

THE LIVED EXPERIENCE OF SEEKING HEALTH CARE THROUGH MEDICAL  
TOURISM: AN INTERPRETIVE PHENOMENOLOGICAL STUDY OF  
ALASKAN PATIENTS TRAVELING INTERNATIONALLY FOR MEDICAL AND  
DENTAL CARE

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## Abstract

**Purpose:** A growing number of people from many countries are traveling internationally to obtain medical care. The purpose of this study is twofold: (a) to explore the experiences of international travel for the purpose of medical or dental care from the perspective of patients from Alaska and (b) to develop insight and understanding of the essence of this phenomenon.

**Study Design and Methods:** The study is conceptually oriented within a model of health seeking behavior. Using a qualitative, interpretive phenomenological design, a purposive sample of fifteen Alaskan medical tourists who have experienced international travel for the objective of medical or dental care were individually interviewed. The data was analyzed using a hermeneutic process of inquiry to uncover the essential meaning of the experience.

**Results:** The hermeneutic analysis of the participants' narrative accounts allowed the themes of *Motivation, Research, Obtaining Care, Follow-up, Advice, and Future Health Care* to emerge. Sub-themes are used to further categorize data for increased understanding. The thematic analysis provides insight into the essential structure of the lived experience of the medical tourism phenomenon. Improved understanding of medical tourism provides further information about a modern approach to health seeking behavior. The conceptual definition and model for health seeking behavior are updated.

**Implications:** Increased understanding of the experience of obtaining health care internationally and motivation for this nature of health seeking behavior from the patient perspective is needed in the global health care arena. Nursing professionals will benefit by being better able to advocate for patients' choices in health seeking behavior, counsel regarding medical tourism options, provide follow-up health care after medical tourism, and actively participate in global health policy discussions.

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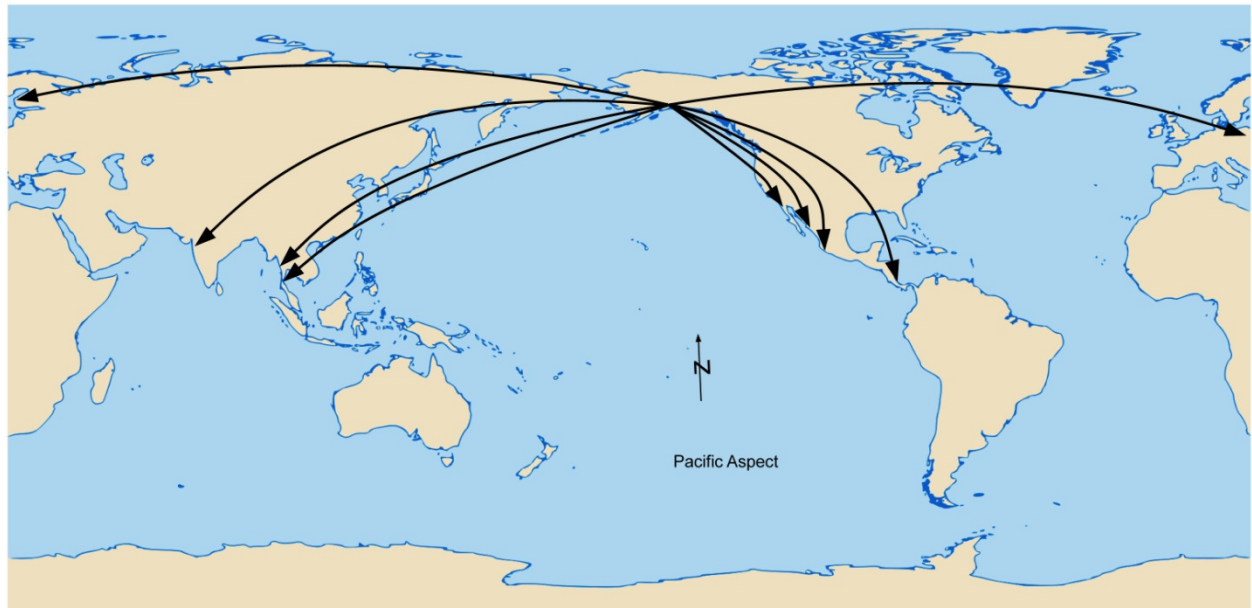
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**Figure 1. Alaskan Participants' Medical Tourism Destinations**



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## **Chapter One**

### **Introduction**

Chapter one provides an introduction of medical tourism, the problem statement, the research question, defined terms, and study implications. The review of available literature on medical tourism is highlighted.

The phenomenon of traveling internationally to obtain health care is becoming increasingly common due to ease and affordability of global travel. Woodman (2007) estimates that one million people worldwide travel for health care purposes. Additionally, it is estimated that 500,000 medical tourists from the United States (U.S.) traveled internationally in 2007 seeking health care (Merrell et al., 2008).

Health services for medical tourists are available in over thirty countries (Woodman, 2007). The list of potential medical and dental procedures available on the global market to medical tourists is extensive and includes technologically advanced surgical procedures, assistive reproductive procedures, organ transplantation, cosmetic surgery, health maintenance, and traditional healing techniques (Bookman & Bookman, 2007; Woodman, 2007). Although, medical tourists often take advantage of vacation activities in conjunction with their health care, their primary objective is medical care and improvement in health status (Bookman & Bookman, 2007; Woodman, 2007).

Lower cost medical and dental treatment is a commonly cited reason for the popularity of medical tourism. Patients may find a forty to ninety percent cost savings in the international health care market over U.S. prices for comparable procedures (Bookman & Bookman, 2007; Burkett, 2007; Merrell et al. 2008; Woodman, 2007). Lengthy wait times for medical procedures

and inability to obtain medical procedures in the country of residence are also reasons given for medical tourism (Blythe & Farrand, 2005; Leahy, 2008).

Concerns regarding medical ethics, global health care economics, and impact on destination countries exist (Bookman & Bookman, 2007; Merrell et al., 2008). Patient safety and follow-up upon return to the country of residence are also topics of concern (Bookman & Bookman, 2007; Merrell et al., 2008; Woodman, 2007). Despite some misgivings, medical tourism is an increasingly common option for health care in today's global health care market and many patients are travelling to obtain medical and dental services.

### **Problem Statement**

Despite the increasing popularity of medical tourism, there are few, if any, studies in scholarly literature exploring the perspective of patients seeking to improve their health status in the international health care market. The essence of the experience of travelling internationally for medical care from the perspective of the patient is unknown.

### **Research Question**

What is the lived experience of patients from Alaska who travel internationally for medical or dental care?

### **Definition of Terms**

Terms used within the dissertation proposal are introduced and defined. Carrera (2006) defines medical tourism as “organized travel outside of someone’s health care jurisdiction to enhance or restore health” (p. 1453). A medical tourist is defined as a person who has traveled for the purpose of improving or maintaining health (Woodman, 2007). Ehrbeck, Guevara, and Mango (2008) define medical travelers as “people whose primary and explicit purpose in

traveling is medical treatment in a foreign country” (p. 2). For the purpose of this study, the medical tourist is an individual who has sought and received medical or dental care during international travel. International travel is defined as crossing country borders. For the purpose of this study, medical tourists will have traveled specifically for the purpose of health care and may or may not have included recreation into their travel plans.

Medical care refers to the treatment of illness or injury. Medical care also refers to activities of health maintenance and surveillance such as screening mammography, laboratory chemistry studies, and colonoscopies. Medical care includes all services rendered by medical professionals and lay persons to promote health and wellness. Further examples of medical care that may be considered include acupuncture, physical therapy, and fertility treatment. For the purpose of this study, elective cosmetic surgery has been excluded.

Dental care refers to treatment of conditions relating to the teeth, gums, and associated structures of the mouth such as crowns, root canals, and periodontal procedures. This also includes preventative dental services and dental hygiene such as routine cleaning and x-rays. Dental care includes all services rendered by dental professionals and lay persons to promote dental health and wellness.

### **Significance of the Study**

Medical tourism is increasingly popular and has become an international health care option and a modern health seeking behavior. Health seeking behavior, as a concept, has evolved and changed since it was first explored in social science literature in the 1960s. Originally, health seeking behavior was viewed from the perspective of individuals engaging in behaviors relating to illness (Suchman, 1965). Over the last fifty years the concept has expanded to include nearly all activities that patients participate in relation to health care and is now

viewed from the lens of patients' socio-cultural framework (Anderson, 1995; Bausell & Bausell, 1987; Cho, 2004; Harris & Guten, 1979; Ward, Mertens, & Thomas, 1997). The concept of health seeking behavior today recognizes an even wider vantage by acknowledging that, "...the process of 'seeking' extends over physical and social space, time *and* the health system in complex ways..." (MacKian, Bedri, & Lovel, 2004, p. 144). Medical tourism is an innovative approach to health seeking behavior which broadens the physical and social spaces of health care that has not yet been effectively explored in literature.

The focus of nursing is inextricably intertwined with the health seeking behaviors of patients. Macnee et al. (2006) emphasize the relationship between nursing and health seeking behavior, recognizing advocacy of patients' individual health seeking behavior as an important nursing care activity. The American Nursing Association states that 'advocacy in the care of individuals' in relation to their social environment falls within the realm of nursing (ANA, 2003). In a qualitative study involving nurse practitioner and patient interaction, Kleiman (2004) found that openness and respect for patient self-determination and health care decisions is a central theme in the provider-patient relationship. Optimal patient support and advocacy involves recognition and understanding of the range of patient health seeking behaviors including international travel for health care.

This study is significant to nursing knowledge because it will add to the understanding of medical tourism, as well as the way that the pursuit of medical tourism fits into the concept of health seeking behavior. Patients who have traveled internationally for medical care are interacting with their local health care system before and after travel (Merrell et al., 2008, Woodman, 2007). Prior to travel, nurses and advanced practice nurses are influential in health seeking behavior and patient care decisions (Kleiman, 2004; Macnee et al., 2006). Upon return

to their country of residence, patients are seeking advice and follow-up care from health care providers (Merrell et al., 2008; York, 2008). Knowledge of medical tourism options, advantages, disadvantages, and follow-up care options, will assist nurses in becoming better advocates for medical tourists and their families. Understanding the health seeking behaviors of medical tourists will also be significant from a health care policy and economics perspective and is pertinent to the larger global health care community.

### **Literature Review of Medical Tourism**

Medical tourism is a term used to describe the growing number of people who are traveling internationally to obtain medical care and is defined as travel for the purpose of improving one's health outside of one's usual health care environment (Bookman & Bookman, 2007; Carrerra, 2006). Traveling worldwide in pursuit of treatment, medical tourists seek a variety of services including medical, surgical, dental, and health maintenance (Woodman, 2007). Although this practice has been in existence for years, there is little information about medical tourism as a method of seeking improvement in health in the scholarly research. Much of the available information is found in media reports, government or industry documents, and editorials.

This literature review begins with the history of medical tourism, geographical areas of current medical tourism development, and prevalence of this option in health care. Motivating factors influencing the increasing rates of medical tourism, options for medical care found within this market, and economic considerations are highlighted. Additionally, concerns regarding patient safety, ethics, and the global impact of medical tourism are reviewed.

### **History of medical tourism.**

The roots of medical tourism are centuries old. Early Mediterranean travelers crossed the waterway to Greece in hopes of better health bestowed by the Greek god of healing, Asklepios (Bookman & Bookman, 2007; MacIntosh, 2004). Later, Roman citizens in Britain traveled to Bath for the restorative properties of the waters (MacIntosh, 2004). Early travelers felt simply the act of travel was therapeutic and traveled to destinations for rest and recuperation (Morgan, 2003). In the 18<sup>th</sup> & 19<sup>th</sup> centuries, British and European patients traveled for physical and mental health related concerns and convalescence, often traveling south for warmer climates and spas (MacIntosh, 2004; Morgan, 2003). Prosperous medical tourists of the past searched for specialized care not available in their locale such as tuberculosis sanatoriums (Morgan, 2003).

The United States has been a destination country for medical tourists for over fifty years with visitors seeking technologically advanced care (Merrell et al., 2008). Large, renowned medical centers in the U.S. such as Mayo Clinic and Johns Hopkins University Hospital see a significant number of international patients each year and continue to market the expansion of medical tourism (Bookman & Bookman, 2007). Long standing history of providing medical care to international travelers also exists in the U.K. and other European nations (Morgan, 2003).

Packaging of services involving an intersection of medical care and tourism has been in existence for over thirty years. In the 1970s, travelers from Europe and Japan frequently visited a faith healer in the Philippines who provided hotel accommodations allowing an opportunity for health care in combination with a cultural experience (Bookman & Bookman, 2007). In the last twenty years, governments of destination countries, hospitals, and travel organizations have increased promotion by offering combination packages of travel and health care (Bookman & Bookman, 2007). As an example, Horowitz and Rosensweig (2007) report, “South Africa has

been very successful selling medical services combined with tourism activities such as safaris.” (p. 28).

Currently, there is high demand for medical tourism; patients are availing themselves of opportunities in the global health market (Bookman & Bookman, 2007; Woodman, 2007). This is particularly evident when considering current internet searches, “Enter a procedure name in a search engine and international options appear among local options. Enter a procedure name with the addition of the term ‘abroad’ and 100,000 or more citations appear...” (Reed, 2008, p. 1435). Today, global travel is commonplace, air travel is considered affordable, and medical tourism is an increasingly popular incentive for travel.

### **Medical tourism today.**

Destinations available for medical tourism are extensive and increasing. Destination countries are found in North and South America, Europe, Asia, and Africa (Woodman, 2007). Both Thailand and India are receiving a large number of medical tourists and the governments and industry are pursuing further expansion of this industry (Bookman & Bookman, 2007; Chinai & Goswami, 2007; Teh 2007; Woodman, 2007). Other popular medical tourism destinations include Mexico, Costa Rica, Brazil, Cuba, Columbia, the United States, South Africa, Hungary, Czech Republic, United Arab Emirates, Malaysia, Indonesia, Singapore, and many others (Woodman, 2007). Approximately thirty countries worldwide are involved in medical tourism (Woodman, 2007).

As evidence of the growth in medical tourism, India anticipates a significant increase in medical tourism in the next several years (Chinai & Goswami, 2007; Colias, 2004). To support this growth, India has a medical travel classification of visa; the M-Visa allows a medical tourist and companion to stay in the country for one year (Chinai & Goswami, 2007). As a further

example of the expanding medical tourism industry, Bangkok's Bumrungrad Hospital reports treating travelers from 150 countries around the world (Cochrane, 2006). In response to increasing demands for beach experiences coupled with medical care, Thailand is expanding their medical tourist destinations to include more coastal locations (Bookman & Bookman, 2007). The literature, internet, and media are replete with examples of growth and development of medical tourism around the globe.

Destination countries vary in the ability to provide all or a portion of sought after procedures, surgeries, and examinations (Woodman, 2007). Different geographical areas are recognized for specialized medical care. As an example, South American destinations are known for cosmetic procedures, while Eastern European destinations are desired destinations for organ transplantation and assistive fertility procedures (Woodman, 2007). As major medical tourism destinations, India, Thailand, and other Asian countries are leading the way in efforts to provide more comprehensive care including health maintenance, health promotion activities, and traditional healing methods (Bookman & Bookman, 2007; Teh, 2007; Woodman, 2007). As demand increases, destination countries are working towards expanding options in relation to services in hopes of appealing to more medical tourists.

Data on the prevalence of traveling for health care is beginning to emerge. It is estimated 400,000 patients from 150 different countries traveled to Thailand in 2005 for the purpose of health care (Cochrane, 2006). Bumrungrad Hospital in Bangkok is a leading health care center of medical tourism, attracting worldwide patients to Thailand. India saw over 150,000 medical tourists in 2005 and anticipates double the number of travelers in the next several years (Medical Tourism India, 2006). Woodman (2007) estimates that one million patients a year are pursuing health care in the international market.

In a report from 2005, Bumrungrad Hospital in Bangkok “...treated 55,000 American patients, three-quarters of whom flew directly from the United States.” (Ramirez de Arellano, 2007). In a round table discussion regarding medical tourism, Merrell et al. (2008) report 500,000 Americans traveled outside of the U.S. for medical care in 2007. Bauer (2009) estimates that two million Americans traveled internationally in 2008 for the purpose of improving health, stating “...evidence suggests that medical tourism has become a force too big to ignore” (p. 36).

Ramsay (2006) reports uninsured and underinsured Americans comprise a large group of prospective medical tourists. As a concrete example of medical tourism used by uninsured patients, Kirkner (2009) relates a scenario of medical tourism,

...a suburban Denver businessman, needed mitral heart valve replacement surgery. He could have gone to the University of Colorado Hospital, or the Mayo Clinic, or the Cleveland Clinic. He chose instead a 15-hour flight and an operation at Escorts Heart Institute in Delhi, India. Last year when he needed a knee replacement, he went back to Delhi. His savings were more than \$200,000 compared to prices he was offered in the United States. (p. 34)

### **Medical tourism care.**

Analogous to the number of possible destinations and the large number participating in the trend, medical tourists are choosing a large variety of required and elective procedures, as well as health maintenance, prevention, and screening activities. Options include orthopedic surgery, dental care, cardiac procedures, cosmetic surgery, eye care, gastric surgery, dermatology, mental health, organ transplantation, assistive reproductive procedures, gender reassignment, and obstetric care (Blythe & Farrand, 2005; Bookman & Bookman, 2007; Burkett,

2007; Teh, 2007; Woodman, 2007; York, 2008). Unti (2009) reports medical tourists take advantage of complex medical procedures available in a number of specialty areas including aortic aneurysm repair, cardiac valve replacement, cochlear implants, intrauterine insemination, arthroplasty, laminectomy, and organ transplantation. Medical tourists are also pursuing health screening and maintenance options such as comprehensive labs, diagnostic imaging, EKGs, colonoscopy, preventative gynecological exams, and complete screening physicals (Blythe & Farrand, 2005; Bookman & Bookman, 2007; Teh, 2007; Woodman, 2007).

### **Motivation for medical tourism.**

There are a number of identified motivations for those patients seeking medical tourism. The most commonly cited reason for medical tourism is low-cost medical treatments (Merrell et al., 2008; Woodman, 2007). The reported cost savings varies, depending on the procedure and the country in which the treatment is performed. A comparison of costs of some orthopedic and cardiac procedures has revealed as much as a forty to ninety percent savings over comparable procedures performed in the U.S. (Bookman & Bookman, 2007; Burkett, 2007; Merrell et al. 2008; Woodman, 2007; York, 2008). Dunn (2007) provides specific examples of cost savings, stating that a coronary artery bypass graft (CABG) is available in Asia for \$10,000 to \$11,000 dollars, whereby in the United States the cost of a CABG is nearly ten times that. A website from India reports liver transplant in India costs \$69,350 compared to \$300,000 in the United States (Medical Tourism India, 2006). Patients from the U.S. and other countries are taking advantage of complex medical care at substantial savings over costs in the resident countries. The growing number of Americans who are underinsured or uninsured will benefit from medical tourism options with health care cost savings. (York, 2008).

Lower labor costs in developing countries accounts for the majority of the pricing difference (Bookman & Bookman, 2007). In some developing countries, physicians' salaries average only ten percent of physicians' salaries in the United States, accounting for much of the destination countries' ability to provide affordable medical care (Woodman; 2007). Forgione and Smith (2007) also report lower malpractice and pharmaceutical costs as contributing factors to the cost differential in medical care on the global market.

Delayed medical service within the country of residence is another reason given for the upward trend of medical tourism (Leahy, 2008). Eggertson (2005) and Turner (2007) state that long wait-lists for non-emergency medical procedures in Canada spur patients to seek health care internationally and companies are marketing this message to health care consumers. British patients are also willing to travel worldwide for health care due to lengthy wait times in England, despite treatment provided by the National Health Service at no or low cost to the patient (Beecham, 2002; Morgan, 2003). The options on the global health care market allow people waiting for medical care in their countries to obtain care in a variety of locations.

Another reason cited for the upward trend in medical tourism is availability of a treatment or procedure in the international health care market that may not be obtainable within the country of residence (Blythe & Farrand, 2005; Cohen, 2006; Leigh, 2005; Pennings, 2002; Spar, 2005). Patients are traveling to avail themselves of assistive reproductive procedures that are not available within their home countries (Blythe & Farrand, 2005; Cohen, 2006; Leigh, 2005; Pennings, 2002; Spar, 2005). Patients are also seeking newer or experimental treatments and procedures not approved for use in the country of residence (Blythe & Farrand, 2005; Cohen, 2006; Leigh, 2005; Pennings, 2002; Spar, 2005). Kangas (2007) discussed needs of Yemeni patients seeking health care for serious illness that is not available or optimal within their

country. People are also traveling for the purpose of legally assisted suicide (Dyer, 2004).

Patients from the United States are traveling for orthopedic procedures, bariatric procedures, and stem cell replacement surgery not currently used in the country (Merrell et al., 2008).

Stem cell tourism is a rapidly growing segment of medical tourism (Ryan, Sanders, Wang, & Levine, 2010). In December 2005, Don Ho, a famous Hawaiian singer, traveled to Thailand for stem cell treatment for his heart to repair damage caused from nonischemic cardiomyopathy (Berger, 2007; Shih, 2006). The stem cell procedure is not approved or available in the United States. In this procedure, stem cells were taken from Ho's blood, sent to Israel for multiplying and processing, and then returned to Thailand for injection into Ho's heart (Shih, 2006). The procedure was considered successful, improving Ho's cardiac status and providing functional improvement (Berger, 2007; Shih, 2006).

