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A Medical Malpractice Model for Developing Countries?

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INTRODUCTION

For all the angst over medical malpractice litigation in developed countries like the United States, very little has been written about it in the developing world. Developing countries account for more than 80% of the world's population,[1] but they are often an afterthought in comparative health law literature.[2] Noteworthy comparative compilations include either very few developing countries or none at all. For example, the iconic treatise *International Medical Malpractice Law* by Dieter Giesen focuses mostly on wealthy, developed countries like our own.[3] And the more recent corpus of comparative

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1. The United Nations estimates that only 18% of the world's population (or 1.2 billion out of 6.9 billion people) live in "more developed" regions. *World Population Prospects, the 2010 Revision*, U.N., DEP'T OF ECON. & SOC. AFFAIRS, POPULATION DIV., POPULATION ESTIMATES & PROJECTIONS SECTION, http://esa.un.org/unpd/wpp/unpp/panel_population.htm (last visited Dec. 6, 2011) (select "Population" under "Select Variables"; then select "More developed regions" under "Select Country/Region"; then select "All variants" under "Select Variant"; then select "2010" under both "Start Year" and "End Year"; then click "Display"). The remaining 82 percent of the population (5.7 billion) live in "less developed" ones. *Id.* (submit same query as previous cite, except select "Less developed regions" under "Select Country/Region").

2. *See* Barbara McPake & Anne Mills, *What Can We Learn from International Comparisons of Health Systems and Health System Reform?*, 78 BULL. WORLD HEALTH ORG. 811, 817 (2000), *available at* http://www.who.int/bulletin/archives/78(6)811.pdf. Note that there is a major difference between the size of the population and the portion of medical care a country consumes. The best example is the United States, which accounts for half of all worldwide health care spending each year.

3. DIETER GIESEN, INTERNATIONAL MEDICAL MALPRACTICE LAW: A COMPARATIVE LAW STUDY OF CIVIL LIABILITY ARISING FROM MEDICAL CARE (1988). In this well-known book, Professor Giesen discusses cases from Australia, Austria, Belgium, Canada, England, France, Germany, Ireland, New Zealand, Scotland, Switzerland, and the United States. *Id.* at IX, 756-831 (noting scope of book and citing case law used throughout). The only less developed countries represented are South Africa and Zimbabwe. *Id.* at 756. Nevertheless, Professor Giesen has been hailed as one of the founders of comparative health law, and this work has long been admired as trailblazing. Arnold J. Rosoff, *Health Law at Fifty Years: A Look Back*, 14 HEALTH MATRIX 197, 207 (2004); Harry D. Krause, *Dedicatory Essay: Professor Dr. Dieter Giesen*, 12 J. CONTEMP. HEALTH L. & POL'Y I, X (1995).

health literature published in American law reviews[4] focuses mainly on the usual suspects—Canada, the United Kingdom, France, Germany, Japan, and Australia.[5]

This is not entirely unjustified. We tend to learn more about ourselves by looking at similarly situated jurisdictions. The more countries differ, the harder it is to isolate variables in a sort of mental regression analysis. Developing countries seem more *foreign* to us and can be considerably more difficult to research.[6] And perhaps most importantly, they often have different health policy predicaments that require their limited attention and resources.[7] Developing countries may not have the luxury of worrying about medical malpractice.[8]

But malpractice in developing countries is worth examining for a few reasons. First, patients from the United States and other Western countries increasingly live in or visit the developing world and consume health care there.[9] So for self-interested reasons, we should understand how these jurisdictions handle medical malpractice disputes and the obstacles patients might encounter.[10]

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4. *See generally* Timothy S. Jost, *Comparative and International Health Law*, 14 HEALTH MATRIX 141 (2004) (discussing the uptick in comparative and international health law scholarship within the past decade and a half).

5. *See, e.g.*, TIMOTHY S. JOST, READINGS IN COMPARATIVE HEALTH LAW AND BIOETHICS (2d ed., 2007) (including materials and case law from China, Haiti, India, Peru, and Venezuela, among others, but focusing mostly on the countries listed in the text). A 2005 symposium in the *Journal of Law, Medicine, and Ethics* included one article on China, with the others focused on these same usual suspects. Symposium, *Medical Malpractice: U.S. and International Perspectives*, 33 J.L. MED. & ETHICS 411 (2005). A notable counterexample is the *International Encyclopedia of Medical Laws*, which includes monographs on several developing countries, including China, Hungary, Malaysia, Peru, and Uruguay. INTERNATIONAL ENCYCLOPEDIA OF MEDICAL LAW (Herman Nys ed., 2010).

6. I learned this lesson as a new academic when I tackled for a single article the medical malpractice systems in three developing countries (India, Mexico, and Thailand) and Singapore. Nathan Cortez, *Recalibrating the Legal Risks of Cross-Border Health Care*, 10 YALE J. HEALTH POL'Y L. & ETHICS 1 (2010). For a critical, thoughtful analysis of how scholars should approach comparative research in health care, see Theodore R. Marmor et al., *Comparative Perspectives and Policy Learning in the World of Health Care*, 7 J. COMP. POL'Y ANALYSIS 331 (2005).

7. Nathan Cortez, *International Health Care Convergence: The Benefits and Burdens of Market-Driven Standardization*, 26 WIS. INT'L L.J. 646, 693 (2009).

8. Cortez, *supra* note 6, at 21.

9. *See, e.g.*, Nathan Cortez, *Patients Without Borders: The Emerging Global Market for Patients and the Evolution of Modern Health Care*, 83 IND. L.J. 71 (2008); Nicolas P. Terry, *Under-Regulated Health Care Phenomena in a Flat World: Medical Tourism and Outsourcing*, 29 W. NEW ENG. L. REV. 421 (2007); I. Glenn Cohen, *Protecting Patients with Passports: Medical Tourism and the Patient-Protective Argument*, 95 IOWA L. REV. 1467 (2010).

10. Cortez, *supra* note 6, at 5.

Second, we should appreciate how medical malpractice law operates and evolves in different environments. Developing countries may utilize legal and regulatory models that look nothing like ours. And even if some jurisdictions derive from Western models—as in the case of India's system deriving from English law—they may function very differently in practice. Developing countries also tend to have very different health care systems. Health insurance is less common.[11] Cash transactions and other out-of-pocket payments predominate.[12] The informal health sector is often large and unregulated. Public resources must confront public health crises like HIV, AIDS, tuberculosis, and malaria. And developing countries must operate within different financial constraints, which can affect all aspects of medical liability, including the power dynamic between doctors and patients, the ability to retain legal counsel, and the ability to find a medical expert who is willing to testify. Many of these things we take for granted.

Finally, medical malpractice law in the developing world is worth studying for its own sake. These jurisdictions struggle with the same problems we do: how to maintain a fair and efficient system for adjudicating malpractice complaints—one that denies meritless claims and compensates claims with merit while holding physicians accountable, deterring negligence, uncovering mistakes, and encouraging quality care.[13] These problems are just as important, if not more so, in developing countries where physicians often enjoy greater professional autonomy from regulators and more deference from courts.

To these ends, this Article explores two contemporary examples of how developing countries have reformed their medical malpractice redressal systems. Both India, a common law jurisdiction, and Mexico, a civil code jurisdiction, have reformed their systems in recent years. India now uses quasi-judicial consumer forums that feature streamlined procedures, allowing patients to bypass India's cumbersome civil courts. Mexico now uses a public medical arbitration system that allows parties to avoid litigating an archaic body of law in its outmoded civil and criminal courts. I evaluate each as a potential model for other developing countries, given the common problems these countries face.

