*2 Introduction

Three patients leave the United States for surgery. The first is self-employed and has no health insurance. He needs life-prolonging heart surgery that would cost at least $50,000 in the United States. On the Internet, he finds a cardiac surgeon at a private hospital in New Delhi, India, who can perform the surgery for no more than $10,000.1 Terms and conditions on the hospital’s website require patients to resolve any complaints in Indian courts or in one of India’s consumer dispute forums. Civil litigation in India can take fifteen to twenty years to resolve, and India’s consumer forums cannot grant non-economic damages like pain and suffering.

The second patient works for a large, self-insured manufacturer. To compete with foreign manufacturers, his employer must cut jobs and benefits. After seeing a segment on medical tourism on the news, the manufacturer’s benefits manager contacts a medical tourism facilitator in North Carolina.2 Together, the companies craft a plan to outsource expensive surgeries by paying employees for travel expenses and offering them 25% of the cost-savings, up to $10,000.3 The employee needs knee surgery, so the facilitator arranges for it at a famous private hospital in Bangkok, Thailand. The contract stipulates that the facilitator shall not be held responsible for any negligence committed by the Thai hospital or physicians. Moreover, the employee must sign a waiver agreeing not to hold the employer liable. The average malpractice payout in Thailand is less than $2500.4

The third patient buys health insurance through her employer. The insurance company recently added to its provider network a private hospital in Monterrey, Mexico, and it now offers a plan with much lower premiums and deductibles to patients willing to visit Mexico for certain procedures. The patient visits Monterrey for cataract surgery. The insurance policy states that all network providers are independent contractors and are not agents of the insurer. Mexican law pegs tort compensation to very modest awards in its federal workers’ compensation statute. Moreover, under Mexico’s new medical arbitration system, the average malpractice recovery is roughly $4800.5

These patients have three things in common. They are gainfully employed. They are leaving the United States to save money on medical expenses. And they have very little legal recourse should they fall victim to medical negligence.

These three scenarios reflect the essential tradeoff. The first patient, by agreeing to Indian jurisdiction, sacrifices potential legal remedies in exchange for life-prolonging medical care that he otherwise could not afford. The risks and benefits accrue directly to the patient. The second and third patients also sacrifice potential legal remedies, as jurisdiction likely resides in Thailand and Mexico. But the benefits accrue diffusely--outsourcing saves money for the patient, employer, and insurer.
Do these parties fully appreciate the tradeoff? Employers and insurers seem to--they use releases, waivers, disclaimers, and other contractual devices to limit their legal liabilities when sending patients abroad. And the medical tourism companies that facilitate these transactions use a similar combination of legal prophylaxes. However, it is unclear whether patients fully understand the legal risks. Patients may vaguely comprehend that they might not receive the same legal or regulatory protections overseas. But there is reason to suspect that they do not fully digest just how few legal remedies remain or what options they have if something goes awry.

More and more patients are accepting this tradeoff, wittingly or not. The patients diligent enough to investigate these legal disparities will not find much helpful information. Currently, the literature assumes that foreign jurisdictions provide lesser legal remedies, but until now, no one has tested or supported these assumptions. To date, there are no reliable, comprehensive sources for patients to learn about legal recourse for malpractice committed in those jurisdictions.

As such, it is highly doubtful that most U.S. patients fully appreciate the legal risks of medical travel. The three scenarios above reflect increasingly common arrangements. Patients are being asked to forego potential legal claims in U.S. courts, leaving them to rely on foreign judicial systems for compensation, venues where it is unlikely they will recover adequate compensation by U.S. standards. For example, the mean and median recoveries by malpractice victims in the United States ($311,000 and $175,000, respectively) dwarf the average recoveries in Thailand ($2500) and Mexico ($4800). Perhaps for this reason, industry observers and representatives warn patients not to travel overseas if they are at all concerned with their potential legal remedies.

