

**Canadians leaving the Canadian health care system  
to seek bariatric surgery abroad:  
Examining patient experience with  
international bariatric tourism**

**by  
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## Ethics Statement

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## **Abstract**

Globally, bariatric surgery, commonly known as weight loss surgery, has grown in popularity among obese individuals as a means to addressing their weight-related negative health when more traditional weight loss programs, such as diet and exercise, fail to elicit long term sustained weight loss. In Canada, however, complex barriers related to social, administrative, and other structural factors restrict access to care domestically, leaving some patients turning to surgical options abroad through the practice of medical tourism. In light of this, it is important that we understand the implications the practice of 'bariatric tourism' may hold for Canadians. Using an interview-based approach with former Canadian bariatric tourists, this study examines the patient experience of bariatric tourism. The analyses highlight specific barriers that are motivating patients to seek care internationally and challenges experienced in care obtainment both internationally and domestically that appear to heighten the health and safety risks these patients undertake.

**Keywords:** medical tourism; bariatric surgery; Canada; qualitative research; patient safety

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## List of Acronyms

ASMBS	American Society for Metabolic and Bariatric Surgery
BMI	Body Mass Index
DS	Duodenal Switch
GERD	Gastroesophageal Reflux Disease
RNY	Roux-en-Y Gastric Bypass
VSG	Vertical Sleeve Gastrectomy
WHO	World Health Organization

## Glossary

Adjustable Gastric Band	Bariatric procedure in which a band is placed around the upper part of the stomach that, when filled with saline, limits the intake of food to the stomach.
Bariatric Surgery	Collection of weight loss surgeries design to surgically induce weight loss in obese individuals through restriction of the size of the stomach and/or reductions in the amount of absorption in the intestines.
Circumvention Tourism	A form of medical tourism in which domestic regulations for access to care are bypassed and medical care is obtained abroad.
Duodenal Switch	Combination restrictive and mal-absorptive bariatric procedure in which the size of the stomach is surgically reduced and the small intestine is split into two channels and re-routed.
Medical Tourism	International travel to privately purchase medical care, beyond the scope of cross-border care arrangements.
Roux-en-Y Gastric Bypass	Combination restrictive and mal-absorptive bariatric procedure in which the size of the stomach is surgically reduced and the first part of the small intestine is bypassed.
Vertical Sleeve Gastrectomy	Bariatric procedure in which the size of the stomach is significantly surgically reduced.

# Chapter 1.

## Introduction

Weight-related conditions have quickly become one of the fastest growing public health concerns of the late 20<sup>th</sup> and early 21<sup>st</sup> century. Statistics from the World Health Organization (WHO) have shown that globally, in 2014, more than 1.9 billion adults were classified as overweight (World Health Organization, 2015b). Out of these 1.9 billion overweight adults, 600 million were classified as obese (World Health Organization, 2015b). These figures are projected to increase to a global prevalence of 2.7 billion overweight adults by 2025 (World Obesity Federation, 2015).

The WHO classifies the health conditions of overweight and obesity based on body mass index (BMI). BMI is calculated as an individual's weight (in kilograms) divided by their height squared (in meters squared). Individuals are classified as overweight when their BMI reaches 25-29.5 kg/m<sup>2</sup>. Overweight individuals are classified as obese when their BMI becomes greater than 40.0 kg/m<sup>2</sup>. However, an individual may be classified as obese if they have one or more significant weight-related co-morbidities present. In these cases obesity may then be defined when an individual's BMI reaches 30.0-34.5 kg/m<sup>2</sup> and morbid obesity when their BMI reaches greater than 35.0 kg/m<sup>2</sup> (Buchwald, Ikramuddin, Dorman, Schone & Dixon, 2011; World Health Organization, 2015b).

Excess weight gain, characteristic of the conditions of overweight and obesity, generally arises from an imbalance in calorie consumption versus calorie expenditure which leads to abnormal accumulation of adipose tissue throughout the body (World Health Organization, 2015a). This abnormal adipose tissue accumulation leads to many other serious obesity-related negative health consequences that lead to a reduced quality of life, as well as a reduced life expectancy, if left untreated. The average life expectancy in Canada in 2014 was 82.2 years (World Health Organization, 2016). The average life expectancy of a female with morbid obesity and significant co-morbidities may be reduced by seven years, whereas a male may experience a reduction in life expectancy of nine years (Buchwald, Ikramuddin, Dorman, Schone & Dixon, 2011). To name a few, some of these significant co-morbidities of overweight and obesity include

metabolic disorders such as type II diabetes, atherosclerotic diseases such as hypertension, and coronary artery diseases and breathing disorders such as obstructive sleep apnea and obesity-hypoventilation syndrome. Other co-morbidities may include gallstones, gastroesophageal reflux disease (GERD), obesity-related fatty liver disease, degenerative joint diseases and certain types of cancer (Buchwald, Estok, Fahrback, Banel & Sledge, 2007; Buchwald, Ikramuddin, Dorman, Schone & Dixon, 2011; Nguyen et al., 2011; Runkel et al., 2011).

In addition to these biological health factors, there are also social and psychological health implications associated with being above what is socially considered a healthy weight (BMI 18-25 kg/m<sup>2</sup>). That is, those that appear to be obese tend to be more highly stigmatized and face greater discrimination than their healthy weight counterparts (Melin, Reynisdottir, Berglund, Zamfir & Karlström, 2006). Psychologically, individuals that appear to be heavier than social norms have deemed socially acceptable have been hypothesized to be at higher risk for developing mental health disorders such as depression and anxiety compared to those that are socially perceived to be at healthy weight (Green, Engel & Mitchell, 2014).

Given the many negative health implications that are associated with being above what is considered to be a healthy weight, significant attention has been given to weight management strategies in public health, bio-medical, and health services literature globally. A first step to achieving weight loss is often pursued via a conservative weight treatment program. While the exact components of a conservative weight treatment program vary between programs, typically they include aspects of lifestyle/behaviour modification, dietary changes, as well as pharmaceutical interventions (Karlsson, Taft, Rydén, Sjöström & Sullivan, 2007). However, evidence has consistently shown that conservative treatment for obesity and morbid obesity is not effective in eliciting long-term sustained weight loss (Karlsson, Taft, Rydén, Sjöström & Sullivan, 2007; Moroshko, Brennan & O'Brien, 2012; Runkel et al., 2011).

When conservative treatments for obesity fail many individuals look to more invasive surgical options including bariatric surgery, more commonly known as weight loss surgery. However, for patients in Canada, administrative and structural barriers exist that restrict access to care. These barriers, which will be discussed in more detail in Chapter 2 of this thesis, prevent many Canadians from receiving the weight loss surgery

they desire and when they want it. As a result, some patients seek to access this care abroad.

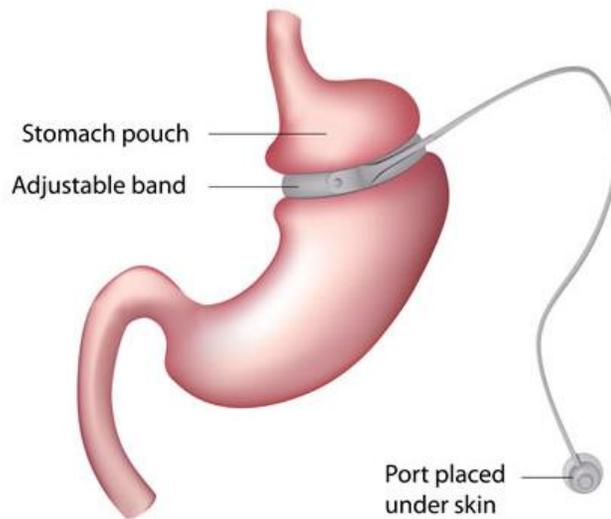
Patients who travel abroad and pay out of pocket to purchase bariatric surgery are colloquially called bariatric tourists. My thesis seeks to qualitatively examine the Canadian patient experience of engaging in international bariatric tourism. This introductory chapter of my thesis provides a background to bariatric surgical practice, medical tourism and, more specifically, what is currently known about the practice of medical tourism for bariatric procedures. This background provides broader context to allow for richer discussion throughout my thesis of the challenges this practice may present for patients and the implications my overall findings may pose for the field of medical tourism and bariatric surgical services within Canada.

## **1.1. What is Bariatric Surgery?**

Bariatric surgery refers to a collection of weight loss surgeries for individuals that are obese or morbidly obese and for which conventional weight loss programs have not produced long-term weight loss (Buchwald, Ikramuddin, Dorman, Schone & Dixon, 2011; Runkel et al., 2011). There are a number of different types of bariatric procedures available. They are classified in terms of the type of surgery performed; namely, if the surgery was purely restrictive, a combination of restrictive and mal-absorptive, or predominately mal-absorptive (Buchwald, Estok, Fahrbach, Banel & Sledge, 2007). There are four main types of surgical procedures that individuals typically pursue, namely gastric banding, sleeve gastrectomy, Roux-en-Y gastric bypass and duodenal switch (Carter, 2015).

First, there is gastric banding which is a purely restrictive surgical option. This surgical procedure is characterized by an inflatable band being surgically placed around the upper part of the stomach, close to where the esophagus meets the stomach. When this band is filled with saline fluid, it restricts the amount of food that can enter the stomach (Figure 1.1). The amount of restriction is controlled by the amount that the band is inflated. Historically, this has been a popular bariatric procedure due to it being completely reversible and minimally invasive. However, this particular procedure has been falling out of popularity worldwide in recent years as some patients experience complications such as extreme vomiting and intolerance to solid food intake. This

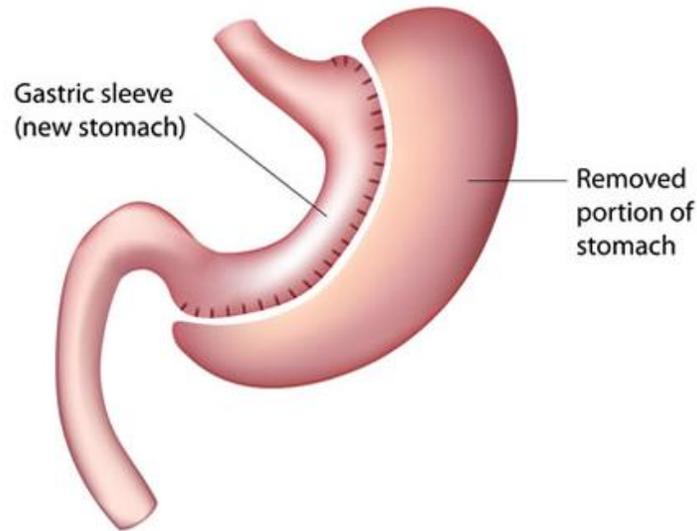
causes these patients to seek alternative surgical procedures to address these complications (Carter, 2015).



**Figure 1.1. Adjustable Gastric Band (Lap Band). (Bariatric Surgery Source, 2017a).**

Note: Used with permission from Bariatric Surgery Source

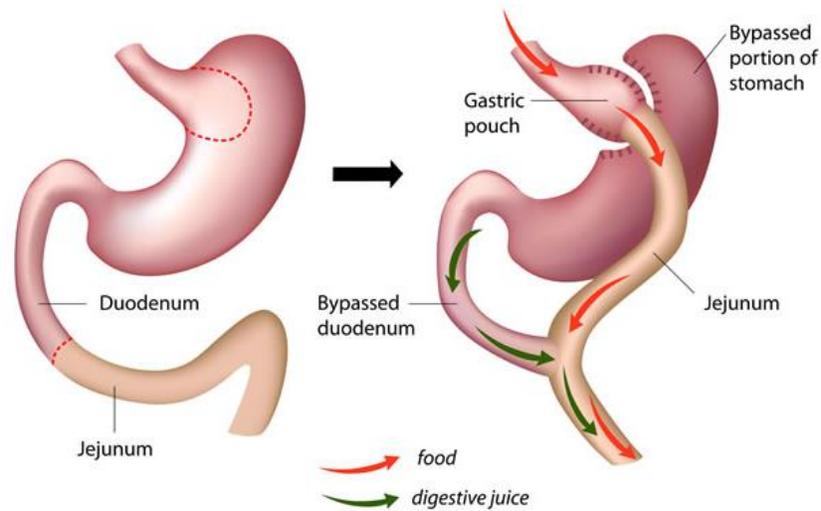
A second bariatric procedure that some individuals pursue is sleeve gastrectomy. It has been increasing in global popularity due to positive weight reduction and health outcomes associated with it. Unlike some other bariatric procedures, there is no risk of internal hernia associated with this procedure and it can be performed completely laparoscopically, meaning the patient does not need to be cut open in the procedure. Rather small holes are made in the patient's abdomen to allow for the surgical instruments to access the necessary digestive organs. This is also a purely restrictive procedure as the vast majority of the stomach is resected, leaving a small portion of the stomach along the lesser curve. This results in stomach capacity being reduced by approximately ninety percent (Figure 1.2). This procedure results in little to no nutritional risk, as there are no changes made to the bowel (Carter, 2015).



**Figure 1.2. Vertical Sleeve Gastrectomy Diagram (Bariatric Surgery Source, 2017b).**

Note: Used with permission from Bariatric Surgery Source

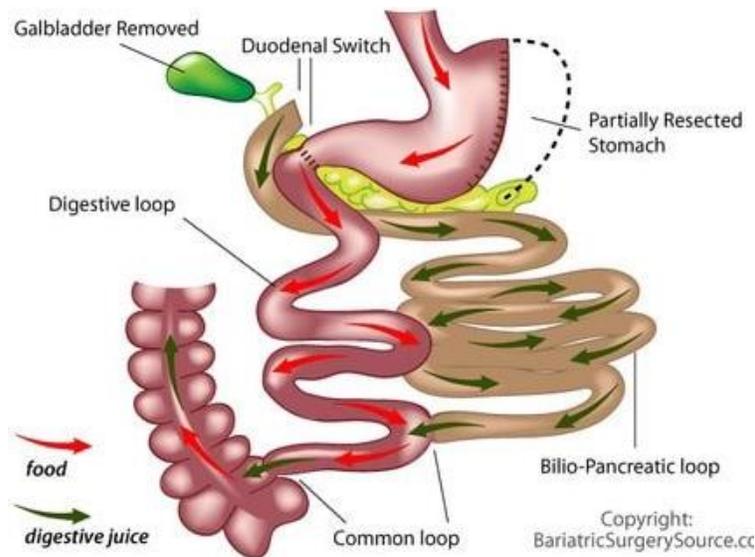
A third type of bariatric procedure that is commonly sought is gastric bypass, or Roux-n-Y gastric bypass. This surgery is a combination restrictive/mal-absorptive procedure. In this procedure, the stomach is made smaller and the remaining small sack is surgically produced at the top of the stomach, which is then directly connected to the middle part of the small intestine, effectively bypassing the remainder of the stomach and the first part of the small intestine (Figure 1.3). This allows a small amount of food to enter the stomach (the restriction) and limits the level of nutritional absorption that can take place as there is less contact in the intestine (the malabsorption). Some patients experience substantial weight regain after this procedure as over time hypertrophy (increase in the diameter of adipose cells) may occur. This increases the surface area in the small intestine and therefore allows for increased fat absorption (Carter, 2015).



**Figure 1.3. Roux-en-Y Gastric Bypass (RNY) Diagram (Bariatric Surgery Source, 2017c).**

Note: Used with permission from Bariatric Surgery Source

The final type of surgery that individuals seeking bariatric surgery typically pursue is the duodenal switch procedure. This surgery is also a combination restrictive/mal-absorptive procedure. This procedure is similar to the sleeve gastrectomy as approximately seventy percent of the stomach is removed in the restrictive portion of the procedure. The small intestine is then re-routed into two pathways that meet at one common channel. One of the pathways carries food from the stomach to the common channel, while the other pathway processes bile from the liver and other digestive enzymes to the common channel (Figure 1.4). As the vast majority, approximately sixty-seventy percent, of the small intestine now does not come into contact with food, only about twenty percent of the fat ingested will actually be absorbed. This is the mal-absorptive portion of this procedure. Therefore, vitamin supplementation with this procedure is paramount, especially for fat soluble vitamins such as A, D, E and K. Despite the positive health outcomes that are associated with this procedure due to the biliopancreatic preservation, this procedure is not widely administered. This could be due to the invasive nature of this procedure as it is not easy to administer laparoscopically (Carter, 2015).



**Figure 1.4. Duodenal Switch (DS) Diagram (Bariatric Surgery Source, 2017d).**  
 Note: Used with permission from Bariatric Surgery Source

There are many complications that can arise from bariatric surgery and not all complications may arise in the immediate time period following the surgery. Therefore, a patient that has undergone a bariatric surgical procedure requires life-long follow-up care. For the best outcomes for the patient, it is essential that the surgeon that performed the surgery play a fundamental role in the patient's follow-up care program in order to address potential complications that may arise (Buchwald, Ikramuddin, Dorman, Schone & Dixon, 2011). The types of complications that may arise vary significantly between cases and greatly depend on the type of surgery performed, namely if the surgery was purely restrictive, a combination of restrictive and mal-absorptive, or predominately mal-absorptive (Buchwald, Estok, Fahrbach, Banel & Sledge, 2007).

