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Thomas S. Terranova

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# PATIENT RECOURSE IN INTERNATIONAL HEALTHCARE: ARBITRATION AND INSURANCE FOR SELF- REFERRED PATIENTS

*Thomas S. Terranova*\*

## I. INTRODUCTION

Modern patients travel extensively for healthcare, across town, across the country, around the world, facilitated by free flowing information and the ability to travel anywhere on the globe. They do so for any number of reasons, and the treatment models under which they receive care are almost infinitely numerous because international healthcare is a vast and diverse marketplace. This Article considers the options available to patients when treatment in the international arena does not go as planned. Economic realities often pose a difficult choice to patients: they can either seek care abroad with no established recourse for medical malpractice, or they can remain in the United States without the resources to obtain needed services; stated simply, no care or no recourse.<sup>1</sup> For the purposes of this Article, first assume patients seek care from a trained medical professional in a facility that, at minimum, purports to provide medical services. Although hotel room surgeries, in a completely inappropriate setting, or surgeries performed by people merely posing as doctors do occur,

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\* J.D./M.B.A. Candidate, May 2017, Loyola University Chicago School of Law. M.A. June 2007 The University of Chicago Committee on International Relations. The author would like to gratefully acknowledge Massimo Manzi, the Executive Director of PROMED for sharing so many documents and thoughts on this subject.

<sup>1</sup> See I. GLENN COHEN, PATIENTS WITH PASSPORTS: MEDICAL TOURISM, LAW, AND ETHICS 96-97 (OXFORD UNIV. PRESS ed., 2014).

these are not considered in this Article. Second, presume that patients, particularly Americans, expect an avenue to collect damages in the case of malpractice. Tort law demands holding parties responsible for injuries they cause, and the principle permeates not only American jurisprudence but also daily life and concepts of fairness. Therefore, the patients whose recourse this Article considers, traverse borders to receive legitimate medical care and expect some opportunity to recover damages—a fundamental concept of common law. The following pages discuss emerging options to provide patients with the expected level of protection by offering avenues for recovery while maintaining sufficient competitive advantages and protections to keep doctors participating in international healthcare. In order to keep this endeavor manageable, this Article only addresses a specific group of international healthcare patients; however, the concepts are broadly generalizable.

The rest of this Article discusses the current situation in international healthcare and examines attractive early stage options for patient recourse. Section II provides basic background information about the phenomenon of international healthcare. Section III discusses the size and scope of international healthcare and focuses the conversation on the market segment being examined here. In Section IV, the Article examines the medical malpractice gap for international patients and its impact on patients, their native countries, the physicians, and the treating countries. Section V explores Costa Rica's alternative dispute resolution scheme as offering a potential solution for the remedy gap that is worthy of further experimentation. Section VI examines procedure-specific insurance products as a way to protect patients and providers from the financial ramifications of malpractice. Finally, Section VII of this Article concludes that international arbitration and one-time insurance regimes provide the bases upon which a framework should be built to offer recourse to patients.

## II. THE GLOBAL HEALTHCARE MARKETPLACE: BACKGROUND AND CONCERNS

Medical Travel, Medical Tourism, Health Travel or any of the other seemingly infinite iterations of the term describing this concept, is a major and growing part of healthcare that simply cannot be

ignored, with an estimated market of approximately \$50 billion in 2014.<sup>2</sup> However, to discuss the topic as if the patients seeking care were a monolithic group with common interests would be a mistake. Also, to attempt to examine the entire phenomenon is too large an endeavor for this Article. Rather, in the following pages this Article focuses on one class of patients and their options for remedy. This Article deals with the hard cases by design. Emulating developments in international healthcare that protect these patients, in turn, has powerful implications for all international patients. There are promising remedial concepts for self-referred outpatient care that can easily be expanded to protect patients with more substantial relationships to the United States' healthcare system and institutions. The industry is at a point of experimentation. It is inconceivable that anyone could devise an entire system of appropriate legal remedies as a planned concept without unintended consequences. Instead, the international healthcare marketplace must mature organically through competent, well-informed engagements and networks of bi-lateral agreements to find the appropriate mix of protection and added costs that give patients from various countries their desired level of security. Now is the time to follow promising concepts, observe the marketplace's reactions, and cultivate a comprehensive system of protections that fits the needs and expectations of the market actors.

This Article uses the term international healthcare rather than medical tourism. While international healthcare is probably the least used term for this sector, it is the most appropriate.<sup>3</sup> To highlight the travel or tourism elements of international healthcare only trivializes care and contributes to patients making decisions with less diligence than when making a "serious" healthcare choice. Minimizing the healthcare features of the transaction exacerbates the deleterious effect of marketing terms like, "minor procedure", "minimally

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<sup>2</sup> Reenita Das, *Medical Tourism Gets a Facelift...and Perhaps a Pacemaker*, FORBES (Aug. 19, 2014, 2:48 PM), <http://www.forbes.com/sites/reenitadas/2014/08/19/medical-tourism-gets-a-facelift-and-perhaps-a-pacemaker/>.

<sup>3</sup> See David Wainer, *Come for the Seven-Star Hotel, Stay for a Nose Job*, BLOOMBERG BUSINESS (Sept. 24, 2014, 3:01 PM), <http://www.bloomberg.com/news/articles/2014-09-24/come-for-the-seven-star-hotel-stay-for-a-nose-job> (exemplifying the use of luxury or adventure as the attraction to bring patients into a country for treatment with less emphasis on care).

invasive”, and others that lead patients to believe they face no medical risks.

International healthcare has gained recent notoriety as a market segment primarily because the United States has become one of the largest exporters of patients in the world.<sup>4</sup> Travelling abroad for healthcare dates back to antiquity. Ancients travelled to more hospitable destinations for mineral treatments and convalescence.<sup>5</sup> In more recent times, the United States was the world’s primary importer of patients due to its advanced technology.<sup>6</sup> The wealthy citizens of the world frequently travelled to America for the pinnacle of specialty care in settings like the Mayo Clinic, Cleveland Clinic, or Johns Hopkins. And while the United States continues to attract such patients, large areas of healthcare have increasingly become commodity services that can be adequately delivered in many parts of the world. As a result, Americans are being targeted as consumers for healthcare abroad. This Article refers to them as outbound patients.

It is concerning that outbound Americans are often treated as consumers, a market segment to be attracted and captured by foreign providers, rather than as patients. By emphasizing travel, leisure, and even adventure to the international patient, the healthcare aspect of the travel becomes secondary and can deemphasize the normal risks associated with treatment or the aftercare components of healthcare that can affect outcomes and long-term patient health.<sup>7</sup> Patients may not always make their decisions based solely on the best medical fit if their judgment is clouded by destination and activity decisions, especially when their medical treatment has been presented as an ancillary consideration. It is critical to focus on the healthcare aspects of international healthcare and develop reasonable patient recourse regimes because by potentially perverting decision-making, patients may choose lower quality care, experience higher rates of adverse events, and actually increase the odds of needing some method of remediation.

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<sup>4</sup> Das, *supra* note 2.

<sup>5</sup> Hao Li & Wndy Cui, *Patients Without Borders: The Historical Changes of Medical Tourism*, 83 Issue 2 Univ. of W. Ont. Med. J. 20, 20 (2014).

<sup>6</sup> *Id.*

<sup>7</sup> See *Medical Tourism*, CTR. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/features/medicaltourism/> (last Updated February 23, 2015) (encouraging outbound patients to verify that any “vacation” excursions or activities are permitted post-operatively before planning them).

