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Author(s): Beth Kangas

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Complicating Common Ideas about Medical Tourism: Gender, Class, and Globality in Yemenis' International Medical Travel

Beth Kangas

Jamila, the wife of a prominent businessman in Yemen, underwent a complete medical checkup in Jordan, visiting a different doctor for each part of her body. Jamila told me during our interview in Jordan that she usually had her checkups in Italy during her husband's business trips there. This year, however, her husband's work kept him in Yemen, so Jamila traveled to Jordan with her son and her husband's sister, who also sought treatment. Her niece, a student in Jordan, advised them on which medical facilities to use. Jamila's husband telephoned every day to check on her and see if she needed more than the \$8,000 she had initially brought.

Nabila's headaches intensified three months after she married. She and her husband visited several doctors and hospitals in Yemen before traveling to Iraq in 1996 at the Yemeni government's expense. Doctors there said she had an untreatable shrinking in her brain. Nabila's husband found his bride to be unsuitable and returned her to her family's home, Nabila's sister, Arwa, told me in our interview in Jordan. Arwa and Nabila visited many hospitals in Yemen, but no one made a clear diagnosis. Day by day, twenty-three-year-old Nabila grew worse. Finally, the two sisters traveled to Jordan. A CT scan and MRI helped diagnose Nabila's brain cancer. Nabila and Arwa stayed in Jordan for the next nine months. They spent over \$11,000 for treatment, most of which the family had borrowed.

Thirty-six-year-old Amal and her brother traveled to Iraq for her kidney transplantation. The family had borrowed the \$3,000 to cover the costs. The kidney came from a Palestinian woman whom her brother located in Baghdad, Amal told me in our interview following her return to Yemen. She could provide no further details about the logistics of the kidney procurement but had been equally unclear about her medical condition

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when I first met her in Jordan. She instead focused on how her mother cried when she and her brother left for the airport and once again when they telephoned home. During our interview, Amal wore a surgical mask to protect her from the germs and dust of the city. Her mother, hovering over her, repeatedly asked me for reassurance that Amal looked better than before she left. Although extremely vulnerable as a result of her transplantation (as her mother was fully aware), Amal still considered dialysis in Yemen's unreliable medical system to have been the greater health risk.

Introduction

The journeys of Jamila, Nabila, and Amal challenge current assumptions about medical tourism. Much of the academic and popular coverage of medical tourism centers on patients from industrialized countries. These patients are said to bypass local services because of the high costs, long waits, or prohibitive regulations. By contrast, Jamila, Nabila, and Amal traveled from Yemen, a capital-poor country in the southwest corner of the Arabian Peninsula. They left their country because of the lack of specialized services or their mistrust of the services that did exist. At the time of my research, in the 1990s, Yemen's medical system did not have the capabilities to treat cancer, heart disease, kidney failure, and other complicated conditions. Patients had to go abroad to pursue medical care they believed capable of prolonging lives and alleviating suffering. Common treatment destinations at the time included Jordan, India, Iraq, and Egypt. As the journeys of Nabila and Amal illustrate, most Yemeni medical travelers had to borrow money and sell whatever assets they could to finance their journeys.

This article's first contribution to discussions of medical tourism is to incorporate patients from developing countries. The second contribution is to dispute the term "medical tourism." Calling this growing global phenomenon "medical tourism" emphasizes the merging of two industries—medicine and tourism—and prioritizes the treatment destinations and facilitators over the patients. The term suggests leisure and frivolity, diminishing the hardships that patients face. As neutral terms, I prefer "international medical travel" or "transnational medical journeys" (Kangas 2010).

The journeys of Jamila, Nabila, and Arwa help to complicate common ideas about gender, class, and globality within medical tourism. They caution us to resist segmenting off parts of the global population into developing and developed countries, immobile females and uncaring

males, and the extravagant wealthy and exploited poor. Speaking in generalizations and stereotypes interferes with our abilities to uncover the commonalities and complexities within international medical travel.

Gender

That the three women traveled outside of Yemen—and for their own medical conditions—challenges a common stereotype of Middle Eastern women as oppressed and lacking mobility. Out of the seventy-one cases I learned about from interviews with Yemeni medical travelers in India and Jordan, twenty-seven (38 percent) were female patients, ranging in age from fifteen to over sixty-five years old (Kangas 2007, 317–25). We might be tempted to generalize from this sample that more males than females have access to expensive medical care abroad. However, for an accurate conclusion, we need additional research on the prevalence of serious medical conditions within Yemen by sex and age. We might find that more males than females need specialized medical care abroad because of a greater likelihood to suffer from cancer and complicated cardiac, renal, orthopedic, and neurological conditions. We must also note that medical journeys for female patients (and children) can cost more than for adult males because they often require two travel companions. Ideally, both a female and male family member accompany a female patient, and both parents accompany a child. The female companion cares for the patient in the hospital while the male companion negotiates the often unfamiliar world “outside.”

