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# Medical Tourism: Winners and Losers

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## Citation

P A Clark, A Adegunsoye, K M Capuzzi, D J Gatta. *Medical Tourism: Winners and Losers*. The Internet Journal of Health. 2013 Volume 14 Number 1.

## Abstract

Medical tourism is a vastly growing medical phenomenon in which patients from around the world travel internationally in search of inexpensive and quick, medical procedures. These economically driven treatments can be as different as plastic cosmetic surgery to fertility treatments. The one aspect that they have in common is the poor quality of treatment and care some hospitals and clinics offer to patients. Medical tourism is risky at best with many aspects of the process lacking monitoring or standardization. The surgical procedures are often medically unsafe, illegal and could be considered unethical. Without a doubt, medical tourism is a growing and very critical public health concern. Despite the many risks, however, medical tourism is a thriving industry: 6 million US citizens alone continue to travel globally into the medical tourism phenomenon. India has become the center for medical tourism over the last 5 years. India is specifically known in field for its specialties in cardiovascular, neurology/spine, orthopedic, oncology and weight loss surgeries. Due to the income it has accumulated from the paying tourists, India is not only expanding in medical tourism, but other countries are imitating their medical entrepreneurship, adding to the growing medical tourism business.

Medical Tourism is being promoted as a viable solution to the financial dilemma regarding the costs of medical and surgical procedures that often result in a medical disaster for the patient. The guidelines being proposed in this paper seek to protect the health and life of patients by making sure they are fully informed of the medical and legal risks and benefits of any proposed treatments and procedures they may seek in a foreign country. The only hope is that with appropriate guidelines and standards, medical tourism can be rendered medically, legally and ethically more acceptable and be in the best interest of patients, physicians and society as a whole.

## INTRODUCTION

A citizen of the United States considering cosmetic surgery has generally three concerns. The first and foremost concern, as cosmetic surgery is virtually never covered by insurance, is "how much does it cost?" A cursory search on the Internet reveals that The American Society of Plastic Surgeons has priced all cosmetic procedures, from breast augmentation to liposuction, anywhere from \$1,000 to \$12,000.<sup>1</sup> A second predictable concern will quickly follow: "where is the best place to have the procedure done?" A few more clicks on the Internet will reveal that Miami, Atlanta and Dallas are the top three United States destinations for plastic surgery. Finally, a typical candidate for plastic surgery will combine the first two questions, and pursue the logical next step: "where is the cheapest place to go for cosmetic surgery?" The curious cosmetic surgery candidate may be surprised to learn that they are directed to clinics and hospitals in India, Singapore, Mexico and a plethora of other foreign destinations, which offer comparable cosmetic surgery procedures for 60-80% less than the average price in the United States.<sup>2</sup> Furthermore the list price includes not

only the surgery but also a "package deal" of roundtrip airfare, accommodations and post-op rehabilitation in decorative health centers. However the most popular, plastic surgery is only one of the innumerable surgical procedures found within these foreign countries, as there is literally no procedure that cannot be found at an extremely discounted price. This practice of international or domestic travel to receive cheap medical procedures is termed "medical tourism," and has become a vastly growing business among third world countries. Although superficially appealing, medical tourism has been risky at best, as there is a lack of sophisticated medical and legal monitoring of the act, primarily due to its recent rise among third world countries. Due to this, medical tourism is not globally controlled and is able to practice while keeping a low profile. Therefore, many aspects of medical tourism are medically unsafe, illegal and unethical. If continued to practice as an uncontrolled and financially driven industry, medical tourism is in route to become a critical public health concern. However, as money is the primary compelling factor, medical tourism is and will continue to be a thriving

industry as over 6 million US citizens alone have traveled globally in support of the medical tourism phenomenon.<sup>2</sup> As quality care has been sacrificed for the discounted price, medical tourism has become the true definition of “cheap” healthcare.

The premise of medical tourism is not a new one. Throughout history, persons in desperate search for healing have traveled far for medical procedures. Recently, for example, The Johns Hopkins Medical Center increased its foreign patient count from 600 to 7,200 in just two years.<sup>3</sup> Across the pond, one fifth of the hospital beds in the United Kingdom are host to foreign patients.<sup>3</sup> For thousands of years travelers have made pilgrimages to the Dead Sea to take advantage of the purported healing properties of the sea’s extreme salt content. In the same way, believers have sought healings at religious sights, such as the grotto in Lourdes, France. It can be argued that these past medical endeavors are comparable to modern medical tourism; however, the intent of travel has differed greatly. Instead of traveling to receive quality treatment, modern medical tourists travel seeking discounted treatment, even if quality care is questionable. In other words, while the concept of such tourism is not new, the motivation of the modern phenomenon is based solely on economics.

Although much less prevalent, medical tourism has been observed within the United States. Boston and South Florida, cities both known for their medicine, cater to thousands of Latin American patients annually.<sup>4</sup> However, unlike third world medical tourism, the availability of discounted treatments in the US is limited and often foreigners are constricted to ordinary doctor visits and small procedures.<sup>4</sup> In addition, a unique aspect of American medical tourism is its attraction to its own citizens. Colorado resident John McNally, for example, needed a knee replacement in 2010. Alpha Coast West Coal Company, his employer, in addition to covering his surgery, offered to pay for his round trip travel and even reward John with a bonus if he traveled to Fort Collins, only five hours away. The medical center there was far cheaper than any in McNally’s area and saved the company thousands.<sup>5</sup> This financially driven domestic medical tourism is not uncommon, as employers can save 20 to 40 percent by routing their employees to low-cost facilities to receive healthcare.<sup>5</sup>

