjudicate, and enforce judgments against persons and property. Presently, the available options in countries such as the United States are legal proceedings in (1) plaintiff’s domicile state or (2) defendant’s domicile state. A party’s domicile is “the state where an individual habitually resides, or the state where a company or legal person has its ‘seat’ or center of management.” As the analysis below demonstrates, each option presents its own set of difficulties and uncertainties.

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98 Singh & Wachter, supra note 36, at 1624.
99 Id.
100 See Daly, supra note 91, at 100; Singh & Wachter, supra note 36, at 1624.
a. Establishing Jurisdiction in Plaintiff’s Domicile State

Should the plaintiff decide to sue in his own domicile state, he must be able to assert personal jurisdiction over the defendant and ensure that any favorable judgment rendered will be enforced.\textsuperscript{103} First, not only do common and civil law countries have different approaches to asserting personal jurisdiction, but countries from either legal system may make different determinations from their counterparts because of their own individual interpretation of the laws in question.\textsuperscript{104} In civil law countries, a defendant may be sued in his domicile and in any jurisdiction where he commits a tort.\textsuperscript{105} This guiding principle elicits a variety of interpretations, with some national laws broadening its meaning to include injury sustained by a plaintiff within a jurisdiction while others restrict its application to the act of committing a tort.\textsuperscript{106} This distinction is crucial in telemedicine disputes where a foreign health care renders a telemedical service, such as a misdiagnosis based on video consultation or misreading of imaging technology in a different location than where plaintiff suffers an injury resulting from that service.

Additionally, some civil law countries have enacted legislation broadening their reach of personal jurisdiction.\textsuperscript{107} In France, the French Civil Code grants its courts the power to hear any case involving a French citizen.\textsuperscript{108} Similarly, Luxembourg and the Netherlands grant their courts jurisdiction over almost all cases where parties are nationals or residents.\textsuperscript{109}

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\textsuperscript{103} Singh & Wachter, supra note 36, at 1624.
\textsuperscript{104} Born, supra note 102, at 13.
\textsuperscript{105} Id. at 14.
\textsuperscript{106} Id. at 14-15.
\textsuperscript{107} Id. at 15.
\textsuperscript{108} Id.
\textsuperscript{109} Id.
\end{flushright}
In comparison to civil law countries, their common law counterparts adopt a flexible multi-factor approach to establish personal jurisdiction. Unlike the civil law reliance on territoriality, the common law system considers the principles of fairness and reasonableness by examining the quantity and quality of contacts between the defendant and forum state. The test utilized by US courts is an emblematic example, as it requires a finding of the following three elements: (1) the plaintiff’s state has a long-arm statute allowing for personal jurisdiction; (2) the defendant has minimum contacts with the plaintiff’s state, as evidenced by foreseeability of liability and “purposeful availment” of the privileges and protections of the laws of that state; and (3) the exercise of personal jurisdiction is reasonable and does not violate “traditional notions of fair play and substantial justice” guaranteed under the Due Process Clause of the Fourteenth Amendment of the US Constitution. Such a test demonstrates that like the civil law approach, it is open to different interpretations and offers no reliable outcome to either party in a telemedicine claim.

Several other common law countries have statutes governing transnational tort claims. For instance, Great Britain asserts personal jurisdiction on a foreign defendant if the tort is committed within its territory. As discussed above, the nature of several telemedical services in which several parties are involved in different capacities and locations makes it difficult to determine where the tort was committed.

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111 Id. at 260.
113 Born, supra note 102, at 12.
114 Id.
Even if a plaintiff succeeds in asserting the claim in his domicile state, the common law doctrine of forum non conveniens may be utilized by the defendant to dismiss the claim.\textsuperscript{115} Forum non conveniens empowers courts to dismiss cases under certain circumstances, and common law countries apply the doctrine differently from one another.\textsuperscript{116} For instance, Great Britain employs at two-step analysis which first requires the defendant to prove that another appropriate forum is available and secondly, for the plaintiff to prove circumstances in which justice demands jurisdiction of a British court.\textsuperscript{117} In the US, courts afford plaintiff domicilairies the presumption of convenience,\textsuperscript{118} but employ the doctrine if it finds that the defendant will experience an undue burden and an alternative, more appropriate forum exists.\textsuperscript{119} Thus, such a doctrine and the various ways in which is applied present another barrier to the adjudication of the claim in plaintiff’s domicile.

Furthermore, it is important to consider the existence of any commercial or civil agreements that a country is a party to, as such membership may impact its rules regarding jurisdiction in relation to fellow member states. An instructive example is the “Brussels Convention on the Jurisdiction of Courts and the Recognition and Enforcement of Judgments in Civil and Commercial Matters,” (Brussels Convention) which only permits EU countries as members.\textsuperscript{120} The Brussels Convention prohibits a member state from employing “‘exorbitant’ jurisdictional devices” against defendants domiciled in fellow member states\textsuperscript{121} and mandates

\begin{footnotesize}
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\item[\textsuperscript{116}] \textit{Id.} at 955.
\item[\textsuperscript{117}] \textit{Id.}
\item[\textsuperscript{118}] \textit{Id.}
\item[\textsuperscript{119}] Cortez, supra note 49, at 11 (2010).
\item[\textsuperscript{120}] Born, \textit{supra} note 102, at 15.
\item[\textsuperscript{121}] \textit{Id.}
\end{itemize}
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enforcement of judgments rendered by fellow member state courts. Such restrictions compelled common law member states such as England and Ireland to abandon their exercise of jurisdiction based on serving process to a defendant member-domiciliary while he was physical present in their territories.

The consideration of agreements such as the Brussels Convention is also important for enforcement of awards against a foreign defendant. Absent such regional agreements, no general consensus exists among countries to enforce another’s court-issued decrees. The first international agreement on enforcement of foreign judgments, adopted by the 1971 Hague Conference, failed as it was ratified by only three countries. Such overwhelming recalcitrance is owed to wariness by most countries in automatically enforcing a foreign decree without domestic judicial review. In this respect, membership in regional agreements offers the advantages of enforcement of judgments against both member-domiciliaries and/or non-member domiciliaries, in the event a member state court rendered the judgment.

b. Establishing Jurisdiction in Defendant’s Domicile State

In contrast with the attempt to sue a defendant in plaintiff’s domicile state, no jurisdictional issues bar adjudication of a claim in defendant’s domicile state. As mentioned above, a defendant’s domicile serves a basis for jurisdiction in civil law countries for disputes involving domestic and international parties. In common law countries, the physical presence

122 Id. at 16.
123 Dubinsky, supra note 110, at 258-259.
124 Singh & Wachter, supra note 36, at 1624; Stückelberg, supra note 115, at 952. In addition to the Brussels Convention, other regional agreements such as Lugano Convention and Inter-American Convention on the Extraterritorial Validity of Foreign Judgments and Arbitral Awards commit member states to automatic enforcement of commercial and civil judgments.
125 Stückelberg, supra note 115, at 952.
126 Id.
127 Born, supra note 102, at 16.
of the defendant or defendant’s property within its territories is sufficient to exercise jurisdiction.\textsuperscript{129} Such relative ease in bringing forth a claim in this forum, however, may be curtailed by a defendant domiciliary’s use of forum non conveniens for dismissal.\textsuperscript{130} In the US, defendant domiciliaries routinely and successfully employ this doctrine to dismiss tort claims by foreign plaintiffs.\textsuperscript{131} Unlike a US plaintiff domiciliary, a foreign plaintiff’s forum selection is not given the presumption of convenience but viewed as a strategic choice of law preference.\textsuperscript{132} As a result, an overwhelming number of forum non conveniens motions are granted in situations where the alleged injury occurred in another country.\textsuperscript{133} This widespread practice provides a warning for prospective plaintiffs seeking to sue health care providers domiciled in common law countries, particularly the US, as medical malpractice claims are a subset of tort law and the nature of telemedical services makes the location of injury a subject of dispute. The observation that a defendant domiciliary’s use of forum non conveniens will likely impact countries other than the US is plausible, especially given several countries’ actions in response to US forum non conveniens dismissals.\textsuperscript{134} For instance, several countries have enacted legislation barring their courts from hearing any action from domiciliary parties previously dismissed on forum non conveniens grounds by another country.\textsuperscript{135}

In the event that a foreign plaintiff successfully brings suit in a defendant’s domicile court, he may face additional challenges. Foreign patients will not only have to navigate an unfamiliar legal system, but adjust their cultural expectations to the forum state’s remedies and

\textsuperscript{129} Id. at 915.  
\textsuperscript{131} Id. at 609.  
\textsuperscript{132} Id. at 613.  
\textsuperscript{133} Id. at 609.  
\textsuperscript{134} Id. at 610.  
\textsuperscript{135} Id.
procedures.\textsuperscript{136} In particular, those patients hailing from industrialized countries are likely subject to more onerous burdens of proof and relatively inadequate legal protection afforded by developing countries.\textsuperscript{137} As an example, scholars have assessed India’s legal and regulatory systems as limited and unable to competently handle medical malpractice claims.\textsuperscript{138} Critics point to India’s failure to devote adequate resources to these claims and label its Medical Council Act as “outdated and ineffective.”\textsuperscript{139}

3. Choice of Law and Adequacy of Existing Laws

In addition to identifying the appropriate liable parties and jurisdiction, telemedicine disputes are not only complicated by choice of law considerations, but also whether the selected law in question adequately resolves the legal issues raised by telemedicine. There is no uniform approach to choice of law determinations, as a court follows the particular rules adopted by its jurisdiction.\textsuperscript{140} For instance, Great Britain applies the lex loci delicti rule, which means that the law of the place of injury governs the dispute -- in Great Britain, this specifically applies to personal injury and death claims.\textsuperscript{141} In the US, a minority of states follows the lex loci delicti rule but the majority adopts the “most significant relationship” rule for tort claims, which requires a court to choose whichever law has the “most significant relationship to the occurrence and parties.”\textsuperscript{142} Factors include: place of injury; place of conduct causing injury; parties’ domiciles, residence, nationality, place of incorporation, and place of business; and place where

\textsuperscript{136} Cortez, supra note 83, at 5 (2010).
\textsuperscript{137} Cortez, supra note 49, at 106 (2008).
\textsuperscript{138} Cortez, supra note 83, at 91, 106 (2010); Kassim, supra note 51, at 446.
\textsuperscript{139} Kassim, supra note 51, at 446.
\textsuperscript{141} Id. at 659.
\textsuperscript{142} Id. at 661—662.
relationship between the parties is centered. The ambiguities surrounding how telemedicine fits within the practice of medicine and the occurrence of injury allow for open-ended and contradictory interpretations of these tests’ outcomes.

As alluded to earlier, only a handful of legal regimes have addressed telemedicine licensure and governance. While more than half of US states have addressed telemedicine licensing, the international community is woefully behind with Malaysia as the only country having a comprehensive telemedicine regime. Malaysia’s Telemedicine Act of 1997 (Telemedicine Act) provides detailed guidelines for telemedicine licensure and informed consent. However, with the exception of informed consent requirements, these laws fail to address the legal liability considerations discussed above. Furthermore, the intent and parameters of the Telemedicine Act have yet to be interpreted and applied, as no medical malpractice cases involving telemedicine have been decided by Malaysian courts.

