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Smoothness as a quality of care: An STS approach to transnational healthcare mediation

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ABSTRACT

Medical travel and transnational healthcare involve various difficulties such as the distance and disconnect between patients and healthcare providers, language barriers or logistical challenges of moving ill bodies across space. Medical travel facilitation steps in with some sort of brokerage service that contributes to overcoming or managing these difficulties and, as this paper suggests, acts to create a quality of 'smoothness'. By unpacking three salient facilitation practices, namely connecting, communicating, and coordinating, this paper conceptualises the empirically derived category of 'smoothness'. This as a disposition, outcome, and spatio-temporal manoeuvre of medical travel facilitation. Based on the way in which such practices of mediation act to create smoothness, namely in an attentive, persistent, and collective tinkering manner, this paper suggests that some practices of medical travel facilitation are productively thought not just about setting up the possibility of care transnationally, but that they are key forms of care in itself. Based on these findings, smoothness is considered to be a central but also contested quality of medical travel facilitation and brokerage in a broader sense, but as proposed here, also for care. This conclusion potentially has implications not just for the study of transnational healthcare and mediation activities, but also that of care and transnational mobilities more generally.

1. Introduction

Healthcare is a basic need and if it is not available or accessible locally, patients may consider seeking healthcare abroad. Medical travel, a long-established practice, developed into an actual industry over the last few decades (Bell et al., 2015; Connell, 2015). The experiences of medical travellers, however, reveal the multi-layered difficulties of transnational healthcare (TNHC) (Ormond, 2011; Kangas, 2012; Kingsbury et al., 2012). The distance between patients and healthcare providers and interactions across physical space, multiple healthcare systems and different cultures result in frictions or 'roughness' that need to be overcome or managed. Time is short due to limited copresence between patients and healthcare providers and the urgency of some medical matters may require speedy processes. There are logistical constraints of moving ill bodies, and also financial ones for utilising services beyond national funding schemes and additional costs for travel and accommodation abroad. In this niche, medical travel facilitators – companies and individuals – have established themselves, offering a service that contributes to navigating and managing the roughness of TNHC and to creating 'smoothness'.

The contribution of this paper is two-fold. Firstly, it conceptualises 'smoothness' as a central quality of brokerage work as performed in medical travel facilitation, and secondly, it analyses how this relates to the mediation of TNHC and care more specifically. 'Smoothness' is an empirical category derived from stepping through some of the immediate practices of medical travel facilitation in an Actor-Network Theory (ANT) and Science and Technology Studies (STS) inspired approach. Starting from following medical travel facilitators as network-builders and analysing the work involved in making connections, the analysis is taken further by also exploring the qualities of and resulting from that work. However, in contrast to the ongoing preoccupation of much of ANT and STS research with frictions and holding networks together, the focus here is on 'smoothness' and its potential as an analytical tool. Vignettes that bring out the complexities of medical travel facilitation will illustrate smoothness as a disposition and outcome of brokerage, and also as a quality of spatio-temporal manoeuvring. Three sets of facilitation practices – connecting, communicating, and coordinating – are at the centre of analysis since they were identified in the empirical material as being particularly relevant for dealing with major roughness and frictions of transnational healthcare, and for generating smoothness.

This discussion of the qualities of and resulting from the mediation work leads to the second contribution of this paper that is to tease out

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how medical travel facilitation and care are connected. Based on the way in which medical travel facilitation acts to create smoothness, namely in an attentive, persistent, and collective tinkering manner, this paper suggest that these practices are productively thought not just about setting up the possibility of care transnationally, but that they are forms of care in itself. Consequently, smoothness is considered to be central not only for medical travel facilitation and brokerage more generally, but also, as proposed here, for care. The next section gives a brief backdrop to the research context of medical travel facilitation between Oman and India. Brokerage and an STS-inspired take on care are reviewed as conceptual framing of the analysis before introducing the methods and research participants. Then, the category of 'smoothness' is elaborated through empirical examples. The conclusion draws the conceptual findings together that potentially have implications not just for the study of transnational healthcare, but also that of mediation in healthcare and care more generally.

1.1. Medical travel from Oman to India and its facilitation

With health and care becoming more and more commodified and private healthcare providers competing for customers in the international market (Crooks et al., 2011; Botterill et al., 2013; Connell, 2015; Bolton and Skountridaki, 2017), medical travel has rapidly become a growing industry in recent decades. In this process, medical travel facilitation became an accompanying business. Companies and individuals assist international patients by informing about treatment options abroad, suggesting healthcare providers, facilitating communication, organising the journey and sometimes assisting patients on site (Snyder et al., 2011; Dalstrom, 2013; Wagle, 2013; see Hartmann, 2017). As an intermediary between patients and healthcare providers, medical travel facilitators are seen as brokers who are often ascribed an ambivalent role. This ranges from being 'patient advocates' (Snyder et al., 2012; Dalstrom, 2013) to agents who use questionable practices to make money from their middle position at the expense and health risk of patients (Snyder et al., 2012; Crooks et al., 2013). Criticism is fuelled by the common business model that consists in commission fees paid to medical travel facilitators by the hospitals for patient referrals, potentially creating false incentives.