For the American citizen, however, the lion’s share of medical tourism is foreign, not domestic. Many of these tourists travel because the cost of US healthcare remains well above the norm.<sup>6</sup> US patients seeking a plethora of

procedures look to medical tourism as a means of saving thousands of dollars.<sup>6</sup> A large percentage of these procedures are cosmetic surgeries or non-emergency operations, but delicate and sometimes hazardous evasive surgeries are also sought. These include several types of fertility treatments, hip replacements, organ transplants, weight loss procedures, spine therapy and numerous others.<sup>2</sup> With the help of the Internet, potential medical tourists can find any procedure they seek for savings of 60 to 80 percent, depending on the destination.<sup>7</sup> For example, consider MedRetreat, an American medical tourism service company. Managing director Patrick Marsek estimates a full cosmetic face and neck-lift procedure would cost domestically an average of \$12,000, but only \$3,800 abroad.<sup>6</sup> He also notes that the cost of a hip replacement surgery, ranging between \$40,000 and \$65,000 in the US, is considerably cheaper at \$8,000 and \$18,000 overseas. This price includes not only the procedure, but also round trip airfare and hotel stay.<sup>7</sup> These alarming price disparities have enticed US surgery patients to venture as far as India, Panama, Brazil, Malaysia and Costa Rica. As these and other medical tourist destinations continue to develop the trade, medical tourism will continue to rise.

Since 2005, India has promoted itself as the medical “tourism centre.”<sup>8</sup> India is known in the medical tourism field for its specialties in cardiovascular, neurology/spine, orthopedic, oncology and weight loss surgeries.<sup>9</sup> There is virtually no treatment that India doesn’t advertise internationally. According to the Confederation of Indian Industry (CII), medical tourism has become one of the world’s largest service sectors with total revenue of around 30 billion dollars. Over 4 million jobs have been created, and an estimated 1.4 billion jobs are projected by 2025.<sup>10</sup> There is no surprise that this sudden economical rise has much to do with the millions of medical tourists.

The Confederation of Indian Industry, an Indian organization that works to form and promote an environment benefiting the growth of industry in India, estimates that medical tourism will reap over 2 billion US dollars in total revenue by the end of 2012.<sup>11</sup> At the outset, one may logically conclude that medical tourism would then be a substantial boom to a stalled Indian economy. It can be safely said, however, that the revenue received is virtually never seen in the local economy. Instead, it is put back into the medical tourism industry, being earmarked for such projects as renovation of hotels, hospitals and airports to better accommodate the medical tourists. However, Indian economy and people remain neglected as the emphasis is put

on the paying foreign customers and their comfort. The medical tourist revenue is unregulated and, in the end, the healthcare for Indian citizens suffers all the more.<sup>12</sup>

While the participation in medical tourism in India is rapidly on the rise, the safety of the procedures generally remains unregulated.<sup>6</sup> The Joint Commission International (JCI), a global organization dedicated to improving the safety of patient care by examining and accrediting hospitals and clinics worldwide, accredited only 76 hospitals in India in 2005.<sup>11</sup> Although this number has risen to 220 in 2008, potential patients are being duped by the false and superficial advertising of the foreign medical institutions.<sup>11</sup> Prospective patients are not fully aware that with cheap treatment comes high risks. For example, the incidence of post-treatment infections and complications from procedures performed in foreign countries has risen at an alarming rate. A study conducted by the European Union shows that in the United Kingdom there has been a rise in hospital infections of patients who have recently returned from a hospital in India and Pakistan.<sup>13</sup> The study also showed that the NDM-*enterobacteria*, an infection linked primarily to hospitals in India, have shown up in the US, Canada, Netherlands and Australia.<sup>13</sup> Such infections have costly side-effects that require specialized and expensive medications. As medical tourism continues to become more popular and mainstream, patients gamble with these potential risks.

Despite the risks, businesses and healthcare companies are now aware of the inexpensive opportunities of medical treatment in India, and are establishing initiatives to encourage candidates to consider medical tourism as an option. For example, in 2006, Blue Ridge Paper Products of North Carolina paid their employees' airfare, sick-time leave and an additional \$10,000 bonus to have any non-emergency surgery performed in New Delhi, India.<sup>14</sup> Blue Ridge Paper is just one of the many companies encouraging their employees to choose a cheaper health care route abroad.<sup>15</sup>

Another serious concern is the effect medical tourism has on the already poor health care on the populace of India. The Indian population struggles with malnutrition, the mass spread of diseases, poor sanitation and inadequate drinking water.<sup>16</sup> India's infant mortality rate is staggering: a quarter of the global deaths of children under one year of age occur in India.<sup>8</sup> Indian citizens are put at higher risk due to the rise of medical tourism. They cannot afford even the discounted price the medical tourists pay at the Indian private hospitals, and must seek medical help at the unsanitary and struggling public hospitals. Dr. Reecha Sharma, a former Indian

physician, worked in both Indian private and public hospitals. In her experience, she noticed that as the private hospitals continued to modernize and flourish, the public hospitals remained crowded, understaffed, under stocked and unsanitary. Due to the higher pay and work environment physicians would preferably work in the private hospitals, even though the public hospitals are in greater need of staff.<sup>51</sup> As medical tourism grows and more private hospitals become accredited to treat tourists, poor Indian citizens will continue to struggle to receive ordinary treatment. In a country where a quarter of the population is living below the poverty line, and 300 million citizens live on less than \$1 a day, it is unethical that there is little wealth distribution from the revenues realized from medical tourism to the general population.<sup>8</sup>