If patients travel overseas for less expensive health care (particularly if they are encouraged to do so), they should understand precisely what remedies they are sacrificing.

This Article recalibrates the legal risks of medical travel by assessing whether patients injured overseas have adequate legal recourse either in the United States or in one of four common destinations: India, Thailand, Singapore, and Mexico. I conclude that U.S. medical tourists will struggle to obtain adequate compensation, either here or abroad. Patients looking to sue in U.S. courts for medical malpractice abroad will face difficulties locating a proper defendant, venue, and theory of liability. Patients suing overseas will also face obstacles recovering adequate, timely compensation in legal systems that use unfamiliar procedures, communicate in foreign languages, limit the remedies available, and impose more onerous burdens of proof. Moreover, I argue that patients cannot accurately appraise the legal risks because 1) no dispositive case law exists indicating whether medical tourists can recover in U.S. courts and 2) until now, there were no reliable resources that explained the remedies patients might have in foreign jurisdictions. In this Article, I attempt to fill this void. Given this information, I also discuss how policymakers might reallocate these risks more fairly and efficiently.

Part I begins by evaluating whether medical tourists can recover in U.S. courts. I use existing scholarship to outline the legal theories patients might use against certain defendants. I emphasize the term “theories” here because courts have yet to test these claims. First, I discuss how patients will struggle to prevail on issues of jurisdiction, venue, and choice of law if they sue foreign providers in U.S. courts. I then discuss how patients will face different obstacles if they attempt to recover from U.S.-based employers, insurers, and medical tourism facilitators. I evaluate several theories of liability, including corporate negligence, informed consent, vicarious liability, and negligent credentialing. Part I concludes by discussing how the industry uses releases, waivers,
disclaimers, and other contractual prophylaxes to shift the legal risks in two directions—toward patients and toward foreign jurisdictions.

Part II proceeds on the assumption that patients will have difficulty suing in U.S. courts for malpractice committed overseas. I evaluate the means of redress available in four popular destinations: India, Thailand, Singapore, and Mexico.

In India, patients can sue in civil court or in one of India’s consumer forums. India also relies on criminal prosecution, self-regulation, and hospital accreditation to impose quality standards on providers. But none of these systems enforce much accountability. Civil litigation is an extremely long process, even by U.S. standards. India’s consumer forums provide an efficient alternative, but patients must contend with procedural hurdles and overcome difficulties securing medical records and expert testimony simply to recover rather modest compensation. Criminal prosecution is rare. Government regulation is virtually non-existent, and self-regulation by the medical councils is deeply flawed. Hospital accreditation is establishing some standards, but does not pretend to address negligence. India should be credited for acknowledging these shortcomings and attempting to mitigate them through its consumer forums. But given the relatively small size of malpractice recoveries reported by the Indian media, it is doubtful that U.S. patients will be satisfied with the remedies offered by these forums.

In Thailand, patients also struggle to hold someone accountable for medical negligence. Few patients file any sort of complaint—either in civil court or with the Thai Medical Council, the Ministry of Public Health, or the Consumer Protection Agency. Those suing in civil courts face several obstacles. Thai malpractice law is underdeveloped. Patients often cannot access their medical records. Thai courts communicate solely in Thai, do not allow pretrial discovery, and seem hostile to tort claims in general. Finally, the average Thai patient recovers less than $2500, which most U.S. patients would find unsatisfying. But like most countries, Thailand is searching for the appropriate balance and is considering several major reforms, including no-fault liability and a patient’s compensation fund. Thus, the Thai system remains in flux.

In Singapore, patients face yet other obstacles. In negligence cases, Singapore adheres to the notorious Bolam rule, an English trial court opinion from 1957 that strongly favors physicians by instructing courts to use a deferential interpretation of the appropriate standard of care. Patients in Singapore also remain exceedingly reluctant to sue, in part because Singaporean law imposes costs on the losing litigant and prohibits contingency fee arrangements. Finally, compensation is modest not only by U.S. standards, but by standards we might expect for a nation with Singapore’s wealth. Nonetheless, Singapore comprehensively regulates its health care providers, and the government seems to be committed to understanding and reducing the frequency of medical errors.

