

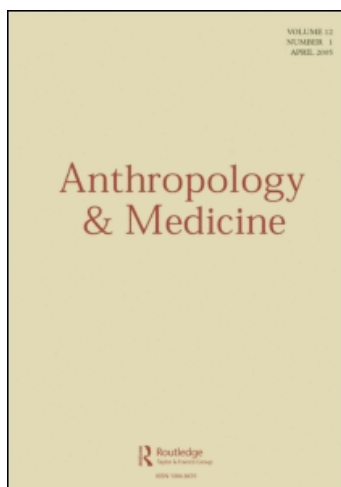
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Affective journeys: the emotional structuring of medical tourism in India

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Affective journeys: the emotional structuring of medical tourism in India

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This paper examines the grid of sentiment that structures medical travel to India. In contrast to studies that render emotion as ancillary, the paper argues that affect is fundamental to medical travel's ability to ease the linked somatic, emotional, financial, and political injuries of being ill 'back home'. The ethnographic approach follows the scenes of medical travel within the Indian corporate hospital room, based on observations and interviews among foreign patients, caregivers, and hospital staff in Mumbai, New Delhi, Chennai, and Bangalore. Foreign patients conveyed diverse sentiments about their journey to India ranging from betrayal to gratitude, and their expressions of risk, healthcare costs, and cultural difference help sustain India's popularity as a medical travel destination. However, although the affective dimensions of medical travel promise a remedy for foreign patients, they also reveal the fault lines of market medicine in India.

Keywords: medical tourism; medical travel; India; affect; caregiving; neoliberalism; corporate hospitals

On December 9, 2009, the American television commentator Glenn Beck threaded his signature angry sarcasm through a report on labour union politics. Explaining how the Service Employees International Union (SEIU) was 'reciprocating' with President Obama for his support, Beck noted that the SEIU's website 'is promoting the greatness of the health care system in India'. He screened a video clip from the SEIU webpage of an American woman who travelled to New Delhi for a hip replacement that cost her \$12,500, and who questioned the \$50,000 price tag for the same procedure in the US. Beck turned to the camera and said plainly, 'The best I can figure is all that money goes to high-tech hospitals and doctors who studied at Harvard rather than Gajra Raja Medical School . . . if you have a choice between getting hip replacement surgery at the Mumbai clinic at Punjab, or the Mayo Clinic, I'm going to go for the Mayo clinic' (Beck 2009; Haniffa 2009). Although he did not term it as such, Beck was ridiculing the phenomenon of 'medical tourism', whereby patients travel to a different country for their healthcare to circumvent high costs, Gordian insurance policies and lengthy treatment wait-times. Among many destination countries, such as Mexico, Thailand, Costa Rica, and Brazil, increasingly such patients are choosing to travel to India for their medical care.¹

Although Beck's disdainful framing of medical travel precluded the possibility that India (a place whose holy river Ganges, he remarked, 'sounds like a disease')

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could provide high-quality medical care to Americans, a different narrative is unfolding in India's 'super-specialty' marble and glass corporate hospitals. In one such hospital, set off a Bangalore highway and emblazoned with an Ivy League university shield on its exterior, this author sat with the head of international patient services, Mr Krishnan.² Mr Krishnan noted that his staff are specially trained to take care of American and British patients, and that the hospital's affiliation with an esteemed US university gives confidence to foreign patients. 'India has positioned itself as tertiary care for the outside world,' he said, more than any other country. 'People trust us with their lives, because caring is part of the Indian tradition.'

Medical tourism makes health a comparative enterprise, wherein treatment options go beyond second opinions and stretch to second countries. Entangled within this journey of comparative consumer choice is an intensely affective reckoning with deep forms of difference. In India, medical tourism's critics have described how it ironically shifts India's place in the colonial medical imaginary, such that 'in spite of fundamental policy failures in public health, India is increasingly seen as an attractive international healthcare destination (Ananthakrishnan 2006). The underbelly of this attraction has even surfaced in popular fiction. For example, Robin Cook's medical thriller *Foreign Body* tells the story of an American medical student who embarks on a quest to India to solve a series of unexplained deaths of elderly Americans who travelled there for low-cost surgery (Cook 2008). These parables of curative exotics and racialized suspicions channel powerful public sentiment, from Beck's insults to the horror of Cook's novel, and from frustrations with roadblocks to healing to the happiness of satisfied patients returned from India.

