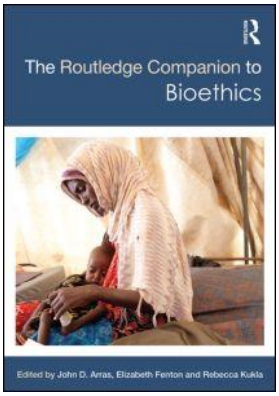

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MEDICAL TOURISM

I. Glenn Cohen

Health care has ceased to be a set of goods and services delivered only locally; it is now a truly globalized phenomenon, including medical migration—the "brain drain" of health care practitioners, largely from the developing to the developed world; telemedicine; multi-regional clinical trials; the global intellectual property regime that both facilitates innovation and stymies access to drugs; and the flow of tissues, including pandemic influenza vaccine strains. This chapter focuses on one part of this globalization: Medical tourism.

The Growth of Medical Tourism

Medical tourism involves the travel of patients from their home country to a foreign country in order to save on costs, receive insurance coverage, or access services unavailable or illegal in their home country. Although studies have come to widely different conclusions about the exact size of the current medical tourism trade, there is no doubt it is significant (Cohen 2013b; Cortez 2011: 878). According to one estimate 750,000 U.S. patients traveled abroad in 2007 for medical procedures, with the total number rising to six million by 2010 (Cortez 2011: 878, n. 119; Murphy 2009; Ehrbeck et al. 2008: 2, 3, 6). In one year alone, 952,000 California residents traveled to Mexico for medical care or prescription drugs, and medical tourism along this border has been consistent and longstanding (Wallace et al. 2009: 662). In 2004, more than 150,000 foreigners sought medical treatment in India, and that number was projected to increase by 15 percent per year (Lancaster 2004). In 2005, Bumrungrad International Hospital in Bangkok saw 400,000 foreign patients (Milstein and Smith 2006: 1638). The revenues generated by this trade are staggering: Some claim that medical tourism will generate in India $2.2 billion in revenues this year, and $8 billion in Thailand between 2010 and 2014 (Cohen 2010b: 1472). This market is likely to expand significantly with the development of robust insurer-prompted medical tourism plans that each of the four largest insurer plans in the U.S. have introduced or are considering (Cohen 2010b: 1486–8; Cortez 2011: 882–4). The European market for medical tourism is poised to continue growing as well (Cohen 2014; European Parliament 2011). These estimates do not include harder-to-quantify forms of medical tourism, such as traveling to obtain abortions, assisted suicide, stem cell treatments, and reproductive technology services (Cohen 2012c).

This chapter considers the bioethical and legal issues raised by medical tourism.

Types of Medical Tourism

It is useful to categorize medical tourism in two separate ways (Cohen 2012a). The first division is by patient population, of which there are three broad categories. First, there are patients paying out-of-pocket. In the U.S., this population includes uninsured or underinsured patients using medical tourism to achieve substantial cost savings, and those seeking to use services unavailable at home in universal health care systems; this group also includes patients seeking to queue jump (Cohen 2010b). A second group consists of patients engaged in private insurer-prompted medical tourism. In its weakest form, insurers simply cover the service abroad without any incentive, but more commonly insurers offer "tourism-incentivized plans," in which individuals are offered rebates, waived deductibles, or other payment incentives for receiving treatment abroad (Cohen 2010b; Einhorn 2008). A final group consists of patients engaged in government-prompted medical tourism. For example, there have been recent proposals in the U.S. to give Medicare and Medicaid patients incentives to use medical tourism; another version is already in place in the European Union (Cohen 2010b, 2014; Baker and Rho 2009; Terry 2007).

The second division is by the legality of the type of service sought. First, there is medical tourism for services that are illegal in both the patient's home and destination countries (such as organ purchase in the Philippines). Second, there is "circumvention tourism": Medical tourism for services that are illegal or unapproved in the patient's home country but legal in the destination country (such as travel abroad for fertility services, abortion, assisted suicide, experimental drugs, and stem cell therapies). Finally, there is medical tourism for services legal in both the home and destination countries—where medical tourism is used because of lower prices or higher expertise abroad, high domestic queuing time, or domestic unavailability (Cohen 2010a). Typically, government-prompted and insurer-prompted medical tourism will only involve the last category, while medical tourism by those paying out-of-pocket can involve any of these categories.