Finally, patients in Mexico must contend with a legal system that uses neither juries nor stare decisis and a civil code that pegs compensation to a formula used in workers’ compensation cases. Tort litigation is virtually non-existent in Mexico, and most U.S. tort victims injured there prefer to sue in the United States if they can. Although Mexico has implemented an innovative new medical arbitration system that is viewed favorably by both patients and physicians, the average recovery is only $4800 per patient, which, again, most U.S. patients would find inadequate.

In addition to obstacles unique to each jurisdiction, suing overseas could discourage even the most resolute plaintiffs, who must retain local counsel, navigate a foreign legal system (most likely in a foreign language), travel to hearings, prove their cases, and perhaps even enforce judgments in their favor. These factors may combine to effectively preclude legal recourse.
Part III concludes by exploring how the public and private sectors might reallocate—and perhaps mitigate—the legal risks of medical travel. In the private sector, an industry association recently began certifying medical tourism facilitators, and this process seems to encourage companies to disclose the legal remedies their customers might have, including remedies in foreign jurisdictions. Also, at least one insurance company now offers medical tourism insurance, and the American Medical Association has published industry guidelines. Part III examines the strengths and weaknesses of these approaches, and concludes by proposing ways the public sector could intervene. Legislatures could impose statutory strict liability on employers, insurers, and intermediaries that send patients overseas. Lawmakers could require these companies to insure against medical errors or pay for any pre-screening or post-operative care that may be necessary. They could invalidate any releases or waivers of liability. Or, policymakers might simply try to correct the information asymmetries that contribute to the current misallocation of legal risks. I propose a combination of these methods that would ease legal impediments to suing in the United States and inform patients of the risks of agreeing to assert claims in foreign courts. Even if these efforts do not generate precisely the same remedies as those available to patients treated in the United States, they should better spread the risks among the parties that benefit from these transactions.

This Article has two major goals, one descriptive and one prescriptive. First, the descriptive goal is to provide much-needed basic information about the legal systems in four countries that foreign patients increasingly visit. As I describe the medical malpractice compensation systems in India, Thailand, Singapore, and Mexico, I try to outline the basic mechanics of each system and the obstacles that might preclude foreign patients from receiving meaningful compensation. Hopefully, this information will be useful to patients, the industry, and policymakers alike.

The second, prescriptive goal of this Article is to suggest how both the public and private sectors might reallocate the legal risks more fairly and efficiently, so they do not fall solely, or even squarely, on patients. I scrutinize private-sector responses to the legal imbalance and recommend specific public sector options that would both eliminate impediments to hashing out these legal claims in the United States and better inform patients who agree to foreign jurisdiction just what they are sacrificing. Again, the goal is to guide this market toward a more optimal allocation of risks and responsibility.

I. Seeking Redress in the United States

Many believe cross-border medical treatment could be the next big trend in global health care. The phenomenon has triggered a torrent of media coverage and academic articles trying to predict what will come of it. Health economist Uwe Reinhardt says it “has the potential of doing to the U.S. health care system what the Japanese auto industry did to American carmakers.”

Estimates vary widely on the precise number of U.S. patients that travel overseas for treatment each year. A 2008 report estimates that only 5000 to 10,000 Americans travel each year specifically for inpatient procedures. But a separate report estimated that 750,000 U.S. patients traveled overseas for medical care in 2007, and some predict that five or six million will do so in 2010. In either case, a mounting number of employers and insurers is garnering national media attention for adding foreign hospitals to their provider networks. Moreover, foreign hospitals and governments are intensifying their efforts to attract American patients. Because the industry remains embryonic, now may be the perfect time to influence how it allocates legal risks.