This paper examines the grid of sentiment that structures the relations between nations, bodies, and forms of care produced through medical travel to India. On these affective journeys, medical travel to India eases linked somatic, emotional, financial, and political injuries of being ill 'back home'. Medical tourism's advocates in India and many foreign patients frame healthcare in the West as inconvenient, expensive, and often hopeless, and assert that India is a place to repair possibilities for hope and healing. Some Indian doctors engage medical tourism as a form of postcolonial critique, and contend that its popularity marks a repair to the imbalance of medical modernity, whereby the hubris of the West has left its citizens sick and stranded, only to be rescued by India's technological ascent. In this circumstance, affect intensifies relations between patients, caregivers, and spaces of care both distant and immediate. The paper's ethnographic focus follows the scenes of medical travel that unfold within the Indian corporate hospital room, a space that materializes the array of sentiments generated through patients' journeys.

The paper's perspective on affect builds on an extensive literature in anthropology and the social sciences concerned with emotions and the structure of caregiving (Lutz 1986; Hochschild 2003). This scholarship does not counter emotion against rationality, or nature against culture; by contrast, it takes seemingly contradictory stances as cultural forms unto themselves (Lutz and White 1986) and as constitutive elements of contemporary public culture (Mazzarella 2009). Affective atmospheres also connect to orders of power and resources that both enable and withhold care, reflected in Sara Ahmed's term 'affective economy' and in Ann Stoler's notion of 'emotional economy' that specifies 'when, where, and with whom sentiments were withheld, demanded, and 'freely' displayed' (Ahmed 2004; Stoler 2002, 168).³ Both poetic and political, these contingencies are 'available to be worked

upon through a whole series of new entities and institutions' exemplified by the assemblage of transnational medical travel (Thrift 2007, 192).

To date, ethnographic engagements with medical travel have focused on the intentions of patients to travel, the problems posed for local communities in 'destination' countries, or prescriptions for future anthropological studies (Augé 1985; Gray and Poland 2008; Kangas 2002, 2007; Sobo 2009; Song 2010; Whittaker 2008, 2009), and a select few engage the issue in India (Bhardwaj 2008; Kangas 2007). These studies clarify medical travel's circuits of bodies and technologies, and begin to address Sobo's (2009) call for anthropologists to disentangle medical tourism's oversimplification as 'globalisation' by many popular media sources. However, although these studies often acknowledge the hope, anxiety, and anger generated through medical travel, some tend to render emotion as ancillary.

By contrast, this paper argues that affect is fundamental to and constitutive of medical travel. Following Biehl, Coutinho, and Outeiro (2001, 94), it considers the affective dimensions of medical travel as 'the new material and medium through which contemporary technoscientific mechanisms of governance are made up' (also see Adams, Murphy, and Clarke 2009; Iedema, Jorm, and Lum 2009; Patel 2007). Thinking about medical travel in this way helps illuminate its mechanics of scale, whereby affect is the linchpin between everyday sentiments and objects, clinical care, and medical travel's institutional structuring. For example, the affect of anticipation guides the journeys of patients seeking what they could not find at home, but it also conditions the handshakes among hospital and government officials that ultimately deem foreigners as possessing more 'return' on investments in healthcare (Adams, Murphy, and Clarke 2009). The affective moments of medical travel mediate locations and scales, from hospital rooms to Ministries of Health to insurance agencies. 'Mediate' is used intentionally here to point to the active force of affect, following Latour's (2005, 39) definition of 'mediators' as forces that 'transform, translate, distort, and modify the meaning or the elements they are supposed to carry'.

Drawing medical travel into these analytics, then, connects transnational forms of biomedical capital (Sunder Rajan 2006) to powerful instances of what Kathleen Stewart terms 'ordinary affects' (Stewart 2007). According to Stewart, everyday forms of emotion, relation, and recognition 'highlight the question of the intimate impact of forces in circulation. They're not exactly "personal" but they sure can pull the subject into places it didn't exactly "intend" to go' (Stewart 2007, 40). The sentiments instantiated through medical tourism exemplify this pull and push of subjects: across geographic borders, through healthcare's apparent dead-ends of solemn resignation and promising, unexpected detours, and into relations with caregivers far from home. On these paths, affect mediates medical travel by connecting illness to consumer choice, and a perceived failure of home healthcare systems to hopes about circumventing them in India. Ordinary affects are not bystanders in life, according to Stewart; instead they give life form. To avoid taking the circuits and flows of medical travel for granted, the paper focuses specifically on the moments of affect that mediate them.

