



Medical Tourism Research Group

***“They go the extra mile, the extra ten miles...”*: Examining Canadian medical tourists’ interactions with health care workers abroad**

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45.1 INTRODUCTION

The Canadian health care system is publically funded (with the exception of some private clinics) and service decisions are primarily made by administrative units housed within provinces and territories that follow broad federal mandates (Health Canada, 2004; Statistics Canada, 2013). All Canadians have publicly-funded coverage for health care that is defined as medically necessary under the Canada Health Act. However, many Canadians choose to supplement this public coverage with private insurance for greater coverage of a range of services that may not be considered 'medically necessary', including dental care (Health Canada, 2011).

In recent years, Canadian health system reforms have targeted enhancing coordination and integration of comprehensive health services. One result is that health care workers are now more likely to work in primary health care teams and, in addition to treating patients, spend more time promoting health, the prevention of illness and injury, and the management of chronic diseases (Health Canada, 2011). This and other system reforms have changed the patient-health care worker relationship. There have also been changes to the 'patient's role'. Canadian patients, including those considering medical tourism, increasingly interact with health care workers as active consumers armed with information from the internet (Crooks et al., 2012; Johnston et al., 2012). Health care workers react to this change in different ways: acting defensively by refusing to engage in shared decision-making, acting collaboratively by finding and interpreting information with patients, or by pointing patients to reliable sources of information (McMullan, 2006). As a result of these and other system reforms, ongoing shifts towards enabling patient empowerment, and the move away from a paternalistic style of practice, Canadian patients are beginning to hold altered expectations of both the health system and health care workers.

Our previous research has shown that some Canadian patients choose to opt out of the domestic health care system for medically necessary procedures and instead engage in medical tourism (Snyder et al., 2011; Johnston et al., 2012). Others choose to go abroad for elective

procedures that are not covered by the public Medicare system (Snyder et al., 2011, 2012). Medical tourism is not a type of arranged cross-border care, which means that these patients must pay privately for procedures. By opting for medical tourism, Canadian patients can obtain a plethora of procedures ranging from the experimental to the routine (Jones and Keith, 2006; Burkett, 2007; Keckley and Underwood, 2008; Turner, 2008; Barclay, 2009; Alleman et al., 2011). Perhaps reflecting an awareness of the potential burden of shouldering such costs, hospitals and clinics seeking to treat medical tourists often advertise the low cost of their procedures (Burkett, 2007; Horowitz et al., 2007; Turner, 2007; Johnston et al., 2012). Additionally, their websites promise superior expertise and care, and some advertise international accreditation (for example: Fortis Hospital-Bannerghatta Road, Bumrungrad International Hospital, Bangkok Hospital, Gleneagles Singapore and Asklepios). However, the medical tourism industry is under-regulated (Terry, 2007). There are currently no means by which medical tourists [en] Canadian or otherwise [en] can obtain reliable information about the industry (Lunt and Carrera, 2010; Lunt et al., 2010) and there exists little to no liability for clinical malpractice (Cortez, 2008; Whittaker, 2008; Johnston et al., 2010).

Media sources often provide potential Canadian medical tourists with their initial impression of the industry. The Canadian print news media typically present medical tourism as an alternative to the domestic Canadian health care system and as a competitive industry that benefits destination countries through job creation (Crooks et al., 2013a). Meanwhile, medical tourism marketing emphasizes safety of care, competence, and availability of treatments (Connell, 2006; Burkett, 2007; Crooks et al., 2011a). Such marketing can create high expectations. One area where these new expectations have impacted domestic health care practice in Canada is through medical tourists' interactions with health care workers abroad. After they go abroad for a procedure, many returning Canadian medical tourists are struck by the contrast between the levels of personal attentiveness and friendliness that they experience while in the destination facility (high) versus those that they experience at Canadian facilities (markedly lower) (Crooks et al., 2013a). The high ratio of health care workers to patients, combined with a culture of care that emphasizes customer service, often results

in a feeling of trust and confidence in the health care workers in destination facilities (Crooks et al., 2011b; Solomon, 2011).

