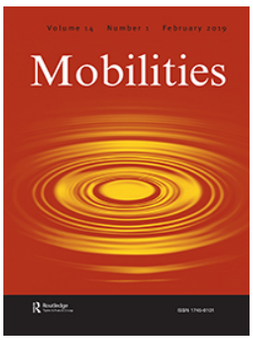

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INTRODUCTION

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Therapeutic mobilities

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ABSTRACT

This Special Issue expands mobilities research through the idea of therapeutic mobilities, which consist of multiple movements of health-related things and beings, including, though not limited to, nurses, doctors, patients, narratives, information, gifts and pharmaceuticals. The therapeutic emerges from the encounters of mobile human and non-human, animate and inanimate subjects with places and environments and the individual components they are made of. We argue that an interaction of mobilities and health research offers essential benefits: First, it contributes to knowledge production in a field of tremendous social relevance, i.e. transnational health care. Second, it encourages researchers to think about and through functionally limited, ill, injured, mentally disturbed, unwell and hurting bodies. Third, it engages with the transformative character of mobilities at various scales. And fourth, it brings together different kinds of mobilities. The papers in this Special Issue contribute to three themes key for the therapeutic in mobilities: a) transformations (and stabilizations) of selves, bodies and positionalities, b) uneven im/mobilities and therapeutic inequalities and c) multiple and contingent im/mobilities. Therapeutic mobilities comprise practices and processes that are multi-layered and mutable; sometimes bizarre, sometimes ironic, often drastically uneven; sometimes brutal, sometimes beautiful – and sometimes all of this at the same time.

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When plants are uprooted in remote Laotian forests, packaged, shipped and sold at farmers' markets in the US (Bochaton), when aspirational young people in the Philippines and India leave their homes to be trained as nurses to care for patients in the West (Thompson; Walton-Roberts)[1], when distressed patients extend their quest for effective therapies – often with the help of intermediaries/facilitators/brokers (Hartmann) – to overseas destinations such as fertility clinics in Mexico (Schurr), cancer wards in India (Kaspar) or corporate hospitals in Malaysia (Chee, Whittaker, and Por), they all become productive of the emerging 'economies of vitality' – as life itself is made amenable to the new economic space of the 'bioeconomy' (Rose 2007). We interpret these as different examples of what we call *therapeutic mobilities*.

This Special Issue expands mobilities research through the idea of therapeutic mobilities. Therapeutic mobilities consist of multiple movements of health-related things and beings, including, though not limited to, nurses, doctors, patients, narratives, information, gifts and pharmaceuticals. These beings and things are made mobile through the work of multiple assemblages (including states, markets, non-markets) creating an infrastructure with the potential to unfold, develop and/or expand the therapeutic capacities of these inputs. Mobility can enhance, magnify, distort or intensify the therapeutic effects and powers of

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these inputs in motion. Mobility thus transforms the practice and product that is being moved.

Therapeutic mobilities come to the aid of bodies that need diagnostics, therapies or palliative care, thus combining movement and stasis to unfold therapeutic capacities. In the process of meeting the needs of end users, the mobility of the thing itself generates transformative powers, which is evident in the mobility of health products, professionals and patients. For example, the transnational trade in traditional medicines exerts therapeutic effects on the communities engaged in these commercial exchanges, not just those using the medicines. Likewise, nurses provide therapy, yet in exercising mobility the profession of nursing is itself enhanced, its motility – potential mobility – bestows something upon not just one nurse who moves, but on the whole profession. And patients driven by hope for cure, well-being, beauty or children travel to distant places. In doing so they change subject positions, transform their own and others' bodies, and contribute to the creation of multiple types of health care landscapes.

These examples and others are examined in the papers in this Special Issue, which address practices and processes relevant to matters of life and death (cancer, reproduction, life-sustaining care, organ replacement), and yet they are also somehow banal in their everydayness. These elements of health and well-being are embedded in national and transnational health care markets, which contribute to the estimated USD $8.7 trillion spent globally on health care (equivalent to over 10% of global gross domestic product) (Deloitte 2018). Some of these therapeutic mobilities are part of the survival strategies of vulnerable, yet resourceful subjects, wounded and skilled, caring for the self and for others; but others are commodities available for those with the necessary power and social, financial and political capital needed to access them. Therapeutic mobilities build connections and departures between home and tradition; they re-configure identities and positionalities; they constitute chances and risks, they offer opportunity and necessity for individual mobile actors as well as unclasping and assembling new and diverse communities.

Inspired by the new mobilities paradigm (Sheller and Urry 2006) and the work of health researchers in various disciplines, this Special Issue engages with work on health mobilities to 'describe some of the forces shaping contemporary human experiences of affiliation and healing that have often gone unacknowledged in studies more tightly organized around specific medical systems or geographic locales' (Dilger, Kane, and Langwick 2012, 2). The papers in the Special Issue entangle health and mobilities research by exploring how diverse mobile agents – plants, body parts, experts and patients – engage in, shape and re-configure medical globalizations (Dilger and Mattes 2018). The traffic of these things can be therapeutic for those involved in the process, but the globalization of therapeutic markets entails intricate and even paradoxical subject positions (Langwick, Dilger, and Kane 2012, 5), producing complex and highly uneven mobilities (Sheller 2016). The papers of this Special Issue explore various therapeutic mobilities and the versatile ways in which resilient, recalcitrant, affective/emotional, relational, responsibilized and resourceful subjects work with, sometimes take advantage of, are empowered and exploited by these consumer-based opportunities present in 'transnational configurations of medicine and health' (Langwick, Dilger, and Kane 2012, 15). In the following, we briefly explain the links between health and mobilities research before introducing therapeutic mobilities as a powerful concept to stimulate analytical engagement with mobilities research in the realm of health and medicine.

