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AMERICAL MEDICAL TOURISM: REGULATING A CURE THAT
CAN DAMAGE CONSUMER HEALTH

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HONORS PROJECT

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AMERICAN MEDICAL TOURISM: REGULATING A CURE THAT CAN DAMAGE CONSUMER HEALTH

Chelsea K. Brown

“The most stringent protection of free speech would not protect a man in falsely shouting fire in a theater and causing a panic. . . . The question in every case is whether the words used are used in such circumstances and are of such a nature as to create a clear and present danger that they will bring about the substantive evils that Congress has a right to prevent.”

—Oliver Wendell Holmes, Jr.

“Observe the physician with the same diligence as the disease.”

- John Donne

I. INTRODUCTION

“Medical Tourism: just what the doctor ordered.”ⁱ Or, so the online advertisements claim.ⁱⁱ Take Ingridⁱⁱⁱ for example; 85-year-old Ingrid is suffering the struggles of old age; upon visiting her doctor for her regular checkup, the woman is advised to receive a hip replacement. Ingrid agrees with the physician, and proclaims that she “just can’t get around like the old days.” The woman goes home that evening and begins her research on hospitals and after-care facilities for her upcoming procedure; a simple Google search for the “cost of hip replacement surgery”^{iv} yields the following results: “average cost of \$39,299,” “\$35,000,” and “\$50,000.” The woman stares at her blinking computer screen and sour disbelief washes over her face. Suddenly, to her extreme delight, the woman spots the bolded text: “Poland hip replacement- cost of operation with a cemented prosthesis = \$6000 USD.”

“That’s the one!” The woman shrieks to her five cats; she jots down the contact information, and begins booking her flight to Poland for the following month, ecstatic over her new financial treasure. Ingrid will jump on a bandwagon that paradoxically risks damaging the very health it promises to enhance. Medical tourism^v refers to a trend on the rise in the United States, with attractive costs and luxurious accommodations.^{vi} Specifically, medical tourism is the practice of traveling to a foreign country for a medical procedure such as major or minor surgery, and alternate therapies.^{vii} In light of the ever-increasing costs of health insurance and medical procedures in the United States, consumers are deciding to take the high prices of health procedures into their own hands.^{viii} With the increased cost of medical procedures^{ix} and decreased access to affordable health services in the United States,^x the market for medical tourism is expected to continue to flourish.^{xi}

There is no doubt that medical tourism is one of the hottest new trends in the United States; but, popularity aside, are there any dangers involved with medical procedures abroad that consumers in the United States should be made aware of, before making a medical purchase?

For a consumer to be able to make an informed autonomous decision regarding a medical purchase, the consumer must be given access to all information that has the potential to affect the safety of a medical procedure abroad. This information includes information about the quality of patient care and any potential hazards that can arise during the procedure abroad. If consumers are provided with all-encompassing information regarding a medical purchase, only then is the consumer provided with the tools to make a safe and reliable decision concerning a choice of physician and venue. When the consumer can make a well-informed decision regarding a medical procedure abroad, medical tourism has the potential to be a beneficial check on the price and quality of the domestic market for those services.

But in the United States, consumers are deprived of full information about the safety of medical tourism by the business practices of intermediary businesses. Despite pervasive regulatory and legal risks abroad, consumers are consistently encouraged to pursue medical tourism by intermediary businesses in the United States.^{xii} Medical tourism intermediaries not only fail to inform consumers of these regulatory and legal risks, but further, paint a deceptive picture of the “safety” of medical tourism. Instead of informing consumers of potential risks, medical tourism businesses focus on price benefits, vacation getaways, and “world-renowned doctors.”

This paper argues that the marketing of medical procedures abroad to American consumers is a business practice that requires a specific form of regulation. Without that regulation, promoters of cheap medical services abroad will continue to promote medical tourism to consumers based on incomplete information that results in unnecessary deception.

The initial component of the paper compares medical safety in the United States with that in India to establish the potential risks consumers should be informed of before making a medical purchase. This comparison is two-fold and includes the following: 1) a comparative look at medical safety regulations in the United States versus India; and 2) a brief comparison of the ability for patients to pursue legal recourse for medical negligence in the United States versus India. This comparison makes evident certain dangers of medical tourism. Specifically, it highlights regulatory pitfalls and infrequent legal remedies for medical negligence abroad.

To correct these pitfalls, the paper then outlines the potential basis for legal amelioration of these harms. Specifically, we discuss the Federal Trade Commission’s authority to regulate unfair or deceptive business practices. After analyzing the criteria created by the FTC for deeming business advertising as “deceptive,” this paper asserts that medical tourism businesses in the United States are in fact engaging in deceptive advertising, and thus, have potentially unlawful elements that require regulation. Third, this paper uses the *Central Hudson* test^{xiii} to determine the constitutionality of the hypothetical regulation of medical tourism

businesses in the United States. This paper argues that the regulation of medical tourism businesses in the U.S. is constitutional according to the *Central Hudson* test.

Last, this paper discusses probable arguments of opponents to the business regulation advocated in this paper. Mainly, this paper asserts that to deny the regulation of medical tourism businesses in the U.S. would consequently deny consumers protection from deceptive advertising. Consumers need protection by an outside entity because consumers are susceptible to cognitive heuristics and irrational decision-making behaviors that detract from the ability to be completely in control of one's decisions. Because of a consumer's irrational decision-making tendencies, it is the duty of the government to protect consumers, and regulate deceptive advertising.

In conclusion, this paper will assert that medical tourism intermediaries in the United States are neglecting to inform consumers about regulatory and legal pitfalls abroad that are hazardous to consumers. This lack of material information is unlawfully deceptive according to the Federal Trade Commission Act.

II. ESTABLISHING THE DANGERS OF MEDICAL PROCEDURES ABROAD: A COMPARISON OF MEDICAL REGULATIONS IN THE UNITED STATES AND INDIA

“Regulation”^{xiv} refers to the government's use of coercive power to impose a range of legal constraints, such as laws, administrative rules, and guidelines, on organizations and individuals.^{xv} When a government or administrative body operates with regulations, that entity is imposing control to mandate behavior that protects public welfare, or the individuals of a society. In the case of medical safety, regulations exist to protect the welfare of patients' seeking medical attention.

Unfortunately, medical safety regulations abroad are not necessarily as stringent as medical safety regulations in the United States. Because of lack of regulation abroad, poor physician conduct and low facility standards are not punishable by law. In addition, without regulatory impositions, physician conduct is operated by personal biases and values of the physician, instead of the public welfare interest of the government.

As evidence of the crucial need for medical tourism businesses to recognize and inform consumers of the regulatory pitfalls mentioned above, the following section of this paper compares medical safety regulations in the United States, to medical safety regulations in one of the most popular destinations for medical tourism,^{xvi} India. As a country currently in high demand for medical tourism, India serves as an example of low-key medical regulation pervasive in several medical tourist destinations, such as Bangkok, Mexico, Sri Lanka, and Nigeria.^{xvii}

A. The United States

Medical safety regulations exist to mandate a “standard of care”^{xviii} for all patients. Regulations in the United States include the American Medical Association’s (AMA)^{xix} Code of Medical Ethics^{xx}, enacted law, which consists of constitutions, statutes, ordinances, or regulations,^{xxi} and the Joint Commission.^{xxii}

i. The United States Code of Medical Ethics

In the United States, the Code of Medical Ethics regulates practicing physicians and their treatment of all patients. The Code consists of ten sections: 1) Introduction; 2) Opinions on Social Policy Issues; 3) Opinions on Interprofessional Relations; 4) Opinions on Hospital Relations; 5) Opinions on Confidentiality, Advertising, and Communications Media Relations; 6) Opinions on Fees and Charges; 7) Opinions on Physician Records; 8) Opinions on Practice Matters; 9) Opinions on Professional Rights and Responsibilities; and 10) Opinions on Patient-Physician Relationship.

The Introduction of the Code, Opinion 1.01, states: “*many of the Council’s opinions lay out specific duties and obligations for physicians. Violation of these principles and opinions represents unethical conduct and may justify disciplinary action such as censure, suspension, or expulsion from medical society membership.*”^{xxiii}

ii. Enacted Law of the United States

Besides the Code of Medical Ethics, there are additional medical safety regulations in the United States. A primary piece of regulation is The Patient Protection^{xxiv} and Affordable Care^{xxv} Act (PPACA).^{xxvi} This legislation is multifaceted and includes titles such as the following: Title III) Improving the Quality and Efficiency of Health Care; Title IV) Prevention of Chronic Disease and Improving Public Health; Title V) Health Care Workforce; Title VI) Transparency and Program Integrity; Title VII) Improving Access to Innovative Medical Therapies; and Title X) Strengthening Quality, Affordable Health Care for All Americans.

Second, the Code of Federal Regulations^{xxvii} serves to outline patient rights and the responsibilities of physicians, medical staff, and hospitals and centers of care in the United States. The Code of Federal Regulations contains three titles that are essential to mandating patient care in the United States: 1) Title 21- Food and Drugs; 2) Title 42- Public Health; and 3) Title 45-Public Welfare.^{xxviii}

Title 21, Food and Drugs, contains Chapter 1: Food and Drug Administration, which is regulated by the administrative body, the Department of Health and Human Services. Within Chapter 1, is Subchapter H: medical devices.^{xxix} This Subchapter contains extensive regulation regarding the requirements of sterility, tamper-resistance packaging, patient examination gloves and surgeons’ gloves, and overall reliability and cleanliness of medical devices used on patients.^{xxx}

Title 42 of the Code of Federal Regulations, Public Health, contains two chapters pertinent to maintaining adequate care for patients: 1) Chapter I: Public Health Service; and 2) Chapter IV: Centers for

Medicare and Medicaid Services.^{xxxii} Chapter I, Public Health Service, regulates hospital and station management and administrative functions, practices, and procedures.^{xxxii}

Chapter IV, Centers for Medicare and Medicaid Services, contains Subchapter G which regulates Standards and Certification of hospitals and medical centers in the United States.^{xxxiii} Within this subchapter exists the “conditions of participation for hospitals.”^{xxxiv} These “conditions” mandate the conduct of physicians and hospitals participating in the medical field of the United States. Specifically, the Code of Federal Regulations states:

1) Hospitals must comply with federal, state, and local laws. Hospitals must be in compliance with applicable federal laws related to the health and safety of patients. The hospital must be licensed or approved as meeting standards for licensing established by the agency of the state or locality responsible for licensing hospitals. And the hospital must assure that personnel are licensed or meet other applicable standards that are required by State or local laws.^{xxxv}

2) The hospital must have an effective governing body legally responsible for the conduct of the hospital as an institution. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body.^{xxxvi}

3) A hospital must protect and promote each patient's rights.^{xxxvii}

Chapter IV of the Code of Federal Regulations contains additional regulations for mandating patient care such as the development, implementation, and maintenance of a quality assessment and performance improvement program,^{xxxviii} the operation of a medical staff responsible for the quality of medical care under an organized system of bylaws approved by the governing body,^{xxxix} 24-hour nursing services serviced or furnished by a registered nurse,^{xl} a medical record service that has administrative responsibility for medical records which must be maintained for every individual evaluated or treated in a hospital,^{xli} pharmaceutical services that meet the needs of the patients,^{xlii} diagnostic radiologic services in all hospitals,^{xliii} laboratory services to meet the needs of patients either directly or through a contractual agreement with a certified laboratory,^{xliv} construction and maintenance of hospitals that ensures the safety of the patient and provides facilities for diagnosis and treatment,^{xlv} a sanitary environment to avoid sources and transmission of infections and communicable diseases as well as a program for prevention, control, and investigation of infections and communicable diseases,^{xlvi} written protocols that regulate organ, tissue, and eye procurement,^{xlvii} and finally, extensive regulation of surgical services.^{xlviii}

Last, in addition to the Patient Protection and Affordable Care Act and the Code of Federal Regulations, there are additional regulatory statutes such as the Public Health Service Act,^{xlix} the Health Insurance Portability and Accountability Act (HIPPA)^l and the Patient Safety and Quality Improvement Act of 2005.^{li}

In the United States, when any of the above regulations are not practiced, patients have the ability to seek legal recourse by suing for “medical negligence,”^{lii} a form of “medical malpractice.”^{liii}

In the United States, the Joint Commission functions primarily to provide Joint Commission on Accreditation of Hospitals (JCAH).^{liv} The Joint Commission provides certification or licensing of hospitals in the United States. To obtain JCAH accreditation, hospitals must comply with JCAH's hospital-wide standards, including standards for organizing and controlling medical staffs.^{lv} Under the Joint Commission on Accreditation of Hospitals (JCAH), the hospital's medical staff assumes responsibility for the quality of physician care within the hospital. According to the Joint Commission Hospital Accreditation Standards^{lvi}, "the governing body [of a hospital] provides for internal structures and resources, including staff that support safety and quality." Today, eighty-eight percent of the nation's hospitals are accredited by the Joint Commission.^{lvii} Though not legally required for operation in the United States, Joint Commission accreditation indicates that the accredited organization "meets at least minimum acceptable standards of care as recognized by the federal government and most states."^{lviii}

B. India

Medical regulations in India^{lix} include the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, enacted law of India, and the Joint Commission International.

i. The Indian Medical Council Regulations

In India, there are Professional Conduct, Etiquette and Ethics Regulations,^{lx} quite like the Medical Code of Ethics in the United States. These regulations were previously maintained by the primary body governing medical practice in India, the Medical Council of India^{lxi}; however, as of May 15, 2010, the Medical Council of India has been repealed^{lxii} due to the alleged corrupt behavior of the former President, Desai, the Vice-President, and additional members of the Council.^{lxiii}

The Code consists of eight chapters: Chapter 1: Code of Medical Ethics; Chapter 2: Duties of Physicians to their Patients; Chapter 3: Duties of Physician in Consultation; Chapter 4: Responsibilities of Physicians to Each Other; Chapter 5: Duties of Physician to the Public and to the Paramedical Profession; Chapter 6: Unethical Acts; Chapter 7: Misconduct; and Chapter 8: Punishment and Disciplinary Action.^{lxiv}

Acts of professional misconduct include: violation of any of the regulations of the Code of Medical Ethics Regulations, adultery or improper conduct, sex determination tests, certificates, reports, and other documents which are untrue, misleading or improper, refusal of services on religious grounds, the disclosure of secrets of patients, performing an operation without consent of patient, using touts of agent for procuring patients, claiming to be a specialist without a special qualification, clinical drug trials or other research involving patients or volunteers, absence on more than two occasions during inspection by the Head of the District Health Authority, and absence on more than two occasions during assigned periods of duty in a medical college or institute.^{lxv}

ii. Medical Acts of India

Medical regulations provided by the Medical Council of India, which is currently superseded by the Central Government of India^{lxvi}, included the Indian Medical Council Act (1956),^{lxvii} which enables inspection of medical facilities by the Medical Council of India, and the Indian Medical Degrees Act,^{lxviii} which focuses on ensuring the legal qualifications of practicing physicians in India. Due to the dissolving of the Indian Medical Council by the Central Government of India, the Indian Medical Council Act has been amended as of 2010.^{lxix} According to the Indian Medical Council (Amendment) Act (2010), *“the Central Government [of India] shall constitute the Board of Governors which shall consist of not more than seven persons as its members, who shall be persons of eminence and of unimpeachable integrity in the fields of medicine and medical education...the Board of Governors shall exercise the powers and perform the functions of the Council under this Act.”*^{lxx} Any specifications regarding the qualifications of the new Board of Governors is not included in the Amendment beyond the required *“integrity in the fields of medicine and medical education.”*^{lxxi}

The primary piece of regulation created by the Indian Medical Association is The Clinical Establishments (Registration and Regulation) Rules, 2010.^{lxxii} These Regulations specify the systems of medicine that are permitted, the type of testing that is permitted, and the records to be maintained by clinical establishments.^{lxxiii} The Rules require every clinical establishment to maintain medical records of patients treated, copies of all records and statistics, compliance with the Standard Treatment Guidelines.^{lxxiv} The Rules classify clinical establishments by 1) systems of medicine (Allopathy, Ayurveda, Unani, Siddha, Homeopathy, and Yoga & Naturopathy), 2) type of establishment (providing out-patient care, providing in-patient care, providing testing and diagnostic services).^{lxxv} The Rules list several records that must be maintained by a clinical establishment in India.^{lxxvi} Last, the Rules contain a minimum list of services for which fees must be displayed in a clinical establishment.^{lxxvii}

Additional acts relevant to medical procedures in India include the Transplantation of Human Organs Act^{lxxviii} which contains a chapter titled *“Regulation of Hospitals.”* This chapter outlines the regulation of hospitals conducting the removal, storage or transplantation of human organs.^{lxxix}

iii. The Joint Commission International

Similar to the Joint Commission on Accreditation of Hospitals in the United States, Indian hospitals seek accreditation from the Joint Commission International,^{lxxx} the subsidiary of the Joint Commission in the United States.^{lxxxi} According to the international website for JCI, benefits of JCI accreditation and certification include improved trust as an organization that values quality and patient safety, a culture open to learning from adverse events and safety concerns, a safe and efficient work environment that contributes to staff satisfaction, and leadership that strives for excellence in quality and patient safety.^{lxxxii} Accreditation generally signals that a facility meets minimum standards of competence and quality.^{lxxxiii}

C. Comparison of the Medical Regulations and Medical Negligence in the United States and India

When comparing the medical regulations of the United States versus India, there is evidence that the United States relies on regulation to a higher degree than India.^{lxxxiv} The safety of Indian hospitals is heavily determined by accreditation^{lxxxv}, versus regulation. While the United States also relies on the Joint Commission for accreditation of hospitals, the extensive government regulations in the United States provide a backbone for the shortcomings of accreditation.^{lxxxvi} Government standards of medical safety, such as the United States Code of Federal Regulations, provide extensive detail of physician and facility requirements, whereas accreditation services provide an umbrella structure of guidelines for safety.^{lxxxvii}

For example, according to the U.S. Department of State's travel website, the Joint Commission International is a body that "attempts to continuously improve the safety and quality of care in the international community through the provision of education and consultation services and international accreditation."^{lxxxviii} An "attempt" to improve safety and quality is not ideal for patient consumers; while attempting to improve the safety and quality of the international community is commendable, it is not reliable. Further, the Joint Commission encourages the "American Model" or "self-governing" of medical staffs.^{lxxxix} The Joint Commission's philosophy of self-governance and autonomy result in the Commission's "guiding" behavior, instead of "governing" behavior.