### III. EVOLUTION AND COMMODITIZATION OF HEALTHCARE: THE UNITED STATES' PATIENT EXPORT AND SEGMENTATION

The global healthcare marketplace is a nascent sector and is often incompletely represented by the media, scholars, and indeed the industry itself. Discussions about international healthcare typically focus on big-ticket inpatient care such as cardiac bypass or joint replacement.<sup>8</sup> This is true of promotional material, quality and safety studies, and examinations of the patient's legal recourse.<sup>9</sup> The international healthcare conversation is familiar with hospital accreditation by the Joint Commission International, but there is little discussion about patients in other settings such as ophthalmology, oncology, diagnostic, or dental clinics. When employers' health plans incentivize patients to seek care in a foreign country for medically necessary procedures, there are numerous actors who are potentially liable for damages in American courts. The employer, insurer, and any affiliated American healthcare institutions are potential parties for a suit through various theories of liability, although it remains to be seen if American courts will accept such theories.<sup>10</sup>

Nonetheless, a sizeable number of America's outbound international patients seek foreign care and pay out-of-pocket for any

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<sup>8</sup> See Symposium, *Cross-Border Health Care: The Movement of Patients, Providers, and Diseases*. LOY. U. CHI. INT'L. L. REV. & BEAZLEY INST. FOR HEALTH L. & POL'Y (2015) (presenting many aspects of international healthcare focused on transplants, health justice, epidemiology, and inpatient care with no mention of patients seeking self-funded outpatient care).

<sup>9</sup> See Deloitte Center for Health Solutions, *Medical Tourism: Consumers in Search of Value*, (2008) [hereinafter Deloitte, *Consumers in Search of Value*] (using the word hospital over eighty times while referring to outpatient-only locations three times); See also COHEN, *supra* note 1 at 80-86 (examining medical malpractice liability for a hypothetical American patient primarily in the context of receiving care at a hospital); See also Edward Kelley, *Medical Tourism*, Presentation to World Health Org. Patient Safety Programme (Oct. 2, 2013) available at [http://www.who.int/global\\_health\\_histories/seminars/kelley\\_presentation\\_medical\\_tourism.pdf](http://www.who.int/global_health_histories/seminars/kelley_presentation_medical_tourism.pdf) (discussing inpatient hospital pilot insurance programs).

<sup>10</sup> Nathan Cortez, *Recalibrating the Legal Risks of Cross-Border Health Care*, 10 Yale J. Health Pol'y L. & Ethics 1, 8, 14-17 (2010) (acknowledging there are no cases or test cases to indicate the potential liability of foreign providers or intermediary, employers, or insurers in the United States and detailing the myriad challenges facing a patient attempting to hold one of these parties liable in the United States).

number of reasons.<sup>11</sup> Such patients may be seeking elective procedures that are not covered by existing insurance.<sup>12</sup> Outbound Americans may also want procedures that are unavailable in the United States due to legal prohibitions or a lack of regulatory approvals, or may be looking for less expensive alternatives because they are among the massive population of uninsured Americans, many of whom will remain uninsured despite the Affordable Care Act.<sup>13</sup> Patients may also go abroad for care because they are immigrants from the treating country, want to receive care in their native land, and possibly be cared for post-operatively by family or friends. Some international patients are also members of the American expatriate community who need or want care while living abroad.<sup>14</sup>

In addition to selecting care providers without being counseled to do so by an employer, insurer, or facilitator, many patients undergo care in outpatient settings that are less likely to have affiliations with American institutions.<sup>15</sup> These patients have fewer potential parties against whom to file suit in American courts, even if case law develops to support such liability theories in cross border healthcare.<sup>16</sup>

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<sup>11</sup> Kelley, *supra* note 9. (citing OECD report indicating cosmetic surgery, elective surgery, & fertility treatment are the most common treatments in international healthcare)

<sup>12</sup> See Brandon Green, *Dental Tourism Could Save You Big Money*, FOXNEWS.COM (Nov. 1, 2013) <http://www.foxnews.com/travel/2013/11/01/saving-big-with-dental-tourism/> (noting an industry publication that estimated there would be approximately 500,000 outbound American patients for dental treatment alone in 2013).

<sup>13</sup> See Wendell Potter, *Millions of Middle Class Americans Will Remain Uninsured Despite Obamacare*, THE CTR. FOR PUB. INTEGRITY (Feb. 2, 2015, 5:00 AM) <http://www.publicintegrity.org/2015/02/02/16681/millions-middle-class-americans-will-remain-uninsured-despite-obamacare> (noting the Congressional Budget Office estimates 31 million Americans will remain uninured in ten years); See also COHEN, *supra* note 1, at 95.

<sup>14</sup> Most estimates and statistics for international healthcare do not include expatriates, however, these patient populations are at least relevant to consider in the context of legal recourse. See *Medical Tourism Statistics & Facts*, PATIENTS BEYOND BORDERS, <http://www.patientsbeyondborders.com/medical-tourism-statistics-facts> (last updated July 6, 2014).

<sup>15</sup> Tilman Ehrbeck, Ceani Guevara & Paul D. Mango, *Mapping the Market for Medical Travel*, McKinsey Q., May 2008, at 2-3 (recognizing that substantial numbers of patients travel for outpatient procedures, the study also excludes expatriates receiving care, wellness care, and emergency care).

<sup>16</sup> See COHEN, *supra* note 1 at 84-85 (noting personal jurisdiction in the United States would be easier to establish if the foreign provider actively targeted American

So the majority of the discussion of globalized healthcare ignores remedies for this large and very exposed subset of international patients. If the marketplace can devise protection for these patients, it will certainly add an extra layer of protection for those patients who are more connected to American jurisdictions by virtue of agents who guide care toward foreign providers. Therefore, this Article focuses solely on American outbound healthcare, in which the patient pays out-of-pocket and uses no professional services in choosing a provider. This is the segment of the international healthcare market that is hardest to protect and may include hundreds of thousands of patients.<sup>17</sup>

#### IV. THE INTERNATIONAL HEALTHCARE MARKET'S REMEDY GAP

This section continues under the assumption that American common law and jurisprudence reinforce the American patient's expectation to have recourse in cases of medical malpractice. Further, it assumes the legal and regulatory communities agree that medical malpractice remedies serve the concept of fairness by issuing judgments against physicians who cause patient injuries. The question remains, how can a patient receive adequate protection against malpractice when the physician is the citizen and domiciliary of a foreign country and has no agents within the United States?

Truthfully, little can be done to fully protect patients who travel for healthcare because the industry represents a vast free-market model in which patients decide how diligently and with what protections they will participate. If adding protective remedies reduces cost savings too much, patients may choose to go farther afield into a less regulated market for the cheapest care. Essentially, the patients assume the level of risk with which they are comfortable. However, an ancillary result of medical complications is the burden on the patient's native health system, in this case the American healthcare system, to perform revisions and follow-up care. Therefore,

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patients or employed an intermediary to avail themselves of a state's laws in order to secure patients for the provider).

<sup>17</sup> The author bases this statement on Patients Beyond Borders' 2012 estimate of 400,000 outbound American dental patients. If only twenty-five percent travelled abroad without the help of an agent, the segment would include over 100,000 patients without even considering those seeking care from other medical specialties. See Green, *supra* note 12.

government agencies have a sizeable incentive to ensure adequate patient recourse in the international healthcare arena. Finally, the lack of clarity regarding remedies also distorts physician participation in international healthcare.

