Transnational Medical Travel:
Ethical Issues, Patient Care & Public Health Concerns

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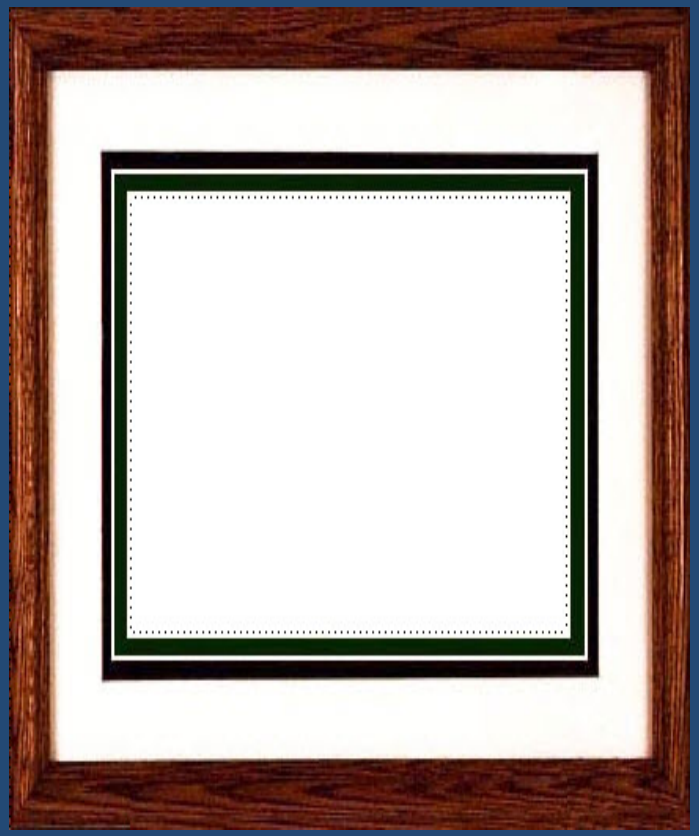
"Medical tourist": Same phrase, multiple meanings

- Health care providers travel to a site and provide short-term medical care. They are labeled "medical tourists" because of the brief period they remain in the field.
- "Medical tourists" travel to a country and are criticized for using that nation's health care system to obtain publicly funded care.
- *"Medical tourists" are individuals who travel to another country or (some would argue) travel intra-nationally for health care.*
- *"Medical tourists" travel for health care and take advantage of local tourist attractions, "5-star" hotels, "VIP" treatment, etc.*

Proliferation of Health-related "Tourisms"

- Medical tourism
- Health tourism
- Transplant tourism
- Stem cell tourism
- Reproductive tourism
- Cosmetic surgery tourism
- Lipotourism
- Abortion tourism
- Suicide tourism
- Wellness tourism
- Spa tourism



- Source: http://www.wildlifephotos.com/Shop-Our-Store/images/frame.jpg

How Do Words Frame Understanding?

- Does the medical tourism (MT) label trivialize various types of travel? (E.g., abortion tourism, suicide tourism, transplant tourism)
- Does the catch-all word “tourism” play a role in lumping together what might otherwise be analyzed as quite distinct activities?
- How does understanding of ethical issues shift when the phrases “medical refugees” or “medical exiles” are used instead of “medical tourism”?
- Effective marketing phrase but is it also a useful tool for ethical, social, policy analysis?

Why Travel for Health care?

- *Cost savings* for individuals and/or health insurers
- *Wait times* at local facilities and immediate treatment elsewhere
- *Unavailability* of treatment at local institutions
- *Reputation* of particular medical facilities
- *Immigrants and former expats* who return home for care

Why Travel for Health Care?

- Seek interventions that are *illegal* and unavailable in country of origin
- Search for interventions that are not approved in country of origin but *inspire hope* of effective treatment (e.g., “stem cell” injections, “Liberation therapy” for patients with MS)
- *Low barriers* to obtaining desired intervention (e.g., sex reassignment surgery in Thailand)
- Search for *alternative/indigenous/complementary medicine*
- *Journeys to sites* reputed to have special healing powers