While it is true that both the United States and India engage in the promotion of accreditation, the United States is not damaged to the same degree as India by complete reliance on the system of accreditation. This is because the United States also relies on extensive government regulations.^{xc}

In addition to the contrast in *size* of regulation between the United States and India, there are also significant differences in the *content* of government regulations between the two countries. For example, when comparing the United States Code of Medical Ethics with the Medical Council of India (Professional, Etiquette, and Ethical) Regulations, 2010, although both Codes seek to regulate the ethical conduct of physicians, the *constituent elements* are dissimilar.

The United States Code of Medical Ethics contains regulations of physician conduct, clinical standards, medical procedures, and patient-doctor relationships. The regulations for these areas of patient care are extensive, and as follows: Organ Transplantation Guidelines, Non-scientific Practitioners, Nurses, Allied Health Professionals, Compulsory, Economic Incentives and Levels of Care, Organized Medical Staff, Confidentiality, Privacy in the Context of Health Care, Ethical Guidelines for Physicians in Administrative or Other Non-clinical Roles, Conflicts of Interest: Guidelines, Ethical Implications of Surgical Co-Management, Financial Incentives and the Practice of Medicine, Prescribing and Dispensing Drugs and Devices, Informed Consent, Neglect of Patient, Patient Information, Ethical Responsibility to Study and Prevent Error and Harm,

Substitution of Surgeon without Patient's Knowledge or Consent, Invalid Medical Treatment, Free Choice, Quality, and Fundamental Elements of Patient-Physician Relationship.^{xc1}

There is more than double the number of regulations listed above included in the Code, however, the sections mentioned above are those that are most pertinent to patient rights and patient protection.^{xcii}

In contrast, the Medical Council of India (Professional, Etiquette, and Ethical) Regulations, contains regulations for the character of the physician, maintaining good medical practice, maintenance of medical records, display of registration numbers, use of generic names of drugs, highest quality assurance in patient care, exposure of unethical conduct, payment of professional services, and evasion of legal restrictions;^{xciii} regulations for obligations to the sick, patience, delicacy and secrecy, prognosis, neglect of the patient, and engagement for an obstetric case;^{xciv} regulations of consultation for the patient's benefit, punctuality in consultation, statements to patient after consultation, treatment after consultation, patients referred to specialists, and fees;^{xcv} regulations of conduct in consultation, appointments of substitute, and visiting another physician's case;^{xcvi} and regulations of public and community health, and pharmacists and nurses.^{xcvii}

The difference between the two ethical codes is the degree of explanation and detail contained in the regulations. Where India's code of ethics contains 103 regulations regarding physician conduct, the United States contains 216 regulations. The point of comparing the length of the ethical codes is not to claim that a longer ethical code is more reliable than a shorter ethical code; in fact, a shorter ethical code could signal more concise language. Unfortunately, clarity is not the reason India's code of medical ethics is shorter than the United States code of medical ethics.

India's code uses ambiguous language. Regulations such as "character of the physician," "good medical practice," and "patience, delicacy, and secrecy," are all feel-good phrases that lack explanation.^{xcviii} For example, Regulation 1.1.2 of the Indian Code states: "He shall keep himself pure in character and be diligent in caring for the sick; he should be modest, sober, patient, prompt in discharging his duty without anxiety; conducting himself with propriety in his profession and in all the actions of his life."^{xcix} The Code does not attempt to define words such as "modest," "patient," or "propriety." The ambiguous phrases in this particular regulation create opportunities for multiple interpretations by the reader regarding the meaning of the appropriate behavior of the physician.

In contrast, the United States Code of Medical Ethics, section 8.021 states: "Adherence to professional medical standards includes:(1) Placing the interests of patients above other considerations, such as personal interests (e.g., financial incentives) or employer business interests (e.g., profit). This entails applying the plan parameters to each patient equally and engaging in neither discrimination nor favoritism.(2) Using fair and just criteria when making care-related determinations. This entails contributing professional expertise to help craft plan guidelines that ensure fair and equal consideration of all plan enrollees. In addition, medical directors should review plan policies and guidelines to ensure that decision-making mechanisms are objective, flexible, and consistent, and apply only ethically appropriate criteria, such as those identified by the Council in

Opinion 2.03, "Allocation of Limited Medical Resources."(3) Working towards achieving access to adequate medical services. This entails encouraging employers to provide services that would be considered part of an adequate level of health care, as articulated in Opinion 2.095, "The Provision of Adequate Health Care."

While the United States Code of Medical Ethics contains double the regulations of the Medical Council of India (Professional, Etiquette, and Ethical) Regulations, the U.S. Code, more importantly, contains more explanation of the implied meaning of standards of care for patients.

i. Comparison of Legal Recourse for Medical Negligence against Consumers

When patients travel to foreign destinations that do not have extensive medical regulations, or, medical regulations that contrast with the patient's country of citizenship, it is difficult for the patient to receive the same protection by courts for medical negligence, or lack of physician care.^{ci}

The systems of litigation for medical negligence differ vastly between the United States and India.^{cii} This is because India's definition of medical negligence differs from that of the United States. In the United States, medical negligence is defined as a violation of the duty of care owed to a patient by a physician.^{ciii} Because the United States has extensive regulation regarding the definition of "duty of care," medical negligence cases in the U.S. are frequent.^{civ} In India, to establish liability on the basis of medical negligence, it must be shown "1) that there is a usual and normal practice; 2) that the defendant has not adopted it; and 3) that the course in fact adopted is one no professional man of ordinary skill would have taken had he been acting with ordinary care."^{cv} Because of the ambiguity of Indian medical regulations, which exist to define the "standard of care" required by physicians, it is difficult to seek legal assistance as a medical tourist if an injury were to occur.^{cvi}

In addition to differences in medical terminology and medical regulations between the United States and India, there are also cultural differences^{cvi} that influence the ability for patients to seek legal recourse for medical negligence. Medical negligence cases are reliant on the court's understanding of medical terminology such as "normal practice" and "standard of care," which are reliant on the pervasive customs and ideologies of a country.

D. The Consequential Need for Consumer Protection

The brief comparison above sheds light on international inconsistencies regarding medical safety regulations and the ability for patients to seek legal recourse for medical negligence. But this paper is not commending the need for stricter regulatory standards in the country of India; such a claim would be insensitive and intolerant to the cultural, political, and historical ideologies and value preferences of India that have shaped the current regulatory environment. Instead, this paper argues that there is an imperative need for consumer protection in the United States. More specifically, this paper asserts the duty of medical tourism businesses

in the U.S. to inform consumers about regulatory pitfalls in the country where a consumer plans on seeking medical care. This informed consent is essential to providing consumers with as much safety information as possible *before* the consumer makes a medical purchase. Without all-encompassing information regarding medical hazards abroad, consumers may make a medical purchase that is not consistent with the best interest of the consumer's health.

III. REGULATION OF MEDICAL TOURISM BUSINESSES IN THE UNITED STATES

With any business, there is a natural temptation to deceive buyers into purchasing those products that maximize profits. This deceit is possible when the relationship between the buyer and seller is unequal, and sellers have more knowledge about a given product than the consumer. Unless the flow of information is abundant, accurate and readily accessible, then consumers are on the receiving end of seller deceit.

The business of medical tourism is not immune to this temptation to deceive. When medical tourism facilities in the U.S.^{cviii} connect consumers with doctors and facilities abroad^{cix}, the seller of medical tourism has more knowledge than the consumer regarding the safety regulations, licensing, and legal elements of a foreign medical procedure. Because sellers of medical tourism in the U.S. have more knowledge than consumers, there is a natural temptation to deceive, and thus, gain the most profit. Medical tourism intermediaries in the United States have succumbed to this business temptation, and consumers are left in the dark.

Unfortunately, consumers do not always have the knowledge or training^{cx} to recognize seller deceit. The consumer's inability to protect him or herself from seller deceit stems from irrational decision-making tendencies, such as cognitive heuristics.^{cxii} Because consumers cannot protect themselves from seller deceit, it becomes the responsibility of the government, the regulatory body in charge of protecting this country's citizens, to protect consumers.

The United States government has the power to protect consumers from seller deceit by regulating the natural effects of business motivation in those markets where there is unbalanced decision-making power. This business regulation is termed consumer protection law.

Consumer protection law is essential to establishing balanced decision-making power. To establish a balanced business transaction, consumer protection law mandates that businesses provide consumers with informed consent regarding any aspect of the product that is essential to the consumer's ability to make an informed decision. Specifically, the federal government created the Federal Trade Commission^{cxiii} under the Federal Trade Commission Act (FTCA)^{cxiiii} to regulate unfair trade and product advertising.^{cxv} The FTCA states that businesses in the United States that practice "unfair methods of competition in or affecting commerce, and unfair or deceptive acts in or affecting commerce, are hereby declared unlawful."^{cxvi}

A. Deceptive Advertising According to the Federal Trade Commission

As mentioned previously in this paper, medical tourism businesses in the U.S. do not inform consumers about regulatory pitfalls or lack of legal recourse for medical negligence in foreign destinations. To determine if the omission of this information is deceptive, one must look at the legal criteria for establishing deceptive advertising. According to the FTC, the three elements necessary to establish deceptive advertising are as follows: (1) there was a representation; (2) the representation was likely to mislead customers acting reasonably under the circumstances, and (3) the representation was material.^{cxvi}

First, it is clear that medical tourism businesses create a “representation.” This representation models medical tourism as safe and reliable for consumers.^{cxvii} Second, consumer trust in American medical tourism businesses is “reasonable” when medical tourism businesses *represent* themselves as trustworthy. For example, one of the most popular medical tourism intermediaries, *MedRetreat*, states the following on their website: “America's most trusted Medical Tourism company: facilitating Medical Travel programs for North Americans seeking affordable surgery abroad.”^{cxviii} The website makes additional claims such as “*MedRetreat* is America's most trusted provider of medical tourism services to savvy North Americans seeking safe, highly effective, personalized programs to receive world-class surgery abroad.”^{cxix} Last, this representation is material because it establishes consumer trust, thus having the power to persuade consumers to purchase a medical procedure abroad.

The representation above omits vital information. Nowhere in the business’s representation of medical procedures abroad is there mention of lack of safety regulation or lack of legal recourse for medical negligence. These regulatory and legal elements are vital information because they may contribute to a consumer’s trust in foreign doctors and facilities, and consequential purchase of a medical procedure abroad. According to the FTC, it is deceptive to fail to disclose different types of product information to consumers.^{cxx} Based on the criteria of the FTC, the lack of informed consent to consumers regarding regulatory pitfalls and lack of legal recourse abroad is deceptive.

B. Applying the Central Hudson Test

Before the government can regulate the advertising of a business, the courts must determine whether or not it is constitutional to regulate a business’s commercial speech.^{cxxi} One way to determine the constitutionality of regulating commercial speech is the *Central Hudson* test, established by the Supreme Court in *Central Hudson Gas & Electric Corp. v. Public Service Comm'n.*

The *Central Hudson* test has four prongs: 1) whether expression is protected by First Amendment to extent that it concerns lawful activity and is not misleading; 2) whether asserted governmental interest to be served by restriction is substantial; 3) if both (1) and (2) yield positive answers, whether restriction directly advances governmental interest asserted; and 4) whether restriction is no more extensive than necessary to serve such interest.^{cxxii}

According to the *Central Hudson* test, commercial speech that is unlawful or misleading cannot pass the first test, and thus, should not necessarily be protected by the First Amendment. As established in the previous section of this paper, the “lawfulness” of medical tourism businesses in the United States is questionable. After assessing the legal regulations enforced by the Federal Trade Commission Act, this paper argues that the FTC has grounds to deem medical tourism intermediaries in the U.S. deceptive, and thus unlawful. Unlawful commercial speech would prevent the deceptive advertising of a business from passing the first prong of the *Central Hudson* test, deeming government regulation constitutional.

IV. OPPOSITION TO BUSINESS REGULATION: ARGUMENTS OF INDIVIDUALISM AND AUTONOMY

The United States is a country rooted in individualism^{cxxiii} and freedom of choice.^{cxxiv} Because these values are pervasive in our systems of law and government, arguments for business regulation in the United States do not stand uncontested. Individualism assumes that human beings are self-sufficient and in control of their own destinies,^{cxxv} and thus, government intervention of any kind is distasteful. Essentially, because an individualist believes to have control over their own reality, government regulation is interpreted as a violation of that individual’s self-sufficient behavior.

In the United States, market thinking is guided by an individualistic view of human beings.^{cxxvi} For instance, neoclassical conceptions of the market assume that if a consumer has access to a plethora of information, that consumer will have the ability to sift through information and make a rational, self-informed decision.^{cxxvii} However, once a market is regulated by the government, a chain reaction inhibits the consumer’s ability to make an autonomous purchase. First, businesses lose the freedom to choose how and what to produce. As a consequence, businesses are inhibited and no longer feel autonomous. This loss of autonomy results in a lack of incentives to maximize production and provide a variety of goods and services to consumers.

In other words, assuming consumers value a variety of goods and services, the individualist contends that when businesses lose autonomy, consumer choice also suffers. For example, the reduction of consumer purchasing options, resulting from government regulation, limits the consumer’s freedom to make autonomous choices and create their own reality.

In regards to medical tourism, the individualistic argument claims that consumers are self-sufficient and have the ability to make rational decisions.^{cxxviii} If medical tourism businesses are regulated, consumer information will be diminished. Consequently, decreased consumer information detracts from the consumer’s ability to engage in rational discernment and calculate the best medical purchase.

This individualistic opposition to business regulation is not without its weaknesses. The following section of this paper will address the flaws

of assuming consumers are rational decision makers, and thus, that government regulation should not be imposed on medical tourism facilities in the United States.

A. The Irrational Consumer

Contrary to individualistic assumptions about human beings, extensive psychological research provides evidence that consumers are not always “rational”^{cxix} decision makers. Specifically, human beings are victim to cognitive heuristics.^{cxx} A cognitive heuristic is a method for reducing efforts associated with decision-making processes, often termed “mental shortcuts.”^{cxxi} Cognitive heuristics provide consumers with cognitive closure,^{cxxii} a psychological phenomena which is defined as “the desire for a definite answer on some topic, *any answer* as opposed to confusion and ambiguity.”^{cxxiii} Cognitive heuristics, or mental shortcuts, lead to illogical reasoning. Because of this tendency for humans to be irrational decision-makers, a given consumer’s decision regarding a doctor or procedure abroad may be ill-reasoned. Although a medical tourist may initially think their choice of doctor and facility is well-researched, reliable, and safe, often times, the medical procedure abroad falls short of success.^{cxxiv}

For the medical tourist, the process of finding a doctor, medical facility, and place of recovery abroad, is a process that has been made simple and fast with internet advertising.^{cxxv} What is not so simple for the consumer is the ability to understand the differences in medical regulations and cultural practices, complexities and potential hazards of medical procedures^{cxxvi}, doctor credentials, the validity and reliability of medical advertising.^{cxxvii} In the case of medical tourism, consumers are often persuaded by vacation getaways^{cxxviii} and low procedural costs, advertised by medical tourism intermediaries in the U.S., instead of doctor credentials and facility reliability and regulation.

The individualistic argument ignores the above evidence of consumer irrationality. Instead, individualists appeal to values of autonomy, and self-sufficiency to support the claim that consumers should have the freedom to determine their own destinies, without government imposition or guidance.

i. Dangerous Consumer Beliefs about Physicians as Unbiased and Scientific

In addition to the irrational decision-making tendencies of human beings, consumers also have dangerous assumptions about the physicians and medicine: the belief that physicians are unbiased, deliverers of medical science.^{cxxix} The word “science” has various interpretations;^{cxli} however the common meaning of the word “scientific” in the United States is one that is associated with words such as “reliable,” “factual,” and “unbiased.”^{cxli} If the physicians are perceived as “scientific” by a consumer, and that consumer has assumptions regarding science such as those mentioned above, it is not surprising that the consumer would then rely on the

advertising of physicians abroad as factual, and unbiased. This scientific characterization of the physicians can be perilous.

