

The Price of Medical Tourism: The Legal Implications of Surgery Abroad

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Summary: Medical tourism, or traveling abroad to obtain medical services, has evolved into a global health care phenomenon, with over 15 million U.S. patients each year seeking medical care internationally, representing a \$50 billion dollar industry in 2017. Speculation and media fascination about the growing industry, diverse destinations, and rationale behind the medical tourists is rampant; however, the legal implications of tourism medicine, particularly when it goes wrong, are often unclear. On the international stage, accreditation agencies are limited in scope and practice, legal jurisdiction is difficult to establish, and the enforcement of rulings is nearly impossible. Patients seeking tourism medicine have little legal recourse and shoulder all the legal burden. (*Plast. Reconstr. Surg.* 142: 1075, 2018.)

Medical tourism, or traveling abroad to obtain medical services, has evolved into a global health care phenomenon, but what occurs if the operation that costs you 4 percent of the American price results in 100 percent of the potential complications, or even death? In the July of 2017 issue of *Plastic and Reconstructive Surgery*, Adabi et al. focus on the population health implications of medical tourism, citing case reports, the financial impact, and the burden tourism medicine places on society.¹ This article aims to expand on the population health research conducted by Adabi et al. and to further discuss the legal implications of medical tourism and the patient's potential rights (Fig. 1).²

Historically, patients from underprivileged areas with little access to advanced medical care would travel to modern urban areas where there existed more sophisticated technology and more temperate climates. In the current model, a reverse flow is the trend, in which patients from highly developed countries travel to less developed ones.^{2,3} Patients are seeking cost saving alternatives to elective or experimental procedures that are not available in their home country.⁴ Recent immigrants with strong ties to their home countries are also being added to the medical tourism

ranks.⁵ Often, there is a mirage of safety in which the appeal of cultural comfort clouds appropriate skepticism on standard of care. In the next 25 years, more than half of the U.S. workforce will be second- or third-generation immigrant Americans who may be more comfortable with the family and medicinal culture abroad (Fig. 2).²

FINANCIAL DRIVERS

The number one driving force for many and varied groups of stakeholders is the cost. The cost differential can be staggering, particularly for complex procedures. Procedures that in the United States are already cost sensitive and market-driven, such as cosmetic surgery, can be obtained for 40 to 50 percent less in developing countries. Services in the United States that are supply driven, such as joint surgery, have even more disproportionate cost. A heart valve replacement in India is 6 percent of the U.S. cost, and a knee replacement in Thailand is 20 percent of what one would pay in the U.S. market.^{6,7} Lower charges in foreign markets are influenced by differences in manpower costs and charges for consumables and implantables (Table 1).⁷

The never-ending drive to rein in health care cost is responsible for changing the dynamic of the medical tourism industry. Initially, supported by a fringe population, the volume increase has created a mainstream cost-driven industry sector; however, patients are not the only ones who have a vested

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Cost Estimation for Spending by Outbound US Medical Tourists (billions \$USD)

