ADR Bulletin
ADR Bulletin

Volume 9 | Number 3 Article 1

11-1-2006

New frontiers in healthcare mediation

Marie Bismark

Tom McLean

Recommended Citation

Bismark, Marie and McLean, Tom (2006) "New frontiers in healthcare mediation," *ADR Bulletin*: Vol. 9: No. 3, Article 1.
Available at: http://epublications.bond.edu.au/adr/vol9/iss3/1

This Article is brought to you by ePublications@bond. It has been accepted for inclusion in ADR Bulletin by an authorized administrator of ePublications@bond. For more information, please contact Bond University's Repository Coordinator.

ADR bulletin
The monthly newsletter on dispute resolution

Information contained in this newsletter is current as at November 2006

Volume 9 Number 3

New developments in ADR

New frontiers in healthcare mediation

Marie Bismark and **Tom McLean**

General Editor
Laurence Boulle
Professor of Law,
Bond University, Queensland

contents

41
New frontiers in healthcare mediation
44
Transformative mediation: differentiating principles from illusions — Part 1
48
Close encounters of the divorce kind
49
ADR Developments
50
Compulsion, delegation and disclosure – changing forces in commercial mediation
60
ADR Diary

Introduction

In today's world, patients and hospitals are increasingly looking across the ocean to find the 'right' doctors for their needs. Already it is possible to recognize two modes of commerce for practicing transoceanic medicine. First there is medical tourism, which involves patients travelling to foreign countries to purchase healthcare services at a discount compared with their home country. Second there is international telemedicine, which involves doctors making virtual house calls to patients in remote country via internet-derived technology. Common to both of these practices is a fair degree of uncertainty as to the extent of the healthcare provider's liability for medical malpractice due to undecided jurisdictional law in cyberspace. This article outlines the growth of transoceanic medicine — and the potential for disputes — and suggests that ADR may play a vital role in this brave new world of healthcare.

Medical tourism and the world of extreme safari

Faced with rising healthcare costs, an increasing number of people from developed countries are choosing to undergo elective surgery and dental treatment abroad. The medical tourism industry is predicted to become a multi-billion dollar industry within a matter of years, and it's not hard to see why. Some of the most advanced hospitals in the world are being built in India to cater to Westerners requiring heart surgery. These hospitals offer the luxuries of a 5-star hotel, employ world-class surgeons and nurses, and can provide a coronary artery for a fraction of the price of the equivalent surgery in the United States, with a tour of the Taj Mahal thrown in for good measure. Plastic surgeons in South Africa offer 'surgery, recuperation, and rejuvenation away from public scrutiny' with the option to undergo a face-lift, tummy tuck, or liposuction, recover in luxurious surroundings, and then enjoy an African safari before flying home. One satisfied client explained the advantages of medical tourism in these words: 'The opportunity to see the animals in their natural habitat. To go where man originated, and at the same time, get the plastic surgery I need at a bargain rate is just fantastic.'[1]

While medical tourism is only in its infancy, travelling abroad for elective medical care is expected to increase for several reasons. First, the Joint Commission for Accreditation of Hospital Organizations (JCAHO) has begun to accredit hospitals in several countries outside the United States, including China and India. JCAHO accreditation goes some way towards assuring patients that they will receive the same quality of care abroad as they would receive at home. Second, healthcare insurers are beginning to steer patients to these providers to save money, and some are even willing to cover the cost of a patient's holiday in order to get a substantial discount for medical services.