Developing an understanding of medical tourists' interactions with their health care workers while abroad is important for a number of reasons. Social support has been linked to improved health outcomes for patients (Berkman et al., 2000; Lee and Rotheram-Borus, 2001; Uchino, 2004, 2006), while a lack of social support has been found to lead to higher mortality rates (Brummett et al., 2001; Rutledge et al., 2004). While abroad, medical tourists are not in a position to draw on their usual social support networks as they are away from home. It could be the case that workers in medical tourism facilities are aware of this and work to form a supportive and trusting bond with the patients given that they are away from home and unable to draw on their usual support networks. Furthermore, when patients perceive their relationship with their health care workers as positive, they have been shown to have a higher chance of improved health outcomes (Stewart et al., 2000; Arora, 2003; Beach et al., 2006; Street et al., 2009). There is no reason to think this would be any different for medical tourists. The patient-health care worker relationship can have important implications for patient health and therefore we believe that research into this topic using medical tourists' own experiential accounts can help to identify strategies that can be used to secure and improve this relationship.

In this chapter, we present the findings of a thematic analysis that examines the interactions and relationships formed between 32 Canadian medical tourists and their health care workers abroad. We have reported on the details of the study design elsewhere (Crooks et al., 2012; Johnston et al., 2012; Snyder et al., 2012; Johnston et al., 2013), and so we will not repeat that information in detail here. In 2010 we conducted telephone interviews with 13 men and 19 women who had previously gone abroad from Canada for a range of surgical procedures to countries such as India, the United States, Germany, Costa Rica, South Africa, China, Israel, and Mexico. The most common procedure obtained by the participants was hip or knee replacement/resurfacing, while others travelled for cosmetic, bariatric, gastrointestinal, and dental surgeries.

Our thematic analysis of the interviews yielded two important themes related to participants' perceptions of clinical and consultative interactions with health care workers and the style of health care worker interactions they had while abroad in medical tourism facilities. In their clinical interactions, participants described health care workers as collaborative, accessible, and engaged. In terms of the overall style of health worker interactions, medical tourists felt that their needs were acknowledged by health care workers, that their interactions were comfortable and informal, and that they could maintain and easily access established relationships with care providers abroad following their return to Canada. Participants frequently compared their interactions with health care workers abroad with interactions they had at home in Canadian clinics and hospitals, suggesting that care abroad was more attentive and more satisfactory. In the remainder of the chapter we examine these two thematic findings in depth, divided into two sections.

45.2 CLINICAL INTERACTIONS BETWEEN MEDICAL TOURISTS AND HEALTH CARE WORKERS

Many participants reported that they were cared for by a large and varied group of health care workers. One participant, for example, was quite struck by the number of care providers who attended to him while in India:

There were a number of different doctors that would come in. There was a surgeon who actually performed the procedure and then he had an assistant and there was a neurologist that was in charge of my overall care ... There must have been about six different doctors come in all the time ... I think over the period that we stayed there I had probably about four or five different nurses.

Such discussion of provider quantity was common throughout the interviews. Participants also listed anaesthesiologists, dieticians, physiotherapists specifically and specialist surgeons and doctors more generally as part of their caregiving team. The roles of various providers were sometimes, but not always, apparent to some participants through the uniforms they wore. This visual cue let these

participants know if a worker was ‘... either there to empty the trash or to give me a shot: [one] could tell by what they had on’ and often validated their expectations of what a hospital worker ‘should’ look like.

Health care workers abroad were commonly characterized as functioning like a ‘multidisciplinary team’, with each worker having a distinct and useful role that was understood by the other team members. One participant recounted the way these roles fitted together to provide collaborative, coordinated care: ‘[The surgeon] came out and said “hi” to me, and then I was wheeled into [a room to see the] anaesthesiologist ... and they had the nurse ... [make] sure I was warm’. Such collaboration often involved communication between health care workers that was visible to participants. For example, a woman noted that ‘the nurses seemed way more well-informed [than at home], it seemed ... like the nurses in Germany were communicating with the surgeon’. Team-based care that incorporated a high level of communication of health care was championed as a core element of the high quality of care received while abroad by many of the people we spoke with. One participant postulated that her surgeon ‘had his team of people supporting him so there were tasks that he didn’t have to deal with, that presumably ... freed up time for him to respond more to patient care’. However, not all participants noticed an unusually large number of health care workers with whom they interacted while abroad, nor did they all note a variety of roles among those they did interact with. Indeed, some participants reported minimal differences between their interactions with and exposure to health care workers at home in Canada and abroad at medical tourism clinics and hospitals.

