

## Motivation, Justification, Normalization: Talk Strategies Used by Canadian Medical Tourists Regarding Their Choices to Go Abroad for Hip and Knee Surgeries

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

### Keywords:

Canada; Medical tourism; Knee replacement; Hip replacement; Hip resurfacing

## 1. Introduction

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

KRHR are surgical procedures performed to reduce pain and increase mobility in damaged or degrading joints (CIHI, 2009). The Canadian Institute for Health Information (2009) reports that 62,196 hip and knee replacement surgeries were performed in Canada (not including Quebec) between 2006 and 2007, a 101% increase since 1996 (p. 5). Given that the most prevalent diagnosis leading to KRHR is osteoarthritis, procedure numbers are likely to continue increasing as the population ages (CIHI, 2009, 2011). Unlike hip and knee replacement, hip resurfacing has limited availability in Canada, due primarily to lack of surgical expertise (Johnston et al., 2012). Meanwhile, there appears to be growing public awareness of, and demand for, access to hip resurfacing (Black, 2013; Kirsch, 2012; Landro, 2013; Picard, 2009). One estimate suggests an increase in this procedure in the province of Ontario alone from 200/year to 1400/year between 2005 and 2010 (Medical Advisory Secretariat, 2006, p. 11). Taken together, there is a growing need for KRHR procedures and this is placing increased pressure upon the Canadian health care system (Hudak et al., 2008).

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

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

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

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

## 2. Patient narratives and their co-construction

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

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

Exploring patients' narratives about opting for medical tourism and their co-construction has the potential to bring forth new information as to why individuals choose to go abroad for private health care. This information is important because it can advance health workers' and administrators' understandings of why some patients seek surgeries abroad, how they rationalize this course of action, and at what points in the decision-making process interventions will be most useful and who (e.g., physicians) or what (e.g., websites) is best positioned to deliver them. For example, a key response consistently called for in interdisciplinary medical tourism literature is the development of informational interventions for patients who are thinking about going abroad given the lack of reliable third-party information available (e.g., Cohen, 2010; Crooks et al., 2010; Turner, 2013). Meanwhile, as Adams et al. (2013) have demonstrated, creating such interventions requires careful consideration of the intended knowledge user group. Analyses, such as this one, that showcase experiential narratives can thus be drawn upon during the design phase in order to tailor the informational intervention.

Table 1. Overview of our analytic approach.

Talk strategy	Motivation talk	Justification talk	Normalization talk
How we understood this talk strategy	This is how the immediate impulse to go abroad for KRHRR surgery is rationalized.	This is how the overall behaviour of going abroad for KRHRR is justified	This is how the appropriateness of going abroad for KRHRR becomes thought of as 'normal' or acceptable.
Key question to answer about this talk strategy through examining participants' narratives:	Why did I go abroad for KRHRR surgery as a medical tourist?	Why was my going abroad for KRHRR surgery as a medical tourist appropriate	What is appropriate about anyone going abroad for KRHRR surgery as a medical tourist.
Unique dimensions identified for this talk strategy derived from participants' narratives:	(1) desired participation (2) diminish bodily pain (3) Lack of access to local care (e.g. domestic wait lists, Lack of resurfacing procedure availability)	(1) Discontent with the Canadian health care system (2) Personalized 'best' care desired (3) Entitlement (e.g., to care, to reimbursement, to esurfacing surgery)	(1) Communicating with (2) Visibility of credentials (3) Previous international/global exposure (e.g. travel experience, knowing people from destination country)

