

Chapter 17

The Dark Side of Medical Tourism?

End of Life Choice, Human Trafficking, and Organ Transplants

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ABSTRACT

There are 4 principles that should govern the response of the healthcare system in its treatment of individual medical problems. These may be summarized as: 1. medical care should be accessible to all; 2. the principle of patient autonomy should govern decision-making; 3. medical treatment should be recognized as being part of cultural behavior; and, 4. the medical profession should support the benefit of the patient. However, the combination of these with the rising cost of healthcare and the impact of globalization, has led to a dark side for medical tourism. In this situation, both patients and physicians are faced with ethical, human security and sustainability issues. This chapter examines 3 major issues in medical tourism: end of life choice, trafficking in human bodies and body parts, and organ transplants. In the healthcare systems of many countries, these issues can also involve criminal activities.

INTRODUCTION: TRENDS IN THE 'DARK' MEDICAL TOURISM MARKET

Traditionally, healthcare is disease oriented, rather than health oriented. Health orientated healthcare is focused mainly on behavior and lifestyle issues. In the medical model of disease, patients are usually not held responsible for the genesis of their illness. When a person becomes ill, the medical judgment implies that they cannot be blamed for their condition. This model goes on to specify that reactive treatment and care are appropriate and morally desirable (the medical treatment model). But the World Health Organization (WHO) has defined healthcare as “a process of enabling people to increase control

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over and to improve their health.” The strategy behind this notion is to relate personal choice and social responsibility in health to the creation of healthy environments, and to encourage positive personal health behaviors within these. However, current medical treatment arguments are not concerned with what individuals have done, but rather with how to repair the damage that resulted, and how they will behave in the future (Engelhardt, 2013).

A very great difficulty for the medical treatment model is that the financial burden of medical care expenses is increasing rapidly in many countries. Much of this rise in the cost of care can be attributed to advances in medical technology, but there is also a changing disease pattern at work too; 63% of all deaths worldwide currently stem from non-communicable diseases often requiring surgery (NCDs - chiefly cardiovascular diseases, cancers, chronic respiratory diseases, and diabetes; WHO, 2013). When these changing patterns conflict with local legal or healthcare structures, and shortages of the resources needed to solve some of them (replacement organs primarily), there rises the opportunity for criminal involvement and ethical disputes in the healthcare system (Scheper-Hughes, 2000; Denier, 2008; Neoh, 2014). Medical tourism can offset some of these issues, but paradoxically has contributed to some of them also. This chapter examines 3 major issues in medical tourism impacted by this situation that are being discussed at the time of writing: End of life choice, trafficking in human bodies and body parts, and organ transplants.

Dark Tourism

Arguably, despite our title, these issues do not absolutely conform to the original definition of dark tourism (also known as *thanatourism*): is the act of travel and visitation to sites, attractions and exhibitions that have real or recreated death, suffering or the seemingly macabre as a main theme (Stone, 2012; www.dark-tourism.org.uk). Tourist visits to former battlefields, slavery-heritage attractions, prisons, cemeteries, particular museum exhibitions, Holocaust sites, or to disaster locations all constitute the initial broad realm of ‘dark tourism’ (iTDR, 2014). However, this subject area has recently been receiving increasing attention from both academia and media alike (Seaton, 1999; Lennon & Foley, 2000; Miles, 2002; Ryan, 2005; Stone, 2006, 2012; IDTR, 2014). A growing body of interdisciplinary research has been undertaken that derives from the concept of ‘*death-related*’ travel, and certainly, our first medical tourism issue of *End of Life* choice fits that definition (Jamal & Lelo, 2011), while human trafficking and organ transplants do also, when we consider the effects of such actions on donor communities and individuals. Thus, this chapter may also assist in our broader understanding of both the production and consumption of dark tourism, especially when we consider the relationships between this form of tourism and the cultural conditions and social institutions of contemporary societies relating to healthcare.

Stone (2012) has moved the conceptual base of dark tourism in a somewhat similar direction to where we think it should go in order to provide a theoretical context for dark medical tourism. Particularly, his work correlates dark tourism with questions of modern-day mortality (Stone & Sharpley, 2008). In this regard, researchers now often concentrate on the privatization and medicalization of death, which has become a relatively private experience (www.dark-tourism.org.uk). In relation to our discussion of medical tourism this secularization and privatization process has allowed medical treatment as technology to take over the dying process, and medical professionals and the State to deny choice as to the way to end life (Mellor & Shilling, 1993; Howarth, 2007; www.dark-tourism.org.uk). This approach also promotes

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