NOTE

MEDICAL MALPRACTICE OVERSEAS: THE LEGAL UNCERTAINTY SURROUNDING MEDICAL TOURISM

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I
INTRODUCTION

Recently, waves of people from developed countries have been traveling to places like India, Brazil, Thailand, and Malaysia for medical procedures ranging from face lifts to knee replacements to cardiac bypass surgery.[1] Cities in these countries have opened up private hospitals that cater specifically to foreigners and that are often staffed by Western-trained physicians.[2] These hospitals charge patients a fraction of what they would pay for similar services in the West and, in some cases, offer procedures that have yet to be approved in developed countries.[3]

This latest form of outsourcing is called "medical tourism," and industry experts believe it has the potential to bring over $2 billion a year to India alone

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1. One hundred fifty thousand foreigners visited India for medical procedures in 2003, and a health-care specialist with the Confederation of Indian Industry predicted that the business would grow at a rate of fifteen percent per year. John Lancaster, *Surgeries, Side Trips for "Medical Tourists": Affordable Care at India's Private Hospitals Draws Growing Number of Foreigners*, WASH. POST, Oct. 21, 2004, at A01.

2. The Apollo Hospital in Chennai, India and the Bumrungrad Hospital in Thailand are two such examples. *See, e.g.*, *60 Minutes Story: Vacation, Adventure, and Surgery?* (CBS Broadcast, Apr. 24, 2005), *available at* www.cbsnews.com/stories/2005/04/21/60minutes/main689998.shtml.

3. Patients at Bumrungrad Hospital in Thailand pay about one-eighth of what they would pay in the United States. *60 Minutes Story*, *supra* note 2.

by 2012.[4] The demand for medical tourism is not surprising, given that millions of Americans remain uninsured and that citizens needing medical attention in Western European countries face long waiting periods. In the United States, private firms have begun to reap some of the profits of this budding business by offering prospective medical tourists all-inclusive packages in which a hospital stay in an exotic location is built around trips to the Taj Mahal or sandy beaches.[5] In the United Kingdom, the National Health Service may even subcontract patient cases to India.[6]

Even though medical tourism has received an increasing amount of attention from the media, there has been remarkably little commentary about medical tourists who have fallen victim to medical malpractice abroad. For these unlucky patients, a website for India's largest medical-tourism hospital, Apollo, presents a grim message: "A prospective medical tourist should also be aware of possible legal issues. There is presently no international legal regulation of medical tourism. All medical procedures have an element of risk. The issue of legal recourse for unsatisfactory treatment across international boundaries is a legally undefined issue at present."[7]

This article explores some of the legal uncertainty surrounding medical tourism—specifically, ways medical tourists can seek relief in U.S. courts for malpractice committed abroad. It concludes, however, that medical tourists face substantial hurdles in obtaining such relief.

Part II explains why courts probably lack jurisdiction over foreign physicians who have allegedly committed malpractice and discusses theories under which U.S. firms in the medical-tourism business could be held liable for the foreign provider's negligence. Part III discusses additional barriers to malpractice actions against firms, such as forum non conveniens and conflict-of-law issues. Part IV presents the arguments for and against holding firms vicariously liable for the negligence of foreign providers. The article concludes by noting that legislation may be necessary to deal with the complex policy issues medical tourism presents.

II

OPTIONS FOR LEGAL RECOURSE: WHOM TO SUE, WHAT THEORY?

A. Suing the Foreign Provider: The Personal Jurisdiction Problem

If a medical-tourism plaintiff brought an action against her overseas

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4. *See* Randeep Ramesh, *This UK Patient Avoided Waiting Lists and Flew to India for a Heart Bypass. Is Health Tourism the Future?* THE GUARDIAN (London), Feb. 1, 2005, at Guardian Home Pages 3 (citing a joint report by McKinsey and the Confederation of Indian Industry).

5. *See*, *e.g.*, Med Journeys, http://www.medjourneys.com (last visited May 27, 2007); *PlanetHospital*, http://www.PlanetHospital.com (last visited Apr. 10, 2007).

6. *See* Ramesh, *supra* note 4.

7. India Profile, Medical Insurance and Legal Aspects, http://www.indiaprofile.com/medical-tourism/medical-insurance-and-legal-aspects.html (last visited Apr. 10, 2007).

provider in the United States, she would need to convince the court where she filed suit that it had personal jurisdiction over the nonresident defendant. The personal jurisdiction requirement may prove to be problematic for medical-tourism plaintiffs. Courts are generally reluctant to assert jurisdiction over physicians who neither reside nor practice in the state where the court sits (the forum state).[8] The traditional notion that physicians have a "localized practice" remains pervasive and consequently courts often find that nonresident physicians do not intend for their services to have an impact beyond the state in which they practice.[9]

1. Jurisdiction over Foreign Physicians Based on Their Transacting Business Within the Forum State

One way a medical-tourism plaintiff might try to overcome the personal jurisdictional hurdle is to sue in a state where the foreign provider does business. Many states have long-arm statutes that permit their courts to exercise personal jurisdiction over nonresident defendants who "transact business" in the state or who regularly "solicit business" in the state while committing a tort without the state that causes injury to a person in the state.[10] Such provisions could be triggered if the foreign provider solicited patients in the forum state or patients came through referrals provided by U.S. medical-tourism firms within the state.

Even with a helpful long-arm statute, however, medical-tourism plaintiffs would still face an uphill battle on the jurisdictional front. Courts typically find that the transacting or soliciting business provisions of a long-arm statute are insufficient to confer them with jurisdiction over nonresident physicians who treat forum-state residents.[11] Nor can such provisions suffice for jurisdiction over nonresident physicians who accept referrals from forum-state physicians and HMOs. For example, in *Ingraham v. Carroll*,[12] the New York Court of Appeals held it lacked jurisdiction over a Vermont physician even though he received frequent referrals from a New York HMO. Similarly, in *Nicholas v. Ashraf*,[13] a federal district court in Pennsylvania held it had no jurisdiction over two West Virginia physicians who had accepted referrals from Pennsylvania physicians.

8. *See, e.g.*, Grove v. Maheswaran, 498 S.E.2d 485, 508 (W. Va. 1997) (holding that there were insufficient contacts between the nonresident third party defendants—physicians and a hospital to support West Virginia's exercise of personal jurisdiction over them); Biggs v. Robert Thomas, O.D., Inc., 893 P.2d 545, 548 (Or. Ct. App. 1995), *rev. den.*, 901 P.2d 246 (Or. 1995) (holding that the defendant, a California optometrist who practiced only in California, did not purposefully direct his activities at the residents of Oregon and therefore the court lacked jurisdiction over the defendant).

9. Wright v. Yackley, 459 F.2d 287, 290 (9th Cir. 1972) (finding that "there is no systematic or continuing effort on the part of the doctor to provide services which are to be felt in the forum state" when the physician practiced elsewhere).

