

HEALTH LAW

Plastic Surgery Overseas: How Much Should a Physician Risk in the Pursuit of Higher-Quality Continuity of Care?

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Abstract

In this article I discuss medical tourism, whereby patients go overseas for plastic surgery treatment in order to save money. However, if malpractice occurs abroad, there are several barriers that make it difficult for patients to recover damages. I explain these legal barriers and then discuss the possible causes of action patients can have over their “domestic physician” (their personal physician who might have referred surgery abroad or who gives postoperative follow-up care) and how these causes of action can create avenues of legal recovery not otherwise available. The possible liability of the domestic physician in the context of surgical malpractice abroad creates an ethical tension in the pursuit of higher-quality continuity of care, as the more involved the physician becomes in the process, the more likely he or she will assume liability.

Introduction

There is a growing trend for patients from higher-income countries such as the United States, Canada, the United Kingdom, and Australia to travel overseas to lower-income countries such as Mexico, Thailand, and India for medical treatment, notably for plastic or cosmetic surgery. This trend is often called “medical tourism” or, more recently “cross-border care.” There are a number of drivers encouraging this trend, the most significant of which are patients seeking substantially lower costs abroad [1].

When patients become injured during surgery abroad, they often have few avenues of recourse. This article will explore the problems that patients injured abroad have in recovering malpractice claims while noting that, for domestic physicians who become involved, an ethical tension exists between fear of liability and the desire to provide continuity of care for patients who seek surgery overseas. In this article, I will focus on the United States and its law as the “domestic” country at issue, although much of the analysis is similar and applicable to other Western common-law countries.

Difficulty in Recovery

There is some debate about the severity of the risks of injury and malpractice in seeking surgical treatment abroad [2]. However, risks do exist, as they do with all surgeries, and injuries and malpractice do happen. Some of the risks of surgery abroad are infection, bloods clots while traveling, and obtaining proper follow-up care after surgery [3]. If an injury does occur from a surgical procedure abroad, legal recourse for the patient can be difficult to obtain.

Suing abroad. Normally, for most torts the case needs to be filed where the injury occurs [4]. Filing a complaint in the place of injury is always an option because the place of injury will naturally confer jurisdiction. In the current context, that would require the injured plaintiffs to file a complaint in the destination country after they have returned to their home country following surgical treatment.

However, many countries that are popular destinations for medical tourism have much less robust medical malpractice law and protections than exist in the United States. Thailand and India are two prime examples [5]. Hospitals in Bangkok require that patients waive their rights to sue doctors [6], and Thailand as a whole places significant limitations on medical malpractice awards and offers no compensation for pain and suffering [4, 5]. India also offers limited awards and no damages for pain and suffering, and India's court system has significant delays and an extremely low plaintiff success rate of about 5 percent [5, 7, 8].

Suing in the US. Even if a US plaintiff decides to sue an international surgeon for malpractice in a US court rather than in a court abroad, there are some notable barriers to successful recovery. The initial barrier is that of personal jurisdiction. A US court must have personal jurisdiction over the defendant for the case to proceed. Personal jurisdiction requires satisfaction of a long-arm statute and due process requirements of the US Constitution [6-8]. The Due Process Clause requires that the defendant have *minimum contacts* with the forum state (i.e., the location where the case is filed and jurisdiction is being sought) and that exercise of jurisdiction of the defendant in the forum state is consistent with notions of fair play and justice [6]. A long-arm statute is a codification of these due process principles that involves a minimum contacts inquiry and analysis. According to Cary Steklof, courts look at the "nature and quality of the defendant's contacts with the forum state, the quantity of those contacts, the relation of the cause of action to those contacts, the interest of the forum state in providing a forum for its residents, and the convenience of the parties" [9]. The typical case involves an international physician whose practice is solely conducted abroad without any contact or involvement with the United States. In such cases, "there are significant impediments to allowing a United States court to assert" jurisdiction over the international surgeon [9]. Minimum contacts requires "continuous and systematic" contacts, typically where the defendant has "longstanding business in the forum state, such as marketing or shipping

products, performing services, or maintaining one or more offices there” [10]. Only in rare circumstances would this standard be met for an international surgeon [6]. Therefore, personal jurisdiction over the international physician will not likely attach, and the case will not be able to proceed in the United States.

Assuming that a plaintiff can satisfy personal jurisdiction, the next hurdle is that of *forum non conveniens*. This legal doctrine gives the US court ability to dismiss the case if (1) jurisdiction is proper in another forum and (2) another forum is preferable after a multifactor balancing test that weighs the burden of the parties against the public interest [8]. I. Glenn Cohen asserts that the first factor “will likely be satisfied in many medical tourism cases, since the legal system of the destination country will often entertain a med-mal suit by a U.S. citizen treated in that country” [11]. As for the multifactor balancing test, some factors courts will consider are: “the relative ease of access to sources of proof; availability of compulsory process for attendance of unwilling, and the cost of obtaining attendance of willing, witnesses; possibility of view of premises” [12]; whether the plaintiff’s “choice of an inconvenient forum, ‘vex[es],’ ‘harass[es],’ or ‘oppress[es]’ the defendant by inflicting upon him expense or trouble not necessary to his own right to pursue his remedy” [12]; the “[a]dministrative difficulties [that] follow for courts when litigation is piled up in congested centers instead of being handled at its origin”; and the “local interest in having localized controversies decided at home” [13]. In the context of the typical medical tourism case, these factors favor dismissal on *forum non conveniens* grounds [8].