There are many factors that influence the overall mortality rates associated with bariatric surgery. These include, but are not limited to, the skill level of the bariatric surgeon, the number of surgeries being performed by the institution and the surgeon, the experience level of the surgical team, the type of surgery (i.e., restrictive versus mal-absorptive) and the specific procedure, demographic characteristics of the patient (i.e., age, race, gender, etc.), and, finally, the exhibition of any significant co-morbidities (Buchwald, Estok, Fahrbach, Banel & Sledge, 2007). In terms of mortality, outcomes have drastically been improving over the past ten years as bariatric surgery is becoming a more effective treatment choice of those with morbid obesity (Nguyen et al., 2011). This is a result, in part, of more laparoscopic techniques being introduced, as well as

more surgeries being performed annually (Nguyen et al., 2011). Even though mortality outcomes are improving, this does not mean that other physical complications, such as malnutrition and vitamin deficiencies, and psychological complications such as depression, anxiety, or social stigma, do not arise as a result of the surgery (Carter, 2015; Guerreiro & Ribeiro, 2015; Green, Engel & Mitchell, 2014; Wilson & Datta, 2014; Aills, Blankenship, Buffington, Furtado & Parrot, 2008).

## **1.2. What is Medical Tourism?**

The practice of medical tourism is a growing health-care practice among prospective patients seeking expanded care options (Crooks, Kingsbury, Snyder & Johnston, 2010). Medical tourism is generally defined as international travel with the intention of seeking medical care. Typically, the care these individuals seek is arranged for privately, and paid for out of pocket. In addition, the procedures that are sought are often elective procedures and beyond the scope of cross-border care arrangements (Snyder, Crooks & Johnston, 2011). There are many different reasons why a prospective medical tourist may seek care abroad. These include, but are not limited to, lengthy wait times for care at home, more affordable price points for procedures abroad compared to domestically, as well as restricted access to care domestically due to legal or regulatory restrictions (Fisher & Sood, 2014; Lunt & Mannion, 2014; Sethna & Doull, 2012; Snyder, Crooks & Johnston, 2011; Crooks, Kingsbury, Snyder & Johnston, 2010).

Prospective medical tourists seek to engage in the practice of medical tourism as a health care alternative for a broad range of medical procedures. Some of these procedures include medically necessary care such as replacement surgery (such as hips and knees), gastro-intestinal, and cardiothoracic surgery. Medical tourism may also occur for more elective procedures, including reproductive/fertility treatments (such as in-vitro fertilization), cosmetic surgeries, and unproven interventions, such as stem-cell treatments (Snyder, Crooks & Johnston, 2011; Crooks, Kingsbury, Snyder & Johnston, 2010). Each of these different procedures and the sub-populations seeking them experience a combination of their own unique challenges in obtaining care and aftercare.

It is also important to note the legality of the desired procedure in both the home and destination country. This legal classification has been examined in the medical tourism literature and imparts varying ethical and logistical challenges on the patient

when seeking the care abroad. In some cases, the procedure is legal in both the patient's home country and the destination country for the procedure, such as for hip and knee replacements (Cohen, 2015). However, in other cases, medical tourists may seek care abroad as their desired care is illegal at home but legal in the destination country, such as for abortion or reproductive/fertility treatment (Cohen, 2015; Sethna & Doull, 2012; Bergmann, 2011). Furthermore, the 'darker side' of medical tourism may be present in cases when the medical intervention sought is illegal in both the patient's home and destination country, such as in the black market for human organs (Cohen, 2015; Cooper & Hieda, 2015). This thesis will be situated in cases where the procedure is legal in both the patient's home and destination country; rather, access to the procedure is restricted or unavailable due to regulatory and/or structural barriers. Medical tourism with the aim of circumventing legal restrictions has been termed circumvention tourism (Cohen, 2015). The challenges associated with this form of medical tourism will be more critically examined in Chapter 2 of this thesis, where the case will also be made for the benefits of examining bariatric tourism through the lens of circumvention tourism.

### **1.3. International Bariatric Tourism**

Medical tourism for bariatric surgery has been referred to as "global bariatric healthcare" by the American Society for Metabolic and Bariatric Surgery (ASMBS) (ASMBS Clinical Issues Committee, 2011). They define this term as "travel[ing] to undergo bariatric surgery across any distance that precludes routine follow-up and continuity of care with the surgeon or team" (ASMBS Clinical Issues Committee, 2011). This definition seems to include not only crossing national borders but also borders within states, such as provincial borders, to obtain care. This does not entirely fit within the understanding of medical tourism that this thesis will operate under (outlined in section 1.2 above). In addition, this definition fails to include some of the defining characteristics of medical tourism discussed above regarding obtainment of private care that is paid for out of pocket and beyond structured cross-border care arrangements. Therefore, in order to encompass an understanding of these characteristics in regards to this practice of medical tourism for bariatric surgery, the remainder of this thesis will use the term 'international bariatric tourism' and refer to individuals engaging in this practice as 'bariatric tourists'.

The popularity of travelling abroad for bariatric surgery is growing as can be seen in the increase in Google hits over a four year span. Using the search terms “medical tourism” and “bariatric”, one study found that in 2007 these terms returned 24,000 hits (Whiteman, 2011). This can be compared to 24,600 in 2010 and then more than 400,000 hits in 2011 (Whiteman, 2011). Given the growing market for bariatric tourism as a health care alternative, it is very important to consider the additional complications international bariatric tourism lends to bariatric surgery. Of most importance for consideration, follow-up care and continuity of care in the context of bariatric surgery pose unique challenges to the bariatric patient, both domestically and internationally (Sheppard et al., 2014). The severity of these issues is heightened by the many serious medical complications that may arise as a result of travelling any large distance for bariatric surgery (Crooks et al., 2013).

There are many risks identified in the broader medical tourism literature to which individuals that engage in medical tourism are potentially subjected. These are also true of international bariatric procedures. For example, one such risk is the potential of contracting an infectious disease that is unique to, or at a higher prevalence in, other parts of the world (Nelson, 2014; Chen & Wilson, 2013). Bariatric tourists are at compounded risk of infection as they not only face the risk of infectious diseases, but also elevated risk of infectious complications in the gastrointestinal tract (ASMBS Clinical Issues Committee, 2011). In addition, travelling long distances has the potential to exacerbate these infections (Nelson, 2014; Chen & Wilson, 2013). Given the extremely invasive nature of bariatric surgery, the risk of venous thromboembolic events occurring is heightened compared to other surgical procedures (Chen & Wilson, 2013; ASMBS Clinical Issues Committee, 2011). This risk is further elevated when the patient travels immediately post-surgery (Crooks, Kingsbury, Snyder & Johnston, 2010). This is just a sample of potential risks for bariatric tourists and others may exist for this understudied group.

Obesity is a chronic health condition often characterized by the presence of one or more significant co-morbidities. To reduce the health and safety risks the patient is exposed to when undergoing surgery, it is essential that patients have complete records of their medical history, both pre- and post-operatively (Whiteman, 2011). Unfortunately, these records are often incomplete or missing entirely in regards to international bariatric tourism (Whiteman, 2011). Having missing or incomplete records has been identified in

most cases of medical tourism as a risk to the patient's health and safety, as well as significantly impacting both the quality of care an individual receives abroad and the quality of their aftercare upon returning (Snyder & Crooks, 2010). This could become especially problematic in cases of international bariatric tourism given the heightened need for a complete medical history for optimal surgical outcomes.

Some of the unique challenges that the practice of medical tourism imposes on bariatric surgical outcomes are best illustrated through a case example offered by Robert G. Whiteman (2011). Whiteman (2011) provides details of a 40-year old woman from Texas suffering from severe obesity. Her insurance company provided her no coverage for bariatric surgery and she could not afford to pay to have the procedure done in the United States. She opted to go to Mexico, where she could have the procedure done for \$12,000, compared to \$24,000 in the United States. The duodenal switch procedure she received was not done correctly and she was experiencing symptoms of starvation when she returned home, as scarring between her stomach and her esophagus only left an opening the size of a pin through which to intake food and vitamins. She went to the hospital with these complications three times and each time was turned away as she could not afford the needed corrective surgery and her insurance would not cover it. When she contacted the surgeon in Mexico, he provided no follow-up care and only the limited advice that she was not 'eating correctly'. The surgeon then cut contact with her. When she found a surgeon in the United States that would help her, she was left with \$70,000 in debt (Whiteman, 2011).

This case, and other similar cases I had come across in the literature, served as my driving force to explore the health and safety risks this practice may impose and helped to determine my research objectives. However, this case, and the vast majority of other similar cases discussed in the literature are contextual to the United States. But evidence has shown that weight-related diseases are also a major health concern in Canada. For example, one in five Canadian adults is considered obese (Canadian Institute for Health Information, 2015). As the United States operates under a very different health care system than Canada, it is likely that Canadian patients experience different challenges in international bariatric tourism. For example, in many medical tourism cases out of the United States, it seems that many prospective patients are motivated by cost savings (Snyder & Crooks, 2010). I imagined that in the Canadian context, the financial complications typically seen in the United States may not be as

severe due to Canada providing universal coverage for all medically necessary care for all Canadian citizens. Therefore, understanding the motivators for Canadians to travel abroad for bariatric care became one of the main research objectives of this thesis. Additionally, the case above illustrates the serious implications that the lack of continuity of care and follow-up care can impose for the health and safety of the patient, and consequently became the other main research objective of this thesis. The limited research of the implications that bariatric tourism has had in a Canadian context will be explored in the following section.

#### **1.4. International Bariatric Tourism within the Canadian Context**

Bariatric tourism in the Canadian context has been significantly understudied. The limited research that has been conducted with a specific focus on Canada has centered on the financial burden that bariatric tourism has imparted on the Canadian health care system. The majority of the financial burden identified thus far can be attributed to the cost of dealing with surgical complications presented by former bariatric tourists upon their return to Canada. For example, one study conducted by Caroline Sheppard and colleagues (2014) found that at just one bariatric clinic in Alberta, 62 bariatric tourists imposed additional health care spending by the province of Alberta of CAD1,834,168.13 between February 2009 and June 2013. The majority of these costs can be attributed to those needing extensive corrective surgery to deal with complications requiring extended hospital stay (Sheppard, Lester, Karmali, de Gara & Birch, 2014). Another study found the cost to care for additional complications presenting within bariatric tourists in Albertan bariatric clinics was 1.9 million dollars more than the cost to care for complications in a comparable domestic group (Sheppard et al., 2014). Findings from these studies illustrate the extreme financial implications bariatric tourism can impose on the domestic health care systems in Alberta. However, it is currently unknown if these figures could be extrapolated to the rest of Canada, given the varying levels of coverage for specific bariatric procedures across the provinces.

In reviewing the literature regarding international bariatric tourism in the Canadian context, it became apparent that this research is very limited. While some assessment has been conducted on the financial burden that bariatric tourism has created for the Canadian health care system, to my knowledge only one study has

attempted some analysis on Canadian patients' perspective on bariatric tourism. However, this was only assessed through set questionnaires with a sample size of only 14 respondents and the questions were limited to reasons for seeking care abroad (Kim, Sheppard, de Gara, Karmali & Birch, 2015). This does not provide a robust understanding of the Canadian patient experience of international bariatric tourism. In the same vein, illustrative case examples, such as the example outlined above, of Canadian experiences of international bariatric tourism are limited. One highly publicized case has been discussed in the Canadian media and academic literature regarding who should hold the financial responsibility for complications arising from bariatric tourism (Snyder, Silva & Crooks, 2016). Additionally, some case examples have been examined to illustrate the medical complications that may arise as a result of this practice (Birch, Vu, Karmali, Stoklossa & Sharma, 2010). However, little remains known regarding the Canadian patient experience of international bariatric tourism. Consequently this thesis will seek to address two main research objectives that together encompass two key aspects of the patient experience of bariatric tourism. These research objectives are:

- 1. To understand the reasons and mechanisms by which a Canadian individual seeking bariatric surgery decides to go abroad for such procedures.**
- 2. To identify any potential health and safety risks the patient may be exposed to through lack of continuity of care or challenges in after-care upon their return to Canada post-surgery.**

## **1.5. Thesis Objectives and Outline**

In summary, it is important to note that while there has been some research regarding bariatric tourism in the Canadian context, major gaps in the understanding of patient experiences of bariatric tourism from Canada exist. My thesis seeks to address this gap in the literature through a strictly qualitative approach through employing the use of semi-structured interviews with former Canadian bariatric tourists. Semi-structured interviews with former bariatric tourists were chosen as the preferred way to answer the research questions outlined above as I had reason to believe that former patients would provide me with a level of detail that I would not be able to capture through quantitative data or through interviews with industry stakeholders. Previous personal experiences with individuals struggling with weight-related challenges have provided me with insights into the struggles, frustrations, and often sense of despair these individuals face on a regular basis. Chapters 2 and 3 will provide a response to

each of the research objectives described above. Both chapters are formatted as peer-reviewed journal articles and will provide additional context to some of the challenges in the Canadian bariatric landscape alluded to in this introductory chapter.

Chapter 2 will explore the first of the two main research objectives concerning the motivators that are driving Canadians to seek bariatric care outside of the Canadian health care system. This analysis will showcase how the main motivators driving Canadians into international bariatric tourism are a result of structural barriers that are restricting Canadians' access to bariatric surgical services in Canada and driving them to seek care abroad. This analysis will seek to frame these motivators and this practice as a previously unexplored form of circumvention tourism. The research objective in this analysis is best answered through semi-structured interviews with former patients because I felt that former patients would provide me with an end-user point of view that would be invaluable when understanding why these patients are seeking this care abroad. This viewpoint could only be speculated from other industry-stakeholders and therefore would not provide the deeper and richer understanding of patient experience that I was seeking. This chapter highlights the advantages of applying a framework of circumvention in examining both the practical and ethical implications that are raised through this practice for Canadian patients and the Canadian health care system. This chapter intends to influence future research on bariatric tourism regarding the barriers that are driving this circumvention behaviour by Canadians.

Chapter 3 of this thesis provides an analysis in response to the second of the two main research objectives concerning what health and safety risks Canadian patients experience when they engage in international bariatric tourism due to disruptions in continuity of care and challenges in follow-up care. This analysis of the interviews with former Canadian bariatric tourists explores how the challenges related to obtainment and perceptions of care or aftercare introduce new or exacerbate patient health and safety risks previously identified in the bariatric surgery and medical tourism literature. To fully understand the potential health and safety risks that may be associated with this practice, it is critical to consult all industry stakeholders, including medical professionals with specialization in bariatric surgery. However as this analysis sought to provide an exploratory analysis into a relatively unexplored phenomenon, I felt qualitative interviews with former patients were best suited to address this research objective. The patient perspective allows for some exploratory insight into the challenges patients may be

experiencing that could be exacerbating potential health and safety risks the patient may be exposed to. As the risks associated with bariatric tourism specifically are underexplored, qualitative data obtained through interviews with former patients will start discussion of these risks and allow risks to be identified that may need more critical examination with the perspectives of other industry stakeholders. By identifying the ways in which these challenges may be influencing the health and safety risks these patients are exposed to, this paper identifies areas in Canadian bariatric health policy that may need to be addressed in order to improve patient safety when engaging in international bariatric tourism.

Chapter 4 of this thesis provides a conclusion to this project. It summarizes and integrates the main emerging themes across both analyses in chapters 2 and 3. A discussion will be provided of the overall strengths and limitations of the qualitative analysis undertaken in this thesis. This section will acknowledge my reflexivity throughout the research process and acknowledge my positionality as the researcher conducting the interviews and how I may have influenced my participants and vice versa. I will link to this in discussion of the strengths and limitations as well as the generalizability of my findings. Contributions of this thesis to the existing body of Canadian bariatric tourism literature will also be examined. This chapter will conclude with identifying emerging questions for future research in the fields of bariatric tourism and bariatric surgical services in Canada.

## Chapter 2.

# **“I didn’t have to prove to anybody that I was a good candidate”: Framing international bariatric tourism by Canadians as circumvention tourism**

## **2.1. Background**

Medical tourism is the act of crossing international borders with the intention of seeking medical care that is paid for out-of-pocket and beyond the scope of government administered cross-border care arrangements (Connell, 2013; Snyder, Crooks & Johnston, 2012). There are many reasons as to why an individual may opt to seek medical care abroad. Some reasons include, but are not limited to, long wait times for care at home, more affordable price points for procedures abroad compared to domestic prices, restricted access to care domestically for legal or regulatory reasons, as well as structural barriers leading to unavailability of desired procedures domestically (Fisher & Sood, 2014; Lunt & Mannion, 2014; Sethna & Doull, 2012; Snyder, Crooks & Johnston, 2012; Crooks, Kingsbury, Snyder & Johnston, 2010).

Within the medical tourism literature, scholars have sought to delineate the types of medical tourism on the basis of legality of the patients’ desired procedures, as well as domestic availability. Three main categories have emerged. The first encompasses patients travelling for procedures that are legal and available in the patient’s home country, such as hip/knee replacements, cardiovascular care, or cosmetic surgery (Cohen, 2015). The second category refers to patients travelling for medical care that is illegal in both the patient’s home country and in the destination country, but where enforcement may be slack and therefore access is more attainable abroad. A classic example of this form of medical tourism is transplant tourism, specifically obtaining illegal organs on the black market (Cohen, 2015; Martin, 2010). Finally, the third category of medical tourism encompasses patients travelling for medical services that are illegal, unavailable, or limitedly available due to regulatory restrictions in the patient’s home country but legal and readily available abroad. This form of medical tourism has been termed ‘circumvention tourism’ as it is characterized by patients circumventing

restrictions in the health care system in their home country by either side-stepping domestic laws or bypassing administrative barriers that result in care being unavailable or limited domestically (Cohen, 2015). The concept of circumvention tourism grew as a framework to critically examine potential legal, moral and/or regulatory concerns that are unique to this 'grey' area of medical tourism.

