Canadian family doctors' roles and responsibilities toward outbound medical tourists

"Our true role is ... within the confines of our system"

Rory Johnston MA Valorie A. Crooks PhD Jeremy Snyder PhD Shafik Dharamsi MSc PhD

Abstract

Objective To explore how Canadian family doctors understand their roles and responsibilities toward patients who seek health care abroad.

Design Six focus groups were held with family doctors across British Columbia to explore their experiences with and perspectives on outbound medical tourism. Focus groups were digitally recorded, transcribed, and subsequently thematically coded to discover common issues and themes across the entire data set.

Setting Focus groups were held with family doctors in 6 cities in British Columbia that provided representation from all provincial health authorities and a range of urban contexts.

Participants A total of 22 currently practising family doctors participated across the 6 focus groups, with groups ranging in size from 2 to 6 participants (average 4 participants).

Methods Thematic analysis of the transcripts identified cross-cutting themes that emerged across the 6 focus groups.

Main findings Participants reported that medical tourism threatened patients' continuity of care. Informational continuity is disrupted before patients go abroad because patients regularly omit family doctors from preoperative planning and upon return home when patients lack complete or translated medical reports. Participants believed that their responsibilities to patients resumed once the patients had returned home from care abroad, but were worried about not being able to provide adequate follow-up care. Participants were also concerned about bearing legal liability toward patients should they be asked to clinically support treatments started abroad.

Conclusion Medical tourism poses challenges to Canadian family doctors when trying to reconcile their traditional roles and responsibilities with the novel demands of private out-of-country care pursued by their patients. Guidance from professional bodies regarding physicians' responsibilities to Canadian medical tourists is currently lacking. Developing these supports would help address challenges faced in clinical practice.

EDITOR'S KEY POINTS

- Medical tourism is a growing mode of health care delivery that poses challenges for family doctors. This study used focus groups to explore how family doctors in British Columbia understood their roles and responsibilities toward patients who sought health care abroad.

- Participants highlighted a number of challenges related to both their pretrip and their posttrip responsibilities to patients seeking care abroad. For example, participants thought it was unreasonable for patients to expect them to be familiar with the details of destination providers and procedures; struggled with disruptions in informational continuity and concerns about posttrip liability for complications when providing follow-up care; and expressed desire for clearer guidance from regulatory bodies.

- Family doctors are well positioned to help ameliorate some of the potential health risks and continuity-of-care challenges posed by this form of medical care by educating patients, ensuring international treatments are properly documented, and enabling access to domestic postoperative care. This study's findings suggest that Canadian family doctors are willing to take on these responsibilities when provided the appropriate supports to do so.

This article has been peer reviewed.
Can Fam Physician 2013;59:1314-9

Rôles et responsabilité du médecin de famille à l'égard des touristes médicaux

« Notre véritable rôle se situe dans les limites de notre système »

Rory Johnston MA Valorie A. Crooks PhD Jeremy Snyder PhD Shafik Dharamsi MSc PhD

POINTS DE REPÈRE DU RÉDACTEUR

- De plus en plus de patients recourent au tourisme médical pour se faire soigner, ce qui cause certaines difficultés aux médecins de famille. Dans cette étude, on a utilisé des groupes de discussion pour connaître l'opinion des médecins de famille de la Colombie-Britannique sur leurs rôles et responsabilités à l'égard des patients qui vont se faire soigner à l'étranger.

- Les participants ont énuméré certains problèmes en relation avec leurs responsabilités envers les patients qui vont se faire traiter à l'étranger, tant avant leur départ qu'après leur retour. Par exemple, les participants estimaient que les patients ne pouvaient pas vraiment s'attendre à ce qu'ils soient bien renseignés sur les soignants étrangers et leurs procédures médicales; craignaient qu'il y ait un défaut de continuité dans la transmission de l'information; s'inquiétaient quant à leur responsabilité en cas de complications après le voyage s'ils prodiguaient des soins de suivi; et exprimaient le souhait d'obtenir des directives plus claires de la part des organismes de réglementation.

- Face au tourisme médical, le médecin de famille est bien placé pour réduire certains risques pour la santé et pour améliorer la continuité des soins en renseignant les patients, en s'assurant que les traitements offerts à l'étranger sont bien documentés et en favorisant l'accès à des soins postopératoires au retour. Les résultats de cette étude donnent à croire que les médecins de famille canadiens sont prêts à assumer ces responsabilités si on leur fournit un soutien adéquat pour le faire.