Ethical Issues

When considering the ethical problems raised by medical tourism it is useful to keep *both* these divisions in mind. For example, paternalistic concerns regarding individuals choosing poorer quality health care may vary depending on whether individuals are making choices in a global marketplace for health services or choosing only amongst medical facilities approved by their home country government, as is the case in some parts of the European Union. Also, in cases where medical tourism is thought to cause negative effects on the health care available to poor destination country residents, whether or not the medical tourism is government sponsored may matter a great deal for determining who has what obligations (Cohen 2011a).

I will explicitly put to one side organ tourism, the main kind of medical tourism for services illegal in both the patient's home and destination country, as it is covered in more depth elsewhere in my work and raises fairly distinct issues (Cohen 2013a; France and Francis 2010: 287; Scheper-Hughes 2000; Transplantation Society 2008).

Medical Tourism for Services Legal in Both Home and Destination Countries

This kind of medical tourism represents the largest share of the existing market for services, with patients frequently traveling abroad for cardiac bypass, hip replacements, cosmetic surgery, and reproductive services, often motivated by huge price savings of 80 percent or more off the cost of their surgery, or the ability to jump queues (Cohen 2010b; Cortez 2008: 74, 91).

Quality

One ethical issue here concerns the quality of health care provided to traveling patients. In the U.S. there are several interlocking regulatory and tort mechanisms designed to protect patients in the health care setting. These include the accreditation, certification, and professional self-regulation of health care providers; the medical-malpractice system; the reporting of malpractice suits to the National Malpractice Database; the licensure and accreditation of hospitals; medical staff bylaws; hospital privileges regulation; conflict of interest regulation; and anti-kickback statutes (Cohen 2010b). Many other home countries have similar safeguards, but many foreign countries lack them or have versions that do not neatly correspond to the home country versions. As a result, some worry that a U.S. patient traveling abroad will receive poorer medical care and argue that this justifies some kind of governmental intervention.

We lack good systematic data on this issue. A few small-scale empirical studies of specific therapies and hospitals suggest high-quality care abroad. Arnold Milstein and Mark Smith (2006: 1639) "doubt" that the average U.S. hospital can "offer better outcomes for common complex operations such as coronary-artery bypass grafting, for which several JCI-accredited offshore hospitals report gross mortality rates of less than 1 percent." Aaditya Mattoo and Randeep Rathindran (2006: 359) single out Bumrungrand Hospital in Bangkok, Apollo Hospital in New Delhi, and Crossroads Center in Antigua as "examples of reputable medical facilities in developing countries that are comparable to the best in industrial countries" and note that the Apollo hospital chain has maintained a 99 percent success rate in more than 50,000 cardiac surgeries performed, which is "on par with surgical success rates of the best U.S. cardiac surgery centers." However, Leigh Turner (2013) has recently compiled a list of several reports of death or serious injury connected to poor quality of care at destination hospitals.

Suppose, however, that a foreign facility really did provide poorer care than that available to a well insured patient in the home country. This would not settle the ethical or legal issues.

To begin with, what baseline should we use in evaluating this issue? The counterfactual care that this particular patient would likely receive at home (including any inability to access the service because of inability to pay domestic prices) or a moral baseline based on that to which the patient is entitled? In particular, in countries without universal health care such as the U.S., where some uninsured patients will not have access to many non-emergency forms of health care, a focus on the counterfactual care baseline will lead us to have a more positive view of medical tourism as expanding their choice set in positive ways.

Further, in shaping regulatory policy, what are the limits of justified paternalism? Providing information is a very easy to justify intervention that even anti-paternalists support. Unfortunately, given what we know about domestic health care markets, such interventions are unlikely to make major headway in guiding patients to make better choices; the evidence shows that when presented with information relevant to choosing physicians or insurers, patients often ignore it in favor of word of mouth and in some instances make objectively irrational decisions (Cohen 2010b). So-called "libertarian paternalists" are also open to the creation of default rules of various levels of "stickiness"—in this approach policy is set at a default that paternalists would favor with individuals free to opt for a different choice, but regulators know that individuals are unlikely to change the default (e.g., opt-out rather than opt-in), especially as the transaction costs of making such changes will increase (Sunstein and Thaler 2003). As default rules become "stickier" these interventions are more likely to succeed, but also more likely to offend anti-paternalists.

