MEDICAL TOURISM AND THE LEGAL IMPEDIMENTS TO RECOVERY IN CASES OF MEDICAL MALPRACTICE

I. DIAGNOSING A RECENT PHENOMENON—MEDICAL TOURISM AS AN ALTERNATIVE TO THE UNITED STATES HEALTH CARE SYSTEM

In abandoning the traditional notion that medical treatment is a service received close to home, millions of Americans are crossing foreign borders to have medical procedures ranging from plastic to open-heart surgery.[1] This trend, known as "medical tourism,"[2] has increased exponentially in recent years by appealing to a common aspect of every patient's anatomy: his wallet. Even when factoring in all of the costs associated with foreign travel to obtain treatment, savings can be as high as 88%.[3] To be sure, medical tourism has provided an array of medical options to millions of uninsured and underinsured American patients.[4] However, beneath the surface lurks an Achilles heel that threatens to derail this trend.

That threat has little to do with medicine and much to do with the law. Medical malpractice, while a concern for every patient, is not something that the average American patient likely plans for in advance. People receive treatment and hope for the best, and if things go awry due to the doctor's incompetence, the patient knows that he can always resort to the American legal system for protection. Once a patient leaves the United States for treatment, however, that assumption is badly mistaken.

A potential victim of malpractice abroad faces significant impediments to obtaining jurisdiction over foreign defendants and enforcing judgments against them overseas. Ultimately, unless patients begin to account for the legal impediments to malpractice suits against foreign doctors before they receive treatment, the United States legal system itself will become an incurable ailment that prevents injured patients from vindicating their rights. Yet to understand why these legal impediments have been largely

1. PAUL H. KECKLEY & HOWARD R. UNDERWOOD, DELOITTE CTR. FOR HEALTH SOLUTIONS, MEDICAL TOURISM: CONSUMERS IN SEARCH OF VALUE 3 (2008), http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/us_chs_MedicalTourismStudy(3).pdf (last visited Feb. 8, 2011).

2. *Id.* at 2.

3. *Id.* at 13.

4. Jonas Bergstrand, *Operating Profit*, ECONOMIST, Aug. 16, 2008, at 75, *available at* http://www.economist.com/node/11919622?story_id=11919622.

overlooked by the medical community, it is important to first consider what has driven the medical tourism phenomenon to date.

While foreign hospitals have made steady and marked improvements in the quality of available medical treatment, the United States has become the most expensive health care market in the world.[5] Accordingly, many Americans have begun to ask a basic question: Why put up with costly, run-of-the-mill health care at home when you can be treated just as well abroad at a fraction of the cost?[6] With millions of people answering this question by electing to travel to foreign countries for a litany of medical procedures, the upward trajectory of this trend carries the potential for economic and legal consequences on an unprecedented scale.[7]

The concept of outsourcing medical treatment has become colloquially known as "medical tourism," whereby Americans seeking medical care are increasingly making trips abroad at their own expense for a wide array of elective and non-elective medical procedures.[8] While any number of factors may be cited to account for medical tourism's rising popularity in the United States, there are at least two common considerations that appear to be driving this trend: cost and the quality of available care.[9]

Viewed purely in monetary terms, the benefits of medical tourism can be staggering. America's health care inflation has consistently outpaced its economic growth, which has contributed to making the United States the most expensive health care market in the world.[10] When contrasting the cost of certain major medical procedures in the United States with the cost of those procedures in leading medical tourism countries such as India, Thailand, Singapore, and Malaysia, the potential savings are of immense proportions.[11] For example, a heart bypass surgery in the average

5. *Id*.

6. *See id*.

7. *See generally* KECKLEY & UNDERWOOD, *supra* note 1.

8. *See* Bergstrand, *supra* note 4. *See also* KECKLEY & UNDERWOOD, *supra* note 1, at 13 fig.12. A sample of procedures for which data are available include knee surgery, shoulder angioplasty, transurethral prostate resection, tubal ligation, hernia repair, skin lesion excision, adult tonsillectomy, hysterectomy, haemorrhoidectomy, rhinoplasty, bunionectomy, cataract extraction, varicose vein surgery, glaucoma procedures, and tymanoplasty. *Id.*

9. Bergstrand, *supra* note 4, at 75. Some have speculated that big businesses and insurers themselves may also soon be responsible for a wave of medical tourism. Recently, "big employers have become interested in promoting medical travel among the employees they insure" because "[m]any are struggling to cope with soaring health costs . . . ." *Id*. Some insurers have launched pilot schemes in partnership with foreign hospitals, such as those in Singapore, which have the potential to save insurers money, particularly for procedures costing $20,000 or more. *Id*.

10. *Id*.

11. KECKLEY & UNDERWOOD, *supra* note 1, at 28. The cost comparison data provided address major medical procedures, including heart bypass surgery, heart valve replacement surgery, angioplasty, hip replacement surgery, hysterectomies, knee replacement surgeries, and spinal fusion.

American hospital will run a patient approximately $130,000.[12] In India and Thailand, this procedure would cost merely 8% of that amount, while in Malaysia it would cost 7%, and in Singapore 14%.[13] Consider also a heart valve replacement, which would cost roughly $160,000 in the United States.[14] In India, Thailand, and Malaysia, it would cost 6% of that amount, while in Singapore it would cost 8%.[15]

While such marked disparities in treatment are most readily apparent when comparing the pure cost of a medical procedure, a true cost comparison must also include the expenses associated with traveling to a foreign country for treatment. Naturally, factoring in travel to and from a surgical facility, the required aftercare, and any other incidental costs may reduce the price differential appreciably.[16] However, even when extraordinary travel and insurance costs are taken into consideration for some of the more inexpensive procedures, "the relative cost advantage for medical tourism is 28 to 88%, depending on the location and procedure."[17]

With these types of savings available for procedures that cost less than $10,000,[18] medical tourism has become a cost effective option not only for uninsured Americans, but also for those who are underinsured. Such people may find it cheaper to travel abroad and pay for an operation out-of-pocket rather than find the money to cover the deductibles or co-payments that would be charged for the same procedure if performed in the United States.[19] Considering that more than "[forty-five million] Americans are uninsured and many millions more are severely underinsured,"[20] the medical tourism market may be a cost-effective

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Id. As a general trend, as the procedure becomes more expensive, savings will increase in terms of pure cost, and the procedure will cost a lesser percentage of the average amount in the United States. *Id.*

12. *Id.*
13. *Id*.
14. *Id*.
15. *Id*.
16. *Id*. at 13.
17. *Id*. The relative cost advantage calculated as somewhere between 28% and 88% reflects the average of the three lowest foreign prices including travel costs. *Id*. at fig.12. Accordingly, even for less expensive procedures, savings may still be significant as a percentage of the cost in the United States if a medical tourist elects to obtain a procedure where it is provided cheaply and with minimal travel costs.
18. *Id*. When considering a number of various common and relatively inexpensive procedures and their respective costs in the United States, each one can be obtained either as an inpatient or outpatient procedure for under $10,000 (with the exception of inpatient knee surgery, which can cost just under $12,000). *Id.* Despite the relatively low costs of these procedures in the United States, the cost savings abroad as a percentage may still be significant.
19. Bergstrand, *supra* note 4, at 75.
20. *Id*.

alternative for a significant number of Americans who might not otherwise be able to afford treatment.