Patients are seeking health care in popular tourist destinations worldwide. Bookman and Bookman (2007) indicate that an appealing location is advantageous in promotion of medical tourism with sun, beach, and seaside attractions ranking highest amongst medical tourists. To this end, travel promotion is occurring with governments, companies, and hospitals promoting relaxation, luxury accommodations, and vacation supplementing the experience of necessary or elective medical treatments (Woodman, 2007). Patients are choosing travel options that allow medical care, luxury treatment, and extra time for enjoyment (Bookman & Bookman, 2007; Hutchinson, 2005; Woodman, 2007).

Economically, many countries are seeing rewards from efforts put into medical tourism. Quoting the Confederation of Indian Industry and a private analysis firm, McKinsey & Co., Colias (2004) states that revenue from medical tourism is expected to net two billion dollars in the year 2012 for India alone. Countries such as Costa Rica, Cuba, Malaysia, Philippines,

Columbia, Argentina, South Africa and many others are recognizing this growing trend and creating or expanding their ability to provide inexpensive health care to patients from around the world (Hutchinson, 2005; Johnson, 2002). Evans (2008) reports medical tourism in 2006 was a sixty billion dollar industry worldwide.

The potential economic impact of medical tourism is significant globally, yet may negatively impact the U.S. health care industry. U.S. hospitals are now competing with global health care for elective and medically indicated surgery dollars, which may well affect the profit margin of U.S. interests (Colias, 2004; York, 2008). It is estimated that the loss to the U.S. health care interests could be billions of dollars with further projections of loss totaling 68 billion dollars in the next few years (Rhea, 2008). In response, many large U.S. health care facilities are expanding services and partnering with medical centers in other countries in hopes of capturing more of the global market (Colias, 2004; Rhea, 2008). Rotenberg (2008) provides specific examples of U.S. hospital expansion in the international health care market including partnerships between Mayo Clinic and Johns Hopkins University Hospital with large facilities in the United Arab Emirates and other Middle Eastern medical tourism destinations. Douglas (2007) believes,

As long as high-quality medical care is available in the rest of the world and outcomes are as good as in the United States, and as long as the cost differential between domestic health care and care overseas is so large, medical tourism will continue to grow. (p.40)

Some employers in the United States, especially those self-insured, are changing health care benefits to encourage medical tourism (Burkett, 2007; Leahy, 2008; Shah, 2007). This shift could save businesses and insurance companies money overall on benefit expenditures (Burkett, 2007; York, 2008). Burkett (2007) reports that a company in the southeastern U.S. recently

provided financial incentives for employees who choose to have elective procedures at a preferred provider facility in India. In a paper discussing the policy change to include medical tourism as an employee option at Blue Ridge Paper Products Inc. in North Carolina, Douglas (2007) states that high costs of hospital and specialist services prompted the action, “These high costs drove me to look for places our patients could go that would provide the same or better quality of care with better pricing. Global healthcare is a possible solution to situations like ours.” (p.37).

Insurance companies such as Aetna and Blue Cross/Blue Shield and third party insurance administrators are currently offering discounted policies and paying claims for patients seeking care outside of the U.S. (Horowitz & Rosensweig, 2007; Pafford, 2009; Unti, 2009). This marks a change in thinking regarding the boundaries of medical care for U.S. patients. Government and policy makers are also responding to the medical tourism trend by convening special hearings and introducing pieces of legislation in several states encouraging use of international medical care (Horowitz & Rosensweig, 2007; Unti, 2009).

With global medical enterprise expanding, entrepreneurs are launching companies to ease the logistical problems of obtaining medical care internationally; many offering luxury travel and medical packages that are substantially less than the cost of surgery or treatment alone within the U.S. (Forgione & Smith, 2007; Hutchinson, 2005). Using internet advertising and word of mouth from previous medical tourists, companies and health care facilities promoting medical tourism are assisting patients with travel and accommodation arrangements, as well as coordinating medical care in the destination and the embarkation country (Eggertson, 2005; Forgione & Smith, 2007; Hutchinson, 2005; York, 2008).

### **Concerns.**

Although medical tourism has many proponents, there are concerns regarding the ability of developing countries to provide safe medical care that meets the standards set in the United States. The prevalence of endemic infections in some developing countries practicing medical tourism raises concern regarding nosocomial infections (Forgione & Smith, 2007). Barclay (2009) reports patient complications such as infection and malignancy as a result of adult stem cell treatment that are available in the international health care market yet not currently approved by Federal Drug Administration in the U.S.

Leahy (2008) raises continuity of care and patient safety concerns. There are shortcomings in communication between U.S. and international providers (Merrell et al. 2007; York, 2008). Concerns have been expressed about informed consent procedures that are different or less consistent than U.S. informed consent standards (Mitka, 2009; Unti, 2009). There are reports of patient deaths resulting from surgical procedures as well as concerns about travel hazards, surgical complications, and follow-up care (Barron, 2008; Beecham, 2002; Eggertson, 2005; Hutchinson, 2005).

In response to criticism, hospitals on the global market are working towards standardized care criteria that will improve patient safety (Bookman & Bookman, 2007; Carrera, 2006; Woodman, 2007). Working with the World Health Organization Collaboration Centre, Joint Commission International (JCI) has set an essential framework for patient care and safety standards (The Joint Commission, 2008). An accreditation process for organizations and hospitals providing care for international patients now exists and many of the facilities promoting medical tourism in Thailand, Singapore, and India have received JCI accreditation (Bookman & Bookman, 2007; Woodman, 2007). Burkett (2007) discusses the potential for U.S.

safety standards to interfere with international trade policies and promulgate culturally inappropriate ideas within the new global health care market. Information regarding patient follow-up upon return to the country of residence and long term outcomes is not found in the literature.

There are also ethical concerns expressed about medical tourism. Reproductive tourism is questioned in countries that have more rigid requirements for reproductive assistance and termination of pregnancy (Blythe & Farrand, 2005; Cohen, 2006; English, Mussell, Sheather, & Sommerville, 2001, 2006; Penning, 2002; Penning, 2004; Spar, 2005). Noting the differences in legality of assistive reproduction, Cohen (2006) suggests that countries become more uniform in regulation of reproductive tourism to decrease need for cross-border travel for care. Penning (2002, 2004) and Spar (2005) also discuss moral and regulatory aspects of reproductive tourism. The ethical dilemma inherent in this debate leaves no clear global solutions. English et al. (2001) summarize the potential ethical issues involved in medical tourism by making the statement,

Given that there are a range of issues, particularly around the beginning and end of life, on which international consensus is unlikely to be achieved, it is inevitable that individuals will travel to other destinations in order to take advantage of different laws.

(p. 284)

Ethical concerns regarding medical tourism is spurring discussion among leaders in many countries. Traveling for the purpose of obtaining an organ not available in a residence country is also a topic creating debate in the literature without clear direction (Evans, 2008; Jafar, 2009). Despite regulations regarding organ transplantation in India, Shroff (2009) reports significant

concerns about the current ethical and legal parameters of the growing trend of transplant tourism.

Kassim (2009) discusses concern about alterations in provider-patient relationships that are occurring as a result of medical tourism. Gray and Poland (2008) also recognize alarm regarding cross borders health care activities, “This new era of globalization in health care has arrived without the benefits of international standards, government oversight, or ethical and legal review.” (p. 193). Despite the discussion needed to decrease international concerns, medical tourism continues to be an attractive health care option for patients. Holland, Malvey, and Fottler (2009) recognize medical tourism as an opportunity “...for the health care industry to use virtual leadership through partnerships with foreign health care organizations...” (p. 122). The authors further recommend health care management teams placed around the world to assist in the globalization of medical tourism. Craig and Beichl (2009) discuss need for global system-wide oversight of the medical tourism market and recognize the opportunity for international case management.

### **Impact on developing countries.**

Concern regarding the negative impact of medical tourism upon developing countries is also found in the literature. Countries such as India, Thailand, Malaysia, and others currently treating large numbers of international visitors, have local health care systems that remain understaffed and often unable to meet the needs of the country’s population (Bookman & Bookman, 2007; Burkett, 2007; Chinai & Goswami, 2007; Kumar, 2009; Leahy, 2008). In India, there are concerns regarding the dichotomy of technologically advanced health care facilities catering to medical tourists while much of the population does not have adequate health care (Kumar, 2009). Leahy (2008) reports a potential detrimental effect on the country’s health

care system if the population is unable to access the care that is available to medical tourists. Burkett (2007) suggests the destination country “suffers because it does not receive the social-political benefit of a healthy citizenry” (p. 233).

In a discussion regarding factors positively and negatively affecting medical tourism, Bookman and Bookman (2007) support the concept that technological and medical advancements aid the destination country. Other authors question whether improvements in a country’s economy as a whole resulting from medical tourism will result in an improvement in overall health of the destination country (Chinai & Goswami, 2007). Despite the potential drawbacks of medical tourism, developing destination countries are encouraging expansion of medical tourism as a pathway to economic development.

### **Summary**

The literature review indicates that medical tourism is becoming an increasingly common activity. Availability of high quality health care services and the ability to provide care in an affordable manner has become an international topic and policy consideration. On an individual basis, it may also indicate a new method of health seeking behavior. As medical tourism escalates, our view of global health care is changing.

Due to the limited amount of research on medical tourism, the literature search generated primarily background descriptive information without substantive data regarding (a) the experience of seeking medical tourism or (b) the perceived benefits of such from the perspective of the patient. As this area has been inadequately explored, qualitative research of medical tourism, exploring the experience from the perspective of patients receiving health care outside of their country of residence, is needed.

## **Chapter Two**

### **Conceptual Orientation - Health Seeking Behavior**

Chapter two presents a review of the concept of health seeking behavior which serves as a framework for the study of medical tourism. The increasingly popular phenomenon of traveling for health purposes suggests a shifting approach in the concept of health seeking behavior that deserves consideration in nursing research arenas.

Health seeking behavior is a dynamic concept that has significantly evolved over the past six decades in health literature. Investigation of the concept of health seeking behavior is a fundamental pursuit for nursing in order to promote optimal health care for patients. Understanding health seeking behavior, including patient decision-making in relation to their health related activities, is central to patient advocacy and care (Macnee et al., 2006). Health seeking behavior is a complex concept with no single definition. The concept, as it has been explored within the health and social science literature, will be discussed. Conceptual models of health seeking behavior are presented as visual representations of the concept. Medical tourism as a new method of health seeking behavior will also be suggested.

### **Background**

The concept of health and illness behavior was introduced and became popular in the 1950s & 1960s in medical and social science literature (Freidson, 1961; Kasl & Cobb, 1966a, 1966b; Mechanic & Volkart, 1960; Parsons, 1951; Suchman, 1965). Many of the early authors focused on health as an absence of illness and characteristics of patients in stages of illness and recuperation. The biological process of disease was emphasized, with limited recognition of social and psychological components of health behavior. For example, Mechanic and Volkart (1960) discussed the concept of illness behavior in relation to patients' assessment of symptoms

of illness and the subsequent patient actions. Suchman (1965) discussed transitions and stages in the illness experience; attempting to incorporate some social considerations within the primarily medical model. Freidson (1961) studied patient behavior in relation to choosing medical providers; determining that the single dimension of attachment was a primary factor in patients' choice.

The concept of health seeking behavior continued to be studied in scholarly literature in the 1970s with expansion of the concept to encompass illness and wellness behaviors (Harris & Guten, 1979; Igun, 1979; Steele & McBroom, 1972; Zola, 1973). Igun (1979) conceptualized health seeking behavior as a dynamic process based on underlying philosophical and societal assumptions and included care sought during asymptomatic periods. Igun further staged health seeking behaviors into ten phases that may occur over the course of an illness or injury. Harris and Guten (1979) studied health protective behaviors as a method of identifying self defined health seeking behaviors. The authors reported that all participants in their study took part in some level of health protective behaviors including self care such as diet and exercise as well as interaction with the health care system.

Health seeking behavior is also being studied within the discipline of nursing. The North American Nursing Diagnosis Association included health seeking behavior as a nursing diagnosis in their publication in 1987. The taxonomy was intended to clarify diagnoses within the nursing realm, promote concept development, and further nursing knowledge (NANDA, 2005; 2007). With this inclusion in the NANDA nursing diagnoses, many health seeking behaviors are identified as part of the bio-socio-cultural client response to illness, wellness, and health promotion. Health seeking behaviors were also studied in relation to nursing outcome classification research of nurse practitioner managed clinics (Macnee et al., 2006). The authors

identified eleven behavioral indicators of patients' health seeking behaviors and reported that illness-related behaviors were more easily identified and supported by the nurse practitioners than health seeking behaviors relating to health promotion and prevention.

### **Examples and Contributing Factors in Health Seeking Behavior**

Definitions and usage of the term health seeking vary considerably across the time continuum, scholarly disciplines, and contextual usages demonstrating the complexity of the concept and potential ambiguity of its use. Additionally, a number of related concepts are often used interchangeably, further complicating the efforts to clearly define health seeking behavior.

The literature is robust with examples of health seeking behaviors. Harris and Guten (1979) recognized thirty different activities that promote health in an attempt to define health seeking behavior. The authors categorized behaviors into groupings: health practices that includes sleep and diet, safety practices such as household repairs, preventive health care including regular physical and dental exams, avoiding environmental hazards such as pollution and harmful substances including tobacco and alcohol. Bausell and Bausell (1987) use similar behaviors and groupings in their research and note additional categories of health monitoring and accident avoidance. Macnee et al. (2006) attempted to evaluate health seeking behavior through use of indicators such as seeking information about health, discontinuation of unhealthy behaviors, contact with health care providers, and performance of activities to improve or maximize health. Though all of these activities may not strictly fall into a category of health seeking behavior, the authors felt that they broadly encompassed the ideas and contributed to the definition. This research is helpful in identifying a large range of behaviors included under the umbrella of health seeking but fails to recognize individual, social, and cultural factors that influence a person's choices and behaviors.

Researchers have also focused on the barriers to health seeking behaviors, often in relation to specific cultural groups or diagnoses. Barriers cited include gender and cultural differences in health care choices. People often make choices regarding use of home remedies and traditional healers in place of, or in addition to, western-style medical services and evaluate the efficacy and quality of health care provided (Ahmed, Carls, Chowdhury, & Bhuiya, 2000; Cho, 2004; Roy, Torrez, & Dale, 2004; Ward, Mertens, & Thomas, 1997; White et al., 2006; Xu, Sun, Zhang, & Xu, 2001; Yamasaki-Nakagawa et al., 2001). Access to health care and economic factors was also found to be major factors in health seeking behavior (Anderson, 1995; Carter, Cuvar, McSweeney, Storey, & Stockman, 2001; Gany, Herrera, Avallone, & Changrani, 2006; Osubor, Fatusi, & Chiwuzie, 2006; Roy et al., 2004; Ward et al., 1997). Again, this information contributes to a conceptual definition but does not encompass the entire meaning.

The literature indicates that there are individual and philosophical determinants of health seeking behavior. This includes basic health care knowledge on an individualized level, perception of needs, and risk factor awareness (Granich, Cantwell, Long, Maldonado, & Parsonnet, 1999; Moses et al., 1994; Rosvold & Bjertness, 2002; Timmins, 2006; Twiss, Dillon, Konfrst, Staffer, & Paulman, 2002; White et al., 2006). Symptom recognition, evaluation of severity, and perceived impact on life and activities are important factors as well (Ahmed et al., 2000; O'Connell, Wellman, Baker, & Day, 2006; Schantz, Charron, & Foden, 2003; Suchman, 1965; Ward et al., 1997). Lastly, personal philosophical beliefs regarding health and illness and perception of personal responsibility are features that influence individual health seeking behavior (Ahmed et al., 2000; Andersen, 1995; Blalock & DeVellis, 1998; Cho, 2004; Gany et al., 2006; Lauriola, Laicardi, Artistico, & Baldassarri, 2000; O'Connell et al., 2006; White et al., 2006; Xu et al., 2001).

## Definitions of Health Seeking Behavior

Definitions of health seeking behavior are identified. Due to use of surrogate terms, where appropriate, definitions of health beliefs and health behaviors are included. Historically, health seeking was viewed from an biomedical and illness perspective as reflected in the definition, “the way in which symptoms are perceived, evaluated, and acted upon by a person who recognizes some pain, discomfort, or other signs of organic malfunction.” (Mechanic & Volkart, 1960). Kasl and Cobb (1966b) made definitional distinction between illness behavior, sick-role behavior, and health behavior with the following definition of health behavior, “any activity undertaken by a person believing himself to be healthy for the purpose of preventing disease or detecting it in an asymptomatic stage.” (p. 246). Steele and McBroom (1972) propose this definition, “Preventive health behaviors are viewed as the use of professional health services in an asymptomatic state and the emphasis is upon behaviors to avoid illness and its effects.” (p. 385).

The following definition presented by Harris and Guten (1979) encompasses more aspects of the health experience, “any behavior performed by a person regardless of his or her perceived or actual health status, in order to protect, promote, or maintain his or her health, whether or not such a behavior is objectively effective toward that end.” (p. 18). Bausell and Bausell (1987) state a goal of their research was to reduce definitional differences in the concept of health seeking behavior, though no definition was suggested by the authors after completion of correlation analysis of specific behaviors. Andersen (1995) provides the following definition as part of his behavioral model, “Health beliefs are attitudes, values, and knowledge that people have about health and health services that might influence their subsequent perceptions of need and use of health services.” (p. 2).

In a discussion of control of sexually transmitted disease and health seeking behavior, this definition is presented by the authors, “Health seeking behaviour can be defined as any activity undertaken by individuals who perceive themselves to have a health problem or to be ill for the purpose of finding an appropriate remedy.” (Ward et al., 1997, p. 21). In a discussion regarding health seeking behaviors and barriers, the following definition was suggested, “Individual and family health beliefs and behaviors are informed, mediated, and ultimately defined by culture; therefore, culture affects health outcomes.” (Xu et al., 2001, p. 22). Researchers in the last two decades demonstrate understanding of health perception and cultural influences in health decision making.

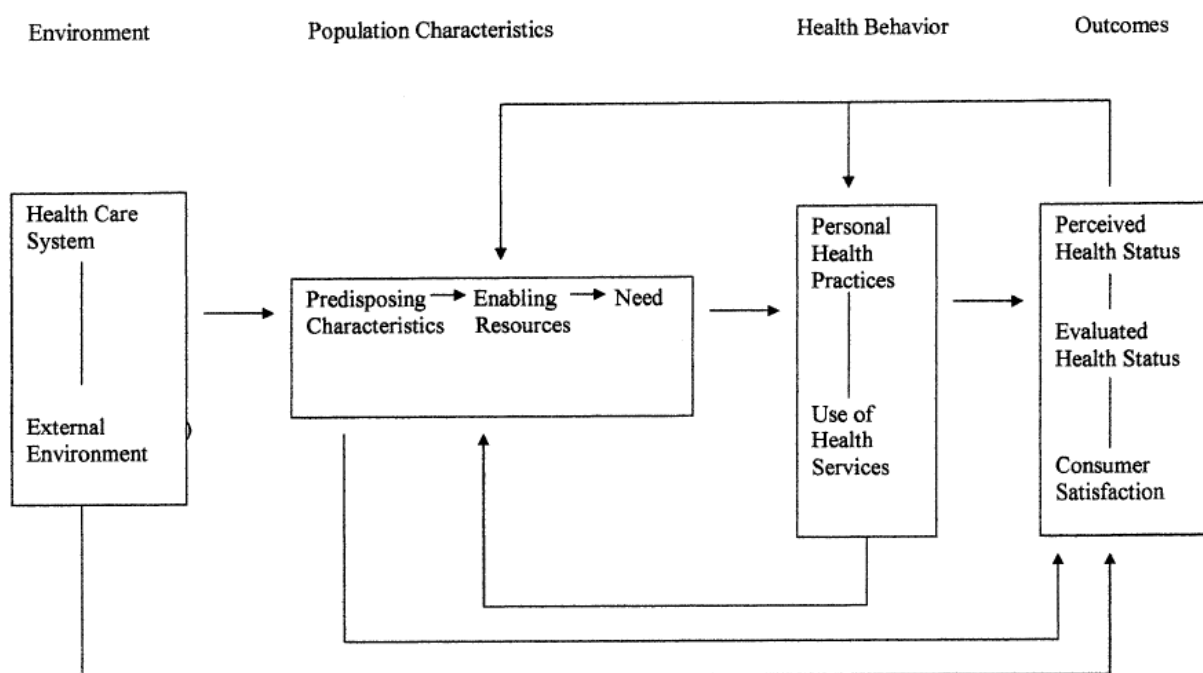
The concept of health seeking behavior has been widely used in scholarly literature, though there has not been a consensus of conceptual definition to this point. The concept is evolving as the health care emphasis has changed from an illness model to its current viewpoint of health as a bio-socio-cultural state. The concept encompasses a vast variety of health related activities.

### **Health Seeking Behavior Model**

A number of researchers have proposed models to enhance the explanation of health seeking behaviors. Several models were examined in relation to medical tourism (Andersen, 1995; MacKian, et al., 2004; Parsons, 1951; Suchman, 1965). No single model was found that incorporates the expansive nature of modern health seeking behaviors or the importance of social, psychological, and cultural influences on individuals seeking health. Andersen’s (1995) Revised Behavioral Model of Health Services Use was found to be multifaceted and evolving in nature; aligning it best with the study of medical tourism. It is chosen as the conceptual foundation for the study of medical tourism.

Andersen's model began with his research in the 1960's. Originally designed to examine use of health services by families and discuss equity in health care access, it has undergone a number of revisions in attempts to incorporate all components of modern health seeking behavior (Andersen, 1995). The model has been successfully used as conceptual framework in further study of health seeking behavior (Bradley, et al., 2002; Thind & Andersen, 2002). The current model incorporates environmental factors, population characteristics, and personal health behaviors with integrated feedback increasing its holistic and modern approach to the concept of health seeking behavior over earlier versions (Andersen, 1995).