Health, medicine and mobilities research

According to Gatrell (2013, 100), '[C]onnections between the literatures on mobilities and well-being have, in general, been neglected'. But attention to and interest in these connections are increasing (Nordbakke and Schwanen 2014, 104). Following the mobility turn, mobility has gained popularity as a theme in a broad range of disciplines (Dilger and Mattes 2018, 269), including those traditionally concerned with the configurations of health and medicine such as public and global

health, medical anthropology and health geography. As a result, the health-mobility-nexus has been analysed in various fora and from multiple perspectives.[2]

In mobilities research itself, the introduction of the new mobilities paradigm (Sheller and Urry 2006), has been expanding the field's thematic scope beyond the movement of beings and things between locations. Among the many engagements, though, health has remained a marginal theme. For example, in Tim Creswell's three progress reports on mobilities research (Cresswell 2010, 2012, 2014) health and medicine are largely absent. A keyword search using health, therapeutic, disease or medical in the journal *Mobilities* resulted in just a handful of papers focused on translocal livelihoods (Schröder and Stephan-Emmrich 2016), later life (Nordbakke and Schwanen 2014), the connection between auto-mobility and urban sprawl (Freund and Martin 2007) and international medical travel (Ormond 2015). Many other papers address issues of health, well-being and medicine, without explicitly mentioning them in the title or in keywords. This includes pathogens' journeys (Schillmeier 2008; Sheller 2016), spatial spread and concentrations of diseases (Emch et al. 2012), the effects of physical or cognitive limitations on everyday mobilities (Goggin 2016; Pyer and Tucker 2017; Rosenkvist et al. 2010), the effects of everyday mobilities on public and individual health (Freund and Martin 2007; Gorman-Murray and Bissell 2018), well-being (Benediktsson 2017; Short and Pinet-Peralta 2010), the intertwining of migration or translocality and unhealthy behaviour (Yang et al. 2016), incidence of illness (Lu 2010) and health inequalities (McLafferty et al. 2012). However, the simple fact that health and medicine rarely make it into papers' title or keyword list mirrors perhaps the marginality of health to the field of mobilities research up until the current moment.

The marginal status of health issues in mobilities research is a missed opportunity, since health is central to social and economic development, and is increasingly a key political issue as health care for all and access to universal health care becomes a central feature of civil demand and debate in national and international fora, especially in light of the *right to health* movement (Leary 1994). In *Mobilities*' 12-year history there has not been a concerted engagement with health; this Special Issue addresses this lacuna and presents the case for an explicit commitment to embed health into the new mobilities paradigm through the idea of therapeutic mobilities.

Therapeutic mobilities

> [A]s medicinal substances, therapeutic practices, and healing practitioners (as well as institutions, technologies, policies, and ethical frameworks to which they adhere) circulate, they shape myriad aspects of social, political, and economic life. (Langwick, Dilger, and Kane 2012, 1)

With a focus on the therapeutic, this Special Issue moves health from the periphery to the centre stage of mobilities research. Rather than focusing on pathogen processes, circumstances and entities, our approach focuses on therapeutics, i.e. practices that attempt to 'do good,' offer cure, support healing, treat and alleviate suffering or foster well-being. In so doing, we aspire to offer a fresh perspective on research addressing the crossroads of health and mobility. Paralleling the interest in the concept of therapeutic landscapes (Gesler 1992, 2005) to excavate 'the positive qualities of places' (Gatrell 2013, 98), therapeutic mobilities foregrounds and draws attention to the beneficial, salutary and restorative qualities and effects of movement, whereby these qualities and effects are relational achievements (Duff 2011), rather than characteristics inherent to a certain place, or mobility per se.

Thus far, mobilities research has focused on the therapeutic as a quality of 'the act of moving from one place to another' (Gatrell 2013), such as in walking (Gatrell 2013; Roe and Aspinall 2011) or pilgrimage (Williams 2010). With this Special Issue we intend expanding mobilities studies' engagement with the therapeutic by adding another modality: the therapeutic as an effect that

requires mobility, but does not necessarily result from movement itself, but rather from encounters with various assemblages resulting from mobility.

Hence, mobility works as a generator of therapeutics. The therapeutic is what emerges from the encounters of mobile human and non-human, animate and inanimate subjects with places and environments and the individual components they are made of (Conradson 2005). Mobility is a means, an instrument, a strategy to facilitate therapeutic impacts or to unfold therapeutic powers. Here, mobility serves as a means to prompt the production or consumption of therapy. As a (desired) effect, the therapeutic is an aspiration, a hope, a potentiality. It is an orientation towards the future, a future that is imbued with hope and hence of an affective/emotional texture. This affective/emotional texture provides the therapeutic with a strong mobilizing power.

Both as a quality and as an effect/aspiration, the therapeutic – just like mobility – is inherently transformative. Therapeutic is the denomination for a felt and/or measured, subtle or apparent, sometimes missing, often desired transformation of the physical, emotional and mental body towards soothing and healing, recovery and hope. As the quotation at the beginning of this subsection indicates, therapeutic mobilities are transformative not only of mobile subjects, but also of the dis/connections and assemblages they are part of.

Irrespective of their aspirational character, therapeutic mobilities might have detrimental effects for those involved. Resulting disadvantages might refer to health outcome and well-being, but also to individuals' and households' livelihoods and resources as well as intimate relations and social positions. A focus on the therapeutic is not uncritical or disinterested in processes and effects that are to the detriment of some, while benefitting others; the realm of uneven mobilities (Sheller 2016). Quite the contrary, the therapeutic mobilities perspective takes as a point of departure the assumption that actions, their contexts and effects usually are multi-layered, complex and ambivalent. Accordingly, paying close attention to the multiplicity of processes, actors and effects involved in therapeutic mobilities – and those kept apart! – and their relation and interconnectedness and how they change over time is a core purpose.

In sum, therapeutic mobilities as a conceptual lens focus on health and medicine in motion as key elements of contemporary life. Understanding the individual and collective practices and socio-material structures that shape mobilities at various scales and how they affect individuals, communities and societies has been at the heart of mobilities research, yet these questions have rarely been projected through the lens of health and medicine. Doing so now allows for multiple engagements, which we outline below.