### 3. Methods

We conducted 32 one-on-one semi-structured phone interviews with Canadians in 2010 who had gone abroad for surgical procedures to ten different countries in order to solicit their experiential narratives. Nineteen women and 13 men who sought procedures as varied as eye surgery ( $n = 4$ ), bariatric surgery ( $n = 3$ ), cosmetic surgery ( $n = 3$ ), gastrointestinal surgery ( $n = 2$ ), dental surgery ( $n = 10$ ), Chronic Cerebrospinal Venous Insufficiency (CCSVI) therapy ( $n = 4$ ), and KRHRR surgery ( $n = 14$ ) were interviewed. Our interviews were thus not restricted to those who sought KRHRR. However, a sizeable number (44%) of participants had obtained such procedures, making KRHRR the most commonly sought procedure type in the sample. The breadth and depth of these narratives, the common health system barriers they encountered in Canada (as outlined above), and the presence of a distinct literature around patient experiences of KRHRR surgeries enabled us to conduct a secondary analysis couched within the context of seeking KRHRR abroad, which resulted in two distinct analyses. One explores talk strategies used among this participant group and their co-constructed nature, which is presented in this paper. The other explores the distinctive attitudinal characteristics of this participant group when compared against the existing literature on patients recommended for KRHRR who choose to have it domestically or not to have surgery, which is published elsewhere (Crooks et al., 2012).

#### 3.1. Recruitment

Participant recruitment started after approval for the study was granted by the Office of Research Ethics at Simon Fraser University. To be eligible, potential participants had to be at least 18 years-old, enrolled in a provincial or territorial public insurance scheme at the time of surgery, and have privately purchased and undergone an elective surgical procedure outside of Canada (transplant and reproductive surgeries were excluded as they have third party involvement that requires separate consideration). We sought out these individuals using multiple recruitment strategies: (1) advertising in national and regional print and online publications; (2) providing study information to medical tourism facilitators to share with past clients who had agreed to be contacted about their experiences; (3) contacting medical tourists who received coverage in news stories; (4) snowball sampling amongst participants' networks; and (5) advertising in online forums used by medical tourists.

People interested in participating were asked to contact the interviewer (the fifth author) by phone or by e-mail. The interviewer confirmed each potential participant's suitability for the study. Those eligible were asked to schedule a

phone interview at their time of choosing and were sent information about the study details and a consent form to review prior to the interview.

### 3.2. *Data collection*

A semi-structured interview guide was created by the team following an initial review of the medical tourism literature. The semi-structured approach allows all interviews to follow the same general form while permitting exploration of unique experiences (Nagy Hesse-Biber and Leavy, 2011). Questions probed participants' decision-making processes, experiences of domestic and international medical care, personal health statuses, and considerations made when choosing medical tourism. To enhance consistency and overall rigour in the design and interpretability of the findings, interviews were conducted by one investigator. An interviewing journal was kept throughout data collection and shared amongst the team to enable ongoing input. Interviews ran between 0.5 and 1.75 h, with most running for approximately 1 h. All were digitally recorded and transcribed verbatim.

### 3.3. *Data analysis*

Anonymized transcripts were uploaded to qualitative data management software, NVivo. A scheme consisting of inductive and deductive codes reflecting both anticipated themes that we had set out to examine and unanticipated themes that emerged from the dataset was created through an iterative process of independent transcript review and group discussion. Coding involved reviewing the transcripts and labelling data that fit a particular inductive or deductive 'code', thereby demarcating the unit of text as a point of interest.

The first step in our coding process involved the interviewer and a researcher not involved in the data collection separately coding two transcripts in order to confirm the interpretability of the scheme. The interpretation of unclear codes was then refined and the scheme was modified by deleting or collapsing redundant or underused codes and unpacking overused codes. Next, the full dataset was coded using the revised scheme. A meeting was held to identify analytic issues emerging from the dataset and contrast them against what was already known about medical tourism, which resulted in agreement about the emerging importance of 'talk' strategies used by participants in discussing their choices to go abroad. Individual codes related to the current analytic focus on talk strategies were next extracted from the dataset and independently reviewed by all authors. Finally, a multi-day face-to-face meeting was held in order to identify themes emerging from the extracts pertaining to talk strategies and seek consensus on their interpretation, which resulted in the development of three talk strategies being identified and their co-constructors.

