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International Outsourcing Plus Inexpensive, Quality Healthcare: Binding Arbitration Makes This Telemedical Dream a Reality

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NOTE

INTERNATIONAL OUTSOURCING *PLUS* INEXPENSIVE, QUALITY HEALTHCARE: BINDING ARBITRATION MAKES THIS TELEMEDICAL DREAM A REALITY[†]

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CASE EXAMPLE

Monday, December 2, 2007 - 10 AM Central Standard Time ("CST")

Robert is a 52-year-old construction worker in good health. He recently developed pains in his chest and abdomen. He walks into St. Christopher's Hospital in Beatrice, Nebraska for an appointment. He receives a physical exam, including an MRI scan of his chest and abdomen. His physician prescribes antacids and pain relievers and makes an appointment for the next day at 8 AM.

Monday, December 2, 2007 - 4 PM CST

St. Christopher's outpatient departments are now closed and the day's radiological data has been uploaded onto the network. The radiology technician emails all of the data to Mahatma Gandhi Memorial Hospital in Bangalore, India, which has a contract with St. Christopher's Hospital for teleradiology diagnoses.

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Monday, December 2, 2007 – 7:30 PM CST (8 AM Indian standard time)

Dr. Roshen is a diagnostic radiologist (M.D Radiology, DMRD, DNB from the All India Institute of Medical Sciences, New Delhi) working with Mahatma Gandhi Memorial. He comes to work at 8 AM, and downloads the radiological data sent from St. Christopher's. He spends the day looking at the data and formulating his diagnoses in all cases including Robert's. Noting the intestinal blockages, he diagnoses Robert with diverticulitis. Dr. Roshen prepares his reports as required by the contract.

Tuesday, December 3, 2007 – 3:30 AM CST (4 PM Indian standard time)

A sub-specialist receives all of Dr. Roshen's reports. He screens them and sends them to a board-certified Radiologist for signing at 7 AM CST.

Tuesday, December 3, 2007 - 8 AM CST

Robert arrives at his appointment, his doctor gives him the diverticulitis diagnosis and sends him home.

January 5, 2008 – 7 AM CST

An artery in Robert's heart bursts. He dies from a misdiagnosed heart attack.

May 3, 2008 – 4 PM CST

St. Christopher's Hospital settles with Robert's estate for $3 million. The hospital then seeks indemnification from Dr. Roshen and Mahatma Gandhi Memorial Hospital through the arbitration proceedings as agreed upon in their contract.

August 4, 2008 – 7 AM CST

Despite Dr. Roshen's absence, the arbitration proceedings conclude and the panel finds Dr. Roshen liable for medical malpractice. The U.S. hospital confirms an arbitration judgment in India against Dr. Roshen and the Indian hospital. The Indian providers have three months to pay $3 million.

November 5, 2008 – 11 AM CST

After Dr. Roshen and his hospital fail to cooperate in the proceedings and neglect to pay the resulting award, St. Christopher's Hospital presents its arbitration ruling and U.S. court order to the U.S. banks that the Indian providers have been using as depositories for the proceeds from their teleradiology services. Because the United

States is obligated to recognize and enforce awards from foreign arbitration proceedings, St. Christopher's Hospital collects the entire $3 million from the bank accounts.[1]

INTRODUCTION

As with most commercial enterprises, economics drives the American healthcare industry to such a degree that "costs represent a *battleground* among competing interests."[2] Medical institutions, including hospitals, biotech companies, and insurance providers, are in relentless pursuit of the next practice, procedure, or pharmaceutical advancement that will provide better care at reasonable, often additional, costs.[3] Meanwhile, incidents of shrinking costs are too few to offset mounting healthcare expenses.[4] Rising costs relentlessly pressure patients, physicians, and insurance providers alike to reduce spending and ration services.[5] Such consequences pose a real concern when those who have assumed the role of assuring healthcare are also straining to reduce costs just like the patients they serve.[6] As health-

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[1] Medical facts are based on a pending case. *See* Rob Stein, *Hospital Services Performed Overseas: Training, Licensing Questions Raised*, WASH. POST, Apr. 24, 2005, at A1. Note that unlike the Indian physician in this example, the Indian physician in the newspaper article is actually board certified in the United States. In order for this note's proposal to have far-reaching success, the Indian physician may not always be board certified in the United States. This scenario's structure is based on an advertisement. *See* Outsource2India.com, Cutting-edge Telaradiology Services from India – How Does it Work?, http://www.outsource2india.com/Healthcare/articles/teleradiology-services-india.asp (last visited Sept. 16, 2007).

[2] Thomas Bodenheimer, *High and Rising Health Care Costs. Part 1: Seeking an Explanation*, 142 ANNALS INTERNAL MED. 847, 847-48 (2005) (emphasis added) (discussing the basic elements of the healthcare industry, specifically the economic relationships among purchasers, insurers, providers, and suppliers).

[3] Thomas Bodenheimer, *High and Rising Health Care Costs. Part 2: Technologic Innovation*, 142 ANNALS INTERNAL MED. 932, 932 (2005) (suggesting that technological innovation is the primary component of health expenditure growth).

[4] *Id.* (arguing that although competition produces technological innovation that may lower per unit costs, the actual quantity of sales and usage multiplies, notwithstanding the addition of supplemental services, all resulting in higher healthcare expenditures).

[5] G. Caleb Alexander, Rachel M. Werner & Peter A. Ubel, *The Costs of Denying Scarcity*, 164 ARCHIVES INTERNAL MED. 593, 594-96 (2004) (discussing patient harm that results from the subconscious and negative impact of high costs and scarce resources on physician decision-making); *see also* Stephen D. Boren, *I had a Tough Day Today, Hillary*, 330 NEW ENG. J. MED. 500, 500-02 (1994) (describing the difficult and life altering decisions that must be made to contain costs in managed care agreements that require utilization review).

[6] *See* Alexander et al., *supra* note 5, at 594 (stating patients suffer when

care expenditures continue to rise and as providers place more financial pressures on patients in an effort to contain costs, the system's delicate balance will demand concessions from all parties in order to forestall drastic system-wide alterations, or worse, lower standards of care.[7]

One method for cost-containment is to seek alternative providers to interpret radiology scans.[8] For example, contracting out to radiologists in India can offer many benefits, including supplementing understaffed radiology departments with comparable services at a fraction of the cost.[9] This note calls for a reexamination of current legal practices that hinder the realizable cost-containment benefits of teleradiology, and illustrates a new system whereby international arbitration effectively replaces the inefficient, traditional attempt at seeking justice for medical malpractice claims in a foreign court.

If providers are unwilling to look for a solution elsewhere, or to concede in the outsourcing of conventional services, then the likely alternatives to rising healthcare costs are a lowered standard of care or patients forgoing care altogether.[10] However, demanding that a patient extend her suffering because treatment is inaccessible or too expensive is counterintuitive if the technology and the services are both currently obtainable to alleviate her affliction.[11] In the meantime,

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high costs compel physicians to order fewer diagnostic tests, make less referrals to specialists, shorten the length of patient visits, and reduce the number of follow-up appointments). In contrast, rather than rationing services to reduce costs, utilizing alternative, adequate, and less expensive providers for similar care would ensure that patients receive all necessary services.

[7] *See generally* David A. Asch & Peter A. Ubel, *Rationing by Any Other Name*, 336 NEW ENG. J. MED. 1668 (1997) (calling for mutual concessions from both frustrated patients and physicians in order to alleviate the inevitable consequences of lowered standards of care and inappropriate compromises, which currently result from the systemic problems of high costs and healthcare rationing).

[8] For purposes of this note, "scans" and related "interpretations" are categorized under the specialized field of Diagnostic Radiology, which includes x-rays, ultrasounds, computerized tomography (CT scans), and magnetic resonance imaging (MRIs). RICHARD M. PATTERSON, HARNEY'S MEDICAL MALPRACTICE 73 (4th ed. Matthew Bender & Co., Inc. 1999) (1973).

[9] Thomas R. McLean, *The Future of Telemedicine & Its Faustian Reliance on Regulatory Trade Barriers for Protection*, 16 HEALTH MATRIX 443, 450-51 (2006) (citation omitted).

[10] *See generally* Asch & Ubel, *supra* note 7 (illustrating the logical consequence of improperly reducing services, cutting healthcare costs, and shifting risks to patients; that is, patients receive less effective treatments and are denied access to appropriate care).

[11] Ciaran P. O'Boyle & Richard P. Cole, *Rationing in the NHS: Audit of Outcome and Acceptance of Restriction Criteria for Minor Operations*, 323 BRIT. MED. J. 428, 428-29 (2001) (describing ill-effects of rationing medical services in the

instead of disregarding care altogether, the patient, physician, and insurance provider typically pursue less drastic means of making care more affordable, even when doing so results in a lower standard of care.[12]

On the other hand, not all healthcare alternatives result in lower standards of care.[13] Indeed, patients who have to absorb increased costs for their healthcare will likely adjust their consumer behavior by experimenting with sufficiently equivalent treatments, even if the adjustment is initially unsettling.[14] Since cost savings is a growing concern for consumers, many are willing to modify their expectations if the benefits from the new practice outweigh the risks.[15] For instance, some patients have gone so far as to travel to India to receive complete care for medical conditions in an effort to contain costs.[16] If a safe and effective substitute is available and less expensive, it should be encouraged in order to preserve limited financial and medical resources.[17] Teleradiology from Indian providers will likely save

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British health system, e.g. patients who are misdiagnosed as having insignificant issues are placed on extensive waiting lists as the condition worsens). Note that as more restrictions are placed on physician services, the more patients' conditions worsen or remain untreated, thus resulting in socially "acceptable" levels of inferior care. *Id.* at 429.

[12] *See, e.g.*, Alexander et al., *supra* note 5, at 595 (stating that managed care organizations are an effort to contain costs and curb disingenuous rationing, and are used even when this alternative healthcare structure arguably sacrifices physician-patient relationships and minimizes patient services).

[13] Generic drugs serve as an example. They frequently offer the same therapeutic benefits as brand names drugs, but at a substantially reduced cost. Ctr. for Drug Evaluation & Research, Consumer Information, http://www.fda.gov/cder/consumerinfo/generics_q&a.htm (last visited Aug. 31, 2007).

[14] Following the generic pharmaceutical example, if an insurance company will cover the entire cost of a generic drug but only twenty-percent of a brand-name drug, a patient will likely choose the generic drug to avoid unnecessary out-of-pocket payments, even if she is suspicious of its efficacy and more confident in the brand-name drug.

[15] *See, e.g.*, Saritha Rai, *Union Disrupts Plan to Send Ailing Workers to India for Cheaper Medical Care*, N.Y. TIMES, Oct. 11, 2006, at C6 (discussing the costs and benefits of receiving medical care in India, and a gall bladder patient's willingness to pursue surgery in India if he would be adequately treated and receive a share of his employer's healthcare expense savings). Note that emailing a patient's scans over an international teleradiology network is hardly as intrusive as requiring that patient to physically travel to another country to be treated. Thus, alternatives that require less drastic demands should likely be more readily accepted.

[16] *Id.* (reporting that an American employer attempted to save costs by outsourcing American employee's gall bladder surgery to India, rather than paying higher costs at an American hospital).

[17] Teleradiology will have similar cost-savings as generic drugs, which are

American healthcare consumers a substantial amount of money.[18] In addition, it follows that in a market strained by high costs, the providers who offer sufficiently comparable alternatives at a significant savings will inevitably garner the most consumers and generate the largest revenue.[19] Currently, the primary solution to achieving a fiscal advantage is to embrace information technology and the innovation that improves both quality and efficiency.[20] Since patients want quality care and are willing to make some concessions when price becomes a factor in their decision-making,[21] it is time to reexamine traditional thinking by looking to a global solution.[22]

However, a significant problem arises when heavy competition forces medicine, technology, and industry management to advance and hastily alter current practices to such a degree that innovation slips away from the confines of current laws, policies, and safeguards.[23] Although the alternative medical procedure may be beneficial, it often leaves someone, typically the patient, without proper recourse or protection from potential harms.[24]

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regularly embraced as less expensive, but adequate, alternatives to brand-name treatment. "[G]eneric drugs save consumers an estimated $8 to $10 billion a year at retail pharmacies. Even more billions are saved when hospitals use generics." U.S. Food & Drug Admin., Office of Generic Drugs, http://www.fda.gov/cder/ogd/ (last visited Sept. 5, 2007).

[18] Rai, *supra* note 15 (stating that certain Indian hospitals offer "first-world health care delivered at third-world costs").

[19] *See* Seong K. Mun et al., *Teleradiology and Emerging Business Models*, 11 J. TELEMEDICINE & TELECARE 271, 275 (2005). "[T]he amount of money that can be earned in the global telemedicine market is prodigious." McLean, *supra* note 9, at 454.

[20] Mun et al., *supra* note 19, at 275.

