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MEDICAL MALPRACTICE LAW “BEST PRACTICES” FOR JORDAN

A Preliminary Study with Recommendations for Next Steps

August 21, 2007

This publication was produced for review by the United States Agency for International Development. It was written by Stephen Creskoff of BearingPoint, with assistance from Maisie Howard of BearingPoint.

MEDICAL MALPRACTICE LAW “BEST PRACTICES” FOR JORDAN

A PRELIMINARY STUDY WITH RECOMMENDATIONS FOR
NEXT STEPS

SUSTAINABLE ACHIEVEMENT OF
BUSINESS EXPANSION AND QUALITY (SABEQ)

CONTRACT NUMBER: 278-C-00-06-00332-00

BEARINGPOINT, INC.

USAID/JORDAN
ECONOMIC OPPORTUNITIES OFFICE (EO)

AUGUST 2007

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DELIVERABLE N^o: 4.20.2.1 POSITION PAPER ON
MALPRACTICE LAW BEST PRACTICE

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FOREWARD

This report on medical malpractice “best practices” to enhance medical tourism (hereinafter the “Report” or “Study”) was prepared as part of the USAID-funded Sustainable Achievement of Business Expansion and Quality (SABEQ) Program. It is SABEQ’s objective to promote and encourage the growth of the medical services sector in the Hashemite Kingdom of Jordan. In working toward that objective, SABEQ is assisting in increasing the capacity of the medical services sector to attract and service international customers, especially from non-traditional markets. In that connection, SABEQ’s specific objectives are (1) to aid in the development and adoption of a medical malpractice law that is consistent with international “best practices” and the needs of Jordan and (2) to assist in the adoption of an appropriate medical malpractice insurance system.

An important goal of this Report is to support the Private Hospitals Association in reviewing and commenting on the recently drafted Medical Doctors and Dentists Malpractice Law. To do this, the Report surveys and evaluates international experience with medical malpractice claims in selected countries representative of the region, selected non-regional countries that attract medical tourists, and selected developed countries. Based upon this survey, the Report sets forth policy options for the Private Hospitals Association, the Government of Jordan, and other stakeholders to consider.

The methodology used for this Report was desk research, consisting of literature review and Internet research. Because of the limited time and resources allocated, it was not possible to examine in detail all the laws and regulations of the countries surveyed. Nevertheless, the authors believe that the Report presents a reasonably accurate overview of malpractice laws and claims payments systems in the countries surveyed and of the policy options available for designing a “best practices” medical malpractice system in Jordan.

EXECUTIVE SUMMARY

The specific objectives of this Report are to support the adoption of a medical malpractice law by Jordan that is in accord with international “best practices” and the adoption of an appropriate medical malpractice insurance system. In addition, this Report is intended to provide clear points of discussion for the Private Hospitals Association and other stakeholders in connection with consideration of the draft Medical Doctors and Dentists Malpractice Law. The Report is also intended to support the Private Hospitals Association in advocating sector strengthening and implementation of the National Strategy for the Medical Services Sector, particularly with respect to increasing medical tourists from non-traditional markets.

Medical tourism involves travel by a medical patient to a foreign country to obtain medical, dental or surgical services. Jordan’s medical sector is considered among the most advanced in the region and medical tourism to Jordan has been substantial. However, it has focused primarily on “traditional markets” –countries such as Yemen, Libya and Sudan - and patients from other Arab countries, such as Algeria, Tunisia, Iraq and Palestine. The development of non-traditional medical tourists – affluent medical tourists from the Gulf States, Europe, North America and elsewhere -- has been impeded by the current state of Jordan’s regime for handling medical malpractice claims. Court proceedings involving medical malpractice claims are slow; judges are unfamiliar with medical issues; expert witnesses are reportedly biased in favor of defendants; and if claimants are successful, damage awards must be collected through further, time consuming court proceedings. Reportedly, medical malpractice insurance is not generally obtained by doctors, dentists and hospitals. Therefore, defendants may not be able to pay large claims awards. Criminal complaints are sometimes used to extort settlements from medical professionals.

The Report surveyed medical malpractice regimes in selected countries in the Middle East that attract medical tourists; selected countries outside the Middle East that attract medical tourists; and selected countries that exemplify international “best practices”. A benchmarking matrix was developed to compare the main features of the medical malpractice regimes surveyed. (See Appendix 1, Section 4) The survey of international “best practices” suggests a number of approaches that may be appropriate for Jordan. These include: 1. claims adjudication exclusively by an arbitration panel or Medical Committee; 2. preliminary screening of claims, mediation and early settlement programs; 3. developing more specificity to the calculation of damages; 4. developing a variety of insurance options to fund claims; and 5. public-private partnerships to facilitate insurance programs.

Jordan is currently considering enactment of a Medical Doctors and Dentists Malpractices Law. This law would improve Jordan’s existing medical malpractice regime in a number of ways. Clearer standards of care would be adopted. Claims would be decided by medical experts, assisted by judges, and the consistency of decisions would be improved. The processing of claims would be greatly expedited, resulting in lower claims costs. Payments would be guaranteed by a Medical Responsibility Fund, linked to the licensing of doctors and dentists. The law would also require improved maintenance of medical records and patient authorizations. Despite these improvements, the draft law has a number of shortcomings. Claims against hospitals and medical personal other than doctors and dentists are not covered by the law, which may lead to multiple litigations. No causal link between a medical mistake and injury is specifically stated in the law. The law’s status vis a vis existing tort and criminal law is unclear. No statute of limitations for claims is provided. There is no provision for joint and several liability. The “cap” on claims of JOD is unrealistically low for both Jordanians and medical tourists, particularly tourists from non-traditional markets. And the draft law does not address other important concerns of medical tourists, such as the fairness of the claims process for a foreigner.

The development of insurance programs to fund claims should be a particularly high priority. The Report identifies several insurance options that may be appropriate for Jordan, including “first party” insurance paid by medical tourists, and insurance programs administered by medical defense organizations. Government can play a role in serving as a guarantor of “last resort” of insurance programs and by providing insurance for medical professionals and medical institutions unable to obtain insurance elsewhere.

An “Action Plan” was developed for further consideration of medical malpractice regime reform. Consideration of this Report and the development of recommendations should involve all relevant stakeholders. The Action Plan calls for working groups to consider insurance and adjudication options and then to report on their findings. A consensus on new measures should be obtained in order for medical malpractice reform to be politically feasible.

1.0 INTRODUCTION

This Report is intended to assist the Private Hospitals Association and other stakeholders in assessing medical malpractice law reforms in Jordan to promote medical tourism. The Report surveys and evaluates international experience with medical malpractice claims in selected countries representative of the region, selected non-regional countries that attract medical tourists, and selected developed countries. Based upon this survey, the Report sets forth policy options for the Private Hospitals Association and other stakeholders to consider.

1.1 WHAT IS MEDICAL TOURISM?

“Medical tourism” entails travel by a medical patient to a foreign country to obtain medical, dental or surgical services. A patient may obtain health care services outside his or her home country for a variety of reasons, including the higher quality of the medical services provided in the foreign country, the lack of specialized medical services in the patient’s home country, long waiting times for surgical procedures in certain countries, and the relative cost of elective services. Reportedly more than 250,000 medical tourists a year visit Singapore, almost half of them from the Middle East.¹ India, perhaps the leading medical tourism destination, attracts about half a million patients a year and expects revenues from medical tourism to be as much as \$2.2 billion within five years.² Thailand is also an important destination for medical tourists, particularly Americans.

In the United States, some insurance companies and employers are now facilitating medical tourism to reduce the cost of insured medical procedures. Earlier this year, Blue Cross Blue Shield of South Carolina formally established a program paving the way for medical tourism by its insured clients. Its new subsidiary, Companion Global Health, Inc. partnered with Bumrungrad Hospital in Thailand to provide certain services that its health insurance plan will reimburse.³ Other health insurance companies have created similar arrangements with hospitals in Mexico and India.⁴

An important advantage of medical tourism travel to developing countries is the speed with which medical procedures can be performed. This is important for both elective and non-elective medical procedures. Patients in the United Kingdom and Canada, nations that have long waiting times for some surgeries because their national health systems cannot meet demand, may travel to medical tourism destinations such as Singapore, Thailand or India where they can be quickly accommodated. Developed country patients may also be attracted to medical tourism destinations because of lower costs. As examples, a heart valve replacement that may cost \$200,000 in the United States may cost only \$10,000 in India. Lasik eye surgery that may cost \$3,700 in the United States may be performed for a few hundred dollars in a world class eye center in the Kyrgyz Republic.

In the Middle East, Jordan, Turkey and Saudi Arabia are known for high quality medical services. In addition, Dubai is aggressively developing its medical sector and medical tourism. Dubai Healthcare City, the largest international medical center in the Middle East, is scheduled to open in 2010. This will include a Dubai branch of the Harvard Medical School.

Experts have noted several drawbacks to medical tourism. These include:

¹ University of Delaware Daily, July 25, 2005.

² *Ibid.*

³ Kaiser Family Foundation, Daily Health Policy Report, May 24, 2007. BlueCross BlueShield of South Carolina Launches Subsidiary to Facilitate Medical Tourism. Available at kaisernetwork.org.

⁴ Washington Post Foreign Services, October 21, 2004. Surgeries, Side Trips for ‘Medical Tourists’.
LA Times, July 2, 2007. Borders are No Barriers to Affordable Health Care.

- The patient's medical insurance and/or government health plans may not pay for medical procedures in a foreign country. This means that patients may have to pay out of pocket.
- Follow up care for the medical procedure performed may be a problem after the patient returns to his or her home country.
- Many medical tourism destinations have weak malpractice laws. Therefore, medical tourists may not be compensated at all, or inadequately compensated, if they are injured by a medical error.
- Medical tourism may divert medical resources away from medical treatment of the local population.

Jordan's plans to promote medical tourism should address all these concerns. This Report specifically addresses improving medical malpractice laws.

1.2 MEDICAL TOURISM IN JORDAN

Tourism in Jordan is a leading sector of the economy, contributing over 10% of GDP and substantial foreign exchange earnings.⁵ Jordan's medical sector is considered among the most advanced in the region and medical tourism to Jordan has been substantial. However, it has focused primarily on "traditional markets" –countries such as Yemen, Libya and Sudan - and patients from other Arab countries, such as Algeria, Tunisia, Iraq and Palestine. Jordan has entered into medical cooperation protocols with a number of these countries. Jordan's health industry is currently earning about \$600 million a year from foreign patients.⁶

The medical services industry in Jordan is comprised of public sector institutions (the Ministry of Health and the Royal Medical Services), public-private institutions (e.g., Jordan University Hospital, King Abdullah Hospital), and private institutions. As of 2004, there were 56 private institutions. Most of these were located in the Amman area.⁷ The occupancy rate of private hospitals in 2004 was only 43.5%, substantially below the overall hospital occupancy rate.⁸ Private medical personnel were also underutilized. Increased medical tourism would improve the utilization rate of both private hospitals and private medical personnel and improve foreign currency earnings.

Jordan's Ministry of Health established a tourism plan in 2004 with the objective of increasing medical tourism revenues to \$1 billion by 2010. In addition, the Strategic Sector Plan for Medical Services, Jordan Vision 2020, Phase II, identified two "pillars" for future improvements of medical tourism: (1) improving the legal and regulatory climate in Jordan and (2) improving marketing. The Plan identified the development of medical malpractice laws and a medical malpractice insurance system as important priorities in the improvement of the legal and regulatory climate.

1.3 WHAT IS MEDICAL MALPRACTICE?

Medical malpractice occurs when an error or omission by a doctor or other medical professional or institution causes an injury to a patient. Errors or omissions that do not cause an injury do not constitute "malpractice" as defined by legal systems because the elements of causation and injury are missing.

⁵ Prospects for Jordan's Medical Services Tourism Section, AKIR Program, May 19,2004, p.4.

⁶ Jordan Seeks to Become Medical Hotspot of the Middle East, Jordan Times, Nov. 14, 2006.

⁷ Prospects for Jordan's Medical Services Tourism Sector, AMIR Program, May 19, 2004, p5.

⁸ The Strategic Sector Plan for Medical Services, Jordan Vision 2020, Phase II.

Generally, the determination of an error or omission is based upon a deviation of the doctor or medical professional from a generally accepted standard of care. An injury that is the result of a medical treatment is not “malpractice” if the medical professional administering the treatment properly advised the patient of all potential risks and exercised due care in providing the treatment. These are known as “iatrogenic injuries.”

The legal systems of most nations provide compensation for patients who are injured by medical malpractice. Two approaches have been developed to address the problem – a “fault” or “tort” approach and a “no fault” approach. The policies underlying a “fault” or “tort” approach to medical malpractice are: (1) appropriate compensation for the victim, and (2) deterrence of future incidents of malpractice by punishing the party at fault. “No fault” systems, in contrast, are only involved with appropriate compensation for the injured patient. Punishment for medical errors and deterrence of improper medical practices under no fault systems are the responsibility of government regulators, licensing bodies and professional organizations.