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11. Mark V. Pauly et al., *Private Health Insurance in Developing Countries*, 25 HEALTH AFF. 369, 369 (2006).

12. *Id.* at 371.

13. TOM BAKER, THE MEDICAL MALPRACTICE MYTH 93–117 (2005).

Although both systems offer an alternative to traditional civil litigation, I conclude that Mexico's is a superior alternative for other developing countries. Unlike India's consumer forums, Mexico's public system for medical arbitration does not require patients to secure medical records and procure expert testimony from reluctant parties—two prerequisites that preclude many successful claims in India and likely plague plaintiffs in many other developing countries. Of course, not every developing country can or should implement Mexico's system—even among similar jurisdictions it can be unwise to superimpose policies from elsewhere.[14] But we should begin to consider how the other three-quarters of the world handles medical malpractice disputes.

I. WORLDS APART

Before evaluating the models in India and Mexico, it is worth pausing to appreciate just how much developing countries can differ from our own, and why these differences matter. Developing countries often struggle with some combination of poverty, infectious diseases, professional shortages, underdeveloped health systems, weak infrastructure, large informal economies, regulatory and civil society deficits, and other problems that tend to be secondary (if they exist at all) for most developed countries. I argue that these differences make it *more*, not less important that patients have a realistic way to redress their medical grievances.

A. Poverty

Money is an obvious yet defining distinction between developed and developing countries.[15] Developing countries struggle with poverty and resource constraints in a way that developed countries simply do not.[16] These fiscal realities limit what they can spend on

14. Theodore R. Marmor, *Global Health Policy Reform: Misleading Mythology or Learning Opportunity?*, *in* HEALTH POLICY REFORM, NATIONAL VARIATIONS AND GLOBALIZATION 348, 362 (Christa Altenstetter & James Warner Bjorkman eds., 1997); McPake & Mills, *supra* note 2, at 811-12.

15. Indeed, the phrase "developing country" is often used to denote low- or middle-income countries, or both. Although this usage can be imprecise—not every low- or middle-income country has a growing, "developing" economy—I will use this phrase for the sake of simplicity. *See* Mark V. Pauly et al., *How Private, Voluntary Health Insurance Can Work in Developing Countries*, 28 HEALTH AFF. 1778, 1778 (2009) (classifying "truly 'developing' countries" as ones with "low but growing per capita incomes").

16. Hasna Begum, *Poverty and Health Ethics in Developing Countries*, 15 BIOETHICS 50, 50 (2001).

health care and health infrastructure.[17] Indeed, lower income countries often lack the basic resources "to afford even some of the most effective care."[18] And the higher income developing countries that *can* afford to spend more on health care have chosen not to, for a variety of complex political reasons.[19] Poverty is perhaps a meta-factor that belies many, if not all, of the following problems.

B. Other Health Priorities

A second, related factor that distinguishes developing countries is that they are often beset by other health policy priorities, which can relegate patients' rights to a secondary or even tertiary concern. HIV/AIDS, malaria, SARS, swine flu, and other infectious diseases plague countries like India, China, and many African nations.[20] For example, in India, "someone dies every minute from tuberculosis."[21] These countries may rightly dedicate more time and attention to addressing public health crises than things like medical negligence.

C. Scarcity of Physicians

Developing countries often struggle with very low ratios of health care professionals to the general population, which likely contributes to the reluctance to over-regulate them. The World Health Organization (WHO) identified fifty-seven countries that face crisis-level shortages of health care professionals, many of which are low-income, developing countries.[22] These countries have an average of 1.1 doctors per thousand residents, compared to 13.2 in the United States.[23] Of course, the countries with the lowest ratios are among the world's very poorest.[24] Many developing countries educate phy-

17. *See* Pauly et al., *supra* note 11, at 371.

18. *Id.* at 372.

19. *See id.* A notable exception is Cuba. *See* Julie M. Feinsilver, *Cuba as a "World Medical Power": The Politics of Symbolism*, 24 LATIN AM. RES. REV. 1, 4–6 (1989).

20. *See* Cortez, *supra* note 6, at 40 (explaining some of these crises in India).

21. *Id.* (citing Rueben Granich et al., *Tuberculosis Control in India*, 3 LANCET INFECTIOUS DISEASES 595, 595 (2003)).

22. *See* WORLD HEALTH ORG., GLOBAL HEALTH WORKFORCE ALLIANCE, LIST OF 57 COUNTRIES FACING HUMAN RESOURCES FOR HEALTH CRISIS (AS IDENTIFIED BY THE 2006 WORLD HEALTH REPORT), http://www.who.int/workforcealliance/countries/57crisiscountries.pdf (last visited Dec. 6, 2011); *Global Health Observatory, Health Workforce*, WORLD HEALTH ORG., http://www.who.int/gho/health_workforce/en/index.html (last visited Dec. 6, 2011).

23. Kate Tulenko, *Countries Without Doctors?*, FOREIGN POL'Y, June 11, 2010, *available at* http://www.foreignpolicy.com/articles/2010/06/11/countries_without_doctors.

24. *See id.*

sicians and nurses locally, only to watch them leave and "alleviate shortages in Australia, North America, and Europe," which contributes to the shortages in those developing countries.[25] This scarcity of physicians can create a monopoly atmosphere[26] that gives health care professionals leverage to deter meaningful external regulation or accountability. Indeed, many patients in developing countries may be grateful to receive any care at all,[27] even if it is substandard.

D. Immature Health Care Systems

Another important distinction is that developing countries often have immature, underdeveloped health care systems. Their public insurance schemes are often weak and underfunded, leading to significant out-of-pocket spending.[28] Among twenty-one developing countries sampled by Mark Pauly and colleagues, out-of-pocket spending ranged from 38% to 84% of all health care spending, with many countries in the 50–60% range.[29] By contrast, out-of-pocket spending accounts for just 13% of all health spending in the United States.[30] These data are symptomatic of inadequate health infrastructure, including the public capacity to organize and regulate health care financing. And, compounding the problem, developing countries frequently lack the expertise and resources necessary to conduct their own health policy research,[31] which limits their ability to self-reflect and generate reforms from within.

E. Large Informal Sectors

Another distinction between developed and developing countries is that a large proportion of health spending in developing countries goes to providers in the informal economy.[32] In India, for example,

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25. Pauly et al., *supra* note 11, at 372 (citing multiple studies, including Fitzhugh Mullan, *The Metrics of the Physician Brain Drain*, 353 NEW ENG. J. MED. 1810 (2005)); *see also* Cortez, *supra* note 9, at 109–10 (describing the "brain drain" from developing to developed countries).

26. Begum, *supra* note 16, at 53.

27. *Id.* at 56.

28. Pauly et al., *supra* note 11, at 370 (listing twenty-one developing countries' percentage of gross domestic product spent out-of-pocket on health care).

29. *Id.* at exhibit 1.

30. *Id.* at 371.

31. *See* Miguel A. Gonzalez Block & Anne Mills, *Assessing Capacity for Health Policy and Systems Research in Low and Middle Income Countries*, 1 HEALTH RES. POL'Y & SYS. 1 (2003), http://health-policy-systems.com/content/1/1/1.

32. *See* Anne Mills et al., *What Can Be Done About the Private Health Sector in Low-Income Countries?*, 80 BULL. WORLD HEALTH ORG. 325, 325 (2002) (noting that the private sector in

"[u]ntrained local practitioners and drug shop owners have grown into the dominant type of provider of outpatient medical care."[33] These providers are often called "rural medical practitioners, village doctors, quacks, and other names" and generally fly under the radar of regulators.[34]

Observers express concerns about the quality of care provided by informal health practitioners.[35] But patients use them because they can be much less expensive and more accessible, and patients may lack the requisite knowledge and information to choose higher-quality providers.[36] Unfortunately, studies show that practitioners without formal medical training and credentials generally provide poor-quality care.[37] In India, most providers in the informal economy "are seen to have a poor knowledge base and tend to follow irrational, ineffective, and sometimes even harmful practices when treating minor ailments."[38] And because these providers tend to operate locally and individually, they are much harder to regulate and hold accountable.

