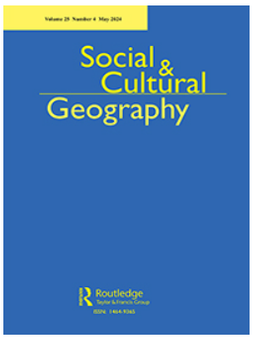

Social & Cultural Geography

ISSN: (Print) (Online) Journal homepage: www.tandfonline.com/journals/rscg20

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Sarah Hartmann

To cite this article: Sarah Hartmann (03 Apr 2024): Care ethics in transnational healthcare: attentiveness, competence, and responsibility in medical travel facilitation, Social & Cultural Geography, DOI: 10.1080/14649365.2024.2334953

To link to this article: https://doi.org/10.1080/14649365.2024.2334953

Published online: 03 Apr 2024.

SOCIAL & CULTURAL GEOGRAPHY
https://doi.org/10.1080/14649365.2024.2334953

Routledge
Taylor & Francis Group

Care ethics in transnational healthcare: attentiveness, competence, and responsibility in medical travel facilitation

Sarah Hartmann

Department of Geography, The Open University, Milton Keynes, UK

ABSTRACT

Travelling abroad and seeking healthcare beyond the national healthcare system is a reality for many patients, and a whole industry has evolved around medical travel over the last decades. Transnational healthcare is highly mediated, and different sorts of facilitators contribute to making medical travel more feasible and comfortable for international patients. However, the negotiation of different options, interests, and values around care is challenging, ethically complex, and compounded by the transnational context. This paper draws on care ethics to discuss the ways in which complexities around care are being negotiated through practices of medical travel facilitation between Oman and India. To do so, the paper analyses the process of selecting a healthcare provider abroad – one of the critical moments of mediating medical travel – in detail, with special attention to the ethical virtues of attentiveness, competence, and responsibility. The empirical data illustrates some of the ethical challenges around care, which are accentuated in transnational healthcare, and builds up a care ethic that allows for negotiations to be a situational and a collaborative effort towards a 'good enough' compromise.

RESUMEN

Viajar al extranjero y buscar atención sanitaria más allá del sistema sanitario nacional es una realidad para muchos pacientes, y en las últimas décadas ha evolucionado toda una industria en torno a los viajes médicos. La atención sanitaria transnacional está altamente mediada y diferentes tipos de facilitadores contribuyen a que los viajes médicos sean más factibles y cómodos para los pacientes internacionales. Sin embargo, la negociación de diferentes opciones, intereses y valores en torno al cuidado es desafiante, éticamente compleja y agravada por el contexto transnacional. Este artículo se basa en la ética de cuidado para discutir las formas en que se negocian las complejidades en torno al cuidado a través de prácticas de facilitación de viajes médicos entre Omán y la India. Para ello, el artículo analiza en detalle el proceso de selección de un proveedor de atención médica en el extranjero, uno de los momentos críticos de la mediación de viajes médicos, con especial atención

ARTICLE HISTORY
Received 24 June 2022
Accepted 4 February 2024

KEYWORDS
Care ethics; care work; transnational healthcare; medical travel; intermediary; competence

PALABRAS CLAVE
ética del cuidado; trabajo de cuidado; atención sanitaria transnacional; viajes médicos; intermediario; competencia

MOTS CLEFS
éthique du care; soins de santé; services de santé transnationaux; tourisme médical; intermédiaire; compétence

CONTACT Sarah Hartmann sarah.hartmann@unibe.ch Department of Geography, The Open University, Milton Keynes, UK

Present affiliation Department of Geography, University of Bern, Hallerstrasse 12, Bern 3012, Switzerland

a las virtudes éticas de la atención, la competencia y la responsabilidad. Los datos empíricos ilustran algunos de los desafíos éticos en torno al cuidado, que se acentúan en la atención sanitaria transnacional, y construyen una ética de la atención que permite que las negociaciones sean un esfuerzo situacional y colaborativo hacia un compromiso 'suficientemente bueno'.

RÉSUMÉ

Voyager à l'étranger et solliciter de l'assistance médicale hors du cadre des régimes nationaux de services de santé est une réalité pour beaucoup de patients, et au cours des dernières décennies une industrie tout entière s'est développée autour du tourisme médical. Les soins de santé transnationaux sont l'objet de facilitation à grande échelle, et toutes sortes de médiateurs contribuent à rendre le tourisme médical plus accessible et plus confortable pour les patients internationaux. Néanmoins, maitriser la gamme d'options, d'intérêts et de valeurs autour des soins est difficile, complexe sur le plan de l'éthique, et rendu plus compliqué par son contexte transnational. Cet article s'appuie sur l'éthique du care pour présenter les manières dont ces complexités autour des soins médicaux se négocient dans les pratiques de facilitation du tourisme médical entre l'Oman et l'Inde. À ces fins, il analyse le processus de sélection du prestateur de soins étranger, ce qui est un des moments critiques de l'organization du voyage médical, et accorde une attention particulière aux vertus éthiques de l'attention, de la compétence et de la responsabilité. Les données empiriques illustrent certaines des questions éthiques autour du care, qui se trouvent accentuées dans le cas des soins transnationaux, et forge une éthique du care permettant des négociations qui sont un effort collaboratif et situationnel vers un compromis « convenable ».

Introduction

Travelling abroad and seeking healthcare beyond the national healthcare system is a reality for many patients. A whole industry has evolved around medical travel over the last decades, due to global connectivity and people's increased mobility. Transnational healthcare is highly mediated and different facilitators contribute to making medical travel more feasible and comfortable. However, mediating healthcare transnationally is not a straightforward endeavour. Multiple spatially dispersed actors are involved in enacting healthcare transnationally. The necessary negotiation of different options, interests, and values around care is challenging and ethically complex, compounded by the transnational context.

Attending to the spatiality and the changing healthcare landscapes, geographers have engaged with the (im)mobilities of patients (Connell, 2011; Kaspar, 2019; Ormond & Lunt, 2020) and healthcare workers (England & Henry, 2013; Walton-Roberts, 2015) and advanced critical debates about transnational healthcare and the commodification of care more generally (Green & Lawson, 2011; Raghuram, 2008; Schilliger et al., 2022). This literature is relevant to medical travel, a prime example of globally marketized healthcare whose facilitation indicates gaps and additional care needs arising from the transnational context. Removing patients from their usual system of care and temporarily transferring

them to another creates a certain 'care vacuum'. Medical travel facilitation responds by occupying this niche in the transnational health market and prompts us to challenge our notions of who cares and how.

Medical travel facilitation accommodates a broad range of needs, from providing information and advice to making travel arrangements, attending to the patients' wishes and concerns, and offering companionship and comfort. Although the work of medical travel facilitators is an entrepreneurial and profit-oriented activity, this paper proposes an understanding of aspects of medical travel facilitation as a form of care in itself, rather than simply as a service to set up medical care. This orientation allows for the consideration of ethical complexities in everyday care situations (Gunaratnam, 2008; Whitmore et al., 2015) that are relevant to understanding the role of medical travel facilitation.

