

Ethics of Care in Medical Tourism: Informal Caregivers' Narratives of Responsibility, Vulnerability and Mutuality

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Abstract

This study examines the experiences of informal caregivers in medical tourism through an ethics of care lens. We conducted semi-structured interviews with 20 Canadians who had accompanied their friends or family members abroad for surgery, asking questions that dealt with their experiences prior to, during and after travel. Thematic analysis revealed three themes central to an ethics of care: responsibility, vulnerability and mutuality. Ethics of care theorists have highlighted how care has been historically devalued. We posit that medical tourism reproduces dominant narratives about care in a novel care landscape. Informal care goes unaccounted for by the industry, as it occurs in largely private spaces at a geographic distance from the home countries of medical tourists.

Keywords: Caregiving; Ethics of care; International healthcare; Landscapes of care; Medical tourism

1. Introduction

Medical tourists are individuals who travel abroad with the intention of accessing private medical outside the context of referral from their home health care system (Hopkins et al., 2010; Hanefeld et al., 2013). To date, reliable quantitative data about medical tourism are limited (Connell, 2013). Researchers suggest that factors such as price, convenience, hope, necessity, and desperation drive patients to consider engaging in medical tourism (Ormond, 2015; Snyder et al., 2014). The majority of movement across borders for private care is regional, diasporic, and often between countries in the Global South (Ormond and Sulianti, 2014; Crush and Chikanda, 2015; Bochaton, 2015). Glinos et al. (2010) offer a typology of patient mobility that describes some key examples, wherein medical tourism is but a single type of global health care mobility, including the travel of un- or under-insured patients for privately-initiated low-cost dental and medical care and the movement of subsidized patients across national borders through formal cross-border care arrangements. These authors emphasize two factors in their typology: the patient motivations and types of funding that drive patient mobility. Hanefeld et al. (2014) highlighted how medical tourism is not just a single phenomenon, nothing that different types of travel (e.g., fertility travel, diaspora travel, dental tourism, cosmetic tourism) are guided by different patient motivations and have different impacts on destination countries. In this paper we are not focused on the impacts of medical tourism on a particular destination country or patient group but, instead, we shed light onto a relatively silent and invisible stakeholder group: the friends and family members who accompany medical tourists abroad.

An emerging area of research in medical tourism has to do with the informal care provided by friends and family who accompany medical tourists abroad, whom we refer to as caregiver-companions. Industry reports and recent studies show that these individuals are often active participants in the practice of medical tourism, although the scope and scale of their care work has only been partially documented (see NaRanong and NaRanong, 2011; Yu and Ko, 2012; Yeoh et al., 2013; Margolis et al., 2013; Casey et al., 2013a, 2013b). These reports and studies document caregiver-companions taking on roles such as providing hands-on care, liaising with health

workers, booking accommodations, coordinating travel, monitoring symptoms, and maintaining communication with friends and family at home. Two autobiographical accounts written by caregiver-companions, *State of the Heart* (Grace, 2007) and *Larry's Kidney* (Rose, 2009), further highlight the broad range of care provided by friends and family in medical tourism. These accounts also demonstrate that caregiver-companions provide informal care not only between countries but across community sites such as the home, hotel, and airplane in addition to the hospital or clinic.

Care is a relational, reciprocal, interdependent and multidirectional practice (Tronto, 1993; Kittay, 2001; Noddings, 2003; Milligan and Wiles, 2010; Wiles, 2011). In this article we draw on an ethics of care framework to argue that medical tourists' caregiver-companions are a significant part of the labor drawn on by the medical tourism industry, and to articulate the ethical implications of such care work. Lawson (2007) advocates for the use of care ethics to inform questions in social research, arguing for the centrality of emotions and social relations in understanding what is happening in the world. Here we employ an ethics of care framework to examine the experiences of Canadian medical tourists' caregiver-companions, how they perceive their relationship to the medical tourists they cared for, and what the effects of the care they provided are. The unique geography of informal caregiving in medical tourism, whereby care provision crosses national boundaries and multiple formal and informal (or community-based) care sites, offers a novel context for applying an ethics of care framework.

