Summer 2016

Toward an International Constitution of Patient Rights

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Recommended Citation


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Toward an International Constitution of Patient Rights

ALISON PODLASKI*

ABSTRACT

In the past decade, medical tourism—the travel of patients across borders to receive medical treatment—has undergone unprecedented growth, fueled by the globalization of health care and related industries. While medical tourism can benefit patients through increased access to treatment and cost-savings, medical travel also raises concerns about ensuring quality of care and legal redress in medical malpractice. Moreover, existing regulations fail to address these unprecedented issues. The multilateral adoption of an International Constitution of Patient Rights (ICPR) is necessary in order to more effectively preserve medical tourism's benefits and guard against its risks.

INTRODUCTION

Vince Ellis is a medical tourism success story.1 The fifty-eight-year-old U.S. citizen needed knee replacement surgery, but the high cost of medical care in the United States was daunting, and even with insurance through his employer, he faced a sizeable deductible payment.2 Instead, his employer sent him to Costa Rica, where he received a knee replacement—along with a luxury vacation package—at

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2. See id.

Indiana Journal of Global Legal Studies Vol. 23 #2 (Summer 2016)
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a far cheaper price than he would have paid domestically. He returned home without complications and is now pain-free and back to work.

Howard Staab was in desperate need of cardiac surgery to repair a failing mitral valve. But as an uninsured carpenter from North Carolina, he could never afford to pay its cost—over $200,000 with a mandatory 50 percent down payment—for the procedure in the United States. Instead, he traveled to India, where he received the same procedure for only $6,700. In 2006, Staab testified before Congress about his experience. Media coverage of Staab's experience in India depicted his procedure as a cost-efficient and life-saving success. Yet little attention was paid to the challenges Staab encountered attempting to receive treatment domestically when he fruitlessly bargained with U.S. hospitals for a reduced rate. Moreover, news stories glossed over the postsurgery complications Staab experienced that required him to undergo another surgical procedure and extend his stay in India, as well as the accompanying physical, emotional, and financial stress.

Joy Williams, a twenty-four-year-old British woman, traveled to Thailand in October 2014 for cosmetic tailbone surgery to correct a previous procedure. She had planned to save money by having the surgery done abroad rather than in Britain. As part of the routine procedure, she was given an intravenous anesthetic. Unfortunately, she suddenly stopped breathing while under the anesthetic and died,

3. Id.
4. Id.
6. Id.
7. Id.
9. Howze, supra note 8, at 1051; see also Lancaster, supra note 8, at A01.
11. Harris, supra note 10; see also Pearlman, supra note 10.
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despite revival attempts. The operating physician, who was not properly certified for the procedure, was arrested and has been charged in connection with her death. Yet there is no way of knowing how far a lawsuit would proceed given the complications of international legal action. Even in a best-case scenario, a lawsuit will not bring her back to life.

These stories indicate the range of patient experiences within this growing global industry in which patients travel across borders for medical treatment. In some instances, like that of Vince Ellis, medical tourism is lauded as a panacea to the skyrocketing cost of domestic health care in countries like the United States. Medical tourism can also allow patients to obtain treatments such as in vitro fertilization (IVF) and experimental drugs that are unavailable or restricted to certain groups in their home countries.

The stories of Staab and Williams, however, highlight some of the undeniable risks of medical travel for patients, including lack of information, unforeseen costs, medical complications, inadequate legal redress for malpractice, and even death. These troubling ramifications have fostered a prolific discussion about possible means of regulating the medical tourism industry. At present, however, most commentaries discuss this burgeoning field in purely economic terms, rather than focusing on patients' rights. These approaches fail to recognize that the globalized health care industry is fundamentally different from other international markets. Though the expansion of medical tourism is inextricably linked with broader globalization

13. Id.
14. Id.
15. Howard, supra note 1.
18. See infra Section II.
trends, it is a distinctive market because it deals not with manufactured goods, but with living, breathing human beings seeking life-altering and sometimes essential medical treatments.

While economic regulation of medical tourism is important, regulation must also be informed by a human element, specifically a focus on patients' rights. Medical tourism implicates fundamental human experiences such as disease, suffering, vulnerability, death, healing, and wellness. In addition, the globalization of health care has a far-reaching impact on the meaning and scope of another human dimension of care: the physician-patient relationship. These unique facets of medical tourism demonstrate the need for increased emphasis on patient-focused approaches to regulation.

This Note examines medical tourism and the impact of globalization on health care through a patient-focused lens, drawing primarily on the experiences of U.S. patients and U.S. laws regulating health care and medical malpractice. The emphasis on U.S. patients is appropriate first because medical tourism is a new and rapidly changing global industry with limited documentation available, especially for patients traveling from countries other than the United States. Moreover, because the United States is recognized as a litigious country, especially when it comes to medical malpractice claims, and has a highly developed system of medical malpractice law, a U.S. focus allows for full examination of the intersection of medical tourism and civil liability. The United States, like many other developed countries, also has various other health-care regulation mechanisms established by governmental and nongovernmental organizations in both the public and private sectors.


22. See Nathan Cortez, Patients Without Borders: The Emerging Global Market for Patients and the Evolution of Modern Health Care, 83 IND. L.J. 71, 73 (2008) [hereinafter Cortez, Patients Without Borders] (noting the scarcity of research on medical tourism and lack of internationally comparable data). While writing this Note, the vast majority of the existing literature on medical tourism that I encountered focused on the United States, with very little analysis on other countries.


24. See Williams, supra note 17, at 654.
Accordingly, much of the discussion, particularly of U.S. quality of care and health care regulation, also applies to other similarly situated developed countries around the world. For these reasons, relying on comparison to the United States not only makes use of the relatively limited data, but also provides a helpful basis for discussing the issues that medical tourism raises in the broader global context.

In response to the legal and ethical challenges posed by global medical tourism, this Note proposes the creation of an International Constitution of Patient Rights (ICPR) as a key component of effective regulation that will maintain the benefits of medical tourism for patients while more fairly allocating the accompanying risks. Part I introduces the concept of medical tourism and examines the complex dynamics that have shaped the emergence of this global trend. Part II discusses the dark side of medical tourism, identifying risks to patients as well as associated legal and ethical issues. Part III then examines existing and proposed options for regulating medical tourism. Part IV argues that the creation and multilateral adoption of an International Constitution of Patient Rights will protect patients' interests as well as those of other participants in medical tourism and so play a pivotal regulatory role. Part V then proceeds to outline preliminary ICPR provisions. Finally, Part VI of this Note identifies issues that must be resolved in the process of drafting the ICPR and responds to potential criticisms.