In a typical “fault” legal system, a complainant must establish three elements to recover damages: (1) the medical professional or institution owed a duty to the patient; (2) the duty owed to the complaint was breached; and (3) the medical error or omission caused injury to the patient.⁹ Medical malpractice cases are usually determined by national courts but in some countries, these cases may be adjudicated by special tribunals or by arbitration. Expert medical witnesses are employed to provide evidence regarding whether the defendant breached a duty of care. Damages awarded typically include compensation for economic losses (e.g., lost income, the cost of future medical treatment), but in some jurisdictions damages may also include compensation for non-economic losses (e.g., pain and suffering) and punitive damages. Damages will vary, depending on the economic losses proved by each complainant.

Countries employing “fault” or “tort” systems include Australia, Belgium, Canada, Czech Republic, Dubai (UAE), France, Germany, Greece, Hungary, Iceland, India, Italy, Japan, Jordan, Luxembourg, Netherlands, Poland, Portugal, Saudi Arabia, Singapore, Slovak Republic, Spain, Switzerland, Thailand, Turkey, United Kingdom, and the United States.

In a typical “no-fault” system, medical malpractice and iatrogenic injuries are compensated under a general accident compensation scheme. A government board or insurance center determines whether an injury has occurred as the result of medical treatment and if so, the appropriate compensation. These no-fault schemes are either funded by insurance or funded directly by the national government. Countries employing “no fault” systems include New Zealand, Finland, Denmark and Sweden.

1.4 MEDICAL MALPRACTICE LAWS IN JORDAN

The current system in Jordan for addressing medical malpractice problems has a number of deficiencies.¹⁰ Like Dubai and a number of other countries in the region, no legislation directly addresses medical malpractice. Instead, malpractice claims are decided based upon general laws dealing with torts. These laws offer little guidance in the adjudication of complex medical malpractice cases. Claims are subject to a lengthy court procedure (the average duration of a civil case in a court of first impression is 534 days; 40% of decisions are appealed). Judges usually lack experience regarding medical issues. Expert opinions

⁹ See, e.g., K. Shanmugarn, Testing the Bolam Test: Consequences of Recent Developments, Singapore Med J 2002 vol. 43(1): 007-011.

¹⁰ The information in this Section is based upon SABEQ Report, Assessment of the Current Legal Environment Related to Medical Malpractice in Jordan (Tabbaa and Partners August 2007).

are reportedly often biased in favor of the medical service providers.¹¹ Damage awards are low and the execution of judicial awards is subject to a lengthy process. See SABEQ Report, Assessment of the Current Legal Environment Related to Medical Malpractice in Jordan (Tabbaa and Partners August 2007).

Jordan follows a “fault” or “tort” system for determining medical malpractice damage awards. Article 256 of the Civil Code provides: “*Every act causing damage to others obliges its perpetrator to pay damages*”. Jordanian courts have stated that the “act” that causes injury must be an act that deviates from the normal action/performance expected from the ordinary and reasonable person. Damages awarded may include economic damages (reimbursement for medical expenses, lost income), physical damage (damage to the person’s body) and moral damage (e.g., damage to reputation, mental health). The claimant must prove that the damages were caused by the act in question, and not an accident or the wrongdoing of third persons or the claimant himself.

Medical malpractice claims in Jordan may also be pursued under the Criminal Code. Monetary penalties are small in criminal cases, but the doctors and other medical personnel may be subjected to prison sentences. An increasing number of criminal cases have been filed, apparently as a tactic to force defendants to settle out of court to avoid public notoriety, mandatory attendance at court proceedings, and the possibility of significant prison sentences.

Jordan applies the rule of joint and several liability, but the general rule under Jordanian law is that a person is not liable for someone else's action unless the person maintains supervisory or controlling authority over the person who is primarily responsible for the injury. Civil claims must be filed within three years of the date of discovery of the basis for the claim.

Lawyers in Jordan are permitted to enter into contingency fee contracts, as long as the contingency fee does not exceed 25% of the amount recovered. In addition, courts may include the legal fees of the winning party in a damage award.

Reportedly, relatively few medical malpractice claims have been pursued in Jordan (judges estimate that less than 10 cases a year are filed¹²) and damage awards are reportedly low.¹³ Some of these claims have been settled by mediation.¹⁴ Medical malpractice insurance is not generally available and the few policies that are issued are financed by foreign insurers (see Section, 7.2 below and SABEQ Report, Assessment of the Current Legal Environment Related to Medical Malpractice in Jordan (Tabbaa and Partners, August 2007)).

¹¹ This is a typical situation in many countries. Expert witnesses are reluctant to testify on behalf of claimants unless there was a gross deviation from the standard of care, as exemplified by a deviation from treatment guidelines, treatment by a non-board certified physician, a physician who had insufficient recent training on the procedure, etc.

¹² SABEQ Report, Assessment of the Current Legal Environment Related to Medical Malpractice in Jordan (Tabbaa and Partners August 2007).

¹³ See, e.g., Private Hospitals Fill Niche with Medical Tourism, The Jordan Times, March 5, 2002.

¹⁴ Ibid.

2.0 CRITERIA AND JUSTIFICATION FOR SELECTION OF COUNTRIES UNDER STUDY

The selection of medical malpractice regimes surveyed by this Study was based upon SABEQ's objective: to assist in increasing medical tourism by making Jordan's medical malpractice regime more competitive. Three groups of countries were considered: (1) countries that compete with Jordan for medical tourists; (2) countries that have similar legal approaches to medical malpractice; and (3) countries that have "best practices" medical malpractice regimes. Countries with "no fault" medical malpractice regimes were eliminated from consideration because of a lack of compatibility with Jordan's existing legal regime and current economic and political development (the few countries that have adopted no-fault compensation have high per capita incomes and have adopted comprehensive social welfare legislation).

2.1 COUNTRIES THAT COMPETE WITH JORDAN FOR MEDICAL TOURISTS

Many countries around the world potentially compete with Jordan for medical tourists. However, Jordan's most likely competitors are other countries in the Middle East and leading non-Middle East medical tourist destinations that are not geographically too distant from Jordan.

2.1.1 COUNTRIES IN THE REGION

Jordan has a highly regarded medical services sector. However, several other countries in the region also have highly regarded medical services sectors. These include Turkey, Dubai and Saudi Arabia. Dubai in particular has been investing heavily to improve its medical services and to attract medical tourism. Reportedly, billions of dollars have been spent on upgrading the healthcare system. Dubai Healthcare City, scheduled to open in 2010, will be the largest medical center between Europe and Southeast Asia. It will include a new branch of Harvard Medical School. Dubai is actively promoting medical tourism based upon high quality medical service, a relatively low cost of treatment compared to Europe and the U.S., an English speaking medical staff, and its general attractiveness as a tourist destination.

Saudi Arabia has also invested heavily in upgrading medical services and recruits medical personnel in Europe and North America. Saudi Arabia is an important religious tourist destination but it is not well known yet for medical tourism. Visa restrictions make it more difficult for tourists to enter Saudi Arabia than many other destinations.

Turkey, an OECD country, is a significant destination for medical tourists. It advertises internationally qualified, English speaking surgeons and specialists, modern state of the art hospitals, and lower costs because of favorable exchange rates. Like Jordan and Dubai, Turkey is also an important destination for non-medical tourists.

Egypt also has attracted medical tourists, particularly patients seeking low cost plastic surgeries. However, concern has been expressed by some regarding the quality of care provided in unregulated clinics.

2.1.2 COUNTRIES OUTSIDE THE REGION

A number of countries outside the region attract medical tourists. India is reportedly the world-wide leader in medical tourism, with half a million foreign patients a year and projected

revenues of \$2.2 billion in 2012.¹⁵ In Southeast Asia, Thailand and Singapore also attract large numbers of medical tourists. Singapore in particular reportedly has a substantial cliental from the Middle East, reportedly about 125,000 patients a year, or about half of all medical tourists attracted to Singapore in a year.¹⁶ Other countries attracting medical tourists include Malaysia, South Africa, Columbia, Costa Rica, Cuba, and several Eastern European countries.

India, Singapore and Thailand were selected for comparison because those countries appear to be the most likely competitors with Jordan for non-traditional medical tourists (i.e., medical tourists who are not from Arab countries). Malaysia, an Islamic country, may also compete with Jordan for “traditional” medical tourists. The other countries listed are either more geographically remote from Jordan than India, Singapore and Thailand (e.g., the Western Hemisphere countries) and/or are less well established as destinations for medical tourists.

2.2 COUNTRIES THAT BASE LIABILITY AND DAMAGES ON A DETERMINATION OF “FAULT”

Because Jordan is currently committed to a medical malpractice regime based on “fault” or tort law, those few countries that have adopted a “no fault” system of compensation were not selected for comparison. (The countries that have developed a “no fault” regime are highly developed economically and have a comprehensive, government run health care system and a comprehensive social welfare system.)

Arbitration may be one option for Jordan to consider in connection with providing a medical malpractice regime that will attract more medical tourists. This is discussed in Section 6.0, below. The United States was selected as one of the countries for comparison purposes because a major Health Maintenance Organization (HMO) in the United States requires binding arbitration of all medical malpractice claims.

2.3 COUNTRIES THAT HAVE “BEST PRACTICE” MEDICAL MALPRACTICE REGIMES

Because medical malpractice compensation regimes are an integral part of the social and cultural fabric of individual countries, it is difficult to select specific national examples as “best practice” which should then be applied to another country with a different culture, economy and government. However, the Organization of Economic Cooperation and Development (OECD), which consists of 30 countries with well developed economies, recently conducted a survey of medical malpractice and insurance issues in its members in an attempt to develop policy options for countries attempting to improve their medical malpractice and insurance regimes.¹⁷ This survey is instructive.

In most OECD countries, claims for medical malpractice are assessed based upon varying interpretations of “fault”. Damages awarded are funded by health care providers; typically, through private insurance policies. However, in four of the OECD countries – New Zealand, Finland, Sweden and Denmark – economic damages are awarded based upon a “no fault” assessment of whether injury resulted from a medical procedure. In these countries, economic damages are paid either by a public fund (New Zealand and Sweden) or from private insurance (Finland and Denmark) without a finding of negligence by a court or tribunal. In some countries, an approach halfway between “fault” and “no fault” has evolved.

¹⁵ University of Delaware Daily, July 25, 2005.

¹⁶ *Ibid.*

¹⁷ Medical Malpractice Prevention, Insurance and Coverage Options (OECD 2006).

For example, in Spain error and causation are presumed if the patient did not provide an informed consent, and in France error is presumed in cases of nosocomial infections resulting in disability over 25%.¹⁸ In addition, in Iceland legislation provides for quasi strict liability.¹⁹

Three OECD countries, Turkey, the United States and the United Kingdom, were selected for comparison in this Study. In all three countries, claims for medical malpractice are adjudicated based upon a determination of “fault” (breach of duty) and proof that medical error caused injury. In the United Kingdom, doctors working in National Health Service Hospitals are indemnified for malpractice by a state funded scheme. Insurance and other financial indemnification is required of private medical professionals and hospitals. In the United States, which has 50 somewhat different medical malpractice regimes because of its federal system, two states were selected for comparison: Louisiana and California. Louisiana has implemented a state funded insurance scheme. California has been successful in controlling medical malpractice recoveries by limiting attorney’s fees and capping damages. In addition, a major private Health Maintenance Organization (HMO) primarily based in California has reduced the costs of malpractice litigation and the size of damage awards by requiring that all claims be subject to binding arbitration.

In addition to the three OECD countries selected for comparison, the recommendations for medical malpractice regime reforms proposed by the recent OECD study are discussed in Section 8, below.

¹⁸ *Ibid.*, p. 19, n. 9 and 10.

¹⁹ *Ibid.*, Table A-2.

3.0 SURVEY OF INTERNATIONAL EXPERIENCE RELATED TO THE IMPLEMENTATION OF MALPRACTICE LAWS IN THE SELECTED COUNTRIES

3.1 MIDDLE EAST COUNTRIES

The malpractice regimes of three Middle East countries that potentially compete with Jordan for medical tourists, Turkey, Dubai and Saudi Arabia, were selected for comparison. Information on these countries was obtained through Internet and library research (and in the case of Dubai, from a law firm in Dubai) and may not be current. (For example, a new medical malpractice law and insurance reforms are scheduled to go into effect in Turkey). A more complete and up to date analysis of the medical malpractice regimes in these countries can be obtained by consulting local attorneys in those countries who are familiar with that country's medical malpractice regime.