Before evaluating how aggrieved patients might fare abroad, I describe how they might fare in the United States. In this Part, I draw on existing scholarship to summarize whether U.S. patients who...
obtain treatment overseas might be able to recover from specific defendants in U.S. courts, including the legal theories they might use. I emphasize the word “theories” because these suits have not been tested. A major caveat in any legal analysis of medical tourism is the pervasive uncertainty over who might be liable for malpractice overseas. It remains entirely unclear whether medical tourists can recover in U.S. courts. My research found no reported opinions or test cases, and I suspect that providers and facilitators have strong incentives to settle complaints outside the public eye. Moreover, the industry is quickly formulating ways to avoid liability, and patients may not appreciate just how few legal remedies remain.

A. Suing Foreign Providers in the United States

Victims of medical malpractice overseas might logically seek recourse directly from the foreign hospital or medical professional that caused the injury. However, the most obvious defendants may also be the most difficult to haul into U.S. courts.

1. Personal Jurisdiction

The first obstacle to suing a foreign provider in the United States is establishing that a U.S. court has personal jurisdiction over the defendant. The law of personal jurisdiction generally requires that a defendant has “minimum contacts” with the forum state through some purposeful contacts or through substantial and continuous connection with the forum. Finding minimum contacts is never straightforward, but medical tourist arrangements complicate the analysis by involving foreign health care providers who communicate with patients to varying degrees over the Internet.

First, in the medical context, courts traditionally have been reluctant to assert jurisdiction over physicians who reside and practice even in another state, particularly if the physician does not make any “systematic or continuing effort” for his or her services “to be felt in the forum state.” Although this analysis should differ if foreign providers systematically target U.S. residents through websites or other avenues, my research uncovered few cases on point.

An aggrieved patient might also argue for jurisdiction based on a state’s long-arm statute if the foreign provider transacts or solicits business in the state. But courts have been reluctant to exert jurisdiction on this basis alone. Even a steady stream of referrals from the United States may not establish personal jurisdiction. However, courts have exercised personal jurisdiction over out-of-state health care providers that have ongoing relationships with referral sources in the forum. Thus, a signed contract between a foreign provider and a U.S. referral source may establish jurisdiction, even though, again, some courts have refused to find jurisdiction based solely on a contract--particularly if the contract does not pertain to conduct being challenged in the litigation. For example, in Romah v. Scully, a federal district court recently held that a Toronto hospital being sued for malpractice by a U.S. patient was not subject to the court’s jurisdiction. Part of the reason the court did not accept jurisdiction over the Toronto hospital was that the patient offered weak evidence that the hospital had targeted patients in the forum state.

Pervasive contact via the Internet, however, could establish jurisdiction over a foreign provider that specifically targets U.S. patients. At least one court has exercised jurisdiction over an Indian defendant based on a website that specifically targeted U.S. customers. Moreover, in Romah v. Scully, part of the reason the court did not accept jurisdiction over the Toronto hospital was that the patient offered weak evidence that the hospital had targeted patients in the forum state. Although many medical tourists may be able to muster more concrete evidence that the foreign entity solicited U.S. patients, these analyses are so fact-specific that it is difficult to predict whether any given U.S.
court would assert personal jurisdiction over a foreign provider. Recent critiques of Internet-based jurisdiction suggest ways courts might better balance concerns of fairness and the limits of state sovereignty, which are particularly applicable in medical tourist arrangements.

Aggrieved patients might also argue for U.S. jurisdiction under a continuing tort theory if the patient continues to be affected in the forum state by the foreign provider’s tortious conduct. But U.S. courts may be reluctant to make this leap unless the patient has some sort of continuing relationship with the provider, which is less likely in medical tourist arrangements.