I. THE EMERGENCE AND BENEFITS OF MEDICAL TOURISM

A. Emergence of the Medical Tourism Industry

In medical tourism, patients travel from a home country to a foreign destination to receive medical treatment.\(^{25}\) While this term evokes modern images of patients going on long-distance flights halfway around the globe for surgeries or experimental medical treatments, the basic idea of traveling for health care is certainly not novel. Ancient Greeks and Romans traveled across borders seeking the health benefits of mineral spas and hot springs along the Mediterranean coast.\(^{26}\) In more recent history, wealthy individuals from foreign countries have traveled to the United States for decades to receive treatment from premiere health care providers like the Cleveland Clinic and Mayo Clinic.\(^{27}\) In the present day, however, medical tourism has taken on a

\(^{25}\) Cohen, Protecting Patients, supra note 17, at 1471.
\(^{26}\) See id.
\(^{27}\) See Bennie, supra note 19, at 585 (discussing how the United States has been a sought after medical tourism destination because U.S. hospitals offer the most cutting
new meaning and has expanded to become a global industry.\textsuperscript{28} It generates an estimated $50 billion to $60 billion annually, with anticipated growth to $100 billion in the next decade.\textsuperscript{29} While the exact extent of medical tourism is difficult to calculate, the U.S. industry group Patients Beyond Borders estimates approximately eleven million patients travel across borders for medical treatment annually.\textsuperscript{30}

Trends in patient travel patterns have shifted dramatically in recent years. In the past, medical tourists were generally wealthy individuals from less-developed countries seeking care in more-developed countries.\textsuperscript{31} Today, however, more and more patients from the United States and other developed countries travel to less-developed countries for treatment.\textsuperscript{32} While estimates vary, the Deloitte consulting group's report on medical tourism calculated that 750,000 patients travelled from the United States to receive medical treatment in foreign countries in 2007, with forecasted growth of 35 percent.\textsuperscript{33} Meanwhile, more recent assessments and studies defining medical tourism more broadly propose estimates of up to one million U.S. patients per year.\textsuperscript{34}
Though the lack of regulation makes data collection difficult, available estimates nevertheless indicate that medical tourism is a sizeable and rapidly growing industry.\footnote{35} Broader trends in health care globalization have fueled medical tourism's explosive growth. Globalization in the medical tourism context is perhaps best understood through the two core ideas of deterritorialization and social interconnectedness.\footnote{36} In deterritorialization, important social practices that were once local have become increasingly separate from participants' physical location.\footnote{37} Deterritorialization has caused the globalization of a whole range of traditionally local health care services once bounded by economics, geopolitical borders, and cultural barriers.\footnote{38} In turn, the markets for health care professionals, pharmaceuticals, and other medical technologies that were once under the control of domestic governments have become increasingly transnational and privatized, potentially evading regulation.\footnote{39} Social interconnectedness characterizes the way that geographically distant events and circumstances shape local and regional activities, economic behaviors, decision-making, and other social practices.\footnote{40} In the medical context, social interconnectedness has allowed international health care providers to compete for patient-customers who formerly obtained treatment locally.\footnote{41} Technological interconnectedness, especially via the Internet, has also increased knowledge sharing, fostering the standardization of medical practices while increasing patient agency and access to information.\footnote{42}
B. Benefits for Medical Tourism Patients

Medical tourism can provide a variety of benefits to patients including enhanced patient agency, financial cost-savings, and increased treatment access. Patient agency refers to a patient's ability to exercise control over medical treatment and who will provide it. Some patients exercise agency and express autonomy through control over medical decision-making, while others choose to delegate decision-making to physicians. Medical tourism arguably enhances patient agency because it allows patients to find practitioners willing to provide care in a manner consistent with patients' values, medical needs, and financial limitations. Medical tourism patients may be prompted to exercise agency for two broad reasons. First, patients may obtain treatment abroad that they cannot afford at home. Second, patients may seek treatments they cannot access at home.

In cost-driven medical tourism, uninsured or underinsured patients obtain treatment abroad to save money. Most cost-driven medical tourists are from Western countries and are unwilling or unable to pay for expensive domestic health care. As globalization has accelerated the diffusion of medical knowledge and technology, these patients turn to providers in developing countries that offer the same treatments at significantly lower prices. Deloitte's 2009 report on medical tourism asserts that U.S. patients obtaining treatment abroad can save up to 70 percent even after including travel expenses. Comparing individual procedures further demonstrates the significant cost discrepancies driving medical tourism. For example, Staab's life-saving mitral heart valve replacement surgery would have cost $200,000 if performed in the

43. Williams, supra note 17, at 618-19; see also Cortez, Patients without Borders, supra note 27, at 111-13 (discussing medical tourism and "enhanced patient autonomy"); Note, Restructuring Informed Consent: Legal Therapy for the Doctor-Patient Relationship, 79 YALE L.J. 1533, 1554 (1970) (discussing how patient agency is rooted in fundamental rights to bodily integrity and self-determination).
44. Williams, supra note 17, at 618.
45. Id. at 619.
46. Cortez, Patients without Borders, supra note 27, at 77.
47. Id.
Traveling to India for the surgery reduced the total procedure cost (including travel expenses for him and a companion) to only $6,700. Nonsurgical procedures and treatments also cost substantially less. For example, a comprehensive fitness exam will cost at least $4,000 in the United States, but only $125 in India.

Access-driven medical tourists seek many treatments that are either illegal or subject to restricted access in their home countries. Restrictive domestic laws may provide incentives for seeking treatment in another country with more permissive laws. Cohen uses "circumvention tourism" to describe the practice where "a patient has traveled to the destination country to circumvent domestic prohibitions on accessing services." These restrictions can exist for several reasons, including home country laws restricting treatment access. Examples of popular circumvention tourism treatments include IVF, abortion, surrogacy, assisted suicide or "death tourism," and cultural practices like female genital cutting.

Other treatments are unavailable because they lack regulatory approval. Patients from the United States cannot access drugs and other medical technologies until the Food and Drug Administration (FDA) has conducted a lengthy and stringent approval process. Patients who urgently need treatment or are unwilling to wait may travel to foreign countries where the treatment is already available. In addition, even when no legal or regulatory barriers restrict access, treatments can be inaccessible if physicians, hospitals, or insurers refuse to provide or

51. Cortez, New Geography, supra note 20, at 877; Senate Hearing, supra note 5, at 26 (statement of Bonnie Blackley, Corporate Benefits Director, Blue Ridge Paper Products).
52. Senate Hearing, supra note 5, at 9 (written statement of Maggi Ann Grace).
53. Samlan, supra note 47, at 138 (discussing disparities in health care costs between the home countries of medical tourists and destination countries).
54. Cortez, Patients Without Borders, supra note 27, at 77.
55. Id.
56. Cohen, Circumvention Tourism, supra note 16, at 1312 (providing a more in-depth discussion of circumvention tourism and proposing legal solutions for dealing with the issues it raises).
57. Id.
58. For example, laws prohibiting abortion in Ireland give rise to circumvention tourism by women seeking abortions in the United Kingdom. See Cortez, Patients Without Borders, supra note 27, at 76.
60. Id. at 1326; see also Cecilia Rodriguez, Legal Euthanasia for Children in Belgium: Will It Trigger Death Tourism?, FORBES (Mar. 6, 2014, 5:17 PM), http://www.forbes.com/sites/ceciliarodriguez/2014/03/06/2378/ (discussing the impact of permissive euthanasia laws in Belgium on attracting medical tourists).
Moreover, providers in some less developed countries may lack particular medical technology or expertise, forcing patients to seek treatment abroad. Finally, patients in countries with socialized health care may use medical tourism to bypass waiting lists and obtain treatment more quickly.

II. THE DARK SIDE OF MEDICAL TOURISM

Although patients use medical tourism to obtain access and cost-savings, they also invariably face accompanying risks. These risks raise significant concerns, demonstrating the need to regulate medical tourism and protect patients' rights.

A. Inherent Risks and Quality-of-Care Concerns

Medical tourism carries certain risks simply because it involves international travel. Medical tourists risk additional travel expenses, miscommunication due to language and cultural barriers, exposure to foreign diseases, as well as aggravated medical conditions and unanticipated travel delays should medical complications arise. In addition, critics have pointed out that treatment prescreening and follow-up care may be insufficient due to the long-distance physician-patient relationship. While physicians in destination countries can view patient records, they cannot physically examine patients until shortly before treatment begins. Furthermore, once patients have returned home, the treating physicians no longer provide care, and patients may have difficulty obtaining and paying for follow-up care if complications arise.