Ethical Issues, Patient Care & Public Health Concerns

- 1) Information disclosure and informed patient choice
- 2) For-profit medicine, clinical judgement, and avoiding doing harm
- 3) Patient safety and variations in quality of care
- 4) Good clinical practice and post-operative care
- 5) Ethics of combining long-distance travel & surgery
- 6) Quality of hospital and clinic accreditation
- 7) Harms to TMT and Compensatory Justice
- 8) Public health & health equity in destination nations
- 9) Public health in source nations
- 10) Fairness & use of public resources following TMT
- 11) Exploitation of individuals living in poverty
- 12) TMT, internet, and vulnerability to fraud

TMT: Case Reports of Infections & Other Complications

- AUS: Infected knee joint after arthroplasty in India (Cheung and Wilson, 2007)
- Canada: 10 pts. with complications (slipped band, perforation, pouch dilation, etc.) following bariatric surgery in Canada, Mexico, and US (Birch, Vu, Karmali et.al, 2010)
- Germany: Infection after cosmetic surgery in Caribbean (Hassler, Braun 2004)
- Germany: pt with vascular prosthesis penetrating gastric wall−pt. was supposed to have adjustable gastric band in Czech Republic(Scheiber, Henniges, Schulze, Thies, 2009)
- Germany: 20 pts. with complications following refractive surgery in China, Greece, Iran, Russia, Switzerland, Slovakia, Spain, South Africa, Turkey, USA (Terzi, Kern, Kohnen 2008)
- NZ: 4 pts with complications following “cosmetic tourism” (Yang, Al-Ani, Bartlett, Moazzam, 2009)

TMT: Case Reports of Infections & Other Complications

- Switzerland: 1 pt. with infected breast and pulmonary embolism following breast augmentation in DR (Handschin, Banic, Constantinescu, 2007)
- UK: 3 pts. with infections following breast augmentation in Brazil, breast augmentation in Belgium, abdominal liposuction and abdominoplasty in Tunisia (Birch, Caulfield, Ramakrishnan 2007)
- UK: 2 pts. with dental complications following dental surgery in SE Asia and Eastern Europe (Milosevic 2009)
- UK: 1pt. infection and abdominal wall reconstruction following mid-urethral tape procedure in India (Walker, Brooker, Gelman 2009)
- US: 20pts developed *Mycobacterium abscessus* wound infections after undergoing abdominoplasty ("lipotourism") in DR (Furuya, Paez, Srinivasan, et.al. 2008)

TMT: Challenges to Informed Patient Choice

- Some patients travel to international medical facilities without prior efforts to discuss risks and benefits of treatment
- Language differences can impede communication of risks & benefits
- Variation in practices of information disclosure
- Ability of distant physicians to make diagnoses and discuss treatment options is undermined if tests, records, recommendations of family physician and/or specialists are unavailable
- For-profit orientation of medical tourism companies & destination hospitals might shape framing of risks and benefits

Selling Medical Procedures

- Goal of communicating with clients: “Converting inquiries to patients at 10%”
- “Call before the competition, address concerns…move patient to the next step.”
- “Treat the call like a free, initial consultation…Push to next step.”
- “Provide more information about your offering—the full pitch, provide additional incentives.”
- “If you have been unable to elicit a response after the 1st email and call, all is not lost! It is time to provide additional information and extra incentives!”

- Rob Passmore. Converting International Patient Inquiries at 10%-Part 2”. *Medical Tourism Magazine* 2009; December 17. http://medicaltourismmag.com/

Selling Medical Procedures

- “Leading providers add incentives at this stage…It is better (and more profitable) to secure the patient without incentives but this can help with a communication tipping point. Pick ‘high perceived value, low actual cost’ incentives. Examples include:
- i. Procedure discounts available if booked before end of month
- ii. Free guides to medical tourism or specific procedures.
- iii. Free limousine from home to/from airport.
- iv. Free hotel upgrade for recuperation.
- v. Free flights or upgrades.”
- “It is worth trying the patient again (and again) if they have provided their phone number.”
- “Implementing these recommendations will significantly increase the levels of patients you secure—we have seen it happen with other healthcare providers who are enjoying extremely high conversion rates and low patient acquisition costs.”

