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Narratives of emotion and anxiety in medical tourism: on *State of the Heart* and *Larry’s Kidney*

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This paper explores the emotional geographies of *State of the Heart* and Larry’s Kidney—two nonfiction narratives about medical tourism wherein American patients and their caregiver companions travel abroad for life-saving surgeries. The paper has two main goals: first, to illustrate the importance of emotional geographies in medical tourists’ lived experiences of travel and tourism, as well as the giving and receiving of transnational health care and second, to generate empirical, theoretical, and methodological discussions between geographical, travel, tourism, and health studies on the relevance of emotional geographies. Medical tourists’ experiences of travel and health care have been usually examined as spatially distinct rather than as entwined phenomena. We address the above goals by discussing how the narratives of traveling thousands of miles to a radically different socio-cultural milieu in order to receive essential medical care produce two interrelated emotional geographies: first, they demonstrate the existence of ‘emotional amplification’ (increase in the intensity of emotions) and ‘emotional extensivity’ (increase in the range of emotions) and second, they show how anxiety is underpinned by proximity to Otherness, uncertain boundaries, and isolated decision making. We conclude by briefly addressing how our examination of these narratives can be usefully expanded.

Key words: medical tourism, emotional geography, anxiety, India, China.

Introduction

Medical tourism (MT) involves patients traveling abroad to intentionally access private medical services that range from minor elective surgery to life-saving operations, which are typically paid for out-of-pocket (Ramirez de Arellano 2007). Medical tourists sometimes stay abroad for part, if not all, of the immediate post-operative recovery period at resorts that cater to international patients (Marlowe and Sullivan 2007). Patients, especially from the...
Global North, are increasingly traveling around the world to access procedures such as plastic, orthopedic, and cardiac surgeries. Prominent destination countries, many of which are in Asia, Latin America, and the Caribbean, actively promote the medical services they have available to international patients, viewing the industry as an opportunity to bring in resources (Jenner 2008). Growth in this multibillion dollar industry has been assisted by push factors such as high costs and lengthy waiting lists for procedures in patients’ home systems (Cheung and Wilson 2007) and pull factors such as the high quality of care available abroad (Kangas 2007).

Recently, health and social scientists have paid increasing attention to the phenomenon of MT. Scholarly and popular literatures routinely emphasize that there is a lack of reliable data on the total number of medical tourists and that their motivations are highly varied and context dependent (Crooks, Kingsbury, Snyder and Johnston 2010). Scholarly attention has mainly focused on the system-level impacts of MT. These include accounts from legal scholars who have focused on issues of the adequacy of medical malpractice laws in destination countries (Cortez 2008); ethicists who have questioned whether or not the industry is ethically defensible (Cohen 2010); tourism scholars who have explored the travel and business aspects of the industry (Heung, Kucukusta and Song 2010); and health services and policy researchers who have characterized the inequitable impacts of MT on destination countries and patients’ home nations (Hopkins, Labonté, Runnels and Packer 2010). While this scholarly work has offered some important critical insights into the practice of MT, it is sharply contrasted with media accounts that typically offer more experiential perspectives. Newspaper articles and television reports about MT often focus on the stories of individual patients, using these first-hand accounts to illuminate the risks and/or benefits associated with going abroad for care (Brown 2008). These accounts bring an experiential aspect to the global practice of MT, conveying what it is like to actually receive care abroad. Although some scholarly research on MT has offered experiential accounts (Soloman 2011), it is overwhelmingly dominated by a system-level focus and therefore does not effectively convey the lived dimensions of medical tourists’ journeys.

MT is an inherently geographic process because it consists of the movement of patients and their companions across borders, people’s exposure to new spatial contexts of life and cultures of care, and the global flow of capital and policy across space. And yet, there is a paucity of studies on the geographical dimensions of MT. A useful way to investigate MT’s complex human geographies is to focus on people’s experiences of traveling to different parts of the world in order to seek medical treatment. Emotions provide rich material for exploring experiential accounts (Ahmed 2004), and within geography emotions are central to the burgeoning subfield of emotional geographies. Davidson and Smith (2009) contend that emotions matter for geographers because they underpin almost all human relations, motivate much of people’s behavior, enable attachments and separations from people and places, as well as profoundly mediate people’s worldly experiences (see also Bondi, Davidson and Smith 2005; Ettlinger 2009). In this paper, we respond to a recent call by Davidson and Milligan (2004: 523) for research that allows geographers to ‘become better placed to appreciate the emotionally dynamic spatiality of contemporary social life.’ They also suggest that ‘much work remains to be done and…many connections remain to be made’ in emotional geographies (Davidson and Milligan 2004: 528). MT comprises one of
the domains in which the complex connections between emotions, space, and society have yet to be examined.

We believe emotional geographies are a vital aspect of medical tourists’ experiences of travel and tourism, and the giving and receiving of health care. Yet these two issues have been routinely examined as spatially isolated rather than as geographically related phenomena (although see Soloman 2011). In other words, while the MT literature does not completely ignore the importance of patients’ emotional experiences (Bookman and Bookman 2007), there is a lack of sustained theoretical and empirical research on how exactly emotions take place in MT and what types of emotions typically accompany MT spaces. In tourism studies, researchers have explored the role of emotions in terms of, for example, mood and leisure (Hull 1990), pleasure and motivation (Goossens 2000), the politics of enjoyment (Kingsbury 2005), and the authenticity of place (Knudsen and Waade 2010). Meanwhile, in health studies, researchers have examined the place of emotions in doctor–patient interactions (Smith et al. 2011) and emotion-focused coping strategies (DeCoster and Cummings 2004), among many other areas (Andrews and Evans 2008). We believe that there needs to be a convergence of these issues in these distinct bodies of literature in order to begin to comprehend the emotional geographies of MT.