62. Cortez, Patients Without Borders, supra note 27, at 78. For example, in Mississippi, there is only one operating abortion clinic even though federal law bans the complete prohibition of abortion. Id. A more common manifestation of restricted access occurs when insurers refuse to cover particular treatments for a variety of reasons and that decision incentivizes patients to seek health care abroad. Id.
63. Id. at 79.
64. Id.
65. Bennie, supra note 19, at 591.
66. Cortez, Patients Without Borders, supra note 27, at 103–04; Klaus, supra note 38, at 227.
68. Id. at 104; Klaus, supra note 39, at 227.
Health care quality is another major concern for patients that has been dubbed the “great unknown” of medical tourism.\(^6\) Health care quality is not uniform within and may vary significantly across different destination countries.\(^7\) Furthermore, the absence of centralized medical tourism regulation and data collection makes it extremely difficult to measure quality.\(^8\) Current methods, such as measuring quality through mortality rates, can be misleading and oversimplify complex treatment contexts that depend on patient characteristics, treatment type, and countless other circumstantial factors.\(^9\) Although mortality statistics can be misleading, other factors like patient satisfaction and level of improvement are difficult to measure accurately.\(^10\) This lack of comprehensive data and of appropriate metrics contributes to ignorance about health care quality in medical tourism.\(^11\)

On the one hand, medical tourism proponents point to evidence suggesting patients can obtain treatment abroad that is at least on par with what they would have received at home, for example, in the United States, where medical care is highly regulated.\(^12\) The staffs at many destination facilities include physicians and other health care professionals who have been certified in and practiced in the United States prior to starting their practices overseas.\(^13\) For example, over 200 U.S. Board-certified physicians staff the popular destination of Bumrungrad Hospital in Bangkok, Thailand.\(^14\) Testimonials suggest

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69. Cortez, Patients Without Borders, supra note 27, at 107; see also Cohen, Protecting Patients, supra note 17, at 1489; Cortez, Recalibrating Risks, supra note 20, at 3; Williams, supra note 17, at 627–28.

70. Cortez, Patients Without Borders, supra note 27, at 102; see also Williams, supra note 17, at 632.

71. Cortez, Patients without Borders, supra note 27, at 107 n.82 ("Measuring the 'quality' of health care is inherently difficult. In the United States, professional licensure, board certification, and hospital accreditation ensure that our health care professionals and facilities meet some minimum quality standards. However, these systems are not necessarily designed to assure that high quality health care is actually being provided.") (citing Timothy S. Jost, The Necessary and Proper Role of Regulation to Assure the Quality of Health Care, 25 HOUS. L. REV. 525 (1988); Timothy S. Jost, Oversight of the Quality of Medical Care: Regulation, Management, or the Market?, 37 ARIZ. L. REV. 825, 858–66 (1995)); see also Williams, supra note 17, at 628–29.

72. See Cortez, Patients Without Borders, supra note 27, at 103; Cohen, Protecting Patients, supra note 17, at 1491–92.

73. Cortez, Patients Without Borders, supra note 27, at 103.

74. See id. at 103.

75. See Cohen, Protecting Patients, supra note 17, at 1492; Klaus, supra note 39, at 225.

76. See Klaus, supra note 39, at 225–26.

77. Id. at 226; see also Fred de Sam Lazaro, Travelers Head to Thailand for Inexpensive Medical Procedures, PBS NEWSHOUR (Feb. 21, 2005, 12:00 AM), http://www.pbs.org/newshour/bb/health/jan-june05/thailand_2-21.html.
that some have even found the health care in destination countries to be superior to that of their home countries.\textsuperscript{78} Furthermore, the Joint Commission International (JCI) (formerly the Joint Commission on Accreditation of Healthcare Organizations), a branch of the U.S. Joint Commission that controls domestic hospital regulation, has established an international accreditation process that foreign hospitals may apply for and receive if they meet certain standards.\textsuperscript{79}

While high-quality medical tourism destinations may meet domestic health care standards, the lack of consistent and enforceable regulation still creates unacceptably high risks.\textsuperscript{80} For example, while JCI accreditation of overseas hospitals supposedly requires compliance with quality standards, destination facilities are not required to obtain accreditation.\textsuperscript{81} Furthermore, skeptics point out that "JCI may have a design that pushes it to be pro-accreditation" since it "has its own incentives that come into play in its role as accreditor and may give us pause: it has a very high rate of accreditation and low rate of revocation, and its revenues depend on the number of hospitals it accredits."\textsuperscript{82}

Media coverage of medical tourism horror stories demonstrates these risks. Many cases involve botched cosmetic surgeries and disfigurement, while others involve unlicensed practitioners or ineffective sterilizations resulting in fatal hepatitis infections and blood clots.\textsuperscript{83} For example, the death of twenty-four-year-old Joy Williams from anesthesia in Thailand illustrates just how grave these risks can be.\textsuperscript{84} Furthermore, patients who return home with complications from botched treatments must find and pay for follow-up care which may be

\textsuperscript{78} See Cohen, Protecting Patients, supra note 17, at 1492; see also Williams, supra note 17, at 633-35.

\textsuperscript{79} Cortez, Patients Without Borders, supra note 27, at 83.

\textsuperscript{80} See generally Cohen, Protecting Patients, supra note 17, at 1493 (explaining the difficulty patients experience when assessing quality of medical care). But see Williams, supra note 17, at 631 ("Despite the absence of adequate evidentiary measures to assess quality . . . several quality assurance measures indicate high quality among common medical tourism facilities.").

\textsuperscript{81} See Bennie, supra note 19, at 589 (stating that patients may avoid low-quality health care by going to accredited rather than unaccredited hospitals); Cortez, New Geography, supra note 20, at 897 ("[S]tates [in cross-border insurance programs] can require that insurers utilize only foreign hospitals that are accredited.").

\textsuperscript{82} I. GLENN COHEN, PATIENTS WITH PASSPORTS: MEDICAL TOURISM. LAW AND ETHICS 60 (2015).


\textsuperscript{84} See Pearlman, supra note 10.
too expensive and provided by domestic physicians who are wary of assuming liability.\footnote{Klaus, supra note 39, at 226–27.} Despite these legitimate concerns, however, medical tourism proponents point out that proactive patients can avoid many risks by thoroughly researching the destination country and only patronizing accredited facilities.\footnote{See Bennie, supra note 19, at 589; Williams, supra note 17, at 635 (explaining medical tourists may select providers who meet their preferred criteria by reviewing physician credentials online).}

**B. Inadequate Legal Remedies for Medical Malpractice**

An even more disconcerting risk is the lack of a legal remedy for foreign medical malpractice.\footnote{See generally Bennie, supra note 19, at 592–93 (addressing the lack of legal remedy both domestically and abroad for foreign medical malpractice).} The challenges faced by some U.S. patients when seeking legal remedies in destination countries are illustrative. While U.S. patients have recourse to well-developed medical malpractice laws, many destination countries do not afford patients anywhere near this level of protection.\footnote{Id.} For U.S. patients who wish to sue foreign physicians for medical malpractice in domestic courts, it is difficult to establish jurisdiction.\footnote{See Howze, supra note 8, at 1031–32.} Even if the plaintiff can show personal jurisdiction over the foreign defendant, the court will likely grant a defendant’s motion to dismiss for lack of a convenient forum (\textit{forum non conveniens}) if the defendant can show that an alternative forum exists in the destination country.\footnote{Id.} The standard for what constitutes a viable alternative forum is quite permissive, and the fact that damage recovery under another country’s law is less favorable than in the United States may carry little weight in a court’s assessment of the alternative forum’s adequacy.\footnote{See id. at 1034.} In turn, a plaintiff-patient may have to resort to suing in the destination country even if the remedies are not comparable as long as some minimal remedy is available.\footnote{Id. at 1038 (discussing the major destination country of India as an example, Howze points out that “[b]ecause of the difficulties associated with adjudication of a medical negligence claim in India and the minimal possible recovery, and because of the unlikelihood of redress in a U.S. court, the potential remedy provided by a direct suit against Indian providers for medical negligence is severely restricted”). Alternatively, patients may try to sue brokers and other middlemen that are usually based in the United}
Moreover, medical tourists may be unaware that they are essentially forfeiting legal remedies. As Cortez points out, "[t]here is reason to suspect that [patients travelling abroad] do not fully digest just how few legal remedies remain or what options they have if something goes awry. . . . The patients diligent enough to investigate these legal disparities will not find much helpful information." For example, in many Asian destination countries, patients are asked to sign waivers barring malpractice suits. While U.S. courts have held such waivers to be void as against public policy, recognizing health care services as relevant to the public interest, many foreign jurisdictions are likely to enforce malpractice waivers.

