SURGERIES AND SAFARIS: CREATING EFFECTIVE LEGISLATION THROUGH A COMPARATIVE LOOK AT THE POLICY IMPLICATIONS, BENEFITS, AND RISKS OF MEDICAL TOURISM FOR THE AMERICAN PATIENT

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I. INTRODUCTION

A. A Brief History of Medical Tourism

Medical tourism, despite its recent surge in the headlines, is not a new phenomenon. One of pop culture's most notable encounters with medical tourism was with Steve McQueen, who died in 1980.[1] He traveled to a clinic in Rosarito, Mexico to receive Laetrile, a cancer treatment not approved by the Food and Drug Administration (FDA).[2] The medical tourism industry, however, has existed for thousands of years in a myriad of cultures.[3] For example, "patients in ancient Greece traveled to Epidaurus to visit the Sanctuary of Asklepios, the Greek god of physicians and healing; in Roman Britain, pilgrims traveled to the waters at Bath; and in the 1800s, wealthy Europeans traveled to spas along the Nile."[4]

Why then, if it is such an ancient practice, has there been such resurgence in attention on it by the media and health care policy writers? Despite its historic roots, medical tourism was all but ignored in the health care industry until as recently as 1995.[5] Today, however, its popularity has exploded.[6] Analyzing several

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1. I. Glenn Cohen, *Protecting Patients with Passports: Medical Tourism and the Patient-Protective Argument*, 95 IOWA L. REV. 1467, 1471 (2010) [hereinafter Cohen, *Protecting Patients with Passports*].

2. *Id*.

3. *Id*.

4. Michael Klaus, *Outsourcing Vital Operations: What If U.S. Health Care Costs Drive Patients Overseas for Surgery?*, 9 QUINNIPIAC HEALTH L. J. 219, 221–2 (2006) (citing Cameron Macintosh, *Medical Tourism: Need Surgery, Will Travel*, CBC NEWS, June 18, 2004, at http://www.cbc.ca/news/background/healthcare/medicaltourism.html); Kristen Boyle, *A Permanent Vacation: Evaluating Medical Tourism's Place in the United States Healthcare System*, 20 HEALTH LAW 42, 42 (2008).

5. Boyle, *supra* note 4, at 47.

6. Y.Y. Brandon Chen & Colleen M. Flood, *Medical Tourism's Impact on Health Care Equity and Access in Low- and Middle-Income Countries: Making the Case for Regulation*, 41 J. L. MED. & ETHICS 286, 286 (2013) (explaining that the number of patients traveling from the developed world to low and middle-income countries for treatments has ballooned in recent years, primarily driven by difficulties with accessing affordable care at home).

countries entrenched in the medical tourism industry can help illustrate the pace of expansion underway. Thailand saw 1.3 million foreign patients in 2007, a 16% rise from 2001.[7] Malaysia saw its number of foreign patients increase 21.4% annually from 2004 to 2008.[8] India has seen annual increases of 15% in medical tourists since 2005.[9] In total, the 2014 worldwide market for medical tourism was estimated to be between $38.5 billion and $55 billion.[10] Eleven million patients were expected to travel for care, of whom 1.2 million were estimated to be U.S. citizens.[11]

Around the world, various entities representing governments and industry have undertaken research and investigative efforts to better understand this trend.[12] Medical tourism's rise is easy to detect through simple economic analysis and government reports. Finding discrete reasons for that rise, however, has proven infinitely harder. Some commentators offer simple answers, suggesting, for example, that cheap travel provides access to locations and medical options previously reserved for the wealthy.[13] Others have proffered more complex, systemic causes, citing, for example, social medical systems like those in Canada and England as contributors to increases in medical tourism.[14] Patients from those countries often travel abroad to receive treatments that are extensively delayed in their home countries.[15] Even other commentators cite a rise in outpatient surgery[16] and demand for dentists as additional reasons for gains in medical tourism.[17] With

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7. *Id*.

8. *Id*.

9. *Id*. India expects its medical tourism revenue to exceed $2.2 billion by 2015. Boyle, *supra* note 4, at 47.

10. *Medical Tourism Statistics & Facts*, PATIENTS BEYOND BORDERS, http://www.patientsbeyondborders.com/medical-tourism-statistics-facts (last updated July 6, 2014) (estimating the average amount spent per visit to be $3,500–5,000 including all related travel and care expenses).

11. *Id*.

12. *See* Nathan Cortez, *Patients Without Borders: The Emerging Global Market for Patients and the Evolution of Modern Health Care*, 83 IND. L. J. 71, 72 n.5 (2008) (noting that the World Trade Organization, World Health Organization, World Bank, and U.S. Senate have all conducted studies on medical tourism).

13. *See* Klaus, *supra* note 4, at 221–22 ("[T]ravel for surgery is no longer a pastime of the wealthy . . . .").

14. Howard D. Bye, Esq., *Shopping Abroad for Medical Care: The Next Step in Controlling the Escalating Health Care Costs of American Group Health Plans?*, 19 HEALTH L. 30, 30 (2007).

15. *Id*.; *see*, *e.g*., Boyle, *supra* note 4, at 42 (explaining that Canadians wait on average 17.9 weeks to see a specialist after their general practitioner, while patients in the United Kingdom wait one to two years for non-emergency surgery).

16. *Medical tourism: Update and implications*, DELOITTE CENTER FOR HEALTH SOLUTIONS, 1, 11, http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20assets/documents/us_chs_medicaltourism_111209_web.pdf (last visited Mar. 8, 2015) (arguing that outpatient surgeries, which comprise nearly 75% of medical tourism procedures, have tripled between 1996 and 2006).

17. *Id*. (suggesting that an increase in demand for dental surgery may fuel medical tourism and that the retirement of a significant number of dentists over the next 20 years may be eased by increased medical tourism).

respect to the United States, experts posit that medical tourism is likely used by citizens seeking lower out-of-pocket costs or procedures not yet approved by the FDA.[18]

Whatever the actual driver of medical tourism's meteoric rise in popularity, analyzing the industry is critical, especially from the perspective of the United States and its legislature. For the United States, it is essential to decipher the risks associated with medical tourism and to weigh those risks against any potential benefits to U.S. citizens. This comment seeks to inform legislative efforts to regulate medical tourism both as proactive, protective measures today and as reactive measures in the future.

B. The Purpose and Structure of this Comment's Analysis

Due to a lack of conclusive data and varying biases among interpreters of the data that is available, the determination of a single definitive cause of the rise in international medical tourism, if one even exists, is unlikely to happen. Furthermore, given that medical tourism has already gained such popularity, and that popularity is only accelerating, it seems more appropriate to look forward, concentrating on how to most effectively deal with medical tourism, rather than to look back and extrapolate theoretical causes.

Thus, this comment arrives first at the normative question of whether the United States, as a matter of legislative policy, should allow, or even encourage, the use of medical tourism by individuals or insurance companies. To answer this question, however, it must first be determined whether by increasing U.S. citizens' utilization of medical tourism, the United States would cause harm to the destination country's population. If it would, then the question becomes whether the United States' duty to its citizens outweighs any duty owed to a foreign population.

After addressing these normative questions, this comment shifts its focus to a substantive question—if medical tourism is a desirable policy, what should be the goal of future legislation? To answer this, underlying issues must again first be addressed. Understanding the medical tourism industry in the United States, including who decides to pursue international medical care and why, is important. Then, it is necessary to identify the specific risks Americans face when traveling for care. These risks include the quality of care available from foreign providers and the legal risks that may arise in international medical malpractice litigation.

In answering the normative question in the affirmative, the discussion relies on two overarching themes: first, there is no reliable evidence of a negative impact

18. Bye, *supra* note 14, at 30 ("Americans for many years have traveled to Latin American destinations, such as Brazil, for lower-cost facelifts, tummy tucks and other cosmetic procedures not covered by health insurance in the United States. Americans living near the borders have long sought out cheaper prescription drugs and dental and other medical services in Mexico and Canada. In addition, some American medical tourists shop abroad for medical procedures not approved by the Food and Drug Administration in this country, but which are established and commonplace in Europe and Asia." (footnotes omitted)).

by medical tourism on a destination country's own health care system; and second, medical tourism offers a net benefit to the U.S. health care system. The first theme is discussed fully by analyzing the current favored arguments against medical tourism and analyzing whether the United States has a duty to limit medical tourism if it negatively affects a destination country. It becomes clear that there is no normative reason to limit medical tourism by U.S. citizens after the lack of evidentiary support for the contrarian position is exposed. The second theme, however, is based on the balance of the comment's conclusions. In sum, although there are risks inherent in medical tourism, they are readily definable. Thus, assuming those risks are effectively communicated, medical tourism offers a net positive gain on the United States' health care system and should be supported.

The discussion then moves on to the substantive question of what role legislation should play in medical tourism. The role of legislation again focuses on two themes: first, the actual risks involved with the medical care provided, which this comment defines as *quality of care risks*; and second, the *legal risks* faced by Americans who desire to sue for international medical malpractice. As with domestic care, patients can never fully avoid the risks involved in international health care. Furthermore, the United States has little ability or incentive to persuade other nations to accept wholesale changes to their health care system to suit American medical tourists. The goal of medical tourism legislation, then, should be directed at full disclosure to consumers so they can make an informed decision regarding the cost-benefit of the various options they face.

II. MEDICAL TOURISM—AN OVERVIEW

This section offers further background and information regarding the medical tourism industry. First, the section explains, in general terms, why a patient may choose medical tourism as an option. Then, the patient's need to choose a destination country, a specific facility, and a specific care provider therein is explored, and some key considerations imposed on the patient throughout the decision-making process are highlighted. Finally, an emerging derivative industry—brokerages—is introduced, and its effect on the industry is commented on.

A. Medical Tourism—Who Travels and Why?

The World Trade Organization's General Agreement on Trade in Services categorizes types of medical tourism.[19] Of particular relevance is the category of

19. The General Agreement on Trade in Services offers four categories of medical tourism, of which "consumption abroad," the category discussed *infra*, is one. *See* Deth Sao et al., *Healthcare Disputes Across National Boundaries: The Potential for Arbitration*, 42 GEO. WASH. INT'L L. REV. 475, 477–80 (2010). The other three are where: (1) supplier and consumer remain in different countries (such as the purchase of international health insurance policies and remote diagnostic services); (2) a foreign supplier establishes a commercial presence in a consumer's country (such as foreign owned health care providers located within a patient's home country); and (3) supplier moves to a consumer's country (such as reverse medical tourism, where the provider relocates to the patient's home country for treatment). *Id*. Interestingly, the first category includes telemedicine, which is a burgeoning subgroup of medical tourism. *See id*. at 479–80

"consumption abroad," where a consumer travels to a supplier's country to consume a service.[20] This is what has been traditionally considered medical tourism—a patient traveling from their home country to a health care provider's home country to receive care.[21]

The industry can also be defined from each country's perspective. For example, based on an American citizen's perspective, traditional medical tourism, as defined in this article, would be "outbound medical tourism"—U.S. patients traveling overseas for care.[22] Conversely, the destination country experiences "inbound medical tourism."

Excluding collateral care[23] and expatriates already overseas, why might a particular person choose to receive health care services abroad? This comment deals exclusively with the population of American citizens traveling overseas to receive affordable or alternative care in developing nations.[24] In the United States,

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(discussing some of the current applications of telemedicine: two-way video conferencing; electronic communications of diagnoses, second opinions, and consultations; and telehealth services such as telepathology, teleradiology, and telepsychiatry). Seemingly, many of the legal complications discussed here would be mirrored under telemedicine. The categories where actual care would be provided in the United States would not be subject to the same legal risks faced in traditional medical tourism. *See id*. at 480 (explaining that cross-border transactions are most likely to involve the legal ambiguities and uncertainties that businesses and consumers face in the event of a health services dispute).

20. *See id*. at 479–80.

21. *Id*.

22. The other possible perspectives would be "inbound"—foreign patients coming to the United States for care—and "intrabound"—U.S. patients traveling intra-nationally to find care. *See Medical Tourism Consumers in Search of Value*, DELOITTE CENTER FOR HEALTH SOLUTIONS, 1, 3 (2008), https://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/us_chs_MedicalTourismStudy(3).pdf. A fourth category of medical tourism—doctors traveling overseas with their patients—also has been identified. *See, e.g*., Zongwei Li, *Medical Tourism Grows Rapidly with Mounting Ethical and Legal Concerns*, MEDMILL REPORTS CHICAGO (June 14, 2013), http://news.medill.northwestern.edu/chicago/news.aspx?id=223151 (telling the story of an orthopedic spine surgeon who traveled overseas with a patient to conduct surgery using a tool—magnetic rods—not yet approved by the FDA, but available overseas and exploring legal and ethical discussions about the medical travel industry, such as whether U.S. patients and doctors should be held accountable for seeking or conducting surgeries that are not approved, or are even illegal, in their home country).

23. Collateral care is health care provided on an emergency basis during, or incidental to, travel. Cohen, *Protecting Patients with Passports*, *supra* note 1, at 1476–77.

24. *See* Sao et al., *supra* note 19, at 482 (explaining that medical tourists have been generally grouped into three basic categories: (1) patients in developing countries seeking specialized or high-quality care in developing or industrialized countries; (2) patients from industrialized countries seeking affordable or alternative care in developing countries; and (3) patients seeking medical services not offered in their home countries, such as abortion, fertility treatments, and euthanasia, due to moral or ideological reasons). While domestic facilities like the Mayo Clinic treat thousands of international patients annually, the legal implications of that care for American citizens is not relevant to the normative question at hand. *Mayo Clinic*, PATIENTS BEYOND BORDERS, http://www.patientsbeyondborders.com/hospital/mayo-clinic (last updated on Jan. 3, 2013) ("Each year more than 8,000 international patients from 140 countries travel to one of Mayo's locations. Mayo's International Patient Offices work to ensure that distance and

there are three general groups with an incentive to travel for health care services: (1) cash customers, comprised of both uninsured or underinsured patients looking for lower cost care;[25] (2) private-insurance-encouraged individuals who are offered incentives like rebates or discounts to travel abroad for health care by U.S. insurers;[26] and (3) government-encouraged patients who, for example, if covered by Medicaid or Medicare, could take advantage of the estimated $18 billion in annual savings that would be available if 10% of the population used international sources for health care.[27]

In general, this comment focuses on the first two groups—cash customers and private-insurance-encouraged individuals. While the normative question regards U.S. policy, these two groups are the only existing examples for analysis. By analyzing these, this comment seeks to extrapolate the implications for governmental insurance such as Medicaid and Medicare.

Having established the general groups of patients likely to travel for care, the next step is to look at why those patients may ultimately choose medical tourism. First, some procedures are simply not available in the United States due to a lengthy FDA approval process.[28] Thus, Americans who can afford to do so may choose to travel abroad for those procedures.[29] While the medical risks of non-approved treatments are relatively straight forward, there can be a myriad of risks lurking just beyond the obvious ones, as well.[30]

Second, surgical procedures can cost 30–80% less overseas than they do in the United States.[31] Of course, for cash customers this is an obvious and vital

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language are not obstacles to receiving excellent care.").

25. I. Glenn Cohen, *Medical Tourism, Access to Health Care, and Global Justice*, 52 VA. J. INT'L L. 1, 7–8 (2011) [hereinafter Cohen, *Medical Tourism*] (suggesting that these patients seek procedures similar to hip replacements).

26. *See id*. ("In its weakest form, insurers simply cover the service abroad without any incentive, but in a more common form, Tourism-Incentivized plans offer individuals rebates, waived deductibles, or other payment incentives for receiving treatment abroad. For example, a plan proposed by Hannaford Brothers Supermarkets in the northeastern United States gives employees incentives to seek treatment in Singapore at Joint Commission International (JCI)-accredited hospitals.").

27. *See id*. (explaining an alternative in place in the European Union, where member states face some obligations to reimburse their citizens for treatments received in other member states).

28. *See* Boyle, *supra* note 4, at 42 (offering hip resurfacing as one example of a procedure not yet approved by the FDA that Americans are traveling overseas to obtain).

29. Sam Amick, *Kobe Bryant in Germany for Blood Platelet Therapy,* USA TODAY (Oct. 3, 2013, 5:53 PM), http://www.usatoday.com/story/sports/nba/lakers/2013/10/03/kobe-bryant-injury-knee-blood-spinning-germany-los-angeles/2917971.

30. The risks faced by medical tourists are discussed in various sections *infra*. An example of a risk that is not particularly obvious would be the *legal risk*, defined *infra* Part IV, Section B, faced by patients who suffer an adverse outcome.

31. *See, e.g*., Bye, *supra* note 14, at 30 (listing costs of surgeries in the United States as compared to abroad, including heart valve surgery, which costs $200,000 in the United States but only $6,700 internationally; herniated disk repair, which costs $90,000 in the United States and $10,000 internationally; and liver transplants, which cost $300,000 in the United States as compared to $30,000 in foreign markets). See also Klaus, *supra* note 4, at 224, which offers additional comparative pricing examples.

factor. Elective procedures have long been a staple for Americans traveling overseas for medical care. For example, Americans have favored Latin America as a destination for plastic surgery because insurance plans traditionally do not cover such procedures.[32] However, with Asian markets gaining exposure for their technical prowess and competitive rates, Americans may begin to shift their medical destinations.[33] While elective surgeries represent the most elastic demand, this analysis looks at medical treatments in general, including both elective and non-elective procedures.

