

**THE IMPACT OF OUTBOUND, INTERNATIONAL MEDICAL  
TOURISM ON PRACTITIONER-PATIENT RELATIONSHIP  
DYNAMICS IN THE UNITED STATES**

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by  
Amber S. Roberts  
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Examining Committee Members:

Stuart Schmidt, Advisory Chair, Management

Monica Wadhwa, Marketing

Daniel Goldberg, Management

Lindsey Lee, External Reader, Sport, Tourism and Hospitality Management

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## ABSTRACT

Healthcare costs and accessibility in the United States have driven growing interest in medical tourism (MT). While existing literature addresses ethics, regulations, and quality, a knowledge gap remains in understanding practitioner and patient experiences and relational dynamics. This research employs an exploratory approach to examine how medical tourism affects U.S.-based practitioners and patients, as well as traditional healthcare relationships.

The first study used a phenomenological design with semi-structured interviews of three MT patients, analyzing themes around trust within the practitioner-patient relationship. Findings informed recommendations for practitioner education, enhanced patient support throughout the MT experience, and improved reimbursement for practitioners supporting MT patients. The study was limited by a small, non-representative sample, partly due to recruitment challenges during the COVID-19 pandemic. Similar challenges have been documented among other researchers; however, survey-based studies targeting dentists have demonstrated greater success, given the frequency of routine dental care and the well-defined nature of the specialty.

Building on these findings and persistent gaps in the literature, a second study was designed to survey U.S.-based dental practitioners. This study examines how practitioners' knowledge of dental tourism influences clinical screening practices and patient discussions regarding outbound, international dental care. Using a six-point Likert scale questionnaire, the survey captures socio-demographic data, knowledge of dental tourism, and trust-facilitating behaviors. Descriptive statistics, correlational, and

regression analyses are applied to identify trends and positive relationships. The results are expected to advance understanding of how therapeutic relationships are shaped by patients' increasing access to and utilization of a global healthcare market.

To my family, friends, and classmates – thank you for the motivation and encouragement throughout this journey. And to the patients and practitioners who gave their time and shared their experiences — I am honored and forever grateful.

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## TABLE OF CONTENTS

ABSTRACT .....	iii
DEDICATION .....	v
ACKNOWLEDGMENTS .....	vi
LIST OF TABLES .....	x
LIST OF FIGURES .....	xii
CHAPTER	
1. INTRODUCTION AND BACKGROUND.....	1
The US Healthcare Market .....	3
Provider Compensation and Reimbursement.....	6
Healthcare Reform and Current Trends .....	9
Medical Tourism: History and Current Market.....	12
Medical Tourism Market Size and Industry Trends.....	13
Risks Related to Medical Tourism .....	25
Global Competition on Cost, Quality, and Safety.....	27
The Practitioner-Patient Relationship in the United States.....	28
Trust and the Practitioner-Patient Relationship .....	30
Shared-Decision Making .....	37
2. OUTBOUND INTERNATIONAL MEDICAL TOURISM AND THE PRACTITIONER-PATIENT RELATIONSHIP IN THE U.S. ....	39
Exploratory Study: Methodology, Data Collection & Analysis.....	39
Participant Recruitment .....	40
Data Collection .....	42
Data Analysis .....	48
Results.....	51

Discussion .....	59
Conclusion .....	67
Limitations .....	71
<b>3. DENTAL TOURISM KNOWLEDGE AND EXPOSURE IMPACTS U.S.-BASED CLINICAL DENTAL PRACTICES .....</b>	<b>75</b>
Overview .....	75
Dental Practitioner Knowledge.....	77
Dental Tourism since COVID.....	78
Methodology & Survey Development .....	80
Survey Design.....	80
Survey Security .....	85
Survey Sample .....	85
Survey Testing.....	85
Survey Distribution & Data Collection.....	87
Data Cleaning & Preparation .....	92
Results.....	93
Descriptive & Correlation Analyses .....	94
Hierarchical Regression Analysis .....	102
<b>4. DISCUSSION AND FUTURE RESEARCH .....</b>	<b>107</b>
Discussion .....	107
Trust as a Clinical and Relational Outcome.....	110
Implications for Medical and Dental Education, Clinical Practice, and Policy...	111
Limitations .....	114
Future Research .....	116
<b>REFERENCES .....</b>	<b>119</b>
<b>APPENDICES</b>	

