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The Regulation of Traditional Practitioners: The Role of Law in Shaping Informal Constraints

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The Regulation of Traditional Practitioners: The Role of Law in Shaping Informal Constraints

Marcus Powlowski†

Abstract

Is the regulation of traditional practitioners a worthwhile endeavor? There is little empirical evidence to support the use of such regulations. Given the poor disciplinary record of comparable regulatory bodies in developed countries and the difficulty in enforcing laws in developing countries, it is unlikely that such regulatory agencies will discipline many practitioners. This does not mean that regulation cannot serve a useful purpose. Regulation is not only about disciplining the occasional bad apple. The regulation of health practitioners has a broader purpose that involves correcting market imperfections, shaping norms, applying self-imposed standards, and other informal constraints. These informal constraints exist in all cultures, and are as important as, if not more important than, formal rules in shaping human behavior. Part of the function of laws regulating traditional practitioners should be to recognize the existence of these informal mechanisms and to encourage and mold them in a socially desirable direction.

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I. Introduction

The World Health Organization (WHO) encourages member states to integrate, as appropriate, traditional and complementary

and alternative medicine (CAM)[1] into their national healthcare systems.[2] This recommendation is evidence of the WHO's respect for the practice of traditional medicine. In many ways, this respect is understandable. The majorities of the populations in countries such as China and India have been using traditional medicine for thousands of years.[3] Some traditional practices, such as acupuncture, have gained widespread international acceptance, even by many members of the Western medical community.[4] Furthermore, the pharmacological literature is replete with promising reports from the *in vitro* testing of traditional medicine.[5] Given this widespread acceptance of traditional medicine, and the

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1 The term complementary and alternative medicine "often refers to traditional medicine that is practiced in a country but is not part of the country's own traditions" or "health care that is considered to be supplementary to allopathic medicine." Allopathic medicine (also known as "Western," "scientific," or "modern medicine") is based on scientific principals and evidence. "Traditional medicine" is used to describe a form of practice "within the country of origin." World Health Organization [WHO], *Legal Status of Traditional Medicine and Complementary/Alternative Medicine: A Worldwide Review*, at 1-2, WHO/EDM/TRM/2001.2 2001 [hereinafter WHO (2001)].

2 *See id.*; WHO, *WHO Traditional Medicine Strategy 2002-2005*, at 5, WHO/EDM/TRM/2002.1 (2002) [hereinafter WHO (2002)]. However, the fifty-sixth World Health Assembly, held in May 2003, gave only a rather tepid endorsement of the need to integrate traditional medicine into national health care systems. WHO, *Traditional Medicine Resolution of the Executive Board of the WHO 111th Session*, WHO Doc. EB111.R12, Jan. 24, 2003.

3 *See* WHO (2001), *supra* note 1, at 131-34, 148-52.

4 *See, e.g.*, Edzard Ernst, *Acupuncture for rheumatic conditions*, Aug. 2006 www.UptoDate.com (discussing the use of acupuncture in treatment of rheumatic conditions); R. Joshua Wootton & Zahid H. Baiwa, *Nonpharmacologic therapy of headache*, Aug. 2006, www.UptoDate.com (discussing the use of acupuncture in the treatment of headaches).

5 MEDLINE® is the United States National Library of Medicine's (NLM®) premiere bibliographic database providing information from the field of medicine and other health sciences [hereinafter Medline]. A Medline search reveals numerous articles supporting this fact. *See, e.g.*, M.H.Dashti-Rahmatabadi et al., *The analgesic effect of Carum copticum extract and morphine on phasic pain in mice*, J. ETHNOPHARMACOLOGY, (2006) (published online before print), *available at* www.sciencedirect.com (search under "analgesic effect of Carum copticum extract and morphine on phasic pain in mice"); J. Purintrapiban et al., *Differential Activation of Glucose Transport in Cultured Muscle Cells by Polyphenolic Compounds from Canna indica L. Root*, 29 BIOLOGICAL & PHARMACEUTICALS BULL. 1995 (2006); P. Siripong et al., *Induction of Apoptosis in Tumor Cells by Three Naphthoquinone Esters Isolated from Thai Medicinal Plant: Rhinacanthus nasutus KUR*, 29 BIOLOGICAL & PHARMACEUTICALS BULL. 2070 (2006).

fact that traditional practitioners, who are often the first ones consulted when someone becomes ill, outnumber allopathic practitioners in many parts of the world,[6] integrating traditional practitioners into national healthcare systems appears to be a pragmatic approach to achieving WHO's objective of health for all.

There is, however, a need for caution. Traditional practices are not always beneficial, nor are they always benign. Recognizing this, WHO encourages the regulation of traditional medicine.[7] Indeed most countries, including many poor countries, now have legislation requiring the licensing of traditional practitioners.[8] This gives rise to a number of questions. Should developing countries regulate the practice? Is such intervention in the free market warranted? Are such regulations enforceable? Are regulations an effective means of ensuring quality of care? Unfortunately, there is scant empirical data to answer these questions. There is a paucity of literature pertaining to the effectiveness of medical regulations in developed countries, and thus it is no surprise that the issue of regulating traditional practitioners in developing countries has received almost no attention. Nevertheless, this is an issue that is ripe for exploration. The WHO and others advocate regulation.[9] Drafting legislation is costly and certainly there are other areas of healthcare that could use the money.

Informal constraints exist in all cultures and undoubtedly play some part in regulating the behavior of traditional practitioners. The question for those considering regulation is whether existing informal constraints are effective in supporting beneficial social exchange. In other words, the issue is whether the informal constraints function effectively in ensuring high-quality service. Although the answer to this question may vary from place to

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6 WHO (2001), *supra* note 1, at 3-4; WHO (2002), *supra* note 2, at 1-2.

7 WHO (2002), *supra* note 2, at 5; Xiaorui Zhang, *Foreward* to WHO (2001) *supra* note 1.

8 *See generally* WHO (2001), *supra* note 1 (providing information on the worldwide development of legal frame works regulating traditional and alternative medicines).

9 WHO (2002), *supra* note 2, at 5; Xiaorui Zhang, *Forward* to WHO (2001), *supra* note 1.

place, there is reason to believe that in many places informal constraints do not benefit social exchange or function effectively in ensuring objectively high-quality service. Given the failures of both the market and informal control mechanisms, regulation is warranted. Having passed the hurdle of justifying regulations, the next question is whether regulations are likely to work. At first blush, the answer is no. The regulation of health practitioners—particularly doctors—in developed countries is presumably the model for regulating traditional practitioners. There is little evidence that such regulations have been effective in developed countries, let alone in developing countries where adherence to the rule of law is at best tenuous. In addition, there would be the problem of establishing standards where such standards would be hard, if not impossible, to quantify.

A more careful and nuanced consideration of the role of law suggests that regulations can serve a useful function. Although establishing standards may be difficult, the law can get around this by prescribing what traditional practitioners cannot do (rather than entering into the difficult task of trying to define what they can do) and by requiring them to refer patients whom they are unable to treat. Lastly, a consideration of the role of law in shaping informal constraints suggests that even though it may be unrealistic to expect regulators to do much actual prosecuting, this does not mean that regulations are a futile endeavor. This is because the government's desire to improve the quality of traditional services might be realized by creating a set of rules that make a variety of informal constraints possible.

This paper will argue that regulating traditional practitioners may improve the quality of services such practitioners perform and that such regulation may be a worthwhile endeavor. In setting forth this argument, the paper is structured as follows: first, evidence is presented in support of the proposition that there is a problem: traditional practitioners can cause harm. Next, taking an economic perspective, the need for regulation will be argued by showing that unregulated markets for traditional medicine in developing countries do not work. The following two sections examine the role of informal and formal constraints, respectively. The paper then turns to the role of law in shaping informal constraints. The final section presents a brief conclusion.

II. A Caveat About Generalizing

One has to question the validity of making generalizations about traditional practitioners and CAM practitioners. Chiropractic therapy is different from massage therapy, and African traditional medicine is different from Chinese traditional medicine. The theoretical bases for such practices also vary widely. Some practitioners claim to be acting on the basis of scientific knowledge, whereas others act according to their spiritual or religious beliefs. Also, the educational backgrounds of practitioners differ widely. Korean traditional practitioners are trained in schools that employ the same educational standards as Western medical schools.[10] Few African traditional healers, on the other hand, will have had any classroom training in their profession.[11] The potential for causing harm also varies widely. Whereas it is hard to see how a Canadian aroma therapist could do any harm, the practice of bone setting in Africa involves considerable risk.

Even though the diverse collection of practitioners considered in this paper differ in many respects, they also share many common characteristics. Practitioners of Korean traditional medicine, massage therapy, or African traditional medicine all hold themselves out as being able to diagnose and treat illness or ailments. Few traditional practitioners make any attempt to base this practice on science or evidence.[12] Finally, like all medical

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10 Chang-yup Kim & Byungmok Lim, *Modernized Education of Traditional Medicine in Korea: is it Contributing to the Same Type of Professionalization seen in Western Medicine?*, 58 SOC. SCI. & MED. 1999, 1999 (2004).

11 WHO (2001), *supra* note 1, at 5-41.

12 WHO (2002), *supra* note 2. The degree to which different types of traditional medicine attempt to be science- or evidence-based varies. Some schools of traditional medicine are making an attempt to become more evidence-based. *See, e.g.*, RESEARCHES IN AYURVEDA: PAST AND PRESENT (Vaidya Gaur & Vaidya Sharma eds., 2000) (discussing the application of Ayurvedic medicine to a number of areas of medical knowledge); SCIENTIFIC BASIS FOR AYURVEDIC THERAPIES (Lakshmi Mishra ed., 2004) (exploring the scientific basis for the Ayurvedic approach to disease diagnosis and treatment). The editor in the latter work might object to the assertion that traditional medicine is not evidence-based. The editor in fact suggests that Western medicine's current emphasis on the need to be evidence-based means that it is becoming more like Ayurvedic medicine which requires the practitioner use "the best available scientific data about the efficacy of treatment modalities." *Id.* at 33. However the editor also seems to acknowledge that most of the treatment modalities used in Ayurvedic medicine have

practitioners, these practitioners make mistakes. When mistakes happen, people suffer.

One might also question the validity of lumping together traditional practitioners from different countries. Many of the considerations that are relevant in deciding whether or not to regulate and whether regulations may be effective will vary from country to country. Additionally, some countries, such as those in Southeast and Southern Asia, have already developed educational and regulatory institutions related to traditional medicine,[13] whereas others countries have not. The primary purpose of this paper is to consider the wisdom of such regulation in developing countries that have yet to regulate the profession. However, the same considerations apply, to varying degrees, to all countries.

In addition to considering whether traditional medicine should be regulated, this paper addresses the question of whether other types of health practitioners should be regulated. Notably, this paper will address whether a large group of Indian private practitioners who are referred to either as rural medical practitioners[14] (RMPs), less-than-fully-qualified[15] (LTFQ) practitioners, or with the less than flattering term "quacks" should be regulated.[16] Like traditional practitioners in Africa, these practitioners provide services for a large percentage of the Indian population,[17] work in poor and rural areas, and have varying levels of both education and proficiency.[18] These practitioners are said to

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been derived solely from experience and have been passed on from generation to generation. *Id.*

13 WHO (2001), *supra* note 1, at 129-41.

14 *See, e.g.*, B.V. Sharma, *Pilot Inventories of Unqualified Health Care Providers in Two Districts in Andhara Pradesh* at 6 (unpublished report to DFID India, British High Commission India) (on file with the North Carolina Journal of International Law and Commercial Regulation).

15 *See, e.g.*, Peter Berman, *Rethinking Health Care Systems: Private Health Care Provisions in India*, 26 WORLD DEV. 1463, 1474 (1998). Berman, *infra* note 19, at 1474.

16 According to a study conducted by the Association of Medical Consultants (AMC) in 1998, there are around 1.5 million "quacks" in India. *IMA Lodges Complaint Against 25 Quacks*, EXPRESS HEALTHCARE MGMT. *available at* http://www.expresshealthcaremgmt.com/20020715/hospi5.shtml# (last visited Dec. 26, 2006).

17 *Id.*

18 Sharma, *supra* note 14.

practice a mixture of allopathic and traditional medicine.[19] At one time RMPs were licensed, but this process came to an end in the mid-1970s.[20]

The second caveat also pertains to generalizing about traditional practitioners. The question of whether to regulate traditional practitioners seems to be a global problem, so this paper attempts a global approach. The subject is an immense one. Thoroughly canvassing all of the relevant literature would be impossible. The discussion here draws primarily from English speaking countries with common law legal systems: the United States, Canada, English speaking Africa, and India. The United States was chosen because of its long history of regulation and the abundance of academic literature that it has engendered. Africa and India were chosen because the issue (regulating traditional practitioners in the case of Africa, and formally unqualified allopathic practitioners in the case of India) is a particularly ripe one. In these two regions, governments are faced with similar problems in trying to decide how to regulate poorly educated practitioners of perhaps dubious quality. The problem is compounded by the governments' lack of resources and the fact that in these countries traditional practitioners provide much of the healthcare.

III. Making The Case For Regulation

This section looks at some of the literature relating to the harmful effects of certain traditional practices. The purpose of this section is not to blacken the name of traditional medicine. Like a surgeon colleague of mine is fond of saying, "what can go wrong, does go wrong, will go wrong."[21] What this means is that even the best clinicians sometimes experience failures and therefore Western medicine has its share of horror stories. The purpose of this section is only to attempt to show that a problem exists. Traditional medical practices are not always benign. Some practices pose real public health threats which merit regulation

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19 Berman, *supra note* 15 at 1465.

20 *Id.* at 1474.

21 Basil MacNamara, Chief of Surgery at Vila Central Hospital, Port Vila, Vanuatu, has considerable experience as a surgeon in developing countries and is an excellent clinician.

where they are not adequately addressed by informal mechanisms. The extent of the problem (and therefore the need for regulation) will vary from country to country and from one type of traditional medicine to another.

A. *Africa*

A Medline[22] search combining "traditional medicine" and "Africa" turns up primarily two types of articles: ethnopharmacology papers testing traditional medicines *in vitro* (few if any are clinical trials) and case series describing adverse effects arising from the use of traditional medicine.[23] The types of practices that most commonly give rise to problems include traditional birth practices,[24] bone setting,[25] and treatment of eye disease.[26] Inadvertent poisoning and delayed referrals also constitute significant problems.[27]

One Nigerian study showed that the babies of women delivered in an "unorthodox health center" had a significantly higher incidence of birth asphyxia[28] than did babies born in a hospital.[29] The birth asphyxia death rate in this study was 20.8%.[30] Other Nigerian case series have documented a number of other adverse outcomes arising from the delivery practices of Traditional Birth Attendants (TBAs).[31] These adverse effects

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22 *See* MEDLINE, *supra* note 5.

23 Although some of these studies have some epidemiological shortcomings, they serve to indicate that a problem exists.

24 *See infra* text accompanying notes 28-35.

25 *See infra* text accompanying notes 45-49.

26 *See infra* text accompanying notes 50-51.

27 *See infra* text accompanying notes 36-44.

28 Birth Asphyxia is defined as a "[b]aby not crying soon after delivery despite stimulation." S. Etuk & I. Etuk, *Relative Risk of Birth Asphyxia in Babies of Booked Woman Who Deliver in Unorthodox Health Facilities in Calabar, Nigeria*, 79 ACTA TROPICA 143, 144 (2001).

29 *Id.* at 145.

30 *Id.*

31 E. Alabi, *Cultural Practices in Nigeria*, 9 INTER-AFRICAN COMM. TRADITIONAL PRACTICES AFFECTING WOMAN & CHILDREN 6 (1990); O. Mabogunje, *Ritual Hot Baths (Wankan-jego) in Zaria, Nigeria*, 9 INTER-AFRICAN COMM. TRADITIONAL PRACTICES AFFECTING WOMAN & CHILDREN 10 (1990).

include vesicovaginal fistulas[32] after primitive symphysiotomies,[33] "agurya cut" (the removal of the hymen in seven day old female infants),[34] and mothers subjected to bathing in boiling water.[35]

Numerous studies have documented poisoning due to traditional medicine.[36] "An analysis of Johannesburg forensic data between the years 1991-1995 found 206 cases where traditional remedy was either stated to be the cause of death or discovered during the autopsy when the cause of death was poisoning due to an unknown substance."[37] Interestingly, in 38% of the cases the poison turned out to be pharmaceutical or industrial toxins.[38] Similarly, Queen Elizabeth Central Hospital in Malawi reported six deaths due to traditional medicine intoxication in a one-year period.[39] In the Chibwana study, the authors cautioned that "traditional medicines are particularly dangerous to give infants less than one year old."[40] Another South African study reported a clinical syndrome associated with the use of traditional enemas for sick children.[41] "Enema syndrome" is characterized by sudden deterioration after administration of a traditional enema.[42] Abdominal distension, respiratory distress, hypotonia, and loss of

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32 A vesicovaginal fistula is a tract linking the bladder to the vagina. This causes urine to leak into the vagina. STEDMAN'S MEDICAL DICTIONARY 731, 2121 (28th ed. 2006).