Beyond cost savings, the available amenities also serve as an incentive to travel for medical care.[34] By treating health care as a service industry, Asian hospitals are working to gain important referral business.[35] Bumrungrad International Hospital (Bumrungrad) in Bangkok, for example, has a lobby designed after a five-star hotel.[36] Further, India's Apollo Hospitals Group uses technology to connect the patient with loved ones still at home.[37]

The patient also can look forward to an exciting vacation once in the destination country, regardless of whether one is a cash customer saving money or a private-insurance-encouraged patient taking advantage of a free exotic vacation.[38] Recreational travel often is done prior to surgery, though there are anecdotal stories of "surgery safaris" where the patient recuperates while on safari because,

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32. Bye, *supra* note 14, at 30 ("Americans for many years have traveled to Latin American destinations, such as Brazil, for lower-cost facelifts, tummy tucks and other cosmetic procedures not covered by health insurance in the United States.").

33. *See* Klaus, *supra* note 4, at 241 (providing evidence of growing plastic surgery market in India). In fact, with additional and even lower cost alternatives becoming available, elective surgery may become even more popular in the future. *See id*. "On the margins, people who previously declined elective surgeries in the United States due to cost considerations would undergo those procedures in Asia when the cost concerns are minimized." *Id*. Since elective surgeries have the most elastic demand curve of medical procedures, they represent a large potential rise in utilization should medical tourism be promoted as offering low cost alternatives. *Id*.

34. Boyle, *supra* note 4, at 44 (discussing other benefits such as the attentiveness and the communicativeness of the doctors and the meticulousness of the assistants).

35. Klaus, *supra* note 4, at 228–29 (suggesting that more patients will likely refer friends or family members to consider traveling for care after being offered luxurious amenities, high quality care, and cost savings).

36. *Id*. at 228 (". . . replete with carpets, sofas, a concierge and even a Starbucks."). Curtis Schroeder, the hospital's chief executive explains, "[p]art of the concept was to create an environment such that when people came in they didn't feel like they're in a hospital. . . . [N]obody really wants to go to a hospital." *Id*.

37. *Id*. (explaining how India's Apollo Hospitals Group offers "virtual patient visits" on its website enabling the patient and his friends at home to exchange pictures and messages). The Apollo Hospitals Group also advertises twenty-four hour personal care as a benefit. Bye, *supra* note 14, at 31.

38. *Id*. at 30–31 (discussing that patients, whether paying cash or receiving insurance policy incentives, can still enjoy an exotic trip with a companion that they might not have otherwise taken).

presumably, the giraffes do not care about their bandaged appearance.[39]

The choice to travel for health care is not always easy and often involves balancing risks. Although many patients will enjoy the significant cost savings, opulent surroundings, and exotic locales, they also may be concerned about the quality of care available in a destination country. Contrary to widespread American perception, foreign private hospitals often utilize the same technologies as major medical centers in the United States.[40] Additionally, many foreign doctors are trained in and have practiced in either the United States or England prior to returning "home."[41] While some question how medical tourism could be bad for Americans,[42] with comparable quality of care available at a vastly lowered cost, the question is not that simple.[43]

B. Choosing a Destination Country and Facility

Choosing a specific destination can be a daunting task in an increasingly crowded marketplace where providers are vying for patients. The top eight destinations for medical tourism in 2012 were spread across almost every continent.[44] While there are some established medical tourism destinations like India and Thailand,[45] recent demand expansion has created a battle among many low and middle-income countries (LMICs) fighting to enter this emerging marketplace.[46]

Many destinations are chosen due to an established reputation for excellence in a particular specialty.[47] For instance, Thailand has become known for sex-

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39. Cohen, *Protecting Patients with Passports*, *supra* note 1, at 1482 ("Indeed I have heard anecdotal reports about 'surgery safaris' for facelifts, where a patient recuperates on safari with medical staff available—her friends back home are not around to observe her bandaged countenance, and the giraffes presumably do not care.").

40. Klaus, *supra* note 4, at 219.

41. *Id*.

42. *Id*. ("If the quality of care in Asia is comparable to the quality of care in the United States, and surgery in Asia saves hundreds of thousands of Americans tens of thousands of dollars, then how could 'medical tourism' present a challenge for Americans, the United States health care industry, insurance companies and the Asian countries that promote surgery-vacations to foreigners?").

43. See *infra* Part III, Section A for discussion on risks to the medical tourist and *infra* Part IV for discussion on risks to the destination country.

44. *See, e.g.*, Jordan Robertson, *Top Travel Destinations for Medical Tourism*, BLOOMBERG TECHNOLOGY (June 25, 2013), http://www.bloomberg.com/slideshow/2013-06-25/top-travel-destinations-for-medical-tourism.html (listing the top eight destinations for medical tourism in 2012: (1) Thailand, (2) Mexico, (3) United States, (4) Singapore, (5) India, (6) Brazil, (7) Turkey, (8) Taiwan).

45. *See* Cohen, *Protecting Patients with Passports*, *supra* note 1, at 1479 (establishing that Argentina, Chile, Costa Rica, Cuba, India, Jordan, Malaysia, the Philippines, Thailand, and South Africa have been the major sites for medical tourism thus far and that there are also substantial industries in Greece, Romania, the former Soviet Baltic States, and Singapore).

46. *See* Boyle, *supra* note 4, at 47 (listing Argentina, Costa Rica, Jamaica, South Africa, Jordan, Malaysia, Hungary, Latvia, and Estonia as some of the many countries breaking into the global market of medical tourism).

47. Cohen, *Protecting Patients with Passports*, *supra* note 1, at 1482–83 (discussing how

change operations,[48] Singapore is known as a top cancer treatment center,[49] and Brazil is known for its cosmetic surgery.[50] Other locations are known for offering treatments not available elsewhere. For example, the Cuban clinic Cira Garcia offers a unique procedure for retinitis pigmentosa (night blindness), and Indian hospitals offer a special form of hip replacement not available in the United States or other western countries.[51]

After choosing a destination country, a patient has to choose a medical facility to perform the procedure. Some foreign hospitals systems are so massive that they span several countries as they continue to evolve and grow with demand.[52] Bumrungrad is an example of this, having set up referral offices in multiple foreign countries as early as 2006.[53] This pioneering effort in attracting medical tourists led experts to predict in 2006 that the future of the industry would be in Thailand and India, with the latter touted to have the greatest growth potential.[54] International hospitals prominently advertise the credentials of their physicians to attract business.[55] Patients often can search available surgeons by specialty, treatment, region, or country, making it easy to find a match.[56]

As is often the case, the growth of a new industry inevitably leads to new collateral business models. In the case of medical tourism, brokerages have emerged.[57] In general, brokers act as a liaison and coordinator for the patient.[58] While some brokers concentrate on a single country,[59] a brokerage commonly

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specialization drives selection, with some foreign providers attracting patients because they are among a select few to offer a particular procedure or have been particularly good at more widely available ones).

48. *Id*. at 1483.

49. Robertson, *supra* note 44.

50. *Id*.

51. Cohen, *Protecting Patients with Passports*, *supra* note 1, at 1482–83.

52. *Id*. at 1479 ("Apollo Hospitals 'has over seven thousand beds in thirty-eight hospitals' centered in India and facilities in Sri Lanka, Bangladesh, Ghana, Nigeria, Qatar, and Kuwait.").

53. Klaus, *supra* note 4, at 222 (establishing that Bumrungrad set up offices in Oman, Australia, and the Netherlands).

54. *See generally id*. at 223–24.

55. *See Bumrungrad International Hospital*, PATIENTS BEYOND BORDERS, http://www.patientsbeyondborders.com/hospital/bumrungrad-international-hospital (last updated Mar. 16, 2014) (advertising 220 U.S. board-certified physicians).

56. *See, e.g*., *Top Specialties*, PATIENTS BEYOND BORDERS, http://www.patientsbeyond borders.com/procedure (last visited Mar. 9, 2015) (allowing searches by multiple factors).

57. Klaus, *supra* note 4, at 227.

58. *See id*. Brokers collaborate with airlines, hospitals and hotels to offer medical tourism packages. *Id*. Brokers also will work with prospective hospital patients to customize a package based on the patient's budget, medical needs, and desire to travel following the surgery. *Id*. The typical process involves the patient first offering information regarding his budget, the type of surgery needed, his proposed travel dates, and the desired destinations. *Id*. at 227–28. As the patient's facilitator, the broker finds and explains various options for each of those factors. After the surgery is complete, the broker facilitates communication between the foreign surgeon and the patient's primary care physician. *Id*. at 228.

59. Leigh Turner, *"Medical Tourism" and the Global Marketplace in Health Services: U.S.*

offers multiple destinations based on price levels and services needed.[60] High-priced locations are typically underutilized U.S. hospitals, mid-priced offerings are often found in Singapore and Belgium, and low-priced services are available in India or Indonesia.[61]

Medical tourism destinations have also partnered with brokerages to aid patients in the planning process. The advertising techniques utilized by these brokerage firms raise some concerns. As an example, experts fear that by advertising a combination of cosmetic surgery and sightseeing, consumers may discount the underlying risks involved in the procedure.[62] Furthermore, some brokerages, like those in Argentina, impose restrictions on post-surgery travel[63] while others openly advertise tourist travel either before or after treatment.[64]

Currently, there is no firm evidence on how Americans choose whether to utilize medical tourism or not. Furthermore, there is little reliable evidence on how destination countries, facilities, or providers are chosen by those patients. Though the increasing utilization of brokerages offers some insight into the decision-making process, there is no conclusive data available. This comment proposes that cash customers, much like consumers in other industries, utilize a combination of advertising, word of mouth advice, and professional references from their local doctors. Internet research must also play a large role in the information gathering process. Private-insurance-driven patients likely rely more heavily on information provided by their insurance provider than on the independent information utilized by their cash-paying counterparts.

Although the precise nature of the decision-making process is not yet known, an analysis of the industry and its potential repercussions on American citizens can still offer valuable insights in shaping legislative efforts. Specifically, because there are real risks involved with this emerging industry, it is imperative that legislation be proactive in taking precautionary regulatory measures to protect consumers. These measures could include the regulation of foreign-provider practices including mandatory disclosure language, limits on deceptive advertising, and other measures already utilized in other industries, such as the financial

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Patients, International Hospitals, and the Search for Affordable Health Care, 40 INT'L J. HEALTH SERVICES 443, 447 (2010) (offering IndUShealth as an example of an agency that deals with multiple hospitals in India).

60. *Id*. (offering Planet Hospital as an example of a broker dealing with Argentina, Belgium, Brazil, Costa Rica, El Salvador, India, Mexico, Panama, Singapore, Thailand, the United States, and Uruguay).

61. *Id*. In addition, brokerage companies like Speedy Surgery and Timely Medical Alternatives take advantage of the slow-pace of medical services in Canada by offering patients the ability to purchase expedited care overseas. *Id*. at 444. Planet Hospital, Global Med Network, World Med Assist, Med Journeys, and Med Retreat are the leading medical brokerages in the United States. *Id*. at 447.

62. Kerrie S. Howze, *Medical Tourism: Symptom or Cure?*, 41 GA. L. REV. 1013, 1027 (2007) (discussing congressional testimony by Dr. Bruce Cunningham, the president of the American Society of Plastic Surgeons).

63. *Id*. at 1028.

64. *Id*. ("Before or after your visit to our hospital, you and your family could just as well book one of the fascinating tours from Diethelm Travel, our designated partner.").

industry.[65] Although financial regulation can offer guidance, the regulations surrounding medical tourism must be stricter due to the inherent level of safety risk involved in the health care sector.

As additional evidence of a patient's decision-making process is made available, further research can be used to craft legislative efforts to ensure the information relied on by these patients is accessible and accurate. Indeed, medical tourism legislation should seek to increase the availability of information rather than to curtail decisions or options for patients.

III. THE UNITED STATES DOES NOT HAVE A DUTY TO OTHER NATIONS TO PREVENT MEDICAL TOURISM BY ITS CITIZENS

In order to answer the normative questions posed earlier, this comment first analyzes the potential for harm caused to a destination nation's own health care system by a U.S. policy approving of medical tourism. This comment relies on a combination of empirical research and economic theory to draw its conclusion.

In order to understand the arguments proffered by both sides of this debate, this comment looks to academia. Academic authors offer a comprehensive view, often incorporating multiple perspectives and disciplines in their analyses. Although the views these authors present are undoubtedly based on opinion, it is the fact finding and analysis that their writing offers that creates a compelling reason to rely on their judgment. Additionally, in comparison to industry members, who have undeniable interests and biases, academics hopefully offer no more bias than their own predilections may serve. As such, when this comment refers to "critics," it does so in regard to academic authors who have written academic articles critical of medical tourism.

As those critics are often quick to point out potential costs to a destination country without much evidentiary proof, this comment concludes that the net effect on a destination country has not yet been conclusively established. This lack of evidence of harm, combined with the voluntary measures taken by destination countries to promote medical tourism,[66] leads to the second normative question being answered negatively—the United States does not owe a duty to the world at-large in creating its policy for medical tourism.

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65. *See*, *e.g.*, *Brief Summary of the Dodd-Frank Wall Street Reform and Consumer Protection Act*, UNITED STATES SENATE COMMITTEE ON BANKING, HOUSING, AND URBAN AFFAIRS, http://www.banking.senate.gov/public/_files/070110_Dodd_Frank_Wall_Street_Reform_comprehensive_summary_Final.pdf (last visited Mar. 9, 2015).

66. *See*, *e.g.*, Klaus, *supra* note 4, at 223 (discussing India's offer of tax breaks on medical equipment and creation of a new visa aimed at medical tourism); Chee Heng Leng, *Medical Tourism and the State in Malaysia and Singapore*, 10 GLOBAL SOC. POL. 336, 337 (2010) (stating that in most destination countries the government is involved to various extents in either developing or supporting the medical tourism industry).

A. There Is Insufficient Empirical Evidence to Conclude Medical Tourism Has a Negative Effect on a Destination Country

A variety of factors are often looked at to establish the effect medical tourism has on a destination country.[67] However, the analysis usually results in a common conclusion—medical tourism reduces access to health care for citizens of destination countries by creating a two-tier system of care, one tier for locals and one for foreigners. I. Glenn Cohen, assistant professor and co-director of the Petrie-Flom Center for Health Law Policy, Biotechnology, and Bioethics at Harvard Law School, listed six factors to analyze before making any determination on the adverse impact of medical tourism.[68] Using Cohen's factors to structure the following discussion, this analysis begins by determining whether medical tourism causes reduced access to health care in the destination country. The discussion then looks at the economics of medical tourism in a destination country, paying specific attention to the access and price of medical care for a destination country's citizens. The arguments often offered in support or against these arguments are not, and likely cannot be, clearly delineated. As such, there is some overlap in the discussion that follows.

1. Competition for Medical Care Resources

The limited resources discussion encompasses several aspects that can generally be classified into two categories: (1) supply related—locals will have reduced access to health care due to the demand from foreign patients; and (2) cost related—competition from private medical facilities will drive up the salaries of doctors, and thus the cost of health care overall in the destination country. This section discusses the critics' arguments, followed by arguments opposing the critics' position. In sum, the critics fail to offer substantial evidentiary support for their position and therefore fail to make a convincing argument.

a. Supply of Doctors: Brain Drain

A deleterious concept commonly cited as "brain drain" holds that the medical tourism industry will compete with the limited supply of health care providers in a destination country, thereby reducing the number of providers available for destination-country citizens.[69] The limitations on supply come from two concomitant sources—the movement of doctors into specialties rather than general

67. *See, e.g.*, Cohen, *Medical Tourism, supra* note 25, at 9–13 (listing six factors that need to be determined empirically before an adverse impact of medical tourism can be made: (1) whether health resources consumed by medical tourists would have otherwise been available to citizens of destination countries; (2) whether the medical tourism industry lures away health providers who served local populations exclusively; (3) the degree to which the supply of health care resources in destination countries can be expanded to meet increasing demand from both local patients and medical tourists; (4) how successful medical tourism is in countering the emigration of LMICs' health professionals; (5) how medical tourism's positive and negative spillover effects on LMICs' public health care systems balance against each other; and (6) the likelihood of economic gains from medical tourism to trickle down in destination societies).

68. *See, e.g.*, *id*.

69. Chen & Flood, *supra* note 6, at 287.

practice and a simple outstripping of supply due to the increased demand created by medical tourism.[70] Due to an already existing shortage of primary care in most LMICs, any drain on the supply of physicians could be immediately dire.[71]

The forecasted shortage of physicians is predicted to occur due to a multitude of factors. Because patients typically receive preventive care domestically, medical tourists are presumably looking for secondary and tertiary care rather than primary care.[72] The prospect of higher profits from foreign patients drives doctors into these sub-specialties, thereby reducing the supply of general practitioners needed for the local population.[73]

In addition to the trend of shifting towards specialties, the raw number of doctors produced by many LMICs is simply insufficient for their nation's demand.[74] Thailand is often offered as evidence of this phenomenon. Critics allege that the 1,300 doctors Thailand produces annually barely support the increased health care demand from its own population, let alone an increase in foreign patients.[75] As such, opponents of medical tourism say medical tourism absorbed any surplus doctors that could otherwise have closed Thailand's current shortage of physicians.[76] Furthermore, they argue that medical tourists do not represent a one-for-one resource displacement.[77] Foreign patients in Thailand require the same resources as four to five locals and therefore present a disproportionate drain on the supply of medical care available for locals.[78]

Critics also suggest that practicing doctors may shift their focus as a result of medical tourism. This subset of brain drain, referred to as "internal brain drain," is the drawing of physicians from the public sector to the private sector and from rural areas to urban areas.[79] Increased salaries are often considered the leading cause of internal brain drain, luring doctors away from the public sector and rural areas.[80]

According to some opponents of medical tourism, geographic considerations also play a role in the competition for resources. Rural areas, which do not see foreign patients, lose doctors to urban regions that house the medical tourism

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70. *Id*.