A. SURVEY QUESTIONS.....129

B. GIFT CARD SELECTION SURVEY .....133

## LIST OF TABLES

Table	Page
1. How Consumers' Health Care Preferences Vary by Age (Advisory Board, 2017).....	11
2. Common cosmetic procedure pricing (US and select countries (in US \$). (Franzblau & Chung, 2013).....	16
3. Costs of cardiac procedures in popular destinations (in US \$) (Lunt et al, 2011).....	19
4. Costs of orthopedic procedures in popular destinations (in US \$) (Medical Tourism Association, 2026) .....	20
5. Cost-effectiveness and sensitivity analysis of IVF services in Turkey & USA (US \$ per successful pregnancy) (Yildiz and Khan, 2016) .....	22
6. Costs of gastric bypass surgery in popular destinations (in US \$)(Medical Tourism Association, 2026) .....	24
7. Categories of patient experience affecting practitioner-patient trust (Thom and Campbell, 1997).....	31
8. Patient / Interviewee Characteristics.....	43
9. Interview Guide – Qualitative Phenomenological Study.....	45
10. Interview Questions Mapped to Dimensions of Trust .....	46
11. Substantive Reference Counts .....	51
12. Dental Tourism Knowledge & Experience .....	83
13. Dental Clinic Practices.....	84
14. Data Response & Quality Progression.....	91
15. Data Cleaning Steps .....	93
16. <i>Age Range of Survey Respondents</i> .....	94
17. Respondents Years Practicing Dentistry .....	94
18. Breakdown of Survey Respondents by Gender .....	95

19. Breakdown of Survey Respondents by Area of Dental Specialty.....	95
20. Conceptual Domains of Dental Tourism Engagement.....	99
21. Correlations.....	103
22. Analysis of Variance <sup>a</sup> .....	104
23. Regressions .....	104
24. Coefficients <sup>a</sup> .....	104

## LIST OF FIGURES

Figure	Page
1. Percentage of People by Type of Health Coverage in U.S. (Excluding Puerto Rico). Kaiser Family Foundation 2019.....	4
2. Top destinations, specialties, and expected savings for US tourists (Medical Tourism Association, 2026) .....	18
3. Geographic Distribution of Survey Respondents .....	96

## **CHAPTER 1: INTRODUCTION AND BACKGROUND**

The medical tourism (MT) market has gained popularity in the United States due to high healthcare costs, long wait times, and limited access to certain treatments available in other countries. The global medical tourism market is projected to be worth \$110.97 billion USD in 2026 and is expected to reach \$258.32 billion USD by 2031 (Mordor Intelligence, 2026). Over the past decade, medical tourism has stimulated significant investments in advanced facilities across many developing countries to attract foreign patients. Patients are targeted through online marketing that offers all-inclusive packages, including assistance with scheduling surgery or treatment, travel and lodging plans, medical insurance, and comfortable destinations for recovery (Grand View Research, 2019).

Traditionally, patients traveled from developing countries to industrialized nations to receive care. However, more recently, patients from developed countries have become increasingly willing to travel abroad for medical treatment at international facilities that offer comparable quality for significantly lower costs. On one hand, rising costs, long wait times, limited access, and inadequate insurance coverage in the US are pushing or "forcing" patients to seek alternatives. On the other hand, foreign countries and facilities now provide safe, high-quality procedures, often in desirable locations where patients can recover comfortably at lower expenses. This situation further attracts or "pulls" patients to seek care abroad. As a result, US healthcare providers are increasingly required to guide and offer pre-travel consultations for patients considering medical tourism; they

must also continually adapt to the ongoing challenge of providing long-term follow-up care for patients returning home after treatments abroad (Carruth & Carruth, 2010; Fetscherin & Stephano, 2016).