33 A symphysiotomies is a surgical procedure that entails cutting the ligament holding together the symphysis pubis. *Id.* at 1884.

34 INTER-AFR. COMM. ON TRADITIONAL PRACTICES AFFECTING THE HEALTH OF WOMEN & CHILDREN, FEMALE GENITAL MUTILATION, *available at* http://www.iac-ciaf.com/whatisfgm.htm (select "Types of Female Genital Mutilation" hyperlink).

35 Mabogunje, *supra* note 31, at 10.

36 *See, e.g.*, Chibwana et al., *Childhood Poisoning at the Queen Elizabeth Hospital, Blantyre, Malawi*, 78(6) E. AFR. MED. J. 292 (2001); M. Stewart et al., *Findings in Fatal Cases of Poisonings Attributed to Traditional Remedies in South Africa* 101(3) FORENSIC SCI. INT'L 177 (1999).

37 Stewart et al., *supra* note 36, at 177.

38 *Id.* at 179.

39 Chibwana et al., *supra* note 36, at 292.

40 *Id.* at 292.

41 D. Moore & N. Moore, *Paediatric Enema Syndrome in a Rural African Setting*, 18 ANNALS TROPICAL PEDIATRICS 139 (1998).

42 *Id.* at 139.

consciousness were reported.[43] Mortality amongst the fifty cases was reported as 28%.[44]

Other studies have reported adverse outcomes arising from treatment by traditional bonesetters (TBS).[45] One Nigerian case series reported that of the 225 limb amputations performed over a ten year period, 63.2% were the result of trauma that had been inappropriately treated by traditional practitioners.[46] Another Nigerian study found that of thirty-six fractures that were first treated by TBS, over half ended up with mal-unions,[47] and another quarter had non-unions.[48] In contrast, only 14% of the control group (treated by Western doctors only) suffered complications, primarily stiff joints.[49]

A number of studies have documented permanent eye injury following the use of traditional medicine for eye problems.[50] One of these studies from Tanzania showed that 25% of corneal ulcers were associated with the use of traditional medicine.[51] Several papers have also documented traditional medicine as a frequent cause of renal failure in Africa.[52]

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43 *Id.*

44 *Id.*

45 *See, e.g.*, E. Garba & P. Deshi, *Traditional Bone Setting: a Risk Factor in Limb Amputation*, 75 E. AFR. MED. J. 553 (1999); D. Olaolorun et al., *Complications of Fracture Treatment by Traditional Bonesetters in Southwest Nigeria*, 18 FAM. PRAC. 635 (2001); J. Onuminya et al., *Traditional Bone Setter's Gangrene*, 23 INT'L ORTHOPEDICS 111 (1999).

46 Garba & Deshi, *supra* note 45, at 553; *see also* Onuminya et al., *supra* note 45.

47 Olaolorun et al., *supra* note 45, at 635.

48 *Id.*

49 *Id.* at 636-37.

50 *See, e.g.*, Paul Courtwright et al., *Traditional Medicine Use Among Patients with Corneal Disease in Rural Malawi*, 78(11) BRIT. J. OPHTHALMOLOGY 810, 811 (1994); Susan Lewallen & Paul Courtwright, *Role for Traditional Healers in Eye Care* 345 LANCET 456, 456 (1995); Thodosia E. McMoli et al., *Epidemic Acute Hemorrhagic Conjunctivitis in Lagos, Nigeria*, 68 BRIT. J. OPHTHALMOLOGY 401, 401 (1984); James Mselle, *Visual Impact of Using Traditional Medicine on the Injured Eye in Africa* 70 ACTA TROPICA 185, 185 (1998).

51 D. Yorston & A. Foster, *Traditional Eye Medicine and Corneal Ulceration in Tanzania*, 97 AM. J. TROPICAL MED. & HYGIENE 211, 211 (1994).

52 *See, e.g.*, V. Luyckx et al., *Herbal Remedy-Associated Acute Renal Failure Secondary to Cape Aloes*, 39 AM. J. KIDNEY DISEASE E13 (2002); L.S. Otieno et al., *Acute Renal Failure Following the use of Herbal Remedies*, 68 E. AFR. MED. J. 993

Failing to refer patients who would benefit from Western medicine is another common problem. A case report from Malawi found that of eighty-nine patients with tuberculosis, 37% reported having consulted a traditional healer before seeking medical attention.[53] The healer treated these patients for an average of four weeks during which twenty-four of thirty-three deteriorated.[54] None were referred to doctors.[55] Similarly, in Madagascar, traditional practitioners are said to rarely refer patients with cerebral malaria (a disease with a very high mortality rate if left untreated) to doctors.[56] Traditional healers fail to refer these patients despite the fact that they can offer no effective treatment for the condition.[57]

A case report from Benin stated that frequent injuries resulting from traditional treatment administered for childhood convulsions.[58] Harmful traditional treatments included flagellation to revive the child, oral administration of urine (from cows or cats) or rubbing alcohol, as well as plunging a limb into boiling water, or into fire, in an attempt to revive the unconscious postictal[59] child.[60]

(1991); R. Wood et al., *Acute Dichromate Poisoning After Use of Traditional Purgatives. A Report of 7 Cases*, 77 S. AFR. MED. J. 640 (1990).

[53] J. Brouwer et al., *Traditional Healers and Pulmonary Tuberculosis in Malawi*, 2 INT'L J. TUBERCULOSIS & LUNG DISEASE 231, 231 (1998).

[54] *Id.*

[55] Between 1989-90, the author worked in Good Shepherd Hospital, Siteki, Swaziland. During that period this author saw numerous patients with advanced cases of tuberculosis. Many of these patients had been receiving treatment from traditional practitioners for prolonged periods before visiting the hospital. As a result of the delay in seeking treatment many, of these people were so far advanced in their disease that they could not be saved.

[56] Karin Leder & Peter Weller, *Epidemiology, Pathogenesis, Clinical Features, and Diagnosis of Malaria* (Burton D. Rose ed., 2006), www.UptoDate.com.

[57] Sheri Fink, *International Efforts Spotlight Traditional, Complementary, and Alternative Medicine*, 92 AM. J. PUB. HEALTH 1734, 1736 (2002).

[58] D. Ayivi, *Accidents Linked to Traditional Treatment of Convulsions of Infants and Children in Benin*, 85 DEV. ET SANTE 25 (1990).

[59] After a generalized seizure there is normally a period of decreased level of consciousness or confusion. The term "post-ictal" is used to describe this period. STEDMAN'S DICTIONARY, *supra* note 32, at 1546.

[60] Ayivi, *supra* note 58, at 25.

B. India

A Medline search of Indian traditional medicine reveals, as with the African literature, ethnopharmacology research showing some *in vitro* evidence that traditional medicines may be efficacious.[61] In comparison to Africa, there are significantly fewer case series reporting adverse outcomes attributable to the practice of traditional Indian medicine.

India's "private doctors"[62] are an eclectic mixture of people with a range of qualifications in an assortment of medical traditions.[63] Sorting out who practices what may be difficult. For example, many practitioners of Indian traditional medicine (particularly Ayurvedic practitioners) include allopathic treatment in their practice.[64] In addition to differences in schools of practice, there are large numbers of "medical practitioners" who have no formal qualifications of any kind.[65] These RMPs are said to practice a mixture of allopathic and traditional medicine.[66]

Surprisingly, given the large numbers of traditional healers and unqualified practitioners practicing in India, there are few, if any, large scale studies or case series looking at adverse outcomes resulting from such practices. However, there are a number of anecdotal reports of malpractice in the popular press. These reports implicate unqualified practitioners more often than traditional practitioners. For instance, in Delhi, a sixteen year old girl died while having her tongue operated on to prevent stuttering.[67] An unqualified practitioner gave an injection to a

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61 *See, e.g.*, Ichikawa et. al., *Withanolides Potentiate Apoptosis, Inhibit Invasion, and Abolish Osteoclastogenesis Through Suppression of Nuclear Factor-kappaB (NF-kappaB) Activation and NF-kappaB-regulated Gene Expression*, 5(6) MOLECULAR CANCER THERAPEUTICS 1436 (2006); R. Anandharagen et. al., *In Vitro Glucose Uptake Activity of Aegles Marmelos and Syzygium Cumini by Activation of Glut-4, PI3 Kinase and PPARgamma in L6 myotubes*, 13(6) PHYTOMEDICINE 434 (2006)

62 *See* HEMA VISHWANATHAN & JON ELIOT ROHDE, DIARRHOEA IN RURAL INDIA: A NATION WIDE SURVEY OF MOTHERS AND PRACTITIONERS 74 (1990). According to the authors, 62% of "rural doctors" have no formal qualifications. *Id.*

63 Berman, *supra* note 15, at 1472-73; Ramesh Bhat, *Regulation of the Private Health Sector in India*, 11 INT'L J. HEALTH PLAN. & MGMT. 253, 257 (1996).

64 Berman, *supra* note 15, at 1472.

65 *Id.*

66 *Id.* at 1473.

67 *Girl Dies on Quack's "Operation Table"*, EXPRESS NEWS SERVICE, June 7, 2004,

woman with a fever, who died the next day.[68] In Uttar Pradesh, a woman went to an unqualified doctor for the delivery of a baby.[69] After complications ensued, the "doctor" had to "amputate" part of the baby.[70] The mother later bled to death.[71] In Kerala, a woman died after registered practitioners of Indian traditional medicine performed a therapeutic abortion.[72]

Many of the problems associated with traditional practices in Africa also occur in India. There have been a number of case reports of heavy metal poisoning due to Indian traditional medicines.[73] Bonesetter's gangrene has also been observed in the Indian subcontinent.[74] The failure to appropriately refer patients is also a problem. One study reported that although 75% of RMPs claimed they referred patients regularly to public health facilities, only 38.7% had done so in the three months prior to the survey.[75]

A number of studies have suggested that the overall quality of many private medical practitioners in India is inadequate.[76] One study assessing sick infants concluded that unqualified practitioners provided a poor quality of care; however, it also found that traditional and allopathic practitioners did not provide significantly better services.[77] Another study from Bombay found

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http://cities.expressindia.com/fullstory.php?newsid=86794.

68 Celia Dugger, *Deserted by Doctors, India's Poor turn to Quacks*, N.Y. TIMES, Mar. 25, 2004, at A1.

69 Rashme Sehgal, *UP's Women Die in Childbirth for Want of a Four-Rupee Dai Kit*, INFOCHANGE, ¶ 7 (May 2004), http://www.infochangeindia.org/features169.jsp.

70 *Id.* ¶ 7.

71 *Id.*

72 *Dr. K. Mahabala Bhat v. K. Krishna*, 2000 CPR 369 (Ker 1999).

73 *See, e.g.*, R.W. Keen et al., *Indian Herbal Remedies for Diabetes as a Cause of Lead Poisoning*, 70 POSTGRADUATE MED. J. 113 (1994); J. Kew et al., *Arsenic and Mercury Intoxication due to Indian Ethnic Remedies*, 306 BRIT. MED. J. 506 (1993).

74 *See* G. Walker, *Traditional Bonesetters Gangrene* (letter), 23 INT'L ORTHOPEDICS 192 (1999).

75 Sharma, *supra* note 14, at 56.

76 *See* Isabelle de Zoysa et al., *Careseeking for Illness in Young Infants in an Urban Slum in India*, 47 SOC. SCI. & MED. 2101, 2101 (1998); C. Ashok Yesudian, *Behavior of the Private Sector in the Health Market of Bombay*, 9 HEALTH POL'Y & PLAN. 72, 76 (1994).

77 Zoysa et al., *supra* note 76, at 2108.

that a majority of key health sector personnel[78] thought "malpractice was rampant in the private sector."[79]

As in many parts of the world, unsafe private abortions are a problem in India.[80] According to one study, two to four of the fifteen to twenty abortions performed by "informal practitioners" each year in Kampur City, Uttar Pradesh result in "complications," including death.[81] Additionally, it has been estimated that 4-5 % of the pregnant women seen with acute bleeding at the University College of Medical Sciences have been "mishandled by untrained people who pretend to be doctors or *dais*."[82] Another study from Madhya Pradesh found that sixteen of twenty "informal practitioners" were using bogus medications as abortificants.[83]

C. *Other Countries*

Literature from other countries also documents adverse outcomes from the use of traditional practices. A 1995 case series from a hospital in Enga Province, Papua New Guinea reported 183 patients with complications of "bush thoracotomies."[84] A "bush thoracotomy is a procedure performed by traditional healers, involving an attempt to open the pleural cavity to let out "bad blood."[85] Of the patients presented, most had either empyemas

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78 Yesudian, *supra* note 76, at 72.

79 *Id.*

80 *See, e.g.*, Vanita Jain et al., *Unsafe Abortion: A Neglected Tragedy Review from a Tertiary Care Hospital in India*, 30(3) J. OBSTETRICS & GYNAECOLOGY RES. 197 (2004) (presenting data from a study looking at emergency gynecologic admissions to a tertiary care center in India over a 15-year period).

81 Alex George, Address at Abortion: a Symposium on the Multiple Facets of Medical Termination of Pregnancy: From Decoctions to Instruments (Dec. 2003) (transcript *available at* http://www.india-seminar.com/2003/532/532%20alex%20 george.htm).

82 Sanchita Sharma, *Delhi takes Scalpel to Cut Quackery*, INDIA EXPRESS NEWSPAPERS, Oct. 2, 1998, *available at* http://www.expressindia.com/ie/daily/ 19981002/27550024.html (quoting a doctor on the condition of anonymity).

83 Alex George, *Informal Providers of Abortion Care in Two Blocks of Madhya Pradesh and Social Perception About Them* (Centre for Health & Social Sector Studies 2003) *available at* www.cehat.org/aap1/mp.pdf.

84 J.J. Wallace & J. Tharion, *Complications of Bush Thoracotomy in the Highlands of Papua New Guinea*, 65 AUSTL. & N.Z. J. SURGERY 183, 183 (1995).

85 *Id.*

(puss in the pleural cavity) or superficial infections.[86] Two deaths were reported.[87]

Certain traditional Mexican practices have been shown to be either harmful or potentially harmful. Some Mexican remedies have been found to be hepatotoxic.[88] Other Mexican traditional medications have been found to be primarily composed of lead,[89] or to be the cause of clinical lead poisoning.[90]

Pneumonia is the leading cause of child mortality in the Philippines.[91] Studies have found that the delay in seeking medical treatment for respiratory infections is often attributable to parents first bringing their children to a traditional practitioner.[92] Likewise, in the Nusa Tenggara Barat province of Indonesia, where the infant mortality rate is estimated to be between 125 and 200 per 1,000 live births, many people first consult a traditional healer.[93] Some of these traditional practitioners were observed treating gastroenteritis with coffee, while others used injections of unknown substances.[94] Another Indonesian study looked at child

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86 *Id.*

87 *Id.*

88 Moustapha Bah et al., *Hepatotoxic Pyrrolizidine Alkaloids in the Mexican Medicinal Plant Packera Candidissima (Asteraceae: Senecioneae)*, 43 J. ETHNOPHARMACOLOGY 19, 19 (1994).

89 Leticia Yanez et al., *Toxicological Assessment of Azarcon, a Lead Salt Used as a Folk Remedy in Mexico: I. Oral Toxicity in Rats*, 41 J. ETHNOPHARMACOLOGY 91, 91 (1994).

90 Center for Disease Control, *Childhood Lead Poisoning Associated with Tamarind Candy and Folk Remedies—California, 1999-2000*, 51 MORBIDITY & MORTALITY WKLY. REP. 684, 685 (2002).

91 REPORT OF THE PHIL. DEP'T OF HEALTH, CHILD MORTALITY: TEN (10) LEADING CAUSES OF CHILD MORTALITY BY AGE-GROUP (1-4, 5-9, 10-14) & SEX NO. & RATE/100,000 POPULATION PHILIPPINES, 2000 (2000), http://www.doh.gov.ph/data_stat/html/child_mort.htm.

92 Andrew McNee et al., *Responding to Cough: Boholano Illness Classification and Resort to Care in Response to Childhood ARI*, 40 SOC. SCI. & MED. 1279, 1283-84 (1995); Mark Nichter & Mimi Nichter, *Acute Respiratory Illness: Popular Health Culture and Mother's Knowledge in the Philippines*, 15 MED. ANTHROPOLOGY 353, 370 (1994).