Such gaps and inconsistencies in telemedicine regulation at sub-national, national, and international levels complicate a court’s application of the facts of telemedicine case to traditional malpractice frameworks. As discussed above, it is unclear whether a physician-patient relationship arises from performance of a telemedical service. Another area of legal ambiguity lies in the appropriate standard of care, as it is unclear whether technological

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143 Id. at 662.
144 See supra Part III.A.1.
146 Hsing-Hao Wu, Evolving Medical Service In The Information Age: A Legal Analysis Of Applying Telemedicine Programs In Taiwan, 27 M. & L. 775, 784 (2008) (Malaysia’s telemedicine law “specifically addresses legal issues concerning telemedicine, such as licensure, informed consent and telemedicine standard development”).
147 Id.
148 Kassim, supra note 51, at 447.
149 Id.
150 See supra Part III.A.1.
151 Kassim, supra note 51, at 448.
innovations and practices associated with telemedical services should change such a standard or a new standard should be created.\textsuperscript{152} In the US, the standard of care for online treatment by physicians in a medical malpractice case is still undefined by many states.\textsuperscript{153} Other issues include whether the duty of confidentiality and informed consent extends to telemedical services.\textsuperscript{154}

**B. Legal Barriers to Consumption of Health Services Abroad**

Many of the legal barriers surrounding telemedical service claims also impede successful adjudication of and recovery from medical tourism malpractice claims. Just as with cross-border telemedicine service claims, no international regime exists for legal remedies resulting from unsatisfactory cross-border medical care.\textsuperscript{155} The analysis below highlights the challenges that parties to the dispute confront.

1. **Potentially Liable Parties**

   There are several potential liable parties in a medical tourism claim: foreign health care providers, intermediaries, employers, and insurers.\textsuperscript{156} Because a foreign health care provider allegedly caused the injury and the circumstances of treatment meet the elements of traditional malpractice frameworks, it is logical to pursue a malpractice claim against this defendant.\textsuperscript{157} Just as with cross-border telemedicine claims, however, a plaintiff must overcome personal jurisdiction and forum non conveniens challenges, which are discussed more fully below within the context of medical tourism.

\textsuperscript{152} Kassim, supra note 51, at 448.


\textsuperscript{154} Kassim, supra note 51, at 448; see Singh & Wachter, supra note 36, at 1624.

\textsuperscript{155} Kassim, supra note 51, at 445.

\textsuperscript{156} Cortez, supra note 83, at 9-19 (2010).

\textsuperscript{157} Id. at 9.
While procedural legal barriers impede pursuit of a foreign health care provider defendant, the difficulty of finding and proving theories of liability impede pursuit of the remaining potential defendants.\textsuperscript{158} In the US, intermediaries that serve as facilitators for overseas care, employers, and insurers may be liable for corporate negligence or failure to obtain informed consent.\textsuperscript{159} For both claims, the difficulties in obtaining evidence in a foreign country and differences in regulatory and credentialing standards between parties’ countries make proving such claims a daunting enterprise.\textsuperscript{160} In Great Britain, citizens who use the publicly funded health care system, National Health Service, have no theory of liability claims against this insurer as case law establishes no non-delegable duty to its patients.\textsuperscript{161} As a result, injured British patients must seek legal recourse at the place of treatment.\textsuperscript{162}

Finally, another category of potential barriers worth noting in determining potentially liable parties are charitable and government immunity for health care institutions.\textsuperscript{163} In the US, charitable immunity shields non-profit entities from liability under circumstances in accordance with the relevant state law in question.\textsuperscript{164} As examples, some state courts restrict immunity to nonpaying patients while others allow recovery from non-trust hospital assets.\textsuperscript{165} In comparison, government immunity requires a government’s consent in order to be sued.\textsuperscript{166} It should be noted

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\textsuperscript{158} Id. at 9-19.  
\textsuperscript{159} Id. at 15-18.  
\textsuperscript{160} Id.  
\textsuperscript{161} Terry, supra note 37, at 464.  
\textsuperscript{162} Id.  
\textsuperscript{163} See John F. Bales, III & Lisa A. DeMarco, Selected Topics in Medical Malpractice Litigation, 669 PLI/COMM 381, 448 (1993).  
\textsuperscript{164} Bales & DeMarco, supra note 163, at 450.  
\textsuperscript{165} Id. at 450.  
\textsuperscript{166} Id. at 449.
that in the US, recent case law has shown these immunities have limited success as defenses for eligible parties.\textsuperscript{167}

2. Determining Appropriate Jurisdiction to Litigate and Enforce a Claim

As discussed above, the injured party may pursue a claim against a foreign health care provider in his domicile state or the defendant’s domicile state. Should a plaintiff choose his domicile state, he faces the same challenges of establishing personal jurisdiction, defeating forum non conveniens motions, and enforcing any favorable judgments in a foreign court.\textsuperscript{168} This is not likely the case if suit is brought in defendant’s domicile, as issues regarding place of injury and whether it is in the chosen forum’s interest are well settled. The major drawbacks to such an option, however, are similar to the challenges of defending a cross-border telemedicine claim in a foreign court.\textsuperscript{169}

3. Determining Choice of Law

Even after jurisdiction is established, parties to the dispute must deal with the additional challenge of choice of law determinations. Depending on the laws of the countries involved, a court’s selection may be pivotal in deciding the outcome and remedies available.\textsuperscript{170} As discussed earlier, each court adopts a different approach to determining choice of law.\textsuperscript{171} In the context of medical tourism claims, several scholars discuss the US case \textit{Chadwick v. Arabian American Oil Co.}, to demonstrate the dispositive impact choice of law.\textsuperscript{172} In that case, a Delaware district court followed the lex loci delicti rule involving a medical malpractice claim

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\item \textsuperscript{167} \textit{Id.} at 451.
\item \textsuperscript{168} See supra Part III.A.2.; Cortez, \textit{supra} note 83, at 8 (2010). Cortez observes that dearth of US case law renders it unclear whether medical tourists can recover in US Courts. Cortez speculates that the absence of such case law is due to private out-of-court settlements. \textit{Id.}
\item \textsuperscript{169} See supra Part III.A.2.;
\item \textsuperscript{170} Cortez, \textit{supra} note 83, at 13 (2010).
\item \textsuperscript{171} See supra Part III.A.3.
\item \textsuperscript{172} Cortez, \textit{supra} note 83, at 13 (2010); Kassim, \textit{supra} note 51, at 446.
\end{enumerate}
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by US plaintiff against a Saudi Arabian defendant, an oil company incorporated in Delaware.  

There, the plaintiff argued the defendant was vicariously liable for malpractice committed by the defendant’s physician in Saudi Arabia.  

The court used Saudi Arabian law because of its adherence to the lex loci delicti rule, and dismissed the action because Saudi law did not recognize vicarious liability.  

Scholars have also criticized other countries’ laws relating to malpractice, observing that countries such as Malaysia and Singapore have a biased standard in favor of physicians for proving medical negligence.  

Furthermore, the differences in legal remedies and award amounts among countries likely add to uncertainty and stress of the litigation process for the foreign plaintiff. For instance, Thailand’s average recovery amount is US $2500 and its courts do not award pain and suffering damages.  

In contrast, the mean and median recoveries for successful US malpractice plaintiffs are US $311,000 and US $175,000 respectively.  

Such variations in substantive laws and legal remedies not only further affirm the uncertainties associated in pursing a cross-border malpractice claim using traditional judicial systems, but also the tremendous investment in cost and time of such a process.

IV. THE CASE FOR ARBITRATION AS AN APPROPRIATE INTERNATIONAL DISPUTE RESOLUTION MECHANISM FOR CROSS-BORDER HEALTH SERVICES CLAIMS

As demonstrated earlier, the fluid and changing nature of the international health services industry continue to create legal dilemmas and ambiguities that escape existing legal protections and remedies afforded by traditional judicial frameworks. Rigid jurisdictional and choice of law approaches are ill-equipped to resolve disputes arising from the cross-border movement of

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174 Id.
175 Id.
176 Kassim, supra note 51, at 446.
177 Cortez, supra note 83, at 4 (2010).
178 Kassim, supra note 51, at 446.
people and health services. Existing substantive legal principles have yet to provide adequate
theories of liability for injuries and damages arising from innovations in medical care and
delivery of health services. Such legal uncertainties and ambiguities call for a uniform means of
redress that is more flexible and predictable than litigation in a court room. Given such needs,
arbitration offers a potential solution, as it is an ADR mechanism that has been successfully
utilized on an international level\(^\text{180}\) and is more efficient and adaptive to changes in the health
services industry than litigation but has the authority and binding force of a court decree.\(^\text{181}\)

The analysis below will serve two purposes: (1) discuss additional concerns with the
existing medical malpractice system that further warrant an examination of arbitration as an
alternative dispute forum; and (2) analyze the potential of arbitration as an international
framework for resolving medical malpractice claims.

A. Medical Malpractice Litigation is an Inefficient and Ineffective Method of Deterrence
and Compensation, Particularly in the International Sphere

Several observations by scholars and studies examining the process of medical
malpractice litigation conclude that it is not only too costly and inefficient,\(^\text{182}\) but poorly
compensates injured patients.\(^\text{183}\) According to one study, only about 40 cents out of every dollar
paid in malpractice insurance premiums goes to injured patients while the remainder goes
towards administrative and litigation expenses.\(^\text{184}\) Another study found that for every dollar an
injured patient receives in compensation, 54 cents goes towards administrative expenses.\(^\text{185}\)

\(^{180}\) Martha Neil, *International Arbitration Has Become a Lucrative Field After a Decade of Disfavor*, 88-SEP A.B.A.
J. 28, 28 (2002).

\(^{181}\) See Keith Maurer, *Implementing Effective Health Care ADR Mediation, Arbitration, and “I’m Sorry” Programs*,
47 VOICE OF THE DEFENSE BAR 37, ¶ 6 (2009).


\(^{183}\) MICHELLE M. MELLO, *UNDERSTANDING MEDICAL MALPRACTICE INSURANCE: A PRIMER* 7 (Jan. 2006),

\(^{184}\) Id.