A second primary factor driving the increased popularity of medical tourism is the quality of care available abroad.[21] "While medical travel to countries outside the United States has existed for years, its potential growth was hindered by capacity and infrastructure constraints—among them, communications, transportation, water and sewer, electricity and power generation—in developing nations."[22] Despite these previous setbacks, "strong economic development in these countries has provided the resources and opportunities to build massive health care centers for patients traveling from all around the world."[23] Some of the leading foreign countries that have developed the infrastructure to accommodate a significant portion of the world's medical tourists include Thailand, with 1.2 million tourists; Singapore, with 410,000 tourists; and Malaysia, with 300,000 tourists in 2006.[24] By 2007, India had also joined this group, hosting 450,000 tourists.[25]

In addition to various countries' development of the requisite facilities and infrastructure to participate in the medical tourism market, the actual quality of care has been aided by partnerships formed between health care centers abroad and reputable medical institutions based in the United States.[26] Further, foreign governments have begun investing in facilities and making it more logistically feasible for foreigners to obtain treatment away from home.[27] With these significant advances, it is unsurprising that,

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21. *Id*.

22. KECKLEY & UNDERWOOD, *supra* note 1, at 6.

23. *Id*. At present, there are ten regions that lead the world in attracting medical tourists: India, Thailand, Singapore, Malaysia, South Africa, Brazil, Costa Rica, Mexico, Hungary, and the Gulf States. *Id*. at fig.5.

24. *Id*.

25. *Id*.

26. Renowned U.S.-based medical centers, including the Memorial-Sloan Kettering Cancer Center, the Johns Hopkins Hospital, and the Cleveland Clinic, have all developed relationships with medical institutes around the world. *Id*. at 16–17. These centers have provided services ranging from advisory aid in treating cancer to collaborative research, education, training for physicians and other technical staff, policy training, clinics, and medical services. *Id*. Additionally, similar services and training have been offered through the partnerships formed between foreign institutions and the medical institutions affiliated with the University of Pittsburgh, Harvard University, Cornell University, Duke University, and Columbia University. *Id*. With such medical expertise moving fluidly across borders and overseas, one expert has posited that the "quality at the best foreign facilities can be much better than at the average American hospital, thanks to greater transparency and better information technology." Bergstrand, *supra* note 4, at 75.

27. KECKLEY & UNDERWOOD, *supra* note 1, at 6. Korea, for example, has planned the construction of new medical institutions for international patients, and the Taiwanese government has announced a $318 million project to help further develop the country's medical services. *Id.* To this same end, the government of Singapore has formed a collaboration of industry and government

in the coming years, an unprecedented number of Americans have been projected to place their health in the hands of foreign doctors.[28] In 2005, approximately 500,000 Americans traveled overseas to receive medical treatment.[29] By 2007, that number had grown to 750,000, with a projected growth rate of 100% for each of the next three years.[30] With more patients

representatives to create a medical hub. *Id*. Moreover, to facilitate a medical tourist's ability to remain in a foreign country for the required period of time, some countries, such as Malaysia, have increased the allowed stay under a medical visa from thirty days to six months. *Id*.

28. *See generally id.* at 4 fig.3 (Patient Demand, Outbound Tourism). Assuming the medical tourism market continues to grow unimpeded, it is predicted that, in the very near future, the number of American medical tourists will balloon from the hundreds of thousands into the millions. *See id*. While there were 750,000 outbound American medical tourists in 2007, the number of patients is expected to double each year through 2010, with 1.5 million in 2008, 3 million in 2009, and 6 million in 2010. *Id*. In the long term, the growth rate is expected to taper significantly after 2010 due to supply capacity constraints in foreign countries. *Id*. Nonetheless, the number of medical tourists is expected to surpass 10 million by 2013. *Id.* With the projected numbers abstracted until 2017, it is estimated that the number of American medical tourists in that year will be approximately 15.75 million. *Id.* If the growth rate is lower than expected, that number by 2017 may be as low as 10.43 million; however, if the growth rate has been underestimated, the high-end range for that number by 2017 may be as much as 23.2 million. *Id.*

The Deloitte 2008 Survey of United States Health Care Consumers indicated a strong interest in outbound medical tourism. *See generally id.* at 5 fig.4. The results revealed that, in general, 88% of respondents would consider going out of their communities or local areas to receive treatment if they knew the outcomes were better and the costs were no higher. *Id*. Further, 39% of respondents said they would consider having an elective procedure in a foreign country if they could save 50% or more and be assured that the quality was equal or better than in the United States. *Id*. Overall, 27% of respondents replied that they might travel outside the United States for treatment. *Id.*

From a demographic perspective, the individuals most likely to consider having an elective procedure in a foreign country include members of Generation Y (the age demographic), males, Asians (the race demographic), those whose health is in the top 20% of Americans (the health demographic), and those who have commercial insurance (the insurance demographic). *Id*.

29. Kristen Boyle, *Permanent Vacation: Evaluating Medical Tourism's Place in the United States Healthcare System*, 20 HEALTH LAW., June 2008, at 42.

30. KECKLEY & UNDERWOOD, *supra* note 1, at 4 fig.4 (Consumer Interest in Outbound Medical Tourism). The number of outbound medical tourists is projected at 1.5 million in 2008, 3 million in 2009, and 6 million in 2011. *Id*. In terms of the number of medical tourists after 2009, a 25% increase is predicted in 2010 and 2011, a 15% increase in 2012 and 2013, a 10% increase in 2014 and 2015, and a 5% increase in 2016. *Id*. Accordingly, the overall projection from 2007 onward is one characterized by substantial increases in the first three years (100% growth each year from 2007 through 2009), followed by a substantial decrease in 2010 (25% growth). *Id.*

From 2010 forward, growth as a percentage is expected to steadily decrease over time. *Id*. In 2010, the increase in the percentage of American medical tourists is predicted to fall off substantially and to decrease steadily thereafter. *Id*. However, each year until 2017 is projected to bring an increase in American medical tourists greater than the 750,000 patients who traveled abroad for treatment in 2007. *Id*. From 2010 to 2011, although the projected increase in patients will fall to 25% (from 100% growth in 2009), the increase in the raw number of patients that are projected to head abroad for treatment is still a relatively high 1.5 million each year. *Id.* Thereafter, the projected increase in patients relative to the year previous is 1.88 million in 2012, 1.4 million in 2013, 1.61 million in 2014, 1.25 million in 2015, 1.36 million in 2016, and 750,000 in 2017. *Id*.

willing to travel abroad, foreign care providers have every economic incentive to attract as many medical tourists as they can accommodate.[31]

Recognizing that medical treatment abroad carries concerns regarding the quality of treatment, various resources have emerged to provide medical tourists with the necessary information to make informed health care decisions.[32] Presently, various international organizations have taken steps to evaluate the quality of clinical care provided by medical tourism facilities worldwide.[33] Their primary mechanism for assessing these facilities is a system of accreditation.[34] Yet, while international

31. *See id*. at 14 fig.13 (Cost Estimate for Spending by Outbound U.S. Medical Tourists). Figure 13 represents a cost estimate for spending by outbound United States medical tourists from the present through 2017. As a base, it is estimated that a total of $2.1 billion was spent abroad by American medical tourists by the end of 2008. *Id*. However, by the year 2017, the base estimate indicates that approximately $49.5 billion will be spent abroad in that year alone. *Id.* Accordingly, the projected increase in the number of outbound medical tourists from 750,000 in 2007 to 15.75 million in 2017 represents anywhere between $30.3 billion (lower bound estimate) to $79.5 billion (upper bound estimate) spent overseas in 2017 alone. *Id*.; *Cf. id*. at 15 fig.15 (Lost Domestic Spending in United States by Outbound U.S. Medical Tourists).