Furthermore, even if patients can sue in the destination country, they rarely prevail because foreign cultural and legal systems oftentimes strongly favor physicians. Even if a patient successfully litigates a foreign medical malpractice case, damages in destination countries are usually only a fraction of comparable awards in the United States. Finally, enforcing judgments and actually collecting damages from uncooperative defendants may prove practically impossible. Along these lines, while foreign hospitals competing for patients certainly have incentives not to injure medical tourism patients, the absence of sufficient legal remedies coupled with medical tourists' ignorance that they are foregoing legal remedies are significant concerns.

States and therefore under the jurisdiction of domestic courts. Williams, supra note 17, at 644. But many patients do not use brokers, and so this remedy is limited to those who do. Id. Moreover, plaintiffs are unlikely to recover damages from brokers because it is difficult to establish actual or proximate causation or vicarious liability based on the relationship between the broker and health care provider. Id.

94. Cortez, Recalibrating Risks, supra note 20, at 3.
95. Id. at 3–4.
96. See id. at 2–3.
97. See, e.g., Tunkl v. Regents of the Univ. of Cal., 383 P.2d 441, 442 (Cal. 1963). For additional discussion of the Tunkl case and the U.S. prohibition of medical waivers, see Cohen, Protecting Patients, supra note 17, at 1528–29.
98. See Williams, supra note 17, at 642.
99. See, e.g., Howze, supra note 8, at 1034–35 (considering that, for example, in India, 95 percent of medical malpractice cases are dismissed, and parties in the 5 percent that proceed must wait a long time to be heard).
100. See Cortez, Recalibrating Risks, supra note 20, at 4 ("For example, the mean and median recoveries by malpractice victims in the United States ($311,000 and $175,000, respectively) dwarf the average recoveries in Thailand ($2500) and Mexico ($4800). . . . If patients travel overseas for less expensive health care (particularly if they are encouraged to do so), they should understand precisely what remedies they are sacrificing.").
101. See Williams, supra note 17, at 645.
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III. EXISTING AND PROPOSED REGULATION OF MEDICAL TOURISM

At present, the medical tourism industry is largely unregulated. Though several regulatory frameworks exist, and others have been proposed, they vary in effectiveness and are inadequate to deal with the unique challenges of medical tourism. The shortcomings of existing frameworks highlight areas in which an International Constitution of Patient Rights (ICPR) can help to more effectively regulate medical tourism.

A. Unilateral Domestic Regulation

Established health care regulatory frameworks are almost exclusively domestic and likely do not apply globally, leaving medical tourism to market regulation. In the United States, for example, domestic health care regulation centers on three core methods: the government may create laws governing health care providers, it may recognize patient causes of action, and it may exercise its power as a large health care purchaser through programs like Medicare and Medicaid to create contractual obligations, thereby imposing requirements on health care providers.

These methods of regulating health care are not readily transferable to medical tourism. U.S. laws and jurisdiction generally do not extend extraterritorially. Even if jurisdiction is established, enforcing laws regarding licensing requirements and malpractice against foreign physicians is likely impracticable. Moreover, U.S. federal and state governments have shied away from acting as a large foreign health care purchaser to exercise regulatory influence.

103. See Williams, supra note 17, at 653–54. Existing literature provides comprehensive discussion of existing health care regulation. See Cohen, Protecting Patients, supra note 17, at 1489 (discussing domestic regulation of health care including “the accreditation, certification, and professional self-regulation of physicians and other healthcare providers, the medical-malpractice system, reporting of malpractice suits . . . the licensure and accreditation of hospitals, medical staff bylaws, hospital privileges regulation, conflict of interest regulation, and anti-kickback statutes.”).
104. See Williams, supra note 17, at 654.
105. See id.
106. See id.
107. See id.
108. See id. at 655–56. (indicating that in addition to the overwhelming domestic opposition to “outsourcing health care,” no substantial quality of care or accreditation requirements have been included in the unsuccessful proposals of Colorado and West Virginia, the only states that have considered becoming medical tourism purchasers).
Other forms of unilateral regulation include efforts to regulate patient travel, brokers, and health insurers along with increasing governmental oversight of medical tourism. In proposed regulations, the federal government would build on domestic regulation by expanding consumer protection measures and licensing requirements. Yet such proposals have significant weaknesses. For example, these domestic regulations would only apply to U.S. citizens who travel to obtain treatments legally approved in both the United States and destination countries. In turn, these regulations could leave both non-U.S. citizens and those patients who obtain treatments only approved in the destination country unprotected.

B. Multilateral Regulation

The United States could also influence the international medical tourism market through promulgating multilateral trade agreements that would ensure service quality. In this approach, countries could mutually agree to quality standards for medical care, protecting foreign nationals traveling either to the United States or to other nations for treatment. Critics argue that a trade agreement would be ineffective because agreements that restrict rather than enhance trade are usually not well received. Moreover, it may be difficult for countries to agree on applicable standards.

To avoid this issue, scholars have proposed various methods of regulating medical tourism by relying on existing agreements such as the General Agreement on Trade in Services (GATS). Regulating medical tourism through GATS may make sense because it is "arguably, the most significant piece of international law with respect to cross-border mobility for tourists." Yet, relying on GATS in the

109. For further discussion, see Cortez, Patients Without Borders, supra note 27, at 113.
110. See id.
111. See Cohen, Circumvention Tourism, supra note 16, at 1331–35 (discussing limitations on jurisdiction and the international legal authority relating to medical tourism).
112. See Williams, supra note 17, at 657.
113. See id.
114. See id. at 658.
115. See id. (discussing how the United States is unlikely to "persuade other nations to restrict their domestic health care market" in order to meet U.S. standards).
116. Cf. id. (assessing GATS as a proposed means of regulating medical tourism and identifying the pitfalls of arguments in favor of this approach).
117. C. Michael Hall, The Contested Futures and Spaces of Medical Tourism, in Medical Tourism: The Ethics, Regulation, and Marketing of Health Mobility 203, 205 (C. Michael Hall ed., 2013) [hereinafter Hall, Contested Futures].
health care sector could actually make it more difficult for countries like
the United States to require higher domestic quality standards.\textsuperscript{118} For
example, if GATS were expanded to include medical tourism, strict
requirements in the United States like rigorous licensing processes for
physicians and hospitals could be considered impermissible barriers to
trade that would have to be removed.\textsuperscript{119} In addition, proposed regulation
of medical tourism through GATS has focused on the "movement of
natural persons [as] one of the modes of supply for services," treating
patients purely as vacation tourists traveling for consumption abroad.\textsuperscript{120}
This approach fails to address the unique challenges of medical tourism
and does not recognize the importance of protecting vulnerable patients
who are oftentimes compelled by unavoidable circumstances to travel
for medically necessary treatment.

