

# **Examining the Role of Family Physicians in the Decision-Making Processes of Canadian Medical Tourists**

**by  
Rory Johnston**

B.A., Simon Fraser University, 2010

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of the Requirements for the Degree of  
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in the  
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**Name:** Rory Johnston  
**Degree:** Master of Arts Geography  
**Title of Thesis:** *Examining the Role of Family Physicians  
in the Decision-Making Processes of  
Canadian Medical Tourists*

**Examining Committee:**

**Chair:** Alison Gill, Professor, Department of Geography, SFU

---

**Valorie Crooks**  
Senior Supervisor  
Associate Professor, Department of Geography, SFU

---

**Nadine Schuurman**  
Supervisor  
Professor, Department of Geography, SFU

---

---

**John Calvert**  
External Examiner  
Associate Professor, Faculty of Health Sciences  
Simon Fraser University

**Date Defended/Approved:** July 31, 2012

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## **Abstract**

Canadians are increasingly engaging in 'medical tourism'. Medical tours mark a shift from the gate-keeping model of care provision that underpins diagnostic and surgical care in Canada, wherein family physicians refer patients to specialists, towards care that has a more self-directed role for the patient. This self-direction raises concerns regarding patient safety, chiefly around informed consent and continuity of care. In light of these risks, it is important that we understand how family physicians assist Canadian medical tourists. The analyses indicate that Canadian family physicians are currently only cursorily involved, if at all, in supporting medical tourists in their medical practices. This lack of engagement persists despite physicians' willingness to be consulted and involved. Improved support for medical tourists by their family doctors is hindered by barriers amongst both stakeholder groups that might be addressed through guidance from medical associations and patient advocacy organizations.

**Keywords:** medical tourism; family physicians, Canada; health geography; qualitative research; international medical travel

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# 1. CHAPTER ONE

## Introduction

The term 'medical tourism' best describes the intentional pursuit of privately arranged and purchased medical procedures at hospitals and clinics outside of a person's home country (Connell, 2012; Lunt et al., 2010). This stringent definition excludes other forms of international medical travel such as medical care that is formally referred to or arranged by physicians or health systems across national borders (i.e. cross border care), emergency care sought by tourists while traveling, and routine medical care accessed by ex-patriots while living abroad (Ehrbeck et al., 2008). While related to these other types of international medical travel, medical tourism carries with it unique concerns surrounding patient safety and health system impacts that are unique (Burkett, 2007; Lunt et al., 2011; Turner, 2007a). I expand on these concerns and other facets of the medical tourism industry in this chapter.

Medical tourism is an implicitly spatial practice. Patients travel across international borders and navigate different social and medical landscapes in the hopes of improving their health (Kangas, 2007; Whittaker, 2008). Despite its spatiality, the topic of medical tourism has only just begun to be documented and explored by geographers (Gatrell, 2011). In this Master's thesis I work to better understand an existing knowledge gap within medical tourism, that of the role of family physicians in the decision-making processes of Canadian outbound medical tourists, using a health geography lens. This chapter sets the context for the thesis by reviewing the relevant background literature and providing an overview of its structure. In the section that follows, I provide a brief overview of the scholarly tradition of health geography that informs this research. Following this, I offer an overview of medical tourism research to date and the knowledge gaps that spurred my Master's thesis project. Finally, I close the chapter with an overview of the study design and objectives that underpin my Master's research.

## 1.1. What is Health Geography?

While the influence of physical surroundings on the health of individuals and populations has long been recognized and documented, scholarly inquiry by geographers into how the social and cultural elements of place shape health has only recently been undertaken within the auspices of 'health geography'. Geographic research concerning health was long defined by epidemiological accounts of the spatial distribution of diseases and their ecological determinants as well as performing spatial analyses for health services planning (Mayer, 1984; Rosenberg, 1998). This research was heavily quantitative and fixed at the scale of populations (Jones & Moon, 1987; Mayer & Meade, 1994). Accordingly, this domain of research developed with the appropriately positivist label of 'medical' geography. The focus of medical geography research during this period was primarily concerned with tracking disease and rationalizing health service distribution, not with understanding health more broadly nor how individuals understand their own health and its promotion (Jones & Moon, 1991; Kearns, 1994).

Health geography emerged from the 'cultural turn' that influenced social sciences departments worldwide in the latter quarter of the 20th century (Gesler, 1992). The cultural turn describes a concerted movement away from a positivistic approach to knowledge acquisition and interpretation, one which long-dominated the social sciences in the post-WWII period (i.e. the 'quantitative revolution'), to include more subjective and nuanced qualitative research methods and critical frameworks (Barnes, 2001; Barnett, 1998). These methods and frameworks aim to understand the many interpretations and meanings surrounding any given phenomenon instead of quantifying existing understandings and outlooks that dominate conventional thought (Seale & Silverman, 1997). Scholars influenced by the cultural turn worked to distance themselves from the mechanical and deterministic models that defined the social sciences in the post-WWII period and instead engaged in scholarship that accepted the necessity of the uncertainty and subjectivity that accompanies explorations of how cultural meanings are constructed, interpreted, enacted, and maintained, especially at the level of individuals (Barnes, 2001; Barnett, 1998).

The influence of the cultural turn was eventually felt within medical geography, challenging the narrow definition of health that geographers had employed in focusing on mapping disease and medical services (Jones & Moon, 1993). Kearns' landmark 1993 paper "Towards a Reformed Medical Geography" firmly widened the boundaries of the sub-discipline to become a more comprehensive 'health geography.' Kearns (1993) sought to acknowledge the valuable traditions of medical geography but advanced the argument that geographic inquiry into health had already moved beyond its origins of spatial epidemiology and medical service planning towards explorations of the cultural, social, and behavioural dimensions of health, and should continue to do so.

Consequently, 'health geography' includes the traditional quantitative spatial epidemiological and health service planning research of medical geography as well as qualitative research into how health is impacted and shaped by cultural and social landscapes (Kearns, 2002; Rosenberg, 1998).

Health geography is a growing and vibrant sub-discipline of geography. Initially centered in Canada, the United Kingdom, New Zealand, and the United States, health geographers' interests are broad and cross-cutting and the countries in which health geographers are based are expanding rapidly. Spatial epidemiology and ecological determinants of health remain as large domains of interest, but these have been joined by studies of how health is defined, promoted, maintained, and/or otherwise impacted amongst individuals and populations within their socio-cultural and physical contexts (Kearns, 2002; Macintyre et al., 2002; Parr, 2002). This has led to a cross-pollination of ideas from across the social sciences within the nexus of health geography. Domains of interest that have emerged and developed since the formal demarcation of health geography range widely, but those with some of the most intensive scholarly activity include studies of food availability and security (e.g. Burns, 2007; Morland, 2009), evaluations of health services access and uptake (e.g. Arcury et al., 2005; Poland et al., 2005), analyses of neighbourhood walkability and health impacts (e.g. Berke et al., 2007; Santana et al., 2009), and theorization of health promoting spaces and places (i.e. therapeutic landscapes) (e.g. Milligan et al., 2004; Williams, 1998).

The development of health geography since its beginnings as medical geography has incorporated qualitative methodologies such as case study, ethnographic and phenomenological approaches while applying a broad number of analytic lenses,

including those oriented around gender (e.g. Dyck, 2003), disability (e.g. Crooks & Chouinard, 2006; Dorn & Laws, 1994), racialized identity (e.g. Wang, 2007; Wilson, 2003;), rural studies (e.g. Cloutier-Fisher & Skinner, 2006; Parr et al., 2004), and urban form (e.g. Curtis & Coutts, 2002; Douglas, 2008). Taken together, health geographers have often worked to contest normative understandings of health, especially those that ignore the constant interplay between people and their surroundings and fix health in individual bodies, in an effort to diversify understandings of how health is socially and culturally constructed. Health geographers have also sought to deepen our understanding of how ecological and social determinants of health are patterned across physical and social space while rooting these inquiries within the rich contexts they exist by employing different methods and methodologies (Hayes, 1999).

Broadly speaking, health services research within health geography has primarily focused on understanding how and why health services are (or are not) utilized by populations and individuals. My Master's research falls within this domain as it seeks to better understand how and why Canadians choose to go abroad to access health services and if their family physicians are incorporated into their care-seeking and in what ways. Perhaps most significantly, this research marks a distinct move away from analysing health services utilization at the local, regional, or national level that informs much of existing health geography research and works to broaden the sub-discipline's focus to include health service provision at an international scale. As such, my research responds to calls made to 'scale up' the focus of health services research in geography and move beyond localized perspectives (Milligan & Power, 2009). The timing of my research also coincides with a move towards thinking of 'mobilities' in health geography, spearheaded by Gatrell (2011). As medical tourists are effectively patients mobilized at a global scale, this research will help to inform debates that will surely emerge within the discipline regarding the logistical and equity challenges that health mobilities pose to existing health services planning.

## **1.2. An Overview of Medical Tourism**

People have traveled to access health services for as long as renowned healers and therapeutic spaces have existed. Early analogues for medical tourism include

pilgrimages to geothermal baths believed to have recuperative properties, retreats to rural sanatoria to relieve breathing problems like tuberculosis and asthma, and medical travel to visit well known physicians in distant cities (Connell, 2012; Howze, 2007).

Contemporary medical tourism has been foreshadowed by the long-established travels of wealthy patients from across the globe to centres of medical excellence such as the Mayo Clinic in Rochester, New York, as well as by strong networks of less wealthy but similarly mobile international patients between countries in the Global South (Kangas, 2002; Lautier, 2008; Weisz, 2011). This earlier era of medical tourism is defined by South to North and South to South movements of global patient flows. In the past two decades, new networks of global patient flows have emerged that have connected patients from countries in the Global North with access to medical care in countries in the Global South (Forgione & Smith, 2006; Lautier, 2008). These networks have grown tremendously in variety and size, and have served to informally connect national health systems via international patients (Smith et al., 2009; Whittaker, 2008). These changes in the direction of patient flow also mark a change in the composition of the medical tourist market. Whereas medical tourism was previously largely restricted to the global elite traveling to Northern centres of excellence and middle-income earners in the Global South traveling to neighbouring nations for care not available in their home countries, the new flows of patients from the Global North to the Global South are understood to be increasingly composed of the middle and upper middle classes who traditionally have relied on their domestic health systems for medical care (Connell, 2012; Ehrbeck et al., 2008; Turner, 2007a).

The conditions that have given rise to recent shifts in international patient flows are thought to involve three factors, those of improved quality of private medical care in many Southern nations, the rise of the Internet, and the increasing ease and affordability of international air travel (Connell, 2008). Private medical care has been the focus of considerable domestic and international investment in many nations now serving as medical tourism hubs. An example of this is Thailand, one of the earliest nations to experience inflows of medical tourists, where marketing medical care to international patients arose as a matter of fiscal necessity. Thailand's economy boomed over the course of the 1990s, resulting in a massive expansion of the country's private medical sector and an improvement in the quality of their services (Pachanee & Wibulpolprasert,

2006; Wilson, 2011). Domestic demand for private medical services sharply contracted during the Asian financial crisis of 1997, forcing Thailand's private hospitals to expand their market in order to survive (Wilson, 2011). Thai hospitals established international recruitment centres for patients in the United States, Saudi Arabia, and elsewhere as well as online resources developed to attract patients (Wilson, 2011). A result of this effort is a lasting inflow of international patients that remains to this day (Pachanee & Wibulpolprasert, 2006; Wilson, 2011). Private hospitals in other nations not previously known for the quality of their medical care, including Singapore, Costa Rica, India, Cuba, and Malaysia, have followed suit in working to attract international patients, often with the support of their national governments (Ormond, 2011; Turner, 2007a).

As with many other global industries, the globalizing influence of the Internet and dense trade networks have been key in allowing medical tourism to grow in popularity. Care providers are now able to disseminate information about their services directly to international customers and consequently build their confidence in the quality of care available, while the air travel of the early 21st century has enabled the transport of patients to distant locations with relative ease and low cost when compared with previous periods (Connell, 2008; Wilson, 2011). While barriers to accessing health care have always existed and are found in all health systems, it is believed that these new developments allow patients to easily identify and travel to places elsewhere in the world to access care, thereby bypassing domestic care barriers (Ehrbeck et al., 2008). The three barriers that are regularly cited as the main motivations for traveling abroad for medical care are those of 1) unaffordable care, 2) long waiting periods for care, and 3) poor quality of care (Ehrbeck et al., 2008; Turner, 2007a). The first two factors are discussed purely in relation to privately financed and publicly financed health systems, such as those of the United States and Canada, while the latter is mostly used in relation to discussions of why outbound medical tourists emerge from lower income nations (Ehrbeck et al., 2008). While the intuitive rationale for the importance of all of these facilitative and motivational factors discussed above seem conceptually sound, there remains a lack of rigorous and in-depth engagement with medical tourists themselves to identify what motivates them to seek care and how they discover and arrange for care abroad (Crooks et al., 2010).

Medical tourism has raised a number of concerns about potential heightened health risks associated with traveling for medical care. Firstly, there are concerns that combining air travel, especially long-haul flights, with surgical interventions can raise the risk of medical complications such as heart attacks, strokes, and pulmonary embolisms (Johnston et al., 2010). Blood clots, the root of all these issues, are associated with both surgery and air travel and are consequently compounded when the two activities are combined (Howze, 2007). Secondly, there is limited reliable third party regulation of hospitals offering services to medical tourists in many destinations (Burkett, 2007). As such, medical tourists are effectively charged with discerning high from low quality medical providers on their own, greatly raising the medical risks for those who choose sub-standard providers (Burkett, 2007). The final most commonly cited concern for heightened risks is that of limited legal liability for medical providers in many emerging destinations such as India and Thailand (Burkett, 2007; Howze, 2007; Turner, 2007). Weak malpractice laws in these and other destinations shield physicians from malpractice claims in cases of medical negligence, and expose international patients to far more financial and physical risk than they may be accustomed to should they develop complications or other care inadequacies (Burkett, 2007). It is unknown how aware patients are of these risks and whether or not they involve professionals such as family physicians in their interpretation (Crooks et al., 2010).

