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Motivation, justification, normalization: Talk strategies used by Canadian medical tourists regarding their choices to go abroad for hip and knee surgeries

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ABSTRACT

Contributing to health geography scholarship on the topic, the objective of this paper is to reveal Canadian medical tourists' perspectives regarding their choices to seek knee replacement or hip replacement or resurfacing (KRHRR) at medical tourism facilities abroad rather than domestically. We address this objective by examining the 'talk strategies' used by these patients in discussing their choices and the ways in which such talk is co-constructed by others. Fourteen interviews were conducted with Canadians aged 42–77 who had gone abroad for KRHRR. Three types of talk strategies emerged through thematic analysis of their narratives: motivation, justification, and normalization talk. Motivation talk referenced participants' desires to maintain or resume physical activity, employment, and participation in daily life. Justification talk emerged when participants described how limitations in the domestic system drove them abroad. Finally, being a medical tourist was talked about as being normal on several bases. Among other findings, the use of these three talk strategies in patients' narratives surrounding medical tourism for KRHRR offers new insight into the language-health-place interconnection. Specifically, they reveal the complex ways in which medical tourists use talk strategies to assert the soundness of their choice to shift the site of their own medical care on a global scale while also anticipating, if not even guarding against, criticism of what ultimately is their own patient mobility. These talk strategies provide valuable insight into why international patients are opting to engage in the spatially explicit practice of medical tourism and who and what are informing their choices.

1. Introduction

Medical tourism involves the travel of patients abroad for private medical care outside of established cross-border health care agreements (Hopkins et al., 2010). It is characterized by out-of-pocket payment and minimal or no clinical oversight from a patients' home health system (Hopkins et al., 2010; Turner, 2013). The medical tourism industry is reported to be a multi-billion dollar sector, and involves patients travelling internationally to hospitals and clinics (Begum, 2013; Cohen, 2010; Rahman, 2010). While systematic and reliable data on the numbers of medical tourists is lacking, reports of patients accessing hospitals abroad suggest that the industry is growing (Connell, 2006; Mainil et al., 2011; Yu and Ko, 2012). Numbers aside, it is known that Canadians are seeking private surgeries, including KRHRR, in other countries (Crooks et al., 2012; Johnston et al., 2011).

KRHRR are surgical procedures performed to reduce pain and increase mobility in damaged or degrading joints (CIHI, 2009). The Canadian Institute for Health Information (2009) reports that 62,196 hip and knee replacement surgeries were performed in Canada (not including Quebec) between 2006 and 2007, a 101% increase since 1996–97 (p. 5). Given that the most prevalent diagnosis leading to KRHRR is osteoarthritis, procedure numbers are likely to continue increasing as the population ages (CIHI, 2009, 2011). Unlike hip and knee replacement, hip resurfacing has limited availability in Canada, due primarily to lack of surgical expertise (Johnston et al., 2012). Meanwhile, there appears to be growing public awareness of, and demand for, access to hip resurfacing (Black, 2013; Kirsch, 2012; Landro, 2013; Picard, 2009). One estimate suggests an increase in this procedure in the province of Ontario alone from 200/year to 1400/year between 2005 and 2010 (Medical Advisory Secretariat, 2006, p. 11). Taken together, there is

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a growing need for KRHRR procedures and this is placing increased pressure upon the Canadian health care system (Hudak et al., 2008).

Legislated by the Canada Health Act (n.d.), Canadians are entitled to obtain medically necessary elective and emergency surgeries in the public system with no out-of-pocket cost. Medical necessity for orthopaedic procedures is typically established by a family physician or specialist and confirmed following referral to an orthopaedic surgeon (Hudak et al., 2008). Canadians who choose to exit the public system for medically necessary procedures must typically seek them abroad as there is limited private, for-purchase care available in Canada (Steinbrook, 2006; Turner, 2012). Patients who do this are circumventing the referral networks that make up the public health care system and jeopardizing continuity of care (Johnston et al., 2011). Meanwhile, long waiting lists for KRHRR, perceptions of long waiting lists, and/or desires to gain access to hip resurfacing drive some Canadians to seek these procedures abroad as medical tourists (Crooks et al., 2012; Johnston et al., 2011). Canadian health care administrators and practitioners have expressed some concern about this trend as patients can be exposed to a range of health and safety risks abroad, can spread antibiotic-resistant organisms upon return home, can develop discontinuous medical records as a result of accessing care in another country, and may not be making truly informed decisions about the procedures they select (Crooks et al., 2013).