\textit{C. Market Self-Regulation Through Private Sector Accreditation}

Though various government regulations could be implemented, the
market currently remains largely internally regulated by private
industry and principles of free-market competition.\textsuperscript{121} Since the Deloitte
report was published in 2009, governmental oversight of medical
tourism is unchanged\textsuperscript{122} but significant private sector regulation has
developed.\textsuperscript{123} While this self-regulation has influenced medical tourism,
it is insufficient to protect patients.

The most significant form of private sector regulation is
accreditation of overseas health care facilities.\textsuperscript{124} Many health care
providers in destination countries seek Joint Commission International
(JCI) accreditation.\textsuperscript{125} As discussed above, the JCI is the international
branch of the Joint Commission, which controls accreditation of U.S.
hospitals.\textsuperscript{126} Though the JCI accreditation process is separate from the
Joint Commission, the JCI uses similar standards when determining

\textsuperscript{118} See Williams, supra note 17, at 658.
\textsuperscript{119} See id.
\textsuperscript{120} Hall, Contested Futures, supra note 117.
\textsuperscript{121} See Deloitte Report, supra note 30, at 4 ("[T]hus far the medical tourism industry as
a whole has remained mostly unstructured, with no meaningful legislation to govern the
practices of participating organizations.").
\textsuperscript{122} See generally Bennie, supra note 19 (analyzing medical tourism from the more
recent 2014 perspective).
\textsuperscript{123} See Cortez, Patients Without Borders, supra note 27, at 78.
\textsuperscript{124} See Williams, supra note 17, at 665.
\textsuperscript{125} See id. It should also be noted that, while the JCI is the most widely recognized
international accreditation body, it is not the only one and organizations based in the
United Kingdom also play a role in accreditations and private sector quality regulation.
\textsuperscript{126} See id. at 666.
whether to accredit a medical tourist destination facility. Due to the JCI's close relationships with the U.S. Joint Commission and trade organizations like the American Medical Association, many in the international community see JCI accreditation as quality assurance. In addition, the JCI goes beyond accreditation by establishing quality standards and educating health care providers about best practices. While obtaining JCI accreditation is not mandatory, it has arguably become a de facto requirement for overseas health care facilities wishing to be competitive in attracting foreign patients. Because patients can access online information to research options, JCI accreditation purportedly indicates to patients whether a facility meets minimum requirements and offers health care comparable in quality to U.S. hospitals.

Nevertheless, skeptics of JCI accreditation assert that it is insufficient to protect patients. One criticism is that the JCI criteria for international accreditations are more lax and less enforceable than the strict standards for domestic certification. In addition, the JCI is subject to very little government oversight. High accreditation rates and low revocation incidences, coupled with the fact that the organization relies on accreditation fees for revenue, raise concerns that the JCI cannot fulfill the role of a patient-centered guardian of care quality.

Several commentators have argued for extending private sector medical tourism regulation through government-mandated transparency or other "information forcing intervention[s]." While increased information access is a step in the right direction, these proposals leave significant gaps and do not go far enough to protect patients. For example, transparency proposals focus either primarily or exclusively on treatments or procedures that are legal in both countries,

127. See Cohen, Protecting Patients, supra note 17, at 1485 (discussing the JCI accreditation process, in which health care organizations are evaluated at the time of accreditation and every three years thereafter). If an organization fails to meet all of the standards, it is given a period to correct the issue and must provide written proof of compliance to the JCI or go through a follow-up evaluation. The JCI has now accredited over 250 organizations outside the United States. See id.
128. See Williams, supra note 17, at 665.
129. See Williams, supra note 17, at 632, 665; see also Facts About the Joint Commission, JOINT COMM'N (July 29, 2015), http://www.jointcommission.org/facts_about_the_joint_commission/.
130. Cf. Williams, supra note 17, at 633.
131. Cortez, Patients Without Borders, supra note 27, at 85.
132. See Williams, supra note 17, at 663.
133. See Cortez, Patients Without Borders, supra note 27, at 126.
134. See id.
135. See Williams, supra note 17, at 669–70.
136. See Cohen, Protecting Patients, supra note 17, at 1506–11.
failing to account for circumvention tourism patients seeking treatments unavailable at home.\footnote{See generally id. at 1477 (focusing a proposal primarily on treatments legal in both countries).}

In addition, simply providing patients with information does not address the problem of malpractice recovery in medical tourism.\footnote{See Cortez, Recalibrating Risks, supra note 20, at 77.} While patients could be more informed about how medical tourism limits their ability to seek legal redress, information alone does not make it easier for current malpractice plaintiffs to recover damages, and even informed patients who choose the ostensibly safest hospitals may be victims of negligence.\footnote{See id.} Moreover, efforts to educate patients about restricted international legal remedies may not help those patients who are financially compelled to seek health care abroad, especially if the foreign country is competing with the prices or services of the patient’s home country.\footnote{Cf. id. (explaining that because many foreign countries are participating in a “race to the bottom” to provide medical services that are lower in cost and often banned in the patient’s home country, patients of lesser means will feel compelled to take advantage of these prices and services, despite being aware of the risks).} Without any additional protections, medical tourists as both consumers and vulnerable patients remain unfairly subject to malpractice risks.\footnote{See id.}

IV. THE INTERNATIONAL CONSTITUTION OF PATIENT RIGHTS: JUSTIFICATION AND BENEFITS

Thus far, this Note has discussed the emergence, benefits, and potential problems of the growing medical tourism industry. An assessment of existing and proposed regulatory approaches illustrates that these means are insufficient to ensure quality care standards and protect patients’ rights to legal redress. Here, I argue that the creation and multilateral adoption of an International Constitution of Patient Rights (ICPR) is a key first step to protecting the interests of patients, health care providers, and other parties so as to maintain the benefits of medical tourism while minimizing and more fairly allocating its risks. First, I build on the preceding discussion to demonstrate why the ICPR is an appropriate means of addressing the challenges medical tourism presents. Next, I provide a preliminary overview of the ICPR, suggesting key provisions that should be included. Finally, I identify areas for further consideration and respond to possible criticisms.
A. Insufficiency of Existing Regulation and Gaps in International Law

Creating an ICPR is both appropriate and beneficial for several reasons. The ICPR would provide a foundation for multilateral governmental action to protect patients by identifying universally recognized patient rights. These agreed-on rights could lay the groundwork for more comprehensive, coordinated government action to regulate health care across borders. Unlike existing regulations focusing primarily on parties' economic interests and portraying patients solely as consumers, the ICPR also emphasizes patients' interests from a human rights perspective. In turn, the ICPR would offer a more holistic approach by taking into account economic benefits, patients' autonomy, and their moral rights to health care and legal redress.142

The ICPR would also address inadequacies in existing international law governing patients' human rights. Existing international law focusing on human rights does little to address the specific issues of patients' rights.143 For example, the Universal Declaration of Human Rights (UDHR), adopted by the United Nations (U.N.) in 1948, is perhaps the most influential international document relating to individual human rights, and has acquired the status of customary international law.144 The UDHR contains provisions discussing human rights to health and well-being generally, but does not specifically address patients' rights and certainly does not anticipate medical tourism's unique challenges.145

142. For further discussion of the role of international law relating to the moral right to health care, see Pavlos Eleftheriadis, Global Rights and the Sanctity of Life, in THE GLOBALIZATION OF HEALTH CARE, supra note 21, at 421.