The scientific characterization of physicians as unbiased is perilous because the consumer often forgets that the instrument making an incision, or creating prescription drugs, or administering medical diagnosis, is human; patients forget that the medical field is operated by imperfect human beings.^{cxlii} Further, because these doctors are in fact human, they are subsequently prone to the same illogical decision-making tendencies mentioned above. In fact, according to a study in 2007, the medical community's failure to routinely apply known scientific principles to patient care translates to a 20 percent incidence of misdiagnosis- a figure that has remained unchanged for seventy years.^{cxliii}

The above evidence, including susceptibility to cognitive heuristics and dangerous beliefs about the reliability of physicians, demonstrates that in fact, consumers are not one capable of recognizing deceptive information, and making rational decisions.

IV. CONCLUSION

In comparing and contrasting the medical safety regulations of the United States and India, and the ability for medical tourists to seek legal recourse for medical negligence abroad, this paper provides evidence that there are significant regulatory and legal pitfalls that make medical tourism a risky purchase for consumers. Medical tourism hotspots, such as India, rely primarily on accreditation as a regulatory system. Regulations outside of the accreditation system in India are limited and ambiguous. In fact, governing bodies such as the Indian Medical Association fight government regulation as an invasion of privacy of medical facilities.^{cxliv}

Despite these regulatory and legal risks, consumers are continually informed by U.S. intermediary businesses that medical procedures abroad are safe and reliable. In fact, instead of informing consumers of the regulatory and legal hazards of medical tourism, sellers zone in on vacation features and low-cost procedures. This omission of material information by medical tourism businesses creates consumer deceit, and further, facilitates uninformed consumer decisions. This deceit is unlawful according to consumer protection laws in the United States. Specifically, the Federal Trade Commission Act bans deceptive advertising.

In past U.S. cases of deceptive advertising, the courts have relied on the *Central Hudson* test to determine the constitutionality of regulating the commercial speech of businesses. The *Central Hudson* test contains four prongs that determine the constitutionality of business regulation. When applied to medical tourism businesses in the United States, a hypothetical *Central Hudson* test deems regulation constitutional.

But business regulation in the United States often results in a clash of ideologies. In general, government regulation usually results in a value conflict of individualism versus paternalism, autonomy versus protection. The United States is a country rooted in individualism and autonomy. Today, rising costs of health services in the United States lead the autonomous patient to take high costs of medical procedures into their own hands.

But individualists that argue consumers should have complete autonomy speak with dangerous assumptions about human ontology. For one to claim that consumers should be able to practice autonomy when making medical decisions, one must assume that medical tourists have the ability to make rational medical decisions.

Medical tourists are *human beings*. There is extensive research that human beings are in fact *not* rational decision makers, but instead, are susceptible to cognitive heuristics. In addition to irrational decision-making tendencies, there is also evidence that consumers make medical purchases reliant on dangerous assertions that physicians and the practice of medicine are unbiased and objective. These stereotypes about physicians and the practice of medicine are incorrect. In reality, almost 100,000 patients die each year from medical errors.^{exlv}

The fact that medical tourism consumers are susceptible to irrational decision making serves as evidence that chips away at the cracks of the individualistic opposition to government regulation. Further, evidence of irrational consumer behavior supports this paper's argument for consumer protection from the deceptive advertising of medical tourism in the United States.

To properly inform consumers about regulatory and legal hazards abroad, and to battle irrational consumer behavior, medical tourism businesses in the U.S. desperately need government regulation. Once government regulation is established, consumers will have access to full information regarding medical tourism: the benefits and the risks, the low costs and the hazards. With this information, consumers will have the tools to make informed autonomous medical purchases, instead of autonomous medical purchases based on deception.

Footnotes

¹See Christine Lee, *Just What the Doctor Ordered. Medical Tourism*, MONASH BUS.RW. 43 (2007) (asserting that it is "easier" to travel to emerging economies with cheaper medical costs).

¹See the brochure titled "*Incredible India! The Global Healthcare Destination*," available at http://www.incredibleindia.org/newsite/cms_page.asp?pageid=492. Directly above the link for this brochure are several links for trip planning and "experiencing India." See also Thomas R. McLean, *Shaping a New Direction for law and Medicine: An International Debate on Culture, Disaster, Biotechnology and Public Health: Article: Telemedicine and the Commoditization of Medical Services*, 10 DEPAUL J. HEALTH CARE L. 131, 162 (2007) ("In particular, medical tourism, which combines a vacation with medical treatment, is growing at a staggering pace"). For a discussion on the marketing technique of medical tourism which offers a "getaway vacation," See *The Globalization of Health Care: Can Medical Tourism Reduce Health Care Costs?: Hearing Before the Senate Special Committee on Aging*, 109th Cong. (2006). (statement of Bruce Cunningham, M.D., M.S., President, American Society of Plastic Surgeons) ("Aside from the qualifications of the physician, Cunningham raised concerns about marketing practices of medical tourism as potentially luring patients abroad under the guise of a medical vacation. Cunningham is concerned that due to the combination of the low cost and marketing strategies that promote the trips as "medical vacations," patients may devalue the precautions that should be taken before and after surgery and may fail to consider the risks of the surgery altogether").

¹ Any reference to a woman named "Ingrid" and a case of medical tourism is purely coincidental, as the name of the woman and instance of medical tourism is fabricated.

¹See google.com, with "cost of hip replacement surgery" entered into the search engine.

¹See Mark S. Kopson, *Medical Tourism: Implications for Providers and Plans*, 3 HEALTH & LIFE SCI. L. 147 (2010) ("How one defines medical tourism is determined, frequently, by

the impact of the phenomenon upon the individual crafting the definition. The definition can range from 'no oversight, no regulatory apparatus . . . the wild west of medical care,' to 'travel[ing] to another country to receive medical, dental, and surgical care while at the same time receiving equal to or greater care than they would have in their own country . . . because of affordability, better access to care, or a higher level of quality of care").

¹See Lee, *supra* note 1.

¹See Lee, *supra* note 1. ("Whether it is for cheaper dental work in Thailand, heart surgery in India, or warm climate therapy in Monte Carlo, medical tourism is big business and getting bigger"). See also *India, Medi Tourism*, available at <http://indiameditourism.com/>. The medical advertisement claims that the "most popular treatments sought in India by medical tourists are alternative medicine, bone-marrow transplant, cardiac bypass, eye surgery and hip replacement. India is known in particular for heart surgery, hip resurfacing and other areas of advanced medicine."

¹See The Deloitte Center for Health Solutions, *infra* note 10. ("An estimated 750,000 U.S. citizens traveled engaged in medical tourism in the year 2007"). With vast price differentials between surgeries in the United States and India, it does not come as a shock that India is one of the most popular destinations for medical tourism. See also Elizabeth Gluck, *Incredible [Accreditable] India: Trends in Hospital Accreditation Coexist with the Growth of Medical Tourism in India*, 1 ST. LOUIS U. J. HEALTH L. & POL'Y 459, 466 (2008) (explaining the cost difference for specific surgeries in the United States and in India). Gluck claims:

"Healthcare in India is less expensive than it is in the United States primarily due to the value of the American dollar in undeveloped countries. This price difference translates to medical procedures in India costing approximately one-fifth to one-tenth of the U.S. price. The cost of advanced surgeries performed in India is estimated to be ten to fifteen times less than anywhere else in the world. For example, a heart surgery that would cost \$ 30,000 in the United States costs approximately \$ 6,000 in India, and a bone marrow transplant with a price tag of \$ 250,000 in the United States would be billed at approximately \$ 26,000 in India. Knee replacement surgery in India costs approximately \$ 8,500, but, if performed in the United States, the same operation would cost approximately \$ 40,000."

See also *The Globalization of Health Care: Can Medical Tourism Reduce Health Care Costs?*, *supra* note 2. ("For the Nation's 46 million uninsured, traveling overseas for low-cost medical procedures, even with the added costs of travel and lodging, is now an understandable attractive option").

¹See Melissa B. Jacoby and Elizabeth Warren, *Beyond Hospital Misbehavior: An Alternative Account of Medical-Related Financial Distress*, 100 NW. U.L. REV. 535, 536 (2006) ("Long after a person recovers physically, illness and injury can have a significant financial impact on individuals and their families. In the past several years, the news media have given front-page attention to the money side of medical problems. Featured stories described how big hospital bills turn families' lives upside down, sometimes costing them their homes, their credit ratings, access to their bank accounts, and occasionally even their liberty").

¹See Kopson, *supra* note 5. Kopson's argument provides insight on the contributing factors of medical tourism. The author provides evidence from research included in the *Wall Street Journal* that claims rapidly rising healthcare costs are one of the primary contributors to the increasing popularity of medical tourism; specifically the "percentage of U.S. residents lacking any healthcare insurance, the decreasing percentage of those with private healthcare insurance, and the increasing enrollment in high-deductible plans." See also The Deloitte Center for Health Solutions, *2009 Survey of Health Care Consumers: Key Findings, Strategic Implications*, available at: www.deloitte.com/us_chs_2009SurveyHealthConsumers_March2009.pdf . The study provides several statistics, including the following:

Most (94%) believe that health care costs are a threat to their personal financial security (regardless of the insurance they have/don't have or their health status). Over half (52%) believe that 50% or more of the dollars spent on health care in the U.S. are wasted.

¹See Vadim Schick, *Data Privacy Concerns for U.S. Healthcare Enterprises' Overseas Ventures*, 4 J. HEALTH & LIFE SCI. L. 173 (2011) ("For example, India's medical tourism sector is expected to grow 30 percent annually from 2009 to 2015").

¹See *MedRetreat*, Retrievable at [http:// www.medretreat.com/](http://www.medretreat.com/). The intermediary medical tourism business advertises as “America’s most trusted Medical Tourism company facilitating Medical Travel programs for North Americans seeking affordable surgery abroad.” It is the deceptive advertising of intermediary companies such as MedRetreat, which this paper asserts necessitates government regulation. One version of deceptive advertising is “asymmetric information,” or imperfect consumer information. This paper argues that the asymmetric information provided by American medical tourism businesses, such as *MedRetreat*, qualifies as “deceptive advertising” by FTC standards, and thus, should be regulated. For further discussion on asymmetrical information, see Shmuel I. Becher, *Asymmetric Information in Consumer Contracts: The Challenge That Is Yet To Be Made*, 45 AM. BUS. L.J. 723,733 (2008) (discussing the controversies surrounding asymmetric information and consumers’ adherence to standard form contracts (SFC)). Becher states that: “generally speaking, the term “asymmetric information” refers to situations where parties are differently informed, with one party having access to better or more information than the other.”

Becher’s definition of asymmetric information is applicable to consumer deceit via American medical tourism businesses. Sellers of medical tourism do not deprive consumers of material information regarding potential hazards abroad. This deprivation of consumer information inhibits consumer knowledge, creating an inequality between buyer and seller information.

For an in depth discussion about asymmetric information, see Facundo Bouzat, *Linking the Regulation of Business to Specific Market Structure: Deconstructing Three Cases to Demonstrate the Salience of “the Market” in Court Decisions*, 41 ACAD. LEGAL STUD. IN BUS. NAT’L PROC. 6 (2010).

¹See *Central Hudson Gas & Electric Corp. v. Public Service Comm’n*, 447 U.S. 557 (1980).

¹ For a discussion on the importance of regulation, see Claire Cowart Haltom et. al, *Quality in Action: Paradigm for a Hospital Board-Driven Quality Program*, 4 J. HEALTH & LIFE SCI. L. 95 (2011). According to Haltom, “law affects social norms and, therefore, the behavior of directors, indirectly. Social norms are affected in part by external factors, such as judicial decisions, which in turn modify the behavior of directors by altering internal constraints. In the corporate world, the recent trend toward a higher standard of care for directors is a result of a shift in belief systems, which was itself partly a result of the “expressive effect of legal authorities, which clarified and added moral force to the social norm of care.” Criminal prosecution and civil suits that targeted nonprofit directors have contributed to shifting the social norms toward a more conscientious board. Likewise, increased attention to patient safety and quality assurance is likely pervading hospital corporate culture. Some notable hospitals and their directors voluntarily and actively make patient safety an institutional priority.”

¹See M. J. Roberts et. al., *Getting Health Reform Right: A Guide to Improving Performance and Equity*, New York: Oxford University Press, 2004.

¹See The Deloitte Center for Health Solutions, *supra* note 10.

¹See Nicolas P. Terry, *Under-Regulated Health Care Phenomena in a Flat World: Medical Tourism and Outsourcing*, 29 W. NEW ENG. L. REV. 421, 470 (2007).

¹ There are several U.S. landmark cases that discuss the meaning of “standard of care” or “duty of care” required by physicians. First, see Barbara Blackmond, *Health Law Developments: Health Law Year in Review: A Hospital Perspective*, 78 PA BAR ASSN. QUARTERLY 117 (2007). Blackmond discusses the Supreme Court of Pennsylvania case, *Thompson v. Nason Hospital*. In *Thompson*, the Court held that hospitals have a duty to prospective patients to exercise “reasonable care in the granting of medical staff appointment and clinical privileges and in ongoing performance oversight. Blackmond also cites *Curtsinger v. HCA, Inc.* In this case, the appellate court noted that the physician mandate of “duty of care” is “not limited to clinical competence, but also includes behavioral and ethical conduct.” See also *Twitshell v. MacKay*, 434 N.Y.S.2d 516 (App. Div. 1980). The New York Supreme Court held that duty of care involves “matters of science or art requiring special skill or knowledge not ordinarily possessed by the average person. As case law reveals, the idea of “duty of care” or “standard of care” in the medical field is highly ambiguous. The pervasive ambiguity outlined above leads to multiple contrasting interpretations of the phrased “duty” and “care.”

¹ The founding of the American Medical Association in 1847 sprung out of reaction to patient exploitation. See Robert Baker, *The American Medical Ethics Revolution: How the AMA’s Code of Ethics Has Transformed Physicians’ Relationships to Patients, Professionals, and*

Society. Baltimore, MD: The Johns Hopkins University Press, xxiii(1999). Baker claims that the AMA was in reaction to a crisis over professionalism and professional standards; “from 1649 on, first colonies and later states sought to protect patients from fraudulent claims of medical expertise through a system that would permit patients to distinguish between trained and untrained medical practitioners.” Baker further states that “never before had physicians voluntarily subscribed to a code of conduct this demanding. The specific obligations that the AMA physicians had unanimously imposed upon themselves far exceeded earlier rather vague only for America but also for the world.”

¹See the American Medical Association, *AMA’s Code of Medical Ethics*. Retrieval at: <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page>.

¹See William H. Putnam, *Legal Research 3* (2nd Edition, 2010).

¹See the Joint Commission. Retrieval at <http://www.jointcommission.org/>.

¹See *Code of Medical Ethics*, *supra* note 20.

¹See Gerald Dworkin, *Paternalism*. 56 *The Monist* 65,66 (1972). Gerald Dworkin defined paternalism as “the interference with a person’s liberty of action justified by reasons referring exclusively to the welfare, good, happiness, needs, interests or values of the person being coerced.” The idea of “protection” or more specifically, “patient protection,” in the United States is exemplified by the paternalistic tendencies of our country. For example, the field of Social Work in the United States is defined by a core set of values that strive to protect the vulnerable human beings of our community. See Code of Ethics of the National Association of Social Workers. Retrieval at <http://www.naswdc.org/pubs/code/code.asp>. According to the National Association of Social Workers (NASW) Code of Ethics, the values and ethical principles of Social Work are as follows: service, social justice, dignity and worth of the person, importance of human relationships, integrity and competence. To separate the name of the profession into two separate words, “social” and “work” is to recognize the purpose of the vocation—to service the social, the individuals of a society. It is important to note, however, that social workers do not spend hours servicing the wealthy or adept, but rather those individuals who are vulnerable, such as the poor, sick, aged, innocent (children), and disadvantaged. When integrating paternalism and social work, there are in fact elements of paternalism that contradict the value system of social work. A key goal of social work is to empower vulnerable clients. The idea of empowerment in the field of social work is related to providing clients with autonomy, a concept which opposes paternalism. See Kenneth R. Greene, *Paternalism in Supervisory Relationships*, 21 *Social Thought* 17,21 (2002) (“Social work practitioners often find themselves in ethical dilemmas between respecting the self-determination and autonomy of clients and promoting their welfare”).

¹See Restatement (Third) of Torts: General Principles § 4(1999) (stating that “reasonable care” “is the same as conduct that is “reasonable,” conduct that avoids creating an “unreasonable risk of harm,” or conduct that displays “reasonable prudence”).

¹See Rakel Meir, *The Link Between Quality and Medical Management: Physician Tiering and Other Initiatives*, 4 *J. HEALTH & LIFE SCI. L.* 36 (2011) (“It is possible that given the focus on accountable care organizations and bundled payments, now incorporated in the Patient Protection and Affordable Care Act of 2010 (PPACA), greater amounts of data and emphasis on patient outcomes will become more readily available”). See also the Patient Protection and Affordable Care Act 42 U.S.C. §§ 2717, 3002, 3011 et al. (2010) (“The Patient Protection and Affordable Care Act requires the Secretary to establish a national strategy for quality improvement in both Medicaid and the private healthcare sector”).