F. Regulatory Deficits

Developing countries largely lack the regulatory capacity to set and enforce standards on health care providers. In contrast, developed countries, like the United States, can rely on overlapping layers of laws and regulations to encourage physicians, hospitals, and other providers to meet at least some minimum standards.[39] But even the larger, wealthier developing countries, like India and Chi-

low-income countries includes "[l]arge and small commercial companies, groups of professionals such as doctors, national and international nongovernmental organizations, and individual providers and shopkeepers."); Pauly et al., *supra* note 15.

33. Gerald Bloom et al., *Regulating Health Care Markets in China and India*, 27 HEALTH AFF. 952, 954 (2008).

34. *Id.*

35. Mills et al., *supra* note 32, at 326. Of course, the quality of care is difficult to measure, and can be even moreso in developing countries. Jishnu Das & Paul J. Gertler, *Variations in Practical Quality in Five Low-Income Countries: A Conceptual Overview*, 26 HEALTH AFF. w296, w297, w303 (2007) ("The overall quality of care documented in [studies on developing countries] is low."); Lilani Kumaranayake et al., *How Do Countries Regulate the Health Sector? Evidence from Tanzania and Zimbabwe*, 15 HEALTH POL'Y & PLAN. 357, 357 (2000).

36. Mills et al., *supra* note 32, at 326.

37. Das & Gertler, *supra* note 35, at w308.

38. Bloom et al., *supra* note 33, at 958.

39. Nathan Cortez, *Embracing the New Geography of Health Care: A Novel Way to Cover Those Left Out of Health Reform*, 84 S. CAL. L. REV. 859, 897–98 (2011).

na, lack an overall framework for regulating their health sectors.[40] For example, in theory, India can rely on the Medical Council of India, various Departments of Health, the Indian Medical Association, and other regulatory or quasi-regulatory bodies to oversee practitioners.[41] But self-regulation by professional medical societies is weak and ineffectual.[42] Instead of sanctioning recalcitrant members, medical societies are more likely to ignore and minimize their behavior.[43] Many developing countries focus on regulating licensing and entry into the medical professions, rather than reviewing medical professionals' performance retrospectively.[44] As a result, medical professionals can escape meaningful regulation in these jurisdictions.

Aside from regulating medical professionals, developing countries often lack effective hospital regulation[45] and consumer protection regimes.[46]

Some of the regulatory deficits in developing countries may be attributable to timing—the health sectors in these countries have grown considerably over the last few decades without a corresponding growth in their regulating capacity.[47] Many countries spent years or even decades pouring money into their public health care systems and, after their inevitable decline in public spending, the private health sector grew to meet demand.[48] Thus, developing countries now have large, often thriving private health sectors that are insufficiently regulated, if not completely unregulated.

Ultimately, legal redress is particularly important in developing countries precisely because of their weak regulatory oversight of the health industry and professions.

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40. Bloom et al., *supra* note 33, at 953.

41. *Id.* at 957; Cortez, *supra* note 6, at 36–38.

42. I have analyzed how weak self-regulation by physicians is in India and Thailand. Cortez, *supra* note 6, at 36–38, 52–56; *see also* Bloom et al., *supra* note 33, at 954.

43. Cortez, *supra* note 6, at 36–38, 52–56.

44. *See* Kumaranayake et al., *supra* note 35, at 360, 364 (noting this emphasis in Tanzania and Zimbabwe).

45. *See* Cortez, *supra* note 6, at 23 n.128 (examining hospital accreditation in India).

46. *See* Mills et al., *supra* note 32, at 327.

47. *See generally* Bloom et al., *supra* note 33 (observing this trend in both China and India).

48. *See id.* at 954, 957–58. *See generally* Cortez, *supra* note 7 (surveying the rise of market-driven medicine and private sector participation throughout the world).

G. Insignificant Private Insurance Markets

An underappreciated regulatory deficit in developing countries is the lack of a robust private health insurance market. Private insurance can act as a channel for regulation.[49] In developed countries like the United States, both public and private insurers often use their contracts with health care providers to "pursue regulatory objectives"[50] such as patient safety and quality outcomes. Insurers often leverage their purchasing power to protect their customers—patients.

In contrast, providers in developing countries often lack such incentives. A study of India and China found that private insurance is an "underused" regulatory mechanism in both countries.[51] As noted above, a large chunk of health spending in these countries is out-of-pocket.[52] In India, "only 3-5% of Indians are covered by any form of health insurance."[53] Again, developing countries lack a key layer of regulation that is relatively common in developed countries.

H. Weak Civil Societies

If a country cannot regulate its health practitioners—or if its efforts are not legitimate, institutionalized, and above all enforced[54]—then the public might fall back on civil society and civil institutions for support.[55] Unfortunately, many developing countries lack strong civil societies to account for their regulatory deficits.[56] The media can be crucial at uncovering and raising public awareness of medical negligence, and fortunately, some developing countries, such as India, have a relatively strong media.[57] But not all developing countries can count on their media in such a manner. In addition, the media often relies on court decisions and other formal adjudications to inform them of medical malpractice. Accordingly, such circum-

49. *See* Cortez, *supra* note 39, at 910-13.

50. Bloom et al., *supra* note 33, at 953; Cortez, *supra* note 39, at 907-10.

51. Bloom et al., *supra* note 33, at 953.

52. *Id.*

53. *Id.* at 959.

54. Jennifer Prah Ruger, *Global Health Governance and the World Bank*, 370 LANCET 1471, 1473 (2007).

55. *Id.* at 1471-74.

56. Bloom et al., *supra* note 33, at 953, 961-62 (noting the absence of a strong civil society in China but the presence of one in India).

57. *Id.* at 954.

stances amplify the need for patients in developing countries to have a genuine avenue for redressing their medical complaints.

I. Patients as Regulatory Sentinels

Rounding out this picture, patients in developing countries are less equipped than patients in the developed world to act as regulatory sentinels, uncovering and reporting medical negligence. Patients in these countries are less able to access, process, and understand information about the medical care they receive.[58] For example, many patients in the developing world who rely on informal practitioners are frequently unaware that they are not professionally trained.[59] The information asymmetries between patients and providers can be particularly severe in developing countries, which further distorts the power dynamic between them.[60] Patients in poverty are even less likely to have the requisite literacy, education, and financial resources to challenge their doctors.[61] Some believe that medical professionals unethically exploit these imbalances.[62] If patients cannot appraise the quality or value of the care they receive, then they are much less likely to serve as early sentinels. Developing countries thus lack a key layer of patient surveillance on practitioners.

Compounding matters, residents of developing countries may be reluctant to sue because they are either unaware of their legal rights, feel powerless to invoke their legal rights against medical professionals or institutions, or have other cultural aversions to litigation.[63] My prior research on India, Thailand, Singapore, and Mexico found significant reluctance to sue, widespread distrust of courts, and general atmospheres that seemed to reinforce these misgivings rather than counteract them.[64]

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58. *See* McPake & Mills, *supra* note 2, at 813.

59. Bloom et al., *supra* note 33, at 958.

60. *Id.* at 953.

