COMPARING CERTAIN ASPECTS OF U.S. AND COSTA RICAN MEDICAL MALPRACTICE COMPENSATION SYSTEMS AS WELL AS SPECULATING ABOUT SOME SOFT COMPARATIVE CLAIMS DATA: BAD NEWS FOR COSTA RICANS AND MEDICAL TOURISTS TO COSTA RICA?[1]

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I. INTRODUCTION

A primary goal of this article is to provide certain information useful to medical tourists, Costa Rican professionals or laypersons, and scholars (including comparativists) who wish to consider or study the prospects of being able to obtain compensation in Costa Rica for harm caused by deficient medical care delivered in Costa Rica. (It might also, likely combined with existing literature, offer insights into medical tourism and legal liability generally.) Medical tourists particularly might need the information provided in this article when deciding to seek services in Costa Rica. They might consider it important that it could be very difficult or impossible for them to bring suit in the U.S. (or whatever country they might be from) or to enforce a home country judgment in Costa Rica even if the potential defendants did not have them sign an agreement to resolve any disputes in Costa Rica.[2] This information is limited to a general description of the following: (1) the basic steps in a Costa Rican "medical malpractice"[3] case compared to those steps in a U.S. matter; (2) some practical difficulties plaintiffs might face in obtaining compensation for injuries in Costa Rica; (3) some soft

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[1] Earlier/ancestor version presented to the World Congress On Medical Law, Maceio, Brazil (Aug, 10, 2012).

[2] Cary Steklof, *Medical Tourism and the Legal Impediments to Recovery in Cases of Medical Malpractice*, 9 WASH. U. GLOBAL STUD. L. REV. 721, 730-34 (2010).

[3] We write this article from the perspective of a U.S. attorney (although author Torrealba is a Costa Rican lawyer). Therefore, all general references to malpractice cases are to U.S. cases unless specified otherwise. "Medical malpractice" is a broad term that can refer to any cause of action that might be filed against a health care provider who allegedly causes harm to a patient or victim, e.g., intentional or negligent infliction of emotional distress, invasion of privacy, breach of fiduciary duty, battery, false imprisonment, and breach of contract. Its most precise meaning is a cause of action for medical negligence.

data concerning the relative frequency and success of medical malpractice claims in Costa Rica and the United States; and (4) the possible relevance of (1) to (3) in decision-making or study regarding seeking medical care or pursuing a medical malpractice complaint in Costa Rica.

We will consider, but cannot prove to any degree of probability or certainty, the following hypotheses: (1) the frequency of claims for medical malpractice is much higher (four times) in the U.S. than in Costa Rica; (2) the rate of successful claims is much higher in the U.S. (39-42% vs. 3%); (3) the amount of damages awarded for like claims is much higher in the U.S.; and (4)—(1) is a direct result of (2) and (3). We do not have information concerning all the various factors that might bear on or confound examination of these hypotheses.

For example, we have no information considering whether the relative infrequency of (successful) Costa Rican claims is the result of victims' or fact-finders' hesitance to charge or find health care providers guilty of crimes given that Costa Rican medical malpractice proceedings are primarily criminal in nature. We can only speculate as to why the frequency of claims is not greater in Costa Rica given that, as explained below, victims are often able to ride the coattails of the public prosecutor and his pursuit of a criminal case. Perhaps plaintiffs are hesitant to seek civil recovery because litigation losers must pay costs, based on a sliding scale percentage of the amount of damages claimed or awarded, intended to at least reimburse the winner of any suit for a portion of his attorney fees. In the same vein, it is also possible, although it seems improbable given our discussion below, that the infrequency of claims in Costa Rica can be explained, in whole or part, by a proportionately lower number of medical blunders in Costa Rica compared to the U.S.

All the information we do have, moreover, does not necessarily support our hypotheses. For example, as to our impression that the frequency of claims is four times higher in the U.S., if one compares Costa Rica claims per 100,000 residents in its most active year, for which we have data, (Table 5, 1999) to claims per 100,000 residents in a representative jurisdiction in the U.S. (Florida) in the closest year for which we have good data (Table 8, 1997), the claiming frequency in Costa Rica is comparable to that in the U.S., i.e., 68% of that in the U.S. Thus, this article does not purport to supply definitive questions, data, information, or answers, but to share information and raise questions useful to scholars and consumers bent on further study or faced with the necessity to make decisions about care or litigation in light of limited knowledge.

The data and information here are drawn from the authors' writings; training and experience; reports of a unit of the Costa Rican government; books on Costa Rican law; articles published in Costa Rican medical-legal journals; and interviews with Costa Rican physicians, attorneys, hospital personnel, and government employees as well as U.S. sources. We cannot verify the data reported by others, and the authors of the Costa Rican articles note certain limitations. Furthermore, we draw impressions, share experiences, and venture extrapolations from these data as much to indicate areas for further study as to inform readers. We do not purport to address each of the factors that are relevant

in deciding whether to pursue a case. For example, we do not have specific data—only general impressions from author Torrealba's experience and statements made in interviews with experienced Costa Rican professionals—concerning the range, median, or average amount of damages that have been awarded in Costa Rican malpractice cases.