An ethics of care, as defined by Noddings (2003), differs from “contract” theories of ethics due to its focus on reciprocity. The defining feature of care is that it requires a focus on taking the needs of another as the basis of action (Tronto, 1993). Critics of this theory have commented on its exclusive adoption of care—traditionally gendered as a woman's task—as its central concern; however, care theorists argue that making the (previously unacknowledged) value of care visible gives voice to a subjugated group (Kittay, 2011). Caregivers perceive that they have a responsibility to look after the needs of the person they are caring for, and many argue that to do so effectively they must feel some sense of mutuality. This is particularly true for informal caregivers who typically have no formal health care training and are not providing care as a form of paid work (Donovan and Williams, 2015). For Noddings, “apprehending the other's reality, feeling what he feels as nearly as possible, is the essential part of caring from the view of the one-caring” (Noddings, 2003, p.16). Many care theorists highlight the centrality of emotion to care work (Kittay, 2001; Held, 2006; Milligan and Wiles, 2010; Wiles, 2011). This affective and physical labor renders caregivers vulnerable to negative mental and physical outcomes – sometimes referred to as caregiver burden (Lilly et al., 2012; Macdonald and Lang, 2014). The affective nature of caregiving relationships is often highlighted, but little research has been done on how care changes across contexts, such as in medical tourism, and how this reinforces existing geographies of power.

Milligan and Wiles (2010) describe ‘landscapes of care’ as the complex spatiality of care, as it is enacted, embodied and organized. This concept acknowledges that the places shaping care, including private spaces (e.g., the home, the community center), institutions (e.g., the hospital, the clinic), and the transitions between them, play a role in how care is delivered and received. Here we explore how features of an ethics of care—responsibility, vulnerability, and mutuality—are enacted across landscapes of care. We posit that the landscapes of care central to medical tourism are at once similar to those experienced in domestic informal caregiving and specific to this transnational phenomenon. This is because many of the activities associated with the care provided, as identified by Casey et al. (2013a), are in keeping with most informal care work (e.g., monitoring symptoms, providing emotional support, liaising with formal care providers), while aspects of the geographical context and the types of care transitions encountered (e.g., from hospital to hotel, from airport to home) are particular to this global health services practice. Further to this, the care work produced by medical tourists' caregiver-companions necessitates that both parties have the financial, emotional, and social means to travel abroad (Kingsbury et al., 2012), and so a very limited number of people will ever encounter this care landscape. The value attributed to informal caregiving varies across landscapes of care. The often invisible labor of caregiver-companions in both private and formal spaces complements the labor of health care workers and others employed in the medical tourism industry in destination countries (Casey et al., 2013a, 2013b). Ethics of care theorists point to the tendency for informal care work to be devalued, in part because it often occurs outside the institution, while privileging formal care work in institutional settings (Tronto, 1993; Lawson, 2007). We contend that medical tourism reproduces this positioning of care: first, by devaluing the labor of caregiver-companions (see Kingsbury et al., 2012; Casey et al., 2013a, 2013b), and second, by hiding care from view in foreign places and private spaces, such as the hotel room.

In this article we present the findings of interviews with Canadian caregiver-companions examined through an ethics of care lens in order to understand how ethical issues emerge in everyday caring relationships in the specific landscapes of care associated with medical tourism. Using inductive coding, we gain unique insight into

the lived experiences of these informal care workers whose unpaid labor propels a multi-billion dollar trade in health services. In the section that follows we set out the recruitment and data collection methods used, and describe our thematic analysis. We then present our findings, elaborating on the ethics of care-focused themes of responsibility, vulnerability and mutuality. We subsequently reflect on how these elements of care exist in medical tourism, and how they are framed more broadly. We conclude that an analysis focused on the ethics of care in medical tourism provides clear examples of the tensions between responsibility and vulnerability. This analysis also makes clear the mutuality of care, and the landscapes of care that are created by a transnational medical tourism industry that requires informal care work to cross a number of formal and informal settings. For ease of description, throughout we use terms such as ‘caregiver-companion’ and ‘care recipient’, but we acknowledge the mutuality of the caregiving relationship and the ways in which we are all continually giving and receiving care (see Kittay, 2001; Wiles, 2011).