This paper, then, seeks to incite empirical, theoretical, and methodological conversations between travel, tourism, and health studies by exploring the emotional geographies of MT. We aim to contribute not only to the growing scholarship on emotional geographies but also to the emerging health geography literature that has taken the emotional aspects of giving and receiving care as its focus (Conradson 2005; Evans and Thomas 2009; Lee, Kearns and Friesen 2009). To do this, we examine the experiences of medical tourists and their caregiver companions recorded in the published autobiographies State of the Heart (Grace 2007) and Larry’s Kidney (Rose 2009). We have chosen to use autobiographical books as the basis for our consideration of the emotional geographies of MT because they are the most comprehensive first-hand narratives available on the experiential dimensions of going abroad for private medical care. While our sample only includes only two such books, it nonetheless represents an exhaustive review of full-length nonfiction English-language books written by people involved in obtaining medically necessary care abroad through MT. We return to this point below.

Echoing Johnson’s (2004) assertion of the importance of ‘fictional journeys’ and ‘tourist trails’ for critical geographic inquiry, as well as Philo’s (1992) use of a quasi-autobiographical text to encourage innovative empirical and theoretical research, in this paper we carefully track emotional instances in two texts. Specifically, we identify when and where emotions are written into the narrative and consider the spatial contexts that reciprocally produce and are produced as they take place. Drawing on autobiographical texts demands an awareness of the politics of authorship, wherein the scenes that are presented, emotions that are described, characters that are depicted, and so on necessarily proceed from the embedded, partial, and interested perspectives of the authors. We elaborate further on this point in the following section that provides important background on the two main narratives.

We argue that the narratives of MT illustrate two interrelated emotional geographies that result from traveling thousands of miles abroad in order to stay alive. The first is broad and consists of ‘emotional amplification’, that is, an
increase in the intensity of emotions, and ‘emotional extensivity’, that is, an increase in the range of emotions. The second emotional geography is partly a result of the former and is more specific wherein it consists of three socio-spatial dimensions of anxiety: proximity to Otherness, uncertain boundaries, and isolated decision making. There is a paucity of research in tourism studies about the role of anxiety in travel (Reisinger and Mavondo 2005) and although there are studies on anxiety in relation to narratives of health care (Reeve, Lloyd-Williams, Payne and Dowrick 2010), these studies normally focus on patients’ experiences in their own countries rather than those in a different part of the world. Our paper addresses both of these research lacunae.

State of the Heart and Larry’s Kidney

Table 1 provides an overview of the main similarities and differences between State of the Heart (2007) and Larry’s Kidney (2009), both of which chronicle the experiences of American patients traveling abroad for necessary surgery. Importantly, both texts are written and narrated by the caregiver companions. Thus the narratives of the events, characters, scenarios, and so on are necessarily inflected through the positionalities of the caregiver companions. State of the Heart, written by Maggi Ann Grace, focuses on a patient, Howard, who seeks treatment in India for a heart defect. His caregiver companion and romantic partner, Maggi (the author), accompanies him. Larry’s Kidney, written by Daniel Asa Rose, chronicles Larry’s trip to China in search of kidney with Dan (the author), Larry’s cousin and caregiver companion. The two narratives have some similarities in terms of the context of their emotional geographies, in that both India and China present significant socio-cultural challenges for the American patients and their caregiver companions. In terms of differences, the degree of planning regarding going abroad for medical care seems to have a profound impact on people’s emotional experiences. Whereas State of the Heart, which involves planning before the trip, mainly consists of emotional upheavals inside specialized hospitals once in India, Larry’s Kidney, which involves short-term planning en route, focuses on the turmoil of the search for a viable kidney on the Chinese black market.

In seeking to examine the emotional geographies of State of the Heart and Larry’s Kidney, we each independently read the books while separately recording what we saw as significant emotional instances. Five meetings were held during the reading of the books, which served as an opportunity to discuss emerging themes, compare and contrast the narratives, as well as confirm our interpretations. Dominant emotional themes within the narratives were discussed until consensus was reached regarding their relevance to our aim of uncovering the emotional geographies of MT as they are lived out through the giving and receiving of transnational medical care. We therefore conducted a thematic analysis of the emotional instances in these autobiographical narratives, using passages in the books, our notes, and our discussions as the material for analysis and couching what we found within the context of the existing MT and emotional geographies literatures.

Before turning to our theorization of the broad emotional geographies that permeate the two texts, it is important to acknowledge our positionalities and how we interpreted the texts. In terms of the former, we are two females and three males all aged between 20 and 40. Each of us is English-speaking, middle-class, Caucasian, university-educated,
Table 1: A comparative overview of the autobiographical narratives.