145. See Universal Declaration of Human Rights, supra note 144; see also I. Byrne et al., Human Rights in Patient Care: Ukraine, in A PRACTITIONER GUIDE 24 (Ser. No. UDC 342.951:351.778(477) 2012), available at http://www.opensocietyfoundations.org/sites/default/files/Practitioner-Guide-Ukraine-English-20130516.pdf. ("Key provisions include: Article 3 (right to life), Article 5 (prohibition on torture and cruel, inhuman, or degrading treatment), Article 7 (protection against discrimination), Article 12 (right to privacy), Article 19 (right to seek, receive, and impart information), Article 25 (right to medical care).")
Building on the foundation of the UDHR, the International Covenant on Economic, Social and Cultural Rights (ICESCR) is a multilateral treaty that the U.N. Member States adopted in 1966. Article 12 provides for the right to the "highest attainable standard of physical and mental health." Although the U.N. General Comment 14 discussing this provision alludes to both the "freedoms and entitlements" of individuals as patients, it does not include detailed discussion of patients’ rights or medical tourism’s implications.

While these two key documents are the most relevant to patients’ rights, by themselves they are insufficient protection. The ICPR would be a first step to filling these gaps. The ICPR drafting process would mirror the methods used in creating international legislation. An international commission supervised by the U.N. would draft it; the U.N. and individual countries would then adopt or reject it. Similarly to the UDHR, the ICPR would hopefully be highly influential and would provide a basis for crafting future international agreements. In this way, the ICPR would rely on a collaborative international drafting process to influence unilateral and multilateral efforts to globally regulate health care.

B. Economic Benefits

From an economic standpoint, the ICPR would help maintain medical tourism’s benefits, more fairly allocate its accompanying risks, and promote efficiency. While globalization has bolstered medical tourism through diffusion of medical knowledge, training, and technology, standardization has not kept pace with globalization. The ICPR would give notice to concerned parties of their rights and duties, including patients, physicians, health care facilities, and brokers. In turn, providing global standards for patients’ rights would conserve resources by eliminating the need for individual health care providers,

146. See generally International Covenant on Economic, Social and Cultural Rights, Dec. 16, 1966, S. Treaty Doc. No. 95-19, 6 I.L.M. 360 (1967), 993 U.N.T.S. 3. In 1976, the ICESCR was ratified by 162 countries and was signed but not ratified by an additional 7, including the United States. Id.


148. U.N. General Comment 14, supra note 148, at 130, ¶ 8.

149. See infra Section VI.B.1.

brokers, and medical tourism trade groups to create their own varied sets of patients' rights.  

In addition, the ICPR would fulfill a role for destination countries similar to that which the JCI fulfills in providing private sector accreditation of individual health care facilities. Destination countries wishing to expand their medical tourism industries would have an economic incentive to adopt the ICPR as a means of assuring patients that their rights will be protected.

C. Protecting Patients and the Integrity of the Medical Profession

Furthermore, the ICPR would protect patients' rights to autonomy and informed consent by promoting transparency and patient access to information. It would increase efficiency through provisions delineating appropriate legal procedures in different circumstances of medical malpractice. In this way, patients and their domestic physicians could identify relevant patient rights and be more informed when weighing the costs and benefits of medical tourism, producing benefits similar to other proposals involving "information forcing" interventions.

Finally, increasing transparency by specifying patients' rights is essential to the policy goal of protecting patients and the integrity of the medical profession. The physician-patient relationship is rooted in trust and respect. Physicians trust patients to fully disclose their medical information and come to them with questions, while respecting patients' rights to be involved in medical decisions. Patients trust physicians to act in their best interests, including giving them information necessary to consent to treatment. In medical tourism, these expectations are often unclear due to varying quality standards, gaps in communication,


152. See Williams, supra note 17, at 633.

153. See infra Section V.B.4.

154. See supra Section III.C.


156. Id. at 5.

157. Id.
and cultural barriers.\textsuperscript{158} Clarifying patients' rights will remedy these concerns and promote patient trust in physicians.

V. CONTENT OF THE ICPR

While providing a comprehensive discussion of the ICPR's contents is beyond the scope of this Note, the following discussion provides a starting point and highlights important questions that the ICPR should consider.\textsuperscript{159}

A. Types of Medical Tourism Treatment Objectives

As envisioned here, the ICPR distinguishes between "approved" treatment objectives that fall within its purview and "disapproved" treatment objectives that are not covered by its provisions. Whether a treatment objective is approved or disapproved is a threshold issue when addressing patients' rights under the ICPR. While it may sometimes be difficult to determine which category a particular treatment objective falls into, most cases can be categorized based on widespread support or acceptance either for or against a particular treatment. As new medical treatments emerge, the ICPR will consider and categorize each particular treatment.

1. Approved

Treatments that are legal in both the home and destination countries are approved under the ICPR. Patients seeking these services generally do so to save money. Examples of incontestably approved medical tourism include common cardiac procedures and surgeries, other nonemergency surgical care, cosmetic surgery, and in many cases fertility treatments and alternative or holistic medicine.\textsuperscript{160}

Treatments that are legal in both the home and destination countries but are subject to restricted access in the home country are

\textsuperscript{158} See Cortez, Recalibrating Risks, supra note 20, at 3.

\textsuperscript{159} The terms "treatment" and "treatment objective" are used interchangeably, though it should be noted that in some circumstances the treatment objective, rather than the procedure itself, is really at issue in determining whether a procedure will be approved or disapproved.

\textsuperscript{160} Cf. Bennie, supra note 19, at 584 (discussing common procedures sought by medical tourism patients). Because of the awareness and acceptance of medical tourists commonly seeking these types of procedures, these procedures have attained public acceptance and thus should be treated as incontestably approved types of medical tourism.
also approved. This includes treatments inaccessible to patients within specific demographic groups, such as IVF cycles that are inaccessible to patients who are unmarried, in same-sex relationships, or past a certain age. In addition, many treatments prohibited in the home country but approved in the destination country are also approved. "Circumvention tourism" may include both outright illegal treatments as well as experimental treatments that have not yet been approved in the home country. Examples include controversial stem-cell therapies, experimental drugs and procedures, and some forms of reproductive tourism.

2. Disapproved

Patients seeking disapproved treatment objectives are not protected under the ICPR. Treatments that are prohibited in both the home and destination countries are disapproved. Even if the destination country does permit the treatment, widespread global consensus that the practice should be banned results in disapproval. Examples of disapproved treatments include transplant tourism where a live donor sells an organ or part of an organ, such as in the case of a kidney or liver transplant. Even though one country currently permits the selling of organs, these treatments are nevertheless disapproved due to concerns about ensuring voluntariness of donation, the coercion and exploitation of the poor, and the creation of perverse incentives.


162. Id.

163. Id. For example, the National Institute for Health and Care Excellence (NICE) in the United Kingdom has published guidelines that recommend that IVF treatment should only be offered to women less than forty-three years of age while Sweden and Denmark permit patients under forty-two and forty-six, respectively. See IVF: Introduction, U.K. NAT’L HEALTH SERVICES, http://www.nhs.uk/conditions/IVF/Pages/Introduction.aspx (last updated Jan. 6, 2015); Having IVF Abroad Through Medical Tourism, U.K. HEALTH CTR. (Sept. 14, 2015), http://www.healthcentre.org.uk/fertility-treatment/ivf-abroad.html.

164. See Williams, supra note 17, at 620.

165. Id.

166. See generally Council on Ethical & Judicial Affairs, Am. Med. Ass’n, Financial Incentives for Organ Procurement, 155 ARCHIVES INTERNAL MED. 581 (1995) (discussing how selling kidneys for cash on open market can lead to exploitation of the poor and raises issues of ensuring voluntariness, and thus should be prohibited).

