Tourism Management 69 (2018) 145–154

Contents lists available at ScienceDirect

Tourism Management

journal homepage: www.elsevier.com/locate/tourman

"We had a ball … as long as you kept taking your painkillers" just how much tourism is there in medical tourism? Experiences of the patient tourist

Brent Lovelock[a,*], Kirsten Lovelock[b]

[a] Department of Tourism, University of Otago, PO Box 56, Dunedin 9054, New Zealand
[b] Department of Public Health, University of Otago, PO Box 7343, Wellington South 6242, New Zealand

ABSTRACT

The debate over 'medical tourism' versus 'travel for medical treatment' largely centres on the role of the voluntary leisure or touristic component. This study provides empirical evidence regarding the nature of leisure tourism occurring during medical travel, drawing on interviews with individuals who have returned from travel overseas for medical treatment. We identify four influences: the medical procedure; personal factors (e.g. travel experience, resilience, accompanying companions); destination factors; and financial matters. The most significant of these is the nature of the medical procedure, its level of invasiveness and requirements for post treatment recovery, and whether or not the patient-traveller suffered any complications. The 'hotel-isation' of hospitals ('hospitels') contributes to participants' perceptions of this type of travel being touristic in nature, even if no other conventional touristic activities are engaged in. We also observe similarities between medical tourism and business travel, both being hybrid forms of tourism, with variable leisure components.

1. Introduction

There is ongoing debate over the concept of 'medical tourism' and the extent to which the participating individuals are motivated by and/or engage in touristic activities, as opposed to meeting their medical needs while abroad. The suspicion is, that many, if not most, people who travel overseas for medical services are primarily motivated by their need for treatment, rather than a desire to have a holiday. Also, that the medical treatment component probably occupies most of their time (and money) spent overseas, or that they may be too ill to partake in the touristic activities on offer in the destination.

This paper draws on the findings of a qualitative research project and explores the leisure tourism behaviour of medical tourists. We consider how medical tourism fits with other forms of tourism and whether there are implications for the tourism supply chain and the medical tourist. There are a range of actors in this supply chain, including medical tourism agents or intermediaries, health providers and accommodation providers to name a few. An insight into the actual behaviours of medical tourists while they are abroad having medical interventions is of utility to all of those in the supply chain and those who seek a diverse range of treatments abroad.

There are few primary research studies of medical tourism which explore the actual tourist experiences of medical tourists. Crooks, Kingsbury, Snyder and Johnston (2010), in a scoping review identified only five papers based on primary data. Most research tends to be in the form of conceptual papers, that address industry wide or destination level concerns, or that develop models of medical tourism. And it is fair to say that the overall emphasis to date of most medical tourism research has been on the medical aspects of travel, rather than tourist behaviour. Indeed, the very term 'medical tourism' is contentious. Connell (2013) suggests conceptualising all cross-border mobility for medical care as 'medical travel' rather than 'medical tourism'. This reconceptualization, however, is not an outcome of primary research which demonstrates that the "tourist" element has been exaggerated. The extent of engagement with standard tourist activities while abroad for medical treatment remains largely unknown and there is a clear need for any conceptualisation or reconceptualization to be evidence based. For the purposes of this paper, we adhere to the term medical tourism, despite its contested nature, and adopt the U.S.-based Medical Tourism Association (2017) definition: "[P]eople who live in one country travel to another country to receive medical, dental and surgical care while at the same time receiving equal to or greater care than they would have in their own country, and are travelling for medical care because of affordability, better access to care or a higher level of quality of care."

In this paper we draw on our qualitative study of medical tourists from New Zealand who sought treatment abroad and focus on their expectations, experiences and reflections on the leisure component of

* Corresponding author.
E-mail addresses: brent.lovelock@otago.ac.nz (B. Lovelock), kirsten.lovelock@otago.ac.nz (K. Lovelock).

https://doi.org/10.1016/j.tourman.2018.05.015
Received 4 October 2017; Received in revised form 14 May 2018; Accepted 29 May 2018

their stay abroad. In particular we seek to shed light on what types of medical tourists seek a tourist experience as part of their medical tourism experience, and how this is manifested in practice. We document what types of tourist experiences are sought and explore whether these differ from what other leisure travellers may experience. We ask: How do the medical procedures that medical tourists undergo influence their leisure tourism expectations, experiences and outcomes? What are the tourist components and how do they manifest? And, to what extent is the 'itinerary' of the medical tourism holiday pre-planned, independent or arranged?

2. Literature review

2.1. The role of tourism vs. treatment

Uchida (2015, page 19), in a similar way to Connell (2013) considers medical tourism as an inappropriate term "because those who travel internationally are patients, not tourists for shopping and a pleasurable holiday". Instead, Uchida prefers the terminology of "medical examination and treatment abroad" (page 19). Presenting a medical perspective, Nahai (2009) in a paper entitled *It's procedure, not tourism,* argues that travelling abroad for a medical procedure simply cannot be considered a vacation. Likewise, Chow, Pires and Rosenberger (2015) prefer 'international medical travel' as preferable to medical tourism – as, in their view, it potentially provides a more accurate understanding of medical tourism decision making. They stress that travel for medical treatment or procedure is the core service being offered, while tourism activities are one of its supplementary benefits. They propose that motivators for medical travel may be: procedure based; cost based; time based; or travel based, the latter focusing on the benefits of having a tourism experience together with the medical services. While offering no hierarchy for decision making, Chow et al. believe that the tourism component may lead to competitive advantage of one medical tourism destination over another.

The view, that the tourism component may be important, is to some extent supported by the work of Fetscherin and Stephano (2016) who in a substantial quantitative study that examined individuals' perceptions of countries as medical tourism destinations identified tourism factors (attractiveness, popularity and exoticness as a tourist destination, cultural or natural attractions, and weather) as one of four dimensions in their Medical Tourism Index that scores medical tourism destinations. It is important to note, however, that Fetscherin and Stephano's sample did not comprise current medical tourists, nor people specifically considering medical travel, but was drawn from the general population. So it remains unclear, when faced with an actual medical condition, and seeking overseas treatment, whether the individual's actual decision making process is shaped by anticipation of tourist activities.

While some researchers have downplayed the role of leisure tourism in medical tourism destination choice and decision making (e.g. Drinkert, 2015; Johnston, Crooks and Snyder, 2012) others have identified the possibility that motivations for medical tourists *can* be travel based (c.f. procedure based) (Crooks et al., 2010). However, in one of the few studies drawing on primary data collected from medical tourists, Johnston, Crooks and Snyder (2012) found that holiday intentions were not among the primary motivations of their participants. In two further studies of medical tourists who chose Thailand for treatment, holiday-related factors featured very low on the range of factors that influenced their choice of medical provider when compared to procedure and cost related factors (Ricafort, 2011; Wongkit & McKercher, 2013). Wongkit and McKercher's (2013) study gauges the extent to which the medical tourism treatment is central to the overall holiday experience of participants, noting that it can be a central motivator, or play a much less important role. They propose a typology based upon the dimensions of trip purpose and decision horizon, identifying four categories: dedicated medical tourist; hesitant medical tourist; holidaying medical tourist; and opportunistic medical tourist. The dedicated medical tourist is "… someone who made the decision to seek treatment prior to departure, and who also identified seeking treatment as the main reason, or as equally important a reason as a holiday for pleasure, for their travel decision … The holidaying medical tourist identified a vacation as the main reason to travel and also pre-planned to undergo treatment at their destination" (Wongkit & McKercher, 2013, p. 7). For the remaining two categories, the medical treatment was fitted into an existing planned holiday. To some extent then, the study reported on in this paper complements Wongkit and McKercher's, where we focus on the centrality, or otherwise, of the holiday experience in the medical travels of participants.