10. See, e.g., N.Y. C.P.L.R. 302 (a)(1) and (a)(3)(i) (2001 & Supp. 2007).

11. *E.g.*, Mosier v. Kinley, 702 A.2d 803, 808 (N.H. 1997).

12. 687 N.E.2d 1293, 1295–96 (N.Y. 1997).

13. 655 F. Supp. 1418, 1419 (W.D. Pa. 1987).

In rare cases, however, courts have employed the transacting business provision to assert jurisdiction over nonresident physicians whose relationships with health-care providers in the forum state is well established and ongoing. For example, in *McLenithan v. Bennington Community Health Plan*, a New York appellate court held it had jurisdiction over a Vermont physician because the physician had "interjected himself into New York's service economy" by contracting with a New York HMO whose subscribers were mainly New York residents.[14]

The holding in *McLenithan* has not been affirmed by the New York Court of Appeals but it may be helpful to medical-tourism plaintiffs' jurisdictional arguments. Invoking *McLenithan*, plaintiffs could argue that their foreign physicians subjected themselves to jurisdiction in the forum state by having ongoing relationships with medical-tourism firms based in that state.

2. Jurisdiction over Foreign Physicians Based on the Continuing-Tort Theory

Another option is for medical-tourism plaintiffs to sue in the state they return to after receiving the overseas medical operation—typically their home state. Under the traditional view, a forum state does not have jurisdiction over a nonresident physician simply because the plaintiff resides there. Indeed, courts have held that the place where the patient resides is inconsequential in a jurisdictional inquiry because medical services are "directed to no place but to the needy person herself."[15] However, medical-tourism plaintiffs may be able to sue in their home states if the courts where they bring their actions recognize the "continuing tort" theory of jurisdiction. Under this theory, a plaintiff's home state court can exercise jurisdiction over a nonresident physician whenever the effects of the physician's tortious act continues to be felt by the plaintiff upon returning to her home state.[16] Unless the plaintiff has a continuing relationship with the nonresident physician, however, courts have been reluctant to accept the continuing-tort theory.[17] For example, the Court of Appeals for the Ninth Circuit strongly condemned the continuing-tort theory in *Wright v. Yackley*: the "idea that tortious rendition of such [medical] services is a portable tort which can be deemed to have been committed wherever the consequences foreseeably were felt is wholly inconsistent with the public interest in having services of this sort generally available."[18]

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14. 223 A.D.2d 777, 778 (N.Y. App. Div. 1996). *See also Ingraham*, where the New York Court of Appeals declined to decide whether a contract like that in *McLenithan*—a "referral/fee arrangement creating mutual obligations"—would suffice as "interstate business activity" for purposes of long-arm jurisdiction.

15. Wright v. Yackley, 459 F.2d 287, 289 (9th Cir. 1972).

16. *See, e.g.*, Torres v. State, 894 P.2d 386, 390 (N.M. 1995).

17. *See, e.g.*, *Wright*, 459 F.2d at 289–90 (holding that refilling a prescription for a resident of the forum state is insufficient to establish personal jurisdiction); *see also* Kennedy v. Ziesmann, 526 F. Supp. 1328, 1330–31 (E.D. Ky. 1981) (holding that "incidental phone calls" to a patient in the forum state are insufficient to establish personal jurisdiction).

18. 459 F.2d at 289–90.

3. The Jurisdiction Problem and Public Policy

The court in *Wright* rejected the continuing-tort theory primarily on public policy grounds. The court reasoned that forcing physicians to defend themselves in a foreign state could inhibit the provision of medical care for nonresidents.[19] Moreover, the court opined that the interest in physician access for its citizens when they travel out of state trumps any additional deterrence of malpractice that might be gained by asserting jurisdiction over nonresident physicians: "[A] state's dominant interest on behalf of its citizens in such a case as this is not that they should be free from injury by out-of-state doctors, but rather that they should be able to secure adequate medical services to meet their needs wherever they may go."[20]

In the medical-tourism context, however, the policy arguments advanced by the court in Wright may not apply with equal force. The plaintiff's home state has a much stronger interest in deterring foreign medical malpractice than in deterring malpractice in other states because, for example, a Kansas court can rely on the Missouri courts to punish negligent doctors, but it cannot always place so much faith in foreign legal systems.

B. Medical-Tourism Firms

The idea of going abroad for surgery is daunting, and many prospective medical tourists look for professional guidance to the process. Private companies in the United States have stepped in to fill this void by offering to work out all the details for medical tourists. A good example is MedRetreat, "the first U.S. based medical tourism service agent facilitating the health care needs and travel desire of Americans."[21] MedRetreat has created a "network of pre-qualified hospitals" from which clients choose.[22] According to the managing director of MedRetreat, this list was created by spending "several hundred thousand dollars in research" and traveling to developing countries to "inspect and verify the quality of healthcare facilities abroad."[23] MedRetreat marketing materials tell prospective clients to rely on its expertise in identifying reputable foreign providers:

> Our team of medical tourism experts have personally visited 5 continents from the perspective of a medical tourist and will be happy to discuss the pros and cons of any destination that you are interested in. They have conducted comprehensive research, performed site inspections of the hospitals and hotels and have interviewed the

19. *Id*. at 290–91.

20. *Id*. at 291.

21. MedRetreat, http://www.MedRetreat.com (follow "About MedRetreat[:] Getting to know us" hyperlink to view slide presentation) (last visited Apr. 10, 2007).

22. MedRetreat Press Release, Nov. 18, 2005, *available at* http://www.medretreat.com/templates/UserFiles/Documents/Press%20Releases/MedRetreatPressRelease20051118.pdf.

23. *Id*.

surgeons and medical staff to verify that they are the world-class institutions they promote themselves to be.[24]

For medical tourists who want to file malpractice claims in the United States, medical-tourism firms make attractive defendants because they are not encumbered with personal jurisdiction problems that might protect negligent foreign physicians. A firm that is incorporated in or has its principal place of business in a particular state is always subject to that state's jurisdiction.[25] Consequently, medical-tourism plaintiffs might try to hold the medical-tourism firms they used liable for including foreign providers who were negligent on their network.

Plaintiffs could invoke a number of theories to hold medical-tourism firms liable, including corporate negligence, the informed consent doctrine, and vicarious liability. However, none of these theories fit perfectly in the medical tourism context.

1. Corporate Negligence

Firms are liable for the torts they commit, including corporate negligence. Under corporate-negligence theory, hospitals have been held liable for negligently hiring or retaining incompetent physicians or for failing to adequately supervise them.[26] However, courts have been hesitant to extend the theory outside the hospital context. As a result, courts have not uniformly applied the theory to managed care organizations (MCOs).[27]

Courts that refuse to hold MCOs liable for corporate negligence would probably also refuse to apply that theory to firms selling medical-tourism packages. Firms are more like MCOs than hospitals. Like MCOs, firms ask their clients to select surgeons from a network of foreign providers. Unlike hospitals, firms have no staff physicians, physician assistants, or nurses.