## 4. Findings

Fourteen Canadians between the ages of 42 and 77 who travelled abroad for KRHRR to treat osteoarthritis between 2005 and 2010 participated in a phone interview. Eight identified as women and six identified as men. Twelve participants travelled to India for KRHRR, one travelled to Cuba for knee replacement, and one travelled to Germany for hip replacement. Three types of talk strategies emerged from the participants' narratives about their choices to engage in medical tourism: (1) motivation talk, (2) justification talk, and (3) normalization talk. As shown in Table 1, three unique dimensions of each talk strategy were identified, though we acknowledge that there are interrelationships between them.

In the remainder of this section we examine each of the talk strategies used by the participants regarding their choices surrounding seeking KRHRR abroad. At the start of each sub-section, we provide an overview and definition of each talk type in order to clarify the parameters of each. We have summarized our approach to understanding each talk strategy in Table 1. We examine some of the interrelationships between the talk strategies in the discussion section that follows by exploring the co-constructedness of participants' use of talk in their narratives.

### 4.1. *Motivation talk*

Motivation talk is defined in accordance with sociological conceptualizations of motivations as retrospective narrative accounts of why particular actions and decisions were taken (Campbell, 1996). The three dimensions of motivation talk were identified:

(1) desires to participate in employment, physical activity, and daily life; (2) determination to diminish bodily pain; and (3) desires to overcome perceived or experienced lack of access to care at home. Motivation talk conveyed participants' initial impulses and rationalizations for choosing to engage in medical tourism.

One dimension of motivation talk was participants' desires to continue or renew participation in employment, physical activity, and daily life. This dimension illustrated participants' eagerness to sustain or resume already-established roles (e.g., paid worker). A 61 year-old male stated: "I figured it was time for me to get something done because I thought of the prospect of going back to work." A number of participants also noted regaining greater physical activity as important to their quality of life. A 57 year-old male talked about a desire to regain physical activity as a key motivation for obtaining hip resurfacing in India:

I was able to ski [with the hip impairment] but the following day I couldn't walk... same with squash. I could play squash. I could get through an hour of playing but then the following day I could hardly walk so I stopped playing squash... I was under the care of... sports medical doctor in [city name] and he advised me not to have a hip replacement [but to get hip resurfacing instead] because being active it [replacement] would wear out.

An important dimension of motivation talk was participants' determination to diminish bodily pain. A 64 year-old male stated: "...I needed remediation, I was in pain." When asked whether she felt she was receiving superior care relative to other Canadians through her choice to go abroad, an 80 year-old female responded: "from looking at it [the choice] from the outside in, maybe it is jumping the queue, but if you... have the chance of getting rid of this pain... that should explain why people do it." Other narratives echoed this motivation of choosing to diminish bodily pain by purchasing medical care abroad.

The third dimension of motivation talk pertained to participants suggesting their choice to travel abroad was due to lack of access to care in Canada. This perceived or experienced lack of access pertained to long wait lists and limited availability of alternative and/ or less invasive surgeries. A 60 year-old female suggested the long wait lists in Canada motivated her to look into other options:

...he [family doctor] also wasn't happy that I was on a waiting list for two years, which turned out to be four years by the way. But... he knew that I was in pain and he knew that, him knowing me for over thirty years, I had to do something, I wasn't just going to sit back and wait for the four years to pass.

The desires to have access to less invasive alternatives and overcome their limited availability within the Canadian health care system were frequently cited reasons for engaging in medical tourism. One male, aged 67, stated: "...there weren't... many people [locally] doing the hip resurfacing. I decided that that's what I wanted because I had heard more positive things about hip resurfacing than hip replacement."