The growth of the medical tourism industry has often been linked with the emergence of medical tourism 'facilitators', also called medical tourism brokers, which are private companies that offer to arrange prospective international patients' medical tours abroad for a fee (Turner, 2007). Facilitators are usually located in a patient's home country and may serve as a first point of contact for prospective medical tourists who are not comfortable arranging for their own international medical care (Turner, 2007; Snyder et al., 2011a). In the Canadian context, it has been reported that facilitation is largely a 'cottage industry' of individuals with personal connections to medical providers abroad, resulting in a wide range of professional attitudes and standards of care amongst Canadian facilitators (Johnston et al., 2011). Some facilitators seek to support their clients throughout their journeys and after their return while others restrict their involvement to that of a one-time middleperson (Johnston et al., 2011). The facilitation industry, both in Canada and worldwide, has a large online marketing and recruitment

presence, reinforcing the suggestion that the growth of medical tourism has been tied to that of the Internet (Lunt et al., 2010; Penney et al., 2011). The lack of professionalization amongst this group and their close relationship to medical interventions has raised a number of patient safety concerns, primarily around informed consent and unrealistic representations of medical risk (Penney et al., 2011). It is currently unknown what proportion of medical tourists rely on facilitators and to what degree they rely upon them in making their decisions to go abroad and for arranging supportive care, providing another rationale for speaking with medical tourists themselves.

In the context of Canada, outbound medical tourists that choose to leave the domestic health system to access care abroad impact other users of the Canadian and destination health systems as a whole both positively and negatively. This is true for patients leaving other publicly-funded health systems. The most commonly cited positive impact for a patient's home health system is that of their removing themselves from procedures that they are on a wait list for, benefiting other wait-listed patients behind them in the queue (Johnston et al., 2010). It has also been speculated that in cases where patients are on exceedingly long wait lists that may ultimately harm their long-term health, such as permanent joint damage or the onset of diabetes from delayed orthopaedic and bariatric surgeries respectively, choosing to go abroad will ultimately lessen their cumulative lifetime burden on their provincial health and welfare systems (Johnston et al., 2010). Critics of medical tourism provide counterpoints to these purported benefits primarily by focusing on the excess burden placed on the Canadian health system by medical tourists returning with costly complications, difficulties that may not emerge for years following treatments such as surgery (Cheung & Wilson, 2007; Turner, 2007a). It is further argued that outbound medical tourists from wealthy nations who could otherwise access their surgery in their home country unjustly use the limited health resources of the nations they travel to, driving up the cost of care for locals and incentivizing the movement of health professionals into private health systems (Sen Gupta, 2008; Turner, 2007a). There is currently little reliable evidence of these claims, and the lack of consultation with medical tourists makes it unclear the degree to which they are aware of these concerns when planning to go abroad (Crooks et al., 2010; Johnston et al., 2010).

### **1.3. The Roles of Family Physicians in the Canadian Health System**

The Canadian health system is not a unified whole. The financing and administration of health services are handled at the provincial and territorial level, resulting in thirteen separate health systems within the country (Romanow, 2002). The structure and delivery of these separate health systems are closely aligned due to significant federal involvement in their funding (Health Canada, 2010). Federal legislation, of which the Canada Health Act is the most important, has attached conditions to the social funding provided to the provinces by the federal government that ensures universal access to care amongst Canadians (Romanow, 2002). These conditions stipulate that all medically necessary care is: 1) publicly administered and not for-profit, 2) available to all Canadian citizens, 3) 'reasonably accessible' to users, 4) provided to Canadian citizens when in other provinces, and 5) comprehensively insured (i.e. no medically necessary procedures can be excluded from public coverage) (Romanow, 2002). As such, all Canadians are entitled to publicly insured health services that are free of charge at the point of service. Importantly, medical necessity is not defined in the Canada Health Act, resulting in variable coverage across the country due to differing interpretation by the provinces and territories (Charles et al., 1997).

The absence of a cost barrier to publicly insured care in Canada ensures that no Canadians are excluded from receiving medical care but it does require provincial health systems to ration care for their users in order for them to function (Romanow, 2002).

Capacity limitations for any publicly insured medical services are experienced by health system users in the form of delayed access to care (Romanow, 2002). Waits may manifest at the primary care level in booking far ahead for a visit to the family physician should there be not enough primary care providers in a region, or at the secondary or tertiary level by being placed on a queue for medical diagnostic tests or intensive treatments. These queues are dynamic and the positions of patients shift based on physician assessments of the urgency of treatment (Naylor et al., 2000). When demand for a treatment far outstrips system capacity, wait-lists can become excessively long and negatively impact the well-being and satisfaction of health system users (Emery et al., 2009; Romanow, 2002). Wait-lists have been used as evidence by advocates for health system reform on both sides of the political spectrum as a rhetorically charged political

tool in pushing for increased public funding versus privatization of health services in Canada (Church & Smith, 2009). In this context, medical tourism has been touted by its advocates as a solution for individuals frustrated by wait lists (e.g. Horowitz & Rosensweig, 2007; Law, 2008; Purdy & Fam, 2011). Wait-lists have dominated speculation as to why Canadians would choose to privately pay for medical care they are already insured for, and it has often been assumed to be a fact that wait-lists serve as the primary motivation (Eggerston, 2006; Purdy & Fam, 2011). The lack of consultation with Canadian medical tourists by researchers raises uncertainty as to the degree wait-lists inform their decision-making, especially as some treatments Canadians are known to go abroad for are not covered by public insurance, including elective cosmetic and dental surgery (Crooks et al., 2010).

Family physicians play a key role in facilitating access to medical care in Canada. While any Canadian can organize a visit to a primary care clinic, appointments with medical specialists who are paid through provincial health insurance must be coordinated with the help of a family physician, wherein family physicians are gatekeepers to secondary and tertiary care in Canada (Health Council of Canada, 2010; Romanow, 2002). If treatment is deemed by specialists to be medically necessary and the patient a suitable candidate, family physicians play an important supportive role in maintaining continuity of care (Health Council of Canada, 2010). Continuity of care is an important tool in evaluating the quality of health services and describes the support available to patients throughout their engagement with the health system (Haggerty et al., 2003). Three forms of continuity of care are commonly considered in health system and treatment evaluations; informational, relational, and treatment (Saultz, 2003).

Informational continuity of care refers to the quality of medical records in a patient's medical history and the ease at which records can be accessed and interpreted by care providers (Saultz, 2003). Interpersonal or relational continuity of care is the quality of a relationship between a care provider and their patient and the degree of trust and knowledge shared between them (Saultz & Albedaiwi, 2004). Longitudinal or management continuity of care describes the quality of support provided to patients before, during, and following a medical procedure, and is important in ensuring a patient is well informed of the risks of treatment and receives adequate follow-up care to minimize the risk of complications (Haggerty et al., 2003; Saultz, 2003). It has been

suggested that medical tourism poses a clear threat to maintaining all forms of continuity of care given the ability for patients to anonymously exit their home health system, access care providers disconnected from their home health system, and return with little or no documentation of their treatment (Leahy, 2008; Turner, 2007b). Family physicians are uniquely positioned to support patients in maintaining all three forms of continuity should they choose to go abroad by remaining a fixed and continuous point of contact between a patient and the Canadian health system, (Turner, 2007b).

A close review of the medical tourism literature reveals that despite their important role in decision-making, maintaining medical records, and coordinating supportive care, family physicians have rarely been discussed. Meanwhile, family physicians' assistance to patients throughout their trajectory of care when seeking and receiving medical treatments likely helps minimize the risks they encounter (Saultz & Albedaiwi, 2004; Turner, 2007b). Given the lack of consultation with both medical tourists and family physicians, it is unclear to what degree the role of family physicians in patient education, providing referrals to reliable specialists, and coordinating follow-up care carries over to patients seeking care outside of the Canadian system, if at all.

## **1.4. Study Overview**

The research that comprises my thesis comes from two distinct analyses of data gathered in two separate studies. In this section I briefly describe the structure of these two studies and identify the objectives that informed the analyses that form the core of this thesis.

My first analysis (Chapter 2) emerged as a subcomponent of a larger study led by my supervisor (Dr. Valorie Crooks) and funded by the Canadian Institutes of Health Research (CIHR). This larger study sought to better understand the ethical dimensions of Canadian medical tourists' decision-making by speaking with medical tourists to probe how their decisions to travel abroad for care unfolded. As part of my thesis research I conducted interviews with 32 former Canadian medical tourists who had traveled for surgical care and worked to develop a sub-component of data collection (i.e. questions in the interview guide) related to medical tourists' engagement with the Canadian health

system. This subcomponent examined the role of family physicians in aiding decision-making. This overall study and the subcomponent were motivated by the evident lack of consultation with medical tourists in the existing medical tourism literature and the resulting absence of empirically-informed claims within ongoing debates. Given the health and safety risks to patients that have been speculated about in the existing literature, there is a clear rationale for grounding these concerns in empirical accounts of how medical tourists actually seek care abroad. Interviews with medical tourists were held and thematic analytic methods used to interpret the resulting data. Three objectives informed the analysis, which were to identify: (1) why Canadian medical tourists decide to travel abroad for care, (2) how these medical tourists gather and interpret information about treatment abroad, and (3) the social supports relied upon in making their decisions, highlighting the role of their family physicians in doing so. A goal of the overall study and my own subcomponent was to generate evidence that could inform future informational interventions aimed at medical tourists that help to best address their needs and help mitigate the health and safety risks they face.

Questions regarding the role of family physicians emerged over the course of the above study and spurred our research team (under my leadership) to run a second study, also funded by CIHR. This second study sought to identify what Canadian family physicians saw their own roles and responsibilities to be towards Canadians that travel abroad for care. Focus groups were held with family physicians across the province of British Columbia and thematic analytic methods were employed to interpret the data generated from the meetings. These focus groups were informed by three objectives, which were to: (1) provide the first assessment of the kinds of experiences Canadian family physicians have had with medical tourists in their practices, (2) articulate the kinds of roles and responsibilities they are (not) willing to take on in supporting medical tourists' decisions and care abroad, and (3) identify what kinds of support are currently available to Canadian family physicians regarding medical tourism and which are prospectively perceived as useful in performing these roles. This study was intended to help policy-makers and physicians with understanding the processes involved in medical tourism and inform their efforts to improve patient care.

Taken together, my thesis aims to fulfill three overall objectives, which are to: (1) comprehensively document if and how Canadians currently incorporate their family

physicians into their medical tours, (2) articulate realistic roles and responsibilities Canadian family physicians have for the outbound medical tourists they care for, as envisioned by physicians and patients themselves, and (3) identify supports for either group that could help improve their engagement with one another regarding medical tourism, ultimately working to reduce the risks faced by medical tourists and the resulting burdens posed to the Canadian health system by the growth of the medical tourism industry.

#### **1.4.1. Thesis Outline**

This section concludes the first of the four chapters that compose this thesis. The second and third chapters are both structured as peer-reviewed journal articles. Both have been submitted to academic journals for review, with the Chapter 2 having been recently accepted for publication by *Globalization & Health*. Chapter 2 documents an analysis of interviews with Canadian medical tourists and traces the common factors and processes in their decision-making. The analysis highlights how medical tourists gather and assess information on treatment abroad, what factors motivate and inform their decision to travel for medical care, and what personal and professional supports they rely upon to interpret these factors and information sources. The degree of involvement by family physicians in supporting the participants spoken with throughout their trajectories of their care was a key domain of inquiry and analysis. It is hoped that this research helps address the many knowledge gaps that exist surrounding the push and pull factors informing medical tourists' behaviour and by doing so, inform effective policy and informational interventions that can help ease the health and safety risks they face.

Chapter 3 provides an analysis of six focus groups conducted with family physicians across the province of British Columbia. The analysis reveals what kind of role Canadian family physicians see as suitable for themselves with regard to treating outbound medical tourists who are their patients, with the aim of both helping to ground some of the emerging scholarly debates surrounding this issue. By doing so, it is hoped that realistic and useful roles for family physicians can be articulated so that they can best support and mitigate the health risks of this unique patient population.

The final chapter in this thesis brings together the themes and issues present in Chapters 2 and 3 and examines what questions are answered and which are raised when the two are examined together. Specifically, the final chapter identifies 1) how and why family physicians are currently (not) incorporated into the journeys of medical tourists from the perspectives of both of these groups and 2) what they see as a useful and desirable engagement with one another to look like. By doing so, current barriers to integrating family physicians into supporting medical tourists are comprehensively identified and the points of agreement and divergence surrounding an idealized role for family physicians between the two groups are noted. This chapter aims to reconcile these envisioned roles and point to the future research questions for health geographers and others engaging in medical tourism research.

## **2. CHAPTER TWO**

### **“I didn’t even know what I was looking for...”: A qualitative study of the decision-making processes of Canadian medical tourists**

#### **2.1. Abstract**

##### **2.1.1. *Background***

Medical tourism describes the private purchase and arrangement of medical care by patients across international borders. Increasing numbers of medical facilities in countries around the world are marketing their services to a receptive audience of international patients, a phenomenon that has largely been made possible by the growth of the Internet. The growth of the medical tourism industry has raised numerous concerns around patient safety and global health equity. In spite of these concerns, there is a lack of empirical research amongst medical tourism stakeholders. One such gap is a lack of engagement with medical tourists themselves, where there is currently little known about how medical tourists decide to access care abroad. We address this gap through examining aspects of Canadian medical tourists’ decision-making processes.