This paper analyses empirical examples of care mediation in the context of Oman and India that reveal the ambiguities of medical travel facilitation. I draw on the ethics of care literature to discuss how the complexities of care and its mediation are negotiated. The process of guiding patients through healthcare provider selection abroad, one of the critical practices of medical travel facilitation and one that is often criticized by practitioners and academics, serves as an example. I analyse ethical complexities such as the tension between patient autonomy and the need for assistance, the question of competencies, and the negotiation of patient and facilitator responsibilities in decision making, and situate these complexities within the commercialized setting. The analysis focuses on ambiguities in medical travel facilitation around three virtues of good care defined in care ethics (Tronto, 1995) – attentiveness, competence, and responsibility – to illuminate different values and how they relate in practice. Medical travel facilitators' narratives reveal, however, that they operate on a principle of 'good enough' compromises that allow patients to become medical travellers and the facilitators to sustain their business.

Context

Transnational healthcare and medical travel from Oman to India

Although medical travel is a well-established practice, over the last decades a medical travel industry has developed that caters to international patients (Botterill et al., 2013; Ormond & Lunt, 2020). Globalization, neoliberal restructuring of healthcare sectors, and privatization have changed the healthcare landscape, and the General Agreement on Trade in Services Act has liberalized international trade in health since the 1990s (Blouin et al., 2006). Market-based competition has resulted in shifts in medical travel destinations and countries of the Global South have positioned themselves successfully in the global healthcare market (Crush & Chikanda, 2015; Kaspar & Reddy, 2017).

India is seen as one of the leading medical travel destinations globally and private healthcare providers promote advanced technology, state of the art infrastructure, relative cost advantages, and doctors with proficiency in several medical disciplines (FICCI, 2019; Sen Gupta, 2015). The foundation for India's lead in the industry was a policy shift towards liberalization and privatization within the healthcare sector in the 1980s (Reddy & Qadeer, 2010; K. Smith, 2012). This shift opened up new opportunities for investments in private healthcare, and the government supported the building of corporate hospitals by providing land at concessional rates or with certain tax exemptions (Duggal et al., 2012;

Thomas & Krishnan, 2010). The development of medical travel as an industry, however, was mainly driven by private healthcare providers. India's government only recently started to promote it more actively when medical and wellness tourism was established as a special division under the Niche Tourism Department and the medical visa was introduced in 2006 (Bhaidkar & Goswami, 2017). The main hubs for medical travel are the National Capital Region (NCR) of Delhi, Bangalore, Chennai, Mumbai, Kolkata, and Hyderabad (FICCI, 2019; Qadeer & Reddy, 2013). In 2019, 63% of people arriving in India with a medical visa were from South Asia, 17% from West Asia, and 8% from Africa (Ministry of Tourism Government of India, 2019, pp. 41–45).

India is a top destination country for outbound medical travel from Oman. A considerable share of this medical travel is coordinated and funded by the Treatment Abroad Scheme, which was introduced in the early 1970s to offer healthcare to Omani citizens when treatment could not be provided locally (MOH Sultanate of Oman, 2014). A health care system in Western sense had only been established after a change of leadership by the Sultan in 1970 (Peterson, 2004). The Treatment Abroad Scheme still operates today, but the number of patients sent abroad is decreasing despite a growing population (MOH Sultanate of Oman, 2017). However, many patients travel abroad independently of the government scheme (Al-Hinai et al., 2011). India and Oman have longstanding geohistorical relations around commerce and trade, geopolitical interests, religious ties, cultural affinities, and the extensive labour migration from India to Oman and other Gulf states (Anjum, 2017; Kohli, 2014). As in many other areas, Indian immigrants are also present in the healthcare sector in Oman (Aravindhakshan, 2010). These entanglements shape the articulation of transnational healthcare spaces in defining ways (Hartmann, 2020) and challenge the narrative of a 'global' medical travel industry. The Treatment Abroad Committee that sent over 90% of the Omani patients seeking care in India in 2018 (MOH Sultanate of Oman, 2018) emphasizes cost savings, high quality of services and short waiting times, cultural similarities, and geographical proximity as important factors in medical travel to India. However, there is no bilateral agreement between the countries and the Treatment Abroad Committee deals directly with individual healthcare providers.

Medical travel facilitation

Medical travel facilitation bridges the gap between healthcare systems and fills in the support, and care as proposed here, needed to overcome the discontinuities resulting from the transnational set-up. Medical travel facilitators are most commonly conceptualized as brokers and service providers who connect patients with doctors or hospitals abroad, give information and advice on treatment options and destinations, and coordinate the journey (Mohamad et al., 2012; Snyder et al., 2012). There are different types of medical travel facilitators. Some work independently, in more or less formalized ways, including students, former patients, and taxi drivers who help patients as a side job. Others work for medical travel companies, the international patient department of a hospital, or for a designated government scheme. Their work ranges from online matchmaking, visa and travel assistance, and language interpretation to more comprehensive and personal on-site support.

Medical travel facilitators play an important role in setting up medical care transnationally, building connections and facilitating a 'hassle-free' experience (Abubakar & Ilkan, 2015). Snyder et al. (2012, p. 2) argue that 'brokers can play an essential role in facilitating communication, providing information, and securing overall quality control by assessing the reputability and reliability of international facilities'. As facilitators may take on authoritative and controlling roles, they are also referred to as 'patient advocates' (Dalstrom, 2013; Snyder et al., 2012) who represent the interests and rights of patients.

Medical travel facilitators are also important to healthcare providers as they channel patients looking for treatment on the global market to their hospitals. The prominent business model – prevalent in the study sites analysed here – is based on a commission structure in which hospitals pay facilitators for the admission of international patients. The agreements and amounts paid vary, but it is often a percentage of the patients' treatment costs. Therefore, medical travel facilitators are suspected of referring patients to expensive or high-commission-paying hospitals, or even of driving up treatment costs. Hospitals usually charge foreign patients an international mark-up fee. This business model raises ethical questions regarding healthcare provision for domestic and foreign patients and the incentives that may compromise facilitators' approaches (Snyder et al., 2012).

Despite these critiques, facilitators can also assume the role of a companion, providing personalized support for the patients' psychological and physical needs by performing emotional labour (Ormond et al., 2014). Some accompany patients over days or weeks on their medical journey, are available on site or constantly on call, and share the highs and lows with patients and their attendants. Some facilitators convey a sense of friendship and familiarity in their relationships, suggesting that they not only care *for* the patients' well-being, but also *about* the patients personally (Hartmann, 2021). Even in facilitators' articulation of their professional role, the boundaries between providing a service and helping those in need become blurred (Hartmann, 2017). Drawing upon a care ethics perspective can therefore further our understanding of the care work involved in transnational healthcare.