Standard Model of Informed Consent vs. Selling TMT

- Duty of physicians to disclose to patients:

- Diagnosis
- Nature of proposed investigation or treatment
- Risks and benefits of recommended treatment
- Risks and benefits of alternatives to recommended treatment
- Consequences of nontreatment
- Significance of risk is informed both by frequency of risk (likeliness of harm) and seriousness of risk (severity of harm)
- For informed consent to exist patients must be informed, consent must be voluntary, and patients must have decision-making capacity

Ethical Concerns: Communication

- How thorough are MT companies and destination hospitals when discussing risks?
- Do sales agents or clinicians discuss procedures with clients?
- What communication practices occur in this context?
- What happens when patients are willing to purchase care that is unnecessary or where risks exceed benefits?

First, Do No Harm

- Fiduciary understanding of health care means clinicians must avoid doing harm and act in best interests of patients
- Can sometimes mean not providing health services pts. seek
- Good clinical judgement includes knowing when not to provide particular interventions even when pt. will pay for treatment
- Global health services marketplace generates 2 concerns:

- 1.) Risk that decisions about treatment occur without adequate discussion of risks

- 2.) Risk that in a global marketplace physicians somewhere will provide service for fee even if local caregivers think particular intervention contravenes good medical practice

Case Report 1

- Elderly male underwent knee arthroscopy at hospital in Australia
- Osteoarthritic changes noted but local surgeon advised non-operative treatment based on arthoscopic findings, previous management of health problem, and relationship with pt
- Pt. instead contacted medical tourism company, flew to India, and underwent total knee arthroplasty
- 3 months post-op septic joint developed and *Mycobacterium fortuitum* identified
- Treatment required 4 operations
- Cost to patient of surgery in India: $8,600
- Cost to Australian hospital providing subsequent care: $140,000

- Cheung I, Wilson A. Arthroplasty tourism. *MJA* 2007; 11: 666-667.

Case Report 2

- 75 yr old woman visited UK gynecology clinic in 2005
- Pt complained of symptoms of stress urinary incontinence
- Advised to see physiotherapists for pelvic floor muscle training (PFMT)
- Clinical guidelines recommend PFMT for min 3 months 1st-line therapy
- 2 yrs later pt. seen after having mid-urethral tape procedure in India
- Nonstandard tape used, pt. presented with infection, symptoms persisted following treatment with antibiotics
- Operation performed to remove tape, inguinal hernia developed, urinary leakage from abdominal wound, vesico-cutaneous fistula developed, laparotomy required
- Cost to NHS for treatment: 19,601 pounds;Cost of PFMT: 31 pounds

- Walker H, Brooker T, Gelman W. Abdominal wall reconstruction following removal of a chronically infected mid-urethral tape. *Int Urogynecol J*. 2009; 20: 1273-1275.

Patient Safety & Variations in Quality of Care

- Education and training of health care providers
- Standards for licensure of caregivers
- Role of professional colleges and other regulatory bodies in maintaining professional standards
- Screening of blood, transplanted tissues and organs
- Infection control in OR, wards, etc.
- Risk of exposure to malaria, hepatitis, etc.
- Standards of clinical practice & laboratory practice
- Quality of hospital accreditation
- Quality of antimicrobials and presence of counterfeit medications
- Food and water hygiene
- Green S. Medical Tourism—A Potential Growth Factor in Infection Medicine and Public Health. *Journal of Infection* 2008; 57: 429.

Good Clinical Practice & Post-Operative Care

- Continuity of care is a problem in some cases
- Surgeons usually treat pts. post-op or transfer care to another MD
- Many infections are not evident immediately after surgery
- Median interval for post-surgery symptom devt. in U.S. pts returned from abdominoplasty in DR: 7 weeks (range 2-18 weeks)
- Lack of post-op care increases risk of morbidity and mortality
- Good clinical medicine requires a continuum of treatment

Ethics of Combining Long-distance Travel & Surgery

- Association between increased length/duration of travel & risk of venous thromboembolism
- Additional risk factors for VTE include:

- Air travel shortly before or after surgery combined with failure to provide adequate thromboprophylaxis
- History of smoking
- Obesity
- Use of estrogen contraceptives
- Previous VTE episode
- Familial thrombophilic disorder
- Dehydration in flight
- Decreased air pressure in flight
- Increased fluid retention in flight
- Thrombosis caused by seat compression and blood vessel lesions

Pulmonary Embolism Following "Plastic Surgery Tourism"

- 31 yr old woman treated in Bern, Switzerland
- Underwent breast augmentation 12 days previously in DR
- 3 days post-surgery pt took 9 hr economy-class flight to Switzerland
- No post-op thrombosis prophylaxis or compressive stockings
- Pt arrived at hospital experiencing acute chest pain
- Right breast implant removed and infection treated
- Pulmonary embolism of upper lobe pulmonary artery diagnosed

- Handschin A, Banic A, Constantinescu M. Pulmonary Embolism After Plastic Surgery Tourism. *Clinical and Applied Thrombosis/Hemostasis* 2007; 13: 340.