3.1.1 TURKEY

In Turkey, medical malpractice cases are subject to both civil and criminal law.²⁰ Damages and death caused by a medical procedure may be investigated in a criminal court proceeding. Expert testimony is obligatory and may be obtained from qualified experts and from the Higher Health Council. The opinion of the Higher Health Council is important but does not necessarily bind the court. If a medical professional is found guilty under criminal law, they are subject to imprisonment and/or fines. However, medical professionals are not normally imprisoned. Fines imposed are based on Turkey's Compensation Act.

Health professionals in Turkey do not currently carry medical malpractice insurance. The Government pays compensation to victims and their families when the health professional found liable worked in a government hospital or other government institution. The Government then has a right of indemnification from the health care professional and may deduct part or all of the damage award from the health care professional's compensation.

The Higher Health Council decides non-criminal malpractice cases. Fault is subdivided into five categories: negligence, inappropriate intervention, diagnostic failure, follow up failure, and practice beyond the scope of licensure. The doctrine of presumed error may be applied. Defendants may be jointly and severally liable. Both economic and non-economic damages may be claimed. During the six year period between 1993 and 1999, the Higher Health Council considered 997 cases; 47.7% of the health professionals sued were found liable.²¹ This is a high conviction rate compared to Saudi Arabia (36%)²², Japan (31.9%), the United States (28%), and Germany (16.7%).

On the other hand, the number of medical malpractice claims in Turkey is small compared to Western countries. This may be the result of a high degree of confidence in medical practitioners, delays and processing claims, and a religious belief in fate.²³ Compulsory insurance for medical practitioners has been proposed.²⁴ This may result in the development of a medical malpractice insurance market in Turkey.

²⁰ Unit Gundogmus, Mehmet Erdogan, Mine Seniralti, Omer Jurtas, A Descriptive Study of Medical Malpractice Cases in Turkey, *Ann Saudi Med* 2005;25(5): 404-408.

²¹ *Ibid.*

²² Ahmed Alsaddique, Medical Liability the Dilemma of Litigations, *Saudi Med J* 2004: vol. 25 (7): 901-906.

²³ Unit Gundogmus, Mehmet Erdogan, Mine Seniralti, Omer Jurtas, A Descriptive Study of Medical Malpractice Cases in Turkey, *Ann Saudi Med* 2005;25(5): 404-408.

²⁴ Medical Malpractice Prevention, Insurance and Coverage Options (OECD 2006), Table A-2.

3.1.2 DUBAI (UAE)

Currently, there is no well developed medical malpractice claims system in Dubai. The United Arab Emirates (UAE), including Dubai, take a “fault” or tort approach to claims of medical malpractice. Article 124 of the Civil Code provides that rights arise out of acts causing harm to others. A duty of care is defined by Article 12 of Federal Law 7 (law concerning the practice of medicine) but there are no provisions for penalties in the event of a breach of the duty. Article 25 of Federal Law 7 provides that a doctor is not responsible for an unfavorable outcome if he/she has accorded normal care and followed recognized procedures in treating the patient. In 2005, the Dubai Court of Cassation held that a doctor could not be convicted of malpractice if relevant professional opinion established that the doctor had conducted him/herself in accordance with professional standards.

The doctrine of strict liability is not applied in Dubai. The burden of proof in malpractice cases is on the claimant. The Civil Code provides that if a number of people are responsible for an injury, they are each responsible and a judge may award damages against them jointly or severally. The Civil Code, Article 298, requires that claims must be filed within three years after the basis of the claim is discovered by the claimant.

The general principle of damages recoverable is defined in the Civil Code, Article 292, which provides that compensation should be assessed based upon harm suffered by the victim, together with lost profit. Punitive damages may be assessed under Articles 337 and 339 of the Penal Code, which provides for prison sentences. Damages awarded in malpractice actions reportedly have been small. In 2005, the Dubai Court of Cassation rejected a medical malpractice damage claim by a medical tourist of AED 1.5 million (approximately USD \$409,000).

Medical malpractice insurance is available in the UAE. The UAE Federal Government is currently preparing a medical malpractice law. However, no legislative proposals have yet been made public.

3.1.3 SAUDI ARABIA

Medical malpractice litigation in Saudi Arabia is based upon determination of fault, causation and damages. Sharia Law may be applied. Most cases are adjudicated by local courts. However, the more significant cases are decided by various Medical Legal Committees (MLCs) of the Ministry of Health. The MLCs deal with cases involving “blood money, indemnity or compensation.”²⁵ Claims have been increasing, most recently at the rate of 26% per year. Ministry of Health Hospitals and small clinics account for 45% of all cases filed. Private hospitals account for 30% of complaints. Small, privately owned clinics account for 11%, military hospitals for 5%, specialized clinics and hospitals for 7%, and university hospitals only 1.5%.²⁶ Negligence has been proved in 36% of cases. Decisions can be appealed to the Board of Grievances within 60 days of receiving a MLC ruling. Some malpractice complaints can be attributed to communication difficulties between medical personnel and patients, particularly with those medical personnel who do not speak Arabic.

In the past, the Saudi Government was reluctant to regulate insurance because of an uncertainty as to the status of profit from insurance contracts under Islamic law. However, new insurance regulations came into effect in 2004, with regulatory authority vested in the Saudi Arabian Monetary Agency. Insurers are required to operate on a cooperative basis. Medical malpractice insurance policies are now offered by insurance companies licensed to do business in Saudi Arabia.

²⁵ Ahmed Alsaddique, Medical Liability the Dilemma of Litigations, Saudi Med J 2004: vol. 25 (7): 901-906.

²⁶ *Ibid.*

3.2 NON-MIDDLE EAST MEDICAL TOURISM DESTINATIONS

The malpractice regimes of three non Middle East countries that potentially compete with Jordan for medical tourists, India, Singapore and Thailand, were selected for comparison. Information on these countries was obtained through Internet and library research, and may not be current. A more complete analysis of the medical malpractice regimes in these countries can be obtained by consulting local attorneys in the countries who are familiar with that country's medical malpractice regime.

3.2.1 INDIA

India has a fault based medical malpractice regime. However, damage awards for medical malpractice are infrequent compared to OECD countries and the amount of awards is relatively low. Medical malpractice cases are determined in special Consumer Courts. In 1992, the Kerala high court construed the Consumer Protect Act of 1986 as covering medical malpractice cases. This decision was subsequently upheld by India's Supreme Court.²⁷ Consumer Courts were established in all states to hear cases. Awards are restricted to actual damages proved. These exclude damages for pain and suffering. Lawyers are not permitted to take cases on a contingency basis. Culturally, doctors hold an exalted status in India and few patients challenge their decisions. Medical malpractice insurance is available for medical personnel and institutions. Premiums are reported to be at much lower levels than in North America and Western Europe.

3.2.2 SINGAPORE

Singapore has a fault based medical practice regime based on English common law and its medical malpractice regime is similar to that existing in the United Kingdom, Australia and United States. This gives Singapore an important advantage in attracting medical tourists from North America and Western Europe, and affluent medical tourists from other areas. (Approximately one half of the 250,000 medical tourists that visit Singapore each year are from Middle Eastern countries.)

Singapore applies the Bolam test, developed under English law, to determine whether medical personnel have discharged their duty of care in the management of a patient.²⁸ There are three elements to the Bolam test. First, a duty of care must be established. A patient bringing a claim can easily establish that a doctor or hospital owes him or her a duty of care. Second, the complaining patient must establish a breach of this duty. This is the heart of the Bolam test. It is the standard of care expected of an ordinary skilled medical professional exercising and professing to have any relevant special skills. The doctor or other medical professional must have acted in accordance with a practice accepted at the time as proper by a responsible body of medical opinion skilled in the particular form of treatment in question. However, the court must be satisfied that the body of opinion relied upon was reasonable and responsible. A defendant is not guilty of negligence merely because there was a body of competent professional opinion that might have adopted a different technique.²⁹

An important part of a doctor's duty of care under the common law system is a full explanation of the medical treatment and any potential material risks or side effects. In other words, patients have a right to assess the risks of medical procedures and decide whether

²⁷ See Bashir Mamdani, Indian Journal of Medical Ethics, April – June 2004 (12-2).

²⁸ K. Shanmugam, Testing the Boalm Test: Consequences of Recent Deveopments, Singapore Med J 2002 vol. 43(1):007-011.

²⁹ *Ibid.*

they want to proceed despite possible risks. The failure to disclose relevant risks and obtain a waiver from a patient can constitute a breach of the duty of care.

Third, in addition to showing the existence of a duty and breach of that duty, a complainant under the common law system must also prove that the breach caused injury. If proof does not establish that the patient's injury was caused by the breach of duty, the case will be dismissed. As an example, in a case where the patient who had lost sight in one eye sued her general practitioner for failing to refer her to specialist, the Singapore Court of Appeal held that there was insufficient medical evidence to establish that the patient's blindness could have been prevented had she seen an eye specialist immediately.³⁰

Medical malpractice insurance is available in Singapore and medical malpractice award experience is similar to that in other English common law countries, excepting New Zealand, which has adopted a no fault scheme.

3.2.3 THAILAND

Thailand has a "fault" based medical malpractice regime. There are currently no code sections in Thai law that specifically address medical malpractice claims. Claims can be made for compensation for bodily injury, impairment of health, or death, caused by negligence based on the commercial code on torts. Compensation may be awarded for reimbursement of expenses and damages for loss of earnings.

In order to receive compensation, a claimant must prove to a court that the defendant has willfully or negligently injured life, body, health, liberty, property, or any right of another person (Code Section 420). Only actual damages may be compensated. There is no compensation for pain and suffering or other non-economic damages.

Malpractice claims in Thailand are very rare. Thais are by cultural non-confrontational and usually have a personal and family relationship with their doctors. Damage awards are also very low compared to countries such as the United States. The highest reported award to date is USD \$100,000.

3.3 DEVELOPED COUNTRIES

The malpractice regimes of the United Kingdom and the United States, developed countries that potentially are sources of medical tourists for Jordan, were selected for comparison. Information on these countries was obtained through Internet and library research and may not be accurate in all respects. A more complete analysis of the medical malpractice regimes in these countries can be obtained by consulting local attorneys in the United Kingdom and the United States who are familiar with the local requirements.

3.3.1 UNITED KINGDOM

In the United Kingdom, medical malpractice is determined by courts based on the Bolam test, previously discussed in connection with Singapore. Breach of duty and causation are established by expert medical testimony. Juries are normally the finders of fact. In addition to economic damages (e.g., compensation for loss of employment and future medical expenses and care), awards may also include non-economic damages (e.g., compensation for pain and suffering) and punitive damages. Joint and several liability is imposed on a case by case basis.

³⁰ *Ibid.*

Doctors and dentists are required to have appropriate and adequate indemnity (insurance or a similar financial undertaking).³¹ Public health care establishments are required to purchase insurance under the Care Standards Act (2000).

Damage awards in the United Kingdom now total around £500 million (more than \$1 billion USD) a year and are increasing at about 10% a year.³² Claims against obstetricians have led these increases.

Doctors working for the U.K.'s National Health Service are directly indemnified against malpractice awards by the Government through a non-insured government funding scheme administered by the National Health Service Litigation Authority. For private doctors and other private practice medical professionals, malpractice insurance is available through three medical defense organizations (MDOs). In addition, Lloyds may provide coverage for non-standard individual risks.

3.3.2 UNITED STATES

The United States is a federal system and its 50 states each approach medical malpractice claims somewhat differently. Law in all the states, with the exception of Louisiana, is based upon English common law; legal principles are developed primarily through court decisions unless the state legislature or U.S. Congress has adopted governing legislation. (The State of Louisiana, as a former French possession, historically has based its law on the Napoleonic Code.)

In general, as under the Bolam test applied by Singapore and the United Kingdom, a plaintiff must establish three elements to prove medical malpractice: (1) the existence of a duty; (2) breach of a duty to the patient; and (3) a causal relationship between breach of duty and injury to the patient.³³ The standard used to evaluate a breach of duty is the quality of care that would be expected of a reasonable medical professional in similar circumstances. However, in at least 20 states there has been some movement away from this standard to a more independent determination by the court regarding what constitutes reasonable conduct.³⁴ Notably, this same trend has taken place in other common law jurisdictions, such as Australia.³⁵

Suing medical professionals and hospitals was a difficult undertaking in the United States until the second half of the 20th century, when courts began removing some of the barriers facing plaintiffs. Most states eliminated charitable immunity for not for profit hospitals. Courts also abandoned rules that required plaintiffs to find expert witnesses within the defendant's immediate locale. Some courts began applying the legal doctrine of *res ipsa loquitur* (literally, the thing speaks for itself) to medical malpractice cases, and presuming negligence. The doctrine of joint and several liability was applied to cases. This made multiple defendants, including hospitals, potentially liable for the negligent acts of doctors and other medical personnel. Juries awarded non-economic damages (damages for pain and suffering and loss of consortium) and punitive damages in more egregious cases.