The regulatory difficulties may be both better and worse when it comes to insurer-prompted medical tourism. On the one hand, insurers may be able to make better quality, more rational determinations than would individual consumers buying for themselves. On the other hand, insurer incentives may not align well with patient desires given the fact that many patients change insurers annually such that insurers do not fully internalize the benefits of higher-cost higher-quality care. Moreover, the empirical evidence shows that patients have difficulty in choosing insurance products, which suggests that patients will have great difficulty choosing between plans incorporating various forms of medical tourism at various price points in a way that furthers their self-interest (Cohen 2010b).

To the extent that patients believe price-to-quality ratio improves their welfare, should the state simply leave patients alone to make their own decisions about where they receive health care? One middle course is what I have called "channeling" regimes, wherein the state attaches penalties or mandates incentives (such as insurance reimbursement) to use facilities that disclose pertinent information, adopt quality control mechanisms, have lower mortality and morbidity rates, achieve accreditation, etc. (Cohen 2010b). A similar approach can be taken to regulate health insurance incorporation of medical tourism. However, creating the necessary regulatory infrastructure would be costly and challenging (Cohen 2010b, 2012a). Finally, as I have argued elsewhere, for uninsured and underinsured Americans in particular, who lack good health care options at home, even if the care provided is not ideal, medical tourism services may prove a necessary way of improving their health care access and too strong an anti-paternalist set of regulations may make these patients even worse off and "protect" them out of their only good option (Cohen 2010b).

Poor quality of care may harm not only tourist patients—the patient protective concern—but it may also lead to substantial externalities. Numerous authors have worried about the propensity for medical tourists to bring back antibiotic superbugs (Hodges and Kimball 2012). Moreover, poorly performed surgeries will often require costly and extensive follow-up care, which in universal health care systems will be paid for by fellow taxpayers and even in the U.S. will indirectly increase costs through uncompensated care pools for the uninsured (Cohen 2014; Crooks et al. 2013). These externalities give home countries another reason to regulate.

Liability

Separate from concerns about quality of care is the question of recovery when medical tourism leads to medical errors or malpractice. The two issues are not entirely separate to the extent that liability rules deter medical error, something that is contested in the domestic medical malpractice literature (Frakes 2012; Currie and MacLeod 2008; Greenberg et al. 2010).

U.S. medical tourists (as well as those from many other home countries) will face a series of difficulties in recovering from medical errors that occur abroad: Difficulties in establishing personal jurisdiction over the defendants, in enforcing judgments patients are granted by courts, and in getting around the fact that much less remunerative foreign laws will often apply to an action even if it can be brought in a U.S. court. If patients are unable to bring suit and must fight in the destination country to recover, the delays and expenses are still discouraging and likely to render a lawsuit non-viable (Cohen 2010b; Cortez 2010: 10).

In the U.S., and in many home countries, we prohibit individuals from contracting with their domestic physician to waive medical malpractice recovery in exchange for a better price. Medical tourism allows patients to circumvent this prohibition. That might seem problematic, but as I have argued elsewhere (Cohen 2010b) there may be some good reasons to distinguish opting into a less remunerative regime through travel versus through contract. In any event, if worried about the lack of recovery, a home country could attempt more muscular "channeling" regimes that required foreign facilities to, for instance, engage in agreements to arbitrate, consent to jurisdiction, or offer medical malpractice insurance.

Effects on Health Care Access for the Destination Country Poor

Even as medical tourism may be a boon for home country patients, it threatens to make things worse for the poor in the destination country. From their perspective, medical tourism presents a host of cruel ironies. Vast medico-industrial complexes replete with the newest technologies provide wealthy medical tourists hip replacements and facelifts, while large swaths of the population die from malaria, AIDS, and a lack of clean water (Cohen 2011a).

These kinds of stark disparities have prompted discomfort and academic and policy critiques (Cohen 2011a; Hopkins et al. 2010; Johnston et al. 2010; Gupta 2008; Bookman and Bookman 2007; Benavides 2002: 55; Chanda 2002: 160; Janjaroen and Supakankunti 2002: 87, 98). As Leigh Turner suggests, "the greatest risk for inhabitants of destination countries is that increased volume of international patients will have adverse effects upon local patients, health care facilities and economies" (2007: 320). This worry has been expressed in discussions regarding Thailand, Cuba, India, and even Israel (Cohen 2011a).

