

The Patient-Doctor Relationship in the Transnational Healthcare

Context

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Abstract

Moving away from paternalism to more equal forms of interaction in the patient-doctor relationship has been seen in positive light by policy-makers, patients' rights advocates, and scholars alike. Nonetheless, against the background of commercialisation and consumerism, empirical research showcases how reduced asymmetries bring in tensions and friction between patients and doctors (Greenfield *et al.* 2012). This paper contributes to the discussion through the examination of the patient-doctor relationship in the niche setting of private transnational healthcare markets which involve patients travelling overseas for care and where commodification, consumerism and care go hand-in-hand. It is geographically focused on two large cities in South-Eastern Europe as settings where healthcare is provided to foreign patients - Athens and Istanbul - and empirically draws on qualitative interviews with doctors who run small/medium practices. The findings highlight that, despite excessive consumerism, power asymmetries are not mitigated but patient vulnerability shapes the patient-doctor relationship. In the transnational context, the patient faces an additional source of vulnerability: a condition of foreignness. As such, the findings stress that one relationship model (the consumerist) does not, per se, replace an older one (e.g., the Parsonian). Instead, the consumer-provider dimension co-exists with the client-expert, patient-doctor and, finally, host-guest relation.

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Keywords

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Introduction

"It is not uncommon to view a physician's office as one would view a retail shoe company, as the notion that health care is a commodity and something to afford and purchase is becoming quite pervasive in 21st century American culture."

Potter and McKinlay, 2005: 469

The excerpt could not, perhaps, better describe a healthcare provision setting other than that of a cosmetic-surgery practice or, perhaps, dentistry in a transnational healthcare context. Transnational healthcare refers to the 'transnational pursuit' (demand) and 'transnational provision' of medical care (Bell *et al.* 2015). It involves patients travelling away from their country of residence in order to receive medical care, commonly known as 'medical tourism'. While state bilateral or multilateral agreements create non-commercial spaces for care provision (e.g., among African countries, see Crush *et al.* 2012 or at the European Union level, see Rosenmöller 2006), transnational healthcare is provided in an environment where, very often, commodification, consumerism and care go hand-in-hand. Roberts and Schepers-Hughes (2011) highlight that, in this context, healthcare is not understood as a *right* of citizens but as a commoditised service bought and sold in markets, and resting on extreme global inequities. In such a highly commercialised context, it is common for patients to take on consumer roles and for medical providers to seek to 'internationalise' their services and thus take on entrepreneurial roles. Simultaneously, several governments have committed resources to the promotion of 'healthcare exports' (Bell *et al.* 2011). Furthermore, insurance funds or businessmen seek opportunities in the niche market (Labonté 2013); while the human body (e.g., in surrogacy) or body parts such as eggs, sperm, or kidneys may turn into a commodity (Schepers-Hughes 2002; Kroløkke 2015). Before choosing a provider, patients

pursuing privately provided care need to consider the level of familiarity with the country they intend to visit, the local language, culture, institutions or political conditions. More importantly, they need to feel that the provider is trustworthy and their treatment of reasonable risk. Nevertheless, when a medical provider is not identified through formal (e.g., a doctor's referral) or informal networks (word of mouth) patients compare providers mostly based on commercial information such as advertisements, 'medical travel' guides, specialised websites and portals listing providers; or based on the 'professional' assistance of specialised agents, commonly known as medical tourism facilitators. Decision-making has, then, unique consumerist elements. Before travelling abroad patients are keen to compare prices, medical techniques, level of technology and quality standards, the qualification of medical doctors, or patient reviews on online portals. To some extent these 'choices' are similar to seeking private care at a national level. Nonetheless, arguably, with the internet functioning as a 'global marketing platform' (Turner 2013) choice for the patient-consumer is extensive. A simple online search reveals hundreds of providers across the continents offering care to foreign patients. It also reveals hundreds of specialised medical travel agencies offering services related to the trip, destination, accommodation or healthcare provider. Therefore, at the transnational level, patient experiences are complex as they may be crossing several boundaries to purchase care, including territorial, legislative, institutional, cultural, and linguistic. Their 'consumerist' decision-making is shaped by the privilege of mobility that allows extensive choice. It is, simultaneously, shaped by their condition of foreignness that adds complexity (Speier, 2006) and reinforces the individualisation of responsibility for healthcare. How, then, is choice in healthcare, and by association medical consumerism, to be understood and evaluated in the transnational context?

Consumerism is often described as a desirable target in health policy at a supra-national or national level (Mead and Bower 2000, Thompson 2007). In the name of consumerism, during the last few decades, choice over the provider, participation in the clinical decision-

making process, ability to express complaints, and request compensation have been promoted by policy-makers as patient rights. Nonetheless, several scholars showcase the contradictions inherent in the commodification of healthcare, the tensions in the idea of the patient as a consumer (Lupton 2007, Mol 2008) and the problems commercialisation and consumerism bring to the patient-doctor relationship (Potter and McKilnay 2005, Oh 2013). Consumerism alongside the commodification of care and the human body have been explored in the transnational healthcare context in some depth (Ackerman 2010, Bell *et al.* 2011, Deomampo 2013, Kroløkke 2015, Scheper-Hughes 2002; 2011, Speier 2016). Implications concerning the patient-doctor relationship, however, remain under-researched. Consequently, the focus of this study is on doctors' opinions of their relationships with overseas patients. The findings show that the transnational healthcare context, a highly commercial yet hardly regulated sector, highlights foreignness as an additional condition and source of vulnerability for patients. Subsequently, this research explores how consumerism plays out in the transnational setting and, in particular, its practical implications for the patient, the medical professional, and their relationship.

This paper draws empirically on the accounts of medical professionals offering cosmetic surgery, dental care, and fertility treatment to patients from Western countries in Istanbul, Turkey and Athens, Greece. Through 29 qualitative interviews with professionals working for small/medium private practices it explores their perceptions of international patient attitudes, their own roles in this highly commercialised context, and their experiences from interacting and treating international patients. The findings show how commercialisation and consumerism shape a consumer-provider relationship. On one hand, these patients draw consumer power from likely financial and mobility privileges and an international supply of providers to choose from. On the other, patient vulnerability creates inevitable power asymmetries between patient and doctor. Even when people are not sick and travel for elective care, post-operative health risks are unavoidable. Being, simultaneously, far from home and, by association, far from social networks or state support accentuates

vulnerability. As such, while medical professionals cling to their role as experts offering services to demanding clients, their narratives also show that medical risks and the condition of foreignness accentuate patient vulnerability, reinforcing power asymmetries in their favour.

