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A Qualitative Exploration of how Canadian Informal Caregivers in Medical Tourism use Experiential Resources to Cope with Providing Transnational Care

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Abstract

Canadians travelling abroad for privately arranged surgeries paid for out-of-pocket are engaging in what has come to be known as medical tourism. They are often accompanied by friends or family members, who we call caregiver-companions. Caregiver-companions provide care in and across a variety of formal and informal settings, such as in hotels, airplanes and at home. This qualitative study examines the experiences of informal caregivers in medical tourism to learn more about the lived experiences or 'experiential resources' they draw upon to cope with providing care and avoiding caregiver burden. The care-giving literature has demonstrated that such burden can negatively impact caregivers' well-being. The unique, transnational context of care-giving in medical tourism and recent growth in popularity of this practice means that there are few supports or resources currently in place to assist informal caregivers. In this article, we report on an analysis that sought to detail how caregiver-companions draw upon their previous lived experiences to cope with providing transnational care and to minimise or avoid the onset of caregiver burden. We conducted semi-structured telephone interviews with 20 Canadians who had accompanied their friends or family members abroad for surgery between September 2013 and January 2014. Thematic analysis revealed the ways that participants had developed practical strategies to deal with the challenges they faced in medical tourism. The interviews revealed three important experiential resources drawn upon by participants: (i) previous experiences of international travel; (ii) previous experiences of informal care-giving; and (iii) dimensions of the existing relationship with the care recipient. Differences in access to and use of these experiential resources related to participants' perspectives on medical tourism and the outcomes of the trip. By identifying the experiential resources drawn upon by informal caregivers in medical tourism, we can more effectively identify supportive interventions.

Keywords: Canada, family caregiver, informal care-giving, international healthcare, medical tourism

Introduction

Political changes and social trends in Global North countries such as Canada are increasingly shifting informal care (i.e. care that is unpaid) into spaces that have heretofore gone unconsidered (Dyck *et al.* 2005, Curtis *et al.* 2009, Skinner & Power 2011), such as in medical tourism. Medical tourism, where individuals travel abroad to obtain privately paid for medical care outside their home countries (Hanefeld *et al.* 2014), is part of a larger trend towards the privatisation and globalisation of care (Greenhough *et al.* 2015). The care provided in the global practice of medical tourism occurs in formal spaces such as private hospitals and clinics in destination countries, and also in informal spaces such as airplanes, airports and hotels, as well as at home before and after the trip is taken (Casey *et al.* 2013a,b). In this article, we examine particular dimensions of the provision of informal care in medical tourism from the perspectives of the friends and family members who previously

accompanied Canadian medical tourists abroad, who we refer to as caregiver-companions. We specifically consider the ways in which participants' lived experiences are drawn upon as 'experiential resources' across formal and informal care sites. These experiential resources aid in coping with care provision in the context of medical tourism, lessening caregiver burden.

Medical tourists have many different motivations for seeking care elsewhere and go abroad for a vast array of procedures, including but not limited to: dental, cosmetic, orthopaedic, bariatric, fertility and experimental treatments (Turner 2012, Hanefeld *et al.* 2014). Medical tourists from Global North countries such as Canada are driven to go abroad by some of the following motivations: cost, avoiding wait times in their domestic systems and/or the ability to access treatments not available at home (Hopkins *et al.* 2010, Cohen 2012, Hanefeld *et al.* 2015). Patients travelling across borders are often accompanied by caregiver-companions. Their experiences and the care that caregiver-companions provide have only recently begun to be documented in a limited number of studies, several of which only mention this group in passing (see NaRanong & NaRanong 2011, Kingsbury *et al.* 2012, Casey *et al.* 2013a,b, Yu & Ko 2012, Margolis *et al.* 2013, Yeoh *et al.* 2013, Ormond 2015, Whittaker 2015). Two lengthy autobiographical accounts written by caregiver-companions detail the complex range of care provided by caregiver-companions, from arranging travel logistics to dressing wounds, across a multitude of formal and informal settings, including the airport and taxi (Grace 2007, Rose 2009). Given such complexity, it is not surprising that Ormond (2015) encourages researchers not only just to look at the most obvious sites where care is provided to medical tourists (e.g. the destination hospital) but also to closely examine *how* care is provided during transitions between home and abroad, hospital and hotel, airport and taxi, and other transitions. In this article, we build on this by considering *who* provides such care during these transitions, showing that the informal care provided by caregiver-companions is enabled by their experiential resources.