Behind this worry are three fundamental questions. First, how likely is it that medical tourism will cause negative consequences on health care access in less developed countries? Second, do home countries (or international bodies) have an obligation to discourage or regulate medical tourism to prevent such consequences? Finally, how might governments do so?

Despite prominent expressions of concern, there currently exists little empirical evidence as to whether medical tourism has adverse effects on health care access in

destination countries (for a review of the best data suggesting it might, see Chen and Flood 2013). As is often the case in bioethics, then, we are judging under conditions of uncertainty and lack of pertinent information, and it is unclear if that argues in favor of or against the status quo (Cohen 2011a; Chen and Flood 2013). I have drawn on health development literature to suggest that increased medical tourism is likely to reduce access to health care in the destination country for its poor citizens when some combination of six triggering conditions obtains, and others have attempted to show these dynamics occurring in some destination countries (Cohen 2011a; Chen and Flood 2013):

1. The health care services consumed by tourists come from the same pool of health care resources available to the destination country poor.
2. Health care providers are "captured" by the medical tourist patient population, rather than serving a mix of tourist clientele and the local population.
3. The supply of health care professionals, facilities, and technologies in the destination country is inelastic, in the sense that it cannot easily be scaled up when there is increased demand.
4. The positive effects of medical tourism in counteracting the "brain drain" of health care practitioners from developing to developed countries are outweighed by the negative effects of medical tourism on availability of health care.
5. Medical tourism prompts destination countries to redirect resources away from basic health care services in a way that outweighs positive health care spillovers.
6. Profits from medical tourism are unlikely to "trickle down" to the destination country poor.

This list is not exhaustive, and assessments can only be done on a country-by-country basis, but there is sufficient support for such negative effects to put the following issue on the radar: Assuming that medical tourism reduces health care access in destination countries for local populations, under what conditions should such a reduction trigger obligations to regulate medical tourism and/or mitigate its effects?

Identifying and weighing the moral claim is not easy. Medical tourism appears to involve willing providers of services (destination country physicians and facilities) and willing consumers (home country patients, insurers, and governments) pursuing an ordinarily morally unproblematic activity (medical services). Moreover, unlike cases such as organ sale or clinical trials in sub-Saharan Africa of drugs that will not readily be available there, there is no plausible claim that the seller (or buyer) is being exploited. Instead, the moral problem, if any, with medical tourism must stem from the negative externality of reduced care for poor patients in the destination country. There may be separate problems with existing health care disparities in destination countries, but, at least on some theories of global justice (especially more statist and some intermediate theories), if not caused by medical tourism then they are not strictly speaking moral problems *with* medical tourism.

The claim that such negative effects of medical tourism are the moral responsibility of home countries or their citizens is best understood as a claim that might be made under either a theory of enlightened self-interest or based on a theory of global justice, which might take a cosmopolitan, statist, or intermediate form. Elsewhere (Cohen 2011a) I have tried to synthesize the work of the most prominent theorists in this area in the last 50 years (e.g., Daniels 2008; Nussbaum 2006; Nagel 2005; Pogge 2002, 2005; Rawls 1999; Beitz 1975, 1979) and then move from political theory to applied ethics by

asking what these theories should tell us about the concrete case of medical tourism. I myself favor intermediate approaches that impose obligations when there are mediating institutions with coercive or rule-making authority connecting home and destination countries. These theories concede to statist theories the importance of "joint authors[hip] of the coercively imposed system" for full-blown duties of distributive justice, but are prepared to find lesser duties of inclusion—wherein the interests of those outside the nation state count for something—under less demanding circumstances (2011a). While I have defended this view in my own work, what one should think about home country responsibility in the context of medical tourism is deeply entwined with one's views of these theories more generally.