Assuming that the American plaintiff can satisfy personal jurisdiction and *forum non conveniens*, there still remains the barrier of choice of law. The legal concept of *lex loci delicti*, which means law where the tort occurred [4], typically requires a court to apply the law of the jurisdiction where the tort occurred. This “choice of law” analysis weighs factors such as the place of injury and residence of the parties. Because of the typical factual circumstances, if a US plaintiff sues a physician who committed malpractice abroad, the US court would very likely apply the other country’s law by default [8]. As discussed earlier, the nature of the destination country’s law is often inadequate to properly redress a plaintiff’s claim.

Even if a plaintiff prevails on a claim in a US court, there is the remaining burden of trying to enforce a judgment on an overseas defendant. Enforcement of a US judgment necessitates a court’s willingness to enforce the judgment, and overseas courts regularly are not willing to enforce US judgments against their citizens for fear that US judgments are too large and punitive [8]. Indeed, many countries (even those with lots of traffic and revenue from medical tourism) will not entertain the notion of enforcing a US judgment absent a treaty [6].

Domestic Physician Liability

In response to these burdens, US plaintiffs and creative attorneys are looking for other avenues of recovery. Some avenues include suing domestic-based health maintenance organizations (HMOs), insurers, and intermediary firms that sponsor medical travel. Suing domestic physicians themselves is another option plaintiffs may choose. Domestic physicians, who participate in the medical tourism process by offering referrals or advice before surgery abroad or by offering postoperative follow-up care, are increasingly at risk of being liable and being sued for surgical malpractice that occurs overseas.

In cases in which a patient is injured by a surgeon abroad, claims (be they against the international surgeon or domestic physician) are supported typically by one of two theories of liability: medical negligence and informed consent. While similar, medical negligence and informed consent are distinct claims with independent rationales [14-16]. The domestic physician will not be liable for medical negligence for direct injuries sustained by the surgery abroad, as he or she was not the physician who performed the surgery. However, the domestic physician might potentially be liable for an informed consent claim via an expanded duty.

Medical negligence. A cause of action for medical malpractice under ordinary negligence requires: (1) a physician's duty of care to the plaintiff, (2) failure to meet the standard of care (breach of the duty), and (3) injury resulting from the failure to meet the standard of care [15]. This is the classical tort theory of negligence, which is most applicable to the surgeon abroad who directly causes injury via malpractice and, for the purpose of recovering damages, is therefore not applicable to the patient's domestic physician.

Informed consent. A cause of action for informed consent requires that: (1) the physician breach a duty to disclose a material risk, (2) a reasonable patient would more likely than not have opted not to undergo the procedure had she known of the risk, (3) the patient suffered injury because of her decision, and (4) the patient's injury was caused by the undisclosed risk [17]. This cause of action, by way of expanding the scope of a physician's duty, can possibly attach liability to a domestic physician who refers or advises a patient to travel. The source of the duty in [informed consent](#) is a fiduciary one between physician and patient [18]. Historically, and, in most jurisdictions, Philip Mirrer-Singer notes that "courts have been reluctant to apply the informed consent doctrine beyond the treating physician" [19], but some courts have been expanding the duty of informed consent to include those physicians who make a referral. Hawaii and New York courts take an approach that looks at the physician's "degree of control" over the treatment of the patient [20-22]. In *O'Neal vs Hammer*, the Supreme Court of Hawaii held that the "degree of participation or the retention of control by the referring physician may obligate the physician to secure informed consent from his or her patient" [21]. In *O'Neal*, degree of control was found because the primary physician created a multiphase treatment plan and coordinated all phases of the treatment, including a referral to, and

consultation with, the oral surgeon who actually performed the surgery [16]. North Dakota takes a more narrow approach and will only attach the duty of informed consent when the physician “formally orders” the procedure [20].

These cases show an opening, one that is being increasingly discussed, in how liability can attach to the domestic physician in the context of medical tourism [7, 23]. If the domestic physician refers a patient for surgery overseas, he or she potentially could be liable for lack of informed consent for a surgical procedure performed overseas. The facts of the case and the legal standard used will determine the physician’s liability. Degree of control arguments are an emerging area of law with regard to physicians’ liability, and they have yet to be applied to a case involving medical tourism. Hence the extent of the risk to the physician and how the law will apply to medical tourism is currently unclear. For example, if such arguments were successfully applied to medical tourism in the surgical context, expansion of the informed consent duty might require that the domestic physician fully understand and disclose various risks of treatments abroad, including the risks of certain surgical facilities and surgeons in other countries. In spite of these uncertainties, awareness of this risk of liability is necessary, as the nature of medical tourism opens the door to informed consent claims: overseas, risk communication is complicated and the risks might be poorly understood and possibly heightened [24]. Such an opening is an attractive solution to patients injured by surgery abroad, as the domestic physician and the tort are located in the United States, thus enabling the plaintiff to more easily sue and collect judgment in the United States, eliminating the recovery problems discussed earlier.