Most of the current conceptualizations of circumvention tourism have been explored in the literature through the legal classification of the procedure, focusing on travel abroad for care that is illegal in the patient's home country. Some of these examples include assisted suicide, abortion, fertility tourism, female genital mutilation, and experimental treatments such as stem cell therapy (Charo, 2016; Cohen, 2015; McGuinness & McHale, 2013; Sethna & Doull, 2012; Bergmann, 2011). Scholars with work focused in this area, such as Glenn Cohen, have educational backgrounds in law. Consequently, much of this literature focuses on the legal ramifications on patients travelling to engage in these practices. For example, questions are asked such as: can (and should) home countries criminalize citizens who travel abroad to engage in care that is illegal at home but legal elsewhere (Cohen, 2015; McGuinness & McHale, 2013)? These questions fundamentally concern whether or not this is something that can be prosecuted domestically, and more importantly, who should be held responsible: the patients, the physicians or others entirely?

Despite the tendency to focus on treatments that are barred legally in the medical tourist's home country, medical tourist activities that mirror those seen in the traditional circumvention tourism literature may arise from individuals attempting to access care in countries where procedures are legal but where structural barriers restrict access. Throughout this analysis structural barrier is will be used as an umbrella term to encompass all barriers that are present within the health system that prevent access to medically necessary or desired care. By structural barrier we are referring to barriers that may be regulatory in nature (i.e. a barrier that arises from national or provincial regulation concerning what qualifies an individual for publicly funded surgery and/or public funding for specific procedures) or administrative in nature (i.e. a barrier that arises due to local availability of operating room space and/or surgeons trained and experienced in specific procedures). Within Canada, these structural barriers may arise for a number of reasons. For example, within Canada's publicly funded health care system, rationing of care and/or resources takes place and therefore access can be

quite limited or strict eligibility criterion may need to be met in order to access care (Brown, 1993). Potential regulatory and/or administrative barriers work to restrict access to care on behalf of the health system as a means to ration resources to those most in need or those with the highest potential to be successful with the procedure (Owen-Smith, Donovan & Coast, 2015). Lack of access to care domestically due to these regulatory restrictions or administrative barriers, either perceived or real, can prompt individuals to circumvent the health care system domestically. While these barriers may not be legal in nature, it does appear that quite often, the barriers that prompt individuals to circumvent their domestic health care system are designed to protect patient health or to ensure the most efficient use of limited health care resources. When these restrictions and/or barriers are critically examined, it appears that circumvention behaviours occur in a relevantly similar fashion to previous understandings of circumvention tourism.

However, this broadened understanding of circumvention tourism does also capture a critical difference between the broadened focus we are arguing for and the previous legal and moral focus of literature. By focusing on patients that are circumventing structural barriers built into the system we can ask questions beyond those that are more legal or moral in nature. More specifically, the fundamental concerns we can now potentially address pertain to continuity of care, disruptions in care, and potentially the usefulness of the barriers in the first place. It could be argued that all medical tourism is, to some degree, circumventive. However this analysis is not advocating for broadening the concept of circumvention tourism to include patients travelling for health care to circumvent high costs or long wait lists. We argue that these factors should not fall under the concept of circumvention tourism because these factors do not represent barriers built into the system, legal or health care, in order to protect any fundamental rights or patient health.

In order to understanding fully the complex nature of circumvention tourism, critical examination is needed of cases in which structural barriers to accessing care prompt the individual to seek care abroad. Consideration is also needed of the distinctive practical and ethical implications this practice has on both the patient and their domestic health care system. One concern is that circumvention tourism can complicate informed decision making. For example, in cases of potentially life-threatening or significantly debilitating illness, patients may be acting out of desperation for a cure or relief of their symptoms when considering treatments abroad. Here a patient may be acting on hope,

or through anecdotal evidence, without truly understanding the risks of the procedure or the chances of success (Snyder & Crooks, 2015). Harms to the doctor-patient relationship may also be a consequence of circumvention tourism. As patients may be travelling for unproven treatments or treatments their home physician does not feel they are qualified for, doctors can face challenges providing the patient with complete information or guiding them in the decision making process (Snyder & Crooks, 2015).

In regard to circumvention tourism for procedures that are legal at home but restricted due to structural barriers, if a doctor does not feel the patient is qualified or that the surgery is appropriate for the patient, significant disruptions in their continuity of care can result from a lack of medical record sharing or updating between the home and destination physician (Crooks, Kingsbury, Snyder & Johnston, 2010). In such cases, a physician that does not support a patient's decision to seek care abroad may choose to withhold medical records or refuse to provide comprehensive aftercare following the patient's return home, leaving the patient to seek aftercare elsewhere.

Through a qualitative examination of Canadians seeking bariatric services abroad and thus outside of the Canadian health care system, we seek to apply the concept of circumvention tourism for procedures that are legal but inaccessible due to structural barriers. As such, this analysis will examine the distinctive challenges this practice can pose. When examining this broader conceptualization of circumvention tourism to encompass both legal and illegal procedures, additional procedure-specific ethical challenges can arise that have not previously been considered, especially given the legalistic focus of previous analyses. In order to examine how bariatric tourism by Canadians may be a form of circumvention tourism, the bariatric landscape in Canada must first be examined.

### **2.1.1. A case of regulatory/administrative circumvention tourism**

Canadian statistics of overweight and obese adults<sup>1</sup> reflect global trends of the proportion of the population classified as obese, meaning that there are approximately

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<sup>1</sup> The WHO classifies the health conditions of overweight and obesity based on body mass index (BMI). BMI is calculated as an individual's weight (in kilograms) divided by their height squared (in meters squared). Overweight is defined as a BMI of 25-29.5 kg/m<sup>2</sup>. Obesity and morbid obesity can be defined in two different ways depending on

5.3 million obese adults currently living in Canada (Statistics Canada, 2015). Many of these individuals struggle with adequate weight control via conventional means of behaviour modification through diet and exercise. Therefore, Canadians are increasingly turning to bariatric surgery to treat their obesity. To qualify for bariatric surgery in Canada one must meet the minimum requirements set out by the National Institute of Health consensus conference in 1991, which requires an individual to have a body mass index (BMI) of 40 kg/m<sup>2</sup> or a BMI of 35-39.5 kg/m<sup>2</sup> with the presence of one or more significant co-morbidities such as type II diabetes, hypertension and/or obstructive sleep apnea (National Institute of Health, 1991; Christou & Efthimiou, 2009). Additionally, Canada requires an individual to have a history of conventional methods of weight loss being ineffective at eliciting sustained weight loss. If a person does not meet these requirements, s/he will not be approved for surgery (Canadian Institute for Health Information, 2015).

If a Canadian does meet eligibility requirements for bariatric surgery, they are eligible to enter the queue for publicly funded surgery. As each province or territory has their own provincial health care coverage, funding for specific procedures, if any, varies between them. In general, Canada only publicly funds three types of bariatric surgery: adjustable gastric banding, sleeve gastrectomy, and gastric bypass (Canadian Institute for Health Information, 2015). See Table 2.1 for a complete list of which provinces cover which procedures.

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the presence of obesity-related co-morbidities. Without the presence of co-morbidities, obesity is defined as a BMI of 30.0-39.9 kg/m<sup>2</sup> and morbid obesity is defined as a BMI greater than 40.0 kg/m<sup>2</sup>. However, if co-morbidities are present then obesity is defined as a BMI of 30.0-34.5 kg/m<sup>2</sup> and morbid obesity is defined as a BMI greater than 35.0 kg/m<sup>2</sup> (Buchwald, Ikramuddin, Dorman, Schone & Dixon, 2011; World Health Organization, 2015).

**Table 2.1. Bariatric procedures covered by Canadian provinces and territories<sup>a,b</sup>.**

Province/Territory	Adjustable Gastric Banding	Sleeve Gastrectomy	Gastric Bypass
<b>British Columbia</b>	-	✓	✓
<b>Alberta</b>	✓	✓	✓
<b>Saskatchewan</b>	-	✓	✓
<b>Manitoba</b>	-	✓	✓
<b>Ontario</b>	-	✓	✓
<b>Quebec</b>	✓	✓	✓
<b>Newfoundland and Labrador</b>	✓	✓	✓
<b>Nova Scotia</b>	-	✓	-
<b>Nunavut</b>	-	-	-
<b>Prince Edward Island*</b>	-	✓	✓
<b>New Brunswick*</b>	✓	✓	✓
<b>Northwest Territories</b>	case-by-case	case-by-case	case-by-case
<b>Yukon</b>	case-by-case	case-by-case	case-by-case

\* Procedures covered by provincial health care but contracted out of province.

<sup>a</sup> Recreated from: Canadian Institute for Health Information, 2015. Retrieved from: <https://www.cihi.ca/en/types-of-care/hospital-care/acute-care/bariatric-surgery-in-canada-infographic>

<sup>b</sup>Note: This table reflects coverage under Canadian public health care as of 2015. This table might not reflect what was available/publicly funded locally for participants in the study at their time of seeking surgery.

The availability of bariatric surgery in Canada has been vastly increasing. Canada has seen a three-fold increase in surgeries performed between 2006 and 2012: specifically, 1,578 surgeries were performed in 2006 compared to 5,989 performed in 2012 (Canada Institute for Health Information 2015). This increase can mostly be attributed to increased surgical capacity in Ontario (Canada Institute for Health Information 2015), which is the most populous province in Canada. Despite the dramatic increase in surgery availability only about 1% of those eligible actually received the surgery through the public system<sup>2</sup> (Kim, Sheppard, de Gara, Karmali & Birch, 2015). This is, in part, attributable to the extensive pre-operative evaluation process that is associated with bariatric surgery in Canada, meaning that some of those that are eligible could be at various points in this multiyear process at any given time. More significantly, most eligible people will never opt to pursue this form of treatment. These regulatory

<sup>2</sup> The 1% surgical output versus eligibility statistic reflects the limited surgical capacity for bariatric surgery across Canada, the multiyear evaluation process that restricts access to care and that not all individuals that are classified as obese will opt to seek surgery as a solution to their weight-related health.

structural barriers in regard to access to care can lead to very long wait times for bariatric surgery, with a national average wait time of just over five years (Christou, 2011; Christou & Efthimiou, 2009).

The pre-operative evaluation process can contribute to delays in accessing bariatric surgery. Under the evaluation process, patients must attend regular meetings with a dietician/nutritionist and a psychologist, as well as lose a pre-determined amount of weight to help improve the chances they will be successful with the surgery (Buchwald, Ikramuddin, Dorman, Schone & Dixon, 2011; Halloran, Padwal, Johnson-Stoklossa, Sharma & Birch, 2011; Runkel et al, 2011). It is only after the evaluation process that patients can receive an appointment with the bariatric surgeon. Further regulations require that the patient will only meet with the bariatric surgeon if they can be guaranteed to receive their surgery within a year. If the wait extends past one year, then the patient must be re-evaluated as co-morbidities may have worsened in this time (Christou, 2011). As resources for bariatric surgery in Canada are quite limited, these bottlenecks in the pre-operative process further strain these resources and can limit access to care (Christou, 2011).

It should be noted that limited private options for bariatric care are available in Canada. The adjustable gastric band, for example, is readily available in private clinics across Canada. A study comparing gastric bypass in the public system to the adjustable lap band in the private system found the wait times in private clinics in Canada can be as short as one month, versus 21 months the public system (Martin, Klemensberg, Klein, Urbach & Bell, 2011). The shorter wait time present in the private system is largely attributed to fewer required pre-operative visits with specialists in private clinics. Most studies examining the wait time for publicly funded bariatric surgery in Canada have found a national average wait time of approximately five years. However, this study determined average wait time in the public system to be only 21 months. This discrepancy is likely the result of only one type of surgery being examined in the study by Martin and colleagues, as opposed to an aggregate of all the publicly funded procedures in Canada. Additionally, studies vary in the methods by which they measure wait times. In the majority of studies, wait times are measured starting from initial office visit/consultation, whereas Martin et al. (2011) measured the wait time starting from when patients actually entered the queue for surgery. Martin et al. (2011) also found that the average cost of a lap band in a private clinic in Canada averages \$16,000, compared

to no direct cost through the public system (Martin, Klemensberg, Klein, Urbach & Bell, 2011). Thus, these private domestic options offer shorter wait times than typically experienced in the public system, but typically require out-of-pocket payments that are higher than what is required in some medical tourism destinations.

As shown above, the present bariatric landscape in Canada indicates there are structural, barriers, that are both regulatory and administrative in nature, restricting Canadians' access to bariatric surgery. Additionally, surveys of former Canadian bariatric tourists indicate that some of these individuals travel abroad for this procedure for reasons related to lack of access domestically (Kim, Sheppard, de Gara, Karmali & Birch, 2015). Although we know that Canadians are indeed going abroad for bariatric surgery, based on media coverage and internet discussion (e.g., CBC, Global News, National Post) (Pagel & Berry, 2016; Goh, 2016; Kirkey, 2016), there has been no attempt to understand these patients' first-hand experiences of engaging in this form of medical tourism. Here we address this knowledge gap by drawing on the findings of 20 qualitative interviews conducted with former Canadian bariatric tourists, specifically exploring three challenges experienced by this group that contributed to their pursuit of surgery abroad. Based on the analytic findings, we build an understanding of how bariatric tourism by Canadians can be conceptualized as a form of circumvention tourism. As previously outlined, circumvention tourism *typically* refers to procedures that are illegal in the patient's home country but legal in the destination country. As bariatric surgery is a legal practice in Canada, we help to broaden the understanding of the ways in which the framework of circumvention tourism can be applied to procedures that are indeed legal, but potentially inaccessible to patients due to structural barriers some of which are regulatory or administrative in nature, and therefore driving them to seek the care elsewhere.

## **2.2. Methods**

The analysis presented in this paper contributes to a qualitative exploratory study examining Canadian patients' first-hand experiences with medical tourism for bariatric procedures.

### **2.2.1. Recruitment**

After obtaining ethical approval from Simon Fraser University's Office of Research Ethics, we sought to recruit Canadians that had previously travelled outside of Canada to receive bariatric surgery to participate in interviews. As there is no system in Canada that tracks individuals leaving the country each year for medical procedures, social media was used as means to advertise to prospective participants. Targeted advertisements asking prospective participants to contact the principal investigator were placed in popular bariatric surgery support groups on the social media website Facebook as well as other online patient forums. Additionally, similar advertisements were placed on the popular advertisement website Craigslist. A post was also written about the research on a popular Canadian obesity/bariatric surgery blog<sup>3</sup> and the primary investigator's contact information was made available for prospective participants. Finally, existing participants were asked to share information about the study with others in their networks who were also eligible.

Participation in the study required that the participant meet the inclusion criteria. Inclusion criteria mandated that they must: (1) be a Canadian citizen or permanent resident and thereby be eligible for coverage under Canada's public health plan; (2) have received care privately abroad that was paid for out-of-pocket with no reimbursement from the Canadian health care system; (3) be over the age of 18 at the time of the interview; and (4) have travelled for their respective surgery within the last 10 years. The 10 year window for surgery was chosen in order to minimize the risk of lack of recall of the experience of travelling for the patients' respective procedures and to capture more recent surgical techniques. As most bariatric procedures are now preformed laparoscopically, older surgical techniques would likely lead to a different experience that would be more presently experienced.

### **2.2.2. Data Collection**

Semi-structured interviews with former Canadian bariatric tourists were conducted by phone from February to May, 2016. These interviews were conducted using a scripted semi-structured interview guide. We elected to use a semi-structured

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<sup>3</sup> The blog is Dr. Sharma's Obesity Notes out of Alberta, Canada.

approach in this exploratory study as it allows participants to provide more detail as they see pertinent beyond simply answering the questions directly being asked. The interview guide was developed after a thorough literature review was conducted of the existing medical tourism research, as well as the literature pertaining to bariatric tourism and, more specially, bariatric tourism and the Canadian context. The interviews covered a wide array of topics including: the patient's reasons for seeking bariatric surgery, their experiences of trying to obtain care domestically, information seeking processes, experiences while obtaining the care abroad, aftercare experiences, as well as reactions/support from family, friends, and members of the Canadian medical system (e.g. family physicians and aftercare specialists, such as dietitians/nutritionists and bariatric surgeons). All interviews were conducted by the same investigator, the lead author of this paper. Each interview ran for approximately 30-50 minutes.

### **2.2.3. Analysis**

All interviews were digitally recorded and transcribed verbatim by the primary investigator. The first step in the analysis was for each of the authors to independently review the transcripts and to note key emerging themes, concepts and issues brought forth by the participants. After this step, the transcripts were reviewed collectively and the independent reviews were compared for overlap. From this collective review, three meta-themes emerged that will be the focus of this present analysis. Upon identification of these themes, the lead author then re-examined all the transcripts to identify excerpts relevant to each theme. The most illuminating or illustrative of each theme was selected by the lead author for use in this analysis which was later confirmed by the other authors.

## **2.3. Results**

In total, 20 former Canadian bariatric tourists from five of Canada's 10 provinces were interviewed. Participants lived in the provinces of British Columbia (n=2), Alberta (n=4), Saskatchewan (n=12), Manitoba (n=1) or Nova Scotia (n=1) at the time of seeking surgery. All participants were Canadian citizens who qualified for provincially funded health care but not all met the criteria for publicly funded bariatric surgery in terms of the BMI requirements. In addition, all participants travelled to Mexico, the majority to the city

of Tijuana, to obtain their respective bariatric procedures. This confirms previous research that has identified Mexico as a popular destination for bariatric tourism among Canadians (Kim, Sheppard, de Gara, Karmali & Birch, 2015). The type of bariatric surgery pursued abroad also varied amongst participants, although the majority underwent the Vertical Sleeve Gastrectomy (VSG) procedure (n=16). Other procedures pursued included: the Adjustable Lap Band (n=1), Gastric Plication (n=2) and Roux-en-Y Gastric Bypass (RNY) (n=1).