If the revenue realized from medical tourism is not put back into the country, where does it all go? With regard to whether medical tourism is helping or hurting their local healthcare, Dr. Nilima Kshirsager, Dean of Mumbai's local hospital, states, "The government has not examined how our [Indian] patients will benefit or whether they will lose out. The need to benefit Indian patients is the main goal, and medical tourism cannot be at their cost."<sup>12</sup>

Dr Manuel Dayrit, director of the World Health Organizations Human Resources for Health Department contends:

Although there are no ready figures that can be cited from studies, initial observations suggest that medical tourism dampens external migration but worsens internal migration... Unless national laws or regulations are set up so that these revenues are taxed explicitly and channeled to the public sector to augment salaries, the likelihood of [medical tourism revenue will find their way into public coffers] is very slim.<sup>12</sup>

Finally, there is speculation about medical tourism in India and the untold impact it may have on society as a whole: medical tourism is medically unsafe, at times illegal and it could be considered unethical. India maintains the dubious distinction as the undisputed model of this phenomenon. It goes without saying that the financial triumph of India's medical tourism industry does not go unnoticed. Few would dispute that medical tourism is here to stay. And, as medical tourism thrives in India, it will continue to grow and develop globally.

Medical tourism is an understudied practice. The biggest problem is that there has been little research on medical tourism to expose its problems and enhance its potentials.

There exist no distinct laws or guidelines to regulate medical tourism, and therefore there is no known precedent on how it should be handled.

People of discretionary income will, as a matter of course, make their own choices, and assuredly many will continue to see themselves as candidates for medical tourism. In this case, medical tourism needs to be monitored, regulated and standardized. In order for this to happen, firm guidelines need to be established to primarily ensure patient safety.

The purpose of this article, therefore, is four-fold: first, to examine the medical data regarding medical tourism; second, to examine the legal implications nationally and internationally regarding medical tourism; third, to give an ethical analysis of the arguments for and against medical tourism; and fourth, to propose international guidelines regarding medical tourism.

### **MEDICAL PERSPECTIVE**

Over 50 million people in the United States currently live without health insurance.<sup>17</sup> This number which has been on the rise in the last decade underscores the fact that access to health care is a growing problem affecting both uninsured and insured individuals as premiums for health insurance sustain an upward trend forcing millions of Americans to acquire low-budget plans which cover limited healthcare services.<sup>18</sup>

The recent economic crisis, concomitant rise in unemployment rates and eventual loss of health insurance benefits provided by employers makes timely access to healthcare even more difficult for affected individuals. Thus outsourcing health care to other countries with more affordable costs for surgical procedures and other treatment alternatives might seem increasingly alluring to individuals requiring medical care; especially as state legislators and larger corporations show interest in this low-cost option.<sup>19-20</sup> After all, elite healthcare facilities have historically attracted wealthy international patients to developed nations for optimal delivery of comprehensive medical services.<sup>21-23</sup> This multibillion dollar industry of medical tourism is anticipated to keep growing over the next 10 years and increasing numbers of private companies with medical concierge services help identify foreign medical facilities where medical tourists can pay for healthcare services out-of-pocket or in alliance with employer-based insurance plans.<sup>24</sup>

The American Medical Association (AMA) recently issued new standardized guidelines for medical tourism to protect

patients travelling overseas for healthcare services and requiring follow-up services upon their return home. These guidelines were instituted to ensure that patients make their decisions based on the availability of all the required information pertaining to their acquiring healthcare overseas and thus ensure they are protected when they go. The longstanding policy of the AMA hinges on patients making the ultimate choice for their treatments and physicians; thus these guidelines emphasize the voluntary nature of the patient's decision to seek diagnostic and therapeutic options without being limited by financial incentives especially since insufficient data is currently available to conclude that risks of medical tourism outweigh the benefits.<sup>25</sup>

As individuals and governments attempt to reduce health care costs by medical tourism therefore patient protective mechanisms should be implemented within the health setting to mitigate the possible risks that accompany this new trend of healthcare globalization. Several regulatory mechanisms which protect patients exist within the United States including licensure and certification, professional accreditation of physicians and other providers of healthcare services, malpractice logs, bylaws for medical staff and regulation of hospital privileges and conflicts of interest. These are notably absent or improperly implemented in several foreign countries raising concern for suboptimal quality of care and its associated risks to the patient.<sup>26</sup>

Thus, in a bid to ensure that patients are not put at risk unduly, the AMA advocates that individuals, employers or insurance companies that facilitate medical tourism only refer patients for care at institutions accredited by recognized international accrediting bodies such as the Joint Commission International. Patients travelling overseas need to have access to physician licensing at the destination institution and outcomes data for surgical and other therapeutic alternatives at that facility. The patient's rights and available legal options should be clearly communicated to them prior to their decision to travel. Before travelling, the guidelines recommend coordination of local follow-up care and adequate financial arrangements for continuity of care upon their return as this is integral to the ultimate well-being of the patient. When travel outside the U.S. is necessary for health care purposes, insurance companies and employers which incentivize such care must include the cost of this necessary follow up care as stated in the current guidelines, and the transfer of their medical records back and forth across health facilities must comply with the Health Insurance Portability and Accountability Act.<sup>27</sup>