Thus medical tourists may either be solely focused on receiving medical treatment, or may include an element of leisure tourism in their trip, combined with their medical treatment (Connell, 2006; Heung, Kucukusta & Song, 2010). Cohen (2008) identifies a five-stage typology which ranges from the 'mere tourist' who does not use any medical service to the 'mere patient', an individual who visits the host country solely to receive medical treatment and does not make use of any of the vacationing opportunities it offers. In essence, Cohen (2008) identifies two broad types of medical tourist: those who travel explicitly for medical treatment, and those who combine a holiday with treatment. It seems reasonable to conclude that "medical tourism is conceptually full of nuances, contradictions and contrasts" (Yu & Ko, 2012, p. 82). And as Fetscherin and Stephano (2016) point out, this lack of a universally accepted conceptualisation makes medical tourism a 'vague concept' with a number of different connotations for a range of stakeholders, including the actual medical tourists themselves.

2.2. Expectations of medical tourists – images and expectations?

Many advertisements for medical tourism stress the links between surgery and tourism, especially during recuperation (Connell, 2011). Advertisements from medical tourism agents aim to encourage 'standard' tourism, and "invoke obvious themes such as the need to stay and enjoy yourself before going home, taking time to recover slowly and restfully, experiencing the country, its people and cuisine, and so on" (Connell, 2011, p. 159). Connell argues that while a relaxing holiday experience may assist in reducing the stress of undergoing a medical procedure in a faraway destination, the extent to which recuperating patients may be able to benefit from 'normal' elements of tourism can be questioned (Connell, 2011). For those receiving less invasive procedures such as cosmetic surgery, or dental treatment, experiencing a holiday may be easier and more common. The more serious the procedure or treatment in terms of health outcome to a large extent determines the proportion of time likely to be spent on it and subsequently active tourism becomes less likely following serious procedures (Connell 2011, p. 171). As Connell notes, much of this is simply stating the obvious: not all tourism is an appropriate sequel to operations (Connell, 2011, p. 170).

However, in Wongkit and McKercher's 2013 study (see above) almost 90% of dedicated medical tourists travelled both to receive treatment and "for the chance to explore new places and cultures", however, the authors do not report on the actual leisure activities pursued by their participants (2013, page 9). Connell (2011, page 164) reports that "Shopping, dining and going to shows, usually comfortable and undemanding activities, often in air-conditioning, are widely seen as elements of tourism that can be linked to medical tourism … Eating, sightseeing, poolside reading, shopping (and window shopping) and taking in a show are neither particularly challenging nor necessarily expensive and most such activities form some part of medical tourism experiences". Most Bangkok hospitals offer and organize night markets and nightclub visits. Some 85% of international Bumrungrad (a Bangkok hospital caring for medical tourists) patients stated that they and/or their companions had participated in some tourist activities such as sightseeing, shopping, eating out or 'enjoying the local culture' (Anon. 2010b cited in Connell, 2011) while a more general survey

found that percentage to be as high as 95% (Anon. 2009 cited in Connell, 2011). An Australian couple, who had made four visits to Malaysia for cosmetic surgery were said to return as much as anything for "shopping and trying traditional Malaysian food" while another Australian medical tourist noted "I felt a bit groggy after surgery but as soon as I got back to the hotel – the day after surgery – I was out shopping" (Weaver, 2008, p. 14). Musa, Thirumoorthi, and Doshi (2012) in one of the few studies of the actual travel behaviours of medical tourists, undertaken in Malaysia, reported that 17.4% of their survey's participants engaged in shopping and 21.0% in touring. This relatively high proportion may be a reflection, however, of the type of procedures sought in Malaysia, which has a focus on cosmetic surgery c.f. rather than more 'serious' non-elective surgeries (e.g. cardiac or orthopaedic). In a similar way, Hanefeld, Lunt, Smith and Horsfall's (2015) study identified dental tourists as a group for which the holiday activities are as important as the cost of the procedure and determine destination choice.

2.3. Influence of travelling companions

While some medical tourists may travel alone, they are often accompanied by caregivers, usually family or friends. Some medical tourists travelling for cosmetic surgery go in small groups, who may include friends and/or strangers. Such travel companions, Connell argues, "fit more easily into a more conventional tourist mode" (Connell 2011, p. 160). Actual tourism in its conventional sense, including enjoying local sights, sounds and tastes, may involve friends and relatives rather more than the patients themselves (Connell, 2011, p. 170). Friends and family may provide a demand for, and help facilitate, a conventional holiday, and similarly, travelling with a group of patients may foster a holiday atmosphere. Similarly, Yu and Ko's (2012)survey of medical tourists in Korea found that when medical tourists are accompanied (by family or caregivers) and for medical tourism 'proper', tourism and tourist facilities become highly important.

Overall then, there is evidence to support Connell's (2013) suspicion that the possibility of 'standard' tourism in terms of information gathering, decision making and actual behaviour "is likely to be highly variable" (page 10) among medical tourists. From this brief coverage of the literature, it is clear, that we need to know more about how medical tourists see themselves, and whether this is "as patients, travellers or tourists – or some fluid combination of these" (Connell, 2013, p. 11) There is also a need for more research which focuses on the importance of the tourism aspects of medical travel including the role of the hospital in providing and/or promoting a holiday experience for either the patient or the travelling care-giver.

2.4. The hospital as part of the holiday experience

While the tourist/medical components of medical tourism spark debate, there is also an interesting reconfiguration around hospital (lity) and hotel (isation). Many destination hospitals have embraced design and furbishments commonly found in hotels, this is referred to as the 'hotel-isation' of hospitals. It also coincides with the increasingly explicit consumption aspect of health care. For some hospitals, hotelisation is achieved through explicit partnerships with hotel operators. For example, the Indian hotel chain Welcomgroup's Fortune Park Lake City Hotel "hotel within a hospital", is on the grounds of the Jupiter Lifeline Hospital in Mumbai and is part owned by the hospital (Express Hospitality, 2010 in Connell, 2011, p. 167). We are, however, observing more than hospitals building hotels alongside, we are also seeing a morphing of the two. In form and function the key hospitals in the medical tourism industry are like luxury hotels. Corporate hospitals are increasingly taking on elements of elite hotels, IT offices and shopping malls, with an architecture that projects "the corporate hospital as anything but a hospital" (Lefebvre, 2008; page 102). As observed by Connell, they have become what Auge (1995) would describe as 'non-places', placeless and largely indistinguishable, and thus more like the basic elements, the hotel chains, of the international tourism industry "where consumption and consumerism have been added to cure and care" (Connell, 2011, p. 167). This expansion of the role of the hospital poses an interesting question concerning at what point, and where, does treatment end and the holiday begin?