*A. Impact on the Patient Population*

The uncertainty surrounding remedies has very obvious implications for patients and their decision-making. American patients receiving care abroad are severely limited in their ability to recover for medical malpractice in comparison to patients treated domestically because of issues with personal jurisdiction, forum non conveniens, choice of laws, enforcing judgments, and suing abroad (in the treating country).<sup>18</sup> Since the individual patient cannot recover for malpractice, the entire patient population is somewhat exposed because there is no medical malpractice deterrent to dissuade physicians from future negligent care.<sup>19</sup> However, given the extremely high cost of healthcare in the United States, the choice for many patients who will pay out-of-pocket is to either accept limited or no medical malpractice recovery, or to forego treatment altogether.<sup>20</sup> Absent a remedy, any complications from international healthcare require the patient to pay out-of-pocket for major follow up care. Self-pay is not an ideal situation for patients that have already made healthcare choices based on cost. It is also possible for the patient to secure private arrangements with the original treating physician to correct medical errors, which is also far from ideal since the patient may not be enthusiastic about being treated by the same physician a second time.

The out-of-pocket patient population is a diverse group with tremendous variation in income and sophistication.<sup>21</sup> Therefore, patients may calculate their selection of providers differently based on balancing the total cost savings, the location's or provider's overall quality and safety, and over time, the opportunity to recover for any medical malpractice. Some patients will certainly sacrifice a degree of

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<sup>18</sup> These challenges are beyond the scope of this Article and are expertly discussed in other works. *see* COHEN, *supra* note 1 at 83-89.

<sup>19</sup> *But see id.* at 81-82 (acknowledging the deterrent effect of malpractice judgments is debatable).

<sup>20</sup> *See id.* at 96-97.

<sup>21</sup> *See id.*

safety and quality standardization, or the prospect of malpractice recovery, in exchange for needed financial relief at the outset. It is imperative to develop the means to offer patients recourse while maintaining a sufficient enough financial incentive to keep them from either foregoing care entirely or opting for treatment in a completely unregulated and undeveloped medical market with a high probability for complications. Ultimately, a system with patient remedies that maintains significant cost savings should result in the channeling regime favored by Professor I. Glenn Cohen.<sup>22</sup> Whether channeling is an organic product of the industry or a formal recognition process devised through an agency such as the State Department or Department of Health and Human Services is unimportant, so long as the patient understands the treatment and remedy options available and no longer faces the choice of no care or no recourse.

### *B. Exposing the Home Country*

The patient's choice to seek care abroad has important implications for the health system of the patient's home country. Should complications arise after international healthcare, particularly acute adverse events requiring immediate medical attention, the American public health system will likely have to assume the responsibility of treating the patient. As discussed above, the self-funded market segment at issue in this Article is likely uninsured or underinsured,<sup>23</sup> leaving a sizeable portion of the financial burden on public institutions.

Although this Article specifically addresses outbound American patients, the British National Health System (NHS) provides useful analogous data that might suggest the total cost incurred by American taxpayers to treat complications for international healthcare.<sup>24</sup> In 2010 the NHS estimated 1,890

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<sup>22</sup> See *id.* at 108-15 (acknowledging that a ban on international healthcare is unlikely and would be ineffective, and discussing disclosing medical malpractice remedies or requiring remedies as conditions for official American agency approval to incentivize countries to adopt medical malpractice regimes and influence patient decision making).

<sup>23</sup> See *id.* at 96-97.

<sup>24</sup> See Neil Lunt, et al., *Implications for the NHS of inward and outward medical tourism: a policy and economic analysis using literature review and mixed-methods approaches*, 2 Issue 2 HEALTH SERV. & DELIVERY RES. at 83, 87, 111-112 (2014).

international patients would need follow up care at a cost of approximately £8.2 million.<sup>25</sup> This figure is based only on the estimated 18,900 outbound British patients who sought cosmetic care abroad.<sup>26</sup> Meanwhile, the entire British outbound international patient population in 2010 was only about 63,000.<sup>27</sup> Compare the British figure with the approximately 875,000 Americans who travelled abroad for care that same year.<sup>28</sup> Assuming public programs also treat the majority of American complications and that complications occur at a comparable rate as they do for British patients, the estimated cost of complications on the United States' health system is staggering.

To date, there is insufficient data to calculate whether the costs of treating those complications outweigh the overall savings that outbound tourism bestows on the health system. However, whether international healthcare is a net profit or loss for the American health system is irrelevant. Tort law demands judgments in favor of a plaintiff be imposed on the party responsible for causing an injury, not incurred by an innocent third party. Therefore, should international healthcare procedures result in complications from malpractice, there must be a system of redress that absolves the patient's home country from shouldering the cost of the foreign physician's tortious act. To impose the cost of errors on the federal or state governments (effectively the taxpayers), violates the concept of fairness and stretches the rational limits of proximate causation. Instead, the physician must be held responsible for any negligence or malpractice directly, but in a manner that does not scare them out of international healthcare entirely.

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<sup>25</sup> *Id.* at 111.

<sup>26</sup> *See id.* (calculating the number of patients travelling for cosmetic treatment based on IPS data and several surveys).

<sup>27</sup> Johanna Hanefeld, et al., Abstract, *Medical Tourism: a Cost or Benefit to the NHS*, PLOS ONE (Oct. 24, 2013) <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0070406#reference> S.

<sup>28</sup> Duncan McGowan, *The Rise of Medical Tourism in Panama*, VACATION NEWS (Oct. 17, 2013, 11:04 AM) <http://www.worldpropertyjournal.com/featured-columnists/the-panama-wire/medical-tourism-panama-healthcare-costs-medical-procedures-medical-tourists-cosmetic-surgery-fertility-treatments-dental-implants-hospital-punta-pacifica-7514.php>.

*C. The Physician's Catch 22*

In the absence of a malpractice regime, American patients face the choice of no care or no remedy. Treating physicians, on the other hand, must decide whether to cede jurisdiction to the American court system, offer no additional protection and potentially scare off patients, or devise a private offering to ease any lingering patient fears. Of all the areas of international healthcare presenting a dearth of information, the physicians' decision making is the least documented. Physicians who work in international healthcare are a sophisticated group of actors, many of whom are familiar enough with American medical malpractice judgments to know that they do not want to be subject to American judgments. If physicians did choose to submit to American jurisdiction, adequately protecting themselves from devastating judgments would raise expenses through additional legal, insurance, and administrative fees. It would diminish the cost savings they offer to Americans and damage their value propositions. For the same reasons a patient may want to subject a doctor to American jurisdiction, no logical doctor would contract to become subject to American courts.

However, physicians do understand that American patients expect some protection. Failing to provide any remedial option diminishes the physician's offering and potentially keeps patients out. As a compromise, many physicians offer to conduct follow-ups or corrections at no cost, or pay for the cost of additional services necessitated by a bad outcome. Once a patient has a complication, however, it is safe to assume that the relationship has become somewhat damaged and the patient may not be willing to trust the operating physician to treat them again, or even to pay for adequate treatment. The system needs something more structured. Physicians and their home countries have an incentive to provide reasonable recourse without submitting to American jurisdiction and being exposed to the risk of the rare mega judgments it produces. They must provide some protection, or risk losing any competitive edge they might have over American healthcare. In the case of the treating country, spoiling inbound international healthcare jeopardizes potentially billions of dollars in revenue.