Participants' motivations to seek care abroad were extensively probed. They repeatedly acknowledged experiencing barriers to accessing care domestically as their main motivations for travelling abroad. Our analysis indicates three types of access barriers: (1) not meeting the body mass index (BMI) requirements to qualify for publicly funded surgery in Canada; (2) structural barriers around which procedures are or are not available locally; and (3) the lengthy pre-operative program required of all surgical candidates in Canada. These three barriers degraded patients' ability to access bariatric surgery domestically and consequently pushed them to seek bariatric surgery internationally. In this way, bariatric tourism by Canadians can be seen as these patients circumventing the system in Canada. These barriers will be examined in more detail throughout this section. Though we discuss each separately, we acknowledge that many participants experienced more than one domestic access barrier. As we seek to understand first-hand experiences, direct verbatim quotation are provided in this section as a means to let the participants 'speak' where possible to the barriers they experienced.

### **2.3.1. Structural Barriers**

Some participants experienced structural barriers to bariatric surgery in their provincial health care systems that they felt were best circumvented by accessing care abroad. By structural barrier we are referring to barriers in the health system that prevented access, such as lacking provincial health care coverage for a *specific* bariatric procedure or the limited availability of experienced surgeons to perform a particular surgery. These barriers may be regulatory or administrative in nature, as outlined previously. Every participant indicated having experienced a structural barrier to access that resulted in them seeking care abroad.

As stated earlier, the vast majority of participants received the vertical sleeve gastrectomy (VSG) procedure (n=16). Participants chose this procedure due to its long-term successful outcomes for slightly smaller (albeit still obese) patients, less invasive nature, and low risk of complications and mal-absorption when compared to more invasive procedures such as the duodenal switch or full gastric bypass. However, at the time of seeking surgery many found that the VSG was not offered locally, or even in their home provinces, despite the fact that most provinces and territories have approved this procedure in their public health care systems, as shown in Table 2.1 above. For example one participant discussed how she travelled to Mexico for the surgery so that she could have:

*a different version of the surgery than they were offering in Canada, or in my local area, at that time. They weren't offering the sleeve, which is the VSG, which I got. They were just doing the straight R-en-Y which is a slightly more invasive surgery than the one that I received.*

Another participant stated: “*and then my understanding was that there's only one surgery that they do [in the province] and it's the gastric bypass and I wasn't interested in that one at all.*” Lack of local availability of procedures that participants felt best suited their needs prompted many to seek their desired care elsewhere by circumventing this domestic barrier to access.

The interviews revealed that in some cases participants opted for care abroad due to concerns about the quality of surgery available locally. One participant, for example, expressed concerned over the way the surgery was performed at home:

*initially when I was looking, what I was understanding is that the one surgeon who was doing it was only just starting this laparoscopically and still seemed to have a preference for doing the gastrectomy versus the sleeve, of the full gastroplasty rather.*

Another expressed concern over the types and variety of procedures being offered in Canada.

*I don't mean to be rude about Canada, but I don't think it would even be an option [to have surgery at home] because they are so far behind here. They'd be doing something that they did twenty years ago. So that was another part of the reasons that attracted me to Tijuana is these physicians, this is all they do.*

She felt constrained in regard to her surgical choices and did not feel she could get quality surgery with the current surgical techniques she desired anywhere in Canada, thus prompting her to seek care abroad.

### **2.3.2. Body Mass Index (BMI) Requirements**

As discussed earlier, Canada follows the recommendations from the National Institutes of Health (1991) that indicate that in order to qualify for surgery a patient must have a BMI of 40 kg/m<sup>2</sup> or higher or a BMI of 35-39.5 kg/m<sup>2</sup> with the presence of one or more significant co-morbidities, such as type II diabetes, hypertension, and/or obstructive sleep apnea. Many participants cited these BMI cut-off points as a barrier to accessing care domestically, referring to them as very strict requirements with little room for consideration of other factors, such as lifetime history of obesity. Thirteen of the twenty participants interviewed explicitly discussed their lower-than-required-BMIs as the primary barrier to accessing bariatric surgery in Canada. One participant discussed how close her BMI was to the requirement but that it was not close enough to qualify her for surgery: *“At the time I was 34 [BMI], but I didn’t qualify, I wasn’t fat enough or my BMI wasn’t high enough to even be looked at for bariatric surgery in Saskatchewan.”* In this case, while the participant’s BMI was quite high she did not have other significant co-morbidities to qualify her even for the lower BMI requirement.

For participants who tried to work with their primary health care physicians to get into the queue for surgery, BMI requirements limited the extent to which physicians could assist with facilitating approval for surgery. For example, one participant expressed frustration with her primary health care provider’s lack of ability to get her into the queue:

*They [doctor] said your BMI’s not high enough. Your BMI has to be at least 35 and I think I was 32 or something. So they said nope, you’re not high enough. And then my weight kept going up and I said ‘oh great, this is nice and now I have to see my weight keep going up’. But it wasn’t 35, it was 33 or 34 so it was close to 35 and they couldn’t refer me and I couldn’t do anything because my BMI wasn’t high enough.*

For this participant, she felt frustrated over not being able to access care because of her weight: *“okay you’re not going to help me because I’m not fat enough?! That doesn’t make any sense.”* Participants also expressed frustration with the medical advice they received when their BMIs were not high enough. For example, one participant expressed

concern over a conversation she had with their family doctor: *“He had said that because I was only obese, like I wasn’t morbidly obese, that it [surgery] wouldn’t really be an option”*. In this case, she was instructed that in order to qualify for surgery she *“would either need to put on a bunch of weight or take off a bunch of weight on my own. There was no in-between, nothing they could really do to help me just because I was just obese.”* In Canada, primary care physicians act as gatekeepers to more specialized care (Chan & Austin, 2003). For many of the participants, not being able to get a referral from a primary health care physician to a surgeon left them with few options for having the surgery in Canada and consequently these individuals felt they had no choice but to circumvent the system and seek care abroad. Furthermore, as discussed earlier, while limited opportunities for private bariatric surgery do exist in Canada, participants felt the cost of these options was also prohibitive to obtaining the care domestically. For example, one participant expressed how she *“didn’t have...\$15,000 to spend on a private surgery.”* Furthermore, many participants lamented that even if they could afford private surgery in Canada, they would still be facing a lengthy pre-operative process for this care, although it was unclear from the participants what all would be involved in this private pre-operative process. Generally, it seems that when individuals are not approved for care in the public system in Canada and face the high cost of private surgery in Canada, together these realities push people to consider circumventing these domestic barriers by opting to go abroad for bariatric surgery.

Not all participants chose to approach their primary care physicians about their desires to access bariatric surgery in Canada. Either through their own research or through word-of-mouth/anecdotal stories, some knew they would not qualify for the BMI requirements and therefore did not even attempt to seek the care in Canada. For example, one participant explained how *“I knew I’d never be a candidate in Canada ‘cause I didn’t have enough weight to lose.”* While another stated: *“I don’t think I could have got it done in Canada. I don’t think I was big enough for their, for that.”* Both of these participants dismissed Canada’s public health care system as even being an option for them to seek bariatric surgery based on the knowledge of their own BMIs and consequently went straight to researching care abroad.

### 2.3.3. Length and commitment required by pre-operative process in Canada

Finally, the third barrier to accessing bariatric surgery in Canada as reported by the participants was the lengthy pre-operative process that added significantly to the surgical wait time. Twelve of the twenty participants interviewed explicitly discussed the pre-operative process and the consequent wait time as a barrier to seeking the care in Canada. For many, knowledge of the wait time for surgery in Canada posed significant concern. All participants acknowledged the negative state of health they were in prior to surgery and expressed a deep desire to take action to reduce weight-related health issues despite failed attempts to do so through conventional diet and exercise. Consequently, the wait time for surgery was seen as a time-draining domestic requirement they opted to circumvent by seeking care abroad. For example, one participant stated:

*Well, I didn't even look into anything in Canada because for one thing I could get it done right away [in Mexico]. Whereas I know in Canada it takes up to five years. Like I had it done within a month and a half after I starting looking for, in, in Mexico.*

For many of the participants, this knowledge of the wait time prevented them from even beginning the process to seek approval for surgery domestically.

Another aspect of the pre-operative process in Canada that some participants found concerning were the multiple steps it required, such as losing a pre-determined amount of weight and consulting with multiple specialists including a dietician/nutritionist, a psychologist and the bariatric surgeon prior to surgery being scheduled. As one participant explained:

*Well the thing is, like I've read several things about the process in Canada and you know they give you a diet and see whether you can follow that procedure for a year and then there's some emotional, some counselling for another couple of years, and then, you know, wait another year and see whether you still want to do it or not. There's lot of pre-scanning that's done before you even get a chance to get in.*

Another participant echoed similar sentiments:

*So I was going to have a three year wait to get it done and I wasn't willing to wait that long because you have to go through all the steps. Go through your dietician and then you gotta see a psychiatrist and then you*

*gotta meet with the surgeon and then they're going to decide if you're a, if you can do the surgery, right?*

The significant number of steps that had to be successfully accomplished in order to be approved for surgery in addition to the depth of involvement required by some steps, specifically the pre-surgery weight loss requirement, was seen as an unnecessary barrier to care by most participants.

Some participants expressed concern that a Canadian patient could spend years trying to prove they are a good candidate for bariatric surgery, only to be denied potentially years later, and that they were not willing to expose themselves to this possibility. Circumventing this process became attractive, if not necessary. As one participant stated:

*I didn't have to prove to anybody that I was a good candidate [to privately have surgery in Mexico] other than health-wise, that I could handle doing the trip and that I could handle loosing 70 or 80 pounds... So I kind of made that decision on my own that I was going to do this. Whereas, going through the procedure that's in Canada, there's a rift there of someone saying you're not psychologically ready for it.*

By circumventing this process, participants felt they were more empowered in their own health care decision-making. They did not have to navigate the possibility of being rejected for the surgery after years of waiting in the queue, as well as lost time and energy spent in multiple appointments with specialists. Pursuing the care abroad consequently was viewed as necessary to ensuring that desired bariatric care was indeed obtained.

## **2.4. Discussion**

In this analysis we have identified three main barriers to access Canadians have faced when attempting to access bariatric surgery domestically. Collectively and individually these barriers serve as push factors that encourage some Canadians to seek bariatric surgery abroad, which was demonstrated in the previous section. The ability of Canadians to access bariatric surgery abroad creates new opportunities for accessing weight-related health care that some patients identify as necessary and urgent while the Canadian health care system may not. As shown throughout our findings section above, by engaging in this form of medical tourism this behaviour can be

viewed as Canadians circumventing the regulations, processes, precautions, requirements, and restrictions built into their domestic health care system.

As we noted at the outset of the findings section, most participants experienced multiple barriers to accessing bariatric surgery domestically in Canada, with some experiencing all three of those identified here. For example, upon discovering that they did not qualify for care in Canada, many participants examined private options for care in Canada but learned they would still have to undergo a pre-operative process before getting approved for their desired surgery. This prompted participants to examine options for care elsewhere. Consequently, the cost for the private care in Canada was not the only barrier to privately funded surgery domestically. Rather, the restrictions for care in Canada, including both not meeting the BMI criteria and the lengthy pre-operative process even for private care, led several participants to go abroad for care. It was also common for participants to not meet the BMI criteria for domestic surgery while simultaneously questioning the quality of surgical options in Canada and the length of the pre-operative wait time. In such cases these barriers – both perceived and realized – acted together in prompting consideration of international surgical options. The presence of such barriers and the ways in which multiple barriers interacted in order to shape one's access to surgery domestically facilitated, if not drove, participants to circumvent domestic options in favour of privately purchasing bariatric surgery abroad.

By examining participants' experiences with attempting to gain access to bariatric care in Canada, it is apparent that many felt the system was not helping them to address their weight-related health concerns. Here we see a parallel to patients who engage in unproven treatments such as stem cell therapies or chronic cerebrospinal venous insufficiency (CCSVI) treatment via medical tourism. In the case of CCSVI treatment and other stem cell therapies, studies have shown that patients are engaging in these treatments abroad as a result of a loss of hope for and trust in the care that can be received domestically (Snyder, Adams, Crooks, Whitehurst & Valle, 2014). Similar sentiments were echoed by the participants in this study, especially in regard to what many characterized as a hopeless pre-evaluation process in which both the strict BMI requirements and repeated evaluations had to be met in order to qualify for bariatric surgery domestically. In the meantime, throughout this period obesity-related co-morbidities would likely be worsening and, in some cases, they could get to the point of negatively affecting surgical outcomes (Lakoff, Ellsmere & Ransom, 2015; Gregory,

Newhook & Twells, 2013; Christou & Efthimiou, 2009). The length of time this process could persist, coupled with low surgical capacity for bariatric procedures across Canada (Canadian Institute for Health Information, 2015), left many participants with similar feelings of a loss of hope for and trust in the Canadian health care system. In the context of this type of circumvention tourism, participants sought hope through treatment abroad. While doing so addressed the immediate perceived need for medical intervention, exiting the Canadian system did nothing to address the loss of trust in the domestic health care system. This is concerning given that patients' health outcomes and continuity of care are best when they form a trusting relationship with their health care providers and also have trust in the quality of care made available (Birkhauer et al., 2017; Lee & Lin, 2008).

As discussed in the background section, traditionally the label of circumvention tourism has been applied to procedures that are illegal in the patients' home country, such as assisted suicide, abortion, commercial surrogacy, and unproven stem cell interventions (Cohen, 2015). Due to their illegal nature and the fact that they often raise moral concerns, these practices have sometimes been described as presenting the 'darker' side of medical tourism (Cooper & Hieda, 2015). However, as this paper has shown, procedures with strict regulatory restrictions can also lead to relevantly similar circumventing behaviour. In the same way, moral concerns may also be raised both by the presence of the structural barriers discussed in this analysis and in the participants actions to circumvent them. However, deeper critical examination of the moral concerns associated with these barriers is beyond the scope of this analysis.

In this way circumvention tourism can also be conceptualized as including procedures that are legal but unavailable in the medical tourist's home country, such as bariatric procedures in Canada that patients are unable to access in their home countries. This analysis has shed light on the specific access barriers Canadians are looking to circumvent in seeking bariatric surgery abroad – and specifically in Mexico. A concern, however, is that by circumventing such regulations and restrictions, participants were also leaving behind the processes put in place to protect their health and safety. For example, there is an extensive literature that demonstrates the utility of pre-operative weight loss and counselling in supporting long-term surgical weight loss success (Neff, Olbers, le Roux, 2013; Breznikar & Dinevski; 2009), and it is clear that Canada's guidelines have a basis in such research. As with other forms of circumvention tourism, in the context of Canadians' pursuit of bariatric surgery abroad, such patients may not be

aware of why certain protections have been put in place or the implications of their avoidance.

Restrictions and regulations regarding access to bariatric surgery help to control costs and resource allocation in the context of the finite resources available in Canada's public health care system (Sheppard, Lester, Karmali, de Gara, & Birch, 2014; Sheppard et al., 2014). Though patients exiting the Canadian system via circumvention tourism are paying for such care privately, research has shown that this practice places further strain on the Canadian health care system once bariatric tourists return home and require aftercare or care for potential complications (Sheppard, Lester, Karmali, de Gara, & Birch, 2014; Sheppard et al., 2014). For example, in one bariatric weight management clinic alone, 62 medical tourists imposed additional health care spending by the province of Alberta of CDN\$1,834,168. The majority of these costs were attributed to those needing extensive corrective surgery and requiring hospital stay due to complications arising following from surgery abroad (Sheppard, Lester, Karmali, de Gara & Birch, 2014). It was also found that when medical tourists presented to the clinic with complications they were potentially taking already very limited resources from those waiting to receive the surgery domestically (Sheppard et al., 2014). Therefore, bariatric tourists engaging in circumvention tourism can be seen as further entrenching and perpetuating the barriers restricting them from obtaining access to care domestically in the first place. This was not, however, a position taken by any of the participants in this study. It is also important to note that, while not a specific focus of this analysis, the participants in this analysis experienced a very low rate of serious complications (n=2) requiring hospitalization. This low rate of serious complication, however, may not reflect a typical complication rate amongst bariatric tourists and may be a characteristic of participants' willingness to participate in the study.

Through an examination of Canadian patients' experiences of international bariatric tourism, we have shown how broadening conceptualizations of circumvention tourism can allow examination of different cases of medical tourism under a framework of circumvention. In the context of the current analysis, we showed how participants were circumventing regulations and restrictions rather than legal barriers. While in this case many of the traditional ethical implications that have been conceptualized in the mainstream circumvention tourism literature that we summarized in the introduction did not apply, the actions of circumventing the domestic barriers by going abroad for

privately-funded medical care were mirrored. In light of the findings of this study, future research should examine the implications the practice of circumvention tourism by Canadian bariatric tourists has on the Canadian health care system beyond financial consequences. Some impacts on Canadian health care by bariatric tourists that are examined in future research should extend beyond the financial consequences to include: 1) bariatric patient trust in the Canadian health care system in situations of bariatric tourism; 2) changes in provincial surgical capacity and any corresponding changes in bariatric tourism by Canadians; and 3) the use of Canadian health care resources both pre-and post-operatively when bariatric tourists are circumventing the pre-operative process required in Canada. The three regulatory and administrative barriers identified in this study included the BMI requirements, structural barriers in regard to procedure availability, and the lengthy pre-operative process required in Canada. Future examination of these barriers, both in regard to their implications *on* the practice bariatric tourism by Canadians and the implications *of* the practice of bariatric tourism on Canadian health care will enhance understanding of this relatively unstudied area of health mobility.