To understand the gender dynamics within international medical travel, we need to examine not only the prevalence of the various medical conditions by sex and the differing costs involved but also the social and symbolic meanings. In Yemen, male household members acquire social and moral capital by sending female members abroad and feel social pressure to do so. Anne Meneley (1996, 115) observes in her study of women’s social gatherings in a Yemeni town that a husband has two sanctioned ways to publicly demonstrate his affection for his wife: through gifts of gold jewelry and through the time and money he spends on her medical care. Expensive foreign medical care proclaims vast affection, to the patient and to those around her; a lack of care raises concerns (Kangas 2002, 49). Jamila emphasized to me her husband’s readiness to send additional money for her medical checkups. Arwa criticized the indifference with which Nabila’s husband sought treatment for her, exerting the effort to travel to Iraq only when the government subsidized the journey. Unmarried Amal received the care and companionship of her brothers. While

exploring the meanings associated with medical care abroad, however, we should not dismiss these efforts as merely symbolic. I do not want to suggest that male family members are only performing their care rather than feeling it.

Class

The journeys of Jamila, Nabila, and Amal illustrate class differences within Yemenis' international medical travel. Jamila has the ready finances to seek complete annual checkups in Italy and Jordan. Nabila and Amal must borrow money they may never be able to pay back in order to pursue life-prolonging treatments for their brain cancer and kidney failure, respectively. Given the contrast in the ease of travel and type of medical care sought, we might want to characterize the medical journeys of the poor as a need and of the wealthy as a desire. We might even be tempted to call Jamila's journey a medical shopping spree. However, in our efforts to criticize inequities in access to health care, I caution against trivializing or ridiculing the care of the wealthy. We risk caricatures rather than compassion.

Stories of wealthy patients from Gulf countries who travel abroad for medical care often dwell on the extravagance—the large entourages and expansive accommodations. We miss the suffering that motivates the travel and the family members' concern for the patients. Similarly, medical travelers from developing countries are often discounted as the elite, as though we needed no additional details. Nonwealthy patients from the Gulf and developing countries are also dehumanized when their travel is interpreted as an elite pattern, the suggestion being that these patients traveled in order to emulate the journeys of prominent members of society rather than to try to prolong their lives (unless trying to prolong lives is an elite pattern).

While calling for equity in health care, we do not want to begrudge the wealthy their care or recoveries. Jamila's annual checkups in Italy and Jordan could allow the early detection of a serious condition. If stricken with one, she too would need to seek life-prolonging treatments abroad. In the pursuit of health, the distinction between a need and a desire is often fraught with judgments, exaggerations, and callousness.

Globality

I begin this section by further critiquing the depictions of the wealthy and poor within international medical travel in order to call for analyses that capture complexities rather than construct dichotomies. I take the

example of what has been called transplant tourism. This form of medical tourism is often defined as rich foreigners traveling to buy the organs of the poor, who have no choice but to sell them. Presented in this way, the issue is easy to condemn: the wealthy are exploiting the poor (see, e.g., Scheper-Hughes 2000, 2003). Once again, however, the suffering of the medical travelers is elided; we gain little knowledge about the medical conditions that sent them abroad and the concerns and fears that they have for their lives. Furthermore, Amal's medical journey complicates the discussion. Amal is a relatively poor patient from a poor country who borrowed money to have a transplantation. She opted for the transplantation because she believed that she would likely die from dialysis in her country's unreliable medical system. She did not have a relative able to donate, but even if she did, she would have needed to travel abroad to have the transplantation performed; at the time of my research, Yemen lacked the ability to do them. The example of a relatively poor person from Yemen going into debt to acquire a kidney from a Palestinian woman in Iraq requires a much more nuanced analysis than "rich foreigners exploiting poor locals."

The issue of procuring kidneys touches on many of the circulations that characterize today's interconnected world, an interconnectedness that I stress with the heading "globality." The dizzying global circulations of people, goods, money, labor, images, and ideas create a sense of connectedness. They also fascinate us as we learn that one more aspect of life has begun shifting locales rather than staying in place—bodies and body parts. These corporal global circulations generate intrigue. The unbounding of organs, cells, tissue, eggs, and sperm commands us to think about entitlement, ownership, and belonging as never before. However, we can become so caught up in the mobility of the body parts and its implications that we overlook the individuals who need (and provide) them.

Conclusion

The journeys of Jamila, Nabila, and Amal from the capital-poor country of Yemen encourage us to delve into the complexities of medical tourism. We need to question the term itself and the prioritizing of the medical tourism industry over the patients. We must also uncover the commonalities and particularities within all international medical travel rather than overlook or discount individuals from developing countries. The gender and class implications of transnational medical journeys require nuanced analyses that guard against caricature. The global circulations of bodies and body parts intrigue us for their refusal to remain in situ, but this

should not lead to the demonization of the recipients. In conclusion, the three journeys remind us of the importance of focusing on people and their experiences to help humanize our concepts.

*Department of Sociology and Anthropology
Oakland University*

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