Conceptualizing care in medical travel facilitation through care ethics

Despite healthcare being at the centre, 'dimensions of formal and informal care work involved in international medical travel' (Bell et al., 2015, p. 288) and more specifically, care as a concept, are surprisingly under-examined. The study of Whitmore et al. (2015), however, sheds light on the informal caregiving of international patients' companions and conceptualizes features of that care from a care ethics perspective. For not being acknowledged as such by the industry, the authors 'posit that medical tourism reproduces dominant narratives about care in a novel care landscape' (Whitmore et al., 2015, p. 113). I have argued that practices of care are also offered in the more formalized setting of medical travel facilitation, but that this care work is often devalued because it is seen as merely organizational work of setting up healthcare transnationally and carried out as part of a business transaction (Hartmann, 2020). Nonetheless, in some more comprehensive facilitation models where facilitators and patients are in close contact, caring can unfold in the personal interactions and relationships, moving beyond logistical aspects of the work. In this paper I draw on the ethics of care as a conceptual framework to analyse

the mediations of care within medical travel facilitation and to discuss some of the ethical complexities involved.

The ethics of care is a normative ethical theory that has evolved from feminist and moral theory, and which resonates with current concerns around care and care work in geography (Bartos, 2019; Green & Lawson, 2011; Popke, 2006; Raghuram, 2016; Smith, 2005) and in other disciplines. It is a deeply relational approach that centres on relationships of interdependence and suggests certain ethical values in defining 'good care'. The four virtues of good care as defined by Joan Tronto (1995, p. 148) – attentiveness, responsibility, competence, and responsiveness – are widely recognized in the ethics of care literature and correspond with four phases of care: caring about, taking care of, care-giving, and care-receiving (Fisher & Tronto, 1990; Tronto, 1995). This entwinement of virtues and practices is central to the conceptualization of care within care ethics (Held, 2006; Raghuram, 2016). This paper builds on this foundation, allowing the practices of medical travel facilitators to reveal their ethical complexities. Given this focus on the 'care givers', the corresponding three virtues (Tronto, 1995) are mobilized to critically analyse how ethical complexities are negotiated in medical travel facilitation.

Methods and empirical material

This paper discusses data from a multi-sited research project that studied practices of medical travel facilitation between Oman and India between November 2017 and March 2018. In Delhi, Kerala, and Muscat, data was collected through semi-structured interviews, informal conversations with different interlocutors, and job shadowing. To better understand aspects of the facilitation work that happened before the moment of job shadowing, previous communication with patients and other stakeholders was examined with participants (e.g. email conversations and text messages). The initial analysis followed an approach inspired by grounded theory with iterative rounds of coding (Charmaz, 2006; Strauss & Corbin, 2008). However, for this paper I position my findings in conversation with care ethics, as many of the negotiations in medical travel facilitation relate to the virtues established in this theory.

Access to the field was gained through contacts established in previous projects, internet searches, snowball sampling, and being present in places relevant to medical travel (mainly hospitals and industry events). This combination of strategies allowed access to different people facilitating medical travel, including designated medical travel facilitators working for medical travel companies registered in India and Oman, facilitators employed by hospitals, individual freelancers, medical professionals, and people working for governmental or non-profit organizations related to medical travel, the healthcare industry, or relevant ministries. While the data provides a view into medical travel and an in-depth understanding of the facilitation work, the perspectives of patients and their attendants are not represented here. This paper draws on information shared by medical travel facilitators who were willing to participate in this study, and it is important to understand that the research context shapes the information that can be gathered. Out of the 84 interviewees facilitating medical travel, 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. Most managers in medical

travel companies had already been working in the healthcare industry before starting their company, many with a background in hospital management, marketing, and administration. Other facilitators had experience in tourism or language interpretation, and only very few had medical training.

Negotiating ethical complexities

Selecting a healthcare provider is a crucial process in medical travel facilitation. Patients who consider treatment abroad and pay out of pocket are theoretically free to choose any healthcare provider within their budget. However, as a medical lay person without much knowledge about healthcare providers abroad, assessing them from a distance is a significant challenge. Recasting patients in the context of 'healthcare consumerism in which self-empowered customers make savvy choices, actively self-managing their care' (Sobo et al., 2011, p. 129) disregards the lived reality of patients who often find themselves incapable of making autonomous and informed choices (Tronto, 2010, p. 159). In the case of transnational healthcare, the options multiply and the costs associated with this decision-making process rise accordingly. Obtaining trustworthy information about foreign healthcare providers and circumstances relevant to medical travel requires additional time and effort, making patients 'apprehensive about the practice' (Dalstrom, 2013, p. 30).

Selecting a healthcare provider is also important to medical travel facilitators. Assisting in this process is one of their core competencies, although the notion of 'competence' will be considered more carefully in the following sections. It is usually their first service, upon which the relationship with the patients and their families evolves and their trustworthiness is assessed. Being convincing is important for the facilitators' business because they will only be paid commission if they refer a patient to a hospital under their name.

I recast the practice of giving advice on selecting a healthcare provider as a caring encounter in which the facilitators and patients negotiate their needs and cocreate a 'good enough' option to move forward in the process. Analysing this process from a care ethics perspective highlights some of the complexities involved and illuminates how medical travel facilitators negotiate different values.

Attentiveness: understanding the patient's needs

Key to providing a satisfactory service is attentively assessing the patients' individual healthcare and assistance needs and to respond adequately. This highly relational component of facilitation acknowledges that making patients feel supported and empowered is a matter of attentiveness and care (White & Tronto, 2004). Caring about patients requires knowledge about their situation and attentiveness may involve 'listening to articulated needs, recognizing unspoken needs, distinguishing among and deciding which needs to care about' (Tronto, 1998, p. 15). Such care is based upon an orientation towards each other and a connection between the individuals involved (Fisher & Tronto, 1990). The scope of pre-travel facilitation and the attention given to the patients varies, and different models exist. Oman's Treatment Abroad Scheme has a standardized procedure that is limited in addressing individual needs. The committee decides based on the medical reports and the recommendation of the consulting doctors who is eligible for

treatment abroad. In a meeting they decide to which of their empanelled hospitals the patient should be referred. One employee explains how they choose the provider:

> It is according to their knowledge; they [the committee] are picking the treatment plans. Sometimes they are similar, and it is easy to choose but sometimes it is complicated. So, it is better for the committee to choose. Then they decide, all this should be decided by the Treatment Abroad Committee, because they are the one who are responsible. Whether it is beneficial for the patient or not. (I.25)

Here the facilitating and funding institution has control over the whole process of choosing a healthcare provider and as the interviewee indicates, they also bear the responsibility of ensuring a good outcome. Given that all committee members are doctors familiar with the process, they are considered competent in acting on behalf of patients. Patients are fully dependent on the funding institution's decision, which is also an economic one. Cost is a primary reason for choosing a healthcare provider in India compared to other medical destinations. However, other factors, such as the ease of collaborating with Indian hospitals, the support provided by a dedicated health attaché, the speed of handling cases, and the availability of appointments and specialists in Indian hospital, are important as well.

In contrast, both individual facilitators and medical travel companies participating in this study explain that they strive to attend to the patient's needs and wishes to deliver personalized guidance. Facilitators provide information regarding the process of medical travel and the benefits of their assistance, and the patients are asked to share their medical records and any requirements, wishes, or apprehensions about medical travel. This can happen in a meeting or through emails and phone calls. Preferences – such as for a particular doctor or hospital, medical procedure, or location – are discussed, as are the conditions of the trip, support from attendants, time availability, type of accommodation, and financial requirements.