The operational mode also depends on the context in which medical travel takes place and where the different actors involved are located. This research looked at medical travel from Oman to India. India is seen as one of the leading medical travel destinations globally (Mishra, 2014; Bhaidkar and Goswami, 2017; FICCI, 2019) and within the region, contributing to South-South medical travel (Ormond and Kaspar, 2019), which is considered to make up the largest part of medical travel (Connell, 2011, p. 113; Crush and Chikanda, 2015, p. 313), contrary to much of the media coverage and studies on North-South medical travel. Political and economic restructuring of the healthcare sector in India in the 1980s resulted in a shift towards liberalisation and privatisation (Reddy and Qadeer, 2010, p. 70; Smith, 2012, p. 5) and since the Apollo Group opened its first corporate hospital in Chennai in 1983, many more have followed (Hodges, 2013, p. 242). In addition to major cost savings, Indian healthcare providers emphasise expertise in multiple medical disciplines, state-of-the-art infrastructure and English-speaking staff (Sen Gupta, 2015; FICCI, 2018; Kannan and Frenz, 2019). In 2019, most people arriving in India with a medical visa were from South Asia with 63%, followed by West Asia with 17% and Africa with 8% (Ministry of Tourism Government of India, 2019, pp. 41–45). For Delhi in particular, the informants participating in this study mention that many international patients come from Central Asia and the Middle East.

India is among the top destination countries for outbound medical travel from Oman. A considerable share of this patient mobility is coordinated and funded by the Treatment Abroad Scheme, which offers healthcare abroad to Omani citizens if treatment cannot be provided locally (MOH Sultanate of Oman, 2014). The scheme was introduced as a transitional solution after a change of leadership in the early 1970s, while a health system in the western sense was being established in Oman (Peterson, 2004). It is still in operation today, albeit on a smaller scale. There are also many patients who travel abroad individually and independently of the government scheme (Al-Hinai et al., 2011; Raza, 2016), even when treatment would now be available, because some people distrust the local health system. That India is today a preferred destination has multiple reasons from geographical proximity to long-standing geohistorical relations between Oman and India, extensive migration-related connections, and cost-effective treatment options (Hartmann, 2020).

1.2. Conceptual framing

1.2.1. On brokerage

For connecting and mediating between different parties, medical travel facilitation can be conceptualised as a brokerage activity (Mohamad et al., 2012; Casey et al., 2013; Dalstrom, 2013; Ormond et al., 2014). Brokerage is a long-standing practice that is discussed in different disciplines and thematic areas and often evolves around the persona of the broker (Smith, 2001; James, 2011; Lindquist, 2015), their function in terms of networking, connecting and handling its logistics (Lindquist et al., 2012; Lindquist, 2017; Thieme, 2017), and brokerage in the sense of socio-cultural mediations (Smith, 2001; Michie, 2014; Salazar, 2015; de Jong, 2016).

Connecting different parties and shaping relationships are central to brokering. This 'being-in-the middle' is an ambivalent and powerful position: "Although intermediaries may mediate or facilitate between groups of actors, they are never neutral in dealing with others and are capable to translating, redefining and fundamentally changing what they transport" (Hiteva and Maltby, 2014, p. 120). In Latour's (2005, p. 39) writings on actor-network theory, the notion of 'mediators' encapsulates this transformative capacity and thus mediation becomes particularly agile and responsive but also precarious and unpredictable. This understanding sharpens the focus of how actors may not react in a clearly prescribed way, but according to the situation and constellation with others. The power involved in this position is discussed for medical travel facilitators in terms of influencing hospital and destination choice, counselling in the medical domain and shaping the image of patients and themselves (Casey et al., 2013; Crooks et al., 2013; Hanefeld et al., 2015; Moghavvemi et al., 2017). Brokerage in the context of logistical infrastructures also involves the networking and mediation of mobilities of different kinds across space. For migration, Xiang and Lindquist (2014, p. 122) propose a focus on brokers as a productive route into better understanding migration infrastructures, defined as "the systematically interlinked technologies, institutions, and actors that facilitate and condition mobility". Mobility brokers move other people and things (Lindquist, 2017) and shape the meanings, experiences, and practices of movement that are also conditioned by the politics of mobility (Cresswell, 2010). 'People as infrastructure', elaborated by Simone (2004, p. 408), looks at how people form conjunctions of "complex combinations of objects, spaces, persons and practice". The ways in which medical travel facilitators build connections (Hartmann, 2019) and become themselves infrastructures for mobilities, illustrate the importance of such mediators and their social networks (Bochaton, 2015) in bringing transnational healthcare into being. However, unlike other mobility brokers who are mainly invested in the connecting work, sometimes remotely, medical travel facilitators often offer a more comprehensive and personalised service: they coordinate between different actors and processes, accompany patients en-route or on-site, and provide practical and emotional support (Ormond et al., 2014; Hartmann, 2021).