First, creating a bridge between the insights of mobilities research and health expertise *contributes to knowledge production in a field of tremendous social relevance: transnational or global health care*. This also challenges dominant social imaginaries of health as a national issue and public good, it stresses the transnationalization of health care seeking and provisioning, which poses important questions not only in terms of markets of exchange for goods, but as radical reimaginings of the relationship between the state and its citizens. This is an expansive field of analysis marked by stark global inequalities, imbued with old and new power structures and relations. The ways in which pharmaceuticals, medical knowledges, health care resources and patients are im/mobilized and dis/connected are a matter of life and death. The unevenness in the provision of health care reflects old and new inequalities that are continuously morphing in response to new technologies, legal and ethical frameworks, public demands and political concessions (Cohen 2013). This Special Issue aspires to further advance the field of medical globalization research by taking the multi-layered, intricate, mutable and transformative character of these social realities and the becoming thereof into account, as well as by identifying and describing the differentiations and inequalities they generate or draw upon in terms of health and human rights; this is the 'pathologies of power' as Paul Farmer (2005) terms it, and also a key site through which to advance recent calls for a focus on mobility justice (Cook and Butz 2019; Sheller 2018).

Second, to reflect on tacit and probably unintended assumptions regarding key research subjects; mobilities research until recently has largely been concerned with healthy, able-bodied subjects as health conditions of mobile subjects are rarely described in research accounts, but rather assumed (recent

exceptions are Goggin 2016; Kaur, Saukko, and Lumsden 2018; Parent 2016; Pyer and Tucker 2017; Sawchuk 2013). We suggest that mobilities research, a field that has been impressively successful in questioning the exceptionalism of mobile and translocal lifestyles, could draw a lot of inspiration by continuing to *think about and through functionally limited, ill, injured, mentally disturbed, unwell and hurting bodies*. Apart from offering fresh assessments, such a shift in perspective acknowledges the ground realities and lived experiences of a majority of the world's population, since being a fully functional body is a privilege – globally as well as across the lifespan, rather than a normalcy. Such elaborations represent important examples of the moorings that are part of the mobilities research approach (Adey 2006), people who are ill and immobilized are the moorings of massive infrastructures of pharmaceutical, health science and mobile professionals and technologies, as well as for families and communities.

Third, this connection *engages with the transformative character of mobilities at various scales*. Health is fundamentally personal and intimate, while at the same time intrinsically political and structured in global terms; the global burden of disease is the spatial manifestation of these scaler inequalities, and neglected tropical diseases signify the uneven mobilities exercised by governments, philanthropic organizations and pharmaceutical companies (Fenwick 2012). These scaler inequalities matter deeply, since illness, disease and disorder, as well as diagnostics, therapies, cure and healing are inherently transformative. Health, therefore, is something that is precarious, endangered and always in the way of becoming.

Fourth, therapeutic mobilities encourages researchers to *think different kinds of mobilities together,* as proposed through the new mobilities paradigm (Cresswell 2012; Sheller and Urry 2006). Mobilities of human and non-human, material and immaterial, animate and inanimate entities hang together prompting new transformations and further mobilities. A focus on therapeutic mobilities is concerned with the question of how individual and collective health practices and imaginaries, medicinal products, therapeutic technologies and healing and diagnostic infrastructures as well as political economies of health care are intertwined with and co-produced by diverse small- and large-scale im/mobilities and dis/connectivities. For example, reproductive technologies join with site-specific marketing and national-based legal regulations to create new spaces for conception and reproduction (Schurr).

Three kinds of therapeutic mobilities: transnationally circulating patients, health professionals and pharmaceuticals

In the past two decades, travelling across national borders to receive or to provide health care has transformed into a phenomenon with ample economic, social and legal relevance (Cohen 2013). Traditionally, social processes as well as health practices have been studied as if they were contained within the borders of nation-states. What is known as methodological nationalism has been critiqued by a growing number of social theorists who encourage an analytical move beyond national-territorial containers and against the narrative of sedentarism (Malkki 1992): 'Mobilities studies called attention to the myriad ways in which people and their cultural practices are not confined to a fixed territory but are parts of multiple spatial networks and temporal linkages' (Glick Schiller and Salazar 2013). The papers in this Special Issue adopt this approach and shift the focus away from 'institutional territories' characterized by the pyramidal organization of care in a national context, towards the 'functional networks' organized to mobilize health resources wherever they are, leading to the emergence of multiscalar territorial forms (Offner and Pumain 1996).

Accordingly, the papers in this Special Issue focus on *transnational* mobilities where mobility involves crossing one or more national boundaries. As such it scales up Gatrell's (2013) suggestion of the therapeutic mobilities as small-scale therapeutic acts of moving (namely walking). It furthermore follows and takes to a global level Gatrell's (2013) call 'to draw together elements of the mobilities literature, and elements of the wellbeing literature, in order to illuminate the ways in which mobilities can sustain health and well-being'.

The papers in this Special Issue observe that the transnational circulation of medicinal goods, biomaterials, patients and accompanying caregivers as well as health, care and reproductive workers is on the way to becoming a normality in many parts of the world. Uneven access to health and medical services has inspired mobilities in terms of medical travel and facilitation services, health worker migration, medical plant shipments, intimate transfers between client and biomaterial provider, and digital data connectivity offering innovative health care service delivery over great distances. These forms of therapeutic mobilities are everywhere, and everyday tens of thousands of people are engaging in this traffic of goods and services. This normality disguises the enormous complexity that undergirds such mobilities, as the papers in the Special Issue reveal. The papers address three kinds of transnational therapeutic mobilities:

(a) *Movement of patients*: Patients travel to places of medical excellence in the Global North and South to access treatments not available or affordable where they live (Bochaton 2015, 2013; Holliday et al. 2015; Kaspar and Reddy 2017).

(b) *Migration of health professionals and service providers*: High-income countries address health care labour force demands by importing skilled and less skilled migrants from low- and middle-income countries (England 2015; Kingma 2006; Walton-Roberts 2012, 2015).

(c) *Flows of health products*: The transnational diffusion of health products used in a preventive, curative or diverted way, is an increasing phenomenon in relation with migrations, neoliberalism and the global pharmaceutical industry (Dilger, Kane, and Langwick 2012; Greenhough 2018; Petryna, Lakoff, and Kleinman 2006).

In the section below, we briefly present the state-of-the art and the respective individual papers in this Special Issue under these three categories. In the subsequent section we highlight key transversal themes that mobilities research and therapeutic mobilities share, and flag the papers' contribution to further advancing the field of mobilities research.