Notwithstanding these hurdles, patients might be comforted to know that U.S. courts often provide remedies when Americans are tortiously injured in Mexico. In fact, U.S. courts decide far more tort cases arising in Mexico than Mexican courts do. One study found that Americans can sue in U.S. courts if the injury is egregious enough. For example, if a company with U.S. ties books a vacationer’s travel and strongly recommends a particular hotel in Mexico, a hotel guest injured in the hotel can often sue in the United States. This scenario suggests that U.S. courts might find ways to exercise jurisdiction in egregious medical tourism cases as well.

2. Venue and Forum Non Conveniens

Even if a patient can establish jurisdiction in the United States, most foreign defendants would move to dismiss under forum non conveniens—a doctrine that allows courts to dismiss cases that would excessively burden the defendant and when a more appropriate forum exists elsewhere. For example, if the defendant resides overseas along with most of the witnesses and evidence, a court would likely dismiss the case. In Jeha v. Arabian American Oil Co., a U.S. court dismissed a medical malpractice suit filed by an employee’s wife against a Saudi Arabian-based employer because the critical evidence and witnesses were all located in Lebanon. Courts considering a forum non conveniens motion must also consider which country’s laws to apply and, more importantly, whether there is an adequate alternative forum. Courts commonly invoke forum non conveniens if foreign rather than domestic law governs the conduct at issue. Thus, for example, a U.S. court might be reluctant to accept venue and be forced to apply Thai law to malpractice allegedly committed in Bangkok.

Courts typically recognize forum non conveniens if an alternative forum can provide adequate legal redress, even if the remedies available are “substantially less than provided by U.S. laws.” Though courts are reluctant to find that a foreign forum is inadequate, some have. For example, in Bhatnagar v. Surrendra Overseas Ltd., the Third Circuit denied a motion to dismiss a personal injury case against an Indian shipping company on forum non conveniens grounds because the alternative forum in India (the Calcutta High Court) was beset by “extreme delays,” lasting possibly even a quarter century. The court held that the severe backlog in Indian courts rendered them inadequate. Testimony in the Bhatnagar case suggested that an “average” case before the Calcutta High Court would take fifteen to twenty years to resolve. Thus, the delayed remedies provided by Indian courts may be “so clearly inadequate or unsatisfactory” that they are “no remedy at all.” However, the availability of India’s consumer forums for malpractice complaints might complicate this analysis, as consumer forums were designed to resolve cases much more expediently. Nevertheless, medical tourists should know that plaintiffs have had difficulty convincing U.S. courts that even extremely small recoveries overseas amount to “no remedy at all.” For example, in Gonzalez v. Chrysler Corp., the Fifth Circuit held that a $2500 maximum recovery in Mexico did not prove that the Mexican court was inadequate under forum non conveniens. Thus, although concerns about lengthy judicial delays abroad may be sufficient for medical tourists to gain access to U.S. courts, those same courts may not be sympathetic to patients’ complaints about the meager
damage awards available overseas.

3. Choice of Law

Patients that sue foreign providers in U.S. courts must establish not only jurisdiction and venue, but also may have to litigate complicated choice of law questions. Defendants no doubt will argue that the laws where the treatment was provided govern because, as I demonstrate in Part II, these laws tend to favor providers.

Choice of law questions could be dispositive in medical tourism disputes. Defeating a motion to dismiss for forum non conveniens may represent a Pyrrhic victory, as U.S. courts will frequently be obliged to follow the defendant-friendly laws of major medical tourism destinations. For example, in Chadwick v. Arabian American Oil Co., a U.S. plaintiff sued a Saudi Arabian company incorporated in Delaware, arguing that the company was vicariously liable for medical malpractice committed by the company’s physician in Saudi Arabia. The court followed Delaware’s conflict of law principles, governed by lex loci delicti (a choice of law rule that applies the law of the place where the tort was committed), and applied Saudi law because the physician allegedly misdiagnosed the plaintiff in Saudi Arabia. But because Saudi law does not recognize vicarious liability, the court dismissed the case. Similarly, a U.S. court applying the law of India to a malpractice case might leave the patient with very little compensation, yielding the same outcome as if the plaintiff had sued in India.