71. *Id*. at 289.

72. *See id*. at 288–89 (describing heart operations and cosmetic surgery as typical treatments for medical tourists in Thailand while India's typical medical tourist receives care for hip or knee replacements and bone marrow treatments).

73. *Id*.

74. *See*, *e.g*., Klaus, *supra* note 4, at 240 (stating that India has four doctors for every 100,000 people compared to the United States at 27 per 100,000 people).

75. Chen & Flood, *supra* note 6, at 288.

76. *Id*.

77. *Id*.

78. *Id*.

79. *Id*. at 289.

80. *See id*. at 290 (discussing private salaries that are six to eleven times that of public salaries in Thailand).

destination facilities.[81] Thus, the medical tourism industry most likely directly affects the poor.[82] Thailand lost nearly five times the number of public sector doctors in 2002 than it did in 2000 while graduation rates remained virtually constant.[83] Further support is found in reports citing nearly 6,000 public sector jobs remaining unfilled due to private sector competition while private sector physicians increased in number.[84]

The sheer number of physicians involved only presents part of the story. Who those doctors are represents another aspect of brain drain for opponents of medical tourism. Foreign patients desire treatment from well-trained, experienced doctors.[85] As such, the damaging effect of internal brain drain is specific to doctors who are prominent in their specialty and are commonly affiliated with local teaching hospitals.[86] The reduction in teaching staff, due to moves to private practice, may then decrease the ability of medical schools to produce doctors, further constraining the supply of doctors available.[87]

Using the classic economic theory of supply and demand, critics argue this net reduction in the supply of doctors relative to the demand for care combined with upward pressure on medical-provider salaries will result in increased costs of health care for locals.[88] Thus, without increased government investment into the health care sector, a rise in costs will result in decreased availability of health care for locals.[89]

Ultimately, this argument concludes that by reducing available resources and causing price increases for the care available, medical tourism results in a two-tier system of health care in the destination country, one tier for the local poor and one for medical tourist foreigners.[90]

b. Rebuttal to Critics' Arguments

This argument, based on supply constraints, is not convincing for multiple reasons. First, medical tourists are not necessarily competing for resources otherwise available to local citizens.[91] The evidence provided by critics concentrates on the poorest populations of a destination country. Thus, they argue, any increase in price would reduce their access to the advanced care sought by medical tourists.[92] However, the poorest citizens of LMICs already have virtually

81. Chen & Flood, *supra* note 6, at 290.
82. *Id*.
83. *Id*.
84. *Id*.
85. *Id*.
86. *Id*.
87. Chen & Flood, *supra* note 6, at 291.
88. *See id*. (citing India's software industry as an analogy for the medical tourism industry's salary bidding wars).
89. *Id*.
90. *Id*. at 296.
91. Cohen, *Medical Tourism*, *supra* note 25, at 9.
92. Chen & Flood, *supra* note 6, at 296.

no access to these advanced procedures, like hip replacements, under current conditions and therefore cannot have their access reduced any further.[93]

Second, the increase in medical students choosing specialties is not necessarily a negative trend. While physicians may choose specialties like plastic surgery that focus on medical tourists, destination countries could regulate this, thus eliminating, or at worst limiting, the corresponding brain drain effect.[94] Additionally, the increased number of specially-trained physicians means a net increase of specialized resources for the destination country.[95] Again, based on effective local regulation and procedures, the domestic health care system could benefit from this specialized knowledge by offering services not previously available due to a lack of resources.[96]

Critics rely on traditional economics to argue that increased demand for services, coupled with a reduced supply of doctors, will increase the cost of health care in destination countries.[97] However, when developed further, those economic theories actually produce a solution to the very problem the critics pose. Specifically, because the supply of medical professionals is elastic, increases in cost of care would likewise create increases in the supply of medical professionals until the market reached equilibrium.[98] Thus, any increase in demand or reduction of supply would be self-corrected under traditional economics.

By ignoring potential alternative outcomes, critics fail to make a convincing argument regarding the relationship between physician supply and medical tourism. Currently, many LMICs without medical tourism industries see substantial numbers of medical professionals fleeing their borders for developed markets.[99] Critics often fail to recognize the potential that medical tourism might create an incentive for doctors to stay.[100]

Additionally, a robust medical tourism industry could lead to an incentive for expatriates to return to the LMICs from which they originally emigrated.[101] This leads to "brain circulation," where providers leave for specialty training abroad then return to their home country to practice and teach other local providers.[102] Together, these outcomes could result in a net increase in specialized doctors available for a destination country's medical system due to medical tourism.[103]

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93. Cohen, *Medical Tourism*, *supra* note 25, at 9.

94. *Id*. at 9–10.

95. Chee Heng Leng & Andrea Whittaker, *Why is medical travel of concern to global social policy?*, 10 GLOBAL SOCIAL POLICY 287, 287–88 (2010).

96. Cohen, *Medical Tourism*, *supra* note 25, at 10.

97. Chen & Flood, *supra* note 6, at 296 (describing India's software industry as a simile for the medical tourism industry's salary bidding wars).

98. *See* Cohen, *Medical Tourism*, *supra* note 25, at 11 (arguing that although the balancing would not be instantaneous, it would still be beneficial).

99. *Id*. at 11–12.

100. *Id*. at 12.

101. *Id*.

102. *Id*.

103. Leng & Whittaker, *supra* note 95, at 287–88.

In direct contradiction to the reports previously cited regarding Thailand, the shortage of doctors may not be nearly as severe as critics contend.[104] There are two possible factors mitigating the severity of the shortage: (1) public hospitals receive a significant number of new physicians who are required by law to work in public hospitals for three years or pay a significant fine; and (2) public hospitals are exempt from legal liability under Thai law, which allows citizens to sue the government directly.[105]

Ultimately, since local citizens in LMICs have virtually no access to advanced health care under current conditions, any increase in access would represent a material gain in the quality of care available. Although they might not gain access to the same quality of care available to foreign patients in private hospitals, local citizens in public hospitals may see at least some incremental benefit from the medical tourism industry.

Local citizens in public hospitals benefit from the medical tourism industry by gaining access to new medical technology. Tax revenues from medical tourism can be used to modernize health care services for local citizens and boost the standard of living for local citizens generally.[106] In addition, medical tourism results in local doctors receiving specialized training in order to meet the demands of western patients. Although local doctors are prompted to gain specialized training by foreign patients, local patients benefit from the availability of these specialized physicians as well.

Lastly, the argument that newly constructed facilities catering to foreigners have been "taken" by medical tourists is not supported by fact. As discussed above, resources utilized by medical tourists are not the same as those utilized by local citizens.[107] Therefore, since these facilities would not have been built except for the demand created by medical tourism, any argument that they have been "taken" by medical tourists fails.

2. Competition for Economic Resources

Another argument often offered against medical tourism relates to the economic effect on a destination country's health care system. This considers the investment decisions of both the health care industry and the government in destination countries.

As to the industry's investments, due to the advanced surgeries performed, the medical tourism industry likely will invest in expensive medical equipment. This equipment in the private industry, it is argued, represents two potential costs to the health care system. The first potential cost is the foregone investment opportunity

104. Nathan Cortez, *Recalibrating the Legal Risks of Cross-Border Health Care*, 10 YALE J. HEALTH POLICY, L. & ETHICS 1, 41 n.291 (2010) [hereinafter Cortez, *Recalibrating the Legal Risks of Cross-Border Health Care*].

105. *Id*.

106. *See, e.g*., Klaus, *supra* note 4, at 240 (describing India's reliance on tax revenues from medical tourism to fund the modernization of health care services for its local citizens).

107. *Id*. (arguing that the construction of hospitals designated for foreign patients does not necessarily harm hospitals or citizens of destination countries).

for the domestic health care system.[108] Second, there is a fear of overprescribing the equipment's use after its purchase in order to recover the capital investment.[109] Private investments, and therefore private profits, also are said to be recycled into the medical tourism industry rather than used to promote care for domestic citizens.[110]

Concerns over government spending also are raised. Data shows that reduced public health care spending correlates to an increase in private spending. For critics, this demonstrates that medical tourism results in less public health care spending.[111] In fact, some critics say that increases in private investment allowed governments to reduce their role in public health care spending.[112]

Once again, critics of medical tourism fail to present a sufficient argument that establishes a negative effect on the destination country. The private facilities that invest in equipment likely represent decisions with no alternative investment cost because their existence and subsequent investments simply would not occur without medical tourism. Thus, the private investments likely do not remove any potential financial investment into the public health care sector. In fact, the net gain of the financial impact of medical tourism likely would result in a larger overall pool of resources for financial investment by both public and private sectors.[113] Increased private investment resulting from medical tourism could free government resources to be spent elsewhere for an even more efficient allocation of public funds.[114]

As an indicative discussion of the "increased overall pool of funds" theory, India is forecasting billions of dollars of net inflow due to medical tourism.[115] Thus, the government could easily use this extra income to fund greater investment into its vastly inadequate health care system.[116] Critics fail to account for many of these potential benefits when they juxtapose the robust medical tourism industry with the country's underdeveloped domestic living conditions.[117] In fact, the growth of medical tourism results in greater foreign investment in both the medical industry and tourism in general.[118] This money could then "trickle down" to infrastructure and hospitality, further enhancing the positive effects of medical tourism.[119]

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108. Chen & Flood, *supra* note 6, at 289.

109. *Id*.

110. *Id*. at 287.

111. *Id*. at 288.

112. *Id*.

113. *Id*. at 291–92.

114. Chen & Flood, *supra* note 6, at 292.

115. Klaus, *supra* note 4, at 240.

116. *Id*.

117. *See, e.g*., Chen & Flood, *supra* note 6, at 289 (stating that, in contrast to India's substantial medical tourism industry providing world-class care, the country has problems containing basic social medical needs like tuberculosis and diarrheal diseases).

118. *Id*. at 287.

119. *Id*.

The nature of the medical tourism industry creates an obvious correlation between the growth in medical tourism and the increase in "technology-intensive" health care in LMICs' private facilities.[120] Although critics point to the higher cost of technologically-dependent care, they seem to miss the obvious underlying question—how does this affect domestic citizens? As previously discussed, locals have virtually no access to those treatments currently, so there is likely no change in their access after. Furthermore, since medical tourists do not utilize the same facilities as local citizens for care, any resulting increase in price at those facilities would only affect medical tourists. Foreign governments could create regulations or legislation requiring access to the systems for domestic care needs, although the domestic affairs of foreign governments are outside the scope of medical tourism legislation in the United States, which is the focus of this comment.

In sum, there is not a sufficient amount of evidence to conclude that medical tourism has a negative impact on a destination country's health care system. The arguments typically presented, be they based on the supply of doctors, the cost of care, or the economic impact on domestic health care, simply are not supported by sufficient facts.

B. The United States Does Not Have a Duty to Curb Medical Tourism by Its Citizens

Having been refuted, the concerns surrounding potential shortages of providers and potential cost increases do not imply any reason to prevent medical tourism by American citizens. In fact, the probable net increase in resources, both provider and economy based, establish a reason to promote utilization of medical tourism by American citizens in order to provide the greatest benefit to destination countries. Despite the positive net effect, critics still point to the potential failure of foreign governments to effectively capitalize on the benefits that medical tourism can provide to their nations.[121] These arguments regarding government spending and collection heavily rely on the inefficiencies of LMIC governments to effectively regulate their tax and investment capacities.[122]

Although a foreign nation's ability to capitalize on potential benefits is of concern to its citizens, it should not shape U.S. policy.[123] In fact, short of American medical tourists actively causing harm, the positive effect of medical tourism on the American health care system in terms of access to care alone should likely trump concerns over a foreign country's ability to care for its own.[124] In sum, given

120. *Id*. at 296.

121. *See*, *e.g*., Leng & Whittaker, *supra* note 95, at 287–88 (discussing how few developing countries have successfully implemented the "robust policy frameworks" needed to capitalize on medical tourism's benefits); Cohen, *Medical Tourism*, *supra* note 25, at 13 (discussing other reasons why national governments may fail to recognize the benefits available from medical tourism).

122. *See, e.g*., Cohen, *Medical Tourism*, *supra* note 25, at 13; Chen & Flood, *supra* note 6, at 293 (discussing the need for a "robust regulatory framework" to manage the new resources available from medical tourism).

123. Cohen, *Medical Tourism*, *supra* note 25, at 16–17.

124. *See id*. (discussing a Senate hearing that made a similar conclusion).

a likely positive net effect on both the American and foreign health care systems with no substantive evidence of any negative effect, there is no normative reason to prevent medical tourism by American citizens.[125] Americans will gain greater access to care than is currently available. The destination country will likely see a variety of benefits including the possibility of an increased number of highly-trained specialists, more technologically advanced facilities, and, most importantly, significant net financial gains through foreign investment and local revenues.

IV. MEDICAL TOURISM LEGISLATION SHOULD BE DESIGNED TO ALLOW FULLY INFORMED DECISIONS BY PATIENTS BASED ON FULL DISCLOSURE BY PROVIDERS

Having answered the normative question in the affirmative, this discussion now turns to the substantive question posed—what role should legislation play in the medical tourism field? Brokerages, by playing an increasingly key part in the decision making process of patients, should be directly monitored and regulated by legislation. Further legislative efforts can then focus on the risks faced by medical tourists, with the end goal being full disclosure in a manner easily understandable to an average patient. This disclosure would then allow for an informed decision by the patient, weighing the risks and performing a cost-benefit analysis of traveling for health care. This section defines those risks and offers some potential solutions for how to best communicate them to patients.

The nature of medical tourism introduces risks not necessarily present in traditional local care. Looking to factors like the patient's home country, the destination country, the specific foreign provider chosen, and the international facility chosen can help to identify the unique risks that a medical tourist may face. Some risks pose direct physical threats to patients, while others pose logistical problems for their care.

During the decision-making process, patients may not think about things like the lack of access to loved ones during a time of need.[126] They also may ignore the risks of jetlag, culture shock, and unfamiliar local food, which are stressors inherent in international travel even during traditional vacations.[127] The travel itself also provides some rather apparent risks for the patient.[128]

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125. It is important here to explicitly recognize the imbalance of power and control between the historically colonial powers often at play in destination countries. Although this imbalance has existed, and continues to unofficially exist in many aspects, the arguments and facts discussed above lend themselves to an unbiased analysis of the impact on a destination country. The implication that the United States does not owe a duty to protect the citizens of other nations is applied solely to the issue at hand—whether or not medical tourism will have a deleterious effect on a destination country's existing health care system. By focusing on that single aspect, the discussion can lead to effective management of the industry going forward, hopefully with substantial beneficial effects on the destination country.

126. *See* Bye, *supra* note 14, at 31 (stating that it may be difficult for a patient to leave loved ones behind while the patient goes through a period of medical crisis).

127. Howze, *supra* note 62, at 1026.

128. *See* Bye, *supra* note 14, at 31 (describing how the rigors of long plane flights to remote

Other commonly overlooked considerations include economic issues and social unrest in destination countries, which can lead to infrastructure neglect and widespread poverty. This can weigh emotionally on Americans not used to seeing such disparate conditions as they travel for medical care.[129] Political turmoil in many regions can also lead to additional environmental risks for American citizens traveling abroad for health care.[130]

This comment focuses on the two basic categories of risk a medical tourist typically faces: (1) risks due to variances in the quality of care received, and (2) risks due to differences in legal recourse available in the event of an adverse outcome in various destination countries.[131]

A. Quality of Care Risks

An American's perception of the quality of international medicine can be very distorted. The average level of care available to a nation's citizens is one indicator often looked at to determine the quality of care in a given country. The average standard of care provided in developing countries is often not equivalent to the average care provided in the United States.[132] This, however, is not an accurate measure of comparison for medical tourists. The more accurate measure is to compare the quality of care available at the prospective foreign facility to the care available for that same person at home.[133] This becomes even more apparent when looking at LMICs where the differential between the average national quality of care and a specific facility's quality of care can be quite pronounced.

For instance, the Apollo Hospitals Group has reported a 99% success rate in over 50,000 cardiac surgeries.[134] This is on par with some of the top American cardiac surgery centers, such as the Cleveland Clinic.[135] The authors of a recent article in *The New England Journal of Medicine* expressed their doubts as to the ability of average American hospitals to "offer better outcomes for common complex operations such as coronary-artery bypass grafting, for which several [Joint Commission International]-accredited offshore hospitals report gross mortality rates of less than 1%."[136] Other publications have also touted the quality

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locations and the time requirements of travel can lead to a degradation of a patient's medical condition before even reaching the chosen health care facility).

129. *Id*.

130. *Id*.

131. Because this comment concentrates on American citizens traveling overseas for health care, the potential risks discussed are limited to those likely faced by this particular subset of medical tourists.

132. Cohen, *Protecting Patients with Passports*, *supra* note 1, at 1491.

133. *Id*.

134. Aaditya Mattoo & Randeep Rathindran, *How Health Insurance Inhibits Trade In Health Care*, 25 HEALTH AFFAIRS 358, 360 (2006).