The argument of this paper is organised as follows. The next section reviews a broad body of literature concerning the commodification of care and the advancement of consumerism, along with the changing doctor and patient roles and the patient-doctor relationship. The third section offers background information on the highly commercialised nature of the transnational healthcare context. This is followed by the methods section detailing the research approach, before the main research findings and basic conclusions are discussed.

Consumerism and its implications on the patient-doctor relationship

Consumerism in healthcare refers to behaviours such as searching for information about a medical condition and treatment options, a broader sense of interchangeability of medical professionals, including autonomously choosing the provider and seeking a second opinion, or even the use of alternative medicines (Timmermans and Oh 2010). Moreover, the consumer metaphor is often adopted to express an informed and empowered patient in the consultation room, where doctor and patient decide together upon the optimum treatment (Potter and McKinley 2005). It may also imply that patient complaint mechanisms and compensation processes for malpractice or negligence are in place (Thompson 2007). Consumerism is often understood as a response to medical paternalism in the clinical encounter and professional dominance in healthcare provision more broadly. In light of this, it is associated with the social and feminist movements of the 1960s and 1970s which challenged professional dominance and medical bureaucracy; advocating patient rights, people with disability rights and women's health (Greener 2009). Through these movements people were also calling for less medical and bureaucratic interference in birth and death (Timmermans and Oh 2010); increased knowledge transfer from the doctor to the patient;

and patient participation in the clinical decision-making process (Goodyear-Smith and Buetow 2001); thereby forging patient attitudes and expectations.

Most notably, however, consumerism has been promoted within the broader framework of neoliberalism and marketization policies. In the mid-20th century, market failures in the healthcare sector led governments in Western countries to take responsibility over public health and mitigate inequalities in access to healthcare (Wallerstein 1974). In the last 40 years, however, against the background of neo-liberalism, increasing commercialisation and marketization in the healthcare sector has deprioritised a collective response to health risks (Stiglitz 2009). The logic and practices of the market have promoted consumerism and patient 'choice' that is interlinked to an individualisation of health responsibilities (Mol 2008, Williamson and Fullagar 2019). In this context, responsibility is increasingly passing from the public to the private sphere, limiting citizens' dependency on the state (Fineman 2004; Wallerstein, 1974). Less dependency on the state, however, contributes to social and medical inequity as individuals' socio-economic backgrounds play an increased role in healthcare outcomes (Williamson and Fullagar 2019).

Despite the impact on equity, marketization has intruded upon healthcare, under the rationale that private sector managerialism and market competition support higher quality and more timely care alongside reduced costs; increased organisational efficiency; and, also, increased choice and responsiveness to the needs of clients (Propper 1993). For example, new public management, quasi-markets, and public-private partnerships have long been promoted within UK healthcare services. Consumer choice, alongside consumer-centred services, have been at the centre of reforms and a 'modernisation' effort of the national system (Newman and Vilder 2006). Similar reforms have taken place in numerous countries with publicly provided healthcare, including Continental European and Nordic countries. The corporatist takeover and wider commercialisation of healthcare - a prime example being private and mediated markets in the US - similarly imply an environment conducive to consumerism. Alongside the increasing adoption of commercial practices (e.g.,

medical marketing), improving 'consumer satisfaction' and offering patient-centred care are prioritised by providers under the rationale that what is good for patients is good for business (Charmel and Frampton 2008). Simultaneously, covering medical expenses out-of-pocket or through co-payments means that patients need to carefully decide upon treatment options based on their financial situation, creating an often misleading impression of choice and empowerment (Fox *et al.* 2005).

Consumerist attitudes towards health also have implications for patient-professional interactions. It is notable that in clinical encounters, consumerism is distinguished from *shared decision-making* (Charles *et al.* 1997) or *relationship-based medicine* (Roter 2000) which imply equal levels of power in the patient-professional encounter and are considered pivotal in improving clinical outcomes and patient and doctor satisfaction. Consumer dominance, in contrast, and like medical dominance, is discussed as being at odds with good communication and optimum patient outcomes (Roter 2000). Consumerism implies low doctor and high patient power which may, thus, reduce the encounter into a market transaction, have an erosive impact on trust, or lead to doctor abdication (Roter 2000: 7). A limited doctor role might also compromise the quality of provided care. For example, according to Greenfield *et al.* (2012) consumerism in the form of seeking a second medical opinion reveals a tension between patient autonomy and loyalty, thus undermining doctor trust. Doctors may feel 'disappointed, offended, embarrassed, and resenting their patients' (Greenfield *et al.* 2012: 1210). Lupton (1997: 380) suggests that policies calling to undermine professional authority and encourage 'active consumers' instead of 'dependent patients' do not take into account the uncertainty involved in illness and, consequently, the necessity of trust in the patient-doctor relationship as a way to cope with lack of knowledge, expertise, and skill. Brown *et al.* (2015) suggest that negotiation, instead of command by an authoritative doctor figure in the British NHS context, results in increased uncertainty, reducing the relationship into an encounter. Against the background of increasingly informal relationships, confrontational communication leads to mutual misunderstanding, fear and

friction (Brown *et al.* 2015). Moreover, empirical research shows that patients are not always active or do not necessarily desire to participate in the decision-making process (Greener 2009, Thompson 2007).

A commercialised context is similarly conducive to conflicts of interest. According to Pellegrino (1999: 252), the patient and health professional relationship ends up being regulated in this context by the ethics and rules of business when it should extend beyond the 'consumption' of a commoditised service and be regulated by professionalism instead. Oh's (2012) observations of patient-doctor interactions in mediated and private markets in the US depicts how financial motives shape their social relations. For example, in mediated markets conflicts over financial issues often lead to the disintegration of the personal relationship (Oh 2012). Similarly, in their examination of the '21st century' patient-doctor relationship in the context of mediated healthcare in the US, Potter and McKinlay (2005) suggest that the relationship has drifted away from depth and continuity to a short-term encounter characterised by superficiality. Feminist scholars also highlight that vulnerability implies the need for *care* in addition to expertise and knowledge, and stress that markets undermine the value of caring work much needed by patients (Held 2006). Mol (2008: 1), in her study of people with diabetes, highlights the contradictions between a patient and a consumer and, most importantly, showcases how 'patient choice' in healthcare may erode practices associated with 'good care' and promote the individualisation of responsibility (and perhaps the blame or shame) over one's health. 'Medical nostalgia' is how Ackerman (2010) describes and reflects on the disappointment of Americans with the fallback in caring work by medical professionals in mediated private markets (Ackerman 2010).

