6 Exceptional Aspects of the Experiences of Canadian Medical Tourists from Patient Narratives

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INTRODUCTION

For the past several years we have been researching Canadians’ involvement in medical tourism, defining medical tourism as the practice of intentionally traveling outside of one’s country to access privately paid for and arranged care (Bookman & Bookman, 2007). Our work to date has involved conducting interviews and focus groups with several key stakeholders, including Canadian medical tourists, medical tourism facilitators, family doctors, and patient health and safety officials. While Canadians have typically been thought to participate in medical tourism out of frustration with wait times for care within Canada (Snyder, Crooks, Johnston & Kingsbury, 2011), our research has confirmed that access to treatments not performed in Canada and cost-savings for elective treatments not covered by public Medicare are also powerful motivators. Our studies have also shown that, while Canadians do rely on the Internet to research and arrange for care abroad, the idea of medical tourism is often sparked by conversations with other Canadians who previously went abroad. This word-of-mouth knowledge is also a powerful source of the confidence they have for the skills of particular surgeons abroad.

We have looked to the scholarly and popular literature to assist us in interpreting the findings of our focus groups and interviews and in doing so have found that certain types of ‘patient narratives’ dominate. These narratives often emphasize patient empowerment and choice, access to improved quality and/or affordability of care, and the novelty of travelling to exotic foreign locales as common features or trends among the patient experience (e.g. Choat, 2003; Ehrbeck, Guevara, Mango, Cordina & Singhal, 2008; Law, 2008; Prashad, 2008). While our research has, for the most part, confirmed the relevance and centrality of these common features to Canadian medical tourists’ experiences, we have also learned about experiences that are very unique and fall completely outside the scope of current knowledge. In this chapter
we present five vignettes that bring forth uncommon or exceptional aspects of particular Canadian medical tourists’ experiences, wherein they deviate in unexpected and important ways from the commonly-reported features of medical tourists’ experiences. Recognizing the value of giving voice to experiences that do not fit with the typical trajectory, these exceptions highlight a range of issues that raise questions and offer caveats to the many generalizations and conspicuous absences that are found in current popular and academic discussions of how a medical tour unfolds.

The five vignettes we share below are drawn from semi-structured phone interviews with a larger sample of 32 Canadians who underwent surgical care abroad. These 90 minute, digitally recorded interviews explored participants’ decision-making processes regarding access to care abroad and their experiences in both the Canadian and non-Canadian health systems. All medical care was obtained outside of Canada and had been privately purchased and arranged, and interviewees were 18 years or older at the time they spoke with us. Following data collection, all interviews were transcribed verbatim and coded thematically using a scheme that included both inductive and deductive codes and that was created through an iterative process of transcript review and team discussion and feedback. The vignettes shared in this chapter were initially noted by the interviewer and data coder, who is the lead author, as being exceptional in deviating from the more standard narratives. This interpretation was confirmed by the other team members.

While the experiences recounted amongst our 32 participants varied widely, most of their narratives had similar decision-making trajectories, comparable outcomes, lasting impressions and common decision making supports such as doctors abroad and other medical tourists. The majority were spurred to consider going abroad for medical care in the face of needing treatment that was not available to them locally or being assigned to a wait list. Only two participants were compelled to go abroad solely by cost. All participants but one researched and arranged their care abroad prior to departure, and all but one were seeking elective care that was typically viewed as needed but not immediately urgent. Research by patients was primarily mediated by the websites of destination hospitals and forums of former patients. Most participants did not use medical tourism facilitators (i.e., agents who make
bookings for international patients) to arrange for their care abroad. Of those that did, only one had a negative experience. By and large, the participants perceived their journeys to be driven by medical necessity, and only included tourist activities as an afterthought or minor add-on, if at all. A slim majority of participants were accompanied by a partner, family-member, or friend as a caregiver-companion. These companions were seen as indispensable supports by those they were accompanying, and often played the role of the tourist while their partner was recovering. Finally, all but one participant were very pleased with the quality of their procedures abroad, even amongst those that experienced complications.

In the following sections each vignette will be presented, followed by a discussion highlighting its significance. The vignettes included here describe the experiences in our dataset that sharply depart from the norm at some point in their recounting. In doing so, their exceptional elements help to illustrate points at which some standard narratives that surround medical tourism break down, revealing important lessons that may go undetected if not highlighted. While none of the vignettes are composites, the names and some non-essential details of participants have been altered to protect their anonymity. Following the vignettes, a short concluding discussion will be offered that draws together the implications of what we convey in the five unique cases for future medical tourism research.