Transnational healthcare also requires aspects of cultural mediation to navigate different cultural systems d and create understanding (Michie, 2014). Cultural competence is discussed as a key asset in nursing and social science literature (Schwab et al., 1988; Campinha-Bacote, 2002; Gunaratnam, 2008). In the context of medical travel, language interpretation is considered to be crucial (Kaspar, 2015;

Suryanarayan, 2017) and Ormond (2013) analysed how cultural diversity is mobilised as a competence for catering for international patients and promoting a medical travel destination.

The literature acknowledges medical travel facilitators as relevant actors in building connections, coordinating mobilities and processes and communicating in multicultural settings and brokerage offers a conceptual lens to situate their role. To conceptualise this further and analyse the contribution of medical travel facilitation to mediating transnational healthcare and the qualities of this work, this paper also draws on Science and Technology Studies (STS).

1.3. An STS-take on medical travel facilitation and care

An STS- and ANT-inspired take on medical travel facilitation has proven to be a productive approach to better understand the qualities of that practice for three reasons. Firstly, it provides some guiding conceptual-methodological principles for closely attending to the transnational networks of medical travel facilitation and understanding their working. The impetus of tracing associations and the making of connections (Latour, 2005) directs attention to the articulations and modalities of transnational healthcare networks. Following "network builders as they stitch together durable associations through space and time" (Murdoch, 1998, p. 367) serves as a starting point for this endeavour. Furthermore, the conceptual underpinning of STS and ANT provides a methodological "set of sensitivities" (Mol, 2010, p. 253), rather than a coherent theory, that draws attention to the multitude of human and non-human actors, the ways they interact, and the spaces and relations they construct. The approach thus stipulates following actions and their traces to get into the thickness, here, of medical travel facilitation. Openness and sensitivity towards various aspects also means patching together different accounts generated with ethnographic methods such as observation, interviewing and job-shadowing.

The second reason for mobilising an STS- and ANT-inspired take on medical travel facilitation is that certain empirical findings open a productive reflection on key concepts of these approaches. The empirically derived category of 'smoothness' constitutes seemingly somewhat of an antithesis to the engagement of this body of literature with patching heterogeneous entities together, attending to frictions and moments in which networks fall apart and, in particular, to the notion of tinkering as a defining practice of care. Thus, taking 'smoothness' seriously and analysing it with its different modalities as they play out in the practices of medical travel facilitation provides an alternative sensitivity and an opportunity to reflect on more established concepts such as that of frictions or tinkering. Moreover, the way in which Annemarie Mol thinks through empirically derived categories (2002) inspires to theorise 'smoothness' as an analytical tool as it emerged during research; as a quality of facilitation work and then more broadly in relation to tinkering and care. Also, her suggestion to think of different versions of the same thing, trace them and how they relate to each other (Mol, 2012) allows for thinking through the different modalities and levels of smoothness.

Thirdly, and following on from this previous point, the conceptual thinking about care proposed by Mol and colleagues (Law and Mol, 2001; Mol, 2002, 2008, 2010; Mol et al., 2010) allows to explore how practices of medical travel facilitation may in themselves constitute forms of care, rather than just being understood as setting up the possibility of healthcare transnationally. One of the foundations of the engagement with care in STS is the conceptualisation of care as a "persistent tinkering in a world full of complex ambivalence and shifting tensions" (Mol et al., 2010, p. 14). Tinkering is understood as "attentive experimentation" (Mol et al., 2010, p. 13) and an ongoing process that requires that we "meticulously explore, test, touch, adapt, adjust, pay attention to details and change them, until a suitable arrangement (material, emotional, relational) is achieved" (, p. 16). This relational practice in which different entities adjust to one another with the purpose to "empirically shape an arrangement" (Winance, 2010, p. 95) that suits them all is also referred to as 'empirical tinkering'. Such tinkering emphasises care as a practice, something that is done in a certain way, in a particular moment, in a given location, and that continues to evolve (Mol, 2008, p. 18). This means attending to the "details and subtleties of practices that are local, embodied and responsive to a variety of heterogeneous and unpredictable elements" (Turrini in Mol et al., 2011, p. 75). This reflects the modality of care as a practice that is continuous, non-linear and situational.