## **2.5. Limitations**

Difficulty in recruitment for the study, as we sought to interview a highly stigmatized population, led to snowball sampling being heavily relied on. Consequently it is possible that individuals had similar experiences due to shared or similar characteristics and overlapping social networks. For example, as the majority of participants were living in Canada's western provinces, they may have experienced similar barriers in access to care due to geographic location. In the same way, this analysis may not have captured more negative experiences due to a lack of willingness to participate among those who do not have a positive experience or a greater level of stigmatization. Additionally, all participants received their respective bariatric surgeries in Mexico and so we captured no diversity in terms of destination location and experience. It is also important to note that no participants lived in Canada's most populous province, namely Ontario. Barriers to domestic bariatric surgery may be quite different for residents of Ontario as the province has increased its surgical capacity in recent years (Canadian Institutes for Health Research, 2015; Christou, 2011; Christou & Efthimiou, 2007).

## 2.6. Conclusion

Here we have presented the findings of interviews with 20 former Canadian bariatric tourists, specifically examining the domestic barriers to care experienced by those who opted to go to Mexico for bariatric surgery and framing this practice as a form of circumvention tourism. Three barriers were particularly relevant to participants in this study, resulting in the circumvention behaviour: (1) not meeting the BMI requirements for surgery through public funds in Canada, (2) structural barriers limiting access to specific procedures and/or in particular locations, and (3) lengthy and multi-stepped pre-operative processes that can leave people stuck at various points in the queue while waiting for care. In many cases participants experienced multiple barriers, only heightening the frustration they experienced while trying to access care domestically while also lessening their trust in the Canadian health care system.

Traditionally circumvention tourism has been conceptualized to encompass procedures sought abroad that are illegal in the medical tourist's home country, and sometimes even in the destination country. However, by examining bariatric tourism through a circumvention framework, we have shown how regulations that restrict access to fully legal care at home can push people abroad in order to obtain desired care that is simply inaccessible domestically. We encourage future research in the medical tourism field to examine the role of inaccessibility in driving private pursuit of care abroad as well as the ways in which inaccessibility and illegality co-exist in shaping how people select destination countries through the practice of circumvention tourism.

## Chapter 3.

# **Exploring Isolation, Self-Directed Care, and Extensive Follow-Up: Factors heightening the health and safety risks of bariatric surgery abroad among Canadian medical tourists**

### **3.1. Background**

In the 21<sup>st</sup> century, obesity and weight-related morbidities have become some of the leading causes of chronic disease worldwide. According to the World Health Organization, globally in 2014 more than 1.9 billion adults were classified as overweight while 600 million were classified as obese<sup>4</sup> (World Health Organization, 2015). The number of overweight and obese adults in Canada reflects these global statistics. In 2014, approximately 5.3 million Canadian adults were classified as obese while 40.0% of men and 27.5% of women were classified as overweight (Statistics Canada, 2015).

Excess weight gain can lead to many serious obesity-related negative health outcomes, which can contribute to a reduced quality of life as well as a reduced life expectancy if left untreated (Buchwald, Ikramuddin, Dorman, Schone & Dixon, 2011). Negative health outcomes can include: weight-related chronic conditions, such as Type II Diabetes or Atherosclerosis (Buchwald, Estok, Fahrback, Banel & Sledge, 2007; Buchwald, Ikramuddin, Dorman, Schone & Dixon, 2011; Nguyen et al., 2011; Runkel et al., 2011); mental health disorders, such as depression or anxiety (Green, Engel & Mitchell, 2014); and social discrimination due to stigmatization (Melin, Reynisdottir, Berglund, Zamfir & Karlström, 2006).

Given the multifaceted negative health outcomes that are associated with being above a healthy weight, weight management strategies are being increasingly examined

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<sup>4</sup> The WHO classifies the health conditions of overweight and obesity based on body mass index (BMI). BMI is calculated as an individual's weight (in kilograms) divided by their height squared (in meters squared). Overweight is defined as a BMI of 25-29.5 kg/m<sup>2</sup>. Obesity is defined as having a BMI greater than 30 kg/m<sup>2</sup> (Buchwald, Ikramuddin, Dorman, Schone & Dixon, 2011; World Health Organization, 2015).

in the public health, medical, and health services literatures. For example, it has been consistently shown that for both overweight and obese individuals, conventional treatments of diet and exercise are generally not effective for eliciting weight loss over the long term (Karlsson, Taft, Rydén, Sjöström & Sullivan, 2007; Moroshko, Brennan & O'Brien, 2012; Runkel et al., 2011). When these conventional treatments fail, some individuals look to surgical options. Weight loss surgery, also known as bariatric surgery, refers to a collection of surgeries that seek to reduce the size of the patient's stomach and/or re-route portions of the small intestine to limit fat absorption. These types of surgeries are generally targeted at individuals who meet the criteria of obesity or morbid obesity and for whom conventional weight loss programs have not produced sustained weight loss (Buchwald, Estok, Fahrbach, Banel & Sledge, 2007).

There are many factors that act as barriers and, therefore, limit access to bariatric surgery in Canada. First, Canada has very strict body mass index (BMI) cut-off requirements to qualify for surgery. Canada follows the recommendations from the 1991 National Institute of Health consensus conference, which stipulates that in order to qualify for surgery a person must have a BMI greater than 40kg/m<sup>2</sup> or a BMI between 35 and 39.9kg/m<sup>2</sup> if they have at least one significant weight-related co-morbidity (National Institute of Health, 1991; Christou & Efthimiou, 2009). Second, provincial variation in funding and lack of resources dedicated towards bariatric surgeries further constrains access to care. Finally, structural and administrative barriers exist as well. For example, to be eligible for bariatric surgery through public funding in Canada, an individual must undergo an extensive pre-operative process in which the individual must provide proof of a history of failed attempts at weight loss through conventional diet and exercise regimes, as well undergo an evaluation process with a nutritionist/dietician, a psychologist, and the bariatric specialist (Christou & Efthimiou, 2009). This process, coupled with these resource constraints, leads to a national average wait time of approximately five years from time of initial office visit with the bariatric specialist to the surgical date (Canadian Institute for Health Information, 2014; Christou & Efthimiou, 2009).

Challenges related to eligibility criteria and timely access to care, among other factors, have prompted some Canadians to seek bariatric surgery outside of the country through the practice of medical tourism (Kim, Sheppard, de Gara, Karmali & Birch, 2015; Birch, Vu, Karmali, Stoklossa & Sharma, 2010; Sheppard, Lester, Karmali, de Gara &

Birch, 2014; Sheppard, Lester, Chuck, Kim, Karmali, de Gara & Birch, 2014). Medical tourism is defined as the practice of individuals travelling internationally to seek medical care outside of their domestic health care system. This care is paid for out of pocket and does not encompass government administered cross-border care arrangements (Adams, Snyder, Crooks and Johnston, 2013). While it is currently unclear exactly how many Canadians are engaging in medical tourism, media coverage and internet discussion has indicated that many bariatric patients unable to receive care in Canada are indeed travelling abroad for such care (Pagel & Berry, 2016; Goh, 2016; Kirkey, 2016).

Studies examining the practice of medical tourism have found some health and safety risks for patients that are either distinctive or amplified when compared to the context of accessing surgery in their home countries (Crooks, Kingsbury, Snyder & Johnston, 2010; Johnston, Crooks, Snyder & Dharamsi, 2013; Lunt, Machin, Green & Mannion, 2011; Turner, 2007; Turner, 2010). In the context of this analysis, a health risk is any risk to the patients' physical or mental health that may be amplified or introduced through the act of medical tourism. For example, flying post-operatively or with a serious medical condition can put a patient at risk for deep vein thrombosis, a serious medical condition that can lead to pulmonary embolism (Lunt, Machin, Green & Mannion, 2011). Medical tourists may also be at an increased risk of contracting an infection in a facility abroad or straining their recovery by engaging in tourist activities post-surgery or during their travels home (Crooks, Kingsbury, Snyder & Johnston, 2010). Continuity of care is another concern for medical tourists. Often when patients are travelling between health care systems to receive care their medical records are not exchanged between the home and the destination physician, consequently undermining the continuity of care (Turner, 2007). Should complications arise upon return home, communication with the facility abroad may be challenging as a result of potential language barriers, challenges with time zones and operating hours, differing clinical or surgical standards of practice, or various other potential reasons (Turner, 2010). Furthermore, a safety risk, in the context of this analysis, is being taken to encompass any element of the travel aspect of medical tourism that may increase the risk to a patient's safety. For example, a patient's safety may be at risk through travelling to an unfamiliar country.

Much of the existing research about bariatric surgery pursued by Canadian medical tourists has focused on the potential financial burden on the public health care

system when they present complications upon return to Canada, which poses financial risks to this system (Kim, Sheppard, de Gara, Karmali & Birch, 2015; Birch, Vu, Karmali, Stoklossa & Sharma, 2010; Sheppard, Lester, Karmali, de Gara & Birch, 2014; Sheppard, Lester, Chuck, Kim, Karmali, de Gara & Birch, 2014). This research has shown that such complications can become quite costly for these patients' local health systems despite the fact that they individually chose to exit these systems to privately purchase surgery in another country.

This existing research on the health and safety risks associated with medical tourism has not explored the specific context of bariatric surgery. We believe this is a pressing knowledge gap given the growing global popularity of these surgeries, the increasing number of clinics worldwide seeking to attract international patients, and the fact that such interventions are typically coupled with therapy and nutritional counselling as well as post-operative follow-up that cannot typically be incorporated into time-limited trips abroad for surgery (Glenn, McGannon & Spence, 2014; Birch, Vu, Karmali, Stoklossa & Sharma, 2010; Snyder & Crooks, 2010; Salant & Santry, 2006; Buchwald, 2004). Broader research regarding Canadians' involvement in medical tourism has shown that physicians can be reluctant to treat patients post-operatively upon their return home due to lack of familiarity with the procedure obtained abroad, concerns about liability, and challenges regarding informational continuity of care, among other factors (Johnston, Crooks, Snyder & Dharamsi, 2013). Bariatric surgery already runs a high risk of surgical and post-operative complications, even when it is performed domestically. The risk of these complications occurring may be heightened when the surgery is performed out of the country (Birch, Vu, Karmali, Stoklossa & Sharma, 2010). Given this, medical professionals in Canada may be especially reluctant to assist with follow-up care in cases of bariatric tourism, although it is currently unknown to what extent this is occurring in Canada.

The current analysis takes a departure from the existing research focus on surgical costs and complications among Canadians who have undertaken bariatric surgery abroad through examining first-hand accounts that provide new experiential insight into this transnational care practice. We do so by thematically examining 20 qualitative interviews conducted with Canadians who had previously traveled to Mexico for bariatric surgery to identify specific health and safety risk factors anticipated, encountered, or avoided throughout this journey. In the context of this paper, the health

and safety risks of concern raised by this practice of international bariatric tourism encompass those previously established in the medical tourism literature. For example, some of the health and safety risks explored in this analysis will include risks from (dis)continuity of care, lack of informed consent, and medical complications from inadequate follow-up care or differing surgical practices abroad (Crooks, Bristeir, Turner, Snyder, Casey & Johnston, 2011). Drawing on the findings of the thematic analysis, in the remainder of this article we show how Canadians engaging in bariatric surgery abroad face three challenges that create potential risks to their health and safety. As we note, the challenges identified by the participants introduce or amplify Canadians' health and safety risks. In the discussion we contrast these findings against the process of seeking and obtaining bariatric surgery domestically in Canada.

## **3.2. Methods**

This analysis contributes to a larger qualitative study exploring former Canadian bariatric tourists' narrative accounts of their experiences of privately obtaining bariatric surgery abroad.

### **3.2.1. Recruitment**

Once ethical approval was obtained from Simon Fraser University's office of research ethics, we commenced recruitment strategies that sought Canadian residents who had previously travelled outside of Canada to obtain bariatric surgical procedures. Canada presently has no system for tracking individuals who leave the country each year for medical procedures and, therefore, social media was used as the primary medium through which recruitment was conducted. Prospective participants were informed of the study through targeted advertisements placed on social media websites, namely Facebook and other online patient support forums and websites. In addition to the targeted advertisements on social media, an article about the study was published on a popular Canadian obesity blog<sup>5</sup>. In all advertisements, participants were asked to contact the principal investigator regarding participation in the study. Finally, participants

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<sup>5</sup> The blog is Dr. Sharma's Obesity Notes out of Alberta, Canada, which can be found at <http://www.drsharma.ca/>.

were asked to provide study details to others in their networks that may qualify for study and be interested in participating.

Eligibility to participate in the study required that the participants: (1) were eligible for coverage under Canada's public health plan through Canadian citizenship or legal residency in Canada; (2) had paid for bariatric surgery privately abroad with no full or partial reimbursement from the Canadian health care system; (3) were not be under the age of 18 at the time of the interview; and (4) had obtained their surgery abroad in the last 10 years (in order to minimize concerns around potential lack of recall).

### **3.2.2. Data Collection**

Data were collected through semi-structured interviews with former Canadian bariatric tourists using a semi-structured interview guide. Interviews were conducted by phone between February and May of 2016. Each interview ran for approximately 30 to 50 minutes. Semi-structured interviews were chosen for this study as they allow participants to elaborate on questions they find especially salient or pertinent to their experience. The interview script was developed through a review of literature on: (1) bariatric surgery, including standard operating procedures and pre-operative and post-operative programs/requirements; (2) medical tourism; and (3) bariatric tourism and, more specifically, bariatric surgery and bariatric tourism in the Canadian context. Questions in the interviews were designed to capture the planning, travel, and after-care experience. Specific topics covered in the interview included: the patient's experience of seeking bariatric surgery within the Canadian health care system, their decision-making processes for seeking care abroad, information seeking processes, experiences while abroad, and aftercare experiences upon return to Canada. In addition, reactions/support from family, friends and members of the Canadian medical system were probed. All the interviews were conducted by the lead author to enhance consistency.

### **3.2.3. Analysis**

All interviews were digitally recorded and then transcribed verbatim. When analysis commenced, the first step was independent review of the transcripts by each member of the team. Through this review the authors independently identified emerging themes, concepts, and issues brought forth by participants. The outcomes of the

independent review were then examined collectively and the themes, concepts, and issues were compared to identify areas of overlap. The collective review identified three main meta-themes that form the basis of this analysis. Once these meta-themes were identified, the lead author then re-examined all the transcripts to identify excerpts relevant to each, which were later reviewed by the other authors to confirm the scope of each theme.

### **3.3. Results**

A total of 20 interviews were conducted with individuals who had obtained bariatric surgery outside of Canada. All participants were Canadian residents who qualified for provincially funded health care. Participants were residing in British Columbia (n=2), Alberta (n=4), Saskatchewan (n=12), Manitoba (n=1), and Nova Scotia (n=1) at the time of seeking surgery. The majority of participants travelled for the vertical sleeve gastrectomy procedure (n=16). Other procedures these participants obtained abroad included: the adjustable gastric band (n=1), gastric plication (n=2), and Roux-en-Y (RNY) gastric bypass (n=1). As all participants obtained their respective surgeries in Mexico, findings from this analysis are in line with previous research of bariatric tourism by Canadians that has identified Mexico as a popular destination country for bariatric tourism (Kim, Sheppard, de Gara, Karmali & Birch, 2015).

Through the participant interviews, three meta-themes emerged that appear to indicate that Canadians that engage in bariatric tourism can experience heightened health and safety risks when compared to having the surgery performed domestically. The first of these factors is feelings of isolation and stigma from family and friends, as well as health care professionals. These feelings led to many of the participants having to engage in self-navigation, the second factor identified in our analysis. Participants were found to have self-navigated not only the potential bariatric services offered by the Canadian health care system, but also the private system in Mexico. A final factor is the extensive life-long follow-up care necessary for bariatric procedures, which, when coupled with isolation and self-navigation, led many participants to receive inadequate follow-up care. In the remainder of this section we expand on these thematic findings in relation to participants' experiences of bariatric tourism and also identify areas where the factors overlap.

### 3.3.1. Stigmatization and isolation from family, friends and medical professionals

The first challenges leading to heightened health and safety risk potential are feelings of isolation and stigma, which led some participants to not tell others in their immediate support networks of their decision to go abroad for surgery. This silence around the surgery continued long after returning to Canada, with many participants echoing similar sentiments of “*I have told very few people that I had, that I had weight loss surgery.*” Or as one participant stated “*My family still don’t know.*” In many cases, participants never told friends or family. Nine participants spoke directly to the stigma associated with being overweight or obese as the primary reason for not informing many friends or family about their decision to undergo surgery:

*I’ve been very private about the fact that I had to have this surgery. So I’ve been private intentionally because I don’t feel that it’s anyone else’s business. I think there’s a lot of judgement around obesity and overweight and interventions as such. And I don’t particularly feel like addressing those.*

Another participant detailed the very negative reaction she received from telling a family member, “*...he’s a paramedic and he was just furious when he heard, yeah just furious, because of the stigma behind it.*” Fear of negative or stigmatizing reactions from family and friends worked to further enforce the isolation these individuals already feel in relation to their weight and weight-related health conditions.