In 2008, the projected loss to American health care providers due to medical tourism was $15.9 billion. *Id*. at 15 fig.15. However, with the estimated increase in the number of medical tourists by 2017, the opportunity cost to American providers may be as low as $228.5 billion and as high as $599.5 billion in that year alone. *Id*. When aggregated from 2008 through 2017, the base estimate indicates that foreign providers stand to reap $248.1 billion in medical tourism over that ten-year period. *Id.* Conversely, American providers could suffer a loss of approximately $1.9 trillion. *Id.*

In 2008, the estimated spending by American patients in foreign countries was $2.1 billion. *Id*. at 14 fig.13. In terms of opportunity cost, this figure represents $15.9 billion in lost revenue for American health care providers. *Id*. at 15 fig.15. In the short term, the amount spent by American medical tourists abroad is expected to double over the next two years, reaching $4.4 billion in 2009 and $9 billion in 2010. *Id*. at 14 fig.13. This would represent a loss to American providers of approximately $32.8 billion in 2009 and $67.7 billion in 2010. *Id.* at 15 fig.15.

In the long term, the payoff for the investments made by foreign health care providers is even more readily apparent. The spending by American medical tourists in 2017 alone is expected to reach $49.5 billion. *Id*. at 14 fig.13. This figure reflects a predicted opportunity cost of $373 billion for American providers, and creates every incentive for institutions abroad to capitalize on their ability to provide quality services at a fraction of the cost. *Id*. at 15 fig.15.

32. Recently, "[i]ncreased access to report cards about provider safety and effectiveness, and patient satisfaction scores for hospitals and physicians have helped to fuel growing consumer and employer awareness of safety and quality differences." *Id*. at 8. Providers of this type of information include outbound medical tourism sponsors who, in responding to consumers' safety and quality expectations, are touting the attributes of their programs. *Id*. Such programs offer attractive characteristics such as U.S.-trained physicians and care teams, the use of clinical information technologies and evidence-based clinical guidelines, affiliations with reputable American provider organizations, and coordination of pre- and post-discharge care. *Id*. Additionally, these programs are able to gain certification for safety and quality through independent organizations. *Id*.

33. *Id*.

34. "Accreditation is particularly important because it can give consumers and employers a level of confidence that the services provided are comparable to those available in the U.S., particularly if accompanied by an affiliation with a reputable, U.S. teaching hospital. . . ." *Id*. at 9. The most well-known of these organizations include the Joint Commission International ("JCI"), the International Society for Quality in Health Care, the National Committee for Quality Assurance, the International

organizations have taken strides toward providing standards to guide medical tourists, the preeminent medical body in the United States—the American Medical Association (AMA)—has fallen well behind in addressing this trend. It was not until June 2008 that the AMA outlined steps for obtaining care abroad.[35] The guidelines, which are extremely brief, were only promulgated as "an important starting point for consideration before making the decision to go abroad for health care."[36] Despite their brevity, the guidelines offer one piece of advice that may be just as important as any medical-related concern: "Patients should be informed of their rights and legal recourse prior to agreeing to travel outside the U.S. for medical care."[37] Even when patients are medically

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Organization for Standardization, and the European Society for Quality in Healthcare. *Id*. at 8. Of these organizations, the JCI is one of the most widely recognized, as it has accredited more than 120 hospitals worldwide. *Id*. at 8 (footnote omitted).

See generally Joint Commission Resources, About Joint Commission International, http://www.jcrinc.com/About-JCI/ (last visited Feb. 12, 2009). The Joint Commission International is a division of Joint Commission Resources, which is a not-for-profit affiliate of the Joint Commission. Joint Commission Resources, About Joint Commission Resources, http://www.jcrinc.com/About-JCR/ (last visited Feb. 12, 2009). The Joint Commission is the largest accreditor of health care organizations in the United States, and surveys 17,000 health care programs through a voluntary accreditation process. The Joint Commission, Facts About The Joint Commission (Nov. 13, 2009), http://www.jointcommission.org/AboutUs/Fact_Sheets/joint_commission_facts.htm (last visited Feb. 8, 2011). The Joint Commission Resources is self-described as a global, knowledge-based organization that disseminates information regarding accreditation, standards development and compliance, good practices, and health care quality improvement. About Joint Commission Resources, *supra*. Its mission is "to continuously improve the safety and quality of health care in the United States and in the international community through the provision of education, publications, consultation, and evaluation services." *Id.*

Among the ten regions that are presently the main medical tourism hubs, those which have received the most JCI accreditations include the Gulf States with thirty-eight (seventeen of which are in Saudi Arabia), Singapore with thirteen, Brazil with twelve, and India with ten, for a total of seventy-three accreditations amongst them. KECKLEY & UNDERWOOD, *supra* note 1, at 6 fig.5. Outside of these four, however, there is a marked drop-off for the remaining six regions, which have a combined nine accreditations. *See id.* These regions include Thailand with four accreditations, Mexico with three, Malaysia and Costa Rica with one each, and Hungary and South Africa with none. *Id*. The lack of accreditations did not seem to deter medical tourists, as Thailand hosted 1.2 million patients in 2006, and Malaysia hosted 300,000 that same year. *Id*.

35. *See* American Medical Association, New AMA Guidelines on Medical Tourism, *available at* http://www.ama-assn.org/ama1/pub/upload/mm/31/medicaltourism.pdf (last visited Nov. 13, 2010).

36. Press Release, Am. Med. Ass'n, AMA Provides First Ever Guidance on Medical Tourism (June 16, 2008) (on file with author). When medical tourism was finally addressed by the AMA guidelines in June 2008, the accompanying press release stated that "[m]edical tourism is a small but growing trend among American patients, and it's unclear at this time whether the risks outweigh the benefits." *Id*. Considering that in the previous year approximately 750,000 Americans traveled abroad for medical care and that trend is expected to double over each of the next three years, *see* KECKLEY & UNDERWOOD, *supra* note 1, at 3, it would seem as through the American medical community has perhaps underestimated the present popularity and projected trend that medical tourism may take.

37. New AMA Guidelines on Medical Tourism, *supra* note 35, at para. f. Of the nine guidelines offered by the AMA on medical tourism, the principle encouraging patients to be informed of their

well-informed, they take on an added liability that extends beyond their health—the risk that a foreign doctor may commit malpractice, and that no adequate legal remedy may be pursued in the United States.

Despite the considerations that have made medical tourism a more appealing option in recent years, a factor that may ultimately stunt the growth of medical tourism revolves around the legal recourse that may or may not be available to American patients when malpractice is committed by a doctor overseas.[38] It may very well be the case that a patient has expressly bargained for and accepted the risk of malpractice without recourse before undergoing a medical procedure abroad. For example, in Bangkok, patients must waive their right to sue their doctors for medical malpractice.[39] In these cases, the patient's assumption of the risk is what permits doctors to offer procedures at the vastly reduced cost that is so attractive to the patient.[40] The waiver allows these doctors to charge lower rates for the procedure since they do not bear any costs for committing malpractice.[41]

However, in the case that a patient elects not to sign away his right to bring a malpractice suit before having a procedure performed, three crucial concerns arise. First, what obstacles might an American plaintiff face in obtaining personal jurisdiction over a foreign doctor in order to try a medical malpractice suit in the United States? Second, where a judgment is obtained against a foreign doctor, what issues might hinder a plaintiff's ability to collect on a judgment if a foreign doctor's assets are located overseas? Third, what steps might a patient take that would provide for recourse that would inure to the benefit of both the patient and the foreign doctor? Without answers that ensure a reasonable amount of protection for the rights of patients, it is possible that medical tourism's popularity will be stunted as risk-averse patients may be unwilling to forfeit legal recourse for the perceived benefits of treatment abroad.