In addition to inefficient allocation of costs and compensation, some scholars argue that medical malpractice litigation is biased against patients and discourages them from bringing claims.\textsuperscript{186} Michelle M. Mello cites epidemiological studies of medical injury and malpractice claims, which indicate that only about two percent of injuries due to medical negligence become malpractice claims.\textsuperscript{187} Also, the Institute of Medicine estimates that between 44,000 to 98,000 US patients die in hospitals as result of preventable medical errors, but a vast majority of these patients do not sue.\textsuperscript{188} Furthermore, defendants prevail in most cases.\textsuperscript{189} In the US, juries overwhelmingly find in favor of physicians at a rate of nearly 80 percent.\textsuperscript{190}

Finally, some scholars argue that medical malpractice litigation fails to deter negligent care because the evidence available suggests that deterrence of medical error is limited at best.\textsuperscript{191} A health care provider at fault experiences no financial set-back from any compensation owed to an injured patient, as that provider’s insurance carrier is (1) responsible for defending and/or settling the claim; (2) compensates the patient for damages or settlement amount; and (3) does not raise the premium resulting from any claims against that provider. Rather, a health provider’s premium is based primarily on his geographical region of practice.\textsuperscript{192} Because of such an arrangement, some scholars observe that limited deterrence may arise to the extent that insurance payments of claims affect a health care provider’s reputation by mandatory reporting of such payments to the National Practitioner Data Bank.\textsuperscript{193}

\textsuperscript{186}MELLO, supra note 183, at 7.
\textsuperscript{187}Id.
\textsuperscript{188}Cortez, supra note 83, at 19 (2010).
\textsuperscript{189}Kenneth A. DeVille, The Jury is Out: Pre-Dispute Binding Arbitration Agreements For Medical Malpractice Claims, 28 J. LEGAL MED. 333, 368 (2007).
\textsuperscript{190}Id.
\textsuperscript{191}MELLO, supra note 183, at 7.
\textsuperscript{192}Bales & DeMarco, supra note 163, at 392.
\textsuperscript{193}Id. at 393.
B. The Domestic Use of Alternative Dispute Resolution Processes, Including Arbitration, to Resolve Medical Malpractice Claims in Several Countries Support the Viability of An Arbitration Framework Across Borders

In addition to the inefficiencies and ineffectiveness of medical malpractice litigation, the practice of alternative dispute resolution (ADR) processes to resolve medical malpractice claims in several countries support reconsideration of using traditional judicial frameworks. The primary ADR processes in question are mediation and arbitration.\textsuperscript{194} Mediation involves a neutral third party, known as a mediator, who facilitates negotiations between parties to a dispute but has no authority to render a decision.\textsuperscript{195} In comparison, arbitration is a private streamlined adjudication process involving a neutral third party, known as an arbitrator, whose role is similar to that of a judge in ensuring compliance with procedural rules and rendering an enforceable judgment.\textsuperscript{196} Unlike litigation, parties to the dispute contractually agree to a set of procedural and substantive rules to govern the process and who will serve as an arbitrator.\textsuperscript{197}

1. National and Sub-National Governments’ Measures Promoting the Use of ADR Resolution Processes

Several national and sub-national governments have enacted legislation or established administrative agencies encouraging or mandating the use of these ADR processes. In the US, arbitration is increasingly recognized as a legitimate dispute resolution alternative to medical malpractice litigation.\textsuperscript{198} Federal and state judicial systems encourage the resolution of health care cases by ADR processes, as courts direct cases to these forums with parties’ consent.\textsuperscript{199}

\textsuperscript{194} See infra Part IV.B.
\textsuperscript{195} Maurer, supra note 181, at ¶ 5.
\textsuperscript{196} Id.
These referred cases must be governed by rules of the jurisdiction in which they were filed.\textsuperscript{200} When parties have entered into a written contract with an arbitration clause, and one party seeks litigation, most federal courts return the case to arbitration.\textsuperscript{201} When the arbitration clause is upheld, and an arbitration organization is identified in the contract, that organization’s rules and procedures will govern the claim.\textsuperscript{202} A variety of arbitration organizations with a national reach are able to preside over these cases, and include but are not limited to: National Arbitration Forum, American Health Lawyers Association, American Arbitration Association (AAA), and Judicial Arbitration and Mediation Services.\textsuperscript{203}

In addition to federal and state courts encouraging ADR processes over litigation, some state legislators have gone the extra step in enacting laws requiring medical malpractice claims to be arbitrated, and/or that the arbitration panel includes physicians.\textsuperscript{204} The Maryland Health Care Malpractice Act requires court-ordered mediation or mandatory arbitration.\textsuperscript{205} According to the state’s legislators, the reasoning behind such legislation is four-fold: (1) prevent non-meritorious claims in litigation because weak claims are exposed in arbitration; (2) promote settlement of meritorious claims because arbitration encourages this result; (3) arbitration leads to more accurate decisions; and (4) arbitration awards are more predictable and reasonable.\textsuperscript{206} Mandatory arbitration is required in medical injuries where a health care provider is involved.\textsuperscript{207} A panel comprising of a lawyer, health care provider, and lay person presides over the claim.\textsuperscript{208}

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\textsuperscript{200} \textit{Id.}
\textsuperscript{201} \textit{Id.}
\textsuperscript{202} DeVille, \textit{supra} note 189, at 338.
\textsuperscript{203} \textit{Id.}
\textsuperscript{205} \textit{Id.} at 34.
\textsuperscript{206} \textit{Id.} at 35.
\textsuperscript{207} \textit{Id.} at 35.
\textsuperscript{208} \textit{Id.}
\end{footnotesize}
Some governments go beyond promoting and/or mandating private ADR processes to establish administrative agencies as an alternative to litigation. India’s 1986 Consumer Protection Act (the Act) led to the creation of Consumer Disputes Redressal Agencies (consumer forums), which offer cheaper and quicker non-judicial forums vested with the legitimacy of courts. These consumer forums include adjudication of medical malpractice claims, and allow patients to sue private physicians and public physicians under certain circumstances for negligent care. Empowered with the same capacity as a civil court, these consumer forums operate similar to judicial proceedings, but with decisions made by a panel of members with judicial and non-judicial backgrounds in place of a jury. While these consumer forums were designed to resolve a claim within approximately half a year, a claim is usually resolved within two to three years. Relative to the ten year or more recovery period in India’s litigation system and the U.S. recovery period of four to five years for malpractice claims, such a delay is arguably a relatively minor weakness of this system. Finally, it is worth noting that India’s consumer forum framework may be more effective in deterring negligent care than traditional malpractice litigation, as decisions are published on the internet alerting consumers to health care providers with adverse judgments against them.

Rather, the major criticisms of these consumer forums lie in the peculiar challenges patients in India face in proving malpractice and the small compensation awards dispensed by

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210 Id. at 26.
211 Id. at 25.
212 Id. at 27.
213 Id. at 24.
214 Id. at 27.
216 Cortez, supra note 83, at 28 (2010).
consumer forum panels.\textsuperscript{217} India’s health care community makes it difficult for patients to obtain experts willing to testify to a colleague’s negligence and to retrieve medical records and relevant information related to their treatment from local hospitals.\textsuperscript{218} While this critique may be valid, the observation that recovery awards are inadequate to satisfy expectations of those from industrialized countries may be off-set by the fact that these awards correspond with India’s low costs of medical treatment.\textsuperscript{219}

Finally, Great Britain offers an instructive example of a government implementing administrative agencies for the purposes of deterring negligent care.\textsuperscript{220} One of these forums is the Hospital Complaints Procedure, which offers a statutory remedy for patients to bring medical injury claims before a consultant and/or regional medical officer. This procedure enables patients to express concerns and prevent similar future injuries.\textsuperscript{221} Another notable British forum is the General Medical Council, which deals with serious complaints and enables patients to seek sanctions against a health care provider.\textsuperscript{222} Although it must be noted that a hypothesis for why British patients are unlikely to sue is because their taxes go towards the cost of health care,\textsuperscript{223} its administrative process of addressing patient concerns and implementation of sanctions is worth considering as part of a potential overarching international health services legal regime.

2. Non-Government Actors’ Preference and Use of ADR Processes

In parallel with government efforts to promote ADR processes for dispute resolution, several businesses and consumers in the health care industry have contractually consented to arbitration as a means of redress. A notable example is Kaiser Permanente (Kaiser), a

\begin{itemize}
\item \textsuperscript{217} Id. at 31.
\item \textsuperscript{218} Id. at 28-29.
\item \textsuperscript{219} Id. at 23.
\item \textsuperscript{220} Simone, supra note 198, at 593.
\item \textsuperscript{221} Id.
\item \textsuperscript{222} Id. at 594-595.
\item \textsuperscript{223} Id. at 590.
\end{itemize}
California-based nonprofit health management organization (HMO), which has mandated and administered its own arbitration among its members since 1971. In 1997, Kaiser handed administrative control of its arbitration process to an independent body in response to a California Supreme Court decision rendered that same year, which cited Kaiser’s self-administration approach as the source of undue delay in resolving claims. To further encourage speed and efficiency, Kaiser pays for neutral arbitrators’ fees and expenses when claims are greater than US$ 200,000 and claimants opt to proceed with only one arbitrator by waiving their state statutory right to three arbitrators and waiving objection to Kaiser paying these fees. As of 2009, Kaiser paid for these fees in 85 percent of cases. In the same year, 91 percent of these cases were medical malpractice disputes.

The most recent annual report on Kaiser’s arbitration system, conducted in 2009, revealed that a majority of participants, including neutral arbitrators and parties to the dispute, felt the process “was better than going to court.” The time frame for dispute resolution averaged twelve months, in comparison to the four to five year average for payouts from litigation in the US. Just as significantly, Kaiser compensated half its claimants by settling the dispute in a majority of cases, with a median award of US $377,589. In comparison, a 2006

225 Id. at 23.
226 Id.
228 Id. at 4.
229 Id. at 3.
230 Id.
231 Cortez, supra note 83, at 27 (2010).
232 ELEVENTH ANNUAL REPORT, supra note 227, at 9.
National Practitioner Data Bank report calculated that the median award arising out of litigation to be $175,000 per patient.\textsuperscript{233}

Furthermore, it is significant to note that arbitration and mediation have been commonly employed for business-to-business disputes in the health care industry.\textsuperscript{234} Business entities such as health care providers, payors, managed care plans, and other health-related companies are typical participants.\textsuperscript{235} Healthcare lawyers trained and experienced in arbitration and mediation handle many large healthcare disputes involving, but not limited to, large reimbursements, managed care or complex healthcare contract disputes.\textsuperscript{236} Business-to-consumer disputes related to long-term care are also common in this sub-sector of the health industry.\textsuperscript{237} Thus, the familiarity that so many players have in the health care industry with arbitration and mediation lends support to the feasibility and success of transferring business-to-consumer medical malpractice claims to these forums.

C. Arbitration of Cross-Border Medical Malpractice Claims Offers an Efficient and Effective Method to Achieve the Goals of Accurate Judgments, Just Compensation, and Deterrence of Negligent Medical Care

In addition to government support and familiarity among participants in the health care industry with ADR processes, several scholars have observed that arbitration achieves the public policy goals of accurate judgments, just compensation, and deterrence of negligent medical care. An analysis below of the features and processes of arbitration will demonstrate the ways in which arbitration is viable alternative to litigation for cross-border medical malpractice claims.

\textsuperscript{233} Cortez, supra note 83, at 19 (2010).
\textsuperscript{234} Katherine Benesch, supra note 199, at 28.
\textsuperscript{235} Id.
\textsuperscript{236} Id. at 31.
\textsuperscript{237} Id.
1. Arbitration Agreements and Awards are Binding Across Jurisdictions under Regional and International Treaties or Customary Law, thereby Eliminating Procedural and Substantive Legal Uncertainties in Adjudicating Cross-Border Health Services Claims

The greatest advantages arbitration has over litigation in resolving cross-border disputes are the enforceability of arbitration agreements and awards in foreign jurisdictions.238 As mentioned earlier, an arbitrator has the authority to render an enforceable, final decision.239 These agreements and decisions are binding on the parties, all jurisdictions empowered by legislation enabling courts to enforce arbitration awards,240 and all countries that are members to various regional and international treaties recognizing other members’ arbitration awards.241

Alternatively, in the event a country is a non-signatory to the relevant treaties in question, arbitration agreements and awards may still be enforced under customary law through Friendship Commerce and Navigation Treaties (FCN treaties)242 or general principles of comity.243 Member countries of FCN treaties will enforce arbitration awards of fellow member countries as long as enforcement does not violate a member country’s public policy.244 When an award is made in a state that is neither a member of an FCN treaty or any relevant commercial arbitration treaty, enforcement may be sought under the principle of comity.245 This principle appeals to a 

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239 Maurer, supra note 181, at ¶ 6.
243 8 AMJUR Trials 1, §236 (1965).
244 See FCN treaties, supra note 242.
245 8 AMJUR Trials 1, supra note 243, at §236.
country’s sense of international duty and regard for the rights of persons under another nation’s laws.\textsuperscript{246}