Two incentives for pursuing medical malpractice claims exist in the United States that may not generally exist in other English common law jurisdictions. These are contingency fee agreements and the rule that the losing party does not have to bear the winning party's legal fees. Under the contingency fee system, plaintiffs do not need to pay their lawyers for

³¹ Medical Malpractice Prevention, Insurance and Coverage Options (OECD 2006), Table A-2.

³² *Ibid*, Table A1.

³³ See, e.g., David Studdert, Michelle Mello, Troyen Brennan, Medical Malpractice, N Engl J Med 350:3 (Jan. 2004).

³⁴ *Ibid*.

³⁵ See Justice Michael Kirby, Medical Malpractice – an International Perspective of Tort System Reforms (Royal College of Physicians, London, Sept. 2000).

malpractice litigation unless the suit is successful and damages are recovered. If the suit is successful, plaintiffs may pay their lawyers as much as 35% to 40% of the damages recovered. If the suit is not successful, plaintiffs owe no fees and also do not have to pay the legal expenses of the defendant. (In the United Kingdom, the losing party generally is responsible for paying the legal fees of the winning party. In India, contingency fee arrangements are not allowed.)

Problems with the U.S. system

By the mid-1970s, damage awards in the United States had escalated, forcing many large property and casualty insurers to withdraw from the market. Similar problems occurred in the mid-1980s, and again after 1999. States responded with a mixture of reform measures. Joint underwriting associations were formed to serve as insurers of last resort. Insurance companies owned and managed by doctors and other medical professionals were created. Special state patient compensation funds were established.³⁶ Some states capped attorney contingency fees and recoveries for non-economic and punitive damages. Statutes of limitations were shortened. Screening panels were established to evaluate the merits of claims prior to litigation. Collateral source offsets and periodic payments of awards were also required by some states.

Repeated attempts have been made to adopt national legislation to reform the medical malpractice systems in the United States. These legislative initiatives have failed to date because of political opposition from vested interests.

The medical malpractice practice situation in New York State in the mid-1980s was the subject of a Harvard University study. Based upon medical records from 30,000 hospital discharges and 3500 malpractice claims, the reviews found that 3.7% of all hospitalizations involved adverse injuries and 1.0% resulted from negligence.³⁷ These results were confirmed by subsequent studies. The Harvard study found that only 2% of negligent injuries resulted in malpractice claims. Conversely, only 17% of claims made involved a negligent injury. "The data reveal a profoundly inaccurate mechanism for distributing compensation."³⁸ The claims process was also found to be inefficient. Approximately 60% of compensation paid as a result of malpractice awards went to pay administrative costs, primarily legal fees. This is about twice the administrative cost of a typical "no fault" workers' compensation program.³⁹

Medical malpractice systems in the U.S. also do not appear to act as an effective deterrent to substandard medical practices. Insurance premiums are rated based primarily on the particular medical specialty involved and the state in which the medical professional or institution is located. Thus, the cost of insurance for medical professionals with a poor claims record may be subsidized to a large extent by medical professionals who have had no reported claims.

The practice of "defensive medicine" – ordering costly additional tests and procedures for the sole purpose of protecting against legal risk – is also an undesirable outcome of the current situation in the United States. Unnecessary tests and procedures by one estimate have increased medical treatment costs by as much as \$15 billion a year.⁴⁰

³⁶ See, e.g., David Studdert, Michelle Mello, Troyen Brennan, Medical Malpractice, N Engl J Med 350:3 (Jan. 2004), p. 284.

³⁷ *Ibid* at p. 285.

³⁸ *Ibid*.

³⁹ *Ibid*.

⁴⁰ *Ibid*.

The medical malpractice systems of two U.S. states that have adopted innovative measures are reviewed, below.

Malpractice law in Louisiana

In the State of Louisiana, a medical malpractice action must be filed within one year from the date of the alleged error, or within one year from the date of discovery of the error (but not more than three years after the alleged act). The doctrine of comparative negligence is applied. This reduces a claimant's recovery by his percentage of fault compared to all others who contributed to the injury. A joint tortfeasor is not liable for more than his or her degree of fault. Cases filed are subject to preliminary screening by a medical review panel to determine whether evidence supports the conclusion that the defendant failed to act according to the appropriate standard of care and whether negligence contributed to the injury. The panel's report is considered expert opinion and is admissible as evidence in a court proceeding, but is not considered to be conclusive evidence. For physicians insured by the State, liability is limited to \$100,000. Judgments in excess of \$100,000 are paid out of a patient's Compensation Fund established by the State. However, the claimant's total recovery is capped at \$500,000 plus future medical costs. No damage cap applies to physicians not insured by the State. Punitive damages are not recoverable except as specifically authorized by statute. There is no limit on the amount of fees a claimant's attorney may receive. Louisiana follows the collateral source rule, which provides that an injured plaintiff's recovery may not be diminished because of benefits received from other sources. Medical patients may enter into binding medical arbitration agreements.

Malpractice law in California

In the State of California, a medical malpractice action must be filed within one year from the date the claimant discovered the negligent act but no more than three years from the date of injury. The doctrine of comparative negligence is applied. A claimant's negligence will reduce his recovery. The plaintiff's negligence is compared to the negligence of all other tortfeasors to determine the amount of the reduction. The doctrine of joint and several liability is applied. Obligations are presumed to be joint except for non-economic damages. California law holds a hospital liable for the actions of a physician if he/she is an actual or ostensible agent of the hospital. To establish a *prime facie* case of malpractice, the claimant must present expert medical testimony substantiating the claim of negligence unless the doctrine of *res ipsa loquitur* applies and negligence is presumed. Compensation for non-economic damages is capped at \$250,000. California limits the amount attorneys can collect pursuant to a contingency fee agreement. On request of a party, a court may order periodic payments. California allows defendants to offer evidence of the claimant's receipt of payments from other sources. California does not have a patient compensation fund or a program of state sponsored liability insurance. Medical patients may enter into binding medical arbitration agreements.

Arbitration of medical malpractice claims

A major Health Maintenance Organization in the United States, Kaiser Permanente, requires patients to have all claims regarding medical malpractice decided by neutral binding arbitration rather than by a court trial. Kaiser Permanente medical facilities are particularly prominent in California.

Proponents of arbitration believe that it has a number of advantages over court decisions, including:

- Quicker resolution of claims
- Confidentiality of proceedings

- Location of arbitration proceeding determined based on the convenience of the parties
- Lower litigation costs
- Decisions made by neutral arbitrators with medical knowledge
- Claimant and defendant have some control over arbitrator or arbitrators selected
- Lower attorney fees because process is simpler
- More suited to small claims and *pro se* representation
- Discovery of evidence is simplified
- Lower average recoveries than court cases
- Much lower likelihood of punitive damage awards

Arbitration of claims is particularly suited to situations where parties to a dispute are of different nationalities and are located in different countries. In these cases, an arbitration agreement may clearly specify the law that will be applicable to a dispute and the locale where arbitration will take place. An arbitrator may be selected who is fluent in the languages of the parties and is considered to be neutral by all. Arbitrators generally receive advanced training or certification in arbitration to ensure the applicable laws are upheld. Arbitration awards issued in one country are enforceable in most other countries pursuant to international agreement.

4.0 BENCHMARKING MATRIX INCLUDING JORDAN AND AT LEAST THREE SELECTED COUNTRIES

The benchmarking matrix below (Appendix 1) illustrates differences and similarities in the medical malpractice regimes of the countries selected for review.

APPENDIX 1

Medical Malpractice ‘Best Practices’ Benchmarking Matrix

	Legal Standard Applied	Damages Available for Recovery	Adjudication of Claims	Attorneys Fees	Payment of Claims/Insurance
Middle East (selected countries)					
Jordan	Fault, but no specific medical malpractice law	Economic Non-economic Damages awarded are low Criminal penalties may be imposed	Court	Contingent fees permitted up to 25%; other fees also awarded by court	Medical malpractice insurance is not currently available
Dubai (UAE)	Fault, but no specific medical malpractice law	Economic ⁴¹ Non-economic Punitive Criminal penalties may be imposed	Court; Commission of Medical Licenses	No information available	Medical malpractice liability insurance available for doctors and hospitals
Saudi Arabia (UAE)	Fault; Sharia Law	Economic Non-economic Punitive Criminal penalties may be imposed	Medical Legal Committees (MLCs); Courts for some cases	No information available	Medical malpractice liability insurance available

⁴¹ Providers convicted of breaching a duty of care are also subject to monetary fines and possible imprisonment.

	Legal Standard Applied	Damages Available for Recovery	Adjudication of Claims	Attorneys Fees	Payment of Claims/Insurance
Turkey	Fault	Economic, Criminal penalties	Higher Health Council -Advisory in criminal proceedings -Binding in civil proceedings Courts decide criminal cases	No information available	Government pays compensation upon finding of liability by government providers; medical malpractice insurance not currently available but insurance legislation is under consideration

Selected Developed Countries

United Kingdom	Fault (Bolam test)	Economic Non-economic Punitive High damage awards are common	Court, typically with a jury	Fee agreement negotiated	National Health Service (NHS) providers are indemnified against malpractice awards by Government; private providers and institutions are required to obtain medical malpractice insurance through a MDO or other insurer
United States	Fault (Bolam test); standard varies somewhat among the 50 states	Economic Non-economic Punitive High damage awards are common; awards may be capped in some states	Court, typically with a jury; Arbitration; First offer programs	Contingent fees permitted but capped in some states	Medical malpractice liability insurance is generally available; in limited cases, the provider may have to pay a portion of the award. Some states have established patient compensation funds as an insurer of last resort.

Selected Medical Tourism Destinations Outside of the Middle East

	Legal Standard Applied	Damages Available for Recovery	Adjudication of Claims	Attorneys Fees	Payment of Claims/Insurance
Singapore	Fault (Bolam test)	Limited information; only case available stated "Increasingly higher awards"	Courts	No information available	Medical malpractice liability insurance
Thailand	Fault	Economic only; damages awarded are very low	Medical Council; Courts	No information available	Medical malpractice liability insurance
India	Fault	Actual proved damages; pain and suffering excluded; damages awarded are low	Consumer Court	Contingent fees not allowed	Medical malpractice liability insurance

5.0 ANALYSIS OF DRAFT LEGISLATION (MEDICAL DOCTORS AND DENTISTS MALPRACTICE LAW)

Jordan's current legal framework for addressing medical malpractice has a number of deficiencies. (See Section 1.4, above) Jordanian legislation does not directly address medical malpractice claims. The general laws dealing with torts and civil compensation offer little guidance in the adjudication of complex medical malpractice cases. Court proceedings are frequently lengthy, and the execution of judicial awards is also time consuming and subject to further court review. The judges that decide medical malpractice claims are generalists who usually lack experience with medical matters. Expert opinions given in court cases may be biased toward the medical defendants. The amount of damages awarded to successful claimants is reportedly low compared to claimants in OECD countries. Payment of damage awards is the individual responsibility of defendants and if defendant doctors do not have the means to pay, claimants may not be able to recover even if they have obtained a court award.

The draft Medical Doctors and Dentists Malpractice Law is intended to correct some of these problems. The text of the draft law is set forth in Appendix 2. The draft law's advantages and disadvantages are discussed below and in SABEQ Report "Assessment Study of the Current Legal Environment Related to Medical Malpractice in Jordan" (Taabaa and Associates, August 2007).

5.1 ADVANTAGES OF THE DRAFT LAW

The draft Medical Doctors and Dentists Malpractice Law corrects some of the problems that currently exist with the medical malpractice claims process in Jordan. The draft provides clearer standards for the decision of medical malpractice claims. Medical experts guided by legal experts will decide cases. Processing of claims will be greatly expedited. Payment of damage awards will be funded by a medical responsibility fund. Medical standards will be developed and promulgated and medical record keeping by hospitals and other medical institutions improved. Patient authorizations for medical procedures after a full disclosure by treating physicians will be required.

5.1.1 CLEARER STANDARDS OF CARE

Article 3 of the draft law provides for the establishment of two Standardization Committees, which will include representatives of all medical and dental specialties. Specialized subcommittees may also be created. Article 3 C requires that committee and subcommittee members must be qualified in his/her area of specialization and be in good standing in the medical community. These Standardization Committees will be responsible for establishing standard medical procedures and protocols, under the supervision of the Minister of Health.

Requiring physicians to comply with appropriate standards as part of their licensing obligations was recently recommended by an OECD report as a way to reduce medical malpractice claims.⁴² Article 3 of the draft law is consistent with this recommendation.