2.5. Similarities with business tourism? (Other hybrid forms of tourism)

The role (or lack) of conventional tourism experiences within medical tourism, or at least the uneven way in which tourism is manifested in medical travel, is similar to some other forms of 'non-leisure' travel. Connell (2011) sees similarities with VFR (Visiting Friends and Relatives), diaspora and MICE (Meetings, Incentives, Conventions and Events) tourism, however, business travel is where the greatest commonality may lie. Hall (2005, page 19) describes business travel as a work-oriented form of tourism, which is not connected to leisure-tourism, and similarly Urry (2002) argues that motivations for business and leisure tourists are different: for business, mainly, to meet people; for leisure tourists, to see the place itself. However, some argue against this conceptual dichotomy, claiming that the boundaries between leisure and business tourism have blurred (Kellerman, 2010). And although we commonly use the term business travel rather than business tourism, the two are often used interchangeably. While this is yet to generate a high level of concern among either researchers, destination managers or other business tourism/travel stakeholders, Serdiuk (2016) distinguishes between leisure and business in a model where the degree of focus on work, length of stay, and mode of travel (individual or group) are the defining criteria. Differentiating and defining in this way suggests that addressing or managing leisure/business requires understanding the differences and what this means in practice. Business tourism includes more leisure-oriented business trips, for a longer period of time and including part leisure and business-related activities, whereas business travel is defined as more business-oriented short trips that encompass not only business-related activities, but other travel experiences (Serdiuk, 2016, p. 7). Conference participation, a specific form of business travel, perhaps shares some characteristics with travel for a medical procedure in terms of its time frame and level of intensity (and possibly degree of enjoyment); the leisure component is variable, Jago and Deery (2005) claiming that only 20% of conference delegates usually visit organized events and that they usually spend too short a time at the destination to enjoy it. The lack of personal time during a conference visit may influence the decision of delegates to extend their length of stay at a destination, referred to as 'leisure extenders'. Extenders are visitors who in advance arrange a multipurpose trip to a destination, combining both leisure and business (Davidson and Cope, 2003, p. 257). While the differences may be subtle, frameworks that address differences may be helpful in understanding the variable role of leisure in medical tourism and what the implications are for management.

3. Method

A qualitative approach was employed for this study as it is especially well suited to research that seeks to understand, rather than describe, particularly complex social and cultural phenomena (Creswell, 2014; Jennings, 2009). We conducted in-depth semi-structured interviews and explored with participants their motivations for seeking both medical services and tourism abroad (Chew & Darmasaputra, 2015). Semi-structured interviews allowed the researchers to be responsive to the often non-linear narrative of the participants' and to understand the subjective aspects of the tourist experience.

The topics for the interviews were developed by the two researchers after an initial review of the literature. The interview schedule covered a wide range of topics Including: participants' medical histories and experiences; their motivations and decision making around the medical

tourism treatment; the role of other stakeholders (e.g. GPs, family, friends) and information sources; their treatment and recovery experiences; and post treatment outcomes and reflections. The touristic/leisure experience was also included but often arose during exploration of other topics, and was pursued by follow-up and/or probing questions at the appropriate moment(s) during the interviews.

In line with the qualitative interpretive methodology employed, the recruitment of participants was conducted using a non-probability, convenience sampling approach (Creswell, 2014). A sample of medical tourists were recruited through media advertising and through posting advertising (posters) in selected General Practitioners' surgeries within the major urban centres of New Zealand. Potential participants were invited to contact the researchers, and were then sent an information sheet outlining the aims of the research, outlining the nature of the interviews, and addressing ethical issues. The researchers travelled to the location of the participants to undertake the interviews in a location of their choice. This was generally the family home, but occasionally in a café or other setting. Two interviews were undertaken by telephone due to difficulties with scheduling a face-to-face interview. These interviews followed the same format as the face-to-face interviews. Throughout the analysis of the interview data the researchers consciously reflected upon the telephone interviews, in relation to the face-to-face interviews, and how the different mode of interview may have impacted upon the data. We concluded that there was no discernible difference between the modes of interview in terms of the range or depth of the data collected. The average length of interviews was 1 h and 15 min, with some interviews being over 2 h in length.

Our sample comprised eighteen New Zealanders who had travelled overseas for medical treatment. Participants included those travelling for cardiac surgery, renal surgery, orthopaedic surgery, breast augmentation and other cosmetic surgeries, radiotherapy, in-vitro fertilisation (IVF), medical screening and dental treatment (Table 1). We purposefully excluded those travelling for 'wellness' e.g. spa, yoga and similar treatments, as there is evidence to suggest that they are distinct from medical tourists (Smith and Puczko, 2009). Participants ranged in age from the early forties to mid-seventies, and were dominated by males (only five were female). Our participants included two family members who were the travelling companions of the person receiving the medical treatment. The interviews were generally undertaken one-on-one by the individual researchers, however one was undertaken by both researchers together, and on some other occasions, the second researcher was invited (by the participant) to meet and engage in informal conversation prior to or following the interview. Following the first interview, and periodically thereafter, the two researchers compared notes from their interviews, discussing which (if any) topics were redundant (none) and whether any further topics needed to be included in our interview schedules. All interviews were digitally recorded, and written notes were taken during the interviews, with interview summary notes also made after the interviews.

Table 1
Study participants.

Participant (pseudonym)	Age	Treatment	Destination
Andrew	40s	Fertility	India
Barbara	40s	Cosmetic	Thailand
Bruce	60s	Cosmetic	UK
Charles	50s	Cardiac	Italy, France
Colin	50s	Cardiac	France
David	50s	Dental	Philippines
Earnest	40s	Cosmetic	Thailand
Fiona	50s	Cosmetic	Malaysia
Harold	70s	Cardiac	France
Kasim	50s	Renal	India
Michael	40s	Screening	Thailand
Peter	70s	Radiation	Australia
Quentin	50s	Cardiac	India
Rachel	50s	Radiation	Australia
Roger	60s	Dental	India
Tim	50s	Dental	India
Vita	40s	Fertility	India
Wallace	20s	Cosmetic	Thailand

The interviews were transcribed in their entirety by an independent contracted transcriber. The interview transcripts were then analysed using a thematic analysis technique, with a data-led inductive approach taken (Braun & Clarke, 2006).Thematic analysis is capable of capturing the nuances and deeper meanings from qualitative data and allows a latent (interpretive) rather than semantic (explicit or surface) approach to be taken (Braun & Clarke, 2006). As noted by Braun and Clarke, thematic analysis is suitable to analyse data that explores both individual experiences and general perceptions of phenomena, and such was considered appropriate for our research objective. The approach generally comprises six-steps: 1) Familiarisation with the data; 2) Coding; 3) Searching for themes; 4) Reviewing themes; 5) Defining and naming themes; 6) Writing up. Both authors undertook stages one to three independently, both generating a set of basic themes. A theme captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set. In terms of the question of prevalence or quantification of themes, "Ideally there will be a number of instances of the theme across the data set, but more instances do not necessarily mean the theme itself is more crucial" (2006, page 82). In our study, the importance of a theme was not necessarily depended on quantifiable measures but on whether it did indeed 'capture' "something important in relation to the overall research questions" (Braun & Clarke, 2006, p. 82). Themes were then shared together and some themes were reassigned, usually being combined with other themes that reflected their content. Both researchers then independently revisited the data with the agreed upon themes, to check that those themes adequately represented the data set. This comprised stages four and five, where some minor changes were made to extant themes and names were adopted for the final themes (Fig. 1). The final write up (stage six) involved both authors. The thematic analysis was conducted manually as the size of the sample was small and manageable. Our analysis of the thematic categories was also informed by other research work in this field and our work that has explored in particular tourism and consumption (Lovelock & Lovelock, 2014).