Participants perceived that when there were many health care workers dedicated to each patient, care was simply more accessible. One participant described this as ‘direct patient access to the [health care worker] you’re dealing with ... If you wanted somebody they’d be there right away.’ Another participant expounded on the level of constant attention she received from the nurses while she was in the hospital abroad: ‘The nurses [were] there constantly ... if you say “boo” there’s someone there immediately.’ Many participants also commented on the perceived accessibility of

the surgeons and other doctors in the hospitals and clinics they had visited. One explained that 'every morning the four or five doctors will come towards your bedside and ask you ... different things ... to make your stay very comforting'. Although most participants were impressed by the level of attention they received from the health workers they interacted with, some found it 'overly helpful' and thought that the number of staff they interacted with was 'ridiculous'.

The ease of access to health care workers while abroad resulted in participants often spending more time with them than expected during their hospital stay. A participant mentioned the frequency of the visits from her nurses and the amount of time her surgeon spent with her during her stay. She was especially impressed with 'how often the nurses come to see you and check in on you ... And the fact that [my surgeon] came every day ... [sometimes he stayed until] I'd say "okay you can go now, I want to go to sleep".' Time with health care workers was regularly spent listening to thorough explanations of the procedure and asking questions that were answered in full. One participant shared his satisfaction with the amount of time his doctors spent answering his questions. He was confident that he 'could still be asking questions today and they wouldn't be rushing [him] out of there'. Indeed, all the health care workers participants encountered appeared to set time aside to answer patient questions during their interactions. Another participant described their interest and willingness to answer questions. 'Before the surgery I met every single person that was going to be [involved,] from the anaesthesiologist to the ... nurses to the two doctors that did the surgery like everybody talked to me before you know did I have any questions, any concerns, they addressed everything.' Participants commonly reported that the time to ask questions and engage in extended dialogue with health care workers in Canada was highly limited.

Overall, participants were impressed at the level of dedication demonstrated by the health care workers they interacted with while abroad. The staff covered all aspects of care during the stay, and according to one participant, that care is constant: '[I was] absolutely taken care of the minute I got off the plane till the minute I left. I had medical assistance, I had massages ... I had nurses washing my hair.' In particular, the diligence of workers in providing high-quality medical care was

touched upon throughout the interviews. One participant noted his anaesthesiologist's competence after she informed him of her previous reaction to anaesthesia: 'I have a tendency to throw up ... I told [my anaesthesiologist abroad] about it, he just said "I'll make up a special recipe just for you". And by golly, I didn't throw up.' Another participant reported on the dedication she observed by recounting the inclusion of her family as potential patients because of the genetic nature of her retinosis. Her surgeon explained to her:

you have that, we know that its genetic ... so let's test everybody and see if there's some in the family and if there is then we need to do some tests on ... the kids, make sure that we can prevent the disease from happening as quickly and maybe we could do surgery right away ...

Once again, it was reported that such caring and attentive interactions with health care workers were not common at home in Canadian hospitals and clinics in the participants' experiences.

45.3 INTERACTIONAL STYLES BETWEEN MEDICAL TOURISTS AND HEALTH CARE WORKERS

Participants commonly described a sense that care abroad was patient centred, and that health care workers were focused on the individual receiving high-quality and empathetic care. One woman who had travelled to Cuba for retinosis treatment expressed a feeling that care abroad 'is different because they're talking to you as a human being not as ... a special case ... they learn at school ... so they're really human ... you feel like your name is something and it's not only on your birth certificate'. Several participants expressed similar sentiments, describing the feeling that health care workers abroad interacted with them as people first rather than patients first. Participants described how health care workers paid attention to their individual experiences. One woman who travelled to China for a mole removal felt that 'there was no coldness about [the care] or ... no assembly line' approach to care. In general, participants felt that health care workers provided them with

personalized care, and regarded them as people as well as patients. Such experiences were often not consistent with those they had at home with care providers in Canada.