93 Jocelyn Grace, *The Treatment of Infants and Young Children Suffering Respiratory Tract Infection and Diarrhoeal Disease in a Rural Community in Southeast Indonesia*, 46 SOC. SCI. & MED. 1291, 1291 (1998).

94 *Id.* at 1296-97.

(under five) mortality in 10,000 households over an eighteen month period starting in July 1991.[95] Of the 141 deaths in this age group, fifty-nine children (42%) were found to have only received treatment by a traditional practitioner before they died, while another 22% received no treatment outside the home.[96]

The Philippine and Indonesian examples illustrate an important principle. They show that to ask traditional and CAM practitioners to "do no harm" is to ask too little. If visiting a traditional practitioner means a critical delay in seeking medical advice then the resultant harm can be just as devastating as when the harm results from a direct act.

IV. Why Regulate?

Why should a government want to regulate traditional practitioners? After reading the above section, the answer may seem self-evident: to prevent harm. However, the academic literature on healthcare regulation offers a more complicated answer. People who believe in the free market would argue that regulation is only necessary in order to compensate for market failures.[97]

Several types of market imperfections occur in the context of healthcare services. In order to have a perfect market, there needs to be perfect information.[98] That is to say, the consumer has to know "exactly what they want and how they can get it."[99] Only then will the consumer know how much he or she is willing to pay. Of course this is practically never the case in healthcare.[100]

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95 Bambang. Sutrisna et al., *Care-Seeking for Fatal Illnesses in Young Children in Indramayu, West Java, Indonesia*, 342 LANCET 787 (1993).

96 *Id.* at 787.

97 *See, e.g.*, ROBERT BALDWIN & MARTIN CAVE, UNDERSTANDING REGULATION 19 (1999); ROBERT BALDWIN ET AL., A READER ON REGULATION 9 (1998); Stephen Breyer, *Typical Justifications for Regulation* , *in* A READER ON REGULATION 59 (Robert Baldwin et al. ed., 1998); MARC ROBERTS ET AL., GETTING HEALTH REFORM RIGHT (2004); Linette McNamara et al., *Regulation of Health Care Professionals, in* CANADIAN HEALTH LAW AND POLICY 55, 56-60 (Jocelyn Downie et al. eds., 2d ed. 2002).

98 *See, e.g.*, McNamara et al., *supra* note 97, at 57; ROBERTS ET AL., *supra* note 97, at 249.

99 CAM DONALDSON & KAREN GERARD, ECONOMICS OF HEALTH CARE FINANCING: THE VISIBLE HAND 21 (1993).

100 *See* McNamara et al., *supra* note 97, at 57; ROBERTS ET AL., *supra* note 97, at

The patient usually goes to the practitioner precisely because they do not know what is wrong with them. In addition, buying healthcare is not like buying a mango. When someone buys a mango they know what they are paying for. The same cannot be said for buying healthcare. Patients do not know what the alternative diagnosis might be, what the treatment options are, or anything about the practitioner's level of knowledge and skills.[101]

Although imperfect information constitutes a major barrier to the formation of an efficient market for health services in developed countries, the problem is potentially much worse in many developing countries. The population in such countries is usually less educated than in developed countries and is less likely to have access to sources of information such as the print media, television, or the internet.

Another requirement for a perfect market is that the individual transaction will not have any effect on third parties. In economic terms, there can be no "externalities."[102] If externalities exist, then the real costs and benefits of the agreement are not being borne by the parties to the agreement but rather by third parties.[103] The possibility of externalities arises not altogether infrequently in the context of health care.[104] For example, say a patient has tuberculosis (TB) and visits the doctor. The doctor misdiagnoses the patient and sends him or her home with a cough syrup. The patient dies six months later from a myocardial infarction completely unrelated to the TB. Although the patient may be happy enough with the treatment, six other people get infected with TB because the cough syrup does not stop the spread of the disease. Infection of the additional people is an externality.

For a perfect market there also needs to be true competition

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[101] *See* McNamara et al., *supra* note 97, at 57; ROBERTS ET AL., *supra* note 97, at 249.

[102] *See, e.g.*, McNamara et al., *supra* note 97 at 57; ROBERTS ET AL., *supra* note 97, at 249.

[103] *See, e.g.*, McNamara et al., *supra* note 97 at 57; ROBERTS ET AL., *supra* note 97, at 249.

[104] *See, e.g.*, McNamara et al., *supra* note 97, at 57; ROBERTS ET AL., *supra* note 97, at 249.

among suppliers.[105] There can be no monopoly. In the context of the market for traditional medicine, this is yet another condition that may not be fulfilled. Some people have no alternative other than to use traditional practitioners. This may be because access to Western medical facilities may be physically difficult or impossible,[106] or because the cost of using Western medicine constitutes an economic barrier.[107]

It may come as no surprise that conditions may not exist for a perfect market, as economists agree that rarely, if ever, is there a "perfect market." Rather, market failure is a question of degree and therefore the need for regulatory intervention should depend on the nature and the degree of market failure. That being said, it has been suggested that extensive government involvement is particularly warranted in the healthcare context.[108] This is because none of the conditions for a perfect market exist and instead there is complete market failure.[109]

Of all the market imperfections associated with healthcare delivery, the most important from the regulatory point of view, is imperfect knowledge. This was the basis for the United States Supreme Court decision upholding the constitutionality of mandatory licensing of doctors in 1889.[110] Justice Field stated the following in that judgment:

> Every one may have occasion to consult him [a doctor], but comparatively few can judge of the qualifications of learning and skill which he possesses. Reliance must be placed upon the

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105 *See, e.g.*, ROBERTS ET AL., *supra* note 97, at 249; McNamara, *supra* note 97, at 57.

106 *See* Litiana Kuridrani, *Institutionalizing Traditional Medicine in the Fiji Islands*, TOK BLONG PASIFIK, Spring 2002, at 13; Food and Agriculture Organization of the United Nations [FAO], Forest Products Division, *Marketing of Indigenous Medicinal Plants in South Africa—A Case Study in Kwazulu Natal* U.N. DOC. W9195/E (1998) (prepared by Myles Mander); WHO (2001), *supra* note 1, at 3.

107 WHO (2001), *supra* note 1, at 3; *Zimbabwe: Boom for Traditional Healers as Health Care Costs Rise*, IRINNEWS.ORG, Aug. 22, 2004, http://www.irinnews.org/print.asp?ReportID=40866.

108 McNamara et al., *supra* note 97 at 57; DONALDSON & GERARD, *supra* note 99, at 28.

109 McNamara et al., *supra* note 97 at 57; DONALDSON & GERARD, *supra* note 99, at 28.

110 Dent v. West Virginia, 129 U.S. 114 (1889).

> assurance given by his license, issued by an authority competent to judge in that respect, that he possesses the requisite qualifications.[111]

A second reason for regulating healthcare is as a means of reducing transaction costs.[112] Many formal and informal constraints may be viewed as ways of reducing transaction costs. Regulations are one formal way of reducing these costs.

The adverse health outcomes resulting from traditional practitioners enumerated in the section above can be seen as arising from market imperfections. Presumably, a well-informed consumer would: 1) choose to avoid a traditional bone setter if they realized that using such services greatly increased his or her chance of requiring an amputation, 2) choose to go directly to a medical practitioner when they had tuberculosis, or 3) avoid traditional medicines with the knowledge that they had the potential to cause corneal scarring and blindness.

Another way to look at the problem is in terms of transaction costs. In poor countries, the cost of acquiring the requisite information to make an informed choice as to whether to use a traditional practitioner is often prohibitively high. The usual sources of information available in the village include grandmother's advice, the reputation of the traditional practitioner (learned by word of mouth), and previous experience with the practitioner. These sources are easy and inexpensive to obtain. In contrast, information about the comparative advantages of Western medicine, its scientific basis, and empirical evidence of its effectiveness, is less accessible and more expensive to acquire. The same is true for ascertaining whether a particular traditional practitioner is actually effective. Although complete information may lead to better treatment and thus a more desirable outcome, the higher costs of obtaining such information are more immediate to the consumer. Therefore, transaction costs favor choosing a practitioner based on cheap but inaccurate information, rather than making a decision based on more expensive but accurate information.

Regulatory intervention can alter transaction costs in a

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[111] *Id.* at 122-23.

[112] *See* ROBERTS ET AL., *supra* note 97, at 249; DOUGLASS NORTH, INSTITUTIONS, INSTITUTIONAL CHANGE AND ECONOMIC PERFORMANCE 27-36 (1990).

multitude of ways.[113] A simple example is a license, which provides the consumer with inexpensive but valuable information about the practitioner. By reducing information costs associated with obtaining accurate information it allows for more complete wealth capture.

Lastly, there is another reason for the need for government intervention in the transaction between practitioners and their clients. This reason illustrates a shortcoming in the economics paradigm. Economists measure value in terms of subjective utility.[114] In the context of the poor and uneducated, there may be cases where the patient is happy with the results of his or her transaction, but in reality, suffers as a result of inadequate treatment. Take for example the healer who tells his patient that his cough and loss of weight are the result of bad medicine put on him by a witchdoctor at the instigation of a village rival.[115] The villager may be perfectly content with the healer's diagnosis. The only action the villager takes, relating to the diagnosis, is to prompt his family to assault, or burn down the house of the rival or the witchdoctor.[116] Although the villager has no complaint about the treatment he has received, he eventually will die a premature death due to TB, a treatable disease.[117] Would the economist say that the government has a role in intervening in this sort of transaction? Perhaps because there are negative externalities (the possibility of transmission of disease), but assume there were none. Perhaps there was incomplete information. The villager, in this example, did not know that he had TB, and maybe if he had known he would not have chosen to transact with the healer. But,

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113 *See* NORTH, *supra* note 112, at 46-47.

114 *See* Marc Roberts & Michael Reich, *Ethical Analysis in Public Health*, 359 LANCET 1055, 1055-56 (2002) (explaining how different ethical schools of thought can lead to different conclusions as to what is desirable in healthcare).

115 *See* Hallie Ludsin, *Cultural Denial: What South Africa's Treatment of Witchcraft Says for the Future of Its Customary Law*, 21 BERKELEY J. INT'L L. 62, 76-77 (2003) (regarding traditional cultural attitudes toward illness in South Africa); Donald Pollock, *Healing Dilemmas*, 69 ANTHROPOLOGICAL Q. 149, 151 (1996) (describing the traditional belief about disease causation held by the Kulina of western Brazil).

116 *See generally* Ludsin, *supra* note 115 (regarding the violence associated with the use of witchcraft in South Africa).

117 *See, e.g.*, John Bass, *General Principles of Treatment of Tuberculosis*, Aug. 2006, www.UpToDate.com (discussing the treatment of tuberculosis).

suppose that even if he was told he might have TB, he preferred the traditional healer's explanation. According to the classic economic model there are no market imperfections in this scenario and therefore regulatory intervention to prevent this sort of outcome would not be justified.

Many people would, however, consider government intervention to prevent the occurrence of the above scenario to be both legitimate and desirable. To advocate such a position is to adopt an objective utilitarian position.[118] According to this view, the government has an interest, and perhaps a paramount interest, in the well-being of the citizenry regardless of whether the citizenry is subjectively content with the treatment that they are receiving. The judgment of the United States Supreme Court in *Dent v. West Virginia* reflects this ethical position in stating that "[t]he power of the state to provide for the general welfare of its people authorizes it to prescribe all such regulations as, in its judgment, will secure or tend to secure them against the consequences of ignorance and incapacity."[119]

V. Informal Constraints

Before considering the role of regulations, it is worth considering the alternative. Legal rules constitute only a small, but significant, part of the total constraints on human behavior.[120] There are many other types of constraints, both formal and informal. Such constraints range from "taboos, customs, and traditions at one end to written constitutions at the other."[121] Macauley's 1963 study of business practices in Wisconsin was one of the earliest works suggesting informal constraints may be more important than legal constraints.[122] Macauley found that, despite the existence of formal legal contracts, merchants rarely sued when sales contracts were broken.[123]

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118 *See* Roberts & Reich, *supra* note 114, at 1055-56.

119 Dent v. West Virginia, 129 U.S. 114, 122 (1889).

120 NORTH, *supra* note 112, at 36.

121 *Id.* at 46.

122 Stewart Macauly, *Non-Contractual Relations in Business: a Preliminary Study*, *28* AM. SOC. REV. 55, 60-62 (1963).

123 *Id.*

In the late 1980's Robert Ellickson went to rural California to see how cattle ranchers solved disputes over wayward cattle.[124] He found that people rarely brought their disputes to court.[125] Instead they resorted to informal constraints in resolving disputes.[126] He concluded that "adaptive norms of neighborliness trump formal legal entitlements."[127] Studies of different American communities have come to similar conclusions; non-legal constraints are often more important than legal constraints.[128] Other examples are Lisa Bernstein's examination of relations within the New York diamond dealers,[129] Bernstein's study of the cotton industry,[130] and James Acheson's study of Maine lobster fisherman.[131] It has even been suggested that the behavior of lawyers in the United States is primarily regulated through the use of informal constraints.[132]

Informal constraints can be broadly classified into the following groups: self-imposed constraints (personal ethics), regulation by those who are directly party to a transaction, informal third party constraints (cultural norms), and formal and informal third party constraints (networks, trade associations and the like).[133] The different forms of constraints interact with each

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124 ROBERT ELLICKSON, ORDER WITHOUT LAW: HOW NEIGHBORS SETTLE DISPUTES (1991).

125 *Id.* at 1.

126 *Id.*

127 *Id.* at 4.

128 *Id.*

129 Lisa Bernstein, *Opting Out of the Legal System: Extralegal Contractual Relations in the Diamond Industry*, 21 J. LEGAL STUD. 115 (1992).

130 Lisa Bernstein, *Private Commercial Law in the Cotton Industry: Creating Cooperation Through Rules, Norms, and Institutions*, 99 MICH. L. REV. 1724 (2001).

131 *See* JAMES ACHESON, THE LOBSTER GANGS OF MAINE (1988).

132 Bradley W. Wendel, *Nonlegal Regulation of the Legal Profession: Social Norms in Professional Communities*, 54 VAND. L. REV. 1955 (2001) [hereinafter Wendel (2001)]; Bradley W. Wendel, *The Legal Profession: Looking Backward: Regulation of Lawyers Without the Code, the Rules, or the Restatement: or, what do Honor and Shame Have to Do with Civil Discovery Practice?*, 71 FORDHAM L. REV. 1567 (2003) [hereinafter Wendel (2003)].

133 *See* Douglass North, *The New Institutional Economics and Third World Development*, *in* THE NEW INSTITUTIONAL ECONOMICS AND THIRD WORLD DEVELOPMENT 17, 23 (John Harriss ed., 1997); Amitai Aviram, *Regulation by Networks*, 2003 BYU L. REV. 1179, 1186 (2003); ELLICKSON, *supra* note 124, at 126-32.

other, sometimes undermining, but most often reinforcing one another.

Informal constraints may play a role in controlling the behavior of traditional practitioners, helping to ensure the provision of quality services. Indeed, in the absence of formal regulation they are the only constraint. A government interested in safeguarding the health of the population may therefore want to know whether these informal mechanisms are adequate. The following section looks at the various forms of informal constraints and how they may act to constrain the behavior of traditional practitioners.

A. *Repeat Dealing, Reputation, and Informal Sanctions*

Economists have argued that in a unique, non-simultaneous transaction where the two parties have little knowledge of each other and there is no third party enforcement mechanism, there will be a temptation for one or both parties to cheat.[134] This is because economists see people as primarily wealth-maximizing, and therefore predisposed to taking advantage of each other.[135] This scenario may potentially lead to an inefficient outcome when one or both parties choose to forego a potentially profitable exchange rather than risk being cheated. This is known as the prisoner's dilemma.[136]

Game Theory suggests that cooperation can arise spontaneously, in the absence of third-party enforcement, when two conditions are met: the game is repeated and the two parties have complete information about each other's past performance.[137] These conditions can best be met in small communities,[138] "close-knit" communities,[139] where there is "lock-in,"[140] where the

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134 *See, e.g.*, NORTH, *supra* note 112, at 12-13; ERIC POSNER, LAW AND SOCIAL NORMS 11-12 (2000).

135 *See, e.g.*, POSNER, *supra* note 134, at 150.

136 *See, e.g.*, ROBERT AXELROD, THE EVOLUTION OF COOPERATION 7 (1984); NORTH, *supra* note 112, at 13; POSNER, *supra* note 134, at 12.