135. *Id*.

136. Cohen, *Protecting Patients with Passports*, *supra* note 1, at 1492; *see also* Klaus, *supra* note 4, at 225 (discussing Escorts Heart Institute and Research Center in India which reported a death rate of 0.8%, compared to 2.35% for the same procedure at New York Presbyterian Hospital and post-operative cardiac infection rates "comparing extremely favorably"

of care available in major international hospitals, discussing similar outcome rates for varying procedures.[137]

Patients looking for "U.S.-trained" physicians should not be quick to dismiss these international hospitals. International hospitals' doctors and specialists are often largely U.S. or U.K. trained.[138] In Bumrungrad, for example, over 100 practicing doctors were board certified by United States medical specialty groups in 2007.[139] That number reached over 200 by 2013.[140] If avoiding "foreign-trained" doctors is a patient's goal, choosing to receive care in the United States is no guarantee of achieving it.[141] In fact, some estimates have placed the percentage of foreign-trained physicians practicing in the United States as high as 25%.[142] Of that 25%, the eight nations contributing the most foreign-trained physicians are all developing countries.[143] Even if domestically trained and educated, American doctors were likely taught by at least one person with an international background, as nearly a fifth of American medical school faculty members are internationally trained.[144]

That is not to say that care received abroad will always be of the highest quality. Improper procedures in tissue matching led German patients who underwent kidney transplants in India and Pakistan to experience higher mortality rates than experienced after kidney transplants performed in Germany.[145] Australian doctors reported complications including "hideous scarring" and infections from breast implants done in Bangkok facilities.[146] The Associated Press also reported that Mexican doctors were practicing nearly unregulated within Mexico.[147] Unlicensed Mexican doctors performed surgery using improper medical

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with most American hospitals).

137. *See, e.g.*, Cohen, *Protecting Patients with Passports*, *supra* note 1, at 1567; Klaus, *supra* note 4, at 225 ("While paying greatly discounted prices for surgery, American patients traveling to Asia do not appear to sacrifice quality or incur greater risks of death or infection."); Thomas R. McLean, *The Global Market for Health Care: Economics and Regulation*, 26 WIS. INT'L L. J. 591, 601 (2008) ("Surgical care provided in a Joint Commission Accredited hospital in India by a member of the Royal College of Surgeons is unlikely to be inferior to the same care provided in an American hospital with Joint Commission Accreditation by a member of the American College of Surgeons." (footnote omitted)).

138. Klaus, *supra* note 4, at 225.

139. Boyle, *supra* note 4, at 44.

140. *Meet Our Doctors*, BUMRUNGRAD INTERNATIONAL HOSPITAL, http://www.bumrungrad.com/en/meet-our-doctors-thailand (last visited Feb. 7, 2014).

141. Bye, *supra* note 14, at 31.

142. Unmesh Kher, *Outsourcing Your Heart*, TIME (May 21, 2006), http://www.time.com/time/magazine/printout/0,8816,1196429,0.html.

143. Mattoo & Rathindran, *supra* note 134, at 359 (listing the top contributing nation as India, where 21% of physicians practicing in the United States were trained, followed by the Philippines, Cuba, Pakistan, Iran, and Korea).

144. *Id*.

145. Boyle, *supra* note 4, at 45–46.

146. *Id*.

147. *Id*.

equipment.[148] Unaccredited Mexican hospitals and unlicensed surgeons caused disfigurement and fatal infections to their patients.[149]

The destination country, facility, and provider are not the only factors affecting a patient's quality of care. A patient's decision must necessarily include weighing the real risks posed by domestic care during this process.[150] For example, patients' residences within the United States directly affect their access to and quality of care received. A Dartmouth University project even declared that "geography is destiny" in American health care.[151] To repeat, the proper comparison here would then be the specific care a patient is likely to receive, not the average care available. Americans in the highest risk areas domestically are likely to receive a quality of care well below the national average. Accordingly, the incremental risk would be lessened when choosing medical tourism as an option.

Analyzing various outcomes by procedure can also illustrate quality of care risks within the U.S. health care system. California hospitals have, on average, nearly four times the mortality rate for coronary artery bypass graft surgery (CABG surgery) as the Cleveland Clinic, which is considered the best U.S. hospital by *U.S. News & World Report*.[152] There is even evidence of wide variances in patient outcomes within the California results. For example, in 2003, the University of California Davis Medical Center had no deaths caused by CABG surgery, while Desert Regional Medical Center had a mortality rate of nearly 6%, twice the California average and ten times the Cleveland Clinic's average rate.[153]

The risks faced by Americans receiving domestic health care are a necessary element of accurately deciphering the quality of care risks faced by American medical tourists. Because domestic care is clearly not risk free, arguments for a complete ban on medical tourism, to the extent they exist, should be summarily dismissed. Furthermore, although there is a risk of receiving international care that is below American standards, some American medical tourists face the alternative of no domestic nonemergency care access at all. When comparing no domestic access to slightly higher risk international access, it seems the potential for a reduced quality of care would not be a valid argument against the availability of medical tourism as an option.[154]

A patient can properly weigh risks when choosing a specific provider or facility, assuming the patient is able to receive adequate information regarding the

148. *Id*.

149. *Id*.

150. Cohen, *Protecting Patients with Passports*, *supra* note 1, at 1493.

151. THE CTR. FOR THE EVALUATIVE CLINICAL SCIS., *The Dartmouth Atlas of Health Care*, DARTMOUTH MED. SCH., 1, 2 http://www.dartmouthatlas.org/downloads/atlases/98Atlas.pdf (last visited Feb. 7, 2014) ("The Atlas once again shows that in healthcare geography is destiny.").

152. Devon M. Herrick, *Medical Tourism: Global Competition in Health Care Thursday*, NAT'L CENTER FOR POL'Y ANALYSIS 1, 14 (Nov. 1, 2007), http://www.ncpa.org/pub/st304?pg=6.

153. *Id*.

154. *See* Cohen, *Protecting Patients with Passports*, *supra* note 1, at 1490–91 (discussing the quality of care in American hospitals versus those received by medical tourists).

quality of care for the providers and facilities. Simply because a given option has higher risks associated with it does not necessarily mean it should be withheld from potential patients. As demonstrated above, there are risks in all health care, even domestic American care.[155] Each patient, with proper information, should be allowed to make an informed decision regarding their own health care choices, whether they are choosing domestic or international providers.

Ultimately the goal must be to utilize a system that offers sufficient and specific provider information, in an independently-verified, uniform manner so that a given patient can make an informed decision regarding the potential risks of receiving care abroad. The key elements here are disclosure and communication of risks, both domestic and international, in a manner an average patient can successfully digest. Only then can a proper cost-benefit analysis be undertaken. This process of data reporting, aggregation, and disclosure must not raise the cost of health care alternatives, as this would negate the cost-risk benefit medical tourism is trying to achieve.

1. Health Care Regulation Systems

One method of monitoring the quality of care available in a given market is through regulation, both governmental and self-imposed. Effective regulation, combined with market forces, provides a layer of protection for patients. For example, in the United States, there is a system of regulatory bodies, lawyers, and private insurance driving providers towards providing a certain minimum standard of care.[156] While improvement of the quality of care is seemingly an inevitable byproduct of effective regulation and accreditation systems, this should not be the primary goal of an accreditation system developed for the medical tourism industry. Rather, the goal of regulation in terms of medical tourism should be to provide accurate, full disclosure of the various quality measures needed to assess the risk level at a given provider or facility. Using the American regulation system as a benchmark, this section looks at typical regulation systems and the issues therein as employed by various destination countries.

The American regulatory system can be viewed as a benchmark for a variety of reasons. It provides effective regulatory controls for facilities and providers, as well as valuable information for patients during the decision-making process. That information comes through a variety of channels, including accreditation of facilities and providers, as well as raw number analysis available for consideration. Thus, the current American regulatory system can be used as a model for medical

155. *See Medical Negligence: The Role of America's Civil Justice System in Protecting Patients' Rights*, AM. ASS'N FOR JUST. 1, 3–4 (Feb. 2011) http://www.justice.org/resources/Medical_Negligence_Primer.pdf (stating that preventable medical errors, which kill 98,000 Americans annually, are the sixth leading cause of death in the United States).

156. Nathan Cortez, *A Medical Malpractice Model for Developing Countries?*, 4 DREXEL L. REV. 217, 223 (2011) [hereinafter Cortez, *A Medical Malpractice Model for Developing Countries?*].

tourism, albeit with some modifications.[157]

Additionally, and perhaps even more importantly, the American regulatory system must be viewed as the baseline when creating a risk profile for international medical care. Ideally, all international providers would utilize the same regulatory system to allow for the most accurate cost-benefit analysis by American patients, as it would allow the proverbial "apple-to-apples" analysis. It is with this view in mind that the discussion progresses, first outlining the American regulatory system and then addressing the various systems in place in popular destination countries.

The largest medical regulator in the United States is the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission).[158] Created in 1951, the Joint Commission is comprised of a thirty-two member Board of Commissioners.[159] As the leading medical accreditation body in the United States, the Joint Commission has an influential role in policy. Joint Commission accreditation is required, for example, as a prerequisite for Medicare and Medicaid participation in the United States.[160] Because the Joint Commission's accreditation program covers over 20,000 American facilities, citizens who wish to research a facility can usually find an accredited provider without much trouble.[161] Perhaps more important than the pure number of certified facilities is the quality of care ensured by the Joint Commission's accreditation program.[162] Therefore, patients can look to a Joint Commission accreditation as a stamp of approval from an independent body when searching for a provider of choice.[163]

The United States is an example of how the accreditation system can serve valuable data-mining functions, as American regulators also demand a large amount of information on patient outcomes. Americans deciding on what hospital to utilize for a given procedure can turn to a variety of resources to locate

157. Although the United States cannot force other nations to follow a specific framework, basic economics would seemingly insinuate that the medical tourism industry would prefer to follow a standard set of protocols rather than multiple redundant ones. As such, the American medical tourism industry can play a leading role in shaping the international regulatory market.

158. THE JOINT COMMISSION, http://www.jointcommission.org/ (last visited Feb. 7, 2014).

159. *History of The Joint Commission*, THE JOINT COMMISSION, http://www.jointcommission.org/about_us/history.aspx (last visited Mar. 4, 2015).

160. Cohen, *Protecting Patients with Passports*, *supra* note 1, at 1485.

161. *Facts About the Joint Commission*, THE JOINT COMMISSION (last visited Apr. 3, 2015), http://www.jointcommission.org/about_us/fact_sheets.aspx. Although this information is readily available through the Internet, most Americans fail to take advantage of it. The important note here is the availability of information, rather than the utilization rate, which instead indicates a personal choice to ignore or use what is available. *See infra* note 169.

162. It should be made clear for those who are not aware that the American system is very much a reactive system in that it is not based on oversight of care as it happens, but rather on the review of events after they happen to determine if the proper course of action was taken. These reviews are part of the regulatory process in that they create an incentive for doctors to adhere to the appropriate standards of practice.

163. *Facts About The Joint Commission*, *supra* note 161. It is important to note that most Americans do not do much, if any, research on medical providers. *See infra* note 169. Thus, although the Joint Commission makes information available, it is severely underutilized in domestic care. *See Facts About The Joint Commission*, *supra* note 161. The potential role that accreditation standards can play in the patient decision-making process is important.

comparative data.[164] Instead of raw numbers and irrelevant statistics, patients are given easy to digest comparisons using key metrics across facilities.[165] This allows patients to make a decision based on a balance of costs and benefits.

In addition to federal Joint Commission regulations, states individually regulate the practice of medicine through the licensure of doctors. States often take an active role in encouraging citizens to research medical providers prior to treatment.[166] Also, the American Medical Association (AMA) has an entire section of its website, called DoctorFinder, dedicated to aiding patients locate and pick doctors in a number of states.[167]

National groups like the American Board of Medical Specialties (ABMS) offer voluntary certifications—called board certifications—for providers.[168] Doctors can then promote their expertise in a given specialty by advertising that they are board certified. This non-profit organization therefore offers an important step in the vetting process for patients. Americans have the ability to make informed decisions about their doctors using these resources, if they so choose. However, it is very possible, and even likely, that they do not utilize the information available to them.[169]

Market factors also play a role in regulating the quality of care available in developed countries. Insurance providers often act as "quasi-regulators,"

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164. *See*, *e.g.*, *CheckPoint*, WIS. HOSP. ASS'N, http://www.wha.org/ (last visited Apr. 4, 2015) (allowing a comparison of Wisconsin hospitals to state and national averages across various metrics); DEP'T OF HEALTH, *New York State Hospital Profile*, NEW YORK STATE, http://profiles.health.ny.gov/hospital (last visited Apr. 4, 2015) (allowing for comparison of New York state hospitals against each other and state averages); *Hospital Compare*, CENTERS FOR MEDICARE AND MEDICAID SERVICES, http://www.medicare.gov/hospitalcompare/compare.html#cmprTab=1 &cmprID=310010%2C310044%2C310110&loc=08540&lat=40.3815302&lng=-74.651754&AspxAutoDetectCookieSupport=1 (last visited Feb. 7, 2014) (offering detailed analysis by comparing hospitals to each other, state averages, and federal averages).

165. See *supra* note 164 and accompanying text.

166. New York, for example, has an entire website dedicated to choosing the "right physician." *How to Choose the Right Physician—How to Tell Us if You Don't*, N.Y. STATE DEP'T OF HEALTH (Dec. 2012), http://www.health.ny.gov/publications/1444. On it are descriptions of what information a patient should ask for and where they can go to verify answers. *Id*. (offering links to state licensure directories, national board-certification bodies, and descriptions of what each particular credential means for patient safety).

167. *Doctor Finder*, AM. MED. ASS'N, https://apps.ama-assn.org/doctorfinder/html/patient.jsp (last visited Feb. 7, 2014).

168. *See generally* AM. BOARD OF MED. SPECIALTIES, http://www.abms.org (last visited Mar. 12, 2015).

169. *See* Zlati Meyer, *Take active role when choosing a new doctor*, USA TODAY (Oct. 7, 2013, 7:31 AM), http://www.usatoday.com/story/news/nation/2013/10/07/take-active-role-when-choosing-a-new-doctor/2935017/ (some studies that found Americans take more time to research car purchases than to evaluate the doctor they see for medical care); *Facts About the 2008 ABMS Consumer Survey: How Americans Choose Their Doctors*, AM. BOARD OF MED. SPECIALTIES 1, 2 http://www.abms.org/News_and_Events/Media_Newsroom/pdf/ABMS_Survey_Fact_Sheet.pdf (last visited Feb. 7, 2014) (discussing a recent survey that showed only 56% of U.S. patients knew whether or not their current doctor was board certified).

leveraging their position and purchasing power to protect their customers.[170] This in turn creates a market-driven demand for higher quality care from health care providers. Educated consumers in developed countries are also better able to identify and pursue remedies for medical malpractice.[171] This also provides a market-driven regulation, whereby health care providers must be careful in their practices. As later discussed, malpractice systems in many LMICs are ineffective and therefore fail to meet their quasi-regulatory functions.

Unlike the United States however, many international health care systems—particularly those in LMICs—are not well monitored or regulated.[172] Traditional regulatory models utilized in developed nations often fail for a variety of reasons in LMICs.[173] Even where there are regulatory bodies in place, they often mistakenly concentrate on licensing entry to the medical profession rather than maintaining a review process for the care actually provided.[174]

Additionally, it should be noted that Americans, who are used to their domestic system, might mistakenly assume the same or similar systems are in place internationally. This assumption may lead to a lack of research by American medical tourists, leading to misinformed and potentially deadly decisions. This provides another reason to fully understand the mechanisms currently in place in destination countries when assessing the quality of care risk medical tourists face.

India, for example, has a variety of regulatory bodies in place, including the Medical Council of India, various Departments of Health within the government, and the Indian Medical Association, among several others.[175] Government regulation of the health care system is virtually nonexistent, however, and the self-regulating bodies have serious flaws.[176] In reality, the laws and regulators in India have little impact on the standard of medical care and do not provide any meaningful accountability for health care providers.[177] Consumer groups, the Indian Supreme Court, and even member physicians all have publicly accused the

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170. Cortez, *A Medical Malpractice Model for Developing Countries?*, *supra* note 156, at 225 ("In developed countries like the United States, both public and private insurers often use their contracts with health care providers to 'pursue regulatory objectives' such as patient safety and quality outcomes. . . . In contrast, providers in developing countries often lack such incentives." (footnote omitted)).

171. *Id*. at 226 ("[P]atients in developing countries are less equipped than patients in the developed world to act as regulatory sentinels, uncovering and reporting medical negligence.").

172. Cortez, *Recalibrating the Legal Risks of Cross-Border Health Care*, *supra* note 104, at 55 (discussing the fact that foreign patients in India or Thailand cannot rely on physicians to self-regulate the medical practice).

173. *See* Cortez, *A Medical Malpractice Model for Developing Countries?*, *supra* note 156, at 220–29 (illustrating some of the issues developing countries face, such as poverty, infectious diseases, professional shortages, underdeveloped health systems, weak infrastructure, large informal economies, regulatory and civil society deficits, and other problems that tend to be secondary).

174. *Id*. at 224 (discussing how doctors in developing countries escape evaluation of past performance).

175. *Id*.

176. *Id*.

177. *Id*.