The informal care-giving literature has repeatedly established that caregivers' health is impacted by the nature of the care they provide. Caregiver burden is the term used to characterise the negative impact that care-giving has on individuals' emotional, physical and/or financial health and overall well-being (Adelman *et al.* 2014). The stress brought on by the simultaneous management of paid and unpaid work, the financial toll of purchasing supplies and equipment, the lack of supports and informational resources available, and the physical demands of providing hands-on care, among numerous other factors, all contribute to caregiver burden (Bruhn & Rebach 2014, Davis *et al.* 2014, Williams *et al.* 2014). Whether or not caregiver burden sets in, the extent to which it impacts individual caregivers varies based on access to formal resources (e.g. respite care, information from professionals), personal resources (e.g. social support, finances), personality characteristics, coping strategies, the needs of the care recipient, as well as the relationship between caregiver and care recipient (Bastawrous *et al.* 2014, Bruhn & Rebach 2014, Chapman *et al.* 2014, Davis *et al.* 2014, Williams *et al.* 2014). Much existing research has shown that there is an extreme lack of information and support available to medical tourists to assist with decision-making, accessing care abroad, enabling continuity of care and ensuring follow-up care (Runnels & Carrera 2012, Eissler & Casken 2013, Turner 2013). It is thus logical to assume that informational supports and other types of formal resources for the caregiver-companions who accompany them abroad are similarly lacking, which may contribute to the burden experienced by this group. In addition, as noted above, the context in which care is provided plays a role in determining if and how caregivers manage burden (Adelman *et al.* 2014). Caregiver-companions provide care in a highly complex transnational context that involves navigating language, cultural, social and healthcare differences (Casey *et al.* 2013a,b, Ormond 2015, Whittaker 2015); a context so complex that it may very well promote the onset of caregiver burden.

In this article, we ask: how do caregiver-companions draw upon their previous lived experiences to cope with providing care in a transnational, unfamiliar context and to minimise or avoid the onset of caregiver burden? We analysed 20 interviews conducted with Canadian caregiver-companions. Our analysis shows that these caregivers makes sense of providing care by drawing on their existing experiences of international travel, caregiving and the relationship with the medical tourist. In the remainder of this article, we explore these three experiential resources. Our purpose was to: (i) understand how these experiential resources shape the informal care work taken on by caregiver-companions; (ii) explore the impact that providing care has on caregiver-companions; and (iii) identify resources that can assist in helping them to avoid or manage burden.

Methods

This analysis contributes to a multi-method study seeking to learn about the informal care responsibilities taken on by friends and family members in medical tourism. The overall study has involved interviews with international patient co-ordinators in destination hospitals/clinics and an online survey with Canadian medical tourism

facilitators. The study also involved conducting semi-structured interviews with caregiver-companions themselves, which we report on in this article. Semi-structured interviews were selected as the method for learning about the experiences of caregivers because other studies have shown that such interviews are effective for soliciting participants' own perspectives and accounts of care (Rothing *et al.* 2014).

Following ethics approval from Simon Fraser University, recruitment of former caregiver-companions began through four strategies: emailing past medical tourism study participants to see if they had been accompanied; snowball sampling with new participants; postings on Craigslist; and contacting medical tourists who had been named in media reports to see if they had been accompanied. We employed multiple strategies in order to recruit a diverse participant group. Once participants had been identified and provided with general study information, their eligibility to participate (i.e. residence in Canada, age over 18 and having accompanied at least one adult abroad for medical tourism) was confirmed via email. They were also provided with study information, participant rights and details of our ethics approval. We ended the recruitment period when our sample target of 20 participants was reached. This target was set in an attempt to capture sufficient information within the allotted recruitment period, rather than achieving 'saturation' of the sample size. The broad adoption of saturation as a criterion for qualitative research has been problematised by some researchers (see O'Reilly & Parker 2013). These authors argue that the notion of saturation has been decontextualised from its origins in grounded theory, and that an adequate and appropriate sample need not necessarily be 'saturated' in all forms of qualitative research.