Overall, the context within which the patient-doctor relationship takes place has a significant impact. The mediated markets in the US bring in friction due to time and financial pressures exercised by third-party payers. The private markets encourage a buyer-seller relationship and may have a corrosive effect on trust; meanwhile consumerist attitudes may not always be desired by patients or be conducive to high quality care. Private markets also exacerbate

health inequalities. In a public healthcare environment, consumerist attitudes may invoke negative feelings towards doctors resulting in a corrosive effect on communication and trust or they may simply be meaningless as it is often the case that illness implies little patient choice. This paper seeks to understand the various facets of the patient-doctor relationship in an environment which remains unexplored, the transnational healthcare setting. Highly commercialised, barely regulated, and involving two different sites (the patient's home and doctor's location), it offers a compelling setting to explore the evolving commodification of care, advanced consumerism, and the impact on the patient-doctor relationship. Before discussing the research design in the methods section, the next section presents an overview of the transnational sector and how it develops.

Transnational healthcare as a highly commercialised setting

Bell *et al.* refer to transnational healthcare as the transnational 'pursuit' and 'provision' of medical care (2015: 285). Known also as medical tourism it refers to receiving and delivering care to non-residents visiting a destination for 'clinical, surgical, and hospital provision' (Carrera and Lunt, 2010). Academic and business interest in transnational healthcare has risen considerably over the last decade. From a marginal or largely unknown practice back in 2000, the sector counts several annual business fares (Labonté 2013b), considerable numbers of providers internationalising their services, governmental interest in different countries around the world (Bell *et al.* 2011) and a booming academic community publishing on various aspects and developments within the field (Chuang *et al.* 2014).

Arguably, the strong commercial character of the sector is hard to miss. Healthcare is reduced to a commoditised service, while the body or body parts are reduced to products that are bought and sold in markets (Roberts and Scheper-Hughes 2011). On the supply side, often under the auspices of governments, large medical providers organise marketing campaigns abroad to attract foreign patients (Crooks *et al.* 2011); meanwhile business fares emerge as important venues for business arrangements among providers, insurers and facilitators who attend hoping to 'make a deal' (Labonté 2013b). A new services industry, the

sector of 'medical tourism' facilitators, has emerged alongside the growing numbers of patients seeking treatment abroad (most often online) which has signalled a new business opportunity (Lunt *et al.* 2011, Turner 2012); and soon become a key intermediary services sector. It is noteworthy that given the geographical distance among patients and clinics, telecommunications and mainly the internet play a profound facilitating role in transnational healthcare. Simultaneously, the internet functions as a 'global marketing platform' (Turner 2013) where providers and facilitators advertise services and individuals discover treatment options beyond their country of residence. Marketing and advertising in healthcare imply increased commercialisation and, while commonplace for decades in the US, many countries still apply marketing restrictions, traditionally also supported by medical professional associations' priority to mitigate competition among their members. It is interesting, then, that a few governments have recently removed advertising restrictions to promote local medical providers abroad (e.g., Turkey and Taiwan) while medical providers find ways to bend the rules and advertise when restrictions remain in place (e.g., in Greece where online marketing is forbidden, small medical providers advertise in foreign websites or create foreign websites so that the Greek law does not apply). Even with marketing restrictions in place, the international field is, overall, open to a wider range of commercial practices as differences in national regulatory frameworks may be exploited. Medical doctors (individually as opposed to collectively) also play a role in the expansion of the market. Perceived as lucrative, the global market nurtures doctors' business aspirations for medical care in numerous destinations including South Africa, Costa Rica, Greece, and Singapore among others (Ackerman 2010, Chee 2010, Crush *et al.* 2012). Doctors engaged in transnational healthcare typically actively pursue international clientele for their small or medium sized medical practices, and attract a segment of patients seeking care abroad. In this context, Turner (2010: 461) suggests that promoting the global medical market compromises the ethos of medicine and is, therefore, reprehensible because it promotes a contractual relationship where 'patients relate to doctors' as buyers to sellers at the expense of their fiduciary relationship.

Consumerism, thus, is another important aspect of commercialisation in transnational healthcare. Out with commercial networks, patients are often referred to foreign providers by medical doctors or family and friends (Bell *et al.* 2015). Yet, identifying a medical provider through commercial networks (e.g., commercial doctor referrals and travel facilitators) is also a prevalent practice, particularly among those who live in more advanced countries (Hanefeld *et al.* 2015). Comparison of providers and destinations in terms of quality of care, and often price, is a major component in the decision-making process, with doctors' qualifications and reputations playing a prominent role, while familiarity with destination, culture, and language possibly down-prioritised. Scholars comment on a consumerist ethos being celebrated or encouraged within the sector. Research on 'medical tourism guides' whose audience is potential patients seeking care abroad celebrate emancipated, savvy and empowered individuals taking their healthcare into their own hands (Ormond and Sothorn 2012); meanwhile, the re-conceptualisation of destinations, people, and treatments in market terms in the online environment is striking as Kangas succinctly notes,

'Articles and websites feature treatment destinations as price points (rather than geopolitical territories) where patients-as-consumers can save—and sightsee—within the one global market. Cost comparison tables encourage wise consumer choices (e.g., Kher 2006: 47)' (Kangas 2010: 354).

Patient consumerist attitudes are also depicted by several contributions within the transnational healthcare literature (Ackerman 2010, Bell *et al.* 2011, Connell 2013, Turner, 2010). Turner (2010: 465) proclaims that 'the age of global comparison shopping for health services has arrived', while Ackerman (2010) vividly describes how American 'cosmetic surgery tourists' in Costa Rica compare prices about body parts as if they are commodities. Commodification of care and the human body are ever starker in reproductive or transplantation travels, where body parts such as eggs, sperm, or kidneys are exchanged for a price or a holiday package (Scheper-Hughes 2002). In this context, travelling for care is framed as a form of consumption (Speier, 2016), pre-conditioned by consumers' socio-

economic backgrounds and ability to travel. Framing the provision of care as consumption, then, disguises increasing inequity and the individualisation of the responsibility over care.

Privilege of mobility and medical divisions

It is, therefore, hard to miss that transnational care not only rests on extreme global inequities but that it exacerbates medical divisions among those with and without access to care, leaving those without the privilege of mobility further disadvantaged (Roberts and Scheper-Hughes 2011).