##### **2.1.2. *Methods***

Semi-structured phone interviews were administered to 32 Canadians who had gone abroad as medical tourists. Interviews touched on motivations, assessment of risks, information seeking processes, and experiences at home and abroad. A thematic analysis of the interview transcripts followed.

### **2.1.3. Results**

Three overarching themes emerged from the interviews: (1) information sources consulted; (2) motivations, considerations, and timing; and (3) personal and professional supports drawn upon. Patient testimonials and word of mouth connections amongst former medical tourists were accessed and relied upon more readily than the advice of family physicians. Neutral, third-party information sources were limited, which resulted in participants also relying on medical tourism facilitators and industry websites.

### **2.1.4. Conclusions**

While Canadian medical tourists are often thought to be motivated by wait times for surgery, cost and availability of procedures were common primary and secondary motivations for participants, demonstrating that motivations are layered and dynamic. The findings of this analysis offer a number of important factors that should be considered in the development of informational interventions targeting medical tourists. It is likely that trends observed amongst Canadian medical tourists apply to those from other nations due to the key role the transnational medium of the Internet plays in facilitating patients' private international medical travel.

## **2.2. Background**

The term 'medical tourism' describes the intentional movement of patients across international borders to seek medical care that has been privately purchased and arranged for (Bookman & Bookman, 2007; Snyder et al., 2011b). The elements of intentionality and private arrangement are key to defining which care-seeking behaviours constitute medical tourism as opposed to other forms of international medical travel such as formal cross-border care arrangements and emergency care for vacationing tourists, although the term has been used at times to describe all of these forms of care. The global medical tourism industry is steadily growing, although accurate estimates of its current size or scale are not available given the presence of exaggerated figures and inconsistencies in tracking flow numbers, in part due to a poor universal definition of what constitutes medical tourism (Johnston et al., 2010, Lunt et al., 2010). Despite this, it is known that steady flows of patients traveling from the Global North (e.g., Canada, the

United States (US), Western Europe, Australia) to clinics in the Global South (e.g., India, Thailand, Costa Rica) have emerged over the past decade (Lautier, 2008; Whittaker, 2008). These new patterns of trade have joined the long-established South–north and North-North flows of international patients to internationally reputed medical centres, such as the Mayo Clinic in the US, as well as existing flows of patients between Southern nations (Cortez, 2008; Neelakantan, 2003). The growth of the medical tourism industry has been made possible by increasingly globalized flows of trade, transportation, and information (Lautier, 2008; Turner, 2007a). In turn, medical tourism ties the interests of disparate populations together, for example by introducing novel global pathways for the spread of infectious disease and through the sharing of scarce health resources amongst citizens of different nations (Galbani et al., 2011; Sen Gupta, 2008).

A series of recent scholarly reviews about medical tourism have consistently revealed that there are significant gaps in our understanding of this phenomenon (Crooks et al., 2010; Hopkins et al., 2010; Lunt et al., 2011; Snyder et al., 2011b). In addition, these reviews have indicated that much of the existing knowledge base is derived from speculative claims (Johnston et al., 2010). These knowledge gaps persist despite an increasing desire amongst global health researchers to better understand medical tourism because of the implications this practice is thought to hold for the equitable delivery of health services, the involvement of new actors (e.g. medical tourism facilitators) in the delivery of health care, and the novel responsibilities of patients seeking and physicians providing health care across international borders, among other concerns (Pocock & Phua, 2011; Snyder et al., 2011b; Turner, 2011). For example, a scoping review completed by Crooks et al. (Crooks et al., 2010) concluded that we have much to learn about patients' experiences of medical tourism, including how medical tourists access and evaluate information sources prior to departure. Lunt et al.'s (in press) more recent article echoes this conclusion, and identifies patient decision-making as one of the priority areas for medical tourism research given its relevance to continuity of care, patient health and safety, and the commodification of care. While media accounts provide some valuable insights into the experiential dimensions of medical tourism (CBC News, 2004; Loose, 2007; Olian, 2005), deep inquiry into the *process* of patients' medical travel, from conception to return, remains lacking. This absence of

knowledge leaves major questions about which factors and actors inform the decision-making of medical tourists, especially in regard to their reliability and modes of dissemination. In this article we address this knowledge gap through examining Canadian medical tourists' decision-making processes regarding seeking surgery abroad.

Canadians are amongst those participating in the medical tourism industry, not only as patients, but also as investors and facilitators (i.e., agents specialized in coordinating international medical care, including arranging for visas and accommodation and dealing with destination hospitals) (Snyder et al., 2011b). The only quantitative report on medical tourism in Canada produced to-date indicates that 2% of 2,304 Canadian survey respondents have traveled outside the country to “consult with a doctor, undergo a medical test or procedure, or receive treatment” (Purdy & Fam, 2011). As a description of how this care has been paid for or arranged is not indicated, other forms of international medical travel (e.g., cross border care arranged through the public system) may be in the estimate. Further, 20 % of those surveyed indicated they would travel abroad for private-pay health services (Purdy & Fam, 2011). Certainly, this is no reliable indication of how many patients are indeed traveling abroad for private medical care. Numbers aside, it is indeed the case that Canadian patients are choosing to take part in medical tourism, a phenomenon that is receiving increasing media attention in the country (Snyder et al., 2011b).

The phenomenon of Canadian patients privately choosing to travel outside of their home health system to access medical care abroad is intriguing, as medically necessary health care in Canada is publicly funded and universal. Federal legislation limits the availability of domestic private health care, making privately purchased, on-demand access for many treatments largely inaccessible to most Canadians (Health Canada, 2010). There is no single Canadian health care system, as the management and delivery of health care is the separate responsibility of each of the 13 provinces and territories (Romanow, 2002). Canada's federal government contributes to the financing of each provincial health system through equalization payments that work to minimize inequities in essential services, with the amount paid to each province differing on the basis of need (Health Canada, 2010). The balkanization of the management and financing of the national health system contributes to substantial differences in temporal

and spatial access to care across the country for the same procedures or treatments due to differences in the priorities and resources of the health administrations in each province or territory (Romanow, 2002). For example, in 2010 42% of patients in the province of Nova Scotia had timely access to knee replacement surgery (i.e. within the national benchmark period of six months between referral to specialist to surgery), compared with 89% of patients in Ontario (Canadian Institutes for Health Information, 2011). These wait times are likely to serve as a prompt to consider care elsewhere for some Canadian patients (Snyder et al., 2011b). Canadians also travel abroad for non-medically-necessary procedures such as dental care and cosmetic surgeries that are not covered by the public health care system. It has been speculated that procedure costs are likely to serve as motivators for seeking such care abroad for Canadian patients (Snyder et al., 2011b).

Much research exists about patients' decision-making as it pertains to surgical care sought domestically. It has been reported that patients are often hesitant to change surgeons, even if it means an earlier surgical date, suggesting that trust and familiarity with care providers and venues can outweigh other decision-making concerns such as wait times (Conner-Spady et al., 2007; Schwartz et al., 2005). Striking a balance between appropriate preparation times and meeting personal expectations of prompt care is also a factor in patients' decisions about if and when to receive care. For example, it has been found that Canadian patients appreciate having time to prepare for elective surgery and will seek to organize about two months between the booking date and surgical date into their trajectory of care (Conner-Spady et al., 2009). However, if this two month threshold is crossed, resentment builds as the wait time is generally perceived to be excessive (Hodge et al., 2007). Another element of surgical decision-making that has been explored is the sharing of information between physicians and patients. While providing informed consent is a keystone principle of Western clinical practice, it has been reported that the comprehensiveness of information shared between surgeons and patients about the risks and benefits of surgery varies widely (Etchells et al., 2011; Mishra et al., 2010). The outcomes of this information sharing are thought to influence the willingness of patients to ultimately seek treatment (Etchells et al., 2011). More generally, it has been shown that the ability of individuals to discern statistical representations of the risks of surgical treatments are greatly influenced by

anecdotal accounts of procedure success or failure, suggesting that personal narratives of treatment can be potent influences on patient decision-making (Freymuth & Ronan, 2004). In the current analysis we extend this existing body of knowledge by investigating how the unique logistical and informational challenges posed by privately accessing care internationally as a medical tourist coincide with or depart from receiving surgical care domestically.

Existing understandings of patients' decision-making for surgical care have yet to consider the unique dimensions of medical tourism, such as concurrently seeking and synthesizing information about surgical treatment, travel, foreign destinations, and how the risks of each may interact to heighten the potential for negative health outcomes (Alvarez et al., 2011; Lunt et al., 2011). While it is often speculated that medical tourists rely primarily on the Internet to inform themselves about destination facilities, the frequency of access to information found online and its actual influence on decision-making requires dedicated attention (Lunt & Carrera, 2011; Sobo et al., 2011). Furthermore, it is widely reported that medical tourists from particular source countries seek care abroad based on singular motivations found in their home context, such as the high cost of medical care in the US, limited availability of medical care in the Global South, or long wait times for medical care in countries with public health care systems such as Canada (Ehrbeck et al., 2008; Horowitz et al., 2008); yet, this tendency toward simplistic accounts potentially belies complex interaction among the factors that compel individuals to investigate seeking care abroad. We seek to unpack some of these assumptions in the current analysis through examining the experiential accounts of 32 Canadians who sought private surgical care abroad.

The purpose of this article is to shed light onto how Canadian medical tourists go about deciding to access surgery abroad and what kinds of information sources inform their decisions. Our goal is to contribute to developing an empirically-informed knowledge base about the global health services practice of medical tourism through addressing the knowledge gaps identified above. Because of their exposure to a public and universal health care system for medically necessary care at home, Canadian medical tourists encounter an entirely different mode of access to care when privately seeking surgery abroad, foregoing public payment for the ability to determine what kind of care they wish to access, and when (Crooks et al., 2010; Eggerston, 2006). Even

when seeking surgical care that is not offered through the public system, such as experimental surgeries only available in other countries or cosmetic procedures, Canadian medical tourists are likely to encounter significant differences in facilitating access to medical care abroad than they would domestically. These differences are likely to include protocols around procedure booking and patient record transfer, among other factors (Crooks et al., 2010). As such, Canadian medical tourists may need to adopt more extensive roles as information assessors and decision-makers than they are used to, shifting them from the more passive role of the traditional patient to the more active, neo-liberalized position of the 'patient-consumer' (Ormond, 2011).

## **2.3. Methods**

This analysis forms part of a larger exploratory study of the decision-making processes and experiences of Canadian medical tourists. The study involved interviewing Canadian medical tourists and medical tourism facilitators. This analysis exclusively considers the former participant group.

### **2.3.1. Recruitment**

We sought to recruit Canadians who had previously undergone surgical treatment abroad for semi-structured phone interviews. As there is no organized tracking or surveillance of this patient group, potential participants were identified through numerous decentralized avenues. These included: (1) collecting names of medical tourists from Canadian news reports and contacting them via phone or email; (2) advertising in Canadian print news outlets; (3) posting invitations to participate on online medical tourism forums; (4) snowball sampling through participants' networks; and (5) providing study details to facilitators to disseminate. No apparent differences emerged between participants based on how they were recruited, such as in their motivations for travel abroad or experiences of medical tourism. People interested in participating in an interview were asked to contact a toll-free phone number or an e-mail address. Detailed study information was provided upon contact and eligibility assessed. Upon establishing a participant's eligibility, an interview time was then scheduled.

Participation was limited to those who met the eligibility criteria of: (1) having successfully pursued privately-arranged surgery outside of Canada paid for out-of-pocket; (2) being enrolled in a Canadian public health care plan at the time of surgery; and (3) being over the age of 18 at the time of the interview. To maintain focus, participants who went abroad for care other than surgery (e.g., diagnostic testing, tooth cleanings or fillings) were excluded. Those who had procedures that involved third parties (e.g., transplants, some reproductive surgeries) were also excluded. This is because confidentiality cannot be guaranteed to participants who report illegal activities, as per Canadian research ethics policies, and it was thought that there is a risk among this population that such activities would be discussed. Because we wanted to extend confidentiality to participants, we did not include people who had had these surgeries in the study. All those who scheduled an interview followed through with participating and no participants elected to withdraw from the study after being interviewed. Prior to participant recruitment, ethics approval was sought from and granted by the Office of Research Ethics at Simon Fraser University.

### **2.3.2. Data Collection**

Semi-structured interviews were conducted by phone between July and November, 2010. A semi-structured approach was employed to allow common issues to be explored, while giving participants the freedom to introduce unanticipated topics of relevance to their experience. Table 1 includes selected questions from the interview guide. All interviews were conducted by the same investigator (the lead author) in order to enhance consistency. Interviews typically ran for 1–1.5 hours and were digitally recorded. The interviews covered a wide range of topics, including participants' motivations, assessment of risks, information seeking process, experiences in both the domestic and international health systems, and pursuit of post-operative care. Data collection ceased upon the exhaustion of all of our recruitment methods. This was determined after no new participants were identified through public sources or contacted us after a month-long period.