II. BASICS OF COSTA RICAN AND U.S. MEDICAL MALPRACTICE CASES

A. A Brief Note about Costa Rican Procedural Law

The victim of medical malpractice has a **procedural right of choice** (*electa una via* principle), either to file his claim within the criminal process (*acción civil resarcitoria*), in which event the criminal court will decide regarding both criminal and civil liabilities while honoring the substantive independence principle, or to file a separate claim before the civil jurisdiction (provided that the defendants are private law persons or entities) or before the administrative jurisdiction (provided that the defendant is a government entity or a group of private-law and public-law subjects). In accordance with the principle *electa una via*, once the claimant has made a choice, he cannot simultaneously file another claim. However, if having chosen to file the civil claim within the criminal procedure (*acción civil resarcitoria*), and the criminal case is dismissed without a trial, the claimant has the opportunity to go before the civil or administrative jurisdiction and file his claim.

As a general rule, it is advantageous to pursue a criminal claim whenever possible because such a case is processed within approximately three years, while a civil case typically takes six to ten years.

B. Costa Rican Substantive Law

Costa Rica is a civil law jurisdiction. A Costa Rican medical malpractice proceeding usually involves a primary criminal and an ancillary civil case. The relations between civil liability and criminal liability are governed by a **substantive independence principle**. This means that both types of legal responsibility may coexist, but not necessarily. Since the conditions for each kind of liability are different, there are cases in which a criminal acquittal is followed by a civil judgment awarding damages or vice versa.[4] For example, the criminal courts tend to apply a narrower conception of causation compared to that employed in the civil courts. Illustrative would be an automobile collision case in which the defendant did not have a driver's license. The criminal court would

[4] A consequence of the independence principle is that statutes of limitation for criminal and civil liability differ.

focus on the immediate events surrounding the accident and not consider it relevant that the defendant did not have a driver's license. If the defendant otherwise acted reasonably, he would be acquitted. The civil court, however, would apply a broader conception of causation and find the defendant liable because of driving without a license. There are a few civil liability rules that apply only when the facts indicate a civil as well a criminal infraction (*responsabilidad civil ex delicto*).[5]

The substantive standards that Costa Rican health care providers are held to are set forth in the criminal code. This is different from the common law system of the United States in which medical malpractice is based in the civil law of torts, with the primary cause of action being negligence. Although the precise standard of conduct required varies among U.S. states, negligence roughly means falling below the standards of knowledge, skill, or conduct exercised by or expected from health care providers of the same specialty or category of practice, either nationally or in a specified geographical area.[6] Medical malpractice only rises to the level of a crime in the U.S. when there is criminal negligence or gross or knowing indifference to risk of serious harm to a patient. Indictments for criminal negligence against a health care provider are extremely rare in the U.S.[7]

Although there are levels of guilt and corresponding disparate sanctions in Costa Rica, there is no distinction between ordinary and criminal negligence equivalent to the sharp distinction drawn in the U.S. Rather, in Costa Rica any negligent (or worse) act that results in physical harm is a crime called "lesiones." The gravity of the crime and attendant sanction depends on the circumstances and the degree of the injury caused. There are three levels of injury: gross, grave, and light. The sanctions for each include, respectively, three to ten years in prison; one to six years in prison; and three months to one year in prison or a fine.[8] A full comparison between Costa Rican and U.S. substantive law in the civil context would require a detailed discussion of nuances among U.S. and Costa Rica jurisdictions concerning the expected standards of conduct and corresponding standards of proof in court. It will only be observed here that, in theory and concerning cases against private physicians or other health care providers, the expected standard of care is similar throughout the U.S. and Costa Rica.[9] This is roughly a standard to behave as a reasonable health care provider in the specialty involved placed in like circumstances. It is a fair generalization that the actual

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[5] These are the special civil liability rules stated by the 1941 Criminal Code, which are enforceable up to this date.

[6] BARRY FURROW ET AL., HEALTH LAW 269-71(2d ed. 2000).

[7] James A. Filkins, *With No Evil Intent: The Criminal Prosecution of Physicians for Medical Negligence*, 22 J. LEGAL MED. 467, 469-72 (2001).

[8] ROGER A. PETERSEN, THE LEGAL GUIDE TO COSTA RICA 44 (5th ed. 2009).

[9] *Id.*; interview with Joaquin Picado, founding partner Picado & Leon, a law firm in San Jose, Costa Rica (Nov. 2008) (notes of interview on file with author Spece). *Compare* CARLOS TIFFER, RESPONSABILIDAD PENAL POR MALA PRAXIS (2008) (Spanish), *with* FURROW ET AL., *supra* note 6, at 264-66.

standards seemingly employed in practice are stricter than their theoretical formulations would suggest, particularly in Costa Rica.[10]

Aside from the general observations just ventured, civil liability rules are quite complex under Costa Rican Law. In an effort to simplify, we will consider the different regimes applicable to the possible defendants.