Semi-structured interviews were conducted by the lead author over the telephone or Skype between September 2013 and January 2014. Informed consent was obtained verbally at the beginning of the interviews, which varied from 40 to 80 minutes in length. The questions asked addressed trip planning and preparation, risks and challenges encountered in providing care, the relationship between caregiver and medical tourist, and the caregiver-companions' experiences in the destination country and at home. Interview recordings were transcribed verbatim, except one which was not recorded due to technical difficulties. The sole unrecorded interview was documented through notes.

Transcripts were independently reviewed by all investigators prior to analysis in order to identify themes related to how caregiver-companions dealt with the challenges they had encountered abroad. From this initial review, it became clear that participants drew on experiential resources in three broad areas (travel, care-giving and relationship experience) to manage transnational care-giving. Once we reached consensus on the scope of each theme, we created a code for each theme and the lead author coded the notes and transcripts in NVivo. Coded excerpts were next extracted and shared among the full team to discuss interpretation of the thematic findings relative to the existing literature (Saumure & Given 2008). Quotes shared in the findings section come from these coded excerpts, and beside each we include a unique participant identifier in order to show that we did not 'cherry pick' excerpts from a limited number of interviewees. We believe that the perspectives of multiple researchers, incorporated throughout the analytic process, enhanced the richness and dependability of our interpretation of the data, thereby contributing to the overall rigour of the analysis presented herein (Saumure & Given 2008).

Findings

Of the 20 participants, 10 had travelled abroad with their spouse while others travelled with a sibling, parent, friend or adult child. The majority of the participants had close, personal relationships with the medical tourist that led to their engagement in the medical tourism process. They ranged in age from 23 to 67, and 13 identified as men and 7 as women. They had collectively travelled to 12 countries to accompany medical tourists (with some having travelled to multiple countries): Mexico, the United States, India, Germany, Poland, Egypt, Turkey, Costa Rica, Spain, Philippines, Venezuela and Aruba. The surgeries obtained abroad included: hip/knee replacement, bariatric surgery, cataract surgery, colorectal surgery, hernia repair surgery and the chronic cerebrospinal venous insufficiency treatment for multiple sclerosis. Trips ranged in length from a few days to several weeks, and all participants provided care before, during and after the trip. The majority of participants had experience providing care to the medical tourist before the trip, although they did not necessarily define themselves as 'caregivers'. Most participants reported that the trip was rewarding, but that they faced burdens related to language barriers, finances and emotional strain that brought on stress and negatively affected their well-being (see also Casey *et al.* 2013a,b, Margolis *et al.* 2013, Ormond 2015, Whittaker 2015). They described coping with these burdens through a variety of means, including drawing on previous experiences of travel, care-giving and knowledge about the medical tourists they were accompanying. The remainder of this section examines how participants characterised these experiential resources.

Prior travel experience

For most participants this was their first experience of engaging in medical tourism, although they had varying experience with prior international travel. This prior travel experience was perceived to be necessary to deal with the stresses of travelling for surgery: 'Unless you're used to travelling internationally ... I think it would be pretty worrisome' (19). Many participants were also accustomed to providing some degree of care (but not post-surgical care) while travelling because of prior travel with the care recipient. One participant said that she provided care 'the same way as if we go on a holiday or just [while] visiting some of our kids away from home' (6). Providing care during the medical tourism trip involved some similar considerations (e.g. locating accessible hotel rooms, ensuring availability of preferred foods, booking appropriate seating options for transportation) as during past travel experiences. Those participants who had previous travel experience in general, and especially with the care recipient, were aware of the challenges they might encounter and were able to prepare for them, avoiding becoming overburdened during the trip.

Some participants had prior travel experience to the destination country where surgery was purchased (although previous trips had not been for medical tourism in any of the cases). When asked about whether he had any concerns about travelling to a foreign country for medical care, one participant said that he had travelled to the destination country a few years prior. As a result of this experiential knowledge of the destination, he was 'quite confident that it was a place where there would be North American standards of healthcare ... and that it was a comfortable place ... [and not] an exotic travel destination' (12). Even some of those participants who had not previously travelled to the destination countries found them to be 'familiar' because the destination hospitals had experience with a Canadian-type clientele. One participant remarked: 'I could tell that I wasn't the first Canadian to do this ... or first you know tourist from outside that area to do, to go there for a procedure' (16). As a result, he did not find it to be a particularly stressful place in which to provide care.