The facilitators emphasize the importance of building a relationship of trust by providing reliable information and forward connections, keeping response times short, being available to discuss concerns, and continuously adjusting to the patients' wishes and circumstances. A facilitator working for a hospital in Delhi explains that, based on many years of experience, he puts himself in the other person's shoes to understand how they feel, and then makes them feel understood through his actions. 'You have to understand the person you are dealing with', he says (I.48). Each patient is assigned to a facilitator on his team. The interviewee elaborates, 'this individual is an expert in empathy and provides them [international patients] care knowing more about the whereabouts of the patients' (I.48). Care is provided by expanding the attentiveness from the pathology to 'the whereabouts' of the patients, suggesting more encompassing knowledge about different aspects of the patient's life. This involves reading cues about the situation in the patients' countries, their educational level, language skills, socio-economic status, religion, previous travel experience, personal desire for comfort, and need for support. One facilitator in Muscat usually meets with interested parties for a talk. In one such consultation, he looked through the medical reports the family brought along and listened to the description of recurring symptoms after treatment had already been sought in India. The facilitator inferred that they were dissatisfied with treating the symptoms and not the root cause and suggested further

investigations before pursuing other treatment. Through this initial assessment and the action taken to arrange a call with a specialist, the facilitator gradually gained trust. From the conversation, the facilitator learned that the family already had experience with medical travel and felt comfortable organizing the trip themselves. However, based on their language skills, he offered the support of a translator on site. Gathering information by listening, asking questions, and reading between the lines demonstrates the facilitator's orientation towards the patient, and helps to better understand the patients and respond to their needs. Eventually, a more personal relationship is established with patients and their families, and support can be attentively tailored to their needs.

Medical travel facilitators professionalize attentiveness to the patients' needs and may provide care in commercial settings. The commodification and professionalization of care is a contested subject (Green & Lawson, 2011; Hochschild, 2003; Lynch & Walsh, 2009; Madörin, 2010). One must consider the particularities of the type of relation in which care is performed and the fact that medical travel facilitators, like other professionals in the care industry, 'might have their own agendas in determining others' needs (Tronto, 2010, p. 163). Medical travel facilitation relies heavily on word-of-mouth (Hartmann, 2019), and to be successful in this business, it is not only important to provide a satisfactory service, but also to build a relationship with patients that could bring more business in the long run. Such incentives, however, do not necessarily diminish the attentiveness with which care is provided to patients.

Competence: giving advice as non-medical professional

Competence, the ability or skills to care, is another virtue upon which good care is calibrated (White & Tronto, 2004). Competent caregiving is based on knowledge that 'requires a more detailed, everyday understanding' (Fisher & Tronto, 1990, p. 10), skills, and the ability to adapt to any given situation. Beyond critiques of the intermediary role in general, the competence of medical travel facilitators in advising patients in the medical field is a subject of significant controversy. Representatives of the industry, the media, and academia question their competence since most facilitators are medical laymen (Snyder et al., 2012), their expertise is considered to be more in the field of tourism (Spece, 2010), and the quality of their information is questioned (Lunt et al., 2010). A representative of the Oman Medical Association shares this opinion and states that medical travel facilitators should not give medical advice:

> Medical travel companies, you know, they are facilitating the things, but they should have a limited role for this. They should not give medical advice. They should only facilitate the things. The medical provider or consultant who is actually specialized they should be licensed to process the things. (I.23)

The interviewee emphasizes the importance of professional and licenced consultants or healthcare providers in reviewing medical cases and advising patients and considers medical travel facilitators to be incompetent in these matters. Competence is described by the interviewee as skills and knowledge as well as formal qualification, indicating struggles over professional boundaries. Another interviewee in Kerala, a doctor who founded a medical travel company, agrees with this description and stresses that his

medical training and work experience in hospitals make him a competent advisor, unlike most of his colleagues who lack a medical background: 'some people travel with someone they can't trust. A taxi driver or travel agent cannot give you guidance, it's a doctor' (I.8).

Medical travel facilitators without medical training (almost all the participants in this study) attempt to mollify such concerns by arguing that they have acquired relevant competencies over time. They emphasize their longstanding experience in the field through which they have built connections with reputable healthcare providers and learned a significant amount about medicine, investigations, and treatments. In their daily routine of accompanying patients on-site, experienced facilitators blend in with hospital teams and procedures, handle medical jargon with ease, and discuss medical reports and possible treatment plans with healthcare professionals and patients so eloquently, that patients often mistake them for doctors. A facilitator of a company based in Muscat says that despite disclosing his background as a technical engineer, 'I sit with the people, and they are calling me doctor. There are people still calling me doctor' (I.26). Other participants shared messages and stories of being addressed as or mistaken for doctors by patients, which they presented as evidence of their competence. The manager of another medical travel company in Muscat extends his competence into other professions, saying that he is 'more than a doctor' (I.14): he believes that 'after handling thousands of patients' and learning how to communicate complex medical content to patients in a simplified way, he has attained enough knowledge to be a competent advisor. Such conscious and unconscious blurring between different roles can mislead patients and invites criticism of medical travel facilitators.

The facilitators' competence is mostly cast against that of medical professionals. However, doctors' competence is itself not fixed, but multiple (e.g. consisting of technical skills, accessibility, or caring competence) and valued differently at different sites. With particular attention to the virtue of competence in care ethics and by looking at professionalized skilled caring sectors, Parvati Raghuram elaborates that care competence is a dynamic construct that varies in different contexts and may be racialized and geopolitical: 'competence is not natural or obvious but is diverse because care itself is defined differently in different parts of the world' (2019, p. 620). The assessment of competence based on formal education shows how care intersects with intersectional categories and illustrates the dominance of certain Western standards that demean other qualifications and devalue certain forms of caring. However, the negotiations that unfold in medical travel facilitation between Oman and India show how context-specific constructions of care competence challenge established values and contribute to expand the concept of care. The facilitators argue that although they have no formal medical training, they gained knowledge about diseases and treatments on the job and bring other competencies that benefit international patients: knowledge about healthcare providers and how to assess them, skills in medical interpreting, networking capacities, coordination skills, expertise in cultural mediation, and experience in providing emotional support to patients and attendants. A medical travel facilitator working for a company in Delhi draws on his longstanding experience in the field to justify his expertise in selecting a healthcare provider with his patients:

Most of the time, we select the doctors. Because we have more experience than them [patients] and we know which doctor has more success rate, who has a lower budget, we

know better. (. . .) We are here, I am working here since 2011 so we know which doctors in Delhi, which hospitals have the better doctors, the best surgeon. (I.61)Competence is relative and this facilitator calibrates his level of competence against international patients' incompetence, reinforcing the asymmetry present in care relationships (Henderson, 2003; Lynch & Walsh, 2009).