#### 4.2. Justification talk

Justification talk was used by participants to rationalize their overall behaviours; this talk strategy was used to characterize *why* they did what they did, and why their choice to seek private care abroad was appropriate despite there being a health care system in Canada that covers recommended surgeries. The three unique dimensions of justification talk were: (1) discontent with the Canadian health care system; (2) inclination to get the 'best' personalized care possible; and (3) conviction of entitlement.

One dimension of justification talk was participants' discontent with their home health care system, and what they saw as flaws and challenges inherent in this system. A 62 year-old said, in response to being asked what the key differences between health workers in India (where she travelled to as a medical tourist) and her home province, that "our medical care [in Canada] is the pits." In another case, a 50 year-old female described her dissatisfaction with the Canadian health care system: "I wasn't in a life or death situation and I know our system is very good for those types of things, but it seems if you're living with chronic pain and... it's really difficult... to get it [re]solved [in Canada]." Comments such as these highlight participants' frustrations with the medical care available in Canada, often reflecting a perceived lack of system capacity for a specific procedure or system competency for chronic health needs across the continuum.

Table 2. Summary of co-constructors referenced in participants' narratives.

Dimension	Co-constructors
<i>Motivation talk</i>	
Desired participation abroad	Family, friends, media, social constructions of 'normal' participation and mobility, medical professionals at home or abroad
Diminish bodily pain	Social construction of pain, media, health care providers at home and abroad, other medical tourists
Lack of access to care	Other medical tourists, media, internet, local and destination health care providers, family, partners, friends
Lack of access to care	Other medical tourists, media, internet, local and destination health care providers, family, partners, friends
<i>Justification Talk</i>	
Discontent with health care system	Other medical tourists, media, internet, local and destination health care providers, family, partners, friends
Personalized 'best' care	Medical tourism industry, friends, family, partners, medical tourists
Entitlement	Other medical tourists, medical tourism internet websites, health care providers abroad
	family, friends, partners, media, internet, social construction of health care entitlement
<i>Normalization talk</i>	
Communicating with others	Former medical tourists, medical professionals in home and destination countries, other medical professionals
Visibility of credentials	Surgeons in destination countries, other medical tourists from Canada, destination hospitals, patient testimonials, medical tourism brokerages and websites
Global exposure	Partners, other travellers, people met in destination countries, relatives in destination countries, travel information and advice websites

A second dimension of justification talk pertained to participants' inclination to obtain what they saw as the "best" care else- where. This included being willing to go abroad for what they thought was the best doctor and/or best procedure. If care else- where was perceived as being better in some manner, this implicitly justified their choice to seek

KRHRR abroad. For example, a 59 year-old female who went abroad for knee replacement “I was told that at this point the Cuban doctors were the best in the field of all the other countries that were available to me.” A 65 year-old female who went to India for hip resurfacing explained “he [doc- tor] is one of the leading orthopaedic surgeons in the world and he’s done more of these procedures than almost anybody else so I felt actually that I was going to get the best possible care.” Comments such as these were embedded within participants’ narratives, showing the commonness of this talk strategy.

Finally, participants’ conviction in various forms of entitlement was a facet of justification talk. This included feeling entitled to: access medical care that they wanted and thought was needed, regardless of where it was to be provided; reimbursement for care sought abroad and/or tax reimbursement for the costs of going abroad; and hip resurfacing. A 68 year-old male described his frustration with having to pay for care out of country that he felt entitled to obtain at home:

I was... particularly upset because I’d been promised the procedure [at home] and then a week before... [they] denied it and then offered it and then was subsequently denied it again. So I was very upset with the... Canadian medical system to put me in that position of having to pay \$10,000 [to go abroad for a procedure].

A 59 year-old female who went to Cuba for knee replacement stated “I knew I needed the surgery and my doctor... knew I needed it and the surgeon knew I needed it but... I’d be put on a waiting list, and the waiting list was going to be around two years.” Her decision to go to Cuba was largely based on the belief that she was entitled to access surgery earlier than she could in Canada. A 57 year-old male conveyed that he felt entitled to obtain hip resurfacing surgery, a procedure that has limited capacity in Canada: “Well my firm decision to go to India... [was] because the procedure I wanted was not available in [home province].”