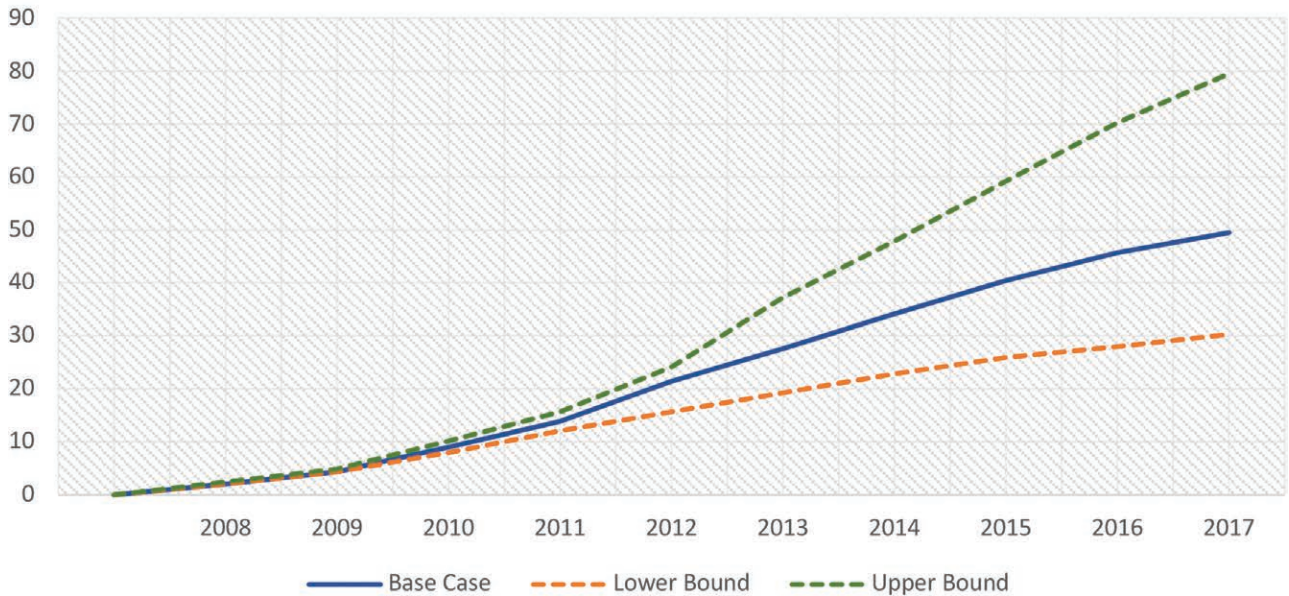


Fig. 1. Cost estimation for spending by outbound U.S. medical tourists. U.S. dollars spent on outbound medical tourism is following a positive trend, with an estimated growth of \$30 billion from 2012 to 2017 alone. Conservative lower bound estimates suggest a leveling off of the industry growth, whereas upper bound estimates suggest continued exponential growth.

Outbound Patient Flow, 10-Year Projection (millions)

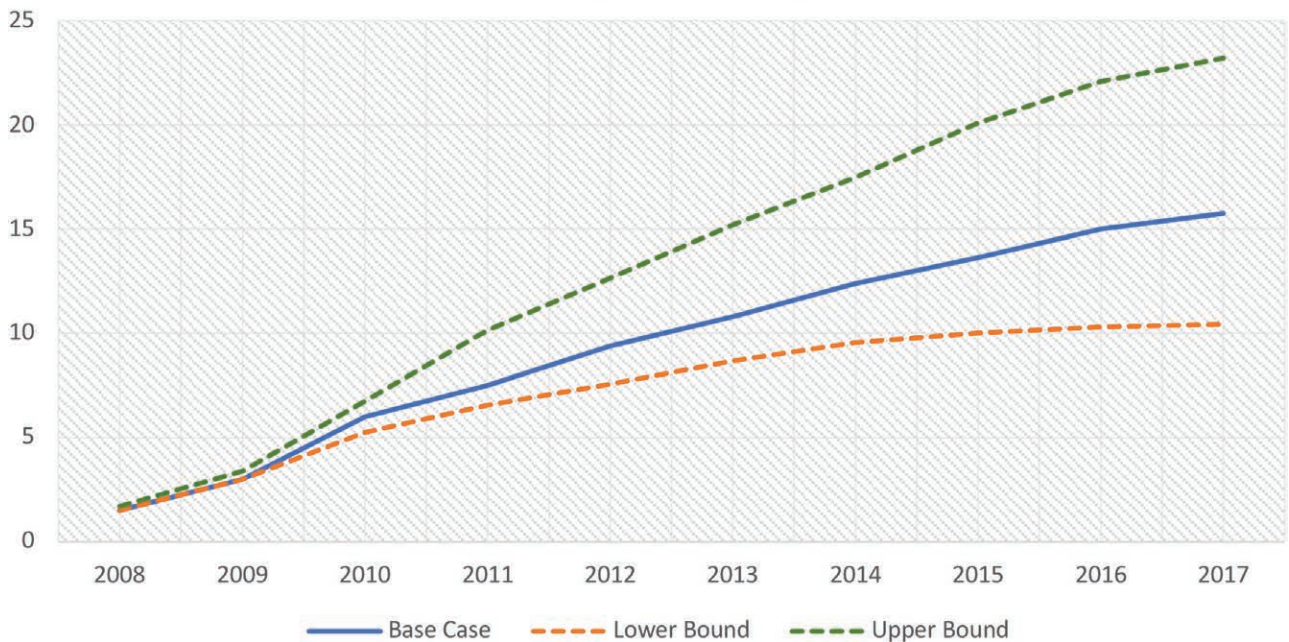


Fig. 2. Ten-year projection (in millions) of outbound patient flow. The number of Americans seeking medical services internationally is projected to continue rising.