**Table 1. Selected Interview Quotes**

Selected Questions	Sub-Probes
<ul style="list-style-type: none"> <li>• Tell me about when you traveled to _____ for surgery.</li> </ul>	<ul style="list-style-type: none"> <li>• What was it like?</li> <li>• What procedure did you get?</li> <li>• How long did you go for?</li> <li>• Did anyone accompany you?</li> <li>• Had you been to _____ before?</li> </ul>
<ul style="list-style-type: none"> <li>• When was it that you traveled to _____ for the procedure?</li> </ul>	<ul style="list-style-type: none"> <li>• For how long before then had you been planning the trip?</li> <li>• For how long before then did you know or decide that you were going to get that surgery done?</li> </ul>
<ul style="list-style-type: none"> <li>• Why did you decide to go to _____?</li> </ul>	<ul style="list-style-type: none"> <li>• Did anyone tell you about it?</li> <li>• What kinds of information did you look at?</li> <li>• Where did you get this information from?</li> <li>• Were personal finances an important deciding factor in choosing to go to _____?</li> <li>• Did you consult with your family doctor about your plan to go abroad for surgery?</li> </ul>

### **2.3.3. Analysis**

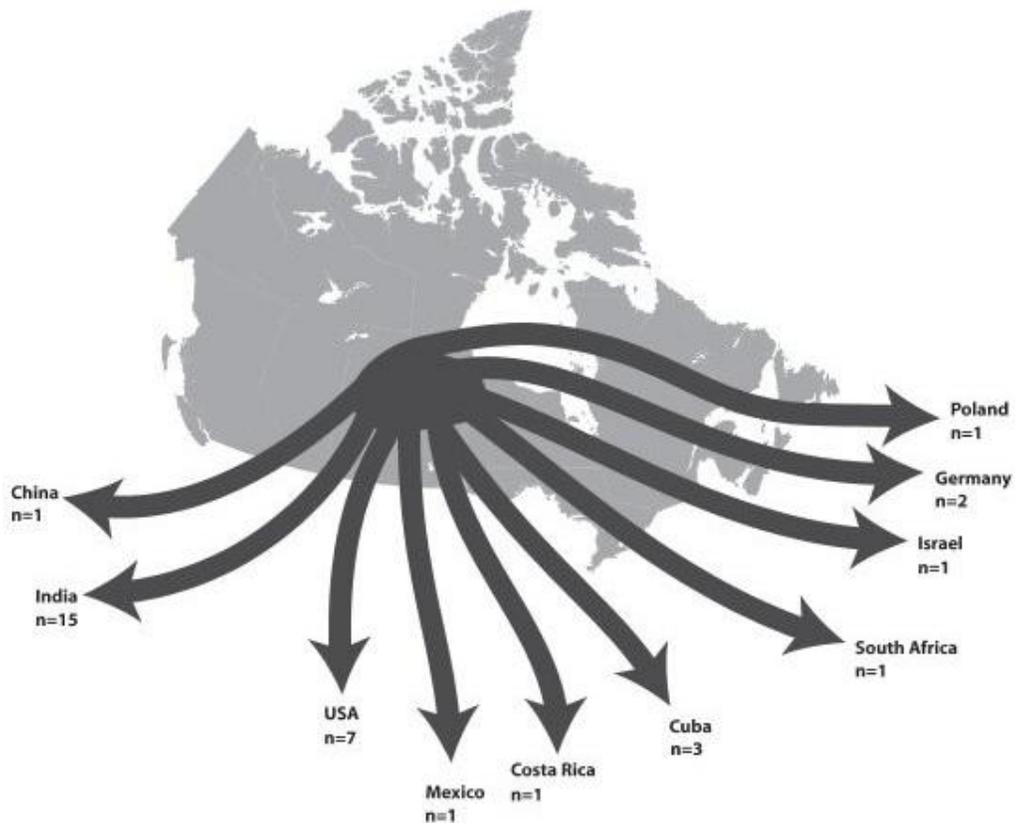
All interviews were transcribed verbatim. A review of the transcripts was conducted by all authors. Following initial review, a meeting was held to share impressions of common issues emerging from the interviews. A preliminary coding scheme was constructed, which was structured around the agreed upon issues. Generally speaking, scheme creation involved identifying umbrella terms or concepts to which data segments were assigned that could be drawn together in different combinations and permutations in order to inform a thematic analysis. Coding of the transcripts followed, which was done using NVivo qualitative data management software. To ensure the utility of the codes, one investigator undertook the coding while another reviewed the first coded transcript to confirm the functionality and interpretation of the scheme. Through an iterative process of coding and team discussion, superfluous codes were eliminated and overpopulated single themes were disaggregated as part of a second stage of coding. Upon completion of the coding process, thematic analysis was undertaken. Thematic analysis involves reviewing coded data to finding patterns or

trends within the dataset that are compared to study objectives and existing knowledge in order to refine the interpretation of their meaning (Aronson, 1994). By examining full narrative accounts by theme, commonalities in particular domains emerged despite the underlying structural differences (e.g., destination location, procedure type) in the medical tourists' raw accounts.

## **2.4. Results**

In total, 32 medical tourists from eight of Canada's 13 provinces and territories were interviewed. On average, two years had elapsed from the time of the surgery abroad to the time of the interview, with the longest being six years. Figure 1 and Table 2 provide an overview of some of the participants' key characteristics. In total, 21 participants sought surgeries that were not available to them in Canada. Of these, six sought procedures not approved in Canada, four were unable to receive referrals for desired surgical care domestically, and 11 sought procedures where expertise was lacking domestically.

**Figure 1.** Destination countries visited by participants



**Note:** This figure outlines where participants travelled for their procedures and how many went to each country. Note that one participant travelled to two countries for treatment addressing the same health problem, resulting in a total of 33 unique trips

**Table 2. Participant Overview**

<b>Characteristic</b>	<b>Count</b>
Recruitment Method for Study Participation	Word of mouth (n = 9); Facilitator referral (n = 8); Study advertising (n = 7); Media reports (n = 5); Online testimonials (n = 3)
Province or Territory of Residence	British Columbia (n = 18); Newfoundland & Labrador (n = 3); Ontario (n = 3); Quebec (n = 2); Alberta (n = 2); Nova Scotia (n = 2); Manitoba (n = 1); Northwest Territories (n = 1)
Procedure Sought Abroad	Orthopaedic surgery (n = 15); CCSVI therapy (n = 4); Eye surgery (n = 4); Bariatric surgery (n = 3); Cosmetic surgery (n = 3); Gastrointestinal surgery (n = 2); Dental surgery (n = 1)
Participant Ages	Average of 53 years; Median of 50 years; Range from 22 to 80
Sex	19 females; 13 males

The processes by which participants discovered, researched, and ultimately decided on pursuing medical care outside of Canada was extensively probed over the course of the interviews. Three distinct themes emerged from the accounts of the decision-making process: (1) information sources consulted during the decision-making process, (2) motivations, considerations, and timing regarding accessing medical care abroad, and (3) personal and professional supports drawn upon during the decision-making process. These themes are expanded on in the remainder of this section. As much as possible we have included verbatim quotations from the interviews in order to enable the participants themselves to ‘speak’ to these issues. Quotations were selected by the lead author as being a cogent representation of an issue assigned to a particular theme, and independently confirmed as such by the other authors.

#### **2.4.1. Information Sources Consulted**

Participants identified four means of initially learning of medical tourism, namely: word-of-mouth (n = 13), non-targeted Internet searches (n = 10), print and televised

media stories and advertising (n = 6), and familiarity with other countries' health systems due to their having emigrated from them (n = 2). One person could not remember how she originally learned of medical tourism. For those who first learned of medical tourism online, the possibility of accessing care abroad usually emerged as an extension of researching treatments or trying to find an alternative means of accessing a surgery for which they were wait-listed domestically. *"I was looking for a magic bullet on the Internet...to address the...wait list issue that I was facing and so I had no idea what was out there...so I wasn't actively seeking...I didn't even know what I was looking for...I just thought there had to be something else..."* For those who learned about medical tourism from other people, former medical tourists (ranging in intimacy from close friends to one-off informal encounters), and friends and family with a passing knowledge of medical tourism served as important prompters. One exceptional case emerged where a Canadian family physician raised orthopaedic care abroad with multiple participants amongst our dataset. While advertisements by medical tourism facilitators initiated some participants' decision-making processes, news stories were more influential in raising participants' awareness. Finally, for the two participants who were motivated by existing familiarity with non-domestic health systems, medical care outside of Canada was always seen as a possibility and there was no process of 'discovering' the option of care abroad.

Upon first learning of medical tourism, the vast majority of participants relied upon the Internet for detailed information. For these participants, it was used as a research tool to access the websites of facilitators, destination hospitals, joint replacement manufacturers, and empirical research. The Internet was also a powerful social tool, facilitating contact between participants and former medical tourists who provided personal anecdotes and advice. This communication sometimes took place in the context of online forums, though it was also common for participants to contact former medical tourists directly by e-mail. This sometimes resulted in having extended telephone conversations about their experiences. Participants also used the Internet to contact surgeons abroad directly for phone or e-mail consultations. These consultations were often informed by the sharing of diagnostic scans or reports between the prospective medical tourist and surgeon, the transmission of which was also facilitated by the Internet. The most common fact-finding approach amongst the medical tourists

interviewed is characterized by this participant's comments: *"I had had so little care here (in Canada) I figured it couldn't be any worse over there. Maybe it could, I knew it was a third world country, but after I researched the hospital on the Internet and I talked to the four or five different people who went over there I had no concerns whatsoever."* Six participants did not use the Internet at all in informing their decisions to go abroad, relying instead on family members in the destination country to obtain and relay information directly from and to the facility, the advice of former medical tourists, and/or the information provided by facilitation companies.

Although it was not directly probed, few participants discussed how they assessed the reliability of the information sources they consulted in the process of learning about medical tourism. Some outlined basic quality and reliability assessment practices. For example, one participant relied heavily on online physician rating sites, saying *"he (the surgeon) didn't have like any...bad write-ups online or anything... and when I didn't see anything bad I figured well it must be okay, because I've looked up some doctors here for other things and I have seen bad comments."* Another participant primarily relied upon a trusted hospital brand, saying *"But there's no real deep research, it's just uh a matter... (of) calling up your Mayo Clinic...on the computer screen, reading a bit and making a few calls and going from there."* Other participants characterized themselves as savvy researchers, suggesting their skills extend to assessing the reliability of information, saying *"...now when some people...say oh they do online research...well sometimes they just mean that they've looked at a lot of ads, at advertisements for this kind of thing (procedure)...I didn't do that, I looked for statistical surveys about the pros and cons of which procedure."* While the majority of participants looked to the Internet as their primary information source, they commonly neglected to clearly delineate or discern what kind of information was ultimately accessed or who hosted it until they were prompted, while a minority made concerted attempts to convey the effort invested in seeking out what they thought was accurate and neutral information provided by third parties without commercial interests.

#### **2.4.2. Motivations, Considerations, and Timing**

Participants identified many different motivations that spurred their initial consideration of medical tourism, which are summarized in Table 3. Despite this variety,

all of the motivations discussed fall into the three broad categories of seeking procedures that are unavailable, wait-listed, or more costly in Canada. Cost was the primary motivation to pursue care abroad for four participants, all of whom sought cosmetic or dental surgeries that were available domestically for private purchase but not covered under public Medicare. Of the 14 participants that identified wait-listing as a key element motivating their trip, only seven ultimately pursued surgeries abroad that were available (and for which they could be put on a wait-list) domestically. The other seven concerned with wait-listing sought surgeries unavailable in their home provinces or territories. These alternate procedures were often described as more technically sophisticated and desirable than the domestic equivalent. These considerations became a keystone in their decision to travel for care that combined with, and sometimes eclipsed, the initial issue of wait-listing. Fourteen participants were solely motivated by procedure availability, seeking procedures that were not available to them in their provincial health or territorial system at the time of their medical travel. Reasons for this unavailability included the procedure not being approved by safety regulators, the patient being ineligible for surgery due to age or the absence of a diagnosis, or the lack of domestic surgical expertise to perform the surgery.

**Table 3. Primary motivations to pursue surgery abroad reported by participants**

Primary Motivation(s)	# of Participants
Availability (where the procedure is not available domestically)	14
Wait-listing (where the procedure is available domestically)	7
Combined wait-listing & availability (where being wait-listed prompted a search for alternative surgeries not available domestically)	7
Cost (where the procedure is not covered by public Medicare)	4

Participants were faced with choosing which destination facility to visit. For many, the key deciding factor was the reputation of a surgeon they had found online and/or through social networks. The quality of the surgeon was assessed by looking at where s/he had trained, experience with the surgery, and/or testimonials from former patients. The perceived skill of the surgeon regularly outweighed more practical concerns, such

as the possibility of encountering language barriers: *“I went for the surgeon. That was...the fundamental reason for going there. It was, not in terms of you know, where it was, no. I went for the surgeon.”* A group who deviated from this tendency to prioritize a particular surgeon over other variables were those who went abroad for CCSVI therapy. The majority who sought this procedure went to whichever clinic could treat them the soonest, regardless of its location. Another group of participants who did not choose their destination based on the surgeon were those returning to their countries of origin for surgery. Related to this, some made decisions based on previous international travel or living experience. The amount of in-hospital recuperation time offered also influenced destination choice. Those who stressed the importance of this put a high premium on the attention they would receive post-operatively, choosing the facility that would offer the most lengthy and attentive recuperation period. Proximity of the destination to Canada was relevant for some, but was never an overriding concern. Finally, cost was influential to a varying degree. For some, the affordability of care in the Global South greatly influenced their decision-making, as they would have accessed the surgery in a more developed nation if they had the money. For example, *“India was the cheapest of all of the ones that I researched or the least expensive rather than cheapest. I didn’t mean to cheapen it. The least expensive option was Chennai and that was a big factor...if I’d been a millionaire...I would have gone to Britain.”* Other participants reported finances as being low on the decision-making hierarchy, characterizing it as unimportant when compared with the other factors mentioned here.