**JOLENE’S VIGNETTE**

Jolene is a retiree in her late fifties. She is in poor health and managing a number of chronic illnesses, including diabetes, depression, and arthritis. Jolene was faced with a lengthy surgical wait list of over two years for an orthopaedic intervention in Canada that could help address her increasingly painful arthritis. Wracked with chronic pain so severe she lay awake many nights, and urged on by her husband, Chris, Jolene was eventually compelled to look into accessing surgery outside of Canada so that she could receive treatment sooner. She began looking at her options in spite of her own inclination to both save money and remain in solidarity with other Canadians by waiting to receive care within Canada.\(^2\)
Chris’ idea for Jolene to access care abroad originated with him seeing an advertisement for a medical tourism facilitation company that was posted in *Maclean’s*, a popular Canadian news magazine. Jolene initially contacted the facilitator and made basic inquiries about where orthopaedic surgery was available and how much it would cost. She then waited to hear back if she was a candidate for surgery, after having shared with the facilitator the details of her health status. The facilitator got back to her within the week to let her know she was a candidate for surgery, and that they could arrange for the care either in India or Costa Rica. Fancying herself a bit of a traveler, she chose to go to Costa Rica because she believed it had greater tourism opportunities suited to her interests. She booked her surgery the following month, planning a three-week stay. At this point, the facilitator made a proposition to Jolene. If she were to help him promote his company’s services and medical tourism on a broader scale by agreeing to be interviewed by Canadian media outlets, he would secure her and her husband an upgrade for the recovery portion of their trip by booking them a stay at a 5-star hotel, up from a 3-star, at no extra charge. However, this upgrade was contingent on Jolene agreeing to ‘blame’ the Canadian healthcare system for her decision to go elsewhere, insisting she must offer herself and her story up as a symptom of a failing system.

The facilitator’s proposal posed a serious ethical conflict to Jolene. On the one hand, she already felt that she was forsaking the ethic of solidarity that underpins the Canadian healthcare system by privately seeking care abroad, and the idea of disingenuously pillorying the Canadian system for the facilitator’s benefit was unappealing to her. On the other hand, she did feel mistreated by the lengthy wait list in her home province that negatively impacted her quality of life by prolonging her exposure to severe pain, and hoped to let others know of the option of care abroad. She ultimately agreed to use the facilitator’s prefabricated rhetoric in the testimonial she provided for news reporters in interviews that were arranged by the facilitator.

Jolene found her experience of accessing surgery in Costa Rica to be excellent, and was especially pleased by the patient-centric care and the quality of services available at the hospital she visited. Regardless, Jolene and her husband found themselves exhausted and homesick by the end of two weeks in the hospital. They chose to forgo a third week recuperating in a resort as was initially planned, instead returning to Canada as soon as she left the hospital.
Interestingly, although Jolene provided her story to Canadian reporters before leaving, the deal offered by the facilitator to upgrade their accommodations was never mentioned again, let alone fulfilled. Neither Jolene nor her husband felt it was appropriate to confront the facilitator and push for the upgrade they were promised, especially given her reticence to provide the ‘groomed’ testimonial in the first place, so they quietly let the promise go unfulfilled.

**Significance**

Jolene was one of the few people we spoke to who used the services of a facilitator to access a non-experimental surgery abroad. Her story is unique because of the offer made to her by the facilitator, and the ethical dilemma she faced in deciding whether to take part in it. We have not shared Jolene’s account to suggest widespread misconduct among medical tourism facilitators. Rather, we raise it to provide a potent illustration of how the lack of any professional regulatory body that enforces common standards or codes of conduct for those working in the industry (Penney, Snyder, Crooks & Johnston, 2011; Snyder et al., 2011) are implicated in allowing the unprofessional behaviour demonstrated by Jolene’s facilitator.

**TIM’S VIGNETTE**

Tim is a middle-aged man employed full-time in a moderately physically-demanding job. He experienced a gradual and prolonged decline in his health over many years, a process that began in his mid-twenties. His energy levels fluctuated regularly in this period, culminating in a feeling of chronic exhaustion and low blood oxygen levels for a number of years. During this time, Tim had access to many rounds of diagnostic testing in his home province to try and locate the source of the problem, but the specialists assigned to his case could not come up with a diagnosis or an effective course of treatment.