Cet article a fait l'objet d'une révision par des pairs.
Can Fam Physician **2013;59:1314-9**

Résumé

Objectif Déterminer ce que les médecins de famille canadiens pensent de leurs rôles et responsabilités envers les patients qui vont se faire traiter à l'étranger.

Type d'étude On a tenu 6 groupes de discussion regroupant des médecins de famille d'un peu partout en Colombie-Britannique afin de connaître leur expérience et leur attitude relativement au tourisme médical à l'étranger. Les discussions ont été numériquement enregistrées, transcrites puis codées thématiquement et on en a ensuite extrait les questions et les thèmes communs à l'ensemble des données.

Contexte Les groupes de discussion ont été tenus dans 6 villes de la Colombie-Britannique, lesquelles représentaient l'ensemble des responsables provinciaux de la santé et un bon échantillon des milieux urbains.

Participants Un total de 22 médecins de famille en pratique active ont participé à l'un ou l'autre des groupes de discussion; la taille de ces groupes variait entre 2 et 6, avec une moyenne de 4 participants.

Méthodes L'analyse thématique des transcrits a permis d'identifier les thèmes récurrents dans les 6 groupes de discussion.

Principales observations Selon les participants, le tourisme médical met en danger la continuité des soins. Le transfert de l'information n'est pas assuré avant le départ à l'étranger, les patients omettant souvent de parler à leur médecin de famille du plan préopératoire, de même qu'au retour, parce qu'ils rapportent souvent des rapports médicaux incomplets ou des traductions de rapports. Les participants croyaient qu'ils redevenaient responsables des patients lorsqu'ils revenaient après avoir été traités à l'étranger, mais ils n'étaient pas sûrs de pouvoir leur assurer un suivi adéquat. Ils s'inquiétaient aussi des éventuels problèmes d'ordre juridique au cas où les patients leur demandaient de compléter des traitements commencés à l'étranger.

Conclusion Le tourisme médical cause des difficultés aux médecins de famille canadiens qui essaient de concilier leurs rôles et responsabilités traditionnels avec les nouvelles demandes de soins de la part de patients ayant reçu des traitements privés à l'étranger. Il n'existe présentement aucune directive des organisations professionnelles concernant les responsabilités des médecins face au tourisme médical. De telles directives pourraient aider à faire face à ce type de défi clinique.

Medical tourism (MT) is the intentional pursuit of privately purchased and arranged-for medical care outside a patient's home country, and it is a phenomenon that has increased in popularity in recent years.[1,2] This care occurs outside established cross-border care arrangements, typically without physician referral. Information about clinics and procedures abroad is available to prospective patients online, which has propelled recent growth of the MT industry.[3] The confidence of international patients in the quality of care available abroad has been bolstered by marketing campaigns for MT by various hospitals and national governments.[2,4]

Although Canadian patients are known to be taking part in MT, little empirical research on MT that engages with stakeholders in the Canadian context has been published.[5] Medical tourism challenges the gatekeeping role that Canadian family doctors perform in referring patients for secondary and tertiary care by allowing patients to access specialized care on demand outside of the country. This alteration to the usual trajectory of care has raised concerns regarding patient safety, continuity-of-care interruptions, and the quality of informed consent.[3,6,7] However, owing to the lack of empirical reporting, these concerns remain primarily speculative. In this article we begin to address the knowledge gap identified above by reporting the findings from focus groups held with Canadian family doctors about outbound MT. We conducted thematic analysis of these data to qualitatively explore Canadian family doctors' perceptions and experiences of MT. Our findings raise questions about family doctors' responsibilities toward Canadian medical tourists and clarify some implications of MT for Canadian family medicine practice.