¹See the United States Code of Federal Regulations at the National Archives and Records Administration. Retrieval at: <http://www.gpoaccess.gov/cfr/>.

¹*Id.*

¹*Id.* 21 C.F.R. § 800.10-§ 800.20 (1982).

¹*Id.*

¹*Id.* 42 C.F.R. § 482.11-§ 482.13(1982).

¹*Id.*

¹*Id.*

¹*Id.*

¹*Id.*

¹*Id.*

¹*Id.* According to Chapter IV of title 42 of the Code of Federal Regulations, “patient’s rights” include the following mandates by physicians and hospitals:

“Notice of rights —(1) A hospital must inform each patient, or when appropriate, the patient’s representative (as allowed under State law), of the patient’s rights, in advance of furnishing or discontinuing patient care whenever possible. (2) The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. The hospital’s governing body must approve and be responsible for the effective operation of the grievance process and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee. The grievance process must include a mechanism for timely referral of patient concerns regarding quality of care or premature discharge to the appropriate Utilization and Quality Control Quality Improvement Organization.(3) The patient has the right to formulate advance directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives, in accordance with §489.100 of this part, §489.102 of this part (Requirements for providers), and §489.104 of this part.(4) The patient has the right to have a family member or representative of his or her choice and his or her own physician notified promptly of his or her admission to the hospital.(5) The patient has the right to receive care in a safe setting. (6) The patient has the right to be free from all forms of abuse or harassment. (7) The patient has the right to the confidentiality of his or her clinical records.”

¹See 42 C.F.R. § 482.21 (2003).

¹See 42 C.F.R. § 482.22 (1986).

¹See 42 C.F.R. § 482.23 (1986).

¹See 42 C.F.R. § 482.24 (1986).

¹See 42 C.F.R. § 482.25 (1986).

¹See 42 C.F.R. § 482.26 (1986).

¹See 42 C.F.R. § 482.27 (1992).

¹See 42 C.F.R. § 482.41 (1986).

¹See 42 C.F.R. § 482.42 (1986).

¹See 42 C.F.R. § 482.45 (1986).

¹See 42 C.F.R. § 482.51 (1986). The Code of Federal Regulations outlines extensively the regulations for surgical procedures in U.S. hospitals. The Code states the following provisions:

“(1) The operating rooms must be supervised by an experienced registered nurse or a doctor of medicine or osteopathy.(2) Licensed practical nurses (LPNs) and surgical technologists (operating room technicians) may serve as “scrub nurses” under the supervision of a registered nurse. (3) Qualified registered nurses may perform circulating duties in the operating room. In accordance with applicable State laws and approved medical staff policies and procedures, LPNs and surgical technologists may assist in circulatory duties under the supervision of a qualified registered nurse who is immediately available to respond to emergencies. (4) Surgical privileges must be delineated for all practitioners performing surgery in accordance with the competencies of each practitioner. The surgical service must maintain a roster of practitioners specifying the surgical privileges of each practitioner.”

Further, the Code requires the following prior to any surgery:

“(i) A medical history and physical examination must be completed and documented no more than 30 days before or 24 hours after admission or registration. (ii) An updated examination of the patient, including any changes in the patient’s condition, must be completed and documented within 24 hours after admission or registration when the medical history and physical examination are completed within 30 days before admission or registration.”

¹See the U.S. Department of Health and Human Services, U.S. Food and Drug Administration. Retrievable
at:

<http://www.fda.gov/RegulatoryInformation/Legislation/ucm148717.htm>.

¹*Id.* (“The HIPAA Privacy Rule provides federal protections for personal health information held by covered entities and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of personal health information needed for patient care and other important purposes.”).

¹*Id.* (“The Patient Safety and Quality Improvement Act signifies the Federal Government’s commitment to fostering a culture of patient safety. It creates Patient Safety Organizations (PSOs) to collect, aggregate, and analyze confidential information reported by health care providers. Currently, patient safety improvement efforts are hampered by the fear of discovery of peer deliberations, resulting in under-reporting of

events and an inability to aggregate sufficient patient safety event data for analysis. By analyzing patient safety event information, PSOs will be able to identify patterns of failures and propose measures to eliminate patient safety risks and hazards”).

¹ See *Ballentine's Law Dictionary*. (defining “negligence” as the following:

“1. A word of broad significance which may not readily be defined with accuracy. *Jamison v Encarnacion*, 281 US 635, 74 L Ed 1082, 50 S Ct 440. The lack of due diligence or care. A wrong characterized by the absence of a positive intent to inflict injury but from which injury nevertheless results. *Haser v Maryland Casualty Co.* 78 ND 893, 53 NW2d 508, 33 ALR 1018. In the legal sense, a violation of the duty to use care. *Fort Smith Gas Co. v Cloud (CA8 Ark)* 75 F2d 413, 97 ALR 833. The failure to perform an established duty which proximately causes injury to the plaintiff. *Northern Indiana Transit v Burk*, 228 Ind 162, 89 NE2d 905, 17 ALR2d 572. The failure to exercise the degree of care demanded by the circumstances; the want of that care which the law prescribes under the particular circumstances existing at the time of the act or omission which is involved. The omission to do something which a reasonable man, guided by those considerations which ordinarily regulate human affairs, would do, or doing something which a prudent and reasonable man would not do. 38 Am J1st Negl § 2. More particularly, the failure of one owing a duty to another to do what a reasonable and prudent person would ordinarily have done under the circumstances, or doing what such person would not have done, which omission or commission is the proximate cause of injury to the other. 2. A negligent act is one from which an ordinarily prudent person would foresee such an appreciable risk of harm to others as to cause him not to do the act, or to do it in a more careful manner”).

¹See *Black's Law Dictionary* 400 (Pocket ed. 1996) (“Specifically, professional negligence is defined as “a tort that arises when a doctor violates the standard of care owed to a patient and the patient is injured as a result”). See also 1 Am. Jur. 2d *Abatement, Survival, and Revival* § 83 (Regarding medical malpractice: “Although under the common law an action for a personal injury caused by the negligence or lack of skill of a surgeon does not survive the death of either party, there is authority to the contrary. Such a cause of action may survive under a survival statute, or may be construed as an action for breach of a contract, which survives under state law. If a patient asserts the right to recover for damages for medical malpractice by filing a claim prior to death, the suit creates a property right that can be maintained by a succession representative”). See also Jennifer Brown-Cranstoun, *Kringen v. Boslough and Saint Vincent Hospital: A New Trend for Healthcare Professionals Who Treat Victims of Domestic Violence?* 33 JOURNAL OF HEALTH LAW 629 (2000) (“The essential element of a cause of action for medical malpractice is the physician-patient relationship. This special relationship gives rise to a duty of care. This duty of care involves matters of science or art requiring special skill or knowledge not ordinarily possessed by the average person. The breach of these professional duties of skill and care that results in injury to the patient constitutes actionable malpractice”).

¹See Karen G. Seimetz, *Medical Staff Membership Decisions: Judicial Intervention*, U. ILL. L. REV. 473 (1985).

¹*Id.*

¹*Supra* note 22.

¹See Brian M. Peters and Robin Locke Nagele, *Promoting Quality Care and Patient Safety: The Case for Abandoning the Joint Commission's “Self-Governing” Medical Staff Paradigm*, 14 MICH. ST. J. MED. & LAW 313, 321 (2010).

¹See Heather T. Williams, *Fighting Fire with Fire: Reforming the Health Care System Through a Market-Based Approach to Medical Tourism*, 89 N.C.L. REV. 607, 632 (2011).

¹ In India, medical regulations exist to provide patients with a “standard of care” by physicians. See *Jacob Mathew v. State of Punjab & Anr.* The Supreme Court of India, Criminal Appellate Jurisdiction 144-145 (2004). The Supreme Court of India held that standard of care refers to “the skill which he professes to possess shall be exercised and exercised with reasonable degree of care and caution.” See also *Bolam v. Friern Hospital Management Committee* 2 All ER 118 (1957). *Bolam* established the *Bolam Rule*, which is used in India to assess the applied standard of care by physicians, and thus, whether or not a physician has acted negligibly. The *Bolam Rule* defines a physician's standard of care as follows:

“A professional man should command the corpus of knowledge which forms part of the professional equipment of the ordinary member of his profession. He should not lag behind other ordinary assiduous and intelligent members' of his profession in knowledge of new advances,

*discoveries and developments in his field. He should have such an awareness as an ordinarily competent practitioner would have of the deficiencies in his knowledge and the limitations on his skill. He 'should be' alert to the hazards and risks in any professional task he undertakes to the extent that other ordinarily competent members of the profession would be alert. He must bring to any professional task he undertakes no less expertise, skill and care than other ordinarily competent members of his profession would bring, but need bring no more. The standard is that of the reasonable average. The law does not require of a professional man that he be a paragon combining the qualities of polymath and prophet."*¹*Id.*

The Indian Supreme Court continued the discussion on medical negligence by stating that deviation from normal practice is not necessarily evidence of negligence. To establish liability on the basis of medical negligence, it must be shown 1) that there is a usual and normal practice; 2) that the defendant has not adopted it; and 3) that the course in fact adopted is one no professional man of ordinary skill would have taken had he been acting with ordinary care." Last, the Supreme Court of India noted that a medical practitioner is not liable to be held negligent simply because things went wrong "from mischance or misadventure or through an error of judgment in choosing one reasonable course of treatment in preference to another." *Id.*

¹*See* The Medical Council of India, retrievable at:<http://www.mciindia.org/>. ("The prime object of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. Who- so-ever chooses his profession, assumes the obligation to conduct himself in accordance with its ideals. A physician should be an upright man, instructed in the art of healings. He shall keep himself pure in character and be diligent in caring for the sick; he should be modest, sober, patient, prompt in discharging his duty without anxiety; conducting himself with propriety in his profession and in all the actions of his life").

¹*Id.* The Medical Council of India (MCI) was the statutory body for maintenance of uniform and high standards of medical education in India. The Council grants recognition of medical qualifications, gives accreditation to medical colleges, grants registration to medical practitioners, and monitors medical practice in India.

¹*Infra* note 63.

¹ The Government of India has essentially dissolved the Medical Council of India. *See* The Indian Medical Council (Amendment) Act 2010, published by the Ministry of Law and Justice, Legislative Department of New Delhi. The Act states the following:

"On and from the date of commencement of the Indian medical Council (Amendment) Act, 2010, the Council shall stand superseded and the President, Vice President and other members of the Council shall vacate their offices and shall have no claim for any compensation, whatsoever. The Council shall be reconstituted in accordance with the provisions of section 3 within a period of one year from the date of supersession of the Council. The Central Government shall, by notification in the Official Gazette, constitute the Board of Governors which shall consist of not more than seven personas as its members, who shall be persons of eminence and unimpeachable integrity in the fields of medicine and medical education. The decision of the Central Government whether a question is a matter of policy or not shall be final: The Indian Medical Council (Amendment) Ordinance, 2010 is hereby repealed."

See also Roger Collier, *Dark Days for Medical Profession in India*, Canadian Medical Association Journal, (2010). Collier notes that "On Apr. 22, Desai and three colleagues were arrested by India's Central Bureau of Investigation for their alleged roles in a 20-million-rupee (\$440 000) bribery case. They are alleged to have accepted a bribe from a medical college that wanted to increase enrolment despite lacking capacity for more students. At the time of his arrest, Desai was the president of the MCI. He subsequently resigned both the presidency and his position as head of the urology department at the B.J. Medical College in Ahmedabad." For further discussion on alleged corruption of the Medical Council of India, *see* Sunil K. Pandya, *Medical Council of India: The Rot Within*, 6 INDIAN J MED ETHICS 125 (2009).

¹*See* the Medical Council of India, (Professional, Etiquette, and Ethics) Regulations, 2009. At

<http://www.mciindia.org/RulesandRegulations/CodeofMedicalEthicsRegulations2002.aspx>

¹*Supra* note 60.

¹*Supra* note 63.

¹ See the Indian Medical Council Act (1956), *supra* note 60. The Indian Medical Council Act (1956) outlines the regulations for practitioners of medicine to be constituted under law by the State Medical Register. The Act also notes the right of inspection of medical institutions, including the inspection of the adequacy of staff, equipment, accommodation, and training facilities.

¹*Supra* note 60.

¹*Id.*

¹*Id.*

¹*Id.*

¹*See* The Indian Medical Association (IMA). Retrieval at: <http://www.ima-india.org/>.

¹*Id.*

¹*See* The Clinical Establishments (Registration and Regulation) Rules, 2010, *supra* note 72.

¹*Id.*

¹*Id.*

¹*Id.*

¹*See* The Transplantation of Human Organs Act (1994), Ministry of Law, Justice and Company Affairs (Legislative Department of India), NewDehli. Retrieval at: <http://www.medindia.net/>.

¹*Id.*

¹*See* <http://www.indianhealthcare.in/>

¹*Id.*

¹ See The Joint Commission International, Accreditation and Certification Process, <http://www.jointcommissioninternational.org/Accreditation-and-Certification-Process/>

¹*See* Cortez, *infra* note 85 at 84.

¹*See* Paul Hunt, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Health*, United Nations General Assembly, (2010), retrieval at: http://www.essex.ac.uk/human_rights_centre/research/rth/reports.aspx.

Hunt describes India's private-sector of healthcare as unregulated. Hunt commends that India's health workforce is in crisis because of lack of regulation; the author states: "Despite (or because of) its enormous power, India's private health sector is largely unregulated. Moreover, there are few signs that it is willing to adequately regulate itself. In these circumstances, the Government has a legally binding responsibility to introduce, as a matter of urgency, an appropriate, effective regulatory framework for the private health sector, including public-private partnerships." *See also* the U.S. Department of State, retrieval at <http://travel.state.gov/>. ("Medical tourism is a rapidly growing industry. Companies offering vacation packages bundled with medical consultations and financing options provide direct-to-consumer advertising over the internet. Such medical packages often claim to provide high quality care, but the quality of health care in India is highly variable. People seeking health care in India should understand that medical systems operate differently from those in the United States and are not subject to the same rules and regulations"). Last, *see* Nicolas P. Terry, *The Politics of Health Law: Under-Regulated Health Care Phenomena in a Flat World: Medical Tourism and Outsourcing*, 29 W. ENG. L. REV. 421, 454-55 (2007). Terry discusses the quality of medical care and inspection in India:

"The difference, however, is in the level of inspection and scrutiny. For example, serious questions have been raised about the adequacy of the medical infrastructure in India to support quality trials, the training of Indian researchers, the quantity and quality of Indian IRBs, and the local ethical standards (including informed-consent deficiencies) applied in dealing with subjects. In a 2001 report, which was triggered by The Body Hunters and confirmed the dramatic increase in the number of offshore clinical trials, the U.S. Department of Health and Human Services' Office of Inspector General (OIG) found key differences in the scrutiny of offshore trials. Specifically, the OIG noted deficiencies in the FDA's tracking of non-IND trials, the absence of FDA inspection of foreign IRBs, the lack of any "attestation" requirement for non-IND investigators and a failure to enforce attestation for foreign-based INDs, and generalized staffing, political, and logistical deficiencies that challenged rigorous FDA inspection of foreign research sites."

¹*See* the National Board for Hospitals and Healthcare Providers (NABH). Retrieved at: http://www.indianhealthcare.in/index.php?option=com_content&view=article&catid=192&id=173. ("In India the health care delivery system has remained largely fragmented and

uncontrolled. The focus of accreditation is on continuous improvement in the organizational and clinical performance of health services, not just the achievement of a certificate or award or merely assuring compliance with minimum acceptable standards”). *But see* Nathan Cortez, *Patients Without Borders: The Emerging Global Market for Patients and the Evolution of Modern Health Care*, 83 IND. L.J. 71, 84 (2008). (“Hospitals around the world are seeking JCI accreditation, which may help them apply for coverage from U.S. insurers. Thus, patients that leave the United States for medical care increasingly find hospitals that meet U.S. standard”). Cortez assumes that because many medical tourist locations rely on an accreditation system approved by the United States, those accredited medical facilities maintain a standard of excellence. However, Cortez later contradicts his argument when stating: “accreditation generally signals that a facility meets minimum standards of competence and quality.” While the JCI accreditation system approves those hospitals that meet “minimal” safety standards, Cortez asserts that JCI accreditation is substantial evidence to deem a foreign hospital safe for a major surgical procedure. Cortez fails to address those circumstances of a hospital that deem the facility “minimally safe” instead of “extremely safe.” The accreditation system’s standards can be ambiguous, and relying on these standards may lead to a misconstrued representation of the safety of hospitals in both the United States and India. See also Meryl Davids Landau, *A Guide to Getting Good Care*, 147 U.S. NEWS & WORLD REPORT 47 (2010). Retrieved from LEXIS (“Still, minimal is often a far cry from excellent, cautions Charles Kilo, chief medical officer at the Oregon Health and Science University and an expert on healthcare improvement. Critics also charge that to ensure enough hospitals will qualify, certifying groups typically set the bar so that the process weeds out awful institutions but does not truly signify top quality”).