However fragmented and mobile, though, these moments cohere in discrete spaces. Navaro-Yashin (2009) focuses on this process of spatialization, by questioning the extent to which recent ethnographies deem affect a matter of interior subjectivity versus a matter of interactions between humans, objects, and environments.⁴

Reflecting on her field research in Northern Cyprus, Navaro-Yashin uses the term 'affective spaces' to bridge the mutual influences of subject, object, and environment. She writes that her informants' subjectivities 'were shaped by and embroiled in the ruins which surrounded them,' but 'the affect of the ruins had a subjective quality, too' (Navaro-Yashin 2009, 15). Similarly, the hospital room operates as a relational, transformational space for medical travel. It bears witness to and conditions a journey focused on India which is constantly in relation to prior injuries back home.

Comparative values

Patterns of foreigners travelling to India for medical care have an extensive history that predates their more recent publicity, due to services and/or technologies unavailable in the patient's place of origin (Kangas 2002) and to historically contingent ideas about illness and geography (Roberts, forthcoming). The destinations for this travel often are corporate hospitals owned by Indian companies that grew during the 1990s' market liberalisation within a landscape of tiered public-private healthcare facilities in Indian metros (Baru 2005; Duggal 1996; Lefebvre 2008).⁵ Along with advanced technology, these facilities offer a sense of care and empathy that Indians across socio-economic divides complain is missing from overburdened and understaffed government facilities. The affect of care advertised to foreigners is one cultivated in high-end hospitals and reserved for anyone, whether Indian or foreign, who is willing to pay for it.⁶ Tie-ups between hospitals and American, European, and Indian 'virtual broker' medical travel companies help arrange procedures for international patients based on the premise of quality at low cost.

Two distinct but linked origin stories account for medical tourism's recent growth in India, which is estimated to yield 100 billion rupees (US\$2.3 billion) by 2012, according to a consultancy report by McKinsey and Company (Confederation of Indian Industry 2002).⁷ One credits the 'IT boom' that brought India international visibility for its technical acumen, and the other credits the Indian-owned Icon Hospital with the marketing know-how and mastery of giving medical tourism its appealing spin. Indian health rights advocates are quick to point out, however, that medical tourism is not exactly a private venture, because it enjoys 'soft' forms of support from the Indian government, including tariff reductions for expensive equipment, discounts on land prices to hospitals, and regulatory oversight that allows the hospitals to shirk their obligations of a minimum amount of indigent care that is the precondition for government support. Such public-sector support for medical tourism, its critics argue, deflects attention and resources away from the public healthcare sector (Ananthakrishnan 2006; Sengupta 2008; Sengupta and Nundy 2005). The Government of India's visible involvement includes a 2002 National Health Policy that explicitly encourages medical tourism, a system of medical tourism councils set up at the state level, and a new visa category for foreign patients and their accompanying caregivers (Government of India 2002; Ananthakrishnan 2006).

The data for this paper come from six months of observations and interviews during 2005 and 2006, consisting of observations of patient and caregiver interactions; 30 open-ended interviews with patients and doctors in several corporate, NGO, and government hospitals, clinics, and research centres; and 15 interviews with staff in healthcare-related public relations offices and media agencies in Mumbai, New Delhi, Chennai, and Bangalore. The clinical contexts

varied widely, as the destinations for medical tourism range from corporate hospitals to 'trust' hospitals set up by charities or other non-governmental organisations. Others, although far less often the case, are government, public sector hospitals.⁸ This paper concentrates on one particular corporate hospital, called 'Icon Hospital', whose branches the author visited in several cities, and whose patients from the US and Europe were interviewed along with medical staff.⁹ Icon's extensive involvement in medical tourism prompted the choice to focus on its hospitals as primary ethnographic sites.