In particular, transnational healthcare implies medical divisions where the most disadvantaged are excluded from healthcare at home or abroad, remain unavoidably vulnerable to health risks, and are largely ignored within the medical travel literature (Wilson 2011). People in this group live either in countries of the Global North or the Global South. Medically excluded at home, they do not have access to either public or private healthcare provision. Simultaneously, they lack the privilege of transnational mobility.

The less disadvantaged are, by comparison, those who might be excluded from healthcare at home but can access care abroad. Being excluded from care at home may be the result of national legislation, failures of the national healthcare provision (Garcia-Altes 2005) often attributed to withdrawal of state support, or expensive private provision. The privilege of mobility, potentially underlined by nationality, social class, and economic status, nonetheless, allows those individuals to access care abroad. Some commentators succinctly note how this privilege leads to new sub-divisions of medically excluded/included (Scheper-Hughes 2002; Wilson 2011; Deomampo 2013). For example, those who might act as providers of body parts in the most contested practices of transnational healthcare such as surrogacy and organ transplantation (e.g., as organ givers or womb 'renters') are often exploited, forced into immobility, or remain invisible and anonymous with medical histories that are not recorded or known (Scheper-Hughes, 2002). Mobility, then, has to be understood 'historically', 'in alliance to power' and 'in light of immobility' (Kroløkke 2015)

against the background of neoliberalism that pushes market activities into spheres of social life that were formerly excluded from it (Kroløkke 2015) and establishes one's socio-economic background as a significant predictor of access to healthcare.

Considering these medical divisions, the group of people medically disenfranchised at home but with the privilege of mobility can be conceptualised as part of a 'global elite' (Wilson 2011). Nonetheless, one would be inclined to argue that they are not necessarily privileged as it is not only the wealthy that travel for care but, disproportionately perhaps, according to Sobo *et al.* (2011), the working poor. Arguably then, social class and economic status mark divisions among those with the privilege of mobility. For example, Laotians and Indonesians travelling to Thailand for medical care 'choose' Thai providers according to their socio-economic background and financial means (Ormond and Sulianti 2014, Bochaton 2015). Scheper-Hughes (2011) similarly acknowledges that, amongst the medically included, viewed and treated abroad as 'moral subjects and as suffering individuals' (Scheper-Hughes 2002, p.3), are those who rely on family or social networks for financial support to travel abroad; and those who take on debt in exchange for the possibility of being treated. It is hard to miss the extent of financial, physical and emotional vulnerability of some of those *with* the privilege of mobility (Bolton and Skountridaki 2017). Even those who travel for elective care and are not sick, often find themselves in great discomfort, stress, post-operatively in pain, and feeling in need of emotional support (see for example Ackerman's 2010 ethnographic study of American cosmetic surgery patients in Costa Rica). Other studies reveal that they may feel anxiety when in a foreign environment (Eissler 2010; Johnston *et al.* 2012); homesick; or may regret having the treatment abroad (Ackerman 2010). Foreignness, then, except for often implying a limited understanding of the destination's culture, language, legislation and healthcare system, also implies that one is undergoing treatment far from home, and the informal support of social networks, or the formal support of the state and its institutions (Bolton and Skountridaki 2017). Decision-making over one's health condition is then individualised, normalising a limited dependence on the state (Wallerstein 1974,

Fineman 2004). Speier (2016), for example, argues that reproductive travellers may put their bodies at more risk as they individualise responsibility of their health and make their own choices. The author gives the example of how a woman travelling for fertility treatment 'put her body under pressure' by transferring more embryos than the gynaecologist recommended because she 'weighed the financial possibilities for future trips' and 'did a cost benefit analysis for each option, with her body the stage for her contradictory experience'.

Consequently, a global elite would best be represented by those who are medically included at home and who, perhaps, also have the means to travel abroad, with those who can access 'elite' providers either at home or abroad being the most privileged. It becomes clear that transnational healthcare is provided within a neoliberal context of stark divisions and inequality, where principles of universal access to care are deemed irrelevant (Bolton and Skountridaki 2017), responsibility for care is individualised and new sub-divisions of the underprivileged are created.

Table 1 – Medical divisions in the transnational healthcare market

Methods

Research Design

The data analysed in this paper were collected through semi-structured qualitative interviews with medical professionals (plastic surgeons, dental surgeons, and gynaecologists specialised in fertility treatment) working in small and medium medical practices they most often own. As discussed above, the focus of the study is the patient-doctor relationship in a commercialised transnational context and for data collection purposes the scope is narrowed down to privately provided healthcare to patients coming from countries in the Global North (including the UK, US, Canada, Germany, France, Australia, Sweden, Italy) seeking medically and non-medically necessary healthcare in South-Eastern Europe. Patients, thus, mainly come from countries with a national healthcare service and a private healthcare sector in place, except perhaps for the case of the US that has a limited public service.

Doctors mentioned that foreign patients visit their practices for a variety of reasons, confirming the findings of previous studies on the complexity of motives. These include primarily: cheaper treatment; national regulatory differences (e.g., in fertility treatment); rare medical specialisation (in plastic surgery or fertility treatment in only two occasions); or a combination of the above. As such, we can infer that these patients present a mixed socio-economic background. As Greece is not as cheap as some other destinations (e.g. Turkey or Eastern Europe), several doctors noted that the political stability and membership of Greece in the EU play a positive role in attracting foreign patients. Simultaneously, they reflected on the fact that had Greece been cheaper, it would have been more successful in attracting foreign patients, bringing thus attention back to the importance of cost competitiveness. Small providers are, most often, medical professionals who typically engage in all phases of communication with the patients, as opposed to large hospitals with higher levels of division of labour and specialised teams taking over the initial phases of the communication and medical doctors mainly performing the agreed treatment plans. As such, small providers offer the opportunity to examine the relationship as it evolves from the very first phases of patient-doctor interactions, including the commercial aspect.