¹See Angeleque Parsiyar, *Medical Tourism: The Commodification of Health Care in Latin America*, 15 LAW & BUS. REV. AM. 379, 393 (2009) (“Further, governmental safeguards ensuring quality of care are generally lacking, with the closest thing being accreditation by the JCI, which causes many people to question the quality of care received abroad. The level of standardization that exists in the United States does not exist in the rest of the world, and there is currently not a sufficient system in place to guide people through determining where good medical care exists”).

¹*Supra* note 57.

¹See <http://travel.state.gov/>

¹*Supra* note 57 at 315.

¹See *supra* notes 37-48 for a detailed a more detailed outline of U.S. medical safety regulations regarding patient rights and surgical procedures.

¹*Supra* note 20.

¹*Supra* note 64.

¹*Id.*

¹*Id.*

¹*Id.*

¹*Id.*

¹*Id.*

¹*Id.*

¹*Id.*

¹*Supra* note 20.

¹See Kerrie S. Howze, *Medical Tourism: Symptom or Cure?* 41 GA. L. REV. 1013 (2007).

¹*Id.* at 1030. (“Medical tourism company IndUSHealth informs patients that ‘in instances where medical mistakes or malpractice is believed to have occurred, patients have the right to seek redress in the Indian court system similar to the procedure followed here in the U.S.’ While the Indian court system may be similar to the U.S. system, the redress for medical negligence could not be more dissimilar. In the United States, damage awards for medical negligence can be in the millions, whereas in India, medical negligence claims are rare and multimillion dollar awards are nonexistent”).

¹*Supra* note 52.

¹See Kenneth C. Chessick and Matthew D. Robinson, *Medical Negligence Litigation is Not the Problem*, 26 N. ILL. U. L. REV. 563 (2006) (discussing the prevalence of medical negligence litigation and the controversies surrounding the rise in medical negligence litigation).

¹*Supra* note 59.

¹ See Williams, *supra* note 58 at 646-47. (“Furthermore, malpractice law in other nations is not as protective of patients, or even as clearly defined, as U.S. medical malpractice law. Foreign jurisdictions may be reluctant to recognize even valid malpractice claims by foreign patients against domestic providers because doing so would create unfavorable precedent encouraging similar suits and potentially harm their medical tourism industry”).

¹ There are several cultural differences between the United States and medical tourist hotspots regarding the practice of medicine. For example, see Barrett P. Brenton & Helen E. Sheehan, *The Annals of the American Academy of Political and Social Science: Preface*, 583 ANNALS 6 (2002). Brenton and Sheehan describe the practice of medicine among cultures other than that of the United States. In Eastern cultures, such as Asia and India, medicine often falls into the category of indigenous, or “folk medicine.” In India specifically, “some cases, such as Unani medicine and homeopathy, long history and interaction with other medical systems, such as Ayurveda in India, have led to their being considered indigenous Indian medical systems.” Still today in India, a large hotspot for medical tourists from the United States, a chief contributory factor for “hospitals of excellence” is that of “total well being.” See *supra* note 2, “Incredible India!” page 20. The brochure reads:

“In Ayurvedic teaching, three vital forces govern the body, and combine to create an individual’s physiological make-up: vata, linked to the wind, governs movement and relates to the nervous system; pitta, the force of the sun, rules digestion and metabolism; and kapha, likened to the moon, governs the body’s organs...In contrast to the Western approach to medicine, Ayurveda works to remove the cause of illness, not just treat the disease, by suggesting lifestyle and nutritional guidelines to reduce the excessive dosha. Though Ayurveda is found across the country, its heart lays deep in the south, in Kerala, where there’s plenty of choice, whatever your needs. So close your eyes, and cast your mind east. The spirit of India lives on.”

See also Gluck, *supra* note 8 at 471. Gluck highlights the stigma surrounding Ayurvedic medicine in the United States due to lack of standardization: “The lack of standardization of Ayurvedic treatments is a major reason why Ayurvedic doctors cannot practice medicine in the United States. Thus, patients have the unique opportunity to pursue this combination therapy in India, where such limitations on the practice of medicine by Ayurvedic doctors do not exist.”

¹ *Supra* note 12.

¹ See Glenn Cohen, *Protecting Patients with Passports: Medical Tourism and the Patient-Protective Argument*, 95 IOWA L. REV. 1467, 1484 (2010).

¹ Specifically, patients do not have the training to recognize medical deceit. See *id.* at 1494. (“Patients often cannot assess the quality of care they receive, either before or after it is delivered. In theory, patients can attempt to correct their information deficiencies by acquiring the necessary information. Doing so may be very costly, however. It is costly to collect raw data and to create and disseminate meaningful quality measures. It is also costly to use quality measures: patients must take the time to read through them and assess their relevance to their decision-making. Problems of bounded rationality may prevent patients from using data appropriately. If the perceived costs of obtaining and using data exceed the perceived benefits from doing so, individual patients will likely decline to seek out this information”).

¹ *Infra* note 129.

¹ See the Federal Trade Commission Act 15 U.S.C.S. §§ 45 (2011).

¹ *Id.*

¹ See Robert Sprague and Mary Ellen Wells, *Regulating Online Buzz Marketing: Untangling a Web of Deceit*, 47 Am. Bus. L.J. 415, 425 (2010).

¹ *Supra* note 112.

¹ *Supra* note 114, at 425-26.

¹ *Supra* note 12.

¹ *Id.*

¹ *Id.*

¹ *Supra* note 114 at 427.

¹ This judicial determination was jumpstarted by the Supreme Court case, *Central Hudson Gas & Electric Corp. v. Public Service Comm’n*, 447 U.S. 557 (1980). *Central Hudson* established the *Central Hudson* test, a four-prong criteria which determines the constitutionality of government regulation on commercial speech.

¹ *Id.*

¹ American individualism is rooted in the ideas of atomism and self-determination. For discussion on atomism, see Andrea Giampetro-Meyer, et. al., *Advancing the Rights of Poor and Working-Class Women in an Individualistic Culture*, 2 LOYOLA POVERTY L.J. 41 (1996) (explaining that a fundamental assumption of atomism is that human beings are “independent disembodied entities”). The idea of atomism assumes that human beings are separate from the society, and thus, society’s external influences. Because atomistic thought proclaims a disconnect between the individual and societal influences, atomistic thought also assumes that the individual creates their own reality; an atomist assumes that the conditions and circumstances surrounding a human being are caused only by that human being his/herself. Essentially, humans self-determine their realities. The understanding of these assumptions of atomism and self-determination are of the essence to understanding individualism as a dominant ideology in the United States.

Although individualism predominates American culture, see Ernest Wallwork, *Ethical Analysis of Research Partnerships with Communities*, 18 KENNEDY INST. J. 57, 58 (2008) (defining the individual as “embedded in narrative traditions, institutions, roles, shared goals, and environments (natural and social), without which human beings can neither survive nor flourish morally”). While the United States bleeds individualism, Wallwork commends that Americans can also have characteristics of collectivism. Wallwork’s ontological assumption about human nature, mentioned above, reflects the fundamental assumption of collectivism. To contradicting the root assumptions of individualism and collectivism, it is vital to note that while individualism characterizes the individual as atomistic and responsible for their own reality and state of being, collectivism characterizes the individual as tied to society; the collectivist commends that human beings are products of socialization and external influences.

¹ See Robert N. Bellah, et. al., *Habits of the Heart: Individualism and Commitment in American Life* 142(1985)(“We [Americans] believe in the dignity, indeed the sacredness, of the individual. Anything that would violate our right to think for ourselves, judge for ourselves, make our own decisions, live our lives as we see fit, is not only morally wrong, it is sacrilegious”).

¹ *Id.*

¹ *Infra* note 129.

¹ *Id.*

¹ *Supra* note 58.

¹ For a discussion on the inhibiting nature of America’s dependence on consumers to make “rational” decisions, a conversation that is pertinent to the ethicality of medical tourism, see Gil Siegal, *An Account of Collective Actions in Public Health*, 99 AM J PUBLIC HEALTH 1583 (2009). Siegal first addresses the popular American reliance on the economic “rational actor theory.” This theory states that individuals act as rational agents:

Economists have advanced the rational actor theory, in which each individual (satirically termed Homo Economicus) is expected to act as a rational agent using available information to maximize his or her own interests—pursuing wealth and well-being, avoiding suffering or unnecessary labor—all in accordance with his or her own predetermined and stable goals and utilities. Id.

After detailing the assumptions behind the rational actor theory, Siegal denounces the validity of these assumptions in his discussion of cognitive heuristics. Cognitive heuristics are the habitual cognitive methods individuals tend to use to solve a problem. Siegal commends that these cognitive heuristics inhibit the individual’s ability to think “rationally.” For example, one cognitive heuristic that immeasurably affects consumer decisions regarding medical procedures is the “framing effect;” the framing effect occurs when:

“...decisions are irrationally influenced by modes of presentation and context—e.g., discussing a 10% chance of failure in a medical procedure is perceived differently from discussing a 90% chance of success in the same procedure. Id.

For further elaboration on pervasive human cognitive heuristics, see also Gregory Mitchell, *Mapping Evidence Law*, MICH. ST. L. REV. 1065 (2003). Mitchell outlines several cognitive heuristics including the conjunction fallacy, outcome bias, confirmation bias and the framing effect; the author reveals the destructive nature of these entities to rational consumer decisions.

The economic assumption outlined above, that consumers are rational thinkers who are capable of making decisions free of logical shortcomings, is further epitomized in P. Gretchen Browne's, *The Conversation Between Economic Man and the Psychological Character: Ontology and Feminist Economics*, *Western Social Science Conference* (1996) (discussing the rational decision-making process of Robinson Crusoe, the "economic man"). Crusoe, a popular literary character invented in the 18th century, is believed to be a one-man model of the ideal rational decision-maker; Because Crusoe is stranded on an island, free of any societal influences, the character is portrayed as a being whose decisions are carefully calculated; Crusoe meticulously weighs all potential costs and benefits. Robinson Crusoe embodies the theoretical "economic man" because he is a man of rationality and individualism- he is economically ideal because he is free of damaging cognitive heuristics.

¹See Anuj K. Shah and Daniel M. Oppenheimer, *Heuristics Made Easy: An Effort-Reduction Framework*, 134 *PSYCHOLOGICAL BULLETIN* 207 (2008).

¹*Id.*

¹See Amir N. Licht, *The Maximands of Corporate Governance: A Theory of Values and Cognitive Style*, 29 *DEL. J. CORP. L.* 649, 669 (2004).

¹*Id.*

¹See Leigh Turner, *First World Health Care at Third World Prices: Globalization, Bioethics and Medical Tourism*, 2 *BioSocieties* 303, 318 (2007) (citing the death of a twenty-three-year-old woman who suffered mycobacterial infections after receiving cosmetic surgery in the Dominican Republic, as well as "substandard tissue matching in organ transplants that occurred in Pakistan and India").

¹See Cortez, *supra* note 85 at 74 and 91. ("Most foreign providers and brokers market their services on the Internet, and a sampling of these sites shows they can be aggressive and potentially misleading. Sites include patient testimonials, breezy descriptions of idyllic sightseeing tours, and even quality comparisons that disparage U.S. providers.... [One] broker assures patients who may be concerned about medical malpractice that they "have the right to seek redress in the Indian court system similar to the procedure followed here in the U.S. [sic],' a claim that is woefully misleading"). See also Roy G. Sece, Jr., *Medical Tourism: Protecting Patients from Conflicts of Interest in Broker's Fees Paid by Foreign Providers*, 6 *J. HEALTH & BIOMED. L.* 1 (2010) "The foreign providers advertise through the internet and various print and broadcast media, which allows a patient not to have to use a broker. There are, however, almost two million entries under "medical tourism" in Google and patients often work through medical tourism brokers rather than attempt to find their way directly to a foreign provider").

¹See Steven J. Katz, et. al., *From Policy To Patients and Back: Surgical Treatment Decision Making For Patients With Breast Cancer; Information has never been more widely available, and treatment decision making has never been more complicated*, *Health Affairs* (2007) (explaining the procedural complexities of a single medical diagnosis, such as breast cancer). Katz explains that the severe and rapid nature of Katz necessitates a multifaceted attack:

"Patients are confronted with a life-threatening disease that requires many treatment decisions related to surgery, radiation, chemotherapy, and hormone therapy, with widely ranging effects on themselves and their families. These myriad decisions are often made quickly in consultation with many physicians whom patients are meeting for the first time."

After elaborating on the complex nature of breast cancer treatment, Katz commends that these medical complexities inhibit the consumer's ability to fully comprehend the medical terminology:

*"There are wide variations in patients' ability and willingness to absorb complex clinical information, particularly competing risk information, is a challenge for many physicians. Information has never been more available. At the same time, treatment decision making has never been more complicated. Some patients arrive for their first consultation visit with a family member armed with information from Internet-based sources; others arrive alone with little preparation."**Id.*

But see Mitchell S. Berger, *A Tale of Six Implants: The Perez v. Wyeth Laboratories Norplant Case and the Applicability of the Learned Intermediary Doctrine to Direct-to-Consumer Drug Promotion*, 55 *FOOD DRUG L. J.* 525, 550 (2000) (revealing that some individuals argue that explaining medical nuances to consumers is "unnecessary"). Berger states that "on the other hand defenders (of the case) respond that attempting to render complex medical language into simple terms risks "both dilution and unnecessary hysteria").

¹Baccus v. State of Louisiana, 232 U.S. 334 (1914) (displaying an instance where an individual falsely advertised “medical” products to citizens on the street). The plaintiff sought to repeal a past court decision that banned him from the “freedom to peddle medical entities” as his vocation. The plaintiff in this case sought repeal from a court decision from the Third Judicial District Court, Parish of Claiborne, state of Louisiana. The judge in the District Court decision adhered to a state statute that banned the practice of itinerant vending of “any drug, nostrum, ointment or application of any kind intended for the treatment of disease or injury,” to penalize the plaintiff in question. While the plaintiff in the case felt they had the right to freely advertise their “medical” product to community members on the street, the court denied the plaintiff’s request. The Supreme Court decided that the Third Judicial District Court made an acceptable decision to regulate the marketing of the peddler/ itinerant vendor, as the individual was selling a medical product that belonged to a previous patent/ proprietor: Rawleigh Medical Co. of the State of Illinois. In addition, the Court ruled under the assumption that drugs or medical compounds are within the power of the government to regulate.

¹ For a discussion on the “luxury factor” of medical tourism, see *supra* note 58 at 623-24.

¹See Chester N. Mitchell, *Deregulating Mandatory Medical Prescription*, 12 AM. J. L. AND MED. 207, 212 (1986) (“The rise of scientific medicine in the late 1800’s is partially responsible for the medical profession’s special success”). See also Olli S. Miettinen, *Evidence-based medicine, case-based medicine; scientific medicine, quasi-scientific medicine. Commentary on Tonelli* (2006), *Integrating evidence into clinical practice: an alternative to evidence-based approaches*, 12 JOURNAL OF EVALUATION IN CLINICAL PRACTICE, 248, 260 (2006), for a discussion on “evidence-based medicine.” Miettinen highlights the Western understanding of “evidence-based medicine” as “empirical evidence, derived from formal and systematic clinical research.” In contrast to the standard western assumptions about evidence-based medicine, Miettinen asserts that medical decisions are instead influenced by values, and personal preferences towards a treatment and patient.

¹See Miettinen, *id.* at 261. The author commends that in the case of scientific medicine, the phrase “scientific” refers to “a commitment to reasoning that is rigorous and explicit.” Miettinen then critiques this common interpretation of scientific medicine by stating that scientific medicine is instead based on probability calculations:

“The knowledge base of scientific medicine thus is one of known probability functions – in practice ‘known’ to the physician’s computer and evaluated by the physician at the gnostic indicators’ realizations constituting the gnostic profile at hand.” *Id.*

¹But see George A. Taylor et. al., *Diagnostic Errors in Pediatric Radiology*, 41 PEDIATR.RADIOL. 327, 332(2011) (“attempts to be constantly vigilant and eliminate cognitive biases are neither possible nor desirable because many of the mental activities in which we engage are outside of conscious awareness and heuristics used in clinical medicine evolve because they yield better overall outcomes than more careful or rational approaches”).

¹See Lars Noah, *Medicine’s Epistemology: Mapping the Haphazard Diffusion of Knowledge in the Biomedical Community*, 44 ARIZ. L. REV. 373 (2002) (“I presume nobody will question the existence of a widespread popular delusion that every doctor is a man of science... As a matter of fact, the rank and file of doctors are no more scientific than their tailors” - George Bernard Shaw). See also McLean, *supra* note 2 at 150. (“For example, the medical community’s failure to routinely apply known scientific principles to patient care translates to a 20 percent incidence of misdiagnosis -- a figure that has remained unchanged for 70 years. The origin of misdiagnosis in treatment is sometimes due a physician’s lack of knowledge. More often, however, misdiagnosis can be traced to the financial incentives given to physicians”).

¹See McLean, *supra* note 2 at 151-52.