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potential rights and legal recourse is the only one that alludes to the legal risks that are being assumed by medical tourists. In the interest of fostering legal protections for medical tourists, the AMA did indicate in its statement released with the guidelines that it planned to "introduce model legislation for consideration of state lawmakers." *Id*. However, rather than implementing safeguards to protect patients against malpractice abroad, this legislation would be aimed at ensuring that insurance companies and others that facilitate medical tourism adhere to the new principles. *Id*.

38. Boyle, *supra* note 29, at 46.
39. *Id.*
40. *Id*.
41. *Id*.

II. AN AILMENT TREATABLE IN SOME CASES AND INCURABLE IN OTHERS—THE LIMITED JURISDICTION OF THE AMERICAN COURTS AND THE CHALLENGE OF OBTAINING PERSONAL JURISDICTION OVER A FOREIGN DOCTOR

As a basic jurisdictional matter in the United States, a court must have both subject-matter and personal jurisdiction in order to properly hear a case.[42] The United States federal district courts are courts of limited subject-matter jurisdiction and the types of cases that they may hear are limited by the Constitution and by Congress.[43] An injured American medical tourist bringing suit against his foreign doctor in a United States federal court would first have to prove that the court has subject-matter jurisdiction.[44] Assuming that the plaintiff was not advancing a complex or novel cause of action and the suit fell squarely within a court's subject-matter jurisdiction, the plaintiff must then prove that the court has personal jurisdiction over the defendant.[45] With respect to a foreign defendant, "whether a case . . . can be litigated in a United States court typically revolves around the issue of whether the court can assert personal jurisdiction over the defendant."[46]

Even with proper subject-matter jurisdiction, a court may only assume personal jurisdiction over a foreign defendant to the extent permitted by the forum state's long-arm statute and by the Due Process Clause of the Constitution.[47] Accordingly, in determining whether personal jurisdiction exists over a foreign defendant, a court would first have to determine

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42. Lori J. Parker, *Proof of Facts Allowing a Federal Court to Assert Personal Jurisdiction Over a Defendant Not Present in the United States*, 102 AM. JUR. 3D 1, 10 (2008).

43. *Id*.

44. *Id*. *See also* Ruhrgas AG v. Marathon Oil Co., 526 U.S. 574 (1999); Constantine v. Rectors & Visitors of George Mason Univ., 411 F.3d 474 (4th Cir. 2005). Determining subject-matter jurisdiction is not a literal prerequisite to determining whether there is personal jurisdiction. *See* Marathon Oil, 526 U.S. at 583; Constantine, 411 F.3d at 480. The validity of an order of a federal court is predicated upon the court having both subject-matter and personal jurisdiction, so a court may address them in the manner it sees fit, particularly if one is lacking and would therefore be dispositive of the matter. *See* Marathon Oil, 526 U.S. at 587–88; Constantine, 411 F.3d at 480.

45. Parker, *supra* note 42, at 9.

46. *Id*. Parker outlines various issues to be considered before a court can assert personal jurisdiction over a foreign defendant, including: the appropriateness of jurisdiction under the forum's long-arm statute, Sloss Indus. Corp. v. Eurisol, 488 F.3d 922 (11th Cir. 2007); the existence of minimum contacts, Eurisol, 488 F.3d 922; whether the contacts were more than random, fortuitous, or attenuated, Int'l Shoe Co. v. State of Washington, 326 U.S. 310 (1945); whether jurisdiction comports with notions of fair play and substantial justice, Int'l Shoe, 326 U.S. 310; and whether the defendant received notice and was served, Mwani v. bin Laden, 417 F.3d 1 (D.C. Cir. 2005).

47. *See* Coen v. Coen, 509 F.3d 900 (8th Cir. 2007).

whether the defendant fell within the terms of the long-arm statute.[48] If so, a court would then determine whether the exercise of jurisdiction over the defendant would violate the Due Process Clause of the Fourteenth Amendment.[49]

Two elements must be met for a court to find personal jurisdiction in accordance with the Due Process Clause: (1) the defendant must have had minimum contacts with the forum state, and (2) the exercise of jurisdiction must be consistent with traditional notions of fair play and substantial justice.[50] Governing the minimum contacts inquiry is the judicial formulation that "[s]ufficient contacts exist when the defendant's conduct and connection with the forum state are such that it should reasonably anticipate being haled into court there, and when the exercise of jurisdiction comports with traditional notions of fair play and substantial justice."[51] To help elucidate the concepts of minimum contacts and "fair play and substantial justice," another formulation of minimum contacts assesses 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.[52] Ultimately, "[m]inimum contacts can be established through activities on the part of the defendant that give rise to specific personal jurisdiction or those that give rise to general personal jurisdiction."[53] Where a foreign medical doctor's practice is solely conducted abroad, there are significant impediments to allowing a United States court to assert either general or specific jurisdiction over the defendant.

Obtaining general jurisdiction over a foreign doctor appears to be an extremely remote possibility. In short, "general jurisdiction exists when a defendant's contacts with the forum state are unrelated to the plaintiff's

48. Parker, *supra* note 42, at 9. With respect to long-arm statutes, Parker explains that

> [i]f the plaintiff's cause of action is one arising from federal statute, the statute itself may describe the individuals and entities over whom the court may exercise personal jurisdiction. Where the plaintiff asserts a federal law-based claim, however, and the federal law is silent as to the issue of personal jurisdiction, the district court applies the law of the state in which it sits.

Id. at 12–13.

49. *Id*. at 13.

50. *Id*. at 11. As Parker elaborates, some states may not extend their long-arm jurisdiction to the full extent permitted by the Fourteenth Amendment. *Id.* at 12. Accordingly, the federal courts sitting in those states are bound by the limitations of the state long-arm statute, even though the Fourteenth Amendment might permit a broader construction. *Id*.

51. *Id*. at 13–14 (citing World-Wide Volkswagen Corp. v. Woodson, 444 U.S. 286 (1980)).

52. *Id*. at 14 (citing *Coen*, 509 F.3d at 900).

53. *Id*.

claim, but are continuous and systematic."[54] Accordingly, the continuous and systematic contacts with the forum state are considered to justify the state's judicial power with respect to any and all claims.[55] In order to meet the "continuous and systematic" requirements for establishing general jurisdiction, the defendant usually must be engaged in longstanding business in the forum state, such as marketing or shipping products, performing services, or maintaining one or more offices there.[56] Save for some rare circumstance, it would seem highly unlikely that a foreign doctor would fall into one of these categories. As such, general jurisdiction over the doctor could not be established even if one were to aggregate the doctor's contacts with the United States as a whole.[57]

The chances may also be remote that an injured patient could obtain specific jurisdiction over a foreign doctor.[58] When evaluating whether specific jurisdiction exists over a defendant, "the court considers factors including the nature and quality of the contacts, and their source and connection to the cause of action."[59] More specifically,

> courts ask whether the plaintiff's case arises from the foreign defendant's purposeful direction of its activities, its consummation of some transaction within the forum, or its performance of some act by which it has purposefully availed itself of the privilege of conducting activities in the forum, thereby invoking the benefits and protections of the forum's laws.[60]

Of the various legal theories supporting the assertion of specific jurisdiction, the most relevant for medical tourists is whether a foreign doctor purposefully directed activity toward the forum state or

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54. *Id*. at 15.