Even those courts willing to hold MCOs liable under a corporate-negligence theory may decline to apply the theory to medical-tourism firms. A court hearing a medical-tourism case would probably apply the law of the country in which the alleged malpractice took place, and that country might not recognize the corporate-negligence theory.[28]

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24. *See* MedRetreat, Why MedRetreat, http://www.medretreat.com/medical_tourism/why_medretreat.html (last visited May 27, 2007).

25. 28 U.S.C.A. § 1332(c)(1) (2006).

26. *See, e.g.*, Darling v. Charleston Cmty. Mem. Hosp., 211 N.E.2d 253, 258 (Ill. 1965).

27. For examples of cases on both sides of the issue of whether MCOs can be held liable for corporate negligence, see Clark C. Havighurst, *Making Health Plans Accountable For the Quality of Care*, 31 GA. L. REV. 587, 609 n.58 (1997). Among other cases, Havighurst cites *Elsesser v. Hospital of Philadelphia College of Osteopathic Medicine*, 802 F. Supp. 1286, 1291 (E.D. Pa. 1992) (recognizing corporate negligence as a theory of liability); *Harrell v. Total Health Care, Inc.*, 781 S.W.2d 58, 60 (Mo. 1989) (relying on a state statute to reject the theory of liability); and *McClellan v. HMO of Pennsylvania*, 604 A.2d 1053, 1056 n.6 (Pa. Super. Ct. 1992) (finding it unnecessary to decide the case on the issue).

28. *See infra* Part III.

Corporate negligence is also difficult to prove. If the plaintiff pursues a negligent-retention claim, she must first prove that the physician was unfit or incompetent.[29] Second, the plaintiff must demonstrate that the firm should have known of the physician's incompetence.[30] That the plaintiff was negligently operated on does not itself satisfy the scienter requirement.[31] Rather, the plaintiff must establish a pattern of misconduct by the physician.[32]

A medical-tourism plaintiff would encounter additional problems in pursuing a negligent-hiring claim. In the United States, a prima facie case of negligent hiring can be made out if the physician has not passed her medical boards. It is unclear, however, what credentials a physician in a developing country must have before a U.S. firm may place her on its network.

A claim for negligent supervision would be no easier to prove. For that claim to apply, a plaintiff must show either that adequate supervision would have prevented the physician's negligence or that "prompt action after the incident would have minimized injuries."[33] As Catherine Butler notes with respect to actions against preferred provider organizations, the standard for negligent supervision presents difficult proximate cause issues.[34] Medical-tourism plaintiffs would be hard-pressed to show that more oversight by the medical-tourism firm would have prevented the foreign provider's negligence.

2. Informed Consent

Given the difficulties with proving corporate negligence, medical-tourism plaintiffs may be better off pursuing a lack of informed consent claim. Firms go to great lengths to vouch for the quality of care their clients will receive.[35] If the quality of care proves to be substandard, a case can be made that the vouching amounted to misrepresentation, and, as a consequence of such misrepresentation, that the plaintiff did not give her informed consent to the operation.

Yet there are pitfalls to a lack of informed consent claim as well. Courts have been reluctant to apply the informed consent doctrine beyond the treating physician.[36] Moreover, the informed consent cases involving misrepresentations

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29. Edmonds v. Chamberlain Mem. Hosp., 629 S.W.2d 28, 29–30 (Tenn. Ct. App. 1981).

30. *Id*.

31. *Id*. at 30.

32. *See* Havighurst, *supra* note 27, at 604 ("[A] hospital is accountable for such a physician's performance only if it was, or should have been, aware of a specific problem—much as, in many jurisdictions, a dog owner is entitled to one free bite.").

33. Catherine Butler, Note and Comment, *Preferred Provider Organization Liability for Physician Malpractice*, 11 AM. J.L. & MED. 345, 361 (1985).

34. *Id*.

35. MedRetreat, for example, states that all MedRetreat partner facilities are "private institutions that either meet or exceed the high standards of quality care, technological innovation and accreditation that American medicine is known for." MedRetreat, Hospitals, http://www.medretreat.com/procedures/hospitals.html (last visited Apr. 10, 2007).

36. *E.g.*, Foflygen v. Zemel, 615 A.2d 1345, 1353 (Pa. Super. Ct. 1992) ("[U]nder normal circumstances, only the physician who performed the operation on the patient has the duty of obtaining the patient's informed consent.").

tend to focus on misrepresentations concerning the surgery's chances of success and the risks accompanying the surgery.[37] Although these causes of action would be applicable in a medical-tourism case, were such representations to be made, prudent firms would shy away from making such promises. The basis of a medical tourist's claim would most likely lie in a firm's misrepresentations about the qualifications of the foreign providers.

A small number of courts have allowed a plaintiff to bring an action against her physician when the physician misrepresented her credentials or experience. In *Howard v. University of Medicine & Dentistry of New Jersey*,[38] the New Jersey Supreme Court recognized a cause of action lying in lack of informed consent based on a physician's misrepresentations about her credentials or experience. It held that physicians do not have a duty to disclose their credentials but that a "significant misrepresentation" concerning their experience can affect the validity of their patients' consents.[39]

The court in Howard sharply limited the misrepresentation theory of liability, however, by establishing a demanding two-part test that plaintiffs must meet to get their cases to a jury. First, a plaintiff must show that an "objectively reasonable person could find that physician experience was material in determining the medical risk" of the procedure.[40] In order to meet the materiality prong, the plaintiff must prove that the physician's lack of experience had a "direct and demonstrable relationship to the harm" the patient suffered.[41] If the materiality prong is met, the plaintiff must then show that a reasonably prudent person in the plaintiff's position would not have consented to the surgery after being informed of the defendant's true credentials.[42]

It would be difficult for a medical-tourism plaintiff to meet these requirements for a misrepresentation claim. First, the plaintiff would have to establish that there was an actual misrepresentation. In Howard, the plaintiff alleged that the neurosurgeon lied about being board-certified in neurosurgery and about performing sixty corpectomies a year.[43] The representations on the

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37. *E.g.*, Salis v. United States, 522 F. Supp. 989, 1005 (M.D. Pa. 1981) (recognizing a cause of action in lack of informed consent when the injured plaintiff was not warned of all the dangers of an angiogram); Wagner v. Georgetown Univ. Med. Ctr., 768 A.2d 546, 560–61 (D.C. 2001) (finding error in granting the defendant's motion in limine in part, because a reasonable jury could conclude that the plaintiff's physician had overestimated the odds of surgical success and therefore the plaintiff did not give her informed consent).

38. 800 A.2d 73, 82, 86 (N.J. 2002); *see also* Johnson v. Kokemoor, 545 N.W.2d 495, 504 (Wis. 1996) ("We reject the defendant's proposed bright line rule that it is error as a matter of law to admit evidence in an informed consent case that the physician failed to inform the patient regarding the physician's experience with the surgery or treatment at issue.").

39. *Id.* at 83, 86. Interestingly, the *Howard* court did not permit an action for fraud. For a critique on this point see Vincent R. Johnson and Shawn M. Lovorn, *Misrepresentations by Lawyers About Credentials or Experience*, 57 OKLA. L. REV. 529, 569–70 (2004).