Table 1. Medical Tourism Prices in Selected Countries as Advertised by MedicalTourism.com*

Medical Procedure	United States	Colombia	India	Jordan	Republic of Korea	Mexico	Thailand	Poland	Singapore	Turkey
Heart bypass	\$123,000	\$14,800	\$7900	\$14,400	\$26,000	\$27,000	\$15,000	\$14,000	\$17,200	\$13,900
Angioplasty	\$28,200	\$7100	\$5700	\$5000	\$17,700	\$10,400	\$4200	\$5300	\$13,400	\$4800
Heart valve replacement	\$170,000	\$10,450	\$9500	\$14,400	\$39,900	\$28,200	\$17,200	\$19,000	\$16,900	\$17,200
Hip replacement	\$40,364	\$8400	\$7200	\$8000	\$21,000	\$13,500	\$17,000	\$5500	\$13,900	\$13,900
Breast implants	\$6400	\$2500	\$3000	\$4000	\$3800	\$3800	\$3500	\$3900	\$8400	\$4500
Rhinoplasty	\$6500	\$4500	\$2400	\$2900	\$3980	\$3800	\$3300	\$2500	\$2200	\$3100
Face lift	\$11,000	\$4000	\$3500	\$3950	\$6000	\$4900	\$3950	\$4000	\$440	\$6700
Liposuction	\$5500	\$2500	\$2800	\$1400	\$2900	\$3000	\$2500	\$1800	\$2900	\$3000
Tummy tuck	\$8000	\$3500	\$3500	\$4200	\$5000	\$4500	\$5300	\$3550	\$4650	\$4000

*The prices advertised on MedicalTourism.com, a popular website for comparing international health care and surgical services for individuals seeking medical care abroad. The comparison tool suggests average costs in varying countries and does not guarantee the price listed.

interest in tourism medicine. Some destinations are procedure specific, such as gender reassignment in Thailand, whereas others are vacation destinations, known as “privacy in paradise.”

Within the past decade, there has been an emergence of medical travel agencies and associations that assist in advising medical tourists in arranging overseas procedures. Seeking medical care abroad is daunting and requires a guidance that can be provided by these agencies. In 2007, the Medical Travel Association was established as a not-for-profit facilitator for health care providers, government, insurance companies, and buyers of health care. Some reputable U.S. institutions, such as Johns Hopkins and the Cleveland Clinic, have become involved in the industry as credentialing bodies.

Medical tourism websites and informational literature make it clear that it is unrealistic for patients to expect financial recourse or protection should surgery go wrong. These patient-recruiting companies express that they are not agents of the tourism health providers, a critical legal definition, with waivers to protect them from lawsuits.

ACCREDITING AGENCIES

Domestic and international accrediting agencies have expanded their influence in an attempt to raise the standard of care in an unregulated market. The United States’ main private hospital accrediting agency, The Joint Commission, opened an international accrediting office in 1994 as tourism medicine expanded. The Joint Commission now routinely accredits hospitals overseas using the same standards as the United States. The Joint Commission International has increased the number of approved foreign sites from 76 in 2005 to 985 in 2017, specifically focusing in places such as Malaysia, Dubai, Mumbai, and China.⁸ Conceivably, Medicare could become the single largest purchaser of tourism medicine,

and, as the primary underwriter of U.S. health care, export a further portion of our Gross Domestic Product.⁸

Although medical tourism continues to expand, the American Society of Plastic Surgeons and International Society of Aesthetic Plastic Surgeons have launched their own Web pages to influence and educate potential travelers.⁹ The American Society of Plastic Surgeons has a patient safety Web page, complete with questions and answers and checklists for potential consumers: “Dangers of Plastic Surgery Tourism: Cosmetic Surgery is Real Surgery. Do it Right the First Time. Find an ASPS Member Surgeon You Can Trust.”¹⁰

A major differential in the cost of providing care is the premium for U.S. malpractice coverage. The corresponding Thailand coverage is 4 percent of the U.S. cost.¹¹ The estimate is that 2.4 percent of U.S. health care costs are related to defensive medicine.¹² In India, on top of court delays in time measured in decades rather than years, a malpractice case would fall under the Fatal Accident in Section 357 of the code of criminal procedure. Of these cases, 95 percent are dismissed in a culture that is less likely to question professionalism in the medical practice.¹¹