[21] Considering the abovementioned generic drug example, the generic drug industry is growing exponentially at sixteen percent per year, and over the course of five years the world-wide market will likely double its revenue to $100 billion by 2010. Jeanne Whalen, *Mixing Medicines: Betting $10 Billion on Generics, Novartis Seeks to Inject Growth; Brand-Drug Makers Usually Battle Copies, but Vasella Wants Profits From Both; A Delicate Dance on Patents*, WALL ST. J., May 4, 2006, at A1.

[22] *See* Rai, *supra* note 15 (paraphrasing one expert who insisted that "the pressure to outsource healthcare is inevitable," and another expert who affirmed that U.S. companies will soon "spend as much on health care on average as they made in profits"). Without change, the inevitable result is less care and reduced coverage for American employees. *See id.*

[23] *See, e.g.*, Mary Carmichael, *Hidden Risks*, NEWSWEEK, Mar. 12, 2007, at 48, 48-49 (suggesting medical errors increase as untrained doctors hastily attempt to appease incessant patient demands for innovative treatments; for example, patient pressure for less invasive, but more risky, laparoscopic procedures).

[24] Rai, *supra* note 15 (stating that the American employee-patient would be left with significantly less malpractice protection if physician negligence were to arise

Regardless, policymakers should explore the benefits before initiating drastic regulations that would stunt medical progress and chill the implementation of viable remedies. Due to the benefits that come from research and general experimentation in the healthcare industry, the focus should not be on slowing development or hindering innovation out of a fear of the unknown.[25] Instead, policymakers should concentrate their efforts on implementing laws that not only provide the necessary safeguards to protect providers and consumers, but also encourage ongoing adaptation to market forces. Thus, both provider and consumer are sufficiently protected and satisfied.

The relatively new realm of telemedicine, specifically teleradiology, is just one example of market forces compelling healthcare providers to seek alternatives that reduce costs. However, this nascent industry may be facing extinction due to trade barriers and liability pitfalls. Although numerous scholars and medical professionals have discussed the advantages and disadvantages of telemedicine and teleradiology, few have proposed and elaborated on a viable solution to the liability quagmire.

Section I of this note explores the precarious state of radiology in the United States and the efforts to remedy its problems by way of telecommunication. It also introduces the contemporary international teleradiology system currently serving as the fledgling foundation to a conceivably larger international industry. Since malpractice claims for misdiagnoses are inevitable, Section II discusses traditional and novel efforts to address liability concerns, and how binding arbitration has evolved into a viable course of dispute resolution under international law. An ultimately successful regulatory system will depend on the parties applying widely accepted policies and procedures to an anticipated set of circumstances, thereby avoiding uncertainty and drastic change within a beneficial yet vulnerable teleradiology industry. Next, Section III illustrates a model for the substantive and procedural components of a contractual arrangement that are necessary to ensure international cooperation, fairness, and enforcement. Finally,

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in an Indian jurisdiction). The evasion of current laws is by no means purposeful, but rather incidental to the demand to adapt in a highly competitive marketplace, not to mention participating in a high-tech industry that is inherently based on evolving processes, scientific advancement, and technological innovation.

[25] *See, e.g.*, TENN. CODE ANN. § 63-6-214(b)(21) (2004 & Supp. 2006) (declaring that using modern technology to communicate information and diagnoses across Tennessee's borders may result in disciplinary action). Similarly, imposing trade barriers, or restricting telemedicine in some other way, would only act as a temporary solution from global competition, would strain the burgeoning foreign telemedicine industry, and would defeat a viable option for decreasing U.S. healthcare costs. *See* McLean, *supra* note 9, at 456-57, 470.

Section IV analyzes the benefits and detriments of the new international arbitration model.

I. DOMESTIC RADIOLOGY: TELERADIOLOGY RESOLVES A SERIOUS PROBLEM

The current American healthcare system is in a state of flux. Limited resources are afflicting both patients and providers. In fact, the domestic radiology practice area poses unique concerns. Subsection A addresses these issues, specifically the increasing need for diagnostic services combined with an ever-decreasing supply of radiology providers. Subsection B follows with an exploration of the relatively new field of teleradiology and how it has temporarily improved the perilous situation. Since the domestic radiology market did not supply the cure for the problem, Subsection C explores efforts to expand the advantages of teleradiology to an international arena. However, as technology and medicine advance at an alarming rate, breaching the comfortable boundaries of the domestic realm creates new concerns. Thus, Subsection D details the new legal apprehensions that arise in an international marketplace.

A. Domestic Radiology Poses Unique Concerns in Troubled Healthcare System

American radiology departments are finding themselves unable to provide patients with adequate care. For example, the President of the American Cancer Society was asked to comment on the "systemic weaknesses in [the health system's] ability to continue to detect [breast] cancers through mammography, and [which] partly, is a result of declining numbers of radiologists."[26] Agreeing to the increasing concern, Dr. Wender stated that the problem is more than simply a lack of radiologists, it is that

> the interest among the radiology community in devoting time to doing a mammography has declined as other attractive options for imaging become available to the radiology community. The reimbursement rate[] is not as good as many radiologists feel [it] should be, the number of facilities is not distributed well throughout the country. And [as] a result, wait-

[26] *Talk of the Nation: Breast Cancer Q and A* (NPR radio broadcast Dec. 19, 2006) *available at* http://www.npr.org/templates/story/story.php?storyId=6647131 (Neal Conan interviewing Dr. Richard Wender, President of the American Cancer Society) (transcript on file with Health Matrix).

> ing times are very long, which makes it less likely for a woman to actually [receive a mammogram].[27]

Thus, local radiology communities lack the resources to attract more radiologists to provide skillful, consistent,[28] and cost-effective services that could solve its staffing and lowered standard of care dilemma.

Moreover, these deficiencies are reflected in the fact that radiology-related complaints contribute to a large portion of the increasing numbers of medical malpractice cases. Indeed, mistaken diagnosis is the single most prevalent cause of malpractice cases.[29] Many missed or inaccurate diagnoses may be directly attributable to radiologists.[30] Incorrect or missed radiographic diagnoses result from over-worked physicians, inadequately staffed radiology departments, or less experienced practitioners.[31]

B. Domestic Teleradiology Comes to the Rescue

Initially used to provide quality radiological care in rural communities that were too distant from better-equipped hospitals, teleradiology enabled geographically isolated individuals to receive quick, first-rate medical care from premier institutions.[32] The rural providers quickly noticed the advantage of outsourcing their interpretive services to other physicians. Most notably, they saved significant costs by not having to fully staff a small-town radiology department around the clock.[33] Now, increasing advances in medical science, computer technology, and quality telecommunication have allowed these rural

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[27] *Id.*

[28] *See* RONALD L. EISENBERG, RADIOLOGY AND THE LAW: MALPRACTICE AND OTHER ISSUES 86 (2004) ("Radiologists reading the same radiograph at different times disagree with themselves in up to 20% of cases.") (citation omitted).

[29] MELVIN M. BELLI & JOHN CARLOVA, BELLI FOR YOUR MALPRACTICE DEFENSE 75 (1986).

[30] EISENBERG, *supra* note 28, at 85 (stating that some studies have shown that radiology errors have comprised thirty percent of malpractice cases, which does not include errors that go undetected) (citation omitted).

[31] *See id.* at 86-90, 101-02 (explaining that errors result from incomplete and/or inadequate knowledge, faulty reasoning, perceptual errors and fatigue).

[32] *See* Cathy Tokarski, *Offshore Teleradiology Services Show Promising Results*, MEDSCAPE MED. NEWS, Aug. 6, 2004, http://www.medscape.com/viewarticle/487194.

[33] *See* Holly Celeste Fisk, *The Virtual Image Courier*, MED. IMAGING, Feb. 2004, http://www.medicalimagingmag.com/issues/articles/2004-02_03.asp (quoting one expert who states teleradiology allows institutions to forgo paying on-call radiologists at night and to overcome the problem of recruiting radiologists who are reluctant to live in rural towns).

providers to outsource an even larger array of diagnostic services,[34] causing a further reduction in staffing, thereby increasing cost savings without sacrificing quality care.[35]

In turn, providers in larger populations also recognized significant advantages to utilizing teleradiology.[36] First, a central institution, or "focused factory,"[37] employs specialists to interpret certain scans, thereby reducing the likelihood of misdiagnoses.[38] Despite the size of medical facilities, errors will always result from a combination of inexperience, over-worked physicians, under-staffed facilities, and the lack of alertness due to working late-nights and third-shifts.[39] Second, it follows that outsourcing these radiology services directly reduces costs by shortening prolonged hospital stays. Third, hospitals save money by not having to fully staff their radiology departments at all hours.[40] Fourth, larger institutions earn millions of dollars in additional revenue by offering interpretations through their radiology subspecialty programs.[41] Ultimately, the savings from teleradiology are

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[34] *See id.*

[35] *See* Robert M. Wachter, *The "Dis-location" of U.S. Medicine - The Implications of Medical Outsourcing*, 354 NEW ENG. J. MED. 661, 663 (2006) (discussing the financial benefits of outsourcing radiology services including those for a "fiscally challenged" hospital).

[36] Tokarski, *supra* note 32. Benefits include interpreter-physician specialization, emergency coverage, surmounting staffing concerns, more scheduling flexibility, better pool of physicians, less overhead costs, decreased workloads, more attention given to emergency cases, faster interpretations, and more medical services covered. Kalyanpur et al., *Implementation of an International Teleradiology Staffing Model*, 232 RADIOLOGY 415, 418 (2004).

[37] Wachter, *supra* note 35, at 662.

[38] Mun et al., *supra* note 19, at 274 (stating that "remote subspecialty consultation[s]" create quality control by offering second opinions to those physicians who are presented with more complicated symptoms or complex images). Such safeguards should be encouraged because, though the statistics admittedly vary by data source, radiologists have a high error rate. *See, e.g.*, McLean, *supra* note 9, at 453 (asserting that "the misperception rate for lung cancer on an initial chest x-ray in the medical literature runs 25-90 percent" (citation omitted)); "The generally *accepted* error rate for the detection of early lung cancer is 20% to 50% . . . ." EISENBERG, *supra* note 28, at 88 (emphasis added).

[39] EISENBERG, *supra* note 28, at 86-90, 101-02. "At present, most of the outsourcing of telemedical services in this country is done to provide medical coverage on the third shift when it is hard to find U.S. physicians who are awake." McLean, *supra* note 9, at 450.

[40] Wachter, *supra* note 35, at 662-63.

[41] Sonia Elabd, *Long-Distance Diagnosis - A Closer Look at Teleradiology*, RADIOLOGY TODAY, May 10, 2004, http://www.radiologytoday.net/archive/rt_051004p20.shtml.

passed to the patient-consumer who receives better, quicker services, at a lower cost.[42]

C. Teleradiology Goes International

Until recently, telemedicine remained a purely domestic industry, in which one American hospital would outsource its radiology work to other American hospitals. Then, hospital management and physicians realized additional benefits from a broader international application, particularly recognizing potential solutions to the ongoing obstacles of both limited money and inaccessible expert medical opinions. First, if the four-hour, coast-to-coast time difference produced more accurate x-ray interpretations and saved money by requiring fewer physicians to staff third-shift radiology departments, imagine the impact of an international system in which physicians in another country and different time zone are wide awake to interpret scans during all late-night hours in the United States.[43] Thus, hospitals, insurance providers, physicians, and patients are rewarded by reducing medical malpractice claims that result from sleep-deprived physicians' misinterpretations.[44] Second, not only would these interpretations be more accurate since the physicians performing them are more alert, but they would also be more accurate because the interpreting radiologists are much more experienced.[45] Third, international teleradiology centers provide

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[42] Ryan J. Spaulding, Ctr. for Telemedicine & Telehealth, The Univ. of Kan. Med. Ctr., Cost Analysis, http://www2.kumc.edu/telemedicine/research/costanalysis.htm (last visited Sept. 1, 2007) (stating that telemedicine has potential to save money for patients, institutions, and the health care system as a whole).

[43] *See* Elabd, *supra* note 41 (quoting one teleradiology provider who stated that "emergency room staff are happy with our services because they have someone who is awake to talk to and readily available to read the study"); Wachter, *supra* note 35, at 662 (stating that physicians welcome outsourcing because the "off-site professionals begin doing work the locals are happy to forgo, such as nighttime reading of radiographs").

[44] *See* EISENBERG, *supra* note 28, at 88 (stating that the largest factor in misinterpretation is "perceptual error," which accounts for up to eighty percent of the "radiologic misses").