**Figure 2. Revised Behavioral Model of Health Services Use, An Emerging Model – Phase 4 (Andersen, 1995)**



Andersen's model is comprised of four overarching elements: (a) environment of the health care system and external environment comprised of physical, political, and economic components (b) population characteristics including predisposing demographic, social, and health belief factors; enabling resources allowing access to care such as income, health insurance, and ease of travel; and perception of need (c) health behaviors which include both personal health practices and use of health services and (d) outcomes which includes perception of health status and customer satisfaction to provide for evaluation of health seeking behavior (Andersen, 1995). Both a systems approach and an individual health seeking behavior approach are evident in Andersen's model. Both approaches are useful and necessary to study medical tourism within the framework of health seeking behavior.

## **Future Health Seeking Behavior**

The study of health seeking behavior has been conducted in a multitude of contexts to this point, but further research is needed to understand how humans seek health in our current health care and social environment. The concept of health seeking behavior has evolved as our views of health and health care have changed over time, thus lending itself to the possibility of expanding further to encompass the health care options of the future. The contemporary behavior of travel for health care purposes is studied within the framework of the concept of health seeking behavior.

## **Chapter Three**

### **Methodology**

The methodology for the phenomenological study of the experience of medical tourism is discussed in chapter three. The chapter includes the research design, a discussion of the philosophical assumptions of hermeneutic phenomenology, human subject protection, recruitment procedures, the sample, data collection and analysis process, and procedures to ensure quality in research, and limitations.

### **Phenomenology**

The experience of traveling for the specific purpose of health care has not been well addressed in nursing research, yet is becoming a viable alternative in the global health care arena. Using a phenomenological interpretive design, the experience of travel for health care is explored. As demonstrated in the literature review, available information on medical tourism exists primarily within media publications, reports, and editorials. As such, a qualitative research approach is appropriate to explore this emerging global health trend. Specifically of interest to this researcher is a deep understanding of the experience of obtaining health care outside of one's resident health care system; how it feels to be in another country during a health care encounter and the motivation behind seeking health care abroad. These questions are best answered using a phenomenological research method.

Mackey (2005) emphasizes the importance of consistency between the philosophical underpinnings of hermeneutic phenomenology which are based in the teachings of the German philosopher Heidegger and the method derived for nursing research. The following discussion focuses on the procedural method in relation to the phenomenological study of the experience of medical tourism with the philosophical ideology supporting each step in the research process.

Heidegger used the term ‘being-in-the-world’ to describe a person’s oneness with their every-day world, yet at the same time having the capability of awareness and inquiry (Heidegger, 1962; Leonard, 1994; Mackey, 2005). In phenomenology, it is the premise that the world, the person, and the phenomenon are conceptually intertwined and the goal, as described by Heidegger, is understanding of the ready-to-hand mode or the hidden meaning that is only discoverable through in-depth exploration of the participant’s every-day engaged in the world reality (Dowling, 2004; Leonard, 1994; Mackey, 2005; van Manen, 1997).

Specifically, the perspective of the person having the experience of obtaining health care outside of one’s own resident health system is explored. Little is known about this multidimensional issue and a hermeneutical design provides a method of exploration that allows participants to express their thoughts using their own words to describe the phenomenon. Insight and understanding is gained through analysis of participants’ descriptions of their experience of medical tourism to uncover the portion that is “taken-for-granted and therefore difficult to describe.” (Benner, Tanner, & Chesla, 1996, p. 352).

### **Sample**

A small purposive sample of participants who have experienced medical tourism was recruited to participate in the study. This is an important aspect of phenomenological research and was done in keeping with the philosophy of hermeneutic phenomenology, as participants who have experienced the reality being investigated are the only valid and sensible data source (Baker, Wuest, & Stern, 1992). van Manen (1997) describes the need to tap or “borrow” the experience of someone who has the life knowledge of the phenomenon under study, “we gather other people’s experiences because they allow us to become more experienced ourselves.” (p. 62).

A total of fifteen people participated in interviews regarding their experience with medical tourism. All study participants are residents of Alaska. Volunteers from other U.S. states were excluded from the sample. Each participant had the personal experience of seeking and receiving medical or dental care during international travel. The sole purpose of participants' travel may have been health care or participants' may have been the dual purpose of health care and recreation. All participants were able to communicate in English, were eighteen years of age or older, and willing to tell their story of obtaining health care outside of their country of residence.

### **Human Subject Considerations**

The study was conducted according to the University of Hawaii Manoa guidelines for protection of human subjects. Before data collection began, the study received approval from the University of Hawaii Manoa Institutional Review Board and the University of Alaska Anchorage Institutional Review Board. The participants were volunteers. The purpose of the research, the interview procedures, and ongoing voluntary participation were discussed in detail before proceeding with the interviews. Participants were informed that there are no direct benefits and no identified risks as a result of their participation. A written consent form was signed by each participant. Strict confidentiality was maintained throughout the research process; names or other identifying information are not attached to audiotapes, transcripts, or field notes and access is limited only to the researcher.

## **Recruitment**

Study participants were recruited by word of mouth and email inviting the prospective participants to contact the researcher. Snowball sampling occurred with medical tourists identifying other medical tourists who were willing to be interviewed.

## **Data Collection**

The interview in hermeneutic phenomenology serves as a dialogue and the pathway for collection of the narrative which is the window for deeper understanding of the phenomenon (van Manen, 1997). For this reason, a semi-structured interview format was utilized to allow participants to freely discuss their experience of medical tourism. Interview questions focused upon the impact of obtaining medical care in countries other than the participants' resident countries, the feelings associated with obtaining the medical care, and motivations for the decision to become a medical tourist. The primary opening question was: 'Tell me the story about your experience of having [a procedure, surgery] in [Thailand, India, etc]'. As the aim of interpretive phenomenology is understanding of the essential experience, the query remained flexible enough to allow the participants' narratives to shape the interview (Benner, 1994; Benner et al., 1996).

The face-to-face and telephonic interviews were audio-recorded and then transcribed verbatim and checked for accuracy prior to analysis. Demographic information was attached to the transcription for contextual purposes only. Field notes were kept to record pertinent information regarding non-verbal communication and the researcher's thoughts during the interviews. These observations were incorporated into the verbatim transcriptions and utilized for enriching analysis (Crist & Tanner, 2003; Fleming, Gaidys, & Robb, 2003). Data collection and analysis occurred simultaneously, as the hermeneutic analysis process is circular and

narratives are explored concurrently with the interpretive process while interviewing continued and participants' narratives guided the development (Benner et al., 1996; Crist & Tanner, 2003; Fleming et al., 2003).

## **Analysis**

In phenomenology, the researcher is the primary instrument during the data collection and analysis process (Beck, 1994; Fleming et al., 2003). A substantial volume of raw data was generated from the interview process. QSR NVivo 8 qualitative research software was used to assist in initial classification and management of data, allowing a systematic and more in depth approach to the analytical process. As much as possible, assumptions of the researcher were acknowledged, yet not bracketed because the researcher possesses a preunderstanding in a situated world or as Heidegger described it, a forestructure of understanding (Crist & Tanner, 2003; Leonard, 1994).

The circular interpretive process described by Heidegger begins with intense engagement with the data, looking to uncover the hidden whole by deconstructing the phenomenon through examination of the elements, thereby allowing new perspective and depth of understanding to a revisited whole (Leonard, 1994; van Manen, 1997). Mackey asserts that listening, reading, and re-reading must occur but understanding will occur with interpretation that starts only with moving beyond the language to the thematic meaning (2005). Transcripts of the interviews were initially viewed globally for perspective. Summaries of the interviews were written to enhance preliminary awareness (Crist & Tanner, 2003; van Manen, 1997). Using a detailed, line by line approach, the transcripts were coded keeping small stories intact to preserve participants' words. The codes were then defined and categorized, allowing themes and then larger patterns to emerge from the data (Benner 1994; Benner et al., 1996; Crist & Tanner, 2003; van Manen,

1997). van Manen describes tying the process of analysis together with the question being studied as, “theme gives shape to the shapeless” (1997, p. 88). This also highlights the circular nature of the process which follows the philosophy of hermeneutic analysis attempting to move from a description of the whole experience to specifics allowing the experience to be re-assessed in new ways of understanding (Leonard, 1994; Mackey, 2005).

### **Quality**

Quality in research is addressed firstly by tying the methods of this study firmly with the methodology of interpretive phenomenology (Benner et al., 1996). The authors also emphasize that elucidation of decision making points for the reader of the research is important for quality and rigor in phenomenological research. As the essential truth of the experience of the participant of medical tourism is the goal of this research, the use of direct quotations of the participants’ words from the transcribed audio-recorded interviews helps the reader assess the quality and trustworthiness of the research process (Fleming et al., 2003).

Benner and colleagues discuss rigor in phenomenological research and summarize principles in conducting quality research. The phenomenological study of medical tourism was conducted using the principles that Benner et al. (1996) emphasize to improve quality: (a) orientation on the part of the researcher to medical tourism in a manner that allows new understanding to emerge, (b) attention to detail in data generation and analysis, (c) careful documentation of the thematic analysis using narrative accounts of medical tourist, and (d) strict maintenance and control of the data ensuring the confidentiality of study participants.

### **Limitations**

As in all research, there are limitations inherent in phenomenology. Rather than discuss the limitations that are commonly critiqued in the quantitative research realm such as

generalizability, van Manen (1997) emphasizes that phenomenological inquiry is not an analytical science, “it is not a science of empirical facts and scientific generalizations...” (p. 21). Phenomenology may be best thought of as an empirical science of deeper understanding of experiences; hence it is not assumed it can be transferred to others with similar experiences. Interestingly, van Manen feels that phenomenological research results provide understanding of the experience that exists somewhere between his description of particularity and universality in time and setting. As previously discussed, the purposive sample of experienced medical tourists and rather open ended interview questions best illuminate the phenomenon.

In evaluation of qualitative research, Leonard (1994) states,

A study can be judged by how carefully the question is framed and the initial interpretive stance laid out, how carefully the data collection is accomplished and documented, and how rigorously the interpretive effort goes beyond publicly available understandings of a problem to reveal new and deeper possibilities for understanding. (p. 61)

Limitations of this phenomenological research were addressed and minimized by cautious attention to detail and consistency with the principles of the methodology.

Bias and prejudice are often considered limitations in research. Byrne (2001) states, “From the hermeneutic perspective, personal experiences are not considered an impediment to the researcher’s ability to understand. In fact, the researcher’s values provide contextual meaning for the consumer.” (p. 969). Researchers’ assumptions are recognized and verbalized and the focus stays true to the participants’ narratives (Benner, 1994; Crist & Tanner, 2003). Use of a research journal and field notes documenting the researcher’s thoughts during interviews and research decisions during analysis help improve qualitative research quality (Byrne, 2001).

van Manen also stresses that phenomenological inquiry are questions of meaning rather than questions to be solved. Early in the study design, the following questions dictated the need for phenomenology and minimized the limitation: “What is the experience of medical tourism? What does it feel like to obtain medical care in another country? and What motivates you to seek care outside of your resident health care system?” The goal is to increase depth of understanding not provide solutions.

## **Conclusion**

Seeking health care internationally is increasingly popular and the need for further understanding of the phenomenon from the perspective of medical tourists is needed. Interpretive phenomenology, as discussed, provides methodology. The philosophy also guides study design to gain insight and understanding into the experience of medical tourism.

## **Chapter Four**

### **Results**

The results of the study entitled *The Lived Experience of Seeking Health Care through Medical Tourism: An Interpretive Phenomenological Study of Alaskan Patients Traveling Internationally for Medical and Dental Care* is presented in Chapter Four. This section includes the description of the sample, thematic analysis with supporting data in the participants' words, synthesis of the findings, and a summary.

#### **Sample**

Fifteen medical tourists from Alaska participated in this study. The sample consists of eight women and seven men ranging in age from twenty-nine to sixty-eight. Nine of the participants live in the urban area of Anchorage. The remaining six live in rural communities in Alaska. Nine participants had some level of private insurance. The remaining six participants were uninsured at the time of medical tourism.

The participants traveled for a variety of health reasons. Five of the participants traveled for medical care. Five of the participants traveled for dental care and five of the participants traveled for a combination of medical and dental care. Medical care received by the participants included preventative health screening, complimentary medical care, physical therapy, cardiac care, assistive reproductive procedures, otolaryngology, bariatric surgery, orthopedic evaluation and surgery, dermatologic evaluation, and ophthalmology. Dental care obtained during medical tourism included preventative dental health, dental cleanings, fillings, implants, root canals, and crowns. See Table 1.

**Table 1. Participant Profile**

Name(Fictional)	Age	Insurance	Destination	Health Care Obtained
Angela	33	Yes	Puerto Vallarta, Mexico	Bariatric Surgery
Candice	60	Yes	Bangkok, Thailand	Preventative, Screening, Dermatology, Colonoscopy, Otolaryngology, Ophthalmology Dental Hygiene
Carl	53	No	Bangkok, Thailand	Hip Surgery
Chris	29	Yes	Talinn, Estonia	Assistive Reproduction
Dana	60	No	Bangkok, Thailand	Preventative, Screening, Knee Surgery
Derek	61	Yes	Bangkok, Thailand	Colonoscopy Dental - Crowns, Implants, Fillings, Hygiene
Dave	57	No	Los Algodones, Mexico	Dental- Crowns, Root Canals
Dianne	68	Yes	Mazatlan, Mexico	Dentures
Evelyn	62	Yes	Poland Bombay, India	Complimentary Medicine Dentures
Jane	58	No	Chang Mai, Thailand	Dental - Crowns, Implants
Jeff	58	Yes	Bangkok, Thailand Chang Mai, Thailand Costa Rica	Preventative, Screening, Cardiac Care Dental - Fillings, Hygiene
Michelle	57	No	Los Algodones, Mexico	Dental Crowns
Nancy	29	Yes	Tallinn, Estonia	Assistive Reproduction
Sara	55	Yes	Bangkok, Thailand	Colonoscopy, Preventative, Screening, Orthopedic Evaluation Dental Hygiene
Tim	31	No	Mazatlan, Mexico	Dental - Crowns, Root Canals, Fillings

The study participants traveled globally in their medical tourism; some making more than one trip. Seven of the participants received care in Thailand. Five of the participants received care in Mexico. Three of the participants received care in Eastern Europe. One participant received care in Costa Rica and one participant received care in India. See Table 1 for participant destinations. The years of travel span from 1998 to 2009. The sample consisted of four couples with both partners receiving health care during medical tourism. See Table 2. The remaining seven participants either traveled alone or with partners and family members that did not receive care.

**Table 2 Participant Profile (Partners)**

Name (Fictional)	Destination	Health Care Obtained
Carl/ Dana	Bangkok, Thailand	Hip Surgery/ Preventative, Screening, Knee Surgery
Chris/ Nancy	Talinn, Estonia	Reproductive Tourism/ Reproductive Tourism
Dave/ Michelle	Los Algodones, Mexico	Crowns, Root Canals/ Crowns
Candice/ Sara	Bangkok, Thailand	Preventative, Screening, Dermatology, Ophthalmology, Otolaryngology, Dental/ Preventative, Screening, Orthopedic, Dental

## Findings

The participants shared their stories of seeking and obtaining medical and dental care during international travel which generated a large amount of rich, descriptive data. Through data analysis using a phenomenological interpretive process, the experience of being a medical tourist was illuminated. The participants spoke of their motivation for seeking care internationally and the research they did prior to travel. They went into significant detail describing the health care they obtained during medical tourism. The participants spoke freely of their impressions and feelings about the care they received. The participants also discussed follow-up medical and dental care, as well as future plans for health care. The participants were articulate and expansive about their health care experiences during medical tourism. Fictional names have been assigned to the participants. Throughout this chapter, the participants' words are in italics.

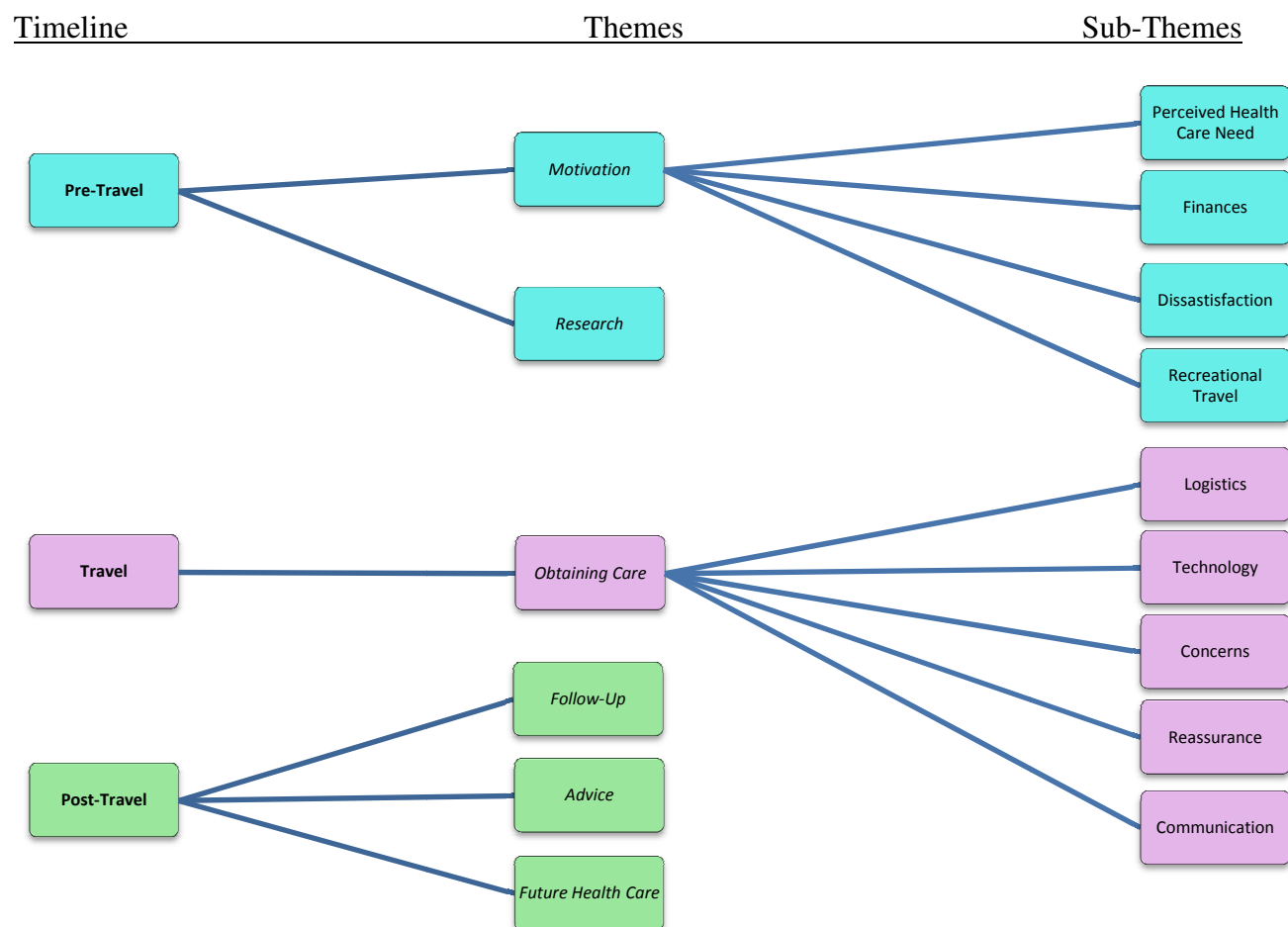
The participants' stories of their medical tourism experience had many common threads. They all expressed some sense of adventure in relation to their travel for health care. The participants recognized that they were somewhat unconventional in their choices of health seeking behavior, but all of them expressed a need for health care and a solution to their unmet needs through medical tourism. In telling their stories, they voiced some trepidation regarding the unknown ramifications of their health care choices. Feelings of unease were relieved by their positive interactions and connections that they formed with their health care teams internationally. They returned to Alaska with the belief that they had received high quality health care that improved their health status, thereby making medical tourism an effective means of health seeking behaviors.

## Thematic Analysis

Thematic analysis of the data revealed six primary themes. Themes were chosen, defined, and named based on the number of participant responses that support that aspect of the medical tourism experience. The themes were further divided into subthemes which are helpful in understanding the complexity of the participants' experiences. The themes that emerged from the interviews are also categorized in a chronological order emphasizing the participants' process of planning prior to travel and health care, followed by the medical tourism experience where the participants described the care and their impressions about obtaining care in international locations, and concluding with post travel follow-up with health care providers in Alaska, advice for other medical tourists, and plans for future health care.

The primary themes that emerged from the data are *Motivation, Research, Obtaining Care, Advice, Follow-Up, and Future Health Care*. The theme of *Motivation* is further categorized in the sub-themes of Perceived Health Care Need, Finances, Dissatisfaction with U.S. Health Care, and Recreational Travel. The theme *Obtaining Care* is further categorized in the sub-themes of Logistics, Technology, Concerns, Reassurance, and Communication. See Figure 3. Each theme and sub-theme is discussed within this chapter.

**Figure 3. Diagram of Thematic Analysis**



### **Pre-travel.**

The participants often conceptualized their experiences of medical tourism by describing important events and thoughts that led them towards traveling to international destinations for health care. Although monetary considerations were universal amongst the participants, other significant motivators for medical tourism also become apparent through the analytic process.