Many facilities abroad were designed specifically to cater to the tastes of medical tourists, and had an aesthetic that was comfortable for individuals coming from healthcare systems in the Global North. Participants reported that despite the distances they had travelled, the hospitals/clinics in destination countries were familiar spaces. One participant said:

If I closed your eyes and then wiggled my nose and then you opened your eyes in that hospital, you would not know you were in India. The [hospital abroad] was all in English, they had all the latest equipment, I didn't see one iota difference between the [hospital abroad] and any of the hospitals that I've been to in [home city], none whatsoever. (02)

Participants also made sense of foreign clinics and hospitals by relating them to a more familiar setting: the resort. Several described hospitals abroad as 'pretty much like a four-star hotel resort' (7) and 'like a resort, it was like a luxurious experience in a way' (8). Even if they had not travelled for medical tourism before, many had travelled to resorts and drew on that experience to navigate the 'international' or 'resort' aesthetic of the destination hospital/clinic.

Prior care-giving experience

Many participants drew heavily on ongoing experiences of providing care at home while abroad, framing many core care-giving duties in medical tourism (e.g. symptom monitoring) as unexceptional. As a result, those who were long-term caregivers did not seem especially overburdened by the care they provided while abroad. One participant said that 'nothing was different than regularly', it was 'just my ordinary [care] that I have to do at home' (6). When asked what it was like providing care while abroad, another participant reported that:

It would be no different than anywhere else ... you just have to think ahead of time before you do anything only because ... things you kind of take for granted ... you can't do sometimes right. So you just have to be a little bit more creative. But overall like I said to me it was no, nothing more than you do at home. (10)

This participant acknowledged that it can be necessary to adapt to changing circumstances in medical tourism, but in general the care recipient's routine needs continued to be the same. Caregiver-companions' knowledge of how and when to care for their friend or family member, drawn from experience at home and during previous travels, helped them avoid unnecessary stressors.

Participants often used their knowledge of navigating other challenging care settings to manage care-giving during the trip. They had typically thought through the awkwardness of providing care in an unfamiliar setting

prior to going abroad. One participant related that helping his partner toilet was difficult because ‘when you’re in a hotel it’s not set up the way our house is, so she was unable to do any of that on her own’ (4). As a long-term caregiver, he had experienced such situations before: ‘You know because everybody’s version of ... a handicapped or a wheelchair friendly suite or a toilet ... is completely different from what people actually require, even in Canada’ (4). As a result of his and his partner’s prior difficulties in finding accessible hotels and facilities, he anticipated the challenges of providing care while abroad and was able to plan ahead to avoid feeling stressed. Another participant related a similar set of concerns about flying: ‘I knew it was going to be hard [on the airplane] since she has no, she can’t lift herself, I had to do all the lifting ... And airlines are very difficult to move a person that (chuckle) that is paralysed’ (5). Caregiver-companions with prior care experience, and especially long-term caregivers, drew on such experiences to address the challenges of care-giving in the unique care contexts encountered in medical tourism, including the hotel, airport and airplane.

Most participants had significant experience navigating the Canadian healthcare system as caregivers to their friend or family member. Commonly, they had spent years interacting with healthcare professionals on behalf of/with the care recipient, and they continued to play a significant role doing so while engaged in medical tourism. Many caregiver-companions framed themselves as ‘advocates’ on behalf of their loved ones, drawing on experiences of acting in this capacity at home to ensure adequate care was provided abroad. As one participant explained: ‘We’ve been working together with this problem [daughter’s health] for years, we would never let our child go on her own, my husband’s retired, we were going to do this together and support her’ (20). This participant had a long history of seeking treatment for her daughter, and the knowledge she had gained doing so was a valuable experiential resource as they undertook medical tourism. She drew on this knowledge to make decisions about engaging in medical tourism, to interact with medical professionals in Canada and abroad, and to provide the care her daughter needed as she recuperated.

Prior relationship experience

Nearly all participants, even those who did not have much experience of care-giving, drew on their knowledge of their friend or family member to aid in care-giving abroad. One participant who did not have much prior experience caring for someone recovering from surgery described it as a: ‘unique experience, I’ve never experienced anything like that, I don’t have any care-giving experience. I was there because she’s my wife and I care for her health and giving her the support that she needs’ (7). Although this participant claimed not to have any care-giving experience, he had knowledge about what support his wife might need as well as her general preferences. Overall, participants felt that the caregiver-companion role necessitated a close existing bond with the care recipient. One participant said that she would travel abroad with a friend or family member obtaining surgery again, but that she ‘wouldn’t just do it for anybody I didn’t know ... because I wouldn’t know their needs’ (18).