While an overlapping consensus on medical tourism between these different theories currently eludes us, it is fair to say that as to medical tourism we can identify two "central tendencies" among them. I have argued that (2011a) private insurer-prompted medical tourism and government-prompted medical tourism are areas where the argument that states and international bodies have a moral obligation to intervene is the strongest, though for different reasons. More robust curbs on insurer-prompted medical tourism are easier to justify because the patients who use this form of medical tourism (as opposed to the uninsured or underinsured) at least typically have access to non-emergency insured medical services in the home country, such that losing the option of traveling abroad puts them in a less perilous situation. The case for intervening in government-prompted medical tourism is stronger because there is a fairly direct causal tie between the state's action and the deficits caused by medical tourism (which matter on intermediate theories). Claims of an obligation on the part of the home country government or international bodies to do something about medical tourism by those purchasing essential services out-of-pocket seem correspondingly weaker. Beyond these central tendencies, however, there is a fair amount of divergence among the theories in picking out which circumstances give rise to obligations (Cohen 2011a).

Home Country Physician Obligations, Follow-Up Care, and Dynamic Effects of Medical Tourism

There are a series of other ethical issues raised by this kind of medical tourism. First, what are the obligations of home country physicians regarding patients who want to go abroad for treatment? If physicians have a preexisting relationship with a patient, they may face moral or legal obligations not to abandon that patient when the patient returns for follow-up care merely because the patient wants to go abroad. However, physicians may subject themselves to significant liability if a patient suffers medical error during medical tourism but the results become manifest only when the patient returns to their care. While in theory the home country physician is not legally responsible for injuries he did not cause, in practice the medical malpractice system may have difficulty disentangling which physician caused the injury, and there is always significant pressure to settle such cases. To mitigate these problems, home countries may want to consider establishing non-tort compensation schemes for medical tourists, similar to worker's compensation funding (Cohen 2010a; Cohen 2014).

More generally, follow-up care for poorly performed medical tourism procedures may generate significant externalities for the home country's health care system. Health care records detailing what transpired abroad may not be available or readily recognizable (Crooks et al. 2013). Many patients may be embarrassed to notify their home country

physician that they went abroad, thus compounding the injury and attendant costs. Despite legal obligations not to abandon patients, many physicians may prove unwilling to assist returning patients—for example, a general practitioner or cardiologist seeing a patient who has gone abroad for cardiac bypass surgery. Medical tourism paid for through insurance schemes, with their robust regulation of home and destination country physicians through insurance authorization, may be better poised to deal with these challenges than will medical tourism for patients paying out-of-pocket, but there remain significant questions about how best to ensure continuity of care and about who should pay for follow-up care.

Finally, ethical issues may arise from the effect, hard to predict, that competition from medical tourism offerings might have on home country health care industries. Thus far the volume of medical tourism has been too small to have anything but local competition effects (Cohen 2010b). But if the volume were to significantly increase, especially in privatized health care systems, physicians may face pressure to price-match their much cheaper foreign "competitors." Some fear this would lead to "cutting corners," arguing that protectionist measures are needed to avoid the problem, while others welcome such competition because they think that this competition will drive down prices but not quality (Cohen 2014).

Medical Tourism for Services Illegal in the Home Country But Legal in the Destination Country ("Circumvention Tourism")

In "circumvention tourism," patients travel abroad to access a treatment that is illegal/unavailable in their home country, but legal/available in their destination country. It can take many forms. Here are a few hypotheticals (adapted from Cohen 2012b, 2012c, 2014):

- Nawal is a 2-year-old U.S. citizen whose parents emigrated from Sudan 20 years earlier and want to have female genital cutting (FGC) performed on her. The procedure is illegal in the U.S., so Nawal's parents take her to Sudan, where a local doctor legally performs the surgery. Could/should the U.S. apply the criminal prohibition extraterritorially to her parents?
- Andrea, a 21-year-old Irish woman, experiences an unwanted pregnancy. Abortion is illegal in Ireland. She travels to "Women on Waves," a floating abortion clinic in international waters. Ships in international waters are governed by the law of the country whose flag they fly, so this ship flies the flag of the Netherlands, where abortion is legal. Nevertheless, on Andrea's return, the Irish government initiates criminal process against her. Can/should Ireland be able to do so?
- Susan is a 50-year-old Connecticut woman diagnosed with Lou Gehrig's disease with very few months to live. Because of the disease, Susan has difficulty speaking, chewing, and swallowing. Assisted suicide is illegal in Connecticut. Her brother Jon helps her travel to Switzerland, where a clinic assists in ending her life. Upon his return, can/should the state prosecute Jon for assisting Susan's suicide?
- Jason and his partner Jonathan are having difficulty securing a surrogate in Canada, where paid surrogacy is criminalized. They turn to a clinic in the village of Anand, India, where the practice is legal. Can/should Canada prosecute them?
- Rea and Mark are considering taking their 6-year-old son, Noah, from their home in Minneapolis to a stem cell clinic in China for stem cell therapy. Noah suffers