British and American patients are the focus here because the author is American and was most often introduced to (non-Indian) American or British patients by hospital staff who were ever-present gatekeepers during this research. Left aside, reluctantly, are the narratives of non-resident Indian (NRI) patients, and of patients from South Asia, the Middle East, and Africa, such as Iraqis seeking advanced wound care and Tanzanian parents who received support from a charity to bring their infant to India for heart surgery. Often, waiting room observations entailed conversations with Indian patients who were travellers themselves, coming from smaller towns or rural areas to the metropolises for treatment. For example, in a waiting room in Chennai, an auto repairman from central India waited for his aunt to come out of daylong diagnostic tests for her unexplained joint pain. He explained in Hindi that they did not want to go to a 'branch' – a smaller hospital – but rather a flagship facility, despite the distance from home. As Inhorn and Patrizio (2009) suggest in their concept of 'reproductive exile', a sense of forced relocation sets the limits of 'choice' in medical travel, which remains a reality for many Indians who navigate uneven opportunities for care yet whose experiences rarely if ever filter through medical tourism's broader discursive formation.

The multi-sited ethnographic approach described here enabled a comparative inquiry across regions of India and across clinical contexts, but it also limited patient visits and follow-up, meaning that the analysis ends at discharge and therefore remains speculative regarding 'the journey' beyond the hospital visit. Indian friends often joked that the project was focused on five-star hotels, as they called corporate hospitals, spaces that Lawrence Cohen (1995, 327) describes as 'hermetically sealed, creating through air conditioning and subdued colour schemes an anti-tropical space'. This isolation means that for many foreign patients, their experience of India unfolds principally in the hospital, and their interactions with Indians are limited largely to medical professionals. This also holds true for the ethnographer engaged with them: 'the field' is separated sharply from the quotidian bustle of an Indian urban centre, within institutions that take pride in carefully calibrating how India appears in their halls and encounters. A sense of the generic infuses these interiors, yet despite the hospital room's globalized, English-speaking, biomedical frame, patients (and the researcher) felt compelled to reconcile it with the vernacular. The paper describes these attempts at connection through the narratives of two foreign patients at Icon, one from the US and one from the UK. Materialized sometimes in the briefest of encounters, their affective journeys reveal the intimate textures of healthcare across geographic bounds.

Rubles and rupees

Walking through the international patient ward of Icon Hospital, Gautham, who worked in Icon's international patient services unit, explained that the hospital

sponsors training sessions for its staff in ‘cultural awareness’ as it relates to national preference, and shared mnemonics he learned such as ‘Americans need personal space’ and ‘the British enjoy silence’. In the quiet, sleek ward, he made introductions to Bill and Judy Jackson, a couple in their 50s hailing from a town near a southern stretch of Interstate 95. Bill was propped up on his hospital bed, and Judy sat cross-legged on the sofa next to him in a pink warm-up suit. Bill was soon to go in for orthopaedic surgery after several days of pre-op tests. Bill and Judy were in India because they are two of nearly 46 million non-elderly uninsured Americans (Henry J. Kaiser Family Foundation 2008). By coming to India, they planned to save at least \$100,000 in medical costs associated with a surgery deemed immediately necessary by Bill’s doctors in the US, but whose American price tag was out of their reach.¹⁰ When Bill’s doctors suggested that he explore the option of coming to India, Judy searched online and discovered Globe Health, one of a growing number of ‘virtual brokers’ of medical tourism, and began exchanging emails with their representative. The calculus of cost quickly became self-evident, and guided by the staff of Globe Health, Judy began the process of working towards a trip to India: getting immunisations, corralling Bill’s medical records, submitting passport applications, making airline reservations, and establishing a line of communication with Gautham’s office at Icon. Globe Health facilitated several of these elements, from travel arrangements to in-country administrative details. Judy and Bill paid Globe Health a fee in exchange for these ‘concierge’ services.¹¹

Judy thought the staff in the hospital were kind, and that they take better care of a patient than in the US. But these advantages, she said, had to be put alongside the challenges of their first visit to India, including their responses to crowds, poverty, and a different set of sense stimuli: ‘Some of the smells are really horrific, and it’s hard to get past the smell to eat... I don’t mind trying different things... it’s just Indian food... the smell.’ These criticisms were each prefaced by an apology to Gautham, who stood by Bill’s bed and responded with a polite nod of acknowledgment. Gautham assured them that these issues were commonplace for Western visitors and that Icon prides itself in being able to offer specially catered meals.