Transnational patients

The ongoing transformation of health care into a profitable industry has led to local, regional and global competition for patients, health providers and products. As a result, people and objects increasingly cross national borders to receive and provide health services (Cohen 2013). This includes so-called medical travel routes to destinations springing up in low- and middle-income countries such as India, Thailand or Costa Rica. People travel for cardiology treatments (Grace 2007), standard joint replacements (Crooks et al. 2012), (illicit) organ transplantations (Cohen 2011; Scheper-Hughes 2011), (experimental) stem cell therapies (Petersen et al. 2017; Song 2010), fertility treatments (Inhorn and Patrizio 2009; Gunnarsson Payne 2015), including surrogacy (Lozanski 2015; Parry 2015), cutting-edge cancer care (Kaspar and Reddy 2017) or plastic surgery (Ackerman 2010; Bell et al. 2011). The reasons for doing so are manifold: costs are up to 10 times lower (Amodeo 2010, 66; Woodman 2008, 10), long waiting lists are circumvented (Connell 2006) or people with migratory background might want to return 'home' for preferential medical interventions (Cohen 2011; Dilger, Kane, and Langwick 2012; Kemppainen et al. 2017). A large share of mobile patients are from countries that offer poor quality or limited availability of affordable diagnosis and treatment (Ormond and Sulianti 2017); these populations can be understood as 'medically disenfranchised' (Roberts and Scheper-Hughes 2011).

Heidi Kaspar and Heng Leng Chee, Andrea Whittaker and Heong Hong Por concentrate on the transnational mobility of patients. They emphasize that the key driver is inadequate local health care. Heng Leng Chee, Andrea Whittaker and Heong Hong Por's case study on the movement of people between Indonesia and Penang in Malaysia for treatments and check-ups investigates international medical travel through the conceptual lens of sociality. In their paper, the authors frame medical

travel as transnational social space, based on the foundations of historical regional transnational connections and built through the active effort of many different stakeholders: state agencies, private hospitals, intermediary businesses, local persons, ex-patients, accompanying persons, etc. The study shows how the arrival of patients is generated through dense linkages and overlapping networks that are both formal (hospital-based) and informal (individual and community-based), multi-faceted (temple-based, church-based, colleagues, neighbours, friends and family) and multi-dimensional (commercial relationships between patients and facilitators as well as intimate relationships between patients and relatives). In their analysis, the authors also highlight two key mechanisms – the transmission of recommendations through 'word of mouth' and the practice of accompaniment – in a heuristic way to illustrate the work of sociality in the mobilities associated with international medical travel. By stretching the concept of transnational social space to cover international medical travel, the paper emphasizes the social life that surrounds these therapeutic mobilities.

In her case study on cancer patients in Central Asia reaching New Delhi for oncology treatment, Heidi Kaspar highlights how medical innovations create new therapeutic needs that, given the existent geographic disparities in health care provision, prompt patient mobility to overcome treatment disenfranchisement. In many cases for patients to become mobile they must become entangled in the economic circuits of a transnational health care market, which may add vulnerabilities to their situation. Kaspar employs the concept of relational subjectivity to reveal the important role of family caregivers who accompany patients on their transnational therapeutic journeys: patient travel initiates wider relational mobilities.

Sarah Hartmann focuses on the mobilizing work of medical travel facilitators in New Delhi, where the market in transnational health care is rapidly developing. Her study reveals that facilitators' mobilizing work includes different practices that contribute directly and indirectly to the acquisition of new clients. Three major strategies exist through which medical travel facilitators in Delhi gain trust. The first consists in acquiring new clients through the facilitators' websites. The Internet is acknowledged as a driver in medical travel and provides accessible infrastructure for patients, health care providers and intermediaries to connect transnationally. However, the study shows that this mobilizing work is more complex than just creating a website and convincing patients at a distance through technically mediated consultations. The second strategy identified draws on the facilitators' ability to create proximity by integrating other people into the trust-building process and establishing channels that pave the way for patient mobility. Finally, 'patient testimonial mobilization' also appears as a powerful way to acquire new clients. This study therefore conceptualizes medical travel facilitators as brokers who draw on and are productive of the broader medical travel infrastructure, and they do so by drawing several other actors and networks into their mobilizing processes.

Carolin Schurr explores the multiplicity of mobilities that constitute transnational reproduction based on ethnographic research on the reproductive tourism industry in Mexico. While current research on transnational reproduction mostly conceptualizes mobility as horizontal movement from A to B, this study shows how horizontal mobilities converge, interdepend and contradict with vertical, representational and embodied forms of mobility. Schurr explores the logics of these distinct mobilities through three steps. First, mobilities are convergent in the promises they offer; discourse of surrogacy in Mexico as a form of economic aid for the surrogates, and as highly therapeutic for those seeking reproduction and fertility services. Second, these mobilities are interdependent, as the continued mobility of surrogates, biomaterials and intended parents depends upon the ongoing promise of convergence. Third, transnational surrogacy is a highly contradictory mobility where biology, legislation, citizenship, race, ability, age and sexual orientation create the conditions of need for the service, but then also complicate the process of return for the family once the surrogacy process is completed.

Migration of health professionals and service providers

Part of the reason for poor local health care provision can be the difficulty in allocating health professionals (Ormond and Sulianti 2017). For example, England (2015) identifies a 'global crisis' in nursing. Wealthier nations are better positioned to cope with this crisis due to their capacity to retain domestic workers and attract skilled health workers from afar. The global recruitment of nurses has led to an 'unprecedented scale of global nurse migration' (143), which appears as a flow along an economic gradient from poorer to more wealthy countries (Connell and Walton-Roberts 2016). Changing patterns of professional migration, though, suggest that movements are not only unidirectional, but more complex, including circular flows as migration is deployed as a means to accumulate credentials that increase a professional's value in the ('home') health labour market (Walton-Roberts 2015), or even cases where migrants trained in a system orientated to global need remain *in situ* and provide care to global clients through e-health industries (Thompson).

Margaret Walton-Roberts' and Maddy Thompson's papers both highlight how mobility has become embedded in nursing labour markets through the growth of an effective export industry in skilled health workers. Drawing on case studies in India and the Philippines, the authors each examine how health worker migration alters the education system and interacts with already existing socio-economic inequalities present in these countries. Each of these papers reveals how the mobilities migration offers shape the occupational status of nursing within and beyond national markets, and how this is interlinked with occupational and gender stereotypes. In each case, the mobility enabled by migration has led to wider changes in how the nursing occupation and the process of nursing education is enacted in the sending country.