But the Chadwick case may be an unrepresentative and relatively simplistic example of how courts might resolve choice of law questions in medical tourism cases. First, very few American jurisdictions use lex loci delicti. Instead, modern choice of law approaches tend to rely on a multitude of “contacts, factors, and policies” that would require courts not only to examine the content of foreign laws, but their underlying policies as well. Second, choice of law disputes will be challenging because medical tourism complicates the traditional analyses. U.S. patients might argue that because foreign providers market themselves as meeting Western standards of medical care, they should be held to those standards in court. Otherwise, divergent standards of care between jurisdictions can affect the choice of law analysis. Moreover, courts assessing choice of law might consider patients’ expectations and role in choosing the foreign provider. For example, in a domestic cross-border malpractice case, a Pennsylvania court declined to apply Pennsylvania law and applied the more pro-defendant law of Delaware, noting that patients who travel out-of-state for care cannot carry with them the more protective laws of their domiciles, because such a rule would require providers to comply with the laws of all states that send them patients. In a medical tourism case, the foreign provider could similarly argue that patients knowingly choose to receive health care in a foreign jurisdiction and that providers cannot be expected to comply with the laws of all of their patients’ home countries.

Thus, although suing a foreign provider seems to be the most straightforward avenue for redress, it could be anything but. Patients not only would struggle to establish jurisdiction and venue in U.S. courts, but they may find that courts would apply foreign law. Moreover, these legal obstacles are only compounded by practical ones, such as the burden of properly serving process to a defendant overseas. Combined, these obstacles could insulate foreign providers from liability in U.S. courts. But until courts are confronted with such cases, we are left to speculate.

B. Suing Intermediaries in the United States

Although medical facilitators located overseas can use many of the same defenses as foreign providers, facilitators located in the United States are not similarly shielded by questions of
jurisdiction, venue, or choice of law, making *15 them more convenient defendants.67 U.S. facilitators could be liable under any of the following theories: corporate negligence, failure to obtain informed consent, and vicarious liability.

1. Corporate Negligence

Aggrieved patients may sue medical tourism facilitators for corporate negligence, just as hospitals have been held liable for negligently hiring, retaining, or supervising unfit or incompetent physicians.68 However, courts might be reluctant to extend corporate negligence beyond hospitals, as shown by decisions absolving HMOs for torts committed by network physicians.69

Moreover, medical tourists could encounter difficulty proving corporate negligence. For example, proving negligent retention would require demonstrating not only that the foreign physician was unfit or incompetent, but also that the U.S. company knew or should have known this based on some pattern of misconduct.70 Patients might find it difficult to muster evidence that a foreign provider was unfit or incompetent, especially if the standards for credentialing and practice depart from U.S. standards. Further, courts may be reluctant to pass judgment on such matters.

2. Informed Consent

Patients may also sue medical tourism facilitators for failure to obtain informed consent if the company misrepresents the quality or qualifications of its foreign providers.71 Facilitators often boast about the quality of foreign providers, and it is not difficult to find marketing hyperbole on their websites.72 Of course, patients will face several hurdles proving not only that a facilitator had a duty to obtain informed consent, but that the facilitator also had failed to do so. Courts remain wary of extending informed consent liability beyond the treating physician.73 And it would be difficult to prove that the misrepresentation was material because it must be shown to have caused the patient’s injuries.74 Most importantly, it would be difficult for U.S. courts to ascertain whether the statements were in fact misrepresentations, because this determination requires *16 courts to assess the quality and credentials of foreign health care providers--a thorny proposition.75

3. Vicarious Liability

Finally, patients may argue that a medical tourism facilitator should be vicariously liable for malpractice committed overseas.76 However, courts generally refuse to hold HMOs and similar entities vicariously liable for malpractice by a physician unless the physician is an employee or the agent of the company.77 Even then, most medical tourism facilitators can safeguard against liability through a well-worded disclaimer.78