REGULATORY OVERSIGHT AND JURISDICTION

Federal oversight is virtually nonexistent for an industry expected to be potentially worth \$30 billion in 2017. In 2006, a U.S. Senate committee held hearings on tourism medicine but took a “wait-and-see” approach.¹³ The hearing was not associated with any bills and did not generate any legislative action. Health care in the United States is the most regulated industry, whereas medical tourism and outsourcing appear to operate outside our traditional regulatory matrix.¹⁴ An article in the *Journal of Legal Medicine* further confirms that the legal foundations of tourism medicine

are turbulent and fluid. There is no concrete body or governing institution to report to when things go wrong.¹³

There are an enormous ethical and legal issues in medical tourism. The primary stakeholder is the patient who is accustomed to U.S. courtesies and privileges, such as the ability to return items to a store or sue your physician. With whom and where can medical tourism patients get their day in court? In the present environment, for a medical plaintiff to sue a foreign defendant, there are enormous hurdles. The plaintiff would have to know whom to sue—the doctor, hospital, or referral company. The plaintiff must not have waived the right to sue and be treated in the country in which medical malpractice is considered. This easily can be done with paperwork in another language. Failing this, a suit could be filed in the United States, where the likelihood of success is only marginally greater against a tourism firm than against an individual defendant. If the case is successful, the ability to receive financial damages is questionable and dependent on treaty agreements, comparative laws, and acceptance of judgment in host countries. On an individual basis, it is almost impossible to seek records or damages for medical tourism by medicolegal means as would be customary in the United States.

A recent court case highlights the difficulty of malpractice tort and medicine tourism. In 2011, Philip Gatte traveled to Cancun, Mexico, for weight loss and body sculpting surgery and unfortunately developed complications from the procedure and died. His surviving relatives brought suit against the medical tourism company R4C and its co-owner along with the physicians and the Clinica Victoria Hospital where the operation took place. In the case, the appellate court could not affirm that the personal jurisdiction was established between R4C and the hospital or physicians in Mexico. The legal reasoning stated that because R4C did not have an agency relationship with Clinica Victoria, no personal jurisdiction transferred. In contrast, the action against R4C and co-owner was remanded to the district courts for another trial.¹⁵

The medical tourist patient has little legal recourse and in some venues specifically loses the right to sue. In markets such as Thailand, the right to sue must be expressly surrendered to participate in the country's international health care market.¹¹ Foreign physicians typically cannot be sued in U.S. courts unless they have strong ties to the United States. Even then, most countries will not accept U.S. judgment or support collection efforts. The U.S. judicial system as a potential

for medical tourism suits is best against the agencies or intermediaries such as travel or referral companies or those with hospital affiliations, such as Johns Hopkins, who predominately conduct business in the United States. However, carefully worded waivers may isolate these entities from responsibility.¹¹

Perhaps India's largest medical tourism hospital, Apollo, sums up the best legal warning for those concerned about protection from harm. It states on their website that "a prospective medical tourist should always be aware of possible legal issues. There is presently no international legal regulation of medical tourism. All medical procedures have an element of risk. The issue of legal recourse for unsatisfactory treatment across international boundaries is a legally undefined issue at present."¹⁶

If foreign physicians transact business within the foreign state, a plaintiff may have possible recourse, as there is a legally required minimum contact established. General jurisdiction exists when a defendant's contacts with the foreign states are unrelated to the plaintiff but are continuous and systematic. These foreign physicians would have to transact or solicit business in the state. An example of this legal definition would be an active referral recruitment and/or trunk show consultation visit to the United States.

In the rare case where jurisdiction has been established, the ability to try this suit is challenged by forum non conveniens, the discretionary power that allows courts to dismiss a case where another court, or forum, is much better suited to hear the case.¹⁷ Forum non conveniens has led to dismissal of multiple cases such as *Jeha v Arabian American Oil Co.*, in which a U.S. oil company providing employee medical care had a malpractice case transferred to the Saudi courts.¹⁷

ENFORCEMENT OF RULING

Even after the hurdle of getting U.S. jurisdiction, having a judgment enforced is even more difficult. The barriers to enforcement include the following:

1. Treaties with the countries in question.
 - a. For example, Saudi Arabia will refuse to enforce a foreign judgment without reciprocal agreement.
2. Jurisprudence rules:
 - a. For example, South Africa will not recognize a U.S. judgment unless it is exercised using South African legal rules.

- b. African countries will only consider final judgment on those that are not rescindable; thus, any chance of appeal has to be exhausted.
 - c. Mexico will not recognize a U.S. judgment unless it is exercised using Mexican legal rules and does not recognize the concept of *forum non conveniens*.
3. Religious reasons: Middle Eastern countries, including the United Arab Emirates and Saudi Arabia, prohibit or limit foreign financial judgment based on religion.