*D. National Embarrassment to the Treating Country*

International healthcare is a matter of national importance for several countries at the forefront of the industry. Some governments

have identified international healthcare as a major national strategic imperative and now compete with the rest of the globe to advance their own particular market offering.<sup>29</sup> The billions of dollars at stake annually justify a major national investment. A prime example is South Korea, which founded the Korea Health Industry Development Institute (KHIDI), a public-private institution, in 1998.<sup>30</sup> The institute has a twofold purpose to improve the national health industry and strengthen the international competitiveness of the Korean health industry.<sup>31</sup> KHIDI has an annual budget of \$400 million, employs approximately 400 people, and maintains six offices outside of Korea.<sup>32</sup> Similarly, Costa Rica identified quality healthcare and English language penetration among its own competitive advantages and created the Council for the International Promotion of Costa Rica Medicine (PROMED) to advance the country's interests in the international marketplace.<sup>33</sup> In 2015, PROMED will host its fifth annual summit series on international healthcare, the second year in which events are set to take place inside the United States.<sup>34</sup>

The above are just two examples of the increasingly common strategic national investments countries have made to attract international patients. There are similar organizations throughout the world but it is unnecessary to detail them all, rather, it is sufficient to note that multiple nations devote millions of dollars toward

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<sup>29</sup> See Deloitte, *Consumers in Search of Value*, *supra* note 9, at 6 (identifying 10 hubs for international healthcare Brazil, Costa Rica, Gulf States, Hungary, India, Malaysia, Mexico, Singapore, South Africa & Thailand & substantial efforts in the Philippines & South Korea).

<sup>30</sup> *History*, KOREA HEALTH INDUS. DEV. INST., <http://www.khidi.or.kr/board?menuId=MENU00773> (last visited Feb. 23, 2015).

<sup>31</sup> *Purpose of the Institute*, KOREA HEALTH INDUS. DEV. INST., <http://www.khidi.or.kr/board?menuId=MENU00772> (last visited Feb. 23, 2015).

<sup>32</sup> *About*, KOREA HEALTH INDUS. DEV. INST., <http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=4&cad=rja&uact=8&sqi=2&ved=0CDcQFjAD&url=http%3A%2F%2Fwww.khidi.or.kr%2FfileDownload%3FtitleId%3D106281%26fileId%3D2&ei=2rTrVKgriewBNbpgAG&usg=AFQjCNG9ayUzU1AQA5N5Ne5nHt-N0p8riA&bvm=bv.86475890,d.cWc> (downloaded Feb. 23, 2015).

<sup>33</sup> *About PROMED*, COUNCIL FOR THE INT'L PROMOTION OF COSTA RICA MED., <http://www.promedcostarica.org/about/> (last visited Feb. 23, 2015) [hereinafter *About PROMED*].

<sup>34</sup> *Home*, MED. TRAVEL INT'L. BUS. SUMMIT, <http://themedicaltravelsummit.com/> (last visited Mar. 31, 2015).

developing and promoting their international healthcare programs.<sup>35</sup> Treating countries have the same incentives as individual treating physicians to offer satisfactory avenues to malpractice recovery. The main difference is that the national strategic interest magnifies the individual concerns of the physician because it aggregates the earnings from all inbound patients. National economic interests also include those from ancillary services related to care and recovery as well as hotels, meals, and non-health related services and excursions.<sup>36</sup> The stakes are high; patients may be scared off in droves to pursue care in a competing nation because of high-profile complications in which the patient was unable to recover. Treating countries may lose out on tens of millions of dollars of income. Recently a British patient died after undergoing surgery in Thailand, the media coverage highlighted the potential financial ramifications of bad outcomes on treating countries.<sup>37</sup>

It is in the best interest of treating countries to help formalize an international regime for patient recovery because leaving patients financially exposed to adverse outcomes threatens the long-term viability of a national economic sector potentially worth millions. Each adverse outcome in which the patient does not receive satisfactory compensation increases the chances of negative public

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<sup>35</sup> There is no consolidated list of official or semi-official national promotion organizations. See e.g. *Medical Clusters in Mexico*, MEX. TOURISM BD., <https://www.visitmexico.com/en/health/hospitals/medical-clusters-in-mexico> (last visited Mar. 30, 2015); see also e.g. *Thailand Medical Tourism Portal*, TOURISM AUTH. OF THAI., <http://www.thailandmedtourism.com/Home/28> (last visited Mar. 30, 2015); see also e.g. *Medical Travel*, SING. TOURISM BD., <https://www.stb.gov.sg/industries/healthcare> (last visited Mar. 30, 2015); see also e.g. *2014 Sponsors: World Medical Tourism & Global Healthcare Congress*, MED. TOURISM ASS'N., <http://www.medicaltourismcongress.com/2014-sponsors/> (last visited Mar. 30, 2015).

<sup>36</sup> JOHN CONNELL, *MEDICAL TOURISM* 132-133 (Sarah Hulbert & Shankari Wilford eds., 2011) (noting medical tourists spend two to three times more than standard tourists with a significant amount of spending outside of healthcare and creating many non-healthcare jobs).

<sup>37</sup> Francesca Infante, *British Woman Who Died in Thailand During Buttock Surgery as Brother Reveals Family 'Still Don't Know What Went Wrong'*, THE DAILY MAIL (Oct 29, 2014, 7:24 PM), <http://www.dailymail.co.uk/news/article-2813420/Pictured-British-woman-died-Thailand-buttock-surgery-brother-reveals-family-don-t-know-went-wrong.html> (explaining the patient died as a result of corrective surgery when her implants became infected, also noting Thailand made £2.68 billion from inbound international healthcare in 2013).

perception and heightened discourse over the ability of treating physicians and advisability of receiving care in the treating country. Creating a robust scheme for patient recourse makes it clear that the treating physician and treating country are responsible, have given adverse outcomes sufficient forethought, and have instituted a reasonable method of resolving disputes.

#### V. EXPERIMENTING WITH ARBITRATION SCHEMES OFFERS THE PROSPECT OF ADEQUATE REMEDY

Ultimately, whatever available safeguards can be implemented to protect patients and the national healthcare system should surely be implemented. In fact, reasonable malpractice remedies are in the best interest of all stakeholders and are beginning to crystallize in international healthcare. International healthcare transactions are, by nature, bi-lateral arrangements. The patient's home country, the United States for this Article, represents one side of the transaction and the treating country represents the other. The United States generally has some sort of broader trade relationship with the treating country, as long as the patient does not undergo treatment in an embargoed nation such as Iran or North Korea. It therefore makes sense to look to those existing relationships for ideas to model a liability and dispute resolution system that will function globally.