Walton-Roberts offers a review of research on the migration of nurses from India to Canada. In India the international opportunities provided by nursing have prompted a masculinization of the profession, which contributes to transforming the status of the occupation in various ways. The potential mobility, or motility, international migration offers can thus be therapeutic for the individual's career and for the status of the nursing profession more broadly. International credentials and practices become part of nursing practice and transform the person, the system they work in, and the processes introduced in both their home and international sites of employment. However, these mobilities are also uneven, and reflective of already existing structural forms of inequality and bias, in this case in the manner through which male nurses who engage in international migration extract relatively greater material returns from their inclusion in the profession than their female peers.

Thompson's paper focuses on nurses in the Philippines who have been trained in a system that is oriented, and geared towards emigration, yet they have no desire to migrate. Nurses who remain in the Philippines face forms of exploitation at home that emerge as a result or in response to the overbearing culture of migration that imprints itself on the profession. In the Philippines, international migration has produced a form of transnational value for nursing that is exploited by the medical system within the Philippines. Even to find work in a Philippine hospital (whether to assist in international migration or not) one must face the exploitative culture of volunteerism. The rise of Business Processing Office or telehealth centres draws upon these nursing skills produced for the international market, but these nurses do not move overseas, they remain based at home but provide medical services to international patients and medical systems. This option offers something more to both the nurses and patients; an interesting and novel form of international caring practices through digital therapeutics. Thompson's use of mobility rather than migration reveals how movements that are not across borders are nevertheless reflective of the globalization of health care.

Flows of health products

Today, drugs are everywhere and concern all fields of social life. Anthropologists refer to this increased presence in the sphere of everyday life by the critical neologism of pharmaceuticalization (Collin and David 2016; Nichter 1996). For Nikolas Rose (2007), the response of Western societies to the challenges of illness is becoming increasingly pharmaceuticalized. In addition, images of well-being and health are increasingly associated with access to pharmaceuticals (Petryna, Lakoff, and Kleinman 2006). In the context of globalization, health products, including medicinal plants and biomedical materials, are shipped across vast distances representing a form of therapeutic mobilities. These transnational movements allow medicines to exist outside the space in which they have traditionally been developed, manufactured and used (Sakoyan, Musso, and Mulot 2011). Health products travel between extraction areas, production sites and consumer areas that draw a transnational territoriality of the drugs. In some cases, diasporic networks can be at the source of these flows (Kane 2012; Tiilikainen 2012) and initiate 'transnational therapy networks' (Krause 2008). Because of their materiality, their tiny size, their functional character and the flexibility of the various distribution networks (particularly with the role of the Internet), pharmaceuticals fit well into the transnationalization of economies and represent a lucrative market that is difficult to quantify because of the formal and informal circuits utilized. The circulation of health products is also favoured by transnational arrangements which regulate this trade and give them an exceptional status because of their contribution to public health. Moreover, the great diversity of pharmaceutical regulations between border countries (Baxerres and Le Hesran 2011) and large regions of the world (Bourdier, Man, and Res 2014) is a major factor in the way health products disseminate between different points of the planet. The notion of 'regulation multiple' (Quet et al. 2018) illustrates the manifold interactions and overlaps between official regulations and unofficial regulatory practices leading to official movements of essential medicines as well as smuggled pharmaceuticals. 'Domestic and international interests, geopolitics and spatial configurations, commercial and health considerations, governmental policies and individual behaviours and legal and illegal transactions all contribute to regulating the pharmaceutical milieu' (Quet et al. 2018: 498), which influences the transnational distribution of health products. The circulations of products are also symbols of hope and the promise of healing through advanced technology or home remedies resulting from tradition.

Audrey Bochaton analyses the mobility of pharmaceuticals, more precisely herbal plants, along diasporic networks. She addresses the notion of therapeutic mobilities through the case study of transnational health care practices and medicinal flows within the Hmong diaspora between Laos and the US. In the light of globalization, she explores how the notion of medical pluralism – the use of conventional, complementary and alternative medicine and medical systems – for health and illness is transformed through transnational health care and therapeutic mobilities in the context of the Hmong diaspora.

Transversal themes in therapeutic mobilities

The type of therapeutic mobilities engaged with in the papers differs, but key to each is how the desire and/or capacity to offer or receive therapy contributes to multiple transformations and reconstructions. From a socio-economic perspective, therapeutic mobilities create wealth by generating economic niche services, such as medical markets rooted in diasporic and spiritual identities (Bochaton; Chee, Whittaker and Por), medical travel brokerage (Hartmann), 'reproductive tourism' (Schurr) and national development agendas (Chee, Whittaker and Por; Thompson; Walton-Roberts). Health and medicine, therefore, serve as a prism through which to reflect on relations to body, self, nation, illness, death, stillness, care, dependence and dependability, on the re/production of inequalities as well as on the effects of marketization and economic entanglements; and how these relations, re/productions and effects change when things and beings move to and

encounter different places and assemblages. We identify four transversal themes that cut across the papers in this collection, which we outline below.

Transformations (and stabilizations) of selves, bodies and positionalities

The therapeutic mobilities examined in this Special Issue raise key questions about human and non-human circulations and highlight their transformative power. The interactions resulting from therapeutic mobilities create new individual career pathways (Thompson; Walton-Roberts), and alter subject positions and subjectivities with respect to homeland, disease and the market (Bochaton; Kaspar). The papers show that the transportation or travel of beings and things across space sets in motion relations, identities and social orderings – what Schurr addressed as vertical mobilities and Kaspar as shifting subjectivities – but also places and assemblages with respect to their material, relational and affective/emotional constitutions. The transformations are multi-layered and shaped by various entanglements prompted through mobility.