61. Begum, *supra* note 16, at 51 n.1 (noting that only 32.4% of the Bangladeshi population is literate).

62. *Id.* at 51–52.

63. *Id.* at 52.

64. Cortez, *supra* note 6, at 23 (India), 45–47 (Thailand), 58, 62–64 (Singapore), 73 (Mexico).

J. Context and Beyond

With this menu of problems in mind, it is worth noting that developing countries are far from monolithic. There can be crucial differences between impoverished, low-income countries and developing, middle-income countries.[65] These distinctions can affect "the capacity of the public sector to regulate, monitor, and negotiate with the private sector," among other things.[66]

Focusing on health care quality in developing countries is long overdue. For the last twenty-five years, the priority in most developing countries has been to expand access to health care.[67] But now that health care usage rates have crept upwards in the developing world, even among lower-income residents, it is time to shift attention to the quality of care they receive.[68] This includes lower-income residents' legal rights if the care they receive is substandard. Medical negligence can truly devastate patients in developing countries, as these patients lack the social and economic safety nets that we enjoy in developed countries. Unfortunately, these patients often face significant barriers to redress.

II. BARRIERS TO REDRESS IN THE DEVELOPING WORLD

As important as it is to redress malpractice in developing countries, it is equally difficult to effectuate a malpractice claim. Patients in these jurisdictions frequently face four types of obstacles.

First, patients often struggle to secure their own medical experts in adversarial litigation. Expertise may be scarce or unaffordable. Physicians may be unwilling to testify against other physicians—known as the "conspiracy of silence."[69] In jurisdictions that require plaintiffs to prove negligence, this burden can be insurmountable without an expert who is willing to testify that the defendant breached the standard of care.[70]

Second, and somewhat related, medical malpractice claims are difficult to prove in developing countries that do not grant patients

65. *See* McPake & Mills, *supra* note 2, at 813.

66. *Id.*

67. Das & Gertler, *supra* note 35, at w296; Kumaranayake et al., *supra* note 35, at 359 (noting Zimbabwe's policy emphasis post-independence).

68. Das & Gertler, *supra* note 35, at w296–w297.

69. *See, e.g.*, Cortez, *supra* note 6, at 28–29, 58, 63 (noting difficulties in India and Singapore, respectively).

70. *Id.* at 28 (noting that most claims in India's consumer forums fail for lack of a plaintiff's medical expert).

access to their medical records. For example, in India and Thailand, patients are routinely denied access to even basic information about their diagnoses and treatments.[71] Self-regulation by medical societies has not significantly changed physician practices.[72] At an institutional level, hospitals and other health care facilities may not be required by licensing bodies to divulge information to patients or their families.[73] Facilities are even known to fabricate excuses for not producing records, such as claiming disappearance.[74] Without proper documentation, plaintiffs will struggle to carry their burden of proof.

A third obstacle for plaintiffs in developing countries is navigating an underdeveloped body of law. For example, legal experts in both Thailand and Mexico lament that the law governing personal injuries in general (and medical malpractice, in particular) is thin and antiquated.[75] In Thailand, courts have few sources of guidance in malpractice cases, as there are very few statutes, books, or articles that discuss malpractice jurisprudence.[76] In Mexico, legal scholars have called the personal injury laws "scant," "skeletal," "obsolete," "simplistic," and "arcane."[77] Judges in these jurisdictions might be reluctant to blaze new trails for plaintiffs because virtually every jurisdiction seems to be concerned about out-of-control medical malpractice lawsuits, whether justified or not.[78] Moreover, where there is law, it is not always favorable. Many common law jurisdictions require judges to grant considerable deference to medical experts. This is particularly true in India and other former British colonies that follow English opinions like *Bolam v. Friern Hospital Management Committee*,[79] discussed below.

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71. *Id.* at 29–31, 44 (referring to patients in India and Thailand, respectively).

72. *Id.*

73. Bloom et al., *supra* note 33, at 959.

74. Cortez, *supra* note 6, at 44.

75. *Id.* at 43, 71–72 (discussing Thailand and Mexico, respectively).

76. *Id.* at 43 (citing S. Saithanu et al., *Management of Medical Liability in Thailand*, 12 J. HEALTH SCI. 876 (2003) (Thai.)).

77. Jorge A. Vargas, *Mexican Law and Personal Injury Cases: An Increasingly Prominent Area for U.S. Legal Practitioners and Judges*, 8 SAN DIEGO INT'L L.J. 475, 478, 487–88, 499 (2007); Cortez, *supra* note 6, at 71.

78. Cortez, *supra* note 6, at 49, 63–64 (noting fears of a malpractice crisis in Thailand and Singapore, respectively).

79. [1957] 1 W.L.R. 582 (Q.B.) (Eng.); JOST, *supra* note 5, at 113–15 (citing Dieter Giesen, *Medical Malpractice and the Judicial Function in Comparative Perspective*, 1 MED. L. INT'L 3, 4–7 (1993)).

Fourth, patients in developing countries often have problems with access to justice. These jurisdictions frequently struggle with massive case backlogs, weak judicial institutions, inadequate legal infrastructure, corruption, and other problems endemic to the developing world.[80] For many of these reasons, parties in developing countries often prefer to settle their disputes informally.[81]

Overall, then, it should not surprise us that researchers have found that courts "have played a limited role in influencing health care practices" in some developing countries.[82] At the risk of superimposing Western values on these jurisdictions,[83] it is important that patients have a venue for adjudicating their grievances. Perhaps developing countries should explore alternative dispute resolution,[84] as Mexico has.

III. COMPETING MODELS: INDIA AND MEXICO

Both India and Mexico have reformed their medical malpractice systems in response to well-known deficiencies in their civil courts. In this part, I evaluate both countries' reforms as potential models for other developing countries.

A. India

Patients injured by medical malpractice in India can seek redress in one of two venues—sue in a consumer forum or sue in civil court.[85] The latter is not much of an option.[86] Plaintiffs can sue for

80. Ronald J. Daniels & Michael Trebilcock, *The Political Economy of Rule of Law Reform in Developing Countries*, 26 MICH. J. INT'L L. 99, 119 (2004); William E. Davis et al., *Implementing ADR Programs in Developing Justice Sectors: Case Studies and Lessons Learned*, 16 DISP. RESOL. MAG. 16, 16 (2010).

81. Ross Cranston, *Access to Justice in South and South-East Asia*, *in* GOOD GOVERNMENT AND LAW: LEGAL AND INSTITUTIONAL REFORM IN DEVELOPING COUNTRIES 233 (Julio Foundez ed., 1997).

82. Bloom et al., *supra* note 33, at 961 (discussing differences between health care in India and China and possible approaches to health care financing in those countries).

83. *See generally* Thomas A. Kelley, *Exporting Western Law to the Developing World: The Troubling Case of Niger*, 39 GEO. WASH. INT'L L. REV. 321 (2007) (explaining the Western world's recent trend of imposing its policy reforms on the developing world).

84. *See* Davis et al., *supra* note 80, at 16 (citing over a decade of work on alternative dispute resolution alternatives in Latin America and the Middle East and using El Salvador as a case study).