In 2012, the Centers for Disease Control (CDC) estimates that 750,000 US residents travel abroad for healthcare annually - a large proportion doing so for the cheaper cost of cosmetic, cardiac, dental or surgical care. Specific risks identified included communication gaps at the receiving facility which increases the possibility of misunderstandings about the care being delivered, chances of needles being reused leading to transmission of HIV and hepatitis, counterfeit medications, antibiotic resistance, unscreened blood and risks of blood clots when flying after surgery. Vacation activities are often included as part of an attractive medical tourism package for patients seeking healthcare overseas and the AMA recommends that patients must be informed of the resultant medical risks when surgical procedures are combined with long flights and these vacation activities.<sup>28</sup>

In addition to the AMA guidelines, the CDC recommends adequate planning in conjunction with a travel medicine practitioner at least a month in advance of travel to discuss issues pertaining to the procedure being considered as well as attendant risks and general information for healthy travel. A written agreement with the healthcare facility arranging the trip should be obtained and this should define the scope of treatment and covered costs of care pertaining to the trip. Individuals should determine how they plan to communicate with their doctors and other caregivers in the destination country, and preferably obtain copies of their medical records and prescriptions of all their medicines prior to travel, as well as from the destination facility before returning home. Vacation activities like swimming, sunbathing, taking long tours and drinking alcohol should not be undertaken except they have been clarified as being permitted after surgery.<sup>28</sup>

To facilitate compliance with the AMA guidelines, current efforts are underway to develop model legislation which can be used by state lawmakers in governing the process of medical tourism. If issues of cost in healthcare delivery and the rising numbers of uninsured individuals are appropriately addressed, the inclination of patients to search for quality healthcare delivery at affordable costs would be significantly reduced and so would the risks associated with this rigorous and complex process.

### **LEGAL PERSPECTIVE**

As evidenced by the overwhelming number of medical malpractice suits filed in the United States each year, it is beyond debate that health care procedures can and do go

wrong. Importantly, federal and state health care laws have developed over the years to not only provide accountability and compensation for medical errors, but to dismiss frivolous lawsuits at an early stage. While medical tourism may present an inexpensive solution to what could otherwise be a costly procedure, assuming everything goes as planned, it may be worth the risk. However, if something does not go as planned, unlike a domestic patient, a medical tourist will most likely be unable to avail oneself of American courts and the protections afforded by the various health care laws. Thus, before electing to participate in medical tourism, it is important that a prospective patient be fully apprised of the legal risk.

Medical tourism raises two of the most basic legal issues: jurisdiction and liability. These are issues covered in every civil procedure class conducted in the first year of every law school as they are core issues to be analyzed before commencing a lawsuit. Put simply, jurisdiction concerns a court's ability to exercise control over a person or entity. Then, assuming a court has jurisdiction, liability means that there is legally-cognizable cause of action that may be imposed to hold such person or entity accountable for some misdeed. Absent either jurisdiction or liability, a lawsuit will be dismissed at the earliest practicable stage.

For the purposes of this legal analysis, assume that a woman living in Philadelphia, Pennsylvania, who was unable to afford breast augmentation in the United States, travelled to India to participate in the surgery at a fraction of the cost. Unfortunately, the surgeon in India did not properly sterilize his medical instruments and she developed a severe infection. Shortly after returning home, the woman died. Now her husband, saddened by the loss of his wife, seeks to sue the surgeon in a Pennsylvania court. Assume further, three different scenarios that are important to understanding jurisdiction and liability. In the first scenario, the woman travelled to India without knowing the name of a surgeon and located one only after she arrived in India. In the second scenario, the woman travelled to India after seeing an advertisement in the Philadelphia Inquirer by a surgeon in India offering inexpensive breast augmentation. In the third scenario, the woman travelled to India specifically for the breast augmentation surgery through a trip arranged by a United States-based "match maker" service.

Depending on which of the three scenarios took place, the Pennsylvania court may dismiss the lawsuit for lack of jurisdiction. Before discussing the various scenarios, it is important to understand the concept of jurisdiction. As

stated above, in its simplest terms, jurisdiction concerns a court's ability to exercise control over a person or entity, here the Indian surgeon. There are two categories of jurisdiction: subject matter jurisdiction and personal jurisdiction. Subject matter jurisdiction means the court can hear the type of case. Generally, this is only an issue when parties are arguing over whether federal court or state court is the proper forum. The more commonly disputed category of jurisdiction, however, is personal jurisdiction. Personal jurisdiction means not only can the court hear the type of case, but it has power over the person or entity being sued. Personal jurisdiction is the issue most commonly raised by medical tourism, as explained below.

The concept of personal jurisdiction is integrally related to the well-known concept of due process. Due process, which is the foundation of American law, entitles one to defend oneself before liability or judgment is imposed. Thus, as an extreme example, a court in Alaska would not have personal jurisdiction over a Pennsylvania-licensed doctor who is alleged to have committed medical malpractice on a Pennsylvania resident during a surgery taking place in Philadelphia. This is a violation of due process, as the Pennsylvania doctor should not be forced to travel to the other side of the country to defend himself against such serious accusations. Without personal jurisdictional requirements, however, plaintiffs may attempt to initiate lawsuits in remote places in hopes of obtaining a judgment before the defendant can appear or coercing the defendant into settling the matter before he or she must incur the expense of traveling to the unrelated state where the lawsuit was filed and retaining a lawyer who understands that state's laws.

While a Pennsylvania court would clearly have personal jurisdiction over a Pennsylvania-licensed doctor who is alleged to have committed medical malpractice on a Pennsylvania resident during a surgery taking place in Philadelphia, today's society is global. In fact, people come to Philadelphia from all over the country and different parts of the world to take advantage of its several world-renown health care institutions. Thus, it is not accurate to say that a court has jurisdiction only over the residents of a particular state or only over an event occurring in a particular state. Thus, states have enacted statutes commonly referred to as "long-arm statutes" which, as the name implies, allows a state to extend its jurisdictional "reach," if certain conditions are met, to impose liability over someone that would not otherwise be subject to its personal jurisdiction.