5.1.2 CASES DECIDED BY EXPERTS; CONSISTENCY OF DECISIONS IMPROVED

Article 6 of the draft law provides for the establishment of two Committees of Technical Investigations. These Committees will consist of at least five doctors and one judge. The conditions of membership are the same as those imposed by Article 3. The Committees will

⁴² Medical Malpractice Prevention, Insurance and Coverage Options (OECD 2006), p. 63

hear and decide complaints against defendant doctors and dentists. This should assure that the deciders of claims have sufficient medical knowledge to understand fully a case's background and the testimony of expert witnesses. It should also promote consistency of decisions, since the Committees will be fully aware of and take into account all prior cases that have been decided and precedents established by prior cases.

5.1.3 PROCESSING OF CLAIMS EXPEDITED; LOWER CLAIMS COSTS

Article 6 of the draft law provides that the Committees of Technical Investigations will decide complaints against doctors and dentists within three months of a case being presented to a Committee. For valid reasons, decisions may be postponed for not more than one month. This will be a much faster process than court proceedings, which now may take two or more years to resolve and as much as several years for the collection of an award.

The detailed procedures for handling claims are not set forth in the draft law and will have to be issued as regulations pursuant to Articles 9 and 10. This will be critical to establish "due process" of law. However, the rapid time for processing claims and the adoption of simplified procedures should result in substantial savings in claims costs. (Claims costs can amount to as much as 60% of awards in OECD countries such as the United States that employ a "fault" claims system.) In Jordan, attorneys who pursue claims in court may enter into fee agreements with clients for payment of up to 25% of the damages recovered, and may be entitled to additional fees awarded by the court.

5.1.4 PAYMENTS GUARANTEED BY MEDICAL RESPONSIBILITY FUND

Article 8 provides for the creation of a Medical Responsibility Fund. All doctors and dentists must be members of this Fund. The Fund may be administered by the Medical and Dental Associations. The Minister of Health will issue regulations governing the performance of the Fund. The creation of a Medical Responsibility Fund for the payment of claims is an improvement over the current situation in Jordan, where individual doctor or dentist defendants may be judgment proof because they have neither insurance nor sufficient assets to pay a claim. However, the details of the financing of the fund through insurance or other means must be developed.

5.1.5 REQUIRES PATIENT AUTHORIZATIONS AND PROPER MAINTENANCE OF MEDICAL RECORDS

Article 5 provides that doctors must explain to each patient every medical procedure and treatment that will be provided and the complications that may ensue, as well as the likelihood of complications occurring. This gives a patient an opportunity to make an informed judgment regarding whether a procedure or treatment is in his or her best interests. Patients will then sign consent forms. Research indicates that a major reason for medical malpractice claims is that treating medical professionals fail to disclose in advance possible negative outcomes of the treatment. (In some countries, the failure to disclose is considered to be *per se* malpractice.) The full disclosure provided by Article 5 should go a long way towards reducing medical malpractice claims in Jordan.

Article 5 also requires the organization of patient medical files by hospitals and other medical centers and sites and the maintenance of patient medical files complete with details regarding procedures and treatments conducted. This recordkeeping should improve the quality of medical service and allow for more accurate determinations of medical mistakes.

5.2 SHORTCOMINGS OF THE DRAFT LAW

The draft law could benefit from further work to clarify terminology (Article 2) and to amplify the medical malpractice claims procedures (Article 6)⁴³ and the funding mechanism for the Medical Responsibility Fund (Article 8). In addition, it has failed to address a number of important issues, including the concerns of medical tourists. These are discussed, below.

5.2.1 GOVERNS CLAIMS AGAINST DOCTORS AND DENTISTS BUT DOES NOT INCLUDE HOSPITALS AND OTHER MEDICAL PROFESSIONALS

Articles 2, 3, 4, 6 and 8 appear to limit the scope of the draft law to claims against doctors and dentists. The draft law does not mention other medical professionals who may be liable for a medical mistake (e.g., nurses, lab technicians). Medical “centers and sites”, including hospitals and clinics, are defined in Article 2 and required by Articles 4 and 5 to issue job descriptions for medical personnel, regulations on patients’ rights, and consent forms, and to meet medical recordkeeping requirements. However, they are not made subject to the claims procedure in Article 6. Unless hospitals and other medical centers and sites are immune from suit under Jordanian law (the doctrine of sovereign immunity applies to government hospitals in some countries; the doctrine of charitable immunity for non-profit hospitals may also apply), they may be subject to medical malpractice claims filed in court. Similarly, medical professionals who are not doctors and dentists will be subject to medical malpractice claims filed in court.

The following example illustrates the problems that could result from not including hospitals and nurses under the draft law and resolving all issues of medical error in one forum:

Hypothetical example: Multiple damage awards in different proceedings. A patient injured by a medical mistake that occurred while the patient was hospitalized files claims against the two treating doctors, three treating nurses, and the hospital itself. The claims against the treating doctors are considered by the Committee under the Medical Doctors and Dentists Malpractice Law. The Committee finds the doctors negligent and the patient receives the maximum award of JOD 30,000, apportioned between the two treating doctors. The patient then sues the three nurses and the hospital in Magistrate Court. The Court rules that the patient’s injury resulted in part from the actions of the nurses and a lack of proper supervision by the hospital, and awards the patient JOD 200,000, and makes all the defendants jointly and severally liable for the award. (See Appendix 1) The nurses are judgment proof and the hospital pays the entire claim. The hospital then sues the two doctors in Magistrate Court, seeking indemnification for the entire JOD 200,000, contending that the doctors were primarily responsible for supervising treatment. The Magistrate Court, relying on the Committee’s decision against the doctors, agrees with the hospital and its decision is upheld on appeal. The two doctors are then responsible for a total of JOD 230,000 in damage awards.

To prevent situations such as the hypothetical example described above, the draft law should be revised to include other medical personnel and medical centers and sites under the claims provisions of Article 6. In addition, the draft law should be the exclusive method of resolving non-criminal claims against medical personnel and medical institutions.

⁴³ SABEQ Report, Assessment of the Current Legal Environment Related to Medical Malpractice in Jordan (Tabbaa and Partners August 2007) expresses concern that hearing procedural “due process” provisions are not set forth in the draft law. The draft law apparently contemplates that procedures will be established subsequently by regulation.

5.2.2 A CAUSAL LINK BETWEEN A MEDICAL MISTAKE AND INJURY IS NOT STATED

A prerequisite of both “fault” and “no fault” medical malpractice award systems is that a medical mistake must have *caused* injury to a patient. If a mistake causes no injury, no compensation is awarded.

Article 2 defines “medical mistake” as any activity conducted or missed that does not comply with the approved medical profession’s code of practices and is not accepted by experienced doctors in the same specialty. Article 6 specifies a procedure by which a Standardization Committee investigates alleged medical mistakes. However, no link between a medical mistake and injury to the patient is explicitly provided for in the draft law. This potentially creates a situation where all mistakes are subject to investigation and damage awards, even if no injury whatsoever have resulted from the mistake. The draft law should be amended to provide that only medical mistakes that cause injury to patients will be compensated.

5.2.3 THE DRAFT LAW’S STATUS VIS A VIS EXISTING MEDICAL MALPRACTICE LAWS IS UNCLEAR

The draft law does not state that it is intended to be the *exclusive* remedy for claims against doctors and dentists for malpractice. If it is not the exclusive remedy, then a patient could pursue claims both under the provisions of the draft law and in Court. As indicated in the hypothetical case in section 5.2.1., above, doctors and dentists could be subjected to multiple awards for the same claim. The draft law should be revised to resolve this issue by providing that its claims provisions are the exclusive remedy for medical malpractice under Jordanian law.

5.2.4 NO STATUTE OF LIMITATION FOR CLAIMS IS PROVIDED

Under Article 272 of the Civil Code, the statute of limitation applicable to medical malpractice claims filed in Jordanian courts is three years after the injured person discovers the act. Will this apply to claims filed with the Committee under the provisions of Article 6 of the draft law? Or will some other limitation provision apply? The draft law should be revised to resolve this issue.

5.2.5 THERE IS NO PROVISION FOR JOINT AND SEVERAL LIABILITY

The principle of joint and several liability is recognized in Jordan in situations where there are multiple tortfeasors. Will this principle apply to malpractice claims decided under the provisions of the draft Act? The draft law should be revised to resolve this issue.

5.2.6 THE “CAP” ON CLAIMS OF JOD 30,000 IS UNREALISTICALLY LOW

Article 8 D of the draft provides that JOD 30,000 is the maximum limit of responsibility for a doctor. Although it is not expressly stated, this responsibility apparently relates to claims awarded under the provisions of Article 6. A “cap” of JOD 30,000 as compensation for a medical error is unrealistically low for Jordanians, unless social security or other compensation is also available. The average per capita income in Jordan is currently around JOD 2000 or USD \$2,800. Even for “average” Jordanians, medical expenses and lost earnings as a result of a medical mistake could far exceed JOD 30,000. As an example, if a 25 year old worker is permanently disabled as a result of a medical mistake and is unable to work, and also has continuing medical expenses, lost undiscounted earnings over 40 years (assuming a work life expectancy of 65) would amount to JOD 80,000. (This does not take into account inflation and future increases in the average wage over 40 years.) Added to that

would be the expenses of future medical treatment and special nursing care that he or she might require.

If Article 8 D is intended to provide an exclusive remedy for a medical mistake (i.e., a claimant will only be able to file a claim under the procedures of the draft law and not in court), the “cap” of JOD 30,000 should be increased to a level that is realistic for average Jordanians. It should take into consideration government benefits, such as unemployment compensation and social security, that an injured patient might qualify for. In addition, patients should be given notice of the “cap” and an opportunity to purchase supplemental “first party” insurance to compensate against injury caused by a medical mistake.

5.2.7 THE DRAFT LAW DOES NOT ADDRESS IMPORTANT CONCERNS OF MEDICAL TOURISTS

It is Jordan’s objective to develop medical tourism, particularly patients from non-traditional markets (e.g., affluent patients from the Gulf countries; other patients from developed countries).⁴⁴ However, the draft law does not appear to have considered this objective and included provisions designed to attract medical tourists.

We are not aware of any research conducted to determine how important a medical malpractice regime is to prospective medical tourists considering medical treatment abroad. Nonetheless, journalists reporting on medical tourism frequently note weak medical malpractice laws as a disincentive to seeking medical treatment in a foreign country.⁴⁵ It is reasonable to assume that medical tourists, as consumers, want to be fully compensated for any medical injury and they want the claims process to be rapid and easy to understand and navigate.

Prospective medical tourists from non-traditional markets may have the following concerns about Jordan’s medical malpractice regime:

- *Damage awards for medical malpractice in Jordan have been infrequent compared to OECD countries.*
- *Damage award amounts have been very low compared to OECD countries and the draft law’s cap of JOD 30,000 on claims would not compensate the economic losses incurred by affluent claimants from a Gulf state or an OECD country.*
- *It is inconvenient and expensive to pursue a claim in a foreign country. Foreigners would have to engage a local attorney and travel to Jordan to give testimony. Foreigners may not understand the language used in the tribunal.*
- *Jordan’s courts and the Committee of Technical Investigation established by the draft law may be biased in favor of Jordanian doctors and against foreigners.*
- *The collection of damage awards in Jordan has been difficult and time consuming and this might also be a problem with the Medical Responsibility Fund established by the draft law.*

The draft law should be revised to take into account the concerns of prospective medical tourists from non-traditional countries. As previously recommended in Section 5.2.6, the cap of JOD 30,000 should be increased to a more realistic amount. The composition of the Committee of Technical Investigations should be revised to include foreign experts in cases involving a medical tourist. Alternatively, an arbitration system could be developed to decide medical malpractice claims received from medical tourists. Lastly, an insurance program

⁴⁴ See, e.g., Medical Tourism Cluster Study, Ministry of Planning and International Cooperation (2004).

⁴⁵ See, e.g., Medical Tourism: Need Surgery, Will Travel, CBC News (June 18, 2004).

should be instituted that would protect medical tourists against any medical injury. Medical tourists should be given the option of purchasing this insurance or relying entirely on Jordan's medical malpractice compensation system. Alternatively, insurance for medical tourists could be made mandatory, with a requirement that the insurance premium be added to the fees charged medical tourists by doctors and hospitals.

6.0 AN ARBITRATION MODEL FOR MEDICAL MALPRACTICE DISPUTE RESOLUTION?

Arbitration has been used in the United States to decide some medical malpractice claims (see Section 3.3.2). Arbitration is a legal process for resolving disputes outside of a national court system. The parties to the dispute refer the dispute to one or more arbitrators, known as the arbitral tribunal or panel. The parties agree to be bound by the arbitral tribunal's decision, or "award". Most nations have enacted legislation requiring the enforcement of arbitration decisions. In addition, 142 nations have acceded to an international agreement requiring the enforcement of commercial arbitration decisions made in other countries.