[45] Limited personal experience is a clear factor causing errors and misdiagnoses. *Id.* at 87. A central radiology facility that performs x-ray interpretation exclusively becomes specialized both by the increased skill acquired from the shear volume of interpretation as well as the variety of diagnoses, notwithstanding the fact that the centralized institution efficiently facilitates physician dialogue and multiple opinions for those x-rays that are more confounding. One expert has referred to this particular advantage as a "focused factory" in which patients benefit from specialist opinions without having to leave their community. Wachter, *supra* note 35, at 662.

ideal viewing conditions that are far removed from distractions.[46] Lastly, although hospitals save money, patients receive the most important benefit by receiving a prompt, expert diagnosis at a lower cost.[47]

Due to the relatively new teleradiology industry, only two international models are widely known for interpreting scans outside normal working hours. The first model is largely based in India.[48] The Second, the Nighthawk model, is an American corporation based in the United States but with offices in international locations such as Spain and Australia.[49] The most notable difference between the two is the background and licensing of the physicians. The former model involves an Indian company, hiring Indian physicians who were not trained or licensed in the United States.[50] The latter model employs American physicians who were trained and licensed in the United States, but have established a practice abroad.[51] Both models share the common goal of offering x-ray interpretation services during the late-night, third-shift hours, during which U.S. health providers either noticed the negative effects from less alert physicians or from understaffed radiology departments.[52]

Since American medical institutions will receive the most benefits from adopting the Indian model, this note focuses on alleviating legal obstacles to advance this particular industry, rather than the Nighthawk industry. The reasons are clear. As with many American industries, India will provide a refuge of inexpensive, skilled labor that is comparable to the more expensive services in the onerous and costly U.S. healthcare system.[53] Outsourcing American healthcare needs to

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[46] EISENBERG, *supra* note 28, at 89. Contrary to the highly pressured, interruption-prone environment of a domestic radiology practice, a teleradiology department can reduce these disturbances and eliminate extraneous light that impairs the detection of subtle details in an image. *Id.*

[47] Wachter, *supra* note 35, at 663. Improvements may be so drastic that international telemedicine raises the standard of care. Thomas R. McLean & Edward P. Richards, *Teleradiology: A Case Study of the Economic and Legal Considerations in International Trade in Telemedicine*, 25 HEALTH AFFAIRS 1378, 1384 (2006).

[48] *See, e.g.*, Kalyanpur et al., *supra* note 36, at 415-19.

[49] *See generally* Nighthawk, http://www.nighthawkrad.net (last visited Sept. 12, 2007); Mun et al., *supra* note 19, at 273.

[50] McLean, *supra* note 9, at 449. Although possible, Indian doctors who are not licensed or certified in the United States most likely do not yet interpret American scans. *See* Robert M. Wachter, *International Teradiology*, 354 NEW ENG. J. MED. 662, 662-63 (2006).

[51] Wachter, *supra* note 50, at 662.

[52] *Id.*; Mun et al., *supra* note 19, at 273.

[53] One estimate asserts that foreign physicians are willing to do the same work for one-tenth the pay of U.S. doctors. McLean & Richards, *supra* note 47, at

India has a proven track record.[54] Indeed, outsourcing to international providers is a trend that is on the rise as employers, patients, and insurers "search[] for a way to tap into a low-wage labor pool of providers to hold down health and pension expenses."[55] Moreover, lower costs and a higher return on investment are more likely realized by trade among other nations' physicians rather than among more expensive American providers who are simply located in other countries.[56] In addition, other countries will more likely participate and support a system in which they directly benefit as well.[57]

D. International Model Raises Concerns

A successful healthcare system is strongly related to the variables of cost, quality, and access to care.[58] It follows that if international teleradiology provides optimal results in all three areas, then excellence in healthcare will result and both patients and providers will be equally satisfied with the new system.[59] On the other hand, although

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1379; another estimate affirmed a higher disparity, suggesting Indian radiologists would make $25,000 per year compared to the American radiologist who makes $350,000. Wachter, *supra* note 50, at 663.

[54] *See* McLean, *supra* note 9, at 443 (citation omitted). Outsourcing healthcare services began when institutions recognized the cost-savings that resulted from hiring lower paid workers to organize and record easily transportable medical documents, specifically patient records and billing. *See id* at 443-44. "[I]n 2003, $340 million moved from the United States to India to cover just the cost of outsourced medical transcription and billing." *Id.* at 443 (citation omitted).

[55] *Id.* at 444 (citation omitted).

[56] *See* Uwe E. Reinhardt, *The Economic and Moral Case for Letting the Market Determine the Health Workforce, in* THE U.S. HEALTH WORKFORCE: POWER, POLITICS, AND POLICY 3, 5 (Marian Osterweis et al. eds., 1996) (stating that healthcare organizations quickly respond to the "relative costliness of . . . health professionals"). If a provider requires a high rate for his service, and another provider offers a comparable service at a much lower cost (even if less qualified), then the U.S. healthcare system tends to adjust to maximize wealth and efficiency, and thus give more work to the less expensive provider. *See id.*

[57] For example, the foreign state that hires its own citizens and receives the increased capital revenue will be open to such an arrangement, as opposed to only allowing the use of its territory but deferring to American regulations strictly among American institutions for the sole benefit of American patients. *See, e.g.*, McLean & Richards, *supra* note 47, at 1380-81 (stating that the United States, not seeing a direct benefit to such an arrangement, established obstacles to protect itself, its own healthcare, and domestic teleradiology market by imposing trade barriers and licensing requirements in an effort to thwart foreign competition).

[58] McLean, *supra* note 9, at 451 (citation omitted).

[59] For instance, "increased use of telemedicine could potentially stabilize the cost of health care because of improvements in access to care, creation of economies-of-scale, reduction of medical errors, and improved competition amongst providers." *Id.* at 450-51. "Economies-of-scale" refers to the advantages that arise by concentrat-

international teleradiology may garner the attention from patients, hospitals, employers, and insurance providers alike, such interest is not without skepticism.[60]

One notable concern is the presumption of inadequacy and inferiority among foreign healthcare systems.[61] However, quality care is available in India.[62] Indeed, experts have empirically verified comparable teleradiology services in an Indian setting.[63] In addition, India has already developed state-of-the-art medical facilities.[64] Moreover, both private and public entities in India are currently sponsoring advancement and innovation in health sciences.[65] In fact, one study insists that India's "vast scientific infrastructure, the familiarity with the English language, the high standards of scientific and technical education, and India's notable achievements in information technology" strongly indicate promising contributions in both medical research and healthcare.[66] At any rate, since U.S. licensed practitioners typically double-check the "preliminary" foreign diagnosis in order to complete a "primary" report, an additional safeguard is already in place.[67]

Utilizing international providers presents another concern that focuses on informed consent.[68] Interestingly, unless a patient is physi-

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ing a specific service or by manufacturing a product at a single location to benefit from the efficiency of mass production; such benefits include general cost savings, resourceful transactions, and an increased knowledge pool. *Id.* at 451-52.

[60] *See* Wachter, *supra* note 35, at 663-64 (stating that international teleradiology may create "new kinds of mischief").

[61] Nighthawk providers have addressed the issue in a number of ways, such as requiring American licensing and oversight, or insisting on abiding by American College of Radiology (ACR) guidelines. Wachter, *supra* note 50, at 662.

[62] Rai, *supra* note 15 (reporting that the "best hospitals [in India] have Western-trained doctors and are equipped with modern equipment").

[63] Kalyanpur et al., *supra* note 36, at 415 (asserting satisfactory results, but note that the interpreting physician in Bangalore, India retained American credentials).

[64] RAJIV MISRA, RACHEL CHATTERJEE & SUJATHA RAO, INDIA HEALTH REPORT 102 (2003); *See* Indraprastha Apollo Hospitals, http://www.apollohospdelhi.com/about-us/whats-new-at-apollo.html (last visited Sept. 29, 2007) (indicating India's first internationally accredited hospital by Joint Commission International, USA (JCI)).

[65] *See* WORLD HEALTH ORGANIZATION, WORKING TOGETHER FOR HEALTH: THE WORLD HEALTH REPORT 45-46 (2006) (stating that the establishment of private universities in India is on the rise, and a new foundation is bridging a partnership between the private sector and the government to improve resources nationwide).

[66] MISRA ET AL., *supra* note 64, at 190.

[67] *See* Wachter, *supra* note 50, at 662 (describing the efforts made by U.S. physicians to comply with CMS regulations that prohibit payment to providers outside the United States).

[68] Consent is an entirely different topic that is beyond the scope of this note. Although healthcare and the physician-patient relationship are inherently private and

cally transported to another country, most patients are "blissfully unaware" that foreign physicians, or American physicians in another country, are making their diagnosis.[69] Since American patients are already often wary of seeing new doctors and receiving services in unfamiliar facilities, a physician trained and located in a completely different country is hardly likely to assuage a patient's discomfort.[70]

Nonetheless, it is important to recognize that teleradiology in some form has already been used extensively even if its existence is unknown.[71] This practice remains unfamiliar simply because radiologists do not need to consult with the patient face-to-face in order to provide a diagnosis. Moreover, India has already become a major international player in providing outsourced services related to healthcare.[72] Thus, since patients are unaware of telemedicine's use, they are unlikely to recognize any difference in care, and consequently remain satisfied. In fact, a properly established teleradiology system will not require patients to accept second-rate norms of another country, but rather by embracing the international system, American healthcare providers can establish stringent standards and high regulations for the foreign providers,[73] thereby increasing the contemporary standard of care.[74]

Licensing and certification requirements remain another unsettled matter.[75] Indeed, some teleradiology companies have overcome these obstacles by having a non-credentialed Indian physician interpret a scan and provide the "preliminary" read for a properly licensed physi-

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personal, lower costs and other benefits may encourage patients' willingness to cooperate with international providers.

[69] *See* Fisk, *supra* note 33.

[70] Media articles heighten patient apprehension by noting the risk that overseas medical institutions may hire unlicensed physicians to read x-rays for American patients. *See* Stein, *supra* note 1.

[71] Todd L. Ebbert et al., *The State of Teleradiology in 2003 and Changes Since 1999*, 188 AM. J. ROENTGENOLOGY 304, 304 (stating that their survey results indicate "67% of all radiology practices in the United States" use teleradiology); Mun et al., *supra* note 19, at 273 (reporting that one study revealed 82% of the queried emergency departments used teleradiology (citation omitted)).

[72] *See* McLean & Richards, *supra* note 47, at 1379 (stating that India has currently obtained two percent of the U.S. healthcare market).

[73] Such requirements will likely follow ACR guidelines, e.g. certain credentials, continuing education, and malpractice insurance coverage. Wachter, *supra* note 50, at 662.

[74] McLean & Richards, *supra* note 47, at 1384; International teleradiology will inevitably create "focused factories" comprised of expert radiologists. Wachter, *supra* note 35, at 662.

[75] Regulatory licensing and proper supervision are beyond the scope of this note.

cian to later review and make a final diagnosis at the image-originating site.[76] However, these protectionist U.S. licensing concerns may give way to the more challenging and worsening crises in healthcare staffing and cost.[77] Certainly, domestic licensing provisions can act as a costly barrier to quality care.[78] Instead, legitimate international medical standards may suffice to regulate the quality of care so that licensing no longer acts as an impediment to international teleradiology.[79]

Yet, even if a system were in place that not only met the current standards of American healthcare, but in fact surpassed it,[80] the liability issue would still arise. Indeed, the primary obstacle hindering investment in a potentially booming telemedical market is the uncertainty created by medical malpractice liability.[81] No matter how alert and skilled the physicians may be, mistakes and negligence will occur in every healthcare system.[82] As a result of the impending lawsuits, new procedural issues arise when litigating teleradiology malpractice in a foreign jurisdiction.[83] How will an American patient or institution be made whole if the negligence occurs by a foreigner in a foreign country? Who can a plaintiff successfully sue: the American physician or hospital, the foreign physician or institution, or the insurance providers? What will constitute sufficient process for serving an international doctor or institution? Will awards even be enforceable against a foreign physician? Where will a victim litigate such dis-

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[76] *See* Mun et al., *supra* note 19, at 273.

[77] *See* Wachter, *supra* note 35, at 664.

[78] MICHAEL F. CANNON & MICHAEL D. TANNER, HEALTHY COMPETITION: WHAT'S HOLDING BACK HEALTH CARE AND HOW TO FREE IT 131-32 (2005) (suggesting that state-based licensing boards purposefully restrict teleradiology to eliminate job and price competition, thereby harming patient welfare).

[79] Private companies are currently building new hospitals in India that meet the specifications of international hospital certification agencies. Rai, *supra* note 15.

[80] McLean & Richards, *supra* note 47, at 1384 (suggesting a higher standard of care may result from teleradiology).

[81] "[I]t is the complexity of calculating exposure to liability in the telemedical market, and not the capital requirements, that chills many investors contemplating entering the telemedical marketplace." McLean, *supra* note 9, at 455. This note attempts to resolve the trepidations concerning liability by discussing a dispute resolution mechanism that ensures a high degree of predictability and judgment enforcement.

[82] *See, e.g.*, Stein, *supra* note 1 (noting one international teleradiology malpractice case involving Dr. Kalyanpur as the Indian provider-defendant and a Pennsylvania patient in which the patient died from a burst artery in his heart but was originally diagnosed with diverticulitis).

[83] Mun et al., *supra* note 19, at 271.

putes? Even if a patient or healthcare entity wins damages in a domestic or foreign court, how might a plaintiff collect?

However, before suppressing a potentially beneficial industry for lack of efficacy, policymakers should consider alternative solutions to obstacles hindering the industry's development. As the following analysis explains, many liability concerns dissipate after implementing appropriate remedial safeguards. Thus, American patients and providers should be able to realize the benefits arising from an international teleradiology system.