While Tim was frustrated with the lack of progress in treating his symptoms, his partner Cynthia was even more so. She was aware of the option of care abroad from working in the health field and hearing about alternatives from her co-workers. Cynthia suggested getting a second opinion from a private hospital in the US, but Tim was comfortable leaving his case in
the hands of his regular doctors as he was still managing to meet the demands of work and home life. Tim’s health nonetheless continued to slowly worsen.

Tim’s condition continued to deteriorate and ultimately resulted in him waking at night breathless and struggling to walk around his house and workplace without becoming short of breath. Despite this, he did not aggressively pursue a diagnosis or treatment. Cynthia continued to suggest going abroad for care for almost two years, and Tim continued to refuse. His attitude shifted abruptly when he fainted while at work. With both Tim and Cynthia believing he was on the verge of reaching a point of irreparable damage or death, Cynthia immediately arranged for a trip to the US to hear a second opinion in hopes that Tim would finally be diagnosed and treated. Tim gladly went along with her plans. After the arrangements were made, the two departed within two days for what ended up being a three week stay at a widely known and regarded private hospital. The speed of their exit was aided by Tim’s family physician, who supplied the files of his case history immediately upon request.

The care Tim received at the private hospital was prompt, and within two days the root cause of the problem that his specialists at home had been unable to locate for years was found and the course of treatment was determined. Tim underwent surgery to resolve a spot of slow, constant internal bleeding. He spent a little over a week recovering there, with Cynthia joining him. The CAN$20,000 cost of the surgery was considerable but the couple did not hesitate in selling a piece of property they owned to pay the medical bills, nor did they regret their decision to seek private care afterwards. Tim credits his ‘life being saved’ to the efforts of his partner, without whom he would not have thought about going abroad, made the arrangements, nor been able to bear the emotional distress.

Significance

Tim’s story differed from the other medical tourists we interviewed because of the perceived immediate severity of his condition. While the rest of our participants were clearly seeking elective treatments, Tim and his partner Cynthia perceived his condition to be an emergency and had lost faith in their healthcare system’s ability to diagnose the problem and deliver the necessary care. The speed at which they arranged and travelled for care in the US reflects this, as does Tim’s lasting belief that he would have died had he remained within his
provincial system. We have chosen to highlight Tim’s account to demonstrate the variety of motivations and conditions that compel people to seek care abroad. While medical tourism is often characterized in a nonchalant fashion by media headlines like “Sun, Sand and Surgery,” those identified as medical tourists also include patients who see their care abroad not only as medically necessary, but sometimes also as an emergency.

EMMA’S VIGNETTE

Emma is a middle-aged woman who engages in part-time volunteer work. She has had MS for many years and leaped at the opportunity to access chronic cerebro-spinal venous insufficiency (CCSVI) treatment, or ‘Liberation Therapy’ as soon as she heard about its availability. As the treatment is experimental and currently unavailable in Canada, Emma and her husband, Matthew, looked at their options abroad through conducting their own research online. Matthew and Emma did not have means to pay for the $20,000 treatment, but were willing to mortgage their home to receive care they saw as integral to slowing the course of Emma’s MS.

Neither Emma nor her husband had ever traveled outside of Canada or the US before, and quickly found the prospect of arranging for travel, visas, accommodation, and medical care overwhelming. The perceived complexity compelled them to seek assistance from a Canadian medical tourism facilitator. Once in touch with the facilitator, Emma and Matthew agreed to all the planning decisions the facilitator made for them and relied exclusively on the information provided to them by the facilitator about the hospital, surgeon, and treatment. As Emma remarked, they traveled to India because “that’s where [the facilitator] sent us.” Upon deciding to go, Emma informed her neurologist of her decision to go abroad to India for the CCSVI procedure. While the neurologist was wholly unsupportive of her decision, he did agree to provide a statement of Emma’s condition to give to her Indian surgeons.

Upon arriving in India, Emma and Matthew went directly to the hospital. Having never left North America before, they felt overwhelmed by the long-haul travel and the striking cultural and material differences between India and Canada. While they had initially intended to
incorporate tourist excursions and a resort recovery following the surgery, Emma and Matthew spent the entirety of their three week trip at the hospital. Matthew had accompanied Emma with the understanding that he would be providing supportive care throughout the trip. However, soon after Emma’s surgery, Matthew experienced a flare-up of an existing chronic condition and required surgery himself. In this same period, Emma experienced a heart attack and required prolonged hospitalization. Due to these unexpected health problems, especially given their severity, Emma and Matthew’s plans to tour and recover in relative luxury were dashed.