¹See The Indian Medical Association’s website, *supra* note 72. The current national President, Dr. Vinay Aggarwal, has posted a Presidential Address on the website which states the following:

“The first of these issues is the attempt by the Government of India to create a high arching body in place of medical council of India. This body will include other unrelated disciplines like engineering and management. It is not clear how this would help in shaping future doctors of India... Existing provisions of the Indian Medical council Act 1956 confer enough powers on Government of India in the affairs of MCI. It nominates 37 members directly and in consultation with state Governments. No one can establish a medical college or open a new

course or increase admission capacity without explicit permission from Government of India. Central Government directly controls the post graduate medical education by nominating six out of nine members. By subjugating the MCI on which it already has adequate powers, the Government has converted it into another Government department. The Government in its wisdom has made its directives binding on MCI. There is no justification in robbing MCI of its autonomous character.”

This Presidential Address was posted in response to the Central Government of India’s removal of the Medical Council of India due to fraud and corruption by the President of the Medical Council of India. See *supra* note 63 regarding the arrest of the President of the Medical Council of India.

¹See Linda T. Kohn et. al., *To Err is Human: Building a Safer Health System*, Nat’l Acad. Press (2000).

ⁱSee Christine Lee, *Just What the Doctor Ordered. Medical Tourism*, MONASH BUS.RW. 43 (2007) (asserting that it is “easier” to travel to emerging economies with cheaper medical costs).

ⁱⁱSee the brochure titled “*Incredible India! The Global Healthcare Destination*,” available at http://www.incredibleindia.org/newsite/cms_page.asp?pageid=492. Directly above the link for this brochure are several links for trip planning and “experiencing India.” See also Thomas R. McLean, *Shaping a New Direction for law and Medicine: An International Debate on Culture, Disaster, Biotechnology and Public Health: Article: Telemedicine and the Commoditization of Medical Services*, 10 DEPAUL J. HEALTH CARE L. 131, 162 (2007) (“In particular, medical tourism, which combines a vacation with medical treatment, is growing at a staggering pace”). For a discussion on the marketing technique of medical tourism which offers a “getaway vacation,” See *The Globalization of Health Care: Can Medical Tourism Reduce Health Care Costs?: Hearing Before the Senate Special Committee on Aging*, 109th Cong. (2006). (statement of Bruce Cunningham, M.D., M.S., President, American Society of Plastic Surgeons) (“Aside from the qualifications of the physician, Cunningham raised concerns about marketing practices of medical tourism as potentially luring patients abroad under the guise of a medical vacation. Cunningham is concerned that due to the combination of the low cost and marketing strategies that promote the trips as “medical vacations,” patients may devalue the precautions that should be taken before and after surgery and may fail to consider the risks of the surgery altogether”).

ⁱⁱⁱ Any reference to a woman named “Ingrid” and a case of medical tourism is purely coincidental, as the name of the woman and instance of medical tourism is fabricated.

^{iv}See google.com, with “cost of hip replacement surgery” entered into the search engine.

^vSee Mark S. Kopson, *Medical Tourism: Implications for Providers and Plans*, 3 HEALTH & LIFE SCI. L. 147 (2010) (“How one defines medical tourism is determined, frequently, by the impact of the phenomenon upon the individual crafting the definition. The definition can range from ‘no oversight, no regulatory apparatus . . . the wild west of medical care,’ to ‘travel[ing] to another country to receive medical, dental, and surgical care while at the same time receiving equal to or greater care than they would have in their own country . . . because of affordability, better access to care, or a higher level of quality of care’”).

^{vi}See Lee, *supra* note 1.

^{vii}See Lee, *supra* note 1. (“Whether it is for cheaper dental work in Thailand, heart surgery in India, or warm climate therapy in Monte Carlo, medical tourism is big business and getting bigger”). See also *India, Medi Tourism*, available at <http://indiameditourism.com/>. The medical advertisement claims that the “most popular treatments sought in India by medical tourists are alternative medicine, bone-marrow transplant, cardiac bypass, eye surgery and hip replacement. India is known in particular for heart surgery, hip resurfacing and other areas of advanced medicine.”

^{viii}See The Deloitte Center for Health Solutions, *infra* note 10. (“An estimated 750,000 U.S. citizens traveled engaged in medical tourism in the year 2007”). With vast price differentials between surgeries in the United States and India, it does not come as a shock that India is one of the most popular destinations for medical tourism. See also Elizabeth

Gluck, *Incredible [Accreditable] India: Trends in Hospital Accreditation Coexist with the Growth of Medical Tourism in India*, 1 ST. LOUIS U. J. HEALTH L. & POL'Y 459, 466 (2008) (explaining the cost difference for specific surgeries in the United States and in India). Gluck claims:

“Healthcare in India is less expensive than it is in the United States primarily due to the value of the American dollar in undeveloped countries. This price difference translates to medical procedures in India costing approximately one-fifth to one-tenth of the U.S. price. The cost of advanced surgeries performed in India is estimated to be ten to fifteen times less than anywhere else in the world. For example, a heart surgery that would cost \$ 30,000 in the United States costs approximately \$ 6,000 in India, and a bone marrow transplant with a price tag of \$ 250,000 in the United States would be billed at approximately \$ 26,000 in India. Knee replacement surgery in India costs approximately \$ 8,500, but, if performed in the United States, the same operation would cost approximately \$ 40,000.”

See also *The Globalization of Health Care: Can Medical Tourism Reduce Health Care Costs?*, *supra* note 2. (“For the Nation’s 46 million uninsured, traveling overseas for low-cost medical procedures, even with the added costs of travel and lodging, is now an understandable attractive option”).

^{ix}See Melissa B. Jacoby and Elizabeth Warren, *Beyond Hospital Misbehavior: An Alternative Account of Medical-Related Financial Distress*, 100 NW. U.L. REV. 535, 536 (2006) (“Long after a person recovers physically, illness and injury can have a significant financial impact on individuals and their families. In the past several years, the news media have given front-page attention to the money side of medical problems. Featured stories described how big hospital bills turn families’ lives upside down, sometimes costing them their homes, their credit ratings, access to their bank accounts, and occasionally even their liberty”).

^xSee Kopson, *supra* note 5. Kopson’s argument provides insight on the contributing factors of medical tourism. The author provides evidence from research included in the *Wall Street Journal* that claims rapidly rising healthcare costs are one of the primary contributors to the increasing popularity of medical tourism; specifically the “percentage of U.S. residents lacking any healthcare insurance, the decreasing percentage of those with private healthcare insurance, and the increasing enrollment in high-deductible plans.” See also The Deloitte Center for Health Solutions, *2009 Survey of Health Care Consumers: Key Findings, Strategic Implications*, available at: www.deloitte.com/us_chs_2009SurveyHealthConsumers_March2009.pdf. The study provides several statistics, including the following:

Most (94%) believe that health care costs are a threat to their personal financial security (regardless of the insurance they have/don’t have or their health status). Over half (52%) believe that 50% or more of the dollars spent on health care in the U.S. are wasted.

^{xi}See Vadim Schick, *Data Privacy Concerns for U.S. Healthcare Enterprises’ Overseas Ventures*, 4 J. HEALTH & LIFE SCI. L. 173 (2011) (“For example, India’s medical tourism sector is expected to grow 30 percent annually from 2009 to 2015”).

^{xii}See *MedRetreat*, retrievable at <http://www.medretreat.com/>. The intermediary medical tourism business advertises as “America’s most trusted Medical Tourism company facilitating Medical Travel programs for North Americans seeking affordable surgery abroad.” It is the deceptive advertising of intermediary companies such as MedRetreat, which this paper asserts necessitates government regulation. One version of deceptive advertising is “asymmetric information,” or imperfect consumer information. This paper argues that the asymmetric information provided by American medical tourism businesses, such as *MedRetreat*, qualifies as “deceptive advertising” by FTC standards, and thus, should be regulated. For further discussion on asymmetrical information, see Shmuel I. Becher, *Asymmetric Information in Consumer Contracts: The Challenge That Is Yet To Be Made*, 45 AM. BUS. L.J. 723, 733 (2008) (discussing the controversies surrounding asymmetric information and consumers’ adherence to standard form contracts (SFC)). Becher states that: “generally speaking, the term “asymmetric information” refers to situations where parties are differently informed, with one party having access to better or more information than the other.”

Becher's definition of asymmetric information is applicable to consumer deceit via American medical tourism businesses. Sellers of medical tourism do not deprive consumers of material information regarding potential hazards abroad. This deprivation of consumer information inhibits consumer knowledge, creating an inequality between buyer and seller information.

For an in depth discussion about asymmetric information, see Facundo Bouzat, *Linking the Regulation of Business to Specific Market Structure: Deconstructing Three Cases to Demonstrate the Salience of "the Market" in Court Decisions*, 41 ACAD. LEGAL STUD. IN BUS. NAT'L PROC. 6 (2010).

^{xiii} See *Central Hudson Gas & Electric Corp. v. Public Service Comm'n*, 447 U.S. 557 (1980).

^{xiv} For a discussion on the importance of regulation, see Claire Cowart Haltom et. al, *Quality in Action: Paradigm for a Hospital Board-Driven Quality Program*, 4 J. HEALTH & LIFE SCI. L. 95 (2011). According to Haltom, "law affects social norms and, therefore, the behavior of directors, indirectly. Social norms are affected in part by external factors, such as judicial decisions, which in turn modify the behavior of directors by altering internal constraints. In the corporate world, the recent trend toward a higher standard of care for directors is a result of a shift in belief systems, which was itself partly a result of the "expressive effect of legal authorities, which clarified and added moral force to the social norm of care." Criminal prosecution and civil suits that targeted nonprofit directors have contributed to shifting the social norms toward a more conscientious board. Likewise, increased attention to patient safety and quality assurance is likely pervading hospital corporate culture. Some notable hospitals and their directors voluntarily and actively make patient safety an institutional priority."

^{xv} See M. J. Roberts et. al., *Getting Health Reform Right: A Guide to Improving Performance and Equity*, New York: Oxford University Press, 2004.

^{xvi} See The Deloitte Center for Health Solutions, *supra* note 10.

^{xvii} See Nicolas P. Terry, *Under-Regulated Health Care Phenomena in a Flat World: Medical Tourism and Outsourcing*, 29 W. NEW ENG. L. REV. 421, 470 (2007).

^{xviii} There are several U.S. landmark cases that discuss the meaning of "standard of care" or "duty of care" required by physicians. First, see Barbara Blackmond, *Health Law Developments: Health Law Year in Review: A Hospital Perspective*, 78 PA BAR ASSN. QUARTERLY 117 (2007). Blackmond discusses the Supreme Court of Pennsylvania case, *Thompson v. Nason Hospital*. In *Thompson*, the Court held that hospitals have a duty to prospective patients to exercise "reasonable care in the granting of medical staff appointment and clinical privileges and in ongoing performance oversight. Blackmond also cites *Curtsinger v. HCA, Inc.* In this case, the appellate court noted that the physician mandate of "duty of care" is "not limited to clinical competence, but also includes behavioral and ethical conduct." See also *Twitshell v. MacKay*, 434 N.Y.S.2d 516 (App. Div. 1980). The New York Supreme Court held that duty of care involves "matters of science or art requiring special skill or knowledge not ordinarily possessed by the average person. As case law reveals, the idea of "duty of care" or "standard of care" in the medical field is highly ambiguous. The pervasive ambiguity outlined above leads to multiple contrasting interpretations of the phrased "duty" and "care."

^{xix} The founding of the American Medical Association in 1847 sprung out of reaction to patient exploitation. See Robert Baker, *The American Medical Ethics Revolution: How the AMA's Code of Ethics Has Transformed Physicians' Relationships to Patients, Professionals, and Society*. Baltimore, MD: The Johns Hopkins University Press, xxiii (1999). Baker claims that the AMA was in reaction to a crisis over professionalism and professional standards; "from 1649 on, first colonies and later states sought to protect patients from fraudulent claims of medical expertise through a system that would permit patients to distinguish between trained and untrained medical practitioners." Baker further states that "never before had physicians voluntarily subscribed to a code of conduct this demanding. The specific obligations that the AMA physicians had unanimously imposed upon themselves far exceeded earlier rather vague only for America but also for the world."

^{xx} See the American Medical Association, *AMA's Code of Medical Ethics*. Retrievable at: <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page>.

^{xxi} See William H. Putnam, *Legal Research 3* (2nd Edition, 2010).

^{xxii}See the Joint Commission. Retrievable at <http://www.jointcommission.org/>.

^{xxiii}See *Code of Medical Ethics*, *supra* note 20.

^{xxiv}See Gerald Dworkin, *Paternalism*. 56 *The Monist* 65,66 (1972). Gerald Dworkin defined paternalism as “the interference with a person’s liberty of action justified by reasons referring exclusively to the welfare, good, happiness, needs, interests or values of the person being coerced.” The idea of “protection” or more specifically, “patient protection,” in the United States is exemplified by the paternalistic tendencies of our country. For example, the field of Social Work in the United States is defined by a core set of values that strive to protect the vulnerable human beings of our community. See Code of Ethics of the National Association of Social Workers. Retrievable at <http://www.naswdc.org/pubs/code/code.asp>. According to the National Association of Social Workers (NASW) Code of Ethics, the values and ethical principles of Social Work are as follows: service, social justice, dignity and worth of the person, importance of human relationships, integrity and competence. To separate the name of the profession into two separate words, “social” and “work” is to recognize the purpose of the vocation- to service the social, the individuals of a society. It is important to note, however, that social workers do not spend hours servicing the wealth or adept, but rather those individuals who are vulnerable, such as the poor, sick, aged, innocent (children), and disadvantaged. When integrating paternalism and social work, there are in fact elements of paternalism that contradict the value system of social work. A key goal of social work is to empower vulnerable clients. The idea of empowerment in the field of social work is related to providing clients with autonomy, a concept which opposes paternalism. See Kenneth R. Greene, *Paternalism in Supervisory Relationships*, 21 *Social Thought* 17,21 (2002) (“Social work practitioners often find themselves in ethical dilemmas between respecting the self-determination and autonomy of clients and promoting their welfare”).

^{xxv}See Restatement (Third) of Torts: General Principles § 4(1999) (stating that “reasonable care” “is the same as conduct that is “reasonable,” conduct that avoids creating an “unreasonable risk of harm,” or conduct that displays “reasonable prudence”).

^{xxvi}See Rake! Meir, *The Link Between Quality and Medical Management: Physician Tiering and Other Initiatives*, 4 *J. HEALTH & LIFE SCI. L.* 36 (2011) (“It is possible that given the focus on accountable care organizations and bundled payments, now incorporated in the Patient Protection and Accountable Care Act of 2010 (PPACA), greater amounts of data and emphasis on patient outcomes will become more readily available”). See also the Patient Protection and Affordable Care Act 42 U.S.C. §§ 2717, 3002, 3011 et al. (2010) (“The Patient Protection and Affordable Care Act requires the Secretary to establish a national strategy for quality improvement in both Medicaid and the private healthcare sector”).

^{xxvii}See the United States Code of Federal Regulations at the National Archives and Records Administration. Retrievable at: <http://www.gpoaccess.gov/cfr/>.

^{xxviii}*Id.*

^{xxix}*Id.* 21 C.F.R. § 800.10-§ 800.20 (1982).

^{xxx}*Id.*

^{xxxi}*Id.* 42 C.F.R. § 482.11-§ 482.13(1982).

^{xxxii}*Id.*

^{xxxiii}*Id.*

^{xxxiv}*Id.*

^{xxxv}*Id.*

^{xxxvi}*Id.*

^{xxxvii}*Id.* According to Chapter IV of title 42 of the Code of Federal Regulations, “patient’s rights” include the following mandates by physicians and hospitals:

“Notice of rights —(1) A hospital must inform each patient, or when appropriate, the patient’s representative (as allowed under State law), of the patient’s rights, in advance of furnishing or discontinuing patient care whenever possible. (2) The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. The hospital’s governing body must approve and be responsible for the effective operation of the grievance process and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee. The grievance process must include a mechanism for timely referral of patient concerns regarding quality of care or premature discharge to the appropriate Utilization

and Quality Control Quality Improvement Organization.(3) The patient has the right to formulate advance directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives, in accordance with §489.100 of this part, §489.102 of this part (Requirements for providers), and §489.104 of this part.(4) The patient has the right to have a family member or representative of his or her choice and his or her own physician notified promptly of his or her admission to the hospital.(5) The patient has the right to receive care in a safe setting. (6) The patient has the right to be free from all forms of abuse or harassment. (7) The patient has the right to the confidentiality of his or her clinical records.”

^{xxxviii} See 42 C.F.R. § 482.21 (2003).

^{xxxix} See 42 C.F.R. § 482.22 (1986).

^{xl} See 42 C.F.R. § 482.23 (1986).

^{xli} See 42 C.F.R. § 482.24 (1986).

^{xlii} See 42 C.F.R. § 482.25 (1986).

^{xliii} See 42 C.F.R. § 482.26 (1986).

^{xliv} See 42 C.F.R. § 482.27 (1992).

^{xliv} See 42 C.F.R. § 482.41 (1986).

^{xlvi} See 42 C.F.R. § 482.42 (1986).