55. *Id*. As a general matter, "[a] defendant who has maintained a continuous and systematic linkage with the forum state brings itself within the general jurisdiction of that state's courts in respect to all matters, even those that are unrelated to the defendant's contacts with the forum." *Id*. at 14. A general jurisdiction inquiry is very different from a specific jurisdiction inquiry and involves a more demanding minimum contacts analysis with a substantially higher threshold. *Id*. at 15.

56. *Id*.

57. *Id*.

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> Specific jurisdiction exists when the nonresident defendant's contacts with the forum state arise from, or are directly related to, the causes of action asserted. . . . As in any minimum contacts case, the assertion of specific jurisdiction must be reasonable. That is, the act within the forum that gives rise to the plaintiff's case must be of such a nature that the defendant should reasonably anticipate being haled into court in that forum.

Id. at 16.

59. *Id*.

60. *Id*.

purposefully availed himself of the privilege of conducting activities in the forum state.[61] The purposeful direction of activity toward the forum state is typical in tort claims, and requires that the plaintiff's injuries arose from that activity.[62]

One way that a foreign doctor may purposefully avail himself in the United States and thereby become subject to personal jurisdiction is through the Internet.[63] Many foreign hospitals that advertise on the Internet discuss their quality in comparison with hospitals in the United States and Western Europe, and emphasize accreditations that they have received from bodies such as the Joint Commission International.[64] To the extent that the hospitals' websites and Internet advertisements only provide information and have no interactive content, they would not constitute the purposeful direction sufficient to establish specific jurisdiction.[65] However, if the website is interactive, such as one that solicits personal information or leads to personal contact with the injured plaintiff, this may be sufficient to establish personal jurisdiction.[66] This would also hold true

61. *See id.* at 18. Where "purposeful direction of activity" for the purposes of specific jurisdiction indicates that a plaintiff's injuries arose from the activity, "purposeful availment" implies that the defendant has exercised the privilege of conducting activities in the forum state, thereby subjecting himself to the jurisdiction of the courts within the state. *Id*. "Where the defendant has purposefully availed itself of the privileges of conducting activities in the forum, courts regard it as foreseeable to the defendant that it might be haled into court in that forum." *Id*. While the purposeful direction theory is typically used in tort actions, the purposeful availment theory is more frequently used in contract actions. *Id.* Other theories for obtaining specific jurisdiction have been advanced, but would likely be inapplicable in a case of medical malpractice abroad.

The "stream of commerce plus" test has been invoked in tort, where "plaintiffs have argued that by placing a product into the general stream of commerce, a defendant purposefully avails itself of the laws of any forum where that product allegedly caused injury." *Id*. at 19. The Supreme Court has rejected this theory, however, and held that "without more, a foreign defendant's mere placement of an item into the stream of commerce is not sufficient to subject it to jurisdiction within the U.S." *Id*. Furthermore, the "effects test" has been invoked to allow the assertion of specific personal jurisdiction for a single act "where the defendant had minimum contacts and could foresee potential effects from the transaction in the state." *Id*. at 20. Under this test, it is the "foreseeability to the defendant that its conduct could cause injury in the forum [that] is sufficient to establish minimum contacts. Further, under this analysis, it is not necessary that the defendant have physical contact with the forum to establish jurisdiction." *Id.*

62. *Id*. at 19.

63. *See generally id.* at 27–30.

64. Levi Burkett, Comment, *Medical Tourism: Concerns, Benefits, and the American Legal Perspective*, 28 J. LEGAL MED. 223, 229 (2007).

65. Parker, *supra* note 42, at 27.

66. Kerrie S. Howze, Note, *Medical Tourism: Symptom or Cure?*, 41 GA. L. REV. 1013, 1031–32 (2007). While an interactive website maintained by a foreign hospital may create sufficient grounds for establishing specific jurisdiction over the hospital itself, it may be a closer case as to whether that is sufficient to assert specific jurisdiction over the individual doctor. To the extent that a court may view the doctor as being synonymous with the hospital, obtaining specific jurisdiction may not be difficult. However, insofar as a court might view the doctor as distinct from the hospital, it would be necessary

for a foreign doctor who personally solicits patients over the Internet, either through e-mail exchanges or some other form of interactive communication.[67]

Another way that a foreign doctor may purposefully avail himself in the United States is by associating with broker firms that are involved in the business of medical tourism.[68] Brokers may be located domestically or internationally, and their services may be minimal or extensive depending on what type of package the medical tourist purchases.[69] As a general matter, "the broker acts as the primary liaison for the medical tourist and the foreign medical care provider."[70] The legally significant inquiry here is whether a doctor's association with a broker that solicits business represents sufficient availment to justify the assertion of specific jurisdiction. Where a doctor personally associates with a broker that directly provides business, this would seem to be a clearer case for asserting specific jurisdiction. The outcome becomes more difficult to predict as the link between the patient and doctor becomes more attenuated, such as when the broker associates with the foreign hospital rather than with the doctor directly.

III. AN AILMENT IN REMISSION WITH THE POSSIBILITY OF FUTURE COMPLICATIONS—THE POTENTIAL LIMITATIONS ON ENFORCING AN AMERICAN MONEY JUDGMENT IN A FOREIGN JURISDICTION

Assuming that an American plaintiff is successful in obtaining jurisdiction over a foreign doctor and prevails in obtaining a money judgment, the plaintiff is still faced with the task of having the judgment recognized and enforced in a foreign country. Where a foreign doctor's assets are all located outside the United States, obtaining such recognition would be the injured plaintiff's only means of collecting on the judgment.[71] In light of this basic procedural limitation, perhaps the greatest legal disincentive to engage in medical tourism is that there is no single convention or internationally recognized standard that governs the

to show that the doctor personally availed himself of the forum state through the website in order to establish specific jurisdiction. *See id.* at 1032 nn.136, 144.

67. *Id*. at 1032.

68. Burkett, *supra* note 64. "Brokers can be located in either the United States or the destination country. Generally, brokers work with patients using their Web site, if they are independent brokers, or the hospital's Web site if they are employees of a hospital group." *Id*. (footnotes omitted).

69. *Id*.

70. *Id*.

71. *See* Weems, *infra* note 72.

enforcement of money judgments obtained in foreign courts.[72] In the absence of a treaty, international law does not require one nation to enforce civil and commercial judgments from the courts of another nation.[73] Unfortunately for the American plaintiff, while the United States has adopted a liberal attitude toward enforcing foreign judgments, this attitude is not necessarily indicative of the current world sentiment toward such judgments.[74]

Most countries around the world continue to strictly interpret their requirements for judgment enforcement, and take the view that, in the absence of a treaty, "a foreign nation's judgment will not be enforced unless local law requirements are clearly met."[75] The court of the country in which the enforcement of the foreign money judgment is sought will typically conduct a hearing to determine whether the foreign judgment meets the local law requirements for enforcement.[76] Additionally, the court may look to other significant considerations, such as "whether reciprocity exists with the country of origin, whether a prior inconsistent judgment exists, and whether the court of origin applied the correct law under a

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72. Philip Weems, *Guidelines for Enforcing Money Judgments Abroad*, 21 INT'L BUS. LAW. 509, 509, *available at* http://www.kslaw.com/library/pdf/guidelines.pdf. In recognition of the problems encountered in enforcing money judgments across national borders, multilateral treaties have been adopted in the last three decades by countries desiring to ensure predictable and efficient enforcement of their judgments. *Id*. While no single international convention governs the international enforcement of judgments, the European Community instituted the Brussels Convention in 1968, and in 1989 entered into the Lugano Convention with the members of the European Free Trade Association. *Id.* "These two conventions, when completely ratified, [] provide a system of judgment enforcement between most West European nations. Additionally, the Inter-American Convention of 1979 is designed to remove uncertainty by ensuring the enforceability of judgments among eight Latin American nations." *Id*.