Advising international patients on the grounds of one's competence illustrates how this practice becomes ethically complex. Firstly, it raises the question of which elements of a practice competence refers to, and whether there is a shared understanding or criteria by which competence is assessed. For example, does it refer to a service with a clearly identifiable scope or a caring practice in which the relational component is itself of particular value? Secondly, different types of competencies are negotiated. Formal training may be compared to experience gained on-the-job or pitted against competencies in other areas. A care ethics perspective illuminates how different understandings and competencies of care are negotiated and helps to situate different lines of argumentation. The analysis of medical travel facilitation then helps to broaden the understanding of what it can mean to care in the context of globalized healthcare. Ambiguity about the competence of the facilitators remains and is part of the negotiation of responsibilities when choosing a healthcare provider.

Responsibility: intervening in the decision-making process

Caring for someone means taking responsibility for meeting their needs (Tronto, 2010). To do so requires knowledge and the ability to judge the situation and anticipate future outcomes, drawing on 'the skill involved in choosing one course of action rather than another' (Fisher & Tronto, 1990, p. 42). Making decisions about how to proceed also comes with being 'accountable for the consequences' (Fisher & Tronto, 1990, p. 42). In selecting a healthcare provider, medical travel facilitators and patients – and their support network – are usually together in the decision-making process; with the aforementioned exceptions of the government sponsored scheme in Oman and facilitators employed by hospitals who only meet the patients after decisions have been made. Facilitators involved in the process of selecting a healthcare provider articulate an awareness of their responsibility. Commitment to patients varies from person to person, but many interviewees express that they care for them as they would for their own families, a position that entails a strong sense of duty: 'we basically replace the family. It's a huge responsibility' (I.46). While this quote reflects the facilitator's viewpoint, a more comprehensive understanding of how caring relationships are built requires a consideration of patients' and other stakeholders' perspectives. In addition to their emphasis on attentiveness and the justification of their competence, medical travel facilitators demonstrate their professional skills in evaluating situations and giving advice. Nevertheless, most of them are cautious in negotiating their responsibilities and accountability to patients, reflected in their reasoning and the way the decision-making process unfolds on the ground.

There is a consistent pattern in how medical travel facilitators participating in this study shape the patients' decision-making process of selecting a healthcare provider abroad. Facilitators respond to the patient's enquiry by making a pre-selection of healthcare providers in their network and creating a manageable shortlist of four to

six providers. Then the facilitators ask the patients to select a provider from this pre-filtered list, based on the treatment plan, cost estimate, and associated amenities. However, practices on the ground shed light on how responsibilities are actually negotiated.

> Sometimes the patient tells the interpreter that they are from outside of the country and you [medical travel facilitator] know better, who is the better doctor. So, you select them. (. . .) Sometimes the patient has a picture or a profile of the doctor, so then we take them to that doctor. But sometimes I assist in selecting the doctor. (I.61)

When this interviewee who has multiple years of experience working for a medical travel company in Delhi was asked how often he selects the doctor on behalf of the patient he responds, 'most of the time' (I.61). Although he emphasizes that they give patients several options, many report that patients ask for their personal opinion. The facilitators are thus often entrusted by the patients with the responsibility of selecting a healthcare provider. This is also the experience of a facilitator based in Muscat, who primarily works in another job but occasionally assists patients on an individual basis, and has been doing so for more than ten years:

> Or they leave it to me sometimes, many leave it to me: 'whatever, you decide for us'. Because they know I'm in the field, so you can give the proper advice. I've visited hotels and hospitals, I know the area, so wherever I am sending the patients I have seen it all. (I.33)

Most of the time, the responsibility of selecting a provider is shared and patients and facilitators co-constitute the decision-making process. This middle ground – between intervention and paternalism by the facilitator and patient choice and autonomy – has emerged as a promising strategy. On the one hand, this approach allows facilitators to demonstrate their competence in screening healthcare providers and giving advice, which strengthens their position as a broker or mediator. On the other hand, they ask the patients to make the final decision, either in recognition of the patients' autonomy, or as a strategy of evading responsibility for the outcome and to protect themselves in case of a patient complaint about the healthcare provider, or both.

In the interviews, facilitators demonstrate their awareness of this difficult terrain and justified their involvement in the decision-making process.

> Interviewee: Then I will contact the patient with the summary of what is my finding [regarding treatment options and healthcare providers]. But I would never insist that you should go to that hospital or that hospital.
>
> Interviewer: But you would give advice on which one to choose?
>
> Interviewee: Yes, sincere advice. But advise that is based on money that is not a good advice. (I.26)

Then I will contact the patient with the summary of what is my finding [regarding treatment options and healthcare providers]. But I would never insist that you should go to that hospital or that hospital. But you would give advice on which one to choose? Yes, sincere advice. But advise that is based on money that is not a good advice. (I.26)

This interviewee, the manager of a Muscat-based medical travel company, is concerned with clarifying that the patient is free to choose. Considering whether their advice is sincere and good, or corrupted by money, shows that the interviewee is

aware of the ethically complex situation and the power and responsibility involved in this practice.

The possibility that facilitators' advice may be biased by commission fees is a recurring issue. Exploring the 'ethical concerns about roles and responsibilities' in relation to facilitators, Jeremy Snyder et al. (2012, p. 7) discuss the 'potential for a conflict between the interests of the facilitators and those of patients' if facilitators receive payment from the hospitals in exchange for referring international patients. Incentives like commission fees or other benefits are likely to distort the relationship between the hospital, the facilitator, and the patient, and may interfere with acting in the patient's best interests. A failure of integrity towards the patient is particularly critical as patients relinquish a lot of control over their care to facilitators.

The interviewees explain that they consider several factors when shortlisting hospitals for the patients. Usually, the hospital's speciality or the reputation of a particular doctor is the most important criterion. However, extended fieldwork and job shadowing facilitators demonstrated that in practice, the recommended hospitals often reflect the facilitator's close network and their immediate geography. While facilitators based in Oman tend to have partners in different cities and countries, facilitators at the destination site are usually closely networked with healthcare providers in their city. Furthermore, facilitators are likely to pre-select hospitals with which they have had good experiences. If facilitators are on good terms with the hospital team, processes can be sped up and special requests are more likely to be granted. Multi-speciality hospitals seem to be preferred, as patients with different conditions can be sent to the same institution, making it easier for the facilitators to handle multiple patients on-site simultaneously. These hospitals can also be beneficial for patients, as it is not uncommon to discover further health complications once patients are on site. The facilitators' consideration of such factors and anticipation of future outcomes may not only reflect their own interests but can also be understood as taking responsibility, and patients may benefit from a facilitator's affiliation with a particular hospital.

Medical travel facilitators also offer a value proposition from which patients, who are in the hands of an individual acting in their interest, can benefit. As Spece argues, facilitators may invest a significant amount of work and the service they provide for patients and hospitals should be remunerated:

Many of these patients, moreover, would have no idea of whether or where they might obtain needed care without the involvement of medical tourism companies. These companies can only exist if they are adequately funded, and broker's fees might be the only practical way that a sufficient number of companies will be adequately funded. (2010, p. 21)However, the patient experience may be compromised if specialists or providers are omitted and if the facilitator is only motivated by money.