1. Doctors

When the doctor has a **contractual relationship** with a patient, governed by private law, civil liability rules bifurcate, depending on the nature of his obligation. Contractual obligations are classified in *obligaciones de medios*, in which the debtor has to perform his undertaking proficiently but without granting a specific outcome; and *obligaciones de resultado*, in which the debtor promises a specific outcome. The standards applicable to *obligaciones de medios* are the state of the art or profession. Thus, civil liability arising from the breach of *obligaciones de medios* is based on *negligence* (in Spanish, *la culpa*). The latter is virtually the same as the reasonable person standard in the U.S., which, in both jurisdictions, is refined in medical malpractice cases to account for physicians' special expertise. The standard applicable to *obligaciones de resultado* is the objective comparison between the actual and the promised outcome. In medical liability, most contractual obligations qualify as *obligaciones de medios*: the doctor complies if his conduct comports with professional standards. Some obligations, however, qualify as *obligaciones de resultado*, e.g., esthetic improvement promised with respect to plastic surgery.

When the doctor acts as an employee for a private entity, e.g., a private hospital, without having a direct contractual relationship with the patient, his personal civil liability is governed by the **general negligence principle** under tort law (extra contractual liability), in accordance with Article 1045 of the Civil Code.

When the doctor acts on behalf of (or as an employee of) a public entity, e.g., *la Caja Costarricense de Seguro Social*, he shares the benefit that Article 199 of the *Ley General de la Administración Pública* (Public Administration General Act) grants to public officers: personal civil liability of public officers requires the proof of *culpa grave o dolo* (gross negligence or intentional behavior). In practice, this requires egregious behavior.

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[10] This is suggested in the U.S. by some evidence that medical negligence plaintiffs obtain about half the success before juries than do plaintiffs in other negligence cases. MARK HALL ET AL., MEDICAL LIABILITY AND TREATMENT RELATIONSHIPS 289 (2d ed. 2008) ("When malpractice complaints go to trial, plaintiffs win only 20 to 30 percent of the time. This compares with an overall success rate of about 50 percent for plaintiffs in general civil litigation."). It is suggested in Costa Rica by the miserably low approximately 3% of cases that are decided in favor of victims by the forensic unit charged with doing investigations for the courts there. *See infra* text accompanying notes 22-25.

If the doctor is criminally convicted for one of the felonies described in the Criminal Code, e.g., *lesiones culposas, homicidio culposo*, the special civil liability rules (*ex delicto*) will apply in the civil case. This means that even if the physician is a public officer, gross negligence need not be proven (at least officially). What is not clear is the standard courts use to determine criminal liability. There are applicable statutes, but in practice, however, there is no clear, agreed upon formulation to guide Costa Rican judges. Such a formulation will be one of the subjects of our expected more detailed examination of Costa Rican case law and authorities relevant to the criminal standard in a subsequent article.

2. Private Clinics and Hospitals

Private clinics and hospitals traditionally have been subject to an **indirect strict liability regime**, which means that they respond as principals for the faults of their employees. However, there is a tendency to apply, to the benefit of patients, the **direct strict liability regime** stated in Article 35 of the Consumers Act (*Ley 7472 de Promoción de la Competencia y Defensa Efectiva del Consumidor*). This means that the private clinic or hospital can be found liable even in the absence of fault.

3. Public Entities

Public entities (mostly the *Caja Costarricense de Seguro Social*) have been subject to an **indirect strict liability regime** (Article 191 of the *Ley General de la Administración Pública*) as well. This means that the public entity is liable for the faults of its employees. This regime has been applied even to cases in which the *specific* wrongdoer cannot be identified, e.g., *Araica Cruz vs. Caja Costarricense de Seguro Social* (AIDS contaminated blood transfusion).[11] Remember that the employees of public entities are only liable for gross negligence; thus, the public entity will generally not be liable without such egregious behavior. In a few cases, the public entity has been held responsible for unforeseeable harms under the **direct strict liability regime** stated in Article 194 of the *Ley General de la Administración Pública* (a law applicable to intense harm caused by the normal functioning of the government). For example, in *Araya Cortés vs. Caja Costarricense de Seguro Social*,[12] liability was found even though

[11] Sala Primera de la Corte, número 95-000135-177-CA, de las 14:15 horas del 15 de enero de 1999.

[12] Civil Branch of the Supreme Court, no. 875-F-2007 (8:00 hrs, Dec. 14, 2007). In Justice Jinesta´s opinion, the *fortuitous event* defense does not exonerate the Government. Since this defense is based upon foreseeability, in the end it is a moral judgment concerning fault, which is incompatible with a strict liability system. *See* ERNESTO JINESTA LOBO, TRATADO DE DERECHO ADMINISTRATIVO, TOMO II (RESPONSABILIDAD ADMINISTRATIVA) 110-11 (Medellín, Biblioteca Jurídica Diké, Colombia-Venezuela-Costa Rica, 1st ed. 2005)

the defendant's physician employee caused nerve injury to the plaintiff without fault. The physician was without fault because, although the plaintiff suffered nerve injury by an injection that collided with his sciatic nerve, the collision was a result of the plaintiff's abnormally located sciatic nerve.