In regard to their attempts to seek weight-management care domestically, nine participants discussed feelings of shame and stigma directed from health care professionals that worked to dismiss bariatric surgery as a viable option to obtain domestically. Variations of the mantra “*eat less, exercise more, watch your portions*” or “*move more, eat less*” were generally the medical advice given to participants from Canadian health professionals when they first started their information seeking regarding surgical options, even after years of failed diet attempts. One participant explained:

*weight would be assessed annually, it would be noted you need to lose weight or there was treatment of hypertension but there was really never any particular support or discussion around achieving it beyond sort of the usual, move more eat less... There was actual dismissal of bariatric surgery as being a viable option by my family physician.*

This participant felt very isolated from the Canadian health care system as it was not seen as addressing her health care needs despite repeated requests and failed attempts to lose weight through more conventional weight loss programs. Although her weight-related health conditions, such as hypertension, would be treated, she still felt that her health care professionals seemed dismissive of her broader weight issues. While these feelings of isolation and stigma from the Canadian health care system may have been experienced even if the participant had been able to move forward with receiving bariatric care in Canada, there is a sense that obtaining care abroad heightens the stigma and isolation that is attached to the surgery. As one participant explained there is *“less of a stigma attached to having the surgery done here.”*

Perceptions about the dangers of travelling to Mexico, namely Tijuana, for surgery led to eleven participants telling few, if any, of their friends, family, or medical professionals about their intention to obtain, let alone travel to Mexico for, the surgery. For participants that did tell family or friends of their intention to travel for the surgery, reactions were quite often negative regarding Mexico as a destination for medical procedures. For example, one participant discussed her experience of trying to tell a friend she was going to Mexico for the surgery:

*I have one friend of mine... she did not like the idea of me at all going to Mexico and having it done and she understood that I wanted to be healthier and have a better life for myself but the whole idea of me going to Mexico definitely scared her.*

Other participants that chose to share their decision to travel with their support networks felt they had to wait until they were actually in Mexico before they could tell anyone about their decisions to go abroad for surgery. As one participant noted *“I told one sister when I was actually in Mexico and that’s it.”* For these participants, stigmatized ideas about the lack of safety of Mexico led to a lack of support from family and friends over the decision to travel for the surgery.

### **3.3.2. Self-navigation of domestic and destination health care systems**

Ten participants discussed experiences of having to self-navigate their own bariatric care, first domestically and then again with the care they received in Mexico. In the context of this analysis, self-navigation is being taken to encompass all aspects of

care obtainment that participants were left to do on their own, either with limited or no support and guidance from a medical professional. As discussed in the previous subsection, many participants noted feeling unable to talk to their regular health care professionals due to negative perceptions surrounding bariatric surgery as a viable option to address their above-average weight and weight-related health care concerns. One participant discussed the negative reaction she received from her family physician in regard to pursuing bariatric surgery, as the family physician only agreed to remain her doctor if she would

*go to this other private weight management clinic and be followed by them, because he said we all know now that if you have that surgery you are going to be a burden on the health care system now for the rest of your life and you will have to be closely monitored.*

Similarly, another participant stated, *“There wasn’t any assistance from the GP’s [family doctor] office, in fact he kind of frowned upon my suggestion of seeking bariatric care.”* For these participants, their regular health care providers were not supportive of their desire to seek a surgical solution to their weight related health problems, leaving them to find self-directed ways of accessing the surgical care.

In many cases, due to the lack of regular physician support or knowledge of the field, participants noted having to do most or all of the information seeking about bariatric surgeries on their own:

*You know, I, so it was really doing my own homework and figuring out for myself that I needed to act now before the co-morbidities and other health issues were going to arise and that you know, just sort of broaden my own understanding, I guess, of obesity itself and that the ‘move more, eat less’, while not a bad recommendation isn’t particularly an encompassing strategy. And so, yeah, I did my own work around that.*

Thus, once participants understood they were not going to be able to receive their desired bariatric care through the Canadian health care system, many were left having to self-navigate and do their own information seeking in their journey to access bariatric care. In this way, they relied on themselves to make up for the lack of information provided by professionals within the Canadian health system.

The primary outlet the vast majority of participants (17 of 20) turned to for information in their self-directed care was the internet. Many noted doing most of their information seeking by seeking advice from previous bariatric tourists from Canada and

the United States through the use of social networking sites, namely through bariatric surgery information and support groups on Facebook and through blogs/forums. As one participant explained:

*So I based my end decision... on the success of other patrons and their feedback on the procedure itself, and the locations, the surgeons. I joined a weight loss forum online, a chat group and people comparing notes and people were brutally honest about which surgeons they liked and who they didn't like eventually.*

Another explained: *"I used what this woman had told me [online]. She told me the clinic she went to, the doctor, and then I went and researched from there. But I totally relied on this woman."* Notably, information seeking online did allow some participants to learn that local surgeons practicing bariatric surgery did not have the experience level they desired, thus further entrenching their plans to seek care outside of Canada. As one participant explained her extensive information seeking processes allowed her to *"[get] a bit of understanding of what is available around the zone that I lived...then I began to look outside of my province and outside of the country for that."* Lack of available local expertise seemed to further entrench the belief that Canada was not a viable option for care and pushed patients to look to Mexico for where they could find the level of expertise they desired, however this care abroad would have to be self-navigated.

### **3.3.3. Inadequate follow-up care domestically**

In Canada, the public health care system requires an extensive pre-operative and then subsequent post-operative program for all bariatric patients. Participants bypassed these required steps by travelling abroad for the surgery. For example, as one participant explained

*I've read several things about the process in Canada and you know they give you a diet and see whether you can follow that procedure for a year and then there's some emotional, some counselling for another couple of years, and then, you know, wait another year and see whether you still want to do it or not. There's lot of pre-scanning that's done before you even get a chance to get in and do your surgery and you would probably be part of a group when you came out. Whereas having had it done in Mexico, I didn't.*

Another participant discussed the implications of bypassing these steps, explaining that if she had been

*able to get [the surgery] in Canada, the pluses would have been: have more professional staff available, more educated staff available. Like dieticians and people that were more familiar in the care, the more immediate care.... More psychiatry. All those kinds of things more available right away if you needed it as opposed to in Mexico you don't really have that.*

While these participants desired to bypass the extensive pre-operative program in Canada and thereby get their procedures done more quickly, doing so meant that they were not able to access the standard post-operative care in Canada. In some instances this included not receiving information about local in-person support groups for those recovering from bariatric surgery, which some participants would like to have attended.

In some cases where participants' regular physicians, and specifically family doctors, supported their decisions to go to Mexico for bariatric surgery, accessing aftercare services domestically became possible. For example, one participant detailed her extensive pre-operative discussion she had with her physician in Canada and the 'game plan' they had in place should complications arise.

*My primary care physician and I walked through what was, what would happen, in theory, if I had complications and it was one of the known risks that I entered in to with, in facing the surgery. If I had the surgery, had a complication and then had to come back here, and so my primary care physician and I discussed well I would have to be referred through emergency to a local surgeon. They would have to know what my surgery was and so on and so forth.*

Another participant had a very different experience:

*My GP wasn't particularly interested in providing any follow up care. He said, "you saw a surgeon in another country and you should be following up with them." So, but I didn't have any problems thankfully, cause that could have been a serious issue if the GP wasn't cooperating and I'm having medical issues, right?*

Support of the regular primary care physician was crucial to successful after care upon return home to Canada, in addition to a robust game plan should complications arise.

Information seeking online and self-navigation of health care affected not only decisions regarding where to travel and which surgery to obtain, but also impacted the types of follow-up care information participants received and acted on. As one participant explained, he felt he was: *"pretty informed when I walked in the door, just by looking at all these other websites."* Similar sentiments were echoed by other

participants. This belief that the internet was sufficient to inform their medical decision making, both pre-operatively and post-operatively, led many participants to not seek any formal follow-up care upon their return to Canada.

### **3.4. Discussion**

The themes identified in this analysis provide a strong indication that people who obtain bariatric surgery outside of Canada face many challenges. We contend that these challenges can introduce or exacerbate particular health and safety risks – see Table 3.1 for an overview of the relationship between the challenges discussed in this analysis and their associated health and safety risks.

**Table 3.1. Relationship between bariatric tourism challenges and associated health and safety risks**

	Challenge	Challenge in Context	Associated Health and Safety Risks
1	Stigma and Isolation	Experiences of stigma and isolation from family, friends, and medical professionals in the Canadian health care system	i. <i>Risk of (dis)continuity of care</i> ii. <i>Risk of lack of informed consent</i>
2	Lack of familiarity with Mexico	Participants' pre-conceived understandings of the safety of Mexico and standard surgical procedures	i. <i>Risk of lack of informed consent (language barriers)</i>
3	Self-navigation of care	Surgical options and care obtainment identified by participant in both home and destination countries	i. <i>Risk of medical complications</i> ii. <i>Risk of (dis)continuity of care</i>
4	Information seeking primarily online	Data on procedures, clinics and health care professionals abroad obtained through online mediums	i. <i>Risk of lack of informed consent</i> ii. <i>Risk of poor outcomes</i>
5	Reliance on anecdotal information	Former patients' testimonials on surgical outcomes and experiences of care abroad heavily relied upon by patients	i. <i>Risk of lack of informed consent</i> ii. <i>Risk of poor outcomes</i>
6	Inadequate follow-up care	The multi-disciplinary care required for strongest health outcomes in bariatric surgery is largely missing due to the international dynamic or lack of support from home physician	i. <i>Risk of (dis)continuity of care</i> ii. <i>Risk of medical complications</i>

For the participants, stigma in regard to their above average weight, coupled with the notion that bariatric surgery is the 'easy way out,' led many to feel isolated from their family, friends, and the Canadian health care system in general. For many participants experiencing stigma and isolation from medical professionals led harms in the doctor-patient relationship, meaning patients were unable to or faced challenges in confirming information medical information with their family physicians, thereby risking harm to informed consent and significant disruptions in continuity of care.

Confirming previous research, Mexico appears to be a popular destination for bariatric tourists (Kim, Sheppard, de Gara, Karmali & Birch, 2015). However, lack of familiarity with Mexico and/or perceptions of the country appeared to add a new form of stigma and isolation for them to contend with and many participants noted experiencing medical professionals that were very uncomfortable with the idea of their patients receiving care in Mexico due to their lack of familiarity with Mexico and their standards for surgical practice. Language barriers experienced by participants while they were in Mexico also appears to increase the risk of harming informed consent as some participants noted struggling to communicate with some of the surgeons and many other medical professionals in the facility, such as the nursing staff.

Feelings of dismissal by the Canadian health care system, coupled with isolation from friends, family, and medical practitioners in regard to medical decision making left many of these former bariatric patients having to self-navigate their own bariatric health care. For these participants, the health and safety risks associated with self-navigation of care (such as the risk of discontinuity of care or the heightened risk for medical complications) were heightened as they were left to self-navigate both the Canadian health care system and their desired care in Mexico. These health and safety risks appeared to stem from a heavy reliance on anecdotal experiences of previous patients or other information found on the internet that patients were unable to, or faced challenges with, confirming the validity of with their family physicians.

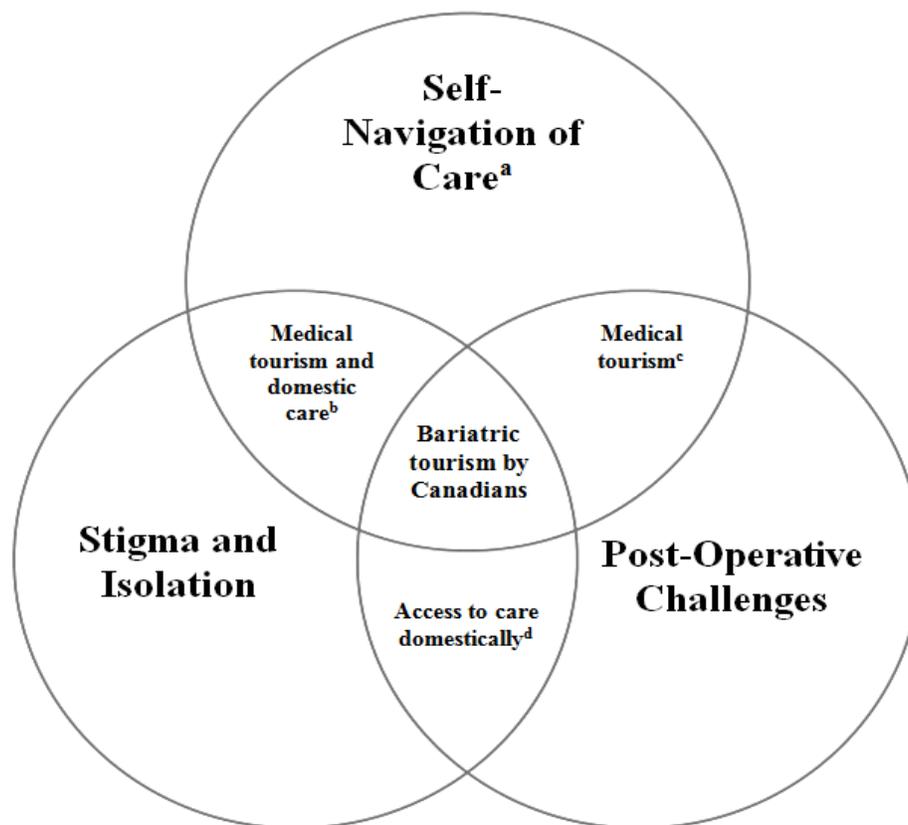
Finally, challenges with accessing follow-up care appeared to be mitigated through support of physicians in Canada or heightened when that support was lacking. When the support of a family physician was lacking challenges with obtaining adequate follow-up care appeared to heighten the risk to continuity of care and the risk of medical complications. Life-long follow-up care is imperative for success with bariatric tourism as medical complications or nutritional deficiencies can occur in a patient any time following surgery (Carter, 2015; Guerreiro & Ribeiro, 2015; Green, Engel & Mitchell, 2014; Wilson & Datta, 2014; Aills, Blankenship, Buffington, Furtado & Parrot, 2008). The risk of (dis)continuity of care and/or medical complication did appear to be heightened through the practice of bariatric tourism as many participants discussed experiencing significant challenges associated with family physicians lack of willingness to refer them for post-operative blood work or scans to ensure proper healing. These challenges appeared to stem from unavailability of resources as a result of not going through the regimented

pre-operative bariatric surgery requirements at home or the lack of support from the family physician over the patient's decision to obtain this surgery abroad

Most of the issues central to the three themes identified in this analysis are not, on their own, unique to bariatric tourism or medical tourism more generally. The three key challenges that lead to health and safety risks in the context of bariatric surgery via medical tourism by Canadians are likely to be present when accessing care domestically and/or in other cases of medical tourism. For example, having to self-navigate various health care systems is a common risk that has been associated with medical tourism, in that it may lead to disruptions in continuity of care, which is an important quality indicator in health service delivery, or even un/mis-informed decision-making, which threatens patients' ability to give informed consent. For example, research has shown that individuals seeking plastic surgery or in-vitro fertilization abroad may expose themselves to these same risks (Glenn, McGannon & Spence, 2012; Murphy, 2009). As discussed in the background section, concerns regarding access to domestic after care, and therefore risks to continuity of care, for returning medical tourists (Johnston, Crooks, Snyder & Dharamsi, 2013; Snyder & Crooks, 2010; Turner, 2010; Turner, 2007) have also been identified by the broader medical tourism literature, so this too is not unique to bariatric tourism. Existing research suggests that reasons Canadian physicians may be reluctant to coordinate after care for returning medical tourists including their lack of familiarity with the procedure or quality/standards of care abroad, unwillingness to disrupt existing waitlists for such care that are populated by those who had surgery domestically, as well as concerns regarding their own legal liability should complications emerge or become exacerbated (Collier, 2014; Runnels, Labonte, Packer, Chaudhry, Adams & Blackmer, 2014; Crooks, Turner, Cohen et al., 2013; Snyder, Crooks, Johnston & Dharamsi, 2013; Turner 2007).

While health and safety risks are present with all surgeries, including bariatric surgeries, here we contend that the added dimension of privately pursuing bariatric surgery abroad heightens or amplifies some of these existing risks while in some cases introducing new ones through navigating the three challenges reported on in the findings. What is clear from this analysis is that bariatric tourists are experiencing challenges *beyond* those that are commonly present when the care is sought domestically in Canada. Not only that, but most participants experienced some degree of each of the challenges. Therefore, what is at the very least worrisome and also likely

distinctive about bariatric tourism by Canadians is that all three of the challenges identified in this analysis are working in conjunction, as shown in Figure 1, to potentially heighten the patients' exposure to health and safety risks. These risks are also likely beyond what the patient may experience when the surgery is obtained domestically. We contend that it is this 'triple threat' of risks that is faced by Canadian bariatric tourists that makes this practice of going abroad for surgery especially problematic, which we explore in greater detail in the following sub-section.



**Figure 3.1. Risk relationships experienced by Canadian bariatric tourists in regard to domestic risks and those heightened by medical tourism.**

<sup>a</sup> Both of the domestic and/or destination health care systems.

<sup>b</sup> Overlap of risks that are present both when the patient seeks care domestically and through medical tourism.

<sup>c</sup> Overlap of risks unique to the context of medical tourism.

<sup>d</sup> Overlap of risks primarily experienced when the patient receives care domestically.

### **3.4.1. Intersecting and Overlapping Challenges**

Perceptions of stigma and isolation from friends and family, as well as health care professionals, impact the information seeking that potential bariatric tourists can

engage in. As discussed previously and shown in the findings, individuals that are overweight or obese tend to experience higher levels of stigma and shame for their weight and weight-related health concerns. These perceptions of stigma are likely to be experienced whether the individual seeks the care in Canada or abroad. But this experience of stigma becomes additionally problematic in bariatric tourism when it limits the information seeking the individual can engage in. This may be particularly problematic in Canada, where family doctors act as gatekeepers to access to more specialized care (Health Council of Canada, 2010; Chan & Austin, 2003; Romanow, 2002;). When surgery is obtained domestically, it can be assumed that the patient's primary care provider approves of the procedure and is supportive of their need to obtain a surgical solution through the act of referral to a surgeon. However, as is apparent from this study, support cannot be assumed or implied in the context of medical tourism for bariatric surgery. Lack of physician support may be for a number of reasons including but not limited to: 1) a physician's belief that the surgical solution may not be appropriate for the patient; 2) a physician's uncertainty about the quality of and standard practice of care abroad and; 3) a physician's inexperience with providing follow-up care for bariatric patients or difficulty with referring them on to appropriate specialists. When self-navigation of care overlaps with a lack of support from patients' regular care providers in Canada, those seeking bariatric surgery options are left with feelings of isolation and stigma within the Canadian health care system. These feelings are amplified along with the potential for exposure to health and safety risks such as care discontinuity.