METHODS

This study aims to identify the implications for family medicine practice in British Columbia (BC) of patients' engagement in MT for surgical interventions. We focused on BC not only because it is where we, a team of health services researchers and social scientists, are based but also because it is a province known to be home to medical tourists and several MT travel agents.[5] In the summer of 2011, 6 focus groups were held with family doctors in 6 BC cities that provided representation from all provincial health authorities and a range of urban contexts. Focus groups are a useful method in exploratory research such as this where participants might not have enough to say on their own to warrant being interviewed, and where ideas exchanged among participants might spur ideas that would remain uncovered through one-on-one conversation.[8]

Before recruitment, ethics approval was granted by the Research Ethics Board at Simon Fraser University. Participant eligibility was limited to family doctors currently practising in 1 of the 6 cities. Potential participants were identified using the British Columbia College of Family Physicians website, and letters of invitation were faxed to all of the practices identified in each city; interested doctors followed up with the lead author. Two moderators and a note-taker were present at each focus group. The focus groups were loosely structured around a series of predetermined probing questions that explored a range of topics concerning participants' experiences with and perceptions of MT. Some examples of probing questions are listed in **Box 1**.

Box 1. Examples of focus group prompt questions

The following are examples of prompt questions:

- Have you had any patients talk with you about wanting to go on a medical tour?
- What has been your response to potential medical tourists in your practice?
- Have you had anyone meet with you after a medical tour or involve you in his or her follow-up care?
- What, if any, are your biggest concerns with medical tourism for your practice and your patients?
- What, if any, opportunities do you see in medical tourism for your practice and your patients?

Procedure

Focus groups lasted between 1.5 and 2 hours and were digitally recorded and transcribed verbatim. Following data collection, transcripts were uploaded into NVivo, a qualitative data management program, for coding. A coding scheme was iteratively developed following full transcript review and confirmation of key emerging themes, with input and consensus from all authors. Inductive and deductive organizational codes that structured these themes were identified, which formed the coding scheme. Coding was performed by the lead author (R.J.).

Following coding, the content of each code was reviewed across the 6 focus groups in order to ascertain the breadth and depth of identified themes. The interpretability of these themes was reviewed and confirmed by the first 3 authors (R.J., V.A.C., and J.S.) following the coding process; patterns and outliers for each theme were discussed. A key theme emerging from the transcripts and confirmed through review of the coded content pertained to family doctors' roles and responsibilities toward patients engaging in MT, which is examined below.

FINDINGS

In total, 22 family doctors participated, with focus groups ranging in size from 2 to 6 (average 4) participants. They

had been practising family medicine for an average of 23 years. Twenty had at least 1 medical tourist in their practices. The number of medical tourists they estimated that they had encountered ranged from 1 to 90 (median 6). Medical tourism was a recognized phenomenon among participants from all 6 locations; however, participants working in cities with higher populations, especially those with concentrations of recent immigrant populations, reported encountering medical tourists more often than participants from smaller cities. In the remainder of this section we present the findings of the focus groups. Findings are organized as themes central to the roles and responsibilities of doctors toward medical tourists and are distinguished by pretrip and posttrip roles and responsibilities. Verbatim quotations are used to illustrate the key themes and are identified by which focus group they originated from.

Pretrip roles and responsibilities. Concerns emerged across all focus groups regarding pretrip consultations with patients considering MT. Foremost among these was that prospective medical tourists often expected family doctors to help interpret research about desired procedures or clinics abroad. Many participants recounted being presented with marketing materials and website printouts. Participants expressed that it was impossible to satisfy these requests, as the research material presented was generally of unreliable quality and there was not enough time during consultations to review the material and address patients' concerns. Participants also thought it was unreasonable for patients to expect them to be familiar with details of the destination providers, the countries where care was offered, or the procedures sought, especially those that were experimental.

> I don't feel it's my responsibility as a … family physician to research this [clinic abroad or surgical intervention being sought] or to counsel … where to go and anything of that sort, other than to [alert them to] be cautious and … they may be getting something they didn't bargain for. (FG-K)

Most participants had experienced situations in which their patients did not consult with them before going abroad, only to learn about the procedure after it had been performed.

> [Patients] haphazardly discuss 1 or 2 things with you and then they're gone before you know and they come back [after surgery abroad] and there hasn't really been a plan or time to work out what we'll do when you get back, or a lot of them go without letting us know. (FG-V)

Participants believed it was important to have the opportunity to help broadly examine the benefits and drawbacks of the medical intervention being considered and to discuss the potential risks involved before a patient booked care in another country. Some of the participants saw a patient's consideration of MT as an indicator of navigational challenges within the provincial health care system, and thus thought that many patients considering MT would be best helped by them advocating for the patients and ensuring their options within the domestic system were exhausted.

Many participants experienced MT as disruptive to the provision of continuous care, and were concerned when they were omitted from planning.