167. See id. Because the sale of organs for profit is currently only legal in Iran, there is a booming black market for kidneys in countries such as India and China. See, e.g., Saeed Kamali Dehghan, Kidneys for Sale: Poor Iranians Compete to Sell their Organs, GUARDIAN (May 27, 2012, 3:00 PM), http://www.theguardian.com/world/2012/may/27/iran-legal-trade-kidney; Denis Campbell & Nicola Davison, Illegal Kidney Trade Booms as New
Other controversial procedures that do not provide therapeutic benefits to patients are also disapproved. For example, medical tourism for cultural practices like female genital cutting that are banned in a patient's home country would not be covered by the ICPR. Likewise, "death tourism," where patients travel abroad for physician-assisted suicide, is disapproved.

B. Patients' Rights

For approved treatments, the ICPR would protect patients' rights and impose obligations on other parties to uphold these rights, including domestic and foreign health care providers, broker companies, and government actors. Four interrelated categories of patients' rights include the right to information, agency, continuity of care, and legal redress for medical malpractice.

1. Right to information: Informed Consent

The ICPR recognizes patients' right to information and informed consent before receiving treatment. Rooted in well-established fundamental human rights to bodily integrity and self-determination, informed consent is the cornerstone of the physician-patient relationship based on trust and ensures patients' ability to exercise agency in decision-making. This right to be informed imposes a corresponding duty to disclose on the treating physician.

In keeping with widely accepted standards, the ICPR protects patients' right to be informed of treatment risks, benefits, and side effects as well as alternatives before consenting. The ICPR requires physicians to disclose material information that a reasonable patient

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168. Note, Restructuring Informed Consent: Legal Therapy for the Doctor-Patient Relationship, 79 YALE L.J. 1533, 1555 (1970) ("According to law, consent is the mechanism by which the patient grants the physician the power to act and which theoretically protects the patient against limitations of his freedom and invasions of his person.") [hereinafter Restructuring Informed Consent].


170. Restructuring Informed Consent, supra note 170, at 1534.

171. Ginsberg, supra note 169, at 27.

172. See id.
would want to know. While globalization has increased knowledge sharing and treatment standardization, the medical technology and professional standards are far from uniform, making a "reasonable physician" standard less desirable. Although the "reasonable patient" is subject to cultural variation, it is preferable to rely on this patient-protective standard because patients are vulnerable consumers who are generally less informed than physicians. The ICPR adopts a universal approach that is as close to the "reasonable patient" standard as possible, and when in doubt, falls back on the "reasonable patient" standard of whichever country, home or destination, has the more patient-protective approach.

Furthermore, the unique context of medical tourism requires that health care providers and physicians disclose certain additional risks along with those risks of a particular treatment. As discussed above, medical tourists are especially vulnerable to being uninformed. They often do not meet the treating physician personally until days before a procedure and may lack knowledge about the accreditation and quality standards of their treatment facility. Informed consent might also require health care providers to disclose information about hospital accreditation, physician certification, potential difficulties in obtaining follow-up care, and limitations on medical malpractice before agreeing to treat patients.

2. Right to Exercise Agency

Under the ICPR, patients' right to agency is closely linked to the right to informed consent as well as rights to bodily integrity and autonomy. When discussing patients' rights, it is more appropriate to use the term agency rather than autonomy because not all patients desire to independently make every important medical decision relating

173. Some U.S. jurisdictions require physicians to disclose what a reasonable physician in a similar situation would disclose, see Michael Rohde, Information Overload: How the Wisconsin Supreme Court Expanded the Doctrine of Informed Consent, 46 J. MARSHALL L. REV. 1097, 1101–02 (2013), while others require disclosure of what a reasonable patient would want to know, see Ginsberg, supra note 169, at 27.

174. See SCHNEIDER, supra note 155, at 7 ("[A] physician's role is to use his or her training, knowledge, and experience to provide the patient with facts about the diagnosis and about the prognoses without treatment and with alternative treatments. The patient's role in this division of labor is to provide the values—his or her own conception of the good—with which to evaluate these alternatives, and to select the one that is best for himself or herself.") (quoting Dan W. Brock, The Ideal of Shared Decision Making Between Physicians and Patients, 1 KENNEDY INST. ETHICS J. 28, 28 (1991)).
to their treatment. For some patients, exercising agency means having sufficient information to choose a treatment; for others, it means having sufficient information to decide they wish to defer to the physician's expertise. Medical tourists often have already exercised considerably agency in seeking treatment abroad. Nevertheless, treating physicians should be cautious and should not assume that patients will continue making all medical decisions, as the patients may wish to have more guidance or defer to physicians. Moreover, physicians treating international patients must be sensitive to cultural differences in how patients exercise agency.

Patients' agency also includes the right to control who can access medical information. Accordingly, physicians should keep medical information confidential unless the patient consents to disclosure, or unless there is a pressing public interest at stake. Given the global reach of medical tourism, protecting patients' control of their medical information across borders is especially important. All health care providers and physicians should have procedures for maintaining confidentiality in place.

3. Right to Continuity of Care

The ICPR also protects patients' rights to continuity of health care. The physician may not discontinue treatment as long as it is medically necessary without giving a patient sufficient time and assistance in finding alternative care. The right to continuity of care also obligates the physician to cooperate in coordinating with other health care providers to ensure treatment continuity. Medical tourism can make it difficult to ensure continuity of care when patients need follow-up care on returning home, whether they simply require check-ups or encounter unanticipated complications. As discussed above, patients obtaining treatment in their home countries can have an ongoing relationship with their physicians. By contrast,

175. While the scholarly discourse on agency versus autonomy paradigms is ongoing, the agency paradigm has gained broad-based support and is more appropriate for the purposes of the ICPR. See, e.g., id. at 5 (discussing negative results of the patient autonomy paradigm as a way that some doctors pass "burdensome problems to patients...whether because of fear or because of indifference, overwork, or diffidence, physicians may be prepared to abdicate responsibility for some decisions to patients.")


177. See id.
medical tourists cannot easily access their treating physicians and often struggle to obtain follow-up care due to financial constraints or physicians who are unwilling to see them.

While these challenges seem inherent to medical tourism, imposing standards on overseas health care providers through the ICPR puts patients in the best position possible to obtain health care on return. Physicians and health care providers must alert patients to the difficulties they may encounter following treatment abroad and either help patients to form a plan for anticipated and unanticipated follow-up treatment or, at the very least, inform patients that they should do so on their own.

4. Right to Legal Redress: Medical Malpractice in Medical Tourism

The ICPR would protect patients' right to legal redress for medical malpractice. To ensure that patients have access to legal redress, the ICPR would prohibit health care providers from requiring patients to waive medical malpractice claims and outline the appropriate procedure for bringing these claims.

As discussed above, perhaps one of the most serious risks for medical tourists is that other countries may restrict legal redress for medical malpractice.178 A complicating factor is that different countries approach medical malpractice in different ways, and the legal systems of major destination countries tend to be less patient-centered than those of more developed home countries.179 Because the public interests in protecting vulnerable patients and more fairly allocating legal risks of medical care persist in the context of medical tourism, the ICPR holds waivers of medical malpractice to be unenforceable.180 In addition to protecting patients, this prohibition on medical malpractice waivers will increase efficiency by delineating liability at the outset, rather than requiring individual providers to create their own standards.