73. *Id*. If there is no applicable treaty, the country that is being asked to recognize the foreign judgment is left to determine the enforceability of that judgment. *Id*.

74. *Id*.

> The vast majority of countries in the world have had an historically in-bred tendency toward self protection and have been naturally suspicious of foreign judgments. Most countries have been inclined to interpret their requirements for enforcement of foreign judgments strictly to ensure that the laws and acts of foreign governments and courts do not conflict with national interests, in particular the rights of the judgment debtor and other parties in the action who are resident in the country.

Id.

75. *Id*. (emphasis omitted).

76. *Id*. at 510. When considering whether local law requirements for enforcing a foreign judgment have been met, a court will generally look to ensure "(a) that the court of origin had jurisdiction over the judgment debtor; (b) that the judgment debtor was properly notified of the commencement of the court of origin's proceedings; (c) that enforcement of the judgment would not violate local public policy; and (d) that the foreign judgment is a final judgment." *Id.* "Although most countries will not review the merits of the original action, some will do so to a limited extent, especially if fraud or a violation of public policy is alleged by the judgment debtor." *Id.*

proper conflicts of law analysis."[77] In the case of a few countries where medical tourism has become popular, a judgment from an American court may not even receive such a cursory review before being disregarded. Saudi Arabia, for example, will refuse to enforce a money judgment absent a treaty, and would require the plaintiff to commence a new action against the judgment debtor.[78]

Even where a foreign country may be willing to enforce an American judgment absent a treaty, a defendant may raise certain issues or assert various defenses that may preclude enforcement of the judgment. First, a defendant may direct a court's attention to the issue of reciprocity.[79] Historically, places such as Singapore and the United Arab Emirates have mandated a showing that the other country would enforce judgments of a similar nature from their courts.[80] Even in places like Mexico that do not treat reciprocity as a prerequisite to recognition, the issue may be raised as a defense to enforcement.[81]

Second, a "lack of jurisdiction of the court of origin over the judgment debtor is perhaps the most often noted reason for a foreign court's refusal to enforce a foreign money judgment."[82] Different countries have varying

77. *Id*.

78. *Id*.

79. *See* SURVEY ON FOREIGN RECOGNITION OF U.S. MONEY JUDGMENTS, *infra* note 80, at 17–18.

80. Weems, *supra* note 72, at 510. *See generally* COMMITTEE ON FOREIGN AND COMPARATIVE LAW ASS'N. OF THE BAR OF THE CITY OF NEW YORK, SURVEY ON FOREIGN RECOGNITION OF U.S. MONEY JUDGMENTS (July 31, 2001), http://www.cptech.org/ecom/jurisdiction/CFCL.rtf. Reciprocity is sometimes complicated by the fact that some countries, such as Canada and Mexico, are federal in their political and legal organization, while others are unitary. *Id.* at 17. In unitary states, recognition is governed by laws that are applicable throughout the state. *Id.* However, in states having a federal structure, "the situation is more complex as judgments may arise (whether by statute or by jurisprudence) either from the state entity or from the federal entity." *Id*. This may pose problems for the recognizing state in deciding whether state law or federal law is relevant in determining whether the reciprocity requirement is met. *Id*.

81. *Id*. In Mexico, "[j]udges have discretion to consider whether the courts of the originating jurisdiction have given Mexican judgments sufficient reciprocity. If the Mexican court finds insufficient reciprocity, the Mexican court can deny recognition of the [United States money judgment] or other foreign judgment." *Id* at 18.

82. Weems, *supra* note 72, at 510. "A wide variety of tests are applied by courts to determine whether the court of origin had jurisdiction; generally the fact that the court of origin had jurisdiction under its procedural rules will not be determinative. In many countries, the court will determine whether the court of origin had jurisdiction under rules similar to its own." *Id.* at 510–11. Medical tourism countries such as Korea, Mexico, South Africa, and Taiwan will determine whether the court of origin had jurisdiction under rules similar to its own, and may not enforce the judgment if a local court would not have had jurisdiction under the facts presented. *Id.* at 511. Further, "[t]he court of origin's jurisdiction will not be recognised [sic] if it is in conflict with the exclusive jurisdiction rules of the foreign country." *Id*. While such jurisdiction typically exists in cases of real property located within the country, any such jurisdictional conflict regarding an action in tort would effectively preclude the recognition of any judgment obtained in the United States. *See id.*

tests for jurisdiction.[83] Many "have concepts of jurisdiction which are inconsistent or incompatible with US concepts of long-arm jurisdiction[,] and are not prepared to see such US concepts expanded into their countries."[84] Of the medical tourism countries that have more restrictive tests for jurisdiction, South African courts, for example, "will not recognize a foreign judgment . . . unless the foreign court exercised jurisdiction according to South African rules. This precludes US-style long-arm jurisdiction as an acceptable means to assert jurisdiction."[85] Similarly, Mexico will recognize and enforce a United States judgment only where "the US court had jurisdiction over the defendant and the [US money judgment] was rendered in accordance with rules of jurisdiction compatible with Mexican law."[86]

Third, "[r]eflecting fundamental political and cultural disharmony with US laws, courts, and procedures, the notion of public policy . . . often acts as an effective deterrent to the recognition abroad of [US money judgments]."[87] For example, United States money judgments that have a punitive component or multiplier are disfavored by many foreign countries, and denial of their recognition "may be justified as furthering local concepts of justice by preventing unjust enrichment."[88] Similarly,

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Another jurisdictional concern may arise from the fact that in some medical tourism countries, such as Brazil, courts will not enforce judgments against their own residents unless the resident clearly intended to submit to the court of origin's jurisdiction. *Id.* In such instances, for a United States judgment to be enforced, the party holding the judgment would have to demonstrate that the judgment debtor's actions constituted a valid implied submission to jurisdiction. *Id.*

83. SURVEY ON FOREIGN RECOGNITION OF U.S. MONEY JUDGMENTS, *supra* note 80, at 5.

84. *Id.*

85. *Id.* at 6. Other jurisdictional concerns in South Africa include the debtor's domicile, which will be recognized as valid jurisdictional grounds "provided the defendant had the opportunity to appear and defend" himself. *Id.* Also, "[n]otice by publication in a local newspaper in the foreign forum has been held to be unacceptable by South African courts if the defendant did not live in the foreign forum." *Id.*

86. *Id.* at 7. "Under Mexican rules of jurisdiction, mere physical presence in the country is not a sufficient basis to assert jurisdiction. Mexican courts require evidence of some other kind of connection, such as doing business in Mexico or committing a tort in Mexico." *Id.*

87. *Id.* at 9. What constitutes "public policy" in a foreign country may be difficult to ascertain, but as a general matter, "courts will use the public policy defence if a significant political, economic, or social policy of the foreign country is seriously affected." Weems, *supra* note 72, at 511. "The various specific grounds for refusing recognition of [United States money judgments] on the basis of inconsistency with local public policy vary widely. Speaking broadly, US or other foreign money judgments will not be enforced if to do so would threaten the sovereignty and security interests of the recognizing state, violate constitutional protections or offend the social or public order." SURVEY ON FOREIGN RECOGNITION OF U.S. MONEY JUDGMENTS, *supra* note 80, at 9.