> [N]o matter where [my patients are] seeking medical care, I still have that sense of: I'm their family doctor and I'm going to want to work with them if they have complications. But if they're someone [who goes abroad and] I don't know about it then … I'm out of that loop. (FG-PG)

This concern about care continuity did not extend to a desire to be involved in facilitating the provision of out-of-country care before a patient's travel, for example by prescribing prophylactic medications for potential complications. Examples from some participants' own experiences were offered to demonstrate how a lack of willingness to offer pretrip support could damage relationships with patients and threaten continuity of care. It was agreed that providing (usually limited) input or guidance in the planning stage could enhance the ongoing doctor-patient relationship, particularly when the procedure being sought abroad was perceived by the patient to be life changing or life saving.

Posttrip roles and responsibilities. The potential for disrupted continuity of care following a patient's private pursuit of medical care abroad was an important issue raised by all participants. For example, instances where informational continuity had been disrupted by poor or nonexistent documentation of procedures or postoperative care orders were reported as very common. These issues made interpreting or integrating medical tours into a patient's history difficult: "[I]t's frustrating for us [family doctors] when [patients] come back with all the results, half of them in a different language or not in metric or whatever and then you have to sort all this out." (FG-V)

All participants expressed a strong conviction that they were responsible for providing postoperative care for their patients to the extent they were able, regardless of where the original treatment was obtained.

> So would I accept the patient back and treat those complications? Yeah absolutely, they're my patient. I'm a family doctor; you know that's my responsibility and

> that's also what you do as family physicians ... we try to do the best for our patients at all times. (FG-PG)

Uncertainty emerged regarding what postoperative care or support was appropriate. For example, concern was raised about taking on liability for postoperative care involving treatments prescribed by an out-of-country physician, especially when the care they were being asked to provide followed an experimental procedure not approved in Canada.

> [Patients] come back and the physician [from the destination facility] and the patient expects me to continue care, so providing certain types of medication, certain types of injections because the patient can't stay down there for all of their treatment; so I'm doing something that I'm just not really comfortable with and its being dictated by someone else abroad and [I'm] thinking, Well what happens if there's a complication? Who is now going to be on the hook for liability? (FG-B)

Another concern was arranging postoperative care by other specialists for medical tourists upon their return. Some participants had directly experienced other specialists refusing to provide postoperative care for these patients. Others expressed that the potential of encountering barriers in forwarding medical tourists within their referral networks was a very real possibility. Participants believed that these postoperative care concerns need to be clearly communicated to prospective medical tourists.

DISCUSSION

The family doctors we spoke with indicated a preference for a limited role when their patients pursued MT, with no functional difference in their desired role when advising patients seeking experimental care versus those traveling for clinically accepted interventions. Liability concerns and knowledge limitations made participants think that many of the responsibilities associated with their gatekeeping role for domestic care, such as coordinating with other specialists and providing considerable support in surgical decision making, are not transferable to outbound medical tourists. Participants did wish to be involved in the decision-making process to the point of exploring the motivations behind a patient's consideration of MT and to ensure options within the domestic system were exhausted before patients went abroad. Some were also willing to help patients achieve a more accurate, but very broad, understanding of the potential risks, costs, and benefits of the medical care they were seeking abroad, but saw themselves achieving this by offering reflective prompts for patients that they might not have considered rather than specific recommendations advising them on the appropriate course of care. At the same time, they did not see any substantial role for themselves as researchers or interpreters of information when discussing decision making. One quote succinctly captured the prevailing attitude behind this:

> I don't see much benefit for us in family practice because [outbound MT] diverts our true role. Our true role ... is to guide our patients in their journey towards health in our system right within the confines of our system. (FG-N)

This finding runs counter to calls made by scholars for family doctors to offer detailed counsel and specific recommendations when patients consider medical care abroad,[9,10] and demonstrates the importance of seeking input directly from family doctors and other stakeholders in future research before putting forth recommendations about their roles and responsibilities toward medical tourists. While physician preferences should not override professional and ethical standards, direct consultations with stakeholders regarding an emerging phenomenon in concert with the drafting of such recommendations are likely to improve the force and relevance of the recommendations for the intended stakeholder group.