Credibility, applicability, transferability and confirmability are cited as the qualitative equivalents of the quantitative constructs of internal and external validity, reliability and objectivity respectively (Lincoln & Guba, 1985). Here, credibility was assured through the iterative process of thematic analysis and paying equal attention to all data items. Researcher triangulation was employed to meet the dependability and confirmability criteria and reduce potential researcher biases in the analysis and interpretation of the data, two researchers coding the data independently (Decrop, 2004). While we interviewed only 18 participants we did reach saturation which enabled us to identify some common and strong themes. We did, however, conclude that a larger sample would have allowed us to explore a greater range of issues and experiences. In this paper we have chosen to focus on the richness of the data we collected within a specific focus. (Fusch & Ness, 2015). While generalization of the findings is not possible (nor desirable) the issue of transferability is addressed through the use of thick descriptions of the material and supporting academic literature. The findings demonstrate how participants defined and experienced medical tourism and also that experience was variable and included subtle differences. Qualitative research methodologies are designed to elicit meaning and to provide an in-depth understanding of the nuances from the participants' perspectives. This understanding can be transferred and contribute to refined and appropriate management techniques and frameworks.

The following section presents and discusses the key themes that emerged in relation to the participants' leisure tourism experiences. We discuss the meaning and place of 'holiday' within the motivations and experiences of our medical tourism participants. We present an analysis

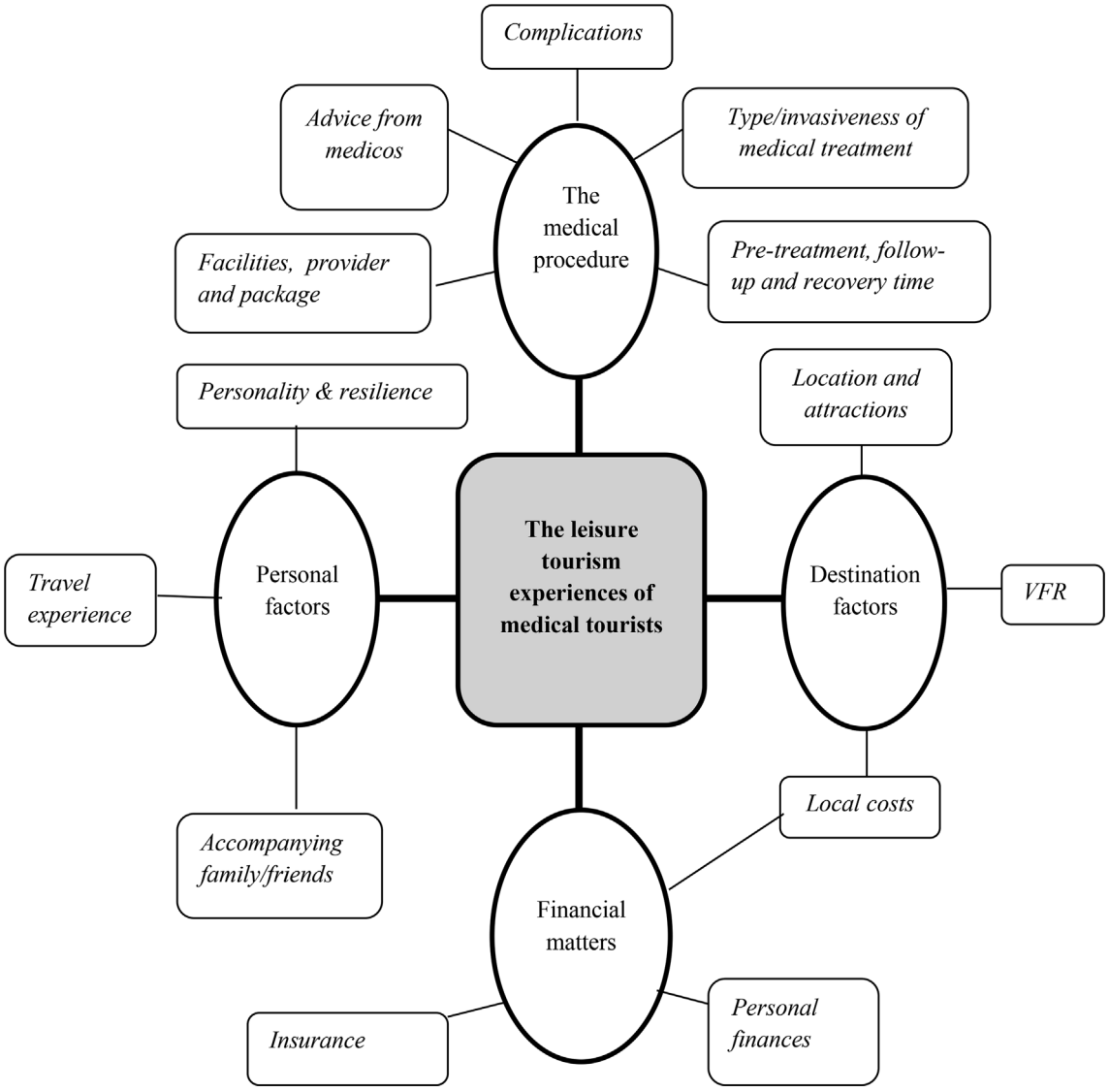

Fig. 1. Thematic network derived from the analysis of interview transcripts.

of the leisure tourism activities anticipated and experienced by the study's participants, and the barriers to and facilitators of such leisure tourism experiences.

4. Findings

Four themes emerged from the interview data with respect to the influences on the type of holiday experiences and behaviours of our participants: the medical procedure; personal factors; destination factors; and financial matters. While these are identified here as four unique themes, our thematic analysis (as is the case for most such analyses) has effectively been a process of simplifying complex data. This runs the risk of the phenomenon under investigation being interpreted as one which is straight forward and simple to understand. With medical tourism, this is not the case, as the themes are interlinked and overlap in a number of ways; for example the financial position of the medical tourist will influence their choice of destination and provider, and thus, ultimately the length and type of holiday possible. So while the four themes are depicted (Fig. 1) as being largely independent, this is simply reflective of the difficulties of graphically portraying the complexities of the interconnections and overlaps among the themes and sub-themes.

4.1. The medical procedure

The holiday component cannot be treated separately from the medical component of the medical tourism experience. While this may appear to be self-evident, we cannot over-emphasise the extent to which the medical procedure impacts upon holiday outcomes. A number of subthemes were identified under this theme, the first speaking to the type of medical treatment and degree of invasiveness, and its impact upon the tourism experience. Our participants went through a range of different types of medical treatment, from dental procedures (tooth implants, root canals and crowns) to cosmetic procedures to cardiac and orthopaedic surgery. Perhaps the most profound way that the nature of the medical procedure impacts upon holiday outcomes is through its level of invasiveness, with more invasive procedures having a greater impact upon the body and requiring longer recovery times, over which period, some activities may be restricted. As a rule dental and cosmetic procedures were less invasive (although some cosmetic procedures are definitely more than 'minor' surgery) and allowed participants to engage in 'normal' holiday procedures. Our participants who were travelling for cosmetic surgery generally placed a higher priority on having a holiday while in the destination, in the knowledge that they would be able to do so. This knowledge was sometimes available from medical tourism agents who manage the

medical tourism packages from common cosmetic procedures, and based upon the experiences of numerous previous clients. Sometimes such advice was passed on by word of mouth from friends or family who had travelled for such a procedure or who know someone who had done so. Barbara and Earnest a couple in their 40s travelling together for cosmetic surgeries had well planned post-procedure holidays in Thailand. Their holiday expectations were based upon their previous travel to Thailand for related medical procedures. Despite some problems with minor post-procedure complications, their holiday experiences mirrored the standard Thailand holiday, incorporating resort, beach and cultural activities.