137 AXELROD, *supra* note 136, at 125.

138 *See* NORTH, *supra* note 112, at 34; ELLICKSON, *supra* note 124, at 182.

139 ELLICKSON, *supra* note 124, at 177-82.

140 John McMillan & Christopher Woodruff, *Private Order Under Dysfunctional Public Order*, 98 MICH. L. REV. 2421, 2426 (2000).

availability of trading partners is limited,[141] through "clientization,"[142] when dealing with family, relatives,[143] or within a homogeneous ethnic community.[144]

Those who have spent time in developing countries where the rule of law is weak may recognize the relevance of this theory. Whereas in small communities there may be a high degree of honesty, doing business in a large community may be frustrating. It is not only outsiders who experience these problems. Geertz found that in the Moroccan bazaar "the pervasive ignorance regarding the quality of goods, and the reliability of traders is mitigated by 'clientization.'"[145]

Although this kind of private ordering is of particular relevance in developing countries where the rule of law is weak,[146] it is also important in the business community of developed countries.[147] This is because informal means of ensuring cooperation are easier to use and less costly than the legal system. In other words, the use of informal mechanisms reduces transaction costs.[148] In addition, non-legal enforcement mechanisms may be preferable because they are less likely to sour relationships.[149]

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141 *Id.*

142 *See* Clifford Geertz, *The Bazaar Economy: Information and Search in Peasant Marketing*, 68 AM. ECON. REV. 28, 30 (1978). Clientization is "the pairing off of buyers and sellers in repetitive transactions." Richard Posner, *A Theory of Primitive Society with Special Reference to Law*, 23 J. L. & ECON 1, 3 (1980).

143 *See* Posner, *supra* note 142, at 12.

144 *See* McMillan & Woodruff, *supra* note 140, at 2433-34.

145 Geertz, *supra* note 142, at 31.

146 McMillan & Woodruff, *supra* note 140, at 2446-48 (presenting some empirical evidence in support of this proposition). *See generally* NORTH, *supra* note 112, at 37-39 (discussing the importance of informal structures in constraining behavior in primitive societies); Posner, *supra* note 142, at 8.

147 McMillan & Woodruff, *supra* note 140, at 2425 (discussing how relational contracting continues to exist even in countries with sophisticated legal systems); NORTH, *supra* note 112, at 39-40; POSNER, *supra* note 134, at 149-50 (discussing the importance of repeat dealing, reputation, and membership in social circles to in modern commercial relations); *see generally* David Charny, *Nonlegal Sanctions in Commercial Relationships*, 104 HARV. L. REV. 375 (1990).

148 *See* ELLICKSON, *supra* note 124, at 281; McMillan & Woodruff, *supra* note 140, at 2425; NORTH, *supra* note 133.

149 *See* ELLICKSON, *supra* note 124, at 62.

Repeat dealing is not always possible. Even in small communities, parties may rarely have occasion for repeat transactions with each other. Parties are often unfamiliar with each others' past performance as well. When this is the case, one or both parties may be tempted to cheat. This temptation can be reduced if information about behavior is spread from one person to another. Gossip is a means of sharing such information.[150] It is a particularly important form of information sharing in small communities, whether the small community is a village or a group of individuals who share a profession.[151] Gossip determines an individual's reputation, which in turn becomes a cheap and easy basis for deciding with whom to transact. It is not surprising therefore that reputation[152] and honor[153] are of particular importance in cultures where there is no recourse to legal enforcement.

Repeat dealing, personal knowledge, knowledge of reputation or the personal information gained through gossip reduces transaction costs, as it provides an inexpensive way of ensuring that individuals only do business with those who will likely keep their end of the bargain. In the absence of third party enforcement mechanisms, the threat of informal sanctions can also be used to ensure enforcement of an agreement after it has been made. In California, ranchers may threaten to seize or kill trespassing cattle, or in Maine those who trespass on someone else's territory may find their lobster pots have been sabotaged.[154] Lawyers will make life difficult for those who are seen to act improperly by excluding them from referral networks and by refusing to extend to them the usual time-saving informalities like carrying out transactions on

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150 Amitai Aviram, *A Paradox of Spontaneous Formation: The Evolution of Private Legal Systems*, 22 YALE L. & POL'Y REV. 1, 20 (2004); ELLICKSON, *supra* note 124, at 181.

151 Wendel (2003), *supra* note 132, at 1605.

152 POSNER, *supra* note 134, at 218; *see also* Charny, *supra* note 147, at 393 (discussing the importance of reputation as a nonlegal sanction in commercial relations); Aviram *supra* note 133, at 1193 (discussing the private ordering literature in general)

153 POSNER, *supra* note 134, at 218; Posner, *supra* note 142, at 27; Wendel (2003), *supra* note 132, at 1605-06.

154 ELLICKSON, *supra* note 124, at 58; James Acheson, *Lobster Trap Limits: A Solution to a Communal Action Problem*, 57(1) HUM. ORG. 43, 47 (1998).

the telephone.[155]

The threat of violence also plays an important role in some societies[156] and in certain subcultures within developed countries.[157] Not only is the threat of immediate violence an important motivating factor in some countries, the mere possibility of violence often has special relevance in that it may result in an ongoing feud between families, tribes, or clans.[158] The desire to avoid a feud can therefore be a powerful incentive for people to ensure that their own family or tribal members engage in fair dealing.

Informal sanctions can also be particularly effective when they threaten to impinge on an individual's personal life. This possibility arises when an individual's personal life and sense of honor are intertwined with their professional life.[159] This is often the case as individuals who are in a common profession or business frequently spend considerable time together, either at conferences or in other non-business settings.[160] Fair dealing is particularly important in these situations, because failure to do so results in social costs to the individual.[161]

How relevant are repeat dealing, reputation, and informal sanctions in the context of traditional healers? Speculatively, these factors play an important role in ensuring that traditional practitioners deliver a certain caliber of service. However, before continuing, a brief digression is necessary. Some Western practitioners might well ask what "quality services" really means. Such skeptics might argue that as the effectiveness of most traditional practices has never been scientifically proven,[162] it is impossible to say what is, or is not, quality service. Although this

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155 Wendel (2003), *supra* note 132, at 1576.

156 NORTH, *supra* note 112, at 37-38; Posner, *supra* note 142, at 27.

157 *See, e.g.*, Curtis Milhaupt & Mark West, *The Dark Side of Private Ordering: An Institutional Analysis of Organized Crime*, 67 U. CHI. L. REV. 41, 50-51 (2000).

158 NORTH, *supra* note 112, at 38.

159 Bernstein, *supra* note 129, at 1749 (detailing how business reputation in the American cotton industry affected status in the community).

160 Bernstein, *supra* note 129, at 1749; Charny, *supra* note 147, at 393-94.

161 Charny, *supra* note 147, at 393-94.

162 *See supra* note 12 and accompanying text (regarding traditional medicine being evidence-based).

may be true, it is still possible to define some basic parameters as to what constitutes quality service. Quality service should, at a minimum, include (a) using treatments which the healer's experience suggests will help the patient, (b) foregoing potentially damaging forms of therapy, (c) informing patients when they think their treatment is unlikely to be effective, and (d) referring patients with medical conditions which are serious and only amenable to Western medicines or surgery.

It seems safe to assume that the desire for repeat business motivates traditional practitioners to do a good job. Literature from Senegal,[163] South Africa,[164] India,[165] and China[166] confirms that traditional practitioners also consider reputation and honor to be important. The fact that traditional practitioners consider this important will encourage a certain quality of service. There is also some evidence that the threat of violence[167] or social ostracism[168]

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163 *See* Sekou Balde & Claude Sterck, *Traditional Healers in Casamance, Senegal*, 15 WORLD HEALTH FORUM 390, 390 (1994).

164 Andrew Maykuth, *Traditional Healers Face a New World|In South Africa, That Includes Insurance*, PHILADELPHIA INQUIRER, Dec. 1, 1997, at A1.

165 K.R. Srikanta Murthy, *Professional Ethics in Ancient Indian Medicine, in* CROSS CULTURAL PERSPECTIVES IN MEDICAL ETHICS: READINGS 126, 128 (Robert M. Veatch ed., 1989).

166 Ricong Peng, *How Professional Values are Developed and Applied in Medical Practice in China*, 30 HASTINGS CTR. REP. S23 (2000); *see also* Tao Lee, *Medical Ethics in Ancient China, in* CROSS CULTURAL PERSPECTIVES IN MEDICAL ETHICS: READINGS 132, 132 (Robert M. Veatch ed., 1989).

167 *See* Ludsin, *supra* note 115, at 86 (according to Ludsin witch doctors and sorcerers in South Africa might have their homes burnt or be killed, however, the reason for this seems to be more often suspicion that the sorcerer caused an illness, death or other misfortune, rather than the sorcerer's failure to cure); *see also* A.J.G.M. Sanders, *Towards the Legalization of African Folk Medicine*, 7 MED. L. 523, 527 (1989) (discussing how witches and sorcerers themselves use violence). This author was personally involved in a situation in Papua New Guinea where a physiotherapist had to make a hasty retreat after an elderly man had a cardiac arrest while undergoing chest physiotherapy. A surgeon returning from Mozambique told the author that he had, at times, been forced to operate with a gun pointed at his head during that country's civil war. If the threat exists for Western practitioners, it also likely exists for traditional practitioners.

168 *See* Edward C. Green, *Can Collaborative Programs Between Biomedical and Indigenous Health Practitioners Succeed?*, 27 SOC. SCI. MED. 1125, 1128 (1988) (suggesting that African traditional practitioners see their standing in their community as important to them).

may also motivate traditional practitioners to provide quality service. Whether or not such constraints are effective in promoting the delivery of objectively high-quality healthcare is a question that will be addressed after considering other forms of constraints.

B. Norms

The next level of sophistication of informal constraints is social norms. Richard McAdams defines norms as "informal social regularities that individuals feel obligated to follow because of an internalized sense of duty, because of fear of external non-legal sanctions, or both."[169] According to North, informal rules or constraints, which include norms, are "socially transmitted information and are a part of the heritage that we call culture."[170]

Ellickson found that social norms he studied in Shasta County, California generally reduced transaction costs by providing a set of mechanisms for quickly and cheaply dealing with situations that could give rise to conflict.[171] For example, the most common response to cattle trespass was to telephone the owner and tell them that the cattle were somewhere they were not supposed to be. The owner would then usually promptly come over, retrieve the stray animal, and thank the individual concerned.[172] Those who invoked formal legal rules instead of applying social norms were considered deviants.[173]

Group norms are important and seem to arise spontaneously. As one commentator suggests, "when men work together in the same place, on the same terms, and with common work problems, they will develop a set of standards and procedures by which to judge and manage those problems, and they will discourage deviation from those standards."[174]

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169 Richard McAdams, *The Origin, Development, and Regulation of Norms*, 96 MICH. L. REV. 338, 340 (1997).

170 NORTH, *supra* note 112, at 36-37.

171 *See generally*, ELLICKSON, *supra* note 124.

172 *Id.* at 53.

173 *See id.* at 60-64.

174 ELLIOT FREIDSON, PROFESSIONAL DOMINANCE: THE SOCIAL STRUCTURE OF MEDICAL CARE 220 (1970); *see also* JOSEPH M. JACOB, DOCTORS AND RULES: A SOCIOLOGY OF PROFESSIONAL VALUES 123 (2d ed. 1988) (citing ELLIOT FREIDSON,

Norms are undoubtedly of some relevance in the control of traditional practitioners. W. Bradley Wendel has written about the relative importance of norms versus legal rules in regulating the behavior of lawyers in the United States.[175] Undoubtedly, norms also play an important role in constraining physician behavior.[176] The literature on this subject is obscured by the fact that most of the medical literature uses a different set of terminology. The extensive literature on "professionalism" is ostensibly about such norms.[177]

In considering the effectiveness of norms, the question is not just whether the norms constrain behavior, but whether those norms constrain behavior in a way that encourages the provision of quality services. In the context of norms within the Western medical profession, it can be argued that the answer is generally that the norms encourage the provision of quality services. This is because the professionalism that the medical community chooses to promote is, in essence, the subset of community norms which lead to objectively beneficial outcomes for the patient. These norms include the need to do the following: stay up to date; use evidence-based medicine; refer patients when "you are in over your head;" "always err on the side of safety;" and "do no harm."[178]

PROFESSIONAL DOMINANCE: THE SOCIAL STRUCTURE OF MEDICAL CARE (1970)).

175 Wendel (2001), *supra* note 132; Wendel (2003), *supra* note 132.

176 *See* JACOB, *supra* note 174.

177 *See, e.g.*, *infra* notes 194-97. According to this author, while "professionalism" is first and foremost an informal code of conduct, this code has frequently been formalized into rules that are enforced by third parties.

178 *Medical Professionalism in the New Millennium: A Physician Charter*, 136 ANNALS INTERN. MED. 243, 243-46 (2002). The Charter on Medical Professionalism, which was produced by the Medical Professionalism Project, ABIM Foundation, ACP–ASIM Foundation, and European Federation of Internal Medicine, offers an alternate list of professional responsibilities: (1) "Commitment to professional competence;" (2) "Commitment to honesty with patients;" (3) "Commitment to patient confidentiality;" (4) "Commitment to maintaining appropriate relations with patients;" (5) "Commitment to improving quality of care;" (6) "Commitment to improving access to care;" (7) "Commitment to a just distribution of finite resources;" (8) "Commitment to scientific knowledge;" (9) "Commitment to maintaining trust by managing conflicts of interest;" and (10) "Commitment to professional responsibilities." *Id.* As of May 2003, "[ninety] professional associations, colleges, societies, and certifying boards [from numerous countries] ha[d] endorsed the Charter . . . ." Linda Blank et al., *Medical Professionalism in the New Millennium: A Physician Charter 15 Months Later*, 138 ANNALS INTERN.

Although norms within the medical profession are, in general, socially desirable, there is some question as to whether such norms would have arisen absent government involvement or the threat of government intervention. Given the long history of government involvement in the regulatory process, teasing apart whether existing norms originated within the medical profession itself or whether the norms are attributable to past government intervention may be impossible.

Norms also play a role in traditional medicine. The extent of the development of such norms will likely depend on a number of factors. These factors may include: whether there is a coherent school of practice of traditional medicine (as there is for example with Auyervedic Medicine), whether training takes place in a school or by apprenticeship, the existence of voluntary or mandatory associations of practitioners, and the degree of interactions between practitioners. It is hard to say how important norms are in determining the quality of care delivered by traditional practitioners. Today's body of literature relates more to professional ethics than to norms.

Certainly, ethical codes of practice are important to traditional practitioners schooled in the well-established forms of traditional medicine practiced in south and southeast Asia. Practitioners of Ayurvedic medicine traditionally were required to take an oath containing provisions similar to the ethical obligations contained within the Hippocratic oath.[179] Likewise, professional ethics have historically played an important role in the practice of traditional Chinese medicine.[180] Many of the ancient codes of conduct express similar principles to those that have been traditionally valued in the Western medical community.[181]

Once again, the question is whether the norms within the

MED. 839, 840 (2003).

179 *See* Murthy, *supra* note 165, at 128 (discussing ethics in ancient Indian medicine). One such oath, the Atreya Anushasana, predates the Hippocratic oath by two centuries. *Id.*

180 Lee, *supra* note 166; Peng, *supra* note 166.

181 *See, e.g.*, Sun Ssu-miao, *The Thousand Golden Remedies*, *in* Lee, *supra* note 166, at 132 (discussing medical ethics in ancient China); Chang Kao, *The Medical Talks*, *in* Lee, *supra* note 166, at 166; Chen Shih-kung, *An Orthodox Manual of Surgery*, *in* Lee, *supra* note 166, at 13 n.6 (listing the five commandments and ten requirements for physicians).

community of traditional healers lead to objectively beneficial outcomes. This is something that will vary from place to place. Perhaps the relative scarcity of literature relating to adverse effects arising from the practice of traditional medicine in south and southeast Asia is due, at least in part, to the fact that practice norms in these countries have been positively influenced by the well-developed ethical codes that exist within these schools of medicine.