The question of whether medical travel facilitators have the responsibility to intervene as a component of their care work arises when patients are on the verge of making a bad choice or if they are committed to a less promising option, contrary to what the facilitator has suggested. Facilitators report that patients often hear about a particular doctor by word-of-mouth and then ask to be connected to that specialist, not knowing that another specialist might be better suited to their particular health concern. One of the Delhi-based facilitators working for a medical travel company shares such an example:

> One of my patients came to Bangalore and he contacted me from there and he said, 'I need the neurosurgeon here [in Delhi]' and I said, 'there is also a good doctor in Bangalore'. But his neighbour said the one here was good. So, the doctor contacted me and said, 'I have a patient who wants to go to Delhi for the neurosurgery'. So, we are ready to help. (I.61)

In this case, the doctor in Bangalore and the facilitator in Delhi suggested that the patient consider a different doctor, but the patient insisted, based on his neighbour's recommendation. This decision led to further travel and additional costs, but the facilitator respected the patient's wish and considered this option 'good enough' to support. Another interviewee who arranges medical travel from Oman on an individual basis reports a similar experience. He seems somewhat uncomfortable in situations where he cannot fully support the patient's wish and is not sure of his responsibility to intervene:

> Sometimes it is difficult to convince them [patients]. (. . .) But there are others who listen to the advice and listen and would like to go to any of the hospital that I recommend. People with some trust. But there are others who do insist. Because Hospital X in Y location is very famous in Oman. They say, 'I want to go hospital X, Hospital X, Hospital X'. But by and by they come to realize that there are hospitals that are even better than Hospital X. (I.33)

In this example, the hospital's reputation abroad undermines the suggestion of the local facilitators. This interviewee does not try to impose his opinion on the patient. Instead, he trusts patients to see what better options are out there, or he steers them there in more subtle ways. Multiple interviewees, however, clarify that when there is no treatment available, they feel morally obliged to communicate so clearly instead of raising false hope. This is also the opinion of the manager of a medical travel company in Delhi who is actively involved in initiating measures to improve the medical travel facilitation industry:

> As I told you, a guideline is there, moral and ethical values mean, ehm see, the relation with the patient is started when they share the query. The patients share their query in the last state of onco[logy], and there is no cure (. . .) If there is no treatment available, we don't say that you come and say there is a treatment available if there is no treatment (I.55)

According to the interviewee, caring for a patient in such a situation means responsibly assessing the opportunities and, if necessary, advising against medical travel.

These examples show that the negotiation of responsibility is a balancing act between facilitator interventions and patient autonomy. Patients often hand the responsibility of choosing a healthcare provider to medical travel facilitators, and to some extent, exclude themselves 'from making judgments because they lack expertise' (Tronto, 2010, p. 165). This dynamic may result in part from facilitators' active promotion of their knowledge and ability to give advice, implying 'that they know better than care receivers what those care receivers need' (Tronto, 2010, p. 161). Nevertheless, practices on the ground illustrate that responsibilities often shift between them and are shared in a compromise. The question of accountability, however, remains.

Discussion: working on a 'good enough' compromise

This paper looks at the process by which medical travel facilitators assist international patients in the process of selecting a healthcare provider. It analyses how ethical complexities are negotiated from a care ethics perspective with regard to attentiveness, competence, and responsibility as three virtues of care (Tronto, 1995, p. 142).

The first complexity involves respecting patient autonomy while remaining attentive to their need for assistance in undertaking medical travel, exemplified in choosing a healthcare provider abroad. Medical travel facilitators present themselves as assisting international patients in making informed choices. According to their narrative, providing patients with a pre-filtered selection of healthcare providers may enable them to make the next step towards accessing treatment abroad, without curtailing their autonomy too much and perhaps even empowering them in the decision-making process. Care might then be constituted in the attentiveness with which medical travel facilitation tries to find the balance between letting the patients choose and giving advice. Generating a compromise that may not be ideal but 'good enough' can be considered a form of care in the sense of being attentive and making an 'effort to improve the situation of a patient' (Mol, 2008, p. 20). For facilitators, the compromise seems to be 'good enough' if patients can move forward with their medical journey and if the assistance they deliver allows them to sustain their business, is manageable, and is compatible with their ethical principles. The importance of building and safeguarding a good reputation and the power of word-of-mouth in this industry limit the extent to which they can promote a profit-driven agenda without delivering a 'good enough' service, as I have argued before (Hartmann, 2019).

The second complexity centres around competence. Different sorts of competencies are being negotiated such as medical expertise, strategic manoeuvring in the transnational healthcare market, the ability to establish a rapport with patients, and the skills to communicate information. Competencies are valued differently shaped by intersectional and geopolitically coded attributions (Raghuram, 2019), and medical travel facilitators negotiate them by comparing and articulating 'good enough' combinations of competencies that speak to the patients' multiple needs. Moreover, by constituting competence as relative between individuals, facilitators argue that they are competent enough for the task of advising on the selection of healthcare providers.

The third ethical complexity emerges in negotiations around the facilitators' responsibility to intervene in the decision-making process while respecting the patient's wishes and pursuing their own interest. The data revealed a certain divergence between letting patients choose a healthcare provider themselves and the actual practice, in which it is often the medical travel facilitator's advice that is followed. This demonstrates that the ideal of patient choice often fails in practice, which is one of the main arguments elaborated by Annemarie Mol (2008) in her book *The Logic of Care: Health and the Problem of Patient Choice*. Patients may not have the resources to make well-informed decisions and the collaborative effort of multiple parties involved in their health project proves to be more promising (Mol, 2008, p. 4). Having competence or presenting themselves as competent enough, medical travel facilitators are entrusted with the responsibility of acting – ideally – with the patient and not on behalf of the patient. Nevertheless, being trusted for their experience, it is to some extent left to individual facilitators to find a compromise between their own interests and the patients' needs, challenging their integrity and responsibility to act ethically.

Conclusion

The commodification of healthcare on a transnational level requires additional support, and as suggested here, additional forms of care to make treatment abroad more feasible and convenient for international patients. Medical travel facilitation responds to the discontinuities in care caused by the transnational setup. Recasting the practice of giving advice on selecting a healthcare provider abroad as a caring encounter allows us to 'explore nontraditional caring practices' (Bartos, 2018, p. 68). These encounters give insights into the 'interstices of care (. . .) where engagement and negotiation, actualisation and failures of care are enacted' (Hanrahan & Smith, 2020, p. 232). Analysing the process of guiding international patients through healthcare provider selection from a care ethics perspective illustrates how medical travel facilitation aims to provide support in an attentive, competent, and responsible manner, as a form of care in and of itself. However, practices on the ground reveal the negotiation of ethical complexities that arise from attempts to comply with the virtues of good care (attentiveness, competence, and responsibility) and patient choice, while also considering practicalities and vested interests. These negotiations illuminate how different values are made to relate in practice and demonstrate that ethical values cannot be considered detached 'from other norms (be they professional, technical, economical or practical)' (Mol et al., 2010, p. 13). Certain ambiguities of medical travel facilitation and tensions between different values remain and are dealt with in the negotiation process. Care may unfold in the form of situational and collaborative efforts of those involved – in this case medical travel facilitators and patients – to craft a 'good enough' compromise oriented towards the overall aim – such as realizing treatment abroad. This study followed the facilitators' narratives, however, whether the compromise will be considered valid and caring by others cannot be anticipated. Following Parvati Raghuram's (2016, p. 512) call to 'remain alive to these tensions within care and to see the productive potential that they offer in theorising care' this paper suggests moving beyond normative values and attending to the negotiations that the empirical material reveals in order to grasp the caring realities on the ground and to eventually build 'care ethics back up' (Raghuram, 2016, p. 524).