In addition, the ICPR proposes appropriate procedures for patients to bring medical malpractice claims. First, for medical malpractice involving approved treatments and procedures that are legal in both the

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178. See supra Section II.B.
179. For example, several major destinations for medical tourists routinely use and enforce medical malpractice waivers that would be void as against public policy in the United States. See Cohen, Protecting Patients, supra note 17, at 1528–29 (discussing the development and justification for the prohibition on medical malpractice waivers in the United States).
180. See Cortez, Recalibrating Risks, supra note 20, at 88–89 (discussing how prohibiting waivers would help to "reallocate more fairly the legal risks of medical travel").
home and destination countries, patients should be able to bring a medical malpractice claim in whichever country they choose. If and when choice of law issues arise, courts should adopt the law of the country most favorable to patients. 181

Allowing these patients to choose either the home or destination country forum more fairly allocates the risk of medical malpractice by placing the burden of coming to the patient’s chosen forum on health care providers and physicians. While this approach may result in expense and inconvenience to providers, these risks create incentives for providers to be more careful and guard against negligence, which benefits medical tourists. Furthermore, health care providers are better positioned financially to bear these costs than vulnerable patients who often seek treatment internationally because they cannot afford domestic care. 182

Patients who engage in circumvention tourism for approved treatments are also entitled to legal redress. These patients, however, should have less flexibility in bringing their claims, and should seek a remedy from the destination country’s legal system. For example, a patient from Ireland who circumvents domestic laws prohibiting abortion and travels to the United Kingdom for an abortion should bring a medical malpractice claim in the United Kingdom in the event of malpractice. Destination country health care providers should ensure that, as part of the informed consent process, patients are made aware of these legal limitations as well as resources for bringing medical malpractice claims in the destination country.

Finally, patients who engage in medical tourism to obtain disapproved treatment are not guaranteed legal redress under the ICPR. This lack of protection should discourage patients seeking these treatments overseas.

VI. LOOKING FORWARD

A. Areas for Further Consideration

In addition to determining whether a particular procedure is approved or disapproved, the ICPR may also provide more guidance for specific types of treatments. Reproductive tourism, including surrogacy, abortion, and IVF, is a large and growing segment of medical tourism that would benefit from specific provisions addressing the various

181. See generally Howze, supra note 8, at 1038 (explaining how “choice of law” scenarios and outcomes affect plaintiffs in U.S. courts).
182. See supra Section I.B.
parties' legal rights and duties. For example, unlike nonreproductive health care that involves the rights of a single patient, surrogacy tourism implicates the rights of the mother, father, gamete donors, surrogate, and child.183

Another issue for further consideration is how the ICPR should regulate quality of patient care. Transparency, mandatory disclosure, and informed consent may not suffice to ensure adequate quality control. Mandatory accreditation for providers may be called on to fill this gap.

Furthermore, additional planning is needed to determine the ICPR's content and structure and to consider how it might work in tandem with existing private sector regulation. Taking advantage of existing structures can ensure efficient and effective ICPR adoption. For example, maintaining established private sector accreditation processes through entities like the JCI, augmented by governmental oversight, may accomplish some ICPR aims.184 Moreover, inviting feedback from participants in the medical tourism industry such as patients, brokers, and destination country physicians and hospitals will help to identify additional concerns and craft an ICPR that will maintain the medical tourism's benefits without exposing patients to unfair risks.

B. Addressing Possible Criticism

1. Is Global Enforcement of the ICPR Unrealistic?

One possible criticism of the ICPR is that global enforcement is unrealistic because individual countries would have to independently ratify, adopt, and enforce ICPR provisions for it to be effective. Nevertheless, existing international instruments protecting individual rights illustrate that such initiatives can have a far-reaching impact on the global community and, as a minimum, lay a foundation for reform. The UDHR and ICESCR provide a helpful model for the ICPR in terms of drafting and global impact. For example, although the UDHR is not a legally binding treaty, the multilateral drafting process and U.N. adoption has allowed it to be highly influential, and it is widely accepted.


184. See Williams, supra note 17, at 680.
as part of customary international law.185 Furthermore, the UDHR has formed the basis for multilateral agreements like the ICESCR.186

Similarly, an international commission of governmental and nongovernmental actors would draft the ICPR, which would then be submitted for adoption by the U.N. Individual states would also be encouraged to adopt the ICPR in keeping with the general aims of protecting human rights set out in the UDHR. In addition, the ICPR would lay the foundation for future international agreements. Through this process, a variety of viewpoints would shape the ICPR and the drafting process would invite comment from the global community. This global approach would enhance the ICPR's credibility, increase its pragmatic effectiveness, and provide a basis for building a more holistic regulatory framework in the future.

2. Do the Costs of the ICPR Outweigh the Benefits?

Critics may question the ICPR's viability on the grounds that protecting patient rights will be prohibitively costly, hinder trade, and render the ICPR impracticable.187 But the ICPR's burdens do not render it ineffective; on the contrary, they represent worthwhile investments in regulating medical tourism.

For example, upholding patient rights pursuant to the ICPR imposes obligations on physicians and other health care providers. For domestic health care providers, recognizing these patient rights may create an obligation to inform patients of the option of medical travel as a possible alternative to domestic treatment. The right to continuity of care for medical tourists imposes a burden on domestic providers as well. Meanwhile, physicians and hospitals in destination countries will assume the burdens of upholding patient rights under the ICPR and expend additional time and resources sharing information with patients to obtain informed consent. In instances of medical malpractice, overseas providers may incur expenses if they have to change established practices of forcing patients to sign waivers or travel to a patient's home country for legal proceedings.

185. Digital Record of the UDHR, supra note 144 (asserting that the UDHR is "widely regarded as forming part of customary international law"). See also Hannum, supra note 144, at 289 ("The Universal Declaration of Human Rights has been the foundation of much of the post-1945 codification of human rights").
187. As one critic of multilateral regulation points out, "[t]he general purpose of international law . . . is to enhance, not impede, trade between nations." Williams, supra note 17, at 657.
Nonmedical participants will also likely incur expenses. For example, broker companies will be required to eliminate blanket waivers and will be held to higher standards in selecting destination countries and facilities that conform to the ICPR. Moreover, the legal systems in both home and destination countries will expend time and resources processing increased medical malpractice litigation. Finally, patients themselves will bear the burden of upholding the ICPR. As the medical tourism industry adjusts to these requirements, costs may shift to patients as consumers. These additional costs may decrease the cost-saving benefits of traveling abroad for medical care.

Nevertheless, the costs of the ICPR do not outweigh its holistic, long-term benefits. While establishing and upholding the ICPR will be expensive initially, these costs are a worthwhile investment in protecting patients' rights since they uphold the integrity of the medical profession, promote justice, and set the stage for effective future regulation.

CONCLUSION

The emergence of medical tourism in recent years demonstrates globalization's far-reaching impact on health care. While this industry's rapid expansion has offered life-changing benefits to patients who might otherwise be unable to access or afford certain treatments, medical tourism has also introduced unprecedented risks, including quality-of-care concerns and inadequate legal redress for malpractice. Furthermore, existing regulations are insufficient to protect patients against potential pitfalls. This Note proposes the creation of the ICPR to more effectively preserve the benefits of medical tourism while minimizing its risks. Regulation of medical tourism through the ICPR will ensure that it is sustainable by preventing the victimization of patients by medical negligence and imposing uniform standards that participating countries all take part in creating. Without the ICPR, regulation will be a complicated and contradictory system of piecemeal regulations from country to country. As the global industry of medical tourism continues to develop, regulation through the ICPR is a key part of what must be a continued collaborative effort to promote the availability of quality health care through holistic regulation that upholds patient rights.

188. See Leigh G. Turner, Quality in Health Care and Globalization of Health Services: Accreditation and Regulatory Oversight of Medical Tourism Companies, 23 INT'L J. QUALITY HEALTH CARE 1, 4–5 (2010) (arguing in favor of limiting waivers on medical malpractice in medical tourism and listing the standards expected of such brokers).