Data were collected in two phases, initially during the summer in Athens, Greece in 2012-2013 and subsequently in Istanbul, Turkey in 2014-2015. Both Athens and Istanbul are located at the South-Eastern borders of Europe and the European Union, with Greece being a member since 1981 and Turkey a long-term economic partner. Both cities offer excellent private healthcare facilities at considerably lower prices compared to most Western countries; they are, therefore, attractive to numerous foreign patients. Istanbul is now an established destination for medical care. Supported by governmental subsidies and with a price advantage based on low labour costs, the city attracts a considerable number of foreign patients, both from Western but also Asian and the Arabic countries¹. While small

¹ State support in Turkey refers to subsidising medical providers to engage in medical tourism. Several interviewees in Istanbul mentioned that through a somewhat bureaucratic process they had applied for governmental subsidy and received it. By contrast, several interviewees in Athens mentioned that there is no

providers advertise internationally and attract foreign patients, it is notable that the engine of 'medical tourism' in Istanbul is its large private hospitals and hospital chains. Athens and Greece, in contrast, lag behind; despite their financial strength large private hospitals have yet to make a noteworthy entry into the global market. As a result, small providers and medical practices, through their own marketing efforts and networking activities, and without state support, account for the bulk of foreign patients coming to the country, mainly from Western countries.

The study in Athens initially had an exploratory character. It was inspired by anecdotal evidence, mainly reports in the news, about doctors treating overseas patients. Simultaneously, the Greek government expressed, on multiple occasions, an interest in supporting the growth of the sector. As there was little academic or systematic research into the conditions, outcomes, experiences of patients and/or healthcare professionals engaged in the practice, the researcher explored healthcare professionals' engagement and experiences, with the patient-doctor relationship prominent in the interview-guide. The study in Istanbul took place for comparative reasons. It was chosen as a destination with international reputation in attracting foreign patients in the 'medical tourism' news outlets but also in the narratives of the interviewees in Greece. Medical doctors in Greece often refer to Istanbul and Turkey as a 'neighbour' and a successful 'competitor' destination, triggering the researcher's interest. Familiarity with Istanbul as a city made the data collection easier.

While the research was initially planned as comparative, medical professionals' accounts have proven similar in all aspects. Except for the differences in the numbers of patients (with practices in Istanbul attracting significantly more foreign patients than in Athens), the experiences, perceptions and roles reveal a rather homogeneous sample. This might be explained by the standardisation of Western medicine and technology which implies a similar structure and operation of similarly-sized private providers, irrespective of location.

state support and made a comparison with the subsidies medical providers receive in the neighbouring country of Turkey.

Furthermore, interviewees compete for patients in the global healthcare market; they often target the same audiences; advertise their services in similar ways; and, often, through the same venues. The remainder of this section briefly introduces the healthcare settings in Greece and Turkey before it discusses in detail the research design and data collection and analysis.

The healthcare setting in Greece and Turkey

Both Greece and Turkey have profitable private healthcare sectors alongside national healthcare systems. Despite significant differences in terms of administration, their national healthcare systems were designed to provide access based on health insurance schemes with special provision for low-income households or the unemployed (Atun *et al.* 2013). Despite reforms, according to Erus *et al.* (2015), the national system in Turkey has never fulfilled its aspiration to provide universal access to all citizens. It is estimated that 44% of those eligible do not make use of the national service, with 30% of very low-income households paying for healthcare expenditures out-of-pocket (Erus *et al.* 2015). Similarly, in Greece, the national system has never fulfilled its aim to provide free public services, mainly due to inefficiencies and corruption (Cabiedes and Guillen 2001) with the most recent debt-crisis austerity measures leading to costs shifting to patients (Kentikelenis *et al.* 2014).

Greece has a profitable private healthcare sector. Private healthcare expenditure ranks second among the OECD countries reaching 3.2% as a percentage of GDP (OECD, 2014). It is mainly financed through private as opposed to public expenditure and, in particular, through out-of-pocket payments (Economou 2010). In Turkey the private healthcare sector is also well-developed and, to a great extent, covered by public expenditure. In the 2000s, cost-sharing between the patient and state for primary, emergency, intensive care and complex conditions in the private sector was replaced by public expenditure (Atun *et al.* 2013). Simultaneously, as mentioned above, a considerable percentage of the population in Turkey continue to cover medical expenditures out-of-pocket (Erus *et al.* 2015).

Data collection and analysis

Study participants were identified via an online search and, in particular, by entering combinations of keywords in the Google search engine. To simulate foreign patients' online search the combinations included the English name of the destination, namely 'Athens' or 'Istanbul', and a number of treatments in the English language, including 'implants'; 'veneers'; 'breast augmentation'; liposuction'; 'hair transplantation'; rhinoplasty'; 'egg donation' and 'IVF' among others. Subsequently, a list with contact details of 56 and 42 doctors (dentists, plastic surgeons, and gynaecologists) in Athens and Istanbul, respectively, was compiled. The researcher visited most of the practices to briefly talk to potential interviewees about the research, providing an information sheet and a consent form. Alternatively, the researcher made the first contact via email, and only a handful of times via phone. Enlisted participants in Athens were contacted in an exhaustive manner. In Istanbul the researcher contacted approximately 30 doctors and ceased efforts to recruit further participants, when the interviews seemed to add little to the collected data. Participants were located both at the centre of the two cities and in the suburbs. Table 1 presents further details on study participants.

Table 2 - Study participants

All interviews in Athens took place in Greek, except for one which was in English as the medical doctor is a foreign national. In Istanbul the majority of interviews took place in English and a few in Turkish with the support of an interpreter. All interviews were recorded and transcribed verbatim. Research in both countries was approved by the research ethics committee at the researcher's home institution.

The qualitative interviews were based on a question-guide including broad questions concerning professionals' perceptions about transnational healthcare; the history of the medical practice and its internationalisation path; their experiences of interacting with patients; perceptions of state support in Turkey or lack thereof in Greece; and anticipation of future developments. The significance of commercialisation and consumerism in addition to

the multiple facets of the patient-doctor relationship were identified as key themes in the first round of interviews in Athens; this was further explored in Istanbul. The researcher became immersed in the data to identify common patterns and organise them into themes. Participant perceptions of patient attitudes (and corresponding doctor roles) were first organised into four thematic parts, subsequently linked to different phases of the interaction and, finally, identified as distinct facets of the patient-doctor relationship.

In particular, it is suggested that the relationship has four intertwined yet distinguishable aspects. First, the consumer-provider aspect dominates the initial phase of interactions, when patients try to choose a medical professional and doctors to render their services. Second, the client-expert aspect dominates when communication advances further and patients perceived as knowledgeable and demanding finally choose their preferred treatment plan and clinical expert. Third, the patient-healer aspect prevails during treatment where patients are perceived as cooperative and engaging but they also expose their vulnerability and dependence upon the doctor both physically and emotionally. The guest-host aspect where doctors perceive patients as vulnerable and exposed to risk is also prevalent during treatment and post-operatively and is attributed to the condition of foreignness. These are analysed and discussed in detail in the following section.