Bill said that their confidence came in part from Indian friends back home who highly recommended Icon Hospital, and this helped ease an abiding sense of fear they had of coming to India: ‘We’re just some Southern people, we’ve never been outside the United States, and we were kinda scared stark.’ The Jacksons came with their two college-age children, who were staying in a local hotel and exploring the city. Bill explained that their kids hired a taxi to travel around, and noted that it cost ‘eleven hundred rubles, whatever that is,’ and turned to Gautham to ask: ‘How much is that in American money?’ Gautham immediately replied, ‘I’ll have to check the exchange rate, sir – we don’t have any rubles.’ This added to the mix-up, and prompted Bill to ask, ‘Well, what’s ya’ll’s money called here?’ Gautham responded, ‘Rupees, sir, rupees.’ Bill’s confusion about currency was perfectly understandable: although he had been in India for a week, he hadn’t seen or touched Indian money. The currency of their experience was dollars saved as much as it was rupees spent. He and Judy were taken directly from the airport to the hospital in a car provided by Icon as part of their package deal on Bill’s surgery. They had not and likely would not leave the hospital during their estimated 5-week stay, until it came time for their return home.

The ‘cashless experience’ of Bill’s procedure is central to advertisements about medical tourism to India. It evokes a hospital stay that is painless, worry-free, and

door-to-door smooth, although Bill and Judy's uneasiness, worked out in nervous laughter with Gautham, belied this promise. It also is foundational to what Gautham described as Icon's plans for tie-ups with American insurance companies so that 'all you have to do is produce your card, whoever is your life or health insurance person. With your number, we'll process it.'¹² The Jacksons would be swiping a different card – their credit card – making the trade-off of travelling to India in order to ease their healthcare debt. Gautham emphasized that Bill's experience at Icon was shaping him to become a 'brand ambassador' upon his return to the US, so that Bill could tell others about the possibilities of travelling to India (and to Icon in particular) for care: 'Now this person who had a culture shock coming to this hospital in this city in this part of the world, *he* is the one who gives confidence to the patients there [in the US].' The hospital room, then, operates in part as a laboratory for affective stumbles and repairs that become marked as 'culture' and that can be leveraged to attract future patients.

During an exchange of goodbyes the afternoon before Bill's surgery, a room attendant brought in two Pepsis for Bill and Judy. Bill raised himself on the bed and said:

I don't know how much research you've done on hospitals, but over in the US, people that pay cash for their visits have to pay more than people with insurance, because we have to pay for the ones that don't pay. For the freeloaders in the US. The people that pay their bills, we have to pay for it. And I don't think that's right at all.

With this charge, Bill pushed aside the farce of rubles and rupees to open the space of the hospital room to critique. At stake was the configuration of American healthcare that impelled his decision to travel, and his position as an uninsured American who pays for the 'freeloaders' with either private insurance or government-funded Medicare. In a 'cashless' space of care, he and Judy had understanding listeners in Icon caregivers like Gautham as they reflected on their journey by tying cost and treatment comparisons to differences in sights, smells, and ways of social interaction. Gautham's hope for Bill and Judy was that upon their return, they would share the sentiments generated through their journey as a sales pitch for India and for Icon. Affect in this circumstance is a relational resource that can travel beyond its space of genesis, through a commitment ignited between patients, caregivers, and everyday objects like cash or food. Bill and Judy's case illustrates one pathway to this commitment, via encounters whose elements of awkwardness and humour trigger political critique. Icon's profit depends on this critique, but the trepidation and confusion that form it could potentially cast the Jacksons as figures of incredulity and naiveté, and the springboard for fear-fuelled accounts of medical travel like those of Glenn Beck or Robin Cook. Judy was aware of these stakes. 'People think we're crazy or just plain stupid,' she said of how the neighbours back home judged their decision to travel to India. But she deemed them less pressing than her immediate concern, pointing to Bill in the bed with a Pepsi in her hand, and showing how prior and future entailments lingered over the measure of their journey's success.