*Motivation* as a theme and the subthemes of Perceived Health Care Needs, Finances, Dissatisfaction with the U.S. Health Care System, and Recreational Travel are discussed.

Planning and research of the participants' health care and recreational travel also occurred prior to the travel experience. The participants were creative in their methods for seeking information about medical tourism. The theme *Research* is also discussed in the section of pre-travel considerations of the medical tourism experience. Both *Motivation* and *Research* are antecedent conditions of the actual international travel for health care purposes. Motivation for medical tourism led the participants to begin the research process. The results are presented in this order, reflecting the progressive nature of the pre-travel experience.

### ***Motivation.***

All of the participants spoke about motivating factors for traveling internationally to obtain health care. The need for health care motivated the participants to travel and become medical tourists. All of the participants experienced unmet health care needs and traveled to international destinations to obtain medical or dental care. Another significant motivator was the high cost of medical and dental procedures in the U.S. All fifteen participants spoke at some length about the financial saving they realized by becoming medical tourists; many of them noting that cost savings were the important motivator for medical tourism. Often the participants compared the price of the care they received as a medical tourist with the cost of comparable

care within the U.S. health care system. Many of the participants discussed lack of adequate health insurance as a motivator for travel. The participants who were privately insured also reported saving money through medical tourism. Dissatisfaction with the U.S. health care system was another apparent theme that emerged from the data, with participants discussing failures within the system creating frustration and motivation for medical tourism. Lastly, the opportunity to travel to international destinations was also an appealing factor in their health care decision making. Each sub-theme is presented with participants' words supporting the analysis.

*Perceived health care need.*

All of the participants discussed the health care they obtained during medical tourism in detail. Unmet health care needs were the primary reason for medical tourism. Health care needs included traditional medical and dental care, as well as other treatment modalities, health screening activities, and complimentary medical care. The participants described an extensive variety of medical and dental care needs; framing their stories of the experience around the care they received. Carl, age 53, lives in rural Alaska and traveled to Thailand to have his hip replaced. He described his unmet health care need for care in this way,

*It progressively got worse, degenerative over the years and it got to the point, well I do a lot of hiking and climbing and stuff like that and skiing and the pain was getting worse and worse...progressively over the years...It had gotten to my point in life where I had to do something because I was just dealing with pain a lot and I didn't want to live that way anymore.*

Carl's painful physical condition motivated him to participate in medical tourism. It was evident from his story that he had an active lifestyle and wished to continue participating in outdoor Alaskan sports and recreation. Nancy, age 29, described her motivation as a long health care

journey of medical testing and treatment in her unsuccessful attempts to get pregnant. She related,

*We have been on a journey for the last seven years in infertility...We decided a couple of months ago that we were going to pursue in vitro fertilization...We went over to Estonia and we were there for three weeks of pretreatment before and then we had IVF done.*

Having exhausted other medical options to become parents, Nancy and Chris became reproductive tourists in Eastern Europe.

Ten of the fifteen participants described their needs for dental procedures. Tim, age 31, works as a mechanic in a small Alaska community. He described the dental care that he obtained in Mexico, *"I just had five root canals and five crowns put on and a bridge installed on one of the crowns...I had so many root canals that needed to be done. I was in constant pain all of the time."* Ongoing pain prompted Tim to explore the idea of traveling to Mexico for treatment. Jane, age 58, also described the extensive dental work that she needed, *"I needed this whole big treatment...basically it is re-crowning all of my teeth and resetting my bite."* Derek, age 61, who has recently retired also traveled to Thailand for dental work. He said, *"I did need a fair amount of dental work done on my teeth...The primary purpose was initially to get this work completed...Essentially I needed several crowns and implants on my teeth."*

The study participants described extensive medical and dental procedures that they needed which prompted their international travel experiences. Some of the participants described significant physical and emotional discomfort that impacted their wellbeing, ability to work, and find enjoyment in their lives.

Other participants spoke about their perceived need for preventative health visits that motivated their travel. Jeff, a 58 year old pilot from Anchorage, discussed the choices that he made, *“I chose to go through their executive program which was the most extensive one. My thinking at the time, I wasn’t having medical problems but I wanted a good baseline for future reference.”* Dana, age 60, described the screening health care and therapy that prompted her health care, *“I did some physical therapy...Other than that...I had probably the best physical I’ve ever had in my life.”* Evelyn, age 62, discussed her stressful work environment in Alaska. She described her health care needs and time she spent in an integrative complimentary health environment,

*In Poland, when you are sick or after hospital and you are still not well, they send you for treatment for weeks in this kind of sanitarium. It is usually in the mountains or on the ocean...you benefit from being on the water or in the mountains...We were going every day...There is some special baths and then into the swimming pool for exercise. This was all for rehabilitation for arthritis, for joint movements. You know it was very intensive.*

The participants were motivated by their perceived health care needs. These unmet needs created a set of health seeking behaviors that led them to explore medical tourism. Although the participants each had a unique experience, they all structured their medical tourism stories around the needed healthcare that prompted the travel.

#### *Finances.*

The cost of medical treatment was a significant motivation for medical tourism in this study. The participants often reported the surprise and delight they felt in discovering the savings involved in seeking health care during medical tourism. Dave, age 58, described himself as a self-employed realtor. He conducted cost comparisons prior to traveling to Mexico with his

wife Michelle for dental procedures. The couple has no medical or dental insurance. With a sense of amazement, he discussed the cost difference, *“It cost us a hundred and eighty dollars apiece for each crown and a hundred and eighty dollars for the root canal. It would have cost fourteen hundred (dollars) apiece here.”* He went on to describe the cost of his airfare and accommodations; reporting the overall savings were significant.

Many of the participants voiced the inability to afford health care within the U.S. health care system. Carl described the financial motivation for medical tourism for his hip replacement,

*I really couldn't afford it, since I didn't have insurance. I couldn't afford to have it done here. I did check out the prices of the type of surgery that I was interested in and it was, prices varied, but it was fifty to eighty thousand dollars and I started looking [internationally]!*

Carl reported a total cost of \$14,000 for his trip and surgery in Bangkok. Recognizing that he saved between \$36,000 and \$66,000, Carl emphasized that medical tourism made it possible to get the hip surgery that he needed.

Lack of adequate health insurance coverage was also an identified factor in the economic aspect of participants' choice in obtaining health care internationally. Participants with no insurance or inadequate coverage had difficulty affording health care in the U.S.

Sara, age 55, discussed her insurance coverage which was not adequately covering her needed preventative health care, *“We have major medical coverage in our U.S. health insurance, but they aren't going to cover very much. It's got to come out of our pockets.”*

Candice, age 60, traveled to Bangkok for a preventative health care visit. She happily reported the long list of health care she received for a fraction of the cost she would have paid in the United States. She adamantly stated,

*We went strictly because it's the deal of the century! It's about four hundred dollars and here's a list on the comprehensive package...every kind of blood work you can imagine, urine examination, stool examination, electrocardiogram, exercise stress test, chest x-ray, ultrasound of the whole abdomen, digital mammogram with ultrasound, breast exam, pap smear, pelvic exam and eye exam, and all of that for four hundred dollars which is just pretty phenomenal!*

Candice's body language further emphasized her very positive feelings about the money she was able to save. Candice also explained that the personal insurance policy that she carries does not include preventative health screening; creating a financial motivator that spurred her travel.

Derek brought a large stack of medical and dental receipts to this interview to demonstrate the amount of money he saved by having medical and dental care in Thailand. Referencing his paperwork, he reported his cost savings,

*With the crowns that I needed, they quoted me here locally that they were running about nineteen hundred dollars each. In Thailand, they were quoted at four hundred and thirty. I also had a temporary front flapper, they call it, manufactured in Thailand for my tooth. I paid about eighty dollars for it there. I was quoted eight hundred dollars here for the same thing.*

Derek was amongst the group of participants that had medical and dental insurance, yet he chose to obtain both medical and dental care in Thailand due to the out of pocket expenses that he

incurs for care in the U.S. He reported feeling pleased that he was able to use his dental insurance coverage for the dental procedures done in Thailand.

*My health insurance covered fifty percent of the cost of a crown and a higher percentage for fillings and one hundred percent for preventative type work, here and also over there, same coverage in Thailand. But there was a two thousand dollar annual benefit of the insurance.*

The amount of dental work needed far exceeded Derek's yearly dental insurance benefit and he stated, *"It would have been a big financial burden if I'd had to pay for that work here locally..."*

Derek also provided information about the cost of his airfare and hotel emphasizing the difference in cost of treatment despite travel and accommodation costs.

Angela, age 33, described her financial motivation for medical tourism in Mexico. As a nurse she has medical insurance, yet the after insurance expenses for a bariatric procedure in the U.S. made it unaffordable.

*I went to a bariatric physician in town who is a great physician, great personality, great bedside manner but insurance was a huge factor. I mean, out of pocket, I was going to be out twenty, thirty, forty thousand dollars and that is with insurance coverage. I mean it's just so expensive...then I started researching outside of the U.S. That's what prompted that...You know I looked into it and its ten grand...all inclusive, ten grand. That's for everything...It was so much cheaper!*

She further detailed that this cost for bariatric surgery in Mexico included airfare, hotel, food for herself and her mother who accompanied her. As evident in her words, Angela was extremely

pleased with the cost differences. She noted that the savings made the surgery a feasible option for her, allowing her to have surgery which has improved her overall health status.

Nancy, the young woman who traveled to Eastern Europe for assistive reproductive procedures, discussed the vast savings that she realized by getting in vitro fertilization in Estonia. Her medical insurance did not cover assistive reproductive procedures. She said,

*Living in Alaska, either way we would have had the travel and food expense and hotel boarding expense, but going over seas, we could have done that four times for the cost of what it cost anywhere I'll say on average in the United States.*

In addition to being emotionally taxing, Nancy spoke of the significant financial toll that assistive reproductive procedures can take on a couple seeking pregnancy. She said, *"You know it could completely destroy a couple financially if right now they would go get this type of procedure done in the United States."*

All of the participants expressed gratitude about being able to obtain affordable health care in international destinations. After receiving a quote of \$50,000 for dental care in Alaska, Jane traveled and stayed in Chang Mai, Thailand for three months to have multiple dental procedures which cost her \$6,500. She stated, *"It felt great to save a ton of money that way! You know, we worked hard to save our retirement and I didn't want to spend a big chunk of it on my mouth."* Dana, a retired nurse, expressed her thoughts about insurance and health care, *"I eat really healthy and I exercise. That is our health insurance, (pause) to take care of ourselves"* After being able to receive preventative health and orthopedic care in Bangkok, she expressed, *"That's really nice to have access to health care. It was amazing!"* Michelle, age 57, poignantly spoke of the problem with access to care, *"It's really important to have basic care, and more importantly, it's really important to have affordable care."* Candice echoed the thoughts of the

other participants by saying, *“It feels really good to me to be able to go to this country and get medical care at a reasonable price.”* Every participant in the study verbalized financial reasons for traveling internationally for health care. The emphasis that the participants placed on this aspect of medical tourism provides insight into the overall experience.

*Dissatisfaction with U.S. health care.*

Many of the participants discussed problems within the U.S. health care system as motivation for becoming medical tourists. Participants were very verbal about their significant discontent and resentment about the state of health care in the U.S. Candice’s frustration with her major medical insurance coverage in the U.S. prompted this statement,

*...We are already spending ten thousand dollars a year just to buy our ridiculously priced policies! And then if we actually went to a doctor, we’d still have to pay until we hit five thousand and then on top of that, we’d still have to pay our twenty percent or whatever the co-pay is...So I am stuck with having to pay for this thing [insurance] that I don’t get and that’s what frustrates me. If I pay the amount of money I pay and I actually got health insurance and I could go to the doctor, it would be okay. Like you go to the grocery store and you spend five hundred dollars on groceries, you have five hundred worth of food. That’s what drives me crazy about this. I don’t really have insurance.*

Candice's words and demeanor expressed her exasperation in trying to obtain health care within the U.S. system. Dana was adamant about her negative feelings about insurance. She said,

*In the United States, you've have all the intermediaries. I'd like to just get rid of insurance companies altogether. You know, I don't hire a middle man to pay my bills. That's what seems bizarre to me. I mean insurance companies are middle men.*

Many of the participants identified frustration by their lack of insurance or inadequate insurance coverage. This in part motivated the participants' medical tourism.

Carl expressed his inability to get needed care in the U.S. health care system,

*...I felt that the American health care system is so expensive and so broken that I didn't have any real alternatives...I was at a dead end as far as getting the medical help that I would need now or in the future through the American system.*

His voice evidenced the helplessness he felt in not being able to afford hip surgery in the United States. Candice spoke about the overall state of the U.S. health care system and the general attitude of the U.S. population about the health care system. She said, *"The whole idea that things can be good anywhere but America is just foreign. People just don't get that. You know, they think that we have the best. And we don't! I mean statistically we don't have the best system."* Her words and body language emphasized the amazement she felt. Candice further shared her frustration,

*I feel a lot of anger and resentment about our whole system here because it is such a system of the have and the have-nots. I don't go to doctors here. I just don't go! I know that's not a good thing and we're not supposed to do that but it's painfully expensive!*

She went on to discuss her anger with the U.S. health care system,

*I'm resentful of the fact that in this country it's almost impossible to get a price. You would never ever take your car to a mechanic and not get a quote. You ask how much something is going to cost to any medical professional here and they are taken back that you've even asked...It's just not a simple thing and it should be a simple thing.*

Jeff voiced very similar concerns,

*What really frustrates me with the American medical system, if you are asking ahead of time what a procedure is going to cost, they immediately start into a big tap dance and either evade the question or they say they just can't answer your question. To me that is just absurd! I mean how many businesses do you walk into and say I'm going to buy something but I have no idea what it is going to cost?*

The participants contrasted these frustrations with their medical tourism experiences where health care costs were readily communicated through websites, email, and telephone. Jeff reported, *"I was impressed how their health screening program was laid out. It allowed you to choose different options as far as what level of health screening you wanted to participate in but all of the costs were itemized."* Other participants echoed Jeff's feelings about the ease in obtaining the cost of services prior to and during medical tourism.

The participants also discussed time and inefficiencies in the U.S. health care system as aggravating elements of the experience of seeking health care. Michelle talked about the length of time it takes to have dental work in the U.S. health care system as a contrast to the convenience of having multiple dental procedures done simultaneously in Mexico. She said,

*When you go to see the dentist and you need crowns they will only do one or two at the most. So you get that done, then you wait three weeks for your crowns with temporaries, then you go to get them fitted and then they'll do the next ones and so forth.*

Jane also discussed the difference in timing for dental procedures between the U.S. and Thailand. She said, *"I just knew that here it would take a long time to go through that whole procedure. I'm sure it would take like six months of going in regularly and I just didn't want to face it..."* She notes the emotional difficulty involved in having multiple, serial dental procedures done in the U.S. She also reported that she postponed her dental work because of this difficulty.

Many of the participants commented upon the decreased time commitment needed for dental and medical care as a motivating factor in their medical tourism experience. Derek had dental insurance but his need for extensive dental work requiring more immediate attention created difficulties in using his insurance. He said, *"...getting to optimize my dental insurance would have taken years."* They also discussed time in relation to the care they receive in the U.S. Jeff described the efficiency of his preventative screening visit that has motivated him to return to Thailand yearly for preventative health purposes,

*This hospital was just so efficiently operated in that regard and I was able to go through their entire program in about six or seven hours at the hospital. I kind of call it having practically every test known to man... I think to do a similar program here in the States would takes you weeks because our system is so archaic.*

Jeff also discussed availability of physicians and scheduling difficulties in the U.S. He verbalized his discontent, *“You are lucky to talk to a physician for ten or fifteen minutes when you go into an office in the U.S.”* and added *“I have to monkey around with scheduling weeks out to get in for the exam here in the states where over there it is just no problem...I usually schedule one day ahead and go in. It is handled very efficiently.”* Dissatisfaction with time and scheduling health care in the U.S., frustrations regarding inadequate insurance coverage, and displeasure with the overall state of the U.S. health care system motivated participants to seek health care in international locations. An overall sense of relief was expressed that they did not encounter the same barriers to care in their medical tourism experience.

#### *Recreational travel.*

The opportunity for international travel also motivated the participants to become medical tourists. Many of the participants richly described their associated recreational travel. They also warmly discussed fascination with the international medical destinations and experiences with other travelers and local citizens. Nancy described her recreational travel,

*We had not been to Europe and this would be a great opportunity to go see my brother for a couple days in Russia...There were times in between appointments. We had four days so we jumped on a train and went over to Moscow...We tried to make it as much of a vacation trip as we could in between visits.*

Derek traveled in Asia in conjunction with his medical and dental care. He said, *“The primary purpose was initially to get this work completed. As long as I was over there, I made the most of it and traveled to Laos. I was also in Burma and traveled extensively through Thailand.”* He was pleased with his overall travel experience, believing it added to the experience of medical tourism.

Dana expressed her enthusiasm for travel in the following way,

*I love to travel! Why not go somewhere, do something like this and see another country. I mean, it's turning it into something from being expensive and maybe depressing, to something where you can have a little fun at the same time and take care of yourself in a nice setting.*

She continued her thoughts, *"It wasn't just the money, but also just the interest of the experience."*

Jane also spoke of her desire for travel, *"We were enamored with the idea of going to Thailand and wanted to spend the whole winter out of Alaska. We started putting together this whole idea of combining it with dental work. The timing just worked out great!"* Michelle, who traveled to Mexico for dental work discussed planning the trip to include recreation as a motivator, *"We turned it into an adventure trip of hiking and meeting up with some folks...It was a total adventure!"* Combining recreation and travel with their health care added to the participants' medical tourism experience.

Participants also spoke of their interest in the cultural aspects of their travels. Jane described meeting people during her medical tourism experience, *"We ended up staying there over three months so we met people and most of them were international travelers. We did meet some local people too."* Dana discussed the cross-cultural aspect of travel, *"You know it is just interesting seeing the differences."* She went on to describe fascinating experiences that she had in restaurants and while walking in Bangkok. Jeff also thoroughly enjoyed his travel experiences, *"Thailand is a wonderful country. It has the nickname 'the land of smiles' which is so true. Thai people are just very friendly open people!"* Jeff returns to Thailand yearly for medical care, partly because he enjoys the international environment. Although the participants

found the opportunity for international travel to be a motivating factor, there were clear benefits from the experience including changes in cultural awareness.

Sara described one of her impressions of Bumrungrad Hospital in Bangkok with a sense of awe,

*The other thing I do want to say that was really different about the experience is that it was multicultural. I felt like I was in the U.N! There were people from everywhere... We went down there to wait and there were a lot of middle eastern women there in their burkas, sitting there in Starbuck's drinking coffee or sitting on their cell phone. Just that international flavor of it was really remarkable!*

Carl used many of the same words in his statement regarding the multinational nature of the hospital,

*I could sit and read the paper, have my coffee. And it was like being in the United Nations. There was people from all over the world walking about in this lobby that were either having some sort of procedure or family of someone that was having a procedure.*

Sara also described cultural differences that she noted in the health care arena,

*When I was in line for the pap smear, many of the Middle Eastern or Arabic women, I don't know where they were from, but they were definitely in head to toe burkas. They had men with them in the waiting areas...so that when they were taken into their appointments, their men went with them.*

Jeff also expressed amazement with the international flavor of the experience, *"It's amazing at the hospital when you realize that people truly come from all over the world for treatment! There's people from Africa. There's people from Europe, America. You know it's truly an*

*international destination.”* Many of the participants commented on recreational aspects and travel adventures as being important to the experience of medical tourism.

In this study, motivation for medical tourism was a cohesive theme that emerged from the data. The participants had many reasons for seeking care internationally and spoke passionately of their rationale and incentives for travel. The sub-themes of Perceived Health Care Need, Finances, Dissatisfaction with U.S. Health Care, and Recreational Travel were discussed and supported with the participants’ descriptive comments.