<table>
<thead>
<tr>
<th>Author’s role</th>
<th>State of the Heart</th>
<th>Larry’s Kidney</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caregiver companion’s name</td>
<td>Caregiver companion (medical tourist’s partner)</td>
<td>Caregiver companion (medical tourist’s cousin)</td>
</tr>
<tr>
<td>Medical tourist’s name</td>
<td>Maggi</td>
<td>Dan</td>
</tr>
<tr>
<td>Medical tourist’s age at time of travel abroad</td>
<td>53</td>
<td>Larry</td>
</tr>
<tr>
<td>Medical tourist’s age at time of travel abroad</td>
<td>Kidney failure</td>
<td>Mid-50s</td>
</tr>
<tr>
<td>Medical tourist’s medical condition</td>
<td>Flailing mitral valve (heart condition)</td>
<td>Kidney transplant</td>
</tr>
<tr>
<td>Medical procedure sought abroad</td>
<td>Heart surgery</td>
<td>Wanted to avoid transplant list</td>
</tr>
<tr>
<td>Reason for engaging in MT</td>
<td>Underinsured and needed to save money</td>
<td>wait time for a donor kidney</td>
</tr>
<tr>
<td>Planning of surgery</td>
<td>Scheduled and organized before departure</td>
<td>China</td>
</tr>
<tr>
<td>Basis for choice of hospital</td>
<td>Caregiver companion’s son recommended the heart surgeon, who he met while training abroad in India as part of his medical school program</td>
<td>USA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Scheduled and organized once in-country</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The caregiver companion met a contact once in China who gave him information for a hospital where he could obtain the surgery and purchase a kidney</td>
</tr>
<tr>
<td>Length of trip abroad</td>
<td>2 weeks</td>
<td>2 months</td>
</tr>
<tr>
<td>Tourist activities pursued</td>
<td>Only post-surgery (e.g. visiting local tourist sites, traveling to a nearby city for a day trip)</td>
<td>Throughout the trip (e.g. visiting local markets)</td>
</tr>
<tr>
<td>Complications experienced</td>
<td>A second heart surgery was required while in India. Upon returning home, Howard suffered problems with the prescribed blood thinners and was admitted to hospital</td>
<td>Complications requiring medical attention occurred once back in the USA due to improper usage of anti-rejection medication.</td>
</tr>
</tbody>
</table>
and North American. In addition, most of us had visited MT health care facilities in the Global South. In many ways, then, we were able to identify with some of the anxieties in the caregiver companions’ narratives. In terms of the latter, there are numerous theoretical approaches to reading texts in geography such as phenomenological, post-structural, post-colonial, psychoanalytic, and feminist approaches to name just a few. Each of these approaches is not only interrelated but also internally differentiated. For example, post-structural approaches include deconstructive, genealogical, and schizoanalytic readings. Rather than restrict our paper to one theoretical conceptualization of textual interpretation, our goal is to alert geographers to the main issues of the geographies of emotion and the centrality of anxiety. Subsequent research can then examine the utility of different theoretical frameworks for developing more comprehensive and nuanced understandings of the main emotional issues we expand upon herein.

We also wish to acknowledge some key limitations of our approach. We have already stated that State of the Heart and Larry’s Kidney represent all full-length nonfiction English-language books written on and by people obtaining medically necessary care abroad through MT. Our sample, then, does not include fictional accounts of MT such as Cook’s (2008) Foreign Body. While there are numerous books on MT that include medical tourists’ anecdotes about their experiences, as well as comparable narratives in, for example, transgender communities on traveling for gender reassignment, our purpose was to only examine full-length autobiographies so as to be able to consider emotional instances in the narratives within as much context as possible.

We should also note that our sample is not intended to represent the majority of medical tourists’ emotional experiences, especially when there is no reliable data on the trends of who is going abroad for medical care that could serve as a basis for establishing representativeness (Crooks, Kingsbury, Snyder and Johnston 2010), nor are the texts we have considered free of class, gender, race, ethnic, national, and other socio-subjective biases. What they do offer that is unavailable to academic analyses is an in-depth, sustained, multiscalar, situated, personal, and above all emotionally interested accounts of the extent to which distance and travel underpin the emotional geographies of two MT narratives. In addition, these two texts provide insights from the perspective of the caregiver companions as opposed to the perspective of the person who is primarily ill or is in need of medical care. Thus, these two texts offer unique insights into the arguably marginalized voices of caregiver companions rather than the patients or ill protagonists that dominate MT studies and the narratives of ‘illness stories’ (Frank 1995).

Emotional amplification and extensivity

According to Davidson and Smith (2009: 440), emotions are

paradoxically, both inordinately diffuse and all-pervasive and yet also heart- and gut-wrenchingly present and personal; sometimes moods seem to envelop us from without, sometimes emotions seem to surge up from within and comprise the very core of our being-here in the world, our human existence.

Emotional geographies, then, are extremely complex and varied because they dynamically
take place amidst the interstices of the particular and the universal, the fleeting and the obdurate, as well as the outside impersonal world and the recesses of our innermost being.