Telemedicine: from video-conferencing to robotic surgery

Of course, once you get over the idea that patients and their doctors need to live in the same city, the next logical step is take advantage of overseas medical expertise,

Editorial Panel

Nadja Alexander
Professor of Dispute Resolution, Australian Centre for Peace and Conflict Studies, University of Queensland

David Bryson
Conciliation Officer, WorkCover Conciliation Service, Victoria

Peter Condliffe
Barrister, Director of Mediate and Facilitate Australia, Victoria

Margaret Halsmith
Consultant, Mediator, Facilitator, Trainer, Perth

Robert Hunt
Barrister, Arbitrator, Mediator, Adjudicator Past President IAMA

Shirli Kirschner
Resolve Advisors Pty Ltd, Sydney

Michael Mills
Partner, Freehills, Sydney

David Spencer
Solicitor and Mediator, Senior Lecturer in Law, Macquarie University

and competitive pricing, without the patient ever having to leave home. And that's exactly what the telemedicine industry offers.

To understand the attraction of telemedicine, just imagine that you're a radiologist whose job requires you to interpret x-rays overnight for a hospital in Kansas. You have two choices: you can stay in Kansas, where you work all night, and sleep all day; or, you can have the x-rays sent to you electronically to Sydney, where you can live in a beautiful, vibrant city, take advantage of the favourable exchange rate, and work a normal work-day during daylight hours. More and more radiologists are coming to the conclusion that the second option is far more attractive than the first, and Australia is leading the world in the provision of teleradiology services.[2]

At present, most telemedical services are provided in the areas of radiology and psychiatry. However, there are really no limits on the kinds of services that can be provided in this way. The first cybersurgical operation took place nearly five years ago — when a surgeon in New York removed the diseased gallbladder of a patient in France using robotic tools and a high-speed network connection. While such procedures remain experimental, we can expect that they will become increasingly commonplace.

Like medical tourism, international telemedicine is going to grow for several reasons. Healthcare is one of the biggest markets in the world with most governments spending between 5 and 12 per cent of their GDP on healthcare. While the growth of telemedicine is currently restricted by licensing and registration requirements, such trade barriers cannot be sustained for much longer. Eighty-eight countries have already committed some aspect of healthcare sector to free trade, and trade agreements like GATS push countries to ensure that license requirements are no more onerous than necessary. Like medical tourism, discount healthcare providers will be welcomed in some countries to stimulate price competition; and in other countries because of a paucity of providers. As the cost of the technology comes down there will be virtually nothing to stop telemedicine providers from selling their services anywhere in the world. In essence, just like automotive engineering in the 1980s, and call centres in the 1990s, many health professionals may one day soon find their jobs being out-sourced overseas.[3]

Great challenges, great opportunities

We already know that hospitals are unsafe places — around one in every 10 patients admitted to hospital is harmed by his or her medical care.[4] Medical errors kill more people than road traffic accidents, breast cancer or AIDS. There's no reason to think that these new technologies will be any safer, and many would be associated with new risks of harm. To date, teleradiology in Australia has an excellent track record. But what happens if the power goes off or the software has a glitch, just as a surgeon requires an urgent radiology report on a critically injured patient?

Most countries have well-developed

contributions

Contributions to the **ADR Bulletin** for 2007 are welcome

Please submit articles or notes (between 500 and 4000 words) for publication to:

PUBLISHING EDITOR
Carolyn Schmidt
Richmond Ventures
8 Ridge Street North Sydney NSW 2060

carolyn@richmondventures.com.au

Submissions should be presented as a Word file, attached to an email.

processes for compensating patients who are harmed during medical care — through medical negligence litigation in America and Australia, or no-fault compensation[5] in New Zealand. But if the patient is in one country and the doctor is in another — whose law do you apply? Who is responsible for meeting the needs of the injured patient? The hospital in Kansas? The radiologist in Sydney? The power company?

The law in this area is complex and murky and there are no clear answers. A medical malpractice suit in this context would be immensely time-consuming, costly, and difficult for both patients and providers due to jurisdictional hurdles, complex regulatory frameworks, and the absence of an internationally agreed legal test for establishing the appropriate standard of care. In the context of a medical tourism or telemedicine malpractice lawsuit, the patient's home country courts are unlikely to be able to assert jurisdiction over the overseas doctor. Conversely, while the patient could potentially sue in a court in the doctor's home country, foreign travel to litigate a time-consuming and costly medical malpractice case would be a hassle that few patients would be willing to endure.