Bi-lateral alternative dispute resolution schemes are those in which the patient's home country and the treating country recognize the validity of arbitration and conciliation awards in each other's territory and have established at least one organization that is sufficiently impartial to conduct an unbiased process.<sup>38</sup> Such programs provide legitimate patient recourse that bridges the gap between an acceptable legal remedy and a wild-west medical environment offering no legal recourse, thus avoiding all administrative and transaction costs associated with a malpractice

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<sup>38</sup> The Costa Rican-American Chamber of Commerce houses the Arbitration and Conciliation International Center and enjoys nearly equal membership from the United States and Costa Rica. The Chamber accounts for the majority of Costa Rica's foreign direct investment and exports. This organization has an incentive to provide an unbiased process for claims between Americans and Costa Ricans because it represents the interests of both parties. See *About Us*, THE COSTA RICAN-AM. CHAMBER OF COM., [http://www.amcham.co.cr/about\\_amcham.php](http://www.amcham.co.cr/about_amcham.php) (last visited Feb. 12, 2015) [hereinafter *About Us*, Am-Cham].

process. As discussed above, physicians treating American patients are well aware of the ramifications of medical malpractice suits and the reputation of the United States court system for granting large judgments. These sophisticated actors often make a conscious decision to limit their exposure while offering patients some measure of protection. One thing patients and lawyers can be sure of is that these doctors will not willingly cede jurisdiction to the United States. However, most physicians are aware that failing to provide any recourse will eventually scare off a large number of patients.

Costa Rica is a leading provider of healthcare to outbound American patients and offers a regime that may provide a path forward. Costa Rica has based its development on its human intellectual capital, with a well-educated but fairly inexpensive workforce.<sup>39</sup> The country considers medical travel a strategic national imperative and has committed to quality throughout the healthcare system.<sup>40</sup> The country established the Council for the International Promotion of Costa Rica Medicine (PROMED) as a non-profit organization to position Costa Rica as a leader in international healthcare.<sup>41</sup> PROMED first attempts to limit adverse outcomes by requiring all members providing healthcare or ancillary services to meet all national licensing standards as well as to achieve international accreditation generally recognized in the United States, Canada, or Europe.<sup>42</sup>

It is admirable that Costa Rica attempts to avoid catastrophes by only allowing the highest quality providers to participate in its national promotion scheme. For the purposes of medical malpractice remedies, however, the country's solution to post-treatment patient dispute resolution is more valuable for study and imitation. In addition to offering international quality, Costa Rica offers internationally

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<sup>39</sup> Andrés Rodríguez-Clare, *Costa Rica's Development Strategy Based on Human Capital and Technology: How It Got There, the Impact of Intel, and Lessons For Other Countries*. UN DEV. PROGRAMME 1, 16-17 (2001). available at <http://eml.berkeley.edu/~arodeml/Papers/CRDevelopmentStrategy.pdf>.

<sup>40</sup> Decretos N°35054-S-COMEX-COM-TUR. 34 LA GECETA 2 (Feb. 18, 2009) available at [http://www.gaceta.go.cr/pub/2009/02/18/COMP\\_18\\_02\\_2009.html](http://www.gaceta.go.cr/pub/2009/02/18/COMP_18_02_2009.html).

<sup>41</sup> *About PROMED*, *supra* note 33.

<sup>42</sup> *PROMED: Requirements For Membership*, COUNCIL FOR THE INT'L PROMOTION OF COSTA RICA MED., <http://www.promedcostarica.org/join-promed/membership/requirements> (last visited Feb. 23, 2015).

acceptable options for legal recourse.<sup>43</sup> To that end, PROMED advises its members to use alternative dispute resolution by including an arbitration clause in their contracts with patients.<sup>44</sup> PROMED endorses the Arbitration and Conciliation International Center (CICA) housed at the Costa Rican–American Chamber of Commerce (AmCham) to settle disputes.<sup>45</sup>

AmCham is more than forty years old.<sup>46</sup> The organization's membership is approximately 400 companies and 1,300 corporate representatives with about equal distribution between Costa Rican and American members.<sup>47</sup> Additionally, AmCham is responsible for about eighty percent of Costa Rica's foreign direct investment and approximately the same percentage of Costa Rican exports.<sup>48</sup> CICA was founded in 1999 and is a non-profit entity dedicated to providing conciliation and arbitration services to resolve commercial disputes.<sup>49</sup> CICA promotes the fact that its conciliation and arbitration processes resolve ninety-five percent of controversies presented.<sup>50</sup> Further, CICA's arbitration process has a maximum time limit of seven months.<sup>51</sup> Alternative dispute resolution is an attractive option compared to the unpredictable and lengthy processes offered by the Costa Rican court system.<sup>52</sup> Even if it takes twice as long to settle a

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<sup>43</sup> *CICA: International Center for Conciliation & Arbitration*, COUNCIL FOR THE INT'L PROMOTION OF COSTA RICA MED., <http://www.promedcostarica.org/join-promed/membership/benefits/conflict-resolution/> (last visited Feb. 11, 2015) [hereinafter PROMED, *CICA*].

<sup>44</sup> *Costa Rica Safe Destination for Medical Travelers*, COUNCIL FOR THE INT'L PROMOTION OF COSTA RICA MED., (unpublished promotional material) (on file with PROMED) [hereinafter *Costa Rica Safe Destination*].

<sup>45</sup> *Id.*

<sup>46</sup> *About Us*, Am-Cham, *supra* note 38.

<sup>47</sup> *Id.*

<sup>48</sup> *Id.*

<sup>49</sup> *About Us*, ARBITRATION AND CONCILIATION INT'L. CTR., <http://www.cica.co.cr/pages/cica> (last visited Feb. 12, 2015) [hereinafter CICA, *About Us*].

<sup>50</sup> *Id.*

<sup>51</sup> *Id.*

<sup>52</sup> PROMED, *CICA*, *supra* note 43 (“PROMED supports the alternative dispute resolution (ADR) process because resolution of a dispute, depending on the complexity of the case, could take years in the Costa Rican courts and with no guarantee of a satisfactory result for either party”).

case as CICA's maximum limit allows, malpractice claims would be resolved long before the average case in American courts.<sup>53</sup>

PROMED, Costa Rica's government ministries, and the medical community recognize that the country's medical infrastructure, educational capacity, human intellectual capital, natural beauty, and English proficiency make an attractive offering.<sup>54</sup> However, they also realize that the offering is incomplete if the country and its healthcare providers fail to make patients feel secure by offering a remedy for malpractice.<sup>55</sup> All industry actors are concerned with the prospect of being held liable for malpractice against an American patient because of America's reputation for litigation and large financial awards.<sup>56</sup> So, no competent foreign physician will willingly submit to American jurisdiction. PROMED, therefore advises healthcare providers to offer conflict resolution as one of four necessary components of making Costa Rica a safe healthcare destination and establish the country as a leader in international healthcare.<sup>57</sup> Conflict resolution through CICA is so central to Costa Rica's value proposition that the organization provides members with boilerplate conciliation and arbitration clause language.<sup>58</sup>

Despite the common criticisms of arbitration in general, the regime offered by CICA is equivalent to arbitration regimes to which American patients may freely contract when receiving domestic care. In fact, CICA boasts a cooperative agreement with the International Section of the American Arbitration Association (AAA).<sup>59</sup> CICA's published rates<sup>60</sup> are comparable to those published by AAA for either

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<sup>53</sup> Jena Anumpam, et al., *Outcomes of Medical Malpractice Litigation Against US Physicians*, 172 No. 11 JAMA Internal Medicine (2012), available at <http://archinte.jamanetwork.com/article.aspx?articleid=1151587> (finding the mean length of a litigated malpractice case in the United States to be 25.1 months).

<sup>54</sup> Stephen Wiener Esq., *An Introduction to Legal Issues In Medical Travel: What to Worry About, or Not*, Presentation at The Medical Travel International Business Summit. San Jose, Costa Rica (May 2-4, 2011).

<sup>55</sup> *Id.*

<sup>56</sup> *Id.*

<sup>57</sup> *Costa Rica Safe Destination*, *supra* note 44.