2. Methods

This thematic qualitative analysis contributes to a multimethod study that aims to learn about the experiences of Canadian caregiver-companions who accompany medical tourists abroad through understanding the roles and responsibilities they take on. The multi-method study emerged from an earlier set of interviews conducted with Canadian medical tourists that revealed the important participation of friends and family in informal caregiving in medical tourism (Crooks et al., 2011). In this analysis we present the findings of subsequent interviews conducted exclusively with caregiver-companions who had accompanied Canadian medical tourists abroad for surgical care.

2.1. Data collection

Following ethics approval, the lead author completed all semi-structured telephone interviews with caregiver-companions between September 2013 and February 2014. We recruited participants by emailing past study participants to ask if they knew any caregiver-companions, snowball sampling through new participants, placing online postings on Craigslist, and reviewing media and newspaper articles that mentioned medical tourists and contacting them when possible. Once a potential participant expressed interest in the study via e-mail or by contacting our toll-free phone line, we emailed them general study information. Follow-up emails confirmed eligibility to participate (i.e., that they resided in Canada, were over the age of 18, and had previously accompanied at least one adult abroad for the purpose of privately obtaining surgical care), and provided more detailed study information, which included information about our ethics approval and participant rights. The recruitment phase ended when our target sample of 20 participants was met.

The 20 semi-structured interviews were completed over telephone or Skype telephone, and ranged in length between 40 and 80 min. Verbal consent was obtained prior to each interview. Our semi-structured interview guide was developed in an iterative and collaborative process following extensive review of the ethics of care, medical tourism, and transnational informal caregiving literatures. Semi-structured interviewing was selected as a method due to its appropriateness for exploring the experiences of participants (Tong et al., 2007) and the meanings they attribute to the care they provided. We determined that telephone/skype interviews were the most viable for this study due to recruitment considerations, and refer to research showing that telephone interviews are an effective method for qualitative research (e.g. Sturges and Hanrahan, 2004). Questions in the guide were about topics such as: how caregiver-companions planned their trip, the risks they experienced in relation to providing care, what their experiences were in the destination country and at home, the preparatory activities they undertook, and their relationship to the medical tourist. All interviews except for one were recorded and transcribed verbatim. The single interview that was not recorded due to technical difficulties was documented through detailed interviewer notes.

2.2. Data analysis

Verbatim transcripts were prepared and reviewed by the team prior to analysis to identify emerging themes. Our thematic analysis was managed with NVivo software, and the transcripts were loaded into NVivo in preparation for coding. Three themes central to the ethics of care framework were identified in the initial transcript review: responsibility, vulnerability and mutuality. A coding scheme was developed collaboratively in order to capture the nuances of these themes, after which we came to agreement on how to interpret the scope and scale of each in relation to the coding process. Following this, the first author coded the transcripts and notes using the scheme that was developed, adding sub-codes as they emerged from the data. The excerpts were then circulated

to the full team in order to achieve agreement regarding the coding of the transcripts, and data extracts for each of the three themes in this analysis were shared in order to achieve consensus on the interpretation of the scope and scale of each.