ADR on the other hand has the potential to address these disputes with timely and context-sensitive processes. ADR practitioners have the ability to restore calm and to help the parties to start talking again. Many ADR practitioners are skilled in helping to address power differentials, which can often arises between patients, families, and healthcare professionals. And, unlike medical malpractice litigation, in which money is often the only available remedy, ADR can satisfy patients' needs for monetary and non-monetary forms of accountability (apology, explanation, assurance of safer care).[6] Ideally, ADR would support the parties to achieve 'principled' dispute resolution. In other words, any proposed solution would need to be one that the parties could live with, and in addition, it would fall within the boundaries of existing legal, medical, and ethical frameworks for decision-making.[7]

Given the existing volume and expected growth of medical tourism and telemedicine, ADR practitioners should begin to see disputes concerning transoceanic medicine in the next three to five years; and steady growth afterwards. ADR practitioners will potentially be called on to deal with conflict between patients, health professionals, hospitals, insurers, regulatory bodies, and even between different members of the healthcare team.

... unlike medical malpractice litigation, in which money is often the only available remedy, ADR can satisfy patients' needs for monetary and non-monetary forms of accountability (apology, explanation, assurance of safer care).

Many ADR practitioners already work in the areas of healthcare or international disputes. For those with an interest in transoceanic healthcare disputes, the time is right to start acquiring the additional training or experience required in order to be able to work comfortably at the interface of these two disciplines. And there is no better place to start than Australia — a country that leads the world in both ADR and the provision of telemedical services.

Conclusions

Healthcare is changing at a dizzying pace and many of the boundaries of what doctors once thought possible are slipping away. Medical tourism and telemedicine are on the rise, and this growth can be expected to continue.

Grievances and disputes are inevitable in this increasingly complex healthcare environment, and as the volume of trade in transoceanic medical services grows, so will the number of patients who are harmed by a foreign physician. Yet, the regulatory environment and legal system seem unable to keep pace with the rate of change, and considerable uncertainty exists over the courts' jurisdiction and the liability of healthcare providers.

Those who enter into contracts for the provision of transoceanic healthcare would be well advised to include ADR clauses in their contracts. In the coming years, ADR practitioners with an interest in healthcare or international dispute resolution can expect an increased volume of work from transoceanic medical providers. Exploring these new frontiers will require courage and a willingness to grapple with uncertainty, complexity, and rapid change. However, the potential rewards are great — for ADR practitioners, healthcare providers, patients and communities. ●

Marie Bismark is a senior solicitor with Buddle Findlay, Wellington and can be contacted at <marie.bismark@buddlefindlay.com>. Tom McLean is a surgeon and attorney in Kansas and can be contacted at <tmclean@dnamail.com>.

Endnotes

1. <www.surgeon-and-safari.co.za>.
2. <www.nighthawkradiologyservices.net/>.
3. McLean TR 'The future of telemedicine and its Faustian reliance on regulatory trade barriers for protection' *Health Matrix* 2006; July.
4. Wilson RM, Runciman WB, Gibberd RW, Harrison BT, Newby L, & Hamilton JD 'The quality of Australian health care study' *Medical Journal of Australia* 1995; 163(9): 458–471.
5. Bismark MM & Paterson RJ 'No-fault compensation in New Zealand: harmonizing injury compensation, provider accountability, and patient safety' *Health Affairs* 2006; 25(1): 278–283.
6. Bismark MM & Dauer EA 'Motivations for medico-legal action: lessons from New Zealand' *Journal of Legal Medicine* 2006; 27, Number (1): 55–70.
7. Dubler NN & Liebman CB *Bioethics Mediation: a Guide to Shaping Shared Solutions*. New York United Hospital Fund of New York; 2004.

Published by ePublications@bond, 2006