40. *Howard*, 800 A.2d at 84.

41. *Id.*

42. *Id.*

43. *Id.* at 76.

medical-tourism firms' websites are probably not false, although some may be misleading. For example, until March 2007, MedRetreat's website stated that all the physicians it partners with are "board[-]certified MD[]s, trained according to the same standards and practices as those operating in The United States."[44] Such language might create a misimpression if the foreign physicians have not received the same rigorous training as physicians in the United States, but it is probably not specific enough to rise to misrepresentation.[45]

A medical-tourism plaintiff would also struggle to prove the materiality prong since courts would be reluctant to judge foreign medical training. For example, a medical tourist may claim that the firm she used misled her into thinking that her foreign physician had the same qualifications as a U.S. physician. In order to clear the materiality hurdle, the plaintiff would then have to show that the physician's non-U.S. credentials increased the risk of harm from surgery. A court might not be willing to hold that foreign training is inferior to the training physicians receive in the United States.

3. Vicarious Liability

Alternatively, a medical-tourism plaintiff could seek to hold the medical-tourism firm vicariously liable for the negligence of the foreign provider. Courts are willing to hold defendants vicariously liable only in specific circumstances, such as when there is an employer–employee relationship and the employee commits a tort within the scope of that relationship. Vicarious liability in such circumstances is based on the principle of respondeat superior. Under the same principle, courts have held hospitals vicariously liable for the negligence of their staff physicians[46] and staff-model HMOs liable for the negligence of plan doctors.[47]

Vicarious liability based on respondeat superior would probably not apply in medical-tourism cases. Foreign providers act more like independent contractors than like employees of U.S. medical-tourism firms: the firms do not pay the wages of the foreign providers, foreign providers treat patients other than those referred to them by the firms, and foreign providers choose their own staffs.

Courts have also been willing to use apparent- or ostensible-agency theories to hold hospitals vicariously liable for the negligence of physicians who are independent contractors rather than staff physicians. In order for the apparent-agency theory to apply, the plaintiff must first show that she thought the

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44. *See* MedRetreat, Physicians, http://www.medretreat.com/procedures/physicians.html (last visited Mar. 1, 2007).

45. Tellingly, MedRetreat has since changed the statement that its partner facility physicians are trained according to the "same" standards and practices that exist in the U.S. with the less contentious statement that its partner facility physicians are trained according to international standards and practices that are "comparable" to those existing in the U.S. *See* MedRetreat, Physicians, http://www.medretreat.com/procedures/physicians.html (last visited Apr. 10, 2007).

46. *See* Havighurst, *supra* note 27, at 596.

47. *See, e.g.*, Sloan v. Metro. Health Council, Inc., 516 N.E.2d 1104, 1109 (Ind. Ct. App. 1987).

physician was the actual agent of the hospital and that this belief was a reasonable one.[48] Second, the hospital must have somehow acted to lead the plaintiff to believe the physician was its agent or at least have failed to give the plaintiff a contrary impression.[49] Third, the hospital's act or failure to act must have been the reason for the plaintiff's mistaken impression that the physician was the hospital's agent.[50]

Hospitals have been held vicariously liable under an apparent-agency theory when the plaintiff proves that she looked to the hospital rather than to the physician for treatment. The prototypical example is when the plaintiff sues a hospital for emergency-room care since "the very nature of a medical emergency precludes [physician] choice."[51] A plaintiff can also establish apparent agency by proving that the hospital held itself out as the provider of care. Plaintiffs have thus relied on hospital advertising to establish their apparent agency claims.[52] For example, in *Pamperin v. Trinity Memorial Hospital*, the Wisconsin Supreme Court held a hospital vicariously liable for the acts of physicians who were, in fact, independent contractors because the hospital had advertised itself as providing complete medical care.[53]

Some courts have also been willing to hold MCOs vicariously liable when their subscribers rely on them, rather than on individual physicians, for care.[54] For example, in *Boyd v. Einstein Medical Center*, a Pennsylvania court found that an HMO could be held vicariously liable for the negligence of a physician on its plan when the plaintiff's decedent "submitted herself to the care of the participating physicians in response to an invitation from HMO."[55]

Hospitals and MCOs have been able to limit vicarious liability claims, however, by requiring patients to acknowledge that their treating physicians are independent contractors.[56] As Professor Havighurst has noted, "A recent review of heath plans' contracts with their subscribers observes how MCO contracts and related literature frequently characterize the plans' relationship with physicians in ways seemingly calculated to permit the plan later to deny responsibility for the quality of care provided."[57]

Courts are willing to find contractual waivers of responsibility effective to limit liability.[58] For example, in *Espalin v. Children's Medical Center of Dallas* a

48. Mejia v. Cmty. Hosp., 99 Cal. App. 4th Supp. 1448, 1456–57 (Cal. Ct. App. 2002).

49. *See, e.g.,* Gilbert v. Sycamore Mun. Hosp., 622 N.E.2d 788, 796 (Ill. 1993) (holding that a hospital holds itself out as a provider of care if it fails to inform the patient otherwise).

50. *See, e.g.,* James by James v. Ingalls Mem'l Hosp., 701 N.E.2d 207, 211 (Ill. 1998).

51. McGill v. Newark Surgery Ctr., 756 N.E.2d 762, 773 (Ohio C.P. 2001) (quoting Clark v. Southview Hosp. & Family Health Ctr., 628 N.E.2d 46, 53 (Ohio 1994)).

52. *See, e.g.*, Pamperin v. Trinity Mem. Hosp., 423 N.W.2d 848, 849 (Wis. 1988).

53. *Id*.

54. *See, e.g.*, Boyd v. Albert Einstein Med. Ctr., 547 A.2d 1229, 1229, 1232 (Pa. Super. Ct. 1988).

55. *Id*. at 1235 (denying summary judgment to HMO by finding "an issue of material fact as to whether the participating physicians were the ostensible agents of HMO.").

56. *See* Havighurst, *supra* note 27, at 608.

57. *Id*.

58. Espalin v. Children's Med. Ctr., 27 S.W.3d 675, 684–85 (Tex. Ct. App. 2000).

Texas court denied recovery against a hospital when the plaintiff's parents had read and signed the hospital admission form stating that their daughter's doctors were independent contractors.[59] Contracts waiving MCO responsibility for physician negligence may also be valid. MCOs generally give their clients more choices in selecting a physician, and the waivers are signed when the clients have time for cool reflection.

A medical-tourism plaintiff attempting to hold the medical-tourism firm vicariously liable for the negligence of her foreign provider would likely rely on an apparent-agency theory. Her claim would be supported by the fact that medical tourists look to firms to select their foreign providers. Firms encourage this reliance through their advertising. For example, MedRetreat promotes itself by telling prospective clients,

> You see, we've done all the legwork for you. Through our due diligence process, we've traveled to these locations to carefully inspect, verify and select our business partners and their facilities. Only the best hospitals, hotels and destination program managers have met our stringent criteria and have been chosen to participate in this program.[60]

Medical-tourism plaintiffs could argue that such statements signal to patients that the foreign providers are the firms' agents and on that basis, the firms should be held vicariously liable for the foreign providers' negligence.