### ***Research.***

Prior to travel and health care, most participants spent a significant amount of time researching available options in the international health care market. Newspaper, internet, radio, books, personal contacts, and references were avenues for information that the participants used to investigate their destinations and procedures. Angela, the participant who went to Puerto Vallarta, Mexico for bariatric weight loss surgery, spent a considerable amount of time researching and planning her trip. She said,

*I’d researched not only the hospital, but the physician, his nutritionist, his back-up physicians extensively. So I felt really comfortable about going down there, in addition to having spoken to someone who had gone to that actual physician and hospital and had a similar procedure done...I’ve been doing a lot of research on weight loss surgeries for about five, six years trying to decide what was best.*

Derek discussed his research activities,

*I found this, the place is called the Bangkok Smile Dental Center. That’s how I initially, just on my own, I did an internet search. I googled Bangkok dental and several places*

*came up. This place looked like a first class facility from what I could see on the website. They had several references.*

Carl described the research that he did on the internet of Bumrungrad Hospital and a surgeon. He said,

*They have a very extensive website so you can do a lot of research. Unlike here, in the states, where it is kind of word of mouth as to what you are going to get or who the doctor and stuff like that, how experienced they are. At Bunrungrad's site, I could go to, there's a link for orthopedics, and I went to that and they have a list of all the doctors that do orthopedic surgery there. And it's a very small resume of each doctor but what I liked about it was seeing the age of the doctor, basic stuff, a photograph, and where they went to school.*

Many of the participants were comforted by the information they discovered prior to traveling. Jane, who extensively researched dental care options in Thailand, was not only comforted but became eager to become a medical tourist as she gained knowledge. She said, *“The more I read about it and researched about it and talked to people about it, the more comfortable I got and the more excited I got! We decided to go for it.”* She also talked about the research that she did once in Chang Mai,

*We did some research online again and made some appointments. Eventually we went to three different medical or dental clinics there in Chang Mai. I was only able to see two different dentists...So I had two different assessments and meet and greets with dentists and staff and things like that in two different clinics.*

Nancy shared information about her research into reproductive tourism in Eastern Europe,

*I really talked to the doctor a lot. I talked to her a lot through email and on the phone and the fact that I had been referred to that particular clinic. I know some people might think, wow, they really kind of did a leap of faith but the fact that I had been referred spoke volumes to me...I felt very confident with the people that I would be working with.*

Angela spoke of the benefits of having spoken to another medical tourist, “*The most motivating factor was probably being able to speak to someone who had been to that physician, been to that facility. She had a different procedure done than I did but same doctor and everything.*” Dave discussed his research activities and referrals prior to travel,

*We talked to a friend of ours who is a dental hygeinist who said, ‘You know my parents live down in Arizona. They are retired down there. They go across the border with their church group and get all their dental work done down there’. So we contacted the clinic that she pointed us to. We researched a number of other clinics in Mexican border communities across from California and Arizona. We were happy with what we got, the responses that we got back from the clinic that had been recommended.*

Carl said, “*We found out about it through our friends and they had real positive experiences.*”

Contact with people who had traveled for health care or referrals from friends and families were central to many of the participants’ research. Jane and her husband went one step further in their research process by having her husband have dental work to trial the experience prior to her extensive procedures,

*The first thing we did after choosing the clinic was we had my husband be the guinea pig. He needed to have a crown so when we told the dentist what we were doing. We said that*

*we want him to go through the whole experience of having a crown and made and seated and finished before we started any of my work...It made us both feel very comfortable.*

The participants were resourceful in finding information about the destinations, facilities, providers, and costs before becoming medical tourists. Collecting information through research, references from friends with experience, and links with organizations that have ties were all means of achieving greater comfort level with the concept of medical tourism prior to travel.

The themes *Motivation* and *Research* have highlighted interesting aspects of the pre-travel experience for the participants. All of study participants described a unique combination of motivators and research that brought them to the point of embarking upon medical tourism. After describing the pre-travel aspects of their experience, the participants discussed their feelings about their travel and health care.

### **Travel**

Following the chronological nature of medical tourism as described by the participants, *Obtaining Care* during international travel emerged as a dominant theme. The theme *Obtaining Care* provides valuable information about medical tourism from the perspective of the sample participants. The sub-themes Logistics, Technology, Concerns, Reassurance, and Communication surfaced and are used to further classify and illuminate the medical tourism experience.

### ***Obtaining Care.***

The participants shared their perceptions of being medical tourists. All of the participants enthusiastically expressed positive feelings about seeking and receiving medical or dental care during international travel. They also spoke about the logistics of being medical tourists, most finding it easy to navigate the health care systems while traveling. They also freely admitted and

shared areas of concern that they had prior to or during their medical tourism experience. The participants also found certain aspects of the experience calming and reassuring.

Communication with others was an important aspect of the medical tourism experience. The participants also voiced advice to others considering medical tourism. The resoundingly positive experiences are evident in the participants' comments.

Speaking of her bariatric surgery in Mexico, Angela said,

*I thought the experience was phenomenal! I think the doctors took extra time and made extra effort and put in that extra leg work to make sure I knew what I was getting into, to make sure I understood the procedure completely and all of the complications...I felt I made a great decision because of the care I got!*

Jeff spoke of the trust he has in his health care team in Bangkok,

*There's been numerous instances with both myself and my wife that I have been truly astounded at the level of care that they are willing to take with each patient...very fair, very competent, very compassionate...I feel very confident. They are engaged in doing the best job that they can.*

The participants also discussed their impressions of nursing care they received during their medical tourism experience. Jeff said, *"I am amazed at their level of nursing staff."* Angela remarked, *"The staff was amazing."* Sara said, *"They just made it as pleasant as possible. You just felt really well taken care of, respected."* Dana, a nurse from rural Alaska spoke about nursing care from a professional perspective. She said, *"It was very much, very personal care...It's just amazing."*

She added,

*Being a nurse I certainly had my eye on what was going on. I spent a lot of time in the hospital room. I was very impressed with the nurses there. I felt that they were checking everything that I would have checked.*

These vignettes emphasize participants' reports of professionalism, dignity, and respect that they experienced.

Sara talked about her impressions of the hospital in Thailand, *"One very vivid image...the lobby looks like a hotel lobby. It is very elaborate and very beautifully architected and there's a Starbucks in the lobby."* Three other participants also mentioned the Starbucks coffee shop in the hospital, indicating that the presence of Starbucks was surprising yet welcoming; a change from a sterile hospital setting. Overall the participants found the international health care settings to be warm, friendly, and inviting. This is evident in Nancy words, *"When we were there and when we arrived, the people were nothing but warm and welcoming."*

#### *Logistics.*

Being a medical tourist and obtaining health care in international destinations created circumstances requiring the participants to navigate new and different environments. The logistics of arrival and receiving health care was imbedded within the participants' stories. A majority of the participants commented upon the simplicity and ease they felt regarding their interaction with the foreign health care system.

Candice summarized her arrival with this comment,

*I think this place has done as much as they can to make that easy with the picking up at the airport and that you can stay right there so you don't even have to negotiate streets to find your way.*

After her second trip to Thailand, she discussed the logistical ease in which she experienced the comprehensive health screening. She described the circular pattern of the health stations that included a fully stocked snack area so that patients could eat after completing fasting lab tests, allowing them to continue the process without interruption. This was perceived positively by the participant as an efficient system that provided for patient comfort and wellbeing.

Other participants spoke of the effortless movement within the hospital and clinic. Dana said, "...As soon as you were ready to go to a new department, someone would pop up and guide you to where you had to go. It was very pleasant, actually to not feel lost." Sara also appreciated the personal care given, "There seemed to be a lot of hand holding involved which was really nice. They didn't just say go to the fourth floor. You know, they took you there and dropped you off."

Angela spent five days in Mexico for her bariatric surgery. She described the logistics and timeline of her experience in this way,

*They took us to the hotel and they got us set up at the hotel and then they had someone pick us up and take us to the hospital the next morning...So, it was, pretty much was taken out of our hands. They had everything squared away for us so we didn't really even have to think while we were down there...I went down one day. We got set up in the hotel. The next morning, I was in the hospital signing all the paperwork, going through*

*everything, making sure that I had a good clear understanding of what to expect post-op. Then it was right into the hospital gown, IVs, to the room, waiting to be next on the table.*

Other participants also commented upon the expediency within the clinical setting and ease in scheduling. Jeff has made ten trips to Bangkok for medical care since 1998. He relates,

*After the stress test and the cardiologist was looking at my EKG and we discussed what was going on, he recommended this (cardiac CT scan)...He got on the phone and I had the option of being in the facility and having it done within the hour.*

Assistance with transportation was viewed as a positive attribute of the medical tourism experience. Jane smiled as she shared,

*Another thing that the clinic offered was free transportation so they picked us up and dropped us back off each time which was just so nice. It was just a small thing but it was just so nice. It was just very sweet. When we got into the clinic they would give us tea and slippers to wear.*

After describing the accommodations in and around the hospital in Bangkok, Jeff said,

*If you're coming from elsewhere in the city to the hospital,...you can take the Skytrain to the two closest stops to the hospital and the hospital has a van that comes every fifteen minutes to the Skytrain station to pick you up to give you a ride to the hospital.*

To summarize the logistical ease that occurred during his experience of medical tourism, Carl shared, *“I mean they cater to foreign tourist; it was a very positive experience. Taking the surgery part out of it...how it was run, the logistics involved, how easy it was; much, much easier that I thought it would be.”*

The topic of logistics and travel were commonly detailed by the participants. Although they traveled thousands of miles to receive health care, the participants did not find the logistical

efforts of travel, accommodations, meals, and navigation of the different health care environments problematic. Overall, the logistics of medical tourism was a positive experience.

*Technology.*

Many of the study participants discussed the use of technology relating to their medical tourism experience; noting that technological advances aided their communication and improved the overall impression of their experience. Others talked about discovering comparable medical technology to the U.S. in their medical tourism destination. A few participants found less technologically advanced health care settings, though this did not change their overall impression of the medical tourism experience.

Jeff related,

*The other thing that really impresses me with medical work in Bangkok is being able to go online and get any questions answered within twenty four hours via email from the U.S. before you arrive, if you have a question about a procedure that you want to do, a recommendation of a physician, scheduling your medical treatments...They've always been prompt and complete in answering my questions.*

Candice talked about the technology that allowed her to obtain screening tests, as well as view and discuss the results of those tests with a physician the same day. With a sense of awe, she said, “How do they do that? I mean how do they get everything back so quickly, so that you and your doctor can talk about it on the same day?” The advanced capabilities of the clinics’ communication system further supported the perception of efficient and competent care for this participant.

Nancy talked about the health care setting in Estonia. She said,

*Once we starting sharing with more family and friends about what we had done, all of their first questions were about the conditions of the facility which kind of surprised me in a way...their equipment, and I can tell you from all of the stuff I have had done in the United States, was as comparable if not maybe a little bit higher grade in this particular fertility clinic.*

Angela talked about the facilities in Mexico, “*You could eat off the floors. The facilities were immaculately clean.*”

Alternatively, some of the participants noted differences in the equipment and facilities during their medical tourism experience. Michelle found the dental equipment in Mexico much like the equipment used by dentists when she was a child. Noting the difference, Jane describes the equipment she encountered in Chang Mai,

*The equipment was a little bit, well it was very simple. I mean, the clinic, they were very simple. They were very comfortable and very nice but you know how medical clinics these days in the states are just so ultra new and modern comfortable and they have all the ultra dental chair and all the equipment is state of the art and everything is just, blows your mind every time you go because it is always something new. And this was a little bit old school to the extent where you have to sit up and spit in the little sink thing instead of having the air drain or suction thing in your mouth, which I hate anyway so I didn't mind. It didn't bother me at all but I did notice that the equipment seemed a little bit old school but not so old that it was scary (laughing) or frightening or cause any discomfort.*

The technological state of medical equipment and the setting were commonly commented upon by the participants and varied based upon location and health care setting. Although viewed from the participants' western perspective, the similarities and differences with the U.S. standard health care environment made an impression and helped to create an overall positive impression.

*Concerns.*

Although the participants' impressions of the experience were positive, a number of the participants voiced the concerns that they initially felt when embarking on medical tourism. For some of the participants, medical tourism prompted their first international travel experience. The majority of the participants had not previously traveled to their medical tourism destination. Anxiety regarding the procedures and health were also expressed by many of the participants. Angela described the fear she felt initially about travel and surgery in Mexico.

*They really take care and are very good about making sure you feel safe and you feel comfortable about having this done because it's scary when you think about it. Oh my God, I had surgery in Mexico...I've never traveled much so it was a big scary thing to me to go and do that. It was a huge hurdle to get over; flying, going to another country, and letting them cut you open...That was very important to me, going to someone who had done numerous surgeries, very important.*

Although any surgical procedure may create anxiety, Angela's medical tourism experience created additional socio-culturally based concerns.

Seeking health care internationally caused most participants some level of anxiety. The motivators for being medical tourists took precedence and they were able to calm their misgivings so that they could receive needed health care. Carl shared his initial fears, "*Being in*

*a foreign country...you know there is that feeling of trepidation or just anticipation especially where you are so far from home.”*

Candice stated,

*We’re in a foreign country. We’re a bit nervous about the whole process...I was terrified. I do remember that. I had not traveled in a country like that and I felt very nervous so I can see why people would be fearful.*

Chris, age 29, related his initial fears during travel to Estonia for assistive reproduction procedures, *“I was a little bit nervous because we had never been overseas before. I wasn’t familiar with the medical system. I think it is more unfamiliarity with their system and their doctors’ knowledge.”* Jane described her lengthy series of dental procedures noting that the initial dental procedure was frightening, *“It was the first thing but it was also probably the scariest thing. But it went very well and I recovered from it perfectly and didn’t have any trouble at all.”* Carl described concerns regarding follow-up care and variations in malpractice practices. He said, *“Since I was going to have surgery in Bangkok and then leave there and go back to Alaska, if I should develop post surgery problems, there wasn’t any legal avenue for me.”* Noting basic differences in global health care systems, other participants also voiced concerns about legal recourse if problems arose from their treatment.

The participants noted unease regarding the process of leaving home to seek health care. The experience of medical tourism was novel to the majority of the participants. Despite the inherent anxiety of new situations and medical care, the participants adeptly dealt with their concerns and allowed themselves to receive care through medical tourism.

*Reassurance.*

Despite many concerning aspects of medical tourism, the participants were comforted by certain features of their experiences. Chris' fears in the anticipatory stages were lessened when he arrived, *"Once I got over there and actually met with them and saw their facilities and everything, it was a lot easier to go through...It calmed me down quite a bit."* As Dana spoke about her medical tourism experience, her story was intertwined with her interpretation of her partner's experience. In speaking about the process that Carl went through choosing his physician, Dana related,

*He was really happy to be able to pick out his own doctor and felt like he had a little control there. The physician that he chose, had actually done his medical schooling in Thailand but then had come over to the U.S. and done a fellowship in spinal surgery...and then did another fellowship at UCLA on total hip. I think that swayed him.*

Interviewed separately, Carl also voiced feeling more ease in being able to choose his provider. Regarding concerns about medical malpractice, Carl states, *"If anything went wrong, they want to make it right because this is big business for them...They said they would go to any extent to make anything right if something happens."*

To offset the potential doubt about the medical care and fear of the unknown, many of the participants traveled with spouses or other family members and found the support reassuring. Jane appreciated her partner's involvement,

*My husband was there as well helping every step of the way, being involved in everything just to make sure that there were two of us that were on top of it to make sure that we both felt equally the same about what was going on.*

Angela traveled to Mexico with her mother. She said, *“My mom, she’s a nurse and the best person to take with you, so she went with me...They want you to go with someone else. They don’t want you to come down by yourself.”* This patient-centered focus on the part of the foreign medical systems further allayed the uncertainty inherent in the medical tourism experience.

In the sub-theme *Reassurance*, the participants discussed features of their experience that they found comforting. They balanced this against the aspects of medical tourism that they found somewhat disconcerting, often intertwining both in the breadth of their stories.

#### *Communication.*

All of the participants discussed the amount of English spoken by the health care team. Despite the potential language difficulties, Angela reported, *“There is the language barrier but they know enough English that they can tend to you. I mean I never had an issue.”* Dianne, aged 68, had some difficulty initially communicating with her dentist in Mexico but returned to the clinic to clarify the treatment plan and finish treatment. Although communication was not easy for her, Dianne reports that her interaction with the dentist and staff was positive. The effort to communicate did not overall negatively influence her medical tourism experience.

Most participants expressed comfort in being able to communicate in their native language. Chris commented, *“When we met the doctor and how nice she was and how well she knew English and just talking with her was very helpful and seeing the facility.”* Tim discussed his experience communicating with the dentist in Mexico, *“He could speak very good English.”* Jeff reported the ease of his communication and the options for translation available at Bumrungrad Hospital in Bangkok.

*The staff you'll meet at the hospital, all the physicians and everything I deal with are fluent in English. Most of the other staff within the hospital is fluent enough in English*

*that there's no problems. Like I say, they've got a huge staff of interpreters that can handle any languages.*

Sara had positive comments about communication with her physicians and the care she received,

*There was also incredible professionalism of all the doctors. All of them spoke very, very clear and understandable English and if there was anything that you had questions about I never felt rushed or hurried. It was really very, very thorough and professional.*

The ability to communicate was an important factor in the participants' experiences with medical tourism. Jane's story of communication with her dentist particularly conveyed this element.

*It was the dentist and his wife who was the office manager. She had better English than he did so we had kind of this round table discussion, between Thai and English and making sure that we all understood exactly what we were talking about each time we went over something. So that worked very well...Any country that you are traveling in you have to allow for the language differences and the cultural differences and let things kind of settle into place where you are all at your comfort level...I felt anytime I had any questions, they were happy to talk to me about it, happy to go over it again if I didn't understand. I mean the communication was just excellent.*

The sub-theme *Communication* provides information about the value that the participants placed on interactions during their medical tourism experience and further elucidates the positive atmosphere that the participants found. The emphasis that the participants have placed upon communication accentuates the need of patients for positive interactions with health care providers. The participants often summarized their overall impressions of the medical tourism experience in advice that they would give to other medical tourists.

The experience of medical tourism was depicted in the stories that the participants told. Within the timeline of their travel, the participants articulated rich narratives describing their impressions of the experience. They provided in-depth descriptions of the logistics of travel, technology encountered in the international experience, concerns that they had, and aspects that they found reassuring. The participants' abundant description of communication and interaction seemed a particularly significant sub-theme of their impressions of medication tourism.

### **Post Travel**

The experience of medical tourism as portrayed by the participants did not end with their return flight to Alaska. Many of the participants had interactions with health care providers in Alaska and included the follow-up encounters as an element of their medical tourism experience. The participants also discussed further medical needs and their thoughts about continuing to travel internationally for care. Post-travel considerations are highlighted in the themes

*Follow-up Care, Advice, and Future Health Care.*

#### ***Follow-up care.***

The nature of medical and dental tourism places the burden of seeking follow-up health care on the participants. Most of the participants had some level of follow-up care upon returning to Alaska. In this theme, some of the participants discussed the ease that they found in following up with medical professionals in the U.S.; others discussed negative encounters with providers when they returned home. Angela said,

*One of the complications when you go outside of the U.S. for a surgery is your follow-up care and that is something else I really looked into. You really have to take it in your*

*hands and make it your responsibility to have something set up in the states, someone who's going to do your follow-up post-op care.*

Candice said, *"There's a down side to traveling for health care and that's the recuperation period and the follow-up care."* Carl also expressed this concern, *"You have to take the initiative on your own follow-up care because you are removed from that country and so the onus is on the patient at that point to do some follow-up care in the states."*

Many of the participants who had dental work expressed the need for a lengthier medical tourism stay. Evelyn discussed her desire to stay longer in India, *"I was very pleased with his job. Only, the bad thing is I have not enough time for follow-up."* Jane spoke of her experience, *Well, I will say that I wish I had had a few more weeks to have more adjusting done...having a whole mouthful, or half a mouthful of crowns done at once, I needed more adjustment when I got back to town here.*

The participants also spoke about their experience with follow-up care upon returning to Alaska. After returning from Mexico, Angela experienced complications requiring an emergency room visit and an appointment with a specialist. Her story about the encounter with the specialist is remarkable. As a nurse, Angela felt particularly incensed by her follow-up experience. She relayed,

*His exact words were 'What in the hell were thinking by going to Mexico for surgery?...Why didn't you come see me?' He said, 'Why did you go to some dirt floor hospital in Mexico? Why didn't you stay in the states? I said, 'I'm here now. I'm hurting. I'm looking for answers.' And he said, 'I'm not helping you.'*

She further discussed her distressful encounter,

*I can't believe a human being would treat another human being like that. Let's take out the fact that he's a doctor and he's taken an oath and he's supposed to help...It was really appalling. I'm glad I went to Puerto Vallarta to have my surgery!*

Angela counts herself lucky that her condition improved and she did not have need for further follow-up intervention in Alaska. The post-surgical complication and follow up with physicians in the U.S. further strengthened her positive feelings about her medical tourism experience.

Once back in Alaska, Jane had follow-up for her dental work when she realized that the new crowns were not aligning correctly. She stated,

*So I went to one dentist and he didn't want to touch it. He was freaked out by it all and he referred me to somebody else who was more of a specialist with crowns. I went to another dentist, this specialist, and I like him very much. He is very low key, very gentle, has a very good attitude.*

Derek reported that a suspicious lesion was found during his colonoscopy in Thailand. Upon returning to Alaska, his physician did not accept the biopsy results and required that he repeat the colonoscopy done in Thailand to verify the pathology.

Conversely, a few of the participants had positive experiences when seeking follow-up care. Sara discussed her interaction with her primary care provider,

*I have a regular GP that I see here for my yearly exam and I know she's very open minded but I wasn't sure how she would receive this report... When I brought this report to her, she was thrilled. She said, 'This is so clear. This is so understandable.' So,*

*again the efficiency and the organization of this make it easy for this report to be read by anybody else.*

Tim reported that he saw a dentist when he returned to Alaska to discuss the procedure that he had done in Mexico. His interaction with a local dentist reinforced the positive nature of his medical tourism experience. He said,

*I told him what the antibiotic was and the period of time for taking the antibiotic before and after the root canal. He said 'That's sound like essentially what I would have had you doing.' He validated for me that she was good.*

In this theme, participants discussed their interactions with health care professionals in Alaska since returning from their medical tourism experience. Some of the interactions were reassuring and professional, but some participants saw providers who were outwardly critical of the participants for having traveled for health care.

### ***Advice.***

As part of the post-travel medical tourism experience, the participants relayed the advice that they would give or have given to other people considering medical tourism. Jeff conveyed his impressions by saying, *"It's just a well run operation. So, I would just say to anyone that is considering it, I wouldn't have reservations."* Jane reported that she returned from Thailand and wanted to tell everyone about her medical tourism experience. She said, *"I am happy to talk about it and excited to talk about it. I thought it was a great experience and a great deal as well!"*

Angela discussed the importance of investigation and research prior to travel as part of the advice she would give to other potential medical tourists.