The richness of theorising care in STS literature lies also in the idea that care is not bound to what may traditionally be identified as 'care settings', for example within familial relationships or the healthcare context, nor does it pre-empt certain groups of people that are often considered as in need of care. Care is considered to be a shared practice and "[t]he art of care is to figure out how various actors (professionals, medication, machines, the person with a disease and others concerned) might best collaborate in order to improve, or stabilise, a person's situation" (Mol, 2008, p. 23). The orientation towards improvement (Mol, 2008, pp. 18–23), rather than perfection (Bingham and Lavau, 2012, p. 1602), is another defining element. Based on a case study in the healthcare context, Mol (2008, p. 20) specified 'good care' as a "a calm, persistent but forgiving effort to improve the situation of a patient". However, different goods around care may coexist and care may lie within practices of "tending the tensions" (Bingham and Lavau, 2012) between different 'goods'. Attending to the subtleties of care as a practice thus helps to better understand the complexities around such qualities.

2. Methods and research participants

This paper discusses data collected as part of a multi-sited research project that followed practices of medical travel facilitation between Oman and India. The data was collected during four months of fieldwork in Delhi, Kerala and in Muscat before the Covid-19 pandemic. It included conducting semi-structured interviews, having informal conversations with different interlocutors, and following medical travel facilitators to their workplace for job shadowing. The data consisted mainly in interview transcripts and fieldnotes from observations and 24 days of job shadowing. The analysis and theory-building followed an inductive Grounded Theory inspired approach with iterative rounds of coding, which have brought forth new categories (Charmaz, 2006; Strauss and Corbin, 2008) that were then related to the STS literature later to further the discussion.

Different sorts of medical travel facilitators were participating in this study ranging from designated medical travel facilitators working for medical travel companies to those employed by hospitals, individual freelancers, medical professionals to people working for governmental or non-profit organisations related to medical travel. Out of the 84 medical travel facilitators that were interviewed, 53 were based in India and 31 in Oman. Most participants were male, with the sample consisting of 74 men and 10 women, which seems to represent the gender split encountered in the field. This probably has to do with working conditions (often high flexibility required, personal contact, long and unpredictable working hours), cultural gender images as well as the fact that women are less represented in leadership positions.

The research design always creates a certain setting in which not all potential participants can or want to engage, and the study reflects the field as it was shaped and encountered by my own positionality as a researcher and a person coming from a different socio-cultural background and an outsider to the industry. The paper's focus on smoothness and care elaborates a particular aspect of medical travel facilitation, which is not to say that medical travel is not also highly critical in various ways, nor that the facilitators' work is by any means always caring and in the best interests of patients.

2.1. Smoothness through connecting, communicating, and coordinating

In the following, empirical examples grouped under three sets of practices of medical travel facilitation are analysed in how they act to create smoothness, and thereby, may potentially also constitute care.

2.2. Connecting: forging connections and providing continuous handovers

The physical distance between patients and healthcare providers is one of the specificities but also difficulties of transnational healthcare and medical travel facilitators are seen as "crucial connectors between foreign patients and host countries" (Wagle, 2013, p. 28). However, this paper suggests that it is not simply about the connection but also about *how* these connections are made, curated and managed and thus the qualities of and resulting from that work.

To illustrate how medical travel facilitation acts to create 'smoothness' in connecting, we follow Rashid,[1] a freelance facilitator based in Oman. He started this avocation after accompanying a friend who underwent a medical journey many years ago. He connects with potential medical travellers by running a group chat on WhatsApp, through which he shares information about treatment abroad and announces upcoming opportunities to meet with foreign doctors. This is an important move for business development and facilitators and healthcare providers at medical travel destination sites often connect first with facilitators in the patient's country. Such 'channel partners' seem to build trust more easily, and thus building such connections became a common strategy for mobilising patients towards the transnational healthcare market (Hartmann, 2019).

The following fieldnotes give insight into how connections between patients and healthcare providers are being mediated and smoothened by medical travel facilitation beyond the initial contact. We are set in a hotel lobby in Muscat on a Saturday afternoon. Rashid hosts an informal meeting in which people from his WhatsApp group can consult with an Indian doctor and the marketing team of a hospital in Kozhikode, India. One interested party, Mr S. has already made plans to travel to Kochi, another South Indian city, to get treatment for his wife, but they take the opportunity to get a second opinion.