Barbara describes how two days after her operation (breast augmentation) she "Lay on the beach with my MP3 player, walked along the beach, business as usual on holiday, sat in the pool up to my waist [to avoid wetting the bandages]". After the third of fourth day she "… had a backpack on and we were through the streets of Phuket shopping for souvenirs … went elephant riding, hired a jet boat, went to Pi Pi [island] … I just wasn't allowed to get my dressings wet". She had, in her own words, a "great holiday". Her partner, Earnest (also undergoing a cosmetic procedure) described having one day in pain, then going on a cruise with Barbara where "We had a ball … as long as you kept taking your painkillers". He maintained that he would "… definitely go overseas [for treatment] because you get a holiday out of it, and you still get a cheap operation".

Similarly, our dental tourist participants participated in normal holiday activities. David, in his 50s travelled to the Philippines for dental treatment where he "… hired a driver for the day … did the entire tourist thing". While his tourism activities were not pre-planned and central to the entire trip as were Barbara and Earnest's, David notes that "once I was there it [tourism] was important … So ah yeah, I enjoyed the tourism part of it".

Some of our participants were a little tentative in their approach to having a holiday. Colin, in his 60s, went to France for cardiac surgery. Initially he did not think about having a holiday as he thought the procedure recovery would preclude that. However he sought tourism advice from his doctor; "We asked the cardiologist here [in NZ] whether there'd be any great problems [with having a holiday] he said no, just, you know, go about your business normally, you've got medications … and so we just took a Renault Eurodrive for 20 days or three weeks or something … and then just stayed in bed and breakfasts.". Although Colin wasn't sure how he was going to be feeling after the operation, he felt "great", experiencing no problems during his holiday.

But despite the best made plans, the tourism component did not eventuate for some of our participants- or at least not in the way that they had envisaged. Quentin, in his 50s, travelled to India for cardiac treatment. While not specifically planning for a holiday post-treatment, he was optimistic that he would have time to explore Delhi. But despite staying for just under one month, he was not able to participate in any tourism activities; "I can say that I felt decidedly unwell … it wasn't really a recovery period. It was more a matter of just waiting to leave … I couldn't walk more than about 10 m. One half of my lung would move one way and the other half would move the other way, so it made me feel very unwell." He describes himself as being so ill that he could barely make it to the bathroom let alone the Taj Mahal; "After the operation I was so unwell all I did was stay in the hotel, watch TV and then go and have my meals. That was it". So although the above two participants had broadly similar cardiac procedures, the outcomes for both varied substantially to the extent that one had quite a pleasant but unexpected holiday, while the other, while expecting to have a similar experience, ended up unwell and confined to a hotel room in Delhi.

4.1.1. Complications

Post-procedure complications sometimes impacted upon the holiday outcomes of participants. For Quentin, the source of his illness was not to be revealed until his return to New Zealand, where he was so ill that he was admitted to hospital, learning that he had picked up an infection in India. Even those travelling for cosmetic procedures were subject to complications. Fiona, in her 50s travelled to Malaysia for cosmetic surgery. However, a negative reaction to her anaesthetic made her feel very unwell. Having had great tourism expectations for the post-procedure period, she stayed for five days, but was too sick to really be able to participate effectively in any tourism activities. She describes how she "just sort of wandered into shops … I had my hair all down here …. big glasses on … I did do some buying, albeit bad purchases". So while this could be interpreted as Fiona having engaged in tourism, it obviously was not the extent or quality that she had envisaged.

4.1.2. Enforced holiday through the recovery period

Often the medical procedures involved extensive recovery periods, over which time the patient is expected to remain nearby, or to return for post-procedure check-ups. Often it simply did not make financial sense to make the long trip back to New Zealand for a short period, then to return to the medical tourism destination for such post-op follow ups. So, in a sense, this enforces a holiday (or at least a period of leisure) upon the individual. As Harold (in his 70s, cardiac surgery) noted, "I had to stay over there for a few months, because there was no point in going backwards and forwards, they had to make regular checks" (he had sold a business so could afford the expense and time to stay that length of time in France). He also stayed longer in case something went wrong and he had to have a second procedure.

Barbara had to stay a minimum of ten days to get the stitches out from her cosmetic surgery, so for her the obvious question was "so why not tie it in with a holiday?" Conversely, Bruce, who travelled to the UK for his cosmetic procedure had self-dissolving stitches so there was no medical reason compelling him to stay longer in the destination. Even David, for what would seem to be minor dental surgery, needed to stay in the Philippines for over a week, as his treatment required three visits to the dentist over eight days. Similarly, Roger's teeth implants required him to be in Goa for ten days; "I went to Bombay and back and things like that". For some procedures the wait is longer. Colin said that his cardiac surgeon wanted him "to try and stay … up to three weeks in the region … they ask you then to hang around". Charles, in his 50s, travelled to France for cardiac surgery, and his surgeon required him to stay for a month after the operation; "You could hop on the plane but once you're in Europe you hang around. And for them [the surgeon] I think recovery is important. So while I was waiting to go back to see [the surgeon] in Bordeaux, we did three weeks sitting on a canal boat cruising at five knots through France". So the length of the holiday period is decided by established medical procedures and any particular issues that may arise for the individual patient. The type of tourism activity is also dictated by the medical procedure and the requirements for recovery e.g. passive holiday experiences rather than more active. In Charles' case, although he engaged in a relatively passive form of tourism, ironically, he actually felt better after his operation than he had a for a long while; "Actually you feel better because normally you go in and you're in atrial fibrillation, you come out and you're in sinus rhythm and you've got 20% more blood supply going to your brain". For others such as Harold, despite having the identical operation to Charles, he "couldn't do a hell of a lot … of holiday stuff".

Some other procedures require a pre-treatment period within the destination. Vita, who was seeking IVF treatment in India was required to take medication prior to her treatment, but these were available in New Zealand. Once in India,

> She [the IVF specialist] needed to see me at the time of one [menstrual] cycle and then she didn't need to see me for two or three weeks … so we thought well, that two or three weeks we can go travelling around India … because it was [partner's] first trip so we did the whole tourism thing with him … She [specialist] didn't mind, she said just go have fun. She said I don't need you now, when I need you I'll call you.

While the role of a holiday was seen as generally positive, mostly in

its contribution to post-operative recovery, in some cases the holiday was reflected upon as being counterproductive to successful treatment. Vita, for example, in reference to her and her partner's Indian holiday, wonders if the travelling around after the IVF treatment was a contributing factor to its initial failure "We travelled. and I don't know, maybe that could be a factor, the fact that I'm travelling, sure I don't lug any luggage or anything, [partner] did all that. But you know you're sitting up for long periods". She noted that her second round of IVF treatment was successful, attributing this to deliberately refraining from strenuous tourism activities; "I was pretty much bedridden thanks to my cousin's wife [who cared for her]".