In Pennsylvania, its long-arm statute (section 5322 of the Judicial Code, 42 Pa.C.S. § 5322) is satisfied, among other ways, if a defendant carries on a "continuous and systematic part of its business under the laws of the Commonwealth [of Pennsylvania]." *Comm. ex rel. Pappert v. TAP Pharma. Prods., Inc.*, 868 A.2d 624, 628 (Pa. Comm. Ct. 2005). The intent of this statute is manifest in that it seeks to prevent persons or businesses which market or sell their products or services to Pennsylvania residents, from hiding behind the artificial border of another state if they are sued on account of such products or services.

Applying personal jurisdiction to the three factual scenarios, it should be evident that in the first scenario a Pennsylvania court would not exercise personal jurisdiction over the Indian surgeon. In that scenario, the woman unilaterally chose to travel to India without any provocation by the surgeon. As such, he had no contacts with the Commonwealth of Pennsylvania which would satisfy the long-arm statute and to hail him to a foreign country to stand trial would certainly offend due process. In the second scenario, however, Pennsylvania's long-arm statute would be satisfied by the Indian surgeon's advertisements in the Philadelphia Inquirer. Since the surgeon purposefully marketed his services in Pennsylvania and to Pennsylvania residents, he would most likely be found to have made "continuous and systematic" contact with the Commonwealth of Pennsylvania such that it would not be a violation of due process to force the surgeon to defend himself in a suit commenced by the husband in Pennsylvania. Likewise, in the third scenario, a United States-based match maker service which targeted Pennsylvania residents to participate in medical tourism in India and arrange such trips would satisfy the long-arm statute. However, in both the second and third scenarios, although personal jurisdiction may exist, it does not necessarily follow that liability may be imposed.

As if the difficulty and uncertainty associated with suing a negligent foreign doctor were not enough to deter the concept of medical tourism, there is the related issue of being able to impose liability on any such doctor over whom a court may find that it has personal jurisdiction. The issue of liability is tricky enough when the doctor is within the United States, let alone in a foreign country. For example, while it is often possible to impose individual liability on the actual doctor, plaintiffs often also sue a hospital or managed care organized with whom the doctor is affiliated for a myriad of reasons, but primarily as an additional source of

insurance. Most doctors, however, are not employees of hospitals, but are independent contractors, and hospitals seek to escape liability on that basis. Nonetheless, a plaintiff may be able to impose liability on the hospital under an “apparent agency” theory if the plaintiff reasonably believed that the doctor was an actual agent of the hospital. A classic example is when a plaintiff sues a hospital related to emergency room care since the plaintiff cannot choose the emergency room doctor. Thus, it is reasonable to assume that the emergency room doctor is an agent of the hospital.

In the context of medical tourism, the issues related to imposing liability are even more complex because foreign doctors are not subject to American health care law. For instance, the husband could not sue the Indian surgeon for negligence in Pennsylvania as Pennsylvania law does not apply in India. Thus, in scenario two, where the Indian surgeon placed his own advertisements in the Philadelphia Inquirer and was not affiliated with any hospital or match maker service, it is highly unlikely that there would be any legally-cognizable cause of action to assert against the surgeon.

The final hope for the husband to vindicate his wife’s unnecessary death would therefore be found in the third scenario – the United States-based match maker service. The husband’s most likely chance at success would be to argue an apparent agency theory of liability. Specifically, if the match-maker service selected the surgeon in India for the wife’s breast augmentation procedure, it would be reasonable for the wife to believe that the surgeon was the match maker’s agent. This is not to suggest, however, that the husband’s case is a grand slam. For instance, the match-maker service may have required the wife to sign an agreement waiving any liability of the match maker or specifically disclaiming any affiliation with the surgeon in India. That agreement, if enforceable (which is a separate question of law and fact), would negate liability.

While the foregoing presents a colorful analysis of personal jurisdiction and liability issues in the context of medical tourism, it is vitally important that the very real possibility of being left without legal recourse to rectify or remedy any medical malpractice caused by a foreign doctor be fully understood before choosing to participate in medical tourism. As set forth at the beginning of this section, both federal and state-based health care law is very well established in the United States. Unfortunately, by choosing a quick and cheap solution to one’s health care needs, the

ability to rely on American courts and its body of case law may be seriously jeopardized.

## ETHICAL PERSPECTIVE

### Ethical Analysis

“Medical tourism,” is an economic activity or industry that involves individuals traveling to other countries to seek medical services that range from infertility treatments to cardiac surgery. In many ways it involves the splicing of two sectors: medicine and tourism. As an industry, medical tourism dates back to antiquity when the ancient Greeks sought what they understood to be sacred or beneficial places of healing in the territory of Epidauria or Herod the Great’s health resort at the Dead Sea<sup>29</sup>. Today, this industry is rapidly growing especially in emerging markets like India, China, Colombia and the Philippines. From an ethical perspective there are numerous issues that stand-out as a serious concern:

1. Patients usually have no idea about potential for infectious and noninfectious complications from medical tourism, and there is little reliable data available regarding destination countries<sup>30</sup>.
2. Patients rarely understand the tradeoff between saving money on medical expenses and obtaining potentially life-prolonging medical care that the patient could otherwise not afford, and sacrificing potential legal remedies should medical negligence occur<sup>31</sup>.
3. There is a lack of government safeguards ensuring the quality of healthcare generally and the safety and effectiveness of certain procedures specifically. There is no international governmental body for accrediting hospitals, physicians or other health care professionals. Standards vary widely from country to country and within countries<sup>32</sup>.
4. Foreign physicians may promise to provide follow-up care to medical tourists using telemedicine, but there are serious limitations in the consistency of law and regulations governing the practice of telemedicine in foreign countries<sup>33</sup>.