> Rashid introduces Mr S. to the doctor who is offering consultations today and suggests they sit down around the table in the hotel lobby. Whilst they exchange a few words, Rashid guides the women and children to the nearby seating area and asks the receptionist to bring them the drinks menu. In the meantime, Mr S. askes his wife to bring the medical reports and to sit with them. The doctor looks through the documents and starts asking questions about different tests and symptoms. Mr S. speaks English but Rashid steps in to translate for the wife who is one of the patients. They talk about previous treatment and reoccurring health problems and the doctor recommends carrying out some further investigations to find the root cause of the illness. Mr S. is already convinced and says: "Okay, when can we go? We want to go now. We only have little time". The doctor responds: "You can come, it's easy". He is back in India on Monday and will prepare the investigation plan. During the next consultation, Mr S. goes outside to arrange the journey and Rashid takes the lead and translates between the other patients and the doctor. A few minutes later Mr S. is back; he cancelled the planned trip to the hospital in Kochi and booked flight tickets for Kozhikode instead, leaving on Monday morning. The hospital offers a complimentary airport pick-up, but Mr S. says that Rashid already told him that he has a friend who will be their driver. The marketing manager of the hospital says: "Rashid, if you were not there, it is not convincing. We need him [Rashid] to be there". (FN, January 18, 2018).

The facilitator creates smoothness with the ongoing active mediation of interactions during the meeting as a way of forging connections, building trust and confidence. Rashid introduces the parties to each other, participates in the consultation by offering translations and makes comments based on his experience and knowledge as well as the perceived needs of his clients. He continuously adjusts his involvement to the respective situation and needs. Here, Rashid also endeavours to manage the location and seating arrangements sensibly, and to make everyone feel comfortable. He is concerned with 'tending the tensions' (Bingham and Lavau, 2012), resolving any issues instantly should they arise during the consultation, and building trust among the parties involved. This capacity of building trust between actors and thus "the alteration of an existing tie by adding or increasing strength of a specific relational dimension" (Obstfeld et al., 2014, p. 144) are defining qualities of brokerage.

Trust building also shows that smoothness has a certain temporality. On the one hand, it is created in an in-situ manoeuvre in the act of facilitation. On the other hand, facilitators project smoothness as a quality on to the future medical travel experience. One of the managers of a medical travel company in Delhi says: "I'm not offering a medical treatment; I am not a doctor. I am not able to treat the patient. But I have to create a setting which ensures that no unexpected development takes place" (I.62). With such future contingencies in mind, it is the facilitator's task to create such an environment. This includes establishing reliable connections between relevant actors in the field and ensuring a continuous handover of patients and processes between them. This future projection of smoothness is cast by Rashid proving the ability to successfully organise the meeting, connect with trustworthy partners and interested clients and mediating their encounter. He and the marketing team ensure the handover to the team in India upon arrival and the transfer from the airport to the hospital is already taken care of, twice over. Practices of medical travel facilitation thus act to project and translate the capacity of forward connections into spatial and temporal smoothness. The effect of successful translations allows patients to move continuously (connectivity solution provided through handing over), quickly (established connections pave the way and prevent from losing time) and relatively directly (level of guidance prevents detours or getting lost along the way). This is reassuring for both parties: Patients feel like they are in safe hands for being facilitated by a local resident who has longstanding experience within this field. The healthcare provider also feels confident that these patients will actually travel to their hospital being provided with business by this entrusted channel.

Reflecting on this example, smoothness becomes a good with personal and commercial value. Whereas for the patients, the value lies in its contribution to the restoration of their health and the feeling of being well cared for along the way, for the hospital and the facilitator, smoothness turns into profit as it renders medical travel more feasible and thus mobilises clients. Smoothness, or the promise thereof, can be seen as a quality of the facilitation service that is transformed "temporarily into a tradable good in the market" (Callon et al., 2002, p. 199). Brokering activities build connections that relate and translate between actors and may result in "mutual enrollment and the interlocking of interests" (Mosse and Lweis, 2006, p. 13). But despite being members enrolled in the same care team, they have different stakes in co-creating smoothness. Medical travel facilitators as mediators in this process of translation (Latour, 2005, p. 65) are in a powerful position by defining their engagement and creating a suitable arrangement of people, places, things, etc. Building and maintaining these connections, being present and mediating interactions according to the situation and individual needs, and ensuring forward connections create smoothness and may be caring in that they reduce uncertainties, contribute to improving the experience of patients and make medical travel more feasible.

2.3. Communicating: translating across different languages and registers

This section looks at communication as a smoothing manoeuvre and

[1] All names changed.