The intertwining with emerging and changing medical and health care markets currently appear to be the most powerful encounters. In Schurr's study, the therapeutic mobilities approach encapsulates the complexity of the transnational reproductive industry, which uses representational mobilities (affective discourses of vacation and happy family life), in order to overcome the realities of exploitation, failure and inequality that frame the industries' very reason for existence – global unevenness in medical technology and regulatory landscapes that deny certain people (due to sexuality, class, age, etc.) the chance to become a parent. Introducing a therapeutic mobilities framework to the fertility industry exposes how unevenness and inequality structures both the demand and supply side; regulatory and technological constraints create the patient demand for this service, and economic and social inequality creates those who would supply the biological materials and service for conception and pregnancy.

In Kaspar's study, cancer patients who resist their local doctors' verdict of being a 'hopeless case' expand their search for effective therapy beyond the country. When turning to the global health care market of medical tourism, they shift from citizens to consumers. Ironically, for patients, this shift simultaneously preserves their entitlement to care, while exposing them to new risks and vulnerabilities.

There is an interesting commonality uniting these two empirical cases. People are set on the move by a desire to stabilize their subject positions – of prospective parents and of patients with a hopeful prognosis – that mobilizes not only the subjects themselves, but further beings like surrogate mothers, family caregivers and things like gametes and medical records and tissue samples. While some are in a position to preserve desired identities and subject positions by engaging in global markets, others obviously are not – and hence have to embody and adjust to unwanted identities, or experience the reproduction of core elements of their already undesired subject positions.

On top of this, therapeutic mobilities include corporeal transformations. This is most obvious in the case of surrogate mothers, patients and health workers. Surrogate mothers are put under constant surveillance and medical scrutiny, and their bodies are stimulated with hormones and complemented with gametes to create life and release a being. Patients' bodies transform as a result of a received therapy. With effective therapies bodies heal, restore or hurt less, whereas in case of no or ineffective treatment bodies continue to be subject to pathologic processes.

The bodies of the aspirational nurses in Thompson's study accumulate the effects of too much work, too little recovery and salary and persisting insecurity about one's future to the point that some move to other, less stressful and more rewarding jobs, exchanging occupational mobility with transnational physical mobility. However, as Thompson highlights, the occupational mobility of nurses trained for overseas employment can be seen as an act of empowerment and offer resistance to the inhuman working conditions of a migration infrastructure that obscenely exploits global inequalities. It entails abandoning the identity of an aspirational migrant. For some, though,

mooring their identity at home as a trained nurse who provides digital care to a global market, is important. This indicates that therapeutic transformations are unevenly distributed. While mobility is therapeutic for some, for others it is detrimental.

The papers in this Special Issue document that therapeutic mobilities intertwine with global labour, health care and medical markets in a way that often is detrimental for some subjects. However, these markets simultaneously provide jobs and hopes for better futures. For example, plant-based remedies that were traditionally used as part of family therapy in the Hmong community are now an economic resource for female pickers and sellers who send them to members of the diaspora abroad (Bochaton; but see also: Schurr; Hartmann; Chee, Whittaker and Por; Thompson; Walton-Roberts). In sum, the papers of this Special Issue document therapeutic mobilities' transformative capacities with respect to individual subjects as well as places and assemblages and show that transformations occur in emotional/affective, material/corporeal and relational aspects of involved beings and things. However, therapeutic mobilities can shape, stabilize and intensify existing inequalities, while creating new ones.

Uneven im/mobilities and therapeutic inequalities

As is the case for transformations, therapeutic mobility has a very ambivalent status with respect to inequalities: It can constitute a form of resistance and hence challenge to, but it can also stabilize and even pronounce existing health, socio-economic and gender inequalities.

The papers in this Special Issue document therapeutic mobilities as a form of resistance to existing inequalities with respect to unequal access to health care (Chee, Whittaker and Por; Kaspar; Hartmann) and labour markets (Thompson; Walton-Roberts). Additionally, therapeutic mobilities manifest the struggle to regain autonomy against nation-states. In the case of Hmong living in the US (Bochaton), for example, therapeutic mobilities appear as a means to resist forced migration outside Laos after 1975 and to perpetuate inherited therapeutic practices as a counterbalance to the health care system of the destination country, thus minimizing 'therapeutic acculturation' (Monnais 2012).

The papers also document how therapeutic mobilities reproduce different forms of inequalities (economic, health, gendered and environmental). For example, in the Philippines, the expansion of the Business Process Outsourcing industry contributes to maintaining the country as the 'source' of much nursing care for more developed nations even as medical care worsens within the country (Thompson). In India, Walton-Roberts' study on male nurses indicates that 'gendered inequalities reassert themselves as subjects move along the educational-migration pathway'. In Laos, the growth of herbal medicine picking for commercial purposes towards the US constitutes an environmental pressure in a context where international regulations concerning the protection of biodiversity are poorly applied, resulting in therapeutic mobilities participating in multinational companies' exploitation of natural resources (Bochaton). In the following, we discuss the papers' contribution to examine how therapeutic mobilities resist or reproduce health and gender inequalities. Both health and gender inequalities discussed below are tightly intertwined with socio-economic asymmetries as well as productive of medical globalization (Dilger and Mattes 2018) and 'economies of vitality' (Rose 2007).

Health inequalities

Mobility has historically been seen to enhance the potency of medical therapies and expert knowledge (Dilger, Kane, and Langwick 2012). In the contemporary period, mobility continues to inform and generate power imbalances in medical and health circulations. The case studies in this issue reveal that the manifold and multidirectional flows of bodies and things with therapeutic capacities or deficits are articulated with prevalent economic systems as part of what Rose (2007) terms the emerging bioeconomy, driven by biocapital investment. Therapeutic mobilities are products and productive of these increasingly inequitable global health systems.

While the mobilities recounted in the papers are attempts to 'do good', they are themselves structured in contradictory ways by global forms of inequity experienced at multiple scales. For instance, medicinal products such as vaccines or pharmaceuticals circulate the globe (Towghi and Randeria 2013) and while bringing life changing therapeutic aid to people, these circulating vaccines and pharmaceuticals stabilize global asymmetries in health care by articulating who is in a position to care for others and to decide who deserves that care. Further examples for the stabilization and reinforcement of global asymmetries are transnational care chains of health professionals and global trade in organs. India and the Philippines may provision the world with well-trained English-speaking health care workers (Thompson; Walton-Roberts), but their own populations are often faced with poor health services. And the human body is even cannibalized by economic systems as body parts move around the globe and up the economic gradient to bring fertility (Gunnarsson Payne 2015; Schurr) and replacement organs to those who can afford them (Cohen 2010; Scheper-Hughes 2011). This clearly debilitates the poor(er) while restoring the rich-(er); it represents therapeutic mobility for some, and is deeply un-therapeutic for others. In fact, each paper in this Special Issue documents mobilities that not only resist or reproduce, but also restructure power asymmetries by re-shaping and re-ordering distributions of therapeutic potentials.