88. *Id.* For the countries that view punitive damages to be contrary to public policy,

> [t]he legal basis for this approach is analogous to the general common-law principle of not enforcing so-called 'penalty clauses' in contracts which have the effect of rewarding a plaintiff beyond the extent of the actual damages suffered. In the civil law context, the

like punitive damages, "[t]he notion of a judgment directed at deterrence and patently out of proportion to the actual pecuniary loss suffered is . . . offensive to the public policy of most nations."[89] In this same vein, "[f]or religious reasons, certain Middle East countries, including the United Arab Emirates and Saudi Arabia, either limit or prohibit the enforcement of the interest portion of a foreign money judgment."[90]

Lastly, a United States judgment that lacks finality may prevent it from being enforced abroad. Most states "require that a foreign judgment be 'final' (res judicata) as a condition to recognition."[91] Typically, "'[f]inal' means either that the judgment has become effective and that all avenues of appeal are exhausted, or that the time period for appeal has expired without action by either party."[92] However, not all countries share the same conception of finality. For example, the medical tourism countries of Mexico, South Africa, and Canada each conceive of finality differently.[93] In none of these courts would a final judgment from a United States trial court necessarily be seen as having the requisite finality for enforcing the judgment.[94] With each of these caveats to enforcement, it is apparent that obtaining a judgment in the United States against a foreign doctor may only be one of many obstacles in an effort to collect on that judgment.

> principle is the same: the public policy rationale is to favor compensation over deterrence in civil matters.

Id. at 10.

89. *Id*. For a general discussion and survey of the principal public policy grounds that various countries invoke for refusing enforcement of a United States money judgment, *see generally* SURVEY ON FOREIGN RECOGNITION OF U.S. MONEY JUDGMENTS, *supra* note 80. The most prevalent grounds include "(a) judgments awarding multiple or punitive damages; (b) judgments deemed to have the effect of unacceptably restraining trade; (c) judgments based on decisions grounded in novel causes of action; and (d) judgments deemed to be based on US public law or having a criminal or quasi-criminal nature." *Id*. at 10.

90. Weems, *supra* note 72, at 511.

91. SURVEY ON FOREIGN RECOGNITION OF U.S. MONEY JUDGMENTS, *supra* note 80, at 15.

92. *Id*.

93. *Id*. at 15–16. "In the US, finality is usually determined by whether the judgment has disposed of all the issues on the merits of the case. Finality thus could arise through a trial judgment. In Mexico, on the other hand, a judge is much less likely to accept a trial court decision as final for the purposes of recognizing a [United States money judgment] or other foreign judgment." *Id*. at 15.

> South African law holds that a decision is final when it is no longer rescindable. Under South African law, even if a foreign judgment is on appeal in the originating jurisdiction, a [United States money judgment] or other foreign judgment is considered to be final. However, South African courts have the discretion to stay a recognition proceeding in South Africa pending the outcome of the appeal. In South Africa it is the defendant, not the party seeking recognition, which has the burden of proving that the judgment is on appeal.

Id.

94. *See generally id.* at 15–16.

IV. TREATING THE PROBLEM BEFORE SYMPTOMS ARISE—ARBITRATION AS A MUTUALLY BENEFICIAL ALTERNATIVE TO LITIGATION FOR THE FOREIGN DOCTOR AND PATIENT

It is apparent that litigation presents an array of difficulties to American plaintiffs in obtaining and enforcing a judgment in a foreign country. As an alternative that can more effectively preserve a patient's legal rights,[95] medical tourists should consider entering into arbitration agreements before having any procedure performed abroad. Securing an agreement with a foreign doctor to arbitrate any potential malpractice claim presents unique advantages to both parties. On the one hand, the prospective plaintiff is guaranteed a forum for his claim and need not be concerned with whether an American court would find personal jurisdiction over the doctor. Such an agreement would also preempt the potential need to pursue suit in a foreign court for the purpose of litigating the merits of the case. On the other hand, the foreign doctor would be able to avoid the excessive cost and potential adverse treatment in defending against a suit in an American court. The foreign doctor would also be able to foreclose the potential of having prolonged litigation in his or her own country. With these and other advantages readily obtainable through arbitration, medical tourists have the potential to more effectively secure their legal rights before traveling abroad for treatment.

Arbitration allows for a dispute to be resolved before a neutral decision maker, and offers numerous advantages over litigation. "In addition to being cheaper, arbitration also has the attractive feature of being less formalistic and more flexible than national courts. . . . [T]he parties have great leeway in choosing expert decisionmakers [sic] and efficient procedural rules,"[96] and also have their choice of applicable law, venue, and language.[97] When conducting international arbitration, the parties can also elect whether to conduct the proceedings on an ad hoc basis or through an arbitration institution that offers its services for a fee.[98] While

95. London Court of International Arbitration, *infra* note 97.

96. Dennis Campbell & Dharmendra Popat, *Strategies for Effective Management of Crossborder Recognition and Enforcement of American Money Judgments*, 56 AM. JUR. TRIALS 529, 550 (1995) (footnotes omitted).

97. London Court of International Arbitration, About the LCIA, http://www.lcia.org/LCIA_folder/lcia_main.htm (last visited Feb. 13, 2009).

98.

> Arbitration is ad hoc when the parties appoint arbitrators to resolve a dispute without institutional assistance. The parties may, and indeed often do, select a set of pre-existing rules to govern ad hoc arbitrations. The United Nations Commission on International Trade Law (UNCITRAL) has published a commonly used set of such rules. Alternatively, the arbitral

each of these elements offers medical tourists and foreign doctors a more efficient alternative to litigation, perhaps the greatest benefit that the medical tourist gains through arbitration is greater predictability in judgment enforcement.[99]

The United Nations Convention on the Recognition and Enforcement of Foreign Arbitral Awards, otherwise known as the New York Convention, governs international arbitration proceedings and agreements involving citizens of contracting states.[100] "The New York Convention requires each Contracting State to '. . . recognize arbitral awards as binding and enforce them in accordance with the rules of procedure of the territory where the award is relied upon, under the conditions laid down in the [New York Convention].'"[101] The Convention accordingly provides for enforcement of arbitral awards in countries other than the state where the award was made.[102] The awards governed by the Convention are those

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> panel may independently formulate a special set of procedural rules, tailored to the specific needs of the parties and their disputes.

Campbell & Popat, *supra* note 96, at 550 (footnote omitted). Where an international arbitration institution is used,

> [t]he institution itself does not decide the case . . . but rather provides assistance to the parties in finding suitable arbitrators, who are likely to be prominent lawyers, businessmen, or academics. The London Court of International Arbitration and the International Chamber of Commerce are two of the better known of such institutions.

Id. at 549–50. In terms of efficiency and expediency, arbitral institutions are beneficial to the extent that they can "proactively monitor the entire process from commencement to conclusion." Thomas Oehmke, *Arbitrating International Claims—At Home and Abroad*, 81 AM. JUR. TRIALS 1, 138 (2001). Further,

> [t]hough it is not the role of an institution to interfere with the conduct of the proceedings . . . such institutions may occasionally and judiciously nudge the proceedings along if matters bog down. . . . In addition to serving as a process expediter, an arbitral institution will also resolve any disputes as to interpretation of rules and will serve as an intermediary for exchanging communications, forwarding pleadings, and arranging fee advances. . . .