from a rare and severely disabling neurological disorder called ataxia telangiectasia that causes, *inter alia*, decreased mental development. The therapy, involving the injection of adult stem cells into the child's cerebrospinal fluid is unapproved in the U.S. In the one case of treatment that has been documented, the child gained no benefit and instead experienced headaches caused by tumors in the brain and spinal cord that developed from the stem-cell-based injections (DeRenzo 2011: 889; Amariglio et al. 2009). Nevertheless, Noah's parents are adamant that they are willing to take a chance. Does their home country physician have an obligation to report them? Is this procedure a form of child abuse and neglect? Should child and protective services become involved?

All of these hypotheticals are based on real world cases. Fertility tourism is dealt with elsewhere in this volume (see Chapter 30), so I will concentrate on the other examples.

Extraterritoriality and Pluralism

The first set of issues concerns attempts by a home country to extend its domestic prohibitions to activities by its citizens abroad, or in legal terms "extraterritorial application of domestic law." More specifically, I am referring to "prescriptive jurisdiction" for criminal law, which involves the power to render a particular offense criminal, as opposed to, for example, the power to extradite (Cohen 2012c; Lowe 2006: 337–40). As a matter of international law, home countries clearly have the *power* to criminalize these activities (although in some cases, the home country's *own domestic* law may prevent it from criminalizing extraterritorially) (Cohen 2012b, 2012c).

Even if a home country does have the power to criminalize the medical tourism activities of its patients abroad, should it use that power? One way of answering the question would be to consider the legality and morality of the activities domestically. If the U.S. permitted abortion on its own soil, it would have no obvious reason to forbid it abroad, except for the kind of patient-protective concerns discussed earlier for medical tourism for legal services. The more interesting and difficult case, though, is where the home country *prohibits* a practice on its home soil. If the home country conceives of these prohibitions as not only lawful but morally well grounded, under what circumstances does it have the moral prerogative or obligation to extend that prohibition to its citizens abroad?

The key question here is the meaning of "citizenship" and whether, on either communitarian or social contractarian theories of the state's power to punish, the location of the conduct and the fact that the conduct is not prohibited under the law of the foreign sovereign matters (Cohen 2012b). One way of framing the issue is to ask whether the sovereignty of the home country and its power to make people answer to it through criminal law is primarily based on territoriality (the presence of a person in the boundaries of the home country), citizenship (the person's "ties" to the home country), or both. The more citizenship is thought of as a justifiable basis for the sovereign to exercise its criminal jurisdiction, the less problematic criminalizing circumvention tourism becomes.

One also needs to develop a way of weighing the destination country's interest in enabling the circumvention tourist to engage in the domestically prohibited activity within its territory. This interest might be economic, as in fertility tourism, which can be a substantial boon to an economy, or it might be moral, as when the destination

country aims to serve as a refuge for those governed by what it perceives to be unjust laws. Because a home country's criminalization of the conduct of its own citizens abroad is minimally disruptive to the destination country—the provision of services by destination country doctors and the design of its health care system are otherwise unaffected—it is easier to justify than, for example, criminalizing the activity of destination country citizen providers.

Beyond this balancing of potentially conflicting interests of the two countries, one must examine a constellation of questions involving "cost of exit," "accommodation," and "cultural defense." Circumvention tourism offers the citizen a middle ground between the political-theoretical Hobson's choice of either being bound by the domestic law or "exiting"—renouncing one's citizenship and presence in the home country. On this view, circumvention tourism is "exit light": The citizen need only temporarily leave the country in order to avoid its criminal laws (Cohen 2012c). Guido Pennings has been the most staunch proponent of this approach in relation to abortion or assisted suicide, claiming that "[a]llowing people to look abroad demonstrates the absolute minimum of respect for their moral autonomy" (Pennings 2002: 337–41). In the case of something like FGC with strong religious or cultural origins, the accommodation may be to "cultural defense" claims by minority groups within the society (Minow 2008: 252).