She said,

*You really need to do your research. You really need to make sure who you're going to is board certified. My physician was board certified in the U.S. As well, I mean just look into their credentials, look into, try to get in contact with real people, real people, not people you meet on the internet. And make sure you just do your research in it.*

Nancy voiced her enthusiasm, *"I highly recommend it. I would recommend it to a lot of other people. And especially until...until there's other options for people that are faced with these kind of decisions [inability to afford desired assistive reproductive procedures] ."* Carl was interviewed by two different news agencies since his hip surgery. He has had the opportunity to talk with other people who have since become medical tourists. He stated,

*It's kind of too bad that word hasn't gotten out. I mean the only way that people are doing this sort of thing, they are having to take initiative on their own. It's not an option if you would talk to a social worker or medical people here in the states, it's not really an option that they are going to give you. They aren't saying, 'you might want to check out medical tourism'.*

The option of international travel for health care was seen as a necessity for some study participants; they commented that they would choose U.S. health care if available and affordable.

Candice succinctly stated her position on medical tourism, *"I guess if all things were equal, if I could do everything here I don't see why I would travel for the medical care."*

Dana concurred,

*I think if you have good option in the United States, you know, I'm not saying you should travel if you have a good option here but if you don't, you are going to go...*

Despite the fact that they would prefer to have health care in the U.S. if feasible, the participants were enthusiastic about the choice of medical tourism and the advice they would give. Candice affirmed, *“Go, go, go. Don't even think twice about it. Don't have any fears. Don't worry about it.”*

The participants often concluded their comments about their impressions of medical tourism with statements of advice for other medical tourists. They spoke from a position of knowledge and communicated their viewpoints and lessons learned during their international travel and health care.

### ***Future health care.***

In this final theme, the participants spoke of future health care needs and their plans to be medical tourists again in the future. This, more than any other theme, affirms that the participants were satisfied with the health care they received on the international market and the overall experience of being a medical tourist. Regarding further dental care, Dave said, *“...if I have major work to be done, I will be going out of the country.”* Evelyn agreed,

*If I don't have to, I'm not going here. I will go, you know, to India. In the end, I have good experience and good memory. If I have even just this little time I have in India, I would do this again because it was wonderful.*

Nancy also plans to return to Estonia for further assistive reproductive procedures. *“We were able to actually also freeze nine extra, about nine embryos and so the likelihood of us going back there is very high.”* She warmly and enthusiastically shared the plans that she and Chris have to expand their family.

As their stories drew to a close, many of the participants visibly relaxed and became much less serious in their approach to their narrative. Telling the story about the experience of

medical tourism spurred thoughts of further surgery for Angela, *“It's got me all motivated. I'm going to start researching plastic surgery (laughing). I'm re-motivated now...I would do it again in a heartbeat, a very positive experience.”* Some of the participants have plans in place to become medical tourists again. Carl said, *“I foresee myself going back. I still don't have medical insurance...We are actually planning on going back next fall.”*

In discussing her planned trip to Bangkok in a few weeks, Candice stated, *I have some sinus issues and blockage so I went ahead and made an appointment to talk to a ear, nose, and eye doctor...just to have that looked into while I'm there. I will probably go ahead and make an appointment for an eye exam. I am due for new glasses, might as well do that while I'm there. And I might as well go get a dental exam while I'm there (laughing). And get new spark plugs, new radiator. (laughing)*

On a more serious note, Sara summarized her feelings about her next trip to Thailand, *“It might be odd to say but I am looking forward to going back and having another screening because it is very thorough and I feel like I am in very good medical hands.”* Candice spoke about her plans to return to Bangkok regularly for health screening and treatment. She concluded her story with the statement, *“I feel secure there, so secure. It feels good knowing that I can get the medical care that I need.”* As a testimony to his plans for further medical tourism, Jeff said, *“I decided that when I need medical, when and if I need any medical attention, if it looks like it is going to cost me more than a couple thousand dollars, I'm on a plane to Bangkok.”* He further affirmed,

*It's given me a lot of peace of mind that they are there, meaning Bumrungrad Hospital and similar facilities are there because if anything major came up, I would in an instant, I would choose to do my treatment there instead of the states.*

The participants often summarized and completed their stories of medical tourism by commented on their desire for future care internationally. The theme, *Future Health Care*, represents the culmination of the participants' experience. Plans to return to medical tourism destinations for health care are in place for many of the participants, indicating a willingness to incorporate this type of health care into their future health seeking behaviors.

## Summary

In keeping with the phenomenological analysis process, the experience of medical tourism is studied from the perspective of medical tourists. The experience of medical tourism has not been adequately explored and the hermeneutical analysis has provided insight through the immersion with the data. The study of the interconnection between the study participant and their experience with medical tourism allows the fundamental meaning of the experience to be uncovered. In-depth exploration of the medical tourism experience as viewed through the eyes of the engaged participants and brought to light through their narrative description reveals a multidimensional experience that has been categorized into themes.

Analysis of the descriptive textual data provided by Alaskan medical tourists revealed six primary themes: *Motivation, Research, Obtaining Care, Follow-Up, Advice, and Future Health Care*. The voices of the participants revealed the significance they placed upon their health care decision making that included the care they sought and received during international travel. These themes represent the essential structure of the lived experience of medical tourism. The themes also embody the complexity of the participants' pre-planning, travel and health care experience, and return to Alaska. Each participant's experience of health care in international destinations was a unique narrative, yet upon analysis, distinctive themes emerged from the data as a whole allowing illumination and insight into the experience of medical tourism.

## **Chapter Five**

### **Discussion**

A discussion of the results of the study of medical tourism in relation to the review of literature is presented in Chapter Five. The interpretive, phenomenological data analysis supports prior literature and broadens understanding of medical tourism. The results of this study are also viewed within the theoretical framework of health seeking behavior. The application of health seeking behavior as a concept is expanded upon to include medical tourism as a modern health seeking activity. A contemporary model of health seeking behavior is introduced. A brief discussion of health care policy influencing medical tourism and health seeking behavior is included. The chapter concludes with the nursing implications, study limitations, and recommendations for further research.

### **Results in Relation to Review of Literature**

The literature review of medical tourism was primarily descriptive and focused upon the definition, history, current medical tourism trends, motivation for medical tourism, concerns regarding the phenomenon, and potential impact on developing countries. The majority of literature found on medical tourism is reports and commentaries with little scholarly research on the topic. The results of this study will add to a growing body of literature and provide valuable information on the phenomenon of medical tourism from a patient perspective.

#### **Definition.**

The results of this study substantiate the broad definition of medical tourism found in the literature which includes a large variety of preventative care, medical treatment, complimentary medical care, and dental care (Bookman & Bookman, 2007; Rhea, 2008; Woodman, 2007). The study participants individualized their medical tourism experience based on unique health care

needs. They researched available options, made travel and treatment decisions, and obtained health care in a variety of global destinations. The participants' activities are consistent with the literature reports of medical tourism. Some of the participants obtained specialized care such as assisted reproductive procedures and orthopedic procedures, activities which are reported commonly in the literature (Blythe & Farrand, 2005; Cohen, 2006; Mitka, 2009; Unti, 2009). Other specialized care such as organ transplantation and stem cell procedures which are frequently discussed in medical tourism literature were not obtained by this study's participants (Barclay, 2009; Evans, 2008).

Medical tourism destinations represented within this study are consistent with popular destinations found in the literature. The participants traveled globally in search of health care to Thailand, India, Eastern Europe, Central America, and Mexico. The literature shows that the destinations chosen by medical tourists of this study are often widely sought after health care locations (Bookman & Bookman, 2007; Woodman, 2007). Other frequently visited medical tourism destinations such as South America, Africa, and alternative Asian destinations are not represented within this study.

The definition and destinations of medical tourism characterized in this study are largely consistent with literature reports on the subject. This research study validates the reported nature of medical tourism which exists primarily in editorial columns, media reports, and commentaries. To further assess the appropriateness of this study's findings, the thematic analysis is also explored in relation to the literature review.

### **Motivation.**

Motivation for medical tourism is a common topic in the review of literature. In the literature, cited reasons for medical tourism include low cost medical care, delayed services in

the country of origin, and the inability to obtain specialized care in the resident country (Bookman & Bookman, 2007; Leahy, 2008; Merrell, et al., 2008; Woodman, 2007).

Recreational travel was also noted in the literature as an appealing feature of medical tourism (Bookman & Bookman, 2007; Woodman, 2007). Motivation was also a dominant theme that was revealed in this study.

All of the study participants spoke effusively about their personal motivation for embarking upon the medical tourism experience. *Motivation* was a major theme that emerged from the interpretive analysis of the research data. In this study, the theme *Motivation* was further categorized into sub-themes, Perceived Health Care Need, Finances, Dissatisfaction with U.S. Health Care, and Recreational Travel. There is evidence of each sub-theme within the literature on the topic of medical tourism.

A perceived need for health care was the primary motivator for medical tourism for the participants of this study. Motivations for medical tourism in the literature include increased wait times in socialized medical systems and unavailability of specialized care in the country of origin, yet unmet significant health care needs as a motivator is largely understated (Bookman & Bookman, 2007; Leahy, 2008; MacIntosh, 2004; Merrell, et al., 2008; Woodman, 2007). This may be due to the editorial nature of much of the medical tourism body of literature and lack of research on the topic from the patient perspective.

This study sought to uncover the essential experience of medical tourism from participants who have sought and received care during international travel. This patient perspective illuminated unmet health care needs as the key motivator in becoming a medical tourist. The participants spoke of unmet dental, orthopedic, ophthalmologic, dermatologic, cardiac, screening and preventative health care needs. They traveled to international destinations

to be able to access necessary health care. The results of this study show that the participants were motivated to obtain health care and exhibited health seeking behaviors. The participants shared valuable information demonstrating that medical tourism provides a means for improving health status.

The study results are consistent with the literature regarding monetary motivation for medical tourism. All of the study participants discussed the need for lower cost medical or dental care as a motivator for travel. The literature is replete with mention of lower cost health care in global locations around the world, often listing differences in costs between procedures in the U.S. and medical tourism destinations (Cochrane, 2006; Colias, 2004; Hutchinson, 2005; Merrell et al., 2008; Mitka, 2009; Rhea, 2008; Woodman, 2007; York, 2008). The literature suggests that medical tourism may yield a forty to ninety percent cost savings for patients over comparable health care in the U.S. (Cochrane, 2006; Colias, 2004; Hutchinson, 2005; Merrell et al., 2008; Mitka, 2009; Rhea, 2008; Woodman, 2007; York, 2008).

This financial need to participate in medical tourism was also an important theme emerging from this research. Each of the fifteen study participants emphasized the monetary gains of traveling internationally for health care; often contrasting costs between their medical tourism care and equivalent care in the U.S. The participants eagerly shared the prices they paid for health care during medical tourism; often bringing documentation such as billing statements to the interview sessions.

Lack of insurance is noted as a motivator for medical tourism in the literature (Burkett, 2007; York, 2008). The large number of U.S. citizens without health insurance is commonly cited as a driving force in medical tourism (Burkett, 2007; Hutchinson, 2005; Merrell et al., 2008; York, 2008). The topic of insurance was integrated within the financial motivation for

medical tourism within this study. Although, sixty percent of the study participants had some level of insurance, many of the participants felt that they had inadequate insurance coverage to meet their health care needs. They determined that medical tourism provided a financially beneficial option to obtaining health care.

Though the topic of financial savings for medical tourists is dominant in the literature and the thematic analysis of this study, solid scholarly research on the significance of cost savings or the financial impact upon individual patients, institutions, or health care systems is lacking.

The study participants expressed a great deal of displeasure and anger with the U.S. health care system. They identified this as a motivating factor in their decision to travel internationally for health care. There is some evidence of like concerns in the literature, yet the fervor with which the participants spoke of their dislike of the current health care situation in the U.S. is not equally reflected in the literature. Available literature on medical tourism often highlights the economic benefits without patient perspective regarding the resident health care system. In this study, participants were very vocal about their displeasure with the U.S. health care system and viewed this discontent as a motivator in seeking health care internationally.

Within the literature, Eggertson (2005) and Beecham (2002) discussed dissatisfaction with socialized medical systems and the difficulties involved in lengthy wait times for some procedures as a motivation for medical tourism. Penning (2002, 2004), Blythe and Farrand (2005), and Cohen (2006) discussed dissatisfaction with assistive reproductive regulations in resident countries spurring cross border reproductive tourism. It is noted that displeasure regarding other countries' wait times and discrepancies in reproductive and transplantation policies found in the literature are not reflected in the results of this study.

Many of the study participants expressed significant anger with their inability to access affordable health care within the U.S. York (2008) suggests that the increasing trend of medical tourism indicates an inherent crisis in the U.S. health care system. Burkett (2007) reports rising health care costs in the U.S. contributing to the increasing popularity of medical tourism. Although elevating costs and diminishing access to care in the U.S. are present in the literature regarding medical tourism, the high level of emotional responses represented by the study participants is not mirrored in the literature.

Some of the participants vocally expressed significant frustration with the overall U.S. insurance environment; often noting an inability to access or optimize care because of constraints imposed by insurance companies operating within the U.S. health care system. Participants also verbalized frustration with the difficulty in determining prices for health services in the U.S. This is mentioned within the literature as an impetus for health care reform and increased medical tourism (Burkett, 2007; York, 2008). The intensity of expressed concerns regarding insurance status that was conveyed by the participants in this study is not adequately illustrated in medical tourism literature.

Dissatisfaction regarding time and efficiency in obtaining medical and dental care in the U.S. was a frequent contrast to the ease of obtaining care in a medical tourism destination for the participants of this study. The participants expressed need for health care that could be accomplished in an effective and professional manner within a timeline that did not negatively impact their other life activities. Many of the participants voiced frustration with the length of time that it takes to schedule appointments with a specialist and accomplish multiple dental or medical procedures in the U.S. health care system. These ideas are not identified as motivators within the literature, though this study's participants were quite vocal about their displeasure

with the timeline involved in obtaining care within the U.S. health care system. As this topic has not been explored in scholarly literature, the participants' desire for timeliness and efficiency indicates the new knowledge in the medical tourism experience that has been gained in this study.

Descriptions of patients traveling to exotic locations, staying in lavish settings, and enjoying recreation combined with medical care is a prevalent topic in medical tourism literature (Bookman & Bookman, 2007; Woodman, 2007). The study participants supported the literature reports by frequently discussing their associated recreational travel. Many of the participants of this study discussed the opportunity and value of recreational travel combined with health care. The participants described the enjoyment they derived by hiking, sightseeing, eating, and shopping during their medical tourism. Although the participants' motivation was not solely centered on recreational travel, the trip and international experiences became embedded within their narrative of medical tourism.

The participants noted the cultural differences in obtaining health care during medical tourism. They commented on the customs regularly experienced within the U.S. health care system and similarities and variances noted during care obtained through medical tourism. Many of the participants noted seeing and interacting with people from around the world at medical tourism facilities. The participants indicated that recreational aspects of their experience added enjoyment and depth to the overall medical tourism experience.

### **Research.**

Discussion of the process of pre-travel research and planning is a commonality between this study and the literature on medical tourism. In this study, the participants described their very individual processes of research and preparation. They talked about the importance of

communication with people who had experienced care in their chosen medical tourism location. The participants also discussed internet sources and communication with medical personnel. The literature focuses on web-based resources and businesses that assist medical tourists in locating reputable medical tourism sources (Eggertson, 2005; Woodman, 2007). Although the participants used the internet and media sources, referrals from acquaintances were highly valued sources of information for the participants of this study. The medical tourists in this study also placed importance in being able to communicate with the foreign health care system and physicians before embarking on the experience.

### **Obtaining Care.**

The study participants provided substantial information about their impressions of their medical tourism experiences. The literature on the subject does incorporate some patient impressions, but only one article was found that entirely focused on patients' perspectives (Kangas, 2007). Although their overall feelings from this study were positive, participants discussed areas of personal concern. This is consistent with the literature on the subject of medical tourism which reports generally positive patient experiences. Also in the literature, concerns regarding medical tourism are frequently voiced by health care professionals in relation to safety and follow-up care. In this study, most participants noted potential difficulties with follow-up care but anxieties were minimal or dispelled through interactions with foreign and local health care systems. The theme *Obtaining Care* is further categorized into the sub-themes of Logistics, Technology, Concerns, Reassurance, and Communication. The sub-themes are discussed in relation to medical tourism literature.

Though not a dominant topic in medical tourism literature, the logistics of traveling for the purpose of obtaining health care are mentioned; many in the form of a patient scenario

emphasizing the relative ease in which medical tourism is accomplished (Burkett, 2007; Morgan, 2003; York, 2008). This is consistent with the sub-theme that emerged from the data of this study. The participants provided concrete details of their arrival, accommodations, and health care experiences; emphasizing the logistical ease that they experienced as medical tourists.

Technology is a common topic in the literature on medical tourism. Often a comparison is made between technology in medical tourism destinations and technology in U.S. health care environments (Cochrane, 2006; Hutchinson, 2005). There are also a number of reports of advanced biotechnological and alternative medical options available to medical tourists such as new orthopedic and cardiac treatment, as well as stem cell procedures (Lindvall & Hyun, 2009; Merrell et al., 2007, Ryan et al., 2010).

The study participants also frequently discussed technology. Some of them commented on similarities between facilities and equipment that they encountered during medical tourism and the expected technology within the U.S. Some of the participants seemed surprised and pleased by the modern technology that they discovered while traveling for health care. This is consistent with the literature on the subject. Conversely, other study participants discussed clean facilities but older equipment. For these participants, this was not a source of concern; they found the equipment adequate and questioned the need for more expensive, ultra modern equipment often utilized in the U.S.

The literature outlines many concerns regarding medical tourism: provider-patient communication, patient safety, continuity of care, and follow-up (Barclay, 2009; Forgione & Smith, 2007; Leahy, 2008; Merrell et al., 2008; Unti, 2009). Although these considerations are frequently discussed, research regarding patient outcomes is not available. The participants in

this study voiced many similar concerns prior to embarking upon their medical tourism experience.

The participants voiced concerns about international travel and receiving treatment in foreign countries. They expressed uncertainty in their ability to communicate, as well as some trepidation due to lack of familiarity with other health care systems. They also discussed significant anxiety about follow-up care. Over the course of their medical tourism experiences, the participants' anxieties were largely dispelled. This may be due in part to the positive interactions they had with their health care teams.

Although the participants of this study voiced many areas of their experiences that they found comforting and supporting, the literature on medical tourism does not accentuate patient reassurances. Patient scenarios are provided in the literature which present medical tourism in a positive manner (Barron, 2008; Berger, 2007; Woodman, 2007; York, 2008). The participants in this study were very expressive about the support they received from family and health care providers during medical tourism. Reassuring factors were important to the participants because they provided counterbalance to aspects of medical tourism that were disquieting. Analysis of both perspectives has provided insight that is not available in the literature.

The ability to speak English was a very important factor for the participants of this study which is not highly emphasized in the literature. Concerns about communication exist regarding informed consent procedures (Mitka, 2009; Unti, 2009). Woodman (2007) discusses translation services available in medical tourism destinations. All of the participants in this study commented on language as a key impression of their experience indicating the significance of communication in the participants' native language that is not prevalent in the literature.

### **Follow-up.**

Concerns and questions exist regarding the ability for medical tourists to obtain adequate follow-up care when returning to the country of origin. These concerns are commonly voiced in health literature, often as part of an editorial or commentary (Leggat, 2009; Merrell et al., 2008; Rhea, 2008; Toral, 2009, York, 2008). Lack of continuity of health care is often noted by these authors as a negative aspect of medical tourism. The literature does not provide detail regarding patient perception of follow-up care or statistics supporting problems in aftercare.

The participants of this study voiced concerns about follow-up care and provided important information about the follow-up care they received after returning to Alaska. Some participants experienced difficulties in finding health care providers willing to provide care after their medical tourism experience. This supports concerns found in the literature. Others reported good experiences with health care providers in Alaska and perceived no difficulty obtaining follow-up care. The participants' narratives of their follow-up experiences provide perspective of the medical tourism experience that is not found in the literature.

### **Advice.**

Recommendations regarding medical tourism are imbedded in patient scenarios within medical tourism literature, yet not a highlighted feature (Barron, 2008; Berger, 2007; Woodman, 2007; York, 2008). In this study, advice to other prospective medical tourists was stressed by the participants. Often the participants ended their narrative about their experiences of medical tourism with stories of advice that they would give to others considering traveling internationally for health care. The participants recognized that they had important information to share with others and provided positive, practical advice. This subset of information is largely missing in the medical tourism literature.

### **Future health care.**

Within the literature, authors discuss the future of medical tourism with predictions of the number of patients who will be traveling for health care (Bookman & Bookman, 2007; Merrell et al., 2008; Rhea, 2008). These authors also speculate about the evolution of medical tourism with concerns about the dynamic global health care environment. Recognized factors that may impact medical tourism include regulatory requirements imposed upon international health care facilities, advancing technology, global competition, and changing domestic health care policies (Burkett, 2007; Merrell et al., 2007, Rhea, 2009; Teh, 2007). The literature does not focus on future medical tourism from the perspective of current medical tourists.

In this study, future health care was a common theme that emerged from the data analysis; the study participants frequently commented upon plans to continue to seek care through medical tourism. Some of the participants discussed the current economic health care environment and felt that they will continue to be motivated by financial reasons to obtain health care in international destinations. The participants related that the positive initial medical tourism experience leads them to consider becoming medical tourists again in the future. This element was not present in the literature on medical tourism.