<sup>58</sup> *Id.*

<sup>59</sup> CICA, *About Us*, *supra* note 49.

<sup>60</sup> *Tarifas, ARBITRATION AND CONCILIATION INT'L. CTR.*, <http://www.cica.co.cr/pages/tarifas> (last visited Feb. 12, 2015) [hereinafter CICA, *Tarifas*].

general arbitration<sup>61</sup> or the International Centre for Dispute Resolution.<sup>62</sup> Similarly, all of these organizations offer arbitration by single neutral parties or tribunals.<sup>63</sup>

Based on the equal distribution of interests and financial commitments between the United States and Costa Rica in AmCham's membership, American patients are not likely to suffer at the hands of a bias and hostile system. CICA has significant incentives to provide fair and equitable resolutions. In addition, the American judicial system is not overly friendly to malpractice plaintiffs. The court dismisses more than half of all claims, and approximately eighty percent of the small number of cases resulting in verdicts find in favor of the physician.<sup>64</sup> American patients are free when undergoing care in the United States to either contract for alternative dispute resolution or, absent an agreement, to bring a claim in America's less than hospitable court system. It is no great gamble to rely on arbitration in CICA. The only difference is that a clause requiring conciliation and arbitration under CICA would likely remove the slight but important chance for the mega awards that have given America its reputation in the international community. Some American courts have even recognized the practical benefits of arbitration over the judiciary.<sup>65</sup>

As two of the nations that have ratified the New York Convention,<sup>66</sup> the United States and Costa Rica agree to the

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<sup>61</sup> *Costs of Arbitration (including AAA Administrative Fees)*, AM. ARBITRATION ASS'N., <https://www.adr.org/aaa/ShowPDF?doc=ADRSTAGE2026862> (last visited Feb. 12, 2015) [hereinafter *Costs of Arbitration*].

<sup>62</sup> *International Dispute Resolution Procedures (Including Mediation and Arbitration Rules)*, AM. ARBITRATION ASS'N., [https://www.adr.org/aaa/ShowPDF?doc=ADRSTG\\_004338](https://www.adr.org/aaa/ShowPDF?doc=ADRSTG_004338) (last visited Feb. 13, 2015) [hereinafter *International Dispute Resolution*].

<sup>63</sup> CICA, *Tarifas*, *supra* note 60; *Costs of Arbitration*, *supra* note 61; *International Dispute Resolution*, *supra* note 62.

<sup>64</sup> Amy Norton, *Docs Win Most Malpractice Suits, but Road is Long*, REUTERS (May 23, 2012), available at <http://www.reuters.com/article/2012/05/23/us-docs-win-most-idUSBRE84M11N20120523>.

<sup>65</sup> See COHEN, *supra* note 1, at 104 (discussing *Madden v. Kaiser Found. Hosps.*, 552 P2d 1178, 1185-86 (Cal. 1976), that arbitration offers a venue for minor malpractice claims that cannot economically be resolved in the courts).

<sup>66</sup> *New York Convention Countries*, N.Y. ARBITRATION CONVENTION, <http://www.newyorkconvention.org/contracting-states/list-of-contracting-states> (last visited Feb. 20, 2015).

fundamental characteristics of arbitration and recognize the validity of the arbitration process employed in each other's jurisdiction.<sup>67</sup> This provides a solid, legitimate foundation capable of supporting an adequate alternative dispute resolution regime. Widespread accession to the New York Convention by so many countries<sup>68</sup> indicates that despite general questions about the validity of arbitration, there is broad international agreement about the process. Thus, this allows many nations to provide a sufficient alternative dispute resolution regime to adequately protect American patients.

The industry must build upon the foundation of bi-lateral arbitration recognition with alternative dispute resolution institutions that are somewhat equally supported by the United States and the treating country. One of CICA's most attractive features is that it represents both American and Costa Rican business interests.<sup>69</sup> Despite the fact that CICA has yet to adjudicate an international medical malpractice claim, the organization's equity of interests imbues it with credibility and suggests a degree of impartiality that is critical to international healthcare. The international healthcare market must experiment with these regimes and encourage copycat institutions to evolve organically by learning from awards and patient behavior to strike the right cord. Ratification of the New York Convention and an alternative dispute resolution scheme housed in a bi-laterally funded organization are essential to the early iterations because such regimes will give patients enough of a sense of home to feel adequately protected.

The Costa Rican model offers quality, safety, and alternative dispute resolution. It presents a mix of risk mitigating safeguards and remedial protections that reduce the likelihood of complications and increase the chances of satisfactory dispute outcomes. The system is worthy of imitation and expansion. Based on America's pervasive trade relationships with almost every country where a patient may seek care, similar safety and recourse layering may already exist in

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<sup>67</sup> Convention on the Recognition and Enforcement of Foreign Arbitral Awards art. III, United Nations Conference on International Commercial Arbitration (1958).

<sup>68</sup> See *Bhutan and Guyana Accede to the Convention on the Recognition and Enforcement of Foreign Arbitral Awards*, UN INFO. SERV. (Sept. 26 2014), <http://www.unis.unvienna.org/unis/en/pressrels/2014/unisl207.html> (indicating The Convention it went into force on December 24, 2014 in both countries bringing the number of state parties to 152).

<sup>69</sup> CICA, *About Us*, *supra* note 49.

other international healthcare providing nations, or if not, the infrastructure may be readily available to create them. The American Chamber of Commerce has chapters similar to Costa Rica's AmCham in more than ninety foreign countries.<sup>70</sup> Each Chamber could support an organization like CICA, if it does not already, particularly where the host nation has contracted to the New York Convention. This type of arbitration relationship requires not only the national relationships to foster a fair alternative dispute resolution forum, but the commitment and sophistication of the physician population to offer such a contract provision and well-informed patients to demand such clauses.

Interested parties such as outbound patients, patients' rights groups, treating physicians, attorneys, and United States government agencies are the stakeholders most appropriate to drive the development of alternative dispute resolution regimes in other countries. The stakeholders should encourage the various Chambers of Commerce to create arbitration bodies that equally represent the interests of both the American patient and the treating physician. The nations involved must recognize each other's processes to legitimize the scheme and then build an institution with equal representation from each country, based on existing trade relationships if necessary. Self-referred outbound American patients will then be covered by a network of bi-lateral arrangements that provide remedial protections consistent with the patient's expectation for fair compensation in cases of medical malpractice. Most important, alternative dispute resolution must develop a fair and equitable process patients can trust without scaring off physicians based outside the United States. Once a global network of alternative dispute resolution venues develops, it will become incumbent upon attorneys to ensure their clients do not merely jump at the least expensive offer or the flashiest website and leave themselves exposed.

#### VI. ELECTIVE PROCEDURE INSURANCE PROVIDES ADDITIONAL MEANS OF RECOVERY FOR THE INTERNATIONAL PATIENT

One-time procedure insurance offers an additional layer of protection by vetting participating physicians and providing a

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<sup>70</sup> *American Chambers of Commerce Abroad (AmCham) Results for Region, CONN. BUS. & INDUS. ASS'N.*, <http://www5.cbiam.com/business/american-chambers-of-commerce-abroad-amcham-results-for-region/> (last visited Feb. 25, 2015).

financial safety net accessible by patients with complications resulting from international healthcare. Procedure-specific insurance programs, especially when paired with alternative dispute resolution schemes such as the one discussed above, provide sufficient protections for patients as well as the health system of the patient's home country.