3. Results

Of the 20 caregiver-companions we spoke with, ten had traveled abroad with their spouse, while others had traveled with their brother, sister, mother, father, friend or child. Participants ranged in age from 23 to 67 and consisted of 13 men and seven women who had collectively accompanied friends and family to Mexico, the United States, India, Germany, Poland, Egypt, Turkey, Costa Rica, Spain, Philippines, Venezuela and Aruba. Many indicated that they had played a role in assisting the medical tourist with decision-making about the destination. The surgical procedures sought were: hip/knee replacement, bariatric surgery, cataract surgery, colorectal surgery, hernia repair surgery, and the “liberation procedure” for Multiple Sclerosis. Some participants had made multiple trips to the same or different countries with friends and family members for repeat treatments or for different procedures. Many stayed in hotels with the medical tourist following surgery, and spent a significant amount of time in the destination hospital or clinic, providing care in both sites and while traveling. The trips ranged between a few days to several weeks in length. Participants provided physical and emotional support, while assisting with record-keeping and communication with health care staff, as well as dealing with travel and transportation arrangements. Most found the experience to be rewarding, although they faced challenges related to language, finances and emotional strain.

As we explore in this section, participants overall saw their caregiver-companion roles as a personal responsibility, but thought that taking on this role exposed them to vulnerabilities, both physically and emotionally. At the same time, their overall involvement in this practice created a sense of mutuality with the medical tourists they accompanied abroad. In the context of this analysis, responsibility refers to caregivers' sense that they had a duty to look after the needs of the medical tourist, and that this duty should be their primary focus during the trip. Vulnerability refers to their susceptibility to physical and emotional stresses resulting from their care activities in particular places. Mutuality refers to the shared nature of the experience, which they undertook with a medical tourist with whom they shared the vicissitudes of the trip.

3.1. Responsibility

Caregiver-companions, by their own account, felt that they had a personal responsibility to provide care while abroad and en route to and from the medical tourism destination. When asked if they had volunteered or were asked to accompany the medical tourist, most participants reported that it was understood that they would go: *“I don't really think we, we just knew I was going (chuckle). It was just like ‘okay you tell me when and we're going’”*. One caregiver-companion described how *“there just wasn't any question, if he was going to do this I was going to be there. So there was no sort of, no question of that one, it was always planning for both of us to go”*.

For several participants, family responsibility meant an implied agreement to provide care, which sometimes meant that no explicit decision was made:

Well I guess what I can say is support...and you do...the best you can because you're trying to save and help a person and you're helping your daughter and she means the world to you...this for us was part of the nature of us as a family... My husband's parents were very ill, we were used of supporting them. My mother went downhill very quickly, we were used to supporting her. My husband and I are really trained caregivers, we've been supporting people, our parents and everything for years. For us, you just do what you do, you have to.

For most caregiver-companions, the purpose of the trip was clearly caregiving, versus sightseeing or tourism. Although some accounts of caregiver-companions did involve significant engagements in tourism activities like shopping or visiting sites of interest, most stayed in the hospital with the medical tourist for the majority of their trips. This further illustrates the sense of responsibility they felt towards the medical tourists.

During the actual procedure, most caregiver-companions described a similar experience: sitting in a facility waiting room, often watching television or reading. Their responsibility was to provide care and support to the medical tourist, and for some that meant staying nearby at all times, particularly while the patient was undergoing

the procedure. A participant described waiting for his spouse:

I sat in the room 'cause the other spouses or brothers or family members that were there for the other people we just kind of sat together and everybody hung around together and we had our own little group cause you were with each other the whole time. So everybody pretty much stayed at the hospital and just entertained each other that way right.

Some caregiver-companions reported having stayed in the hospital for almost the entire time they spent in the destination country:

When he was at the hospital I stayed the time that he, while he was going through the procedure. The only time that I left the room is when we both went out together to get some fresh air or just go for a walk...we didn't really do too much except stay mostly in the room.

Participants' foci on providing care and attending to the needs of the medical tourist is demonstrated by their desire to stay in close proximity while in the destination country.

