You Had It Done Where? The Rise of Medical Tourism

As a card-carrying baby boomer, the dawn of the global economy has been difficult for me to conceptualize. This includes a bias that care transitions are an American issue. But as the younger generation might reply, “Guess again!” Here are a few cases in point:

• On an amazing trip to India, on the road to the ancient city of Orchha, I saw an unexpected structure in rural India: a new cardiovascular hospital, dedicated to open heart surgery. I complemented the guide on India’s commitment to the health of its citizens in this rural area. He courteously and clearly indicated this hospital was not for the native populace — it was for contracted care with American health plans. This hospital was delivering coronary artery bypass grafting at roughly one-tenth of the cost for the same procedure in America. Additionally, the patients and their families stayed in a five-star hotel with all meals included throughout the perioperative period. Were there established provisions for the transmission of information to the physicians in the United States? None were known.

• During my role as medical director of the California Quality Improvement Organization, I met with the medical director of the UCLA Transplant Center. He said his most distressing problem was the individuals who appeared on his doorstop asking — demanding — that they be started on immunosuppressant therapy with follow-up care for their recent, overseas transplant procedures. Typically these patients had been recipients of kidney or pancreas transplants primarily performed in China, and their postsurgical care had to be initiated with no knowledge of the medications, specific procedures, complications, or other associated events of their surgery. There was no provision for transmission of this type of information to the physician team in the United States.

• A Newsweek article entitled “Sun, Sea and Stitches” published on Jan. 16, 2015, by Anna Bernasek discussed medical tourism further. The World Health Organization estimated 750,000 Americans traveled abroad for medical treatment in 2007, increasing to a projected 16 million in 2017. There are no international standards for transmission of information to clinicians in the patient’s country of origin.

• Dean Schnabel, MD, of the Maryland Department of Public Health and Hygiene and colleagues noted an outbreak among 21 patients in six states of rapidly growing mycobacterial infections (Emerg Infect Dis 2016;22:1340–47). Most of these patients (62%) had undergone cosmetic surgery at the same clinic in the Dominican Republic. There was no mention of transmission from the Dominican Republic to any U.S. clinical team.

• A friend has been undergoing treatment for metastatic cancer, using both traditional and alternative methods, and has been doing exceptionally well. The alternative treatments are conducted in Mexico, and exactly what is being done is unknown to the local physicians. The local oncologist summarized the last visit with “You look great. Just keep doing whatever you are now doing.”

Growth of Medical Tourism

Globalization — our shrinking world — has transformed trade, the economy, education, immigration, and our worldview. The concept of care transitions, and the associated perils of transitions, must likewise transform with the times. In the ruthless pursuit of reduced costs, medical insurers and medical providers are discovering the financial common sense of contracting with lower-cost providers across the world to purchase medical services — typically surgical procedures. This, in turn, provides more competitive premiums to their customers. Not to be outdone by the corporate entities, the thrifty American medical consumer is finding an active marketplace around the world for performing non-emergent but desired procedures that are not covered by insurance.

This intersection of the desire to have the surgery with the availability of foreign low-cost providers has spawned the birth of medical tourism. The non-American locales are a given: with lower expenditures for clinicians, a lower cost of living, and the lack of professional liability costs, this lucrative practice is driven out of the United States. There appear to be three basic aspects to the medical tourism trade. First is vanity, where cosmetic plastic surgery reigns supreme. Second is unavailability of organs to transplant in America, including inability to be considered for a transplant list or being low on the transplant list with declining health; in a foreign locale, organ donor availability may not be an ethical problem, and the inappropriateness of the patient for transplant is less an issue than the ability to pay. Third is hope for those with terminal diseases; many foreign practitioners offer a wide variety of purported curative treatments that are untested, un estudied, and unsubstantiated by conventional medicine here.

It becomes all too easy for those of us in conventional medicine to get lost in the discussion of whether an overseas intervention is proven, safe, or even appropriate. That discourse is irrelevant. The brutal truth is that these foreign ventures will continue, Americans will pursue them in greater numbers, and the practice will only increase in scope and frequency given the trend toward globalization. In the face of this reality, perhaps our patients are better served by an emphasis on how to best obtain information on their foreign care in a fashion that promotes quality care.

An online search reveals any number of entities that offer insurance coverage for travelers, overseas businessespersons, and expatriates in general, especially in foreign nations for unexpected illness or injury. These programs offer the reassuring prospect that they will not only connect the ill traveler with physicians or medical facilities, but will also cover the expenses involved. After the patient is stabilized, these same programs will in addition transport the patient home. They provide a necessary and welcome service when the traveler must access them, and no doubt they have saved lives. But this conversation is about care transitions.

No Transition Information

Nothing in the available information on these programs mentions what clinical information is passed between the foreign and domestic providers. Likely key clinical data are transmitted, but there appear to be no standards to guide what information about the illness or injury, interventions, medications, or care provided is to be transitioned to the care providers in the United States, or what the expected timeframe for data transfer will be or in what format it will arrive.

This column has attempted to bring innovative and potential solutions to gaps that threaten clinical quality in care transitions. With medical tourism, we face a scenario where answers are yet to be developed. The potential of the Internet has yet to be fully tapped, and it must be a component of any solution to information transfer. For example, during a business trip to Heidelberg, Germany, I was able to insert my bank card and enter my password at an ATM, and I was addressed immediately in English and could withdraw money — the entire interaction took less than 5 minutes. To my discom fort, I realized this level of worldwide, instantaneous communication could not have occurred if my needs had been medical rather than financial. Surely there is potential to morph this type of near instantaneous data transfer from financial transactions to clinical ones.

Could our lack of interaction with international practitioners be related to the out-of-country sites realizing that they represent inappropriate care? Or are we “traditional” providers the problem? Do we project a persona that denigrates receiving overseas care so that our patients feel they must hide the fact? Do we ignore attempts by foreign practitioners to communicate with us? Do we blow off the information we receive?

So what do we do to increase the chance we learn about overseas care? Here are some thoughts in the absence of obvious guidelines:

• Be open to the potential that care may be delivered outside the United States, especially for those with late-stage malignancies, those who are in need of organ transplantation (especially if they are low on transplant lists or have been rejected for transplant), or those who have a chronic disease not responding to traditional medicine.

• Understand that medical care and surgery overseas can be of exceptional quality — do not dismiss that care or the patients who seek it.

• Be willing to accept information from foreign providers, whatever the source. In fact, request that the patients who are obtaining foreign care ask their practitioners to send the relevant clinical information.

• Have in mind what you wish to know about the care to be delivered and inform the patient, to increase the chances of obtaining clinical data.

There are no simple answers to our international transitions problem, but hopefully these ideas will help open the door to a better flow of information that assists clinicians and patients alike.

Dr. Saltzman is the section chief of geriatrics and transitional care for Lahey Health, Burlington, MA. He is the current chair of the Transitions of Care Committee. Dr. Lett, this column’s author, is past chair of the Society’s Transitions of Care Committee and previous editor of this column.