In spite of the unexpected twists in her trip, Emma remains adamant that seeking care abroad was the best course of action, given the unavailability of CCSVI treatment in Canada. She bears her care providers in India no ill will, does not hold them liable for her complications, and feels she received excellent care throughout her stay.

**Significance**

Most of the Canadian medical tourists we spoke with reported having had no complications related to their surgery, either at the time of their trip or after returning to Canada. Of those that did report experiencing complications, Emma’s story was unique. The severity of the complications that both she and her partner experienced were striking, and serves to underscore the very real risks faced by medical tourists and their caregiver-companions. While the flare up of Matthew’s chronic condition cannot be directly linked to the physical stress of unfamiliar travel and surgery, the added layer of complexity posed by the distance and isolation where the couple experienced the complications poses a unique risk in itself. The unexpected surgery Matthew underwent brings the role of the caregiver-companion to the forefront. Caregiver-companions are relatively invisible figures in current discussions of medical tourism, despite their often considerable roles in helping to arrange for care and in assisting medical tourists while abroad. Matthew’s own experience is a reminder that the kinds of risks faced by caregiver-companions are shaped, and also may be complicated, by their novel environments. This case raises important questions regarding the types of stressors to physical and mental health caregiver-companions may be exposed to when assuring the care recipient’s wellbeing in a foreign environment.
MOLLY’S VIGNETTE

Molly considers herself to be an adventurous person, and takes international vacations regularly. While on an extended trip to Malaysia with her boyfriend Terence, she met Samantha, a friend of a friend who had recently undergone breast augmentation from a local surgeon. Molly had been considering having her breasts augmented, and was familiar with what the surgery entailed and its typical cost in Canada from casual research she had done online in the past. She took the opportunity to ask Samantha detailed questions about her experience with the surgeon and the surgery in Malaysia. Excited at the prospect of saving thousands of dollars and the purported skill of the surgeon, Molly contacted the clinic within a day of talking with Samantha and arranged for a consultation.

At the consultation, Molly was set at ease and was impressed by the surgeon’s confident attitude and the orderly, sterile appearance of the clinic. Most concerned with the symmetry and natural appearance of her breasts following surgery, Molly was thrilled by the photo album of previous patients’ post-surgical bodies, all of which showed outcomes she thought desirable. Motivated by the combination of cost savings, perceived surgical expertise, and recovery time that her remaining two weeks of vacation offered, Molly booked the surgery for later that week.

As the breast augmentation was offered as a day surgery, Molly went back to her hotel room with Terence after it was complete. She went to bed as soon as they returned, as she was groggy from the anaesthesia and found that her breasts were very sore. Later that night, Molly awoke in extreme pain. Alarmed by the severity of her discomfort, she woke her boyfriend. They quickly discovered that one of her breasts was swelling alarmingly. Both Molly and Terence grew very worried, and he called the surgeon on his personal cell phone to alert him of the situation. The surgeon told Molly to come back to the clinic right away, so her boyfriend drove her there in the middle of the night. On the way to the clinic, their car hit a bump and caused a suture in the swollen breast to tear, spilling blood all over Molly. At this dramatic sight, Terence grew panicked at the thought that Molly might die. Meanwhile, Molly
tried her best to keep pressure applied to the haemorrhaging breast for the remainder of the
drive. Molly’s complications were dealt with at the clinic that night with no further issues
arising, although she extended her vacation a week to allow herself more time to recover from
the surgery.

Despite experiencing a dramatic complication, Molly remains pleased with her decision
to access cosmetic surgery abroad. She advises that others who choose to have surgery while
already on vacation should be aware of the exhaustion that can accompany recovery, and to
not anticipate a high energy trip after surgery.