C. Self-Imposed Restraints—Personal Standards/Ethics

Self-imposed regulations, such as personal standards or ethics, are some of the most important forms of behavioral constraint. Ellickson cites a work by Georg Simmel from 1902 which states:

> [i]n the morality of the individual, society creates for itself an organ which is not only more fundamentally operative than law and custom, but which also spares society the different sorts of cost involved in these institutions. Hence the tendency of society to satisfy its demands as cheaply as possible results in appeals to "good conscience," through which the individual pays to himself the wages of his righteousness, which otherwise would probably have to be assured to him in some way through law or custom.[182]

Where self-imposed constraints come from and why they are more effective in controlling the behavior of some people rather than others are fundamental questions in the fields of psychology, sociology, criminology, philosophy, and anthropology, among others. Although thoroughly canvassing this issue is clearly beyond the scope of this paper, some consideration of this form of constraint is necessary. "Internalized standards of personal conduct"[183] play an important role in constraining the behavior of Western medical practitioners,[184] as well as other professional

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182 ELLICKSON, *supra* note 124, at 245 (citing Georg Simmel, *The Number of Members as Determining the Sociological Form of the Group*, 8 AM. J. SOC. 1, 19 (1902)).

183 Wendel (2001), *supra* note 132, at 1960.

184 *See generally* CHANGING AND LEARNING IN THE LIVES OF PHYSICIANS 80 (Robert D. Fox et al. eds., 1989) (addressing the issue as to what motivates doctors to change their practices); Hans Asbjorn Holm, *Quality Issues in Continuing Medical Education*, 316 (7131) BMJ 621, 621 (1998) (discussing what motivates doctors in the context of continuing medial education); PHIL R. MANNING & LOIS DEBAKEY, MEDICINE:

groups, such as lawyers,[185] and are also likely an important factor in constraining the behavior of traditional practitioners as well.

The Fox study illustrated the importance of self-imposed standards in constraining the behavior of physicians was.[186] The authors of the study interviewed 356 doctors in the United States and Canada and asked them about recent changes in their practice and what had been the impetus for change.[187] "The largest single impetus of changes was primarily driven by the desire for a sense of competence or excellence."[188] Among that group of 184 changes, the "desire to do 'one's best' was described . . . as the primary cause for making changes."[189] In contrast, only twenty-six changes were attributable to fear of liability.[190]

Obviously, the content of internalized codes of conduct varies from one person to another. However, that being said, norms are still important because people, to varying degrees, internalize those norms.[191] The process of internalizing norms is actively encouraged by various institutions in our society. Most notable among these institutions are schools, which take a key role in inculcating norms.[192] The process of compelling people to accept professional norms begins in professional schools.[193]

Although the educational process that doctors go through in Western countries is undoubtedly essential in inculcating

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PRESERVING THE PASSION IN THE 21ST CENTURY (1987) (discussing what motivates doctors in the context of continuing medial education).

185 Wendel (2001), *supra* note 132, at 1960.

186 CHANGING AND LEARNING IN THE LIVES OF PHYSICIANS, *supra* note 184.

187 *See Id.* at 2-5.

188 *Id.* at 80.

189 *Id.*

190 *Id.* at 138. Note, however, that this study is somewhat dated. *See contra* David M. Studdert et al., *Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment*, 293 J.A.M.A. 2609, 2609 (2005) (suggesting that a fear of litigation has resulted in a large percentage of physicians practicing defensive medicine).

191 ELLICKSON, *supra* note 124, at 282; Cass R. Sunstein, *Social Norms and Social Rules*, 96 COLUM. L. REV. 903, 922 (1996) (discussing how people internalize social norms about the role they play).

192 *See* Lawrence Lessig, *The Regulation of Social Meaning*, 62 U. CHI. L. REV. 943, 974 (1995) (dealing with the role of schools in the construction of social meaning).

193 *See* Wendel (2001), *supra* note 132, at 1986.

professional norms,[194] norms can not be simply learned in the classroom. The attitudes, values, beliefs, modes of thought, and behavior of medical students are largely influenced by the culture of the academic learning centers or teaching hospitals.[195] Numerous articles have referred to the importance of role models in instilling professional values.[196] According to one observer, the role of mentoring young doctors involves an "integration of that person into the existing community through socialization of its norms and expectations."[197] One question to consider is: are internal constraints also important in controlling the behavior of traditional practitioners? It would seem likely that they are, since such constraints influence most people in most societies. The more relevant question, however, is whether these internalized norms of conduct are of such a nature that they constrain the behavior of traditional practitioners in a way that leads to objectively desirable outcomes.

D. *Third Party Informal Enforcement, Networks, and Other Trade Intermediaries*

Historically, in the absence of formal rules networks, trade associations and other intermediaries have arisen as another level of private ordering. Examples of these intermediaries range from trade associations of footwear manufacturers in Mexico[198] and

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194 Most medical schools, at least most of those in the United States, incorporate formal instruction on professionalism in the curriculum. Herbert M. Swick et al., *Teaching Professionalism in Undergraduate Medical Education*, 282 J.A.M.A. 830, 830 (1999).

195 *See* Kenneth M. Ludmerer, *Instilling Professionalism in Medical Education*, 282 J.A.M.A. 881, 882 (1999); Preston Reynolds, *Reaffirming Professionalism through the Education Community*, 120 ANNALS INTERN. MED. 609, 609 (1994).

196 *See, e.g.*, Scott M. Wright, et al., *Attributes of Excellent Attending-Physician Role Models*, 339 NEW ENG. J. MED. 1986, 1991 (1998) (discussing the characteristics of physicians who serve as good role model); Preston Reynolds, *Reaffirming Professionalism through the Education Community*, 120 ANNALS INTERN. MED. 609, 612 (1994) (considering the role of the educational community in transmitting professional values); Scott M. Wright & Joseph A. Carrese, *Excellence in Role Modeling: Insight and Perspectives from the Pros*, 167 C.M.A.J. 638, 638 (2002) (looking at what qualities make a physician a good role model).

197 Reynolds, *supra* note 196, at 611.

198 Christopher Woodruff, *Contract Enforcement and Trade Liberalization in Mexico's Footwear Industry*, 26 WORLD DEV. 979, 979 (1998).

Taiwan,[199] to fur dressers associations in the United States,[200] to the medieval Maghribi traders coalition,[201] and trader coalitions in Mexican California in the mid 1800s.[202] These groups have historically provided a useful means of solving collective action problems and have been useful in enforcing trade rules in the absence of an effective third-party enforcer.[203] It has been suggested that such networks may be superior to courts in enforcing norms because: (a) they can more efficiently monitor their members[204] and spread information about reputation;[205] (b) their information is more readily accepted because it is seen as unbiased;[206] (c) the threat of exclusion from the network,[207] or the threat of social sanctions[208] provides a ready and effective means of sanction; and (d) rule making and enforcement by such groups may be more nuanced than if it were done by the government.[209]

E. Third-Party Enforcement: Government

In most instances, it is easier and cheaper to invoke informal rules than it is to use the formal legal system. However, these informal mechanisms of control are rudimentary[210] and never completely successful, so third party enforcement is necessary.[211] In developed countries, the formal rule system never completely

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199 You-tien Hsing, *Trading Companies in Taiwan's Fashion Shoe Networks*, 48 J. INT'L ECON. 101, 101 (1998).

200 McMillan & Woodruff, *supra* note 140, at 2441.

201 Avner Grief, *Contract Enforceability and Economic Institutions in Early Trade: The Maghribi Traders' Coalition*, 83 AM. ECON. REV. 525, 525 (1993).

202 Karen Clay, *Trade Without Law: Private-Order Institutions in Mexican California*, 13 J.L. ECON. & ORG. 202, 202 (1997).

203 McMillan & Woodruff, *supra* note 140, at 2423.

204 Aviram, *supra* note 150, at 10-11.

205 McMillan & Woodruff, *supra* note 140, at 2423, 2427-29

206 Aviram, *supra* note 150, at 11.

207 *Id.* at 13; *see* Aviram, *supra* note 133, at 1227.

208 Aviram, *supra* note 133, at 1225.

209 Ellen Katz, *Private Order and Public Institutions: Comments on McMillan and Woodruff's 'Private Order Under Dysfunctional Public Order'*, 98 MICH. L. REV. 2481, 2482 (2000).

210 Posner, *supra* note 134, at 221.

211 *See* NORTH, *supra* note 133, at 35.

replaces the informal system; rather, the informal rules lie "in the shadow of the law,"[212] and the possibility of legal action encourages conformity to cheaper forms of regulation.[213]

The government can often be the best candidate for acting as a third party enforcer.[214] It has a monopoly over the legal use of force as a coercive tactic and is in a unique position in that it alone can impose sanctions such as jail terms.[215] Economies of scale may also make the government the least costly enforcer.[216]

The discussion of the role of government as a third-party enforcer follows. Tort law, contract law, and criminal law are other institutions that the government can use to constrain behavior.

F. Choice of Regulator: Do Informal Sanctions Work in the Case of Traditional Medicine?

People will generally choose the lowest cost regulator, which means choosing informal control mechanisms. For example, where there is repeat dealing, or the possibility of lock-in, agreements tend to become self-enforcing. Additionally, in a small community, information can be readily shared and informal mechanisms can also be effective. Ellickson suggests that informal control also works better where there is "reciprocal power, ready sanctioning opportunities, and adequate information . . . ."[217] He further suggests that both the size and degree of technicality of the dispute are important.[218] Size matters in that only larger disputes warrant the higher costs that arise from using the formal legal system.

However, under certain circumstances, formal constraints may be preferable. Because informal sanctions work better where there is either repeat dealing, or in a small community where information can be readily shared, one might speculate that

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212 Aviram, *supra* note 133, at 1191.

213 *See id.* at 1191 n.33.

214 *See id.* at 1188.

215 *Id.*

216 *See* NORTH, *supra* note 112, at 58.

217 ELLICKSON, *supra* note 124, at 181.

218 *See id.* at 257.

informal mechanisms are likely to work better in smaller communities than in large ones.

There is, however, a fundamental obstacle which prevents these informal mechanisms from achieving a utility-maximizing outcome. The problem is, once again, imperfect information. A poor African mother whose child has gastroenteritis and dies from dehydration after being given bad advice by a traditional practitioner may be more likely to blame the death on the child being sickly, or to an exceptionally strong curse, rather than to think of it as a medical failure. The problem is that the consumer has incomplete information. He or she does not recognize the practitioner's inadequacies and therefore the possibility of using informal mechanisms, such as loss of prospective advantage (repeat dealings), loss of reputation, social ostracism, and the threat of violence, simply does not arise.

Lack of reciprocal power may also impede the functioning of informal mechanisms. At least in some communities, people fear the power of traditional healers. In many places in Africa[219] and in Melanesian countries,[220] people fear that such practitioners might poison them. People might therefore be loath to use any form of sanctions or to even spread negative gossip about the practitioner. This is a further barrier to the use of informal sanctions.

Norms within the medical profession play an important and positive role in constraining the behavior of physicians. Could it be that norms in the traditional healer community also play an important role in achieving beneficial outcomes? Evidence from clinical studies presented earlier suggests that in many parts of the world the answer is no.[221] Consider, for example, the situation in countries where traditional practitioners do not refer patients when they have medically treatable conditions and, as a result, patients die. Within the normative environment of the Western medical

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219 *See* Kenneth Leonard, Research Page, *African Traditional Healers: Are They as Good at Economics as They Are at Medicine?*, at 4-5 (Feb. 2001), http://www.arec.umd.edu/kleonard/papers/trhl_pd_pr.pdf (discussing traditional healers using poisoning to ensure payment).

220 From this author's experience in Vanuatu and Papua New Guinea, poisoning was reputed to be widely used in traditional Melanesian society in order to kill your enemies. Unexplained deaths were often attributed to poisoning.

221 *See supra* Parts III.A-C.

community, this is considered a travesty.[222] Such deaths arise because the healer either has inadequate knowledge or refuses to ask for help when he or she is in over his or her head, or when the traditional healer does not care about the welfare of the patient. According to the norms of Western medicine, a death that arises from any of those reasons constitutes a breach of professional responsibility.[223] If the community of traditional healers were to have a developed set of socially desirable norms on par with the Western medical community, failing to refer medically treatable patients would not happen with the frequency that it does.

Ellickson refers to "social imperfections," which are "analogous to market imperfections."[224] These social imperfections may lead to people being less likely to "engage in objectively beneficial social exchange."[225] It can be argued that, in some parts of the world, there are numerous social imperfections that result in dysfunctional informal mechanisms of control of traditional practitioners. The fact that informal constraints do not work well is an important reason for advocating the use of regulations.

VI. Formal Constraints: Regulation

Since informal sanctions have proven ineffective in ensuring a wealth maximizing outcome or a high quality of service, the regulation of traditional practitioners may be justified. The next question that arises is whether regulations actually work. Unfortunately there appears to be little, if any, research addressing this question. Absent empirical data or even anecdotal literature on the subject, what can one usefully say about such regulation? First, the history of the regulation of doctors in many parts of the world suggests that such regulation has primarily advanced the interests of the medical profession rather than the population at large. Second, the rule of law is weak in developing countries,

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222 *See, e.g.*, Green, *supra* note 168, at 1126.

223 This author posits that perhaps a significant part of the animosity that Western practitioners feel is not related to economic competition, or different world views, as Green suggests, but rather due to the perception that the traditional practitioner who cause harm are acting in an immoral fashion. *Id.*

224 ELLICKSON, *supra* note 124, at 181.

225 *Id.*

and this presents a further impediment to effective regulation. Third, the holistic and spiritual nature of traditional medicine may render conventional regulation problematic.

A. *The History of the Regulation of Doctors: A Story of Self Interest?*

According to many, the history of medical boards in the United States is overwhelmingly the story of the medical profession acting in order to further its own interests rather than acting to protect the public interest.[226] Those who hold this view assert that medical boards in the United States originated in the 19th century when the medical profession was under siege.[227] During this period, physicians appealed to state governments to limit the supply of physicians.[228] The states responded by forming medical boards that allowed the physicians to assume a gate-keeping function whereby they could exclude others from working in medical care.[229]

The validity of the interest group theory is supported by statistics that show that until the 1980s, medical boards in the United States disciplined physicians exceedingly infrequently.[230] From 1963 to 1967, American "boards [only] prosecuted a total of seven cases of incompetence."[231] American medical boards only began to get serious about "discipline [of doctors] in the 1970s and 1980s."[232] From 1986 to 1996, 1,677 cases were prosecuted for incompetence,[233] and in 1996, "2,675 'serious' disciplinary

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226 *See, e.g.*, CARL F. AMERINGER, STATE MEDICAL BOARDS AND THE POLITICS OF PUBLIC PROTECTION 1 (1999) (concerning the history of state medical boards). *But see* ROBERT DERBYSHIRE, MEDICAL LICENSURE AND DISCIPLINE IN THE UNITED STATES xi-xiii (1969) (providing a more positive view of why medical licensing arose).

227 AMERINGER, *supra* note 226, at 7.

228 *Id.*

229 *Id.*

230 *See* Richard J. Feinstein, *Special Report: The Ethics of Professional Regulation*, 312 NEW ENG. J. MED. 801, 801-02 (1985).

231 AMERINGER, *supra* note 226, at 6.

232 *Id.* at 5.

233 *Id.* at 6 (citing SIDNEY WOLFE ET AL., PUBLIC CITIZEN HEALTH RESEARCH GROUP, QUESTIONABLE DOCTORS 23 (1993)).

actions" were brought against doctors.[234] Still, according to the Public Citizens Health Research Group,[235] American boards were not, as of 1993, doing an adequate job of protecting the American public.[236]

Although a thorough analysis of the history of regulation of doctors in other developed countries is beyond the scope of this paper, it is worth noting that the experience of the United States seems typical of developed countries. For example, it has been suggested that the early legislation regulating the practice of medicine in Holland was a way of formally establishing a monopoly for certain types of practitioners and for excluding competitors.[237] Similarly, statistics from the United Kingdom show that prior to 1996, few complaints regarding the quality of service gave rise to disciplinary actions by the Family Health Service Authorities Service Committee.[238] Dissatisfaction with the medical profession in the United Kingdom parallels the American experience as evidenced by statistics showing a sharp rise in the number of complaints during the late 1980s and early 1990s.[239]

Some commentators have suggested that the licensing of CAM practitioners in the United States has also largely been driven by professional self-interest. Like doctors, CAM practitioners have been accused of using licensing as a barrier to competition.[240] CAM providers may also actively seek regulation as it lends an aura of legitimacy to their particular area of practice, a legitimacy which may allow practitioners to charge more for their services or

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234 *Id.* (citing WOLFE ET AL., *supra* note 233, at 13).

235 *Id.*

236 *See* Timothy Jost, *Oversight of the Quality of Medical Care: Regulation, Management, or the Market?*, 37 ARIZ. L. REV. 825, 863 (1995) (arguing that boards rarely prosecute because doctors are reluctant to sanction other doctors).

237 R.M.J. Schepers & H.E.G.M. Hermans, *The Medical Profession and Alternative Medicine in the Netherlands: Its History and Recent Developments*, 48 SOC. SCI. & MED. 343, 344-45 (1999).