II. MALPRACTICE LIABILITY WITHIN INTERNATIONAL TELERADIOLOGY

No matter the country of origin, incidents of medical malpractice are inevitable, and victims will demand compensation to make them whole again. Humans are fallible, and although we may like to believe physicians are the exception, errors arise whether during intake, at diagnosis, throughout the medical procedure, or in the course of recovery. In the practice of teleradiology, mistakes will most frequently occur at the interpretation stage as either "cognitive" or "perceptual" misinterpretation.[84] Indeed, plaintiffs often sue for harm caused by the physician's negligent failure to diagnose a condition.[85]

However, whether a physician is ultimately found liable for negligence is immaterial to the following illustrations. More importantly, the plaintiff must commence the arduous procedures, initiate intense discovery, evaluate the facts and law, and assess recovery options even *before* the adversarial process is fully underway. Therefore, no matter the selected system of dispute resolution, international teleradiology will only succeed if the chosen forum facilitates a fair outcome and ensures potential for full recovery from the very start. Subsection A recounts the arduous procedures for settling potential malpractice disputes in foreign courts. Subsection B then addresses contemporary attempts at reforming malpractice adjudication via alterna-

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[84] *See* EISENBERG, *supra* note 28, at 86 (explaining that cognitive misinterpretation occurs when "a perceived abnormality is misinterpreted due to lack of/incomplete knowledge or faulty reasoning/judgment," and perceptual misinterpretation results if the physician completely fails to recognize the abnormality).

[85] JOHN HEALY, MEDICAL NEGLIGENCE: COMMON LAW PERSPECTIVES 52 (1999). Many of these misinterpretation cases are associated with cancer detection, and for example, often "turn on the question of causation – whether the disease or the doctor's negligence could be said to have caused the patient's death." *Id.* This suggests the importance of a structured and predictable dispute resolution process when radiologists are parties to the dispute.

tive dispute resolution and suggests binding arbitration for relieving liability concerns in the realm of international teleradiology.

A. Approach to Medical Malpractice Claims in Foreign Courts

The potential for a successful outcome in a tort case litigated in traditional foreign court is disheartening. The first hurdle in pursuing malpractice litigation in foreign courts is determining jurisdiction based on geography.[86] The use of cyberspace technology convolutes this assessment because the exact location of the tort is open to debate. Traditional notions of geographic borders and jurisdictional determinations collapse when the lawsuit's subject matter involves the boundless expanse of the internet.[87] Arguably, however, the radiologist's relevant misinterpretation will directly involve an Indian physician in an office in India, rather than in the ubiquitous realm of cyberspace. Since courts can then ascertain the location of the tort, determining geographical jurisdiction should not be a significant impediment.

Upon determining jurisdiction, a plaintiff-patient must sufficiently serve process on the putative defendant-physician in a foreign country.[88] As a matter of reciprocity, or comity, many foreign courts will cooperate and serve process on their own citizens.[89] In addition, a number of courts are legally bound to do so if their state is a signatory of the Hague Convention on the Service Abroad of Judicial and Extrajudical Documents in Civil or Commercial Matters.[90] On the other hand, problems will likely arise because a foreign court is presumably

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[86] "No law has any effect . . . beyond the limits of the sovereignty from which its authority is derived." Hilton v. Guyot, 159 U.S. 113, 163 (1895).

[87] McLean, *supra* note 9, at 473 (citation omitted).

[88] Volkswagernwerk Aktiengesellschaft v. Schlunk, 486 U.S. 694, 707 (1988) (holding that at a minimum, the U.S. Constitution's Due Process Clause guarantees foreign nationals notice via personal service or a substituted service that sufficiently provides reasonable notice of the pending action and an opportunity to object to the claims) (citation omitted).

[89] *See* GEORGIOS PETROCHILOS, PROCEDURAL LAW IN INTERNATIONAL ARBITRATION 7 (James J. Fawcett ed., Oxford Univ. Press 2004). Comity requires that states respect each other's decisions in the hopes that their conduct will be equally supported on a reciprocal basis. Comity may be regarded as an honor system, rather than a legal system in which the findings are enforceable at law.

[90] Hague Convention on the Service Abroad of Judicial and Extrajudical Documents in Civil or Commercial Matters, Nov. 15, 1965, 20 U.S.T. 361, 658 U.N.T.S. 163. Although using the assistance of the Hague Convention is a viable avenue when suing a teleradiology company within another country, it will not suffice for Indian providers because India is not a signatory state. *Id.*

reluctant to serve process on its own citizen-telemedical provider who generates a large amount of money and tax revenue.[91]

Finally, assuming that the plaintiff resolves the personal jurisdiction and service of process issues, she would still need to contend with bewildering cross-cultural discovery, litigate the dispute in an Indian court, and most importantly, convince an understandably biased foreign fact finder that she deserves a favorable judgment.[92] Above all, she would be faced with the daunting task of finally collecting damages from that foreign court.[93] Appeal is unlikely, and if the plaintiff loses in Indian court, then she will likely be estopped from bringing a similar suit in the United States.[94] Moreover, McLean suggests that the case will never even reach this point due to the exculpatory clauses in malpractice insurance contracts:[95]

> Imagine a hypothetical situation in which a remote foreign provider is named as defendant in a medical malpractice [suit]. Assuming that process is properly served, after obtaining the advice of local counsel in the provider's home country, the provider concludes that even if a U.S. court asserts jurisdiction, there is little likelihood that any judgment will be enforced. Accordingly, the remote foreign provider elects to ignore the summons, and refuses to cooperate further with the judicial proceedings. After a default judgment is entered, the plaintiff attempts to collect from the telemedicine provider's medical malpractice carrier. At this point the malpractice carrier would play the *exculpatory trump card.* Because the physician did not cooperate, the insurer is under no duty to perform under the insurance contract.[96]

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[91] McLean, *supra* note 9, at 475 (citation omitted).

[92] *See* RALPH G. STEINHARDT, INTERNATIONAL CIVIL LITIGATION: CASES AND MATERIALS ON THE RISE OF INTERMESTIC LAW 663 (2002) (stating that when in foreign courts, "U.S. litigants do not compete on a level playing field").

[93] A plaintiff will likely struggle when attempting to collect damages that arose from an Indian decision in India. Additionally, without a binding treaty, collecting foreign assets in another jurisdiction remains difficult at best. *See id.* at 613 (stating that courts generally have the freedom to uphold or disregard foreign judgments). In contrast, the enforcement of arbitration decisions is much less discretionary because both India and the United States are bound by international law to give arbitral awards more uniform and definite treatment. *Id.* at 695.

[94] A "transnational *res judicata* policy" among U.S. courts prevents an American judge from reviewing a case even if a foreign court decided its outcome on erroneous law or facts. *Id.* at 625.

[95] McLean, *supra* note 9, at 475.

[96] *Id.* at 476 (citations omitted) (emphasis added).

Lastly, if the plaintiff instead attempted to file a malpractice claim in an American court and pursue recognition and enforcement of an award in an Indian court to collect from an Indian provider, the result would be just as distressing.[97] The only hope is to pursue the claim in U.S. courts and attempt to collect whatever assets are available in the United States, which would remain difficult without a properly served defendant.

Alternatively, if a prospective American plaintiff remains optimistic and is determined to pursue her case in an Indian court, she should reconsider due to the amount of time that she would likely invest in the procedures.[98] India's judicial system is so deprived of financial and personnel resources that its delays are legitimately deemed "unconscionable."[99] Indeed, India's twenty-one High Courts have a backlog of 3.5 million cases and the number rises to 30 million backlogged cases among its lower courts.[100] In addition, Indian judges fall disastrously short of exercising their proper authority to sanction uncooperative parties.[101] Moreover, not only is there no substantive or procedural component within the system to encourage settlement,[102] but worse, Indian lawyers lack the knowledge and incentive to even consider an out of court settlement as an option for resolution.[103] Consequently, alternative forms of dispute resolution become increasingly

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[97] A combination of factors prevents the recognition and enforcement of awards in traditional foreign courts: the foreign court may interpret the American decision to be based on an illegitimate extraterritorial application of U.S. law; the court will refuse to enforce a controversial effort to obtain personal jurisdiction; the court will bar a U.S. judgment that is contrary to its own public law; the court will refrain from upholding a decision in which the defendant was not afforded fair proceedings; and the foreign court will refuse to enforce excessive damage awards (which is problematic for an American patient who is seeking punitive and compensatory damages related to malpractice). STEINHARDT, *supra* note 92, at 663-64.

[98] If the injury that originally required radiology services is severe, the patient-plaintiff does not have much time before she needs a substantial amount of money to cover the soaring medical expenses.

[99] R.D. Sharma, *Raising the Strength of Judges*, HINDU, Sept. 24, 2002, *available at* http://www.hinduonnet.com/thehindu/op/2002/09/24/stories/2002092400060200.htm. India designates less than 1% of its total revenue to the judiciary, compared to other countries such as the United States and Britain, which typically devote 12-15% of their revenue to their judicial systems. *Id.* As a result, it has the worst judge to citizen ratio among all major democracies in the entire world. *See id.*

[100] *Id.*

[101] Hiram E. Chodosh et al., *Indian Civil Justice System Reform: Limitation and Preservation of the Adversarial Process*, 30 N.Y.U. J. INT'L L. & POL. 1, 33 (1997-1998).

[102] *Id.* at 44.

[103] *Id.* at 48.

important in order to avoid being ensnared by an impotent judicial system.

Whether a patient confronts a barrier at the initial exculpatory clause defense or some other stage in the traditional process, there is little doubt that she will have an increasingly expensive uphill climb toward recovering from the harms caused by a foreign physician. Furthermore, assuming she successfully collected from the domestic healthcare provider, that American provider would find itself in the same role as the patient when it seeks indemnification or subrogation from the Indian teleradiology company or provider. Thus, the arduous process would simply start anew, but with a different plaintiff. Therefore, the benefits of an international teleradiology system demand consensus over an alternative form of dispute resolution that will divert the traditional Indian court system and ensure security for voluntary and involuntary creditors.

B. Arbitration as an Alternative to Traditional Medical Malpractice Litigation

There is little doubt that the current adjudicative system requires some adjustments. Legal and medical scholars continue their unceasing efforts toward reforming various components of medical malpractice litigation.[104] With the traditional adversarial system already under intense scrutiny in the United States, using a similarly ineffective system in the international realm will be an exercise in futility and potential resolutions will suffer the same demise, especially in India.

Federal efforts to restructure medical malpractice suits began making serious headway in the mid-1990s.[105] One of the earliest efforts was Congress's attempt to abandon individual physician liability under traditional negligence law.[106] The goal was to "replace it with a model of enterprise medical liability under which statutorily identified health care plan organizers would bear and channel the loss."[107] If a group comprised of a larger number of individuals is responsible for the loss, three advantages become readily apparent. First, a single physician or his insurance provider no longer has to absorb all of the damages since the patient's compensation will likely spread across

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[104] VASANTHAKUMAR N. BHAT, MEDICAL MALPRACTICE: A COMPREHENSIVE ANALYSIS, at xi (2001) (suggesting that physicians, lawyers, and consumers have been battling the malpractice crisis for well over one hundred years).

[105] *Id.* at 148.

[106] HEALY, *supra* note 85, at 239.

[107] *Id.* (citation omitted).

numerous sources or a single source with a larger pool of money.[108] Second, by requiring that only an institution can be liable rather than individual physicians, litigators may spend less time and money arguing exactly which individual is at fault, particularly when a plaintiff sues multiple defendants.[109] Third, by virtue of holding a single institution potentially liable in any given suit for the torts committed by numerous individuals, the institutions will respond by providing greater oversight. Also, physicians who are threatened by termination will likely put forth a greater effort to prevent injury either by implementing "defensive medicine" or by improving their skill and communication.[110] Although the bill passed, Congress was not able to muster enough votes to overrule President Clinton's veto.[111] Since then, efforts at medical malpractice reform remain at a near standstill.

Indicative of the growing need for alternative dispute resolution for malpractice claims, members of Congress recently made another push at reforming medical malpractice litigation by reducing jury involvement.[112] Critics assert that either of the bills would effectively deny plaintiffs guaranteed access to the courts, prevent having their cases heard by a jury, and impose unfair damage caps.[113] Proponents of the House resolution argue that the proposed tribunal system would be less threatening and surpass the requirements set forth in the Senate's bill because the tribunal arrangement likely "makes the medical liability system more reliable by prompt and fair resolution of claims; encourages early disclosure of health-care errors; enhances patient safety; and maintains access to liability insurance for health-care professions."[114] Opponents rebut that a tribunal system would strip plain-

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[108] *See* BHAT, *supra* note 104, at 21-22.

[109] *Id.* at 21.

[110] *See id.* at 22; HEALY, *supra* note 85, at 240 ("Where the institution is made responsible to assimilate losses, it is better placed to ensure that channels of communication between doctors, nurses, and paramedics are improved, that medical equipment is updated, and that management of hospital health care is competent and efficient.").

[111] BHAT, *supra* note 104, at 149.