Our analysis indicated that the desired roles of family doctors in providing or coordinating postoperative care could be enabled by improving informational continuity-of-care standards for medical tourists, as was indicated by their dismay when they were totally omitted from the planning process and at the poor quality of records patients returned with. For example, encouraging pretrip contact between patients and their family doctors to discuss appropriate documentation could assist these same doctors in caring for their patients upon return. The concern expressed by numerous participants that there might be difficulties finding a specialist willing to provide postoperative care for a patient who had sought surgery abroad grounds speculation that this is an implication of outbound MT for patients' home health care systems.[11] This concern also indicates a need for patients to be clearly informed about what kind of postoperative care will be available to them in their home system when pursuing MT in consultations with their family physicians before traveling for care. Participants' varying concerns regarding liability in dealing with medical tourists suggests a possible lack of guidance from professional and regulatory bodies to help them with understanding if and how they should assist such patients. Some participants directly expressed their desire for clearer guidance on what their roles and responsibilities toward medical tourists were. Recent moves by the Canadian Medical Protective Association to develop guidelines for

physicians relevant to MT are a sign that guidance from regulatory bodies is forthcoming,[12] but these could be bolstered with endorsement or further guidance from other professional bodies.

Limitations

This research is primarily limited by the composition of its participant sample. Being restricted to BC physicians pursuing a call to participate in research about MT, these findings are unlikely to have uncovered issues specific to other regions of Canada or among physicians with no knowledge of MT.

Conclusion

The growth of MT will likely intensify as networks of international trade deepen and more care providers seek to attract foreign patients.[1-3] Family doctors are well positioned to help ameliorate some of the potential health risks and continuity-of-care challenges posed by this form of care by educating patients, ensuring international treatments are properly documented, and enabling access to domestic postoperative care.[6,10] Our findings indicate that Canadian family doctors are willing to take on these responsibilities when provided the appropriate supports to do so.

Mr Johnston is a doctoral student in the Department of Geography at Simon Fraser University in Burnaby, BC. **Dr Crooks** is Associate Professor in the Department of Geography at Simon Fraser University. **Dr Snyder** is Assistant Professor in the Faculty of Health Sciences at Simon Fraser University.

Dr Dharamsi is Associate Professor in the Department of Family Practice at the University of British Columbia in Vancouver.

Contributors

All authors contributed to the concept and design of the study; data gathering, analysis, and interpretation; and preparing the manuscript for submission.

Competing interests

None declared

Correspondence

Mr Rory Johnston, Simon Fraser University, Geography, 8888 University Dr, Burnaby, BC V5A 1S6; e-mail **rrj1@sfu.ca**

References

1. Connell J. Contemporary medical tourism: conceptualisation, culture, and commodification. *Tour Manage* 2013;34:1-13.
2. Ormond M. Shifting subjects of health-care. *Asia Pac Viewp* 2011;52(3):247-59.
3. Lunt N, Hardey M, Mannion R. Nip, tuck and click: medical tourism and the emergence of web-based health information. *Open Med Inform J* 2010;4:1-11.
4. Leng CH. Medical tourism and the state in Malaysia and Singapore. *Glob Soc Policy* 2010;10(3):336-57.
5. Snyder J, Crooks VA, Johnston R, Kingsbury P. What do we know about Canadian involvement in medical tourism? *Open Med* 2011;5(3):e139-48.
6. Turner L. Medical tourism. Family medicine and international health-related travel. *Can Fam Physician* 2007;53:1639-41 (Eng), 1646-8 (Fr).
7. Lunt N, Carrera P. Medical tourism: assessing the evidence on treatment abroad. *Maturitas* 2010;66(1):27-32.
8. Sim J. Collecting and analysing qualitative data: issues raised by the focus group. *J Adv Nurs* 1998;28(2):345-52.
9. Levine AD, Wolf LE. The roles and responsibilities of physicians in patients' decisions about unproven stem cell therapies. *J Law Med Ethics* 2012;40(1):122-34.
10. Crozier GK, Baylis F. The ethical physician encounters international medical travel. *J Med Ethics* 2010;36(5):297-301.
11. Cortez NG. Patients without borders: the emerging global market for patients and the evolution of modern health care. *Indiana Law J* 2008;83(24):71-132.
12. Canadian Medical Protective Association [website]. *The impact of medical tourism on Canadian physicians*. Ottawa, ON: Canadian Medical Protective Association; 2012. Available from: **www.cmpa-acpm.ca/cmpapd04/docs/resource_files/web_sheets/2012/com_w12_003-e.cfm.** Accessed 2013 Oct 25.