MEDICO-LEGAL SOCIETY OF NSW INC.

SCIENTIFIC MEETING

WEDNESDAY, 10 SEPTEMBER 2014 AT 6.15 P.M.

THE TOPIC:

MEDICAL TOURISM

SPEAKERS: DR GARRY BUCKLAND
MS KATE GILLMAN

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DR DIAMOND: I would like to welcome everybody in my capacity for the first time as the current President of the Society. You will notice that your President is now about a metre shorter than your previous one and about twice as wide, but I will do my best to carry the load.

Tonight's presentation is about medical tourism, which is a small title covering a very large number of issues. What we have this evening are two very interesting and interested speakers who will address the topic from their respective perspectives. I will introduce our first speaker now and our second speaker in the second half of the program.

Our first speaker is Dr Gary Buckland, who is a consultant surgeon and consultant plastic and reconstructive surgeon by sub-specialty. He has two fellowships in relation to his surgical training and his surgical background starts from an exceptional undergraduate career that I will not spell out but just note in the introductory comments.

As I said Dr Buckland is a specialist plastic surgeon with a special interest in reconstructive and cosmetic breast surgery. He has worked in a number of major teaching hospitals, including Prince of Wales Hospital, the Sydney Children's Hospital and the Royal Hospital for Women. He was a member of the New South Wales training committee of the Royal Australasian College of Surgeons in Plastic and Reconstructive Surgery from 1998 to 2008 and the head of department of Plastic Surgery at the Prince of Wales Hospital from 2003 to 2008. Dr Buckland has been a member of the Council of the Australian Society of Plastic Surgeons since 2006 and has been responsible for the writing and implementation of the revised Code of Conduct as Chairman of the Ethics Committee for that Society. Finally Dr Buckland as a member of the Medical Advisory Committee of Avant, is very familiar with the medico-legal issues that arise within his specialty.

I would like to welcome Dr Buckland to the lectern.

DR BUCKLAND: Thank you very much for inviting me to speak this evening. I am going to speak to this topic from a fairly objective basis, although I do have some fairly strong subjective opinions on the matter.

Initially I will talk about the current state of medical tourism on a global basis because in Australia at the

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moment we are very much just the tip of an iceberg. Then I will look at it at on a more local basis, especially with regard to my specialty and the implications of medical tourism on plastic surgery both in this state and Australia-wide. Finally I will talk about some thoughts on what we need to do to make this a better situation for our patients, which ultimately is the most important issue.

Medical tourism is not a new phenomenon. For many years people have travelled the world in search of new technology and increasing expertise in healthcare. Generally this was a group of wealthy people who usually lived in less advanced countries and then travelled to more advanced countries to obtain higher quality healthcare. The current situation is very different. Today medical tourists travel in much larger numbers. They now tend to travel from wealthy economies to developing countries. They are motivated significantly by cost savings, the ability to circumvent waiting times and ultimately to do this at the same time as having a vacation. Their motivations are those of perceived quality, availability, accessibility and affordability.

How big is this worldwide marketplace? In 2004 it was estimated that there was $40 billion in the worldwide medical tourism marketplace. In 2012 it was $100 billion and in 2013 the United States alone estimated it lost $208 billion to outbound medical tourism from its economy. So it is a very significant marketplace. The globalisation of the world economy has resulted in healthcare becoming a global commodity where patients have become customers and clients. The expansion is the result of the internet, the reduced costs of international travel and entrepreneurial opportunities.

The centres of medical tourism are now world wide and in order, by volume of care, the top destinations are Thailand, Hungary, India, Singapore, Malaysia, The Philippines, United States, Costa Rica, Brazil, Mexico, South Korea, Columbia, Belgium and Turkey. It should be noted that of the top five four of them are in Australia’s backyard. Further in Thailand alone last year, its economy benefited by $14 billion from medical tourism. Basically all bar Singapore and the Middle East Gulf States are largely pre-occupied with cosmetic surgery and dental surgery. The Gulf States and Singapore have a more comprehensive compass that includes orthopaedic surgery and cardiothoracic surgery. The Asian countries are also providing an increasing amount

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of fertility treatments. The cost savings for cosmetic procedures range from 50 to 20 per cent of costs compared to developed world costs. However for cardiothoracic surgery and orthopaedic surgery the cost savings can range from 90 to 75 per cent (American Medical Association figures).

What are the issues of medical tourism? There are issues for patients, there are issues for the country of departure and there are issues for the country of destination.

Firstly the patient issues which may be either positives or negatives. The positives are the reduced costs; having the surgery bundled with a vacation; and, certainly from a cosmetic surgery point of view, being able to recover in the privacy of a foreign country where no one else will know what they are up to.