Parties who contract to resolve disputes through arbitration avoid jurisdictional and choice of law concerns because they consent to a set of procedural and substantive rules to govern the process and who will serve as an arbitrator.\textsuperscript{247} Arbitration operates much like pre-trial and trial phases of litigation, in which parties may file counter and cross-claims throughout this process.\textsuperscript{248} Procedural and substantive rules are governed by either or a combination of arbitration statutes, agency rules, and/or the contract entered into by parties binding them to arbitration.\textsuperscript{249}

3. An Arbitrator’s Expertise in the Subject Matter of the Dispute and Decision-Making Powers Helps Resolve Legal Ambiguities and Uncertainties of Cross-Border Health Services Claims

Another key attribute of arbitration is its procedure of selecting qualified decision-makers for evaluating complex, specialized cases such as medical malpractice claims. Arbitrators are more appropriate decision-makers than juries because parties to the dispute most often select arbitrators who have a background and expertise in the subject matter of the dispute.\textsuperscript{250} Arbitrators in medical malpractice cases are typically selected from a list of qualified candidates.\textsuperscript{251} Furthermore, all national laws, institutional rules, and international arbitration treaties require arbitrators to be neutral and independent in their decision-making.\textsuperscript{252}

In the global and ever changing industry of health services, it is crucial to have decision-makers who are neutral and independent, able to adapt existing substantive legal principles to

\textsuperscript{246} Id.
\textsuperscript{247} Fiske, \textit{supra} note 197, at 458.
\textsuperscript{248} DeVille, \textit{supra} note 189, at 338-339.
\textsuperscript{249} Elg, \textit{supra} note 240, at 16.
\textsuperscript{251} DeVille, \textit{supra} note 189, at 338.
\textsuperscript{252} Biukovic, \textit{supra} note 250, at 344.
new conflicts and ambiguities that arise from continuous transformations to medical care. As discussed earlier, technological advances in cross-border delivery of telemedical services have impacted the legal relationships of health care providers and consumers and the standard of care owed to the latter. Just as importantly, the globalization of health services has created even more variation in the standard of care, as one country’s assessment of acceptable care may be deemed unacceptable by another country. Given these considerations, expertise in health care enables decision-makers to have realistic expectations of defendants and to make more accurate and informed judgments of whether a medical practitioner violated the relevant standard of care.

The participation of parties in the process of selecting decision-makers in an arbitration system also contributes to a sense of confidence and fairness in the process. The process of choosing an arbitrator customarily requires each party to select his own arbitrator, and then the selected arbitrators together decide upon a third arbitrator who serves as the only neutral judge. For medical malpractice disputes, an arbitration panel comprises of three arbitrators, with two arbitrators individually selected by each party and one arbitrator chosen by the parties’ selected arbitrators.

4. Arbitration Offers a Forum for Adjudication that is More Neutral and Fair than Litigation

Just as importantly, evidence suggests that the decision to use an arbitration panel over a judge and jury in adjudicating medical malpractice claims would offer a more neutral forum for both parties. First, arbitration dilutes suspicions of bias towards any one party by removing the

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253 See Mclean, supra note 89, at 252 (2005).
254 Id.
255 Id. at 252-253.
256 DeVille, supra note 189, at 341
258 Elg, supra note 240, at 16.
259 DeVille, supra note 189, at 338.
claim from either party’s domicile court. Second, arbitration may reduce or eliminate the well-documented bias that judges and juries have for defendant health care providers. In the US, juries side with the defendant in nearly 80 percent of medical malpractice claims. Notably, two decades of studies conducted in the US confirm that defendants win an overwhelming majority of these disputes. Such bias towards the defendant is not isolated to the US, as other countries’ judicial systems share the same perspective. Several Indian courts have expressed criticism of patients who bring medical malpractice claims. Thailand’s judicial system is also hostile to medical malpractice suits; the low rate of tort litigation and dramatic decrease in tort claims in the past twenty years in certain provinces are indicative of such hostility against plaintiffs. Such bias towards defendants, in combination with studies discussed earlier demonstrating that a vast majority of injured parties do not sue, underscores the failure of litigation in meeting the public policy goals of just punishment and compensation.

While the above observations indicate arbitration would serve as more neutral forum, it is worth noting that several scholars have also identified shortcomings in this process. Some studies show that plaintiffs prevail more often in arbitration than litigation, and therefore one may argue that the process is biased towards plaintiffs. But such an outcome should be considered within the context of the arbitration process. Unlike litigation, both parties play a role in selecting the decision-makers and a defendant health care provider arguably has an advantage because it has gone through arbitration more often and therefore able to design the

260 Martha Neil, supra note 180, at 28.
261 DeVille, supra note 189, at 368.
263 Cortez, supra note 83, at 36 (2010).
264 Id. at 45-46.
265 MELLO, supra note 183, at 7; Cortez, supra note 83, at 19 (2010).
266 Maurer, supra note 181, at ¶36.
process to suit their needs.\textsuperscript{267} In fact, a related concern that deserves attention is that arbitrators may be biased towards businesses because businesses are repeat clients.\textsuperscript{268} Although the studies mentioned above revealing that plaintiffs have a higher rate of recovery in arbitration than litigation undercuts this critique, it is worthwhile to consider arrangements or mechanisms that discourage an appearance of or actual bias. For an instance, an initial critique of Kaiser’s arbitration system was that the HMO’s policy of paying for neutral arbitrator fees would result in the tribunal’s bias towards the HMO.\textsuperscript{269} To resolve this situation, Kaiser’s independent arbitration administrative body recommended that counsel from both parties work out a voluntary arrangement or revise Kaiser’s rules so that payment appears to come from a neutral source.\textsuperscript{270}

5. Arbitration Offers an Efficient and Quicker Resolution of Medical Malpractice Claims Relative To Litigation

In addition to providing predictability in the decision-making process and a more neutral forum for aggrieved parties, arbitration offers a quicker, more efficient, and more flexible approach to resolving unique or particular issues of medical malpractice claims than traditional court proceedings for the following reasons. First, discovery time and procedures are limited by the arbitrator or relevant procedural rules.\textsuperscript{271} This also means that parties typically require an arbitrator’s permission to take depositions.\textsuperscript{272} Second, there is no jury because the arbitrator also serves as a fact finder in the decision-making process, and as discussed earlier, usually has expertise in the area of the dispute.\textsuperscript{273} Third, the arbitrator has wide discretion for his decisions,

\textsuperscript{267} DeVille, supra note 189, at 373.
\textsuperscript{268} Id.
\textsuperscript{269} FIRST ANNUAL REPORT, supra note 224, at 31.
\textsuperscript{270} Id.
\textsuperscript{271} DeVille, supra note 189, at 338.
\textsuperscript{272} Marchand, supra note 204, at 34..
\textsuperscript{273} Id. at 35.
but is bound to follow the procedural and substantive rules of law of the arbitration agreement.\textsuperscript{274} Finally, the grounds on which a party may appeal are much more limited than those provided to an appellate court and such limited appellate rights may facilitate quicker and more certain resolution of the dispute.\textsuperscript{275} It has been observed that arbitrator decisions are “virtually unreviewable” on appeal, including mistakes of law, procedure, and evidence.\textsuperscript{276} Appeals usually only succeed in instances of fraud, exceeding the scope of the arbitration agreement or blatant disregard for the law.\textsuperscript{277} As a result of such truncated procedures, aggrieved parties who prevail receive a greater portion of the judgment and within an earlier time frame than in litigation.\textsuperscript{278} As a point of comparison, an arbitrated medical malpractice claim takes approximately 19 months to reach a final judgment while a litigated medical malpractice claim takes 33 approximately months to resolve.\textsuperscript{279}

Another related, but disputed, benefit to such a streamlined process is lower costs. Some scholars argue that arbitration decreases transaction costs for all parties involved as claims are heard more quickly and the discovery process is less lengthy than traditional trials.\textsuperscript{280} To confirm such an assertion, Maurer points to studies demonstrating that overall arbitration costs are far less than litigation costs.\textsuperscript{281} But other scholars have come to a different conclusion, noting that costs are not necessarily lower and further dissuade injured parties from filing a claim.\textsuperscript{282} Arbitration administrative fees may exceed the damages owed to a plaintiff, which include the high fees a plaintiff must pay to initiate case and to arbitrators to adjudicate the

\textsuperscript{274} DeVille, \textit{supra} note 189, at 338.  
\textsuperscript{275} \textit{Id.} at 339; Marchand, \textit{supra} note 204, at 34.  
\textsuperscript{276} DeVille, \textit{supra} note 189, at 339.  
\textsuperscript{277} \textit{Id.}  
\textsuperscript{278} DeVille, \textit{supra} note 189, at 340.  
\textsuperscript{279} Maurer, \textit{supra} note 181, at ¶ 36.  
\textsuperscript{280} \textit{Id.} at ¶ 37; Marchand, \textit{supra} note 204, at 34; DeVille, \textit{supra} note 189, at 340.  
\textsuperscript{281} Maurer, \textit{supra} note 181, at ¶ 38.  
\textsuperscript{282} DeVille, \textit{supra} note 189, at 372.
Furthermore, administration charges are imposed for every action requested by a party. As a consequence, it may be more economical for a plaintiff with a relatively low-value claim to forgo arbitration. The global nature of health services and the differences in economic backgrounds of potential aggrieved parties requires an examination of the ways in which arbitration may be a realistic and affordable means of redress, which is addressed in part V of this paper.

D. Arbitration Is a Proven Successful International Forum for Cross-Border Claims

In addition to the features and flexibility of the arbitration process discussed above, arbitration also offers a viable alternative forum for adjudication of cross-border medical malpractice claims because it is a well established international dispute resolution framework. The development of arbitration as a private dispute resolution process that is legally enforceable arose out of circumstances similar to challenges that the international health services industry faces today. After World War II, the reduction of trade barriers made it more attractive for businesses to engage in cross-border transactions for goods and services. The ability to successfully conduct cross-border transactions was hampered by several of the same legal uncertainties that parties in cross-border medical malpractice claims presently struggle with. Multinational businesses faced the challenges of (1) asserting personal jurisdiction if they sued in their domicile or (2) the prospect of unfamiliarity with a foreign legal system if they sued in the defendant’s domicile, and (3) enforcement of a foreign judgment. In particular, multinational

283 Id. at 370-371.
284 Id. at 371.
285 Id.
286 See Fiske, supra note 197, at 455-458.
287 Id. at 455.
288 Id. at 456-457.
289 Id.
businesses were reluctant to adjudicate a claim in a foreign court, as it was not uncommon for foreign judges to be incompetent and/or corrupt.\textsuperscript{290}

To resolve these dilemmas and encourage cross-border trade, a comprehensive international arbitration regime arose comprising of international commercial arbitration organizations (ICAOs),\textsuperscript{291} national and sub-national legislation enabling courts to enforce arbitration awards,\textsuperscript{292} and the ratification of international and regional commercial arbitration agreements by many countries recognizing and enforcing foreign arbitration agreements and awards of member states and/or ICAOs.\textsuperscript{293} As the below analysis demonstrates, these pre-existing agreements and networks establish a foundation upon which an international arbitration framework for health services disputes may be built.