238 Will Bartlett, *The Regulation of General Practice in the UK*, 11 INT'L J. HEALTH PLAN. & MGMT 3, 10-11 (1996).

239 *Id.* at 10.

240 *See* Peter J. Van Hemel, *A Way Out of the Maze: Federal Agency Preemption of State Licensing and Regulation of Complementary and Alternative Medicine Practitioners*, 27 AM. J.L. & MED. 329, 332 (2001).

allow them to receive payment from insurers.[241]

If health practitioner self-regulation has been self-serving, it is not entirely surprising. It has been alleged that those who are self-regulating typically do not serve the public interest as they should,[242] and that self-regulating agencies generally have a poor record of enforcement.[243] The traditional belief is that governments regulate in order to further the public good.[244] The first serious challenge to this theory began in the 1970s,[245] with the development of theories that postulated that regulations arise either as the result of different groups competing for power (interest group theory) or the result of individuals acting to maximize their own welfare (private interest theory).[246] Though it may seem somewhat cynical, safeguarding the public interest is seldom a major factor either in the development or implementation of regulatory frameworks.

B. An Added Problem in Developing Countries—The Rule of Law is Weak

The history of regulation of physicians in developed countries is of some relevance to the question of regulating traditional practitioners in such countries. But it is an imperfect model. One of the biggest differences between developed and developing countries is that the rule of law in developing countries is generally weak. This weakness further undermines the prospects of successful regulation.

According to the World Bank, the deficiencies in the legal

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241 *See id.* at 332-33.

242 BALDWIN & CAVE, *supra* note 97, at 129.

243 ROSS CRANSTON, CONSUMERS AND THE LAW 62 (Robert Stevens et al. eds., 2nd ed. 1984) (1978); *see also* Anthony Ogus, *Rethinking Self-Regulation*, 15 O.J.L.S. 97, 98-99 (1995).

244 *See, e.g.*, George J. Stigler, *The Theory of Economic Regulation*, 2 BELL J. ECON. & MGMT. SCI. 3, 3 (1971); George Priest, *The Origins of Utility Regulation and the "Theories of Regulation" Debate*, 36 J.L. & ECON. 289, 289-90 (1993).

245 *See* Priest, *supra* note 244, at 289; *see also* NORTH, *supra* note 112, at 48 ("[A]s a first approximation[,] rules are derived from self interest."). *See generally* Richard A. Posner, *Theories of Economic Regulation*, 5 BELL J. ECON. & MGMT. SCI. 335 (1974) (providing a challenge to the belief that governments regulate to promote the public good).

246 *See supra* text accompanying notes 210-28.

systems of developing countries can be divided into five categories.[247] First, laws and regulations that are enacted or promulgated are often not published, and if so, are not widely accessible or intelligible to the public.[248] Second, laws and regulations are often changed and are therefore considered unstable.[249] Third, laws that are enacted may not be enforced.[250] Fourth, the laws that are adopted are often inefficient as a result of the lack of public participation and scrutiny.[251] Finally, there is inadequate attention devoted to designing public administration systems that will ensure that the laws are completely and efficiently administered.[252]

Many of the problems of law enforcement in developing countries may simply be attributed to inadequate resources. A lack of resources in the judiciary, the Attorney General's office, or the police department will undermine a country's ability to enforce laws. Similarly, budgetary constraints in the health department hamper the implementation of health regulations.[253] In developing countries there are often not enough public health inspectors to visit workplaces and food outlets, or to effectively monitor for breach of regulations.[254]

A lack of resources may also affect the judiciary and as a result, the judiciary may be ineffective.[255] This affects all aspects

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247 World Bank, *Governance and Development* at 30 (1992).

248 *Id.*

249 *Id.* at 32.

250 *Id.* at 35.

251 *Id.* at 35-38.

252 *Id.* at 38-39.

253 Charles Hongoro & Lilani Kumaranayake, *Do They Work? Regulating for Profit Providers in Zimbabwe*, 15(4) HEALTH POL'Y & PLAN. 368, 375 (2000); *see also* Ngoyi Bukonda et al., *Implementing a National Hospital Accreditation Program: the Zambian Experience*, 14 (Supplement 1) INT'L J. QUALITY HEALTH CARE 7, 14-15 (2002) (describing how a Zambian hospital accreditation program stalled due to lack of funding)

254 WORLD HEALTH ORG. [WHO], THE WORLD HEALTH REPORT 2000–HEALTH SYSTEMS: IMPROVING PERFORMANCE, at 121 [hereinafter WHO, 2000].

255 *See* World Bank, WORLD DEVELOPMENT REPORT 1997: THE STATE IN A CHANGING WORLD, at 36 (1997) ("[u]nfortunately [a well functioning judiciary] seems to be the exception rather than the rule"); *see also* Michael Trebilcock, *What Makes Poor Countries Poor?: The Role of Institutional Capital in Economic Development*, *in* 3 THE LAW AND ECONOMICS OF DEVELOPMENT 15, 40 (Buscaglia, E. et al. eds., 1997) (noting

of law enforcement as "a well functioning judiciary is a central pillar of the rule of law."[256] This is in part because an effective judiciary constitutes the primary constraint on the other arms of government (the legislature, administration, the executive, and the police). Such a constraint may be necessary in order to prevent the other great impediment to regulation: corruption. The sad reality in many countries is that employees of the state not only fail to enforce the rules, they actively break them, or use the rules for their own private gain.

Statistics on the percentage of firms reporting having to pay bribes provide some indication of the extent of the corruption problem.[257] These rates range from 43.1% in Central and Eastern Europe to 74.2% in South Asia.[258] Transparency International in its annual Corruptions Perception Index found seven out of ten countries scored 5/10 or less on their index.[259] Also, 4% of all countries scored less than three, indicating a high level of corruption.[260]

Corruption affecting the law creating and enforcing branches of government constitutes a particularly troubling obstacle to effective law enforcement. In many countries such corruption is rampant. For example, in Kenya, 86% of those who dealt with the Attorney General's office reported having to pay bribes.[261] Corrupt police forces are also a problem.[262] In Kenya 81.6% of

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that a deficiency in resources affects the legal systems in developing countries).

256 World Bank, *supra* note 255, at 36.

257 *See* WORLD BANK, WORLD DEVELOPMENT REPORT 2005, A BETTER INVESTMENT CLIMATE FOR EVERYONE 40 (2005).

258 *Id.*

259 Press Release, Transparency International, *Transperancy International Corruption Perceptions Index 2003: Nine Out of Ten Developing Countries Urgently Need Practical Support to Fight Corruptions, Highlights New Index* (Oct. 7, 2003), http://www.transparency.org (follow "Corruption Perceptions Index" hyperlink; then follow "2003" hyperlink; then follow "2003 press release" hyperlink).

260 *Id.*

261 Transparency International, *The Kenya Urban Bribery Index 2001: Corruption in Kenya: Findings of an Urban Bribery Survey*, at 10 (2001) *available at* www.transparency.org (follow "bribe payers index" hyperlink; then follow "Africa & Middle East" hyperlink).

262 *See, e.g.*, Simon Coldham, *Legal Responses to State Corruption in Commonwealth Africa*, 39 J.AFR. L. 115, 121 (1995).

people reported paying bribes as being a part of their interaction with the police.[263] In a Transparency International survey, over 30% of respondents in a number of countries, including Mexico, Malaysia, and Nigeria, indicated they thought corruption in the countries' police force was the countries single most worrisome form of corruption.[264] In 1993, a Philippine non-governmental organization (NGO) estimated that half of all crimes committed in the country involved the participation of a policeman.[265]

Numerous surveys and articles indicate that health services are not immune to corruption.[266] In Eastern Europe, Central Asia,[267] and Africa,[268] patients are frequently forced to pay bribes. A study from Latin America likewise found widespread corruption in public hospitals.[269] There is ample reason to expect that in some countries, corrupt officials might exploit any opportunity created by the regulatory process.

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263 Transparency International, *The Kenya Bribery Index 2005*, at 10 (2005), *available at* http://www.transparency.org (follow "bribe payers index" hyperlink; then follow "Africa & Middle East" hyperlink).

264 Transparency International, *The Global Corruption Barometer Survey 2003*, at 31 (2005), http://www.transpearancy.org (follow "global corruption barometer" hyperlink; then follow "2003" hyperlink).

265 JAN WILLEM BAKKER, THE PHILIPPINE JUSTICE SYSTEM: THE INDEPENDENCE AND IMPARTIALITY OF THE JUDICIARY AND HUMAN RIGHTS FROM 1986 TILL 1997 44 (Centre for the Independence of Judges and Lawyers 1997).

266 *See, e.g.*, WORLD BANK, WORLD DEVELOPMENT REPORT 2004: MAKING SERVICES WORK FOR POOR PEOPLE 24 (2003); Wim Van Lerberghe, et al., *When Staff is Underpaid: Dealing with the Individual Coping Strategies of Health Personnel*, 80 BULL. WORLD HEALTH ORG. 581 (2002) (examining the coping strategies of health worker's in response to inadequate salaries).

267 WORLD BANK, MAKING TRANSITIONS WORK FOR EVERYONE: POVERTY AND INEQUALITY IN EUROPE AND CENTRAL ASIA 258 (2000).

268 Daniel Levy-Bruhl et al., *The Bamako Initiative in Benin and Guinea: Improving the Effectiveness of Primary Health Care*, 12 INT'L J. HEALTH PLAN. & MGMT. S49 (Supp. 1997); DEEPA NARAYAN ET AL., CRYING OUT FOR CHANGE: VOICES OF THE POOR 103-05 (2000); Hongoro & Kumaranayake, *supra* note 253 (regarding corruption in the Zimbabwe medical private sector)

269 *See* RAPHAEL DITELLA & WILLIAM SAVEDOFF, DIAGNOSIS CORRUPTION: FRAUD IN LATIN AMERICA'S PUBLIC HOSPITALS (Inter-American Development Bank 2001).

C. The Experience of Developing Countries in Regulating Doctors

The regulation of doctors is presumably the model for regulating traditional practitioners. What is the experience of developing countries in regulating doctors? Although there is scant literature on the subject, what literature exists is consistent with our knowledge of medical boards in developed countries and the general difficulty in enforcing the rule of law in developing countries.[270]

In India, pursuant to the Indian Medical Council Act, the practice of allopathic medicine is regulated by the central government, as well as by the states.[271] State Medical Councils (SMCs) are supposed to maintain a register of providers.[272] These councils are reportedly under-funded, and as a result, some elections to the councils have been postponed for years.[273] Additionally, there have been "irregularities" in the elections.[274] Furthermore, these councils are said to be vulnerable to political pressure.[275]

In India, people appear to lack confidence in the ability of SMCs to enforce standards of care.[276] Anecdotal evidence would

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270 *See generally* Sara Bennett et al., *Carrot and Stick: State Mechanisms to Influence Private Provider Behaviour*, 9 HEALTH POL'Y & PLAN. 1 (1994) (discussing some of the difficulties encountered in trying to regulate private healthcare providers in developing countries); Lilani Kumaranayake, *The Role of Regulation: Influencing Private Sector Activity within Health Sector Reform*, 9 J. INT'L DEV. 641 (1997) (discussing how regulations aimed at the private health sector in developing countries have a low rate of enforcement); *see also* Tim Ensor & Sabine Weinzierl, *A Review of Regulation in the Health Sector of Low and Middle Income Countries* (Oxford Policy and Management, Working Paper, 2006), *available at* http://www.opml.co.uk/docs/Health_Sector_Regulation_Working_Paper_Jan_2006.pdf (reviewing the current literature on health sector regulation in low and middle income countries).

271 *See, e.g.*, Indian Medical Council Act No. 102 of 1956 (1956), *available at* http://indiacode.nic.in/fullact1.asp?tfnm=1956102; *see also, e.g.*, Karnataka Medical Registration Act, No. 34 of 1961 (1961), *available at* http://dpal.kar.nic.in/pdf_files%5CMEDICAL%20REGISTRATION.pdf.

272 Bhat, *supra* note 63, at 269-270.

273 *Id.* at 269-70.

274 *Id.* at 270.

275 *Id.*

276 Yesudian, *supra* note 76, at 78.

seem to support such skepticism. Dr. Ramesh Bhat held "informal discussions" with one member of a council and was told that "not many councils have suspended the registration of any member, even though many complaints are received by the council. In the case of one council, inquiry was initiated in only three cases and, in those, no disciplinary action has been taken."[277] The Registrar of the Andhra Pradesh Medical Council also reportedly stated that they hear only thirty-five to forty cases of professional misconduct in a given year.[278] Of these, the majority are complaints related to the issuance of medical certificates.[279]

Indeed, it seems that many of the laws related to healthcare in India are seldom enforced. Despite the existence of the Bombay Nursing Home Act of 1949, which requires the registration of private hospitals and nursing homes, over 100 nursing homes in that city were, as of 1992, not registered.[280] The local government also failed to formulate any standards for such hospitals/homes despite being required to do so under the Act.[281] In Delhi, which has similar legislation, only 130 of approximately 1200 nursing homes were registered.[282] Likewise, although empowered to do so under the Act, officials in Bombay admitted that inspection of nursing homes is rare, and in some wards no nursing homes had been visited for years.[283]

The situation in other poor countries appears to be similar to that in India. Bennett and Ngalande-Banda[284] have reported that enforcement of professional regulation is weak or absent in Sub-

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277 Bhat, *supra* note 63 at 270.

278 Alex George, Updates and Assessment of Current GoAp Laws, *Capacities and Activities to Regulate Private Health Care Providers* 15 (unpublished DFID document, on file with the Centre for Health and Social Sector Studies).

279 *Id.* Most often an employer questions whether certificates are legitimate or issued after receiving a bribe. Letter from Dr. Alex George, Director, Centre for Health and Social Sector Studies (July 2004) (on file with author).

280 Yesudian, *supra* note 76, at 77.

281 *Id.*

282 Bhat, *supra* note 63, at 271.

283 *Id.* at 272.

284 Sara Bennett & Ellias Ngalande-Banda, *Public and Private Roles in Health: A Review and Analysis of Experience in Sub-Saharan Africa*, at 34-36 (Mar. 1994), *available at* http://whqlibdoc.who.int/hq/1997/WHO_ARA_CC_97.6.pdf.

Saharan Africa.[285] The Zimbabwean Health Professions Council (HPC), for example, reportedly suffers from a number of shortcomings.[286] According to Dorothy Mutizwa-Mangiza, the council has, for political reasons, been forced to register doctors that it considered unsuitable,[287] including foreign-trained doctors who are unable to speak English.[288] Effective discipline in that country reportedly suffers from a lack of clarity as to what constitutes improper conduct.[289] Furthermore, the public is poorly informed as to the existence of the HPC or how to lodge a complaint.[290] When complaints are made, few are ever referred to the Disciplinary Committee—reportedly only three cases one year[291]—and fewer yet result in discipline.[292] In the years between independence and 1999, only one medical practitioner was struck off the register.[293]

Given such statistics it is not surprising that a survey of public and private stakeholders in the Zimbabwean healthcare system found that most people believed that health laws were not being enforced.[294] Stakeholders attributed the ineffective functioning of the HPC to a number of factors. Not surprisingly, these factors included inadequate recourses[295] and regulatory capture.[296]

Thailand has also had problems regulating doctors. To begin with, the Medical Council of Thailand receives few complaints related to substandard care; between 1995 and 1999 there were a

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285 *Id.*

286 DOROTHY MUTIZWA-MANGIZA, DOCTORS AND THE STATE: THE STRUGGLE FOR PROFESSIONAL CONTROL IN ZIMBABWE 8 (Abebe Zegeye & John Higginson eds., 1999); Hongoro & Kumaranayake, *supra* note 253.

287 MUTIZWA-MANGIZA, *supra* note 286, at 191; Hongoro & Kumaranayake, *supra* note 253, at 375.

288 MUTIZWA-MANGIZA, *supra* note 286, at 191.

289 *Id.* at 197.

290 *Id.* at 199.

291 *Id.* at 202.

292 *Id.*

293 *Id.* at 199.

294 Hongoro & Kumaranayake, *supra* note 253, at 373.

295 *Id.* at 375-76.