The medical tourism industry is unregulated and has minimal elective industry oversight. In emerging market countries, there is considerable incentive with infrastructure and tax breaks to promote tourism hospitals. In others, such as United Arab Emirates, there is a drive for business diversification into medicine. There is no U.S. legislative oversight and little potential for controlling other countries' practices. The American Medical Association advice that patients should independently arrange legal declaration before treatment is, at best, naive.¹⁸

ETHICAL CONSIDERATIONS

In this unregulated industry, there is significant risk of exploitation by unscrupulous and underqualified individuals and organizations. The most vulnerable here are those desperate for a medical cure of a terminal illness when none exists.

A high-profile example occurred when U.S. actor Steve McQueen traveled to Mexico for an unorthodox treatment from an unlicensed orthodontist that included laetrile, an unproven and potentially fatal drug. He was hoping for a last-ditch effort that would cure his mesothelioma. He died of cardiac arrest in a Mexican hospital after surgery to remove a large tumor that U.S. doctors advised him was inoperable because his heart was too weak to survive the surgery. Similar instances have been reported in the media for surgical therapy using stem cell injections and new cures for cancer that are patently false.

Standard-of-care issues also raise more ethical concerns. For example, who follows the patient after surgery? Surgery is inherently dangerous. Although most procedures go as planned, there are well-known complications that occur at established rates after every procedure. Without a reputable standardized plan to follow patients after their tourism experience, the medical care cannot

be considered complete. This circle of care has previously been addressed by Iorio et al. as a problem with microtourism within the U.S. mainland, not only out-of-country care.⁵ Should insurance companies foot the bill for treating complications for procedures they did not cover at the outset? What is the social and economic burden of caring for that person? What about the rights and protections for the domestic physician? Overall, the current ethics of the U.S. medical culture expects the physician to put aside financial implications and to treat damaged patients.

Plastic surgery has established a code of ethics and caring for patients, including guidelines from the American Board of Plastic Surgery and the American Society of Plastic Surgeons. After careful review, there is an ethical duty to help patients who have complications, but there is no obligation to take responsibility for results or revisions. However, patients may return to the local physician they consulted with before selecting tourism medicine, creating resentment and tension. For plastic or cosmetic surgery patients, the cost for complications can be considered for insurance coverage, yet revisions are still considered a patient responsibility.⁵

THE FUTURE OF TOURISM MEDICINE

Medical tourism will expand in the future, both nationally as microtourism and internationally as macrotourism, for elective (e.g., cosmetic surgery, joint replacement surgery) and semielective (e.g., cancer care, heart surgery) procedures as the health care industry continues to find new methods to contain costs. Insurance providers trying to control costs will be the primary drivers of increasing tourism facilities that provide procedures covered in their benefits plan. Destinations for medical tourism will continue to be created to attract and entice patients. There will be a potential influx of new medical tourists from the aging U.S. population, many of whom will be on fixed incomes with Medicare or Medicaid plans not accepted by local physicians. In addition, high-deductible policyholders will be increasingly attracted to international out-of-pocket rates. Ultimately, the competitive forces will drive reference pricing into the international arena. The practice of consumers choosing the highest quality indexed with a lower cost hospital will control the market, in which the United States will not be a winner.

As medical tourism expands, there will be legal implications for all involved. As the evidence

suggests, the complication rates or postsurgical problems may be no greater than with domestic care, but accommodations are, as patients have limited ability to return to the original surgeons.¹ Arbitration may become a vehicle to serve society by determining negligence in the care of medical tourists. In the future, medical tourism companies and hospitals in other countries may sign arbitration agreements as a potential remedy for malpractice outside the United States. Furthermore, legislative action in response to the public health burden is not beyond reason. The U.S. government reserves the right to restrict travel in the interest of public health, a right that may be exploited as tourism medicine continues to burden the American system postoperatively.¹³

CONCLUSIONS

Tourism medicine will undoubtedly grow with increasing interest in decreasing U.S. health care costs. It is, however, not as regulated an industry, and lacks any of the legal recourse afforded in the domestic U.S. market. Succinctly put, the tourism patient has few rights, should not expect to be covered within U.S. legal jurisdiction, and has little chance of recovery for damages. Tourism medicine patients can reasonably expect ethical continuity of care and coverage on their return, but there is little legal love to be found abroad.

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