4.1.3. Facilities, provider and package

Some of the comments that our participants made about their medical providers and medical facilities suggested that there can be a blurring between the medical and touristic components of the experience, in particular that the medical component can take on touristic aspects. A number of participants spoke about the standard of care and facilities reminding them of being in a hotel rather than a hospital. Barbara's medical treatment in Thailand was arranged as part of a package, with all bookings undertaken by an agent; "When we arrived we got picked up in an air-conditioned leather seat [limousine] … and they had the little signs up ready for us, I mean we felt like VIPS from the moment we landed". She goes on to describe the hospital; "it was like going to the Hilton, the hospital was marble with beautiful stainless and brass fittings". Her hospital room "… was sensational I think it was a super-king single bed, had a flat screen TV … en-suite bathroom, was all marble and just beautiful fittings, brand new." Fiona shared a comparable experience she had in Malaysia, where she described her "beautiful" private hospital, noting that her hospital was "superb, as Asian hotels can be … absolutely fabulous hospital". Similarly, Quentin reflected on his hospital stay in India; "I must say the hospital care in Delhi was a brilliant part, excellent … it was just so good. That was my room. Just one bed. Cable TV, a view of sorts". Michael (in his 40s, travelled to Thailand for medical screening) observed that "there was a real tourist feel to it [the hospital], in the sense that you went to the desk and they just helped you through everything and arranged everything" – similar in a way to a hotel concierge service. Others describe the range of shops (like shopping malls) in their hospital. The 'hospitel' experience was not, however, confined to Asia. Colin, who travelled to France described how "You get your own ward - a two bedroom ward … and my wife was able to go and stay in the other bed in the ward for a small fee … and receive meals as well", a very hotel like experience. Harold, also in France, likewise described his hospital room as being "like a hotel room".

Alongside the luxurious hotel-like physical appearance of the hospital and the hospital room, almost universally among our participants, the level of service they received in hospitals was described as being of a very high standard. For Earnest it was the "wee old fashioned nurses' hats" and uniforms that were signifiers of a standard of care that was of a time past. For most of our participants, who had had many experiences within the public health system at home, to receive what seemed to them to be a caring and almost loving level of attention was the type of service that they associated with hospitality rather than a hospital. Interestingly, during Quentin's interview, when we were discussing hotels, he inadvertently confused hotels with hospitals; "… there are stacks of inexpensive hospitals in Delhi …" "Hotels you mean, sorry?" "Yes yes". This parapraxis or 'Freudian slip' could be interpreted as occurring from an internal train of thought that conflates hotels and hospitals.

4.2. Personal factors

Three personal factors were identified as influencing the holiday experiences of participants; travel experience/history; personality/resilience; and accompanying family/friends. Travel experience refers to the previous travel experiences of participants – where they had been and when-their travel career. This was significant in two ways - first that it sometimes determined the destination choice – where the medical treatment would take place, and thus what holiday opportunities would be available, as well as shaping the holiday expectations.

Andrew who travelled to India with his wife for fertility treatment, recounted that he "… was quite curious about the country", and that "My wife was quite keen to show me different parts of India". He recounted his experiences of travelling as a child and had looked forward to recreating those experiences e.g. bargain hunting in markets. Similarly, Quentin had, as a young man, travelled to India and to Delhi-which is why he chose Delhi for the operation. Barbara, while settling on Thailand for her cosmetic surgery deliberately chose Phuket over Bangkok for her medical procedure; "[in] Phuket you get the experience of a holiday and down time relaxation". Barbara had been to Thailand before, and she chose Phuket for her operation because it was a holiday destination with "so many different beaches and resorts". Fiona, who had travelled widely, had, however, not been to Malaysia, so thought she would get her cosmetic surgery there. She was also planning a trip to the Philippines for dental work, "because I haven't been to the Philippines". Roger, a New Zealander, lived in France and travelled for a holiday to Goa in India each winter; thus his choice of India for his ongoing yearly dental treatment. In all of the above cases, the envisaged holiday experience was the main factor in destination choice, with the medical provider being a secondary consideration. For some, the holiday experiences were as expected, for others, this was not the case.

Those who travelled alone were less likely to engage in a range of normally expected holiday behaviour. And they were also more impacted by post-treatment complications e.g. Fiona and Quentin. It seems that travelling companions provided both help in recovery (moral support) and the motivation to behave in a more conventionally touristic way. If Colin's wife hadn't been with him in France, it is unlikely that he would have been motivated or well enough to take a motoring holiday after his cardiac surgery. Similarly, for Peter, his wife, accompanying him for his cancer treatment in Australia, it is unlikely that he would have engaged in tourism to the extent that he did. Even Harold, who after the operation on his spine was too ill to enjoy an active holiday, booked a suite in a five star hotel in France for him and his wife, so that at least they could have some semblance of a tourism-like experience during his lengthy post-op recovery.

Some participants who had experienced post-op complications even persisted in pursuing their holiday goals. This appeared to be a personality-driven determination to enjoy their time away, to fulfil their holiday expectations, but also appears to be related to their overall level of resilience - psychological and physiological-to the medical procedure. Earnest provides a good example of this, remarking that he would go overseas again, even for cancer treatment; "… well, shoot, I could be on my last legs, so I might as well get a trip out of it and enjoy the experience at the same time". We asked Peter, in his 70s, who actually did travel to Australia for cancer treatment (accompanied by his wife) if he felt he was having a holiday or whether he was constantly aware that he was there because of his cancer. Peter replied "No, no we treated it as a bit of a holiday quite frankly … only 35 min a day getting treatment". And although tired, and having diarrhoea on occasion, "we'd jump on the free tram and hook off down there [wharf area] and have a glass of beer and fish and chips and come home again … it was a lovely break for us …. I treated it as a glorious holiday".

4.3. Destination factors

To some extent, destination factors are partly addressed in the discussion above regarding the travel experience/history of participants – in that the travel histories and travel aspirations in some cases determined the destination which then determined the type of holiday that would or could be available, depending upon other factors such as

post-treatment outcomes, including complications. So the influence of the destination itself is within a causal chain between travel aspirations and medical treatment outcomes. Sometimes purely pragmatic destination factors came into consideration, such as Kasim deciding against Delhi as a location for his kidney operation, as it would be very hot at that particular time of year.

The other destination factor evident from the interviews was that of cost. However this was not a common factor, and was seldom raised. Most participants seemed to have factored any holiday expenses in to their overall costs- and in reality, the cost of any tourism activity is likely to only a small percentage of the overall cost of the medical travel, the actual procedure usually being, by far, the most expensive item (apart from the less invasive dental procedures). For one or two participants, however, the cost of any tourism activity was important, and they either addressed this by not engaging in tourism, or through enlisting the help of relatives in providing accommodation while in the destination. Kasim, an Indian expat living in New Zealand travelled to India for kidney surgery. Post-surgery he was required to stay for two weeks; "I stayed at home with my mum and dad" addressing VFR ambitions and saving costs. Although he would have engaged in more VFR tourism, this turned out not to be possible as he was "still fragile" after his operation. Similarly during Vita's fertility treatment, she and her husband stayed with her brother, who lived in Bombay so they had "free accommodation in India". VFR was an important facilitating component for both of our Indian expat participants, enabling them to stay for pre and post treatment, saving money, and supporting or subsidising (at least for Vita and Andrew) their other tourism activities.

4.4. Financial factors

While financial matters are largely addressed above, for example through VFR assisting with local costs, other participants made a conscious effort to keep costs down-through choosing locations with low local costs – mainly in Asia. A destination with relatively inexpensive hotels, for example, frees up money for tourism activities. Participants did not specifically mention cost as an inhibiting factor for engagement in holiday activities-however this is likely to be related to our sample of medical tourists, largely comprising middle class New Zealanders – not that this discounts the high cost of their medical procedures.