C. Back to Procedural Law: Major Steps in U.S. and Costa Rican Cases

The basic steps in a U.S. medical malpractice case—unless special elements have been added by "tort reform" legislation[13]—are filing of a civil complaint; an answer or various other possible responses by the defendant (e.g., a demurrer or motion to dismiss based on legal insufficiency, even if the facts are assumed to be as stated by the plaintiff); discovery (including interrogatories, depositions, and physical examinations); (further) motion practice (e.g., for summary judgment on the basis of affidavits and other evidence); pre-trial and settlement proceedings to organize for or avoid further proceedings; and trial (usually with a jury). Appeals are possible at two or three levels (i.e., court of appeals and the U.S. Supreme Court for federal matters and court of appeals, state supreme court, and the U.S. Supreme Court for state cases).

As indicated above, Costa Rican medical malpractice litigation usually involves simultaneous pursuit of both a criminal and a civil case.[14] Here, we will discuss the main steps in such a case. A death or injury case is initiated by a complaint (*denuncia*), which triggers an initial screening by a prosecutor within the Ministry of Justice. The prosecutor decides whether there is enough evidence to justify issuing a formal summons requiring the defendant to appear and be examined, unless he invokes his right against self-incrimination. At this point an investigation is conducted by the Forensic Medical Clinic of the Department of Legal Medicine of the Judicial Branch (Forensic Unit) in injury cases and the pathology division of the Forensic Unit (Pathology Division) in death matters.[15] These units issue findings of guilt or innocence. These recommendations to the court are subject to prior appeal within the forensic units.[16] Once the Forensic

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(Spanish). In the same sense, Eduardo Ortiz Ortiz argues that because the force majeure excludes the causation connection, the fortuitous event, being unforeseeable, excludes fault. EDUARDO ORTIZ ORTIZ, EXPROPIACIÓN Y RESPONSABILIDAD PÚBLICA 52 (Lil, San José, 1996) (Spanish). Gianfelici, on his side, qualifies as "classic" the doctrine in accordance to which the fortuitous event excludes the fault, and as "modern" the doctrine that analyses such defense as a matter of causation. Gianfelici, op.cit., at 55.

[13] Regarding tort reforms, including a requirement, in certain jurisdictions, of presentation to a medical liability review panel before being allowed a court trial, see FURROW ET AL., *supra* note 6, at 354-61.

[14] Except as otherwise footnoted, the description here of Costa Rican medical malpractice proceedings is based on the sources cited *supra* notes 8 and 9.

[15] Interview with Dr. Juan Gerardo Ugalde-Lobo, Costa Rican physician and medical-legal scholar (Nov. 2008) (notes of interview on file with author Spece).

[16] *Id.*

Unit's recommendations are finalized and the prosecutor's investigation is complete, the prosecutor decides whether to continue the case by issuing a formal indictment (*acusación*). If he does so, then this initiates the preliminary hearing phase of the case.

The victims are allowed to file a civil complaint in the criminal court where the case is lodged. If guilt is ultimately found, the criminal court will decide the amount of any damage award to the plaintiff. The civil case can also be disposed of in the conciliation process alluded to below. (There is no jury in any event.)

Prior to the preliminary hearing before the court, all parties are allowed to review the evidence gathered by the prosecutor. All parties are allowed to attend the preliminary hearing, and the defense is allowed to request a dismissal. The court rules on evidentiary matters and decides whether the case should proceed further or be permanently or provisionally dismissed. A provisional dismissal can give the prosecutor one year to gather more evidence that might result in reversal of the conditional dismissal.

If the court determines that the case should proceed, it enters the intermediary procedure phase. This phase is intended either to resolve the case before trial or narrow the issues for trial. One way the case can be resolved is in a conciliation proceeding. Another possible disposition is that the court responsible for this intermediary stage, which can differ from the preliminary hearing court, finds there is good cause for dismissal. If the case is not resolved, the court declares the trial phase open and sets a trial date. At trial, both sides present their cases orally, and then the court issues a ruling on guilt. If there is a guilty finding, then the case moves on to sentencing. The decision of the criminal court can be appealed at two levels.

D. Some Practical Difficulties

There are several practical difficulties plaintiffs face in both the U.S. and Costa Rica. Here, we will focus on the difficulties in Costa Rica by analogy to corresponding contexts in the U.S. Authors Spece and Ibanez have a combined experience of six decades of practice in the U.S. system.

There are two fundamental but conflicting working premises held by U.S. medical malpractice attorneys and physician experts. The attorneys generally advise that a plaintiff should not pursue a medical malpractice case unless each fact necessary to success is contained in the medical records. Physician experts contend, on the other hand, that if a required step of care is not reflected in the medical records, there is a strong presumption that it was not performed. We cannot reconcile this conflict, but we note the agreement between attorneys and physicians concerning the importance of medical records.