In many interviews, when asked to elaborate on the tasks they had completed in their role, caregiver-companions had difficulty articulating caregiving tasks because they felt it was their duty to do whatever was needed. In many ways these tasks were a seamless part of the ongoing relationships they held with the medical tourists and were not explicitly associated with their roles as caregiver-companions, even if they had never performed such tasks before:

You know it's hard to say it's just [I did] this, that and the other thing. Since "M" has mobility challenges I would certainly be there to help her move, you know sleep, in pain or things that are, you try to help within terms of massage and a little prayer and some laughter. But I wouldn't, I wouldn't go to a point and say 'whoa, I had to do so many different things', it's just part and parcel of two individuals who've been together for a good chunk of their lives.

Participants who were long-term caregivers were accustomed to the type of tasks they undertook while engaging in medical tourism, which further underscores the implied nature of their responsibilities as carers. For example, a participant described the care tasks that he undertook in the medical tourism context as "just normal, my normal caregiving support. Just what I always do." This description of caregiving tasks as "just normal" indicates the general sense that many participants had: the care they provided was a responsibility and not outside the bounds of that typically provided in close relationships.

3.2. Vulnerability

Heightened vulnerability for caregiver-companions in medical tourism exists because patients undergo medical treatment in what is often an unfamiliar environment. Participants described how this creates a need for physical and emotional care, most obviously for the medical tourist. All participants said that it would be necessary for medical tourists to travel abroad with a caregiver-companion:

Like to be in a strange place having an unfamiliar medical procedure, I think that for most people...that would just be stressful and frightening situation, no matter how, how minor the procedure or how confident you are about how, how it was going to turn out. And you know part of the time you're [the medical tourist] entirely helpless too, like you don't speak the language, you're on the operating table or you're bound up or whatever. And I think to face that alone that would be quite nerve-wracking.

This quote highlights the two factors that participants commonly described as creating their own vulnerability: being in an unfamiliar environment and having a friend/family member undergo a surgery.

Participants reflected on how the factors that promoted their own vulnerability could be stress-inducing and may contribute to experiencing caregiver burden. For example, participants reported feeling anxiety due to travel and feeling isolated or unsure in foreign environments: "I'm a creature of habit and...it was a little bit stressful of course going into the unknown and trying to figure out how you're going to do things... So yeah there was quite, there was a fear of the unknown for sure." The diverse care environments experienced by caregiver-companions, in addition to the sheer stress of being in an unfamiliar country, made providing care in medical tourism challenging and ultimately stressful at certain times and in certain places. Caregiver-companions found it particularly stressful to provide care in airports and on airplanes for medical tourists with mobility limitations or impairments.

Two areas of particular concern to participants were the risk of the medical tourist experiencing complications and the need to address financial challenges incurred abroad. In both cases caregiver-companions felt responsible for ensuring that medical tourists, who they perceived to be vulnerable, did not have to deal with negative health or financial outcomes:

...that was my biggest fear, that I'm in the hotel room at midnight and something [a complication] happens. Because we had to watch over them, every two hours we had to wake them up... and...what happens if something, if the wound opens up kind of thing? Then I'm going to panic...

As shown in this example, the medical tourist's vulnerability led his caregiver-companion to experience fear. Another participant similarly described feeling emotionally scared and physically drained to the point of exhaustion: *"I was passed out on a couch, I remember this cause it was, you know I was at the point of, I was a bit scared and I was like just hoping everything would be fine... At that moment I just sort of gave out 'cause I was exhausted with the whole process."* Caregiver-companions' desires to care for medical tourists throughout a vulnerable process in turn left them vulnerable to experiencing various forms of stress and burnout.

3.3. Mutuality

Many caregiver-companions had positive experiences of medical tourism and felt that they had personally benefited from the experience due to the improved health status of the medical tourist. As one participant explained, *"you know, the good stress is hard work and then you get something out of it and then it's over so that was fine...so it was a good stress, it was hard work but for a particular purpose and it turned out well and then it was done, it was great"*. In this quote the participant relates 'good stress' to worrying about the medical tourists' positive health outcome, in which case both parties had a mutually positive experience.