What are the major contributions of the emotional geographies literature? Briefly, while theoretically diverse, much of the subfield is united by skepticism toward Cartesian and positivistic conceptualizations of space, society, and subjectivity. In response to simplistic Cartesian dualisms of matter versus mind, object versus subject, and reason versus emotion, as well as positivism’s overreliance on objectivity, measurement, predictability, and repeatability, geographers have used phenomenological, feminist, psychoanalytic, and non-representational theories to assert the complex, dynamic, contextual, historical, and thoroughly social dimensions of emotional spaces. Taking inspiration from the phenomenological emphasis on experiential and embodied senses of self and world, Tuan (1977) has explored emotional attachments to place and Casey (2001) has examined the relationships between perception and landscape. Feminist theories have informed Pain’s (2008) work on ‘globalised fear’ as part of the war on terror and Thien’s (2005) studies of women’s emotional lives and well-being. Psychoanalysis has oriented Sibley’s (1995) writings on the emotional underpinnings of social exclusion and Pile’s (2005) investigations on the emotional work of urban life. Nonrepresentational theories of emotion and affect have guided Thrift’s (2007) inquiries into political performances and capitalist commodification, as well as a wide-ranging work on the ‘more-than-human’, nature, representation, ethics, care, the political, and the environmental (Anderson and Harrison 2010).

Fundamental to the complex emotional geographies of State of the Heart and Larry’s Kidney are the long and winding journeys through specific places that produce and are produced by emotions. In the former text, for example, in India, the hospital is constructed as a medical site in which Howard is a patient, while the hotel is a recovery site in which he and Maggi take on the role of tourist. At the outset, Maggi portrays the hospital as a place brimming with promise, hope, and healing, while the hotel and other nonclinical environments are connected to enjoyment, cautious optimism, and discovery. This distinction, however, is not realized in practice because of the post-operative complications that Howard continued to experience throughout his recovery while still in India. Instead, both the hospital and nonclinical spaces such as the local community and other tourist destinations are read as sites of anger and frustration. As such, Howard and Maggi struggle on a profoundly emotional level with reconciling their desires as tourists with the sheer necessity of enabling Howard the recovery time and space that he needs during their stay at the hotel.

What drives much of the plot and action in Larry’s Kidney is the surprising extent to which socio-emotional values are not only generated through the book’s singular places but also responded to and constructed with pre-existing emotions. Here, we read of Dan’s descriptions of how taxis, a synagogue, Tiananmen Square, cafeterias, and numerous waiting rooms materially enlace Larry and himself into their unique obstacles and opportunities, which give rise to fleeting yet intense emotional states. From this perspective, Larry’s Kidney illustrates a key challenge for medical tourists: not so much achieving the desired health outcome such as a successful kidney transplant, but rather the ability of the medical tourists to successfully navigate and overcome the numerous emotional challenges that arise through a prolonged and uncertain
journey. Such a challenge brings to the fore the role of place in healing, which is already an established area of health geography inquiry (Gesler et al. 2004; Kearns, Barnett and Newman 2003; Smyth 2005). Yet there is a paucity of studies that examine where, why, and how these places of healing are emotionally registered as a result of traveling across and within places both near and far.

While tourists and patients cannot avoid emotional experiences, these published narratives reveal that it is highly likely that medical tourists experience similar emotions as these groups, but to a much greater degree. Research on emotions in travel has already emphasized that vacationing in unusual destinations, especially those in the Global South, can foster strong emotions such as anxiety about harassment (Kingsbury 2005) and attachments to authentic places (Knudsen and Waade 2010). Similarly, emotions in health care are often elevated when coping with the prospect of possible death (DeCoster and Cummings 2004) and during doctor–patient interactions (Smith et al. 2011). By uniting the processes of travel and health care, experiencing extremes of emotions becomes highly probable, if not unavoidable. That is to say, emotional amplification—the increased intensity of individual emotions—is central to the narratives of MT. By compounding the distance from home (a component of tourism) with isolation and a lack of spatial freedom in the hospital environment (a component of health care), MT considerably and forcibly intensifies emotions such as loneliness, anxiety, and joy. In Larry’s Kidney, for example, Dan tells us how, in 6 weeks, Larry had ‘been yanked away from everything safe and reliable in his life and had been exposed to trauma and fear. Broken down to his core, it’s like he’s been depatterned so he could be reprogrammed’ (pp. 234–235).

The above examples of emotional displays alert us to another distinctive characteristic of emotions in the MT narratives: emotional extensivity, that is, the increased range of different emotions, when compared to patients or tourists alone, and their stretching across space. In State of the Heart, for example, Howard and Maggi not only experience amplified emotions; they also experience an extremely extensive array of emotions ranging from utter terror to vehement anger to exceptional relief. Maggi tells us how Howard’s pursuit of heart surgery teems with numerous emotions including nervousness about the impending journey, jollity after his body shave for catheterization, anxiousness when deciding about surgery procedures, sadness when he was admitted into hospital in the USA upon returning from India, and affection toward India when both he and Maggi returned to everyday life. Emotional extensivity also refers to how medical tourists’ mobility stretches out or extends emotions across large physical distances that comprise a vast range of different socio-spatial contexts. The gravity of a potentially life-saving procedure does not determine Maggi and Howard’s emotions alone; they are also determined by the diversity of places they encounter. As international travelers and tourists, Howard and Maggi undertake an emotional journey that takes them from the familiarity of their North Carolina home, to New Delhi’s foreboding cramped streets, to the loneliness of hospital waiting rooms, to the all-too brief reprieve in a Jodhpur hotel, and back to the irritabilities of having to be admitted to a hospital upon their return to the USA. State of the Heart and Larry’s Kidney illustrate how the sheer range of people’s emotions across different social spaces or emotional extensivity is central to the emotional geography of MT.
A wide range of intense emotions infused Maggi and Howard’s and Dan and Larry’s travels to, within, and back from India and China, characterized by what we have identified here as both emotional amplification and emotional extensively. To what extent, then, is this range or intensity of emotions different compared to those in tourism or health care alone? And how do medical tourists’ range or intensity of emotions compare to the range or intensity of emotions experienced during similar medical treatment in one’s own country rather than abroad? Because of the constraints of space, we do not pursue such a comparison here, but suffice to say that notwithstanding the singular contexts of the patients’ illness and prospects for recovery, not having to travel a significant distance for care would, on the whole, likely reduce rather than increase the possible range or intensity of emotions in many cases. In the following section, we discuss the consequences of increases in the range and intensity of medical tourists’ emotions. Specifically, we argue that anxiety is an important—if not the most important—facet of the emotional geographies of amplification and extensivity in State of the Heart and Larry’s Kidney. Lack of space also prevents us from discussing other important emotions in the texts such as joy, hope, trust, sadness, and anger. Our wager, however, is that anxiety is not only the most common emotion in both narratives; it also frequently coincides with or displaces many other emotions. It is to illustrating where, how, and why anxiety can occur in the contexts of the MT narratives that we now turn.