This leads us to share here a striking publication about the deficiency of medical records at a major Costa Rican hospital. The Medical Director of the

private Costa Rican hospital, Clinica Católica, reports on a sample of the medical records of 237 Clinica Católica patients:

> Most of the records give insufficient consideration to epicrisis, clinical histories and notes on evolution . . . . Only 19% of patients on leave have adequate epicrisis and only 77% had an adequate clinical history on arrival; surgery descriptions met minimal requirements only in 30% of patients. In no case was a written consent filed, only 60% of patients had the minimal pre-surgery exams and only 2% received the necessary pre-surgery assessment for anesthetics.[17]

This report could indicate a substantial departure from standards of care that would be expected in the U.S., and its tone suggests that the self monitoring by professionals and medical institutions are not acceptable in Costa Rica. The facts in the report indicate that there might be numerous potential medical malpractice cases in Costa Rica. On the other hand, any such cases might be hard to establish given that the prosecution/plaintiff has the burden of proof.[18]

Another observation concerning a possibly unique attitude toward records in Costa Rica and the possible relevance of such an attitude to liability concerns comes from authors Spece and Ibanez's interview of the Medical Director of one of Costa Rica's largest and most prestigious hospitals. When asked whether the hospital kept morbidity or mortality records concerning the performance of the many doctors practicing there, the physician answered that there were no such data but that he knew the identities of the good and bad doctors.[19] In comparison, such records are commonly kept in U.S. hospitals.

Other practical impediments to plaintiffs' success in Costa Rica include the protracted nature of litigation (it is not uncommon for a civil case to run for ten years when appeals are included); general absence of provider malpractice insurance; damages usually possibly only a small percentage of those awarded in comparable U.S. cases; great difficulty in obtaining expert witnesses; and a system that could be biased in favor of health care providers (as described above

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[17] MARIO ALBERTO SANCHEZ ARIAS, EL EXPEDIENTE MEDICO EN LA MEDICINA PRIVADA, 5 REVISTA LATINOAMERICANA DE DERECHO MEDICO Y MEDICINA LEGAL 25 (2001) (Spanish). It is inconceivable that a Medical Director in the U.S. would be so critical of care within his own institution in published literature. This article could reflect candor helpful to improvement in medical care or a very different relationship between hospital administration and health care providers in Costa Rica.

[18] See *infra* text accompanying notes 24-29, regarding miserable success rate for victims in actual Costa Rican cases.

[19] Interview with Dr. Jorge Cortes, Hospital Clinica Biblica, San Jose, Costa Rica (Nov. 2008) (notes of interview on file with author Spece). As to the keeping of such records in the U.S., see Timothy Jost, *Oversight Of The Quality Of Medical Care: Regulation, Management, Or The Market?, in* HALL ET AL., *supra* note 10, at 40-43

and below).[20] As might be expected given the many impediments mentioned here, it appears that medical malpractice complaints are a relatively rare phenomenon in Costa Rica, while successful claims are much more infrequent.

III. FREQUENCY OF MEDICAL MALPRACTICE CLAIMS IN COSTA RICA AND THE U.S.

We have three key sources of information on the frequency or success of Costa Rican medical malpractice claims: two articles in the Costa Rican medical-legal literature and reports of the Departamento de Planificación, Sección: Estadística, of the Costa Rican government from 1995 to 2011.

A. Dr. Ugalde-Lobo's Description of the Emergence of Malpractice Litigation in Costa Rica

Dr. Juan Gerardo Ugalde-Lobo explains the emergence of Costa Rican medical malpractice litigation in his 1994 article, *Court Demands for Professional Responsibility: the Case of Costa Rican Medicine*.[21] Prior to 1981, there were demands for health care provider professional responsibility before administrative agencies and within the Costa Rican College of Medicine and Surgery. The first such case before the courts was in 1981. It involved a woman named Cruz whose leg had to be amputated when a vein was mistaken as an artery during surgery. This case received extensive media attention.

Ugalde-Lobo also reports on 110 cases reviewed by the Forensic Unit between 1981 and 1991. Chart 1 from Ugalde-Lobo's article, reproduced here in English as Table 1, sets forth these cases by year of decision. Ugalde-Lobo explains the limitations on this data as follows: "This study does not include all of the demands that were made during those years, nor the demands of 1982 because medical records were not found for that year. It also does not include death cases because they are usually considered in the [Pathology Division]."[22] Ugalde-Lobo also states: "The demands for professional responsibility are only increasing. In 1991 there were 51, in 1992 there were 44, and 33 as of September 1993."[23]

Table 1. Cases in Forensic Unit

Year	No. of Cases
1981	1
1983	3

[20] Interview with Dr. Juan Gerardo Ugalde-Lobo, *supra* note 15; interview with Joaquin Picado, *supra* note 9.

[21] 10 MEDICINA LEGAL DE COSTA RICA 34 (1994) (Spanish).

[22] *Id.* at 35.

[23] *Id.* at 37.