Medical Council of India of corruption and ineptitude in regard to punishing member physicians.[178]

In Thailand, the Ministry of Public Health is a cabinet-level department responsible for regulating national health care.[179] Despite its authority, it has traditionally failed to regulate the safety or quality of medical services offered.[180] Although it has seemingly comprehensive laws, enforcement is poor, and few severe penalties were handed out through the 1990s.[181]

The Kingdom's Medical Council—another Thai regulatory body—regulates medical professionals.[182] Like many other self-regulatory bodies, the Kingdom's Medical Council suffers from poor enforcement practices.[183] Research has shown that the Kingdom's Medical Council reacts "passively" to consumer complaints and allegations of misconduct by fellow professionals, even when they include charges of negligence, including allegations of negligent or substandard care.[184] Repercussions for the few cases that were investigated by the Kingdom's Medical Council were mild.[185] In fact, penalties likely only resulted from the pressure accompanying press coverage.[186] This lack of effectiveness has even led experts to recommend that the Kingdom's Medical Council no longer deal with malpractice cases to avoid conflicts of interest and improve public perception of its actions.[187]

Opposite to the United States, insurance markets are typically non-existent, even in wealthier LMICs like India, thus denying another major quasi-regulator present in America.[188] Also, citizens in destination countries tend to be uneducated both about their right to recovery and their right to sue for malpractice for receiving substandard care.[189] This combination results in a health care system devoid of market forces driving up the available standard of care.

As this analysis has shown, government regulation can create a health care system with rigid quality standards and valuable information dissemination. Even

178. Cortez, *Recalibrating the Legal Risks of Cross-Border Health Care*, *supra* note 104, at 38–39.

179. *Id*. at 52.

180. *Id*. at 52–53.

181. *Id*. at 53.

182. *Id*. at 54.

183. *Id*. (discussing the typical problem of self-regulation and conflicts of interest in punishing a regulator's own members).

184. Cortez, *Recalibrating the Legal Risks of Cross-Border Health Care*, *supra* note 104, at 54 (explaining that only 1% of physicians actually had their licenses revoked).

185. *Id*.

186. *Id*. (discussing a study that showed penalties only resulted from media coverage of potential violations).

187. *Id*. at 55.

188. Cortez, *A Medical Malpractice Model for Developing Countries?*, *supra* note 156, at 225 (noting that most citizens in developing nations do not have health insurance).

189. *Id*. at 226 (explaining that impoverished patients do not have the same requisite knowledge to challenge their doctors, and, even if they did, they feel powerless to use their legal rights against medical professionals).

self-regulation can promote compliance by medical professionals, provided it remains outside of a neutralizing conflict-of-interest stalemate. Domestic regulation regimes, however, are not a solution that would be best suited for the medical tourism industry. First, the United States has little political influence to force other nations into implementing specific regulatory frameworks in their health care systems. Furthermore, domestic regulatory schemes in LMICs have not been effective, and there is no evidence they would suddenly become so now. Lastly, a domestic regulation scheme introduced by an LMIC would likely apply to all of its domestic facilities, whether the facilities provided care to medical tourists or not. In order to minimize the effect of incremental regulation on an LMIC's domestic care system, any regulations should be narrowly targeted to facilities providing care to medical tourists.

American citizens are only interested in the quality of care of the potential destination facilities and providers that they may specifically encounter. Therefore, a regulatory system that concentrates on the facilities catering to medical tourists and their accompanying medical providers would be the most efficient and effective method of regulating medical tourism destinations. International regulatory bodies have already begun to create an international system that could effectively offer the information required to fully disclose risks, on which disclosure American legislation should focus.

Although many international facilities are still largely not subject to rigorous accreditation and inspection processes, this is changing.[190] In 1994, the Joint Commission created Joint Commission International (JCI) to improve the quality of care standards internationally.[191] In 2005, JCI partnered with the World Health Organization (WHO) to create the WHO Collaborating Centre for Patient Safety Solutions to further the goal of patient safety.[192] Today, JCI assists patients in over ninety countries and is expanding its accreditation rates of health care organizations on five continents.[193] Other international medical facilities seek accreditation by the United Kingdom's Joint Commission equivalent, the British Standards Institute.[194]

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190. *See* Boyle, *supra* note 4, at 45–46 (discussing Mexican doctors practicing without licenses or proper equipment); Cohen, *Protecting Patients with Passports*, *supra* note 1, at 1490–91, 1485 (discussing the fact that more than 250 hospitals worldwide are now JCI-accredited).

191. *Facts About The Joint Commission*, *supra* note 161.

192. *WHO Collaborating Centre for Patient Safety Solutions*, JOINT COMMISSION INT'L http://www.jointcommissioninternational.org/WHO-Collaborating-Centre-for-Patient-Safety-Solutions/ (last visited Feb. 7, 2014).

193. *About Joint Commission International*, JOINT COMMISSION INT'L http://www.jointcommissioninternational.org/About-JCI/ (last visited Feb. 7, 2014). JCI accreditation ensures the facility meets a certain set of standards for patient safety, outcomes, and other quality of care factors. *Id*. Those factors include six international patient safety goals and the use of "tracer methodology," which together reduce the risk of error. *Id*. Much like the United States' successful Joint Commission process, JCI hospitals must undergo an initial inspection and then be reaccredited at three-year intervals. Cohen, *Protecting Patients with Passports*, *supra* note 1, at 1485; *Pathway to Accreditation*, JOINT COMMISSION INT'L, http://www.jointcommissioninternational.org/improve/pathway-to-accreditation/ (last visited Mar. 7, 2015).

194. Bye, *supra* note 14, at 31.

The general accreditation process offers reassurances about the actual medical practices at the foreign facility.[195] In fact, Asian hospitals specifically seek accreditation by Western organizations for their facilities and providers. They hope this will assuage foreign patients' fears that the care remains "primitive" by American standards.[196] For example, Fortis Escorts Heart Institute,[197] Bumrungrad,[198] and Apollo Hospitals Group[199] each prominently display the JCI Gold Seal, representing JCI accreditation, on their website landing page. This is designed to overcome the American perception of international care in order to maximize utilization.

International accreditation of doctors is also gaining popularity. ABMS has created ABMS International (ABMS-I).[200] Using its over eighty years of experience in the United States, ABMS-I works internationally to promote the establishment of accreditation systems in various markets.[201] Doctors in medical tourism destinations often use their American board certification qualifications as part of their marketing campaigns.[202]

2. Enabling Informed Decisions By Medical Tourists

Unlike choosing a domestic provider, prospective patients may have difficulty evaluating the quality of care of a specific international doctor or facility. Americans, in particular, struggle through a variety of obstacles, including a lack of data on international providers. Many countries do not require hospitals to report patient outcomes, positive or adverse, nor do they require hospitals to participate in international accreditation programs.[203] This results in an overall lack of data with which a patient may make an informed choice of provider and facility. Patients must have access to metrics of quality in order to make an informed cost-benefit decision when choosing international health care providers. Furthermore, those measures must be uniform and independently verified in order to be useful

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195. *See* Cohen, *Protecting Patients with Passports*, *supra* note 1, at 1484–85 (discussing that the presence of medical tourists in foreign countries is an incentive for facilities to attain accreditation).

196. *See* Klaus, *supra* note 4, at 234–35 (discussing the concerns of foreign patients regarding technology, sanitation, and other standards in developing nations' medical procedures).

197. FORTIS ESCORTS HEART INST., http://www.fortisescorts.in/Home.aspx (last visited Feb. 7, 2014).

198. BUMRUNGRAD INT'L HOSP., http://www.bumrungrad.com/thailandhospital (last visited Feb. 7, 2014).

199. APOLLO HOSPS., http://www.apollohospitals.com/ (last visited Feb. 7, 2014).

200. AM. BOARD OF MED. SPECIALTIES INT'L, http://www.abms-i.org/ (last visited Feb. 7, 2014).

201. Press Release, *Second Meeting in Doha Between ABMS International, LLC and Representatives of Healthcare Institutions from Across the Middle East*, WEILL CORNELL MED. C. IN QATAR (June 23, 2013), *available at* http://www.abms-i.org/images/DohaMtgPR.pdf (addressing a meeting of representatives of health care organizations from across the Middle East).

202. *See Top Specialties*, *supra* note 56.

203. Cohen, *Protecting Patients with Passports*, *supra* note 1, at 1491.

for comparison.

Some locations do offer minimal quality of care statistics. However, without any uniformity in the methodology of compiling the data or what data is reported, these statistics often provide little useful information for the patient. For example, potential patients have a tendency to look at misleading statistics like mortality rates in a given foreign setting. Mortality rates, however, are a "crude measure of quality."[204] There is a very real concern that mortality data does not accurately capture the risks involved for a given patient in a certain facility.[205] Simply having access to non-uniform, unverified, and very limited data points is thus not sufficient for an informed decision by patients.

Even if all the proper information needed for an informed decision is available, without proper analysis by the patient, there is no guarantee of an improved decision-making process. Thus, the first step is to make "all" of the information available for review. Here, the universe of information available is all of the data from all of the providers and facilities available to provide care to the patient. Even assuming the data is readily accessible, gathering such a large quantity of data poses several problems for an individual. First, the actual process of gathering and analyzing data is likely cost prohibitive.[206] Second, a patient's lack of understanding of the data gathered may frustrate the process of analysis and therefore ultimately prevent the patient from making informed decisions.[207] Namely, even if the patient is to do the necessary analysis, without an understanding of the data gathered, an individual may draw erroneous conclusions. Finally, any individual who perceives the difficulty of either gathering or analyzing the data to be too high may likely simply forego the entire data-gathering and analysis process, necessarily rendering any decisions they make uninformed ones.[208]

Thus, simply having access to the entire universe of relevant data needed does not guarantee an informed decision is likely or even possible by an individual. To combat this problem, the information must be made available in a controlled manner. Specifically, the data should be gathered, sorted, filtered, verified, and then presented for consumption by patients in an easily digestible format. Because individuals are unlikely to perform this complex operation successfully and international health care facilities would face a major moral hazard if conducting their own analysis, a third-party organization would be the best choice to serve this function. This would enable informed cost-benefit decisions by individuals based on an analysis of their care options.

Patients would need help in digesting the vast amount of information potentially available under mandatory reporting. Without help, patients could not

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204. *Id*. at 1492.

205. *Id*.

206. *See* Kristin Madison, *Regulating Health Care Quality in an Information Age*, 40 U. CAL. DAVIS L. REV. 1577, 1583–84 (2007) (discussing the cost-benefit analysis of researching and creating a database of information for medical providers).

207. *See id*. at 1584 (discussing the limitations of having a database of medical providers).

208. *Id*.

decide in any meaningful way what provider or facility to choose based on the cost or quality of care available. Facilities lack an incentive to raise their quality of care to the standards patients demand when patients cannot accurately compare the cost value across providers.[209] Since the patient cannot make an informed decision based on quality of care outcomes, the actual quality of care provided becomes an irrelevant point for the provider. The irrelevance of quality of care incentivizes providers to actually lower the quality of care to match the downward pressure on the price of services offered from the competitive marketplace.

Therefore, providers and facilities who may wish to provide the highest level of care cannot charge prices sufficient to cover the costs of the higher quality of care, as potential patients who do not understand the benefit of an increased level of care are not willing to pay an increased price for high-quality care.[210] This creates a perverse incentive for low-quality providers to complicate a potential patient's ability to accurately judge the quality of care available at various facilities, as doing so allows the low-quality providers to provide a lower quality of care at higher prices.

Although raising the quality of care in a given facility or by a given doctor is certainly a worthy goal, it should not be the end target of medical tourism legislation. Rather, legislation should focus on a full and accurate disclosure of the actual quality of care available. Only with this type of disclosure can medical tourists make an educated decision as to the cost-benefit of various destinations and providers.

Arguably, improved awareness of the outcomes for a given provider will enable that provider to raise their prices to reflect the higher quality of care they offer relative to competitors. The health care marketplace would likely have varying effects on physician behavior. Higher quality providers could increase their prices based on their perceived value, while lower quality alternatives could either differentiate themselves through lower price or strive for higher quality results, thereby allowing the alternatives to increase their price. Of course, normal market forces would temper these behaviors to some extent. Even the highest quality provider could only charge a limited premium before losing their advantage in cost of care over domestic care for American medical tourists, while the lowest quality provider would be forced to provide at least a minimum level of quality or consumers would perceive the cost advantage of medical tourism insufficient based on the risks of low-quality care.

The medical tourism industry has reacted internally to the demand for information disclosure.[211] The first non-profit industry group, the Medical Tourism

209. Cohen, *Protecting Patients with Passports*, *supra* note 1, at 1493–94.

210. *See* Madison, *supra* note 206, at 1584 ("Even providers who for personal or professional reasons seek to deliver the highest quality of care possible may face difficulty doing so, because if quality is not observable, they may not be able to raise prices sufficiently to cover the costs of improving quality.").

211. *See* Cortez, *Recalibrating the Legal Risks of Cross-Border Health Care*, *supra* note 104, at 78 ("Demand for reassurance in the chaotic medical tourism market has led the industry to

Association (MTA), was recently formed, boasting many U.S. hospitals as well as major international destinations like Bumrungrad as members.[212] MTA has three tenets: transparency in quality and pricing, communication, and education.[213] It specifically markets the International Patient Services Certification as a supplement to options like JCI accreditation,[214] noting that the certification focuses on, though not exclusively, non-clinical patient satisfaction scores.[215] Focused on medical tourism facilitators and destination facilities, the MTA hopes to use accreditation both to create best practices and to reassure patients and providers that members meet certain criteria.[216] The MTA provides a two-year, renewable certification for facilitators by asking over 200 questions on topics ranging from how they select facilities to how they earn revenue.[217] Given the concerns over self-regulating agencies, such as those in Thailand and India, it is unclear whether the MTA will offer any meaningful insight into any facilitator's performance.[218]

3. Medical Tourism Should Utilize Existing International Regulatory and Accreditation Bodies for Its Information Gathering and Vetting Process

The goal of the accreditation process, in terms of medical tourism, must be to provide information to potential patients. Medical tourism destinations must ultimately provide data on quality controls and processes, equipment availability, and other key metrics that define the risk of care at a given facility, and doctors must provide evidence of their education, training, and specialty skills for the procedures being offered. That combination of information must then be vetted, synthesized, and presented in a manner that the average patient can easily digest. Existing examples of regulatory bodies are insufficient sources of information for medical tourists.

Utilizing international accreditation agencies, like JCI, would force destination facilities to disclose information on standardized metrics in standardized forms. Furthermore, JCI could validate the data provided, thereby ensuring Americans receive an accurate measure of the risk at given facilities.

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respond.").

212. *Id*.; MED. TOURISM ASS'N, http://www.medicaltourismassociation.com (last visited Feb. 7, 2014).

213. *About the MTA*, MED. TOURISM ASS'N, http://www.medicaltourismassociation.com /en/about-us.html (last visited Feb. 7, 2014) ("[The MTA] is the first membership based international non-profit trade association for the medical tourism and global healthcare industry made up of the top international hospitals, healthcare providers, medical travel facilitators, insurance companies, and other affiliated companies and members with the common goal of promoting the highest level of quality of healthcare to patients in a global environment.").

214. *International Patient Services Training And Certification Program*, MED. TOURISM ASS'N 1, 2 (2014), *available at* http://www.medicaltourismassociation.com/upload/file/MTA_ CONF_0031_IPSC_BROCHURE.pdf.

215. *Id*. at 1.

216. Cortez, *Recalibrating the Legal Risks of Cross-Border Health Care*, *supra* note 104, at 78.

217. *Id*.

218. *Id*. at 78–79.

Many international doctors are already ABMS board certified. ABMS-I likewise allows international doctors to gain independent accreditation for their training and skills. Regardless of which version is used, board certification by an accredited body offers medical tourists some assurance of a given doctor's abilities. In addition to certifying the training they have received, individual doctors should also be mandated to disclose patient outcome statistics, perhaps in conjunction with similar disclosures by facilities, to better gauge the effectiveness of their treatments.

Insurance companies should also be involved in medical tourism so that they can perform a quasi-regulatory function abroad. They could help to lower the risk medical tourists face by pressuring facilities and providers to provide higher quality care at lower costs by using their unique purchasing power. This provides a built-in check on price increases that do not reflect increases in outcome quality.

Critics of formal regulation and accreditation processes claim that they increase the cost of care provided without also increasing quality of care.[219] Although this seems like a facially legitimate concern, the facts do not support it. Regarding the cost of being accredited, the average cost of a full JCI survey in 2010 was $46,000.[220] The effect of this process on the cost of services is demonstrable. For example, Apollo Hospital Chennai is already JCI certified and offers procedures at a fraction of the cost of U.S. hospitals.[221] Bumrungrad, which touts JCI accreditation, advanced technology, and ABMS board-certified doctors, also offers treatments at a fraction of domestic costs.[222] Accreditation alone does not create prohibitively high costs of providing health care.

Another concern is the effect of additional regulations or reporting requirements on already challenged health care systems abroad. By concentrating

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219. *See*, *e.g.*, CHRISTOPHER J. CONOVER, CATO INSTITUTE, HEALTH CARE REGULATION: A $169 BILLION HIDDEN TAX (Oct. 4, 2004), *available at* http://www.cato.org/publications/policy-analysis/health-care-regulation-$169-billion-hidden-tax (arguing that health care industry regulation has a net cost of $169.1 billion in the United States after subtracting the value of the benefits consumers receive from regulation from the total cost of $339.2 billion); *Healthcare Is Turning Into An Industry Focused On Compliance, Regulation Rather Than Patient Care*, FORBES (Nov, 5, 2013, 8:52 AM), http://www.forbes.com/sites/physiciansfoundation/2013/11/05/healthcare-is-turing-into-an-industry-focused-on-compliance-regulation-rather-than-patient-care/ (proposing that compliance regulation in the United States has caused unnecessary increases in health care costs).