Acknowledgment

I would like to thank the editors and anonymous reviewers as well as Prof. Karin Schwiter and Prof. Susan Thieme for their valuable comments and suggestions on earlier versions of this article. Furthermore, I would like to thank Prof. Parvati Raghuram and Dr. Nick Bingham for the supervision of the research this paper follows from. Special thanks go to all participants in this research for generously giving their time and sharing their insights.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

This research was supported by a PhD studentship from the Faculty of Arts and Social Sciences at The Open University (United Kingdom) and institutional funding from Prof. Karin Schwiter of the Department of Geography at the University of Zurich and from Prof. Susan Thieme of the Department of geography at the University of Bern for the preparation of the manuscript.

ORCID

Sarah Hartmann http://orcid.org/0000-0003-0239-4157

References

Abubakar, A. M., & Ilkan, M. (2015). Impact of online WOM on destination trust and intention to travel: A medical tourism perspective. *Journal of Destination Marketing & Management*, *5*(3), 192–201. https://doi.org/10.1016/j.jdmm.2015.12.005

Al-Hinai, S. S., Al-Busaidi, A. S., & Al-Busaidi, I. H. (2011). Medical tourism abroad: A new challenge to Oman's health system – Al Dakhilya region experience. *Sultan Qaboos University Medical Journal*, *11*(4), 477–484.

Anjum, F. (2017). Indian diaspora in GCC countries. *International Journal of Research Culture Society*, *1* (10), 82–88.

Aravindhakshan, B. R. (2010). Globalization of Health Care and medical tourism – a case study from Oman. *Asiabiotech*, *14*(1), 19–22. www.asiabiotech.com

Bartos, A. E. (2018). The uncomfortable politics of care and conflict: Exploring nontraditional caring agencies. *Geoforum; Journal of Physical, Human, and Regional Geosciences*, *88*, 66–73. https://doi.org/10.1016/j.geoforum.2017.11.010

Bartos, A. E. (2019). Introduction: Stretching the boundaries of care. *Gender, Place and Culture*, *26*(6), 767–777. https://doi.org/10.1080/0966369X.2019.1635999

Bell, D., Holliday, R., Ormond, M., & Mainil, T. (2015). Transnational healthcare, cross-border perspectives. *Social Science & Medicine*, *124*, 284–289. https://doi.org/10.1016/j.socscimed.2014.11.014

Bhaidkar, A., & Goswami, A. (2017). Medical tourism in India and the health policy of the NDA government: An overview. *Aweshkar*, *XXII*(1), 82–106.

Blouin, C., Drager, N., & Smith, R. (2006). *International trade in health services and the GATS. Current issues and debates*. The World Bank.

Botterill, D., Pennings, G., & Mainil, T. (2013). *Medical tourism and transnational health care* (D. Botterill, G. Pennings, & T. Mainil, Eds.). Palgrave Macmillan. https://doi.org/10.1057/9781137338495

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. SAGE Publications.

Connell, J. (2011). *Medical tourism*. CABI Publishing. https://doi.org/10.1580/1080-6032(2001)012[0066:MT]2.0.CO;2

Crush, J., & Chikanda, A. (2015). South–south medical tourism and the quest for health in Southern Africa. *Social Science & Medicine*, *124*, 313–320. https://doi.org/10.1016/j.socscimed.2014.06.025

Dalstrom, M. (2013). Medical travel facilitators: Connecting patients and providers in a globalized world. *Anthropology & Medicine*, *20*(1), 24–35. https://doi.org/10.1080/13648470.2012.747592

Duggal, R., Kurian, O. C., Bhate-Deosthali, P., & Wagle, S. (2012). Political economy of health care in India. *Health for the Millions*, *38*(4), 3–33.

England, K., & Henry, C. (2013). Care work, migration and citizenship: International nurses in the UK. *Social & Cultural Geography*, *14*(5), 558–574. https://doi.org/10.1080/14649365.2013.786789

FICCI. (2019). *India: Building best practice in healthcare services globally*. Federation of Indian Chambers of Commerce & Industry.

Fisher, B., & Tronto, J. C. (1990). Towards a feminist theory of caring. In E. Abel & M. Nelson (Eds.), *Circles of care: Work and identity in women's lives* (pp. 36–54). State University of New York Press.
Green, M., & Lawson, V. (2011). Recentring care: Interrogating the commodification of care. *Social & Cultural Geography*, *12*(6), 639–654. https://doi.org/10.1080/14649365.2011.601262
Gunaratnam, Y. (2008). From competence to vulnerability: Care, ethics, and elders from racialized minorities. *Mortality*, *13*(1), 24–41. https://doi.org/10.1080/13576270701782969
Hanrahan, K. B., & Smith, C. E. (2020). Interstices of care: Re-imagining the geographies of care. *Area*, *52*(2), 230–234. https://doi.org/10.1111/area.12502
Hartmann, S. (2017). The work of medical travel facilitators: Caring for and caring about international patients in Delhi. In *Geographien Südasiens* (p. 6). Geographien Südasiens). CrossAsia-eBooks. https://doi.org/10.11588/xabooks.251.33
Hartmann, S. (2019). Mobilising patients towards transnational healthcare markets – insights into the mobilising work of medical travel facilitators in Delhi. *Mobilities*, *14*(1), 71–86. https://doi.org/10.1080/17450101.2018.1533694
Hartmann, S. (2020). *Medical travel facilitation between Oman and India: Articulating spaces, creating smoothness and negotiating ethical complexities*. The Open University.
Hartmann, S. (2021). Caring for" and "caring about" international patients in Delhi. Medical travel facilitation between strategy and sympathy. In C. Vindrola-Padros (Ed.), *Care work and medical travel: Exploring the emotional dimensions of caring on the move* (pp. 91–114). Lexington Books.
Held, V. (2006). *The ethics of care: Personal, political, and global*. New York: Oxford University Press.
Henderson, S. (2003). Power imbalance between nurses and patients: A potential inhibitor of partnership in care. *Journal of Clinical Nursing*, *12*(4), 501–508. https://doi.org/10.1046/j.1365-2702.2003.00757.x
Hochschild, A. R. (2003). *The managed heart. Commercialization of human feeling*. University of California Press.
Kaspar, H. (2019). Searching for therapies, seeking for hope: Transnational cancer care in Asia. *Mobilities*, *14*(1), 120–136. https://doi.org/10.1080/17450101.2018.1533688
Kaspar, H., & Reddy, S. (2017). Spaces of connectivity: The formation of medical travel destinations in Delhi national capital region (India). *Asia Pacific Viewpoint*, *58*(2), 228–241. https://doi.org/10.1111/apv.12159
Kohli, N. (2014). Indian migrants in the gulf countries. In R. Dahiya (Ed.), *Developments in the Gulf region. Prospects and challenges for India in the next two decades* (pp. 115–147). Pentagon Press.
Lunt, N., Hardey, M., & Mannion, R. (2010). Nip, tuck and click: Medical tourism and the emergence of web-based health information. *The Open Medical Informatics Journal*, *4*(1), 1–11. https://doi.org/10.2174/1874431101004010001
Lynch, K., & Walsh, J. (2009). Love, care and solidarity: What is and is not commodifiable. In K. Lynch, J. Baker, & M. Lyons (Eds.), *Affective equality. Love, care and injustice* (pp. 35–54). Palgrave Macmillan.
Madörin, M. (2010). Care Ökonomie – eine Herausforderung für die Wirtschaftswissenschaften. In C. Bauhardt & G. Caglar (Eds.), *Gender and Economics. Feministische Kritik der politischen Ökonomie* (pp. 81–104). VS Verlag für Sozialwissenschaften.
Ministry of Tourism Government of India. (2019). *India tourism statistics 2019*.
Mohamad, W. N., Omar, A., & Haron, M. S. (2012). The moderating effect oF medical travel facilitators in medical tourism. *Procedia – Social & Behavioral Sciences*, *65*, 358–363. https://doi.org/10.1016/j.sbspro.2012.11.134
MOH Sultanate of Oman. (2014). *Health vision 2050. Quality care, sustained health*. Oman: Ministry of Health.
MOH Sultanate of Oman. (2017). *Statistics Treatment Abroad*. Department of the Ministry of Health.
MOH Sultanate of Oman. (2018). *International Centre for Statistics & Information* (p. 9).
Mol, A. (2008). *The logic of care. Health and the problem of patient choice*. Routledge Taylor & Francis Group. https://doi.org/10.4324/9780203927076
Mol, A., Moser, I., & Pols, J. (2010). Care: Putting practice into theory. In A. Mol, I. Moser, & J. Pols (Eds.), *Care in practice. On tinkering in clinics, homes and farms* (pp. 7–26). transcript Verlag.
Ormond, M., Holliday, R., & Jones, M. (2014). Navigating international medical travel: A three-country study of medical travel facilitators sending patients to Malaysia. *ISA Annual Conference*, Yokohama, Japan.