Due to their existing relationship with the medical tourist, most participants had detailed knowledge of the patient’s health status prior to travelling abroad for surgery. One participant reported monitoring his brother’s diabetes while abroad: ‘I know him very well so ... I can kind of like pick up on his attitudes and stuff to, to know when his blood sugars are out of whack and whether he needs help or not’ (8). In terms of advice for other caregiver-companions, one participant suggested that it is essential that they understand and have experience with the health needs of the medical tourist: ‘make sure you know the situation of the person and their needs cause that’s so important that you have ... someone that knows everything and that person’s comfortable with this person’ (18). In other words, it is key that the caregiver-companion knows the medical tourist’s health needs, and that they are comfortable providing care in this context. This experiential knowledge, derived from the relationship between caregiver and care recipient, was perceived by many participants to be the most important experiential resource that enabled them to cope with care-giving abroad.

As a result of their existing relationship with the medical tourist, many participants drew on experiences of shared decision-making to navigate aspects of the trip. For example, the medical tourist and caregiver-companion often researched and planned the trip in tandem: ‘we researched where you were treated and everything, we looked up the hospital and everything and ... we felt that their care seemed to be the best before and after’ (20). In contrast, others reported that they did not explicitly help the medical tourist decide when or where to travel, but that they were accustomed as caregivers and friends or family members to participating in shared decision-making about healthcare. For example, when asked how he had decided to accompany his wife abroad, one participant said that: ‘it was just, she’s my wife so obviously I agreed, it was a mutual decision’ (4). Some participants had a more hands-off approach to research into destinations and ongoing considerations, but were

involved in the final decision-making about engaging in medical tourism: ‘when she started to sort of finalise what she wanted to do, then I, I got involved in all the pros and cons’ (11). These different contexts reflect the range of ways the caregiver-companions participated in decision-making, typically drawing on their experience in the relationship.

Discussion

The aim of this analysis was to examine how medical tourists’ caregiver-companions draw on experiential resources to aid in coping with the complexities of providing transnational, informal care. The findings shared above reveal that their experiences shape the impact that caring has on them and how they manage this burden. Importantly, this analysis shows that providing informal care in medical tourism, for most participants, shares many similarities to care provision in other contexts (e.g. the provision of long-term care at home, providing care while on holiday, acting as an advocate in routine medical appointments). This overall finding is important because the medical tourism literature tends to place emphasis on how vastly different the experience of receiving care abroad is for medical tourists (e.g. Cohen 2012, Eissler & Casken 2013, Whittaker 2015). Instead, what we found is that the range of settings that caregiver-companions encountered did not drastically change the informal care provided. Rather, it intensified certain aspects of the care-giving experience (e.g. needing to lift the medical tourist in a non-accessible hotel wash-room, which they could manage independently at home). Experiential resources, such as previous travel and the ongoing relationship with the patient, were drawn upon by participants to make sense of these new care settings, anticipate medical tourists’ needs in unfamiliar spaces and navigate transitions between settings.

Transitions in informal care, both between settings and across countries, intensify responsibilities and thus may be stressful for caregiver-companions. Previous research has shown that care transitions – such as between the home and hospital – can be a time where poor management occurs and there is an increased risk of medical complications (Borthwick *et al.* 2009, Brock *et al.* 2013, Cadogan *et al.* 2014). Manderson *et al.* (2012) conducted a systematic review that highlighted the need for ‘navigators’ to assist patients and caregivers in transitions between healthcare services. All three types of experiential resources identified in this analysis aided participants in navigating these transitions while minimising burden. For example, participants could draw on previous knowledge of air travel and opt to reserve well-placed seats in advance. The findings also point to the fact that such transitions are a key point of intervention for policy, given the heightened stress and responsibility that they cause for caregivers. Access to additional resources and supports provided by policy makers and industry professionals would enable caregiver-companions to plan ahead accordingly.