However, this middle position is not without problems. First, it would result in a kind of masking of what some (especially the home country legislators that prohibit it domestically) might think of as murder or child abuse, whereby we allow ourselves to avoid confronting evils by making sure they happen outside our view. Second, the accommodation privilege seems to be distributed in a morally arbitrary way since it correlates with an individual's ability to afford to travel. If we were serious about accommodation of the views of home country citizens by allowing them to perform these acts abroad, it seems fairer instead to hold a lottery for those who want to perform the service in the home country and grant them a fixed number of permits, or at least pay for the expense of traveling abroad for those who want to circumvent, so that not only the rich have access to the accommodation, although this would introduce an additional level of complicity. If we are uncomfortable with such suggestions, this may indicate that there is something wrong with accommodation through circumvention tourism. Finally, and most importantly, when the interest is preventing harm to a home country citizen who has not meaningfully consented (e.g., a child, and on some views that are especially likely to be subscribed to in home countries banning abortion domestically, a fetus (Cohen 2012c)), it seems irrelevant to the "victim" that the injury took place outside of the territory; it is, at least on some understandings, still a home country citizen (or at least a "stateless person") who has been harmed by another home country citizen, and the "victim" is not in the destination country voluntarily in a robust sense (Cohen 2012c).

The push and pull of these considerations cannot be resolved in a one-size-fits-all way that generates a single answer for all forms of circumvention tourism. Instead, one should evaluate the propriety of extraterritorial criminalization in light of the reasons that underlie the home country's domestic prohibition along with a determination of who is the "victim" (Cohen 2012c). Putting these two criteria together—type of justification and victim citizenship—can help us sort through these and other case studies.

On communitarian and social contractarian grounds, the permissibility or obligation of the home country to criminalize the activities of its citizens engaged in circumvention tourism is at its zenith when there is a "double coincidence of citizenship"—when both the "perpetrator" and "victim" are citizens of the same home country that has a

domestic criminal prohibition of the act. In such cases, excusing the perpetrator-citizen from criminal liability forces the victim-citizen to forego the protection of the country's criminal law. Extraterritorial criminalization is particularly appropriate when the "victim's" presence in the destination country is not voluntary in a meaningful sense: This is certainly the case with abortion (for home countries that view the fetus as a person, of course) and, given the infancy of the "victim," FGC. For reproductive technology, the issue depends on a specification of who the "victim" is, and for assisted suicide, on whether the home country is willing to accept consent to the killing as negating its criminality.

Where the justification for the domestic prohibition is preventing serious bodily harm and the "victim" is also a home country citizen—e.g., fetuses in abortion, children in FGC, and on some accounts (though I am skeptical (2011b)) some reproductive technology use—the state has very good reasons to extend its prohibition extraterritorially, and the claim for accommodation is at its weakest. This is because under criminal law theory the sovereign is most justified in criminalizing in order to prevent serious bodily injury by one citizen against another, the core of the Harm Principle. By contrast, the state's justification for extraterritorial prohibition is more complex when it comes to "corruption" or "attitude-modification" concerns, exploitation of destination country citizen "victims," and paternalistic protections of patients (justifications often at work in the context of travel for assisted suicide, stem cell therapies, and reproductive technology). In sum, only under some conceptions of why the domestic prohibition is in place may the home country have a prerogative or obligation to criminalize extraterritorially (Cohen 2012c).

Paternalism, Child Abuse, and Home Country Physicians as Double Agents

Medical tourism for stem cells or other experimental therapies raises some distinct issues.

The existing literature paints a sobering picture of the quality, effectiveness, and safety of stem cell therapies currently offered to medical tourists, particularly in China. Clinics often overpromise, given that few existing therapies have peer-review data supporting them; are not always forthright about the type of stem cells they use; and rarely mention the serious risks associated with these therapies (Cohen 2014; Levine and Wolf 2012: 122; Chen and Gottweis 2011; DeRenzo 2011: 889; Ryan et al. 2010; Lau et al. 2008). Yet despite these risks and lack of benefits, many patients are desperate to try stem cell therapies and even report gains afterwards and a desire to pursue further treatments (Chen and Gottweis 2011; Ryan et al. 2010).