85. Cortez, *supra* note 6, at 23. This section builds on my previous research, which analyzed the redressal options for medical malpractice victims in India, and whether U.S. patients treated there can recover adequate compensation. *See id.* at 21–40.

malpractice in India's civil courts under the Fatal Accidents Act, which compensates the families of those killed by an "actionable wrong," defined as death caused by a "wrongful act, neglect, or default."[87]

Those lucky enough to survive can sue in civil court for common law negligence.[88] India inherited its common law system from the English, so it uses a familiar formula that requires tort plaintiffs to establish duty, breach, causation, and damages.[89] Unfortunately for medical malpractice plaintiffs, Indian courts also follow English precedents,[90] including the infamous *Bolam* decision that helps courts determine the standard of care.[91] *Bolam* and its progeny require courts to defer almost completely to medical experts when ascertaining the appropriate standard of care in each case—essentially requiring a defense verdict if any medical expert concludes that the defendant acted reasonably, regardless of whether the expert's opinion is not persuasive or is outweighed by conflicting expert testimony.[92] The *Bolam* line of cases has neutered Indian courts,[93] making it difficult for plaintiffs to prove medical negligence.

Civil litigation in India is also known for its interminable delays. Plaintiffs may wait ten, twenty, or even twenty-five years for cases to conclude.[94] Such delays undoubtedly deter many would-be plaintiffs. Authors have documented other reasons why India's civil courts are inhospitable to medical malpractice claims,[95] and in aggregate, these obstacles make it difficult for plaintiffs to recover in civil courts.

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86. *See id.* at 34–36 (explaining how civil courts in India are infamous for their delays, taking up to twenty years to conclude certain cases).

87. The Fatal Accidents Act § 1A, No. 13 of 1855, INDIA CODE (1993), *available at* http://indiacode.nic.in.

88. Cortez, *supra* note 6, at 35.

89. *Id.*; R.K. Nayak, *Medical Negligence, Patients' Safety and the Law*, 8 REG'L HEALTH FORUM 15, 20–22 (2004).

90. Nayak, *supra* note 89, at 20; Sidhartha Satpathy & Sujata Satpathy, *Medical Negligence or Diagnostic Conundrum? - A Medico-Legal Case Study*, 21 MED. & L. 427, 428 (2002).

91. Bolam v. Friern Hosp. Mgmt. Comm., [1957] 1 W.L.R. 582, 593 (Q.B.) (Eng.); *see also* Bolitho v. City & Hackney Health Auth., [1998] A.C. 232, 239 (H.L.) (appeal taken from Eng.).

92. Bolam, 1 W.L.R. at 593. *See* Kumaralingam Amirthalingam, *Judging Doctors and Diagnosing the Law:* Bolam *Rules in Singapore and Malaysia*, 2003 SING. J. LEGAL STUD. 125, 137.

93. Cortez, *supra* note 6, at 57–62.

94. Bhatnager v. Surrendra Overseas Ltd., 52 F.3d 1220, 1228 (3d Cir. 1995) (reporting that Indian legal experts provided statistical and anecdotal evidence that the "average" case heard by the Calcutta High Court could last fifteen to twenty years); Sanjay Kumar, *India: Doctors Dispute Trader Role*, 340 LANCET 1400, 1400 (1992).

95. *See* Cortez, *supra* note 6, at 34–36.

The second avenue for redressing medical malpractice in India is to file a complaint in its consumer forums, also known as Consumer Disputes Redressal Agencies (CDRAs).[96] India originally created its consumer forums as an alternative to civil courts in general, not as a venue for resolving medical malpractice claims. India's 1986 Consumer Protection Act implemented the United Nation's 1985 Consumer Protection Resolution, which called for signatories to strengthen their consumer protection laws and enact "measures enabling consumers to obtain redress."[97] The Resolution was targeted at developing countries like India.[98] A major goal of both the Resolution and the Act was to create a more accessible, realistic alternative for adjudicating consumer grievances, like complaints for receiving defective goods or services. No one expected consumer forums to become the main avenue for adjudicating medical malpractice disputes.

Indeed, at first it was unclear whether the consumer forums even had jurisdiction to hear medical malpractice cases. The forums began hearing general consumer complaints in 1987, but it was not until 1992 that the National Consumer Disputes Redressal Commission declared that the Act covered medical services.[99] It took another three years for the Indian Supreme Court to confirm this interpretation.[100] Since then, the medical community in India has become intimately familiar with the Act,[101] frequently citing it as a "source of anxiety."[102]

India's Parliament designed the consumer forums to be a quicker, more economical, and more accessible alternative to civil courts.[103] To achieve these goals, India structured the consumer forums as quasi-judicial forums, vested with the imprimatur of the government, along with various judicial powers—but without the full panoply of powers that civil or criminal courts enjoy.[104] For example, forums may summon witnesses and receive documentary evidence,

96. Consumer Protection Act, No. 68, Acts of Parliament, 1986. *See* Cortez, *supra* note 6, at 23.

97. G.A. Res. 39/248, U.N. Doc. A/RES/39/248 (Apr. 16, 1985).

98. *Id.*; Cortez, *supra* note 6, at 24 n.134.

99. Cortez, *supra* note 6, at 24 n.136.

100. *See* Indian Med. Ass'n v. V.P. Shantha, A.I.R. 1996 S.C. 550.

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

102. Kumar, *supra* note 94, at 1400; Cortez, *supra* note 6, at 24.

103. *See* Bhat, *supra* note 101, at 264.

104. Cortez, *supra* note 6, at 24.

including affidavits and laboratory results,[105] but the forums seem reluctant to handle more complex cases.[106] The forums use panels of professional adjudicators rather than juries, and the members can have judicial or non-judicial training and experience.[107]

The Consumer Protection Act created district, state, and national consumer forums. Each forum has primary jurisdiction to hear complaints, and the state and national forums also have appellate jurisdiction to hear appeals from below.[108] Original jurisdiction depends on the amount of compensation the plaintiff seeks: the roughly 600 District Forums have jurisdiction over matters involving up to two million rupees in claimed compensation (roughly $44,300); 34 State Commissions have jurisdiction over matters involving up to ten million rupees (roughly $221,400); and the National Commission has jurisdiction to hear matters involving more than ten million rupees.[109]

The Consumer Protection Act itself created causes of action for consumer forums to resolve.[110] Medical malpractice plaintiffs typically file complaints for "deficient" medical services, defined as "any fault, imperfection, shortcoming or inadequacy in the quality, nature and manner of performance."[111] Legal scholars in India interpret this to require simple negligence,[112] though it seems redundant with section 14 of the Act, which awards compensation for negligence as well.[113]

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105. Consumer Protection Act, No. 68, Acts of Parliament, 1986.

106. Herambalal Das v. Dr. Ajoy Paul, (2001) 2 C.P.R. 498, 498; Cortez, *supra* note 6, at 34.

107. Cortez, *supra* note 6, at 24–25 (citing Consumer Protection Act § 10(1)(a) by way of example).

108. Consumer Protection Act §§ 9–27A.

109. *Id.* §§ 11(1), 17(1)(a)(i), 21(a)(i). The dollar amounts were calculated using the United States Federal Reserve Bank's database of foreign exchange rates for the Indian rupee. *See Historical Rates for the Indian Rupee*, BD. OF GOVERNORS OF THE FED. RESERVE, http://www.federalreserve.gov/releases/h10/hist/dat00_in.htm (last visited Dec. 6, 2011) (using data for May 27, 2011, showing that 45.17 rupees equaled one dollar). For information on the structure and number of consumer forums, see *Addresses of the State Consumer Disputes Redressal Commissions*, NAT'L CONSUMER DISPUTES REDRESSAL COMM'N, http://www.ncdrc.nic.in/sDetails.html (last visited Dec. 6, 2011). *See also District Forums*, NAT'L CONSUMER DISPUTES REDRESSAL COMM'N, http://www.ncdrc.nic.in/districtforums.html (last visited Dec. 6, 2011).

110. Consumer Protection Act §§ 2(c)(i)-(vi).

111. *Id.* § 2(c)(iii), (g).