the second set of practices central to medical travel facilitation. Cross-cultural communication in healthcare and nursing is complex and translation across different languages and registers may be further complicated by other socio-cultural peculiarities, emotionally charged situations and the need to negotiate the doctor-patient relationship (Davidson, 2001; Gunaratnam, 2008; Schouten et al., 2012). Participants in this research are ambivalent about whether problems with language translation persist despite the help of an interpreter or facilitator. On the one hand, they believe that with their help communication gaps between patients and medical staff can be closed, which also justifies their own services. One the other hand, some acknowledge that issues around language barriers can only be mitigated to a certain extent and not completely. This ambivalence is evident in the statement from the manager of the international patient department of a hospital in Kochi. First, she says: "Communication works, it is, the patients that come over here they don't need to speak in English. We have translators." (I.7) Then she concedes that some nuances and jargon are hard to convey, when staff, patients, or interpreters communicate in a language other than their mother tongue: "Some patients they speak English but when it comes to medical pain, they also find it difficult to express, also the local translators speaking English. They speak English but the medical thing this has to be – see, if some doctors explain to me some medical terms, it will be difficult for me to understand. But if it is in my mother language which is Malayalam mother tongue it will be much easier to get understood. (I.7)". Although translation bridges language barriers, some frictions in communication remain when it comes to conveying health-related sensations and medical jargon. Smoothness in communicating in a foreign language seems to be achievable only to some extent. Also, because translation is often provided by people who are not specifically trained for this role within the medical field and participants explain that they only acquire knowledge about medical matters and translation over time. Translation across different languages and registers constitute a balancing act of smoothing communication that, if done attentively, requires continuous tinkering to create an adequate level. During a medical consultation, interpreters need to simultaneously listen to the conversation, whilst also making sense of the medical matter and translate that accordingly. This means making immediate decisions about what to say, what to filtered out, and how to convey the meaning, whilst balancing understandability and simplifications with complexity and accuracy. A study by Fallah and Akbari (2017, p. 2) identified "omission, personal interpretations, replacement, and wrong usage of medical terms" as the most common mistakes of non-professional interpreters in medical contexts. Such errors can have drastic consequences and the marketing manager of a hospital clearly states: "Speaking a language is not the same as knowing a language. Only when you use a language regularly you get to know it. Otherwise, it is difficult. There are communication gaps. And errors can be fatal (I.10)".

Depending on the skills of the interpreters and the degree of their interventions in terms of simplifying translations, different levels of smoothness can be achieved. If the interpreter lacks translation or language skills, or the patients are overwhelmed with the amount of information and level of detail, communication may not be smooth enough and the process stalls. Or, on the contrary, communication may be particularly smooth if all those involved share a similar understanding of the subject matter and are able to navigate this knowledge system. However, communication could also be *too* smooth, for example if oversimplification bypasses critical details in favour of the comprehensibility and speed of process, which may have negative consequences later on and ultimately lead to "unsmoothness". Medical interpreting can thus act as a smoothing manoeuvre in the immediate moments of communication but also further down the line as it extends to the general proceeding of medical travel facilitation.

This conceptualisation of smoothness in communication, raises questions about the extent to which smoothness is achievable, desirable and considered to be 'good' that may also be relevant in other practices and contexts. Creating an adequate level of smoothness requires attentiveness and persistent adjustment to the circumstances and future contingencies and may be caring in its orientation towards improving understanding, enabling informed decisions, and advancing processes.

2.4. Coordinating: anticipating, aligning, and timing in medical travel logistics

The third set of practices that was identified in the empirical material as being particularly relevant for creating smoothness evolves around 'coordinating'. In transnational healthcare, "the full potential of this sector requires strategic planning and coordination among key players such as hospitals, medical travel agencies, hotels, and the medical tourists themselves" (Mohamad et al., 2012, p. 360). However, in much of the medical travel literature, 'coordinating' refers to overseeing travel logistics (Cormany and Baloglu, 2011; Turner, 2011; Snyder et al., 2012) without specifying it further. The following vignette thus unpacks such coordination work and how it acts to create smoothness through anticipation, alignment of human and non-human actors and timing.

We are with Nasim, a medical travel facilitator in Delhi, who is on the way to the international airport at 1:45am to receive a patient and coordinating the ambulance transfer to a hospital in one of the satellite cities of Delhi National Capital Region.

> While the driver navigates the traffic on that foggy night, Nasim checks the arrival time of the plane online and calls the driver of the ambulance provided by the hospital. It is tricky to coordinate the arrival of the patient, the ambulance and himself factoring in the traffic and the proceedings at the airport, but he has gained a lot of experience. He can estimate fairly well when to tell the hospital ambulance to leave for the airport, so it won't be there too early or too late. Nasim makes another phone call, and he is annoyed when it does not go through. I ask him what happened, and he tells me that he tried to call someone from the airline who is working on the ground at the airport. He says that he got to know this guy because he himself is flying frequently. He thought that connecting with someone who has access to the transit zone could be useful and one day they exchanged numbers. For a tip this man keeps an eye out on Nasim's patients and keeps him posted about what is happening, whilst the patients and attendants are in transit. (FN, December 6, 2017).

Nasim is concerned with continuously checking in that everything goes according to plan and aligning the ongoing contributions of the various actors involved in receiving the patient. Despite the place is beyond a traditional healthcare setting, they temporarily form a care team (Mol, 2008, p. 23) that works on improving the patients situation in this in-between space at the airport.