Touching lives

On another visit to Icon, Pooja, an international patient care 'hospitality officer,' made introductions to Mark, a barrister from London in his late 50s who had been in the hospital for nearly six weeks for spine surgery. While Mark ambled over to say

hello, a nurse came into the room to take his blood pressure. Cuff on his arm, he grinned: 'You see, this is just how they all are – the help is unbelievable.' The nurse hushed him with a wagging finger so she could get a reading.

Over the course of several meetings together, Mark narrated his back injury in detail, beginning with the car crash in France he believed was its cause, and emphasised his 20 years of chronic pain. The accident gradually reconfigured his life: 'Everything becomes the pain.' His pain became so severe that he was unable to socialise, or to even sit down for dinner. Nor could he play with his children, whose photos were taped around his hospital bed. His wife eventually left him: 'You deteriorate as you go along, and people start saying you're boring,' he said. This was several years ago. His pain was deemed 'in his head' by his doctors in London, and despite his protests, he couldn't get on an expedited list for an MRI. He learned about Icon from a friend, and had an MRI within a day of arriving to India:

The second night I was here, it was 1:30am and I was awake and they asked if I wanted my MRI done, and I said yippee, and they stuck me in the bloody wheelchair and took me downstairs. You wait half an hour, they do so many, over and over. In the UK I would've waited 8 or 9 months, maybe more, for something I've been waiting for, for years and years.

The doctors at Icon eventually found and removed spurs in his spine that Mark insists his doctors in the UK had missed for 20 years.

'This place is very well equipped,' Mark said assuredly. 'Did anyone tell you about the TV?' Mark asked Pooja to turn on the television, and the black screen fizzled and expanded to what looked like an infomercial about Icon. Mark said it was on continuous repeat, and he wound up watching it often at night when he couldn't sleep. Backgrounded by jovial Muzak, testimonial after testimonial from patients attested to the 'magic' of Icon's services on the screen. A distinguished older man came into the frame, explaining the history of Icon with hands confidently folded. 'That's the CEO,' Pooja whispered. The words 'loving care' frequently were uttered in the montage. 'They're right, they're absolutely right,' Mark said matter-of-factly. 'You will not believe the love you get in this place.' On cue, still-shots of the testimonials froze into a mosaic of smiling doctors, patients, and nurses, while an American-accented female voice soared in song in the background:

*Reach out and touch
It's simply magical, knowing you have the power to heal.
Every day, every night
Saving lives by the minute . . . touching lives!*

Mark kept his gaze fixed on the TV, and pointed to his arm: 'Look at my skin. I'm getting – look! – I'm getting goose bumps. Because it's true.' Icon's invocations of love, magic, and salvation were visceral to him. These were not empty promises, he said. He *felt* them in his daily interactions. 'They all speak to you with such courtesy,' Mark noted. 'We'd like this sort of stuff to be in the West a bit, wouldn't we? We'd like people to behave like that a bit on our shores, instead of behaving as we see them on the telly, and the rap videos.'

Channel Icon became an interactive backdrop for the remainder of the time spent together, and reinforced the centrality of the television to the room's affective atmosphere. Mark would offer insights into his condition ('I've been in pain for over 20 years, I've been taking 14 painkillers a day'), and then a crisp feminine voice on the TV would croon an administrative tidbit ('Patients on Icon's package option are

requested to deposit the specified amount in full upon admission'). It seemed impossible to sidestep the intense sense of care at Icon, found in the hospital's slogan of 'Touching Lives' printed on bed sheets and dishes, or materialized in the constant warm, focused attention. Nurses, staff, and doctors all stopped by to greet Mark, and he took several photos with them. Later in the day, in reflecting on Mark's case, a public relations staff member told me, 'Icon's people and services... it's quality care with a human touch... it's just machines and people, but it's definitely the kind of tender loving care which is extended to patients which makes the world of difference.' The intimacy of Icon's care and its incorporation as touch reinforced India's power to set right the affective entailments of foreign injuries.