As stated above, there are numerous benefits and disadvantages to medical tourism. The main ethical issues focus on the impact of medical tourism on the patient-physician relationship; the ethical standards of informed consent; do the benefits outweigh the burdens; and is there a need for international safeguards and guidelines for accreditation of hospitals, physicians and other health care professionals. To determine if medical tourism is ethical it will be evaluated by the basic ethical principles of respect for persons, beneficence, nonmaleficence and justice.

Respect for persons incorporates two ethical convictions: first, individuals should be treated as autonomous agents; and second, persons with diminished autonomy are entitled to protection. The principle of respect for persons thus divides into two separate moral requirements: the requirement to acknowledge autonomy and the requirement to protect those with diminished autonomy<sup>34</sup>. The physician-patient relationship is a covenant that is based on mutual trust. It is a fiduciary relationship that is based on honesty. Ethicist Edmund Pellegrino argues that the patient-physician relationship is composed of three elements: the patient who is ill and seeking assistance with a need, the physician who will take responsibility for assisting with the needs, and the act of medicine<sup>35</sup>. In this relationship the patient is vulnerable, because the patient needs the assistance of the physician to help make the correct medical decision. “The decision-making process initiates the relationship between the two and will result in a chosen form of treatment”<sup>36</sup>. Physicians must be sensitive to the patient’s vulnerability and respect the patient’s autonomy unless it violates the conscience of the physician. The next phase is the medical intervention. The physician employs his or her skills to help restore the patient to health or alleviate as much suffering as possible. Therefore, the patient and the physician are in a relationship that hopefully results in a particular medical treatment. Ethicists Edmund Pellegrino and David Thomasma argue that among the obligations that arise from the patient-physician relationship is technical competence: the act of the medical professional is inauthentic and a lie unless it fulfills the expectation of technical competence<sup>37</sup>. This means that patients can expect their physicians to offer the same standard of diagnostic and therapeutic services to all patients. The final phase of the relationship is the outcome. The effect of the caring activity is assessed according to the physical well-being of the patient. It is the reciprocity of the relationship that completes the physician-patient relationship and upholds the respect and dignity of the patient. There are no international standards for medical tourism and in most cases there are no national standards in many countries. As a result, patients potentially can be subjected to procedures in clinics and hospitals that are not accredited and by surgeons who may or may not be skilled and qualified to perform the procedure, thus subjecting vulnerable patients to undisclosed potential post-operative complications, unsatisfactory results and risks to their general health. In addition, in many cases there is limited follow-up care and monitoring with no continuity of care if complications arise and revision surgery is

necessary—the costs for which may not be covered by health insurance in the patient’s home country<sup>38</sup>. This clearly violates the physician-patient relationship by failing to give the patient the respect that all patients deserve. Critics argue that this violates the physician-patient relationship because this could be seen as a form of patient abandonment. Abandonment of patients violates their basic human right of respect for persons, because they are not being treated with dignity and respect. If a patient is abandoned medically this patient can be considered vulnerable because their medical conditions are being untreated and their quality of life suffers. This violates the principle of respect for persons because we are failing to protect those individuals with diminished autonomy.

Another area that relates directly to the principle of respect for persons is the issue of informed consent. Patients have a right to be informed about the services that are covered and not covered, risks and benefits, consequences, as well as the cost for their medical care. Proponents argue that medical tourism offers patients access to procedures that are accessible, affordable, and often in exotic vacation locations. Despite these advantages, critics of medical tourism argue that the procedures offered, the technology utilized and the training and certification of the health care professionals can have the potential to dehumanize patients and reduce them to objects. The amount of information provided to international medical travelers at destination health care facilities is unclear. Because there are no international guidelines or standards the elements of informed consent and information disclosure vary across countries<sup>39</sup>. This has the potential to dehumanize the patient by diminishing one’s human dignity. Proponents believe that if the patient understands the full implications of the procedure and agrees to the technology, then the patient has given informed consent, which would counter the objectification and dehumanization criticism. For a patient to give informed consent, he or she must have the necessary information to make such a decision. The basic components of informed consent are: (1) competence, (2) disclosure, (3) understanding, (4) voluntariness, and (5) consent. “One gives an informed consent to an intervention if (and perhaps only if) one is competent to act, receives a thorough disclosure, comprehends the disclosure, acts voluntarily, and consents to the intervention”<sup>40</sup>. The problem with international medical travel is that there is a lack of clarity concerning what transnational or local legal, ethical and professional standards are in place to limit profiteering, ensure that patients are offered only medically indicated care and guarantee that perspective patients are



given sufficient information to make thoughtful and informed choices<sup>41</sup>. Verifying that the patient gives informed consent is the only way to eliminate the dehumanization and objectification of the patient. At present, the only way this can be assured is by providing international safeguards and guidelines in this area to ensure patient autonomy as well as the well-being of all patients and the basic dignity and respect that all patients deserve.