112. *See* Bhat, *supra* note 101, at 265; K.K.S.R. Murthy, *Medical Negligence and the Law*, 4 INDIAN J. MED. ETHICS 116, 116–17 (July-Sept. 2007), *available at* http://www.issuesinmedicalethics.org/pdfs/153oa116.pdf; Talha Abdul Rahman, *Medical Negligence and Doctors' Liability*, 2 INDIAN J. MED. ETHICS, (Apr.-Jun. 2005), *available at* http://www.issuesinmedicalethics.org/132hl060.html.

113. Consumer Protection Act § 14(1)(d).

The forums may award different types of compensation, including compensatory damages, punitive damages (where appropriate), and costs,[114] but they generally do not award noneconomic damages like pain and suffering.[115] During my prior research, I did not find evidence that courts award punitive damages or costs very often.[116]

The Act creates streamlined adjudications, calling for forums to resolve complaints within five to six months after being filed.[117] Plaintiffs have two years to file a complaint after the cause of action arises, though forums can waive that requirement if the plaintiff shows cause.[118] After receiving the defendant's response, the forum must resolve the case within three months,[119] bringing the adjudication to the five or six month total.

Of course, these statutory deadlines are infrequently met in practice, despite national regulations calling for forums to clear a certain percentage of cases each month.[120] Thus, consumer forum cases typically take two to three years to be resolved.[121] Although this still compares very favorably to civil courts, it is not the quick six-month adjudication that the Act contemplates.

India's use of consumer forums certainly has been an antidote to its notoriously inefficient civil courts, but the forums are not ideal venues for resolving medical malpractice claims. Plaintiffs must overcome two significant, if not insurmountable, obstacles.

First, patients in India often struggle to find a medical expert willing to testify that another physician was negligent. Whether this is a matter of physician scarcity in India—there are only 0.6 physicians per thousand residents in India, and the WHO listed India as one of the fifty-seven countries facing crisis-level shortages of health care

114. *Id.*

115. Cortez, *supra* note 6, at 31 (citing Harjol Ahluwalia v. Spring Meadows Hosp., (1986) 199 Consumer 4457; Spring Meadows Hosp. v. Harjol Ahluwalia, (1998) 4 S.C.C. 39); Charan Singh v. Healing Touch Hosp., A.I.R. 2000 S.C. 3138, 3142.

116. *See* Cortez, *supra* note 6, at 31–32.

117. *See* Consumer Protection Act §§ 12–14.

118. *Id.* §§ 24A(1)–(2).

119. *See id.* § 13(3A).

120. Consumer Protection Regulations, 2005, 342(E) Gen. S. R. & O. § 19(1), *available at* http://ncdrc.nic.in/Regulations2005.html.

121. Tim Ensor & Sabine Weinzierl, *Regulating Health Care in Low- and Middle-Income Countries: Broadening the Policy Response in Resource Constrained Environments*, 65 SOC. SCI. & MED. 355, 363 (2007); K.T. Sangameswaran et al., *Consumer Laws Implementation*, HINDU, Nov. 6, 2007, *available at* 2007 WLNR 21848658; *see* Cortez, *supra* note 6, at 27–28 for an analysis of the delays.

professionals[122]—or the "conspiracy of silence,"[123] this is likely a major problem in many other developing countries as well. In India, most plaintiffs ultimately fail to present any kind of expert testimony.[124] Conversely, defendants seem to have no problem finding colleagues to testify. These realities combine to make it very difficult for plaintiffs to carry their burden of proving that a physician was negligent and thus provided "deficient" services under the Act.[125]

The scarcity of plaintiff-friendly medical experts is not necessarily a design problem with India's consumer forums. Virtually any adversarial system that relies on experts to set the standard of care in tort cases will pivot on the ability of adversaries to find experts willing to testify. For that reason, some in India have proposed solutions, such as using independent advisory panels on medical negligence cases,[126] using special panels staffed with medical experts to hear all malpractice cases once a month, or requiring each panel in these cases to have at least one medical expert on staff.[127] Nevertheless, my research on India's consumer forums has not found any major movement to address this problem.[128]

The second obstacle for malpractice plaintiffs in India's consumer forums is obtaining medical records. Physicians and hospitals in India often refuse to hand over documents to patients suing them, including even basic information about their course of treatment or the medications they receive.[129] For a long time, no laws in India required providers to maintain such records or disclose them to patients.[130] A 1996 opinion by the Bombay High Court held that medical providers must give records to patients or their families, but this opinion did not ignite a revolution.[131] In 2002, the Indian Medical

122. *Global Health Observatory, Total Density of Physicians Per 1,000 Population, Latest Available Year*, WORLD HEALTH ORG., http://www.who.int/gho/health_workforce/physicians_density/en/index.html (last visited Dec. 6, 2011); WORLD HEALTH ORG., GLOBAL HEALTH WORKFORCE ALLIANCE, *supra* note 22.

123. JOST, *supra* note 5, at 121.

124. Bhat, *supra* note 101, at 265.

125. ANOOP KAUSHAL, MEDICAL NEGLIGENCE AND LEGAL REMEDIES, 12, 26 (2004).

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

127. *See* KAUSHAL, *supra* note 125, at 6-7.

128. Cortez, *supra* note 6, at 28-29.

129. Nayak, *supra* note 89, at 22; Bhat, *supra* note 101, at 265.

130. KAUSHAL, *supra* note 125, at 24; *see generally* Nayak, *supra* note 89, at 19-22 (explaining how patients' rights in India are only indirect rights).

131. Raghunath G. Raheja v. Maharashtra Med. Council, 1996 A.I.R. 198 (Bom.) 203; K. Mathiharan, *Medical Records*, 1 INDIAN J. MED. ETHICS (Apr.-June 2004), *available at* http://www.issuesinmedicalethics.org/122hl059.html.

Council finally created regulations that require practitioners to keep records for at least three years and disclose them to patients,[132] but my research did not find evidence that the Council enforces them.[133] Finally, the National Commission has held that a hospital is not required to maintain or disclose medical records under the Consumer Protection Act.[134] There have been various calls to require hospitals and physicians to disclose medical records to patients,[135] but not always for the benefit of patients.[136] Thus, malpractice plaintiffs in India struggle to document what happened to them.

For these reasons, plaintiffs rarely succeed in bringing complaints against physicians under the Consumer Protection Act. Various sources report that plaintiffs lose between 70 and 90% of malpractice cases in the consumer forums.[137] A physician described the medical malpractice atmosphere as "absolute chaos."[138] Given these shortcomings, is there a better model for developing countries to follow?

B. Mexico

Patients in Mexico can sympathize with their counterparts in India. Mexico's civil courts are not a palatable option either. Fortunately, as in India, the government has given patients an alternative.

Unlike India, Mexico is a civil code jurisdiction.[139] Mexican courts do not use familiar common law staples like juries or stare decisis.[140]

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132. Med. Council of India, Code of Ethics Regulations, 2002, Gazette of India, Apr. 6, 2002, § 1.3, *available at* http://www.mciindia.org/RulesandRegulations/CodeofMedicalEthicsRegulations2002.aspx.

133. *See* Cortez, *supra* note 6, at 30, 36–38.

134. Poona Med. Found. v. Maruttrao Tikare, (1995) 1 C.P.R. 661.

135. Ganapati Mudur, *Indian Doctors Not Accountable, Says Consumer Report*, 321 BRIT. MED. J. 588, 588 (2000) (describing how India's Central Consumer Protection Council "has periodically urged the Indian health ministry to make it mandatory for all hospitals to provide medical records to patients").

136. *See* Cortez, *supra* note 6, at 30 (describing the efforts of the Medical Council of West Bengal, which amended its Code of Medical Ethics to require doctors to keep and disclose medical records, in part to protect doctors during malpractice suits).