The negatives are more numerous. They include the risks of travel after surgery (with some of worrying figures on the incidence of deep venous thrombosis on long haul flights after surgery, but the data is poor); the potential to introduce foreign pathogens; privacy issues with records kept in foreign countries; inadequate or inappropriate follow up (a big issue with those of us that have seen patients treated overseas); a total lack of legal recourse; and the enormous difference in communication and the informed consent process in these foreign countries.

As an example I have had a situation where a patient came to see me after travelling with a girlfriend to Thailand for a weekend. The girlfriend was going over to have some facial surgery and this lady decided she would have a face lift while she was there. She spoke to the surgeon for the first time in the anaesthetic bay. He could not speak much English, she could not speak any Thai and it all went wrong from that point. She came back and consulted me because she had total unilateral facial nerve palsy. She was the wife of a surgeon which demonstrates these people are not necessarily from demographic that you might expect.

Secondly the issues for the country of departure and again these may be positives or negatives. The positives are reduced domestic waiting lists; and a potential for increased collaboration with less resourced countries. The negatives are the loss of patient revenue (as noted

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above the United States estimated it lost $208 billion from its economy to outbound medical tourism in 2013); the transfer of micro-organisms and foreign pathogens; and the cost implications of assuming follow up care and especially the care of complications.

Thirdly the issues for the country of destination are also both positives and negatives. The positives are hugely increased economic revenue from medical services; improved facilities and technology (and there is no doubt about the quality of some of the facilities in these countries); and their ability to retain their own medical workforce that traditionally has departed to western countries. However the negatives are the significant cost of upgrading facilities; and the increased local health inequality because there is this perception that foreigners are being treated in preference to the local population. Consequently these facilities are not necessarily improving the quality of healthcare for the indigenous people of these countries.

One of the things that is marketed with these facilities in the third world is standards, This is because a criticism has always been how do we know that their facilities are up to the standards of our own country. Accordingly a number of American organisations have gone about accrediting these institutions. One such organisation is ISO (International Organisation for Standardization), which we all know here, and another is JCI (Joint Commission International). Interestingly, when we investigated this we found ISO was not using the same criteria by which it accredits our own facilities in Australia. Instead ISO has created a whole new set of criteria that does not live up to the level of accreditation that we would expect for our own facilities. However it is a badge by which these facilities can market themselves.

Turning now to the Australian experience we find people travel to the places that you would expect. They go to Thailand, India, Malaysia and South Korea. Currently it is largely for cosmetic surgery and dental surgery. However there is now a move into orthopaedics, which is a significant revenue earner for these offshore facilities. The budget in Australia is about $300 million a year treating 15,000 patients offshore at costs that are 50 to 30 per cent of what the costs are here.

The demographic is worrying being largely late teens and early twenties having breast augmentations and dental

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work. However that is not the only demographic. As I noted above I have seen the surgeon's wife who had a facial nerve palsy after a face lift. I am also aware of a retired CEO of a multinational healthcare company in this country, who went to Vietnam to have all his dental implants done. He too was a doctor.

What are the local implications of this industry? The Australian Society of Plastic Surgeons (ASPS) in November 2011 did a survey of its members to try to obtain some idea of the number of patients that were being treated from overseas and the complications of overseas surgery. There were 80 respondents – a 25 to 30 per cent response rate. The responses showed there was a 38 per cent increase on the previous year of the number of cases that were being treated for complications from surgery overseas. These cases largely arose following surgery of the breast (68 per cent) but also face (15 per cent) and body (13 per cent). Seventy two per cent of the patients could not be fully corrected while 62 per cent of them were left with permanent deformity. The average surgical cost of that corrective procedure was $6,000 with 31 per cent of the revisions being performed in a public hospital (and paid for by our taxpayer dollar).

Based on these findings ASPS came out with a checklist for patients to use to assist them to make informed decisions about whether the surgery they were contemplating having overseas was appropriate. The criteria ASPS advised were that the surgeon was a member of ISAPS an international society of plastic surgeons requiring specialist qualifications for membership – not someone who has done a weekend course and calls him/her self a cosmetic surgeon; the importance of informed consent and the time delay between consultation and the actual surgery; the accreditation and standards of the medical facility; the need for devices or prostheses used to be of Therapeutic Goods Administration (TGA) standard; the need to explore the potential for post-operative care should there be complications and how they can be treated; who are the third parties involved in organising these "trips" for them; and what recourse do they have in terms of trying to get adequate follow up from such third parties.