Beneficence involves the obligation to prevent and remove harms and to promote the good of the person by minimizing possible harms and maximizing possible benefits. Beneficence includes nonmaleficence, which prohibits the infliction of harm, injury, or death upon others. In medical ethics this principle has been closely associated with the maxim *Primum non nocere*: Above all do no harm. Proponents argue that medical tourism offers access to affordable health care to individuals who could not afford it in their own countries and whose lives may be in jeopardy without such procedures. In order to benefit patients worldwide there has been a proliferation of medical brokerages in foreign countries and a multiplication of “medi-cities” around the world. The “menu” of packages offered by medical brokerages extends from wellness packages, spa retreats, Ayurvedic medicine and traditional Chinese medicine to cosmetic surgery, orthopedic procedures, cataract surgery, dental care, cardiac surgery, organ and bone marrow transplants and stem cell injections<sup>42</sup>. These brokerages offer quality care for patients by certified physicians in first-class hospital facilities. Their marketing emphasizes personalized nursing care, prompt access to expert medical professionals, advanced medical devices, massage therapies, five-star hotel quality room accommodations, door-to-door transport services from airport to hospital and delectable meals, as well as exotic side trips<sup>43</sup>. In addition, proponents of medical tourism argue that it is not only good for the international patients but for the people living in the host countries. Increased patient volume has the advantage of promoting economies of scale, maximizes institutional efficiencies, and helps hospital chains and government ministries negotiate better contracts with companies selling medical devices, hospital supplies and pharmaceuticals. This will benefit public health and the poor in the host countries. Medical tourism also provides a long term economic justification for building infrastructure, encourages economic and social development, permits expansion of the private and public health care sector, complements efforts to promote public health and preventive medicine, and serves the interests of even the poorest

members of society by generating additional revenue for provision of publically funded health care<sup>44</sup>. The problem is that while this sounds very good in theory it has not translated into reality. Data on this topic is scarce and few studies have been done that prove this is happening as a result of medical tourism.

Critics argue that medical tourism violates the principle of nonmaleficence for numerous reasons. First, there is no international accreditation of hospitals and medical professionals. An international traveler would be unaware of the quality of the medical facility or the credentials of the physicians and nurses. Many surgeons may not be skilled and qualified to perform the procedure, which puts the patient in potential harm. Second, usually there is limited follow-up care and monitoring offered to patients with no continuity of care if complications arise and further surgeries are needed. Third, there is no meaningful legal recourse for surgical negligence. Fourth, devices are often used in surgery that do not meet U. S. standards for safety and efficacy and this information has not been disclosed to the patient prior to surgery, which also violates the ethical principle of informed consent. Fifth, patients may be exposed to organisms, which the patient has no built-in resistance. Infectious disease rates are variable and this is a particular hazard for people in fragile health. Sixth, despite those who argue that medical tourism helps the most impoverished in the particular country, numerous governments and national ministries of health have been accused of sacrificing their public health sectors, particularly in terms of access to rural/provincial and indigent populations, in favor of attracting medical tourists. Governments argue that increased revenue from international tourists strengthens public health care, and that a certain percentage of the revenues will go to the poor and indigent citizens of the host country. These arguments have been challenged in such countries as Cuba, India, the Philippines and Thailand to name a few<sup>45</sup>. Overall, it does not appear that medical tourism maximizes the benefits to patients and minimizes the harms.

Lacking international safeguards and guidelines, it is possible that medical tourism could fail not only the test of beneficence, but also fail the test of nonmaleficence. However, with these safeguards and guidelines in place, medical tourism has the potential to raise the standard of patient care to a level that is in the best interest of patients, physicians and society as a whole. As a result, prevention and wellness could become mainstream and affordable and healthcare costs could decline. This would satisfy the tests of

both beneficence and nonmaleficence by maximizing benefits and minimizing harms.

Finally, the principle of justice recognizes that each person should be treated fairly, equitably, and be given his or her due. Justice also pertains to distributive justice, which concerns the fair and equitable allocation of resources, benefits and burdens, according to a just standard. Inequality concerning access to medical care is a well-documented fact. To allow some patients, in similar situations, to have better access to physicians and medical treatments is an egregious violation of the principle of justice. Justice dictates that patients should be treated in a similar manner if at all possible. If there are medical treatments that are good for patients, and these are prescribed for some but not others in the same category, then failure to treat all equally violates the basic tenet of justice, that is, to treat all people fairly and equitably. The principle of justice can be applied to the problem under discussion in two ways.

First, one of the most challenging problems confronting health care today is the uneven distribution and relative shortage of providers not only in the United States but worldwide. If the promotion of medical tourism creates a scenario where patients from foreign countries can purchase considerably better health care than most local patients can afford, then this is a violation of the principle of justice. Proponents argue that medical tourism will create revenue in the host country that can be utilized to strengthen public health care and build a new health care infrastructure. As shown above, this has not become a reality in most countries. In fact, it creates a two-tiered system, which fails to improve access to health care for the poorest members of society. With appropriate financing, auditing and regulatory mechanisms, perhaps revenue generated from international patients could be used to improve access to care for local citizens. However, under the current unregulated system, the profits from providing care to international patients has not been used to cross-subsidize and improve care for local citizens and the result has been a widening of the already massive health care gap. High quality medical facilities would be unaffordable to all but a tiny segment of local individuals. Instead of contributing to broad social and economic development, medical tourism appears to exacerbate existing inequalities and further polarize the richest and poorest members of society<sup>46</sup>. Under the current system, medical tourism is not a viable option that treats all people fairly and equitably by providing a means to primary and specialty care for those who do not have reasonable access to healthcare.