Caregiver-companions noted the downside of mutuality, wherein there was the potential for sharing in the negative experiences of medical tourists. One participant, who traveled with his brother for an experimental surgery, noted the disappointment they shared in the lack of follow-up care received: *"it's like once the six months was up or the four months was up there's been no contact at all, so it's kind of like take the money and run"*. The participant and his brother shared feelings of frustration at the lack of health improvements following the surgery and what they perceived as the poor quality of care provided by the surgeon abroad upon their return to Canada.

Medical tourists and caregiver-companions shared the vulnerability created by medical tourism. Recognizing such mutuality, many participants considered the impacts on both caregiver-companions and care recipients when deciding to engage in medical tourism:

I guess my role is one of a...care partner, as opposed to caregiver. So the effects of "M's" MS [Multiple Sclerosis] has plenty of impact upon myself [already], so when we were sitting down and considering these [medical tourism] options it isn't without a view of the person who is standing next to that individual. The days of stresses and the days of angst and the days of pain affect both of us in different ways.

Caregiver-companions identified strongly with those they accompanied and are therefore impacted by the practice of caregiving. As such, the effects of medical tourism are shared, rather than borne solely by the medical tourist.

4. Discussion

An ethics of care takes as its starting point the notion that caring for another involves understanding their needs and acting to try and meet those needs (Tronto, 1993). Caregivers therefore often feel a sense of mutuality; they share the experience with the care recipients and they can feel what the other person feels (Noddings, 2003). The labor of caring is highly affective, and this plays out in the transnational care landscape of medical tourism as clearly as it does in other settings, such as informal caregiving in the home. For example, participants reported how medical tourists' vulnerability to negative health outcomes exacerbated their own vulnerability to experiencing stress as a result of having to navigate an unfamiliar care landscape. Meanwhile, caregiver-companions perceived that the potential benefits of enacting their ongoing responsibilities to the medical tourists far outweighed the potential for such vulnerability. This meant they were unlikely to decline the opportunity to provide care in the first place. Further to this, there was also a recognition that the caregiver-companion and medical tourist both shared in the risks and rewards of medical

tourism, which may have helped to mitigate the concerns they had about this role. Given the nature of the ongoing relationships caregiver-companions had with the medical tourists (and their attendant obligations and responsibilities), would the risks to their wellbeing outweigh the need of the medical tourist and the potential rewards of taking on this experience? The interview findings suggest that the answer to this question is no. Perhaps the strongest indication of this is that many participants did not even conceive of themselves as having a choice in taking up this role and some were reluctant to even conceptualize themselves as caregivers.

The findings highlight the ways in which caregiver-companions feel responsible to care, are made vulnerable by care, and feel that care is a mutual experience. Milligan and Wiles (2010) offer examples of the “micro-landscapes of care” that are formed in the hospital room, the home and other spaces where formal and informal care takes place. These landscapes are a product of the social and working conventions present in destination facilities, and of informal caregivers' own internal narratives of responsibility, vulnerability, and mutuality. The interviews show that caregiver-companions have to interweave care across a number of micro-landscapes, playing a key role in enacting the landscapes of care in destination facilities and across other care settings (e.g., the hotel), and mediating interactions between medical tourists and health care professionals abroad (see also Casey et al., 2013a, 2013b). These micro-landscapes were nested within the larger context of enabling the provision of care across countries, cultures, care contexts, and sometimes also languages. The findings also point to the fact that some caregiver-companions found or created micro-landscapes of coping throughout their transnational journeys as caregivers. For example, it was commonly reported, as noted in the findings, that caregiver-companions would group together in hospital lounges and waiting rooms to talk, eat, and watch television together. Similarly, the potential for informal care between patients is created in the shared spaces that they occupy (Ackerman, 2010), although this was not noted by participants in our study. While a medical tourist's hospital room or hotel bed may have been a space anxiety at times, such micro-landscapes could be drawn upon to enact the mutuality of experience they shared with other caregiver-companions.