Narratives of anxiety

Anxiety can be defined as ‘the tense, unsettling anticipation of a threatening but vague event; a feeling of uneasy suspense...closely related to fear that in many circumstances the two terms are used interchangeably’ (Rachman 2004: 3). Unlike fear, anxiety does not usually have a specific perceivable focus, stimuli, event, or object and is therefore typically slow to dissipate and difficult to understand. Indeed, anxiety ‘seems to be present, as if in the background, almost all of the time...a state of heightened vigilance rather than an emergency reaction’ (Rachman 2004: 3).

There are numerous theoretical approaches to anxiety which have already appeared in human geography and can usefully orient research on the many spaces of anxiety in MT. For example, from a psychoanalytic perspective, Jacques Lacan’s writings on desire and anxiety can theoretically attune researchers to the spaces of anxiety in the commodification of labor in MT services (Kingsbury 2011) and Julia Kristeva’s writings on abjection and anxiety can theoretically guide research on Western medical tourists’ perceptions of disorder and uncleanliness in MT sites (Moore 2009). Below, taking inspiration from psychoanalytic accounts of anxiety, which engage with Otherness, boundaries, and isolation, we explore three socio-spatial dimensions of anxiety which permeate the narratives.

Proximity to Otherness

One of the most influential concepts to have emerged since the 1980s in social and cultural geography is that of the ‘Other’. Geographers have used the notion of Other and the related concepts of Otherness and Othering to illustrate how many socio-discursive systems of power such as segregation, exoticism, and bigotry frequently rely on the dualistic designation of a stigmatized Other codified
as Other spaces, objects, groups of people, values, and so on in order to define and maintain a benign, coherent sense of Self codified in a unified ‘us’, shared locales, values, objects, and so on. Especially relevant to our discussion of MT are geographers’ assertions that encounter with Others and Otherness can produce states of anxiety that overlap with a wide range of phenomena such as enjoyment (Kingsbury 2005), disorientation (Sibley 1995), and repulsion (Wilton 1998).

*State of the Heart* and *Larry’s Kidney* are driven with examples of how proximity to, navigation through, and encounters with an Other or Otherness result in anxiety. In terms of navigating unfamiliar social landscapes, Maggi writes how she and Howard confront traffic jams and the hustle and bustle of the streets of New Delhi. Grateful to be met by hospital staff at the airport upon their arrival, Maggi asks ‘What if they hadn’t met us and we had to find a hotel?’ to which Howard replies, ‘I wouldn’t know where to start’ (p. 5). When they travel to a new city (Jodhpur) as tourists after Howard’s operations and navigate the strangeness of its public space, Howard and Maggi’s emotions oscillate between the fear of being exploited as naive tourists and the enjoyment of being in a nonclinical space. In another scene, a dishonest cab driver takes Howard and Maggi to the wrong sightseeing destination. After this event, Maggi notes that, ‘I don’t know whether to be angry or scared’ (p. 206).

Dan and Larry confront the Otherness of Chinese taxicabs wherein they mistakenly think that they have been kidnapped. Two chapters are dedicated to the ‘kidnap cabbie’ wherein Dan writes: ‘In the backseat, Larry and I are wet with perspiration, giving each other as much berth as possible’ (p. 119) and ‘I’m sweating a new sweat now, colder than the one back in Beijing… In preparation for anything, I stash my passport and wallet in a buttoned pants pocket, adjust my fake Rolex so it doubles as brass knuckles’ (p. 124). Dan and Larry are also forced to navigate the Otherness of China’s legal system and kidney black market, wherein nothing seems fixed or certain. Much of this uncertainty is because of their limited grasp of Mandarin. Given the illegality of acquiring a kidney on the Chinese black market, much of Dan’s conversations with Larry are permeated with paranoia in terms of a fear of being overheard and being reported to the authorities. Dan, then, is under tremendous pressure to not only navigate the uncertain linguistic terrains of Mandarin and ‘Chinglish’ but also acquire information on how to obtain a suitable kidney for Larry without raising suspicion. Similarly, in the context of India, Maggi often feels overwhelmed by misunderstanding medical terms and her inability to adequately thank the hospital staff.