Air Travel, Surgery, and VTE: Ethical Concerns

- Does informed consent in TMT include discussion of risks of combining travel & surgery?
- What are travel & surgery related risks for individual patients?
- Is information tailored to risk profiles of individual patients?
- How often are TMT provided prophylactic therapies before/after travel and surgery?
- Does TMT underestimate risks of combining surgery & air travel?
- What would good clinical practice guidelines recommend as an appropriate delay between travel and surgery?

Quality of International Hospital & Clinic Accreditation

- International accreditation often used to claim that particular health care facilities provide an “international” standard of care
- “Gold seal of approval” provided by JCI is used to market international health care facilities
- Many MT companies build networks of JCI accredited institutions

Joint Commission: History of Controversy

- 1999: Office of Inspector General of DHHS publishes report concluding that JC was “unlikely to detect substandard patterns of care or individual practitioners with questionable skills.”
- 2004: Government Accountability Office determined that 78% of time JC surveys did not find serious deficiencies noted by state inspectors
- Criticism that JC suffers from “regulatory capture” and fails to identify substandard care, negligent caregivers & other deficiencies found by state and federal inspectors

Meaning of JCI Accreditation?

- JCI website indicates which international facilities are accredited but does not disclose survey results and basis for decisions
- JCI provides publicly accessible Accreditation Quality Reports for U.S. hospitals but no comparable reports for international facilities
- JCI will release information about # of complaints for particular institutions but additional info is not disclosed
- JCI website does not reveal which international facilities fail to receive accreditation, had accreditation revoked, or have accreditation under review
- Critics argue that direct payment by hospitals to JCI compromises quality of accreditation process

Harms to TMT and Compensatory Justice

- Numerous researchers argue that TMT will find it difficult to sue and obtain legal redress in event of medical malpractice
- Need to be cautious when addressing legal protections for TMT—there are as many legal systems as there are countries to which patients travel for care
- Recognizing this point, there are some noteworthy TMT destinations where pts might find it difficult to sue in event of negligent care
- Need well-defined legislation and/or case law, investigators, courts able to address complaints in a timely manner, health care providers willing to testify that pt. received treatment falling outside a professional standard of care, consistent practice standards, etc.

Medical Tourism Companies: Adequate Accountability?

- Many MT companies insist that clients sign waiver of liability forms
- Clients must agree that in event of medically negligent care they will not sue MT company
- Many waivers stipulate that MT companies do not provide medical services and provide no assurances about medical care
- If client wishes to sue lawsuit must be directed at hospitals and health care providers in destination nations
- If MT companies cannot be sued and there are practical obstacles to suing destination facilities and health care providers TMT can find it impossible to obtain compensatory justice

Public Health & Health Equity in Destination Nations

- TMT risks promoting highly stratified health care systems with “5-star” facilities reserved for international patients and local elites
- Focus upon selling procedure-oriented, technology-driven health services rather than promoting preventive medicine, public health & access to primary care
- Higher salaries for clinicians working at private hospitals and risk that health care providers will migrate from public health care facilities to for-profit hospitals
- Local patients cannot afford care at for-profit private hospitals and public facilities are understaffed
- Local officials often assert that MT will be used to cross-subsidize publicly funded medical care for local patients but at least in India claims do not appear to match some corporate practices

Health Equity & Public Health Considerations

- Critics suggest that public funds used to subsidize care of international patients should instead be directed toward improving basic public health infrastructure and promoting health equity
- Little reason to assume that all TMT destinations will successfully compete for patients—risky use of public resources if goal is to promote economic development
- Lack of access to health care, health care providers serious problem in many countries attempting to attract international patients

Public Health In Source Nations

- Elderly male pt. with no prior history of Hepatitis B traveled to India and received a renal transplant there in February 2001
- Returned to UK with HBV—not diagnosed until October 2002
- Outbreak of Hepatitis B in 2 hospitals and community in UK
- Before infection was detected in primary case HBV transmitted to at least 8 other individuals
- 3 individuals were family members of pt, 4 cases linked to 2 hospitals in which pt received treatment, 1 case was spouse of individual treated in 1 of the hospitals in which primary case treated
- 7 developed acute Hepatitis B, 1 seropositive, did not experience acute illness, but was link between his spouse and primary case

- Harling R, Turbitt D, Millar M et.al. Passage from India: an outbreak of hepatitis B linked to a patient who acquired infection from health care overseas. *Public Health* 207; 121: 734-741.