Ethics of care theorists advocate that ethical responsibility is not derived from abstract rules, but from relationships (Tronto, 1993; Noddings, 2003). Caregiver-companions felt a clear responsibility to care, which stemmed from their connections to and relationships with the patients. The informal caregiving literature emphasizes caregiver burdens (e.g., Adelman et al., 2014; Tramonti et al., 2014), but rarely recognizes mutuality in caregiving. Our findings reveal that while caregiver-companions experienced stress due to the complexity of having to provide care across multiple micro-landscapes of care, they also reported some benefits of providing care in the context of medical tourism. For example, they emphasized the importance of being able to aid their friends or family members in achieving improved health, which is a benefit that has been reported elsewhere in the caregiving literature (e.g., Petersen et al. (2014)) – though not from a perspective that has emphasized this is an aspect of mutuality. Wiles (2011) examines the experiences of care recipients, suggesting that more attention should be given to those receiving care and that vulnerability should not be framed solely as weakness or susceptibility but also as openness or receptiveness. Our findings support this view, while also pointing to the fact that the medical tourist should not be constructed simply as a passive care recipient, but as an engaged actor in their experience of care abroad who also plays a role in outcomes for the caregiver-companion. Such a perspective also underscores the established notion that care is not provided in a linear fashion from caregiver to care recipient in a static place. In reality, the need for care and practice of giving care is bidirectional and often unpredictable, occurring in settings that are informed by complex processes and practices (Milligan and Wiles, 2010; Wiles, 2011). These unique settings or landscapes of care in medical tourism shape caregivers' experiences of responsibility, vulnerability and mutuality.

We contend that caregiving in medical tourism is part of the ‘changing topography of care’ that Milligan and Wiles (2010) describe. Medical tourism fits into larger trends brought to light by an ethics of care, such as privatization and marketization, and is enabled by processes such as globalization and trade liberalization. It is one of several global health care mobilities that have gained in scope and scale in the last decade (Bell et al., 2015). Thus, informal caregiving within this practice reflects not only a changing topography of care but also a changing topography of the commodification of health. In her 2007 Presidential Address to the Association of American Geographers, Victoria Lawson argued that care has been marginalized by two trends: the extension of market relations into the caring arena, and the reduced public provision of social care. The privatized, market-driven practice of medical tourism thrives on these trends (Bell et al., 2015). Lawson (2007) suggests that care ethics provide a useful lens for examining power relationships, interdependence and mutuality in research on social phenomena. Given the pre-existing tendency for care work to be privatized and devalued (Tronto, 1993; Lawson, 2007), the omission of informal care from discussions of medical tourism provides a clear mandate for further research on this topic. From this perspective, further investigation of the experiences of paid caregivers in medical tourism is also warranted, including both medical and nonmedical caregivers (e.g., coordinators, translators, cleaning staff, drivers). In addition, medical tourism provides a key example of marketization in the provision of care, as destinations compete to attract consumers of medical services (Connell, 2013; Hanefeld et al., 2013; Lunt et al., 2014). Research on the trade in global health services has highlighted the ethical and equity impacts of medical tourism in destination countries (Meghani, 2010; Cohen, 2012; Chen and Flood, 2013; Turner, 2013). An ethic of care requires that we continue to examine the ethical ramifications

of this industry at multiple scales, including the micro-landscapes of care, and examine the consequences for individuals in destination as well as source countries, including caregiver-companions.

5. Conclusion

This analysis contributes to the developing literature on medical tourism, linking the idea of an ethics of care to the unique landscapes of care in medical tourism. We found that informal caregivers in medical tourism are driven to take up this role by a sense of responsibility to care, and that providing this care renders them vulnerable physically and emotionally while also bonding them to the medical tourist through mutuality. Given the important role that caregiver-companions play in the global medical tourism industry, we believe it is essential to continue to articulate the ethical and practical implications of their unpaid labor. We further contend that medical tourism provides an example of a unique landscape of care, where informal care provision crosses countries and takes place in novel care sites, including hotels and airports, and thus advocate for others to employ the landscape of care concept when researching this transnational practice.

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