This example shows that smoothness is achieved by a combination of relatively fix logistical operations, that constitute some sort of a mobility infrastructure, and ad-hoc practices of finetuning to respond to the situation and processes as they unfold. The facilitator attempts to make the patients' experience – and his own work – smoother by routing them through the regulated space and administrative landscape at the airport and providing almost seamless handholding. This move of enrolling another person into assisting the patients transfer is an example of the "resourceful creativity" (James, 2011, p. 319) that brokers may display. This "trick", as Nasim calls it, is 'tending the tensions' in two ways: It anticipates difficulties medical travellers may face in the transit zone, which could cause delays in the carefully planned process and put patients under stress. Moreover, it is a way to connect with clients right upon arrival, which anticipates another issue, namely that of 'snatching patients'. It happens that patients are misled at the airport by strangers who speak their language and pretend to be their guide. Therefore, Nasim pays extra money to use a special entrance that allows people to wait and receive the new arrivals inside the building instead of waiting

with hundreds of others at the gates outside. The facilitator anticipates issues, manages the space and coordinates the arrival effectively with his knowledge and experience about travel routes and timing, about process flows and peculiarities of the business. Nevertheless, some tinkering is still required to fine-tune the situation.

> A man is heading towards Nasim; it is the person from the airline ground staff who is sometimes assisting his patients in transit but didn't take the phone call earlier. With a big grin because his helper turned up unexpectedly Nasim shows him a photo of the patient and attendant on his phone, gives names and flight details and asks him to go and find them. It is 3:30 a.m. when he returns and brings the news that the patient and attendant are both waiting outside. He had troubles recognising the attendant because he shaved his beard and doesn't look like on the photo anymore. On the way to the ambulance, we meet the attendant and Nasim gives him a heart-warming welcome, takes his suitcase and guides him to the car. (FN, December 6, 2017).

The anecdote about not recognising the attendant because he had shaved his beard shows just how important certain details are and how easily the process flow could break down, leading to delays and confusion. That night, however, the spatio-temporal manoeuvre of navigating the new arrivals through the various administrative steps and guiding them from the transit to the car park and from there to the hospital ambulance works smoothly.

The virtue of medical travel facilitation lies in coordinating the multiple actors and practices spatially and temporally in a way that smoothens the patients travel. Humans, and non-human entities such as mobile phone, photos, contact numbers, passports, visa, cars, stretchers, planes, and much more need to be aligned and ordered in a sensible succession. While Nasim waits for the attendant in the arrival hall overseeing the whole process and connected with others over his phone, his helper guides the patient through the special pathway of ambulance-assisted immigration. Meanwhile the hospital ambulance is approaching the airport and Nasim's driver is waiting in the car park for his call. To make it work effectively as a whole, time management is of particular importance.

> The airport ambulance driver is in a rush to hand over the patient. If the hospital ambulance does not arrive in the next 5 min additional charges apply. Nasim calls the driver and hands his phone over to the driver of the airport ambulance, so that the two can coordinate directly while he can move on to the next step. Nasim gets into the car from the backdoor to welcome the patient. He makes a few jokes to make the young man feel more at ease and in safe hands. Then, Nasim starts moving the stretcher so they can shift the patient over to the other car. As soon as it arrives, he gives directions to the men who all help to lift the patient. Nasim collects the handover forms and the patient's passport before he sends the ambulance to the hospital and calls his driver. In a swift movement he pays his helper from the airline 500 rupees and around 4:30 a.m. the driver follows the ambulance to the hospital. (FN, December 6, 2017).

This episode illustrates the importance of collaborative efforts in smoothing the transfer of the patient from one ambulance to the other and the benefit of having someone taking the lead in coordinating those efforts and holding the different practices together to work effectively and under time pressure. Nasim as the designated facilitator in the example is checking in with the other actors involved, connects them, and gives instructions so that eventually everyone and everything is in the right place at the right time, set with the necessary documents or equipment, doing their assigned task. Having the lead in coordination, it is upon Nasim as the broker to prioritise different tasks and decide on strategies on how to complete them best possible (Zarazaga, 2014, p. 29). Alignment as an "aspect of coordination" (Hönke and Müller, 2018, p. 339) "requires the ability to coordinate perspectives and actions in order to direct energies to a common purpose" (Wenger, 1998, p. 187). Knowledge and experience and the competences of individual actors are skilfully employed to anticipate possible difficulties, taking preventative measures and developing good practice of handling processes.

Based on this vignette of the carefully orchestrated airport pick up of an international patient, coordinating, and thereby creating smoothness, could be analytically divided in anticipating (working ahead, establishing good practice, preventing issues), aligning (cleverly associating and positioning people and non-human entities in space and time), and timing (managing time and overseeing the whole process). All of these practices take place in a tinkering manner that holds flexibility for situational fine-tuning and adjustments to the spatio-temporal set-up and the needs of different individuals. They contribute to making the medical travel experience smoother and more comfortable, and thus constitute a form of care beyond the actual medical treatment.