The key ethical question here is how to balance patient autonomy and patient protection. One approach again focuses on providing information. The International Society for Stem Cell Research (ISSCR), a leading voice in stem cell research regulation, has developed "Guidelines for the Clinical Translation of Stem Cells" and proposed developing a web-based resource wherein individuals can "submit an entity to the ISSCR for formal inquiry," whereby the ISSCR would then perform an evaluation of the clinic for each of the diseases for which it advertises therapies (Cohen 2014; ISSCR 2008, 2010). Unfortunately, this proposal was never implemented, in part due to legal threats by clinics worried about bad reviews. There is a clear opportunity for home country governments or intergovernmental organizations to step in and fill this informational gap (Cohen 2014).

The bigger question is whether such informational interventions would go far enough. For stem cell therapies specifically, one focus group study concluded that even when individuals were exposed to "cautionary information . . . most remained receptive to obtaining (unproven) treatments under desperate circumstances" (Einsendel and Adamson 2012). Other studies show that these patients are deeply skeptical of the motives or attitudes of naysaying home country authorities (Chen and Gottweis 2011: 11, 13).

Another possibility would be to extend domestic criminal prohibitions extra-territorially, but even if this were possible, it is not clear that it is desirable, at least for adult patients. A long libertarian tradition, for instance, rejects the use of criminal law sanctions to protect individuals from their own bad decisions, and the experimental drug case for terminally ill patients seems a particularly hard one on such views because there is (at least in the patient's own mind) some chance of benefit for which they may be prepared to accept the risk (Stein and Savulescu 2011; Volokh 2007; Feinberg 1986). Indeed at least one author has analogized the right involved to be one of "medical self-defense" (Volokh 2007). Moreover, some patients might prefer hope (even if false) with risks, to no hope and no risks (Murdoch and Scott 2010: 18).

The situation is quite different, though, when it comes to parents transporting their children for stem cell therapies, which makes up a significant portion of this type of medical tourism. Such cases raise two related questions. First, can and should the state try to prevent parents from taking their children abroad for these therapies? Second, what is the role of home country pediatricians in advising parents and potentially reporting them to authorities if they fear for the child's health and safety because of the parents' desire to seek such therapies in destination countries?

On the first issue, parents who opt for stem cell therapies are arguably engaging in acts that might constitute child abuse or neglect, at least in the U.S. and Canada (Cohen 2014; Zarzezcny and Caulfield 2010: 5). Existing case law in both countries has mostly focused on parents who decline conventional cancer therapies for their child in favor of experimental ones, a scenario that offers a compelling analogy with states assuming medical or other guardianship in the case of parents who seek to have their kids use stem cell therapies (Re M.M. 2007; Children's Society of Peel Region v. B. (C.) 1988; Custody of a Minor 1978). While stem cell therapy is a somewhat harder case because it involves more unknown risks, in general more muscular application of child protection laws in this sphere is arguably appropriate (Cohen 2014).

Usually, however, the state will not even know that a parent intends to take the child abroad for a stem cell therapy. Health care providers thus play a crucial role in activating child protective service mechanisms, but placing such obligations on providers also forces them into the uncomfortable position of a double agent. The best approach to this problem may be multi-step, for providers to first provide information and an assessment of the risks, then seek to actively dissuade parents from choosing stem cell tourism, and only then consider reporting the parents to protective services (Cohen 2014; Zarczeny and Caulfield 2010; AAPCCD 2001: 600). However, given robust reporting requirements relating to child abuse in the U.S. and other jurisdictions, when attempts to dissuade fail, providers should face real legal and ethical duties to report parents if the safety of the therapy has not been established. The fact that these parents love their children and are only trying to help makes the situation

particularly poignant, but it does not change the underlying legal or ethical rules that should apply (Cohen 2014).

Conclusion

Medical tourism poses varied and difficult ethical questions, and the analysis provided in this chapter merely scratches the surface. Governments, physicians, hospital administrators, and others are already facing these issues in day-to-day decisions, and as the trade grows so will its problems. It is exciting to see bioethics increasingly shaping the landscape of this complex and challenging area.

Related Topics

Chapter 9, "Do Health Workers Have a Duty to Work in Underserved Areas?" Nir Eyal and Samia Hurst
Chapter 30, "Reproductive Travel and Tourism," G.K.D. Crozier

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