Postoperative liability. If the domestic physician only treats the medical tourist patient postoperatively (thus eliminating any potential informed consent liability), in theory he or she should not be at risk of medical malpractice liability for any tortious acts that occurred overseas. Under this scenario, if something goes wrong in the surgery overseas, domestic physicians are essentially detached from the tortious act. Despite this detachment, domestic physicians are, according to Kristen Boyle, often “reluctant to treat patients for postoperative care, due to resentment or reluctance to take clinical responsibility for surgery that was performed abroad” [25]. Similarly, Elizabeth Gluck asserts, “Due to legal liability, among other reasons, doctors are generally not eager to inherit problems created by other doctors” [26]. According to Jeremy Snyder et al., domestic physicians providing follow-up care “often have inadequate information about the procedure performed abroad. This situation also raises legal issues for doctors who are concerned they may be held responsible for post-operative complications” [27].

Domestic physicians have two concerns related to their fear of a postoperative medical malpractice suit. Their first concern is that they would actually be more likely to commit postoperative malpractice because they are dealing with prior complications with limited information. While such a malpractice suit would technically be for conduct that occurred

during postoperative follow-up treatment, their second concern is that they can end up indirectly paying for the damage caused overseas regardless of whether they were actually responsible for postoperative malpractice. With a postoperative injured patient, the judge or jury must decide how much damage was caused during the initial overseas surgery and how much damage was caused postoperatively. Parsing such damage can be difficult to do with accuracy because causal linkages between injury and follow-up care and between injury and international care are not always clearly delineated. It is easy to envision the domestic physician being required to pay for some damage that he or she did not actually commit.

Domestic physicians in this scenario are not officially liable for medical malpractice committed overseas. However, they are in essence acting as proxies for overseas physicians who commit malpractice, particularly if they are managing follow-up care in a domestic setting; they might find themselves being the ones to pay for damage inflicted overseas (even if they didn't care for the patient overseas). This scenario, in an ideal sense, should not occur, as it runs afoul of justice. However, such injustices in the application of the law can occur, and the risk, which is difficult to quantify with precision because of its nebulous character, is one that physicians must weigh.

Conflict with Continuity of Care

As the trend increases for patients from higher-income countries to go overseas for surgery, there has been greater emphasis on the quality of the continuity of care between the domestic country and the country abroad. As Ian Cheung and Anthony Wilson explain:

The issue of continuity of care is important. The surgery itself should be seen as one of many components in the patient's overall care. Other elements include the initial consultations, optimisation of non-surgical treatment, preoperative education programs, postoperative hospital and home rehabilitation, and long-term follow-up. The better coordinated these elements are, the more streamlined the patient's overall care will be [28].

Research indicates that physicians are aware of both the need for and the barriers to providing [continuity of care](#). A survey of domestic physicians found that respondents believe that medical tourism does threaten continuity of care, as the flow of information is disrupted before patients' travel when patients omit or fail to discuss travel plans with their physician [29]. With greater communication of the risks and benefits of surgery at facilities overseas, physicians could help reduce risks and provide greater continuity of care for their patients who go abroad for surgery [29]. However, Valorie Crooks et al.'s focus-group study found that though domestic physicians desire to give their patients useful information to help them "make an informed decision" about obtaining treatment abroad, they prefer not to "take on significant responsibility in the decision-making

process" [30], thereby avoiding a greater scope of fiduciary duty that brings with it a heightened risk of liability.

Domestic physicians can completely insulate themselves from these risks of liability by having zero interaction with the patient before and after the surgical procedure abroad. Zero interaction provides full protection from liability, as it means that the domestic physician would have provided no referrals, recommendations, advice, or postoperative care. Without any referrals, recommendations, or advice about treatment overseas, legal degree of control arguments become void. Additionally, a lack of interaction postsurgery removes any risks of treating patients with postoperative complications. This insulation from liability, attractive from the physician's perspective, encourages a breakdown in the continuity of care. Under this scenario, the overseas surgery becomes an isolated event and, according to Cheung and Wilson, "isolating the surgical component from the overall management plan may not be advantageous to the patient" [31]. Conversely, the more interaction the physician has before and after the procedure, the more risk of liability the physician assumes, but the higher will be the quality of the patient's care throughout the entire process, which presumably is better for the patient.

Conclusion

Former professor of plastic surgery Nahum Ben-Hur asks, "How much risk should a physician take for the benefit of his patient?" [32]. This philosophical question goes to the heart of the ethical tension in the matter of medical tourism. The more a physician chooses to involve herself with a patient's care overseas, the more likely liability will attach. There is thus incentive for the physician to distance herself from referral or follow-up regarding her patient's surgery abroad. However, the more the physician is involved, the more likely it is that there will be a better medical outcome for the patient.

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ISSN 2376-6980**