1. Numerous ICAOs Are Based in Different Parts of the World and Serve as Private Forum for Arbitration of Cross-Border Disputes

The numerous ICAOs that serve as private forums for business-to-business disputes offer a comprehensive framework for arbitral tribunals, as they assist in the process of selecting arbitrators, set procedural rules, and facilitate the timely operation of a hearing.\textsuperscript{294} The proliferation of ICAOs reflects the preference by an increasing number of participants in transnational transactions for ADR processes such as arbitration to litigation to resolve disputes.\textsuperscript{295} In 1999, the EU had approximately 300 ADR organizations.\textsuperscript{296} In comparison, there are an estimated 1,500 ADR organizations based in the US, but it should be noted that many of

\textsuperscript{290} See, generally, Brent T. White, \textit{Putting Aside The Rule Of Law Myth: Corruption And The Case For Juries In Emerging Democracies} 43 \textsc{Cornell Int'l L.J.} 307 (2010).
\textsuperscript{291} \textit{Id.} at 457.
\textsuperscript{292} Elg, \textit{supra} note 240, at 16.
\textsuperscript{293} \textit{Id.} at 458-459.
\textsuperscript{294} BENYEKHLEF & GÉLINAS, \textit{supra} note 241, at 51
\textsuperscript{295} \textit{Id.} at 20-21.
\textsuperscript{296} \textit{Id.}
these do not deal with international disputes. The procedures and rulings of ICAOs are supported and enforced by legislative measures and treaties ratified by many countries. For instance, US courts will mandate that an arbitral institution’s rules and procedures govern if such an institution is identified in an arbitration contract. Similarly, Great Britain’s 1996 English Arbitration Act supports ICAOs and flexibility and private party control in the arbitration process by limiting the grounds upon which awards may be challenged.

2. National and Sub-National Legislation Empower Domestic Courts to Enforce Foreign Arbitration Agreements and Awards

As discussed earlier, governments generally encourage the use of arbitration as an alternative to litigation. In the US, arbitration statutes are in place at federal and state levels. Notably, the Federal Arbitration Act (FAA) reflects Congress’s support of arbitration as more efficient resolution process than litigation by rendering all arbitration agreements “valid, irrevocable, and enforceable, save upon such grounds as exist at law or in equity for revocation of any contract.” The FAA upholds arbitration agreements and awards involving interstate and foreign commerce, the latter of which is possible because the FAA also ratifies certain international arbitration agreements into domestic law. Most courts have interpreted activities in the health care industry to be interstate commerce and thus subject to the FAA. This includes, but is not limited to: shipping of medical supplies, performance of certain lab tests,

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297 Id.
298 DeVille, supra note 189, at 338.
305 DeVille, supra note 189, at 338.
recruitment of physicians across state lines,\textsuperscript{306} services acquired from out of state during the course of a local health care provider’s delivery of health care services, transactions via interstate forums of communication, and receiving insurance payments from out of state.\textsuperscript{307} This means that arbitration contracts and awards involving international medical malpractice disputes will likely be enforced in the US, as the FAA is charged with the duty of honoring these types of arbitration contracts.\textsuperscript{308}

3. International and Regional Commercial Arbitration Agreements Bind Enable Widespread Enforcement of Foreign Arbitration Awards Rendered by Member states and/or ICAOs

Finally, the popularity of international and regional commercial arbitration agreements among many countries signals the global community’s widespread preference and support for arbitration. As discussed earlier, these agreements enable arbitration agreements and awards to be enforced in any member state.\textsuperscript{309} A closer examination of some of these agreements is useful to show the extent of their effectiveness. The 1958 United Nations Convention on Recognition and Enforcement of Foreign Arbitral Awards (New York Convention) is one of the most prominent international agreements, with more than 135 member countries.\textsuperscript{310} The New York Convention requires that its members’ courts (1) recognize written arbitration agreements; (2) reject disputes subject to arbitration clauses; and (3) enforce arbitration awards in accordance with criteria established by the member state in question.\textsuperscript{311} A notable regional agreement is the Inter-American Convention on International Commercial Arbitration (Panama Convention), which recognizes and enforces arbitration agreements and awards involving international

\begin{footnotesize}
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\item\textsuperscript{307} Kroupa v. Casey, 01-05—0024-CV (Tex.App. 1\textsuperscript{st} Dist. Dec. 8, 2005).
\item\textsuperscript{308} See id.
\item\textsuperscript{309} LOOKOFSKY, supra note 238, at 10.
\item\textsuperscript{310} David Buoncristiani, Enforcement Of International Arbitration Awards In The United States, 27 CONSTRUCTION LAW. 14, 14 (2007).
\item\textsuperscript{311} BENYEKHLEF & GÉLINAS, supra note 241, at 51.
\end{enumerate}
\end{footnotesize}
commercial transactions between citizens of member countries of the Organization of American States. Several scholars conclude that such agreements are responsible for arbitration’s success in resolving international commercial disputes. In particular, the multilateral nature of the New York Convention “has no equal with respect to ensuring the exclusive jurisdiction of national tribunals and obtaining enforcement abroad of resulting judicial decisions,” which stands in contrast to the lack of a similar treaty for enforcement of court judgments as noted earlier in the text. Thus, the availability of arbitration forums on a global scale and binding nature of arbitration awards involving commercial disputes across national boundaries offers a solid foundation upon which to establish an international arbitration framework for cross-border health services disputes.

V. CHALLENGES AND CONSIDERATIONS IN IMPLEMENTING AN INTERNATIONAL ARBITRATION FRAMEWORK TO ADJUDICATE CROSS-BORDER MEDICAL MALPRACTICE CLAIMS

In order to fully assess whether the features and flexibility of the arbitration process, and its well-established international framework, offers a viable alternative to litigation in adjudicating cross-border health services claims, it is instructive to determine the feasibility of its application. The analysis below considers the challenges and strategies of applying the arbitration process and its framework to disputes between businesses and consumers in the health services industry.

312 Buoncristiani, supra note 310, at 15.
314 BENYEKHLEF & GÉLINAS, supra note 241, at 51.
A. Whether Cross-Border Health Services Transactions between Businesses and Consumers are Entitled to Protection under Commercial Arbitration Agreements, as it is Uncertain Whether They Constitute “Commercial” Transactions as Required by These Agreements

One potential obstacle to the application of an international arbitration framework in resolving cross-border health services claims between businesses and consumers is whether they constitute commercial transactions that merit protection under commercial arbitration treaties. The existence of various regional and international treaties of this nature, and the option to sign on with reservations and include criteria when ratifying such treaties necessarily requires individual analysis of these treaties and countries for comprehensive analysis. But this paper seeks merely to offer a broad overview of this issue, and will limit examination to the New York Convention, as it recognized in the international community as the primary legal basis for recognizing arbitration agreements and enforcing arbitration awards.315

The applicability of the New York Convention to health services disputes between businesses and consumers is called into doubt because of the treaty’s commercial reservation exception.316 This treaty gives signatories the option of electing a “commercial reservation,” which restricts coverage to “commercial” transactions.317 More than half of the signatories have signed on to this exception.318 The definition of “commercial” is undefined, as the New York Convention defers to domestic laws of the enforcing country for guidance in this determination.319 Several countries statutorily exclude certain types of disputes as

316 See id. at 54.
317 Buoncristiani, supra note 310, at 14.
318 Gibbons, supra note 315, at 52.
319 Id. at 53.
“commercial.” 320 The US has also signed to this reservation, and federal law has broadly defined “commercial” as “a contract evidencing a transaction involving commerce.” 321 As discussed earlier, US case law has affirmed that activities in the health care industry to be interstate commerce and thus subject to the FAA and by extension, the New York Convention. 322 However, the definition of “commercial” may not necessarily turn on the type or location of the transaction, but the status of the participants to the transaction. 323 Some scholars speculate that member countries may exclude enforcement of business-to-consumer arbitration contracts and awards by redefining the meaning of “commercial” relationships under their domestic laws. 324

Such a concern may be more relevant in some member countries than others. For example, the body of US federal and state legislation and case law supporting arbitration of medical malpractice claims examined earlier in this paper indicates that the US would be unlikely to carve out an exception for business-to-consumer health services disputes. As a reminder, federal and state courts encourage ADR processes over litigation and some state legislators have enacted laws requiring arbitration of medical malpractice claims. 325 Furthermore, arbitration contracts are allowed in patient contracts as a matter of private contract law and require no justification by legislation. 326

In comparison, concerns regarding the “commercial” reservations may be more relevant among EU countries. The Brussels Convention, discussed earlier in the context of jurisdictional challenges in litigation, emerges again as one factor that may impact the enforceability of cross-

320 Id. at 54.
321 Id.
322 See supra Part V.D.2.
323 See Gibbons, supra note 315, at 54.
324 Id.
325 See supra Part III.B.3; see Cal. C.C.P. § 1295.
326 DeVille, supra note 189, at 343-344.
border business-to-consumer arbitration agreements and awards.\textsuperscript{327} Similarly, the EU Directive on Unfair Terms in Consumer Contracts (EU Directive on Unfair Terms) is another regional agreement that may have the same adverse impact, as both agreements place restrictions on a consumer’s rights to waive access to court.\textsuperscript{328} Specifically, the EU Directive on Unfair Terms invalidates any “unfair” contract term, which means any term that “exclude[es] or hinder[s] the consumer’s right to take legal action or exercise any other legal remedy, particularly by requiring the consumer to take disputes exclusively to arbitration not covered by legal provisions.”\textsuperscript{329} A consumer is defined as “any natural person who... is acting for purposes which are outside his trade, business or profession.”\textsuperscript{330} As a consequence of these restrictions, some scholars conclude that at the very least, any business-to-consumer arbitration agreements must be made post-dispute and with the same degree of procedural fairness afforded in court in order to withstand violations of these complementary commercial agreements.\textsuperscript{331} An equally valid alternative opinion of this situation is that no member country will exclude consumer arbitration awards, as there no examples yet of such an action.\textsuperscript{332} And furthermore, such an action would undermine the very purpose of the New York Convention itself.\textsuperscript{333}

B. Whether Public Policy Considerations Prohibit the Adjudication of Cross-Border Health Services Claims through Arbitration

Another potential challenge to the implementation of an international arbitration framework for cross-border health services dispute claims arises from public policy considerations. It is common for parties to go to court to contest the validity of arbitration

\begin{footnotesize}
\begin{enumerate}
\item Id.
\item Id. at art. 2(b).
\item MORRISON & FÖRSTER, supra note 327, at 3.
\item See Gibbons, supra note 315, at 56.
\item Id.
\end{enumerate}
\end{footnotesize}
clauses, and business-to-consumer disputes involving health services is likely to invite concerns surrounding fairness of parties’ bargaining positions.\textsuperscript{334} The New York Convention allows foreign arbitration contracts and awards to be invalidated if they violate the public policy of any involved member country.\textsuperscript{335} While the treaty defers to member states to determine what constitutes a valid public policy defense, the treaty’s drafters recommend domestic courts to apply such a defense “to cases in which the recognition or enforcement of a foreign arbitral award would be distinctly contrary to the basic principles of the legal system of the country where the award was invoked.”\textsuperscript{336} In practice, courts have followed this recommendation and their narrow application has generally resulted in rejection of this defense.\textsuperscript{337} In the context of medical malpractice disputes, the below analysis shows that the validity of arbitration agreements depends on a variety of factors: the domestic court and its relevant laws in question; and the timing and manner in which their terms are presented to the parties.