296 *Id.* at 376.

total of 206 cases.[297] When a complaint is received, it is slow to be processed.[298] Finally when a doctor is found guilty, the punishment is said to be "mild."[299] Between 1995 and 1999, less than 1% of doctors who were found guilty had their licenses revoked (although 22% had their licenses suspended).[300]

D. *The Experience of Developing Countries in Regulating Traditional Practitioners*

There is even less literature on the subject of the regulation of traditional practitioners than there is on the regulation of doctors in developing countries. Most countries have, at least on paper, instituted licensing schemes for traditional practitioners.[301] India, for example, has developed regulatory regimes for their systems of traditional medicine.[302] The Ayurveda, Unani, and Siddha systems of medicine are all recognized by the Government of India pursuant to the Central Council of Indian Medicine Central Council Act of 1970.[303] There is also state-level licensure.[304] Despite the extensive formal recognition and regulation of Indian traditional medical systems, it is difficult to find any articles critically analyzing how well this regulatory structure has worked.

E. *The Problem of Standards*

Another problem inherent in the use of regulation of doctors as a model for traditional practitioners stems from the fact that standards of education and practice are much harder to identify for traditional practitioners then they are for doctors. Whereas formal

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297 Yot Teerawattananon et al., *Health Sector Regulation in Thailand: Recent Progress and the Future Agenda*, 63 HEALTH POL'Y 323, 330 (2003).

298 *Id.* at 330.

299 *Id.*

300 *Id.*

301 WHO (2001), *supra* note 1.

302 *Id.* at 132.

303 *Id.*

304 *See, e.g.*, The Karnataka Ayurveda & Unani Practitioner's Registration & Medical Practitioners Miscellaneous Provisions Act, No. 9 of 1962, *available at* http://www.karnataka.gov.in/dpal/pdf_files/AYURVEDIC%20AND%20UN ANI%20PRACTITIONERS-new-11.pdf.

training programs exist in places like China, Korea, and India, in other parts of the world there is no set curriculum for traditional medicine. For example, most African countries have no "official" schools teaching traditional medicine.

Although the lack of formal education is a legitimate concern, evidence of having completed an apprenticeship with an established or eventually a licensed traditional practitioner could be used as an alternative to a schooling requirement. Another approach could be to require a traditional practitioner to complete a course offered by the Ministry of Health before they could be licensed. This would afford the Ministry an opportunity to provide instruction about basic hygiene, prevention of transmission of blood-borne diseases, and the identification of medically treatable diseases.

Defining the scope of practice of traditional practitioners may also be a problem. Traditional practitioners in many places, including Botswana,[305] Mozambique,[306] Ethiopia,[307] Brazil,[308] Indonesia,[309]Papua New Guinea,[310] and Samoa,[311] believe that illness arises in the spirit world, or through acts of sorcery.[312] Additionally, in many places people visit traditional practitioners

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305 *See* Liv Haram, *Tswana Medicine in Interaction with Biomedicine*, 33 SOC. SCI. & MED. 167, 168-71 (1991) (discussing the interaction of traditional and western belief in Botswana).

306 *See* Victor Igreja, *"Why Are there So Many Drums Playing Until Dawn?" Exploring the Role of Gamba Spirits and Healers in Post-War Recovery Period in Gorongosa, Central Mozambique*, 40 TRANSCULTURAL PSYCHIATRY 459, 465-66 (2003) (discussing how the war in Mozambique affected traditional medical practices).

307 Makonnen Bishaw, *Promoting Traditional Medicine in Ethiopia: A Brief Historical Review of Government Policy*, 33 SOC. SCI. MED. 193, 193-94 (1991) (examining the nature of traditional medicine in Ethiopia).

308 *See* Pollock *supra* note 115, at 151.

309 *See* Pam Gaines, *A Visit with the Revered Dukuns of Indonesia*, 102 AM. J. NURSING 69, 69-71 (2002) (relating the authors personal experience with traditional healers in Indonesia).

310 *See* Maria Lepowsky, *Sorcery and Penicillin: Treating Illness on a Papua New Guinea Island*, 30 SOC. SCI. & MED. 1049, 1049 (1990).

311 *See* W. ARTHUR WHISTLER, SAMOAN HERBAL MEDICINE 6-11 (1996); W. ARTHUR WHISTLER, POLYNESIAN HERBAL MEDICINE 16-17(1992).

312 Haram, *supra* note 305, at 172-73.

for non-health related reasons:[313] to try and improve their performance on exams,[314] to make a business prosper,[315] or to fix marital or other family-related problems.[316] These reasons for visiting a traditional practitioner make setting standards of care somewhat difficult.[317] A similar concern also arises in the context of CAM in developed countries. Since the vast majority of CAM practices have not been scientifically proven as beneficial, there is no reason to choose one form of treatment over another as the standard. What standards can, for example, be set for the use of therapeutic touch?[318]

Part of the solution to this dilemma may be for regulators to concentrate on what practitioners cannot do, rather than on what they can do. Other worthwhile requirements include requiring traditional practitioners to both refer patients when the practitioner is unable to effectively manage care and not mislead patients about the prospects of the treatment working.[319]

In the United States, the scope of practice of CAM practitioners is generally set out in specific legislation aimed at

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313 In fact, one small survey from Nigeria found that only 9% of people who visited diviners (one type of traditional practitioner) had complaints of a physical nature. Tola Olu Pearce, *The Assessment of Diviners and their Knowledge by Civil Servants in SouthWestern Nigeria*, 28 SOC. SCI. MED. 917, 921 (1989).

314 Green, *supra* note 168, at 1128; Maykuth, *supra* note 164; Sjaak van der Geest, *Is There a Role for Traditional Medicine in Basic Health Services in Africa? A Plea for a Community Perspective*, 2 TROPICAL MED. & INT'L HEALTH 903, 905 (1997) (discussing how the concept of "medicine" in many African countries is quite broad and encompasses a multitude of other subject areas which in western culture are not considered in the medial realm).

315 Green, *supra* note 168, at 1128; van der Geest, *supra* note 314, at 905.

316 Maykuth, *supra* note 164.

317 *See generally* O. Ajai, *The Integration of Traditional Medicine in the Nigerian Health Care Delivery System: Legal Implications and Complications*, 9 MED. L. 685 (1990) (on the legal implications of trying to integrate traditional medicine into the Nigerian National Health Care System).

318 Michael H. Cohen, *Healing at the Borderland of Medicine and Religion: Regulating Potential Abuse of Authority by Spiritual Leaders*, XVII J.L. & RELIGION 307, 348 (2003).

319 *See generally* Mehmet Oz, *Complementary and Alternative Medicine: Legal Boundaries and Regulatory Perspectives" by Michael Cohen*, 20 J. LEGAL MED. 1 (1999) (book review).

controlling the profession.[320] Emphasis is in some cases placed on what practitioners are not allowed to do. For example, in some states, allied practitioners are expressly prohibited from practicing medicine.[321] Sometimes what constitutes practicing medicine is defined specifically. For example, a Mississippi law stipulates that a chiropractor shall not prescribe or administer medicines to patients or perform surgery.[322] The legislation from some developing countries takes a similar approach. The Nigerian Medical and Dental Practitioners Act of 1988 allows for traditional practices, however it prohibits such practitioners from performing surgery or prescribing drugs.[323] Likewise, the Malawi Medical Practitioners and Dentists Act of 1987 prohibits traditional practitioners from performing any act which is dangerous to life.[324]

One of the greatest harms likely to arise from the use of CAM or traditional practices is the failure to refer patients when they suffer from ailments that can readily be treated by conventional medicine. Regulations aimed at traditional practitioners should contain provisions dealing with this issue. One approach is to require traditional practitioners "to refer the patient to a physician whenever the patient's condition exceeds the scope of their training, education and competence."[325] Legislation in the United States dealing with CAM providers often contains such provisions.[326] An alternate approach, taken by a British Columbia (Canada) law requires that a practitioner refer a patient when the patient is not getting better.[327] The Vietnamese government also

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320 MICHAEL H. COHEN, COMPLEMENTARY AND ALTERNATIVE MEDICINE: LEGAL BOUNDARIES AND REGULATORY PERSPECTIVE 39-55 (1998).

321 *Id.* at 39.

322 MISS. CODE ANN. § 73-6-1 (2004).

323 WHO (2001), *supra* note 1, at 39.

324 *Id.* at 32.

325 47 WHO INT'L DIGEST HEALTH LEGIS. 314 (1996) (discussing Circular No. 8-BYT/TT of 2 May 1994) (pertaining to the regulation of traditional practitioners in Vietnam).

326 COHEN, *supra* note 320, at 412.

327 Health Professionals Act: Traditional Chinese Medicine Practitioners and Acupuncturists Regulation, R.S.B.C. 1996, ch. 183 (Can.).

takes this approach in regulating traditional practitioners.[328] Either of these may be worthwhile approaches when regulating traditional practitioners since they are ways of limiting harm without getting into the tricky business of trying to specify what traditional practitioners can do. However, the usefulness of the first of these approaches is contingent on the practitioner being able to identify treatable medical conditions. Such provisions are therefore most useful if they are instituted in conjunction with a program to educate traditional practitioners about some common, readily treatable, medical conditions.

VII. The Role of Law in Shaping Informal Constraints

If, as suggested, the problem with standards is not insurmountable, what else can one conclude from the above discussion? First, any agency established to regulate traditional practitioners in developing countries is unlikely to discipline many practitioners. This is, in part, due to the nature of such boards and also to the fact that the enforcement of regulations in developing countries is haphazard at best. The governments of most poor countries simply do not have the resources for adequate enforcement. Secondly, corruption may undermine the regulatory process, both in terms of policing and adjudication. Finally, in many developing countries neither the society in general, nor the ministry of health in particular, will have a culture that recognizes the importance of the rule of law. Furthermore, there is reason to believe that in most developing countries informal sanctions are the primary form of constraint and that the use of traditional healers is a deeply engrained norm. But there is reason to believe the regulation of traditional practitioners is not doomed to failure.

It can be argued that the cynicism expressed in the above section is unwarranted, as it is based on a faulty premise and a poor choice of countries to use as a model. The mistaken premise is that if boards rarely prosecute doctors, then regulation must be ineffective. Two things suggest that this is not necessarily true. First, the extent to which a board's effectiveness depends on prosecution is contingent upon the choice of regulatory framework. Some regulatory frameworks, such as the American

328 WHO INT'L DIGEST OF HEALTH LEGIS., *supra* note 325.

system, seem to depend heavily on prosecution.[329] Others, such as the Canadian system, are less dependent on prosecution.[330] American state boards are perhaps somewhat unusual in that their function appears to be limited to licensing and reviewing complaints against doctors and, where necessary, taking remedial action including prosecution.[331] Boards in other countries typically perform a broader range of functions.[332] It is perhaps true that the prospect of an American-style board affecting healthcare in developing countries is somewhat remote. Prosecution is likely to be infrequent and even the investigation of individual complaints may be unlikely. In addition, as Troyen Brennan has pointed out, there is no evidence that regulation that entails only "removing a few bad apples" has had any effect in improving the quality of healthcare, even in the United States.[333] The second point is that even an American-style board might still be useful because even when prosecution is rare, it can still serve as an effective deterrent.

Laws do not have to be just about prosecuting the bad. The regulation of health practitioners can have a broader purpose that involves correcting market imperfections and shaping norms, self-imposed standards, and informal constraints. The regulation of health practitioners in some countries (for example Canada) seem, at least in part, geared towards this end.[334] These are important functions of regulatory agencies, and functions that are often neglected when equating the effectiveness of professional regulation solely with the number of annual prosecutions. A

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329 *See, e.g.*, CAL. [BUS & PROF] CODE § 2003-2005 (2005) (defining the purpose of the California Medical Board); MINN. STAT. § 147.001 (1995) (defining the purpose of the Minnesota Board of Medical Practice); California Medical Board, *Board Role* http://www.medbd.ca.gov/boardrole.htm (stating the purpose of the California Board); Minnesota Board of Medical Practice, *Mission Statement,* http://www.state.mn.us/portal/mn/jsp/content.do?id=-536882533&agency=BMP (follow "General Information" hyperlink, follow "Mission Statement" hyperlink) (stating the purpose of the Minnesota Board).

330 *See infra* note 359 and accompanying text.

331 *See supra* note 329.

332 *See infra* notes 359, 370-76 and accompanying text.

333 Troyen A. Brennan, *The Role of Regulation in Quality Improvement*, 76 MILBANK Q. 709, 713 (1998).

334 *See infra* note 359 and accompanying text.

consideration of the broader role of regulatory bodies leads back to the issue of informal constraints.

A. *The Role of Government in Shaping Informal Constraints*

Informal constraints can be important than formal constraints in controlling behavior. Given this, it stands to reason that a potentially effective way for the government to influence behavior is to try to shape these informal control mechanisms in a socially desirable direction. Governments have a few ways of doing this. Undoubtedly education is a key tool in the government's arsenal.[335] By educating consumers about common medical conditions (malaria, respiratory tract infections, gastroenteritis, TB, HIV) and their treatment, a government can help to correct imperfect information. This imperfect information undermines both a well-functioning market for traditional medicine and the effective functioning of informal constraints. When the population realizes that a practitioner erred, it is likely to forgo future dealings and to spread negative gossip, thereby undermining the reputation of the practitioner. The practitioner will then have to either enhance the quality of service or suffer one of a constellation of adverse outcome including loss of business, social ostracism, or potential violent retribution. The law is another weapon that can be used in an attempt to influence traditional practitioners. In fact, using laws in order to shape informal constraints may be one of the most effective ways for the government to regulate. According to North, "third party enforcement is best realized by creating a set of rules that make a variety of informal constraints effective."[336]

B. *Laws Shaping Informal Constraints*

Laws can shape informal constraints in a number of ways. Laws can affect personal mores because most people, at least to some extent, internalize the duty to obey the law and feel guilty if they do not.[337] But people's willingness to internalize government-imposed rules is something that likely varies widely

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335 *See* Sunstein, *supra* note 191, at 961-62.

336 NORTH, *supra* note 112, at 35.

337 McAdams, *supra* note 169, at 407.

from culture to culture.

Laws can also affect norms. A number of mechanisms have been proposed to explain how this can happen. First, law has an "expressive function"[338] by which the law expresses the wishes of the government. Furthermore, in a democratic society, a law may signal a consensus[339] and symbolize societal values.[340] Another suggested explanation is that "there is a general norm in favor of obeying the law."[341] By shaping informal sanctions, laws can either strengthen or weaken a norm without necessarily providing any enforcement.[342] It has been suggested that smoking laws in the United States are an example of this.[343]

C. Licensing and Competency

A license provides valuable information to the consumer. The information costs in determining the true value of the services of a traditional practitioner are prohibitively high in developing countries, and therefore people are forced to work with imperfect information.[344] The lack of information means the free market does not work well, and people purchase a service that, if fully informed, they might well choose to forgo. A license serves a useful purpose in correcting this market imperfection.[345] Justice Field's comments in *Dent v. West Virginia*[346] are as applicable in

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338 Sunstein, *supra* note 191, at 964.

339 McAdams, *supra* note 169, at 407.

340 *Id.* at 407.

341 Sunstein, *supra* note 191, at 958-59.

342 McAdams, *supra* note 169, at 408; Sunstein, *supra* note 191, at 958 Please note this author by no means advocates the enactment of laws which will not be enforced. The non-enforcement of laws in developing countries contributes significantly to people's cynicism about the law.

343 McAdams, *supra* note 169, at 406; Sunstein, *supra* note 191, at 958; *see also* Lessig, *supra* note 192, at 1025-30 (explaining how the U.S. government managed to change the social meaning of smoking).

344 *See supra* notes 98-101 and accompanying text.

345 Note that "certification," reserves the right to use a designated title but does not preclude non-certified individuals from doing the same job (as long as they do not use the designated title), and it also serves to correct this market imperfection, but without limiting consumer choice. I will not address the advantages and disadvantages of certification versus licensing in this paper.

346 *See* Dent v. West Virginia, 129 U.S. 114, 121 (1889).

today's developing world as they were over a century ago in the United States.

D. Self-regulation as a Way of Encouraging Desirable Norms

For some countries, encouraging or forcing traditional practitioners to organize and practice some degree of self-regulation seems a worthwhile way to improve the quality of traditional medicine. This is because, irrespective of whatever else such organizations do, the organizations become a vehicle for encouraging the development of desirable norms. This approach is particularly attractive because experience with networks suggests that they may work even in places where the rule of law is weak.[347]

Associations of traditional practitioners may form their own organizations just as medical professional associations initially did. It should be noted, however, that the organizations that have arisen spontaneously as a means of private ordering[348] have offered more material benefits to their members than we can reasonably expect an association of traditional practitioners to provide. Furthermore, associations such as the American Medical Association (AMA), which has played a key role in developing professional ethics and standards, have evolved over a long period of time.[349] Governments may not want to wait for such groups to organize on their own. The state may therefore want to intervene in order to encourage traditional practitioners to organize.