#### 4.3. *Normalization talk*

Normalization emerged as a talk strategy participants used to characterize the reasons they went abroad for surgery. Such talk was used to discuss the process of finding normalcy in the perception of oneself as a medical tourist. Normalization was also about constructing one’s choices as appropriate and obtaining reassurance from others about the normalcy of one’s decision(s). The three dimensions of normalization talk identified were: (1) communicating with others; (2) the visibility of medical credentials/reputation; and (3) existing international/global exposure.

One dimension of normalization talk pertained to participants’ communication with others who had previously opted for medical tourism in order to receive reassurance that they were making the right choice. A 68 year-old male who went to India for hip resur- facing commented:

After I made arrangements to go... I met with some of the Canadians who had been there and [they] assured me that I was doing the right thing and had no concerns. A 62 year-old explained that once a friend “heard I was considering going to India... [he] told me that he had gone to Delhi for heart surgery... He said ‘You will be treated like royalty, do not worry about a thing’.”

In addition to offering reassurance, awareness of others’ patient narratives served to normalize the practice of medical tourism, in that knowing others had made this choice underscored the perceived commonness of the decision to go abroad for surgery.

A second important facet of normalization talk was the visibility in the media and on the internet of medical credentials of surgeons and reputations of destination hospitals, which served to underscore the commonness of medical tourism. A 68 year-old male ‘normalized’ his decision to travel to India for hip resurfacing in terms of what he had learned about a particular surgeon’s cre- dentials through internet research: “As soon as I saw [Doctor’s name] credentials I knew I was in good hands.” Becoming informed about surgical procedures and materials used by a particular surgeon was also important in this dimension of normalization talk. A 64 year-old male who opted to go to India for hip resurfacing explained that he went because: “...I felt he [the surgeon] had better operative care, his... closing methodology was more thorough, he would repair every muscle.” Familiarity with the training credentials of doctors also emerged as important in some patients’ normalization talk. A 60 year old female who travelled to Cuba for knee replacement commented: “Well... I had done some research that the doctors in Cuba have been trained by... the best US [United States-based] and Canadian doctors that are out there.”

Participants’ existing ‘international/global exposure’ was the third dimension of normalization talk. ‘International/global exposure’ refers to experiences such as previous travel abroad, knowing people from destination countries, and being comfortable in travelling internationally. A 68 year-old male who travelled to India for hip resurfacing explained: “We spend a lot of time overseas in third world countries, which had an influence on why I went to India and was comfortable doing so.” Likewise, an 80 year-old woman who had travelled to Germany for total hip replacement was comfortable with her choice to do so because she was born there, spoke the language, had a relative there who suggested she could receive faster treatment in Germany than Canada, and was familiar with the German health

care system. Conversely, a 62 year- old male who travelled outside of Canada for the very first time to obtain a total knee replacement in India described his journey as daunting. He referred to a lack of 'international exposure' in his narrative and the impact it had on his ability to normalize the practice of going abroad for medical care.

## 5. Discussion

In this discussion section we focus on the ways in which participants' talk strategies and narratives were co-constructed, by actors and by social constructs that played a role in shaping their choices to become mobile and transnational patients, after which we consider the implications of the findings for future research.

### 5.1. Co-constructing narratives and talk strategies

Narratives about opting to be a medical tourist for KRHRR are, like other illness narratives, co-constructed in social interactions. Co-constructors of narratives about KRHRR to treat osteoarthritis through medical tourism are diverse and include: health care providers (both local and in destination countries), other medical tourists, partners, families and friends, social constructs, media, medical tourism brokerages, and websites documenting the credentials/reputations of surgeons and hospitals. Table 2 summarizes dimensions of motivation, justification, and normalization talk examined in the findings section and the co-constructors relevant to each dimension.