Follow-up care for patients returning after receiving treatment outside the United States can be complicated, especially when complications develop, when the procedure performed abroad is rare in the U.S., or when U.S.-based healthcare providers have little or no experience with the treatment. The practitioner–patient relationship and continuity of care can be further strained if a provider does not support or has directly advised against a patient’s decision to pursue medical tourism (MT). In these cases, practitioners may face clinical uncertainty, while patients might sense reluctance or skepticism from their providers. Therefore, the increasing popularity of the MT industry poses potential challenges for the traditional practitioner–patient relationship and the delivery of follow-up care (Pashley, 2012).

These clinical challenges arise alongside broader structural changes in the U.S. healthcare system that may encourage patients to seek care abroad. The uncertain future of the Affordable Care Act (ACA), especially after the removal of the individual mandate tax penalty, has raised concerns about the program's long-term sustainability and the stability of the insured population from 2016 to 2026. As a result, the medical tourism industry could benefit from potential declines in domestic insurance coverage, shifts in employer-sponsored health plans, and insurer experiments with covering treatments abroad (Rae et al., 2019). Despite these changing policies and market dynamics, little research has examined how medical tourism affects U.S. healthcare delivery, particularly

the relationship between practitioners and patients. To fill this gap, this proposal explores the following research question:

*How does outbound international medical tourism (MT) affect the healthcare practitioner-patient relationship in the United States?*

A better understanding of this dynamic, especially regarding trust, will improve knowledge about medical tourism among practitioners and provide insights for education, practice guidelines, and policy development. This chapter reviews the literature on outbound international medical tourism and its potential effects on practitioner–patient relationships in the United States. The review begins with an overview of the U.S. healthcare system, including insurance structures, provider compensation models, and recent healthcare reforms that affect access, affordability, and patient decision-making. It then examines the rise and development of the global medical tourism market, covering its history, current trends, and the main reasons patients seek medical care abroad. By analyzing existing research across these areas, this chapter establishes the conceptual and contextual framework for understanding how medical tourism could influence practitioner–patient interactions within the U.S. healthcare system.

### **The US Healthcare Market**

The healthcare market in the United States currently makes up 17.9% of the country's gross domestic product (GDP) and is projected to reach 19.7% by 2026 (CMS.gov, 2019). This growth exceeds that of other sectors of the economy and government spending (Medical Tourism Association, 2019). Medical care is typically managed by local providers near a patient's home (Alleman et al., 2010); however, the US healthcare system is unique among developed nations because it does not provide

universal coverage and varies in quality across the country (DeMichele, 2019). Instead, it consists of a mix of public and private facilities and insurance plans, with patients navigating a complex landscape of insurance policies, medical providers, clinics, hospitals, and billing procedures (Department for Professional Employees, AFL-CIO, 2016). Government healthcare programs serve populations through the Veterans Administration, Medicare, and Medicaid. Medicare is a federal program offering coverage for people aged 65 and older, as well as individuals with disabilities, while Medicaid is a state-operated program that provides insurance for children and those in poverty (Kaiser Family Foundation, 2019). Most Americans with health insurance have private coverage through their employers, with Medicare and Medicaid remaining the primary sources of public insurance (see Figure 1).