The firms would still probably escape liability, however, because they require medical tourists to sign agreements acknowledging the foreign providers' independence. MedRetreat's "Medical Tourism Agreement" cautions that MedRetreat "is not a medical referral service and does not endorse, recommend, or approve any travel agency or healthcare provider."[61] Mediescapes India similarly warns its clients that it "does not control or operate any Treating Institution" and therefore is not responsible for a Treating Institution's negligence.[62] After *Espalin*, disclaimers like those made by MedRetreat and Mediescapes India are probably valid if voluntarily signed and may be sufficient to defeat a medical-tourism plaintiff's claim that the medical-tourism firm should be held vicariously liable based on the apparent agency theory.[63]

59. *Id.* (finding no error in granting summary judgment where the waiver stated that the physicians were not employees of the hospital).

60. *See* MedRetreat, *supra* note 21.

61. MedRetreat, Medical Tourism Agreement, http://www.medretreat.com/templates/UserFiles/Documents/Medical%20Tourism%20Agreement%20-%20Jane%20Doe(1).pdf (last visited Apr. 16, 2007).

62. *See* Mediescapes India, http://www.mediescapes.com/Legal_Issues_and_Risks.html (last visited Apr. 10, 2007).

63. *See Espalin*, 27 S.W.3d at 684–85 (although the discussion concerning waivers in *Espalin* was confined to the hospital context, courts will likely find that medical-tourism firms can similarly waive risks, especially since firms have even less control over doctors).

III
CONFLICT OF LAW ISSUES

A medical-tourism firm would likely try to dismiss a lawsuit against it on forum non conveniens grounds. The firm would contend that the most appropriate forum for litigation would be the foreign country in which the surgery took place. If its motion were denied, the firm would proceed to argue that the case should be governed by the foreign country's laws. To some extent these issues overlap: a court's decision to grant a motion for dismissal on grounds of forum non conveniens may be based in part on the potential for conflict of laws.[64]

A. Forum Non Conveniens

A plaintiff's choice of venue is typically respected when it is the plaintiff's home state.[65] A court is also less likely to grant a forum non conveniens motion when the plaintiff's choice of venue is located where the defendant has its principal place of business or is incorporated (presumptively convenient locations).[66] But when the plaintiff brings suit in a foreign forum and the subject of the litigation arose outside that forum, the plaintiff's choice will be given less deference.[67]

In addition to considering the plaintiff's and defendant's residences, courts will also consider a number of public and private factors to determine what forum is most appropriate for the litigation.[68] Private-interest factors include (1) the ease of access to evidence, (2) the availability of compulsory process to compel attendance of unwilling witnesses, and (3) the cost of willing witnesses' attendance.[69]

The private-interest factors have been invoked by courts to dismiss medical malpractice actions that arose overseas. For example, in *Jeha v. Arabian American Oil Co.,* the cost of importing critical witnesses was a private-interest factor that led a federal district court sitting in Texas to dismiss a malpractice suit against a Saudi oil company. [70] Allegedly negligent treatment had been given by company doctors in Saudi Arabia, and critical evidence and witnesses

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64. *See infra* text at note 89.

65. Koster v. Lumbermens Mutual Casualty Co., 330 U.S. 518, 524 (1947).

66. Stangvik v. Shiley Inc., 54 Cal.3d 744, 755–56 (Cal. 1991) ("[T]he presumption of convenience to a defendant which follows from its residence in California remains in effect . . . ."). However, the convenience of a state of incorporation or principal place of business is not always dispositive. *See* Ussery v. Kaiser Found. Health Plan, 647 A.2d 778, 781–82 (D.C. 1994) (holding that a Maryland plaintiff could not sue her health plan in the District of Columbia for malpractice that occurred in Maryland even though the defendant was incorporated in the District).

67. *See, e.g.*, Gundlach v. Lind, 820 N.E.2d 1, 5, 6 (Ill. Ct. App. 2004) (holding that the circuit court abused its discretion in denying defendant's motion to transfer venue when neither the plaintiffs nor the defendants resided in the county where the plaintiff brought suit and the acts giving rise to the litigation were also located outside the forum county).

68. *See, e.g.*, *Stangvik*, 54 Cal.3d at 751.

69. *Id.*

70. 751 F. Supp. 122, 126, 128 (S.D. Tex. 1990).

were located overseas.[71] The court held that "to require these doctors to travel to Texas or to require the lawyers to go to them in Lebanon would be wasteful."[72] Moreover, "[d]octors should not be forced to "endure unnecessary, prolonged absences from their medical duties."[73] Finally, the court expressed concern as to whether it could compel the testimony of necessary foreign witnesses.[74]

Two important public-interest factors in a forum non conveniens analysis are the local interest in resolving local controversies and the avoidance of difficult problems of a potential conflict of laws and the application of foreign law.[75] In *Gibbon v. American University of Beirut*, a federal district court in New York dismissed a British plaintiff's claim against a university incorporated in New York but having its principal place of business in Beirut for alleged malpractice that took place in Lebanon.[76] The court determined that New York's local interest in deciding cases involving companies incorporated in New York was inferior to Lebanon's interest in adjudicating medical-malpractice claims that arose in Lebanon and involved Lebanese citizens.[77] Additionally, the court held that, were it to try the case, its having to apply Lebanese law weighed heavily in favor of dismissal.[78] The court quoted Judge Friendly's cautionary advice about applying foreign law approvingly:

> [T]here is an inevitable hazard that, in those areas, perhaps interstitial but far from inconsequential, where we have no clear guides, our labors, moulded by our own habits of mind as they necessarily must be, may produce a result whose conformity with that of the foreign court may be greater in theory than it is in fact.[79]

A court may grant a forum non conveniens motion when an alternative forum lies in a foreign country.[80] The alternative forum must, however, be available and adequate.[81] The forum is available if "all the necessary parties are amenable to its jurisdiction."[82] The forum is adequate if it allows the plaintiff "reasonable access to some legal remed[y]."[83] The foreign forum need not have the same protections and benefits available to plaintiffs in the United States, but need only be capable of providing a remedy that is not "so clearly inadequate or unsatisfactory that it is no remedy at all."[84]

71. *Id*. at 126.
72. *Id*.
73. *Id*.
74. *Id*.
75. Gulf Oil Corp. v. Gilbert, 330 U.S. 501, 509 (1947).
76. Gibbon v. Am. Univ., 1983 U.S. Dist. LEXIS 13401, *1 (S.D.N.Y. 1983).
77. *Id*. at * 7.
78. *Id*. at *9.
79. *Id*. at *9 n.6 (quoting Judge Friendly in Conte v. Flota Mercante Del Esatado, 277 F.2d 664, 667 (2d Cir. 1960)).
80. Jeha v. Arabian Am. Oil Co., 751 F. Supp. 122, 128 (S.D. Tex. 1990).
81. *Gibbon*, 1983 U.S. Dist. LEXIS at *10.
82. *Jeha*, 751 F. Supp. at 125.
83. *Id*.
84. Piper Aircraft Co. v. Reyno, 454 U.S. 235, 254 (1981).