^{xlvi} See 42 C.F.R. § 482.42 (1986).

^{xlvi} See 42 C.F.R. § 482.45 (1986).

^{xlviii} See 42 C.F.R. § 482.51 (1986). The Code of Federal Regulations outlines extensively the regulations for surgical procedures in U.S. hospitals. The Code states the following provisions:

“(1) The operating rooms must be supervised by an experienced registered nurse or a doctor of medicine or osteopathy.(2) Licensed practical nurses (LPNs) and surgical technologists (operating room technicians) may serve as “scrub nurses” under the supervision of a registered nurse. (3) Qualified registered nurses may perform circulating duties in the operating room. In accordance with applicable State laws and approved medical staff policies and procedures, LPNs and surgical technologists may assist in circulatory duties under the supervision of a qualified registered nurse who is immediately available to respond to emergencies. (4) Surgical privileges must be delineated for all practitioners performing surgery in accordance with the competencies of each practitioner. The surgical service must maintain a roster of practitioners specifying the surgical privileges of each practitioner.”

Further, the Code requires the following prior to any surgery:

“(i) A medical history and physical examination must be completed and documented no more than 30 days before or 24 hours after admission or registration. (ii) An updated examination of the patient, including any changes in the patient's condition, must be completed and documented within 24 hours after admission or registration when the medical history and physical examination are completed within 30 days before admission or registration.”

^{xlix} See the U.S. Department of Health and Human Services, U.S. Food and Drug Administration. Retrieval at:

<http://www.fda.gov/RegulatoryInformation/Legislation/ucm148717.htm>.

^l *Id.* (“The HIPAA Privacy Rule provides federal protections for personal health information held by covered entities and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of personal health information needed for patient care and other important purposes.”).

^{li} *Id.* (“The Patient Safety and Quality Improvement Act signifies the Federal Government's commitment to fostering a culture of patient safety. It creates Patient Safety Organizations (PSOs) to collect, aggregate, and analyze confidential information reported by health care providers. Currently, patient safety improvement efforts are hampered by the fear of discovery of peer deliberations, resulting in under-reporting of events and an inability to aggregate sufficient patient safety event data for analysis. By analyzing patient safety event information, PSOs will be able to identify patterns of failures and propose measures to eliminate patient safety risks and hazards”).

^{lii} See *Ballentine's Law Dictionary*. (defining “negligence” as the following:

“1. A word of broad significance which may not readily be defined with accuracy. *Jamison v Encarnacion*, 281 US 635, 74 L Ed 1082, 50 S Ct 440. The lack of due diligence or care. A wrong characterized by the absence of a positive intent to

inflict injury but from which injury nevertheless results. Haser v Maryland Casualty Co. 78 ND 893, 53 NW2d 508, 33 ALR 1018. In the legal sense, a violation of the duty to use care. Fort Smith Gas Co. v Cloud (CA8 Ark) 75 F2d 413, 97 ALR 833. The failure to perform an established duty which proximately causes injury to the plaintiff. Northern Indiana Transit v Burk, 228 Ind 162, 89 NE2d 905, 17 ALR2d 572. The failure to exercise the degree of care demanded by the circumstances; the want of that care which the law prescribes under the particular circumstances existing at the time of the act or omission which is involved. The omission to do something which a reasonable man, guided by those considerations which ordinarily regulate human affairs, would do, or doing something which a prudent and reasonable man would not do. 38 Am J1st Negl § 2. More particularly, the failure of one owing a duty to another to do what a reasonable and prudent person would ordinarily have done under the circumstances, or doing what such person would not have done, which omission or commission is the proximate cause of injury to the other. 2. A negligent act is one from which an ordinarily prudent person would foresee such an appreciable risk of harm to others as to cause him not to do the act, or to do it in a more careful manner”).

^{liii}See *Black's Law Dictionary* 400 (Pocket ed. 1996) (“Specifically, professional negligence is defined as “a tort that arises when a doctor violates the standard of care owed to a patient and the patient is injured as a result”). See also 1 Am. Jur. 2d *Abatement, Survival, and Revival* § 83 (Regarding medical malpractice: “Although under the common law an action for a personal injury caused by the negligence or lack of skill of a surgeon does not survive the death of either party, there is authority to the contrary. Such a cause of action may survive under a survival statute, or may be construed as an action for breach of a contract, which survives under state law. If a patient asserts the right to recover for damages for medical malpractice by filing a claim prior to death, the suit creates a property right that can be maintained by a succession representative”). See also Jennifer Brown-Cranstoun, *Kringen v. Boslough and Saint Vincent Hospital: A New Trend for Healthcare Professionals Who Treat Victims of Domestic Violence?* 33 JOURNAL OF HEALTH LAW 629 (2000) (“The essential element of a cause of action for medical malpractice is the physician-patient relationship. This special relationship gives rise to a duty of care. This duty of care involves matters of science or art requiring special skill or knowledge not ordinarily possessed by the average person. The breach of these professional duties of skill and care that results in injury to the patient constitutes actionable malpractice”).

^{liv}See Karen G. Seimetz, *Medical Staff Membership Decisions: Judicial Intervention*, U. ILL. L. REV. 473 (1985).

^{lv}*Id.*

^{lvi}*Supra* note 22.

^{lvii}See Brian M. Peters and Robin Locke Nagele, *Promoting Quality Care and Patient Safety: The Case for Abandoning the Joint Commission's "Self-Governing" Medical Staff Paradigm*, 14 MICH. ST. J. MED. & LAW 313, 321 (2010).

^{lviii}See Heather T. Williams, *Fighting Fire with Fire: Reforming the Health Care System Through a Market-Based Approach to Medical Tourism*, 89 N.C.L. REV. 607, 632 (2011).

^{lix} In India, medical regulations exist to provide patients with a “standard of care” by physicians. See *Jacob Mathew v. State of Punjab & Anr.* The Supreme Court of India, Criminal Appellate Jurisdiction 144-145 (2004). The Supreme Court of India held that standard of care refers to “the skill which he professes to possess shall be exercised and exercised with reasonable degree of care and caution.” See also *Bolam v. Friern Hospital Management Committee* 2 All ER 118 (1957). *Bolam* established the *Bolam Rule*, which is used in India to assess the applied standard of care by physicians, and thus, whether or not a physician has acted negligibly. The *Bolam Rule* defines a physician’s standard of care as follows:

“A professional man should command the corpus of knowledge which forms part of the professional equipment of the ordinary member of his profession. He should not lag behind other ordinary assiduous and intelligent members’ of his profession in knowledge of new advances, discoveries and developments in his field. He should have such an awareness as an ordinarily competent practitioner would have of the deficiencies in his knowledge and the limitations on his skill. He ‘should be’ alert to the hazards and risks in any professional task he undertakes to the extent that other ordinarily competent members of the profession would be alert. He must bring to any

*professional task he undertakes no less expertise, skill and care than other ordinarily competent members of his profession would bring, but need bring no more. The standard is that of the reasonable average. The law does not require of a professional man that he be a paragon combining the qualities of polymath and prophet.”*Id.

The Indian Supreme Court continued the discussion on medical negligence by stating that deviation from normal practice is not necessarily evidence of negligence. To establish liability on the basis of medical negligence, it must be shown 1) that there is a usual and normal practice; 2) that the defendant has not adopted it; and 3) that the course in fact adopted is one no professional man of ordinary skill would have taken had he been acting with ordinary care.” Last, the Supreme Court of India noted that a medical practitioner is not liable to be held negligent simply because things went wrong “from mischance or misadventure or through an error of judgment in choosing one reasonable course of treatment in preference to another.” *Id.*

^{lx}See The Medical Council of India, retrievable at:<http://www.mciindia.org/>. (“The prime object of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. Who- so-ever chooses his profession, assumes the obligation to conduct himself in accordance with its ideals. A physician should be an upright man, instructed in the art of healings. He shall keep himself pure in character and be diligent in caring for the sick; he should be modest, sober, patient, prompt in discharging his duty without anxiety; conducting himself with propriety in his profession and in all the actions of his life”).

^{lxi}*Id.* The Medical Council of India (MCI) was the statutory body for maintenance of uniform and high standards of medical education in India. The Council grants recognition of medical qualifications, gives accreditation to medical colleges, grants registration to medical practitioners, and monitors medical practice in India.

^{lxii}*Infra* note 63.

^{lxiii}The Government of India has essentially dissolved the Medical Council of India. See The Indian Medical Council (Amendment) Act 2010, published by the Ministry of Law and Justice, Legislative Department of New Delhi. The Act states the following:

“On and from the date of commencement of the Indian medical Council (Amendment) Act, 2010, the Council shall stand superseded and the President, Vice President and other members of the Council shall vacate their offices and shall have no claim for any compensation, whatsoever. The Council shall be reconstituted in accordance with the provisions of section 3 within a period of one year from the date of supersession of the Council. The Central Government shall, by notification in the Official Gazette, constitute the Board of Governors which shall consist of not more than seven persons as its members, who shall be persons of eminence and unimpeachable integrity in the fields of medicine and medical education. The decision of the Central Government whether a question is a matter of policy or not shall be final: The Indian Medical Council (Amendment) Ordinance, 2010 is hereby repealed.”

See also Roger Collier, *Dark Days for Medical Profession in India*, Canadian Medical Association Journal, (2010). Collier notes that “On Apr. 22, Desai and three colleagues were arrested by India's Central Bureau of Investigation for their alleged roles in a 20-million-rupee (\$440 000) bribery case. They are alleged to have accepted a bribe from a medical college that wanted to increase enrolment despite lacking capacity for more students. At the time of his arrest, Desai was the president of the MCI. He subsequently resigned both the presidency and his position as head of the urology department at the B.J. Medical College in Ahmedabad.” For further discussion on alleged corruption of the Medical Council of India, see Sunil K. Pandya, *Medical Council of India: The Rot Within*, 6 INDIAN J MED ETHICS 125 (2009).

^{lxiv}See the Medical Council of India, (Professional, Etiquette, and Ethics) Regulations, 2009. At

<http://www.mciindia.org/RulesandRegulations/CodeofMedicalEthicsRegulations2002.aspx>

^{lxv}*Supra* note 60.

^{lxvi}*Supra* note 63.

^{lxvii}See the Indian Medical Council Act (1956), *supra* note 60. The Indian Medical Council Act (1956) outlines the regulations for practitioners of medicine to be constituted under law by the State Medical Register. The Act also notes the right of inspection of medical

institutions, including the inspection of the adequacy of staff, equipment, accommodation, and training facilities.

^{lxviii} *Supra* note 60.

^{lxix} *Id.*

^{lxx} *Id.*

^{lxxi} *Id.*

^{lxxii} *See* The Indian Medical Association (IMA). Retrievable at: <http://www.ima-india.org/>.

^{lxxiii} *Id.*

^{lxxiv} *See* The Clinical Establishments (Registration and Regulation) Rules, 2010, *supra* note 72.

^{lxxv} *Id.*

^{lxxvi} *Id.*

^{lxxvii} *Id.*

^{lxxviii} *See* The Transplantation of Human Organs Act (1994), Ministry of Law, Justice and Company Affairs (Legislative Department of India), NewDehli. Retrievable at: <http://www.medindia.net/>.

^{lxxix} *Id.*

^{lxxx} *See* <http://www.indianhealthcare.in/>

^{lxxxi} *Id.*

^{lxxxii} *See* The Joint Commission International, Accreditation and Certification Process, <http://www.jointcommissioninternational.org/Accreditation-and-Certification-Process/>

^{lxxxiii} *See* Cortez, *infra* note 85 at 84.

^{lxxxiv} *See* Paul Hunt, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Health*, United Nations General Assembly, (2010), retrievable at: http://www.essex.ac.uk/human_rights_centre/research/rth/reports.aspx. Hunt describes India's private-sector of healthcare as unregulated. Hunt commends that India's health workforce is in crisis because of lack of regulation; the author states: "Despite (or because of) its enormous power, India's private health sector is largely unregulated. Moreover, there are few signs that it is willing to adequately regulate itself. In these circumstances, the Government has a legally binding responsibility to introduce, as a matter of urgency, an appropriate, effective regulatory framework for the private health sector, including public-private partnerships." *See also* the U.S. Department of State, retrievable at <http://travel.state.gov/>. ("Medical tourism is a rapidly growing industry. Companies offering vacation packages bundled with medical consultations and financing options provide direct-to-consumer advertising over the internet. Such medical packages often claim to provide high quality care, but the quality of health care in India is highly variable. People seeking health care in India should understand that medical systems operate differently from those in the United States and are not subject to the same rules and regulations"). Last, *see* Nicolas P. Terry, *The Politics of Health Law: Under-Regulated Health Care Phenomena in a Flat World: Medical Tourism and Outsourcing*, 29 W. ENG. L. REV. 421, 454-55 (2007). Terry discusses the quality of medical care and inspection in India:

"The difference, however, is in the level of inspection and scrutiny. For example, serious questions have been raised about the adequacy of the medical infrastructure in India to support quality trials, the training of Indian researchers, the quantity and quality of Indian IRBs, and the local ethical standards (including informed-consent deficiencies) applied in dealing with subjects. In a 2001 report, which was triggered by The Body Hunters and confirmed the dramatic increase in the number of offshore clinical trials, the U.S. Department of Health and Human Services' Office of Inspector General (OIG) found key differences in the scrutiny of offshore trials. Specifically, the OIG noted deficiencies in the FDA's tracking of non-IND trials, the absence of FDA inspection of foreign IRBs, the lack of any "attestation" requirement for non-IND investigators and a failure to enforce attestation for foreign-based INDs, and generalized staffing, political, and logistical deficiencies that challenged rigorous FDA inspection of foreign research sites."

^{lxxxv} *See* The National Board for Hospitals and Healthcare Providers (NABH). Retrieved at: http://www.indianhealthcare.in/index.php?option=com_content&view=article&catid=122&id=173. ("In India the health care delivery system has remained largely fragmented and uncontrolled. The focus of accreditation is on continuous improvement in the

organizational and clinical performance of health services, not just the achievement of a certificate or award or merely assuring compliance with minimum acceptable standards”). *But see* Nathan Cortez, *Patients Without Borders: The Emerging Global Market for Patients and the Evolution of Modern Health Care*, 83 IND. L.J. 71, 84 (2008). (“Hospitals around the world are seeking JCI accreditation, which may help them apply for coverage from U.S. insurers. Thus, patients that leave the United States for medical care increasingly find hospitals that meet U.S. standard”). Cortez assumes that because many medical tourist locations rely on an accreditation system approved by the United States, those accredited medical facilities maintain a standard of excellence. However, Cortez later contradicts his argument when stating: “accreditation generally signals that a facility meets minimum standards of competence and quality.” While the JCI accreditation system approves those hospitals that meet “minimal” safety standards, Cortez asserts that JCI accreditation is substantial evidence to deem a foreign hospital safe for a major surgical procedure. Cortez fails to address those circumstances of a hospital that deem the facility “minimally safe” instead of “extremely safe.” The accreditation system’s standards can be ambiguous, and relying on these standards may lead to a misconstrued representation of the safety of hospitals in both the United States and India. See also Meryl Davids Landau, *A Guide to Getting Good Care*, 147 U.S. NEWS & WORLD REPORT 47 (2010). Retrieved from LEXIS (“Still, minimal is often a far cry from excellent, cautions Charles Kilo, chief medical officer at the Oregon Health and Science University and an expert on healthcare improvement. Critics also charge that to ensure enough hospitals will qualify, certifying groups typically set the bar so that the process weeds out awful institutions but does not truly signify top quality”).

^{lxxxvi}See Angeleque Parsiyar, *Medical Tourism: The Commodification of Health Care in Latin America*, 15 LAW & BUS. REV. AM. 379, 393 (2009) (“Further, governmental safeguards ensuring quality of care are generally lacking, with the closest thing being accreditation by the JCI, which causes many people to question the quality of care received abroad. The level of standardization that exists in the United States does not exist in the rest of the world, and there is currently not a sufficient system in place to guide people through determining where good medical care exists”).

^{lxxxvii}*Supra* note 57.

^{lxxxviii}See <http://travel.state.gov/>

^{lxxxix}*Supra* note 57 at 315.

^{xc}See *supra* notes 37-48 for a detailed a more detailed outline of U.S. medical safety regulations regarding patient rights and surgical procedures.

^{xci}*Supra* note 20.

^{xcii}*Supra* note 64.

^{xciii}*Id.*

^{xciv}*Id.*

^{xcv}*Id.*

^{xcvi}*Id.*

^{xcvii}*Id.*

^{xcviii}*Id.*

^{xcix}*Id.*

^c*Supra* note 20.

^{ci}See Kerrie S. Howze, *Medical Tourism: Symptom or Cure?* 41 GA. L. REV. 1013 (2007).

^{cii}*Id.* at 1030. (“Medical tourism company IndUSHealth informs patients that ‘in instances where medical mistakes or malpractice is believed to have occurred, patients have the right to seek redress in the Indian court system similar to the procedure followed here in the U.S.’ While the Indian court system may be similar to the U.S. system, the redress for medical negligence could not be more dissimilar. In the United States, damage awards for medical negligence can be in the millions, whereas in India, medical negligence claims are rare and multimillion dollar awards are nonexistent”).