Second, besides equality in access to health care there is also the issue of cost effectiveness. Health care has become increasingly expensive and complicated, while at the same time efforts are being made to find cost-effective ways of treating patients, especially those with chronic medical conditions in less costly environments that are more appropriate and beneficial for the patient. Proponents argue that the prices of medical procedures in foreign countries are cost-effective. A hip replacement in the U. S. would cost approximately \$75,399, while in India the cost would be \$9,000; an angioplasty in the U. S. would cost \$98,618, while in India the price would be \$11,000<sup>47</sup>. The price is right for those participating in medical tourism, but at the expense of the poor and underserved in the host countries. Unregulated medical tourism does not meet the criteria for being a cost-effective way of treating patients. Numerous patients have returned home after medical procedures in a foreign country with serious medical complications that have placed a burden on the U. S. health care system. Follow-up care and even corrective surgeries have had to be performed that has added costs to the U.S. health care system. Second, medical tourism can “deprive U.S. hospitals of revenue that they use to cross-subsidize care for the poor.”<sup>48</sup> Third, there is an increased risk of a “global market of privatized, commercial health care delivery that threatens the future of public health care systems.”<sup>49</sup> Fourth, Americans traveling to foreign countries could severely impact the comparative advantage for the U. S. in hospital business by causing a loss of reputation and prestige for the U.S. health care system and create a possible impact on the immigration of international physicians to the U.S. upon whom the U.S health care system depends for primary medical care<sup>50</sup>. All of these issues can impact on the cost-effectiveness of health care in the U.S and abroad. International standards and safeguards must be established to protect the best interest of patients.

Justice demands that resources be equitably distributed, fairly priced and properly paid for by patients. Under the present conditions, medical tourism does not increase the quantity, quality and access to medical care and do so cost effectively. Important questions about medical tourism regarding medical issues, legal issues, ethical issues and cost-effectiveness will need further evaluation. However, it is clear that medical tourism will continue to evolve as research further clarifies its benefits, burdens and costs. Justice dictates that all people should be treated fairly and equitably. Medical tourism offers a new and innovative way of providing access, quantity and quality health care to people. Failure to acknowledge this fact and to establish

safeguards and guidelines to protect and promote the best interest of patients is ethically irresponsible and morally objectionable. If proper guidelines and safeguards are established nationally and internationally for medical tourism it can be medically, legally and ethically justified. However, without these guidelines and safeguards numerous problems can and will arise.

### **PROPOSED MEDICAL TOURISM GUIDELINES**

Considering the medical, legal and ethical perspectives, the authors of this paper have concluded that medical tourism cannot be stopped, but should rather be controlled by proposing the following guidelines. The following guidelines will aid in the safety of the patients by outlining requirements of medical tourists, the Medical Tourism Association and the international hospitals involved:

1. Medical tourism should not be forced upon an employee or an insurance member. Likewise, an employer or insurance company should not use incentives in order to promote medical tourism.<sup>27</sup>
2. Medical tourists should receive a physical examination and a referral from their primary care physician approving of their international procedures. Prior to international travel, medical tourists should be given the recommended vaccinations approved by the Centers for Disease Control to avoid prevalent diseases in the host country.
3. The Joint Commission International should accredit any and all hospitals or clinics that provide medical tourism. These hospitals should apply to be inspected and accredited, in order to ensure their healthcare staff, facility and practices meet proper standards.
4. Medical tourists should contact their insurance companies prior to participating in medical tourism. This includes reporting all planned procedures and travel length/plan and intended stay. Insurance companies reserve the right to deny coverage of any treatments they find to be unnecessary to the patient's overall health.
5. The Medical Tourism Association should inform medical tourists of any and all viable options around medical tourism. This includes the institution of Medical Tourist Advisors; a sector of professionals trained to advise international patients on the safest treatment paths. This advisement includes information on safer and more affordable treatment paths.
6. Hospitals that treat international patients should inform them of the infection/success rate of their hospital. This information should be published prior to the patient's travel.
7. Hospitals that treat international patients should institute a

private internal sector to control the revenue of their medical tourists. These finances should be audited and regulated in order to ensure a portion will be distributed to the local public hospitals and clinics.

8. The Medical Tourism Association should keep records of all international procedures approved by insurance companies. They must publish the data taken from medical tourism in order to endure international patients are aware of the health risks they may encounter.
9. Medical tourists who use match-maker services to connect with foreign doctors, should review any legal agreement carefully for possible agency or liability waivers, and insist on a consent to jurisdiction provision.
10. Countries participating in medical tourism should establish a formal legal framework to protect international patients seeking medical care abroad. This includes adoption of international legal standards for informed consent and information disclosure.

The majority of patients considering medical tourism are not fully aware of the serious long-term medical, legal, financial and ethical complications that can arise from slickly advertised, seeming straightforward, uncomplicated and trouble-free procedures and treatments. Medical Tourism is being promoted as a viable solution to the financial dilemma regarding the costs of medical and surgical procedures that often result in a medical disaster for the patient. The guidelines being proposed seek to protect the health and life of patients by making sure they are fully informed of the medical and legal risks and benefits of any proposed treatments and procedures they may seek in a foreign country. The reality is that the potential public health dangers, personal and global economic fallout, legal ramifications and ethical consequences of medical tourism have been significantly underestimated. However, it is also a reality that the growth of medical tourism will not be limited. The decreased costs to medical tourists and the financial profits to medical professionals and governments are far too attractive and lucrative. The only hope is that with appropriate guidelines and standards, medical tourism can be rendered medically, legally and ethically more acceptable and be in the best interest of patients, physicians and society as a whole.

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