Proximity to Otherness can pertain to the intimate transformation of the body: an enduring topic in studies of the Other (Nast and Pile 1998). Affirming the relevance of health geographers’ calls to consider embodiment in how people experience place and the body as a place in and of itself (Dorn and Laws 1994; Hall 2000; Parr 2003), bodies emerge throughout *State of the Heart* and *Larry’s Kidney* as important sites of struggle over power and control between family members and caregiver companions, hospital staff, locals, and tourists. Notably, geographers have addressed the overlaps between embodiment and anxiety in terms of, for example, proximity to illness and death (Wilton 1998), the pressures to enjoy (Proudfoot 2010), colonial violence and the racialization of sexuality (Nast 1999), and the unstable boundaries of individual and collective bodies such as those of the nation (Longhurst 2001).
To offset his embodied bouts of anxiety, Howard uses humor such as joking with Maggi about being shaved in preparation for catheterization: “He shaved me dry!” Howard says, pointing to his belly and groin. “A straight razor and quick!” He makes slashing motions in the air. “Zip. Zap. Zip. Done! Like Zorro” (p. 20). In this case, humor about the Otherness of Howard’s body offsets anxiety over not knowing why he had been taken out of his room by an orderly. Elsewhere, Howard reacts to his doctor informing Maggi that he had not needed to be sedated while having a tube inserted down his throat by pretending to gag uncontrollably. During this scene, which removes anxieties between Howard and the staff, Maggi rolls her eyes to the delight of the other observers. In Larry’s Kidney, Larry similarly plays on the humor afforded by the paradoxical spectacle of his pained, failing foreign body reveling in the embodied delights of eating unhealthy food. Here, what little agency Larry has is empowered through the staged absurd delight in eating fast food that mesmerizes those around him.

Uncertain boundaries

According to Sibley (1995: 8), ‘the urge to make separations, between clean and dirty, ordered and disordered, “us” and “them”, that is, to expel the abject, is encouraged in western cultures, creating feelings of anxiety because such separations can never be finally achieved.’ The sudden breakdown or subtle blurring of boundaries, then, is an important element in the socio-spatial production of anxiety. MT, which can consist of Westerners traveling to Non-Western contexts, is an activity par excellence that threatens the maintenance of boundaries. In this section, we consider how the narratives illustrate the uncertain boundaries that define people’s identities and roles, as well as senses of time.

State of the Heart is full of examples of how Howard seeks to maintain boundaries in his life as a medical tourist. According to Dan, he attempts to do so by contributing to decisions over the surgical procedure. For example, prior to departing for India and in an attempt to defer the surgery date (which led to an argument with Maggi), Howard asks: ‘What’s a couple of more weeks?’ to which Maggi responds, ‘It could mean your life!’ Maggi describes her reaction as ‘sharply bristled’ until she realizes that ‘Howard was procrastinating. Dropping everything and hopping on a plane to India added drama and reality to a situation that we still hadn’t come to grips with’ (p. 38).

As Howard’s caregiver companion, Maggi is forced to navigate shifting boundaries of her alternating roles of caregiver, guardian, friend, interpreter, and family member. The uncertain boundaries between these roles shift in relation to Howard’s health status. The unstable nature of Maggi’s identity, a constant source of stress to her, is compounded by the physical distance and cultural isolation of engaging in travel and risky medical procedures far from home and loved ones. In Larry’s Kidney, Dan is quickly thrown into the role as a caregiver companion as a result of receiving an unexpected call from his long-lost cousin Larry. Much of Dan’s role involves dealing with Larry’s colorful and frequently trying personality during their protracted search for a viable kidney. Like Maggi, he questions why he has gone abroad and what support he can offer Larry at times.

Both of the caregiver companions’ narratives illustrate the shifting temporal boundaries that separate the past, present, and future. Patients and caregiver companions alike are cast into an uncertain journey that
demands a radical openness to what the future may or may not bring, to how the present is experienced, and to the challenges that have been or yet to be overcome. With a past once full of health, a present full of fear and hope, and a future that could provide healing or death, the challenges to maintain a sense of proportionate behavior toward these horizons of time are considerable and frequently lead to irruptions of anxiety.

Given the uncertainty of obtaining a kidney in China, Dan’s sense of the present is informed by the strategy of maintaining a clear boundary between the present and the future by not planning too far ahead. For example, he states: ‘So Larry and I’ve had a couple of conversations, and the plan is, we’re giving it one week in China, and if nothing turns up, we’ll try the Philippines, then maybe Singapore and Hong Kong’ (p. 17). Although Dan embraces contingency planning, much of the success of the trip is the result of a chance encounter with a person who provides key information. In Dan’s case, it is the result of meeting a journalist from New York at a synagogue who informs him about a ‘surgeon [“Dr. X”] out in the city of Shi a few hours west of Beijing’ (p. 85). Larry’s experience of temporal boundaries involves the gradual worsening of his physical condition during the search for a kidney. Whereas the transformation into a tourist marks the onset of recovery for Howard, for Larry the letting go of the past as a tourist marks the onset of being a patient. Unlike Howard, Larry does not grow increasingly upset with the passing of time. One of the reasons for this capacity to avoid frustration and boredom is that Larry is able to keep anxiety at bay in the present by telling long and elaborate stories as a source of entertainment both to himself and those around him.