The desire to maintain and take part in employment was an important dimension of participants' motivation talk. Engagement in employment is also a value-laden practice that is socially constructed as 'normal' among Canadian adults. The finding that participants talked about being motivated to seek surgery abroad in order to improve their osteoarthritis and maintain employment is thus not surprising. This finding also draws attention to the ways in which participants struggled with changing identities as their mobility and activity levels changed due to osteoarthritis, a struggle that has been well documented in the social science health literature (see Driedger et al., 2004; Swoboda, 2008). Participants' need to diminish bodily pain was another important facet of motivation talk. Many talked about increasing physical activity and minimizing pain in order to increase quality of life. These aspects of participants' narratives reflect social constructions of what it means to be healthy, experience bodily pain, regain ability, and actively participate in the context of socially normative practices (Sharf and Vanderford, 2003). These constructions informed how participants talked about their choices to 'go global' in seeking health care, and so we position social constructions as a co-constructor of participants' narratives. Such positioning suggests that the ways people view their bodies, health, participation, and pain can have substantial bearing on why they choose medical tourism and how far, literally and metaphorically, they are willing to go for relief.

The desire to attain personalized 'best' care, including going to the 'best' surgeon, receiving the 'best' procedure, and receiving it in the 'best' place came up frequently throughout interviews as justification for having surgery abroad, and thus was an important aspect of participants' justification talk as was the actual use of the word 'best' as a descriptor. This aspect of participants' narratives was actively co-constructed through three main interactions. First, recommendations from other medical tourists were often referred to when discussing the desire to receive personalized best care. Second, media and internet sources were used to actively co-construct these narratives. A number of participants 'justified' their decisions to go abroad based on consulting websites for information. Finally, these narratives were co-constructed by health care providers abroad despite how distant they were from the participants we spoke with. Such a finding illustrates how a single aspect of participants' narratives can have multiple co-constructors. Considering how motivation, justification, and normalization talks are collectively co-constructed sheds light on the ways in which Canadians opting for medical tourism strive to become 'experts' on their own health care needs: choosing procedures that they see as most promising in regaining health; cultivating the view the Canadian health care system is not adequately meeting their needs; and evaluating health care options available abroad. The practice of patients becoming 'experts' in their own self-directed medical care has been well documented in existing health literature (Forkner-Dunn, 2003; Sarasohn-Kahn, 2013). These facets of participants' co-constructed narratives and talk strategies reveal some of the ways in which medical tourists are challenging biomedical authority and health care practices in home and/or destination countries through the act of engaging their transnational mobility. Such insights are important for health professionals who may need to adjust care and information-sharing practices to accommodate patients who regard themselves as experts or wish to take a self-directed approach.

Understanding the ways in which medical tourists' talk strategies are co-constructed helps to highlight the kinds of social interactions involved with specific dimensions of motivation, justification, and normalization talk. This illuminates medical tourists' processes of choosing surgery abroad through consulting with social actors near and far for information and advice, the kinds of information these actors provide, and what differences such information or lack thereof makes in deciding to seek surgery abroad. We believe that such illumination is pragmatically important for health professionals in home and destination countries because it helps to highlight patients' information needs and identify gaps in that which is available - an issue that has been critically examined in medical tourism research (Cormany and Baloglu, 2011; Lunt and Carrera, 2011; Lunt et al., 2010; Mason and Wright, 2011; Spece, 2010; Turner, 2013). With respect to the visibility dimension of normalization talk, patients sought information on surgeons' credentials, health outcomes following surgery, and others' experiential accounts of medical tourism from websites, online discussion boards, and former medical tourists, all of which are sources that have been identified in

other empirical studies about medical tourism as key knowledge tools for patients (Penney et al., 2011; Turner, 2011). Information was also sought by some participants on infection and complication rates. Yet information about these aspects of medical tourism, such as that obtained through websites, is notoriously industry-driven and unreliable (Spece, 2010; Turner, 2013). Our findings show that this information is being mobilized by medical tourists to others in their networks through normalization talk strategies, which expands the number of people who can potentially benefit from informational interventions led by health professionals as well as the scope of this transnational health service practice.