Insurance and coverage for medical procedures was important for some participants. While most participants met the cost of their medical procedures out of their own pockets, some were covered by their medical insurance, or in one case, were funded by the New Zealand government. The latter was Peter and his wife; when Peter's "[specialist] said you'll be going to Melbourne or Sydney … you'll be there for eight weeks' and he turned to [my wife] and he said and you'll go with him' I said hang on, who's paying for this?' He said 'the government'. And we had this eight week trip to Melbourne … and the government paid for everything apart from our food". This level of financial support made the tourism activities affordable for Peter and his wife.

For Harold's cardiac surgery in France "The insurance company gave me ten thousand dollars towards it, well that paid one first class airfare one way". Colin, who also had heart surgery in France recounted (somewhat bitterly) that his health insurer didn't cover anything.

5. Discussion and conclusion

The role that 'having a holiday' played in the motivations of our participants and their destination choice or choice of provider/hospital within the destination, varied substantially from participant to participant. Apart from a few, the leisure tourism component of participants' medical travel was relatively unimportant, with decision making very much based upon factors relating to the medical procedure (e.g. reputation of the hospital or surgeon; or cost). The participants for whom the holiday was paramount were what Wongkit and McKercher (2013) would term either 'holiday medical tourist', or 'opportunistic medical tourist'. For our dental tourist who travels to India each year or so for a holiday and ties this in with a visit to a dentist there, while the holiday itself is his primary motivation, his fortuitous discovery of a cheap and reliable dentist at the destination adds another layer of motivation and meaning to his holidays in India. Other participants, notably those who were travelling for cosmetic surgery, generally placed a higher priority on having a holiday while in the destination. Barbara and Earnest, as noted above, travelling together for cosmetic surgeries, had well planned out post-procedure holidays in Thailand. Despite some problems with minor post-procedure complications, their holiday experiences mirrored the standard Thailand holiday, incorporating resort, beach and cultural activities. This supports the contention (Chow et al., 2015; Cohen 2008) that for some, the motivator, while primarily medical, is also partially leisure-driven.

We could, however, generally categorise the vast majority of our participants as 'accidental tourists' or even as 'disappointed tourists'. The former included those who, beyond their expectations, managed to engage in some standard tourism activities. This was sometimes brought about by long periods of inaction before, between or after medical treatment. For example, our couple waiting for IVF treatment in India, filled in time sight-seeing there. Similarly, others were forced to stay for a period of recuperation and monitoring after their surgery, or when undergoing lengthy treatments such as radiation therapy, participated in local sightseeing. For participants in this category, their tourism experiences were 'accidental' as they were really unsought and unplanned and they did not expect to either have the desire to do 'touristy' things or because of their health, to be able to do these things - in the midst of often serious treatment. The latter category, of 'disappointed tourists', included a smaller number of participants who had optimistically felt that they would be able to take a holiday after their treatment, but found themselves not well enough to do so. Our heart surgery participant in India could barely walk from his hotel bed to the bathroom, let alone visit the Taj Mahal.

The mix of motivations underlying medical tourism does present some similarities with business travel, in terms of the intentionality of the leisure component, which for some business travellers is important, while for others it is less so, and when occurring is somewhat opportunistic, in the nature of Davidson's (1994) 'leisure extenders'. The continuum that Serdiuk (2016) identifies between the business tourism and business travel experience may have a parallel in a medical tourism-medical travel continuum, the important question being whether or not there are essential differences in the leisure component between the two, and if so, what those differences are. Our participants described a range of leisure tourism experiences, mostly undertaken post-medical procedure, that for some were indistinguishable from a 'normal' holiday, but for others this differed in terms of the participant's capacity to enjoy their time while recovering from a medical procedure, suffering a degree of post-procedure pain or discomfort, being on medication, and having limited mobility, either physically, or in terms of risking travelling too far from the clinic/hospital. The presence or lack of a supporting partner or family member to holiday with also impacted upon the nature of their leisure travel component. These variables could be used to delineate a medical tourism/travel continuum.

For many of our participants, the 'hospitel' was inarguably something that formed a part of and enhanced the touristic component of their time away. The hospitel has both tangible and intangible elements, with the physical presence and the service quality and style of a five star hotel. The hospitel is an ambiguous 'non-place' where tourism can occur. Obtaining the medical service from 'exotic servers' (i.e. people who are of different ethnicity) who are demonstrating an enhanced *ethic of care* (to what patients may be used to in a public health system at home) (Lovelock & Lovelock 2014). Being in an exotic locale, transforms the medical component itself into one more tourist-like, enhanced by the use of marble and glass and the 'hotel-like' physical appearance of the hospital. For our participants this contributed to the

feeling of being on a (luxury) holiday, rather than in a foreign hospital for a serious medical procedure. However, the disappointment expressed by some of our participants who, following their hospitel stay were unable to have their expected post-procedure holiday because of health/recovery/complication issues, suggests that participation in a range of other touristic activities is essential in order for the medical *tourism* conceptualisation to be complete.

From these findings, we provide empirical support for Connell's (2013) supposition that the role of 'standard' tourism is highly variable among medical tourists. Overall, key factors that came into play that influenced the role and extent of 'the holiday' for our medical tourism participants, included the type of treatment sought, their pre and post treatment condition, and the presence of caregivers or companions who could help facilitate tourism activities. With this is mind, we also agree with Connell's view that the intentionality implicit in the term 'medical tourism' is open to challenge. Our findings highlight that for some the leisure tourism component is in fact unintentional (Nahai 2009; Uchida 2015). But even though some may travel for life-saving medical interventions, it is still clear that there may be hedonic pleasures – whether these are intentional or not – associated with such travel. So, in a similar way to Serdiuk's (2016) observation that we cannot claim that leisure is always a part of business travel (even if it is frequently likely to be so), we cannot claim that leisure activities are always a part of medical tourism.

The accidental or unpredictable nature of the leisure component may provoke challenges for the individual medical tourist, for their travelling family/friends, and also possibly for the medical provider in terms of ensuring that post-procedure leisure tourism behaviours do not take the patient out of contact from the provider, or imperil their recovery. This entails the medical provider giving good advice (e.g. Barbara's surgeon's advice not to get her dressings wet), and the patient disclosing to the medical provider what they intend to do and where they intend to go. For some patients (and this was the case for some of our participants), staying and having a holiday in the medical tourism destination (rather than undertaking an early and possibly arduous return journey home) may be the best possible choice in terms of facilitating recovery in a safe location (i.e. with the provider who performed the medical procedure nearby).

In terms of tourism providers, the implications are less clear, but hinge upon three issues: addressing uncertainty; aligning touristic expectations with the realities of post-procedure recovery (or pre-procedure requirements); and providing an appropriate level of care. Some medical tourists may be treated in the usual manner, and will behave as normal tourists; others may have their stays unexpectedly shortened or extended depending on medical outcomes. This necessitates a degree of flexibility along the supply chain, and that uncertainty be mitigated through communication and transparency of intentions (between the patient, the intermediary, the medical provider and the tourism providers), but also through insurance. As indicated above, medical tourists' leisure expectations do not always align with the realities of medical requirements and outcomes. This presents potential problems for the tourism/hospitality provider in terms of risk management. Where specialised medical tourism intermediaries are involved in tourism arrangements, the expectation is that they will provide accurate advice to their clients on tourism possibilities. When such help is absent, however, for example where the client is self-booking or relying upon a non-specialised traditional travel agent, this poses challenges in reconciling tourism expectations against medically imposed constraints. In terms of level of care, challenges exist in that some medical tourists, once discharged by their medical providers, may still require special individualised attention, depending upon the medical outcomes of their procedures and the impact upon their recovery. For some tourism/hospitality providers this may be seen as an opportunity, but for others a liability.