Ormond, M., & Lunt, N. (2020). Transnational medical travel: Patient mobility, shifting health system entitlements and attachments. *Journal of Ethnic and Migration Studies*, *46*(20), 4179–4192. https://doi.org/10.1080/1369183X.2019.1597465

Peterson, J. E. (2004). Oman: Three and a half decades of change and development. *Middle East Policy*, *11*(2), 125–137. https://doi.org/10.1111/j.1061-1924.2004.00157.x

Popke, J. (2006). Geography and ethics: Everyday mediations through care and consumption. *Progress in Human Geography*, *30*(4), 504–512. https://doi.org/10.1191/0309132506ph622pr

Qadeer, I., & Reddy, S. (2013). Medical tourism in India: Perceptions of physicians in tertiary care hospitals. *Philosophy, Ethics, and Humanities in Medicine*, *8*(20), 1–10. https://doi.org/10.1186/1747-5341-8-20

Raghuram, P. (2008). Thinking the UK's medical labour market transnationally. In J. Connell (Ed.), *The international migration of health workers* (pp. 182–198). Routledge. https://doi.org/10.5860/choice.51-2973

Raghuram, P. (2016). Locating care ethics beyond the global north. *ACME: An International Journal for Critical Geographies*, *15*(3), 511–533.

Raghuram, P. (2019). Race and feminist care ethics: Intersectionality as method. *Gender, Place and Culture*, *26*(5), 613–637. https://doi.org/10.1080/0966369X.2019.1567471

Reddy, S., & Qadeer, I. (2010). Medical tourism in India: Progress or predicament? *Economic & Political Weekley*, *XLV*(20), 69–75.

Schilliger, S., Schwiter, K., & Steiner, J. (2022). Care crises and care fixes under covid-19: The example of transnational live-in care work. *Social & Cultural Geography*, *24*(3–4), 391–408. https://doi.org/10.1080/14649365.2022.2073608

Sen Gupta, A. (2015). Medical tourism in India: Winners and losers. *Indian Journal of Medical Ethics*, *5*(1), 4–5.

Smith, K. (2012). The problematization of medical tourism: A critique of neoliberalism. *Developing World Bioethics*, *12*(1), 1–8. https://doi.org/10.1111/j.1471-8847.2012.00318.x

Smith, S. J. (2005). States, markets and an ethic of care. *Political Geography*, *24*(1), 1–20. https://doi.org/10.1016/j.polgeo.2004.10.006

Snyder, J., Crooks, V. A., Wright, A., & Johnston, R. (2012). Medical tourism facilitators: Ethical concerns about roles and responsibilities. In J. Hodges, L. Turner, & A. Kimball (Eds.), *Risks and challenges in medical tourism: Understanding the global market for health services*. Praeger.

Sobo, E. J., Herlihy, E., & Bicker, M. (2011). Selling medical travel to US patient-consumers: The cultural appeal of website marketing messages. *Anthropology & Medicine*, *18*(1), 119–136. https://doi.org/10.1080/13648470.2010.525877

Spece, R. G. (2010). Medical tourism: Protecting patients from conflicts of interest in broker's fees paid by foreign providers. *Journal of Health & Biomedical Law*, *VI*(1), 1–36.

Strauss, A., & Corbin, J. (2008). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (A. Strauss & J. Corbin, Eds., 3rd ed.). SAGE Publications. https://doi.org/10.4135/9781452230153

Thomas, G., & Krishnan, S. (2010). Effective public-private partnership in healthcare: Apollo as a cautionary tale. *Indian Journal of Medical Ethics*, *7*(1), 2–4. https://doi.org/10.20529/ijme.2010.001

Tronto, J. C. (1995). Care as a basis for radical political judgments. *Hypatia*, *10*(2), 141–149. https://doi.org/10.1111/j.1527-2001.1995.tb01376.x

Tronto, J. C. (1998). An ethic of care. *Generations: Journal of the American Society on Aging*, *99*(1), 15–20. https://doi.org/10.1016/S0002-9343(99)80127-2

Tronto, J. C. (2010). Creating caring institutions: Politics, plurality, and purpose. *Ethics and Social Welfare*, *4*(2), 158–171. https://doi.org/10.1080/17496535.2010.484259

Walton-Roberts, M. (2015). International migration of health professionals and the marketization and privatization of health education in India: From push–pull to global political economy. *Social Science & Medicine*, *124*, 374–382. https://doi.org/10.1016/j.socscimed.2014.10.004

White, J. A., & Tronto, J. C. (2004). Political practices of care: Needs and rights. *Ratio Juris*, *17*(4), 1–30. https://doi.org/10.1111/j.1467-9337.2004.00276.x

Whitmore, R., Crooks, V. A., & Snyder, J. (2015). Ethics of care in medical tourism: Informal caregivers' narratives of responsibility, vulnerability and mutuality. *Health & Place*, *35*, 113–118. https://doi.org/10.1016/j.healthplace.2015.08.004