[112] Fair and Reliable Medical Justice Act, S. 1337, 109th Cong. (2005) (seeking alternative to current malpractice litigation); Medical Liability Procedural Reform Act of 2005, H.R. 1546, 109th Cong. (2005) (offering grants to states that create specialty health tribunals for deciding malpractice claims).

[113] William F. Stute, *Congress Considers Bills Creating Health Courts*, LITIG. NEWS, July 2006, at 7; *see also* HEALY, *supra* note 85, at 241 (stating that England is also considering the benefits and detriments of arbitration in incidences of medical malpractice, as well as specially trained malpractice courts that provide more timely and financially efficient results).

[114] Stute, *supra* note 113, at 7.

tiffs of the very rights protected under the U.S. Constitution,[115] particularly the Seventh Amendment.[116] Importantly, the recent legislative action suggests that arbitration is an increasingly viable solution, even in domestic cases.[117]

Whether Congress passes and actually implements the abovementioned alternatives is not as important as the fact that professionals on all sides are experiencing the pitfalls of traditional medical malpractice litigation and are demanding change. The fact that Congress and healthcare professionals are even entertaining the thought of requiring special tribunals to decide medical malpractice cases is clear evidence to support the following model, which is centered around arbitration.[118] If professionals understand that some form of an arbitration system may work in the United States, it follows that it is a workable solution to teleradiology liability issues abroad; at least, better than pursuing claims under the precarious traditional court approach as discussed above.[119]

Binding arbitration is a likely substitute for traditional foreign malpractice claims because of the advantages that stem from its predictability. Under the current system, American litigators find it difficult to serve process on foreign defendants,[120] questions as to the appropriate forum remain open to considerable debate, and there is no

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[115] *Id.* "[T]he House Delegates of the ABA announced that it 'opposes the creation of health care tribunals that would deny patients injured by medical negligence the right to request a trial by jury or the right to receive full compensation for their injuries." *Id.* (citation omitted).

[116] "In Suits at common law, where the value in controversy shall exceed twenty dollars, the right of trial by jury shall be preserved, and no fact tried by a jury shall be otherwise re-examined in any Court of the United States, than according to the rules of the common law." U.S. CONST. amend. VII.

[117] Alternatively, some propose no-fault liability laws for medical malpractice cases. Such a rule would shift the risk and the patient's loss to society in general, thereby distributing the burdensome damage awards over a larger pool of contributors, potentially creating a more equitable and efficient alternative. HEALY, *supra* note 85, at 235. No-fault liability effectively shifts "the law's focus from proof of fault to proof of causation." *Id.* at 237. Reports from England have shown that "[a]dditional cost is usually offset by a saving [sic] in administrative costs through simplification of the compensation process and a lowering of compensation levels." *Id.*

[118] With a panel of experts, the "specialty health courts/tribunals" are akin to arbitration.

[119] Although this note focuses on agreements and disputes between American institutions or patients and Indian physicians, due to the current trend's progression and pressing need for patient protection, there is no reason why U.S. healthcare providers and other physicians around the world cannot establish a similar system within and among themselves.

[120] STEINHARDT, *supra* note 92, at 259.

escaping the contentious choice of law issues.[121] Moreover, even if a foreign court awarded judgment to a lucky American plaintiff, that individual would have tremendous difficulty realizing damages by attaching the judgment to a guaranteed source of payment.[122] Therefore, the parties would benefit from a system in which they understand and agree to procedural and substantive terms prior to entering into a service contract.

As illustrated below, arbitration offers numerous advantages that are unavailable in traditional litigation. At the outset, participating parties agree to the substantive and procedural rules of any dispute arising from the contract.[123] Also, since the entities to these international transactions tend to come from countries with different legal foundations, and without uniform laws applicable to the dispute, the parties' contract and the laws of arbitration provide an alternative to the ongoing conflicts over choice of law and jurisdiction.[124] In addition, the primary advantage to arbitration, compared to other alternative forms of dispute resolution, is its presumably binding force upon the parties.[125] Moreover, an independent tribunal helps ensure that the geographic location of the arbitration has little chance of biasing the arbitrators, the parties, the applicable laws, or the underlying rules.[126] This independence encourages consensus among the parties to the arbitration agreement and the commercial contract; otherwise without agreement, neither party is necessarily bound to the laws or precedent of the other's home jurisdiction. In addition, the subject matter of arbitration disputes can be kept confidential, thus giving parties the luxury of remaining anonymous and avoiding bad publicity or the tabulation of negative statistics, such as rates of misinterpretation.

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[121] *See id.* at 615.

[122] *See* Chodosh et al., *supra* note 101, at 5-8.

[123] "[A]rbitration means, 'the process whereby a third party determines a dispute between two or more parties in exercise of a jurisdictional mandate entrusted to him by the [disputing] parties.'" PETROCHILOS, *supra* note 89, at 3 (citation omitted).

[124] *Id.* at 12-13.

[125] *Id.* at 3 (stating that this obligatory nature distinguishes arbitration from other forms of dispute settlement, such as "expert valuation, mediation, conciliation, 'mini-trial', and so forth").

[126] *Id.* at 4.

III. A MODEL ARBITRATION SYSTEM FOR OUTSOURCING TELERADIOLOGY SERVICES TO INDIA

In order to better envision the practicability of an international arbitration system for teleradiology malpractice, the following model provides an illustrative example.[127] This section discusses the two primary concerns of an arbitration agreement in an international teleradiology contract; the substantive provisions and the mechanisms for enforcing judgment. Subsection A begins with a discussion of the pertinent provisions in a model agreement under the umbrella of contract law. Subsection B details the relevant steps for achieving a fair arbitral judgment. Lastly, Subsection C elaborates on collecting the awarded damages. Because an American patient is likely to receive damages against an American hospital that deferred to an overseas teleradiology service,[128] this illustration involves an institution's attempt to collect from the original tortfeasor; that is, the American hospital's effort to sue the Indian teleradiology provider or physician.

A. Making the Contract and Settling on Its Provisions

Due to the private and commercial nature of teleradiology, *commercial* arbitration should be the foundation for dispute resolution of international medical malpractice issues. The commercial component is clear. Teleradiology involves contracts in which parties exchange money for the sale of services that in turn generate revenue. For example, American hospitals will purchase MRI interpretations from Indian physicians. Supply, demand, and other market forces determine the price of these services. If one provider fails to offer competitive services at comparable rates, the American purchaser is likely to seek alternative providers. Additional commercial aspects of the transaction include insurance provisions, financial accounting, transmission of services, and receipt of payment. Even if the patient's health is the basis of the exchange, healthcare is arguably a for-profit industry, and as such, healthcare providers cannot ignore its multiple commercial features.[129]

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[127] This model is for discussion purposes. Thus, interested parties should more deeply explore all options, laws, and potential scenarios before entering into their own unique contractual obligations.

[128] McLean & Richards, *supra* note 47, at 1378 (suggesting the burden for paying malpractice insurance premiums will shift from the American radiologists to the hospitals); *see, e.g.*, Stein, *supra* note 1 (reporting that the Pennsylvania patient is suing the hospital for harm allegedly caused by a radiologist in India).

[129] For example:

Before the start of their business venture, the American hospital and Indian teleradiology provider will have entered into a contract that includes an arbitration clause establishing binding arbitration as the primary form of dispute resolution.[130] This contract is critical because it contains the arbitration provisions, which include the forum, the list of scenarios triggering the provisions, and the procedural and substantive terms governing any arbitration proceeding.[131] Also, in order to reduce costs and increase efficiency, the parties may include specific disputes to be decided on an expedited basis, known as "fast-track" arbitration.[132] Since many fast-track proceedings are resolved in as little as sixty days, a larger number of contracting parties are considering fast track provisions in the hope of reaching even quicker resolutions.[133]

The most difficult decision will likely be agreeing to mutually beneficial procedural and substantive rules. Compromise is important not only to encourage cooperation between the parties, but also to

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> The term 'commercial' should be given a wide interpretation so as to cover matters arising from all relationships of a commercial nature, whether contractual or not. Relationships of a commercial nature include, but are not limited to, the following transactions: any trade transaction for the supply or exchange of goods or services; distribution agreement; commercial representation or agency; factoring; leasing; construction of works; consulting; engineering; licensing; investment; financing; banking; insurance; exploitation agreement or concession; joint venture and other forms of industrial or business co-operation; carriage of goods or passengers by air, sea, rail or road.

U.N. Comm'n on Int'l Trade Law [UNCITRAL], *UNCITRAL Model Law on International Commercial Arbitration*, ch. I, art. 1(1), n.**, U.N. Doc. A/40/17, annex 1 (June 21, 1985) [hereinafter UNCITRAL].

[130] A written contract is important because under Indian arbitration law, enforcement requires that "[t]here must be an intention of the parties to have the differences referred and decided quasi-judicially." Roland Amoussou-Guenou et al., *International Fast-Track Commercial Arbitration*, *in* DISPUTE RESOLUTION METHODS: THE COMPARATIVE LAW YEARBOOK OF INTERNATIONAL BUSINESS 357, 393 (Dennis Campbell & Susan Cotter eds., 1995).

[131] In an effort to avoid some litigation from the start, the parties should include a clear indemnification provision within the contract stating that the Indian teleradiology provider promises to indemnify the American hospital.

[132] This model assumes that the parties "will be highly sophisticated international actors, having the requisite resources to support the accelerated resolution of fast-track disputes." Amoussou-Guenou et al., *supra* note 130, at 358. Such a fast-track procedure is quite possible if the institutional parties initially agree to a respected arbitration institution that places medical experts on the tribunal.

[133] *Id.* at 387 (citation omitted). Because the courts may be involved to some extent in an arbitrated dispute, the main advantage to fast-track arbitration is that the parties pursue it under an already established arbitration institution and thus avoid the court's intervention altogether. *Id.* at 393.

facilitate the collection of arbitral awards. Fortunately, Indian arbitration law encourages bargaining amongst parties as it contains provisions that actually "guarantee the freedom of the parties to select their own procedures" and substantive law.[134]

The American party to the arbitration should understand that successfully enforcing the judgment is much more likely when the parties resolve the dispute utilizing a system with which the defendant is comfortable; typically its own legal system.[135] For example, the Indian physician will be hard-pressed to escape an unfavorable ruling if the arbitration occurred in his own country and applied a significant portion of his own country's laws to the proceedings.[136] Although Indian arbitration law may aid in settling disputes and enforcing tribunal decisions, one of two prerequisites must be met in order for it to apply: "(1) When the arbitration is conducted in India; [or] (2) When the arbitration is conducted outside India applying the Indian arbitration law."[137] Since the collection of damages is likely to be most successful when there is some connection to Indian law, the parties should negotiate and agree that arbitration proceedings will either occur in India applying American arbitration law, or in a different location, applying Indian arbitration law. It follows that to maximize potential for full collection of damages, the parties should agree on an unbiased arbitration forum with neutral rules, but the location of the arbitration should be in India.[138]

American plaintiffs should not be skeptical of Indian law as it actually encourages fair and proficient arbitral resolutions. In fact, both Indian and American arbitration laws and institutions utilize a similarly flexible structure to resolve disputes effectively and efficiently.[139] Arbitration in India, notably international commercial arbitration, is governed by the Arbitration and Conciliation Act of

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[134] *Id.* at 394. Although the choice is discretionary, India's Arbitration Act provides the default rules if the parties do not agree otherwise. *Id.*

[135] *See* John B. Tieder, Jr., *Selecting an Arbitral Institution to Administer International Arbitration: Are National or Regional Centers a Viable Option?*, *in* HANDBOOK ON INTERNATIONAL ARBITRATION AND ADR 95, 100 (Thomas E. Charbonneau et al. eds., 2006) (suggesting the host-state's law affects the arbitration's outcome).

[136] Presumably, a final judgment is more easily realized when the plaintiff travels to the defendant, rather than trusting that the defendant will come to the plaintiff's jurisdiction for resolution.

[137] Amoussou-Guenou et al., *supra* note 130, at 393.

[138] If the American party grants the other party a location in India, then the American party may be able to bargain for more favorable substantive rules.

[139] Indian arbitration law "strives for early conclusion of the arbitration and, at the same time, ensures freedom of the parties to select their own procedures and applicable laws." Amoussou-Guenou et al., *supra* note 130, at 393.

1996.[140] Any deference by the parties to Indian law should not significantly strain justice for two reasons. First, Indian lawmakers specifically passed the Arbitration Act to incorporate UNCITRAL (United Nations Commission on International Trade Law) provisions in order to expedite arbitrations, and presumably to facilitate commerce among other countries.[141] In an effort to eliminate prejudicial judgments, the United Nations sponsored an international panel to draft UNCITRAL for the purpose of serving as model rules in international commercial disputes and judgment enforcement.[142] Second, UNCITRAL, and therefore Indian law, not only guarantees the enforcement of arbitration awards around the world, but it is founded on the same international treaty that binds both India and the United States,[143] namely the United Nations Convention on Recognition and Enforcement of Foreign Arbitral Awards of 1958.[144] Also known as the New York Convention, this mutually agreed upon treaty overrides India's own arbitration laws.[145] Its superseding effect should reassure American hospitals, since essentially the same law in both the United States and India governs the award, and courts in both countries recognize and enforce the resulting arbitration decision.[146]

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[140] *See generally* The Arbitration and Conciliation Act, No. 26 of 1996 (India) [hereinafter Arbitration Act], *available at* http://legalservices.maharashtra.gov.in/download.htm. This law supercedes India's 1940 Arbitration Act. *See* Amoussou-Guenou et al., *supra* note 130, at 392 (discussing the 1940 Arbitration Act that regulated arbitration in India).