The International Society of Aesthetic Plastic Surgeons (ISAPS) has partnered with an insurer to provide international coverage for complication and revision treatments for outbound British patients. The program is called ISAPS Insurance and is provided by Sure Insurance Services Limited.<sup>71</sup> The insurance plans attempt to keep the rate of complications consistent with high-quality care provided around the globe. This and similar regimes protect patient interests and allay physicians' concerns over major financial damages enough to keep them involved in the international healthcare marketplace.

This procedure-specific insurance offers an additional layer of protection by vetting participating physicians as well as providing a financial safety net. The ISAPS Insurance program is available exclusively to ISAPS member surgeons.<sup>72</sup> ISAPS membership, and by extension the insurance policy, requires participating surgeons to be board certified or the local equivalent in countries without official board certification.<sup>73</sup> By requiring board certification or its equivalent, the society and insurance program seek to assure the highest levels of clinical competency and specialty training.<sup>74</sup> The mitigating effect of such a requirement theoretically drives down the need for patient claims.

In the event of a complication, however, The ISAPS Insurance program offers protection to the patient, the patient's home country, and the physician through various instruments. Such programs,

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<sup>71</sup> *Who We Are*, ISAPS INS., <http://isapsinsurance.com/> (last visited Jan. 20, 2015).

<sup>72</sup> *The Policy*, ISAPS INS., <http://isapsinsurance.com/the-policy> (last visited Jan. 20, 2015).

<sup>73</sup> *International Society of Aesthetic Plastic Surgery By-Laws*, INT'L SOC'Y OF AESTHETIC PLASTIC SURGERY, <http://www.isaps.org/Media/Default/downloads/ISAPS-By-Laws.pdf> (last visited Jan. 20, 2015).

<sup>74</sup> See Susumu Takayanagi, MD., *A Letter from the President of ISAPS*, INT'L SOC'Y OF AESTHETIC PLASTIC SURGERY, <http://www.isaps.org/about-isaps/letter-from-president> (last visited Jan. 20, 2015).

especially when paired with an alternative dispute resolution scheme, provide sufficient protections for all parties.

#### A. Covering the Patient

The ISAPS Insurance program covers patients and companions through three different instruments sold under the product name Medical Travel Shield (MTS).<sup>75</sup> The plans are divided into three products that cover international dental treatment, cosmetic surgery, and elective surgery or in vitro fertilization treatment.<sup>76</sup> All three products cover various travel related incidents as well as certain medical circumstances for patients between eighteen and sixty-six years old.<sup>77</sup> The plans provide for corrective treatments, but do not cover medical or legal costs related to the planned treatment.<sup>78</sup> This is why it is so important to pair this type of instrument with an appropriate method of recovery (e.g., arbitration), in order to fully protect the patient. Any disputes arising out of the policy are governed by the patient's home country, in this case, England and Wales, and bring these claims firmly back into familiar jurisdiction.<sup>79</sup>

The policy ensures the patient receives necessary care up to £2 million in the event of a serious incident, including a life threatening complication during the planned procedure and the cost of repatriation.<sup>80</sup> Covered patients also receive a £50 daily hospital

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<sup>75</sup> *The Product*, MED. TRAVEL SHIELD, <http://medicaltravelshield.com/> (last visited Feb. 22, 2015).

<sup>76</sup> *Id.*

<sup>77</sup> *Medical Travel Shield Key Facts Document: For Persons Travelling Abroad to Receive Dental Treatment*, MED. TRAVEL SHIELD, <http://medicaltravelshield.com/insurance-documentation> (last visited Feb. 24, 2015); *Medical Travel Shield Key Facts Document: For Persons Travelling Abroad to Receive Elective Surgery*, MED. TRAVEL SHIELD, <http://medicaltravelshield.com/insurance-documentation> (last visited Feb. 24, 2015); *Medical Travel Shield Key Facts Document: For Persons Travelling Abroad to Receive Cosmetic Surgery*, MED. TRAVEL SHIELD, <http://medicaltravelshield.com/insurance-documentation> (last visited Feb. 24, 2015) [hereinafter cited collectively as *MTS Key Facts*] The forms are substantially similar in content and format, except each corresponds to coverage for a different type of care. The collective citation indicates the breadth of services covered. Subsequent pin cites reference the location of content on each of the three forms.

<sup>78</sup> *See, MTS Key Facts, supra* note 77, at 2.

<sup>79</sup> *See MTS Key Facts, supra* note 77, at 3.

<sup>80</sup> *See MTS Key Facts, supra* note 77, at 4, 5.

benefit up to a maximum of £1,500, up to £500 for additional foreign healthcare consultations before returning home, and up to £2,000 to return to the original treating hospital within twelve months for any required corrective treatment.<sup>81</sup> It is quite difficult to obtain exact prices because of the pricing structure for insurance. However, the insurance program offers exemplars that suggest patients can protect themselves for a modest investment, especially considering the cost savings usually associated with foreign treatment.<sup>82</sup> One such example is a policy covering a seven-day trip from the United Kingdom to Poland for elective surgery that costs £191.50.<sup>83</sup>

Patients must keep in mind they are receiving medical care, not a “minor procedure” that is treated with little more concern than a haircut. Purchasing coverage will slightly reduce their substantial savings but will cost less than many insured patients pay for one month’s premium, therefore it should not be too unpalatable.<sup>84</sup> The ISAPS Insurance discussed here is currently limited to patients from Britain, but it should be replicated and tried in the United States. The model employed by the policies,<sup>85</sup> which only covers supremely trained physicians, should reduce the instances of payouts and exert downward pressure on premiums. Hopefully this will keep the instruments affordable and offer the right value of contingency planning for patients. The policy’s underwriters at Lloyd’s<sup>86</sup> are surely capable of replicating a quality-driven regime in the United States that will not price out patients and drive them to lower cost, lower quality treatment locations.

Insurance coverage such as MTS protects the patient from exorbitant out of pocket expenses for emergent or revision treatment as a result of the original care.<sup>87</sup> Since many of the outbound international patients addressed by this Article are financially vulnerable when it comes to healthcare expenses, the cost of follow-

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<sup>81</sup> See *MTS Key Facts*, *supra* note 77, at 5.

<sup>82</sup> See *PATIENTS BEYOND BORDERS*, *supra* note 14 (estimating the range of cost savings for American patients in popular treating nations).

<sup>83</sup> *How Much Does it Cost?*, MED. TRAVEL SHIELD, <http://medicaltravelshield.com/how-much-does-it-cost> (last visited Feb. 8, 2015).

<sup>84</sup> See *PATIENTS BEYOND BORDERS*, *supra* note 14 (estimating the range of cost savings for American patients in popular treating nations).

<sup>85</sup> See *ISAPS INS.*, *The Policy*, *supra* note 72.

<sup>86</sup> See *MTS Key Facts*, *supra* note 77, at 8.

<sup>87</sup> See *MTS Key Facts*, *supra* note 77.

up care is likely to fall on the public health system, specifically Medicare, Medicaid, or the hospital whose emergency room admits the patient.<sup>88</sup> Therefore, procedure-specific insurance also protects the patient's home country from bearing the cost of malpractice and it does so in a far more economical way than purchasing traditional health coverage. Outbound American patients need such an option, and since it would benefit the public healthcare system, institutions like the Centers for Disease Control and Prevention and the Department of State should produce public service content on the subject.