**Isolated decision making**

Much of anxiety concerns anticipating negative or harmful future outcomes. Such apprehensions can be compounded by social isolation. These two factors are a major part of MT insofar as medical tourists frequently face an uncertain future in terms of health, as well as the likelihood of leaving friends and family in order to pursue health care abroad. MT is very much a journey into unknown realms where psychosocial distances from home and the familiar elevate levels of anxiety and anticipation. In this section, we focus on how the two narratives illustrate the confluence of socio-spatial isolation and high-pressure decision making.

To begin with, the caregiver companions’ narratives show how anxiety about the future is manifest even before MT travel formally begins. Given the importance of the surgery and the vast distance between their home in North Carolina and the hospital in New Delhi, Howard and Maggi must ensure that their trip is carefully planned, including their intended activities as tourists. Howard and Maggi become increasingly anxious as they are transformed into medical tourists by initiating research about India and budgeting for travel before and after the operation. On preparing to travel, Maggi recalls: ‘We were intrigued with the idea, although we know very little about India aside from the stereotypes: poverty, cobras, the land of explorers who’d traveled there for spices and silk’ (p. 50).

As Howard’s emotional advocate and supporter, Maggi confesses how wary she is about making decisions for him. Fortunately, Howard takes some steps to include her in his conversations with his US-based doctors. In an early scene, Howard pointedly introduces Maggi to a doctor who had been ignoring
her. She observes, ‘Howard doesn’t want me to
be invisible to these doctors who do not
automatically include me in their greetings’
(p. 12). Maggi’s role as Howard’s supporter
also means that she has to be careful not to
overwhelm him with too many strong
emotions. Too much support threatens to
dissolve Howard’s sense of (very limited)
autonomy. In many ways, Maggi takes on a
maternal role toward Howard during the post-
operative period. When Howard experiences
slurred speech and stroke-like symptoms,
Maggi describes him as ‘like a two-year-old
on the loose’ (p. 186).

These anxiety-ridden tasks of the caregiver
companion are ineluctably related to decision-
making responsibilities. Maggi has to remain
unflustered when she makes crucial decisions
regarding Howard’s care, including the choice
of the heart valve and the post-operative
recovery site. During these times, she feels the
burden of responsibility for having to make
decisions for someone else’s health, which is
confounded by the fact that she is not legally
Howard’s wife and is physically distant from
her own support network. When consent is
needed for a second surgery, Maggi hesitates:
‘But I am not his wife. He is not my child. For a
split second I wonder how sure I am that
Howard would even say yes’ (p. 83). In this
short sentence, Maggi confronts feelings of
inadequacy and unsuitability.

Unlike Howard and Maggi, Dan is well
traveled, and, relying on this, he and Larry are
forced to make quick decisions about where to
travel once they arrive in China. As stated
earlier, Dan’s responsibilities as Larry’s care-
giver companion are intensified by the
unlawfulness of obtaining a kidney. What is
more, given Larry’s rapidly declining health,
Dan writes about how he must make decisions
on his own and within a short period of time.
The pressure is such that in one scene, Dan
admits that it ‘even almost crosses my mind to
pass out flyers in Tiananmen Square—figuring
I’m giving up on China in a few days anyhow.
What’re they going to do, detain me for being
desperate?’ (p. 58). The anxiety of taking
responsibility for Larry means that he even
recalls dreaming about Larry’s health and his
own responsibilities in caring for him while in
China.

Conclusion

In this paper, we explored the emotional
geographies of State of the Heart and Larry’s
Kidney, two narratives written by American
caregiver companions who travel abroad for
the life-saving surgeries of a husband and a
cousin. We argued that traveling to profoundly
different socio-cultural contexts resulted in an
increase in the intensity of emotions or what
we called emotional amplification, as well as
an increase in the range of emotions or what
we called emotional extensivity. We asserted
that an increase in emotional intensity and
range helps to explain the prevalence of
anxiety in both of the narratives. We then
turned to elaborate on the social and cultural
spaces of anxiety in the narratives in terms of
proximity to Otherness, uncertain boundaries,
and isolated decision making.

To repeat an earlier point, our study is far
from empirically or theoretically exhaustive.
Our main aim is to incite belated empirical,
theoretical, and methodological discussions
between geographical, travel, tourism, and
health studies by exploring some key emotion-
al geographies in MT wherein medical
tourists’ emotional experiences of travel and
health care are regarded as spatially enlaced
rather than separate phenomena. To conclude
the paper, we briefly address how studies on
the emotional geographies of MT could be
fruitfully expanded both theoretically and empirically.

To begin with, it is important to note that encounters with Otherness do not necessarily lead to irruptions of anxiety. In *State of the Heart*, the Otherness of Hindi inspired Maggi to write poetry and delight in the learning of a new language. In *Larry’s Kidney*, we read an oftentimes heroic rather than anxious discourse of saving one’s life by successfully navigating, or perhaps more accurately exploiting, the black market of organ trade. Such instances in the narrative have scant regard for the ethics of MT (Snyder, Crooks, Johnston and Kingsbury, forthcoming), the ethics of illegal donor trade, the emotions of the caregivers in China, or the commodification of the Other’s body parts. These are significant themes and space constrains us from adequately addressing them. However, the theoretical works of Emmanuel Levinas on the spaces of the Other in terms of ethics, exploitation, responsibility, and community seem especially helpful here (Popke 2003).