[141] Arbitration Act, pmbl.

[142] PIETER SANDERS, THE WORK OF UNCITRAL ON ARBITRATION AND CONCILIATION 1-2 (2001). Although the United States has not yet adopted the UNCITRAL model rules like India, individual states have done so, such as California, Texas, Oregon, and Connecticut. *Id.* at 127. This suggests an increasingly uniform international law, such that a California hospital and an Indian physician under an arbitration agreement are bound to the same UNCITRAL default rules despite their countries of origin.

[143] David P. Stewart, *National Enforcement of Arbitral Awards under Treaties and Conventions*, *in* INTERNATIONAL ARBITRATION IN THE 21ST CENTURY: TOWARDS "JUDICIALIZATION" AND UNIFORMITY? 163, 164-65 (Richard B. Lillich & Charles N. Brower eds., 1994).

[144] Convention on the Recognition and Enforcement of Foreign Arbitral Awards, *opened for signature* June 10, 1958, 21 U.S.T. 2517, 330 U.N.T.S. 38 [hereinafter New York Convention].

[145] Amoussou-Guenou et al., *supra* note 130, at 392.

[146] Assuming teleradiology is a "commercial act" under the ICC, neither the United States nor India made any relevant reservations or declarations that might render the treaty inapplicable to the proposed arbitration provisions. *See* H. SMIT & V. PECHOTA, SMIT'S GUIDES TO INTERNATIONAL ARBITRATION: INTERNATIONAL ARBITRATION TREATIES 61, 69 (1998).

Although American and Indian law both support arbitration, a neutral forum is important to avoid unnecessary bias. When selecting a forum, the parties should be aware of potential favoritism.[147] India may have well-established arbitration organizations, [148] but its laws also offer wide latitude for selecting other arbitrators.[149] In order to avoid default rules that may favor either party, the parties should focus on neutrality and adopt the recommended rules and forums from the International Chamber of Commerce Rules (ICC).[150] Not only does the ICC use UNCITRAL rules to ensure both certainty and flexibility, but it also promotes customization by leaving provisions open either for the parties to negotiate around or for the arbitrators to have more procedural latitude.[151]

The ICC's rules on the selection of the arbitrators can ensure impartiality and promote expert decision-making.[152] Within the arbitration clause of the contract, the parties may agree to either specific individuals who will comprise the tribunal, or their own specific system for appointing arbitrators at the time of arbitration.[153] In either case, each party should appoint the same number of arbitrators to

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[147] *See* Tieder, *supra* note 135, at 97.

[148] A number of arbitration institutions are currently established in India: the Bengal Chamber of Commerce and Industry, the Federation of Indian Chamber of Commerce and Industry, the Indian Council of Arbitration, and the Madras Chamber of Commerce and Industry. AM. ARBITRATION ASS'N, THE INTERNATIONAL ARBITRATION KIT: A COMPILATION OF BASIC AND FREQUENTLY REQUESTED DOCUMENTS 391 (Laura Ferris Brown ed., rev. 4th ed. 1993).

[149] *See* Arbitration Act, ch. III, § 11; *see also* Amoussou-Guenou et al., *supra* note 130, at 394-95 (explaining that parties can choose the form of arbitration they wish to pursue).

[150] *See generally* International Chamber of Commerce, http://www.iccwbo.org/court/ (last visited Sept. 22, 2007); Amoussou-Guenou et al., *supra* note 130, at 395 (stating that Indian law supports the inherent flexibility of arbitration allowing parties to adopt the ICC Rules or the Indian Council of Arbitration Rules to avoid default terms). Recall that "[t]he term 'commercial' should be given a wide interpretation so as to cover matters arising from all relationships of a commercial nature, whether contractual or not." UNCITRAL, *supra* note 129.

[151] Howard M. Holtzmann, *Balancing the Need for Certainty and Flexibility in International Arbitration Procedures, in* INTERNATIONAL ARBITRATION IN THE 21ST CENTURY: TOWARDS "JUDICIALIZATION" AND UNIFORMITY? 3, 7-8 (Richard B. Lillich & Charles N. Brower eds., 1994).

[152] *See* Frank W. Swacker, Kenneth R. Redden & Larry Wenger, *WTO & ADR, in* HANDBOOK ON INTERNATIONAL ARBITRATION AND ADR 299, 302 (Thomas E. Charbonneau et al. eds., 2006).

[153] *See* Michael F. Hoellering, *International Arbitration Agreements: A Look Behind the Scenes, in* HANDBOOK ON INTERNATIONAL ARBITRATION AND ADR 53, 57 (Thomas E. Charbonneau et al. eds., 2006) (highlighting general principles of international arbitration law).

promote fairness.[154] After the parties each select the same number of arbitrators, the chosen arbitrators will then agree on an umpire whose opinion will function as the deciding vote in the event of a tie among the parties' chosen arbitrators.[155] An additional advantage to an ICC forum is that it permits the parties to either select a tribunal that is partially or completely comprised of radiology or malpractice experts;[156] or if needed, the tribunal may appoint its own experts.[157] Most importantly, even if one party refuses to cooperate in the proceedings or fails to select an arbitrator, the ICC requires that the arbitration continue through disposition.[158] Thus, the selection of a well-established arbitration institution is crucial because the structured system will facilitate a fast-track process more so than an *ad hoc* tribunal, which would require more coordination, training, ambiguous provisions, and most of all, more time.[159]

After settling on the arbitration forum and accompanying procedural rules, the parties should agree to other substantive terms. Pertinent provisions requiring contractual elaboration may include: restrictions on admitting collateral sources of payment or insurance; damage caps; inclusion of attorneys' fees in damage awards; payment plans for damages; the confidentiality of proceedings and patient informa-

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[154] *See* Amoussou-Guenou et al., *supra* note 130, at 395 (stating that the default rule for a multiple arbitrator panel requires each party to choose the same number of arbitrators).

[155] *See* Arbitration Act, ch. III, §§ 10-11.

[156] However, despite the ostensible reasonableness of having experts act as arbitrators in matters associated with highly technical fields of science and medicine, one must remember that the average person often sits on the jury to hear most medical malpractice cases in traditional courts because medical experts tend to be biased and to unfairly favor the clinicians. *See* Maxwell J. Mehlman, *Promoting Fairness in the Medical Malpractice System, in* MEDICAL MALPRACTICE AND THE U.S. HEALTH CARE SYSTEM 137, 145 (William M. Sage & Rogan Kersh eds., 2006). On the other hand, the "repeat player" roles within the teleradiology procedures may require an exception to the general rule of avoiding experts acting as judges. For example, a tribunal comprised of experts reduces transaction costs if expert witnesses do not need to be called to testify.

[157] *See* Int'l Chamber of Commerce, Rules of Arbitration art. 20(4) (1998), *available at* http://www.iccwbo.org/court/arbitration/id4424/index.html ("The Arbitral Tribunal, after having consulted the parties, may appoint one or more experts, define their terms of reference and receive their reports. At the request of a party, the parties shall be given the opportunity to question at a hearing any such expert appointed by the Tribunal.").

[158] *Id.* art. 6(3). This becomes extremely important because if the tribunal rules against the uncooperative party, notwithstanding his presence or defense during the arbitration, the prevailing party may still collect damages from the losing party's assets.

[159] *See* Amoussou-Guenou et al., *supra* note 130, at 358.

tion; a statute of limitations; and a specified standard of care by which to measure negligence. A cap on damages could be based on the average American jury award for a negligent act that resulted in harm that is similar to the malpractice incident at issue before the tribunal.[160] Additionally, the parties may agree to a broad standard of care; such as, finding a provider negligent when he fails to interpret the radiology scans as a radiologist acting reasonably under similar circumstances.[161] Moreover, the contract could be narrowed to demand that a radiologist is *per se* negligent if he does not have the equivalent qualifications of a physician accredited under the guidelines established by the American College of Radiology.[162] When agreed upon in the contract, this "new" standard supersedes any precedent formerly established in any jurisdiction in the United States or India.[163] The parties may also elaborate on the agreed upon standards by including notes or case examples to illustrate the standards and principals for the arbitrators. Therefore, the parties can, theoretically, contract around any substantive or procedural terms, or even out of liability altogether, and still be bound under general international contract law and the ICC.

Assuming the American hospital and Indian teleradiology provider entered into a contract with an arbitration agreement, the following sections discuss the procedure for arbitrating negligence and enforcing the resulting judgment.

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[160] *See* Neil Vidmar, MEDICAL MALPRACTICE AND THE AMERICAN JURY: CONFRONTING THE MYTHS ABOUT JURY INCOMPETENCE, DEEP POCKETS, AND OUTRAGEOUS DAMAGE AWARDS 234 (1997) (noting a study in which lay-person jury awards were reasonable and actually quite comparable to the same findings of legal professionals).

[161] *C.f.* TOM BAKER, THE MEDICAL MALPRACTICE Myth 114 (2005) (noting that tort law holds liable doctors who fail to provide a standard of care commensurate with that of another doctor acting reasonably under similar circumstances).

[162] *See, e.g.*, American College of Radiology, Accreditation Programs, http://www.acr.org/accreditation/radiation/requirement.aspx (last visited Oct. 26, 2007) (listing the necessary requirements for an institution's radiologists if it were to become accredited under the ACR, e.g. physicians must complete a certain number of scans and continuing education credit per year). Because the ACR is an American institution, it is not necessarily neutral. Thus, the parties should simply extrapolate from the ACR's guidelines to ensure a fair and effective standard, but contract in their own provisions.

[163] *See* Jennifer Arlen, *Private Contractual Alternatives to Malpractice Liability, in* MEDICAL MALPRACTICE AND THE U.S. HEALTH CARE SYSTEM 245, 246-50 (William M. Sage & Rogan Kersh eds., 2006) (discussing contracting over liability and arguing that patients should not be allowed to contract over liability due to their unfair bargaining position and substantial risk of harm, but inferring institutions *may* be able to do so amongst each other because they are the more informed, sophisticated parties, and the benefits may outweigh the costs).

B. The Arbitration Hearing

Prepared with previously agreed upon procedures, adequate research, and applicable substantive laws, the parties should be primed to present their case to the arbitration panel.[164] Under the ICC, the arbitrators may consult any necessary reference to make an informed decision, including witness testimony, expert testimony, reports, and other documents that the parties may submit.[165] Because witness and expert testimony may be discretionary, it is important that the parties take full advantage of the flexible nature of the arbitration laws to contract around the more limited scope of default rules and ensure adequate discovery and fair evidence rules.[166] Notably, the ICC is more than willing to give parties access to qualified experts who will assist them in resolving the dispute.[167]

After considering all presented evidence, the arbitrators will follow the agreed upon rules and "natural justice" to make a final decision.[168] The holding may be as simple as a finding of fault. On the other hand, the final decision does not necessarily have to be limited to a determination of the defendant's liability. If the parties agreed in the contract, the tribunal may consider degrees of fault and contributory negligence in its deliberation and holding. In fact, as a default rule, Indian arbitration law allows arbitrators' decisions to take any form that justice may require.[169]

A tribunal's decision is considerably more final than a trial court's judgment. As long as the parties agreed in the contract, the tribunal's final decision is legally binding.[170] Nonetheless, the ICC has a review

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[164] Note the potential for speed and convenience if the parties are prepared for resolution before malpractice even occurs; the procedures, substantive laws, location, and forum have already been established and agreed upon via contract. A prompt resolution reduces costs for either party.

[165] *See* Int'l Chamber of Commerce, Rules of Arbitration art. 20 (1998), *available at* http://www.iccwbo.org/court/arbitration/id4424/index.html.

[166] "Discovery, as used in the United States legal system, is not used in arbitration proceedings under the Arbitration Act. However, limited discovery is available in India. The arbitrator is empowered to administer such interrogatories to the parties as may in his opinion be necessary." Amoussou-Guenou et al., *supra* note 130, at 396 (citation omitted).

[167] Int'l Chamber of Commerce, Expertise: Dispute Resolution Services, http://www.iccwbo.org/court/expertise/id4595/index.html (last visited Sept. 1, 2007) ("Areas of expertise available through the centre (*sic*) are as diverse as business itself. . . . The possibilities are endless.").

[168] Amoussou-Guenou et al., *supra* note 130, at 396.

[169] *Id.* at 399.