3. Conclusion

This paper advanced the empirically driven elaboration of 'smoothness' as a concept relevant for medical travel facilitation and brokerage more generally, and also for care. Connecting, communicating, and coordinating were analysed as three sets of practices that are integral to facilitating medical travel for dealing with major roughness and frictions of transnational healthcare, and for generating smoothness. They proved to be particularly important for handling a number of difficulties such as the disconnect between different parties, language barriers or logistical challenges. Unpacking these practices shows diverse ways in which medical travel facilitation acts to create smoothness that makes transnational healthcare more feasible in practice and possibly more caring.

Throughout the analysis smoothness has shown in three interrelated ways. It may be constituted as a disposition in the sense of a potential for smoothness that is held, for example, in the network or mobility infrastructure that simply needs activation and then provides forward connections or in the strategic enrolment of gatekeepers that facilitate future processes. Certain practices not only create smoothness in the immanent situation, but at the same time create a disposition for smoothness in future processes, which constitutes a particular temporality of smoothness. Smoothness as spatio-temporal manoeuvre refers to it being actualised or implemented in practices such as tending the tensions in a meeting, managing time and aligning the doings of multiple actors. Smoothness as a quality that results from medical travel facilitation can be seen in the smooth travel of people and things along the mobility infrastructure, in speedy processes or in the comfortable experience for patients and the manageable work for facilitators. The conceptualisation of smoothness as a disposition, outcome and spatio-temporal manoeuvre can be helpful to think through brokerage beyond the context of medical travel facilitation as other sorts of mediation may also work towards smoothness. Smoothness could become a quality or criteria on which mediation practices are calibrated.

Moreover, the modality of these practices that create smoothness resonates with prevalent conceptualisation of care in STS literature such as a "persistent tinkering in a world full of complex ambivalence and shifting tensions" (Mol et al., 2010, p. 14). The concern of medical travel facilitation with "how various actors (professionals, medication, machines, the person with a disease and others concerned) might best collaborate in order to improve, or stabilise, a person's situation" (Mol, 2008, p.23) suggests that these practices of socio-technical mediations are not simply setting up the logistical infrastructure to provide medical care to international patients but that they can themselves be a form of care. On the one hand, by managing 'roughness' by anticipating, mitigating, omitting or bypassing problems. On the other hand, by carefully planning ahead, attuning actors and things, and coordinating processes sensibly and in a well-timed manner. This involves tinkering with constellations of members in a patients care team, with the level of detail in medical interpreting, or with optimising timing. Mediating healthcare transnationally and making medical travel feasible is thus an ongoing

process of attentive and careful adapting, coordinating, testing, and fine-tuning in order to improve the situation of international patients but also that of the facilitators themselves. This suggests that medical travel facilitation in such a careful and tinkering manner is about more than an auxiliary brokerage service but can itself constitutes forms of care, for the patient and also for the work of medical travel facilitation.

Smoothness may consequently become a relevant quality not only for brokerage but also for care. However, this must be considered in a differentiated way. The examples discussed in this paper indicate that smoothness may not always be achievable, desirable or caring. The suitable level of smoothness is contingent with the specificity of any given situation and thus smoothness as a quality or criterion needs to be explored, adapted, and questioned situationally, in terms of what it enables but also what it hinders, and how it actually contributes to care, and to care for whom or what.

The conceptualisation of smoothness and the discussion it opens around tinkering for smoothness as a quality of care provides an example of how empirically derived categories can productively be brought in conversation with more established concepts. Considering aspects of medical travel facilitation and with-it creating smoothness as a form of care and a result of transnational tinkering efforts could inform the care literature in STS. Exploring smoothness as manoeuvre in space and time elaborates the spatio-temporal dimensions of tinkering. The care medical travel facilitation provides is of temporary and intermitted nature but particularly well-timed while being constituted by geographically dispersed actors and therefore often mediated virtually with only a limited time of co-presence. Such care is thus conditioned by very particular spatialities and temporalities that require some sorts of 'highspeed tinkering' that is mediated across virtual and physical spaces. The study takes tinkering beyond an intimate localised setting and thus raises the question of how it may be scaled up in transnational spaces. The spatial and temporal constraints may lead to glossing over certain deficiencies along the way because of the focus on the main objective of satisfactorily facilitating medical travel. Such potential drawbacks of calibrating care on smoothness need further elaboration.

All in all, this paper shall provide an impetus to think further about the concept of smoothness in relation to brokerage and care beyond the context of medical travel but also to be attentive to different forms of care and their absence in the transnational mediation of mobilities and healthcare.

Declaration of competing interest

No potential conflict of interest was reported by the author.

Data availability

The data that has been used is confidential.

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