Data Analysis

The Consumer-Provider and Client -Expert Dimensions: Consumer choice and power

Participants often reflect on foreign patients' consumerist behaviour and, by association, their own role as service providers. For example, consumerist attitudes are demonstrated by patients' strong sense of interchangeability of medical professionals (Timmermans and Oh, 2010) in their global search for care. Choosing a medical professional largely takes place through online search followed by inquiries, often to numerous medical providers. Doctors, either plastic surgeons, dental surgeons, or IVF experts, acknowledge that in the competitive

environment of the transnational market, they need, as *providers*, to give fast and prompt responses to incoming inquiries from potential *clients*. Only a portion will finally choose their medical practice, revealing an industrious selection process. In contrast, local patients most often choose medical provider based on the word of the mouth and the initial consultation takes place in the doctor's practice. The dental surgeon's account below is highly illustrative of a market exchange negotiation, where the provider and potential client spend the first phase of their communication discussing prices alongside treatment plans,

"When a foreigner comes they say that 'he [the surgeon] is a little bit expensive': my veneers cost 300 euros, they can find them with 200 euros. They see the photographs, they read the reviews, they write to me and ask me, what do you do different than the others? And I explain [...] if they are satisfied by that they come to see you [...] Sometimes they have doubts. Do I have to do all that? And I say just take it [the recommended treatment plan], go to another place [medical provider] too, think about it. 75% of those who come to see me stay, 25% go to other places. It is a kind of selection...and that satisfies me (Dental Surgeon D, Istanbul).

The privilege of mobility in a competitive international market, thus, implies increased options for patients as consumers. Mobility, however, is not necessarily underpinned by wealth (Sobo *et al.* 2011) as it is often associated with medical and travelling cost concerns. Most often, those who travel choose providers according to their financial means (Ormond and Sulianti 2014, Bochaton 2015) or even beyond these by borrowing money or taking on debt (Scheper-Hughes 2011). According to study participants, foreign patients' motivation to travel depends on the healthcare system provisions in their home country. The country of origin (e.g., Italy or the UK) is mentioned in the interviews to explain how the healthcare setting patients come from fails to cover their desired treatment (e.g., expensive dental implants or cosmetic surgery, non-eligibility for IVF at home often coupled with an expensive private sector etc.). Unsurprisingly, treatment costs are typically of high importance to foreign patients according to study participants, even when affordability is not the single motive for going abroad. This reveals a mixture of socio-economic backgrounds potentially skewed

towards the low end. It is not uncommon among interviewees to depict patients as shopping around, comparing prices and services and looking for solutions that suit their budget. Plastic surgeons, for example, often explain that travelling abroad for aesthetic surgery is largely associated with medical consumerism,

‘It is, let’s say, like shopping for them [patients]. They are interested in having it at the lowest possible cost. For many women, this is dominant. Possibly a woman that with high treatment cost could not do anything [any treatment], is really interested in low cost, because this places her within the group of women that can access this service’ (Plastic Surgeon C, Athens).

The above account highlights participants’ perceptions of consumerist attitudes and patients’ conceptualisation of healthcare as a service or commodity (Pellegrino 1997). The cost of veneers, dental and breast implants or of an IVF cycle are a basic component in the discussion. In search of solutions that suit patients’ budgets, in this initial stage of communication, interaction is less about a patient and a doctor and more about the consumer-provider aspect of the relationship.

The selection process instead of challenging is, overall, well-perceived. Price negotiation (except for demonstrating consumerist attitudes) is perceived by the majority of participants as a sign of active, knowledgeable, and demanding patients. Reflecting the dominant discourse of empowered consumers (Fox *et al.* 2005), the IVF expert below suggests that transnational healthcare is about patient choice and open-minded people,

‘It is all about what people want; people come with very specific requests. And it is not how it is presented abroad [in the media]; a mindless action of mindless people. These people are very conscious and open-minded [...] I have worked with them for years now, I am convinced they know what they want, and I am happy to be working with them’ (IVF expert A, Athens).

A dental surgeon in Istanbul similarly narrates,

“We are talking [a lot]. They ask many, many questions before the treatment. We try to show every detail before we start and they ask. They ask for instance do you have laser, do you do implants, do you have this, that, specific questions. They do not sit to have everything done immediately. They [first have to] trust the standards of the clinic” (Dental Surgeon C, Istanbul).

Simultaneously, most interviewees acknowledge that international patients are, on one hand, demanding and, on the other, showing increased cooperation during treatment.

‘On the one hand they are more demanding, but on the other, once they know the plan and they feel that they participate, they are really cooperative [...] she [the patient] does not, normally, she does not raise strange demands, out of space. You explain right from the beginning what you want to do and you do it: if she participates in the treatment plan, she is very obedient let’s say, and afterwards, much more cooperative’ (Dental Surgeon E, Athens).

Unsurprisingly, cooperation increases doctor satisfaction. Empirical evidence suggests that better educated and more sophisticated patients can contribute to a meaningful doctor-patient relationship (Mechanic 1996: 173) as engaging patients support improved communication and a reciprocal relationship where doctors are more willing to share control over decision-making and health management (Greenfield *et al.* 2012). Furthermore, several medical professionals perceive the development of a foreign clientele as a form of recognition of their work and expertise. Similar to the doctors quoted earlier, an IVF expert in Athens reflects,

‘It fills you with satisfaction because these people do not go just to anybody, they do search [...] so when you gain their trust you feel a great satisfaction’ (IVF expert B, Athens).

Taken out of context, this might seem unusual; doctors are typically challenged by consumerist attitudes. Greenfield *et al.*’s (2012) research on MDs’ perceptions of second opinions shows how they often resent their patients consulting other professionals for a

second opinion. Similarly, Yagil and Medler-Liraz (2015) describe identity tensions when medical professionals' clinical knowledge is challenged by some patient requests. Nonetheless, in the particular context of the transnational market, medical professionals cling to their role, first as providers in a competitive market, and second as experts (Brint 1994) offering high-value solutions to their international clientele. In the transnational context medical professionals commit time and resources and enter by choice into what is perceived to be a niche, promising 'market'. By association, treating demanding and knowledgeable patients implies an internationally competent expert in the *expert-client* metaphor, while the entrepreneurial role implies that of a competitive provider in the *consumer-provider* metaphor.