There was great variety in the length of time it took participants to come to the ultimate decision to travel abroad for medical care, ranging from ten years to one week. Excluding the outlier of ten years, the average time from the discovery of the possibility of going abroad for surgery to contacting a facilitator or destination hospital with the intent to book a trip was six months (median = 3 months). This six month period was commonly spent researching potential destinations, assessing risks, speaking with other medical tourists, undertaking multiple calls or e-mails to facilitators and/or destination clinics, and in some cases attending local information seminars arranged by facilities seeking international patients. The time between booking and surgery was much more compressed, ranging from under one week to six months, with the average being two months (median = 2 months). For those who were assigned this two month period, it was

seen as a reasonable and desirable amount of time to get things in order prior to travel and surgery while also giving time to arrange travel visas, where necessary.

### **2.4.3. Decision-Making Supports**

Two groups of people were commonly reported to have played supportive roles during participants' decision-making processes. First, participants greatly appreciated and heavily considered anecdotal accounts from former medical tourists. These accounts were overwhelmingly positive endorsements of particular surgeons, destination hospitals, and/or the practice of medical tourism itself. In fact, the majority of participants sought advice from other medical tourists, ranging from reading online testimonials to speaking directly with such individuals. The following account is characteristic of the potency of these supportive encounters: *"I talked to some (former medical tourists), one guy especially who has been there a year before me...and his experience actually made me really go for it and have no, no more doubts...(because) he said 'it's totally up to standard, to Western standards, and a lot of people are trained in the West,' and he said the service was so good he would send his daughter there on her own."* Several participants also reported being contacted 'out of the blue' by former medical tourists who had heard about their upcoming trip through acquaintances or the local news media and offered strong support and additional advice, further validating their decision to go abroad for care. Second, family members played key supporting roles in helping to research and interpret information. For at least four participants this support extended to assistance with financing their medical care abroad. Although an important source of support, the opinions of friends and family had little impact on the outcomes of the decision-making process, with many participants adamant that they would have pursued their medical tour with or without the approval of their family or friends. This conviction was largely hypothetical, though, as none reported being seriously challenged by anyone during their decision-making.

Although most participants reported visiting with either their family physician or treating specialist during the time in which they were considering booking surgery abroad, they rarely sought physicians' advice during the decision-making process. Instead, they more commonly waited to hear their regular physicians' opinions on their decisions after having made a booking. Interestingly, the perception that one's family

physician or treating specialist would be unsupportive was cited as justification for not informing them of the plan to go abroad for surgery prior to booking. For example, one participant who did not speak with their family doctor explained that her surgery was *“None of his business... and he would have been prejudiced and he was prejudiced in any case.”* One of the most common reasons participants consulted with their regular physicians prior to going abroad was to acquire medical records or diagnostic tests in order to relay this information to destination physicians. While these physicians commonly complied with participants’ requests for records and/or tests, their reaction to the decision to go abroad for surgery ranged from supportive and caring to dismissive and dissuading. Remaining neutral and offering neither support nor discouragement was most common. Two examples of demonstrating uncommonly supportive family physicians include one who brought up the possibility of pursuing surgery abroad to patients before they had considered it and another who provided their personal cell phone number for the patient to provide their overseas surgeon in the case of an emergency to try and ensure a high degree of informational continuity. In both examples these physicians served as a significant source of support and guidance during decision-making.

Participants reported drawing on two industry-based sources of support in the course of their decision-making, those of medical tourism facilitators and clinics abroad. Ten participants reported using a medical tourism facilitator to arrange for care abroad. Many of them solely relied upon the facilitator for information about their procedure, the facility, and the surgeon abroad. For example, when asked *“Did you hear about the hospital that you went to in Bangalore from anyone else or was it just solely through the recommendation of the facilitation company?”* a participant replied *“Yeah. That was through the company that sent us; we had no idea where we were going.”* In the course of their decision-making, participants regularly reported having direct contact with their surgeon abroad via e-mail, phone, or less commonly, at in-person information seminars. Participants took the opportunity to ask questions regarding the potential risks of surgery, probable outcomes, and their suitability for the procedure. These interactions were greatly valued, and strengthened the resolve of many to access care abroad. When asked what the main deciding factor was in seeking surgery abroad, one participant appealed to these interactions with the surgeon, saying: *“You know it*

*probably was the doctor, I can't think of anything else...I was in touch with him two or three times, he called me by telephone and spoke to him about a lot of the concerns and things and...I think...he was the main factor."*

## **2.5. Discussion**

The opportunity to seek care abroad through the medical tourism industry creates new means of acting on motivations and needs that have likely always underpinned surgical decision-making in domestic contexts but may have been constrained by structural arrangements. The current Canadian model of accessing surgical care privileges the position of the expert over the non-expert by requiring patients to seek referrals to tertiary care providers from their primary care physicians (Watt, 1987), with the exception of surgical care not provided through the public health care system. The medical tourists we spoke with, however, tended to seek advice and information from many sources other than their regular physicians or other members of the medical community and were ultimately responsible for deciding when and where care was to be delivered as long as they could find a willing surgeon abroad. As such, involvement in medical tourism changed participants' typical enactment of the 'patient role' and the means by which they decided on medical treatment. The significance of these changes is discussed below in regard to participants' layered motivations, the timelines of care commonly seen, and the sources of information accessed and relied upon in their decision-making processes.

The current literature on medical tourism broadly categorizes patient motivations, typically attributing a single motivator to medical tourists from any given health system (e.g., Horowitz et al., 2008; Singh & Gautam, 2012). In these accounts, Canadian medical tourists have generally been afforded only one motivation for accessing medical care abroad, that of wait-lists (e.g., Law, 2008). While wait-lists and wait-listing played a role in motivating many of the participants to look for care outside of Canada, it is important to note that participants provided examples of all three of the regularly cited motivations for medical tourism, those of procedure cost, availability, and wait-listing (Crooks et al., 2010). Given the lack of universal coverage by public insurance plans for dental and cosmetic surgeries in Canada, it was not surprising to have heard accounts of Canadians choosing to access these treatments at more affordable rates abroad.

Cost also served as a secondary motivator for many, serving to promote more affordable destinations once participants were seriously researching their options for a specific procedure abroad. The role of procedure availability played a far more nebulous role as a motivator when compared with cost. It played a primary motivating role for those seeking experimental surgeries (e.g., CCSVI, eye surgery for retinosis pigmentoria), as there are no similar treatments available in Canada. It also served as a primary motivator for those who were unable to get specialist referrals domestically, or whose conditions were deemed inoperable by their domestic physician. Similarly, previous discussions of medical tourists have rarely accounted for individual backgrounds that might influence the countries they visit for medical care. Meanwhile, our analysis suggests that previous exposure to foreign countries, either through travel or emigration, might bear influence on the destinations they ultimately select.

For many participants who were *initially* motivated to explore the option of care abroad as a result of having been wait-listed or being worried about the prospect of one, the availability of procedures performed abroad which were perceived to be technically superior supplanted this initial motivation. This supplantation of availability with wait-listing was seen repeatedly for those who sought hip resurfacing, an alternative to a total hip replacement, and vertical sleeve gastrectomies, a form of gastric bypass surgery. Meanwhile, the desire to avoid a wait list for the same surgery available domestically played a role in only six participants' accounts. These layered motivations suggest that the decision to access surgery abroad cannot be crudely reduced to a single motivator, and that contextual elements and secondary motivators should be considered alongside the most powerful motivator in any given account. Perhaps unsurprisingly, a common element to all of the accounts was a strong hope that the surgery sought abroad would improve the participants' quality of life, as a sentiment of the importance of achieving good health at any cost emerged in many of the interviews. If the barrier to a good quality of life through surgery was perceived to be availability, cost, or a lengthy domestic wait list, participants were compelled to find the means abroad to overcome them, regardless of the procedure's objectively scored urgency and/or necessity.

Notably, the particular contexts of individual destination countries were relatively unimportant in most of participants' decision-making processes. More specifically, the particular details of a destination country's wealth, politics, history, language, and other

characteristics were of minor importance when compared to the reputation of the surgeon and the facility. In this way, the 'global' aspect of medical tourism is both effaced and affirmed as the differences between potential destination nations disappear and are replaced by placeless images of homogenous clinical spaces in the imaginations of medical tourists. This finding departs from some of the conceptual decision-making models that have been published in the tourism studies literature that have emphasized the importance of destination nation characteristics to potential medical tourists' decision-making processes (e.g. Heung et al., 2010; Smith & Forgione, 2008).

While word-of-mouth information sharing has been noted as an important factor in other studies of surgical patient decision-making (e.g., Hawker et al., 2001), the degree to which word-of-mouth recommendations and endorsements serve as a primary consideration for medical tourists was found to be remarkably consistent. This factor was found to be equally important in a recent study of Omani medical tourists (Al-Hinai et al., 2011). Another consistency among our participants was a general lack of consultation with their regular physicians during the decision-making process. Within the Canadian system, family doctors and other primary care physicians serve as a keystone in patients' pursuit of the majority of elective surgical care by assessing need, providing counseling, and arranging for appointments with specialists who relay detailed information about the risks and benefits of surgery (Bederman et al., 2010). Despite these established roles in supporting patients' medical decision-making, far more valued was the advice and support provided by other medical tourists. This mirrors Kangas' (2007) findings amongst Yemeni medical tourists, whose considerations of and where to go abroad for medical care were deeply informed by word-of-mouth networks recommending particular destination clinics and physicians.

While the value placed on the expertise from former medical tourists by those engaging in decision-making around pursuing care abroad should not be discounted given their first-hand knowledge of what to expect from particular hospitals or surgeons, the conspicuous absence of a neutral, yet informed, third party informing the decision-making process must be noted. Positive testimonials have been found to skew the interpretation of surgical risk, resulting in a disproportionate weighting of the potential positive outcomes even when presented with the statistical likelihood of the potential

negative outcomes (Freymuth & Ronan, 2004). This raises concern about whether or not medical tourists are always in a position to give informed consent to care abroad based on the information they have considered, given that such consent requires a sound understanding prior to surgery of their condition, success rates, treatment options, and risk of complication (Kangas, 2007; Mishra et al., 2010). Given the current lack of comprehensive and neutral guidance available to medical tourists, there have been a number of calls for stronger informational support by third-parties that do not have a vested financial interest in medical tourism (Lunt & Carrera, 2011; Penney et al., 2011; Turner, 2010). Knowing that former medical tourists play such an influential role in informing prospective medical tourists could be useful to those designing such interventions, wherein former medical tourists could be targeted in informational campaigns with the intent of having them pass such information along to those contacting them for advice. Furthermore, awareness of our finding of the wide variance in the timing of the pre-booking research period by medical tourists and the relative two month consistency of the post-booking period could aid in developing strategies to disseminate informational interventions that are sensitive to the timeline of prospective medical tourists' informational needs.

### **2.5.1. Wider Relevance**

The growth of the medical tourism industry has clear implications for global health equity (Johnston et al., 2010; Turner, 2010). By extension, the decision-making considerations of individual medical tourists and the information they access is tied to the development of this industry and its potential to operate equitably and ethically. One commonly cited health equity concern pertains to the use of public resources by the private medical tourism industry (Johnston et al., 2010). Although much consideration has been given in the medical tourism literature to the potential for patients to require expensive follow-up care in their home countries (Birch et al., 2010; Cheung & Wilson, 2007; Crooks et al., 2010), our findings show that most of the medical tourists we spoke with sought out some degree of advice or logistical support from their family physicians and treating specialists *prior* to going abroad (but not necessarily before booking the procedure). As primary care consults and many lab costs in Canada are covered by public funding, this is another potential pathway through which public funds support the operation of this private, for-profit industry. More research attention needs to be given to

uncovering the ways in which patients' home health care systems indirectly support the medical tourism industry in order to inform health equity debates surrounding this global health services practice.

In terms of health equity in medical tourism destination countries, it is thought that medical tourists traveling to economically developing nations may exacerbate existing health inequities by raising the cost of care and/or lessening the availability of specialists to local citizens through increasing demand for their services (Pachanee & Wibulpolprasert, 2006). Meanwhile, it has also been suggested that the revenues from medical tourists could be used to cross-subsidize the care local patients in order to mitigate potential negative health equity impacts (Sen Gupta, 2008). Should the appropriate redistributive financing mechanisms and regulations be developed in destination countries or at individual facilities, medical tourists' willingness to incur added fees to access more equitable care is likely contingent on their understanding of the health challenges faced by economically developing destination nations. Our findings suggest a general lack of awareness amongst the medical tourists we spoke with in terms of their knowledge of contextual details of the particular destinations they chose to travel to during decision-making about seeking care abroad. In fact, consideration of the destination country in any way held little weight in the decision-making process. Medical tourists may more carefully consider health equity in the destination and the impacts of their decisions if prompted to do so in informational interventions or through other means and mediums.

While this analysis has focused specifically on Canadian medical tourists, our findings have relevance for medical tourists from other nations. Here we highlight three such issues. First, while the contextual details of medical tourists' home health systems may differ, they seek care in a common global marketplace. Our findings have confirmed that this marketplace is largely mediated through the Internet, where much of the information that prospective medical tourists consider is accessed online. Second, amongst our participants, context-specific domestic health system considerations informed their decision making processes. For example, particular strengths (e.g., universal access) and weaknesses (e.g., care rationing) of the Canadian public health care system underlay the kinds of surgeries that were sought out-of-country and the motivations to go abroad. Patients exiting other countries with universal public

healthcare coverage, such as the United Kingdom and Norway, may too be motivated to go abroad for the same reasons as the Canadian medical tourists we spoke with. Third, upon entering the same global marketplace, potential medical tourists are exposed to many of the same web pages and advertisements regardless of the regulatory, legal, and political environments from which they will depart. This reality underscores the importance of thinking of this patient group as influenced, but not strictly defined by, their home health system contexts.