^{ciii}*Supra* note 52.

^{civ}See Kenneth C. Chessick and Matthew D. Robinson, *Medical Negligence Litigation is Not the Problem*, 26 N. ILL. U. L. REV. 563 (2006) (discussing the prevalence of medical negligence litigation and the controversies surrounding the rise in medical negligence litigation).

^{cv}*Supra* note 59.

^{cvi} See Williams, *supra* note 58 at 646-47. (“Furthermore, malpractice law in other nations is not as protective of patients, or even as clearly defined, as U.S. medical malpractice law. Foreign jurisdictions may be reluctant to recognize even valid malpractice claims by foreign patients against domestic providers because doing so would create unfavorable precedent encouraging similar suits and potentially harm their medical tourism industry”).

^{cvii} There are several cultural differences between the United States and medical tourist hotspots regarding the practice of medicine. For example, *see* Barrett P. Brenton & Helen E. Sheehan, *The Annals of the American Academy of Political and Social Science: Preface*, 583 ANNALS 6 (2002). Brenton and Sheehan describe the practice of medicine among cultures other than that of the United States. In Eastern cultures, such as Asia and India, medicine often falls into the category of indigenous, or “folk medicine.” In India specifically, “some cases, such as Unani medicine and homeopathy, long history and interaction with other medical systems, such as Ayurveda in India, have led to their being considered indigenous Indian medical systems.” Still today in India, a large hotspot for medical tourists from the United States, a chief contributory factor for “hospitals of excellence” is that of “total well being.” *See supra* note 2, “*Incredible India!*” page 20. The brochure reads:

“In Ayurvedic teaching, three vital forces govern the body, and combine to create an individual’s physiological make-up: vata, linked to the wind, governs movement and relates to the nervous system; pitta, the force of the sun, rules digestion and metabolism; and kapha, likened to the moon, governs the body’s organs...In contrast to the Western approach to medicine, Ayurveda works to remove the cause of illness, not just treat the disease, by suggesting lifestyle and nutritional guidelines to reduce the excessive dosha. Though Ayurveda is found across the country, its heart lays deep in the south, in Kerala, where there’s plenty of choice, whatever your needs. So close your eyes, and cast your mind east. The spirit of India lives on.”

See also Gluck, *supra* note 8 at 471. Gluck highlights the stigma surrounding Ayurvedic medicine in the United States due to lack of standardization: “The lack of standardization of Ayurvedic treatments is a major reason why Ayurvedic doctors cannot practice medicine in the United States. Thus, patients have the unique opportunity to pursue this combination therapy in India, where such limitations on the practice of medicine by Ayurvedic doctors do not exist.”

^{cviii} *Supra* note 12.

^{cix} *See* Glenn Cohen, *Protecting Patients with Passports: Medical Tourism and the Patient-Protective Argument*, 95 IOWA L. REV. 1467, 1484 (2010).

^{cx} Specifically, patients do not have the training to recognize medical deceit. *See id.* at 1494. (“Patients often cannot assess the quality of care they receive, either before or after it is delivered. In theory, patients can attempt to correct their information deficiencies by acquiring the necessary information. Doing so may be very costly, however. It is costly to collect raw data and to create and disseminate meaningful quality measures. It is also costly to use quality measures: patients must take the time to read through them and assess their relevance to their decision-making. Problems of bounded rationality may prevent patients from using data appropriately. If the perceived costs of obtaining and using data exceed the perceived benefits from doing so, individual patients will likely decline to seek out this information”).

^{cxii} *Infra* note 129.

^{cxiii} *See* the Federal Trade Commission Act 15 U.S.C.S. §§ 45 (2011).

^{cxiv} *Id.*

^{cxv} *See* Robert Sprague and Mary Ellen Wells, *Regulating Online Buzz Marketing: Untangling a Web of Deceit*, 47 Am. Bus. L.J. 415, 425 (2010).

^{cxvi} *Supra* note 112.

^{cxvii} *Supra* note 114, at 425-26.

^{cxviii} *Supra* note 12.

^{cxix} *Id.*

^{cxx} *Id.*

^{cxxi} *Supra* note 114 at 427.

^{cxxii} This judicial determination was jumpstarted by the Supreme Court case, *Central Hudson Gas & Electric Corp. v. Public Service Comm’n*, 447 U.S. 557 (1980). *Central Hudson*

established the *Central Hudson* test, a four-prong criteria which determines the constitutionality of government regulation on commercial speech.

^{cxxii} *Id.*

^{cxxiii} American individualism is rooted in the ideas of atomism and self determination. For discussion on atomism, see Andrea Giampetro-Meyer, et. al., *Advancing the Rights of Poor and Working-Class Women in an Individualistic Culture*, 2 LOYOLA POVERTY L.J. 41 (1996) (explaining that a fundamental assumption of atomism is that human beings are “independent disembodied entities”). The idea of atomism assumes that human beings are separate from the society, and thus, society’s external influences. Because atomistic thought proclaims a disconnect between the individual and societal influences, atomistic thought also assumes that the individual creates their own reality; an atomist assumes that the conditions and circumstances surrounding a human being are caused only by that human being his/herself. Essentially, humans self-determine their realities. The understanding of these assumptions of atomism and self-determination are of the essence to understanding individualism as a dominant ideology in the United States.

Although individualism predominates American culture, see Ernest Wallwork, *Ethical Analysis of Research Partnerships with Communities*, 18 KENNEDY INST. J 57, 58 (2008) (defining the individual as “embedded in narrative traditions, institutions, roles, shared goals, and environments (natural and social), without which human beings can neither survive nor flourish morally”). While the United States bleeds individualism, Wallwork commends that Americans can also have characteristics of collectivism. Wallwork’s ontological assumption about human nature, mentioned above, reflects the fundamental assumption of collectivism. To contradict distinguish the root assumptions of individualism and collectivism, it is vital to note that while individualism characterizes the individual as atomistic and responsible for their own reality and state of being, collectivism characterizes the individual as tied to society; the collectivist commends that human beings are products of socialization and external influences.

^{cxxiv} See Robert N. Bellah, et. al., *Habits of the Heart: Individualism and Commitment in American Life* 142(1985)(“We [Americans] believe in the dignity, indeed the sacredness, of the individual. Anything that would violate our right to think for ourselves, judge for ourselves, make our own decisions, live our lives as we see fit, is not only morally wrong, it is sacrilegious”).

^{cxxv} *Id.*

^{cxxvi} *Infra* note 129.

^{cxxvii} *Id.*

^{cxxviii} *Supra* note 58.

^{cxxix} For a discussion on the inhibiting nature of America’s dependence on consumers to make “rational” decisions, a conversation that is pertinent to the ethicality of medical tourism, see Gil Siegal, *An Account of Collective Actions in Public Health*, 99 AM J PUBLIC HEALTH 1583 (2009). Siegal first addresses the popular American reliance on the economic “rational actor theory.” This theory states that individuals act as rational agents:

Economists have advanced the rational actor theory, in which each individual (satirically termed Homo Economicus) is expected to act as a rational agent using available information to maximize his or her own interests—pursuing wealth and well-being, avoiding suffering or unnecessary labor—all in accordance with his or her own predetermined and stable goals and utilities. Id.

After detailing the assumptions behind the rational actor theory, Siegal denounces the validity of these assumptions in his discussion of cognitive heuristics. Cognitive heuristics are the habitual cognitive methods individuals tend to use to solve a problem. Siegal commends that these cognitive heuristics inhibit the individual’s ability to think “rationally.” For example, one cognitive heuristic that immeasurably affects consumer decisions regarding medical procedures is the “framing effect;” the framing effect occurs when:

“...decisions are irrationally influenced by modes of presentation and context—e.g., discussing a 10% chance of failure in a medical procedure is perceived differently from discussing a 90% chance of success in the same procedure. Id.

For further elaboration on pervasive human cognitive heuristics, see also Gregory Mitchell, *Mapping Evidence Law*, MICH. ST. L. REV. 1065 (2003). Mitchell outlines several cognitive heuristics including the conjunction fallacy, outcome bias, confirmation bias and

the framing effect; the author reveals the destructive nature of these entities to rational consumer decisions.

The economic assumption outlined above, that consumers are rational thinkers who are capable of making decisions free of logical shortcomings, is further epitomized in P. Gretchen Browne's, *The Conversation Between Economic Man and the Psychological Character: Ontology and Feminist Economics, Western Social Science Conference* (1996) (discussing the rational decision-making process of Robinson Crusoe, the "economic man"). Crusoe, a popular literary character invented in the 18th century, is believed to be a one-man model of the ideal rational decision-maker; Because Crusoe is stranded on an island, free of any societal influences, the character is portrayed as a being whose decisions are carefully calculated; Crusoe meticulously weighs all potential costs and benefits. Robinson Crusoe embodies the theoretical "economic man" because he is a man of rationality and individualism- he is economically ideal because he is free of damaging cognitive heuristics.

^{cxxx}See Anuj K. Shah and Daniel M. Oppenheimer, *Heuristics Made Easy: An Effort-Reduction Framework*, 134 PSYCHOLOGICAL BULLETIN 207 (2008).

^{cxxx}*Id.*

^{cxxxii}See Amir N. Licht, *The Maximands of Corporate Governance: A Theory of Values and Cognitive Style*, 29 DEL. J. CORP. L. 649, 669 (2004).

^{cxxxiii}*Id.*

^{cxxxiv}See Leigh Turner, *First World Health Care at Third World Prices: Globalization, Bioethics and Medical Tourism*, 2 BioSocieties 303, 318 (2007) (citing the death of a twenty-three-year-old woman who suffered mycobacterial infections after receiving cosmetic surgery in the Dominican Republic, as well as "substandard tissue matching in organ transplants that occurred in Pakistan and India").

^{cxxxv}See Cortez, *supra* note 85 at 74 and 91. ("Most foreign providers and brokers market their services on the Internet, and a sampling of these sites shows they can be aggressive and potentially misleading. Sites include patient testimonials, breezy descriptions of idyllic sightseeing tours, and even quality comparisons that disparage U.S. providers.... [One] broker assures patients who may be concerned about medical malpractice that they "have the right to seek redress in the Indian court system similar to the procedure followed here in the U.S. [sic], a claim that is woefully misleading"). See also Roy G. Sece, Jr., *Medical Tourism: Protecting Patients from Conflicts of Interest in Broker's Fees Paid by Foreign Providers*, 6 J. HEALTH & BIOMED. L. 1 (2010) "The foreign providers advertise through the internet and various print and broadcast media, which allows a patient not to have to use a broker. There are, however, almost two million entries under "medical tourism" in Google and patients often work through medical tourism brokers rather than attempt to find their way directly to a foreign provider").

^{cxxxvi}See Steven J. Katz, et. al., *From Policy To Patients and Back: Surgical Treatment Decision Making For Patients With Breast Cancer; Information has never been more widely available, and treatment decision making has never been more complicated*, Health Affairs (2007) (explaining the procedural complexities of a single medical diagnosis, such as breast cancer). Katz explains that the severe and rapid nature of Katz necessitates a multifaceted attack:

"Patients are confronted with a life-threatening disease that requires many treatment decisions related to surgery, radiation, chemotherapy, and hormone therapy, with widely ranging effects on themselves and their families. These myriad decisions are often made quickly in consultation with many physicians whom patients are meeting for the first time."

After elaborating on the complex nature of breast cancer treatment, Katz commends that these medical complexities inhibit the consumer's ability to fully comprehend the medical terminology:

*"There are wide variations in patients' ability and willingness to absorb complex clinical information, particularly competing risk information, is a challenge for many physicians. Information has never been more available. At the same time, treatment decision making has never been more complicated. Some patients arrive for their first consultation visit with a family member armed with information from Internet-based sources; others arrive alone with little preparation."**Id.*

But see Mitchell S. Berger, *A Tale of Six Implants: The Perez v. Wyeth Laboratories Norplant Case and the Applicability of the Learned Intermediary Doctrine to Direct-to-Consumer Drug Promotion*, 55 FOOD DRUG L. J. 525, 550 (2000) (revealing that some individuals argue that explaining medical nuances to consumers is “unnecessary”). Berger states that “on the other hand defenders (of the case) respond that attempting to render complex medical language into simple terms risks “both dilution and unnecessary hysteria”).

^{cxxxvii} *Baccus v. State of Louisiana*, 232 U.S. 334 (1914) (displaying an instance where an individual falsely advertised “medical” products to citizens on the street). The plaintiff sought to repeal a past court decision that banned him from the “freedom to peddle medical entities” as his vocation. The plaintiff in this case sought repeal from a court decision from the Third Judicial District Court, Parish of Claiborne, state of Louisiana. The judge in the District Court decision adhered to a state statute that banned the practice of itinerant vending of “any drug, nostrum, ointment or application of any kind intended for the treatment of disease or injury,” to penalize the plaintiff in question. While the plaintiff in the case felt they had the right to freely advertise their “medical” product to community members on the street, the court denied the plaintiff’s request. The Supreme Court decided that the Third Judicial District Court made an acceptable decision to regulate the marketing of the peddler/ itinerant vendor, as the individual was selling a medical product that belonged to a previous patent/ proprietor: Rawleigh Medical Co. of the State of Illinois. In addition, the Court ruled under the assumption that drugs or medical compounds are within the power of the government to regulate.

^{cxxxviii} For a discussion on the “luxury factor” of medical tourism, see *supra* note 58 at 623-24.

^{cxxxix} See Chester N. Mitchell, *Deregulating Mandatory Medical Prescription*, 12 AM. J. L. AND MED. 207, 212 (1986) (“The rise of scientific medicine in the late 1800’s is partially responsible for the medical profession’s special success”). See also Olli S. Miettinen, *Evidence-based medicine, case-based medicine; scientific medicine, quasi-scientific medicine. Commentary on Tonelli* (2006), *Integrating evidence into clinical practice: an alternative to evidence-based approaches*, 12 JOURNAL OF EVALUATION IN CLINICAL PRACTICE, 248, 260 (2006), for a discussion on “evidence-based medicine.” Miettinen highlights the Western understanding of “evidence-based medicine” as “empirical evidence, derived from formal and systematic clinical research.” In contrast to the standard western assumptions about evidence-based medicine, Miettinen asserts that medical decisions are instead influenced by values, and personal preferences towards a treatment and patient.

^{cxli} See Miettinen, *id.* at 261. The author commends that in the case of scientific medicine, the phrase “scientific” refers to “a commitment to reasoning that is rigorous and explicit.” Miettinen then critiques this common interpretation of scientific medicine by stating that scientific medicine is instead based on probability calculations:

“The knowledge base of scientific medicine thus is one of known probability functions – in practice ‘known’ to the physician’s computer and evaluated by the physician at the gnostic indicators’ realizations constituting the gnostic profile at hand.” *Id.*

^{cxlii} *But see* George A. Taylor et. al., *Diagnostic Errors in Pediatric Radiology*, 41 PEDIATR. RADIOL. 327, 332 (2011) (“attempts to be constantly vigilant and eliminate cognitive biases are neither possible nor desirable because many of the mental activities in which we engage are outside of conscious awareness and heuristics used in clinical medicine evolve because they yield better overall outcomes than more careful or rational approaches”).

^{cxlii} See Lars Noah, *Medicine’s Epistemology: Mapping the Haphazard Diffusion of Knowledge in the Biomedical Community*, 44 ARIZ. L. REV. 373 (2002) (“I presume nobody will question the existence of a widespread popular delusion that every doctor is a man of science... As a matter of fact, the rank and file of doctors are no more scientific than their tailors” - George Bernard Shaw). See also McLean, *supra* note 2 at 150. (“For example, the medical community’s failure to routinely apply known scientific principles to patient care translates to a 20 percent incidence of misdiagnosis -- a figure that has remained unchanged for 70 years. The origin of misdiagnosis in treatment is sometimes due a physician’s lack of knowledge. More often, however, misdiagnosis can be traced to the financial incentives given to physicians”).

^{cxliii} See McLean, *supra* note 2 at 151-52.

^{cxliv}See The Indian Medical Association's website, *supra* note 72. The current national President, Dr. VinayAggarwal, has posted a Presidential Address on the website which states the following:

"The first of these issues is the attempt by the Government of India to create a high arching body in place of medical council of India. This body will include other unrelated disciplines like engineering and management. It is not clear how this would help in shaping future doctors of India... Existing provisions of the Indian Medical council Act 1956 confer enough powers on Government of India in the affairs of MCI. It nominates 37 members directly and in consultation with state Governments. No one can establish a medical college or open a new course or increase admission capacity without explicit permission from Government of India. Central Government directly controls the post graduate medical education by nominating six out of nine members. By subjugating the MCI on which it already has adequate powers, the Government has converted it into another Government department. The Government in its wisdom has made its directives binding on MCI. There is no justification in robbing MCI of its autonomous character."

This Presidential Address was posted in response to the Central Government of India's removal of the Medical Council of India due to fraud and corruption by the President of the Medical Council of India. See *supra* note 63 regarding the arrest of the President of the Medical Council of India.

^{cxlv}See Linda T. Kohn et. al., *To Err is Human: Building a Safer Health System*, Nat'l Acad. Press (2000).