C. Suing Employers and Insurers in the United States

Today, many patients venture overseas not on their own planning, but because an employer or insurer encourages it. In such cases, patients might assert yet additional theories of liability. In fact, patients sent overseas by an employer or insurer may have an easier path to redress in the United States than patients venturing overseas independently.79 Some legal theories available to patients suing employers or insurers overlap with those that would hold facilitators liable. For example, patients might argue that an employer or insurer failed to obtain informed consent or exerted some control over a negligent foreign provider and should be vicariously liable.80 If an HMO physician recommends a foreign surgeon, the U.S. physician would probably have some duty to disclose the risks of the procedure and obtain preliminary informed consent; at least one court has imposed such
a duty on the referring physician in a domestic case.81 In spite of this domestic precedent, courts in medical tourism cases would still need to resolve complicated questions regarding the scope of the risks, disclosures, and consent required.82

Like hospitals, insurers could be responsible for negligent credentialing if the insurer negligently approved a foreign physician for treating its customers.83 Some observers argue that if HMOs and other employer-sponsored health plans outsource surgeries to foreign providers, they may violate their fiduciary duties under the Employee Retirement Income Security Act of 1974 (ERISA).84 Health plans covered by ERISA must act “solely in the interest” of plan beneficiaries and must at minimum avoid making any material misrepresentations about the plan.85 Health plans that outsource surgeries risk violating both duties.86 Even though an ERISA claim would not compensate victims of malpractice, it might encourage health plans to be more careful about the financial incentives they offer and perhaps the representations they make about foreign providers. Otherwise, insurers might be liable for civil damages as a result of the breach.87

Overall, employers and insurers that send patients overseas may be the least sympathetic defendants because they generally save a significant amount of money without accepting much risk in return.88 Some authors even suggest that offering financial incentives to patients may increase an insurer’s risk of liability.89

But as with other defendants, there are real obstacles to proving these claims against employers and insurers. For example, a court would have to resolve several knotty questions outlined above to hold a U.S. employer or insurer liable for failing to obtain informed consent from medical tourists.90 Vicarious liability is unlikely unless the employer or insurer exerted some control over the foreign provider,91 which would be relatively unusual. A complaint based on negligent credentialing may have some teeth but would require courts to scrutinize the credentials of foreign providers operating in vastly different environments.

D. Inoculating Against Liability

The medical tourism industry is well aware of its potential legal liabilities. Companies have identified these risks and are taking steps to minimize them.92 Lawyers are busy formulating ways to avoid liability, particularly in U.S. *18 courts.93 In fact, companies may be able to limit their exposure (or at least discourage lawsuits) by asking patients to acknowledge disclaimers or sign releases or waivers. For example, companies can try to use contracts to limit the remedies available, to cap damages, to allocate liability between suppliers, to require indemnification, to shift jurisdiction to foreign courts, and to designate alternative dispute resolution or other non-judicial methods of settling disputes.94

As a practical matter, medical tourism companies can also reduce their exposure by limiting the representations they make about foreign providers, including any claims about surgical success rates or express comparisons to U.S. hospitals.95 The industry might also discourage litigation by informing customers of medical malpractice accident insurance and other forms of protection,96 which I explore further in Section III.A. Together, these safeguards may inoculate the industry against liability, particularly in U.S. courts.

Nevertheless, the unsettled legal questions raised by medical tourism introduce pervasive uncertainty for patients, providers, and facilitators in the market. These issues will be litigated eventually, and the first reported opinions will quickly set standards for the industry. Patients undoubtedly will assert creative legal theories, and defendants will devise even more creative defenses. Until then, we are
left to speculate. In the meantime, companies that outsource health care to less expensive jurisdictions will continue to try to outsource potential legal disputes as well.

II. Seeking Redress in Foreign Jurisdictions

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