### **2.5.2. *Limitations***

As recruitment was limited to English, we have excluded French-language participants as well as other linguistic minorities who do not have spoken English fluency. Additionally, given the difficulty of recruiting the study population and our subsequent reliance on snowball sampling, there is likely a disproportionate focus on particular surgeries sought in specific destinations and medical tourists from certain regions of Canada. Finally, our reliance on the retrospective recollections may have resulted in the omission of key details and/or heightened the bias of their recall of events when compared with a prospective approach to data collection.

## **2.6. Conclusions**

In this article we have presented the findings of interviews with 32 Canadian medical tourists, with a specific focus on their decision-making processes regarding seeking surgery abroad. Our analysis confirms accounts of medical tourism that attribute its growth to the ability of the Internet to connect distant parties with mutual interests to one another (Connell, 2006; Moore, 2009). That prospective Canadian medical tourists relied upon the Internet to put them in touch with information about clinics, surgeons, and other medical tourists is therefore not surprising. What is noteworthy, however, is the degree to which the opinions and advice of other medical tourists informed participants' awareness of medical tourism and their ultimate decision to travel abroad for care. This adds evidence to existing concerns that prospective medical tourists may have limited access to accurate and unbiased sources of information about their treatments, especially online (Lunt & Carrera, 2011; Turner 2011a). The creation of such

sources could greatly benefit all medical tourists considering surgery abroad by providing a more complete picture to inform their decision-making.

The accounts provided by Canadian medical tourists complicate existing broad characterizations in the medical tourism literature that attribute the motivations of medical tourists leaving any given country to a single motivating force, such as cost of care, wait-listing, or the availability of procedures. The medical tourists we interviewed made it clear that all three of these motivators were at play in their decision to seek care abroad, often in combination with one another. Future accounts or investigations of medical tourism would benefit from a more nuanced consideration of the layered motivations that are driving patients to seek medical care abroad, rather than accepting the current broad-stroke accounts that attribute a single motivator to the medical tourists of any one locale. It is also important that future research addresses the quantitative knowledge gaps rife in medical tourism research to provide broader context and grounding for the trends described in this analysis and other qualitative studies.

### **3. CHAPTER THREE**

## **“Our true role...is within the confines of our system”: Canadian family doctors’ roles and responsibilities towards outbound medical tourists**

### **3.1. Abstract**

#### **3.1.1. Purpose**

Medical tourism is a growing mode of health care delivery that poses novel challenges to family doctors. This study explores how Canadian family doctors understand their roles and responsibilities towards patients that seek health care abroad as outbound medical tourists.

#### **3.1.2. Methods**

Six focus groups were held with 22 family doctors across the province of British Columbia in 2011. Thematic analysis of the transcripts identified cross-cutting themes.

#### **3.1.3. Results**

Canadian family doctors find that medical tourism threatens patients’ continuity of care. Informational continuity is disrupted prior to patients’ going abroad by regular omission of family doctors from pre-operative planning and upon return home when patients lack complete or translated medical reports. Participants felt that their responsibilities to patients resumed once they had returned from care abroad, but were worried about not being able to provide adequate follow-up care. Participants were also concerned about bearing legal liability towards patients should they be requested to clinically support a treatment started abroad.

### **3.1.4. Conclusions**

Medical tourism poses challenges to Canadian family doctors when trying to reconcile their traditional roles and responsibilities with the novel demands of private out-of-country care pursued by their patients. Informational tools to help patient decision-making and guidance from professional bodies regarding physicians' responsibilities to Canadian medical tourists are seen as currently missing. Developing these supports would help address challenges faced in clinical practice.

## **3.2. Introduction**

Medical tourism is the intentional pursuit of privately-purchased and arranged-for medical care outside a patient's home country (Bookman & Bookman, 2007). This care occurs outside established cross-border care arrangements and typically without physician referral. Information about clinics and procedures abroad is readily available to prospective patients online, which has propelled recent growth of the medical tourism industry (Connell, 2011; Lunt et al., 2010). Concurrently, the confidence of international patients in the quality of care available abroad has been bolstered by marketing campaigns for medical tourism by various hospitals and national governments (Crooks et al., 2011; Leng, 2010). Medical tourists may choose to arrange for their own care abroad or use the services of 'facilitators' – agents who specialize in booking international medical travel but who typically have no medical training (Cormany & Baloglu, 2011; Turner, 2011).

While the phenomenon of people traveling abroad to access medical care is not new, the increasing scale of international medical travel is (Whittaker, 2008). Meanwhile, little empirical research has been done to examine how these international networks of care impact outbound medical tourists' domestic primary care systems, including Canada's (Hopkins et al., 2010; Johnston et al., 2010) – wherein Canadian patients are known to be taking part in medical tourism (Crooks et al., 2011; Turner, 2011b). Canada's healthcare system uses a single-payer model (i.e. publicly funded and administrated) to ensure universal coverage for necessary services. As such, access to public healthcare is rationed (Romanow, 2002). Canadian family doctors play

a key role in this rationing by serving as ‘gatekeepers’ to diagnostic and surgical services, providing assessments of need, and offering referral beyond primary care when warranted. Medical tourism challenges this gate-keeping role by allowing Canadian patients to circumvent their family doctors and access specialized or surgical care on demand. This alteration to the usual trajectory of care has raised concerns regarding patient safety, interruptions to continuity of care, and the quality of informed consent (Lunt & Carrera, 2010; Snyder et al., 2011a; Turner, 2007b). However, these concerns have remained primarily speculative due in part to the lack of consultation with primary care providers about medical tourism. In this article we begin to address the knowledge gap identified above by reporting the findings from focus groups held with Canadian family doctors about outbound medical tourism. We conducted thematic analysis of this data to qualitatively explore what family doctors see their roles and responsibilities to be for patients in their practices who seek medical care abroad as medical tourists. Our findings raise questions about family doctors’ responsibilities towards these patients and clarify some implications of medical tourism for Canadian family medicine practice. These findings can inform action or intervention development in other similar countries experiencing outflows of patients pursuing medical tourism, such as Australia, Britain, and the United States (Cheung & Wilson, 2007; Ehrbeck et al., 2008).

### **3.3. Methods**

The purpose of this qualitative study is to identify the implications of patients’ engagement in medical tourism for surgical interventions for family medicine practice in the Canadian province of British Columbia (BC). We focused on BC not only because it is where we, a team of health services researchers and social scientists with domain expertise in medical tourism and family medicine, are based but also because it is a province known to be home to medical tourists and several facilitation agencies<sup>17</sup>. In summer 2011, six focus groups were held in six BC cities that provided representation from all provincial health authorities. Focus groups were organized to offer a forum for BC family doctors to discuss their experiences and concerns about outbound medical tourism. Focus groups are a useful method in exploratory research such as this where participants may not have enough to say on their own to warrant being interviewed, and

where ideas exchanged amongst participants might spur ideas that would remain uncovered through one-on-one conversation (Sim, 1998).

Prior to recruitment, ethics approval was granted by the Research Ethics Board at the authors' institution. Participant eligibility was limited to family doctors currently practicing in one of the six cities. Potential participants were identified using the BC College of Family Physicians website, where the contact information for all practicing family doctors was gathered. Letters of invitation were faxed to all of the practices identified, from which interested doctors followed up with the lead author for further information and consent forms. This information indicated that CND\$150 would be given to participants to acknowledge their contributions to the study. A notable limitation of our recruitment strategy is that it was limited to a single Canadian province and subsequently may not capture the full range of issues that may be present across Canada. Focus groups took place at meeting rooms in hotels or university campuses in the six cities. Two moderators and a note-taker were present at each. The focus groups were loosely structured around a series of pre-determined probes that explored the: experiences participants had with medical tourists in their practices; concerns and/or benefits medical tourism offered their patients; and usefulness of current and prospective informational tools available to patients considering medical tourism. As is standard with focus groups, moderation was only used to keep conversation going or to move discussion on to new or more pertinent topics (Sim, 1998).

Focus groups ran from 1.5 to 2 hours and were digitally recorded and transcribed verbatim. Following data collection, transcripts were uploaded into NVivo, a qualitative data management program, for coding. A coding scheme was iteratively developed with input from all authors following full transcript review and confirmation of consensus on key emerging themes when compared to the study aims and existing literature on medical tourism. Inductive and deductive organizational codes that structure these themes were identified, which formed the coding scheme. Coding was performed by the lead author. The cross-interpretability of the coding scheme and its application to the dataset was verified by the second author following coding of the first transcript.

Following coding, the content of each code (i.e., the coding extracts) was comprehensively reviewed across the six focus groups in order to ascertain the breadth

and depth of identified themes. The interpretability of these themes was confirmed by the first three authors following the coding process, wherein patterns and outliers for each theme were discussed. A key theme emerging from the transcripts and confirmed through coding extract review pertained to family doctors' roles and responsibilities towards patients engaging in medical tourism, which is what is examined in this article. Quotes that best suit the scope and breadth of this theme were identified for inclusion by the first and second authors and confirmed by the others.

### **3.4. Results**

In total, 22 family doctors participated in this study. They had been practicing family medicine for an average of 23 years. Twenty had at least one patient in their practices that had opted for medical tourism. The number of medical tourists they estimated that they had encountered over their careers ranged from one to 90 (median = 6). In the remainder of this section we present the findings of the focus groups. Findings are organized as themes central to the roles and responsibilities of doctors to their patients who seek healthcare as medical tourists. These themes are distinguished between pre-trip versus post-trip roles and responsibilities, and concerns versus desires surrounding their potential or realized roles. Table 1 contains verbatim quotes that characterize key themes.

**Table 4. Illustrative Quotes**

Quote #	Quote Text
1	“I don’t feel it’s my responsibility as a...family physician to research this (clinic abroad or surgical intervention being sought) or to council...where to go and anything of that sort, other than to (alert them to) be cautious and...they may be getting something they didn’t bargain for” (FG-K, pg.10)
2	“...if a patient comes to me and says ‘the purpose of my visit today is to talk about maybe I want to go to India’, there’s no diagnostic code for ‘I want to go to India, you know’ so I’m not actually supposed to bill for that right. So there is no benefit for us” (FG-N p.1, pg.6)
3	“(Patients) haphazardly discuss one or two things with you and then they’re gone before you know and they come back (after surgery abroad) and there hasn’t really been a plan or, or time to work out what we’ll do when you get back, or a lot of them go without letting us know” (FG-V, pg.26)
4	“...no matter where (my patients are) seeking medical care I still have that sense of: I’m their family doctor and I’m going to want to work with them if they have complications. But if they’re someone (who goes abroad and) I don’t know about it then...I’m out of that loop” (FG-PG, pg.15)
5	“...it’s frustrating for us (family doctors) when they (patients) come back with all the results, half of them in a different language or not in metric or whatever and then you have to sort all this out and you know we’re in a small business that has five to ten minutes per patient and we’re expected to solve all those issues as well as the day to day maintenance of the patient” (FG-V, pg.20)
6	“So would I accept the patient back and treat those complications, yeah absolutely, they’re my patient. I’m a family doctor, you know that’s my responsibility and that’s also what you do as family physicians...we try to do the best for our patients at all times, all situations” (FG-PG, pg.20)
7	“...you know I have patients going abroad, getting care and then they come back and the physician (from the destination facility) and the patient expect me to continue care, so providing certain types of medication, certain types of injections because the patient can’t stay down there for all of their treatment, so I’m doing something that I’m just not really comfortable with and its being dictated by someone else abroad and thinking well what happens if there’s a complication, who is now going to be on the hook for liability” (FG-B, pg.6)
8	“I don’t see much benefit for us in family practice because (outbound medical tourism) diverts our true role. Our true role... is to guide our patients in their journey towards health in our system right within the confines of our system” (FG-N, pg.14)

### **3.4.1. *Pre-Trip Roles and Responsibilities***

Concerns emerged across all focus groups regarding pre-trip consultations with patients considering medical tourism. Foremost amongst these was that prospective medical tourists often expect family doctors to help interpret research about desired procedures or clinics abroad. Many participants recounted being presented with an overwhelming amount of marketing materials and website print-offs. Participants expressed that it was impossible to satisfy these requests as there is not enough time during one consult to review the material and address patients' concerns. Participants also thought it was unreasonable to expect them to be familiar with details of the destination providers, the countries where care was offered, and/or the procedures sought, especially those that are experimental (Table 1, quote 1). Compounding their hesitation to speak beyond their level of familiarity was the absence of a billing code for medical tourism consults, offering them no way to be compensated (Table 1, quote 2).

Most participants had experienced situations where their patients did not consult with them prior to going abroad, only to learn about the procedure after it had been performed (Table 1, quote 3). Participants expressed concern for the well-being of their patients and felt it was important to have the opportunity to help broadly examine the pros and cons of the medical interventions being considered and to discuss the potential risks involved prior to a patient booking care in another country. Some of participants saw a patient's consideration of medical tourism as a possible indicator of navigational challenges within the Canadian healthcare system. Participants across the focus groups thus thought that many patients seeking care abroad would be best helped by first advocating for their patient and ensuring their options within the domestic system were exhausted.

Many participants experienced medical tourism as disruptive to the provision of continuous care, and were concerned when they were totally omitted from the planning stage (Table 1, quote 4). This concern about informational discontinuity did not extend to a desire to be involved in facilitating the provision of out-of-country care prior to a patient's travel, for example by prescribing prophylactic medications for infection.