1. Whether Arbitration Agreements May Withstand the Defense of Unconscionability

The most common challenge raised against the legitimacy of arbitration agreements involving businesses and consumers is unconscionability, which requires that a party knowingly enter into a contract and understand its terms in order to be bound to that contract.\textsuperscript{338} This situation is often arises in contracts of adhesion, which are standardized forms preventing one party from negotiating the terms of a contract or to receive goods or services without signing the

\textsuperscript{334} See Benesch, supra note 199, at 29.
\textsuperscript{335} Convention on the Enforcement of Foreign Arbitral Awards, June 10, 1958, 21 U.S.T. 2518, 330 U.N.T.S., 38 [NY Convention, art. 2(b)].
\textsuperscript{337} Id.
contract.\textsuperscript{339} In the context of arbitration agreements between businesses and consumers, this would apply to pre-dispute clauses binding parties to arbitrate before the dispute arises and without negotiating the terms of arbitration beforehand.\textsuperscript{340}

In the US, this defense does not invalidate an arbitration clause per se, but will subject the contract to greater scrutiny.\textsuperscript{341} In order for an adhesion contract defense to be valid, US courts must find the contract to be unconscionable on both procedural and substantive levels.\textsuperscript{342} Procedural unconscionability refers to whether the weaker party had a reasonable opportunity to understand the terms of the contract during negotiations.\textsuperscript{343} US courts find no violation if the arbitration clause was in plain sight, understandable, and patients were encouraged to ask questions.\textsuperscript{344} Substantive unconscionability refers to whether the terms of a contract are fair.\textsuperscript{345} This means that if arbitration requirements apply equally to both parties, courts will find no violation.\textsuperscript{346} It is also important to note that case law involving this defense makes it clear that mere inequality in bargaining power is not enough.\textsuperscript{347} Thus, as long as businesses account for the considerations listed above, US courts will likely honor arbitration clauses in their agreements.

In comparison, pre-dispute clauses may constitute a public policy violation by courts in several EU countries. Under Community Laws, the Commission recommends that the “use of the out-of-court alternative may not deprive consumers of their right to bring the matter before

\textsuperscript{339} DeVille, supra note 189, at 357.
\textsuperscript{340} Maurer, supra note 181, at ¶ 40.
\textsuperscript{341} See Wilkerson v. Nelson, 395 F. Supp. 2d 281 (M.D.N.C. 2005) (denying plaintiff claim that contract was void against public policy because it was a contract of adhesion).
\textsuperscript{342} DeVille, supra note 189, at 358.
\textsuperscript{343} Id.
\textsuperscript{344} Id.
\textsuperscript{345} Id.
\textsuperscript{346} Id.
\textsuperscript{347} Id.
the courts unless they expressly agree to do so, in full awareness of the facts and only after the dispute has materialized."\textsuperscript{348} This likely means that arbitration clauses must be post-dispute, which allows parties the choice between arbitration and litigation after a dispute arises.\textsuperscript{349} Such a recommendation reveals that while pre-dispute clauses may be valid in the US, EU countries may diverge by requiring post-dispute clauses.

Such divergence in position complicates a business’ ability to enter into transactions with consumers on a global scale, as higher costs are incurred for ensuring that arbitration agreements are drafted in compliance with a nation’s public policy requirements, and/or the prospect of having to go to litigation in post-dispute clauses. Because this situation brings parties closer to the quandaries of a cross-border litigation system, it is useful to consider why the best approach towards adopting an international arbitration framework for health services claims is the uniform use of pre-dispute clauses, rather post-dispute clauses or a combination of both. An agreement to arbitrate from the beginning of the parties’ relationship tends to result in parties’ compliance should a dispute arise, as the absence of conflict between the parties at the time of agreement enables both parties to appreciate the benefits of arbitration.\textsuperscript{350} In comparison, parties who must decide between a lawsuit and arbitration in post-dispute situations are often so antagonistic towards one another that litigation becomes the preferred approach.\textsuperscript{351} Several studies support these observations, including a 2003 report finding that parties in employment disputes rarely arbitrate post-dispute.\textsuperscript{352} Counsel for these parties may also contribute to this outcome, as

\textsuperscript{348} See Morrison & Foerster, supra note 327, at 3, FN 4.  
\textsuperscript{349} Id.; see Maurer, supra note 181, at ¶ 40.  
\textsuperscript{350} Maurer, supra note 181, at ¶ 41.  
\textsuperscript{351} Id.  
\textsuperscript{352} Id. at ¶ 46.
another 2003 report found that only 4.2 percent of attorneys advise their clients to arbitrate post-dispute.\textsuperscript{353}

Just as importantly, it should be noted that the use of pre-dispute clauses does not mean that the public policy goals behind post-dispute clauses are automatically sacrificed. With careful drafting and presentation, the concerns of the EU Commission discussed earlier regarding the importance of informed-decision making by consumers may still be met. The same considerations that businesses must be mindful of in order to withstand the defense of unconscionability in US courts should also apply here. Specifically, agreements should be drafted in such a way that it is clear arbitration is voluntarily entered into through the informed consent of the consumer, and not a condition to receiving treatment.\textsuperscript{354} Additionally, some scholars recommend enhanced information and consent standards to help ensure that consumers are informed.\textsuperscript{355}

2. Whether Arbitration Provisions Capping or Barring Exemplary Damages are Valid

Another challenge to the enforceability of an arbitration agreement may rest with provisions that cap or bar recovery for economically non-quantifiable claims, such as pain and suffering. In the context of medical malpractice claims, one of the major advantages of arbitration for businesses is to contractually avoid liability for punitive damages. Although it is uncertain whether such provisions violate public policy, some scholars surmise that in US courts at least, these restrictions will be upheld as long as a patient retains the right to be made whole for measurable economic loss.\textsuperscript{356} Such a view is supported by analogy to widely accepted

\begin{footnotes}
\begin{enumerate}
\item Id. at ¶ 48.
\item Marchand, supra note 204, at 36.
\item DeVille, supra note 189, at 383.
\end{enumerate}
\end{footnotes}
provisions in commercial contracts imposing limitations on recoverable damages for contract breaches.\(^{357}\) Furthermore, many US jurisdictions prohibit arbitrators from awarding punitive damages by reserving such a right to courts.\(^{358}\) As a result, should businesses decide to permit punitive damages, some scholars recommend detailed provisions stipulating specific conditions in which these damages apply and any limitations on award amounts.\(^{359}\)

C. Approaches to Implementing an International Arbitration Framework to Resolve Business-To-Consumer Health Services Disputes

In addition to ensuring that the arbitration agreement qualifies under the protection of existing commercial arbitration treaties and withstands public policy defenses, it is instructive to consider practicable approaches towards implementation of an effective international arbitration regime. While this paper has demonstrated that arbitration is a preferable means of dispute resolution to litigation, additional mechanisms should also be considered in the construction of an arbitration approach in order to minimize legal ambiguity and allocate risk between businesses and consumers to the fullest extent practicable. One such potential complementary mechanism is a no-fault compensation scheme, as a review of earlier scholarship and real-world examples of tort reform reveals its proven capacity to eliminate many contestable issues of liability and adequate relief.\(^{360}\) Just as importantly, the combination of no-fault and arbitration models have been successfully implemented on a domestic level, thus pointing to a potentially

\(^{357}\) Id. at 467.

\(^{358}\) Id.

\(^{359}\) Id.

viable application at the international level. Building upon such existing models, the authors advocate a two-step claim evaluation process that first utilizes a no-fault compensation scheme and secondarily mandates arbitration when a dispute arises concerning any aspect of a decision regarding award compensation. The analysis below will assess the feasibility of such a two-tiered approach and offer recommendations on the establishment of an effective arbitration framework that addresses the needs, rights, and responsibilities of all participants involved in the event a party elects to arbitrate a claim after an adverse decision.

A dispute resolution framework involving no-fault compensation and binding arbitration in resolving cross-border health care disputes offers a feasible approach that should effectively reduce exposure to legal liability on the part of businesses and maximize means of redress for consumers. To support these assertions, it is necessary to start with an explanation of the mechanics and benefits of a no-fault model as the first step of the claims evaluation process. In the event of injury arising from substandard medical care, consumers would submit a claim to a health care provider’s insurer or designated body chosen by a health care provider for review. Consumers would receive compensation without having to prove negligence, as providers would be strictly liable for any injuries sustained during medical treatment. Compensation would be calculated from a pre-determined schedule of payments based on type and extent of injury. Any disputed issues that fall outside designated compensable events and adverse decisions against a party would be brought to arbitration.

As alluded to earlier, real-world examples support the feasibility and success of this two-tiered dispute resolution process. One of the most well known precursors of this model is the

361 See Huang & Soleimani, supra note 360, at 11-15.
362 See Coylewright, supra note 360, at 44.
363 Id.; MacCourt & Bernstein, supra note 360, at 529.
364 Coylewright, supra note 360, at 44.
workers’ compensation system used in some foreign countries and all of the U.S. states, most of which cover employees’ wages up to a certain amount and time period and medical costs associated with a workplace injury.\textsuperscript{365} Thus, jurisdictions such as Sweden, Denmark, Norway, Finland, France, and New Zealand, and states such as Florida and Virginia, have utilized the no-fault approach in varying degrees to resolve medical malpractice claims.\textsuperscript{366} Notably, New Zealand and Sweden have implemented one of the most comprehensive no-fault schemes, with the latter employing both no-fault and arbitration as part of its dispute resolution process.\textsuperscript{367} The discussion below will consider features from these countries’ models and other relevant real-world examples in contemplating the construction of no-fault compensation and arbitration framework at the international level.

1. Establishing Patient Notice and Informed Consent to No-Fault Compensation and Binding Arbitration

An initial step requires the informed consent of patients to be bound to no-fault and arbitration dispute resolution mechanisms.\textsuperscript{368} Given the diversity of cultures and languages of consumers who seek medical care abroad or telemedical services, it behooves businesses to follow the recommendations detailed above to avoid any public policy defenses of unconscionability and failure to provide informed consent. It may also be instructive to borrow from the Swedish model here, as Sweden introduces its no-fault scheme to patients through information packets provided by hospitals and offers guidance from social workers in filing a claim.\textsuperscript{369} In place of social workers, businesses may train its medical and/or support staff to help patients understand the claims process and pursue any potential claims. Additionally, businesses

\textsuperscript{365} Coylewright, \textit{supra} note 360, at 44-45.
\textsuperscript{366} Douglas, \textit{supra} note 360, at 31.
\textsuperscript{367} Huang & Soleimani, \textit{supra} note 360, at 11-15.
\textsuperscript{368} See id. at 26.
should review Malaysia’s Telemedicine Act, as mentioned earlier, it is a global forerunner in offering detailed guidelines on obtaining informed consent in the context of telemedical services.  

2. Determining an Appropriate Entity to Establish a No-Fault Scheme and Review Cross-Border Medical Malpractice Claims for Compensation

Second, the successful implementation of a no-fault scheme requires a designated body to implement and oversee the processing and evaluation of cross-border malpractice claims. New Zealand charges the Accident Compensation Corporation (ACC), a government agency and sole insurer of almost all personal injury claims, with the duty to handle medical treatment injuries. Similarly, Sweden utilizes the Federation of County Councils (FCC), a central administrative body that represents county councils, to evaluate all claims. Unlike the ACC, however, the FCC does not also operate as an insurer but works with a consortium of private insurers who agree to the same terms of coverage. Because it is impracticable and politically unrealistic for a government or international entity to oversee one overarching no-fault scheme for cross-border claims involving parties of different nationalities, the onus is on private parties to establish their own no-fault mechanisms and designate an administrator for evaluation of these claims. The involvement of insurers in both the New Zealand and Australian models suggests that insurers for health care providers should be responsible for both these responsibilities.