Id. at 138–39.

99. *Id.* at 27.

100. *Id*. at 37.

101. *Id*. at 44 (quoting United Nations Convention on the Recognition and Enforcement of Foreign Arbitral Awards art. III, June 10, 1958, 21 U.S.T. 2517, 330 U.N.T.S. 3 [hereinafter New York Convention]). Article III of the New York Convention further provides that "[t]here shall not be imposed substantially more onerous conditions or higher fees or charges on the recognition or enforcement of arbitral awards to which this New York Convention applies than are imposed on the recognition or enforcement of domestic arbitral awards." *Id.* art. III.

102. Article I of the New York Convention states:

> This Convention shall apply to the recognition and enforcement of arbitral awards made in the territory of a State other than the State where the recognition and enforcement of such awards are sought, and arising out of differences between persons, whether physical or legal. It shall also apply to arbitral awards not considered as domestic awards in the State where their recognition and enforcement are sought.

New York Convention, *supra* note 101, art. I.

arising out of foreign commerce—in particular, "commercial relationships involving foreign citizens, property located outside the United States, performance or enforcement abroad, or some other reasonable relation with a foreign state."[103] So long as the arbitration occurs in a New York Convention country, the arbitration award will be confirmed, even when the prevailing party is not a national of a country that has signed on to the Convention.[104]

When an arbitration agreement is carefully drafted and voluntarily entered into by both doctor and patient, it eliminates significant barriers for the medical tourist.[105] First, the difficulty in obtaining personal jurisdiction over a foreign doctor in an American court is eliminated.[106] For all intents and purposes, the personal jurisdiction requirement is replaced by the conditions of the New York Convention regarding the proper form of an enforceable arbitration agreement.[107] Second, the broad

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103. Jain v. de Mere, 51 F.3d 686 (7th Cir. 1995), *reh'g and suggestion for reh'g en banc denied* (May 5, 1995).

104. Oehmke, *supra* note 98, at 27–28.

105. While arbitration has been advanced as a favorable safeguard for the patient in this note, courts have been wary of enforcing arbitration agreements between doctors and patients. As Carol Crocca explains,

> since patients as a class are not apt to be familiar with arbitration, and may perceive the health care provider as an authority figure, courts have scrutinized agreements carefully, sometimes analyzing a contract to arbitrate medical malpractice claims as a contract of adhesion, particularly when it is presented to the patient as a condition of treatment.

Carol Crocca, Annotation, *Arbitration of Medical Malpractice Claims*, 24 A.L.R. 5TH 1, 20 (1994). "[H]owever, when the legislature has provided a statutory framework for such agreements, with safeguards against overreaching by the health care provider, the courts have interpreted and applied the statute in the light of the legislative goal of encouraging arbitral rather than judicial settlement of medical malpractice disputes." *Id*.

This indicates that, when seeking enforcement of an arbitration award in the United States in accordance with the New York Convention, public policy concerns ought to be considered when drafting the arbitration agreement. If an arbitration agreement is considered void as against public policy, the New York Convention does not require enforcement of the award. *See* New York Convention, *supra* note 101, art. V(2)(b). The Convention gives the court of any contracting state the leeway to refuse enforcement of an arbitration award where "[t]he recognition or enforcement of the award would be contrary to the public policy of that country." *Id.* Accordingly, before entering any arbitration agreement, a patient would be well served to seek counsel to ensure that the courts where the award would be enforced do not have public policy concerns that would preclude enforcement. For further reference to the circumstances under which recognition and enforcement of an award may be refused, *see generally id*. art. V.

106. So long as the prevailing party in arbitration seeks to enforce the award in a country that is a signatory to the New York Convention, the issues of personal jurisdiction and nationality are rendered moot. *See* New York Convention, *supra* note 101, art. III. Under the New York Convention, an arbitration award will be confirmed, even when the prevailing party is not a national of a country that has signed on to the Convention. Oehmke, *supra* note 98, at 27–28.

107. Assuming that the subject matter of the dispute falls within the purview of Article I of the New York Convention, Article II requires that each Contracting State "shall recognize an agreement in writing under which the parties undertake to submit to arbitration all or any differences which have

international reach of the New York Convention provides for a variety of fora in which valid arbitration agreements may be enforced. While a valid arbitration agreement does not guarantee enforcement under the New York Convention, there is undoubtedly a greater degree of certainty than is otherwise available through foreign courts.[108] At the very least, these aspects of arbitration make it an efficient alternative to litigation, where key issues such as personal jurisdiction and enforceability are largely preempted. At best, arbitration agreements provide the most practical means for a concerned medical tourist to preserve his legal rights before ever leaving home.

V. THE LONG-TERM PROGNOSIS OF MEDICAL TOURISM

Undoubtedly, the advent of medical tourism has provided an array of medical options to American patients who would otherwise be unable to afford them. Growing confidence in the quality of treatment overseas has made the option of traveling abroad an appealing one even for those who have some form of health insurance. However, it is clear that preserving the benefits of medical tourism may also depend on the patient's willingness to safeguard his legal rights in advance of receiving treatment. If the primary benefit of medical tourism is its cost-saving aspect, the prospect of hiring an attorney to research and appropriately negotiate an arbitration agreement is a potential cost that must be factored into the equation. Accordingly, for any given patient, the decision of whether to safeguard his rights is tantamount to a gamble with serious health and legal implications.

This gamble provides two distinct options. On the one hand, the patient may elect to sacrifice some of his cost savings in favor of protecting his legal rights, knowing that recourse for foreign malpractice within the American legal system entails significant obstacles to recovery. On the other hand, the patient may elect to save his money and forego legal safeguards before having the procedure, recognizing that malpractice is the exception rather than the rule. For the patient whose procedure is relatively

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arisen. . . ." New York Convention, *supra* note 101, art. II. An "agreement in writing" includes "an arbitral clause in a contract or an arbitration agreement, signed by the parties or contained in an exchange of letters or telegrams." *Id*. art. II(2). Article IV further provides that a party seeking recognition and enforcement of an agreement and award present "[t]he duly authenticated original award or a duly certified copy thereof" and "[t]he original agreement [in writing] or a duly certified copy thereof." *Id*. art. IV(a)–(b).

108. Article V of the New York Convention provides a variety of grounds on which recognition and enforcement of an arbitration award might be refused by a foreign court. *Id.* art. V.

inexpensive and carries a low rate of malpractice, securing his rights beforehand may not be economically efficient. However, for the patient receiving a more expensive procedure with higher rates of malpractice, the expense of securing one's rights becomes a much more reasonable investment.

While medical malpractice and the obstacles to recovery in the United States may not single-handedly derail medical tourism's popularity, they hold the potential to stunt its growth significantly. Alternatively, should foreign doctors come to offer patients the option of arbitration as a mutually beneficial alternative to litigation, it is possible that the legal aspect of foreign treatment may even facilitate medical tourism's popularity. To the extent that patients view arbitration as providing more certainty than the American legal system, such agreements may provide more of an incentive to travel overseas for treatment. At present, it is simply unclear what long-term effects the legal impediments to recovery may have on the medical tourism industry. It is certain, however, that these impediments present obstacles that may be insurmountable for the patient who is unwilling to roll the dice with his legal rights.

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