Examples from some participants' own experiences were offered to demonstrate how a lack of willingness to offer pre-trip support could damage relationships with patients and

threaten continuity of care. It was agreed that providing (usually limited) input or guidance in the planning stage could enhance the ongoing doctor-patient relationship, particularly when the procedure being sought abroad was thought of as life-changing or -saving.

### **3.4.2. *Post-Trip Roles and Responsibilities***

The potential for disrupted continuity of care following a patient's private pursuit of medical care abroad was a major issue raised by all participants. For example, instances where informational continuity had been disrupted by poor or non-existent documentation of procedures or post-operative care orders were reported to be common, as were patients returning with treatment documentation in languages other than English or using diagnostic metrics not used in Canada. Both of these issues made interpreting or integrating surgical interventions sought abroad into a patient's history difficult (Table 1, quote 5).

All participants expressed a strong conviction that they held a responsibility to provide post-operative care for their patients as best as they were able to regardless of where the original treatment was obtained (Table 1, quote 6). Uncertainty emerged regarding what forms this post-operative care or support should appropriately take. For example, concern was raised about taking on liability for post-operative care should it involve treatments prescribed by an out-of-country physician, especially when the care they were being asked to provide followed an experimental procedure not approved in Canada (Table 1, quote 7). Another concern pertained to arranging post-operative specialist care for medical tourists upon their return. Some participants had directly experienced specialists refusing to provide post-operative care for these patients. Others expressed concern about the potential for encountering problems in forwarding medical tourists within their referral networks as a very real possibility. Participants felt that these post-operative care concerns needed to be clearly communicated to prospective medical tourists, and that they reinforced the importance of pre-trip consultations between family doctors and their patients.

### 3.5. Discussion

The family doctors we spoke with indicated a preference for a limited role when their patients seek private medical treatment outside of Canada. Liability concerns and knowledge limitations made participants think that many of the responsibilities associated with their routine gate-keeping role for domestic care, such as coordinating with specialists and helping in surgical decision-making, are not transferable to outbound medical tourists. Participants did wish to be involved in the decision-making process to the point of exploring the motivations behind a patient's consideration of medical tourism and to ensure options within the domestic system are exhausted before patients went abroad. They also wanted to help patients achieve an accurate understanding of the potential risks, costs, and benefits of the medical care they were seeking abroad. At the same time, they did not see any significant role for themselves as a researcher or interpreter for information when discussing decision-making. Quote 8 (Table 1) succinctly captures one of the primary reasons for this. This finding runs counter to calls made by some scholars for family doctors to offer detailed counsel and specific recommendations when patients consider medical care abroad (Crozier & Baylis, 2010; Levine & Wolf, 2012), and demonstrates the importance of seeking input directly from family doctors prior to putting forth recommendations about their roles and responsibilities towards medical tourists.

Family doctors strongly felt their roles and responsibilities for facilitating and administering post-operative care within Canada remained the same regardless of where initial treatment was obtained. These responsibilities were less certain in cases where the procedure was experimental or poorly documented. Our analysis revealed that the desired roles of family doctors in providing or coordinating post-operative care could be enabled by improving informational continuity of care standards in the practice of medical tourism. For example, encouraging pre-trip contact between patients and their family doctors to discuss appropriate documentation could assist these same doctors in caring for their patients upon return home. The concern expressed by numerous participants that there may be difficulties finding a specialist willing to provide post-operative care for a patient who has sought surgery abroad confirms speculation that this is an implication of outbound medical tourism for patients' home healthcare

systems (Cortez, 2008). This concern also indicates a need for patients to be clearly informed of what kind of post-operative care will be available to them in their home system when pursuing medical tourism. Participants felt that there was a lack of external guidance from professional and regulatory bodies to help them with understanding if and how they should assist medical tourists while protecting themselves from legal liability. They wanted guidance on what their roles and responsibilities towards these patients were. They also expressed concern over the lack of guidance available to Canadian patients considering medical tourism. While a minority of participants thought that the creation of informational tools aimed at patients or family doctors would be an 'admission of failure' by the Canadian healthcare system, most saw such tools as desirable. Simple informational interventions were favoured, including pamphlets or websites that outline common surgical risks, potential limitations of Canadian system responses to complications from surgery, and questions for patients to ask their surgeons abroad. Given the knowledge limitations of family doctors around specific procedures and destinations and the limited time available to them to counsel patients, it was generally agreed that such informational supports would be very useful to direct patients to the tools to review in their own time. This desire for informational interventions for medical tourists and health professionals is consistent with the findings of other studies (Crozier & Baylis, 2010; Lunt et al., 2010; Turner, 2011a), including one involving health administrators responsible for patient safety in BC (Crooks et al., 2011b).

While this analysis is limited to the perspectives of Canadian family doctors in 6 BC communities, the findings are transferrable to a range of healthcare contexts. Here we highlight two main points. First, family doctors play a key role in supporting informational continuity for their patients across many health systems (Stokes et al., 2005), and are thus likely to be concerned about the implications of medical tourism on their own practice regardless of the system in which they are based. This analysis suggests that in light of the existing role of family doctors in supporting continuity of care, family doctors must be considered in creating effective responses that aim to improve the health and safety of medical tourists. Second, family doctors beyond Canada will also conceivably be faced with liability concerns similar to those raised in the current study related to patients seeking detailed advice prior to their trips or the administration

of post-operative care prescribed by out-of-country physicians. As such, those practicing in other health systems may also see the benefit in the development of informational tools or other resources for family doctors that provide guidance on what their specific roles and responsibilities are towards these patients.

The growth of medical tourism will likely continue to intensify as networks of trade continue to deepen and more care providers seek to attract foreign patients (Carrera & Bridges, 2006; Connell, 2011; Whittaker, 2008). Family doctors are well positioned to help ameliorate some of the potential health risks and continuity of care challenges posed by this form of care by educating patients, ensuring international treatments are properly documented, and enabling access to domestic postoperative care (Crooks & Snyder, 2011; Turner, 2007b). Our findings indicate that Canadian family doctors are willing to take on these responsibilities when provided the appropriate supports to do so.

## **4. CHAPTER FOUR Conclusion**

### **4.1. Overview**

The two analyses that comprise this thesis have addressed important knowledge gaps about medical tourism. The first analysis (Chapter 2) presented the findings of interviews conducted with medical tourists while the second (Chapter 3) presented the findings of focus groups conducted with Canadian family doctors. These analyses work together to meet my overall thesis objectives, which are to: (1) document the degree of involvement of Canadian family doctors in the care trajectories of outbound medical tourists, (2) articulate a realistic set of roles and responsibilities between family doctors and medical tourists using the perspectives and experiences reported by both stakeholder groups, and (3) identify what informational supports are currently available to both groups in order to identify existing gaps and suggest possible solutions to addressing currently unmet needs. In the current chapter I revisit these objectives in light the findings presented in of Chapters 2 and 3, with the intent of articulating their shared significance. To accomplish this I first summarize the key findings in both analyses and then move to bring together both sets of findings as they relate to my objectives. I conclude by reflecting on directions for future research.

#### **4.1.1. *Summary of Analyses***

The analyses included in my thesis worked to include the perspectives of both Canadian medical tourists and family doctors in order to explore the phenomenon of outbound medical tourism from Canada. Chapter 2 provided the results of a thematic analysis of interviews with 32 Canadian medical tourists. This analysis achieved a detailed understanding of why and how this group chose to travel abroad, and identified who they relied upon during their decision-making processes. Informed by the rationale that family doctors are key players in facilitating patients' access to secondary and

tertiary care in Canada (Chan et al., 2003; Romanow, 2002), the analysis sought to parse out what role, if any, family doctors played in participants' international surgical care trajectories. By demonstrating that motivations are varied and multi-layered, rather than homogenous and singular, the findings of this analysis disrupted some dominant assumptions about patient motivations that are widely found in the existing medical tourism literature. The findings also confirmed the importance of the Internet in driving the growth of medical tourism. Related to this, it was found that family doctors were largely excluded from participants' decision-making. When examined together, these findings provided evidence that medical tourism represents a shift towards a patient-as-consumer framework of medical care delivery that departs from the traditional structures and ethos of the Canadian health system. While this departure poses numerous challenges, two dominant issues arose. Firstly, informational resources that are readily available to medical tourists are primarily provided by the medical tourism industry, not by a neutral and informed third party, and are therefore likely to incorporate a misleading bias. Secondly, Canadian medical tourists often do not engage with the domestic health system in planning their care abroad, creating breaks in the continuity of their care trajectories and raising the possibility of encountering heightened health risks over the course of their care. Both of these issues speak to the importance of developing and/or improving the availability of high quality informational resources for medical tourists considering going abroad for care.

Chapter 3 presented results of a thematic analysis from six focus groups undertaken with Canadian family doctors. This analysis offered insights into how primary care providers, largely neglected in the existing medical tourism literature, are incorporated into supporting the planning and follow up stages of care provision for medical tourists. The findings of this analysis spoke to the challenges medical tourism poses to the existing role of Canadian family doctors. Family doctors were alarmed at their exclusion from medical tourists' planning, wanting to be at the very least aware of patients' intentions to travel outside of Canada for medical care. However, these desires to be involved in their patients' decision-making and planning for care abroad did not extend to providing any assistance in research or information assessment, due primarily to liability concerns. This desire to be involved, but to a poorly defined, limited degree, indicated one source of tension that medical tourism raises for Canadian family doctors.

The findings further indicated that Canadian family doctors lack informational and institutional supports with which they might confidently assist medical tourists in their decision making. These supports are lacking both in regard to guiding family doctors with best practices and in directing them to trustworthy information that they can direct their patients to. It was suggested that this information-poor environment produces friction between the inclinations of Canadian family doctors to support their patients, both prior to and following care abroad, and their own professional liability concerns. This friction compounds the uncertainty of individual Canadian family doctors as to what an appropriate level of involvement should be. The findings from Chapter 3 provided further rationale for the calls for the creation of neutral and accurate informational supports for Canadian medical tourists by outlining the impacts this absence has on another stakeholder group (Penney et al., 2011; Turner, 2011a).

Academic research on the phenomenon of medical tourism is in a nascent stage (Hopkins et al., 2010; Johnston et al., 2010). As such, the existing literature abounds with knowledge gaps in almost every conceivable area. Two broad knowledge gaps informed my analyses presented in Chapters 2 and 3. Firstly, the bulk of the academic literature deals with the macro- and meso-level implications of medical tourism at the level of national health systems, regional economies, and individual hospitals (e.g., Blouin, 2007; Ormond, 2011; Ramirez de Arellano, 2007; Turner 2007a). This level of focus largely neglects the experiences of medical tourists themselves (Crooks et al., 2010). At the outset of this study, only Kangas (2002; 2007), Ehrbeck et al. (2008), and Al-Sharif et al. (2010) had provided grounded, empirical evidence at the micro-level that highlighted the experiences of medical tourists themselves. Major limitations existed with all of these accounts, either due to their limited relevance to North-South / North-North flows of medical tourists (e.g., Kangas, 2002 & 2007; Al-Sharif et al., 2010), or due to methodological constraints that produced an overly 'rough grained' resolution of results (e.g., Ehrbeck et al., 2008, Al-Sharif et al., 2010). This absence of a 'fine grained' engagement with medical tourists from the Global North, in a manner that offers a detailed understanding of their experiences, provided the rationale for the research found in Chapter 2. Like Chapter 2, Chapter 3 was informed by the relative absence of fine-grained accounts of medical tourism, but worked to address the lack of engagement with the domestic health systems of medical tourists. While physicians have written on

their experiences with medical tourists returning to their home health systems (e.g., Birch et al., 2010, Cheung & Wilson, 2008), these have been from the perspectives of surgeons addressing complications, not of primary care providers who have ongoing relationships with patients.

## **4.2. Revisiting Objectives**

In this section, I revisit the objectives of my thesis research. I then explore the themes and issues that are present in both Chapters 2 and 3, as these serve to unite the thesis as a whole. By speaking to both medical tourists and family doctors independently of one another about the same phenomenon, these analyses provided the opportunity to examine where accounts converge and diverge from one another. This composite analysis creates a more accurate and coherent understanding of the phenomenon of outbound medical tourism from Canada than if either stakeholder group was consulted alone.

### **4.2.1. *Reported Engagement between Canadian Family Doctors and Outbound Medical Tourists***

With regard to the first objective of my thesis, documenting how Canadian family doctors are involved in the care of outbound medical tourists, Chapters 2 and 3 demonstrate that there is considerable overlap between the experiences of these two groups and little divergence. Perhaps most importantly, both medical tourists and family doctors reported limited to no meaningful engagement with one another prior to or following a medical tour as a common circumstance. The lack of concern expressed by medical tourists at this degree of engagement is contrasted by the significant concerns raised by family doctors at the current state of interaction between these two groups.