[170] Arbitration Act, ch. VIII, § 35.

process in which the tribunal submits its decision to the International Court of Arbitration of the ICC for substantive comments or consideration for a rehearing.[171] Parties are cautioned that a successful appeal to Indian courts is unlikely because they strongly favor arbitration awards.[172] Indeed, Indian law states that "*no suit shall lie on any ground whatsoever* for a decision on the evidence, effect or validity of an arbitration agreement or award, nor shall any arbitration agreement or award be set aside, amended, or modified or in any way affected otherwise than as provided in this Act."[173]

C. Enforcing the Decision and Achieving Collection

Collection from the losing party as a result of a foreign arbitral award should be significantly easier than if an Indian or American court made the ruling. Because India is a member of the New York Convention, its courts will enforce foreign arbitral awards.[174] An Indian court may set aside the arbitration award only if the appealing party can prove to the court that:

> (i) A party was under some incapacity; or
> (ii)The arbitration agreement is not valid under the law to which the parties have subjected it or, failing any indication thereon, under the law for the time being in force; or
> (iii) The party making the application was not given proper notice of the appointment of an arbitrator or of the arbitral proceedings or was otherwise unable to present his case; or
> (iv) The arbitral award deals with a dispute not contemplated by or not falling within the terms of the submission to arbitration, or it contains decisions on matters beyond the scope of the submission to arbitration: Provided that, if the decisions on matters submitted to arbitration can be separated

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[171] *See* Int'l Chamber of Commerce, Rules of Arbitration art. 27 (1998), *available at* http://www.iccwbo.org/court/arbitration/id4424/index.html. In contrast, the parties' agreement may permit appeals.

[172] Amoussou-Guenou et al., *supra* note 130, at 399. Importantly, Indian "courts do not investigate into the merits of the case, nor examine the documentary and the oral evidence for the purpose of finding out whether or not the arbitrator had committed an error of law." *Id.*

[173] *Id.* at 399-400 (quoting Arbitration Act, § 32) (emphasis added); *see* Arbitration Act, ch. VII, § 34 (listing the narrow requirements allowing an arbitration decision to be reviewed by an Indian court).

[174] *See* Amoussou-Guenou et al., *supra* note 130, at 400 ("A foreign award is enforceable in India to the same extent as if it were made on a matter referred to arbitration in India.").

> from those not so submitted, only that part of the arbitral award which contains decisions on matters not submitted to arbitration may be set aside; or
> (v) The composition of the arbitral tribunal or the arbitral procedure was not in accordance with the agreement of the parties, unless such agreement was in conflict with a provision of this Part from which the parties cannot derogate, or, failing such agreement, was not in accordance with this Part.[175]

Additionally, Indian law, as well as Article V of the New York Convention, permits a court to vacate an arbitration ruling if "[t]he subject matter of the dispute is not capable of settlement by arbitration under the law for the time being in force, or the arbitral award is in conflict with the public policy of India."[176]

Although one may assume a loophole in the above provisions could be quite readily available to extend appeals indefinitely, one must remember that "the courts in India have considered institutional arbitration quite favorably."[177] Moreover, as stated earlier, a mistake in law or fact is not sufficient for a party to successfully argue that an award should not be enforced.[178] In fact, the Supreme Court of India has set forth strict conditions to assure courts do not interfere with arbitration proceedings.[179] Thus, arbitration remains a stable method to resolve disputes between Indian and American enterprises.

Indeed, the primary goal of the New York Convention was to legitimize arbitral decisions and facilitate the collection of their awards across nations.[180] It requires that "each Contracting State shall recognize arbitral awards as binding and enforce them in accordance with the rules of procedure of the territory where the award is relied

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[175] Arbitration Act, ch. VII, § 34(2). Note that these provisions are almost verbatim to Article V of the New York Convention, suggesting India's support for and compliance with international law and the parties' arbitration agreement. *See* New York Convention, *supra* note 144, art. V.

[176] Arbitration Act, ch. VII, § 34(2)(b); *see also* New York Convention, *supra* note 144, art. V(2).

[177] Amoussou-Guenou et al., *supra* note 130, at 398.

[178] *Id.* at 401.

[179] Chodosh et al., *supra* note 101, at 45 n.138 (referring to the Indian Supreme Court decision in *General Electric Co. v. Renausagar Power Co.*, Civil Appeal Nos. 71 & 71A of 1990 and No. 379 of 1992 Sup. Ct. of India, Oct. 7, 1992, which held "that the grounds for refusing enforcement of arbitral awards should be interpreted more narrowly" so as to promote the enforcement of the arbitral awards).

[180] GARY BORN, INTERNATIONAL COMMERCIAL ARBITRATION: COMMENTARY AND MATERIALS (2d ed. 2001), *reprinted in* INTERNATIONAL LAW 375 (Barry E. Carter et al. eds., 4th ed. 2003).

upon."[181] Thus, courts within both India and the United States must defer to the arbitration's final holding, unless an exception falls under Article V of the New York Convention.[182] Since these exceptions are unlikely in the realm of medical malpractice and private disputes, an appeal is likely futile.[183] Moreover, even if a party appeals the arbitration's decision to the courts, the losing party will likely have to provide money amounting to the tribunal's award as security in case the court agrees with the arbitration decision and affirms the finding of liability.[184]

If the prevailing party has trouble collecting on an award, it can enforce the judgment locally or in another country that has ratified the New York Convention. The states that are named parties to this convention, including the United States and India, agree to enforce an arbitration's final decision by attaching the damage awards to any source of funds in another member's territory.[185] The plaintiff-hospital should first attempt to enforce the judgment in the country that hosted the arbitration by initially "confirming" the award to make the judgment official.[186] Enforcement "will involve commencing legal proceedings, under local law, in which the award provides the basis for coercively appropriating money or imposing other conse-

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[181] New York Convention, *supra* note 144, art. III.

[182] BORN, *supra* note 180, at 375. "Article III of the [New York] Convention requires signatory states to recognize arbitral awards made in other countries, subject to procedural requirements no more onerous than those for domestic awards." *Id.*

[183] *See generally* Mitsubishi Motors Corp. v. Soler Chrysler-Plymouth, Inc., 473 U.S. 614 (1985) (holding that despite antitrust subject matter that is traditionally associated with public law and public policy considerations, the Court will deny protection from federal courts and defer the Puerto Rican corporation's antitrust counterclaim against a Japanese corporation to the Japan Commercial Arbitration Association as the parties originally agreed). Thus, if U.S. courts are likely to refuse cases that arguably fall under the public policy exception of the New York Convention's Article V, courts will be hard-pressed to adopt a public policy exception for medical malpractice cases.

[184] *See* New York Convention, *supra* note 144, art. VI (stating that the court may require the losing party to provide suitable security if the party "claiming enforcement of the award" applies for such a demand).

[185] "This Convention shall apply to the recognition and enforcement of arbitral awards made in the territory of a State other than the State where the recognition and enforcement of such awards are sought, and arising out of differences between persons, whether physical or legal. It shall also apply to arbitral awards not considered as domestic awards in the State where their recognition and enforcement are sought." *Id.* art. I(1).

[186] *See* BORN, *supra* note 180, at 374 ("[T]he prevailing party in the arbitration may commence proceedings in the national courts of the arbitral situs to 'confirm' the award.").

quences on the 'award-debtor.'"[187] If the local court fails to enforce the judgment, the prevailing party is not at a loss. Instead, "the award can be taken to another state for enforcement."[188] Thereafter, the New York Convention relies on its signatory states to assist in enforcement.[189] Such a system practically guarantees damage collection.

Thus, parties are secure knowing that upon a finding of liability, American, Indian, and international law will protect and guarantee proper payment to the prevailing party. Compared to traditional court adjudication, international arbitration proves to be the only predictable form of decision-making and enforcement. Note that the American hospital and the Indian physician or teleradiology provider introduce and agree upon a substantial portion of the abovementioned provisions prior to any dispute. Accordingly, it is imperative that the parties remain open to negotiation and compromise at the time of contract formation. Therefore, from the start the parties should imagine potential disputes, hypothesize advantageous provisions, choose appropriate timelines, and select beneficial rules.[190] Although agreeing on an arbitration arrangement is a labor intensive endeavor at the beginning of the business relationship, the parties will save time and money when a dispute eventually requires resolution.

IV. ANALYZING THE ARBITRATION MODEL

Some contend that the current healthcare system is adequate and there is no need for change. Others argue we should encourage international teleradiology as a means of improving access to care and reducing costs, but that traditional courts are sufficient to adjudicate medical malpractice disputes.[191] In contrast, neither approach guarantees the fairness that should be inherent in any healthcare system or

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[187] *Id.* "An award which is subject to the New York . . . Convention does not generally need to be confirmed in the arbitral situs before it may be confirmed and enforced in other forums." *Id.*

[188] *Id.*

[189] For example, the prevailing party simply needs to investigate and learn of the losing party's bank accounts in a member state (which can be the United States, Switzerland, or any other of the 130 signatory countries); prove that the losing party is within a state that has ratified the New York Convention; obtain and provide a copy of the arbitration order; and finally, present evidence that the bank account does indeed trace back to the losing party. Upon fulfilling the abovementioned conditions, the plaintiff is finally made whole.

[190] *See* Amoussou-Guenou et al., *supra* note 130, at 404 (suggesting that "careful drafting" is necessary to avoid difficulties throughout the arbitration process).

[191] VIDMAR, *supra* note 160 (stating that empirical evidence suggests trials and jury awards are actually quite reasonable, even in medical malpractice cases).

judicial setting.[192] People deserve a system that is fair to patients, hospitals, physicians, employers, and all related institutions.[193] Most importantly, when an international tort is involved, fairness cannot be achieved in traditional trial courts because the final judgment may only be collected from a foreign entity only after substantial hardship, if at all.[194] Only international arbitration can assure the substantive and procedural fairness for which law and healthcare strive.[195]

Initially, litigators will likely be frustrated at the lack of precedent in the new arbitration system. However, they should be encouraged knowing India has embraced arbitration as a legitimate means for resolving disputes and is prepared to enforce arbitral awards.[196] In addition, this uneasiness will dissipate as more parties use arbitration to resolve their malpractice disputes. Contracting parties will structure their substantive and procedural provisions around the developing tenets accepted as the primary principles underlying arbitration precedent.[197]

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[192] *See* Mehlman, *supra* note 156, at 137.

[193] Even if the jury and judicial system are fair, the lack of access to quality radiologists is unfair, a low standard of care is unfair, high costs for medical care are unfair, languishing in an international medical malpractice trial is unfair, increased expenses due to physician error is unfair, unpredictable outcomes are unfair, and not being able to collect on a final judgment is truly unfair.

[194] U.S. Dep't of State, Enforcement of Judgments, http://travel.state.gov/law/info/judicial/judicial_691.html (last visited Aug. 31, 2007) (reporting that the lack of bilateral treaties between the United States and other countries makes the enforcement of extraterritorial judgments incredibly difficult, but suggesting that arbitration is a potential solution to this collection obstacle).

[195] Arbitration under the ICC will allow parties to negotiate around all of the elements that make a system fair. For example, the parties may bargain for reasonable practice guidelines as measures of liability or standards of care; a tribunal comprised of medical experts; a fair compensation amount that is proportional to the prospective injuries; and a fair compensation that is adequate and based on average jury awards for similar damages rather than capped. *See* Mehlman, *supra* note 156, at 145, 152. Since both the Indian providers and American institutions are sophisticated parties throughout the negotiation process, unfair bargaining power should not be as problematic as when one party is an unsophisticated patient. *See id.* at 146.

[196] *See generally* Arbitration Act, its UNCITRAL foundation, and the New York Convention.

[197] If not confidential, arbitration outcomes may become so prevalent that certain principles are used as "authoritative evidence," similar to precedent. STEINHARDT, *supra* note 92, at 14 (explaining that the principles underlying arbital awards may provide authoritative evidence about the law). This basis of *lex arbitri* can be divided into three categories: "the law determining jurisdiction; the law of the merits; and the law applicable to procedure." PETROCHILOS, *supra* note 89, at 8 (citation omitted). The UNCITRAL model rules for arbitration proceedings is a perfect example of this growing *lex arbitri*.

Until international arbitration becomes more widely utilized, parties will have to rely on their own set of stopgap provisions to fill the inevitable void resulting from inexperience and new subject matter. Initially, a new system supplemented by contract law creates bright-line rules that determine the scope of deliberation; that delineate the pertinent substantive and procedural laws; that set forth a framework for establishing a *prima facie* case of medical liability; and that create predictable outcomes. On the other hand, such a foolproof system inscribed in black letter law will likely remain a litigator's fanciful dream. The law is rarely established in so clear and simple a form, especially after precedent accrues. Instead, determining fault and liability entails a complex array of rules, customs, depositions, expert opinions, and scientific rhetoric. Therefore, even arbitration will depend upon the nuances of skilled litigation.

However, the model for international arbitration under the ICC provides many benefits. Most notably, its contractual foundation ensures fairness for both sides. Both parties are well-informed and in a position to bargain as sophisticated entities, specifically the Indian radiology provider and the American healthcare institution. Also, both sides are aware of the applicable arbitration laws and can negotiate all substantive and procedural contractual provisions to ensure timeliness, cost, expert testimony, admissible evidence, and damage collection.