**Significance**

Molly was the only medical tourist we spoke to who decided to have her surgery done
while she was already abroad as opposed to planning it prior to departure. Other medical
tourists or their caregiver-companions did report having additional treatments or diagnostic
tests unrelated to their planned surgeries done while they were abroad, but Molly was unique
in seeking an impromptu surgery while she was on vacation. Seeking care in this manner clearly
excludes any pre-operative input from a patient’s domestic physicians, and raises concerns
around both continuity of care and adequate preparation for surgery. Additionally, Molly’s
account of her complications from what was, in her understanding, a minimal risk surgery,
highlights the danger inherent in a popular conception of medical tourism that perceives
elective, and in particular cosmetic, surgery as a mundane experience (see, for example, Jesitus,
2006 and Alsever, 2006). The role Terence played in providing important supportive care
during her post-operative emergency also provides further justification to more seriously and
conscientiously consider the role of the caregiver-companion as a key support for medical
tourists during their care abroad.

**JESSICA’S VIGNETTE**

Jessica is a woman in her early fifties and is in very good health. Well-travelled from
numerous overseas trips with her husband for his work, she has visited many low-, middle- and
high-income countries in the course of her life. In recent years Jessica was experiencing chronic
pain in her hips and a specialist recommended she receive a hip replacement. The wait list for this procedure in her home jurisdiction was three years. She agreed to be placed on the wait list. Her quality of life was rapidly declining as she waited for a surgical date, and by the second year of waiting she was largely bedridden. With no surgical date in sight in her third year, Jessica switched to a different surgeon's wait list in another city, having been told this would cut her wait time. Soon after this switch, Jessica’s husband, Tom, saw a segment on hip resurfacing on the popular newsweekly *60 Minutes* television program, and together they began researching the procedure online. They found hip resurfacing an attractive alternative to a total hip replacement. In hip resurfacing, artificial surfaces are fixed to the degrading hip joint. This conserves more of the original bone and permits greater post-operative flexibility and mobility when compared to hip replacement, although the long term success of the approach remains uncertain (Ollivere, Darrah, Barker, Nolan & Porteous, 2009).

Jessica and Tom quickly found that hip resurfacing was largely unavailable in Canada, and that the most experienced surgeons were in other countries. Excited by the perceived technical superiority of the procedure and the potential of obtaining an immediate solution to her debilitating pain, Jessica decided she was going to undergo a hip resurfacing abroad and take herself off the local wait list for hip replacement. Weighing the surgical expertise, long recovery time, and relatively low cost of the procedure in India against her long held discomfort with the extreme material poverty found there, Jessica ultimately decided to pursue surgery at an Indian hospital rather than the European centres that also offered the procedure.

Jessica’s surgery in India went well with no complications. She chose to recover in a beachside resort outside the city she and Tom had travelled to, which regularly received foreign patients from the hospital. The resort was more commonly used by vacationers, and was a focal point for local craftspeople and other vendors hoping to benefit from tourist dollars. While staying at the resort, Jessica and Tom struck up a friendship with Mohinder, a beach trinket seller, and proceeded to meet his entire family. The Canadian couple was struck by the degree to which the region had been affected by a devastating tsunami in 2006, and was especially moved by what they saw as the resilience of Mohinder’s family in the face of the poverty in the
region. Inspired by this resilience, Jessica and Tom asked Mohinder and his wife if they would be willing to let them finance their three daughters’ educations, to which they eventually agreed.

The relationship between the two families has continued for many years since Jessica and Tom’s trip to India. They exchange emails weekly, and the charitable financial relationship has not only allowed Mohinder’s daughters go to school, but also enabled Mohinder’s wife to access life-saving medical care. Jessica’s perception of India has greatly changed following her surgery there, and she and Tom have returned twice since her first surgery - once to have her other hip resurfaced and a second time as a leisure vacation to visit Mohinder and his family.

Significance

Jessica’s account of charitable involvement was not totally unique amongst the Canadian medical tourists we spoke with, as others also talked of personally giving back to the economic and social well-being of the low-income communities in which they had received care. For example, an interview participant spoke of paying for orthopaedic surgery for an athletic youth in India, and another sent care packages with hard-to-get consumer goods and medical supplies to the physicians and nurses who had treated her in Cuba. However, the degree of Jessica and Tom’s initial and continuing involvement with the destination country was unique, and spoke to a powerful affinity to India that Jessica established after first going as a medical tourist.