There are a number of approaches that the state can use in order to promote the organization of traditional practitioners. One approach is to make membership in a professional college mandatory.[350] Alternatively, the government could threaten to

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347 *See supra* Part V.D.

348 *See supra* text accompanying notes 199-209.

349 The AMA was founded in 1847. *See* American Medical Association, *AMA History*, http://www.ama-assn.org/ (follow "about AMA" hyperlink, then follow "AMA history" hyperlink).

350 In Canada provincial colleges license physicians. Once licensed, physicians become members of the college. *See, e.g.*, Medical Practitioners Act, R.S.B.C. 1996, ch. 285. Section 81 makes it an offence to practice medicine without being registered under the Act. Section 4 states that members of the college (College of Physicians and Surgeons of British Columbia) are those persons that are registered under the Act. *See id.* ; *See also* Ontario College of Physicians and Surgeons,

impose regulations if self-regulation proves ineffective.[351]

Once practitioners form a group, it is perhaps inevitable that norms will develop. However, as such norms may not necessarily be socially desirable,[352] it may be in the government's interest to try to mold them in the right direction. Self-regulation can range from informal, non-binding arrangements, to rules of full legal force.[353] Ayers and Braithwaite have suggested that governments use a pyramid strategy with respect to regulation.[354] Only where voluntary self-regulation does not bring about the desired results is punishment—first discretionary and later mandatory—used to bring about the desired results.[355] Examples of differing levels of government involvement in the self-regulatory process are evident when comparing the American and Canadian approaches to regulating the medical profession. In the United States, the development of codes of ethics, standards, and guidelines has largely been left to the AMA and specialty academies,[356] which are not-for-profit corporations.[357] In Canada, although specialist associations are involved in performing these functions,[358] these

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http://www.cpso.on.ca/About_the_College/thecollege.htm (follow link to "General college information").

351 Katz, *supra* note 209, at 2491.

352 Wendel, *supra* note 132, at 1953.

353 BALDWIN & CAVE, *supra* note 97, at 126.

354 IAN AYRES & JOHN BRAITHWAITE, RESPONSIVE REGULATION-TRANSCENDING THE DEREGULATION DEBATE 35 (1992).

355 *See* BALDWIN & CAVE, *supra* note 97, at 41 (writing with respect to a graduated approach to self regulation); *see also* AYRES & BRAITHWAITE, *supra* note 354, at 35; KEITH HAWKINS, LAW AS A LAST RESORT: A READER ON REGULATION 292 (1998).

356 *See* American Medical Association, *Ethics Group*, http://www.ama-assn.org/ (follow "Professional Resources" hyperlink, then follow "Medical Ethics" hyperlink then follow "Ethics Group" hyperlink). *See, e.g.*, American Academy of Pediatrics, homepage, http://www.aap.org (providing links for practice guidelines for pediatricians).

357 *See, e.g.*, American Academy of Pediatrics, *AAP Fact Sheet*, http://www.aap.org/ (follow "About AAP" hyperlink, and then "Fact Sheet" hyperlink); American College of Obstetricians and Surgeons, *ACOG Governance Structure*, http://www.acog.org / (follow "about us" hyperlink, then "about ACOG" hyperlink, then to "ACOG Governance Structure" hyperlink).

358 There are also individual specialty associations which specialists can voluntarily become member of, and which frequently publish sets of clinical guidelines. *See, e.g.*, The Society of Obstetricians and Gynecologists of Canada, *Clinical Practice Guidelines*, http://sogc.medical.org/ (follow "Clinical Guidelines" hyperlink) (listing practice

functions also fall within the mandate of provincial colleges[359] which are statutory bodies.[360]

Even without any organized form of self-regulation, governments can hold workshops for practitioners or establish training facilities in an attempt to influence norms within professional organizations. However, in the Canadian model, once a board or other regulatory body is formed, the responsibility is largely transferred to the board.[361] The enabling legislation that establishes such boards or colleges normally sets out the board's duties and responsibilities. These duties often amount to a duty to promote the development of socially desirable professional norms and standards. For example, the Ontario Health Professions Procedural Code[362] section 3(1) lists the following as objects of each college:

> 3. To develop, establish and maintain programs and standards of practice to assure the quality of the practice of the profession.
>
> 4. To develop, establish and maintain standards of knowledge and skill and programs to promote continuing competence among the members.[363]

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guidelines for those doing obstetrics and gynecology); Canadian Anesthesiologists Society, *Guidelines*, http://www.cas.ca/ (follow "Guidelines" hyperlink) (stating practice guidelines for anesthetists)

359 *See infra* notes 362-65 and accompanying text. *See, e.g.*, College of Physicians and Surgeons of British Columbia, *Clinical Guidelines Protocol*, https:// www.cpsbc.ca/cps (follow "Physician Resources" hyperlink,, then follow "Physician Education" hyperlink, then follow "Clinical Practice Guidelines and Protocols" hyperlink) (listing practice guidelines as well as a Code of Conduct for British Columbia physicians); College of Physicians and Surgeons of Ontario, *Policy and Publications*, http://www.cpso.on.ca/default.htm (follow "Policies" hyperlink) (listing clinical and ethical guidelines).

360 Keith W. Brownell & Luc Côté, *Senior Residents' Views on the Meaning of Professionalism and How They Learn about It*, 76 ACAD. MED. 734 (2001).

361 *See infra* notes 362-65 and accompanying text.

362 Regulated Health Professions Act R.S.O. 1991, ch. 18, Schedule 2 (Can.). Pursuant to § 4 of the Regulated Health Professions Act, R.S.O. 1991, ch. 18 (Can.), the Code is deemed to be part of each of the provinces health profession Acts.

363 As an example of how a college can try to affect conduct without actually prosecuting, consider how the Manitoba College of Physicians and Surgeons tries to promote continuing education when in Manitoba there is no formal requirement that doctors participate in CME. The College's Code of Conduct includes a requirement to "engage in lifelong learning to maintain and improve your professional knowledge, skills, and attitudes." Manitoba College of Physicians and Surgeons Bylaw Number 1,

5. To develop, establish and maintain standards of professional ethics for the members.[364]

Just as voluntary associations will not necessarily develop socially desirable norms, mandatory boards can also go astray. Governments can ensure that the development of standards and ethics are in accordance with the needs of the population by maintaining some control of the board. Legislation aimed at health practitioners, including traditional practitioners, often gives the government such control. For example, pursuant to the new South African Act, the Minister of Health appoints members to the Traditional Health Practitioners Council.[365] In Singapore the Minister of Health determines who sits on the Traditional Chinese Medicine Practitioners Board.[366] Similarly the Indian Government also has significant control over who sits on the Central Council of Indian Medicine.[367]

The threat of more extensive government involvement also helps to ensure that boards evolve in a direction which furthers the public interest. Self-regulation may be a result of a bargain between the state and the profession. As long as the profession continues to act in the public's best interest, the profession is allowed to self-regulate.[368] The Merrison Report in England recommended a predominantly professional General Medical Council but added, "[t]he ultimate safeguard of the public interest is the power of Parliament . . . . Parliament will be able to intervene if the contract to which we have referred is not operating

Code of Conduct, art. 5. The college admonishes members that "we have a responsibility to keep up with advances in our discipline and to be accountable." 39 *CPSM Newsletter* (2003). A college bylaw also requires that, as part of the annual membership review, members declare whether they have participated in CME in the last year. The same by-law also instructs members that they should keep a record of all CME credits for the two years prior to the declaration. Manitoba College of Physicians and Surgeons Bylaw Number 1.

364 *See also, e.g.*, Medical Practitioners Act, R.S.B.C. 1996, ch. 285, § 3 (listing the objects and duties of the College of Physicians and Surgeons of British Columbia).

365 Traditional Practitioners Act 35 of 2004, § 7 (S. Afr.).

366 Traditional Chinese Medicine Practitioners Act, No. 34 of 2000, ch. 333A, § 3 (Sing.).

367 Indian Medicine Central Council Act, No. 48 of 1970; India Code (1970), ch. 2, § 3.

368 JACOB, *supra* note 174, at 134.

in the general public interest."[369]

Legislation that promotes self-regulation and involves the government in the ongoing process of developing socially desirable norms might be a useful way to try to improve the quality of traditional medicine. It seems evident that many countries seem to have taken this broader regulatory approach. For example, the South African parliament recently passed the Traditional Health Practitioners Act,[370] which established a Traditional Health Practitioners Council.[371] Some of the objects and functions of the Council are to: "ensure the quality of health services within the traditional health practice; . . . promote and maintain appropriate ethical and professional standards required from traditional health practitioners; [] promote and develop interest in traditional health practice by encouraging research, education and training . . . ."[372] Other jurisdictions that have used this approach include Singapore,[373] Hong Kong,[374] and Zimbabwe.[375]

E. Achieving Compliance Without Prosecution

Though medical boards in developed countries have rarely prosecuted and there are gross inefficiencies in rule enforcement in developing countries, establishing and enforcing conventional regulations for health practitioners in developing countries is not necessarily futile. Compliance may be achieved through the use of informal mechanisms and by de-emphasizing prosecution. A regulatory approach based on education, advice, persuasion, and negotiation, rather than prosecution, is known as a compliance

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369 *Id.* at 135.

370 Traditional Health Practitioners Act 35 of 2004 (S. Afr.).

371 *Id.*

372 *Id.* § 5.

373 *See* Traditional Chinese Medicine Practitioners Act, No. 34 of 2000, ch. 333A, § 3 (Sing.).

374 *See* Chinese Medicine Ordinance (1999) Cap. 549. (H.K.)

375 Traditional Medical Practitioners Act of 1981 tit. 27 ch. 14. (Zimb.). The Zimbabwe law established a Traditional Medical Practitioners Council whose task is to "supervise and control the practice of traditional medical practitioners" and "to promote the practice of traditional medical practitioners". *See id.*

approach.[376] This contrasts with the deterrence approach which emphasizes prosecution.

Regulatory approaches vary between countries. Baldwin has suggested that, in general, the compliance-based approach is more the English approach and the deterrence model, based on prosecution, is more typically an adversarial American approach.[377] The compliance model, which is less transparent and more informal, is perhaps internationally more the norm.[378] Baldwin cites Japan as another example of a country that has an informal regulatory style.[379] Authorities there exercise wide discretion and compliance is largely voluntary.[380]

In Britain, agencies often adopt a position that legislative purposes can best be furthered by the extensive "(formal) non-enforcement of specific offences."[381] Prosecution is a symbolic act, "the dramatization of the moral notions of the community."[382] The regulator may seek to prosecute occasionally just to show that "something is being done."[383]

F. The Shadow of the Law

A number of authors have suggested that informal constraints work better "in the shadow of the law."[384] Even the rare prosecution of the odd itinerant practitioner may be enough to cast a useful shadow. The fact that medical boards in developing countries rarely punish doctors does not necessarily mean that the threat of prosecution holds no deterrence value. The threat of malpractice litigation in developing countries is also very remote and yet the doctors in the hospitals where this author worked in Swaziland, Papua New Guinea, and Vanuatu all staunchly held the

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376 BALDWIN ET AL., *supra* note 97.

377 *Id.* at 22 (addressing regulation in general, rather than regulation of the medical profession).

378 *Id.*

379 *Id.* (citing H. BAUM, INTRODUCTION: EMULATING JAPAN? (1997)).

380 *Id.*

381 HAWKINS, *supra* note 355, at 292.

382 *Id.* at 291.

383 *Id. at* 292

384 Aviram, *supra* note 133, at 1191.

belief that if you were to make a major mistake, particularly a surgical mistake, you had a good chance of being sued. Had it been pointed out to these doctors that the evidence showed that medical mistakes rarely give rise to law suits, even in a comparatively highly litigious society like the United States,[385] and that the chances of being sued in their country were even more remote, what would have been their reaction? They would likely still have been resistant to absorbing information that was inconsistent with their folklore[386] when their folkloric beliefs about the law were questioned.

Doctors in the countries, including Swaziland, Papua New Guinea, and Vanuatu, where this author worked, appear to overestimate the chance of being prosecuted. Doctors in India also seem prone to doing the same. A survey of doctors in that country showed that the Consumer Protection Act succeeded in changing the way medicine was practiced.[387] This occurred despite the fact that comparatively few doctors are actually sued pursuant to the legislation.[388] For example, 58% of respondents felt that, because of the Act, doctors spent more time with their patients.[389] Sixty-three percent of respondents believed that the Act had led to an increase in information sharing.[390] Finally, 91% believed that it had led to an increased cost and the use of

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385 *See* A.R. Localio et al., *Relation Between Malpractice Claims and Adverse Events Due to Negligence*, 325 NEW ENG. J. MED. 245 (1991); *see also* PATRICIA M. DANZON, MEDICAL MALPRACTICE: THEORY, EVIDENCE AND PUBLIC POLICY 18-19 (1985) (concluding that medical malpractice litigation infrequently compensates patients injured by medical negligence).

386 *See* ELLICKSON, *supra* note 124, at 115 (for a comparable reaction by the cattlemen he studied in Shasta County, CA). According to Ellickson, "cattlemen repeatedly get reports that insurance companies and courts have not followed the adage that 'the motorist buys a cow in open range.' The cattlemen treat the receipt of these reports not as occasion for updating their beliefs about the law but rather as occasions for railing about the incompetence of courts and insurance companies." *Id.*

387 Bhat, *supra* note 63, at 266-67.

388 Data from Andhra Pradesh shows that between 1995 and 2002, on average 16.75 cases per year come before the AP State forum, with an estimated 15-25 more appearing before the district forums. *See* George, *supra* note 278, at 24-25. In 1991 there were 32,931 doctors registered with medical councils in Andhra Pradesh. *See* Bhat, *supra* note 63, at 258.

389 Bhat, *supra* note 63, at 266-67

390 *Id.*

diagnostics.[391]

What holds for tort law may also hold true for regulation. It might not matter much that medical boards prosecute infrequently. A few highly publicized prosecutions may have a significant impact on perceived risk. Some governments are quite adept at manipulating the media so as to deceive people into thinking that their chances of being caught are much higher than they actually are.

G. Regulations May Change Societal Norms Favoring the Use of Traditional Practitioners

In many societies, when people get sick they go first to a traditional practitioner. It is the norm. By requiring that such practitioners be licensed, that the practitioners must refer patients that they can not effectively treat, and by occasionally prosecuting those who commit egregious wrongs, regulations may help to change societal norms. Perhaps it will lead people to question whether treatment by traditional practitioners is always in their best interest.

VIII. Conclusion

There is little empirical evidence as to whether regulating traditional practitioners is an effective way of improving quality of care. Given the history of comparable regulatory agencies in developed countries, and the difficulties in enforcing laws in developing countries, there is reason to believe that agencies established to regulate traditional practitioners in developing countries are unlikely to discipline many practitioners. This does not mean that regulation cannot serve a useful purpose. Regulation is not only about disciplining the occasional bad apple. The regulation of health practitioners can have a broader purpose that involves correcting market imperfections, shaping norms, self-imposed standards, and informal constraints.

In every culture there are informal constraints that exist alongside the formal constraints. These informal constraints are as important, if not more, in determining the quality of healthcare. Part of the function of regulation should be to recognize the

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391 *Id.*

existence of these informal mechanisms and to attempt to both encourage such constraints and to mold them in a socially desirable direction.

Whether regulations will be effective in the way described is admittedly a matter of conjecture. Although this kind of regulatory approach is not as dependent on a functioning enforcement agency as is the rigid enforcement of standards through prosecution, it still requires resources. For example, someone needs to issue licenses, and although a licensing fee may make the process more attractive, lack of manpower may still be a factor. The licensing process also presents an opportunity for corruption and this too may compromise the regulatory initiative. Encouraging norms by forming boards, educating practitioners and promulgating codes of conduct also takes resources.[392] Similarly, although the occasional well-publicized prosecution may have deterrent value this means that the regulatory process, at least occasionally, must work and that there must be some form of media to spread word of that fact. The expressive function of the law is also dependent on the law being publicized.

Although the value of regulation is not clear, it is perhaps not quite so doomed to failure as some would believe. The chances of such laws resulting in a radical change in practice seem highly unlikely. However, according to North, the single most important point about institutional change is that such change is overwhelmingly incremental.[393] Laws regulating traditional practitioners may well contribute to an incremental change in the way traditional medicine is practiced.

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392 Bishaw, *supra* note 307, at 197. In Ethiopia, for example, the Ministry of Health organized traditional healers into professional associations but the Ministry did not have the funds, personnel, or perhaps interest to continue to promote the idea and as a result many of these organizations disbanded. *Id.*

393 NORTH, *supra* note 112, at 89; NORTH, *supra* note 133, at 23.