### 5.1. Implications for future research

An important avenue for future research is to explore whether motivation talk differs for patients addressing other illnesses and conditions through medical tourism as a way to further consider if and how people's motivations to go abroad are informed by different bodily realities. For example, health geographers and others could ask: what motivation talk strategies are engaged in the narratives of Canadians with multiple sclerosis who have gone abroad for CCSVI treatment? Related to this, it would be useful to look at the motivation talk engaged in by medical tourists going abroad for surgeries that are not medically necessary, such as some cosmetic procedures. These types of analyses will advance our understanding of differences and similarities in needs, goals, and health expectations amongst diverse people.

An important dimension of justification talk amongst Canadian medical tourists seeking KRHRR was discontent with the Canadian health care system. Elsewhere we have shown that this same dimension serves as evidence of the ethical defensibility of Canadian medical tourists' decisions to seek care abroad (Snyder et al., 2012). Future research can compare perceptions of the adequacy of the domestic public health care system amongst patients opting for KRHRR surgery in Canada to those who have engaged in medical tourism for these procedures. Such research would shed further light on perceptions of the quality of health care at home and abroad, which is important insight for those developing policies to outbound medical tourism from Canada.

A third avenue for future research is to investigate why specific social actors or co-constructors are *most* influential in talk that 'normalizes' opting for surgery abroad. For example, our current study suggests that it is direct consultation with other Canadian medical tourists that is especially influential in constructing travel abroad for surgery as 'normal'. Examining the relative importance of specific co-constructors falls outside the purview of the current study, and we recommend this for future research. Understanding the weight given to different co-constructors in the process of choosing to engage in medical tourism would be beneficial because this would enable health professionals and health care administrators to tailor informational interventions targeting intended medical tourists (see Adams et al., 2013 for an example of how patient narratives were used to inform the creation of an informational intervention).

## 6. Conclusions

In this article, we have used medical tourists' narratives of KRHRR abroad to illustrate the three distinctive, yet overlapping, forms of talk they used when discussing their choice to go abroad for private medical care. These talk strategies provide important insights into why Canadians are opting for medical tourism and what their needs, concerns, and health expectations are. As the Canadian population ages the demand for KRHRR will increase and so understanding why some patients choose to go abroad and how they discuss this choice is timely. We have also argued that it is important to understand how these talk strategies and narratives are co-constructed by actors and social constructs.

The findings of this analysis reveal that discontent with the Canadian health care system and a sense of entitlement to the 'best' care options are important facets of Canadian patients' choices to engage in medical tourism for KRHRR. Some patients perceive that there is an unmet demand for hip resurfacing in Canada, which raises important practical questions that extend beyond the scope of this analysis, such as: Is there a need for patient education around this procedure and its long term-effectiveness to enable a greater understanding of *why* it has limited availability in Canada (see Malviya et al., 2012; Sehatzadeh et al., 2012 for discussions that question the long-term effectiveness of the procedure)? Alternatively, what reforms, if any, are needed to the domestic health care system in order to ensure that such demand is better met? Building on these practical questions, one can ask: would increasing capacity for hip resurfacing domestically impact the outflow of Canadians for this procedure abroad? And if this domestic capacity was altered, would justification talk strategies regarding going abroad for this procedure change at all?

There is a great deal of scope for further empirical research concerning why Canadians are opting for medical tourism by health geographers and others, including how they talk about their choices to go abroad, and how patients who do and do not opt for surgery abroad view their health status and health care. We hope that this article encourages scholars and health care administrators within and beyond Canada to delve further into the reasons why patients are choosing to engage in medical tourism and become mobile patients.



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