Courts have been leery about pronouncing a foreign forum inadequate.[85] For example, in *Banco Mercantil*, a federal district court in Puerto Rico held that the Dominican Republic was an adequate alternative forum: "[It] is not the business of our courts to assume the responsibility for supervising the integrity of the judicial system of another sovereign nation."[86]

Foreign courts have been considered inadequate, however, when their justice systems are incapable of providing plaintiffs timely protection. For example, in *Bhatnagar v. Surrendra Overseas Ltd.,* the Third Circuit refused to surrender a case to the Indian courts because of their notorious delays,[87] holding that an alternative forum is inadequate when "the prospect of judicial remedy becomes so temporally remote that it is no remedy at all."[88]

Whether foreign courts should be deemed inadequate when they do not recognize certain doctrines that a plaintiff relies on for relief is case specific. In one of the seminal decisions on the issue, *Piper Aircraft Co. v. Reyno*,[89] the Supreme Court held that "the possibility of a change in law unfavorable to the plaintiff should not be given substantial weight" when the plaintiff still has the chance to recover in the foreign court.[90] However, the Court cautioned that an unfavorable change in law may be given substantial weight when its application would entirely preclude the plaintiff from recovery.[91] The deciding factor, therefore, is whether the doctrine that is unrecognized in the foreign court is truly vital to the plaintiff's claim.

It is often difficult to predict the outcome in cases where a foreign forum is challenged on the grounds that it does not recognize a theory vital to the plaintiff's case. For example, in *In re CINAR Corp. Securities Litigation*,[92] a New York federal district court dismissed a securities class-action suit on forum non conveniens grounds despite the fact that the alternative forum, located in Canada, did not recognize the "fraud-on-the-market theory."[93] That many of the plaintiffs would have no basis for relief without the theory was an insufficient consideration for the court to retain the case.[94] Yet, in a similar class-action suit, *In Re Lernout and Hauspie Securities Litigation*, [95] a Massachusetts federal district court found that Belgium was an inadequate forum, in part, because it did not recognize the fraud-on-the market theory.[96]

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85. *See, e.g.*, Banco Mercantil, S.A. v. Arencibia, 927 F. Supp. 565, 567–68 (D.P.R. 1995).
86. *Id*. (quoting Chesley v. Union Carbide Corp., 927 F.2d 60, 66 (2d Cir. 1991)).
87. Bhatnagar v. Surrendra Overseas Ltd., 52 F.3d 1220, 1227–28 (3d Cir. 1995).
88. *Id*. at 1228.
89. 454 U.S. at 249–55.
90. *Id*. at 252 n.19.
91. *Id*. at 254.
92. 186 F. Supp. 2d 279, 298–99 (E.D.N.Y. 2002).
93. *Id*. at 298.
94. *Id*.
95. 208 F. Supp. 2d 74, 91–92 (D. Mass. 2002).
96. *Id*. at 92. The court was also persuaded to find that Belgium was an inadequate forum because Belgium lacks a class-action mechanism. *Id*. at 91.

The same forum non conveniens analysis would be applied to medical-tourism cases. Assuming the long-arm statute of the plaintiff's home state accommodated the suit, a medical-tourism firm's motion to dismiss on forum non conveniens grounds would probably be denied if the plaintiff brought suit there since a plaintiff's choice to sue in her home state is generally respected.[97] It is also more likely that the motion would be denied if the action was brought in the state where the firm was incorporated or had its principal place of business.[98] Even if suit was brought in such a forum, however, the case could be dismissed because of overriding private interest factors, such as the ones articulated in *Jeha v. Arabian American Oil Co*.[99] A court considering a medical-tourism case would be similarly concerned about making foreign physicians, hospital staff, and hospital representatives travel to the United States for a lengthy trial.[100]

The public-interest factors that courts consider in a forum non conveniens motion do not decisively favor either party. That a court would probably have to apply a foreign country's law would support the motion to dismiss.[101] On the other hand, American courts have a strong interest in hearing cases involving American citizens that allege American firms have committed tortious acts against them, even if their effects are felt elsewhere.[102]

In considering a medical-tourism firm's forum non conveniens motion, a court would have to decide whether the alternative forum for litigation was both available and adequate.[103] The plaintiff could argue that the foreign forum would be incapable of providing her with an adequate remedy because it does not recognize theories such as corporate negligence or vicarious liability, which are vital to her cause of action.[104] The plaintiff could also claim that the foreign forum is inadequate because of flaws in its legal system. As in *Bhatnagar*, lengthy delays in the time it takes to proceed to trial could constitute proof of the foreign forum's inadequacy.[105] Alternatively, the plaintiff could contend that the foreign forum would be biased because it has an incentive to protect its medical-tourism industry. The defendant firm could counter, however, that a biased decision would actually harm the industry by turning away prospective medical tourists who are concerned about the ability to seek redress for malpractice in a foreign country. In the end, as in *Banco Mercantil*, a court might refuse to cast judgment on another country's justice system.[106]

97. *See supra* text at note 65.
98. *See supra* text at note 66.
99. *See* Jeha v. Arabian Am. Oil Co., 751 F. Supp. 122, 126 (S.D. Tex. 1990).
100. *Id.*
101. *See* Gulf Oil Corp. v. Gilbert, 330 U.S. 501, 509 (1947).
102. *Id.*
103. *E.g.,* Gibbon v. Am. Univ., 1983 U.S. Dist. LEXIS 13401, *10 (S.D.N.Y. 1983).
104. *E.g., In re* Lernout and Hauspie Secs. Litig., 208 F. Supp. 2d. 74, 91–92 (D. Mass. 2002).
105. Bhatnagar v. Surrendra Overseas Ltd., 52 F.3d 1220, 1227–28 (3d Cir. 1995).
106. Banco Mercantil, S.A. v. Arencibia, 927 F. Supp. 565, 567–68 (D.P.R. 1995).

B. Choice-of-Law Issues

If a court decided that venue was proper, it would then have to decide what law would govern the medical-tourism case. Although choice-of-law rules for medical-malpractice actions are not uniform among the states, they have substantial overlaps.