1984	7
1985	12
1986	10
1987	13
1988	17
1989	4
1990	24
1991	19
Total	**110**

The last quoted statement is confusing because Table 1 lists only nineteen 1991 cases, not 51. Author Spece queried Ugalde-Lobo about this discrepancy, and he explained that 19 is the number of cases actually examined by the Forensic Unit, while 51 is the number of cases brought to the justice system, all but 19 of which were screened out without referral to the Forensic Unit because of unenumerated deficiencies. He also explained that the article's reference to not all the demands being included was made necessary because approximately 30% of the Forensic Unit's files had been lost.[24] Table 2 extrapolates what the numbers in Table 1 become when increased by 30%, the figure given by Ugalde-Lobo for missing records in the Forensic Unit.

Table 2. Projected Cases Accounting for Missing Records (30%)

Year	No. of Cases
1981	1.3
1983	3.9
1984	9.1
1985	15.6
1986	13
1987	16.9
1988	22.1
1989	5.2
1990	31.2
1991	24.7
Total	**143**

Data in one U.S. article indicate that approximately 29% of medical malpractice cases involve death.[25] In an effort to *speculate* what the numbers for all claims reviewed by both the Forensic Unit and the Pathology Division might have been, Table 3 indicates what the numbers in Table 2 become when increased on the basis of the 29% figure given by the U.S. article for the percentage of

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[24] Interview with Dr. Juan Gerardo Ugalde-Lobo, *supra* note 15.

[25] Charles Silver & David Hyman, *Access To Justice In A World Without Lawyers: Evidence From Texas Bodily Injury Claims*, 37 FORDHAM URB. L. J. 357, 362-363, tbl.1 (2010).

medical malpractice cases involving death. (The heroic assumption is that the rate of death cases to total cases is the same in the U.S. and Costa Rica.) To carry the speculation further, building on Table 3's hypothesized package of death and non-death complaints all in the Forensic Unit, Table 4 hypothesizes the number of all claims that might have been filed at the earliest stage before any screening out prior to forwarding to the Forensic Unit using the ratio (2.68 to 1) of screened out claims (51/19) for 1991 according to Ugalde-Lobo.

Table 3. Cases Projecting Inclusion of Death Cases (29%)

Year	No. of Cases
1981	1.83
1983	5.49
1984	12.81
1985	21.97
1986	18.31
1987	23.80
1988	31.13
1989	7.32
1990	43.94
1991	34.79
Total	**201.41**

Table 4. Cases Prior to Screening Assuming 2.68 to 1 Ratio of Unscreened to Screened

Year	No. of Cases
1981	4.90
1983	14.71
1984	34.33
1985	58.88
1986	44.94
1987	63.78
1988	83.43
1989	19.62
1990	117.76
1991	93.24
Total	**539.78**

Another observation regarding the Ugalde-Lobo data is that only five of the 110 cases reviewed by the Forensic Unit resulted in a finding that there was malpractice. When author Spece asked Ugalde-Lobo about this, he stated that, regardless of the legal definition of malpractice, it is very difficult for the prosecution to establish the same before the Forensic Unit; there could easily have been a finding of malpractice in 30% of the cases.[26]

[26] *See* interview with Dr. Juan Gerardo Ugalde-Lobo, *supra* note 15.

The low percentage of findings in favor of victims and the nature of the cases in which malpractice was found indicate that regardless of Costa Rica's similar theoretical formulation of negligence as a standard for culpability, there is a strong argument that in practice a gross or aggravated negligence standard is being employed. We have already mentioned one of the five cases, the Cruz matter in which an artery was mistaken as a vein. The other four cases involved two operations on healthy limbs, a hysterectomy on a pregnant patient, and leaving a foreign object in the patient's vagina.

The obvious pessimistic implications for plaintiffs of Ugalde-Lobo's data concerning the dearth of malpractice findings are even harsher when one considers that, even if the Forensic Unit concludes there is malpractice, liability still must ultimately be established to the satisfaction of the judiciary. According to the physicians and attorneys authors Spece and Ibanez interviewed, the criminal court almost always follows the recommendations of the Forensic Unit, but it might find legal technicalities that would lead to a finding in favor of the defendant even if the Forensic Unit found malpractice.[27]

B. Chaves-Moreno, Madrigal-Ramirez, and Ugalde-Lobo Report on Malpractice Cases from 1996-2000

Medical malpractice claims from 1996-2000 are set forth in a 2001 article by Allan Chaves-Moreno, Edgar Madrigal-Ramirez, and Juan Gerardo Ugalde-Lobo, *Complaints for Medical Responsibility in Gynecology/Obstetrics*.[28] The data contained in their Chart 3 is reproduced here in English as Table 5. Although the authors state that their statistics are from the Forensic Unit, they do not assert that the numbers represent only cases forwarded to the Forensic Unit, as opposed to the Pathology Division or only non-death files. The authors flatly state that the numbers are for cases before the judiciary. Therefore, we assume these to be the total number of complaints brought at the earliest possible stage of litigation.