Most medical tourists we spoke with reported feeling comfortable in their interactions and conversations with health care workers abroad. Some described their comfort as resulting from the non-hierarchical interactions they experienced in the destination facilities they visited, and the feeling that they were on equal footing with the health care workers they interacted with. For example, one woman who travelled to India described how 'it was a very relaxed atmosphere ... sometimes doctors [elsewhere] have a tendency to talk down to their patients [but] these people were not that way at all'. Beyond the perception that they engaged with patients as equals, health care workers abroad were also perceived to expend time and effort on facilitating comfortable interactions. 'Over there they go, man they go the extra mile, the extra ten miles, they're just incredible, their graciousness and their helpfulness there just compared to here [in Canada].'

Participants valued the social quality of the interactions and conversations they had with these workers. One man who travelled to India even described his experience as fun, 'as much as it can be fun when you're being all cut up'. Participants overall described feeling at ease in interactions with health care workers abroad, although some were uncomfortable with the close degree of attention.

One participant recounted his feelings during a bed bath:

I suppose I was little embarrassed because they erred on the side ... of overdoing it ... so you got more than you would get here [in Canada] ... I was a little embarrassed about ... having a bed bath ... by a young nurse who was giving me 24-hour constant care which I ... thought was unnecessary. It was overkill.

Some participants likened their interactions with health care workers abroad to familial interactions. For example, one man who travelled to Mexico commented that his experience 'was basically like being taken in by a huge family'. Another participant who travelled to the United States for a gastrectomy said: 'I remember the nurses, like there was one [who] was like a mother almost'.

The description of health care workers as family members further indicates that these participants

did not perceive their interactions with them to be detached or impersonal, which is how their interactions with health care workers in Canada were typically portrayed.

Interactions with health care workers abroad were generally regarded as more casual and intimate than interactions in the Canadian system. A female participant who travelled to Cuba described chatting with nurses in her room, noting that ‘we’d get engaged in a conversation about ... their family or their backgrounds or their desires, hopes and dreams ... it was a very personable open, it was fun’. The same participant also noted that ‘whenever [the health care workers] would ... see you, they would greet you with a kiss, they’d kiss you on your left side and the right side every friggin’ time they saw you’. This quote serves as a reminder of the fact that such interactions can actually serve as an irritant at times. The level of familiarity with which patients and health care workers interacted abroad led to participants experiencing different social boundaries than those to which they were accustomed in the Canadian health care system. For example, several participants considered their interactions with health care workers abroad to be friendly, with one participant stating that he and his doctor ‘were able to transcend the doctor/patient relationship and ... become ... a good friend’. The characterization of ‘transcending’ the professional relationship to engage in a more friendly, personal way with health care workers was a common theme among participants. Most participants described interactions with health care workers abroad as relaxed and informal, and particularly when contrasted against their experiences at home where interactions were experienced as rushed and impersonal in Canadian hospitals and clinics.

Some participants continued to interact with the health care workers they met abroad after their return to Canada, sometimes in the form of follow-up health questions sent by email or in telephone conversations. One participant emailed his doctor abroad for advice on contraindications: ‘after I got home ... I emailed [my surgeon abroad] and asked him for some advice on some vitamins that I was thinking of taking and ... I had a response the next day saying take this one not that one’. Other participants retained a consultative relationship with their doctors abroad based on their positive experiences with the staff while they were away. One participant sent pictures to be placed

on the hospital unit's bulletin board as a sign of gratitude for the quality of care he received, and he has retained his doctor's services for follow-up consultations: 'I sent [my doctor] a couple pictures ... And he ... said "well thank you for the pictures ... don't forget ... I'm going to need an x-ray from you here in the next couple months".'

In another case, a participant and his doctor abroad used social media to continue their relationship following the participant's return to Canada: 'we're on Facebook together ... I am having a longer-term relationship with the doctor in India than I have ever had with any doctor in [home town in Canada] or throughout my life'. This quote captures a sentiment that was shared by many participants: that they maintained closer, more friendly, and more sustained relationships with the health care workers (and physicians in particular) they had interacted with abroad when compared to the health care workers they are regularly treated by at home.