6.1 ADVANTAGES OF ARBITRATION

Arbitration has many advantages over litigation of a claim in a nation's court system (see Section 3.3.2). Arbitrators with knowledge of the subject matter of the dispute make decisions; the parties choose the arbitrators, so they are perceived as being neutral. Proceedings and arbitration awards are confidential and the details of the proceedings and arbitration awards are not generally made available to the public. Arbitration procedures are usually simpler and less costly than court proceedings, and cases are decided more quickly.

Arbitration is particularly suited to disputes involving parties of differing nationalities for two reasons: (1) a decision in a foreign court may be perceived as being partial to the party native to the court and (2) the judgment of the foreign court may be unenforceable in another country, resulting in multiple suits regarding the same claim, whereas arbitration awards are generally enforceable. The United Nation's Convention on the Recognition of Foreign Arbitral Awards (the "New York" Convention), provides for the recognition of foreign arbitral awards regarding commercial disputes. Jordan and the 141 other countries have acceded to this Convention.

The potential advantages of arbitration to decide medical malpractice claims involving medical tourists are illustrated by the following three examples: A medical tourist from Egypt is treated at a private hospital in Jordan by a team of physicians. One of the physicians is a citizen of the United Kingdom, who subsequently returns to the U.K. The others are Jordanian nationals. During the course of the treatment, the physicians consult with a specialist located in Dubai who is a national of India. The medical outcome is unfavorable.

Example 1: A claim is filed in court. The medical tourist attempts to sue all the physicians and the hospital in a local court in Jordan. This is difficult for a non-resident of Jordan. The non-resident must obtain local counsel in Jordan country and incur travel expenses to give testimony and pursue the case. The Jordanian court may be biased in favor of the local Jordanian defendants. Moreover, the Jordanian court may have a problem obtaining jurisdiction over the physician who is a citizen of the United Kingdom if he has returned to the U.K. and the Indian national specialist located in Dubai. Even if jurisdiction has been obtained over these defendants, if the claimant receives an award it may be difficult to enforce against the defendants in the United Kingdom and Dubai (or India). Conversely, if defendants are found not liable by the Jordanian court the claimant may not be bound by this adverse judgment in a subsequent law suit based on the same claim filed in Egypt, the United Kingdom, Dubai or India.

Example 2: A claim is submitted to a Committee of Technical Investigations (pursuant to the draft "Medical Doctors and Dentists Malpractice Law"). The medical tourist files a claim against all the physicians and the hospital with the Committee of Technical Investigations. The Committee has no jurisdiction over the two defendant physicians who are non-Jordanians and are not located in Jordan. The Committee may also have no jurisdiction over the hospital because the Medical Doctors and Dentists Malpractice Law as drafted

does not apply to claims against hospitals. If the Committee finds in favor of Jordanian physicians and the hospital, this decision may not bind a foreign court in Egypt or elsewhere in a subsequent suit. An adverse judgment of a foreign court might then be enforceable against the assets of defendants in Jordan or assets of defendants that are found outside of Jordan.

Example 3: A claim is submitted to binding arbitration. If the medical tourist, the hospital and all the physicians and specialists have agreed to arbitration of claims as the exclusive method of resolving a dispute, the jurisdictional and “fairness” problems noted in examples 1 and 2 will be avoided. The arbitrators can issue awards against non-resident parties and the awards can then be enforced in foreign countries in accordance with the United Nation’s Convention on the Recognition of Foreign Arbitral Awards. The jurisdictional problems and the problems of conflicting suits in other countries may be eliminated. In addition, as previously noted, arbitration of medical malpractice claims has many other advantages over court litigation, including quicker resolution, confidentiality of proceedings, arbitrators with medical expertise and lower litigation costs.

6.2 ARBITRATION FOR MEDICAL TOURISTS: AN OPTION FOR JORDAN?

Medical tourists, as non-nationals of Jordan, could be required to enter into an agreement to arbitrate any claims against medical professionals and hospitals as a condition of obtaining medical treatment in Jordan. They would then be subject to the rules promulgated in connection with these arbitrations and waive the right to pursue a claim in court in either Jordan or any other country. Medical tourists could also be advised regarding the limits of any recovery under an arbitration scheme and advised to obtain independent “first party” insurance to cover any losses above the limits imposed by Jordan. (Some insurance options for funding claims payments are discussed in Section 7, below.)

7.0 INSURANCE FOR MEDICAL TOURISTS

7.1 INSURANCE FOR MEDICAL PROFESSIONALS AND MEDICAL INSTITUTIONS

The normal approach to funding medical malpractice claims in countries employing a “fault” or “tort” system of determining liability is through insurance purchased by doctors and other medical service providers, including hospitals. This overhead cost may then be passed on to patients as part of the fees paid for medical services. However, problems with this approach have arisen in some countries because of a rapid escalation in the number of claims and size of damage awards.

A recent OECD study notes that there has been a global expansion of consumers’ demand for financial compensation in the event of a medical error or accident causing injury.⁴⁶ Rapidly increasing claims and losses have led to much higher premiums and a withdrawal of insurance providers from the market in many countries. Three factors make accurately predicting losses from medical malpractice claims difficult.⁴⁷ First, most medical malpractice claims in OECD countries take more than five years to resolve. Surveys in Europe show that claims are reported a long time after the injury occurs, which makes it difficult for insurers to calculate the number of claims that will be reported in a given year. In the United States, many insurers have shifted to “claims” insurance from “occurrence” insurance to combat this problem. However, this creates problems for medical professionals who wish to change insurance companies or retire since the insured is responsible for claims that have not been reported when the insurance policy was in effect.

The second complicating factor for insurers is that the range of potential losses is difficult to predict. Courts, particularly courts employing juries to find facts and set damage awards, can make widely varying determinations even for similar injuries. Application of the legal doctrine of joint and several liability can complicate the situation by making a defendant that has little personal culpability liable for an entire damage award.

The third complicating factor is that it is difficult for insurers to “experience rate” medical malpractice liabilities because insufficient historical data exists regarding claims against individual medical professionals. Insurers have addressed this problem by rating individual medical specialties and the locations in which the medical service providers are located. Thus, “good risks” are considered to be areas of medical practice and geographic areas less affected by claims and insurers may refuse to cover high risk specialties, such as surgeons, anesthesiologists and obstetricians. Providers located in a particular city or state or province may be considered to be a higher risk than a provider in another location.

7.2 MEDICAL MALPRACTICE INSURANCE IN JORDAN IS NOT COMMONLY EMPLOYED

The insurance industry in Jordan is not well developed.⁴⁸ This reflects primarily an underdevelopment of life insurance, which has annual premiums of only 0.3% of GDP. In contrast, the level of general insurance, with annual gross premiums of 1.65% of GDP, is comparable to other developing countries in the region and elsewhere.⁴⁹

⁴⁶ Medical Malpractice Prevention, Insurance and Coverage Options (OECD 2006), p. 25.

⁴⁷ *Ibid*, p. 30.

⁴⁸ Jordan Insurance Commission, First Initiative, April 2005.

⁴⁹ Dimitri Vitas, Insurance Regulation in Jordan: New Rules- Old System, World Bank Policy Research Working Paper 3298 (May 2004).

In 2005, there were 26 insurance companies operating in Jordan with a capital amounting to 130.7 million JOD.⁵⁰ These companies issued insurance policies covering automobile accidents and casualty, marine casualty, fire risk, general accidents risk, credit risk, and life and health insurance. Of the 26 companies, 7 issued general insurance policies, 18 issued life and general insurance, and one issued life insurance only. Jordan currently has no reinsurance companies.

Jordan's insurance companies are members of the Jordan Insurance Federation, a trade association that is mainly concerned with regulating and developing the local insurance market. In addition, the Insurance Commission, established under the Insurance Supervision Act of 1999, is responsible for regulating the insurance sector and supervising its activities.

Medical malpractice insurance and other professional liability insurance is not commonly available today in Jordan.⁵¹ A 2004 World Bank report stated that the use of professional liability insurance in Jordan was non-existent.⁵² Research by a local law firm established that local insurance companies that transfer most or all of the risk to international re-insurers sell a very small amount of medical malpractice insurance in Jordan. Jordanian insurance companies reportedly are unwilling to provide medical malpractice insurance directly because the legislative environment in Jordan is unclear.

7.3 “FIRST PARTY” INSURANCE: AN OPTION FOR MEDICAL TOURISTS?

Medical first party insurance pays compensation to the insured for medical injury irrespective of a determination of medical malpractice by doctors or other medical service providers. This insurance is not widely used. However, several examples have recently emerged.⁵³ In France, an insurance policy called “guarantee des accidents de la vie” is offered. These policies protect against all types of personal injury, including medical malpractice. This may not obviate the need for medical malpractice insurance for medical providers, however, because insurers who pay claims resulting from medical malpractice may then seek indemnification from the responsible medical providers. In the Netherlands, compulsory first party insurance is required for persons taking part in medical experiments. This insurance funds a no-fault compensation system for persons injured as a result of participating in an experimental program. A similar insurance plan exists in Germany, providing for economic losses.

In Jordan, first party insurance may offer a method of financing medical malpractice claims from medical tourists without reforming the existing medical malpractice legal regime in Jordan or creating a market for traditional medical malpractice insurance. Medical tourists arriving for treatment could be given the option of purchasing first party insurance to cover potential damages or relying entirely on Jordan's system of compensation, which under the proposed law may cap damages at JOD 30,000. First party insurance coverage could either supplement damages otherwise obtainable under Jordanian law, or provide insurance coverage completely independent of any coverage obtainable under Jordanian law.

⁵⁰ See Jordan Insurance Federation, www.joif.org/

⁵¹ See Emerging Jordan 2006 (Oxford Business Group).

⁵² Dimitri Vitas, *supra*, p. 10.

⁵³ Medical Malpractice Prevention, Insurance and Coverage Options (OECD 2006), p. 49-50.

8.0 OECD RECOMMENDATIONS APPLIED TO JORDAN

A recent OECD Study of medical malpractice regimes in OECD countries suggested policy options for countries dealing with escalating claims and damage awards to consider. See Medical Malpractice Prevention, Insurance and Coverage Options (OECD 2006). These policy options are also relevant for Jordan. An overriding concern of the OECD is patient safety, and the OECD's recommendations should be read with that concern in mind.

8.1 A “FAULT” SYSTEM OR A “NO FAULT” SYSTEM?

According to the OECD Study, the key initial decision in designing a national medical malpractice compensation system should be whether that system will be based upon a determination of fault, or will compensate all patients who have been injured by a medical error, irrespective of fault.⁵⁴ Most countries, including Jordan, have opted for the “fault” or tort approach and do not provide compensation for iatrogenic injuries. However, a few countries have adopted a no fault approach and provide compensation for any injury caused by a medical procedure without a determination of fault. This is discussed in Section 2.2, above.

The selection of a no fault approach in which iatrogenic injuries are compensated pursuant to programs analogous to government workers’ compensation depends on a country’s existing health care and social framework, level of economic development, and legal and cultural traditions. Important advantages of no fault systems are that the costs of pursuing claims are substantially reduced and medical injuries that do not result from “fault” are compensated.

We have assumed in this Report that Jordan’s legal and cultural traditions and level of economic development predispose it toward a fault system similar to that employed by other Middle East countries and most countries around the world. Accordingly, issues related to the implementation of a no fault system have not been discussed.

8.2 TORT REFORM

The OECD recommends consideration of three types of reforms to improve the functioning of tort or “fault” systems: (1) improving the functioning of the dispute resolution process; (2) redefining the definition of fault in medical liability litigation; and (3) reassessing how damages are calculated.⁵⁵ These are discussed, below.

8.2.1 IMPROVING THE FUNCTIONING OF DISPUTE RESOLUTION

Two approaches can be taken to improve the functioning of the dispute resolution process. First, dispute resolution systems can be developed that are alternatives to lengthy and expensive court proceedings. Second, reforms can be made to the court litigation process itself.⁵⁶

Alternative Dispute Resolution:

- Arbitration (Arbitration of claims has many advantages and is particularly suited to resolving cases involving parties located in two or more countries. Arbitration of claims is discussed in Section 6, above)
- Pre-trial screening to eliminate weak cases and settle strong cases. (Pre-trial screening can take various forms. It is intended to encourage settlement of

⁵⁴ *Ibid*, p. 58.

⁵⁵ *Ibid*, pp. 58-60.

⁵⁶ *Ibid*.

meritorious claims and dismissal of nuisance claims. In some U.S. states, a panel comprised of a judge, a lawyer and a doctor reviews medical malpractice cases. If the panel unanimously concludes that a case is weak and the claimant goes forward with the suit, the panel's conclusion will be presented to the court. Conversely, if the panel unanimously concludes that the case is strong, the defendant is obligated to negotiate a settlement.)

