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Are Your Patients Packing Their Bags? *Precautions for the Domestic Provider in the Era of Medical Tourism*

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Your patient makes an appointment to inform you that his longstanding knee pain is soon to be addressed through an offshore surgical procedure in India. Or perhaps, your patient advises you that while uncertain as to the source of his skin rash, fevers and general malaise, she recently returned from an elective plastic surgery procedure in the Dominican Republic.

Medical Tourism has been estimated as a $20 billion industry which may even reach $100 billion by 2012. Some sources report that by 2007, more than 500,000 Americans sought medical treatment electively in a foreign jurisdiction.

Patients seek medical tourism for a wide variety of reasons such as, the ability to recover in an exotic locale, expertise of foreign hospitals in certain procedures, and cost-savings. Employers and their health care insurers have begun promoting medical tourism in an effort to control health care costs by offering surgery abroad at a reduced cost to the employer and with generally no out-of-pocket expense for the employee.

Hospitals overseas are affiliating with domestic hospitals and even becoming accredited by the Joint Commission International. Wockhardt Hospitals in India proudly displays that they are an associate hospital of Harvard Medical International, with easy access to potential patients through 1-800 telephone numbers in Canada and the United States. Numerous travel sites and companies offer to schedule the patient for travel, surgery and recuperation. Robin Cook, the author of many medically-based mystery novels, has even published Foreign Body, a novel about a medical student's grandmother who dies after undergoing hip replacement surgery in a New Delhi hospital.

With the rising popularity of medical tourism, the provider of health care in the United States (the domestic provider), whether a primary care physician or a specialist, is increasingly likely to encounter a patient who is planning travel abroad or who has returned from travel abroad for a medical procedure.

This article does not seek to advocate for or against medical tourism. Further, this article does not weigh in on the motivations, success rates or cost comparisons of offshore procedures. Rather, this article intends to highlight precautions that must be considered by the domestic physician when encountering a patient who is scheduled to receive, or who has received offshore medical treatment. Through awareness of the potential risks of medical services provided to the medical tourist,

the domestic physician can reduce their risk of liability exposure. From preparing the patient for overseas travel, to encountering infection when the patient returns, the domestic physician must understand that he or she will be only tangentially involved in the care of a patient for a procedure over which he or she has no control. It is this lack of control by the domestic physician where risk of an adverse outcome is greatest.

One of the primary concerns that a domestic physician must have over a patient's planned or past offshore medical adventure is the loss of continuity of care. With the patient planning to seek treatment through a foreign medical trip, it is in the best interest of the domestic provider to equip that patient with, or at least provide the patient with the opportunity to acquire his medical history, list of medications, relevant test results, and any known co-morbid conditions which could influence the delivery of anesthesia and surgery. This information can be provided through copies of the medical chart or an electronic medical chart. The electronic medical chart can be placed on a flash drive, CD-Rom or other suitable media. Naturally, if sending the records (in any format), directly from a domestic provider to a foreign provider, would be considered a permitted use and disclosure under HIPAA, but obtaining a patient authorization is prudent.

For example, a patient with a known arrhythmia traveling to have knee arthroplasty performed, would benefit from having a copy of her most recent EKG or samples of her aberrant rhythm for the operating surgeon and anesthesiologist to review. Similarly, a patient with a coagulation disorder should be equipped with the necessary labs for the offshore practitioners to review. Without this continuity of care, it is conceivable that a surgical mishap could result in a theory of negligence being asserted against the domestic provider for failing to adequately inform the operating physicians of any relative contraindications to surgery, or anesthesia, or conditions which warrant precaution, especially where the domestic physician has been requested to provide that information.

Perhaps of greater concern with medical tourism is the lack of continuity in care when the patient returns from a foreign medical procedure. There is no guarantee that the patient will return with any medical records, let alone records that are available in English. Further, the domestic physician will have no knowledge of the surgical procedure performed, the techniques used, the equipment used, the drugs administered, or the implant used.

Indeed, equipment, devices, and implants may not be FDA approved in the United States, or otherwise recognized by surgeons performing similar procedures in this country. While a primary care physician may have given medical clearance based upon expectations for surgery to proceed in a customary practice for the United States, the use of anesthesia or recovery procedures may be different in a foreign land.

The domestic provider is likely to face limited access to the offshore physician, such that consultation in the event of a complication that first manifests after the patient's return may be impossible. Liability laws vary greatly in many foreign jurisdictions and the lack of accountability in other countries may create an environment where the foreign physician has little incentive, let alone interest, in communicating further once the procedure has concluded and the patient has returned to the United States.

Physicians in this country encountering patients who have returned from overseas medical procedures must also recognize that the patient may have received postoperative nursing care that is less attentive to aseptic technique or close observation. If the patient required blood or blood products, they may not have been screened to the same degree as they are in the United States.

Medical tourists often recover for a very short period of time in the hospital setting, only to be further recovered in a resort or hotel setting without regard to an aseptic environment.

Additionally, these patients, depending upon their locale, may be exposed to unrelated tropical illness, respiratory disease, unknown infectious agents, parasites or even insect-born illnesses.

When such disease and illness is superimposed on a recovering patient this can represent a very dangerous situation, particularly where the unrelated illness has an incubation period such that the condition first manifests after the patient's return. Patients returning from medical tourism are typically traveling by air, such that the prudent physician may be called upon to consider the effects and timing of travel on the patient's condition. A basic knowledge of aeromedical concepts may be in order.

Finally, as any surgical procedure carries the risk of infection, the offshore surgical procedure carries the risk of an exceptionally virulent bacteria or an infectious agent that is not familiar to practitioners in this country.

In July, 2005, Cleveland Clinic researchers reported in the *Annals of Plastic Surgery*, regarding five patients returning from plastic surgery in the Dominican Republic with Mycobacteria abscessus infections. New York City residents were also reported as returning from offshore cosmetic surgery vacations with unexplained boils, swelling and red splotches.

On August 11, 2010, the BBC News reported the existence of a superbug infection, which manufacture an enzyme, NDM-1, that is resistant to even carbapenem class drugs. The infection was reported in patients returning from medical tourism procedures in India and Pakistan. This past summer, NDM-1 infections were also identified in at least three patients returning to the United States from surgery in India.

It has been theorized that the world we live in is now flat, a global marketplace. This is likely to be true for medical services as well. With the global delivery of healthcare to domestic patients, the domestic health care provider will be called upon to assist in preparing patients for travel abroad for medical purposes and will also receive patients who have undergone such procedures.

An awareness of the potential risks that can ensue from such care will lead to safer travels for the patient and reduce the risk of complications developing postoperatively and after the patient returns to the United States. A prudent global awareness is the best tool to reduction of global risk.

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