Public Health Consequences of TMT

- Decisions by individuals who arrange TMT can have public health consequences in home countries
- 732 “at risk” patients identified at 2 hospitals
- All contacted but only 336 underwent testing for HBV & possibility of cases not identified in study
- If inadequate testing, screening, and infection control occurs in health care destination infectious diseases can travel with TMT
- Risks may be unknown to pts. and health care providers
- Possibility of additional outbreaks if >pts travel for treatment
- Investigating outbreaks uses public resources

Questions of Fairness and Use of Public Resources: Who Should Pay When Patients Require Care After TMT?

- Many publicly funded health care systems do not provide coverage for elective cosmetic surgery.
- Substandard surgery and infections can lead to complications
- Should publicly funded health care plans cover costs of treatment when TMTs return home with complications after undergoing inexpensive cosmetic surgery procedures?
- Questions concerning fairness and resource allocation raised when treating complications of TMTs

Fairness and Use of Publicly Funded Health Services

- "Inadequate arrangements for follow-up care mean that patients routinely present to local plastic surgeons with post-operative complications or concerns that arise after their return to the UK…At the present time there is no clear or consistent policy across NHS providers or commissioners for the treatment of such patients presenting with acute complications of their surgery or, in the longer term, for elective revision procedures. Such procedures would not normally be funded by the NHS and the question is therefore raised as to who should fund treatment of complications following overseas private cosmetic surgery."

- Jeevan R, Armstrong A. Cosmetic Tourism and the burden on the NHS. *Journal of Plastic, Reconstructive & Aesthetic Surgery* 2008; 61: 1423-1424.

Exploitation of Vulnerable Populations: TMT & Kidney Transplants

- Impoverished populations as “spare parts supply” for citizens from comparatively wealthy societies
- Movement from highly regulated to poorly regulated clinical settings
- Poverty & corruption as common backdrops to kidney selling
- Numerous studies report no long-term economic benefits combined with deterioration of health for most sellers
- Inadequate screening puts sellers and transplant recipients at risk
- Risk of infection, graft failure, morbidity, and mortality is greater with commercial kidney transplants

TMT, Fraud, and the Internet

- Internet facilitates global shopping for health services and also transnational fraud
- Desperate, seriously ill individuals are vulnerable to “cures” advertised on internet
- Health-related fraud poses significant practical, jurisdictional, and financial challenges to law enforcement agencies

TMT & Internet Fraud

- Erwin Benke, 54, travelled from AB to Philippines for liver transplant
- Contacted “Dr. Mitch Michaelson” after finding www.liver4you.org
- Arrived in Manila May 31, 2008
- Wired $70,000 CDN to account in DeWitt, NY
- Benke died in Philippines without receiving a transplant and after accumulating over $20,000 in hospital expenses
- “Dr. Michaelson was one of 9 aliases of Jerome Feldman
- Feldman was a fugitive from U.S. justice system, former psychiatrist who had state and federal fraud charges brought against him for Medicare and Medicaid fraud in Florida
- Engaged in transplant fraud in Philippines for 6-10 years
- Feldman extradited to US, charged with 5 counts wire fraud, sentenced to 15+ years in prison

Summary of Ethical Issues

- 1) Provision of information and barriers to IC
- 2) Clinical judgement and for-profit medicine
- 3) Quality of care gradients
- 4) Good clinical practice and importance of post-op care
- 5) Wisdom of combining surgery & long-distance travel
- 6) Quality of international accreditation
- 7) Accountability when medical negligence occurs
- 8) Health equity in destination nations
- 9) Public health in source nations
- 10) Fairness and burden of providing post-op care for TMTs
- 11) Exploitation of impoverished individuals
- 12) TMT, internet, and vulnerability to fraud
- Goal of presentation: Provide a rough “map” of ethical issues warranting analysis when examining TMT

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