137. *See id.* at 10 (citing sources that plaintiffs lost 76% of cases reported by State Commissions, the National Commission, and the Supreme Court between 1988 and 1998, 71% of cases reported by the Gujarat State Commission between 1990 and 1994, and roughly 90% of cases in district forums in a two-year period).

138. George Thomas, *Consummate Justice or Complete Folly? Doctors and Consumer Protection Act*, 10 ISSUES MED. ETHICS, *available at* http://www.issuesinmedicalethics.org/102le028.html.

139. Vargas, *supra* note 77, at 486.

140. *Id.*

Judges decide cases and are not really bound by any common law precedents.[141]

Traditional U.S.-style tort litigation is alien to Mexico and, as a subset, medical malpractice litigation is exceedingly rare.[142] Personal injury cases in Mexico are governed by the Federal Civil Code, or one of the thirty-one state codes that largely track it.[143] These codes remedy personal injuries and deaths through "extra-contractual liability" that arises from illegal acts based on duties and obligations owed to one another.[144]

As a civil code jurisdiction, Mexico's legislature, the Congress of the Union,[145] is responsible for developing the law in the area of personal injury. However, as Mexican law expert Jorge Vargas has emphasized, the legislature has largely neglected personal injury law.[146] Only 35 of the over 3000 sections in the civil code address what we would think of as tort law.[147] Moreover, "the legal principles that control personal bodily injuries and wrongful deaths in [Mexico] have been kept in isolation and virtually untouched in a legal time capsule that is today legally obsolete and completely out of sync with Mexico's economic and industrial realities."[148] The Mexican Congress "has not clarified when courts should find fault, negligence, or causation," leaving significant discretion to the court in each case.[149] And Mexican courts cannot fill the void in the same

141. Note, however, that opinions by Mexico's Supreme Court and various Circuit Collegial Courts have persuasive power over lower court judges. Jorge A. Vargas, *An Introductory Lesson to Mexican Law: From Constitutions and Codes to Legal Culture and NAFTA*, 41 SAN DIEGO L. REV. 1337, 1353 (2004). Legally binding precedents that satisfy certain procedural and substantive criteria are known as *Jurisprudencias*. *Id.* On factual issues, judges have significant discretion on what evidence to admit and how much weight to give it. Boris Kozolchyk & Martin L. Ziontz, *A Negligence Action in Mexico: An Introduction to the Application of Mexican Law in the United States*, 7 ARIZ. J. INT'L & COMP. L. 1, 13 (1989).

142. Jorge A. Vargas, *Tort Law in Mexico*, *in* 2 MEXICAN LAW: A TREATISE FOR LEGAL PRACTITIONERS AND INTERNATIONAL INVESTORS 214 (West Grp., 1998); Vargas, *supra* note 77, at 488.

143. Vargas, *supra* note 142, at 210–11; Vargas, *supra* note 77, at 478.

144. Código Civil Federal [CC] [Federal Civil Code], *unamended*, Diario Oficial de la Federación [DO], 26 de Mayo de 1928; Jorge Mario Magallón Ibarra, *La Responsibilidad Profesional de los Medicos* [*The Professional Responsibility of Physicians*], 1 MEX. L. REV. 45, 54 (2004).

145. *See* M. CONGRESO DE LA UNIÓN: SISTEMA E-CONGRESO, http://www.congreso.gob.mx/ (last updated 2006).

146. Vargas, *supra* note 77, at 478–79.

147. Jorge A. Vargas, *Moral Damages Under the Civil Code of Mexico*, 35 INTER-AMERICAN L. REV. 183, 186 (2004) (citing corresponding sections of the Code).

148. Vargas, *supra* note 77, at 487–88.

149. Cortez, *supra* note 6, at 72; *see also* Vargas, *supra* note 77, at 499–500 (noting that the Mexican legislature grants significant discretion to judges to find negligence and that the Mexican Supreme Court only briefly discusses these principles in its *Jurisprudencias*).

way that common law courts can. Thus, Mexican law governing personal injuries remains severely underdeveloped and outdated.

The way Mexican law calculates compensation also deters plaintiffs from using civil courts to redress medical malpractice claims. As in India, laws in Mexico do not grant damages for noneconomic injuries like pain and suffering.[150] Rather, the Civil Code requires Mexican courts to calculate compensatory damages by using a statutory workers' compensation formula.[151] This formula, found in the Federal Labor Act, compensates injured plaintiffs as if they were employees injured on the job.[152] This allows courts to award the costs of medical care incurred after the injury, for example, but limits economic losses to four-times the minimum wage in that state for the duration allowed for the corresponding disability in the Federal Labor Act.[153]

For all these reasons, patients rarely bring malpractice cases in Mexico's civil courts. In fact, Professor Vargas has found that U.S. courts actually hear more personal injury cases arising from Mexico than Mexican courts.[154] Culturally, there is widespread distrust of courts and an aversion to litigation.[155] Parties tend to settle personal injury cases informally, and medical providers generally offer to treat whatever harms they might have caused.

But as in India, an alternative emerged. In 1996, then-President Ernesto Zedillo declared that a new national arbitration agency would be formed within Mexico's Ministry of Health.[156] Thus, the National Commission for Medical Arbitration (Comisión Nacional de Arbitraje Médico, or "Conamed") was born.[157]

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150. Vargas, *supra* note 77, at 479, 484 (noting that Mexican law does grant "moral damages" as "equitable compensation," but this is limited to one-third of the amount of total liability); Codigo Civil Federal [CC] [Federal Civil Code], *as amended*, art. 691, Diario Oficial de la Federación [DO] 31 de Agosto de 1928. *But see* Kozolchyk & Ziontz, *supra* note 141, at 34 (noting that judges have significant discretion to award more than one-third of the total compensatory damages as moral damages).

151. Vargas, *supra* note 77, at 479.

152. Cortez, *supra* note 6, at 72; Vargas, *supra* note 77, at 478 (citing Ley Federal del Trabajo [LFT] [Federal Labor Law], *as amended*, Diario Oficial de la Federación [DO], Title IX, arts. 477–80, 487, 491–93, 495–97, 500–02, 1 de Agosto de 1971 (Mex.)).

153. Vargas, *supra* note 77, at 479; Cortez, *supra* note 6, at 72.

154. *See* Vargas, *supra* note 77, at 478.

155. *Id.* at 502.

156. Magallón Ibarra, *supra* note 144, at 47–48; Carlos Tena-Tamayo & Julio Sotelo, *Malpractice in Mexico: Arbitration Not Litigation*, 331 BRIT. MED. J. 448, 449 (2005).

157. For background information on Conamed, largely in Spanish, see COMISIÓN NACIONAL DE ARBITRAJE MÉDICO, http://www.conamed.gob.mx/index.php.

Like India's consumer forums, Conamed was designed as a more accessible, efficient, and less costly alternative to civil courts.[158] But unlike India's consumer forums, Conamed was designed specifically to handle disputes over medical care—a feature that developing countries might emulate.

Conamed's primary charge is to mediate disputes between patients and providers,[159] saving the parties from litigating in civil, criminal, or administrative venues.[160] Conamed can resolve cases at any one of these three stages.

Roughly 73% of cases are resolved at the first stage, within two days of a conflict being submitted to Conamed.[161] The first stage involves an immediate, somewhat informal intervention that opens the lines of communication between the patient and provider, sometimes involving one of Conamed's specialized consultants.[162] This relatively quick and informal initial intervention might be particularly attractive to both patients and providers in developing countries that have a low tolerance—and few resources—for adversarial litigation.