To Mark, this form of healing intersected directly with his perspective on global flows of capital and power. During early moments of talking about medical tourism, he casually mentioned that he was 'anti-globalization' and that 'globalization is another stick that beats the poor'. When prompted to elaborate, he settled into his custom-fit back support chair ('they brought it especially for me'), and pointed to a stack of books on the desk:

See, I've got these books on globalization, one that I'm giving to Gautham. I was actually going to do a thesis on it, and it was going to be called 'Globalization or the New Colonization?' or something like that. You're colonizing people via trade agreements, whereby you go into their countries, you rape them of their labour, pay them a pittance. I mean, yeah, I'm in India, I'm shocked at the price I'm paying. See, colonization was all about economy, it was about some people from one country going to another country, because they wanted to make loads of money. They wanted their gold, they wanted their spices, they wanted whatever they could get out of them. And then you have the example of India, where a company, I call it the biggest company take-over in the world, The East India Company took over the whole bloody country.

Mark continued on, mentioning the vicissitudes of Coke, McDonalds, and Starbucks invading 'the hearts and minds of the populace'. When asked what he thought about Americans who came to India for medical care, he scoffed:

The richest country in the world has a system that forces dying people to go work to get treatment for terminal illnesses, when they're spending billions of dollars obliterating other societies, whether by globalization, or by funding roads in Afghanistan, or funding warlords who are running the cocaine industry.

Mark thought that Icon had found a way to use medical tourism to its advantage, enabling the treatment it gave to foreigners to be an avenue for caring for sick Indians. 'I think that what's happening is that we're paying for their people,' he said. 'Because the whole ethos of Icon is to give service with a smile, and to make you better.' There was a circuit of service at play in his analysis of the broader healthcare framework in India. Icon gave foreigners love, foreigners gave Icon money, and the money would translate into medical care for sick Indians. The atmosphere of care in the room trumped Mark's critiques of the rapacious nature of globalization. By connecting this space imaginatively to both past and contemporary spaces of coloniality, he envisioned its trickle-down possibilities to underwrite the broader healthcare system in India.

On Mark's last day at Icon, his room buzzed with doctors and nurses taking photos with him and saying their good-byes. The room was filled with a cool, metallic smell from the topical analgesic he sprayed on himself. After the room emptied out, he shared his feelings about leaving India. He said that he was always worried about having spine surgery, wherever it might take place. But after arriving in India and

deeming Icon's surgeons 'very competent' and its facility top-notch, he surrendered: 'I just said, you do what you want, I'm the layperson.' Interrupting him, the electricity in the room cut out and the hum of the generator switched on. Channel Icon (now running on backup power) filled the pause in conversation. Soon after, Gautham called the room to thank Mark for the book about globalization. 'I hope you enjoy it', Mark replied. 'That book is very interesting for what you're doing.' He hung up, and said:

You can write a song about it, a poem about it. All I can say is that the fact is, I came here, they found something wrong, and within a week I had surgery, and because I had so much pain... the pain was distorting my body's view of pain... as far as they're concerned it was small, but my body feels different.

Mark's pain was the touchstone for his recent life, and his visit to Icon opened up new possibilities for that life to become pain-free. He embodied his care at Icon, from the goose bumps of the infomercial to a cooling Ayurvedic sandalwood paste he was bringing back with him to London. Critical as he was of globalization, even locating medical tourism in its scope, Mark insisted that medical travel was a public good for India because it conveyed the 'loving care' of corporate medicine. Icon transformed his body, after freeing him from what he called a prison-like situation of doctors in the UK's National Health Service who concluded that he was imagining his pain, and who prevented him from getting the one diagnostic tool – the MRI – that might yield a remedy. In his analysis, colonization and globalization may be all about economy, but medical tourism (and Icon specifically) was about care, love, and healing, and offered an intimate antidote to suffering.

The promise

Medical tourism offers the promise of escape and repair to patients in dire healthcare straits. In India, the journey often crystallizes within the circumscribed spaces of the corporate hospital – spaces exemplary of the very form of market healthcare deemed to be hopeless in places like the US. Foreign patients in India reflected diverse sentiments: a sense of betrayal by their home countries, often in the register of an escape from restriction; a sense of being off-centre amidst stark differences in India; and a sense of comfort and deep gratitude to their Indian caregivers. Satisfaction over differences in cost and a sense of India tethered to loving care became medical tourism's salient features, as the affective journey of medical travel reanimated the parable of a foreigner who travels to a strange land filled with uncertainties (Pfeiffer 2002). Through the arc of an affective journey, a politics of repair coheres in these narratives by joining together patient subjectivity, risk, healthcare costs, and cultural difference. Affect serves as one channel for what Sherine Hamdy terms the 'political etiologies' of disease: how patients 'explain their disease etiology and illness experience as outcomes of social and political failures' (Hamdy 2008, 554). Judgements that patients make in India constantly tack back and forth to prior injuries, missed opportunities, and present possibilities, and unfold in the hospital room as a chronicle of ordinary sentiments.