The ground realities of therapeutic mobilities presented in this Special Issue prompt us to move beyond simple dichotomies. For example, some health-related mobilities can be considered as neo-imperialist practices that exploit the scarce health care resources at destinations (Buzinde and Yarnal 2012). It is increasingly evident, though, that the bulk of transnational patient flows occurs from South to South, rather from then North to South (Kaspar and Reddy 2017; Ormond and Sulianti 2017). Obviously, South–South relations are also imbued with power asymmetries (see Fiddian-Qasmiyeh and Daley 2018), they are, however, highly variegated and therefore impede quick conclusions about who benefits at whose expense through these movements.

Such practices can represent resistance on the part of patients denied needed services at home (for example those who travel to access surrogate and fertility treatments that are denied to them at home based on their sexuality). Access to mobility options are reflective of power inequalities, but mobility is also used to resist power imbalances (Sheller 2016). Migrants exit disadvantaged labour markets, patients move to find services they would otherwise be denied, people seek out culturally meaningful medical care and products that allow them to retain their identity and sense of community.

With therapeutic mobilities, conflicting simultaneities are the norm, rather than the exception. Internationally, mobile patients often are privileged *and* disenfranchised at the same time. They have the resources to travel, yet, traveling to get treatment often becomes a necessity due to limitations in local health care. Analogously, immobility can be an incapacity to become mobile, but it can also be the capacity to stay. This is the case for people who can access needed pharmaceuticals locally, health professionals who can find deserving jobs in their places of residence, and patients who find reliable diagnostics and effective treatment at home.

Such differential mobilities are themselves evidence of the uneven mobilities this Special Issue highlights, but also part of the analysis of mobility justice. Not everyone needs to move, but the act of moving and the ability to do so is an important right, and can be an act of resistance when needed or desired medical services are denied. This can be seen in the now rather mundane practice of state funded international medical travel (Knoll 2017; Ormond and Kaspar forthcoming). Therapeutic mobilities problematize these classifications through close inspection and consequent deployment of a relational approach.

Gender inequalities

The papers in this Special Issue furthermore clearly show that inequalities are particularly persistent with respect to gender. Gender remains a pivotal aspect of mobilities and therapeutic labour, particularly through the representation, provision and valuing of care work. The reproductive labour of surrogacy (Schurr), nursing (Thompson) informal caregiving for patients within families

(Kaspar), and traditional healers, pickers, sellers (Bochaton) are exclusively or predominantly provided by women, and when men enter these fields they can benefit from a professional bonus that reflects structural advantage evident across the labour market (Walton-Roberts). With respect to medical travel facilitation, identified as consisting of a variety of caring activities, men are also predominant in this service, and they deliberately emphasize the importance of care in their work as an expression of their competence in the field (Hartmann). In these processes, care becomes masculinized through a form of classificatory and competitive hierarchy, thereby reproducing predominant market and social-based power hierarchies and relations.

The papers examine therapeutic mobilities across different institutional settings and in relation to more varied forms of care (health care products and services). They also elaborate on how men's and women's mobilities are implicated in various forms of health care-giving. Approaching care work from the vantage point of therapeutic mobilities, rather than from a global care chain perspective allows including care work beyond tasks commonly associated with feminized work and seeing the contingent nature of supposedly 'female' activities and capacities. Yeates (2012) highlights the risk of reifying the feminization of care work in global care chain research (see also Kilkey 2010). The concept of therapeutic mobilities offers a promising opportunity to address this challenge. Approaching care work from a therapeutic lens offers notions that are less coined by gender stereotypes and hence more attentive to destabilizations. As the papers in this Special Issue reveal, gender remains a key site where socio-economic and therapeutic inequalities are re/produced and re/negotiated.

Multiple and contingent im/mobilities

Irrespective of the locations they refer to, the papers show that therapeutic mobilities are contingent; they depend upon continued movements interspersed with detours, unexpected halts and deadlocks, rather than always predetermined travels from provenance to destination. Furthermore, movements are often linked to previous and future mobilities, but also immobilities, constituting chains of im/mobility events that take place over space and time. Take the case Kaspar highlights, that cancer, one of the predominant conditions experienced by foreign patients traveling to Delhi, requires a series of high-tech diagnostic and therapeutic interventions that stretch over years, demanding repeated and ongoing visits.

As Hartmann and Chee, Whittaker and Por meticulously describe, it is the medical travel facilitators' job to smooth the arduous edges out of therapeutic itineraries as best as possible to actually set patients in motion. Before patients move, not only are medical records and money transferred, but information and narratives circulate transnationally; these im/material mobile things are doing the mobilizing work (Hartmann). Furthermore, brokers rely on transnational social networks they have established through migration (Chee, Whittaker and Por) and current circulations of medical plants and knowledge of traditional medicine between Asia and the US are part of wider diasporic networks (Bochaton).

However, transnational mobility often is preceded by internal mobility. This applies to mobile patients, pharmaceuticals and health workers. In a case presented by Kaspar, one patient moved from a peripheral place to the capital and from there went to seven medical specialists, all denying him a prognosis of survival, before he finally discovered the option of treatment abroad. In this case, internal mobility, led to transnational mobility that was repeated several times, prompting a chain of mobilities, all tightly connected. Surrogate mothers travel from the village to the city, intended parents travel from the North to the South, using gametes that have also travelled from other bodies to the Petri dish (Schurr). In the case presented by Bochaton, plants are picked in Laotian remote mountain regions and transported to local markets and then to overseas destinations along a chain of connected intermediaries.

In health worker migration, as described by Thompson and Walton-Roberts, internal migration constitutes a necessary step to facilitate potential international skilled labour migration.