Empirically, most, if not all, surgeries are traumatic. Numerous narratives of surgery, especially organ transplantation (Green 2007), could provide a comparative baseline that would establish the ways in which MT intensifies anxiety and other emotions. We also believe that there is much research to be done on considering how issues of anxiety are relevant not only to the spaces before and during MT journeys but also to the experiences of returning home. *State of the Heart*, for example, depicts how upon Howard’s return to the USA he becomes anxious about delays in his recovery. Howard also becomes saddened upon his admission into hospital in the USA due to health complications. In *Larry’s Kidney*, Dan describes a return to the everyday as follows: ‘Home sweet home. It’s good to be back among so many Western faces, so much English lettering. Except I’m not in America but Beijing, which only feels like home after I’ve spent seven weeks in Shi’ (p. 283). Dan’s description reveals how one’s sense of home is not necessarily tied to one’s birth country or continent.

Importantly, there are a growing number of medical tourists whose homes are located in the Global South. A pressing empirical question, then, is: to what extent do the emotional geographies of MT taking place entirely within the Global South differ from those where medical tourists travel from the Global North to the Global South? The notion of international patients traveling to other countries to access cost savings and recover in high-end resorts pertains primarily, though not exclusively, to patient flows from the Global North to the Global South. As Kangas (2007) has observed, the narrative of patients traveling within the Global South to access care that is unavailable or unaffordable in their home countries is markedly different. In addition, we must ask: how do the axes of class, race, gender, ethnicity, and so on on structure medical tourists’ experiences of anxiety when they travel entirely within the Global South, as well as Global North to the Global South? And, what are the emotional geographies of caregivers in the Global South? These are important questions because they address the geopolitical aspects of power that underpin Others and Otherness in unfamiliar contexts within MT’s global market. The two narratives are markedly different in this respect because *State of the Heart* depicts MT’s formal system while *Larry’s Kidney* illustrates less regulated context of illegal care. The final domain in which our study could be empirically extended is through addressing other textual sources and modes of narration. In addition to other comparable narratives of MT such as those (noted above) written by and
for transgender communities traveling for gender reassignment, it would be useful to examine the burgeoning narratives that comprise electronic media such as webpages, blogs, and social networking sites.

To conclude, while there are numerous speculations, debates, and disputes in popular and academic literatures about the scope, scale, and impacts of MT on the source and destination countries, as well as patients and employees (Crooks, Kingsbury, Snyder and Johnston 2010; Johnston, Crooks, Snyder and Kingsbury 2010), very few of these accounts address or even acknowledge the geographies of emotions in MT. We believe that the emotional geography of MT should be an essential component of present discussions of global health services practice and should receive greater theoretical and empirical study beyond *Larry’s Kidney* and *State of the Heart*, as well as inside and outside of social and cultural geography.

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Narratives of emotion and anxiety in medical tourism

Cet article examine les géographies émotionnelles de *State of the Heart* et *Larry’s Kidney* – deux œuvres non fictionnelles s’agissant du tourisme médical dans lesquelles des patients américains et leurs aidants font des voyages à l’étranger pour subir des interventions chirurgicales de secours. L’article retient deux objectifs: primo, illustrer l’importance des géographies émotionnelles exprimées par des touristes médicaux au cours de leurs voyages aussi bien que celles exprimées par conséquence de donner et recevoir les soins médicaux transnationaux; secundo, générer des débats empiriques, théorétiques, et méthodologiques sur le regard au tourisme médical émotionnelle entre les études géographiques, de voyage, de tourisme, et de santé. Jusqu’alors les expériences de voyage et de soins médicaux sont normalement examinées comme phénomènes spatialement distincts plutôt que entrelacés. Nous visons les objectifs ci-dessus en considérant la production de deux géographies émotionnelles interdépendantes à partir des narratives qui racontent un voyage des milliers de miles pour aboutir à un milieu fondamentalement différent au niveau socio-culturel où l’on reçoit les soins médicaux essentiels: tout d’abord, ces narratives démontrent l’existence d’une « amplification émotionnelle » (soit une augmentation de l’intensité desdites émotions) aussi bien que l’existence d’une « extensivité émotionnelle » (soit une augmentation de l’étendue des émotions); ensuite, elles révèlent comment l’inquiétude se base sur une proximité à l’Autrui, aux limites indistinctes, et à la prise de décision en isolation. Nous concluons en discutant brièvement les possibilités pour élargir notre étude de ces narratives.

Mots-clés: tourisme médical, géographie émotionnelle, inquiétude, Inde, Chine.
inados como espacialmente distintas en lugar de estar examinado como fenómenos entrelazados. Dirigimos los dichos objetivos por discutir como las narrativas de viajar miles de millas a un entorno social y culturalmente distinto para recibir atención médica esencial se produce dos geografías emocionales interrelacionadas: primero, se demuestran la existencia de “amplificación emocional” (la aumento de la intensidad de emociones) y “extensividad emocional” (la aumentación del ámbito de emociones); y segundo, se demuestran como ansiedad está apuntalado por la proximidad a la Otredad, límites inciertos, y la toma de decisiones aisladas. Concluimos por dirigir como nuestra examinación de estas narrativas pueden ser extendidos útilmente.

Palabras claves: turismo médico, geografía emocional, ansiedad, India, China.