Our findings are in accordance with previous studies that demonstrate that caregivers’ personal resources and experiences can help them avoid burden (Bastawrous *et al.* 2014, Bruhn & Rebach 2014, Chappell *et al.* 2014, Davis *et al.* 2014, Williams *et al.* 2014). This analysis highlights three domains of experience that help informal caregivers in medical tourism to avoid burden. However, which factors are *most* important in mitigating burden is not clear, so continued study is necessary in order to assess their relative importance. Also, participants undoubtedly had varying degrees of experience in these areas, which would likely impact their experience of providing care. For example, those with more experience travelling would find the travel elements less stressful than those who had not travelled outside Canada. However, we were unable to determine which caregivers were more or less experienced in each area based on these interviews alone. That said, numerous participants did place particular importance on having first-hand knowledge of the medical tourists’ health status as an essential experiential resource. This is not surprising given how central the relationship between patient and caregiver is to the overall experience of informal care provision (Bastawrous *et al.* 2014, Chappell *et al.* 2014).

This analysis points to some areas where meaningful interventions can be developed in order to enable caregiver-companions to minimise the onset of burden. First, participants’ accounts highlighted the need to plan for mobility challenges in informal care settings such as airplanes and hotel bathrooms. For medical tourists who face physical difficulties in boarding and being on board planes, ensuring access to early information about flight schedules or gate changes, airplane layout, adequate seating space and on-board first aid supplies are key interventions (Poria *et al.* 2010). Poria *et al.* (2010) noted that the specific needs of each individual vary, and that no single intervention will suffice. In terms of hotel rooms, a key intervention is for destination clinics or facilitators to ensure that hotel rooms are designed to accommodate the *actual* physical needs of the medical tourist, and not just as standard ‘accessible’ rooms (Kim & Lehto 2012). Participants also pointed to the need for detailed information provision about accessibility regimes, both in terms of the layout of hotel rooms and the built environment (Darcy 2010), and more broadly (Eichhorn *et al.* 2008, Buhalis &

Michopoulou 2010). Second, the importance participants attributed to planning before the journey highlights the need for caregiver-companions to familiarise themselves with the needs of the medical tourist, as well as the logistics of the trip and the specifics of the medical procedure to be undertaken prior to departure. Research by Casey *et al.* (2013b) suggests that international patient co-ordinators in destination hospitals are well positioned to provide such information and offer informational resources to caregiver-companions that can prompt them to take on such familiarisation. Third, other studies have noted that informal care burden is greatest immediately after a change in health status, and that some caregivers are unfamiliar with recovery processes which can then bring on stress (Nahm *et al.* 2010). This may be heightened in the medical tourism context given that participants reported additional stress being brought on by transitions in care settings and not just changes in care recipients' health. Thus, a useful intervention that the industry itself could initiate would be to provide educational resources about the medical aspects of providing informal care-giving in the context of medical tourism. For example, they could provide informational resources that would describe what types of hands-on care may be needed and/or what a patient may look like following surgery.

This analysis has several limitations. First and foremost, it is impossible to know whether or not our participants are representative of Canadian caregiver-companions as a whole, given the lack of population-level data about medical tourism (Hopkins *et al.* 2010). Our recruitment may have biased the research towards those able to volunteer for an interview, and to commit to an interview within the timeframe of our study – a group who may not be reflective of caregiver-companions as a whole. However, this is not a genuine concern in the context of the current study given that the goal of qualitative research is transferability and not generalisability (Whittemore *et al.* 2001). Second, because our interviews were only conducted in English, potential participants with limited English language skills were excluded. Third, our study used telephone and Skype interviewing, which lack visual cues for the interviewer and may have resulted in less detailed answers from participants and/or difficulty communicating. However, we refer to other research that has found that telephone and face-to-face interviewing yield similar results, as well as enabling access to difficult-to-reach or geographically dispersed participants (Sturges & Hanrahan 2004, Novick 2008).

Conclusion

Our thematic analysis of 20 interviews with Canadian caregiver-companions revealed the experiential resources they use to deal with the challenges they face in medical tourism and to avoid the onset of caregiver burden. Specifically, participants drew on:

(i) prior experience of international travel; (ii) prior experience of informal care-giving; and (iii) their existing relationship with the care recipient. Identifying these resource domains helps identify points of intervention to support caregiver-companions. This analysis also highlights the factors that heightened stress for participants, such as unfamiliar foreign contexts and care transitions. By providing suggestions for policy that focus on these key stresses, we can minimise the onset of caregiver burden among this group of transnational informal caregivers.

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