If the parties do not resolve their dispute during this initial intervention, a complaint is filed with Conamed, and the case proceeds to conciliation.[163] Conamed's experts will screen complaints before formally accepting them for conciliation, separating medical malpractice cases from disputes over other matters, like a physician refusing to treat a patient.[164] Conamed will advise the parties on the latter, but will not admit complaints formally unless the dispute involves allegations of malpractice.[165] This second, conciliatory phase introduces a medical review by both Conamed's experts and the treating physician(s).[166] At this phase, the parties can sign a conciliatory agreement, opt out of the Conamed process and file a lawsuit,

158. *See* Cortez, *supra* note 6, at 6.

159. Magallón Ibarra, *supra* note 144, at 47–48; Jorge Fernández Ruiz, *The National Commission of Medical Arbitration and the Responsibility of Civil Servants*, 3 MEX. L. REV. 311; Tena-Tamayo & Sotelo, *supra* note 156, at 449.

160. Héctor Gerardo Aguirre-Gas et al., *Quality of Medical Care and Surgical Patient Safety: Medical Error, Malpractice and Professional Liability*, 78 CIRUGIA Y CIRUJANOS [SURGERY AND SURGEONS] 454, 458 (2010).

161. Tena-Tamayo & Sotelo, *supra* note 156, at 450 (noting that 73% of the roughly 15,000 cases Conamed handled between 2001 to 2003 were resolved at this stage).

162. *Id.* at 449–50.

163. *Id.* at 449.

164. *Id.*

165. *Id.*

166. *Id.*

or proceed to the last stage, arbitration.[167] Between 2001 and 2003, roughly 27% of cases proceeded to conciliation, over half of which were resolved at this second stage, typically within three to six months.[168]

To arbitrate, the parties must sign an agreement that precludes them from taking the case to court.[169] The arbitrators are independent physicians or attorneys trained to handle these cases.[170] Conamed supports the arbitrators by peer-selecting expert consultants based on the medical issues in each case.[171] Conamed thus enjoys credibility both with the judicial and medical communities in Mexico—it provides expert opinions for courts and consults with hospitals about medical errors.[172] This is a key component to its success, and one that might be difficult to replicate for developing countries with weaker pools of medical and legal experts.[173]

If arbitrators conclude that the physician committed malpractice—typically through "negligence or inexperience"—it can award compensation, including damages, medical expenses, or cancelling the patient's debt to the provider.[174] Conamed arbitrators calculate damages based on the same workers' compensation formula used in the Civil Code, though arbitration awards are usually less than those awarded by a court.[175] Conamed may not sanction physicians and cannot award "moral damages" like civil courts can.[176] As a counterbalance, patients avoid the costs of litigation.[177]

Of the roughly 15,000 cases filed with Conamed between 2001 and 2003, only 81 (0.05%) were resolved by arbitration, taking an average of fifteen months to resolve.[178] Over 10% of all cases filed during

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167. *Id.*

168. *Id.* at 449–50 (noting that 2037 of the 3969 cases (51.3%) reaching conciliation are resolved in that stage).

169. *Id.*

170. *Id.* at 450.

171. *Id.*

172. *Id.* at 449–50. Conamed employees also publish studies in peer-reviewed journals under their Conamed affiliations. *See, e.g.*, Germán Fajardo-Dolci et al., *Patient Safety Culture in Healthcare Professionals*, 78 CIRUGÍA Y CIRUJANOS [Surgery and Surgeons] 522, 522 (2010).

173. *See* Tena-Tamayo & Sotelo, *supra* note 156, at 449.

174. *Id.* at 450 (citing Comisión Nacional de Arbitraje Médico, Procedimiento Arbitral en la Conamed, http://www.conamed.gob.mx (last visited Aug. 23, 2011)).

175. *See id.* at 449–50.

176. *Id.* "Moral damages" are equitable remedies available at the discretion of judges to indemnify victims for noneconomic injuries. *See generally* Vargas, *supra* note 77 at 509.

177. Tena-Tamayo & Sotelo, *supra* note 156, at 449.

178. *Id.* at 449–50.

that period were not resolved.[179] Of those, Conamed estimates that a third of complainants simply left the process, and "the remaining unresolved cases probably went to court."[180]

Conamed certainly is not perfect. Providers still win roughly two-thirds of the cases surveyed.[181] The remaining third receives somewhat modest compensation—free treatment, costs, or financial compensation (averaging only $4841 per patient).[182] And it is not clear whether or to what extent patients and physicians are represented by counsel and if there is any discrepancy between the parties. In that vein, Conamed is markedly less judicial than India's consumer forums. Indeed, they are entirely different phenotypes, with Conamed sharing much more in common with other arbitration systems.

Overall, the parties before Conamed report high levels of satisfaction with the process—Conamed received ratings of "good" or "excellent" by 97% of roughly 5500 patients and providers surveyed anonymously by Conamed.[183] I have never seen a similar survey of U.S. medical malpractice plaintiffs and defendants, but it is probably safe to say that those numbers might be the inverse of Conamed's.

CONCLUSION

Developing countries differ from ours in important ways, and these differences suggest that it is particularly important for patients to have realistic avenues to redress their medical grievances. India and Mexico provide two different models, both of which depart from traditional civil litigation. Mexico's model is a superior alternative to India's because Mexico eliminates the requirement that patients carry the burden of proof by securing medical records and expert testimony from reluctant parties. Mexico's system is also less adversarial, which may better accommodate the fiscal and cultural realities in developing countries.

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179. *Id.*

180. *Id.*

181. *Id.* at 450; Maria-Eugenia Jimenez-Corona et al., *Epidemiology of Medical Complaints in Mexico: Identifying a General Profile*, 18 INT'L J. QUALITY HEALTH CARE 220, 221 (2006) (finding evidence of malpractice in a similar ratio of randomly-sampled cases). However, a later retrospective study by Conamed found no evidence of malpractice in roughly 75% of over 8000 cases surveyed between 1996 and 2008, which suggests the success rate for patients should be even lower. Aguirre-Gas et al., *supra* note 160, at 457.

182. *See* Cortez, *supra* note 6, at 75 (dividing $2.9 million awarded by Conamed between 2001 and 2003 by the 599 patients that received these payments).

183. Tena-Tamayo & Sotelo, *supra* note 156, at 451.

However, developing countries are not monolithic, and countries can organize, finance, and regulate health care much differently, even within the same country.[184] We cannot impose Western values like U.S.-style "adversarial legalism," on developing countries.[185] Even stopping short of that American ideal, developing countries have shown resistance to alternative dispute resolution.[186]

Nevertheless, medical malpractice litigation has social value,[187] particularly for developing countries in which physicians enjoy such significant professional autonomy, monopoly-like benefits, and virtually no meaningful state regulation. It is time that the comparative literature embraces the cause in these jurisdictions.

184. Das & Gertler, *supra* note 35, at w297, w301 (referring to the diversity of health care delivery among and within developing countries).

185. ROBERT A. KAGAN, ADVERSARIAL LEGALISM: THE AMERICAN WAY OF LAW 3-17 (2001) (describing exceptionalism in the American desire for litigant-driven, rights-focused, formal "adversarial litigation").

186. *See* Christine Cervenak et al., *Leaping the Bar: Overcoming Legal Opposition to ADR in the Developing World*, 4 DISP. RESOL. MAG. 6 (1998) (describing resistance in Bangladesh, South Africa, Sri Lanka, Ukraine, and Uruguay).

187. For a compelling argument that medical malpractice litigation has social value in the United States context, see BAKER, *supra* note 13, at 6.