### **Health Seeking Behavior**

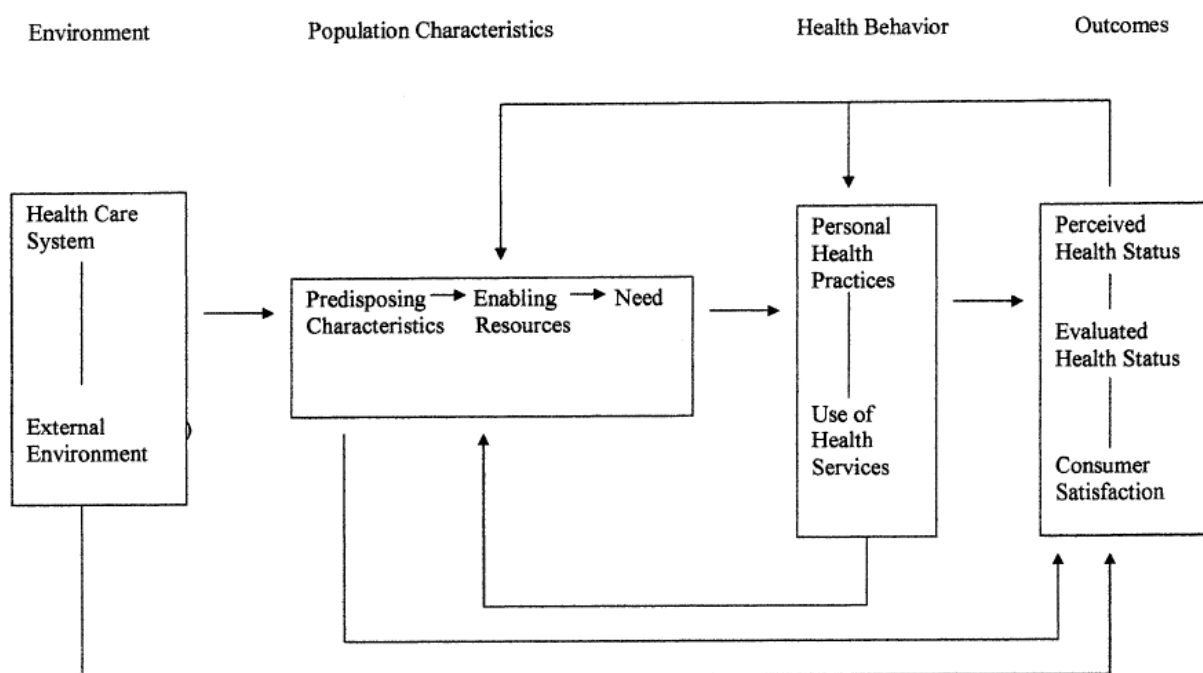
The concept of health seeking behavior was used as a foundation for this study. As noted in Chapter Two, health seeking behavior has been studied in many contexts over the last fifty years. Recent literature has considered gender, cultural, and economic differences in health seeking behavior. Prior to this study, the concept of health seeking behavior has not focused upon seeking and obtaining health care in international destinations, yet the concept underlies the motivation and experience of medical tourists who participated in this study.

Health seeking behavior is defined in a variety of ways in the literature. Harris and Guten (1979) define health seeking behavior as, “any behavior performed by a person regardless of his or her perceived or actual health status, in order to protect, promote, or maintain his or her health, whether or not such a behavior is objectively effective toward that end.” (p. 18). The authors list a number of activities or behaviors that are considered health seeking in nature. Although a number of other definitions exist, this expansive definition is useful when viewing this study of medical tourism.

The participants provided concrete examples of their health status that necessitated their travel for health care. They also noted a number of examples of medical and dental care that they received which they perceived as promoting, maintaining, enhancing, and improving their overall health. For the study participants, medical tourism was an important aspect of their health seeking behavior. This is also evident in their plans to incorporate further international travel into their future health seeking behaviors.

Andersen’s model of health seeking is also helpful in examining the study results. See Figure 4. Andersen’s model was originally designed to explore health services utilization and equity in health care access. Both of these characteristics are pertinent to the discussion of medical tourism. The study participants chose health seeking methods that involved the utilization of health services in the global health care market. Although this is a departure from standard health utilization discussions in the literature, this study shows that medical tourism has been a viable alternative for patients. The study participants also strongly voiced an inability to access affordable health care in their home environments. This was an important motivator for the medical tourists and supports Andersen’s explanation of health systems in environmental factors which influence a person’s health behaviors.

**Figure 4. Revised Behavioral Model of Health Services Use, An Emerging Model – Phase 4 (Andersen, 1995)**



Andersen also discussed population characteristics that impact health behaviors. He divided this aspect of the model into three areas: predisposing characteristics, enabling resources, and need. The study results support factors inherent in the sample which contribute to their health seeking behaviors resulting in medical tourism. Unmet health care need was the first theme that emerged from the data. Participants spoke of a variety of medical and dental conditions that needed treatment. Many participants also discussed need for health screening and preventative services that they felt necessary to maintain their health status. This primary motivator for medical tourism is consistent with need in Andersen's model. Andersen's model reflects predisposing characteristics that factor into health seeking behavior. Although not outwardly stated by the majority, many of the participants revealed an adventurous nature that may have predisposed them to look outside of the U.S. health care system to solve their unmet

health care needs. This was expressed by participants' comments about the international flavor of their medical tourism destination and desire to travel internationally. Andersen used the term enabling resources to describe another population factor. In view of medical tourism, the ability to research and plan their travel and medical care, as well as the financial ability to afford international travel and health care are considered enabling resources that influenced the participants' ability to seek health care through medical tourism.

The participants' descriptions of their medical tourism including details about the logistics of obtaining care, technology involved, concerns, and reassuring aspects of the experience support the third aspect of Andersen's model, termed Health Behavior. The participants provided extensive information about receiving health care and their impressions of their encounters during medical tourism. Many of the participants also discussed their personal health practices before, during, and after medical tourism.

The study can also be viewed in relation to Andersen's final aspect of the model which he terms Outcomes, and further divides into Perceived Health Status, Evaluated Health Status, and Consumer Satisfaction. The medical tourists in this study reported improved health status as a result of their travel experience. Many participants have also had further medical and dental evaluation upon completion of their medical tourism. Lastly, the participants effusively demonstrated their satisfaction with the care they received. This is especially emphasized by the participants' plans to engage in medical tourism again in the future.

Although medical tourism does not appear to have been previously examined in relation to the body of literature or existing models of health seeking behavior, the results of this study indicate that it is an applicable concept for the study of health seeking behavior. The participants sought health care services and traveled to find them on the global health care market.

Andersen's model of health services utilization was a useful framework to begin viewing this health seeking behavior, yet the results of this study suggest that a model further emphasizing the antecedents and behaviors of health seeking would be useful. The collective experience of medical tourism through the use of the following participant exemplar provides basis and helps demonstrate the contemporary health seeking behavior model.

### **The Medical Tourist**

Today, the medical tourist is a health seeker using contemporary methods to obtain needed health care. Although each participant in the study had unique travel and medical experiences, themes emerged from the data representing a shared health seeking experience through medical tourism. One of the participants particularly exemplified health seeking behavior through medical tourism. Carl is an uninsured Alaskan with a significant health need that motivated him to travel to Bangkok, Thailand for his care. He lives and works seasonally in a rural Alaskan area. Carl experienced considerable hip pain stemming from a serious motor vehicle accident in his early adult years and ensuing degenerative changes that limited his ability to engage in the activities that he wished to continue doing. He could not afford orthopedic surgery in the U.S. and discussed his dissatisfaction with the U.S. health care system that he was unable to fully access. He said, *"I really felt that I had no alternative, that I was at a dead end as far as getting the medical help that I would need, now or in the future through the American system."* Carl was open to health care in foreign destinations as an option to alleviate his pain and researched options. He described the process that he went through to choose a facility and a surgeon, *"They have a very extensive website so you can do a lot of research."* He had personal motivators that led him to consider medical tourism. Carl's lack of insurance and financial means to afford needed health care indicates that socio-economic factors and limited access to

U.S. health care prompted him to find care on the international health care market. He said, *“The prices [in Thailand] were just a fraction of what they were here.”*

Carl’s medical tourism was an action taken on his part to enhance his overall health and wellbeing. In addition to his hip replacement, Carl chose a comprehensive health screening package which was also perceived as necessary health care that he was unable to obtain in the U.S. Overall, he was pleased with his decision to travel to Thailand and the care that he received. He stated, *“It was a good experience.”* He readily discussed his travel and care logistics, as well as the concerns that he had prior to receiving health care and reassuring aspects of his experience. He said, *“There’s that feeling of trepidation or anticipation, especially when you are so far from home.”* and *“I was a little worried about it but they made us feel very relaxed about the whole thing.”* He also spoke of the importance of communication and support in his health care experience, noting appreciation that he could communicate in English with his health care team. He said, *“I was amazed by the level of staffing that they had...All of their employees speak some level of English, especially the nurses and the doctors. So that was a big plus...We didn’t feel lost at all.”*

Lastly, Carl’s complex orthopedic procedure in Thailand warranted follow-up health care once he returned to Alaska. His overall positive medical tourism experience prompted advice to consider medical tourism as a health care option to many people. He also plans to return to Thailand for further medical care; indicating long term and future health seeking behavior. As Carl does not anticipate a change in his living circumstances, his future health seeking behavior will again be based on his personal health motivators, socio-economic considerations, and his ability to access health care.

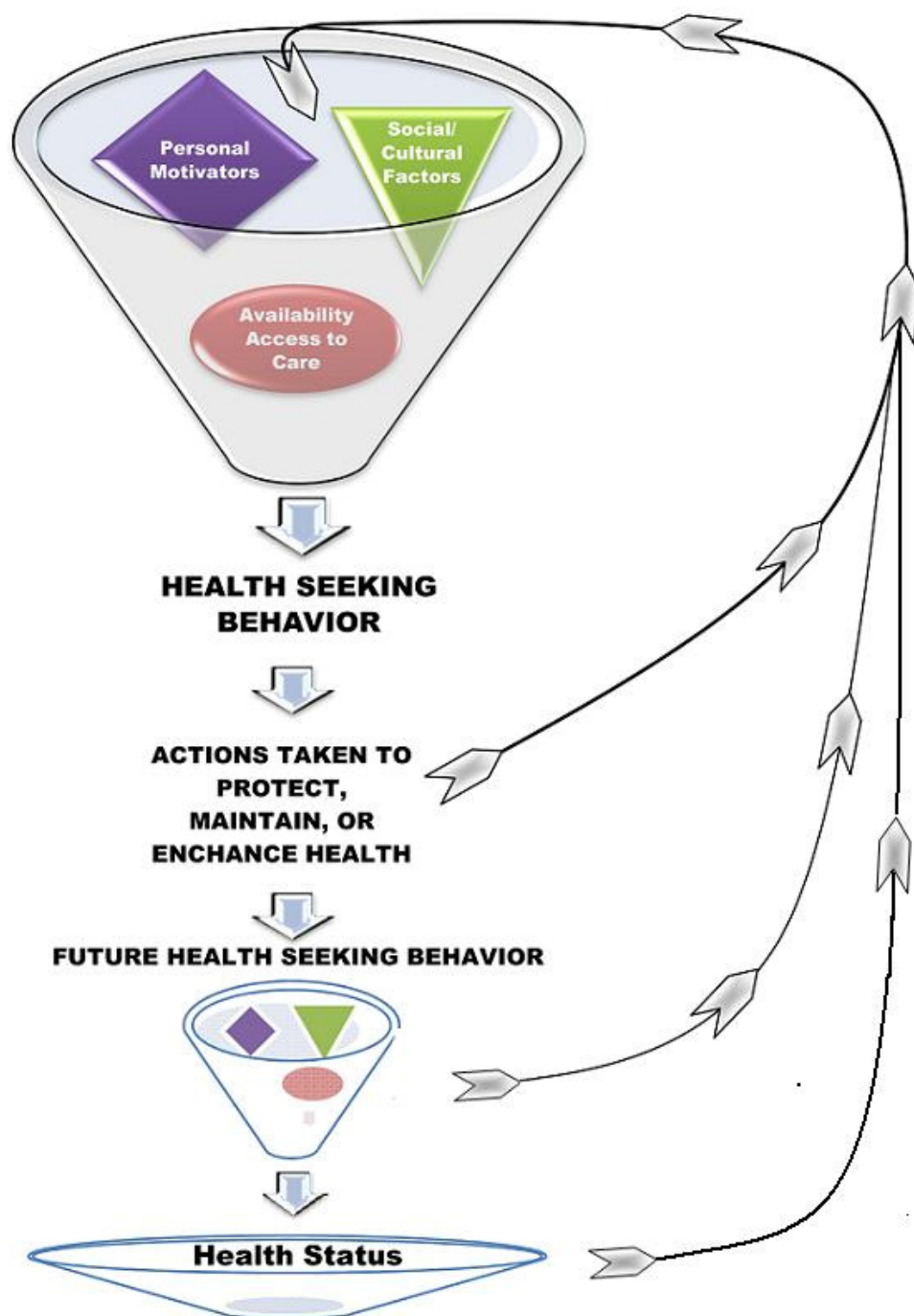
Carl's story is used as an exemplar of medical tourism as a means of health seeking behavior. Although each participant has conceptualized his or her travel experience and health seeking behaviors using different words, the essence of the medical tourism experience as a necessity for ongoing health has emerged. In further explanation, the experiences of the study participants can be viewed in a concise model summarizing a contemporary approach to health seeking.

### **Contemporary Health Seeking Behavior Model**

Although Andersen's model proved useful as the main theoretical framework for this study, the results indicate that contemporary health seeking behavior includes medical tourism as an alternative method used by some individuals to improve their health status. Andersen's model has been used in many situations, yet the focus on health services utilization limits adaptability when considering the behaviors involved in those seeking health today. The findings of this study call for an updated lens through which we view health seeking behavior that includes travel and the global health care market. International travel for medical and dental care might be considered a complicated approach to obtaining health care, yet for this study's participants; medical tourism was an effective health seeking behavior. See Figure 5.

Figure 5. Contemporary Health Seeking Behavior Model

### Contemporary Health Seeking Behavior



Each individual's health seeking behavior encompasses a variety of motivating factors leading towards medical tourism. In this study, the participants were motivated by unmet health care needs, finances, dissatisfaction with the U.S. health care system, insurance, time and efficiency of medical care, and recreational travel. Other medical tourists may have different personal motivators for travel. In effect, each person has a unique set of personal motivating factors that prompts health seeking behavior. This individual set of motivators is emphasized within the model.

The participants recognized social and cultural factors that influenced the choices they made in seeking health care internationally. The participants discussed societal factors that influenced their choices in health care including current socio-political factors limiting access to care for many Americans. The participants also voiced personal and cultural beliefs about health and health care that influenced their health seeking behaviors. Again, the individual combination of social and cultural elements contributing to health seeking behavior is emphasized within the Contemporary Health Seeking Behavior model. Additionally, the participants spoke of previous health care experiences within the U.S. influencing their medical tourism experience.

For the participants, availability and access to health care was a necessary factor in their health seeking behaviors. The medical tourists participating in this study found available and accessible health care on the global health care market and traveled internationally to obtain needed care. As noted in previous literature on health seeking behavior and the results of this study, access to health care is paramount to effective health seeking behavior. This is also represented as a dominant consideration in the model.

In this study, the participants shared their impressions of the medical tourism experience. The participants obtained medical and dental care internationally that protected, maintained, or

enhanced their health status; by definition they were pursuing health seeking behaviors. Within their experiences they discussed logistics of seeking care, technology encountered, concerns about the process, factors they found reassuring, communication during health care encounters, and advice they would give others participating in medical tourism. The participants also planned future health care, both through medical tourism and domestic health care options. This is viewed as an important aspect of life-long health seeking behavior. The model reflects health seeking behavior as a dynamic system of influencing factors providing contextual basis for individual intention to improve health status.

In addition to increasing our understanding of the phenomenon of medical tourism, the results of this study provide information needed to reformulate the concept of health seeking behavior into a modern and globally appropriate model. The results of this study provide support for a redefinition of health seeking behavior. Through analysis of the literature and results of this study it is evident that health seeking behavior is a highly individualized process involving a variety of actions taken to protect, maintain, or enhance a person's perceived health status that is influenced by an individual's unique cultural and social perspective of health.

### **Nursing Implications**

The influence of nursing on the medical tourism experience is evident in the analysis of the study results. Many of the participants spoke of their experiences with nurses during medical tourism. Results of the study demonstrate that nurses are playing a positive role in the experience of medical tourism. The medical tourists in this study found exceptional nursing care during their travel and expressed reassurance and trust in their interactions with nurses internationally and in Alaska. This is consistent with research on public trust in nurses; Saad (2008) reports that Americans rate nursing consistently as the most ethically trustworthy

profession. The study of medical tourism supports the importance of nursing influence on health care encounters and health seeking behavior.

Research regarding available health care options, support, and follow-up was a time intensive task that all of the participants took upon themselves as part of their medical tourism experience. As patients look towards the global health care market for solutions to their health care needs, nurses and advanced practice nurses have the ability to positively influence patients' health seeking behaviors and advocate for patients' choice in health care environments by including education, counseling, and support for medical tourists. The results of this study also indicate that nursing care and advanced practice nursing care had a positive role in participants' follow-up care after returning to Alaska.

Continuity of care is a widespread concern both in the literature and amongst the study participants. Medical tourists are challenged by little, if any, communication between health care professionals abroad and those in their home health care system. Effective exchange of information is currently an uncertain aspect of medical tourism that may impact quality of care. The nursing philosophy provides a platform for care coordination. Nursing can play an important role in the medical tourism industry by establishing connections amongst medical care providers.

As medical tourism expands, nurses will have increasing opportunities to care for patients who are considering traveling or have traveled internationally for health care. The results of this study improve insight and understanding of the medical tourists' choices in health seeking behaviors. As familiarity with the health care options available on the global market increases, nurses will be able to advise patients considering medical tourism. As our knowledge and understanding of the medical travel experience increases, nursing professionals will also be

better able to care for patients who have obtained health care internationally. The study results will benefit nurses caring for patients before, during, and after international travel for health care.

### **Health Policy**

A discussion of medical tourism is not complete without addressing health care policy issues that impact all aspects of medical tourism. In this dynamic global health environment, many factors influence medical tourism. As in most industries, the health care industry is experiencing the positive and negative benefits of globalization (Chan, 2008; Forgione & Smith; Shah, 2007). Holland et al. (2009) recognize the need for leadership and direction in regards to changes in the health care environment created by globalization. Along with global issues such as outsourcing labor, cross-border communication, innovations in practice, and standardization of care, medical tourism is a topic discussed in the global health care policy arena. Most of the issues brought forward in this discussion are without clear answers in the current milieu surrounding medical tourism, yet indicate need for further consideration and research.

As there is limited research on medical tourism from the patient's viewpoint, policy makers are unable to incorporate this perspective in their decision making process. It is noted that opinions voiced in medical tourism literature are often from medical and travel industry professionals. As further research becomes available to policy makers, the medical tourist perspective may be heard.

On an international level, questions about quality of care and liability are common-place (Burkett, 2007; Hutchinson, 2005; Lunt & Carrera; 2010; Toral, 2009). International medical tourism destinations and global health care organizations are addressing concerns through adoption of standards of care and facility accreditation procedures (Joint Commission, 2008; Woodman, 2007; York, 2008). The literature suggests that attempts to provide high quality

standardized care on a global market are favorably viewed by policy makers and medical tourists (Merrell et al., 2008, Toral, 2009). In an opposing view, Burkett (2007) speculates that imposing standards of care with increased regulation within the global health care market poses risk to international trade policies.

There are also global policy concerns regarding the potential for medical tourism to introduce culturally unsuitable ideas and negatively impact destination countries' domestic health care systems (Bookman & Bookman, 2007; Burkett, 2007; Leahy, 2008). The authors note that many medical tourism destinations in developing countries often have local health care systems that are underfunded, understaffed, and inadequate to meet the needs of the domestic population. This contrast of insufficient health facilities to support the population with modern, advanced medical facilities available to medical tourists may negatively impact the health of the citizens in destination countries (Burkett, 2007; Leahy, 2008). Conversely, Bookman and Bookman (2007) support the concept that developing countries may benefit from the financial gains of medical tourism. The true impact from the introduction of technologically advanced and fiscally prosperous health care facilities into underserved areas has not yet been studied but will continue to be deliberated.

There are significant concerns about differences in ethical positions regarding reproductive, transplantation, and stem cell procedures that may not be legal in patients' countries of origin (Blyth & Farrand; 2005; Bramstedt & Xu, 2007; Penning, 2002; Ryan et al., 2010; Shroff, 2009). With the significant diversity amongst the world population regarding the ideological underpinnings which are often inherent in health care policy decision making, it is likely that policy debate will continue on the advisability of allowing medical tourists to seek care not available to them in their countries of residence.

Medical tourism should also be viewed from a policy perspective within the current health care environment within the United States. The participants of this study were very vocal about their displeasure with decreased ability or inability to access affordable health care within the U.S. This sub-theme coupled with financial gains realized through medical tourism became a primary motivator for travel. York (2008) and Burkett (2007) indicate that medical tourism may lend momentum to changes in favor of more affordable health care with transparency of prices in the U.S. Many of the participants specifically mentioned the need for health care reform and felt hopeful that legislative change will improve health care access for Americans.

Prior to policy changes with the U.S. health care system, several strategies were employed by U.S. companies to increase health care revenue. Several prominent U.S. health care facilities have increased their marketing of domestic and international patients and partnered with international medical tourism facilities to increase revenue (Colias, 2004; Merrell et al., 2008; Nolan, 2008). The literature also illustrates cost saving measures on the part of insurance companies who have advocated international travel for health care as a less expensive and attractive option for U.S. patients (Burkett, 2007; Leahy, 2008; Shah, 2007; York, 2008). It is unclear how insurance companies will respond to medical tourism with upcoming changes in the U.S. health care system.