In tort actions, states generally follow either the *lex loci delicti* approach, in which the law of the place of injury governs; the most "significant relationship test" adopted by the *Restatement of Law—Conflict of Law* (2d); or a state-interest analysis, which examines which state has the greatest interest in the application of its laws.[107] The Restatement Second approach, adopted by a substantial number of states, takes into account a number of factors including (1) the site of the injury; (2) the place where the conduct giving rise to injury occurred; (3) the parties' residence, domicile, principal place of business, or state of incorporation; and (4) the place where the parties' relationship is centered.[108]

Most medical-malpractice actions follow the *lex loci delicti* approach, whereby the law governing the case is that of the state in which the operation occurred.[109] For example, in *Chadwick v. Arabian American Oil Co.*,[110] a federal district court in Delaware considered a medical-malpractice action brought by a Florida plaintiff alleging that an oil company incorporated in Delaware, with its principal place of business in Saudi Arabia, was vicariously liable for the negligence of the defendant company's doctors. The court held that Saudi law applied because Delaware conflict-of-law principles were governed by *lex loci delicti* and the plaintiff alleged that he had been misdiagnosed in Saudi Arabia.[111] The court in *Chadwick* dismissed the action because Saudi law did not recognize vicarious liability.[112]

The Restatement test and the state interest inquiry often yield the same result as the *lex loci delicti* approach to conflict of law issues in medical malpractice actions. In *Blakesley v. Wolford*,[113] the Third Circuit used both approaches in deciding to apply the laws of Texas rather than those of Pennsylvania to a medical-malpractice action.[114] During a visit to Pennsylvania, a Texas dentist had advised the plaintiff to undergo oral surgery; she subsequently did so, in Texas, then returned to Pennsylvania.[115] The court rejected the plaintiff's argument that because Pennsylvania was the state in

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107. RESTATEMENT (SECOND) OF CONFLICTS OF LAWS § 145 (1971).

108. *Id.*

109. *See* Shirley A. Wiegand, *Fifty Conflict of Laws "Restatements": Merging Judicial Discretion and Legislative Endorsement*, 65 LA. L. REV. 1, 39–40 (2004) (quoting Symeon C. Symeonides, *Choice of Law in the American Courts in 2003: Seventeenth Annual Survey*, 52 AM. J. COMP. L. 9, 33 (2004)).

110. Chadwick v. Arabian Am. Oil Co., 656 F. Supp. 857, 858 (D. Del. 1987).

111. *Id.* at 860.

112. *Id.* at 860–61.

113. 789 F.2d 236 (3d Cir. 1986).

114. *Id.* at 239.

115. *Id.*

which she felt the effects of the operation, the injury had taken place in Pennsylvania rather than Texas.[116] The court also refused to consider the place where the initial consultation and diagnosis were made (Pennsylvania) as the place where the conduct causing injury occurred.[117] It held that the only relevant conduct occurred in Texas since that was where the alleged negligence occurred.[118] Concluding that Texas's interest in protecting its physicians trumped Pennsylvania's interest in protecting its citizens that voluntary travel out of state for medical care,[119] the court applied Texas law to the case.

In the context of medical tourism, as in that for medical malpractice generally, a court using the *lex loci delicti* approach to conflict-of-law questions would apply the law of the country in which the medical tourist's operation occurred. If a court followed the *Blakesley* decision, it would decline an invitation to find that the place of the medical-tourism plaintiff's injury was the state where she felt the effects of the surgery.[120]

Similarly, foreign law would probably govern under the Restatement test.[121] The first and second prongs of that approach clearly favor foreign law since the foreign country would be the site where the injury and the conduct directly causing the injury occurred. The third and fourth parts of the Restatement test weigh against using foreign law: a medical-tourism firm's principal place of business and place of incorporation are in the United States, as is the relationship between a medical tourist and the firm.[122] However, where the relationship is centered may not weigh heavily in a court's analysis since most of the transactions in medical tourism occur over the internet or telephone.

It is unclear how a court hearing a medical-tourism malpractice case would rule on choice of law if it used a state-interest approach. A nation has an interest in deterring domestic firms from taking advantage of vulnerable medical tourists. If the host nation is unable to prevent its firms from engaging in opportunistic behavior, it is unlikely that any other country could do so. Foreign countries may lack jurisdiction over the host-nation's firms and may be unable or unwilling to regulate them. Foreign countries nonetheless have an interest in medical-malpractice actions that arise within their borders. This interest would be strengthened if citizens of the foreign country were joined as defendants in the case.

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116. *Id*. at 241.
117. *Id*. at 242.
118. *Id*.
119. *Id*. at 243.
120. *See id.* at 241.
121. *See* RESTATEMENT (SECOND) OF CONFLICTS OF LAWS, *supra* note 107.
122. *See* Chadwick v. Arabian Am. Oil Co., 656 F. Supp. 857, 858 (D. Del. 1987).

IV
PUBLIC POLICY CONSIDERATIONS

The legal challenges that medical-tourism plaintiffs would encounter in stating claims against medical-tourism firms in the United States may be at odds with good public policy. Although a case may be made that it is too premature to impose stricter liability standards on medical-tourism firms, the status quo may not sufficiently deter firms from taking advantage of their vulnerable clients by partnering with substandard foreign providers.

A. The Case for Stricter Liability Standards

Public policy favors holding firms legally accountable for the negligent acts of foreign providers. First, medical tourists' particular vulnerability in the area of international health-care makes it prudent for the law not to defer to caveat emptor principles. Many medical tourists are uninsured whereas others are in need of surgery not offered within the United States.[123] These tourists have little choice but to engage in medical tourism, which makes it difficult for them to fully appreciate the risks.

Second, public policy favors placing liability on the firms because they have a substantial information advantage over their clients.[124] The firms' marketing material emphasizes the hundreds of thousands of dollars they spend investigating the quality of their foreign partners.[125] Clearly, medical tourists lack the resources to independently evaluate the reputations of foreign providers whose selection is the main purpose of medical-tourism firms.

Third, public policy favors placing liability on firms because they are the better cost avoider. Firms have the ability to exert influence on the foreign providers and thereby reduce the frequency of malpractice. For example, firms could set quality standards to which foreign partners would have to adhere in order to stay on the firms' networks. Firms could also hire teams of independent inspectors consisting of respected U.S. physicians to inspect the foreign hospitals and their physicians.

Finally, public policy favors imposing liability on firms because they may be the only source of redress for a medical tourist who is the victim of malpractice. U.S. courts probably lack jurisdiction over the foreign providers,[126] and the courts of the country where the malpractice occurred may also be unwilling or unable to hear suits against them.[127] Not only is the medical-tourism plaintiff harmed by her inability to obtain a remedy to right the wrong that has been

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123. *See 60 Minutes Story*, *supra* note 2 (explaining that many medical tourists receive treatments not covered under their insurance or not FDA approved).

124. For the parallel argument in the MCO context see Havighurst, *supra* note 27, at 618 (arguing MCOs are "in a position to make quality a desideratum in selecting specialists").

125. *See, e.g.*, MedRetreat Press Release, *supra* note 22.

126. *See supra* text at Part II.A.

127. In India, for example, the delays in judicial proceedings are notorious. *See supra* text at note 87.

done to her, but future medical tourists are also disadvantaged by the inability of courts to deter future negligence through the imposition of liability.