What sort of ethical horizons extend from such politics? As Nancy Scheper-Hughes (2005, 164) asks about the organ trade, 'Are we witnessing the development of biosociality or the growth of a widespread bio-sociopathy?' For media outlets and marketers, globalization becomes a convenient, flimsy rationale for India's rise as a

destination of medical care (Applbaum 2000; Mazzarella 2003). Many patients – even Mark with his invocations of colonialism and plunder – consistently landed on a refrain of rescue and relief, and not one of sociopolitical pathology. With few options available, medical tourism offered them a last-chance possibility of getting better. What was pathological, according to them and to their Indian caregivers, was their home healthcare systems whose shortcomings prompted the journey to India. Some patients expressed regret that their isolation in hospital rooms meant that there was little opportunity for them to critically assess everyday life and illness outside the hospital's walls. Very few planned on vacationing after treatment; most were like the Jacksons, who would be in Icon's care from the moment of arrival to departure.

In this sense, the affective spaces of the corporate hospital render other spaces invisible, like those in which Indians themselves turn to private facilities for care in lieu of the often gruff and harried treatment they receive at public clinics and hospitals strained by underfunding and administrative neglect (Das and Das 2006, 188). As Indian health activists have rightly asked: if public resources are funnelled to support corporate hospitals because of medical tourism's profit potential, what will become of public-sector facilities and the kinds of trade-offs their neglect instantiates? These issues merit further debate as medical travel increases, and this article has suggested that an ethnographic engagement with affect can articulate medical travel's problems and possibilities. The affective journey of medical travel encompasses 'countless intricately detailed little worlds built around major social injuries' (Stewart 2007, 43). It is in the spark of encounter where these injuries are found, and perhaps also where they can be eased.

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Notes

1. 'Medical tourism' and 'medical travel' are used interchangeably in this paper to balance the discursive ubiquity of the term 'medical tourism' in Indian media with the term 'medical travel' used in social science scholarship. In interviews, most patients expressed that the vacation element of medical travel was irrelevant if not ridiculous. See Inhorn and Patrizio (2009) and Sobo (2009) on terminology.
2. All names used here, both personal and institutional, are pseudonyms unless noted otherwise.
3. See Ahmed (2004) and Ducey (2007) on emotion, value, and capital.
4. Also see Berlant (2000), Clough and Halley (2007), Mazzarella (2009), and Thrift (2007) for in-depth explorations of 'the affective turn.'

5. See Lefebvre (2008) on the rise of corporate hospitals in urban India.
6. The notion of 'cost advantage' attached to Indian medicine is not new, as historian of science Shamshad Khan points out (2006).
7. The actual numbers reported of travelling patients vary; a common figure is 150,000 international patients coming to India each year, of which Europeans and Americans constitute a small (but growing) percentage, but can vary up to one million, exemplifying what Jean and John Comaroff call 'quantifacts', figures whose 'assertions of the real . . . fill the space between the unknowable and the axiomatic, imagination and anxiety' (Comaroff and Comaroff 2006, 209).
8. The paper's focus is on biomedicine (sometimes called 'allopathic medicine' in India), although there is a significant amount of medical tourism for local healing modalities such as Ayurveda.
9. The author visited several branches of this hospital chain across India, but for the purposes of simplicity each hospital is referred to as its parent company name.
10. This evokes Gay Becker's (2007, 302) notion of 'containment' whereby US health insurance policies marginalize people without insurance. For explorations of these stakes outside the US, particularly following neoliberal restructuring of national health services, see Biehl (2005), Das (2003), and Rylko-Bauer and Farmer (2002).
11. Judy's actions illustrate Gay Becker's emphasis that uninsured Americans are not passive agents in the process of containment, and defy the hotel-like leisure indicated by the term 'concierge'.
12. Icon has since solidified partnerships with several insurance companies, including Blue Cross/Blue Shield and CIGNA.

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