Authors' contributions

The two co-authors contributed equally to conceptualising this research and bringing it to publication. Both authors contributed to developing the initial research grant, planning the study, recruiting participants and undertaking the interviews. The thematic analysis was jointly undertaken. Associate Professor Brent Lovelock drafted the article, which was critically commented on by Dr Kirsten Lovelock.

Acknowledgements

We are extremely grateful for the involvement of our returned medical tourist participants who kindly shared their personal experiences with us. The University of Otago funded this project through a University of Otago Research Grant.

References

Auge, M. (1995). *Non-places.* London: Verso.
Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101.
Chew, Y. T., & Darmasaputra, A. (2015). 12 Identifying research gaps in medical tourism. *Destination Marketing: International Perspectives, 36*, 119.
Chow, C. L. J., Pires, G. D., & Rosenberger, P. J., III (2015). Towards a rigorous conceptual framework for examining international medical travel. *International Journal of Behavioural and Healthcare Research, 5*(1–2), 88–103.
Cohen, E. C. E. (2008). Medical tourism in Thailand. *AU-GSB e-journal, 1*(1).
Connell, J. (2006). Medical tourism: Sea, sun, sand and… surgery. *Tourism Management, 27*(6), 1093–1100.
Connell, J. (2011). *Medical tourism.* Wallingford, UK: CABI.
Connell, J. (2013). Contemporary medical tourism: Conceptualisation, culture and commodification. *Tourism Management, 34*, 1–13.
Creswell, J. W. (2014). *Research design: Qualitative, quantitative, and mixed methods approaches.* Thousand Oaks, CA.: Sage.
Crooks, V. A., Kingsbury, P., Snyder, J., & Johnston, R. (2010). What is known about the patient's experience of medical tourism? A scoping review. *BMC Health Services Research, 10*(1), 266.
Davidson, R. (1994). *Business Travel.* Harlow, U.K.: Pearson Education.
Davidson, R., & Cope, B. (2003). *Business Travel: Conferences, incentive travel, exhibitions, corporate hospitality and corporate travel.* Harlow: Pearson Education.
Decrop, A. (2004). Trustworthiness in qualitative tourism research. In J. Phillimore, & L. Goodson (Eds.). *Qualitative research in tourism: Ontologies, epistemologies and methodologies* (pp. 156–169). London: Routledge.
Drinkert, A. (2015). *Medical tourism: A post-travel study measuring the impact of push & pull factors on the perceived quality of the medical tourism experience.* Doctoral dissertation, California State Polytechnic University, Pomona.
Fetscherin, M., & Stephano, R. M. (2016). The medical tourism index: Scale development and validation. *Tourism Management, 52*, 539–556.
Fusch, P. I., & Ness, L. R. (2015). Are we there yet? Data saturation in qualitative research. *Qualitative Report, 20*(9), 1408.
Hall, C. M. (2005). *Tourism: Rethinking the social science of mobility.* Harlow: Pearson.
Hanefeld, J., Lunt, N., Smith, R., & Horsfall, D. (2015). Why do medical tourists travel to where they do? The role of networks in determining medical travel. *Social Science & Medicine, 124*, 356–363.
Heung, V. C. S., Kucukusta, D., & Song, H. (2010). A conceptual model of medical tourism: Implications for future research. *Journal of Travel & Tourism Marketing, 27*(3), 236–251.
Jago, L., & Deery, M. (2005). Relationships and factors influencing convention decision-making. *Journal of Convention & Event Tourism, 7*(1), 23–41.
Jennings, G. R. (2009). Methodologies and methods. In T. Jamal, & M. Robinson (Eds.). *The SAGE handbook of tourism studies* (pp. 672–692). London: Sage.
Johnston, R., Crooks, V. A., & Snyder, J. (2012). "I didn't even know what I was looking for": A qualitative study of the decision-making processes of canadian medical tourists. *Globalization and Health, 8*(1), 23.
Kellerman, A. (2010). Business travel and leisure Tourism: Comparative trends in a globalizing world. In J. Beaverstock, B. Derudder, J. Faulconbridge, & F. Witlox (Eds.). *International business travel in the global economy* (pp. 165–176). Burlington: Ashgate.
Lefebvre, B. (2008). The Indian corporate hospitals: Touching middle class lives. In C. Jaffelot, & P. van de Veer (Eds.). *Patterns of middle class consumption in India and China* (pp. 88–109). New Delhi: Sage.
Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry.* Newbury Park, CA: Sage.
Lovelock, K., & Lovelock, B. (2014). Medical tourism: Consumptive practice, ethics and healthcare – the importance of subjective proximity. In C. Weeden, & K. Boluk (Eds.). *Managing ethical consumption in tourism* (pp. 207–224). London: Routledge.
Medical Tourism Association (2017). Medical tourism FAQ's. Available at http://www.medicaltourismassociation.com/en/medical-tourism-faq-s.html, Accessed date: 11 February 2017.
Musa, G., Thirumoorthi, T., & Doshi, D. (2012). Travel behaviour among inbound medical tourists in Kuala Lumpur. *Current Issues in Tourism, 15*(6), 525–543.
Nahai, F. (2009). It's procedure, not tourism. *Medical Tourism, 1*, 106.

Ricafort, K. M. F. (2011). *A study of influencing factors that lead medical tourists to choose Thailand hospitals as medical tourism destination*Doctoral dissertation. Webster University.
Serdiuk, A. (2016). *Not only for professional utility? Leisure motivations in conference tourism*Master Thesis in Tourism, Department of Geography and Economic History. Sweden: Faculty of Social Science, Umeå University.
Smith, M., & Puczko, L. (2009). *Health and wellness tourism.* Oxford: Elsevier.
Uchida (2015). Medical tourism or "medical examination and treatment abroad': An economic study of the phenomenon. In M. Cooper, K. Vafadari, & M. Hieda (Eds.). *Current issues and emerging trends in medical tourism (p18-30)*. Hershey, PA: Medical Information Science Reference.
Weaver, C. (2008). Under the Knife on a cut-price holiday. *The Sunday Telegraph, 13–14* 25 May.
Urry, J. (2002). Mobility and proximity. *Sociology, 36*, 255–274.
Wongkit, M., & McKercher, B. (2013). Toward a typology of medical tourists: A case study of Thailand. *Tourism Management, 38*, 4–12.
Yu, J. Y., & Ko, T. G. (2012). A cross-cultural study of perceptions of medical tourism among Chinese, Japanese and Korean tourists in Korea. *Tourism Management, 33*(1), 80–88.

Brent Lovelock is an Associate Professor in the Department of Tourism, University of Otago, New Zealand. His research interests are sustainable and ethical tourism, and he has published widely in this field, more recently including medical tourism. He has co-authored a book on ethical tourism.

Kirsten Lovelock is a medical anthropologist with research interests in health services (medical tourism); occupational and environmental health and labour and migration. Kirsten has conducted research in a range of industries including agriculture, forestry, construction, the meat industry and tourism. In addition to this Kirsten has also conducted a number of evaluations of health interventions and implementation processes in the public sector. Kirsten is an Honorary Senior Fellow in the Department of Public Health, University of Otago, Wellington.