Each American Embassy and Consulate typically has a United States Citizen Service section that lists available services in the diplomatic mission's district, including healthcare.<sup>89</sup> This site would be the ideal place to educate patients about available healthcare coverage as well as legal recourse options in the event of malpractice. Combined with expanding the main State Department travel website to include the same information on each country, such public outreach would be extremely effective in channeling patient behavior.<sup>90</sup> These organizations are valuable conduits of information because so many people reference their websites before travelling to identify needed travel vaccines, visa requirements, and travel advisories. Integrating information into these sites about healthcare quality, options for malpractice claims, and available self-insurance products will provide outbound patients with information about international healthcare that is relevant to making an informed decision about their choice in care. It would encourage patients to seek care in an environment that provides coverage and recourse at a level that satisfies patient expectations and with which they are comfortable. It will encourage better care and remedy and effectively channel patients into a higher quality care environment.

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<sup>88</sup> See COHEN, *supra* note 1, at 96–97.

<sup>89</sup> See e.g., *U.S. Citizen Services: Lawyers and Doctors*, EMBASSY OF THE U.S.: SAN JOSE, COSTA RICA, <http://costarica.usembassy.gov/service/lawyers-and-doctors2.html> (last visited Feb. 3, 2015) (listing typical information found on the website or from the office of each American diplomatic mission).

<sup>90</sup> See COHEN, *supra* note 1, at 108–15.

*B. Keeping Physicians Engaged*

The obverse party in the international healthcare relationship is the physician. For all of the reasons detailed above, physicians have powerful incentives to both offer patients remedy and mitigate the potential costs of those remedies to preserve the financial savings they offer. If physicians continue to present no remedy in the face of high profile adverse outcomes, they will forfeit their opportunity to attract patients. However, if transaction costs associated with remedies erode cost savings, physicians will once again forfeit their chances at winning over American patients. Finally, if the only option is to pay out-of-pocket for corrective care in the United States and be hauled before an American court, many physicians will walk away from the American market, focusing instead on patients from a less litigious society where big damage awards are less common.<sup>91</sup> The treating countries share the same concerns as individual physicians; not because of the prospect for personal financial ruin, but for the possibility of massive losses to the national reputation affecting many economic sectors.<sup>92</sup> The country's worries aggregate those of all the individual physicians with added concern over harming the tourism, hospitality, and travel sectors of their economy.<sup>93</sup>

The ISAPS Insurance regime protects these interests as well. Once again, the insurance attempts to use quality indicators to keep complication rates, and therefore premiums, low.<sup>94</sup> The plan limits the physician's exposure by allowing them to choose their indemnity to between 2,000 and 15,000 in either American Dollars, Euro, or Pounds.<sup>95</sup> The operating physician pays a premium of six percent of the indemnity coverage.<sup>96</sup> As a result, the patient receives coverage

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<sup>91</sup> Wiener, *supra* note 54.

<sup>92</sup> See Jonathan Head, *The Dark Side of Cosmetic Surgery in Thailand*, BBC NEWS (Feb. 12, 2015), <http://www.bbc.com/news/business-31433890> (suggesting specific cases implicate the overall quality of Thai healthcare).

<sup>93</sup> See Kelley, *supra* note 9 (noting Singapore received 850,000 patients in 2012 generating \$3.5 billion in revenue); See also Connell, *supra* note 36, at 132-33 (noting medical tourists spend two to three times more than standard tourists with a significant amount of spending outside of healthcare and creating many non-healthcare jobs).

<sup>94</sup> See ISAPS, *The Policy*, *supra* note 72.

<sup>95</sup> *Surgeon's Guide*, ISAPS INS., <http://isapsinsurance.com/documents> (last visited Feb. 25, 2015).

<sup>96</sup> *Id.*

for corrective procedures for up to two years following the original treatment.<sup>97</sup> Especially important in the context of international healthcare, if the patient-physician relationship has broken down or it is not possible for the patient to return to the original physician, the insurance will cover the correction by a highly trained and qualified surgeon in the patient's home country.<sup>98</sup>

The resulting remedy helps bridge the gap between a potentially crippling financial award and leaving the patient out in the cold with no options. If a physician coverage regime were employed reasonably and in conjunction with patient purchased coverage, the adverse outcomes would be less acerbic except in the most extreme cases. Just like cases in domestic healthcare, any adverse outcome is sensitive but when patients have options, the situation is less likely to balloon into a damaging media firestorm that harms the physician's and nation's reputation.

The premiums involved are modest but do consume some of the cost savings foreign providers tend to present, which can challenge the allure of international healthcare.<sup>99</sup> As costs increase, patients may be more likely to bypass protections and go to another provider. Perhaps patients will be won over by more impressive marketing and patient testimonials, thinking the additional insurance unnecessary in a location that looks, but might not actually be, higher quality. Alternatively, some patients may simply opt to stay home.<sup>100</sup>

It is difficult to strike a balance in the international healthcare market. Physicians must attract patients by demonstrating comparable quality to that available in the patient's home country. They must also be careful not to over trivialize healthcare into a purely consumer endeavor so that patients believe they can go anywhere and be treated safely. And they must do so while offering sizeable cost savings. The phrase "but it was just a minor procedure" abounds. Patient and physician insurance policies offer a significant development capable

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<sup>97</sup> *Id.*

<sup>98</sup> *Id.*

<sup>99</sup> See Deloitte, *Consumers in Search of Value*, *supra* note 9, at 6 (identifying cost savings as a key driver in international healthcare).

<sup>100</sup> See Deloitte Center for Health Solutions, *Medical Tourism: Update and Implications* 1, 11 (2009) [http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20assets/documents/us\\_chs\\_medicaltourism\\_111209\\_web.pdf](http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20assets/documents/us_chs_medicaltourism_111209_web.pdf) (indicating a fifty percent cost saving is a critical threshold to get patients to travel outside their community for care).

of protecting those who seek care abroad before costs are incurred and in a way that limits the exposure of both parties to financial distress.

## VII. CONCLUSION

The people who seek foreign care are not merely passengers, travelers, consumers, or customers. They are patients, and it is the responsibility of the legal profession to keep that distinction in focus, while helping foster the appropriate protective institutions. The large number of patients traveling for care, whom have not been incentivized to do so by employers or insurers, are utterly exposed at present. They have no opportunity to recover for malpractice. As a result, the patients and the American healthcare system risk absorbing the cost of complications on a personal and national level. In the absence of a universally recognized international court system to enforce malpractice judgments, which seems unlikely, a network of bi-lateral institutions is needed.

The Romulus and Remus of international medical malpractice have been born in the form of Costa Rica's bi-lateral alternative dispute resolution forum and ISAPS' procedure-specific insurance regime. These are not mature and finished solutions. They are the infant versions of what will eventually emerge to offer patients malpractice protection. These schemes must be studied, emulated, and improved upon to create an international healthcare system that approximates the protections American patients enjoy at home without driving costs beyond reach.

The solutions discussed in this Article pose the greatest benefit to the independent patient seeking outpatient care in an unaffiliated clinic. Such patients act without the prodding of an employer or insurer, and without the help of a facilitator. Therefore, no established theories of liability exist to give these patients recourse against tortfeasors in American courts. However, even if American case law develops to hold domestic agents liable for foreign malpractice against insured patients or those who have been referred to international care by their employer, the regimes discussed herein would still add an additional layer of patient consumer protection that is currently unavailable.