When the medical tourists reported on in Chapter 2 included their family doctors in their course of care abroad, it was almost never in a consultative capacity to assess the benefits and risks of seeking care abroad. Participants sought assistance from their family doctors only to gain access to their medical records or to diagnostic testing requested by the out-of-country physician in order to assist their care abroad. This assistance was typically sought by medical tourists only after their having firmly decided

to travel for care. It is notable that this pursuit of diagnostic testing was independently raised multiple times by family doctors as a source of possible tension around a medical tour. Across four of the six focus groups, some family doctors expressed concern that supporting medical tours abroad through publicly insured means such as referral for diagnostic testing is a misuse of public resources. This tension highlights one of the challenges posed to the traditional values and arrangement of the Canadian system by the patient-consumer framework that informs medical tourism, where medical care is perceived as a commodity available on demand and driven by patient desires (Ormond, 2011; Turner, 2007a). The values of solidarity and universality that underpin the Canadian system are maintained and put into practice, in part, by the actions and decisions of individual physicians that evaluate the necessity and urgency of care. The realization of these values is directly challenged by the consumer framework of medical care that medical tourists adopt when enlisting their family physicians support. As demonstrated by the behaviour of medical tourists in pursuing diagnostic testing through their family doctors, the Canadian system is capable of supporting the patient-consumer framework necessitated by medical tourism to a limited degree, but strains may emerge in patient-physician relationships when the perceptions of these groups regarding the necessity and quality of privately purchased surgery abroad do not align. This potential for strain requires a more coherent articulation of the responsibilities of each group toward one another.

The accounts of limited engagement between medical tourists and their family doctors presented in Chapter 2 were consistent with those of the family doctors in Chapter 3, reflecting a high degree of confirmation between the datasets. Family doctors reported being either over- or under-engaged by medical tourists, and rarely felt they achieved a productive middle ground with this patient group. When asked why they thought they were not being consulted prior to medical tourists' trips, family doctors suggested it was either because medical tourists believed their family doctor would be of little assistance to them, or that patients felt uncomfortable raising the issue of medical tourism due to concerns that it might negatively impact their long term relationship. Both rationales were indeed reported by the medical tourist interviewees, with the former being most common. This widespread lack of confidence in the knowledge and outlook of family doctors by medical tourists discussed in Chapter 2 and confirmed by the family

doctors in Chapter 3 speaks to the necessity of improving the standard of care available to this group of patients. This could be achieved by better educating family doctors on how to best support patients considering leaving the country for medical care as well as by informing medical tourists of the importance of making family doctors aware of their medical care abroad so that they can assist in supporting them. Clarifying the appropriate roles and responsibilities of both groups might also help reduce the likelihood of any conflicts or ethical tensions emerging between family doctors and their patients.

#### **4.2.2. *Desired Engagement between Canadian Family Doctors and Outbound Medical Tourists***

The current mode of engagement between patients and family doctors that was most commonly described by participants in Chapters 2 and 3 indicate that there is a great deal of room for improvement in the interactions between these groups. Such improvement is chiefly centered on two domains; (1) communication between family doctors and medical tourists prior to and returning from receiving care abroad, and (2) the quality of information and support available to each group. The medical tourists discussed in Chapter 2 rarely incorporated their family doctors in their course of care abroad and were undisturbed by this lack of involvement. Given the concerns expressed both by the family doctors in Chapter 3 and in the wider medical tourism literature (Burkett, 2008; Crooks et al., 2010; Lunt & Carrera, 2010), medical tourists' lack of concern is likely informed, at least in part, by a lack of knowledge of the heightened health and safety risks they face both domestically and abroad when engaging in medical tourism. This lack of concern makes it difficult to determine medical tourists' desired degree of engagement with their family doctors, and necessarily results in a greater focus in this sub-section on the views expressed by family doctors in Chapter 3.

The findings of Chapters 2 and 3 suggested that improving communication between family doctors and medical tourists, as a form of desired engagement, can be achieved primarily through increasing the likelihood and frequency of contact between them prior to and following care abroad. The family doctors made it clear that communication between these groups should be made the rule, not the exception, and

that they want to play a supportive role towards patients. Furthermore, Chapter 3 provided evidence that family doctors wish to be engaged in both the planning and follow-up stages of a medical tour, but are aware that they are under-utilized in this regard. The kinds of interactions they wish to have, however, are strictly bounded by liability concerns; thus, Canadian family doctors desired being made aware of their patients' intents to travel, broadly gauging these patients' outlook and expectations, and if possible, 'course correcting' their navigation of the domestic health system, but did not want involvement in destination selection or thoroughly assessing the quality of their patients' research. Related to this, family doctors wanted to be able to refer patients to trusted third party materials that could help them assess the risks of traveling for care more effectively.

With regard family doctors' desires to improve the quality of information between them and medical tourists, medical tourists commonly saw no need to provide their family doctors with medical records from their treatment abroad although they often returned home with them in hand. Family doctors in Chapter 3 echoed the rarity of being provided records by medical tourists upon return home. This challenge to integrated medical record keeping raises concerns about the continuity of care that Canadian family doctors can provide medical tourists immediately upon return and into the long-term future. Interestingly, despite their desires to have access to such records, family doctors also raised concerns about the usefulness of international medical care records, citing language and differing record-keeping methods as barriers to their interpretation. Even having acknowledged this, family doctors did want to incorporate the medical records from abroad into their patients' histories. The fact that Canadian medical tourists often do return home with these records and Canadian family doctors desire access to them suggests that this is a key nexus for improving the quality of information exchange between them. Should the frequency of pre-trip engagement between these groups improve, developing a clear plan that outlines how to effectively collect and integrate a patient's medical records upon returning to Canada is a relatively simple and effective responsibility that could be assumed by both parties in consultation with one another.

### **4.2.3. *Supporting Canadian Family Doctors and Outbound Medical Tourists***

In reflecting on the third objective of my thesis, which is to identify the current quality and kinds of support available to Canadians and family doctors regarding medical tourism, it became clear from speaking with these stakeholders that both groups lack access to high quality informational supports. Given the recent and relatively short period in which medical tourism has grown in popularity, the lack of reliable informational supports for both of these groups is unsurprising. The absence of informational supports for either group presents an opportunity for coordination between the resources that could be made available to stakeholders, in terms of content, modes of delivery, and consistency of messaging. This said, each group requires a different form of informational support. For Canadian family doctors, professional guidelines must be developed and disseminated to provide a more consistent standard of care that protects them from liability, while prospective Canadian medical tourists require high quality, neutral information to more accurately inform them of risks and benefits of privately purchasing surgery abroad in addition to encouraging them to incorporate their family doctors into their courses of care. These supports are needed in order to make the shift from the now common limited involvement between medical tourists and family doctors to the desired engagements aimed at mitigating the risks faced by Canadian medical tourists both within and outside of the Canadian health system.

Professional guidelines were expressed as desirable informational support by participants from Chapter 3, as they would assist them in more clearly interpreting their professional responsibilities towards medical tourists. Lacking a professional standard for the depth and kinds of responsibilities deemed suitable likely contributes to some of the inconsistency in the roles and responsibilities adopted by family doctors towards medical tourists that were reported in both Chapters 2 and 3. This lack of standardization also serves as a barrier to achieving the degree and quality of engagement with medical tourists prior to travel (if not even booking) desired by family doctors. The lack of reliable informational supports for medical tourists available to family doctors negatively impacts their abilities to achieve their desired kinds of engagement with medical tourists by leaving them with no resources to refer these patients towards. From the perspective of medical tourists interviewed for Chapter 2,

this lack of capacity amongst family doctors may contribute to Canadian medical tourists' limited regard for the current usefulness of family doctors in their course of care abroad.

### **4.3. Remaining Knowledge Gaps and Future Research Directions**

A number of knowledge gaps related to this thesis remain. Perhaps most significantly, there is no surveillance or tracking of Canadian medical tourists (Eggerston, 2006; Snyder et al., 2010; Turner, 2007b). While precise figures are lacking, it is known that, at a minimum, thousands of Canadians are exiting the country for medical care every year (Johnston et al., 2011). This bolsters the relevance of calls made here and elsewhere for the development of better supports for this patient group. However, the lack of fine-grained accounting to capture patient flows leaving or returning to Canada makes accurate assessments of the impacts of medical tourism on provincial health systems impossible. Quantitative research into Canadian medical tourism would assist in both targeting interventions towards regions experiencing high outflows of medical tourists, in which family practices would be a key intervention site, and in helping to communicate the urgency or relevance of this thesis research to a wider audience.

A knowledge gap that became evident over the course of my analyses pertains to how 'the Internet' was employed by the medical tourists who participated in the study. When participants spoke of using the Internet to gather information on care abroad, they rarely could remember in detail the kinds of websites they accessed. Furthermore, I neglected to have them comment in detail on how they assessed the reliability of these websites and the information on them, leading to unanswered questions of what kinds of specific online information were considered to be the most important or relevant in their decision-making processes. Future studies examining the experiences of medical tourists would benefit from employing a focused set of questions to capture what kinds of online information bolster the confidence of prospective medical tourists to understand the decision-making processes in greater detail.

The relevance of my thesis research beyond Canada could be confirmed or disrupted by future research examining the experiences of medical tourists from different

countries, especially regarding their engagement with their primary care providers. The only medical association to have yet issued guidelines to their members to assist them in supporting medical tourists is the American Medical Association (Caffarini, 2008). It would be useful to know if these (limited) guidelines improve the quality of care and degree of support they are able to provide to their patients due to potentially clearer understandings of where their professional roles and responsibilities begin and end. Similarly, it would be helpful to know if the findings of the focus groups held with family doctors in British Columbia hold true elsewhere in Canada. Family doctors in other provinces may be exposed to differing numbers of medical tourists due to varying regional popularity. As a consequence, family doctors in other regions may be more or less equipped to support this patient group. Knowing the variability of attitudes and experiences of primary care providers across Canada may also improve the relevance and quality of guidelines that might be created by a national organization for this stakeholder group.

This thesis holds particular relevance to future research conducted by health geographers. Most broadly speaking, medical tourism is a spatial phenomenon well suited to geographic inquiry, of which this thesis represents an early, focused example. As health systems continue to evolve within larger and increasingly dense networks of communication and transportation, the traditional regional, provincial, and national scales at which health systems have been conceived of and operated at will likely change both subtly and drastically. These traditional scales of operation may conceivably be joined by the wider emergence of international health services over the same period in which their boundaries erode and intermingle with one another. Health geographers are well situated to conceptualize and investigate potential pathways for these developments in the hopes that better documenting and understanding them will allow them to develop in as equitable and widely accessible fashion possible.

#### **4.4. Overall Limitations**

In Chapters 2 and 3 I have identified limitations specific to the analyses presented in each. There are some limitations to also acknowledge in the thesis as a whole. It was common for family doctors to report that they were unaware of when their

patients had traveled for care. It was most often the case that family doctors became aware of medical tourists in their practices when they came across unexplained surgical scars during physical examinations or in cases where their patients consulted with them after developing complications from a procedure abroad. This is consistent with the accounts provided by medical tourists and raises a key limitation. Many of the concerns raised by the family doctors were informed by the sample of medical tourists they were exposed to, which likely heavily consisted of those experiencing (often severe) complications. These outlier experiences may have coloured the perceptions of many of our participants and the kinds of issues they raised in the questions asked of them.

Related to the above limitation, I was unable to recruit any more than four medical tourists who experienced complications as a result of their surgeries abroad. Because of the lack of reliable statistics on medical tourism and medical tourists there is no way of knowing whether this group was under- or over-represented in the sample. At the same time, my research has not sought representativeness, so this is not an issue per se. Of those participants that did experience complications, none regretted their pursuit of care abroad. What is lacking in my thesis are the voices of patients who have had significant complications following surgery abroad to the point that they have become outspoken critics of the industry. These individuals exist, and are simply not represented in my thesis. This reality may have limited uncovering further knowledge gaps, especially from the perspectives of Canadian medical tourists who experienced serious complications and sought supportive care from their family doctors.

## **4.5. Conclusion**

While the lack of surveillance makes quantitative projections of the future flows of Canadian medical tourists a rash effort, the underlying pressures pushing Canadians to seek care abroad give no signs of drastic change, while at the same time the pull factors associated with the medical tourism industry continue to expand (Connell, 2011; Philippon & Braithwaite; Purdy & Lam, 2011; 2008). Consequently, the phenomenon of outbound medical tourism from Canada is unlikely to diminish in coming years, and is more likely to increase in popularity as word-of-mouth networks between prospective patients normalize and advertise the notion (if not even acceptability and tolerance) of

accessing medical care abroad. Given the likelihood of these latter trends, there are clear and pressing reasons to improve the quality of supports available to this patient group. This must be done in order to help mitigate the unique risks they face when exiting their provincial and territorial health systems, such as interrupted continuity of care, uncertain quality of informed consent, and poorly documented medical complications. This thesis provided evidence that informs this call for improved support for Canadian medical tourists to help ensure their safety and well-being.

Ultimately, the evaluation of future interventions aimed at having medical tourists engage with their family doctors must be measured by their success in reducing the risks faced by these patients while supporting family doctors to practice confidently, free from uncertainty about liability or physician overreach. As Canadian family doctors are ideally the first point of contact between Canadians and their health system (Chan, 2003; Romanow, 2002), I believe they are an important group to target in crafting better supports for Canadian medical tourists and have asserted this in my thesis. While supports in and of themselves, family doctors are also in need of access to professional guidance in the forms of guidelines for themselves and informational resources for their patients in order to perform their desired roles.

A key message that cross-cuts the findings of my analyses is that: interventions designed to improve the domestic support available to Canadian medical tourists must simultaneously work to alter their care-seeking behaviours in order to increase the frequency of engagement with family doctors, produce informational supports for family doctors and patients alike, and ultimately improve the quality of engagement between these groups by clearly demarcating roles and responsibilities for each. Failing to implement interventions in any of these areas, while proceeding in others, will likely result in a continued mismatch between the supports available to Canadian medical tourists and these patients' informational needs, along with those of their family doctors. At the same time, such a mismatch will ultimately result in failure to decrease the novel health risks medical tourists currently face and increase family doctors' comfort levels in meaningfully engaging with these patients within the bounds of their professional practice.

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