However there are other local implications arising from this cosmetic medical tourism industry. For example there is an organisation in Sydney (which is about to become Australia-wide), where one trained plastic surgeon is advertising salaried positions for doctors who have no

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formal post-graduate surgical qualifications and is paying them $900,000 a year. He is teaching them how to do breast augmentations and liposuction. He is targeting that group of patients who are going overseas and trying to match the overseas facilities for price. He is advertising the price of his own surgery slightly above the price that he is advertising for his lesser qualified practitioners. There is a lot of glossy advertising with a high website profile. However the patient has no understanding of what is going on in his practice. Currently this surgeon has 15 practitioners operating for him. He pays them a wage and the rest is profit for his facility.

Another example is a group of young surgeons who have just completed their fellowship training and accordingly are very well trained. They are all working in public hospitals as they are unable to find any private work. There is no private practice for them because they do not have established practices with established referral bases and all their potential patients are going offshore. These surgeons have formed a group and now it is a race to the bottom. Again, these surgeons are trying to compete on a dollar basis with the overseas tourist destinations. There is no joy in that. The demographic of the patient they are attracting is something that is going to be a noose around their neck for the rest of their careers.

A further local implication is the involvement of third party providers such as NIB Options which advertises: "Make an informed choice about cosmetic and dental treatment: Australia or overseas; Accredited medical facilities; Qualified clinical specialists; 12-month After Care Promise, conditions apply; and Airfares, transfers and luxury accommodation." It goes on to state "Clinical Specialists: Make an informed choice with confidence through our network of qualified Australian and international clinical specialists."

The reality is NIB Options has signed up 20 plastic surgeons each of whom has paid them $25,000 and they offer for the patient to be treated in Australia by the plastic surgeon; be treated in Thailand by a Thai surgeon and followed up by the plastic surgeon in Australia; be treated in Thailand by the Australian plastic surgeon and followed up by the Australian plastic surgeon in Australia. However they have managed to set themselves up with very limited liability.

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A case study of what “failed” medical tourism can mean to the patient. An American woman went to Mexico where she had a breast augmentation and lift, a tummy tuck, liposuction and fat injections to her bottom. The cost was $5,000. A week later back in her home town she became very sick. She went to the Accident and Emergency (A&E) of the local hospital where she was admitted and was treated for a week. She had her breast implants taken out because they were infected and a seroma drained from her abdomen. She needed antibiotics for the infection. The total cost to her was $78,000 and that is without the cost of the breast reconstruction she now requires. That initial surgery in the United States would have cost $30,000 but she made her choice and is now paying the price.

In my personal practice I have had numerous patients who have had treatment overseas and the majority have had no problems at all. For example the CEO doctor noted above had his dental implants in Vietnam without any problems. However it was a very different story for a very overweight young man in the army. He was bullied to such an extent he was discharged from the army with significant compensation. He then lost a lot of weight and needed to have all his excess skin removed. He consulted a number of appropriately trained and qualified plastic surgeons in the southern states of Australia. All of them agreed it was appropriate to remove the excess skin but for it to be done safely, it would need to be staged over three, four or five operations with complete recovery between each. He did not want to hear that advice. Instead he went to Thailand where he had five operations in seven days. The last operation was 12 hours in duration. The next day he boarded a plane and flew back to Melbourne where he died at the airport from a pulmonary embolus. His mother is now telephoning ASPS demanding to know why we failed to prevent this from happening.

On another note altogether is my experience where I had a young women come and talk to me about breast augmentation. She sat opposite me and she wrote down every word I said. She made me go through the implant catalogue and then wrote down the serial numbers of the implants that I had recommended. She made me talk her through how the surgery should be done step by step. Then she went away and had her breast surgery overseas.

We have to accept that the medical tourism industry is a growth industry. It is here for good and it will

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continue to flourish. As health professionals we have an obligation to educate our patients about the decisions they make but ultimately they are the ones who must make the decision. Certainly as a specialty we plastic surgeons need to be promoting ourselves as a superior and safer alternative. However more importantly government needs to look at medical tourism and it needs to legislate. In particular government needs to control third party providers and make them accountable. Personally, as a doctor, I find it difficult to understand how patients can entrust their health to a surgeon whom they have never met, to perform a significant operation in a foreign country with no plan for appropriate follow up by the provider. Perhaps it is just me but I cannot understand how patients can do that.

I am of a generation that is very fortunate. I have an established practice. I do not have to delve into this world of medical tourism. However I do see the repercussions of it and the implications on younger surgeons. Even more so I see the implications potentially on patients. Most of them will "get away with it" but every now and again situations will occur like that of the unfortunate young man in Melbourne who was given appropriate advice in Australia but chose not to hear it. Thank you.

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