Literature is beginning to reflect discussion about the impact that the Patient Protection and Affordable Care Act may have upon medical tourism. Rhea (2009) surmises that U.S. health care reform will not dramatically change medical tourism practices or economics. It is difficult to know if the timing of this study within the midst of U.S. health care reform is significant to the findings. Although the study participants anticipated changing policies regarding health care and insurance, they indicated plans to continue to seek health care through medical tourism.

The U.S. health reform was designed to improve access to health care by mandating insurance for all U.S. citizens. It is noted that two-thirds of this study's participants had some level of health insurance, yet chose to maximize their health care dollars by traveling internationally for health care. It is possible that international health care providers that accept U.S. insurance may see an increase in medical tourists. As it will be several years before changes in the U.S. health care system are fully realized, it is difficult to project the impact on medical tourism.

Health policy on a domestic and international level does and will continue to influence the phenomenon of medical tourism. In discussion of health care access, it is understandable that an individual's health seeking behavior is also influenced by social and political climate. Further research will be necessary to understand the impact of current policy and health care economics, including U.S. health reform on the medical tourism industry.

### **Limitations**

Limitations with phenomenological research include the descriptive nature of the results, as well as sample selection and characteristics. The factors that limit this study are discussed. Where applicable, factors used to lessen study limitations are also discussed.

This study of Alaskan medical tourists was undertaken to gain understanding into the experience of traveling internationally for health care, making the choice of an interpretive phenomenological research design appropriate. The goal was a rich description of the essential structure of the lived experience of medical tourism from the perspective of the sample that have personal knowledge and understanding of the experience. As such, generalization of the results is not appropriate or expected.

The participants of this study contacted the researcher or gave permission for the researcher to make contact. It is possible that the positive nature of the participants' medical tourism experiences encouraged participation in the study skewing the results towards the benefits of medical tourism. It is possible that an equal number of people exist that had negative medical tourism experiences who did not fall under the recruitment umbrella or self selected not to participate.

Only participants who are residents of Alaska were recruited and interviewed for this study. This parameter may be a limitation to the study. With only one urban center and large expanses of rural territory, Alaskan patients are often challenged by limited health care options. Patients in Alaska often need to travel within the state or out of the state to urban medical centers. As the experience of traveling for health care is not foreign to most Alaskans, it is possible that medical tourists from Alaska have considerably different experiences and understanding of medical tourism from those who live in other states or countries.

As noted, four partner groups were interviewed as part of this study. Both members of the partnerships experienced medical tourism, thereby meeting selection criteria. All participants were interviewed individually, yet it is possible that interviewing two people who traveled together for medical tourism may be a limitation to this study. Traveling with a partner who is also seeking health care internationally may influence the resulting experiences and therefore the thematic analysis. In attempt to minimize this limitation, disclosure of the partner groups is provided within the study findings.

The participants traveled for medical tourism to many geographical regions. Failure to reduce the study to one specific geographical area such may limit the findings. Despite data representing the medical tourism experience from six different countries, common threads

emerged in this study providing valuable information on medical tourism. The possibility remains that study of the phenomenon in different geographical locations would reveal further depth of the essential structure of the medical tourism experience.

This study was initiated during a period of time in which the U.S. health care system had recognized deficits such as escalating cost of medical care, a large number of uninsured Americans, and declining health indices compared to other industrialized nations (Berwick, Nolan, & Whittington, 2008; Cantor, Schoen, Belloff, How, & McCarthy, 2007). Many of the study participants vocalized displeasure and concern that they were unable to access affordable care in the U.S. After data collection was completed for this study, the U.S. legislative bodies passed the Patient Protection and Affordable Care Act. Although the outcome of health care reform won't be realized for many years, the current dynamic health policy atmosphere may be considered a limitation of this study.

### **Future Direction for Research**

The results of this study provide insight into the essential structure and meaning of medical tourism and add to knowledge of health seeking behavior. Phenomenological thematic analysis allowed the lived experiences of the participants to be revealed, yet further study is necessary to fully understand medical tourism from a patient and system perspective. Although a broad definition of medical tourism was explored in the literature review and this study by including a variety of medical and dental procedures in many international locations, further research is needed on specific medical tourism activities such as reproductive tourism, stem cell tourism, dental tourism, and complimentary medical tourism. There are many avenues open and ripe for in depth exploration.

This study also took a far reaching approach and included medical tourism destinations around the globe. Further research is needed that is location specific such as medical tourism in India, Thailand, and Costa Rica. One approach to future study might be activity and location specific research such as reproductive tourism in Eastern Europe or orthopedic tourism in India.

Phenomenological research is descriptive in nature and hermeneutic interpretation allows insight into the experience of medical tourism and health seeking behavior. Additional research, including quantitative analysis, is needed to further understanding of medical tourism and the impact it may have on health seeking behavior, patient outcomes, financial implications, as well as consequences of medical tourism on resident and destination countries.

### **Summation**

To accurately reflect the activity and experience of medical tourism, a terminology change would be advantageous. Medical tourism might be considered by popular U.S. opinion an elective, frivolous, or dangerous means of obtaining health care that is available and optimal in a patient's country of origin. The words tourism and tourist denote travel for the purpose of pleasure or sightseeing, often with an accompanying negative connotation about the superficial nature of the tourist's experience. The results of this study indicate that medical tourism is much more than a travel experience for entertainment purposes with health care peripherally attached. For these participants, it reflects a means to obtain basic health care and improve their core health status and quality of life. The use of the term 'medical tourism' deemphasizes the significance that the study participants placed on the basic health care needs, economic considerations, and dissatisfaction with the ability to obtain health in the U.S. that motivated these health seekers to travel internationally for medical care. As such, the term medical tourism

deflects from the state of the domestic health care system which is prompting people to look internationally for health care.

A description or term for the activity of purposeful international travel for health care is needed. The terms 'medical travel' or 'health seeking travel' more accurately capture the inherent objective and as alternatives to 'medical tourist', the terms 'health seeking traveler' or 'medical traveler' are better suited nomenclature which reflect the rationale for this specific type of travel. Much like the 'business traveler', a health seeking traveler has a reason for travel that is outside of pleasure tourism; and also like the business traveler may or may not include some aspects of recreation while traveling which does not deemphasize the necessity of the travel. Health seeking travelers are focused on improving and maintaining their health status through care obtained internationally. The participants recognized that they were unconventional in their choices of health seeking behavior, but all of them expressed that the solution to their unmet health care needs was health seeking travel. The participants of this study returned to Alaska with the belief that they had received high quality medical and dental care that improved their health status, thereby making international travel for health care an effective means of health seeking behavior.

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## **Appendix A – Consent Form**

### **Agreement to Participate in the Study of**

**The Lived Experience of Seeking Health Care through Medical Tourism: An Interpretive Phenomenological Study of Alaskan Patients Traveling Internationally for Medical and Dental Care**

**Lee Ann Eissler  
Primary Investigator  
(907) 351-8038**

This research project is being conducted as a component of a dissertation for a doctoral degree. The purpose of the project is to learn about the experience of travelling internationally for medical and dental care.

You are being asked to participate, because you have traveled for the purpose of medical or dental care and you have sought and received medical or dental care while traveling internationally.

Participation in the project will consist of filling out a form on background information about yourself and an interview with the investigator. Interview questions will focus on your experience of seeking and receiving medical or dental care while traveling internationally and the motivation for seeking care. Data from the interview will be summarized into broad categories. No personal identifying information will be included with the research results.

Completion of the form containing background data should take no more than 5 minutes. Anticipated interview length will be 30 to 60 minutes. Interviews will be audio recorded for the purpose of transcription.

The investigator believes there is little or no risk to participating in this research project. However, there may be a small risk that you will experience psychological discomfort when relating your experience of previous medical or dental care. If needed, a list of mental health professionals will be provided to you if follow-up mental health care is needed or if increasing psychological symptoms occur. Mental health care will be at your expense.

Participating in this research may be of no direct benefit to you. It is believed, however, the results from this project will increase knowledge and understanding of health care professionals providing care to patients who travel internationally for medical and dental care.

Research data will be confidential to the extent allowed by law. Agencies with research oversight, such as the UH Committee on Human Studies, have the authority to review research data. All research records will be stored in a locked file in the primary investigator's office for the duration of

the research project. Audio tapes will be destroyed immediately following transcription. All other research records will be destroyed upon completion of the project.

Participation in this research project is completely voluntary. You are free to withdraw from participation at any time during the duration of the project with no penalty, or loss of benefit to which you would otherwise be entitled.

If you have any questions regarding this research project, please contact the researcher, Lee Ann Eissler at (907) 351-8038.

If you have any questions regarding your rights as a research participant, please contact the UH Committee on Human Studies at (808)956-5007, or [uhirb@hawaii.edu](mailto:uhirb@hawaii.edu)

**Participant:**

I have read and understand the above information, and agree to participate in this research project.

---

Name (printed)

---

Signature

---

Date

**Appendix B – Background Form**

Initials:

Alaskan Resident:

Age:

Occupation:

Medical Tourism Destinations:

Approximate Dates:

Private Health Care Insurance:

### **Appendix C - Interview Guide**

Tell me the story about your experience of having [a procedure, surgery] in [Thailand, Brazil, etc]’.

Tell me about the research you did prior to traveling for medical care.

What does it feel like to obtain medical care in another country?

Describe your thoughts when you arrived at your health care destination.

Describe your thoughts as you received care?

What was your motivation for seeking health care in a country other than your resident country?

How did you decide to become a medical tourist? Tell me about the process that you went through in your decision making.

Describe the impact of obtaining medical care in a country other than your resident country.

How do you feel about the health care that you received?

Did you seek follow-up care upon return to Alaska?

## Appendix D – Human Subjects Approval Letters

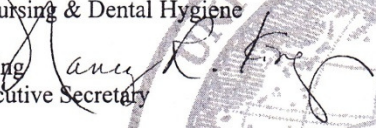
### UNIVERSITY OF HAWAII

Committee on Human Studies

#### MEMORANDUM

November 9, 2009

TO: Lee Ann Eissler  
Principal Investigator  
School of Nursing & Dental Hygiene

FROM: Nancy R. King   
Interim Executive Secretary

SUBJECT: CHS #17594- "The Lived Experience of Seeking Health Care through Medical Tourism: An Interpretive Phenomenological Study of Alaskan Patients Traveling Internationally for Medical and Dental Care"

Your project identified above was reviewed by the Chair of the Committee on Human Studies through Expedited Review procedures. The project qualifies for expedited review by CFR 46.110 and 21 CFR 56.110, Category (6) of the DHHS list of expedited review categories.

This project was approved on November 5, 2009 for one year. If in the active development of your project you intend to change the involvement of humans from plans indicated in the materials presented for review, prior approval must be received from the CHS before proceeding. If unanticipated problems arise involving the risks to subjects or others, report must be made promptly to the CHS, either to its Chairperson or to this office. This is required in order that (1) updating of protective measures for humans involved may be accomplished, and (2) prompt report to DHHS and FDA may be made by the University if required.

In accordance with the University policy, you are expected to maintain, as an essential part of your project records, all records pertaining to the involvement of humans in this project, including any summaries of information conveyed, data, complaints, correspondence, and any executed forms. These records must be retained for at least three years from the expiration/termination date of this study.

The CHS approval period for this project will expire on November 5, 2010. If your project continues beyond this date, you must submit a continuation application to the CHS at least four weeks prior to the expiration of this study.

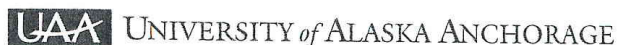
We wish you success in this endeavor and are ready to assist you and your project personnel at any time.

Enclosed is your certification for this project.

Enclosure

1960 East-West Road, Biomedical B104, Honolulu, Hawaii 96822-2303  
Telephone: (808) 956-5007, Facsimile: (808) 956-8683, Website: [www.hawaii.edu/irb](http://www.hawaii.edu/irb)

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Office of Research and Graduate Studies

December 3, 2009

Dr. Lee Ann Eissler  
School of Nursing  
University of Alaska Anchorage  
3211 Providence Drive

Dear Dr. Eissler:

Your proposal entitled *The Lived Experience of Seeking Health Care through Medical Tourism: An Interpretive Phenomenological Study of Alaskan Patients Traveling Internationally for Medical and Dental Care* received an expedited review and was granted approval. Therefore, in keeping with the usual policies and procedures of the UAA Institutional Review Board, your proposal is judged as fully satisfying the U.S. Department of Health and Human Services requirements for the protection of human research subjects (45 CFR 46 as amended/revised). This constitutes approval for you to conduct the study.

This approval is in effect for one year. If the study extends beyond a year from the date of this submission, you are required to submit a progress report and to request continuing approval of your project from the Board. At the conclusion of your research, submit the required final report to the IRB. These report forms are available at the IRB website at <http://www.uaa.alaska.edu/research/ric/irb/documents.cfm>.

Please report promptly proposed changes in the research protocol for IRB review and approval. Also, report to the IRB any injuries or other unanticipated or adverse events involving risks or harms to human research subjects or others.

On behalf of the Board, I wish to extend my best wishes for success in accomplishing your objectives.

Sincerely,

A handwritten signature in cursive script that reads 'Dianne Toebe'.

Dr. Dianne Toebe  
Co-Chair, Institutional Review Board

cc: Faculty Services  
Dean Cheryl Easley, College of Health and Social Welfare

## Appendix E – Samples of Medical Travel Documents

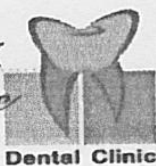
### HEALTH SCREENING PROGRAMS

Examination/Test	Regular	Executive	Executive with Stress Test	Comprehensive (Over 40)
Vital Signs and Physical Examination	•	•	•	•
Blood Tests				
• Complete Blood Count (CBC)	•	•	•	•
• Fasting Blood Sugar	•	•	•	•
• Lipid (Fats) Profile				
* Cholesterol, HDL and Triglyceride	•	•	•	•
* Cholesterol/HDL Ratio	•	•	•	•
* LDL Cholesterol	•	•	•	•
• Gout * Uric acid	•	•	•	•
• Kidney Function Panel				
* Creatinine	•	•	•	•
* BUN				•
• Liver Function Panel				
* SGOT (AST) and SGPT (ALT)	•	•	•	•
* Alkaline Phosphatase (ALP)		•	•	•
* Total Bilirubin, Albumin, Globulin				•
* Gamma GT (GGT)				•
• Thyroid Panel * TSH and Free T4				•
• Hepatitis Screening				•
* HBsAg and HBsAb, Anti-HCV				
• Tumor Markers				
* CEA for GI Cancer				•
* AFP for Liver Cancer				•
* PSA for Prostate Cancer				• (Male only)
Urine Examination	•	•	•	•
Stool Examination with Occult Blood	•	•	•	•
Electrocardiogram (EKG)		•	•	•
Exercise Stress Test (EST)			•	• (Male only)
Chest X-ray	•	•	•	•
Ultrasound Whole Abdomen		•	•	•
Digital Mammogram with Ultrasound Breast				• (Female over 40)
PAP Smear and Pelvic Exam		• (Female only)		• (Female only)
Eye Exam (Acuity and Tonometry)				•
<b>SPECIAL PRICE (inclusive of doctor's fee)</b>	<b>2,600</b>	<b>6,300</b>	<b>9,000</b>	<b>Male 13,000</b>
		<b>Female 7,500</b>		<b>Female 15,300</b>
				<b>Female (Under 40) 11,500</b>

■ Prices are per person in baht  
 ■ All prices are subject to change without prior notice

Bumrungrad Hospital – Bangkok Hospital

**B**angkok  
*Smile*

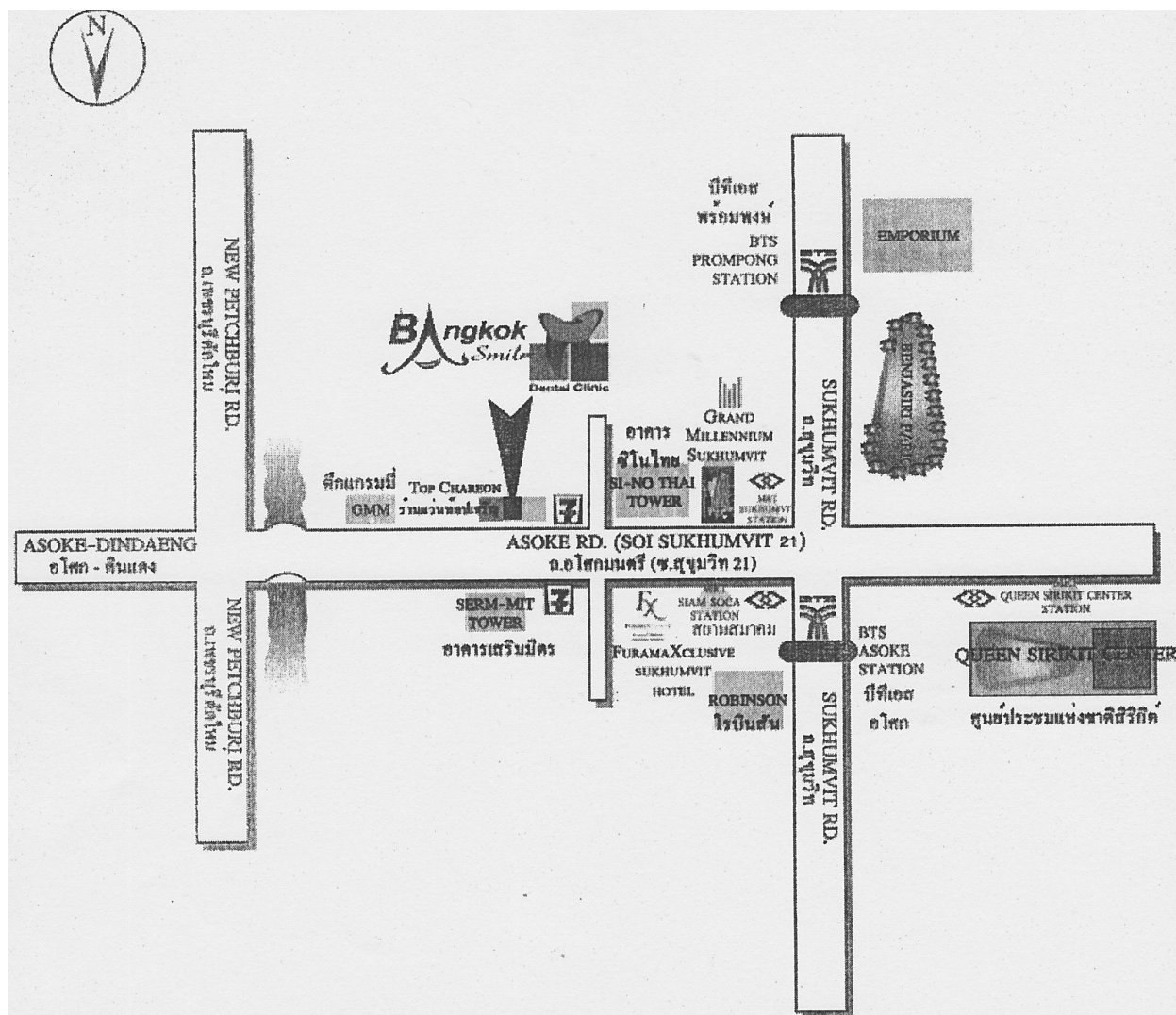


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  2. คลินิกทันตกรรมบางกอกสไมล์ สาขาสุขุมวิท 21  
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- International phone number: + 662 664 2711, Australia local phone number : 086 365 4497



#### HOW TO COME?

ADDRESS : SUKHUMVIT 21 Rd.(ASOKE) NEXT TO SINO-THAI BUILDING, CLOSE TO 7 ELEVEN AND TOP CHAROEN OPTICAL SHOP TEL. 0 2664 2800 FAX. 0 2664 2900

By SKYTRAIN (BTS): SUKHUMVIT STATION (E4), 15 MIN. (350 M.) WALKING FROM EXIT 3

By SUBWAY (MRT): SUKHUMVIT STATION (SUK), 3 MIN. (80 M.) WALKING FROM EXIT 1

FOR TAXI: สถานีบางกอกสไมล์ ถนนสุขุมวิท 21 (อโศก) ช่วงระหว่างแยกเพชรบุรีกับแยกสุขุมวิท  
ฝั่งเดียวกับตึกแกรมนี ใกล้กับอาคารชิโนไทย ครบถ้วนอาคารเซรมิตร คัดเซเว่นโอเล่และร้านแว่น  
ที่อปเจริยู ก่อนถึงทางเลี้ยวซ้ายที่จะเข้าซอยประสานมิตร (สุขุมวิท 23)

## ใบรับรองแพทย์ Dental Certificate

ทันตแพทย์.....  
Dentist's name

เลขที่ใบประกอบโรคศิลป์.....  
License no

หนังสือรับรองฉบับนี้ ขอรับรองว่าข้าพเจ้าผู้มีชื่อข้างต้น ได้ทำการตรวจหรือรักษาสุขภาพช่องปากของ  
This is a letter to certify that I, named above, had examined or treated the following person

.....เลขประจำตัวบัตรประชาชน.....  
ID or passport no

ที่อยู่.....  
Address

เลขทะเบียนคนไข้..... บริษัท/ประกัน..... เมื่อวันที่..... DEC 2009  
Chart No. Company name/Insurance On

รายการ List of Tx	ซี่ฟัน Tooth number	วินิจฉัยโรค Diagnosis	การรักษา Treatment
1	# 21		crown on implant
2	#		
3	#		



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 Neurosurgical Gamma Knife Treatment for brain tumors, AVM, Epilepsy, Parkinsonism
- MRI (Intra Achiva 3.0T MRI):**  
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