The above arrangement offers a fair and efficient allocation of legal liability and redress, as insurers are increasingly exposing consumers to potential disputes by providing coverage for

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371 Schuck, supra note 360, at 190.
372 Huang & Soleimani, supra note 360, at 15.
373 Danzon, supra note 369, at 204.
health services performed by foreign health care providers\textsuperscript{374} and cross-border health coverage.\textsuperscript{375} This trend towards extending covering cross-border health services results in cost savings for insurers.\textsuperscript{376} Some US private insurers are covering medical services performed in India, Mexico, and Thailand\textsuperscript{377} - locations that notably offer treatment at bargain prices relative to US prices, as discussed earlier. US public insurers are also beginning to take advantage of such price differentials. In 2006, West Virginia legislators proposed a bill offering incentives for public employees to obtain medical treatment abroad, as the state would be able to keep 80 percent of the cost savings from such a proposal.\textsuperscript{378}

Alternatively, those health care providers who underwrite their own coverage (provider-owned companies) should designate an internal administrative body or contract with an independent administrator, as in the case of Kaiser Permanente’s utilization of a law firm to administrate its arbitrations.\textsuperscript{379} Because health care providers and insurers are financially benefitting from placing consumers in potential disputes that offer no reliable legal redress, it is reasonable to expect these businesses to shoulder part or all of that risk as well.

3. Determining Criteria for No-Fault Compensation

Just as importantly, a successful no-fault scheme requires clearly defined criteria for determining compensation eligibility in order to minimize any contestable issues of coverage. New Zealand’s no-fault scheme covers “treatment injuries,” which adopts a strict liability approach by compensating for injuries resulting from medical treatment by health care

\textsuperscript{374} Mclean, \textit{supra} note 76, at 163 (2007).
\textsuperscript{375} Cortez, \textit{supra} note 49, at 100 (2008).
\textsuperscript{376} \textit{Id.} at 99-100.
\textsuperscript{377} \textit{Id.} at 100.
\textsuperscript{378} \textit{Id.}
\textsuperscript{379} \textit{See, generally, ELEVENTH ANNUAL REPORT, supra} note 227.
professionals.\textsuperscript{380} New Zealand’s ACC further limits this category by providing benefits based on a schedule of designated compensable events.\textsuperscript{381} Other eligibility requirements include a disability threshold of fourteen hospital days or twenty-eight “days of significant disability.”\textsuperscript{382} In comparison, Sweden’s FCC grants compensation only if an injury resulted from inappropriate medical care or avoidable injury.\textsuperscript{383} As a result, such an evaluation is not technically a “no-fault” scheme in the sense that no compensation will be given for any adverse outcomes resulting from justified medical care or conformity with medical customs.\textsuperscript{384} Eligibility requirements also include a minimum disability threshold of ten days in the hospital or thirty sick days from work.\textsuperscript{385}

While New Zealand and Sweden employ similar minimum disability thresholds, the differences in standards of care between these countries highlights the need for consideration of the most appropriate standard for cross-border health services claims. Both these standards have benefits and disadvantages. New Zealand’s strict liability approach would likely be the better option in minimizing contestable issues of coverage but may have the adverse effect of a greater number of claims and expenditures in settling these claims.\textsuperscript{386} When New Zealand enacted its strict liability approach in 2005, medical malpractice claims nearly tripled, the ACC’s denial rate dropped by half, and expenditures rose almost 28 percent as a result.\textsuperscript{387} In comparison, the application of a stricter standard of care similar to Sweden would likely result in a lower number of approved claims and expenditures, but may increase the potential for arbitration or litigation.

\textsuperscript{380} Schuck, supra note 360, at 194.
\textsuperscript{381} Huang & Soleimani, supra note 360, at 15.
\textsuperscript{382} Id.
\textsuperscript{383} Danzon, supra note 369, at 200.
\textsuperscript{384} Id.
\textsuperscript{385} Huang & Soleimani, supra note 360, at 15.
\textsuperscript{386} See Schuck, supra note 360, at 194.
\textsuperscript{387} Id.
resulting from denial of coverage. Sweden’s avoidability standard is a middle ground between the customary standard used in medical malpractice law and strict liability standard.\textsuperscript{388} The FCC’s interpretation of this standard results in an approximately 60 percent denial rate of claims.\textsuperscript{389} Because such a standard easily lends itself to the discretionary judgment of those authorized to review the claim (in this case, the health care provider or his insurer),\textsuperscript{390} it is logical to anticipate that rejected claimants would appeal such decisions. Thus, in determining which standard works best for a no-fault scheme, businesses and/or insurers should compare the costs incurred by both a lower and higher standard of care at both the front and back end of the claims process in order to utilize the best cost-effective and predictable approach.

4. Determining Appropriate Recovery Amounts From No-Fault Compensation

In addition to determining criteria for compensation, businesses and/or insurers must also create a pre-determined schedule of benefits for approved claims. New Zealand has a list of injuries deemed compensable events, which covers the following costs: wage replacement at an 80 percent of weekly earnings; rehabilitation and transportation costs; and entitlements for surviving spouses and children.\textsuperscript{391} Payments end once patients reach 85 percent of their capacity to work,\textsuperscript{392} or patients receive lump sum awards for certain injuries, such as permanent loss or impairment.\textsuperscript{393} In comparison, the Swedish model is based upon a schedule of an injury’s severity and patient’s age, and covers full damages for income loss, medical expenses, and noneconomic damages.\textsuperscript{394} Any collateral coverage from other insurance polices are deducted.\textsuperscript{395}

\textsuperscript{388} Id. at 196.
\textsuperscript{389} Danzon, supra note 369, at 227
\textsuperscript{390} Id.
\textsuperscript{391} Schuck, supra note 360, at 190.
\textsuperscript{392} Huang & Soleimani, supra note 360, at 16.
\textsuperscript{393} Schuck, supra note 360, at 190.
\textsuperscript{394} Danzon, supra note 369, at 213.
Pain and suffering and loss of amenities damages are available to a patient who suffered a physical injury, but it may not extend to anyone connected with that patient or third parties.  

The breadth and variation of these compensation schedules point to the flexibility that businesses and/or insurers have in determining their own schedules, but more importantly, such flexibility should encourage the construction of compensation schemes that eliminate costs of settling contentious disputes over adequate recovery. Expenses and/or losses related to substandard medical care that fall outside the scope of designated compensable events would likely be appealed. One potential approach to eliminating disputes surrounding any inadequacies or short-comings of a pre-determined schedule is to charge patients supplemental insurance coverage, which provides automatic compensation for all damages and/or additional treatment when required rather than filing a claim under a no-fault scheme or bringing the claim to arbitration. This supplemental insurance would be similar to coverage that airlines and rental car companies charge to customers who seek to buy coverage for all damages without any deductible or co-payments.

5. Determining Exceptions to No-Fault Compensation

Another important consideration that businesses and/or insurers must address is an allowance for arbitration or litigation of certain actions that otherwise would be inadequately compensated by a no-fault scheme. Because the goals of this paper are not to only minimize legal liability exposure and costs to businesses and consumers, but to also advance mechanisms that deter substandard care, a cross-border no-fault model should include public policy-based

395 Id.
396 Id.
397 See Huang & Soleimani, supra note 360, at 26.
exclusions for it to have lasting success. A notable aspect of New Zealand’s no-fault scheme is that it permits injured patients to pursue exemplary damages and certain types of tort actions in addition to receiving ACC benefits.\textsuperscript{399} Exemplary damages are allowed because they fall outside the scope of the ACC statute by intending to punish the defendant and not compensate the plaintiff.\textsuperscript{400} In order to obtain these damages, a plaintiff must show either (1) harmful or reckless intent or (2) exceptional or outrageous negligence on the part of the defendant.\textsuperscript{401} With regards to permissible tort actions, patients may receive common law damages for the following cases: mental injury absent physical injury, and unwanted pregnancies or births resulting from negligent sterilizations or vasectomies.\textsuperscript{402} In comparison, Sweden permits a patient to file a medical malpractice lawsuit through the tort system in place of or in addition to filing for no-fault compensation and at any time during the process.\textsuperscript{403} It is important to note here that the Swedish tort system has unique mechanisms that discourage litigation of medical malpractice claim in most circumstances.\textsuperscript{404}

While the Swedish approach would undercut the purpose of a no-fault scheme if patients were able to file suit in other tort systems other than Sweden, New Zealand’s limited public policy-based exceptions are worth consideration. Because arbitration is preferable to litigation as demonstrated above, any no-fault injury exceptions should be arbitrated. With regards to

\begin{footnotes}
\textsuperscript{399}Schuck, \textit{supra} note 360, at 194; Nicola Sladden & Sarah Graydon, \textit{Liability for Medical Malpractice – Recent New Zealand Developments}, 28 \textit{MED.} & \textit{L.} 301, 303-304 (2009).
\textsuperscript{400}Sladden & Graydon, \textit{supra} note 399, at 303.
\textsuperscript{401}Schuck, \textit{supra} note 360, at 194.
\textsuperscript{402}Sladden & Graydon, \textit{supra} note 399, at 304.
\textsuperscript{403}Huang & Soleimani, \textit{supra} note 360, at 11; Danzon, \textit{supra} note 369, at 205.
\textsuperscript{404}Danzon, \textit{supra} note 369, at 205. It is important to note that despite the availability of this option, the Swedish tort system discourages litigation because a patient must offset any recovery from a tort award with any recovery from no-fault benefits. \textit{Id}. Because compensation from Sweden’s no-fault scheme are comparable to tort benefits, there is no significant advantage in filing suit. \textit{Id}. Other means of deterrence employed by the Swedish tort system include (1) use of a schedule for pain and suffering damages that is lower than one used in no-fault claims; (2) prohibition of contingency fees; and (3) difficulties in obtaining medical testimony on the plaintiff’s behalf. \textit{Id.} at 226.
\end{footnotes}
exemplary damages, businesses may understandably deny this as an exception for actions where a patient consciously experienced pain and suffering.\textsuperscript{405} Presumably, a no-fault scheme would already furnish sufficient compensation, and as discussed earlier, one of the advantages of opting for private dispute resolution mechanisms is to contractually avoid such liability. However, for actions where a health care professional acted egregiously, either intentionally or negligently, public policy considerations for deterrence of substandard care demand specific redress against the offender that no-fault schemes are unable to provide.\textsuperscript{406} An allowance for such exceptions would mitigate the negative impact of absolving blame in no-fault schemes, as several scholars contend that “without fault in the compensation process, there is no (or at least less) stigma associated with fault, and therefore less incentive to prevent mistakes.”\textsuperscript{407}

6. Appealing an Adverse Decision and Adjudicating Exceptions: The Arbitration Process

In instances where the no-fault approach fails to satisfactorily resolve a claim or the issue(s) in question qualify under a no-fault exception, these issues of dispute should be handled through binding arbitration. As alluded to earlier, Sweden incorporates arbitration as part of its appeals process of adverse FCC decisions. In the event a patient’s claim is denied, a patient may pursue an appeal by first going to a special panel (comprised of chairperson, patient representatives, government-appointed medical expert, and health care representatives), and subsequently binding arbitration.\textsuperscript{408}