Second, medical malpractice arbitration would be incredibly predictable compared to a traditional court resolution. For example, if an Indian radiologist is accused of negligence, then the parties know the exact forum in which to litigate, as opposed to shopping for a favorable jurisdiction. In addition, the parties have already agreed upon the procedural rules and standards by which the tribunal shall determine fault, and are thus immediately aware of the pending dispute's scope. Furthermore, if an arbitration judge determines that an Indian radiologist is at fault, the plaintiff knows exactly how to collect damages. This "closed system" distinction is exactly what gives arbitration an advantage over traditional legal remedies.[198]

Third, arbitration proceedings have the potential for complete confidentiality.[199] Although this obstructs efforts to set precedent,

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[198] PETROCHILOS, *supra* note 89, at 9. "[Arbitration laws] unilaterally define their international scope of application," and will only venture outside the boundaries in exceptional circumstances. *Id.*

[199] Int'l Chamber of Commerce, Guide to ICC ADR, art. 7 (2001), http://www.iccwbo.org/court/adr/id4306/index.html (affirming that "[c]onfidentiality is an important, if not essential, aspect of ICC ADR proceedings and permits the parties to participate therein with complete confidence").

rates of malpractice and the award amounts may remain undisclosed for the benefit of the physicians and healthcare institutions.

Fourth, Indian and U.S. arbitration law will enforce the binding nature of the tribunal's decision as the parties intended.[200] Thus, the arbitral decision arguably holds more legal weight than even a trial court's decision, which depends more on unreliable international comity and reciprocity,[201] notwithstanding a trial's inefficient appeals process.

Fifth, a particular advantage to the arbitration procedure is its efficiency in terms of time. Typically, arbitrations in India do not last longer than 120 days.[202] However, the parties may extend the time by mutual consent, as can the supervising arbitration institution, such as the ICC Court of Arbitration.[203]

Sixth, any national bias of the arbitration system in India is offset by the international character of the proceedings and accompanying rules and law. Both India and the United States have ratified the New York Convention.[204] India's arbitration laws are founded on UNCITRAL, which is essentially an adoption of the international standard for arbitration as determined by the United Nations.[205] Above all, the ICC demands that the arbitrators be independent.[206]

Skeptics may assert that no arbitration panel can escape the confines of a country's influence to assert its own self-interests, specifically its partial statutory and procedural laws. However, experience shows that such a result is not the case. For example, the United States Supreme Court recognizes the efficacy of arbitration, and holds that the United States is a member of numerous arbitration treaties and conventions, and as such, it shall continue to hold itself to their terms,

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[200] *See* STEINHARDT, *supra* note 92, at 13; New York Convention, *supra* note 144, art. III.

[201] *See* U.S. Dep't of State, *supra* note 194.

[202] Amoussou-Guenou et al., *supra* note 130, at 397. Taking advantage of domestic arbitration in India is limited to *two months* after the filing of a case management order. *See* Chodosh et al., *supra* note 101, at 70.

[203] Amoussou-Guenou et al., *supra* note 130, at 397. "In practice, the courts in India normally grant extension where there is no reason for suspecting willful delay, collusion or bad faith." *Id.* at 398 (citation omitted). Although it is possible that a party may abuse the option of an extension by pursuing a number of continuances, a court will likely recognize the pattern of delay and expedite the proceedings. *See id.*

[204] *See generally* New York Convention, *supra* note 144.

[205] SANDERS, *supra* note 142, at 2.

[206] Int'l Chamber of Commerce, Rules of Arbitration art. 7(1) (1998), *available at* http://www.iccwbo.org/court/arbitration/id4424/index.html.

even to its detriment.[207] It follows that other courts understand the policy and rationale behind arbitration proceedings.[208] Furthermore, the parties will likely protect themselves by structuring their arbitration provisions around laws with which they are most familiar. Thus, a substantial disadvantage toward either party during the arbitration procedure is unlikely, and lawmakers and courts should refrain from meddling in private disputes.[209] As a result, states and traditional courts should uphold arbitration agreements because the parties have bargained for the enumerated terms, and such interference would unjustly upset their expectations.[210]

Lastly, and most importantly, arbitration restrains transaction costs.[211] In addition to arbitration's less time-intensive process, fewer appeals ensure that the victim will quickly receive the damages owed. Similarly, the New York Convention acts as a guaranteed payment system, which also reduces the number of transactions and results in increased systemic efficiency. In contrast, there is no New York Convention for trial judgments. As a result, parties have a difficult time enforcing trial damage awards in foreign courts, and generate exorbitant expenses while trying to do so.[212] By streamlining the dispute resolution process, costs may be reduced and the savings may be passed to the consumer. Also, the surplus dollars could be allocated elsewhere to make certain more people have access to healthcare.

The abovementioned model does not presume that traditional courts will remain completely uninvolved in the parties' arbitration

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[207] *See* Mitsubishi Motors Corp. v. Soler Chrysler-Plymouth, Inc., 473 U.S. 614, 628 (1985); *see also* Scherk v. Alberto-Culver Co., 417 U.S. 506, 520 n.15 (1974).

[208] Courts typically defer to the private nature of commercial dealings. "Arbitral practice is, at most, evidence of commercial usage, which national courts will try to accommodate within the bounds of the law applicable and upon which legislators will draw to keep arbitration law in tune with the needs of the international commercial community." PETROCHILOS, *supra* note 89, at 168 (footnotes omitted).

[209] If challenging the sufficiency of arbitration, one must remember that under most circumstances, "[t]he parties have sought an internationally efficacious dispute resolution mechanism coupled with certain due process guarantees. The purpose of an arbitration agreement is to avoid litigating in . . . the courts. It follows that the parties cannot be taken as having surrendered to the regulatory power of any given state." *Id.* at 10.

[210] "[P]arties must be presumed to have intended the arbitral process to lead to an award which would be as widely enforceable (i.e., efficacious) as possible." *Id.* at 12.

[211] Ruth Roemer, *The Continuing Issue of Medical Malpractice Liability, in* CHANGING THE U.S. HEALTH CARE SYSTEM 470, 485 (Ronald M. Anderson et al. eds. 2d ed. 2001).

[212] *See* STEINHARDT, *supra* note 92, at 663.

process. However, these are courts of last resort, and should be used to enforce the collection of damages or serve as an example for applying procedural law.[213] Using the courts in a minimal manner will promote the effectiveness of the entire arbitration process. In addition, an indirect benefit from the courts' involvement is that a court may use the tribunal's order to institute *res judicata* or collateral estoppel, thereby barring the losing party from pursuing similar claims against third parties.[214] Therefore, although the Indian provider and American healthcare institution may squabble over preliminary terms while refining certain provisions within their arbitration agreement, such indecision should not discourage them from pursuing their ultimate goal of bargaining out of litigation and achieving arbitration's many benefits. International law and legal policy within both India and the United States demonstrate the overall stability of this private arbitration proposition.

CONCLUSION

A severe problem in the American healthcare system has become self-evident. As the population ages, treating acute symptoms shifts to treating chronic conditions;[215] the situation only worsens as the average lifespan increases.[216] The only way to alleviate the burden is to diagnose the condition as soon as possible and maximize efficient use of preventive medicine.[217] However, early detection becomes increasingly taxing when there is already a limited supply of diagnostic radiologists capable of interpreting various scans.[218] Compounding

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[213] *See* PETROCHILOS, *supra* note 89, at 168.

[214] *See* Med. Liab. Reporter, *Arbitration Decision in Favor of HMO Bars Subsequent Malpractice Action Against Individual Physician*, 27 MED. LIABILITY REP. 103, 103 (2005) (citing a California court that applied collateral estoppel by using a finding of no negligence in an arbitration ruling between patient and healthcare organization against patient in subsequent proceeding where patient attempted to sue the operating physician who was not a party to the arbitration).

[215] Steven P. Wallace et al., *Long-Term Care and the Elderly Population, in* CHANGING THE U.S. HEALTH CARE SYSTEM 205, 205 (Ronald M. Andersen et al. eds., 2d ed. 2001).

[216] *Id.*

[217] *See* Charles Lewis, *The Role of Prevention, in* CHANGING THE U.S. HEALTH CARE SYSTEM 436, 442-43 (Ronald M. Andersen et al. eds., 2d ed. 2001).

[218] Arjun Kalyanpur, *Teleradiology Goes Mainstream*, PHARMABIZ.COM (Nov. 30, 2006),

http://www.pharmabiz.com/article/detnews.asp?articleid=36629&sectionid=50&z=Y (stating that regional shortages of radiologists are as high as twenty percent).

A downward spiral results because as more Americans age, more early detection procedures are required, but the supply of qualified physicians dwindles.

the malignancy is the high cost of healthcare services.[219] Moreover, new technology does not provide a simple answer because it only amplifies the dismal situation. Not only does technology raise costs,[220] but it also increases exposure to medical malpractice liability.[221] Uncertainty arises as technology and science proliferate.[222] Unfortunately, without increased specialization, an overload of information causes medical errors to escalate in number.[223] Simply put, healthcare in the United States needs help.

It follows that increasing certainty and using traditional diagnostic care by way of the relatively benign internet may create a pressure valve to relieve the American healthcare system of its strains on cost, quality, and access to care. We can no longer afford to protect our domestic radiology market.[224] Before allowing the situation to worsen,[225] we should look to qualified providers in other countries who are ready to assist. If uncertainty is linked to an increase in error, the optimal solution is one that reduces such uncertainty.

The international arbitration model remains a practicable solution to utilizing radiology services abroad while ensuring domestic healthcare providers will not be left defenseless in the event of a rare, but inevitable, radiology misinterpretation.[226] A properly organized and managed system will provide patients with faster, better care at reduced costs. The "focused factories" that result from more experi-

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[219] If healthcare costs remain high while the demand for radiology interpretations increases, the system must surrender to reasonable alternatives at some point.

[220] Bodenheimer, *supra* note 3, at 932-34.

[221] Peter D. Jacobson, *Medical Liability and the Culture of Technology*, *in* MEDICAL MALPRACTICE AND THE U.S. HEALTH CARE SYSTEM 115, 134 (William M. Sage & Rogan Kersh eds., 2006) (suggesting that unrealistic public expectations drive technological advancement and implementation before proper safeguards can protect patients and physicians from malpractice and resulting litigation). Such consequences are not unlikely when considering the aging population and the persistence to relieve the burden of expensive, limited healthcare resources.

[222] Medical researchers are making new discoveries on a daily basis overwhelming practitioners with new procedures, trends, and alternatives; particularly the radiologists who must sift through the piles of scans and information to make a diagnosis. Limited time and increasing demands aggravate physician error. STEPHEN L. FIELDING, THE PRACTICE OF UNCERTAINTY: VOICES OF PHYSICIANS AND PATIENTS IN MEDICAL MALPRACTICE CLAIMS 81 (1999).

[223] *Id.*

[224] *Contra* McLean & Richards, *supra* note 47, at 1380-81.

[225] BHAT, *supra* note 104, at 155 (reporting that there is already a trend to permit less qualified personnel to render medical services).

[226] *Id.* at 31 (listing statistics that suggest malpractice is nearly inevitable and remedial measures are necessary to protect patients); *see* STEINHARDT, *supra* note 92, at 613 (noting the potential and need for arbitration, particularly when a nation's laws are strictly territorial and are thus ineffective in other countries).

enced physicians may even *raise* the standard of care. Since the system is heavily dependent on the contract between the parties, the long and tedious work will be at the front-end of the business relationship when deciding and deliberating the contractual terms. Afterward, the parties can conveniently assess their positions as related to the malpractice incident prior to full-blown litigation because the binding arbitration agreement has already established the dispute's substantive and procedural components. Thus, the new system creates a more predictable outcome and finally assures certainty.

Most importantly, the arbitration model likely guarantees full collection of damages. For example, if an American party successfully argues that an Indian radiologist caused the harm, the party no longer needs to rely on a reluctant Indian court to enforce the judgment. Instead, the prevailing party may access the assets of that Indian tortfeasor in another country unrelated to the dispute. Compliance becomes more likely as providers subject themselves to various international enterprises and investments, while their assets extend to worldwide markets.

Ultimately, policymakers should want to encourage commerce and trade to benefit both medical providers and patients alike. Thus, before regulating or limiting innovation, practitioners and medical institutions should explore possible advantages that may result from consumer demand and market trends.[227] Everyone profits when healthcare providers can capitalize on faster turn-around times, reduced work loads, quicker yet more accurate diagnoses, and greater patient satisfaction. Therefore, uncertain adjudication or any other dispute resolution obstacles should not impair outsourcing teleradiology services. Instead, healthcare institutions should consider international law and arbitration as feasible solutions to overcome the risk of liability, to ensure predictability, and to provide better quality healthcare for all. Only then is any system of care and adjudication both certain and fair.

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[227] Although the United States has a shortage of radiologists, many European countries have a surplus of qualified physicians who are ready to collaborate with U.S. hospitals and physicians via telemedicine networks. L. Jarvis & B. Stanberry, *Teleradiology: Threat or Opportunity?*, 60 CLINICAL RADIOLOGY 840, 841 (2005).