The findings show that when isolation from the Canadian health care system is coupled with the self-directed navigation of the Mexican health care system, both the quantity and quality of advice and information these patients are receiving can be negatively impacted in the context of bariatric tourism. When individuals are faced with an unsupportive health care practitioner, it appears they often rely on the internet and/or word-of-mouth forms of information seeking. This becomes concerning when they are not able to confirm the accuracy of this information with their regular health care practitioner, as a central role of Canadian family doctors is to engage widely in patient education (Williams, Davis, Parker & Weiss, 2002). This potential over-reliance on anecdotal or experiential evidence from previous patients may impart a false sense of security in prospective patients and limit the quantity of strong peer-reviewed evidence

that patients would typically have access to in the domestic context. As a result, the risk that patients may not be giving truly informed consent is increased.

The final overlap of challenges that appears to be especially problematic occurs when challenges with follow-up care happen in conjunction with self-navigation of care. As shown in Figure 2, this particular intersection of challenges has been identified in previous medical tourism literature (e.g., Eissler & Casken, 2013; Johnston, Crooks, Snyder & Dharamsi, 2013; Snyder, Crooks, Johnston & Dharamsi, 2013), but is also present in a significant way in cases of bariatric tourism by Canadians. Research has shown that not having access to the extensive, life-long follow-up care that should be provided following bariatric surgery can be risky and have negative health impacts for these patients (Zeigler, Sirveaux, Brunaud, Reibel & Quilliot, 2009; Wheeler, Prettyman, Lenhard & Tran, 2008; Gould, Beverstein, Reinhardt & Garren, 2007; Poole, Atar & Kuhanendran et al., 2005). The Canadian system for bariatric surgery has a significant pre and post-surgery program with a specialized team, including a nutritionist/dietician, a bariatric surgeon, and a psychologist all trained in bariatric care, to ensure that patients are physically and psychologically ready for success with the surgery (Aarts, Sivapalan, Nikzad, Serodio, Sockalingam & Conn, 2017; Karmali, Stoklossa, Sharma, Stadnyk, Christiansen, Cottreau & Birch, 2010; Saltzman, Anderson, Apovian, Boulton, Chamberlain... & Young et al., 2005). This type of continuing care is simply much more challenging, if not prohibited, in the context of medical tourism because of the spatial and temporal constraints of the transnational nature of care delivery prohibits patients from routinely accessing follow-up care and therapy from the centre where they obtained surgery. Canadians who opt for bariatric surgery abroad must thus be proactive in assembling a follow-up team that can address their aftercare needs. Failure to do so means that health and safety risks of medical complications or significant disruptions to continuity of care are more likely.

### **3.4.2. Future Research Directions**

As was apparent from the interviews with former Canadian bariatric tourists, unless the qualification requirements or surgery becomes more available in throughout Canada as there is only evidence of increased surgical capacity in Ontario at this time, this practice of going abroad for care is likely to continue regardless of if an individual qualifies for care in Canada or not. Canadian bariatric tourists will continue to be

exposed to health and safety risks in order to obtain the care they feel is necessary for their health. Given the significant amount of time participants spent discussing family doctors, including whether or not these physicians supported their decisions to go abroad for surgery, we believe an important direction for future research is to investigate the potential for informational interventions to be developed to inform this provider group about trends and key issues associated with bariatric tourism. While primary care providers are not directly providing follow-up care, increased awareness of the challenges associated with accessing bariatric surgery abroad may help to reduce the feelings of stigma/isolation prospective patients experience from their primary care physicians. Additionally, participants discussed the lack of knowledge or information family doctors in Canada appeared to have on this subject. Empowering physicians with a better understanding of how to support patients in their bariatric care through their referral networks may help to alleviate some of this heightened risk potential that these patients are facing. In this way Canadian family doctors may be better situated to help their patients through the decision-making process if they continue to engage in bariatric tourism.

### **3.4.3. Limitations**

The study sought to recruit a particularly small and hard to reach population due to high levels of stigmatization. Consequently, snowball sampling was quite heavily relied upon. This may potentially limit the findings of this study as snowball sampling can result in participants sharing similar experiences due to similar characteristics or similar contexts/situations (Sadler, Lee, Lim, Fullerton, 2010; Magnani, Sabin, Saidel & Heckathorn, 2005). While our recruitment did capture important aspects of difference among participants, such as in socio-economic status, there was no variation in the destination country for bariatric tourism. We also failed to recruit any participants from Canada's most populous provinces, namely Ontario. Recent changes to increase surgical capacity in Ontario may mean that more individuals requiring surgery are being approved for the procedures domestically and therefore fewer are travelling for care (Canadian Institutes for Health Research, 2015; Christou, 2011; Christou & Efthimiou, 2007). However, this does not mean individuals from this province are not engaging in bariatric tourism. Overall, we believe the rigour we incorporated into the design of the study (e.g., use of investigator triangulation, establishment of an audit trail, inclusion of

verbatim quotes in reporting) has assisted in ensuring that none of these potential limitations has negatively affected the integrity of our analysis.

### **3.5. Conclusion**

This paper has presented the findings of a thematic analysis derived from qualitative semi-structured interviews conducted with 20 Canadians who had previously privately obtained bariatric care outside of Canada. This paper sought to examine the challenges experienced by Canadian bariatric tourists and the associated health and safety risks that work in conjunction to heighten the risk potential these patients are undertaking beyond what they would normally experience should they have received the procedures domestically. Overall, it appears that these patients face a 'triple threat' of challenges compared to if the surgery was performed domestically. This 'triple threat' includes: (1) perceptions of stigma and isolation from family, friends, and the Canadian health care system which is coupled with (2) self-navigation of both the Canadian and Mexican health care system in regard to information seeking and obtainment of care, and finally (3) a significant need for extensive life-long follow-up care which may or may not be achievable once the patient returns home. It appears that the conjunction of these challenges heighten the risk potential these patients experience. In the future more research and examination into bariatric tourism by Canadian medical tourists is needed.

## Chapter 4.

# Conclusion

### 4.1. Overview

The two analyses that inform this thesis provide important new insights and address knowledge gaps in both the medical tourism and the Canadian bariatric health services literature. The first analysis (Chapter 2) provides a critical examination of the structural and administrative barriers restricting or preventing access to bariatric surgeries for Canadians. This analysis consists of a novel use of the framework of circumvention tourism, allowing for examination of the practice of bariatric tourism by Canadians as a form of circumvention – in this case of domestic, pre-operative and availability barriers to accessing surgery. The second analysis (Chapter 3) explores challenges, as well as health and safety risks, Canadian bariatric patients experience in obtaining bariatric care both domestically and internationally. When combined, these two analyses provide insights into the motivating factors that are driving Canadians to seek bariatric services abroad and their challenges in attempting to reintegrate their bariatric care into the Canadian health care system upon their return to Canada.

The remainder of this chapter will outline key findings from the two analyses presented in this thesis and discuss how these findings relate to my research objectives. This chapter will conclude with a discussion of the significance of these study findings while considering strengths and overall limitations of the study. Any remaining knowledge gaps will be acknowledged and suggestions for future directions for research will also be examined.

### 4.2. Summary of Analyses

#### 4.2.1. Framing International Bariatric Tourism by Canadians as an example of Circumvention Tourism

The first objective of my thesis research was to develop an understanding of the motivating factors that are driving Canadians unable to obtain bariatric care in Canada to

instead seek this care abroad through the practice of medical tourism. This objective was developed in response to the existing gap in testimonial evidence regarding *why* Canadians are seeking bariatric surgery outside of Canada (Kim, Sheppard, de Gara, Karmali & Birch, 2015). Chapter 2 addresses this first objective by identifying key barriers raised in interviews with former Canadian bariatric tourists that are serving as push factors for these individuals to seek care abroad. While various reasons for seeking care abroad were identified by our participants, three specific barriers emerged as the most common push factors, including: 1) not meeting strict BMI requirements to qualify for publicly funded surgery; 2) limited availability of desired procedures and expertise locally; and 3) an extensive pre-operative program extending the wait time for surgery by multiple years. Collectively, these challenges represent structural and administrative barriers built into the Canadian system that restrict access to care. While some participants reported only experiencing one of these barriers, it was quite common for participants to face more than one of these barriers in their attempts to access bariatric surgery.

The analysis provided in Chapter 2 applied a framework of circumvention tourism to examine these administrative and structural barriers identified by participants. Previously, the concept of circumvention tourism has been used in cases in which patients are circumventing legal restrictions to care in their domestic health care settings (Cohen, 2015). However, the same circumventing behaviours have been seen in cases of medical tourism in which patients seek to bypass structural barriers restricting access to care in their domestic health care systems. This was the position in which the concept of circumvention tourism was taken up in this analysis. It is important to acknowledge that in this study, participants did not frame their discussion of their motivations for seeking care abroad using the terminology of circumvention. Additionally, the concept of circumvention tourism has not previously been applied to the act of bariatric tourism by Canadians or others. However, it was applicable and enlightening in this case as the circumventing behaviours discussed by participants mirrored similar behaviours previously identified in this literature. Findings from this analysis are important to illustrate the effectiveness of applying a framework of circumvention to situations of medical tourism in which structural barriers restrict access to care domestically in order to examine the practical and ethical implications imposed by the practice.

#### **4.2.2. Exploring Challenges and Associated Health and Safety Risks imposed on Canadian Bariatric Tourists**

The second objective of my thesis research is to identify and describe new and exacerbated health and safety risks Canadian bariatric patients are exposed to through the practice of bariatric tourism. These risks are related to disruptions in continuity of care and inadequate follow-up care as a result of engaging in international bariatric tourism. Previously, any bariatric tourism research in the Canadian context was focused on the risk of medical complications that can arise from bariatric tourism and the resulting financial implications this can impose on the Canadian health care system (Kim, Sheppard, de Gara, Karmali & Birch, 2015; Birch, Vu, Karmali, Stoklossa & Sharma, 2010; Sheppard, Lester, Karmali, de Gara & Birch, 2014; Sheppard et al., 2014). A gap in the literature remained regarding challenges in care and aftercare obtainment and any additional health and safety risks that may be associated with this practice. Therefore, this second research objective was identified in response to this existing gap.

The analysis provided in chapter 3 presents findings that address this second objective. Our interviews with former bariatric tourists identified three key challenges patients experienced in seeking bariatric surgery and follow-up care, including: 1) stigma and isolation from family, friends and medical professionals in their desire to have the surgery and in their decisions to obtain these surgeries in Mexico; 2) often problematic information seeking and self-navigation of care both domestically and internationally; and 3) often inadequate follow-up care stemming from (dis)continuity of care. While many of these challenges are present in the broader medical tourism literature for other procedures (Johnston, Crooks, Snyder & Dharamsi, 2013; Snyder & Crooks, 2010; Turner, 2010; Murphy, 2009; Turner, 2007), findings from this analysis nuance this discussion regarding health and safety risks for medical tourists by highlighting that, in many cases of bariatric tourism by Canadians, the challenges found in this analysis are happening in conjunction. When compared to other forms of medical tourism, these challenges are, on their own, not unique to bariatric tourism. However, findings from this analysis are important as they suggest the health and safety risks Canadian bariatric tourists may be facing are ultimately heightened due to these challenges happening simultaneously.

### **4.2.3. Overall Implications and Enhanced Understandings**

A few findings emerged across both analyses, illustrating key considerations for possible implications for this research. Common experiences and perspectives from our participants provide new insight into Canadians' participation in bariatric tourism and other forms of medical tourism while highlighting important considerations regarding access to bariatric surgical services in Canada. As I will discuss below, this insight provides a deeper understanding of the systemic and structural factors informing Canadians' involvement in medical tourism as well as their experience as medical tourists.

First, frustration with perceived, or realized, lack of access to care both in attempting to obtain surgery domestically and in attempting to reintegrate into the Canadian health care system was the most dominant theme underlying participants' discussion of their experiences. For many, this represented a loss of hope and trust in the Canadian system. This appeared to contribute to the circumventing behaviour described in Chapter 2 stemming from real or perceived understandings on their eligibility in Canada for their desired surgical procedures. In addition, factors heightening frustrations associated with the stigma and isolation faced by Canadian bariatric patients, not only from friends and family but also medical professionals, further informed patients' desire to seek care abroad. This frustration and isolation also elevated the health and safety risks these patients may have been exposed to resulting from (dis)continuity of care or inadequate follow-up care. Therefore, this thesis indicates that for some Canadians, whether real or not, there is a strong sense of a perceived inability of the Canadian health care system to address the perceived bariatric surgical needs and/or desires of obese Canadians. While this particular project did not seek to assess the actual versus perceived clinical need for bariatric surgery for each participant, the fact that it appears that some obese Canadians are of the belief that the system is not addressing their specific bariatric needs is an area in which future research should more critically examine. This could allow policy makers to better determine any actual gaps or failings in service delivery for these individuals.

Second, across the thesis it is clear the level of importance the role of the family physician plays in supporting patients in bariatric tourism, whether actively or through their referral networks. As family physicians in Canada act as gatekeepers to more

specialized care (Health Council of Canada, 2010; Chan & Austin, 2003; Romanow, 2002), the role of the family physician appears to be key, both in supporting patients in their desire to address their weight-related health through a surgical solution and in working through the challenges associated with care and aftercare obtainment. Furthermore, the active role of the family physician appears to optimize positive health outcomes for patients both clinically and psychologically, as illustrated in both Chapters 2 and 3.

Finally, throughout the thesis, patient reliance on the internet as a source for information seeking and support was also highlighted. Information found on the internet, often quite anecdotal, was pervasive in shaping the experiences discussed in this thesis. Testimonial experiences of previous bariatric tourists weighed heavily in further entrenching patients' decisions to circumvent Canadian structural barriers and consequently seek care abroad. Furthermore, the sheer number of bariatric support networks found online and the volume of information quite often further heightened risks to patients' health. This form of information seeking appears to be especially problematic in the case bariatric tourism as it appears that this information is serving as a substitute for comprehensive follow-up care from medical professionals specializing in bariatric care.

In regard to bariatric surgical services in Canada, it is important to note that the sample population represented in this thesis research is in line with Canadian statistics of the typical patient seeking surgery domestically, averaging 45 years of age and female (Canadian Institute for Health Information, 2015). My sample similarly reflects this with 90% of the sample being female, with a significant portion of the participants between the ages of 40 and 50. Despite these similarities between the populations, one clear difference between these two groups (i.e. those able to access bariatric services in Canada and those unable to) stands out. As highlighted by participants, the majority of my participants identified as being too small (albeit still obese) to qualify for surgery in Canada. This highlights that there appears to be nothing especially different about the demographic that is seeking surgery internationally, as opposed to in Canada, apart from BMI status. Thus, the challenges in qualifying for and access to care outlined in Chapter 2, and to a certain extent, Chapter 3 appear to drive bariatric tourism by Canadians; this is distinct from factors typically associated with other forms of medical tourism, such as cost savings and/or lengthy wait times domestically. This highlights that

many Canadians seeking bariatric surgery abroad don't appear to be operating under the same drivers typically seen in other cases of medical tourism and the domestic BMI cut-off requirement are serving as a unique driver of medical tourism for bariatric services. Future research should examine this particular driver more critically as a means of addressing the potentially negative health and financial outcomes the practice of bariatric tourism in Canada may impose.

## **4.3. Study Significance**

### **4.3.1. Strengths of this Study**

This thesis research contains several strengths in its contributions to the existing body of literature in the fields of medical tourism and bariatric health services within Canada. First, findings from my thesis research achieves the overall goal undertaken in this study: to conduct an exploratory study of first-hand accounts of the Canadian patient experience in bariatric tourism. To my knowledge, no such qualitative studies have been undertaken within a Canadian setting with the intention of developing a rich understanding on the overall patient experience. Previously reported quantitative data, such as on the financial burden of complications resulting from bariatric tourism for the province of Alberta (Kim, Sheppard, de Gara, Karmali & Birch, 2015; Birch, Vu, Karmali, Stoklossa & Sharma, 2010; Sheppard, Lester, Karmali, de Gara & Birch, 2014; Sheppard et al., 2014), does not present the full picture of this practice, nor does it foster an understanding of the frustrations felt by Canadians that lack access to bariatric care in Canada. Therefore, a strength of this study is that it allowed us to start a critical discussion of this practice, specific to some challenges experienced within Canada. This is especially the case in care obtainment both before and after travel that was not captured by the limited quantitative data that has been previously produced with a specific focus on Canada. Research within the Canadian context has now captured an understanding of the financial burden the practice of bariatric tourism can impose on the Canadian health care system and an understanding of the experience of Canadian patients seeking this care both within Canada and abroad. Both of these add important pieces to the puzzle of fully understanding this phenomenon, however more research within the Canadian context needs to be conducted before informed policy decisions can be reached.

This thesis project also demonstrates the usefulness of broadening previous understandings and conceptualizations of the concept of circumvention tourism as a framework for examining cases of medical tourism for specific surgeries and/or procedures. As described in Chapter 2, previous applications of this concept have mostly surrounded the domestic and international legality of the procedures being sought through medical tourism (Cohen, 2015). However, as this thesis illustrates, applying a framework of circumvention can also be useful in cases where regulatory and administrative barriers restrict access to care. Novel application of this framework to examine participants' motivations to seek care abroad worked to strengthen and nuance our previous understandings of both the scope of circumvention tourism and implications of bariatric tourism for Canadian patients' access to care. By broadening the scope of circumvention tourism to include such cases as the one illustrated in this thesis, we can extend our understandings of the implications beyond the concerns of legal ramifications and moral dilemmas raised in our previous understandings of circumvention tourism (Charo, 2016; Cohen, 2015; McGuinness & McHale, 2013; Sethna & Doull, 2012; Bergmann, 2011). For example, through extending our previous understandings of circumvention tourism and applying it to this case, we achieved deeper insights of potentially unintended consequences of participants' circumvention behaviours though consideration of concerns and challenges previously identified in the circumvention tourism literature, such as the further entrenchment of barriers restricting access to care and exacerbated risks to patients health by the bypassing the domestic regulations set in place to protect overall patient health.