220. *Cost of Accreditation*, JOINT COMMISSION INT'L, http://www.jointcommissioninternational.org/cost-of-accreditation (last visited Feb. 7, 2014).

221. *See Apollo Hospitals*, COMPANION GLOBAL HEALTHCARE, INC., http://www.companionglobalhealthcare.com/patients/providernetwork/apollohospitalschennai.aspx (last visited Feb. 7, 2014) (comparing costs for certain procedures: a heart bypass by the Apollo Hospitals Group would cost $10,500 but in the United States would cost $144,317; a hip replacement by the Apollo Hospitals Group would cost $9,500, but in the United States would cost $100,047).

222. *See How Much Will It Cost*, BUMRUNGRAD INT'L HOSP. http://www.bumrungrad.com/en/realcost-thailand-surgery/procedures-surgery-cost-pricing (last visited Feb. 7, 2014) (offering average procedure costs at Bumrungrad on a "real cost" calculator as $21,811 for heart bypass surgery and $15,509 for a hip replacement).

on specific facilities and providers that provide services to medical tourists, the formal regulatory and reporting process could minimize any costs incurred by the destination nation's health care system due to the new demands. Under this approach, hospitals focusing solely on domestic care would not be forced to meet the regulations. This focus would prevent unneeded incremental costs on the system as a whole. For hospitals already offering services as tourism destinations, the costs of full disclosure would add little incrementally to their operating expenses, as many already participate in JCI and other accreditation programs. Any incremental increase in reporting costs would easily be offset by increased utilization by medical tourists.

Ultimately, U.S. policy should focus on promoting international regulatory bodies and accreditation services to ensure full and accurate disclosure of the quality of care risks medical tourists may encounter at a given facility and from a given provider. This disclosure should be mandatory for any insurance company using medical tourism as an alternative, either as an incentivized or mandatory option, for its customers. Only then can the consumer make an informed choice regarding the cost-benefit of the plan they choose.

For cash customers, it is equally imperative that the information is available in an easy-to-digest manner. Such information could be available in a manner similar to the existing Medicare website for domestic facilities and state-run websites for providers. Although many people would likely not utilize the information available, the legislation should make sure it is available, but not force utilization.

4. Additional Concerns Relating to Quality of Care

In addition to the international quality of care, many other factors play a role in the safety of international care for American medical tourists. Thus, although the primary goal of legislation should be full disclosure to American patients, some supplemental topics should be addressed here because these topics relate indirectly to the quality of care risk faced by American patients traveling for health care services.

One such potential issue is domestic follow-up care. Currently, brokerages typically play an intermediary role, coordinating care between international providers for initial services and domestic providers for follow-up services.[223] Without brokerages, patients may have trouble finding providers willing to offer follow-up care due to resentment or other issues.[224] In order to maximize the safety of American medical tourists, legislation should ensure that any patients who receive care internationally by virtue of their insurance policy would be covered

223. *See* Klaus, *supra* note 4, at 227–29 (explaining how brokers collaborate with airlines, hospitals, and hotels to offer medical tourism packages and also work with prospective hospital patients to customize a package based on the patient's budget, medical needs, and desire to travel following the surgery).

224. *See* Bye, *supra* note 14, at 31 (discussing problems receiving post-treatment care); Klaus, *supra* note 4, at 226–27 (noting that doctors may be unwilling to provide care for procedures they did not perform).

for all follow-up care needed upon their return. Such legislation would prevent insurance companies from shifting the financial burden of the risk from themselves to their customers. Likewise, the solutions discussed in the next section also should include the ability for cash customers to recover for domestic care needed to remedy damages caused by an international provider.

Legislation also should address the need for extended stays abroad.[225] If complications arise, a patient is likely to spend unplanned amounts of time in the destination country.[226] Legislation should require insurance companies that promote or require international care to cover any additional stay, due to the medical care received, for the patient and any authorized companion traveler. Again, in order to prevent the shifting of risk to the patient, this coverage should include any foregone incremental income due to traveling for care. Cash customers should also be able to recover for damages including time based income loss for themselves and any companion authorized by the international provider.

Data privacy and informed consent are further concerns of potential medical tourists. Health Insurance Portability and Accountability Act (HIPAA) does not apply outside of the United States, meaning foreign providers are not bound to follow the strict data privacy safeguards that are required in the United States.[227] Some combination of patient release and mandatory compliance with HIPAA standards by international providers could help minimize any data risk.[228] Likewise, international providers should be required to offer the same level of informed consent that a medical tourist would receive domestically prior to a procedure.[229]

In sum, there is a plethora of issues that need to be addressed regarding medical tourism. Information and full disclosure of risks should be at the top of list to allow Americans to make fully informed decisions regarding their care. The AMA offers nine guidelines for patient safety in medical tourism that address many of these additional topics.[230] While their recommendations may not entirely

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225. While it is true that extended hospital stays also happen domestically, the risks faced by the patient, specifically access to needed additional medicines and treatments, family support, and other resources are substantially different when traveling abroad for care.

226. Klaus, *supra* note 4, at 225.

227. *See* Bye, *supra* note 14, at 31–32 (discussing the role of HIPAA in medical tourism).

228. *See id*. (discussing potential solutions for group health plans trying to incorporate international providers into their plans).

229. Aaron D. Levine & Leslie E. Wolf, *The Roles and Responsibilities of Physicians in Patients' Decisions About Unproven Stem Cell Therapies*, 40 J. L. MED. & ETHICS 122, 126 (2012).

230. *Id*. at 124. The nine AMA guidelines on medical tourism are:

(a) Medical care outside of the U.S. must be voluntary.

(b) Financial incentives to travel outside the U.S. for medical care should not inappropriately limit the diagnostic and therapeutic alternatives that are offered to patients, or restrict treatment or referral options.

(c) Patients should only be referred for medical care to institutions that have been accredited by recognized international accrediting bodies (e.g., the Joint Commission International or the International Society for Quality in Health Care).

(d) Prior to travel, local follow-up care should be coordinated and financing should be

encompass the risks faced, they certainly provide a starting point for considerations of medical tourism legislation. They have promised model codifications of these recommendations, hopefully prompting domestic legislatures to begin adopting something similar.[231]

B. Legal Risks: International Malpractice

The legal risk inherent in international medical care is an additional concern that must be addressed by this article.[232] Disclosure in a manner understandable by an average medical tourist should be the primary goal of any legislation regarding medical tourism. As part of this, due to the potential for adverse outcomes resulting from international medical care,[233] patients must understand their rights of recovery in a given country. Only with this understanding can they make an informed decision regarding the cost-benefit analysis of medical tourism.

The medical tourism industry, insurers, and other parties involved in the process certainly understand these risks,[234] though they are not quick to disclose them.[235] This is clearly evidenced by the releases, waivers, and other contractual measures the parties take to inoculate themselves from liability.[236] However, it is easy to question whether the patient has the same level of comprehension about not only what risks exist, but also what limits have been placed on potential recoveries due to these imposed terms.[237]

Patients should have the right to make the decision they feel is best regardless

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arranged to ensure continuity of care when patients return from medical care outside the US.

(e) Coverage for travel outside the U.S. for medical care must include the costs of necessary follow-up care upon return to the U.S.

(f) Patients should be informed of their rights and legal recourse prior to agreeing to travel outside the U.S. for medical care.

(g) Access to physician licensing and outcome data, as well as facility accreditation and outcomes data, should be arranged for patients seeking medical care outside the U.S.

(h) The transfer of patient medical records to and from facilities outside the U.S. should be consistent with HIPAA guidelines.

(i) Patients choosing to travel outside the U.S. for medical care should be provided with information about the potential risks of combining surgical procedures with long flights and vacation activities.

Id.

231. Cortez, *Recalibrating the Legal Risks of Cross-Border Health Care*, *supra* note 104, at 82.

232. *Id*. at 88.

233. *See* Klaus, *supra* note 4, at 241–42 (noting that, holding error rates constant, a rise in surgeries will necessarily equate to a rise in malpractice and adverse outcomes).

234. Turner, *supra* note 59, at 461–62.

235. Turner uses the analogy of a car salesman—why would a car salesman discuss alternatives like walking or a bus? *Id*. at 462.

236. *See id*. (explaining that brokerages state they "facilitate" or "coordinate" medical services but assume no liability and that customers are told to "do their homework" before being forced to sign seemingly comprehensive disclosure forms, for which reason Turner labels the medical tourism industry a classic "buyer beware" business.).

237. Cortez, *Recalibrating the Legal Risks of Cross-Border Health Care*, *supra* note 104, at 3.

of the underlying risks involved,[238] provided of course those risks are sufficiently disclosed. This would also allow the industry to ensure that the costs of that risk are properly allocated between providers and patients.[239]

The comparative analysis of malpractice systems need not result in a solution that attempts to reform or perfect a given country's options, either for medical tourists or its domestic citizens. What is of import is not an ideal recovery for medical tourists, but rather an informed comparison of likely outcomes.[240] As such, the legal risk for American medical tourists should be defined as the potentially foregone recoveries for adverse outcomes of international care as compared with similar outcomes domestically.

While the goal of medical tourism legislation should not be reformation of any particular malpractice system, it is prudent to discuss the various systems available to better understand why and how they coexist.

1. The Medical Tourism Industry Should Offer Malpractice Recovery Options

Deciding whether or not or to what extent malpractice damages should be available for medical tourists requires an understanding of the various malpractice systems currently in use and their criticisms and benefits. Critics who flatly oppose introducing malpractice protections to medical tourists often cite the American malpractice system as an example of a failed malpractice system. Low effectiveness and high costs, they say, make it untenable for destination providers. They argue that any system of malpractice will introduce unnecessary costs to the process with no benefit gained.

Malpractice systems are, like all legal systems, generally designed to achieve certain goals. In the United States, for example, malpractice laws are designed to meet three ends: (1) to deter unsafe practices; (2) to compensate victims of negligence; and (3) to enforce corrective justice.[241] Although worthy goals, many opponents of introducing malpractice awards to medical tourism argue that the current American system does not actually accomplish any of these three goals effectively.[242] In actuality, the international community views the American system

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238. *Id*. at 88.

239. *Id*.

240. *Id*. Cortez argues:

> Patients should know what legal recourse they will have under different medical tourism arrangements, particularly those that ask patients to waive various legal rights or litigate in a foreign jurisdiction. Patients should remain free to have surgery overseas—either of their own volition or at the behest of an employer or an insurer—but patients should fully appreciate what legal and regulatory protections they might be sacrificing.

Id.

241. Klaus, *supra* note 4, at 235.

242. *See, e.g*., Cortez, *Recalibrating the Legal Risks of Cross-Border Health Care*, *supra* note 104, at 19–21 (arguing that for numerous reasons the United States' current laws fail to provide medical consumers with adequate protections against malpractice); Klaus, *supra* note 4, at 237.

negatively.[243] The following discussion outlines the contentions that form the basis of the argument that malpractice laws should not be introduced into the medical tourism industry.

The deterrent effect of the American tort system is widely regarded as its primary rationale by law and economics scholars.[244] However, due to the financial costs of litigation, the desired deterrent effect is not achieved in the medical field.[245] The existence of malpractice insurance negates the economic costs of rational actors failing to take proper precautions.[246] This is especially true when considering the nature of malpractice insurance for providers whose cost is usually not experience related, but rather varies by specialty.[247]

Evidence of the system's failed deterrent effect is widely researched. The Institute of Medicine published a now famous report in 1999, *To Err is Human*, which cited 98,000 preventable deaths in American hospitals annually.[248] Although originally disputed, these numbers are now regularly quoted and accepted by doctors and hospitals in the United States.[249] In 2010, the Office of the Inspector General for Health and Human Services reported that hospitals contributed to the death of 180,000 Medicare patients annually.[250] Also, 13.5% of Medicare patients experienced adverse events during their hospital stay, with 44% of those events deemed to be "clearly or likely preventable."[251] Regardless of which of these numbers is the most accurate, it is easy to understand the concern regarding the effectiveness of the malpractice system as a deterrent for negligent care. Physicians consistently overestimate the risk of being sued.[252] This seems to indicate that the

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243. Cortez, *Recalibrating the Legal Risks of Cross-Border Health Care*, *supra* note 104, at 19–21.

244. Michelle M. Mello & Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 TEX. L. REV. 1595, 1603 (2002).

245. *Id*.

246. *Id*.

247. *See id*. at 1616 (discussing how the deterrent effect is greatly lost due to the lack of experience-related premiums for physicians).

248. Marshall Allen, *How Many Die From Medical Mistakes in U.S. Hospitals?*, PROREPUBLICA (Sept. 19, 2013, 9:03 AM), http://www.propublica.org/article/how-many-die-from-medical-mistakes-in-us-hospitals.

249. *Id*.

250. *Adverse Events In Hospitals: National Incidence Among Medicare Beneficiaries*, DEP'T OF HEALTH AND HUM. SERVICES (Nov. 2010), https://oig.hhs.gov/oei/reports/oei-06-09-00090.pdf. The most current, but still highly debated, study, created by the Journal of Patient Safety, estimates the number of people who die due to preventable physician error to be between 210,000 and 400,000 annually. As a point of reference, this would make preventable error the third leading cause of death in the United States behind heart disease and cancer. For more information see John T. James, *A New, Evidence-based Estimate of Patient Harms Associated with Hospital Care*, 9 J. PATIENT SAFETY 122, 122 (Sept. 2013), *available at* http://journals.lww.com/journalpatientsafety/Fulltext/2013/09000/A_New,_Evidence_based_Estimate_of_Patient_Harms.2.aspx.

251. *Adverse Events In Hospitals: National Incidence Among Medicare Beneficiaries*, *supra* note 250, at i–ii.

252. Mello & Brennan, *supra* note 244, at 1609 . Mello and Brennan write:

While data [from a study conducted by researchers from Harvard Medical School] showed

threat of malpractice litigation serves some deterrent effect despite the poor statistics on preventable error.[253] Researchers have not yet established a statistical correlation, however, between the U.S. malpractice system and physician negligent error.[254]

The second purpose of the U.S. malpractice system—to compensate victims of malpractice—has also been widely questioned. The vast majority of those injured never sue.[255] In New York, for example, there are approximately seven times as many negligent injuries as there are claims.[256] For those who do file claims, approximately 70% do not receive any compensation.[257] These statistics show the insufficiency of the distribution of malpractice awards.[258] Even when awards are paid, the money is not efficiently distributed. Administration costs, mainly legal fees, account for nearly 60% of the total amount of money spent on the malpractice system.[259]

Malpractice protection of American citizens abroad also would necessarily increase the number of malpractice suits faced by medical tourism providers or facilities. The virtual lack of current litigation surrounding medical malpractice cases in most LMICs means that any increase in litigation would be statistically significant. Since, as of now, medical tourists face nearly impossible odds of litigation recovery, foreign malpractice suits are nearly nonexistent. In fact, some authors failed to find a single reported case of a medical tourist successfully suing an overseas provider.[260]

Not only is there inconclusive evidence regarding the American malpractice system's ability to achieve its three goals, but some research shows that it is no more effective than a typical Asian system in doing the same.[261] Critics often argue that although malpractice systems abroad often have little to no practical chance of

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> that only 13% of negligent injuries, and only 4% of all medical injuries, resulted in malpractice claims, the physicians surveyed estimated that 60% of negligent injuries and 45% of all injuries led to claims. Further, the physicians estimated the annual rate of suit per 100 physicians in New York at nearly three times the true rate (19.5% versus 6.6%).

Id. (footnote omitted).

253. *Id*. at 1610.

254. *See id*. ("'Although we did observe the hypothesized relationship in our sample—the more tort claims, the fewer negligent injuries—we cannot exclude the possibility that this relationship was coincidental rather than causal.'" (footnote omitted) (quoting PAUL C. WEILER ET AL., A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION 126 (1993)).

255. Cortez, *Recalibrating the Legal Risks of Cross-Border Health Care*, *supra* note 104, at 19.

256. Klaus, *supra* note 4, at 237.

257. Cortez, *Recalibrating the Legal Risks of Cross-Border Health Care*, *supra* note 104, at 19.

258. Klaus, *supra* note 4, at 237 ("[O]nly 2% of negligent injuries resulted in claims and only 17% of claims involved a negligent injury.").

259. *Id*.