We view medical tourism as an explicitly spatial practice and work from this perspective in the current article. This practice involves multiple forms of mobility and movement and also connects distant places in a relational way through the activities of patients, physicians, and other stakeholders alike, all of which reference its spatial nature (see Gatrell, 2011). It is thus not surprising that in recent years health geographers have started to empirically examine this practice from topics as diverse as consumption and promotion, emotional geographies, neoliberal governance, and patient decision-making (e.g., Warf, 2010; Kingsbury et al., 2012; Bell, 2011; Ormond, 2013; Ormond & Sothern, 2012; Crooks et al., 2010; Johnston et al., 2012). Much research on medical tourism also contributes more broadly to health geographers' interests in understanding the spatiality of peoples' health-seeking behaviours (Cummins, 2007; Gesler and Meade, 1988; MacKian, 2002; Narayan, 1999), wherein engaging in the practice of medical tourism is an intentional interaction with an international health system in order to address a health need. In this article we contribute to these areas of health geography scholarship through our examination of how talk strategies are used by former medical tourists to discuss, and at times justify, their choices to engage in this spatially explicit practice.

Though this analysis serves as a novel contribution to the medical tourism literature, there is an established area of inquiry in health geography around the theoretical and practical interconnections between language, health, and place (see, for example, Carolan et al., 2006; Gesler, 1999; Giesbrecht, Crooks, & Stajduhar, 2012; Poland et al., 2005). We situate the current analysis within this disciplinary tradition. Much of this research examines how place, and the site of care in particular, informs language use or how language is used in health care places. For example, Giesbrecht et al. (2012) looked at the ways in which language use by homecare nurses changes in different spaces of the home and how it is used to define the boundaries of their practice. In the current analysis we offer a different perspective on the language-health-place interconnection through our consideration of how talk, as an expression of language, is used to communicate about engagement in a spatially explicit transnational health care practice. In doing so we focus on 'talk strategies' and use the sociological construct of the co-construction of patient narratives as a conceptual framework for the analysis. Co-construction recognizes that events and occurrences, including those that are health-related, are simultaneously influenced by multiple factors, both human and non-human in nature, that "come into being together" (Rice, 2013, p. 238).

In the remainder of the paper we work to illustrate *what* Canadians who go abroad for KRHRR have to say about why they chose medical tourism and why they chose specific destinations, *how* they say it via talk strategies, and *who* is involved in co-constructing their narratives about these choices. We do this by examining the thematic findings of 14 interviews conducted with Canadians who previously went abroad for these surgeries. In the section that follows we discuss the value of examining patient narratives and the role of co-construction in such narratives to provide context for the findings. We next introduce the study design and methods. Following this we examine in-depth the three talk strategies that emerged from the 14 narratives examined: motivation, justification, and normalization talk. We then move to discuss the ways in which these narratives are co-constructed and implications for future research. Overall, the findings contribute to our understanding of patient perceptions of care available in the Canadian health system in comparison to medical tourism destinations. They also reveal some of the factors that enable and constrain international patients' engagement in the spatial practice of medical tourism.

2. Patient narratives and their co-construction

Patient narratives are stories or retrospective accounts of health, illness, impairment and/or medical treatment from the patient's perspective (Sakalys, 2000). They are valuable in illuminating the challenges faced by patients with illnesses and impairments, the meanings assigned to being ill or healthy, and the decision-making process with regard to undergoing treatment (Ochs & Capps, 1996; Sakalys, 2000). Health researchers have used patient narratives as a source of information across a number of disciplines. Health geographers have used them to illuminate female psychiatric patients' perceptions of mental health care facilities (de la Cour, 1997), patients' lived experiences of bipolar disorder (Chouinard, 2012), and Korean immigrants' use of homeland health care (Lee et al., 2010). Patient narratives can be produced through self-initiated life-writing and storytelling, such as in the form of poetry and journals. They can also be produced when patients are asked to share their stories through an interview (Chase, 2003; Wiklund-Gustin, 2010), as is the case in the current study.

Patient narratives seek to make sense of, and give order and meaning to, people's experiences (Ochs & Capps, 1996). Sakalys (2000) emphasizes the value of narratives as a challenge to dominant health care ideologies and practices. In the current analysis narratives are used to challenge the expected behaviour of seeking surgery domestically within the public health care system. Researchers have emphasized the need to recognize that while these stories emerge from an individual's experience, they are also co-constructed (Eggly, 2002; Padfield, 2011; Pasupathi, 2001). We explore the co-constructedness of the narratives examined in this paper in order to gain the most complete understanding of how talk strategies are employed by Canadian medical tourists in discussing their choices to have KRHRR abroad. Use of patient narratives by health geographers has yet to fully engage with the concept of co-construction, and thus this paper serves as an example of how this conceptual framework can be used to advance our understanding of the language-health-place interconnection.

Exploring patients' narratives about opting for medical tourism and their co-construction has the potential to bring forth new information as to why individuals choose to go abroad for private