Table 5. Complaints/Demands for Malpractice

Year	No. of Complaints
1996	160
1997	200
1998	213
1999	506
2000	280
Total	**1359**

[27] *See* interview with Joaquin Picado, *supra* note 9; interview with Dr. Juan Gerardo Ugalde-Lobo, *supra* note 15.

[28] 7 REV. LATINOAM. DE DERECHO MEDICO Y MEDICINA LEGAL 47 (2001) (Spanish).

The Chaves-Moreno article's main purpose is to report on the review of a sample of 50 obstetrics/gynecology cases handled by the Forensic Unit. The authors explained: "Twenty-nine (58%) were classified as unfounded, eleven (22%) were iatrogenic results, five (10%) were pending judicial investigations, and in five (10%), the doctor did not have a duty of care."

In other words, none of 45 cases actually ruled on resulted in a finding of malpractice—very bad odds indeed. Combined with the 5 in 110 successful cases reported by Ugalde-Lobo, the success rate is 5 out of 155, i.e., 3%.

C. Medical Malpractice Determinations by the Pathology Division from 2000-2010

According to Ugalde-Lobo, medical malpractice death cases are ruled upon by the Pathology Division.[29] The Statistics Section of the Department of Planning of the Costa Rican Judicial Branch publishes an annual report on deaths by homicide, suicide, and certain other causes. These reports—entitled *Anuario Policial*—include deaths found to be the result of medical malpractice.[30] The Pathology Division makes these determinations based on established criteria.[31] Such findings for the years 1995-2011 are set forth in Table 6. These data are included to indicate the relative infrequency of findings of medical malpractice by the Pathology Division. They can also serve as a starting point for possible extrapolations by others to the total number of claims made at the earliest point of entry by use of data concerning the percentage of cases in which the Forensic Unit finds malpractice (3%)[32] and the percentage of cases that do or do not involve death (29% death).[33] (The heroic *assumption* is, again, that the Costa Rican percentage is the same as that in the U.S.)

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[29] Interview with Dr. Juan Gerardo Ugalde-Lobo, *supra* note 15.

[30] The reports are available at http://www.poder-judicial.go.cr/planificacion/Estadisticas/policiales.html.

[31] Interview with Dr. Franklin Gonzalez Morales, Jefe: Departamento de Planificacion-Seccion: Estadistica (July 23, 2012) (notes of interview on file with author Spece).

[32] *See supra* note 25 and accompany text.

[33] *See supra* Part III.B.

Table 6. Death Cases Reported in *Anuario Policial*

Year	Death Cases
1995	3
1996	3
1997	10
1998	4
1999	14
2000	8
2001	15
2002	27
2003	13
2004	16
2005	24
2006	17
2007	9
2008	1
2009	13
2010	17
2011	15

D. The Number of Claims per 100,000 Costa Rica Residents for 1996-2000

The best numbers we have for Costa Rican claims are not extrapolations but the precise 1996-2000 numbers reported in the Chaves-Moreno article (Table 5 herein). Table 7 sets forth the population of Costa Rica and the number of claims per 100,000 residents for 1996-2000 based on the Table 5 data.

Table 7. Costa Rican Claims per 100,000 Residents

Year	Population Mid-Year	No. of Claims per 100,000 Residents
1996	3,536,004	4.52
1997	3,625,030	5.52
1998	3,713,735	5.74
1999	3,800,169	13.3
2000	3,882,581	7.2

E. The Number of Claims per 100,000 Residents of Florida, U.S. for 1996-2000

Table 8 sets forth the number of claims and the percentage of those where payment was made in Florida for 1996-2000. This table is a copy of certain

years from a table published in an article by U.S. scholars reporting on closed insurance claims in Florida.[34] Table 9 is the number of claims per 100,000 residents in Florida (1996 and 1997) and Costa Rica (1996-2000), respectively. 1996 and 1997 are the only years for which the Vidmar article supplies good Florida data. Table 9 is based on data in the Vidmar article and our calculations using both Vidmar's Florida population figures and Costa Rica population figures from the U.S. Census Bureau.[35] We used the Vidmar data because we feel they are the best available, and we have no reason to believe that Florida is atypical among the states. The authors explain the strength of their data as follows:

> Until now, obtaining a systematic profile has proven difficult. Pre-trial settlements are typically confidential and researchers cannot gain access to what actually resulted from the litigation. Moreover, if claims are settled without formal litigation they never appear in public court records even though such cases may account for substantial insurer losses. This is true for cases resulting in payment to claimants and for claims resulting in no payment; the latter still result in transaction costs for the defense. Similarly, jury verdicts for plaintiffs may be settled for lesser amounts in post-trial negotiations but the settlements usually remain invisible as confidential post-trial agreements between the parties. In this Article, we begin to piece together a basic profile of the medical malpractice tort system, including its "invisible" parts, over a fourteen-year period from 1990 through 2003. Our efforts are centered on the State of Florida . . . . A Florida statute, dating back to 1975, has required medical liability insurers to submit detailed reports of all closed claims to the Florida Department of Health. These reports form the backbone of this Article but they are supplemented by a second data source, an archive that we have constructed from jury verdict reports compiled by Westlaw.[36]

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[34] *See* Neil Vidmar et al., *Uncovering The "Invisible" Profile Of Medical Malpractice Litigation: Insights From Florida*, 54 DEPAUL L. REV. 315, 332 tbl.3 (2005).