260. Cohen, *Protecting Patients with Passports*, *supra* note 1, at 1494.

261. Klaus, *supra* note 4, at 235.

recovery, Asian physicians' fear of losing medical tourist patients is a sufficient replacement for the deterrent effect of potential litigation costs.[262] Medical tourism is still a growing industry and relies on referrals and the internet for communication.[263] Patients injured abroad can use those same communication means to denounce the quality of care available at certain facilities.[264] Arguably, this is a robust incentive for destination physicians and facilities to be sure all patients leave satisfied with their care to maximize future business.[265] Thus, critics say there is no need to introduce any malpractice system to medical tourism because doing so would not provide a sufficient increase in safety to offset the additional costs.[266]

An additional factor considered is the counter-productive effect of malpractice suit costs on the medical tourism field. Some research points to the American malpractice system as one of the reasons American health care is so much more expensive than that in LMICs.[267] For example, a heart surgeon in New York likely spends $100,000 annually on malpractice insurance compared to just $4,000 spent annually by a heart surgeon in India for such coverage.[268] Combined, American doctors pay over $6 billion annually to protect themselves from potential malpractice suits.[269] Many researchers argue that these costs are directly passed on to patients and insurance companies.[270] These rising costs, they argue, have caused health insurance premiums to become unaffordable, resulting in more than forty-five million Americans being uninsured.[271] Somewhat ironically, those uninsured individuals have the largest incentive to utilize medical tourism.[272]

The malpractice system is also accused of producing other costs, such as those associated with defensive medicine. In a recent national survey, 75% of American doctors admitted to ordering more tests and procedures than medically necessary, specifically to reduce the risk of malpractice lawsuits.[273] Gallup reported

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262. *Id*. at 236–37; Boyle, *supra* note 4, at 46.

263. Klaus, *supra* note 4, at 236–37.

264. *Id*.

265. Boyle, *supra* note 4, at 46; *see also* Klaus, *supra* note 4, at 236–37. On this subject, Boyle stated:

> Considering that medical tourism is susceptible to skepticism because it [sic] not nearly as established or trusted as the United States health care network, foreign doctors seeking to establish a reliable international clientele may make sure they perform the surgery beyond expectations. Thus, either medical tourism will become a difficult tradable service due to decreased quality of care as reputation can spread fast about specific facilities and surgeons or the patient could try to get jurisdiction over the surgeon.

Boyle, *supra* note 4, at 46 (footnotes omitted).

266. Klaus, *supra* note 4, at 236–37.

267. *Id*. at 229.

268. *Id*. at 230.

269. *See, e.g.*, *id*. at 229–30 (discussing the various malpractice insurance costs for doctors in the United States).

270. *Id*. at 229.

271. *Id*.

272. Klaus, *supra* note 4, at 229.

273. Hal Scherz & Wayne Oliver, Op-Ed., *Defensive Medicine: A Cure Worse Than The*

that these procedures—about one in four of the total procedures ordered—cost nearly $650 billion annually.[274] Again, critics argue that by introducing medical malpractice to medical tourism, the costs will be driven up, thereby reducing both the incentives and benefits currently offered by the industry.

These arguments put forth a convincing case for not introducing any malpractice protection into medical tourism. If the costs rise, the benefit of medical tourism as currently realized would be lost. Furthermore, because the American system fails to effectively prevent negligent care or compensate those injured, an international malpractice system would likely suffer the same results. However, both the costs and efficacy of the American system are highly debated topics. As such, it is important to understand the counterpoints to many of the arguments presented above before deciding the value of malpractice protection for medical tourists.

First, malpractice protection can more effectively allocate the risks of medical tourism among the patients, providers, and facilities involved in a transaction. In general, the American belief is that the party at fault should be responsible for paying the associated damages, including lost earnings, additional medical bills, and other expenses.[275] The party at fault, here either the facility or provider, is best suited to bear the costs of injury, as they have the ability to pool the costs among many incidents, as well as the resources to obtain sufficient insurance.[276] The possibility of malpractice liability for the facility offers a well-balanced approach to allocating the risks of care while maintaining recovery potential for patients. This approach is often called channeling.[277] Facility insurance premiums could then be experience based.[278] Premiums would be tied directly to the risk a given facility faces for malpractice claims and would therefore be based on the facility's particular history rather than the specialty that they practice, as is currently the practice in the American system. Facilities would then have greater incentive to provide higher quality care, as it would directly lead to a reduced number of claims

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Disease, FORBES (Aug. 27, 2013, 10:52 AM), http://www.forbes.com/sites/realspin/2013/08/27/defensive-medicine-a-cure-worse-than-the-disease/. These defensive medicine costs should be considered evidence of the deterrent effect of the malpractice system. However, this analysis would require determining if the additional procedures, although not medically *necessary*, actually produce better quality outcomes.

274. *Id*. It is important to note, however, that studies attempting to approximate the costs of defensive medicine have been regularly discounted and criticized. *See* David M. Studdert, et al., *Medical Malpractice*, 350 NEW ENG. J. MED. 283, 286 (2014).

275. *Id*. at 283.

276. *Id*.

277. Mello & Brennan, *supra* note 244, at 1624. Mello and Brennan define "channeling":

> Channeling refers to the aggregation of individual physicians into larger enterprises—hospitals and hospital networks—by consolidating malpractice insurance coverage in a single carrier. The hospital would cover the cost of malpractice premiums for its affiliated physicians, and the insurer would mount a joint defense to claims brought against both the hospital and individual physicians.

Id..

278. *Id*.

and consequently reduced premiums. Without malpractice insurance coverage at a given facility or for a given provider, all patients face the risk of being injured without the ability to recover for their injuries.[279] This results in a disproportionate allocation of risk between the patients who are injured and the doctors causing those injuries.[280]

Second, the costs of malpractice protection would not add significantly to the price of medical tourism. In total, defending against medical malpractice claims represents less than 1% of total health care expenditures in the United States.[281] In a cursory examination of the cost differential between the United States and destination countries, medical malpractice costs do not account for a significant, or even meaningful, portion of the cost of health care.[282] Additionally, improved efficiencies in any proposed malpractice system could reduce the current 60% administration cost associated with malpractice claims,[283] enabling similar or even larger effective payouts to injured patients with lower net costs to the destination system.

Third, although reportedly linked to malpractice fears, defensive medicine does not correlate to cost inflation as strongly as some critics propose that it does. Looking at states such as Texas and Massachusetts, where significant tort reforms have limited damage payouts, physician behaviors have not significantly changed.[284] In fact, 90% of Massachusetts doctors reported no change in their defensive-medicine behaviors since the passing of the state's tort reforms.[285] Likewise in Texas, 77% of doctors reported no change in their prescribing habits since the passing of state tort reform legislation.[286] If the argument is that malpractice risk changes a doctor's prescribing or practice habits, thus raising costs, this evidence offers a strong rebuttal against that argument.

Lastly, having malpractice protection would actually allow individual providers and patients to more fully negotiate the terms of their agreements. This could create a system where a patient could voluntarily sign away potential malpractice awards in exchange for lower costs.[287] Individual patients could then take a calculated risk with a specific provider or facility, given the information provided, by contracting out of malpractice protection in exchange for lower out-

279. Klaus, *supra* note 4, at 237–38.

280. *See id*. at 238 ("As a policy matter, the cost of medical errors falls almost entirely on the victims of medical errors, not the doctors responsible for those errors, yet that cost is borne by only a few unfortunate patients rather than all patients paying more for medical care.").

281. Cortez, *Recalibrating the Legal Risks of Cross-Border Health Care*, *supra* note 104, at 20. Other sources place the number closer to 2% of the total health care spending. Cohen, *Protecting Patients with Passports*, *supra* note 1, at 1481–82.

282. *See* Cohen, *Protecting Patients with Passports*, *supra* note 1, at 1481–82 (noting that it is estimated that the directs costs of medical malpractice make up just 2% of U.S. health care costs).

283. Klaus, *supra* note 4, at 237.

284. Scherz & Oliver, *supra* note 273.

285. *Id*.

286. *Id*.

287. Klaus, *supra* note 4, at 237–38.

of-pocket costs.[288] Alternatively, the American system forces all patients to share in the costs of malpractice protection despite the statistical probability that they will never recover monetary compensation for injuries resulting from malpractice.[289]

In all, malpractice protection would offer a net benefit to medical tourists. First, risks could be more accurately allocated among the parties involved in the transactions. Second, payouts to injured patients could actually be raised in effective payment terms without incremental increases in costs to the system due to improved recovery efficiencies. Third, doctors abroad are not more likely to adopt defensive medicine practices as a result of potential malpractice liability. Lastly, allowing malpractice recovery would offer an additional point of negotiation between the parties involved in a given transaction, again increasing the efficiency of the cost-benefit allocation in the medical tourism industry. Although the current malpractice system in the United States may not be ideal, the information available affirms the benefit of malpractice protection for medical tourists. In fact, if the system is effectively designed for medical tourists, it may even serve as a blueprint for countries looking to modify or create their own domestic malpractice systems.

2. Legal Risk—The Variance in Recovery Potential

Knowing that malpractice protection would offer a net gain to medical tourists allows for the next logical question—what is the potential for malpractice recovery? This article defines *legal risk* in the medical tourism context as the difference in potential recovery for adverse outcomes between that in one's home country and that in a destination country. Under current systems, the risk of non-recovery for medical tourists can be quite large. As discussed throughout this article, quantifying a "proper amount of recovery" should not be the goal of medical tourism legislation. The full disclosure of the probable recovery in various systems is important. The total-cost calculation of traveling for health care can then include the potential for recovery or lack thereof. Only through this inclusion can a medical tourist properly weigh the cost-benefit of traveling for medical care.

The risk of non-recovery is particularly present internationally, where malpractice systems often offer a much lower likelihood of recovery than in the United States.[290] Interestingly, much of the current academic literature assumes, without providing any support or evidence, that medical tourism destinations provide inadequate remedies or no remedies at all.[291] This may be due to a lack of existing case law with which to build a thesis.[292] Accordingly, this comment uses existing academic research to formulate the most probable outcomes for various destination countries. In order to pursue international malpractice claims, injured American patients have two options—sue foreign providers in U.S. courts or sue

288. *Id*.

289. *Id*.

290. Cohen, *Protecting Patients with Passports*, *supra* note 1, at 1489.

291. Cortez, *Recalibrating the Legal Risks of Cross-Border Health Care*, *supra* note 104, at 1 n.6.

292. *Id*. at 8–9.

foreign providers in their domestic systems.

a. Procedural Issues of Suing Foreign Providers in the United States

The process of suing a foreign provider in U.S. courts can be a herculean task.[293] First, the patient has to establish personal jurisdiction over the physician who both practices and resides in a foreign country.[294] Traditionally, U.S. courts have been reluctant to find personal jurisdiction over these physicians, even when they practice in countries directly adjacent to the United States.[295] Using a state's long-arm statute to establish personal jurisdiction over a physician in a state he or she does not practice in has proven unsuccessful even when employed against a U.S. physician practicing in a U.S. hospital in another state and accused of injuring a citizen of the first state.[296] This reluctance to claim personal jurisdiction over physicians from a different state arises from a feeling that it would be "*fundamentally unfair* to permit a suit in whatever distant jurisdiction the patient may carry the consequences of his treatment."[297]

In *Beh v. Ostergard*, for example, a woman who resided in New Mexico attempted to establish personal jurisdiction over a California-based physician through New Mexico's long-arm statute.[298] In applying the long-arm statute, the court engaged in a three step process determining: (1) if the defendant committed an act within the bounds of the statute; (2) whether the cause of action arose from those acts; and (3) whether there were sufficient minimum contacts under the Fourteenth Amendment Due Process Clause.[299] New Mexico's long-arm statute provides personal jurisdiction for any person who commits a tortious act within the state regardless of citizenship status.[300] Here, the court held the doctor had

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293. For a discussion on the variations that can occur when suing health maintenance organizations, brokerages, and other parties involved in medical tourism in U.S. courts, see Howze, *supra* note 62, at 1039–45, Cohen, *Protecting Patients with Passports*, *supra* note 1, at 1467, Cortez, *Recalibrating the Legal Risks of Cross-Border Health Care*, *supra* note 104, at 14–18, Sao et. al., *supra* note 19.

294. Howze, *supra* note 62, at 1031.

295. Cortez, *Recalibrating the Legal Risks of Cross-Border Health Care*, *supra* note 104, at 9. *See generally* Romah v. Scully, CIV.A. 06-698, 2007 WL 3493943 (W.D. Pa. 2007).

296. *See* Philip Mirrer-Singer, *Medical Malpractice Overseas: The Legal Uncertainty Surrounding Medical Tourism*, 70 L. & CONTEMP. PROBS. 211, 213–14 (2007) (referencing several U.S. cases dealing with this issue).

297. Mosier v. Kinley, 702 A.2d 803, 807 (N.H. 1997) (quoting Gelineau v. New York U. Hosp., 375 F. Supp. 661, 667 (D.N.J. 1974)).

298. 657 F. Supp. 173 (D.N.M. 1987).

299. *Id*. at 174. While not all state long-arm statutes will mirror this exact language, state courts' analysis in applying long-arm statutes will be similar. First, there will be an analysis of state law based on the applicable long-arm statute. A constitutional analysis under *Int'l Shoe Co. v. Washington*, 326 U.S. 310 (1945), to determine the "sufficiency of contacts" will follow.

300. N.M. Stat. Ann. § 38-1-16 (West). The statute reads:

> Any person, whether or not a citizen or resident of this state, who in person or through an agent does any of the acts enumerated in this subsection thereby submits himself or his personal representative to the jurisdiction of the courts of this state as to any cause of action arising from . . . the commission of a tortious act within this state . . . .

Id.

committed a tortious act in New Mexico by relying on well-established precedent that commission of a tortious act happens when and where the actual injury happens.[301] As for the third prong, the court found that there were not sufficient contacts under the Due Process Clause. Importantly, *Beh* also reasoned that a physician's advertising and solicitation of patients does not fulfill the sufficient contacts requirement by itself.

Put more directly, simply by treating a patient from a different state, an American doctor does not submit himself to personal jurisdiction in the patient's home state, even if there is an adverse outcome. It is reasonable to conclude that by treating American patients, foreign doctors would not, without more, submit themselves to personal jurisdiction in American courts. Using the same logic, it follows that foreign doctors advertising their services to medical tourists would likewise not have sufficient contacts to confer personal jurisdiction in the United States over foreign doctors.[302]

b. Alternative Routes to Suing Foreign Providers in the United States

There are other alternatives for establishing personal jurisdiction available to an American medical tourist who wishes to sue domestically.[303] An ongoing contract between a foreign provider and a domestic referral service could be sufficient to establish jurisdiction, though it is not clear where courts would fall.[304] In *Romah v. Scully*, a federal district court held a Toronto hospital was not bound by jurisdiction in Pennsylvania.[305] The court reasoned that although the hospital had advertised its medical services in Philadelphia and Pittsburgh, the mere advertising of services was insufficient to meet the sufficiency of contacts burden.[306] Furthermore, the existence of ongoing contracts was insufficient to establish jurisdiction because the contracts were signed outside of Pennsylvania and the act in question also happened outside of the state.[307] Thus, since medical tourists will receive care outside of their state and advertising medical services to citizens of a state is itself insufficient to assert jurisdiction over a foreign medical provider, foreign doctors will likely not be found subject to jurisdiction in U.S. courts.

c. The Reasonableness Requirement

If a patient is able to establish personal jurisdiction, the jurisdiction must still

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301. *Beh*, 657 F. Supp. at 175–76.

302. Burger King Corp. v. Rudzewicz, 471 U.S. 462, 475 (1985).

303. *See, e.g.*, Nathan Cortez, *Recalibrating the Legal Risks of Cross-Border Health Care*, *supra* note 104, at 10–11 (discussing whether Internet advertising constitutes sufficient contacts with a forum state to establish jurisdiction); Mirrer-Singer, *supra* note 296, at 214–15 (discussing the use of the continuing tort theory to establish jurisdiction over foreign doctors).

304. Cortez, *Recalibrating the Legal Risks of Cross-Border Health Care*, *supra* note 104, at 10.

305. No. 06-698, 2007 WL 3493943, at *5–6 (W.D. Pa. Nov. 13, 2007).

306. *Id*. at *7.

307. *Id*. at *7–8.

be found to be reasonable.[308] To define reasonableness, American courts look to many factors, including the burden on the defendant and the forum state's interest in litigating the case.[309] There is evidence that the greater the seriousness of the injury, the greater the chance an American court will apply jurisdiction.[310] As Cortez points out, agencies that strongly recommend a particular hotel to a traveler can be held liable for injuries the traveler suffers there.[311] U.S. courts may similarly find a way to establish jurisdiction in medical tourism cases.[312]

While this may be so, *Carnival Cruise Lines, Inc. v. Shute* implies foreign providers could avoid this with purposeful contract clauses.[313] Namely, a disclaimer clause relinquishing the patient's right to sue in U.S courts on any pre-treatment invoice signed by a patient would likely protect any provider from jurisdiction in a U.S. court. Here, the argument would parallel the reasoning in *Carnival Cruise Lines*—that the patients are taking advantage of a benefit by dealing with this provider. The doctor would argue that two such benefits are lower costs due to lower risk of litigation for the doctor and increased access to care for the patient due to lower prices for care. This would mirror the rationale in *Carnival Cruise Lines* that by offering benefits directly related to the contract clause in question—here lowering costs by limiting litigation risk—the clause might be read as an enforceable adhesion contract.[314]

d. Forum Non Conveniens Analysis

Even if the patient fulfills the reasonableness component, the court could still dismiss the case under a forum non conveniens analysis.[315] A foreign physician likely would use the unreasonable burden analysis from the Supreme Court's decision in *Piper Aircraft Company v. Reyno* and file a forum non conveniens motion to dismiss the case.[316] Although significant delays in international courts may be enough for Americans to prevail here, insufficient awards from foreign courts likely would not be.[317]

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308. World-Wide Volkswagen Corp. v. Woodson, 444 U.S. 286, 291–94 (1980) (listing the factors that are considered in the reasonableness standard and discussing the various interpretations of them).

309. *Id*.

310. Cortez, *Recalibrating the Legal Risks of Cross-Border Health Care*, *supra* note 104, at 11 (discussing the role of American courts in tort cases involving Mexican actors).