The Patient-Doctor and Guest-Host Dimensions: Vulnerability and power asymmetry

Participants' accounts, however, reveal different perceptions and experiences in later phases of their interaction with foreign patients, portraying extensive patient vulnerability and potential asymmetries. Whilst a consumerist behaviour before patients choose provider implies considerable patient power (reinforced by the privilege of mobility), and knowledgeable and engaging patients imply shared decision-making in the clinical encounter, after patients make a choice over their treatment plan and provider, the condition of vulnerability surfaces. Participants often reflect on such vulnerability when talking about patient anxiety.

"Patients feel stress. [...] because you know they decide to come here from far, it is maybe an excitement for them, they only think 'I have to trust her', they have no other option. They are always very stressed but they say 'doctor, do all you can for me'"
(Dental Surgeon C, Istanbul).

Vulnerability in the transnational context stems, thus, from the dual hardship (and inherent risk) of undergoing medical treatment and being a foreigner. The first stems from the medical risk involved in most invasive operations where, unexpectedly, anything can go wrong (either at home or abroad). This reflects the role of participants as healers in the patient-doctor

aspect of their relationship. Nevertheless, it is hard to miss that dependency on the surgeon and the medical team increases in the transnational context. Patients feel ‘they have no other option’ but to trust the doctor. This dependence is underlined by lack of state and social networks patients typically may have at home. It gives an additional dimension to the patient-doctor relationship. The excerpt below illustrates the perceived vulnerability of the patient as a foreigner,

‘I need to keep an eye on them. [...] They do not know the place at all. They do not speak the language [...] the patients are scared, they are alone. Imagine that a whole family might leave their home to come...and you as a doctor you are also their host, you need to keep an eye on them, do they take care of them at the hotel?’ (Plastic surgeon G, Athens).

As a result, providers often assume the role of the host next to the role of the healer. Their foreign patients’ increased needs coincide with a call for additional responsibility. This varies from doctors and assistants personally caring about their patients’ stay to hiring personnel to accompany, transport or help patients with translation (companions and drivers are very common in Turkey albeit uncommon in Greece).

The way interviewees perceive foreignness is also indicative of their perception of patient vulnerability. Foreignness is a condition largely conceived by doctors through a dichotomy. On one hand there are patients who do not have ties to the destination country and, on the other, those who do. This dichotomy becomes clear when asked if a significant portion of the foreign patients are from the diaspora. While, overall, only two dental practices in Turkey seemed to have had a steady flow of patients from the diaspora, it is important to clarify that interviewees make a distinction between members of the diaspora who can speak the language and have family in the destination country, and those who do not. For example, a dental surgeon in Turkey explains,

'Yes, we have quite a few Turkish patients from Germany...but these patients are not foreigners. They speak Turkish so communication is not different [to locals] ... they have family in Istanbul and they return [to the practice]' (Dental Surgeon G, Istanbul).

A dental surgeon in Athens similarly clarifies,

'Well, yes, I had patients that said they had Greek roots, but ...it is not like they had anyone here or a place to stay...they could not speak Greek so they were more like other Americans' (Dental Surgeon A, Athens).

What seems to capture interviewees' attention in their role as hosts is the familiarity with the place and the kind of informal support patients have in Athens or Istanbul, respectively.

Patient vulnerability and foreignness, however, are also highlighted in their role as a doctor in the post-operative phase. Geographical distance is now a significant aspect of foreignness. A potentially important hardship is the case of follow up care and post-operative complications. In light of this, the majority of plastic surgeons clarify that they only offer specific surgeries to foreign patients which typically require short recovery periods,

"The difference with the Turkish patients is very important on my side...I really concentrate more on foreign patients' follow-up problems. I do not offer them operations which need very close follow-up [...] anything which is really risky is best for them to do in their home country" (Plastic Surgeon B, Istanbul).

"Two to three operations with fast recovery and minimal complications. Breast augmentation [..]; liposuction but not large scale; upper eyelid surgery, and healthy patients, right? I wouldn't operate on breast reconstruction after cancer treatment, which is seven to eight hours' operation requiring four to five days' hospitalisation" (Plastic Surgeon E, Athens).

Several dental surgeons also mention there are limitations to the treatments provided to foreign patients. Beyond that, some participants explain that not being able to closely follow-

up on their patients is often medically acceptable as in the case of dental implants, but they may still cause concern,

"It is not that something will happen, all right, the patient leaves, goes back home. Neither are there legal concerns as I follow the medical protocols, but then it is this moral issue... typically I check a [local] patient every two weeks for months after the operation [implants]...so that I sleep in peace of mind at nights. I cannot offer this to the foreign patient. She knows that and agrees to it, and all patients were happy after leaving the practice...and, luckily, there have been no issues so far, but I always have the fear" (Dental Surgeon B, Athens).

The dental surgeon post-operatively reveals a sense of disempowerment due to the distance between his practice and patients' homes. What options do both patients and medical professionals have in case of complications after the patient returns home? Here, the notion of 'choice' becomes obsolete. Even if doctors act with due diligence and avoid highly risky operations, they cannot 'look on patients as "theirs"' or carry on having meaningful responsibility for their welfare (Pellegrino 1999: 252-3) after they leave the country. Delivering a *service* to foreigners is, arguably, possible but offering *care* and continuity in care may become problematic. Responsibility, then, for patients' health status largely falls on their own shoulders (Mol 2008). The commercial setting of transnational healthcare exemplifies the logic and practice of neoliberal policies, encouraging the individualisation of responsibility. Health professionals typically keep in touch with their patients via phone or email but, as several professionals highlight, it is the patient's own 'choice' whether they follow clinical advice once they travel home.

"Actually it is up to the patient. It is important and all after-treatment care is explained to them...you should use this toothbrush, toothpaste, we give examples... After that it is up to the patient, we cannot manage that...it is impossible when they go back to their country, we cannot follow up" (Dental Surgeon F, Istanbul).

Foreignness, in this case, is highlighted by the geographical distance between the patient and the doctor, as noted above. While it is true that doctors may have limited control on whether patients follow their advice - whether local or foreign - geographical distance further mitigates doctors' capacity to know. Follow-up care is the exception rather than the rule. It becomes clear how the condition of foreignness reinforces the condition of medical risk creating a vicious cycle of accentuated vulnerability. In many ways, the other side of the 'privilege' of mobility is the vulnerability associated with the condition of foreignness because, when travelling abroad, people leave at home their social networks of support, state protection and citizen's rights; a dependency deficit hard to fill. The consumer-provider and client-expert aspects of the patient-doctor relationship or consumers' choice in the global private markets do not counterbalance such vulnerability. It is the healer and host roles of doctors and, by association, the care and caring work grounded in their personal and professional ethics that may protect the patient-traveller. Against the background of lack of transnational regulation combined with patient vulnerability, power asymmetries on the doctor's side are restored; bargaining and consumer power do prevail but are inevitably limited to the first phases of the relationship.