- Special tribunals dedicated exclusively to medical cases. The advantage of special tribunals is that the deciders usually have more medical knowledge than judges in courts that decide a wide variety of cases. (The draft Medical Doctors and Dentists Malpractice Law establishes a special tribunal to decide malpractice claims. Similar special tribunals exist in Saudi Arabia and Turkey.)
- Mediators and Ombudsmen. Ombudsmen (a Swedish term) and mediators are persons who facilitate dispute resolution impartially, without bias. Organizations such as hospitals may employ independent mediators and ombudsmen to attempt to resolve complaints from patients soon after an adverse event has occurred.
- "Early offer" programs. Early offer programs give medical malpractice defendants an opportunity to offer compensation for economic damage on a "no fault" basis, i.e., compensation is paid without admission of fault. Early offers must be made soon after a claim has been filed. Early offers give both sides of a dispute financial incentive to settle quickly and avoid a protracted legal battle.

Reform of the court litigation process

The OECD Study recommends a number of reforms to the litigation process. These are listed, below:

- Limiting the period in which a claim for damages resulting from medical injury can be filed (i.e., adopting a shorter statute of limitations for medical claims).
- Restricting the application of the doctrine of joint and several liability, so that a defendant who is only remotely responsible for a medical error is not potentially liable for 100% of the damages because they have the financial means to pay a large damage award.
- Limiting or capping contingency fees received by attorneys to reduce the incentive to file questionable claims. (Jordan limits contingency fees to not more than 25% of an award.)
- Encouraging measures to combat unmeritorious claims. (In the United States, a federal court rule provides that penalties may be imposed on attorneys who file unmeritorious cases.)

8.2.2 REDEFINING THE DEFINITION OF "FAULT"

The OECD Study recommends redefining the concept of fault to provide a clearer distinction between fault and iatrogenic injuries. The concern is that the "Bolam" test applied by some countries has led to an expansive definition of "fault" that has included injuries that may not have been preventable.

An additional concern is that a broad definition of "fault" may impair the improvement of medical systems. Research indicates that medical mistakes frequently result from inadequate medical risk management systems in hospitals, doctors' offices and other medical institutions and not from the lack of care on the part of individual medical professionals. Medical professionals may be stigmatized as being "at fault" when the problem is primarily systemic. As an example, in Spain the failure of a doctor to provide a

proper and full disclosure to a patient about treatment is considered to be malpractice. However, this may result from an inadequate medical system in the hospital or doctor's office. In some countries, systemic problems in hospitals and doctors' offices are concealed because of concern that identifying and reporting problems may result in litigation and damage awards. This impedes the development of improved medical systems.

8.2.3 REASSESSING THE CALCULATION OF DAMAGES

The OECD Study recommends a number of approaches regarding a reassessment of the calculation of medical malpractice damages to reduce damage awards in OECD countries to more realistic levels. These include:

- Setting standards and detailed criteria to assess the amount of economic and non-economic damages (if non-economic damages are awarded). This could include establishing fixed discount rates for the calculation of loss of earning and impairment of the quality of life and establishment of harmonized disability rates.
- Applying caps to economic and non-economic damages. (The draft Medical Doctors and Dentists Malpractice Law) caps damage awards at 30,000 JOD.)
- Limiting the award of punitive damages to very exceptional cases.
- Measures to reduce legal costs. (For example, caps on contingency fees.)
- Allowing periodic payments of awards to allow defendants to reduce the financial impact on defendants.
- Abolishing the collateral source rule. (The collateral source rule is a rule of evidence applied in some countries that bars defendants from introducing evidence that the claimant's damages were paid for by some other source of compensation, such as insurance.)
- Allowing the use of the right of subrogation by the insurer.

8.3 INSURANCE OPTIONS

In many countries, medical professionals and hospitals have obtained medical malpractice insurance from general insurers. However, the increasing number of claims and size of damage awards in some countries have led to these insurers withdrawing from certain markets or restricting coverage. The OECD Study recommends several alternative insurance approaches to expand market capacity and insurability:⁵⁷

- Introduction of a claims-made basis trigger (in contract to an event trigger) for insurance.
- Distinguish between coverage for physicians and medical establishments.
- Develop experience-rated policies through better collection of data regarding medical errors and information from physicians and hospitals regarding the risk management procedures that they follow.
- Encourage private alternative financing mechanisms. Examples include medical defense organizations (e.g., Australia, U.K.), "captive" insurers and risk retention groups (liability insurance companies owned by their members with the capital provided by members).

⁵⁷ *Ibid*, pp. 60-61.

8.4 ROLE OF GOVERNMENT

The OECD Study recommends various public-private partnerships to enhance market capacity and assure that affordable insurance coverage is available to all health care workers and institutions.⁵⁸ These options include:

- Compulsory medical liability insurance for health care providers and establishments (e.g., Canada, France, Spain, Iceland).
- Under government sponsorship, a pool of insurers that determines rates for health care workers unable to find coverage (e.g., France, some U.S. states).
- Creation of a risk equalization fund aimed at pooling bad risks.
- Creation of a fund, privately or publicly financed, that would provide excess loss reinsurance to cover high liability claims.
- A limited no fault compensation scheme to cover medical injuries where a liable party cannot be identified.
- Subsidies from the government to compensate for part of doctors' insurance premium payments (e.g., Canada).

8.5 ENHANCING MEDICAL “RISK MANAGEMENT”

Patients' safety should be improved by the introduction and continual improvement of medical risk management systems. These systems should be particularly aimed at enhancing the reporting of medical errors, identifying risks, and seeking solutions to identified risks in improved management systems. Medical risk management systems should include.⁵⁹

- Independent and confidential reporting and analysis of medical errors
- Requirements for physicians to study medical malpractice prevention, risk management, and comply with appropriate standards of care as part of their licensing obligations.
- Development of practice standards for each medical specialty.
- Participation of doctors and other medical professionals in safety and quality activities.
- Specific patient disclosure requirements coupled with a formal procedure to obtain informed consent from patients.
- Use of appropriate recordkeeping measures, including electronic technology.
- Regular training on new medical treatments and medical devices.

⁵⁸ *Ibid*, pp. 61-62.

⁵⁹ *Ibid*, pp. 63-64.

9.0 RECOMMENDATIONS FOR NEXT STEPS, AN ACTION PLAN AND A DRAFT SOW FOR IMPLEMENTATION PHASE

It is important that the process for revising Jordan's current medical malpractice regime involve all significant stakeholders. These include but are not limited to the Private Hospitals Association, the Jordanian Medical Association, the Jordanian Dental Association, representatives of Jordan's insurance industry, the Ministry of Health, the Ministry of Justice, the Ministry of Tourism, other representatives of Jordan's medical tourism industry, and representatives of consumers, i.e., medical patients and medical tourists. Strong opposition from one or more stakeholder groups could block legislative and other reforms. Therefore, each interest group must participate fully in the development of new solutions and be satisfied with the recommendations developed in order for a new medical malpractice regime in Jordan to be adopted.

9.1 INITIAL POLICY ISSUES TO BE CONSIDERED

Prior to developing a final action plan for improving the medical malpractice regime in Jordan, a consensus should be reached regarding two fundamental policy issues.

First, should medical malpractice claims from medical tourists (non-Jordanian nationals living outside of Jordan) and from Jordanians (Jordanian nationals living in Jordan) be treated differently? Instituting a process for claims from medical tourists that would permit medical tourist claimants some control over selection of the adjudicators, where the adjudication takes place, and the standards used to decide claims and to award damages would make Jordan more attractive to medical tourists. This could be done by implementation of an arbitration approach similar to that used to adjudicate international contract disputes. (Arbitration has been used by a major HMO in the United States to resolve medical malpractice claims. See Section 3.3.2, above.) A disadvantage of this option is that Jordanian nationals with malpractice claims may feel that foreigners would be obtaining preferential treatment, unless they could opt into this system (for example, an arbitration system could be mandatory for medical tourists and optional for Jordanians).

Second, how will medical malpractice claims be funded? The method of funding claims may determine the system of adjudication adopted and the damages awarded. This is illustrated by the following examples:

First party insurance for medical tourists. If the claims of medical tourists (and some Jordanians who seek additional coverage) will be funded by "first party" insurance paid for by all medical tourists and Jordanians opting for this insurance, claims will be determined by a process specified by the insurer and the insurer's decision may then be appealed to another body (a court, tribunal, or arbitration panel). If first party insurance covers all injuries from medical treatment irrespective of whether fault was involved, no adjudication of fault would be necessary. The legal issues would be whether the treatment caused the injury and if it did, the measure of damages.

Medical defense organization insurance. If all claims will be funded from insurance policies issued by a medical defense organization operated by Jordanian doctors, dentists and hospitals and other medical institutions, a Medical Committee process such as that envisioned by the draft Medical Doctors and Dentists Malpractice Law, or the existing court process, may be appropriate. It is unlikely that this insurance would be on a "no fault" basis. The cost of this insurance would be initially borne by doctors and hospitals but ultimately would be passed on to the patients through increased fees.

Commercial insurance. Commercial medical malpractice insurance reportedly currently does not exist in Jordan. If claims will be funded in the future by commercial insurance policies, a Medical Committee process such as envisioned by the draft Medical

Doctors and Dentists Malpractice Law, or the existing court process, may be appropriate. The cost of this insurance would be borne initially by doctors and hospitals, but in the long run the costs would be passed on to patients through increased fees.

Government. Claims against government employed doctors and government hospitals may be paid directly by the government through the establishment of a medical accident fund. If the fund covers all injuries from medical treatment irrespective of whether fault was involved, the only issues would be whether the treatment caused the injury and the measure of damages. The Government could also act as a guarantor of last resort of the financial viability of medical defense organization insurance funds. The Government could also act as a guarantor of last resort for commercial insurance in order to develop a market for commercial medical malpractice insurance. Lastly, the Government could act to assure that all individual doctors and institutions are able to obtain insurance by creating a special insurance fund for doctors and institutions otherwise unable to obtain insurance.

9.2 PROPOSED ACTION PLAN

The following Action Plan to introduce a new medical malpractice claims regime in Jordan taking into account the concerns of medical tourists is proposed:

1. **Initial workshop.** Convene all stakeholders in a workshop (led by local SABEQ staff) to discuss the current status of medical malpractice reform in Jordan and this Report. The workshop and its agenda should be publicized in advance and all responsible interested parties should be allowed to attend and to present their views. The workshop's proceedings should be recorded. The workshop should make initial recommendations regarding the two basic policy issues identified above and on next steps. The workshop should also form two working subgroups – a working subgroup to develop recommendations regarding insurance funding of claims and a working subgroup to develop recommendations regarding the claims adjudication process.
2. **Insurance options and claims process subgroups.** The insurance options and claims process subgroups will fact-find and develop recommendations. International consultants would be provided by SABEQ to support the work of these subgroups. For the insurance options subgroup, a medical malpractice insurance expert would be appropriate. For the claims process subgroup, an expert knowledgeable about international arbitration and/or an expert familiar with medical committee adjudication in Turkey, Saudi Arabia, or elsewhere, would be appropriate. If initial screening of claims or early offer programs are of interest, an international expert familiar with these programs may also be employed.
3. **Second workshop.** A second workshop including all stakeholders (led by local SABEQ staff) will consider the recommendations of the insurance options and claims process subgroups, receive the views of international insurance and arbitration and medical committee experts, and issue final recommendations about system design. The workshop's proceedings should be recorded and its recommendations made public. Public comment on the recommendations should be received and taken into account.
4. **Recommendations submitted to Government for action.** The recommendations of the second workshop and all comments received should be submitted to the Government of Jordan, for appropriate action (e.g., the preparation of legislation and regulations to implement the new system).
5. **Legislation drafted.** Legislation and implementing regulations should be drafted to put the policy decisions arrived at as a result of stakeholder and governmental consideration into effect. The SABEQ team may aid with the drafting of these

documents. An international legislative/medical malpractice expert may be retained to assist with this.

6. ***Implementation of new system.*** The new medical malpractice claims system will be put into effect. Consultants may be required to assist with the further development of new insurance and adjudication procedures required by the new system.

9.3 SOW FOR INTERNATIONAL ADVISOR

A scope of work (SOW) for an international medical malpractice insurance advisor has been drafted since this will likely be the highest priority for the development of a new medical malpractice system. This is attached at Appendix 3. However, it is likely that international advisors may also be required for the work of the adjudication subgroup and for the actual drafting of new legislation and regulations.

10.0 CONCLUSION

This Report reviews international “best practices” relating to processing medical malpractice claims. Based upon this review and the special concerns of medical tourists, an arbitration regime is suggested as a possible alternative to deciding claims through court proceedings or by a Medical Committee. An arbitration regime could be applicable only to medical tourists, or could also apply to Jordanian claimants who agreed to be subject to arbitration.