[35] *International Programs—International Data Base*, U.S. CENSUS BUREAU, *available at* http://www.census.gov/population/international/data/idb/informationGateway.Php (last visited July 23, 2013).

[36] Vidmar et al., *supra* note 34, at 318-19.

Table 8. Frequency of Claims by Year and Percentage of Claims Resulting in Payment ***

Year	Reported Total Claims	Percent of Claims Resulting in No Payment	Total Paid Claims
***			
1996	3,093	42%	1,807
1997	2,882	39%	1,758
1998	2,289*	*	1,713
1999	1,510*	*	1,470
2000	1,577*	*	1,538
***			
* After 1997, the total claims data and the no payment claims data become unreliable because claims resulting in no payment were not required to be reported from 1998 through 2002.			

Table 9. Comparison of Claims per 100,000 Costa Rica and U.S. Residents

Year	Claims per 100,000 Florida Residents	Claims per 100,000 Costa Rican Residents
1996	21.15	4.52
1997	19.29	5.52
1998		5.74
1999		13.3
2000		7.2

The Vidmar authors explain certain limitations of their data, but these do not detract from the thrust of our observations here because they would lead to an understatement rather than an overstatement regarding the frequency of claiming behavior in Florida.[37] Here, we suggest that the frequency is higher in Florida than in Costa Rica.

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[37] *Id.* at 325.

> It is important to outline some of the limitations of the closed-claim files. They are not comprehensive of claims involving all health care providers. The Task Force reported that some parties claim that not all insurers comply with the statute. Certain health care professions are not covered. Certain neurological injuries sustained during birth are diverted to the Birth-Related Neurological Injury Compensation Plan. Not all physicians are represented in the data because they have opted

To compare the Florida numbers to the Costa Rica numbers is like mixing apples (closed insurance claims) and oranges (complaints at the earliest stage of Costa Rica's criminal/civil process). The comparison is useful nevertheless. What we are searching for here are the rates of claiming behavior and success of complaints in the U.S. and Costa Rica. There is a high correlation between insurance company claims and court claims in the U.S. The Vidmar article reports that there is a formal case filed in 80% of insurance claims.[38] In Costa Rica, most providers are not insured, and the best evidence of claiming behavior is therefore complaints brought in the criminal justice system rather than insurance company filings.

III. CONCLUSION

What conclusions can we draw regarding our hypotheses set forth at the beginning of this article? Our impressions are that the frequency of claims is relatively low in Costa Rica compared to the U.S. and that this is at least in part because of the poor prospects of winning and of obtaining adequate compensation even if one establishes liability. We have only the experience of Author Torrealba and interviews with Costa Rican professionals to support a general statement that damages are significantly more modest in Costa Rica. However, the prospects of losing are stark given the low percentage (3%) of Forensic Unit findings in favor of victims and the gross malpractice involved in the handful of cases in which there was a finding of malpractice in the cases reviewed in the Costa Rican literature. This compares to statistics indicating that U.S. plaintiffs win verdicts 20% to 30% of the time (note 10) and U.S. claimants (in Florida) received some payment in 39% to 42% of all matters (Table 8). Although the negligence or culpability standard is theoretically similar in the U.S. and Costa Rica, the latter seems in reality to require the prosecution/plaintiff to show gross or aggravated negligence. As to frequency of claims, in the two years for which there is good data for claims per 100,000 residents in both Florida and Costa Rica in 1996 and 1997, the numbers are 21.15 and 19.29 in Florida and 4.5 and 5.52 in Costa Rica,

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> not to buy liability insurance by signing a nonrevocable letter of credit to cover any medical negligence injuries suffered by their patients. In 2003, over 600 Florida doctors opted for this alternative means of maintaining a medical license. As already mentioned, after 1997, insurers were no longer required to report claims resulting in nonpayment, although the requirement was reinstated with an amendment in 2003. For this Article we have not separated hospitals or other institutional health care providers from individual health care providers. *** Nevertheless, the data are the best available and they provide important insights into the profile of medical negligence claims in Florida.

Id. at 328.

[38] *Id.* at 349.

respectively. The frequency of claiming is in the range of four times greater in Florida. However, if one compares the 1997 Florida figure of 19.29 to the uncharacteristically high 1999 Costa Rica figure of 13.3, the frequency in the two jurisdictions is similar. Specifically, the frequency in Costa Rica is over two-thirds (69%) of that in the U.S. It is also noteworthy that in Costa Rica claims grew from 1 in 1981 to 506 in 1999. At the same time, it is possible that the frequency of claims was decreasing in Florida (Table 8).

At the least, the information in this article raises interesting questions for further consideration and provides some insight to scholars and consumers alike.