Conclusion

The changing nature of the patient-doctor relationship, against the background of public policies promoting consumerism and individualisation of responsibility over healthcare, remains at the centre of sociological discussions. The wider context of marketization, commercialisation and, close to these, patient consumerism, are linked to moving away from a paternalistic relationship to one with reduced power asymmetries between the patient and doctor. This is typically seen in a good light; a form of emancipation from an authoritative figure with potentially positive impact on clinical outcomes. Yet, the broader context of state withdrawal and increasing individualisation of the responsibility for healthcare problematizes the discourse of patient choice and empowerment. Empirical research showcases how

reduced power asymmetries bring new tensions into the patient-doctor relationship (Brown *et al.* 2015, Greenfield *et al.* 2012, Yagil and Medler-Liraz 2015), often against the background of structural changes in healthcare provision (Oh 2012, Potter and McKinley 2005). The empirical findings suggest that consumerist attitudes often have a corrosive impact on patient-doctor trust and mutuality.

A plausible explanation to such tensions emanating from marketization and consumerism is the fact that asymmetries in the consulting room are potentially inescapable. Pilnick and Dingwall (2011) and the feminist approach of Mol (2008), for example, highlight that the condition of illness unavoidably places people in the role of the sick; patients, in other words, are in a vulnerable situation and in need of (professional) help and care. Even those who seek elective care and are not sick, often find themselves in great discomfort, stress, post-operatively in pain. While recovering from surgery these patients are thus vulnerable and feeling in need of support. Inevitably, the personalised relationship between patient and doctor extends beyond the consumption of a service (Pellegrino 1999). Furthermore, trust is a viable way to cope with a patient's lack of knowledge, skill and expertise, where she places herself in the hands of the doctor (Lupton 1997). This paper contributes to the discussions around the evolving nature of the patient-doctor relationship by highlighting that even in the most extreme conditions of commercialisation (and consumerism) patient vulnerability shape the patient-doctor personal relationship. As such, one model (e.g., the consumerist) does not, *per se*, replace an older one (e.g., the Parsonian) but different dimensions of the relationship co-exist. These dimensions may manifest themselves in different stages of the interaction as it develops. The findings of this research offer an example of such a multi-dimensional relationship between the patient and doctor as it evolves in the transnational healthcare setting. Drawing on the narratives of doctors in Athens and Istanbul, the research findings imply that a consumer-provider dimension coexists with the client-expert, patient-healer and, additionally, host-guest relationship summarised in Table 2.

Table 3 - Patient-Doctor Relationship in the Transnational Context

There are two important conclusions to be drawn. First, the multi-faceted relationship can be helpful in understanding the patient-doctor relationship in private markets. We have seen how patients may exercise consumer power when choosing a medical professional. Yet, the findings show that excess consumerism co-exists with power asymmetry naturally tilting to the doctor's side during treatment; given the patient's physical vulnerability consumerism is less relevant at this stage of the relationship. The patient is in need of the doctor's skill to perform the treatment and the doctor's care to perform it in the best possible way, assume responsibility of the outcome and post-operative care and, ideally, emotionally support the patient. Inevitably, asymmetries in the patient-doctor relationship persist. The second observation is relevant to the context of transnational markets and the condition of foreignness. Foreignness implies additional hardships and accentuated vulnerability for patients. By association, dependence upon the doctor's caring work increases. Somewhat ironically, however, foreignness limits the doctor's ability to take responsibility of a patient's post-operative health. Several interviewees admit (or resent) a lack of capacity to offer international patients the post-operative care they typically provide to local patients.

Considering the limitations of this research, it has to be acknowledged that it is based solely on doctors' accounts. While informative, what is only marginally discussed by doctors, but is of increased importance in terms of power relations, is the individualisation of responsibility for patients over a poor clinical outcome. At the transnational context, the condition of foreignness implies a deficit in statutory protection. In cases of after-treatment disputes the 'consumer' is powerless in comparison to the provider. For example, in cases of medical malpractice or negligence, there are hardly any complaint mechanisms or grievance procedures in place, to potentially hold a medical professional responsible and liable to compensate the patient. Thus, the patient relies on market mechanisms (relevant to the provider's reputation and the potential harm to 'business'), her own resources, familiarity, and knowledge of the host country's regulations and grievance systems in place to claim for compensation and, ultimately, on the professional norms and personal ethics of the medical

professional for care. Consumerism, while excessive in the initial phases, cannot empower patients in later phases of the patient-doctor relationship. Choice is rendered irrelevant and power asymmetries grounded in patient vulnerability persist and are exacerbated in the transnational context. An alternative research design, potentially based on observation of patient-doctor interactions or interviews with patients treated in a foreign country, may shed light upon such aspects of vulnerability.

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Table 1 – Medical divisions in the transnational healthcare market

Medical divisions	Medically Excluded	Medically Included
Lack of mobility	No access to healthcare at home or abroad Exploited by transnational healthcare market (e.g. surrogate mothers forced to immobility)	Individuals with access to healthcare at home for all their medical needs
Privilege of mobility	Individuals exploited by the transnational healthcare market (e.g. organ donors travelling abroad to sell their organs)	No access to healthcare at home but access abroad: of various socio-economic backgrounds Access to healthcare at home and abroad: potentially most advantaged, global elite

Table 2 – Study participants

Specialisation	Istanbul	Athens
Plastic Surgeons	4	8
Dental Surgeons	8	6
IVF experts	1	2
Total	13	16

Table 3 – The Patient-Doctor relationship in the transnational context

Relational metaphors	Patient	Doctor	Phase of treatment
Consumer-Provider	Consumerist attitudes, shopping around, price sensitive, asking about medical qualification & techniques	Responsive to consumer requests; makes client offers (recommended solution & fee)	Selection process: Provider and treatment choice by patient
Client-Expert	Active, empowered, knowledgeable, savvy, demanding	Good communication, increased cooperation, realistic expectations, good orientation; feeling of recognition	Provider and treatment choice by patient; treatment phase
Patient-Healer	Risk-taker, vulnerable, anxious about treatment	Concern over continuity of care,	Treatment phase; post-operatively
Guest-Host	anxious about the foreign environment	additional responsibilities as the 'host'; concern about the patient as a 'guest'	Treatment phase; post-operatively