The Report also reviews international “best practices” regarding the funding of medical malpractice claim awards and concludes that insurance programs developed by Medical Defense Organizations and doctors’ cooperatives are models that should be considered by Jordan. First party insurance should also be considered for medical tourists. The Government may play a constructive role as an insurer of last resort.

The Report’s review of the draft Medical Doctors and Dentists Malpractice Law indicates a number of positive features in the draft law. These include clearer standards of care, claims decided by a Medical Committee comprised of experts, expedited procedures and reduced claim costs, creation of a Medical Responsibility Fund, improved recordkeeping, and procedures regarding disclosures to patients and patients’ authorization of treatments.

On the other hand, the draft law does not address a number of important issues. The draft law does not include hospitals and medical personnel other than doctors and dentists in its claims procedure. The definitions section does not require that a medical mistake must cause injury, therefore two of the usual three normal elements of a medical malpractice claim are omitted. The draft law’s relationship to existing tort law in Jordan is unclear. No statute of limitations is specified, nor is there any provision regarding joint and several liability. The “cap” of 30,000 JOD on claims recoveries is unrealistically low. Lastly, the draft does not address many of the concerns of medical tourists. These concerns should be addressed before the Medical Doctors and Dentists Malpractice Law is enacted.

The development of a new medical malpractice claims regime by the Kingdom of Jordan based on international “best practices” will benefit both medical tourism and Jordanian citizens who have medical malpractice claims. In addition, the quality of healthcare will be strengthened by the adoption and implementation of medical standards and improved medical recordkeeping. New insurance products linked to the adoption of a new claims regime should strengthen Jordan’s insurance sector of the economy. Finally, the adoption of an alternative dispute resolution system – a Medical Committee or arbitration – should substantially improve the speed and cost effectiveness of the medical malpractice claims process.

APPENDIX 1 (SEE SECTION 4, ABOVE)

APPENDIX 2 (ATTACHED)

APPENDIX 3 (ATTACHED)

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APPENDIX 2

A Project of Law for Medical Responsibility

Article (1): This law is entitled “Medical Doctors and Dentists Malpractices Law” Number () for year 2007, this law will become active two month from its publication in the official Gazette .

Article (2): Wherever these words and phrases are mentioned in this law they stand for the below assigned meanings unless evidence proves otherwise:

- Ministry: Ministry of Health
- Minister: Health Minister
- Association: Jordan Medical Association and Jordan Dental Association
- Unionist: Chairmen of Jordan Medical Association and Jordan Dental Association
- Doctors: Medical Doctors and Dentists

Medical Mistake: is any activity conducted or missed that doesn't not comply with the approved medical profession codes of practices, and is not accepted by experienced Doctors in the same specialty of the medical doctor under complaint

Mistakes are:

- Errors in treatments and lack of follow up.
- Lack of technical knowledge that any specialized Doctor must know.
- Performing illegal experimental surgery that has not been previously performed on a human being.
- Performing illegal studies and scientific research/experiments on patients.
- Prescription and use of medicine to patients on experimental basis
- Using medical equipment and devices without having sufficient knowledge on operating instructions, and without taking proper precautions to prevent any damages from using the equipment.
- Lack of observation and supervision.

- Not consulting a specialist when the situation calls for it.

Medical Error: is an accident that occurs on the body tissues despite all the precautions a doctor takes to avoid it during the medical action

Medical Complications: is the spiraling of a medical situation despite the precautions taken to avoid that.

Centers and Sites: Sites prepared to provide diagnoses, treatment, nursing and infant delivery services; this includes hospitals, health centers, clinics, nursing houses, rehabilitations centers and addictions, recovery houses or equivalent locations all. They may provide these services for free or through payment.

Medical responsibility: is based on the relationship between a medical Doctor and a patient in order to provide the patient with medical care and not to neglect him/her and not to guarantee cure. Medical profession in one of the humanitarian services of a special and complicated nature consisting of a number of medical, medications, techniques and biological elements to produce it.

Article (3):

- A. The Minister in coordination with the two unionist are to formulate two Standardization committees that include representatives of all medical and dental sectors with experience in medical profession from the different medical specialties. They are to be responsible for setting the standard medical protocols and procedures of medical treatments and surgeries, and to determine new and stable rules so that if any Medical Doctor violates any of these rules, is considered to be responsible for the mistake.
- B. The Minister has the right to formulate specialized sub-committees to develop and issue characteristic standardizations which are required in form of paragraph (a). The Standardization Committee must approve the practice of the sub committee.
- C. Members of both committees and other sub-committees must:
 1. Have 15 years of practical experience in his area of specialty
 2. Be qualified in his/her area of specialty and have a good standing in the medical community.
 3. Must not have prior criminal convictions.
 4. Must not have prior medical mistake convictions.
- C. Committees' chairmen and members, meeting mechanism and legal status are defined according to the Minister's instructions, regards this purpose.
- D. Membership cycle of the Standardization Committee is four years, and two years for the specialized sub- Committee. The Minister has the right to replace any member if he/she does not attend three meetings in a sequence without presenting any valid excuse for the absence accepted by the Minister.

Article (4) : Each center and site that provides medical services, must provide job descriptions for all of its employees working in the medical health fields..

Article (5):

- A. Each center or site that provides medical services must have set regulations, rules based on patient rights while providing a proving and authorizations form that are provided to the doctor by the patient. A Doctor must explain to each patient every medical procedure and treatment that will be provided and the complications that may occur, in addition to the likelihood of those complications actually occurring.
- B. Each center or site that provides medical services must organize its patient medical files complete with a listing of medical procedures conducted, as mentioned in paragraph (A). Each must be documented by the treating Doctor or any authorized doctor in the treating medical team that has supervises the medical case.

Article (6): Minister of Health will coordinate with the Minister of juristic and both associations' chairpersons that form two committees of technical investigations; they consist of at least five doctors and one judge. Conditions of membership are the same of Standardization Committee in paragraph 3(A). The committees will perform the following duties:

- Provide input and feedback regarding medical mistakes, which are presented against the defendant Doctor.
- Study, investigate and listen to witnesses on the medical mistake case, and delegate a professional Doctor.
- Facilitate the help of any Doctor to perform duties correctly.
- The committee must decide on complaints within a period of no less than three months from the date of a case being presented. Exception to this would be if investigations related to field complaints need more time to be completed, whereby the deadline would be extended for one month, pending approval for a valid reason for the delay.

Article (7): Despite what is mentioned in the laws, partial court principles and any other legislation may not prevent a defendant doctor from practicing medicine while indicting him/her with medical mistakes, unless the committee determines that a medical mistake has in fact occurred.

Article (8):

- A. A Doctor must not have or renew his practicing license unless he has presented a certificate that he is a member of the Medical Responsibility Fund.
- B. The Medical Association has the right to form a special fund to provide the service mentioned in paragraph A.
- C. The Dental Association has the right to form a special fund to provide the service mentioned in paragraph A.
- D. 30,000JOD is the maximum limit for the responsibility.

Article (9): Minister will issue regulations to organize the performance of the fund and the ranks of compliant doctors.

Article (10): Council of Ministers has the right to issue necessary regulations which apply the principle of this law.

APPENDIX 3

TERMS OF REFERENCE

Deliverable(s):	Advice on international medical malpractice insurance systems
Resource Names:	
Approved Level of Effort:	20 days LOE
Planned Start Date :	
Planned End Date:	
Subcontractor:	

INTRODUCTION AND BACKGROUND

The USAID-funded **Sustainable Achievement of Business Expansion and Quality (SABEQ)** program is a broad economic development initiative implemented by BearingPoint, Inc. and a broad team of international and Jordanian partner firms. By both supporting improvements in the business environment and providing assistance to expand innovation and productivity in Jordanian businesses, SABEQ's technical components support the common objective of building up the private sector—Jordan's companies, innovators and entrepreneurs—as a powerful engine of economic growth.

One of SABEQ's critical challenges is to help move Jordan's economy from a sector driven economy to one that is investment and innovation driven. Enhanced productivity component focuses on how best to engage the Public/Private sector to stimulate productivity, developing productivity, human capacity, and innovations that drive improvements resulting in increases in employment, exports, new products and new markets.

SABEQ - Enhanced productivity – component will act as catalyst and key player in the development and promotion of the Medical Services sector by undertaking integrated initiatives and relevant strategic actions to promote and encourage Medical services sector growth. Targeted efforts shall seek to create interest among stakeholders, provide them with the necessary data/information and assist them in market expansion they require.

This activity relates to improving the capacity of the medical services sector to attract and service international customers. The overall objective is to create a legal and regulatory environment that enables the sector to enhance its efficiency and improve its competitiveness. This is expected to increase the number of incoming patients, especially from non-traditional markets. The specific objects will be to advance the adoption of a medical malpractice law that is in accord with international “best practices” and the needs of Jordan and the adoption of an appropriate medical malpractice insurance system.

TOR OBJECTIVES

The main objectives of this TOR are to advise the Private Hospitals Association, the private insurance industry in Jordan, the Government of Jordan, and other stakeholders respecting the development of medical malpractice insurance programs in Jordan. The advisor will provide assistance to a working group formed to consider various insurance options that may be appropriate for Jordan, including “first party” insurance, insurance programs administered by Medical Defense Organizations, doctors’ owned and operated insurance programs, insurance programs offered by commercial insurance firms, government operated insurance programs, and others. This assistance will entail an “in depth” exposition of the various medical malpractice insurance program options as they have operated in other countries, including the pros and cons of each approach. After researching the current insurance situation in Jordan and consulting with all stakeholders, the consultant will prepare a position paper with recommendations and action plans to be submitted to the working group. A workshop for stakeholders will also be conducted by the consultant to explain the various options.

Specific objectives include:

- Verifying the current state of medical malpractice insurance coverage in Jordan.
- Survey “best practices” for medical malpractice insurance potentially applicable to Jordan.
- Develop recommendations and action plans for implementation of one or more insurance programs.

Tasks and Activities

This assignment will require the consultants to visit Jordan. Tasks and activities will include:

- Review existing studies regarding the current status of the insurance industry in Jordan and conduct interviews with members of Jordan’s insurance industry to amplify and update these studies.
- Review all previous reports and studies regarding Jordan’s medical malpractice regime and the draft Medical Doctors and Dentists Malpractices Law and consult with the Ministry of Health, the Private Hospital Association, the doctors’ and dentists’ associations, and other stakeholders regarding their views.
- Review the recent OECD study on medical malpractice insurance options (Medical Malpractice: Prevention, Insurance and Coverage Options, 2006).
- Prepare a report setting forth in detail insurance options for Jordan to consider, taking into account the current state of development of the insurance industry and possible preferences for a cooperative insurance scheme for medical malpractice insurance administered by medical professionals and medical institutions.
- Conduct a workshop for stakeholders explaining the options set forth in the report.
- Based on the initial work outlined above, prepare an action plan for the development and implementation of an appropriate medical malpractice compensation system.
- Prepare a Final Report summarizing and justifying all findings, survey results and recommendations

DELIVERABLES AND EXPECTED RESULTS

Deliverables will include:

- USAID-Mandated End of Mission Report.

- Final report summarizing the findings, results and recommendations of the study.
- Workshop for stakeholders presenting Report's findings.

Results will include the following:

- Clear points of discussion for the Private Hospital Association to discuss during the discussion of the Medical Doctors and Dentists Malpractices Law.
- Role of the Private Hospitals Association in advocating medical malpractice insurance.
- Implementation of the National Strategy for the Medical services sector supported.

TEAM REQUIRED AND LEVEL OF EFFORT

The technical team will consist of the following members:

- Senior medical malpractice insurance systems advisor(LOE 20 days)

PERSONNEL AND QUALIFICATIONS

Senior medical malpractice insurance systems advisor, Proposed:

The Contractor will ensure that the consultant will be experienced medical malpractice insurance systems advisor. Particular expertise required:

- An advanced degree in insurance administration and/or actuary science.
- A minimum of 20 years of experience in the insurance industry.
- Specific experience with medical malpractice insurance systems.
- Experience with Medical Defense Organizations, medical cooperatives, "first party" insurance, and commercial medical malpractice insurance.
- Experience with medical malpractice claims financing in an OECD country.
- Good communication and interpersonal skills.
- Excellent command of English (both written and verbal). Some knowledge of Arabic and prior experience in Jordan desirable.

POLICIES AND PROCEDURES

All staff members, whether provided through a subcontractor or contracted directly by SABEQ, are expected to become familiar with and abide by the SABEQ program policies and procedures. These policies and procedures will be provided on arrival and are available online through the SABEQ program network and portal. Any questions on the policies or procedures should be directed by the staff member to his or her project supervisor or the project leadership team. Failure to seek clarification does not relieve the staff member of the responsibility to follow these policies and procedures.

A key policy is that no staff member is authorized to enter into any agreements that obligate SABEQ project resources. Only the Chief of Party and Deputy Chief of Party may obligate project resources.

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