Current liability standards are not sufficient to hold firms fully accountable for the negligence of foreign providers. Firms will not be held vicariously liable if they distance themselves from their overseas partners because vicarious liability presently turns on the ability (real or apparent) of the firms to control the providers.[128] Without the threat of liability, firms have less of an incentive to select the best foreign hospitals for their networks. Instead, they can take advantage of uninformed medical tourists by contracting with inferior providers.

B. The Case against Stricter Liability Standards

Firms would argue, first, that changing the existing legal regime is unnecessary. At this early stage in the industry, there is no evidence indicating that firms take advantage of their clients. This stands in contrast to MCOs, in which examples of opportunistic behavior are rife.[129] Moreover, firms would argue that opportunistic behavior will not develop in the medical-tourism industry because firms compete vigorously on the issue of safety. Whereas MCOs take pains to distance themselves from the providers on their panels,[130] firms boast about the steps they have taken to ensure their clients receive top-quality care.[131] Since market forces already demand that firms act as loyal agents for their clients, creating liability rules designed to achieve that objective would be superfluous.

If the medical-tourism industry were fully transparent and medical tourists had perfect information, the market's invisible hand would be a strong deterrent against firms' engaging in opportunistic behavior. The reality is, however, that medical tourists have just as little information about medical-tourism firms as they do about foreign providers. The industry is simply too new.[132] Thus, at least in the short term, market forces will be ineffective in weeding out the less-reputable firms.

Second, firms may contend that stricter liability standards are unnecessary because firms that select incompetent providers can already be held liable for corporate negligence. Consequently, the current legal regime gives firms sufficient incentive to ensure that they work only with quality providers.

The flaw with this argument is two-fold. To begin with, it is not clear whether courts would accept the corporate-negligence theory of liability in the medical-tourism context.[133] Yet even if they did, corporate negligence is not a

128. *See* Clark C. Havighurst, *Vicarious Liability: Relocating Responsibility for the Quality of Medical Care*, 26 AM. J.L. & MED. 7, 23 (2000).

129. *See* Havighurst, *supra* note 27, at 591–95.

130. *Id*. at 594–95.

131. *See, e.g.*, MedRetreat, Why MedRetreat, *supra* note 24.

132. MedRetreat, for example, has only been in existence since 2003. MedRetreat, *supra* note 21.

133. *See* discussion *supra*, Part II.B.1.

panacea for the problem of firms engaging in opportunistic behavior. The reasons why a pure negligence regime underdeters negligent conduct is well documented in the health-care field, and those reasons appear applicable to medical tourism.[134] Because corporate-negligence actions against firms, like malpractice actions against physicians themselves, would be expensive and time-consuming, firms could count on a substantial number of victimized medical-tourism clients to settle for low amounts or not to sue at all.[135] In addition, because proving corporate negligence requires plaintiffs to show that the foreign providers had such a poor track record that the firms should have known not to partner with them, [136] a number of plaintiffs with valid claims will lose at trial.[137]

Consequently, firms would not have to fully compensate all plaintiffs with valid malpractice claims and therefore it would be economically rational for them to select inferior providers and to underinvest in quality control. Stricter liability standards are needed to make firms internalize the costs of deciding not to act as loyal agents for their clients.

Third, firms would defend the current liability regime by arguing that it appropriately places responsibility for malpractice on the foreign providers. If firms were always held liable for the negligence of their foreign partners, then those partners would lack an incentive to provide better care.

This argument, too, is flawed. The assumption that increasing physicians' liability risks will motivate them to provide better care has been heavily criticized.[138] Physicians are covered by malpractice insurance and, as Professor Havighurst observes, the insurance "is generally not priced so that future premiums reflect the physician's actual claims experience."[139] Although the insurance system in the country where the physician practices may not be as effective at softening the impact of malpractice claims, there are other reasons to believe that direct actions against the foreign providers are not an effective deterrence mechanism. As Professor Havighurst notes, for example, physicians may be in "psychological denial" about the connection between malpractice actions and the quality of their care.[140]

Finally, firms would argue against stricter liability standards on the grounds that higher standards could cripple the infant industry. Their contention would be that the number of firms offering to guide the tourists through the process would diminish and that those firms that could afford to pay out large damage awards would pass the costs along to their clients. Since medical tourism's main

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134. *See, e.g.*, Jeffrey O'Connell & James F. Neale, *HMO's, Cost Containment, and Early Offers: New Malpractice Threats and a Proposed Reform*, 14 J. CONTEMP. HEALTH L. & POL'Y 287, 296–98 (1998).

135. *Id*. at 294.

136. *See supra* Part II.

137. O'Connell & Neale, *supra* note 134, at 294.

138. *See, e.g.*, Havighurst, *supra* note 128, at 18–19.

139. *Id*. at 18.

140. *Id*.

attraction is the cost savings, many medical tourists would then simply forego the firms' services.

Of course, if stricter liability standards actually did send firms out of business or made them prohibitively expensive to use, public-policy objectives in encouraging such firms would be defeated. Firms play an important role in the medical-tourism industry since medical tourists are ill-equipped to identify reputable foreign providers on their own. Yet it is not clear that subjecting firms to higher liability standards would necessarily impede their growth. First, firms may become more attractive to medical tourists if they are held liable for compensation in the event of malpractice. In essence, firms would serve as limited insurance providers. Second, the firms would probably not go out of business if they raised their prices to reflect their higher costs. The cost savings associated with medical tourism would remain substantial and tourists would likely continue to pay for a firm's expertise in the field.

V
CONCLUSION

Despite the growth of the medical-tourism industry, information on the quality of the foreign providers is sparse. Consequently, medical-tourism firms with expertise in the business are valuable intermediaries. As a result of their information advantage over the public, however, these firms are in a position to engage in opportunistic behavior.

The best way to deter firms from taking advantage of their positions would be to hold them vicariously liable for the malpractice of their foreign partners. This would create an incentive, stemming from a legal duty, for the firms to select the best providers and exercise adequate supervision over them. However, the current legal regime is a long way off from this ideal. As this article has demonstrated, firms have enough defenses to malpractice actions that they will rarely be held accountable for failing to act in their clients' best interests.

Legislation should be introduced to regulate medical tourism. The industry presents myriad complex policy issues that need to be resolved. For example, MCOs could begin offering deeply discounted plans whereby patients will be insured only for operations performed in foreign countries. The question of whether such plans should be permitted is not too premature in light of the recent decision by Blue Cross Blue Shield to insure its first medical tourist, a three-year-old boy who went to India to receive care for a heart problem.[141]

In determining whether to restrict the activities of businesses connected to the medical-tourism industry, legislators will need to weigh the virtues associated with freedom of contract against the need to protect vulnerable medical tourists. The level of paternalism reflected in medical-tourism

141. M. Dinesh Varma, *Insured in U.S., Treated in India*, THE HINDU, Feb. 8, 2006, *available at* http://www.hindu.com/2006/02/08/stories/2006020817240300.htm.

regulations should parallel the transparency of the industry. As more information about medical-tourism becomes available, there will be less need to protect medical tourists.