311. *Id*.

312. *Id*.

313. 499 U.S. 585 (1991).

314. *Id*. at 585–86.

315. Howze, *supra* note 62, at 1034.

316. 454 U.S. 235 (1981).

317. Cortez, *Recalibrating the Legal Risks of Cross-Border Health Care*, *supra* note 104, at 13 (comparing a case where "extreme delays" rendered an Indian court inadequate to another case where a statutory limit on recoveries of $2,500 in Mexico was not sufficient for inadequacy under forum non conveniens analysis).

e. Choice of Law Issues

After overcoming the forum non conveniens challenge, the patient has to face choice of law questions. Here, defendants certainly may argue that the laws of their home country, where the services were rendered, should control.[318] The laws in most destination countries greatly favor the health care provider. In fact, a patient's victory on a forum non conveniens challenge could very well be an empty victory if the court chooses to apply the laws of the destination country.[319] American patients could argue that by marketing themselves as "meeting Western standards of care," international providers should be held to Western legal standards.[320] This is purely theoretical, as there is no clear indication of how courts would resolve the issue.[321]

f. The Burden of Proof

In general, Americans will face many procedural hurdles attempting to sue a foreign doctor in U.S. courts. Once in court, the patient will have to deal with U.S. burden of proof requirements. The burden of proof in a U.S. malpractice action lies with the patient, who must establish the doctor breached the standard of reasonable care by a preponderance of the evidence.[322] Reasonable care is generally defined as the skill a physician under the same or similar circumstances should "reasonably possess."[323] Gaining access to both testimonial and documentary evidence, which is usually located in the destination country, can be so difficult in many destination countries as to entirely preclude many cases from even reaching trial.[324]

g. Enforcing Judgments

Thus, even if a patient decides to sue their foreign provider in a U.S. court, the process is far from certain. After prevailing on jurisdictional issues, forum non conveniens motions, and choice of law issues and sustaining the burden of proof, the patient must still enforce the judgment against a foreign provider, a process no less difficult than the others.[325] Unlike arbitration,[326] there is no prevailing

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318. *Id*. at 13.

319. *Id*. (discussing a case where Saudi law, which does not recognize vicarious liability, was applied, and the court dismissed the case).

320. *Id*. at 14.

321. For an analysis of potential outcomes, see *id*., which discusses a domestic inter-state malpractice suit that applied the law of the destination state instead of the patient's home state.

322. For a more thorough discussion of the standard of care in American malpractice law, and what constitutes the boundaries of that standard, see STEVEN E. PEGALIS, THE AMERICAN LAW OF MEDICAL MALPRACTICE § 3:3 (3d ed. 2005).

323. *Id*.

324. *See infra* notes 339, 353, 359 (demonstrating the difficulties plaintiffs face in medical malpractice cases).

325. Howze, *supra* note 62, at 1038.

326. International arbitration awards are recognized and enforced by the 149 signatory countries of the The Convention on the Recognition and Enforcement of Foreign Arbitral Awards, also known as the New York Convention, 330 U.N.T.S. 38 (1968). This provides a

international treaty on the enforcement of court awards. This fact has begun to change recently[327] but can still present a real problem in enforcing international awards.[328] Thus, Americans face a real legal risk when choosing medical tourism instead of receiving care domestically.

h. Logistical Issues of Foreign Suits

Suing for malpractice in foreign courts presents no less of a struggle than suing domestically in U.S. courts. Unfamiliar procedures, the need to retain local counsel, the conducting of proceedings in foreign languages, and more demanding burdens of proof are just some of the issues patients are likely to face.[329] Additionally, like the previously discussed regulatory systems, Americans traveling for health care may not be aware of the differences in foreign legal systems. This lack of understanding poses a real threat to the patient's decision-making process and underscores the importance of thoroughly understanding the variances that exist in potential outcomes.

As discussed above, Indian law attempts to punish and deter medical malpractice as well as to compensate victims.[330] In reality, regulation is virtually nonexistent and courts offer little hope for malpractice victims.[331] Indian law allows for litigation of malpractice claims in one of two venues, civil court or consumer forums.[332] Civil litigation can be a very long process, even by U.S. standards, while the consumer forums are supposed to provide a more efficient alternative.[333] India created the consumer forums in 1986, hoping to offer an alternative that avoided the burdens of traditional litigation.[334] Today however, the consumer forums are plagued by many of the same issues present in the civil courts.[335] A typical consumer forum case takes two to three years to reach a resolution, which compares favorably to the U.S. civil case average of nearly five years.[336]

Legal obstacles present the largest hindrance to suit in India by Americans.[337]

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reason why arbitration may be a solution better suited to medical tourism malpractice cases than traditional litigation.

327. Philip R. Weems, *Guidelines for Enforcing Money Judgments Abroad*, 21 INT'L BUS. L. 509, 509 (1993) (discussing several treaties that were signed in the years preceding Weems's article).

328. For a more thorough look at the multiple variations and issues that can arise in enforcing international financial awards, see Cary D. Steklof, *Medical Tourism and the Legal Impediments to Recovery in Cases of Medical Malpractice*, 9 WASH. U. GLOB. STUD. L. REV. 721 (2010) and Weems, *supra* note 327, at 509.

329. Cortez, *Recalibrating the Legal Risks of Cross-Border Health Care*, *supra* note 104, at 5.

330. *Id*. at 22.

331. *Id*.

332. Howze, *supra* note 62, at 1034.

333. Cortez, *Recalibrating the Legal Risks of Cross-Border Health Care*, *supra* note 104, at 5.

334. *Id*. at 23–24.

335. *Id*.

336. *Id*. at 27.

337. *Id*. at 28.

Usually, the plaintiff carries the burden of proof.[338] However, due to lack of access to medical records and the difficulty plaintiffs face in finding qualified medical experts willing to testify against a colleague, that burden becomes nearly unreasonable.[339] The president of the Consumer Information Center has stated that it is very difficult to establish negligence due to most doctors' unwillingness to testify against fellow doctors, even if they are guilty.[340] Despite a 2002 Indian law requiring medical records be kept for three years and furnished to patients upon request, there is no evidence of the Medical Council of India's enforcement of the law.[341]

Nearly all Indian malpractice cases are dismissed.[342] Even when a patient is fortunate enough to win a malpractice case, non-economic damages are not recognized, leaving patients with minimal recovery.[343] Enforcing Indian judgments is difficult, though recent amendments should allow for better award recoveries.[344]

Indian courts rely on the British precedents of *Bolam v. Friern Hospital Management Commission*[345] and *Bolitho v. City & Hackney Health Authority*[346] in malpractice litigation.[347] These two cases dramatically changed the landscape of malpractice law in India.[348] Under precedent, judgment is required for a malpractice defendant if *any* expert concludes that the physician's actions were appropriate.[349] Therefore, a doctor need only find one expert to testify on his behalf to win a case.[350] Time delays also are inherent in Indian litigation with average cases in civil court taking fifteen to twenty years for completion.[351]

Thailand's system similarly makes malpractice claims difficult.[352] Few cases are ever brought, despite the availability of several venues.[353] Those plaintiffs that

338. *Id*.

339. Cortez, *Recalibrating the Legal Risks of Cross-Border Health Care*, *supra* note 104, at 28–29 (offering examples of how the system makes malpractice cases inherently difficult for plaintiffs).

340. *Id*. at 29.

341. *Id*. at 29–30.

342. *Id*. at 33. In fact, nearly 95% are likely dismissed. *See* Howze, *supra* note 62, at 1035.

343. Cortez, *Recalibrating the Legal Risks of Cross-Border Health Care*, *supra* note 104, at 31.

344. *Id*. at 33–34.

345. [1957] 1 W.L.R. 582 (Eng.).

346. [1998] A.C. 232 (H.L.).

347. Cortez, *Recalibrating the Legal Risks of Cross-Border Health Care*, *supra* note 104, at 35.

348. *Id*.

349. *Id*.

350. *Id*.

351. *Id*. at 35–36.

352. *Id*. at 46 (noting that just twenty-two of roughly 1,350 malpractice allegations made to the Medical Council of India between 1980 and 2006 went to trial).

353. Cortez, *Recalibrating the Legal Risks of Cross-Border Health Care*, *supra* note 104, at 6 (explaining that few cases are ever brought in civil courts, the Thai Medical Council, the Ministry of Public Health, or the consumer protection agency).

do proceed in Thailand's civil courts face an underdeveloped body of malpractice law.[354] Like in India, patients often cannot access medical records in Thailand.[355] Also, courts communicate solely in Thai and pretrial discovery is not permitted.[356] Similar to India, there is hostility towards malpractice litigation and lawsuits in general in Thailand.[357] Analysis of Thailand's malpractice system will require further research in the future, as the country is currently evaluating several major reforms, including no-fault liability and a patients' compensation fund.[358]

Singapore offers even more obstacles for malpractice plaintiffs. Malpractice lawsuits are exceedingly rare in Singapore due to a cultural aversion to challenging medical experts, modest awards, and the fact that losers must bear the entire litigation cost.[359] Once again, plaintiffs often find it difficult to find experts to testify against doctors.[360] Using British precedent, like India, Singapore courts strictly adhere to the *Bolam* rule.[361] In general, Singaporean courts are very reluctant to overrule the decisions of the medical industry, leaving plaintiffs to face extreme obstacles in obtaining recovery.[362]

Based on the variety of hurdles that Americans will face when suing a provider in his or her home country, it is easy to understand why many consider it a nearly insurmountable burden. Even after navigating a difficult procedural process, the few cases in which damages are awarded result in recovery insufficient by American standards.

In 2006, the U.S. National Practitioner Data Base reported 12,500 U.S. malpractice payouts with a mean payout of $311,965 and a median payout of $175,000.[363] The average recovery came 4.88 years after the date of the incident.[364] These figures represent a robust malpractice system available in the United States, but they also represent the problem inherent in comparing alternative malpractice systems.[365] Any comparison between the American system and a foreign system will result in a determination that foreign compensation is insufficient for injured

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354. *Id*.

355. *Id*.

356. *Id*.

357. *Id*. at 45.

358. *Id*. at 6.

359. Cortez, *Recalibrating the Legal Risks of Cross-Border Health Care*, *supra* note 104, at 57–58.

360. *Id*. at 58.

361. *Id*.

362. *Id*. at 60–61. Cortez writes:

> It would be pure humbug for a judge, in the rarified atmosphere of the courtroom and with the benefit of hindsight, to substitute his opinion for that of the doctor in the consultation room or operating chamber. We often enough tell doctors not to play God; it seems only fair that, similarly, judges and lawyers should not play at being doctors.

Id. (quoting Dr. Khoo James v. Gunapathy d/o Muniandy [2002] 2 S.L.R. 414, 3 (Sing.)).

363. *Id*. at 19.

364. *Id*.

365. Cortez, *Recalibrating the Legal Risks of Cross-Border Health Care*, *supra* note 104, at 21.

patients.[366] Even members of the medical tourism industry directly tell potential patients that if they have any concerns about legal recoveries, then they should not utilize the industry.[367]

For example, the average recovery for malpractice in Thailand was just $2,500.[368] Of additional import is that Thailand does not award pain and suffering damages.[369] Even Singapore, arguably the most economically advanced of the large medical tourism destinations, has a history of modest malpractice awards.[370] There has been newspaper coverage of individual awards topping $1 million in Singapore, but in general the system is not known for large payouts.[371] In fact, media coverage of a malpractice award for $1.4 million was quickly met with a reversal of the verdict by an appeals court.[372]

In India, meager malpractice payouts make national headlines.[373] This includes just $5,433 paid to the family of a patient who died during an appendicitis operation,[374] $2,177 paid out for an eye operation that resulted in death,[375] and $1,742 paid out for a needle left inside a patient after surgery.[376] Like Thailand, India does not award non-economic damages for malpractice. Americans would likely be disheartened by their recovery potential if they knew these statistics.[377]

3. Future of Medical Tourism Legislation

Medical tourism legislation need not address what is an appropriate recovery for an international malpractice suit. Likewise, it need not address the malpractice system of a given country in hopes of reforming it. Legislation should concentrate on creating a full disclosure of the risks to which American medical tourists are exposed. These disclosures must include the risks patients face suing foreign practitioners in American courts, as the average patient likely overlooks this risk.

Depending on the progress of the industry and trends that may emerge, future

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366. *Id*. at 21.

367. *Id*. at 4.

368. *Id*.

369. Sao et al., *supra* note 19, at 496.

370. Cortez, *Recalibrating the Legal Risks of Cross-Border Health Care*, *supra* note 104, at 64–65.

371. *Id*.

372. *Id*. Cortez notes:

> For example, in 2001 *The Straits Times* published an article describing a S$2.25 million medical negligence judgment by the Singapore High Court ([U.S.] 1.4 million). The full-page article describing this "astronomical sum" triggered a "torrent of letters to the newspaper" and "terrified" local physicians. The Court of Appeal swiftly overturned the decision. . . .

Id. at 64 (footnotes omitted) (quotations omitted).

373. *Id*. at 32.

374. *Id.*

375. *Id*.

376. Cortez, *Recalibrating the Legal Risks of Cross-Border Health Care*, *supra* note 104, at 32.

377. *Id*. at 33–34.

legislation may be needed to address contractual concerns including liability waivers, choice of forum clauses, and other contract terms already familiar in American courts.[378] Here, any legislation should force plain language regulations for the industry.[379] Medical tourism legislation focused on providing information to patients would give patients the best chance of making a fully informed decision regarding their health care choices by weighing the costs and benefits of the various options.

V. LEGISLATION SHOULD FOCUS ON FULL DISCLOSURE BY PROVIDERS TO ENABLE INFORMED COST-BENEFIT ANALYSIS BY PATIENTS

The evidence is indisputable that medical tourism is on the rise. Although the exact reasons why are not clear, there are many readily identifiable causes. For example, access to health care, even in developed countries, is not perfect and costs can be prohibitive for domestic cash payers in those same countries. In the United States, private insurance and, in some cases, government insurance plans will look to medical tourism to help offset the cost of health care. Thus, the role of medical tourism in the United States and the role legislation should play in dealing with it should be considered now.

The United States should allow, or even promote, medical tourism. This is in part due to the economics and politics of medical tourism's effect on a destination country's health care system, along with the potential burden on the United States of preventing negative consequences on foreign systems. There is insufficient evidence of a negative impact on a destination country's health care system to warrant not supporting medical tourism. Furthermore, the United States does not have an affirmative duty to consider outside nations when creating its medical tourism policies.

Because medical tourism deserves an affirmative or supportive U.S. policy, legislation should focus on full disclosure of the risks faced by a traveling patient. Namely, these risks involve the quality of care risks and the legal risks involved with medical tourism. By accurately and fully disclosing these risks in a manner easily digestible by a medical tourist, the potential patient can then engage in an informed cost-benefit analysis of the options presented. Like many other risky ventures, legislation should not be aimed at removing options, but rather creating

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378. For an in-depth discussion of some of the various solutions currently proposed to the international malpractice conundrum, see Cortez, *Recalibrating the Legal Risks of Cross-Border Health Care*, *supra* note 104, at 86 (discussing liability waivers); Sao et al., *supra* note 19, at 510–11 (supporting international arbitration systems); Kenneth A. DeVille, *The Jury Is Out: Pre-Dispute Binding Arbitration Agreements for Medical Malpractice Claims Law, Ethics, and Prudence*, 28 J. L. MED. 333, 370–80 (2007) (discussing problems associated with arbitration); Klaus, *supra* note 4, at 237–39 (discussing allowing patients and doctors to contract into and out of liability).

379. This could be something similar to the Bureau of Consumer Protection, with an agency playing a part in regulating the language used in international medical care contracts. *See About the Bureau of Consumer Protection*, FED. TRADE COMMISSION, http://www.ftc.gov/about-ftc/bureaus-offices/bureau-consumer-protection/about-bureau-consumer-protection (last visited Feb. 7, 2014).

full disclosure for informed decisions.

A framework of information, disclosure, and assimilation does not have to be created from scratch. There are many examples of effective implementations already in place. JCI already offers regulatory processes for providers and facilities. With few changes, this could also include a standardized reporting system and information vetting to ensure patients receive accurate data regarding the quality of care available at those facilities. ABMS-I already offers accreditation procedures to allow patients the opportunity to weigh various providers' training and educational backgrounds. Lastly, the incorporation of American insurance companies into the field would provide an important quasi-regulatory system. By actively supporting and recommending these processes to the medical tourism industry, the United States would not only implement legislation, but also see nearly immediate results. Many of these processes, or something very similar, are already in place in the medical tourism industry. This means that following these examples would not create significant burdens to providers, thus increasing the likelihood of their participation.

Looking forward, it is possible that through a more complete economic analysis, medical tourism could be proven to have greater beneficial, or detrimental, effects on destination countries or the United States. As those studies become available, it may become necessary to reassess the normative questions posed earlier. Furthermore, the potential solutions for international malpractice may well become viable alternatives to the American system that many claim is in need of reform.

Perhaps most important, and as of yet undefined, is the role medical tourism can play in the evolution of the American health care system domestically. To avoid losing business to offshore sources, American health care providers will be forced to participate in a globally competitive economy, lowering costs and increasing access domestically. Medical tourism may yet prove to be the greatest reformer available for an ailing American health care system. Ironically then, the greatest role medical tourism may yet play, that of reformer, could also be the one that leads to the demise of its necessity in America.