45.4 CONCLUDING DISCUSSION

Academic discussions of medical tourism have largely focused on patients' motivations for travelling abroad for medical care and especially on systemic push factors that result in unaffordable, delayed, or unavailable services in home health systems (Crooks et al., 2011b). Less common are nuanced explorations of how the patient experience differs across health care contexts. By examining the narratives of Canadian medical tourists in this chapter, we have shown how a particular style of highly personalized, attentive, and empathetic care can be replicated across a range of medical tourism providers in different locations. It is revealing that the dominant narrative of warm and attentive care abroad and cold and impersonal care domestically was repeated across participants and the range of destinations and procedure types sought. Of note is that all participants reported highly positive experiences as medical tourists and none experienced negative health outcomes as a result of treatment abroad. It is likely that this shapes how they now view their interactions with health workers abroad. In other words, if they had experienced surgical complications or other risks associated with going abroad as medical tourists (see Crooks et al., 2013b for a detailed discussion of

such risks), their retrospective narratives of interactions with health workers abroad may have been markedly different.

As a mode of health care where patients are chiefly positioned as consumers, it is likely that medical tourism providers are prioritizing customer satisfaction in order to enhance their reputations and encourage repeat visits among their users (Crooks et al., 2011a). In many ways, though, participants' narratives seemed to lose sight of this fact: they were directly paying for the hands-on, attentive, patient-centred care they received from health workers abroad. This is certainly not the case when receiving medically necessary care in the Canadian health care system, where no money is exchanged and patients are not customers. Meanwhile, the exceedingly warm and empathetic care that Canadian medical tourists report receiving abroad may also result from their role as *guests* who are travelling far away from their homes in unfamiliar cultures, often while in a physically vulnerable state.

It is evident from these Canadian medical tourists' accounts that the highly affective quality and service-oriented nature of care offered in facilities abroad serves as a powerful point of reference for elements of their domestic care with which they are dissatisfied (see also Snyder et al., 2012). This contrast might, most constructively, empower returning medical tourists to clearly articulate which elements of their domestic care interactions they are least satisfied with and advocate for improvements in their interactions with care providers. Less constructively, the differences in interactions with health care providers abroad may be rooted in perceived class differences, inefficient uses of available health care resources, and/or cultural, gender, or professional norms, ultimately cultivating unproductive expectations of health care providers among returning patients. Further research is required in order to tease apart such nuances.

Participants placed great emphasis on feeling satisfied with their interactions with health workers abroad. In fact, they said little about these workers' training backgrounds and qualifications, their clinical abilities, or other quality indicators. Instead, their narratives focused on issues such as ease of access to health workers and other such factors that contributed to their own sense of

satisfaction. An overemphasis on patient satisfaction may obscure other important aspects of the treatment experience, such as continuity of care and actual health outcomes. Patient health and safety experts have cited risks that Canadian medical tourists may face abroad, including complications, the transmission of antibiotic-resistant organisms, discontinuity of care and uninformed decision-making (Crooks et al., 2013b). Given the lack of regulation (Terry, 2007) and reliable information (Lunt and Carrera, 2010; Lunt et al., 2010) in the medical tourism industry, patients may be exposed to standards of care that put them at risk of complications or infection. In addition, they may be provided with incomplete or partial information with which to make decisions about their care, which can compromise their abilities to achieve informed consent. Even if medical tourists maintain sustained relationships with care providers abroad, they may return with incomplete or non-existent medical records from destination facilities, disrupting continuity of care (Crooks et al., 2013b). Clearly, achieving patient satisfaction with more affective, customer-oriented care in medical tourism does not mitigate these risks.

Despite the caveats associated with an overemphasis on patient satisfaction, the great affective power of interactions between medical tourists and their care providers is especially notable in the accounts shared in this chapter. This insight into medical tourists' experiences abroad should inform future considerations of the 'pull' and 'push' factors driving internationalizing networks of care.

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