Thompson's analysis shows that the 'immobility' that might follow internal migration to the city is not necessarily a failure to live up to migrant 'hero' aspirations. Some achieve their aspirations by re-defining their career goals and engaging in occupational mobility into new sectors of digital and remote e-health that are emerging in the Philippines.

The range of im/mobilities involved in the provisioning of therapeutic mobilities demonstrates the multiple mobilities are at work. In Bochaton's paper, therapeutic mobilities represent movement through space and time. Herbal remedies from Laos to the US arise because of the nature of the product sought: pure and unadulterated, the same plants used by generations and generations of Hmong before the time of migration. This quest for and the circulation of herbal remedies improves the standard of living of the pickers who have never left Laos, and whose mobility is strictly local. The return migration for care of Hmong Americans also reflects a desire to return to a pre-migration space and time. Medicinal plants embody the landscapes and social relations of Laos, and constitute a form of healing through memory.

Multiple im/mobilities – or 'crisscrossing mobilities' (Söderström et al. 2013, 5) – thus are not only incidents of im/mobility across time and space tightly connected to each other as conditions and consequences. They must also be seen as connecting a variety of different caregiving actors, and their relative im/mobilities which are connected to their own experiences of socio-economic inequality. In sum, the Special Issue papers demonstrate how the im/mobility of different types of entities – body parts, plants, data, humans, emotions – necessitate, constitute, trigger, support (or hamper, halt, overcome, deny) each other.

Critical therapeutic mobilities

This Special Issue documents some of the uncounted intertwinings between the therapeutic – as a quality, as a capacity, as a desire or need or as an effect – and mobility. But there are facets of therapeutic mobilities we have not examined. Foremost, norms, regulations and policies (e.g. McCann and Ward 2012; Robinson 2013) as well as innovations and technologies (e.g. Bärnreuther 2016; Prasad 2014) are absent as im/mobile entities explored here. Such entities certainly merit to be integrated more fully into therapeutic mobilities. For example, Hartmann's study on medical travel brokers leaves no doubt about the mobilizing power of transnationally circulating therapeutic immaterialities such as patient testimonials and information on hospitals and doctors as well as systems of trust emerging from these circulations.

The insights provided in this Special Issue show that therapeutic mobilities contribute to what Söderström et al. (2013) have called 'critical mobilities', and offer a key means by which to advance mobility justice (Cook and Butz 2019; Sheller 2018). First, they host the 'capacity to provide critical perspectives on societies' (Cresswell 2014, 713) through a focus on the 'interplay of mobility and power' (Söderström et al. 2013, 6). The presented papers show that moving can be a strategy to overcome geographical disparities in health care (Bochaton; Chee, Whittaker and Por; Kaspar), while creating new asymmetries (Walton-Roberts), as well as moorings that themselves can be a constraint (Schurr) or privilege (Thompson). Second, they 'probe the limits of mobilities research itself' (Cresswell 2014, 713), such as highlighting the ableism prevalent in mobilities research. Third, they focus on 'diverse mobile entities considered (at least by some) as problematic' (Söderström et al. 2013, 2). The dis- and re-assembling of bodies through the donation/selling of body parts such as egg cells (Schurr) or organs, the outsourcing of diagnostics (Thompson), the uprooting of plants in remote and wild regions and integration into transnational diasporic trades (Bochaton), health professionals who migrate to use their therapeutic capacities where it yields more revenues (Thompson; Walton-Roberts) and patients who travel to places where therapies are existent in the first place, but also effective and trusted (Chee, Whittaker and Por; Hartmann; Kaspar) and agents doing profit and/or solidarity work by setting people and things in motions (Hartmann; Schurr; Kaspar). These practices all constitute highly contested social phenomena; they are debated in public, policy and academic discourses – enthusiastically welcomed by some, fiercely fought by others.

Conclusion

This Special Issue presents original empirical work that examines the global and transnational extent of therapeutic mobilities that encompass diverse sets of beings and things. In this introduction we have suggested that mobilities researchers have not fully engaged with issues of health and well-being. This Special Issue has revised this situation by introducing the idea of therapeutic mobilities to facilitate a deeper integration between the new mobilities paradigm and health research. We argue that this interaction offers at least four important benefits. First, it contributes to knowledge production in a field of tremendous social relevance, that of transnational or global health care. Second, it encourages mobilities researchers to think about and through functionally limited, ill, injured, mentally disturbed, unwell and hurting bodies. Third, it engages with the transformative character of mobilities at various scales and fourth, it brings together different kinds of mobilities.

The papers in the Special Issue align with three kinds of therapeutic mobilities: transnationally circulating patients, health professionals and pharmaceuticals. We reviewed the relevant papers in each of these categories, but then moved beyond this analysis by highlighting four transversal themes that inform the entire collection: (a) transformations (and stabilizations) of selves, bodies and positionalities, (b) uneven im/mobilities and therapeutic inequalities, and (c) multiple and contingent im/mobilities. We then highlighted how the idea of therapeutic mobilities offers an important avenue for future research which contributes to a wider interest in critical mobilities. Understanding the nature of therapeutic mobilities foregrounds the insights of the new mobilities paradigm in exposing the resultant unevenness, ambivalence and complexity of outcomes, and what it means for whom. The papers in this Special Issue reveal practices and processes that are multi-layered and mutable; sometimes bizarre, sometimes ironic, often drastically uneven; sometimes brutal, sometimes beautiful – and sometimes all of this at the same time.

Notes

1. The references without year in this introduction paper refers to the papers in this Special Issue.
2. See the Special Issue on medical globalization in *Global Public Health* (Dilger and Mattes 2018), on transnational health care in *Gender, Place & Culture* (Greenhough et al. 2015), *Social Science and Medicine* (Bell et al. 2015) and *European Journal of Transnational Studies (EJOTS)* (Pordié 2013), as well as the Special Issues on medical travel/tourism/migrations in the *Journal of Ethnic and Migration Studies (JEMS)* (forthcoming), *Asia Pacific Viewpoint* (Chee, Whittaker, and Yeoh 2017), *Signs* (Mazzaschi and McDonald 2011), *Body & Society* (Roberts and Scheper-Hughes 2011) and *Medical Anthropology* (Smith-Morris and Manderson 2010).

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