\textsuperscript{406} See Huang & Soleimani, \textit{supra} note 360, at 7-8.
\textsuperscript{407} Huang & Soleimani, \textit{supra} note 360, at 7-8.
\textsuperscript{408} Id. at 15. Danzon, \textit{supra} note 369, at 215.
In the event arbitration is elected, each party appoints one arbitrator and the government appoints an arbitrator to serve as chairperson.\textsuperscript{409} At this stage, patients typically have legal representation.\textsuperscript{410} In the endeavor to reduce the costs of claims filing and adjudication, the arbitration process imposes the following restrictions: (1) only matters of process and not substance may be reviewed; (2) claims are evaluated based upon written evidence unless there are special grounds for oral hearings; (3) and medical experts are permitted only upon arbitrator request.\textsuperscript{411} Despite the well meaning intentions behind these restrictions, scholars maintain this truncated approach deprives parties of an adequate means for redress against an adverse decision.\textsuperscript{412} Given the complexity of medical malpractice disputes, as demonstrated earlier in this paper, such criticism is warranted and prompts another formulation of a potentially successful arbitration framework for resolving these disputes. The analysis below will discuss and offer recommendations on the essential features needed to in order to develop such a framework for cross-border health services claims.

a. Determining Appropriate Choice of Law

Because cross-border health services claims necessarily involve parties of different nationalities, choice of law considerations must first be resolved in order to successfully adjudicate these claims in arbitration. In the endeavor to minimize an appearance of bias against either party insofar as possible, the authors propose a third country approach whereby selection of substantive law is based upon a country’s well-developed jurisprudence and prominent status in medical malpractice law and not on a party’s domicile. For instance, Australia would be an

\textsuperscript{409} Danzon, \textit{supra} note 369, at 215.
\textsuperscript{410} Id.
\textsuperscript{411} Id.
\textsuperscript{412} Id. at 228.
appropriate candidate, as several countries defer to Australian case law for guidance in interpreting legal principles.\(^{413}\) Furthermore, Australia’s jurisprudence on medical negligence is highly regarded among its common law counterparts.\(^ {414}\)

b. Considerations and Approaches to Selecting an Appropriate Forum for Arbitration of Cross-Border Health Services Claims

In addition to determining appropriate choice of law, another key consideration is the choice of forum for the arbitration process. This issue imports such significance because it implicates cost considerations, which as discussed earlier, is dispositive in parties’ ability to seek legal redress and successfully resolve disputes.\(^ {415}\) The importance of cost considerations is underscored by the fact that arbitration agreements in consumer disputes may be invalidated in some jurisdictions when the process incurs unreasonable fees.\(^ {416}\) For example, a New York court invalidated an arbitration agreement between buyers and a direct sale manufacturer because the arbitral institution’s costs were “excessive” and “unreasonable and surely serves to deter the individual consumer from invoking the process.”\(^ {417}\) In determining an appropriate forum, it is first useful to examine the feasibility of the following available options.

1. Ad Hoc Arbitration

One option is to conduct ad hoc arbitration, which are self-administered proceedings.\(^ {418}\) In the absence of a presiding arbitral institution providing guidance, scholars have observed that it mainly works well for experienced businesses that seek to maintain longstanding relationships


\(^{414}\) *Id.* at 136.

\(^{415}\) See supra Part IV.C.5.


\(^{417}\) Brower, 676 N.Y.S. 2d at 574.

\(^{418}\) BENYEKHLEF & GÉLINAS, *supra* note 241, at50.
with one another.\textsuperscript{419} In addition to concerns that this forum may not be user-friendly for consumers, another major disadvantage is that parties must seek legal recourse from the court of the country in which the arbitral tribunal is located if there is a disagreement arising from the establishment of a tribunal.\textsuperscript{420} This is an undesirable result, as it defeats the intent of parties to avoid court bias and inefficiencies in adjudicating claims.\textsuperscript{421}

2. Arbitral Institutions

As discussed earlier, arbitral institutions are another option as they have successfully facilitated many cross-border business-to-business disputes by assisting in the process of selecting arbitrators, setting procedural rules, and facilitating the timely operation of a hearing.\textsuperscript{422} In addition to providing a comprehensive framework for establishing an arbitral tribunal and ensuring the smooth operation of the arbitration process, courts and parties regard have more respect and confidence in arbitrations conducted by major institution.\textsuperscript{423} These advantages, however, may incur a price beyond what many consumers may be able to afford. As discussed earlier, arbitration administrative fees may exceed the damages owed to a plaintiff.\textsuperscript{424} It should be noted, however, that administrative costs between institutions may be relatively low.\textsuperscript{425} Furthermore, it may be financially feasible to utilize arbitral institutions that have or are willing to implement online platforms for administering and adjudicating claims. The prospect of capturing future business in a significant number of cross-border medical malpractice claims, and the increasing ease and falling costs of online mechanisms such teleconferencing, would

\textsuperscript{419} See id.
\textsuperscript{420} Id.
\textsuperscript{421} Id.
\textsuperscript{422} BENEYKHLEF \& GÉLINAS, supra note 241, at 51
\textsuperscript{423} See 81 AMJUR Trials 1, § 113 (2001).
\textsuperscript{424} DeVille, supra note 189, at 370.
make it attractive for entities such as the AAA to work with stakeholders to develop a viable online system. As a consequence, businesses should conduct price comparisons and consider arbitral institutions that utilize or are willing to implement online arbitration platforms, the latter of which are discussed more fully below.

3. Online Arbitration

Because the ad hoc approach is unworkable for business-to-consumer disputes, and arbitral institutions should be used in limited circumstances when employed in the traditional face-to-face setting, it is worth considering online arbitration as a potentially successful alternative. Some scholars argue that this form of cyberjustice can “increase access to justice and ensure greater legal certainty on the Internet by reducing the cost and time required to settle disputes.” 426 One of the biggest arguments against arbitrating cross-border health disputes online may be that these disputes are too complex for such a forum. 427 However, in light of technological advances in communications and the increasing use of online mechanisms by arbitral institutions analyzed more fully below, such a proposal may be feasible.

First, to better understand how arbitration of cross-border health services may be conducted online, it is instructive to provide an overview of the fundamental features of online arbitration. One of these features is a software application that communicates the procedural framework of the arbitration process, thereby allowing the user to perform all the steps of these procedures. 428 This software also stores, transmits, and manages any submitted evidence. 429

426 Id. at 9.
427 Cf. Nicolas de Witt, Online International Arbitration: Nine Issues Crucial to its Success, 12 AM. REV. INT’L ARB. 441, 455 (2001) (Online arbitration’s “objectives are to cut down the registration fee by virtue of its standardized and computerized process, and to reduce the arbitrator’s fee, considering the lack of complexity of most of the cases that should be presented”).
428 BENYEKHLEF & GÉLINAS, supra note 241, at 5.
429 Id.
Another feature is permanent online technical support. Finally, there is a network in place of neutral third parties who are experts in the relevant area in question.

A qualified forum that may implement these online arbitration mechanisms for business-to-consumer health services disputes are arbitral institutions. Notably, these entities “increasingly acknowledge that it has become necessary to put … arbitration procedures online in order to speed up the dispute resolution process, reduce costs and thereby become more efficient in handling cases.” Several arbitral institutions that have the capacity to administer cases anywhere in the world have already begun to use online arbitration for certain disputes. For instance, AAA entered into an exclusive agreement with the National Research Exchange (NRE) in 2004 to develop a Rapid Alternative Dispute Resolution (RADR) mechanism to resolve NRE member disputes. According to NRE Chief Executive David Wield IV, NRE and AAA’s joint goal was to design a quick and inexpensive dispute resolution process that still retained all of the AAA’s expertise. [They] accomplished this by conducting much of the mediation and arbitration processes in parallel, and by moving as many activities as possible to the AAA’s online system.

Significantly, the AAA’s implementation of an online webfile system demonstrates that it is feasible to arbitrate complex cases online. In particular, this webfile system was used in a multi-million dollar case involving the filing of over 280 documents and the confirmation of communications via message board. AAA’s webfile system facilitates online case

430 Id.
431 Id.
432 Id. at 20.
435 Id.
management and communication between parties, and goes beyond the basic features of online arbitration to include the following: (1) filing new claim; (2) selecting neutral arbitrators / mediators; (3) communication with parties and case managers via message board, with a case manager assigned to monitor case and communicate with parties via message board; (4) upload and downloading documents; (5) tracking financial transactions; (6) reviewing case progress; and (7) viewing cases commenced by traditional methods offline.

In addition to the feasibility of handling high-volume and complex communications and documents online, technology has also rendered person-to-person proceedings irrelevant. The availability of web cameras demonstrates that online processes may also facilitate human interaction when required, such as witness testimonies and cross-examinations. Similar forms of technology are currently used in judicial and administrative proceedings, as witnesses are allowed to testify by videoconference or video recording in these forums. Additionally, digital whiteboard technology enables users to share markings online should visual aids be required. Another useful online feature is virtual private meeting rooms, which allow confidential exchanges and meetings by requiring password entry. Thus, these online procedural mechanisms and the availability of forums to administer and oversee such mechanisms demonstrates the feasibility of using online arbitration for cross-border health services claims, regardless of the level of their complexity.

436 Id. at 395.
437 Id. at 397-398.
439 de Witt, supra note 427, at 458.
440 Id.
441 Id.
c. Selection of Arbitrators

Given the power of arbitrators to render a binding decision, the process of selecting an arbitrator is another important consideration for businesses and consumers. As discussed earlier, medical malpractice arbitration panels traditionally have three arbitrators comprised of the following: attorney, physician or hospital administrator, and layperson. While it is understandable that such a mixed panel is preferable to account for any bias and to ensure a well-informed and thorough evaluation of the claim, parties should be open to other arrangements as well. For instance, the reader should be reminded of Kaiser’s arbitration program that paid for a neutral arbitrator’s fees and expenses when parties agreed to one arbitrator in order to facilitate speed and efficiency. In the context of online arbitration, some scholars advise that the choice of arbitrator may be randomly chosen by a software program that is retrieved from a list of qualified candidates or based on open criteria.

d. Mechanisms for Deterrence of Substandard Care

Finally, it is worth giving some attention to mechanisms that may facilitate deterrence of substandard care within this proposed international arbitration framework. A major critique of the arbitration process is that its decisions are confidential, thereby removing any stigma associated with fault and reducing incentives to prevent mistakes. The protection such confidentiality affords could easily be eliminated through publication of these arbitration decisions. For instance, the Swedish government recently began annually publishing all arbitration decisions related to medical malpractice in order to encourage public awareness and

442 Simone, supra note 198, at 597.
443 FIRST ANNUAL REPORT, supra note 224, at 23.
444 de Witt, supra note 427, at 449.
To make these decisions even more accessible to the public, online publication similar to that of India’s consumer forum decisions (discussed earlier) should be considered. In being made aware of those health care providers with a record of adverse decisions, consumer choice and willingness to pay a certain amount based on a health care provider’s reputation should go far in helping to prevent substandard care.

VI. CONCLUSION

The above examination demonstrates the advantages of an international arbitration framework in resolving the legal complexities of cross-border medical malpractice claims. By itself, arbitration goes far in eliminating many of the legal ambiguities and obstacles of litigation in traditional court systems. But this paper has also demonstrated that another major advantage of arbitration is its adaptable and inclusive capacity to utilize complementary mechanisms that further reduces contestable issues of liability and redress. This is a key advantage when addressing disputes involving differing medical malpractice regimes, expectations of recovery, and business practices. The proposal of a two–step dispute resolution mechanism employing no-fault compensation and arbitration has the potential to accommodate a wide range of claims and businesses and consumers from different economies and backgrounds. While this approach may not fully satisfy the recovery expectations of all consumers or offer the strongest protection against legal liability for all businesses, it offers an efficient and fair compromise by minimizing contestable issues of liability and offering several routes of reliable redress to the fullest extent practicable.

446 Danzon, supra note 369, at 216.