Finally, a significant strength of my thesis project was the methodological rigour that was established through consistent collaboration with the supervisory committee in including different viewpoints throughout the study design phase, data collection, and analysis. Given that my thesis project undertook a strictly qualitative analysis, establishing this rigour was critical to minimizing the potential research bias and enhancing reliability of the findings (Mays & Pope, 1995). In their 1995 paper, Mays and Pope outline several critical strategies for qualitative researchers to help ensure rigour is appropriately established in strictly qualitative research. These strategies pertain to methodological concerns regarding validity, reliability and generalizability of qualitative findings (Mays & Pope, 1995). As a young researcher, I found these strategies were clear and easily applied to my research during the planning and data collection phases

of my thesis project. To establish rigour in participant recruitment, strict and narrow eligibility criterion were selected to ensure sampling of a group of informants with specific lived experiences of engaging in bariatric tourism, rather than a representative sample of the Canadian population (Mays & Pope, 1995). Through this form of recruitment, depth of experience was achieved to allow for meaningful discussion of participants' experiences of engaging in this practice. When conducting the analysis, reliability in the coding of the data was achieved first through an individual reading of interview transcripts and then, second, through a team collaborative process of reading and untangling emerging themes (Mays & Pope, 1995). This process allowed for reliability and rigour to be established through consensus among the team regarding key themes through the consideration of differing viewpoints and ideas.

Consistent researcher reflexivity throughout the research process regarding my positionality in relation to my participants allowed for consideration of the ways I related to my participants and the ways in which this relationship may be shaping the interviews and data being collected. Acknowledging this also helped to foster rigour throughout my thesis project. However, while I maintained this conscious reflexivity throughout the research process, there may still be some researcher bias that may have been introduced to the study. This will be discussed in the limitation subsection below.

#### **4.3.2. Overall Limitations**

While this thesis research does contain significant strengths, as described in the previous subsection, it is not without limitations. As discussed in more detail in the limitation subsections of both Chapters 2 and 3, the sample recruited in this study was likely subject to sampling bias. Reasons for such bias include: heavy reliance on snowball sampling in participant recruitment, lack of diversity in destination countries due to all participants receiving their respective surgeries in Mexico, and lack of nation-wide perspective diversity due to potential over-representation of participants living in Canada's western provinces at the time of seeking surgery. The majority of participants underwent surgery between 2010 and 2015 (2008: n= 1; 2010: n=2; 2011; n=6; 2012; n=3; 2013: n= 3; 2014: n= 1; and 2015: n=3; 2016: n=1). During 2012-2013, the number of bariatric surgeries performed in Canada dramatically increased from previous years. This is likely reflective of increased surgical capacity in Ontario (Canadian Institute for Health Information, 2015). Given the rapidly changing bariatric landscape in Canada and

that many of my participants had their surgeries performed before the 2012-2013 changes in surgical capacity in Canada findings from this thesis may be very likely affected. In particular, patients seeking care abroad may experience slightly different barriers in attempting to seek surgery now in Canada, as opposed to in 2010-2011. For example, patients unable to obtain their desired surgeries locally in 2010 due to lack of funding or local availability, may not experience these challenges now if availability has changed in their local area. However, it is unknown if this would indeed be the case.

In addition to these limitations, additional limitations remain within this thesis research as a whole that must be acknowledged. First, I was unable to recruit more than two participants that experienced any major complications that required hospitalization in Canada as a result of the surgery that was obtained in Mexico. As Canada does not collect statistics on medical tourism, there is no way of knowing for certain if this complication rate is representative of the actual rate of complication within Canadian bariatric tourists or if it is being over or under-represented here. It appears to be an under-representation as one study did estimate the complication rate among Canadian bariatric tourists to be 56.1%, but this study was limited to a survey of physician estimates and only in the province of Alberta (Sheppard et al., 2014), so this too may not reflect the true complication rate.

The relatively low level of major surgical complications present in my study may be reflective of a bias due to willingness to participate, meaning that participants may have been more likely to participate and share their stories with me if they had a positive experience with bariatric tourism. Given the highly stigmatized nature of bariatric surgery and the social perception of the surgery as being the 'easy way out' of obesity, participants with negative experiences of bariatric tourism may have been less likely to share their experiences. Also, given the extensive pre-operative evaluation program required in Canada, individuals with a higher risk of experiencing complications, potentially due to their BMI or associated co-morbidities, may have been denied for surgery in Canada for this very reason. Capturing experiences of these individuals in this thesis research may have introduced additional barriers in access to care or potential health and safety risks not considered in this research project.

A final limitation of my research implications must be recognized due to my positionality as the researcher. As I have a strong passion for the viability of bariatric

surgeries as an option for all obese individuals, including for those for whom diet and exercise has been ineffective in reducing their weight and related negative health conditions, I developed an emotional reaction to my participants' experiences. As a result, I was particularly sensitive to stories related to loss of hope and frustrations with the lack of options from being denied access to surgery and/or referrals to aftercare in Canada. These stories highly informed my analysis and my desire to highlight challenges in access to care and aftercare for this population. My experiences with and perspectives on this topic informed my research questions, interactions with my participants, and the lens through which I analyzed my data. While my analysis may have differed had I not experienced this emotional reaction to my participants' stories, I believe the perspective I brought to this research enabled me to present multiple challenges and struggles facing this particular population. This focus complicates existing discussions regarding Canadians' participation in medical tourism and provides a direction for future research and policy regarding improved access to bariatric surgery for Canadians who do not currently qualify for care.

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

A number of knowledge gaps related to this thesis research remain. First, Canada does not track the outflow of medical tourists from Canada. Therefore, it continues to remain unclear to what extent this practice is occurring among Canadians, the impact it is having on provincial health care systems, and the long term consequences, both positive and negative, this practice holds for patients' physical and mental health. Chapter three of this thesis did identify a number of challenges and potential health and safety risks patients may be exposed to when engaging in international bariatric tourism, these risks may have been under-represented in this thesis project as the participants largely had very positive experiences. Other negative repercussions to patient health may be occurring in individuals that may have had a more negative experience with bariatric tourism and not captured by this thesis project. Furthermore, while this exploratory study has provided some qualitative evidence to suggest there are deficiencies in the system that are driving patients abroad, more robust nation-wide data on the outflow of Canadians for health care in the global healthcare marketplace for specific procedures, such as bariatric surgery, could help

public health professionals and policy makers in Canada better identify regions in which bariatric surgical services are not meeting patient need.

A significant knowledge gap that became clear over the course of my research is the lack of clarity in the role family physicians can, and should, play in a patient's bariatric care experienced through medical tourism. Participants consistently identified a lack of physician knowledge and support as a key barrier to: 1) accessing care in Canada; 2) having a robust pre- and post-travel care plan; and 3) verifying the credibility of information obtained over the internet. The patient perspectives highlighted in this thesis project appear to indicate that patients' outcomes, both clinically and psychologically, seem to be better when they did not face the challenges associated with a lack of support from their family physicians. While family physicians in Canada do not provide direct medical support for bariatric surgery, whether it is obtained domestically or internationally, they do act in a gatekeeper role to access to more specialized bariatric services through their referral networks (Health Council of Canada, 2010; Chan & Austin, 2003; Romanow, 2002). Future research in this field should attempt to facilitate discussion and education with family physicians around their support of Canadian bariatric tourists.

Finally, it remains unclear if Canada should continue to follow the current eligibility requirements for publicly funded surgery or whether these requirements need to be reassessed. Many of these requirements, such as the BMI criteria, were originally conceived based on understandings of best clinical practice in bariatric surgery in 1991 and to foster the greatest level of success with the surgery (National Institute of Health, 1991; Christou & Efthimiou, 2009). The potential to revisit the BMI guidelines currently being practiced is a topic of debate in the literature, especially in regard to patients with lower BMIs who also have a severe level of Type II Diabetes (Segal-Lieberman, Segal & Dicker, 2016; Ryan, 2012; Senger, 2011). Empirical evidence is now coming forth of the higher potential for long term success of Type II Diabetes remission in younger patients with much lower BMIs (Segal-Lieberman, Segal & Dicker, 2016; Ryan, 2012). Advancements in bariatric procedures, including new forms of bariatric procedures designed for individuals with smaller BMIs and the ability to perform the majority of these procedures laparoscopically may indicate that individuals that do not meet current eligibility requirements may also be likely to have high success with these bariatric surgeries. Many of the participants in this thesis research were considered 'too small' for

publicly funded surgery and yet, discussed a very high degree of success with the surgery, often reducing their weight significantly and eliminating weight-related co-morbidities. Furthermore, additional evidence has also come forward since 1991 of the success and appropriateness of having additional guidelines beyond simply BMI status and a history of failed weight loss attempts (Yermilov, McGory, Shekelle, Ko & Maggard, 2009). This research suggests having more comprehensive guidelines that critically examine the patient's age, BMI, weight-related co-morbidities, readiness for surgery and any other health indicators that would affect their success with the surgery on a more holistic basis as opposed to simply based BMI cut-off points ((Yermilov, McGory, Shekelle, Ko & Maggard, 2009). Health care professionals and policy makers should conduct future research to examine if these eligibility requirements still represent best clinical practice. If this research continues to illustrate the effectiveness of potentially changing these requirements, some of the financial complications imposed by bariatric tourism on the Canadian health care system may be curbed.

## **4.5. Conclusion**

In conclusion, my thesis research was successful in achieving what it sought to conduct: an exploratory qualitative examination of the previously poorly understood Canadian patient experience of engaging in bariatric tourism. As obesity continues to rise globally, and within Canada, bariatric surgery as a viable option to reduce the burden of elevated weight and weight-related negative health conditions on both patients and the Canadian health care system continues to need critical examination. This thesis research illuminated the strong desires of obese Canadians to improve their health through bariatric surgery when years of diet and exercise have remained ineffective. However, insights drawn from my thesis point to significant challenges Canadians are facing in accessing bariatric surgical services in Canada, as well as heightened risks to their health and safety as a result disrupting their weight-related care in Canada and obtaining care abroad. Through the analyses presented in this thesis, this research builds on existing conversations and identifies new areas for research regarding the implications, risks, and (potential) success of bariatric tourism for Canadians.

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## Appendix A.

### Abstract for Manuscript Chapter 2

**Background:** Medical tourism is a practice where patients travel internationally to purchase medical services. Medical tourists travel abroad for reasons including costly care, long wait times for care, and limited availability of desired procedures stemming from legal and/or regulatory restrictions. This paper examines bariatric (weight loss) surgery obtained abroad by Canadians through the lens of ‘circumvention tourism’ – typically applied to cases of circumvention of legal barriers but here applied to regulatory circumvention. Despite bariatric surgery being available domestically through public funding, many Canadians travel abroad to obtain these surgeries in order to circumvent barriers restricting access to this care. Little, however, is known about why these barriers push some patients to obtain these surgeries abroad and the effects of this circumvention.

**Methods:** Semi-structured phone interviews were conducted with 20 former Canadian bariatric tourists between February and May of 2016. Interview questions probed patients’ motivations for seeking care abroad, as well as experiences with attempting to obtain care domestically and internationally. Interviews were digitally recorded, transcribed verbatim, and then thematically analyzed.

**Results:** Three key barriers to access were identified: (1) structural barriers resulting in limited options for which specific procedures were available locally; (2) strict body mass index cut-off points to qualify for publicly-funded surgery; and (3) the extended wait-time and level of commitment required of the mandatory pre-operative program in Canada. It was not uncommon for participants to experience more than one of these barriers while some participants reported experiencing all three.

**Conclusions:** Collectively, these barriers restricting domestic access to bariatric care in Canada may leave Canadian patients with a sense that their health care system is not adequately addressing their specific health care needs. In circumventing these barriers, patients may feel empowered in their health care opportunities; however, significant concerns are raised when patients are circumventing these protections built into the health system. Given the practical limitations of a publicly funded health care system, these barriers to care are likely to persist. Health professionals and policy makers in Canada should consider these barriers in the future when examining the implications medical tourism for bariatric surgery holds for Canadians.

## Appendix B.

### Abstract for Manuscript Chapter 3

**Background:** Bariatric (weight loss) surgery has experienced increased popularity among obese Canadian adults struggling with weight loss through traditional programs of diet and exercise. However, many structural and administrative barriers exist in Canada that lead to difficulties in domestic access to this type of surgery. Consequently, many obese Canadians seek this care abroad through the practice of medical tourism, i.e. international travel to privately purchase medical care. While researchers have identified many of the challenges and associated health and safety risks imposed on patients by engaging in medical tourism generally, little is known about the specific challenges experienced by Canadians seeking bariatric surgery abroad. This paper addresses this knowledge gap and identifies any health and safety risks these challenges may introduce or exacerbate.

**Methods:** Between February and May of 2016 semi-structured interviews were conducted by phone with 20 former Canadian bariatric tourists. The interviews probed subjects related to experiences attempting to access bariatric surgery in Canada, decision-making processes, information sources consulted, and experiences with aftercare upon return to Canada. A thematic analysis was conducted of the recorded interview transcripts.

**Results:** From the interviews, three main themes emerged that pose challenges in bariatric care obtainment including: (1) stigma and isolation from friends, family and medical professionals; (2) Self-directed navigation of domestic and destination health care systems; and (3) challenges with obtaining adequate follow-up care in Canada. Participants discussed experiencing one or all of these challenges. Heightened health and safety risks related to inadequate information seeking and (dis)continuity of care most commonly resulted from these challenges.

**Conclusions:** While the challenges identified by participants may occur in other forms of medical tourism, it appears that these challenges are occurring in simultaneously in cases of bariatric tourism by Canadians. These challenges work in conjunction to heighten the health and safety risks potential Canadian bariatric tourists may be exposed to. Unless structural changes occur to increase domestic availability of bariatric surgery, Canadians are likely to continue seeking this care abroad. Future research should examine avenues through which to support patients and mitigate these health and safety risks.

## Appendix C.

# Semi-Structured Interview Guide for Participant Interviews

### Medical Tourist's Experiences with travelling abroad for Bariatric Surgery Semi-Structured Interview Script

- Complete verbal consent script
- Begin recorder

#### **Background:**

- First, I have a few questions about your background:
  - How long have you lived in Canada?
  - What age category are you in?
    - Under 20
    - 20-30
    - 30-40
    - 40-50
    - 50-60
    - 60 or older
  - Which gender do you identify as?

*In this section I would like ask a few questions about your experiences in seeking bariatric care in Canada.*

- How long have you experienced weight related health concerns?
- What prompted you to seek bariatric surgery to improve your health?
- What have your experiences been with accessing bariatric care in Canada?
  - Have you ever received weight-related medical care in Canada? What kind? What was your experience?
  - Who did you speak to regarding such care?
  - Did you experience any barriers to receiving this care in Canada?
  - Did you experience a wait time in Canada for bariatric care? If so, how long was it?

*In this section I would like to ask a few questions about your experiences receiving care abroad.*

- What was your motivation for going abroad for care?
- I would like to ask some questions about your trip abroad for medical care:
  - To where did you travel? When?

- How did you decide to travel to this country?
  - What information sources did you consult?
  - What advice did you receive when deciding where to travel?
  - Did you use a medical tourism facilitator?
  - Did you consult with medical professionals within Canada about traveling abroad for care?
  - How important was cost when deciding where to receive care? What other factors influenced your choice?
- What surgery did you receive?
  - How did you decide what type of surgery to receive?
  - Do you know if your surgery was performed laparoscopically or through open surgery?
  - Was the surgery you received abroad the same as the treatment you would have received if you had had the surgery performed in Canada?
- Can you tell me about your experience abroad?
  - What were your impressions of the clinic/hospital and the surgeon/staff?
  - What did you like about the care you received abroad?
  - What concerns did you have, if any?
- Did you travel with anyone when receiving care?
  - If so, who and how was this decision made?

*In this section I would like to ask you about your health care experiences upon returning home post-treatment.*

- Did you travel with your medical records?
  - Were these records kept up to date between your surgeon abroad and your health care professional in Canada?
  - Did your home and destination care teams exchange records or any other medical information or communicate in any other way?
- Did you encounter any problems with your primary health care professional in Canada upon your return to Canada?
  - With your delivery of care?
- Did you experience any medical complications upon your return to Canada?
  - If so, of what nature?
    - Were you hospitalized with these complications?
    - What were your experiences like obtaining care for these complications?
- What were your experiences with follow-up care when you returned to Canada?
  - Which health care professionals did you consult with?
  - How long did you continue follow-up care with each of these professionals?
  - How about a (dietitian/nutritionist; psychologist)?
    - Were you informed about any dietary restrictions that your surgery may now pose or of any vitamin supplementation you would now have to follow?

- Did you have any problems with following these recommendations?
- How about social support during your recovery or upon returning home?
  - Did your friends and family know you had had the surgery?
  - Did you join any other support networks or groups following your surgery?
    - What were your experiences with these networks?
- In general, how do you think your experience of receiving bariatric surgery abroad was different that it would have been had you received this care at home?
  - Would you change anything knowing what you know now?
  - What advice do you have for those considering bariatric surgery abroad?

**This brings me to the end of the questions I have. Is there anything you would like to revisit or add that we have yet to touch on?**

- End recorder
- Record information for honorarium payment