Jessica’s vignette highlights two points of interest. Firstly, unprompted personal charitable acts may suggest a nascent willingness amongst medical tourists to offset their use of medical resources elsewhere with more structured cross-subsidization schemes for local users by foreign patients. Doing so could provide one mechanism for addressing some of the health equity concerns that have been raised regarding medical tourism for destination nations, although cross-subsidization schemes may serve as a distraction from the larger, systemic inequities that medical tourism represents and arguably exacerbates in healthcare systems (Johnston, Crooks, Snyder & Kingsbury, 2010). Secondly, Jessica’s experience underscores the need for the affective dimensions of medical tourism to be readily acknowledged and explored; both visiting foreign environments and undergoing surgery can be deeply emotional experiences (Knudsen & Waade, 2010; Panagopoulou, Maes, Rime & Montgomery, 2006; Reisinger & Mavondo, 2005). While the structural and system-level accounts of medical tourism that
dominate much of the scholarly literature are clearly important, they cannot capture the potential shifts in personal perspective that medical tourists undergo. These patients enter contexts they would otherwise never visit, and do so in a vulnerable a position. A full understanding of the experience of medical tourism requires consideration of the lived experience, including its emotional dimensions.

CONCLUSION

The vignettes shared above bring forth a number of important lessons for medical tourism researchers. We see three such lessons to be most important. First, these vignettes highlight the value of gathering and analyzing patient narratives in order to understand all facets of medical tourism. As we said at the outset, published narratives characterizing the experiences of medical tourists tend to emphasize commonalities. While this is not problematic as there is much use in identifying common trends and experiences, our vignettes show the value in bringing forth uncommon or unique aspects of the patient experience highlighted in narratives in order to advance our knowledge about medical tourism. As research in this field is at an early stage, there is great potential for these unexpected or unanticipated insights to meaningfully inform future studies.

Second, all five of the vignettes demonstrate the very important role that caregiver-companions can play in medical tourists’ experiences. In some instances caregiver-companions prompted medical tourists to consider going abroad for surgery, often assisting in the research process, while in others they provided valuable emotional support during the recovery period abroad. In effect, the vignettes position caregiver-companions as an important stakeholder group in the global health services practice of medical tourism. The lesson here is that it is important that research on medical tourism be designed in such a way to allow unplanned or unanticipated perspectives to be brought forth on issues that we know little or nothing about. In the case of our research, we did not initially set out to learn about caregiver-companions, nor did we even ask about them at the outset, but many valuable insights about this stakeholder group emerged throughout the process of data collection.
Third, the heterogeneity captured by the vignettes in relation to the experiential accounts of medical tourists demonstrates the importance of approaching research in this field with a non-homogeneous understanding of who medical tourists are. If research is limited to or overly-focused on a narrow definition of who engages in medical tourism and what their experiences are, then this will have an influence not only on study design but also on research findings and ultimately on the messages that get disseminated about who medical tourists are.

Many research questions emerge from the vignettes and our articulation of their significance. These questions include: how common or uncommon are the 'unexpected' experiences we have showcased here among medical tourists, including those departing from other countries or traveling abroad for non-surgical procedures; what interventions, if any, should be implemented in order to address health and safety-related issues; and, what else do we need to know about caregiver-companions in order to have a more complete understanding of the roles they play in the care and decision-making of medical tourists and the types of unique health and safety risks they might experience? Addressing these questions in future research could positively influence the operation and regulation of the medical tourism industry as it develops over the coming years. While some of these questions have been posed by other medical tourism researchers, some aspects of the vignettes presented herein may warrant reinterpreting their scope, meaning, and/or intent. We believe that these and other questions emerging from the vignettes offer important directions for future medical tourism research.

The accounts shared in this chapter describe five exceptional experiences pulled from our interviews with 32 Canadian medical tourists. While elements of these five participants’ decision making and care-seeking trajectories fit larger trends seen within the entire group, the anecdotes shared above illustrate unique instances that we had yet to share. The vignettes aim to highlight exceptions that demonstrate the variability of Canadian medical tourists’ experiences. Our hope is that they serve as springboards for future qualitative research that can further document the varied practices of facilitators, supportive roles of caregiver-companions, motivations for traveling for care, risks faced while in destination countries, and the affective shifts in perspective that might accompany these journeys abroad for medical care.
Details about the study design and methods can be found in Crooks, Snyder, Johnston and Kingsbury (2011). A listing of study publications can be found at www.sfu.ca/medicaltourism. Canadians are largely unable to privately purchase medical services that are offered through the public Medicare system, including orthopaedic surgeries, due to provisions in the Canada Health Act that discourage private financing of care.
REFERENCES