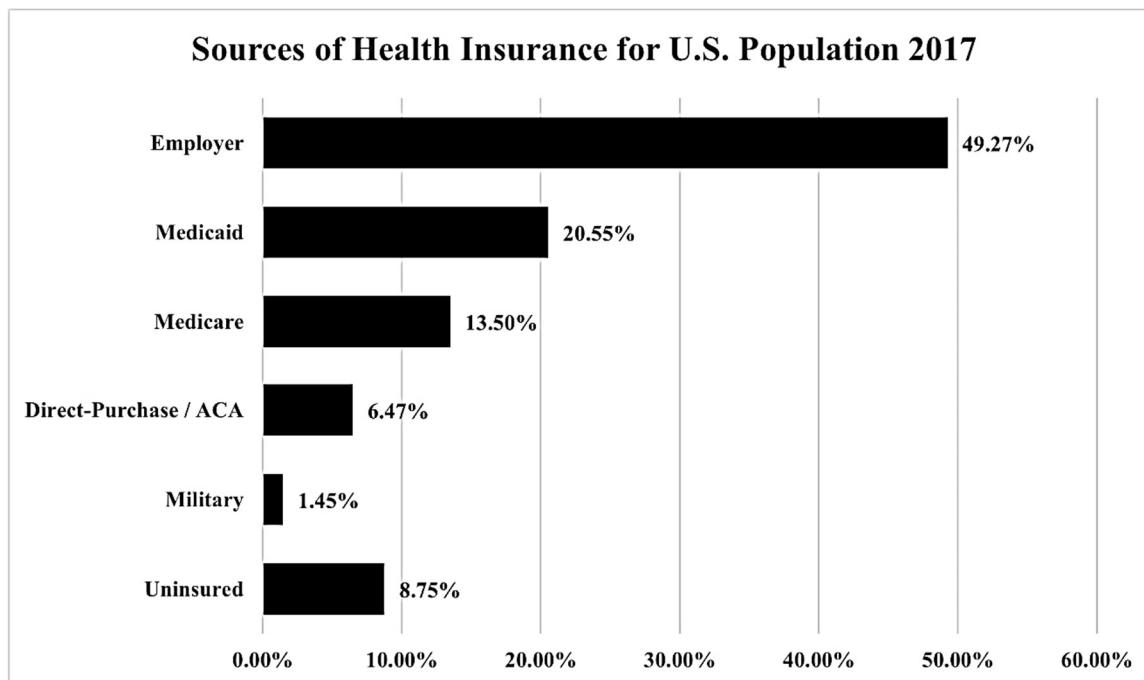


Figure 1. Percentage of People by Type of Health Coverage in U.S. (Excluding Puerto Rico). Kaiser Family Foundation 2019

Among private and public health insurance options, various plans are available where individuals pay monthly premiums based on the plan type, level of coverage, deductible amount, and whether the plan covers an individual or a family. Depending on their employer's benefits, military affiliation, or socio-economic status, a person may qualify for vouchers or subsidies to help maintain their health insurance coverage. These plans help patients cover a range of healthcare costs, including hospital fees, office visits, procedures and treatments, medications, and therapy. However, health insurance policies do not cover all types of care and have traditionally excluded benefits like dental and mental health care entirely. Patients have historically paid for these excluded services through optional, supplemental policies, out-of-pocket payments, or by choosing not to seek care (Medicare.gov).

Plan types include Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Point of Service (POS) plans, Fee-for-Service (FFS) plans, and Health or Medical Savings Accounts (HSAs or MSAs). Health Maintenance Organizations first emerged in the US in the 1970s as a possible solution for systemic quality issues, unpredictable and escalating costs, and lack of accessibility in healthcare. The HMO consists of an administrative arm, responsible for compliance in legal, financial, quality, marketing, and customer service activities, while the professional (practitioner) arm is responsible for healthcare services (Marcarelli, 1976). The continued implementation and expansion of HMOs throughout the 1980s and 1990s significantly impacted the finance and healthcare delivery model in the US, and since that time, the HMO model has been widely adopted but has also given rise to modified offerings allowing greater flexibility and choice for patient-consumers and practitioners (Sullivan

& Rice, 1991). To control costs, HMOs restrict patients to care from a single network provider, known as a Primary Care Physician (PCP), who determines whether patients require specialty care and then provides referrals for such services within the HMO network. This model relies on fixed, periodic payments to increase the predictability of costs, thereby reducing incentives for overutilization (Marcarelli, 1976).

Preferred Provider Organizations contract with healthcare providers on a fee-for-service basis, making it easier for patients to obtain care from providers outside of a network without referrals; however, this comes at a higher cost to patients. Point-of-Service plans are a hybrid between PPOs and HMOs. Similar to HMOs, patients must have an in-network PCP to coordinate their care but may also choose providers both within and outside their network, with higher costs associated with providers outside the network (Sullivan & Rice, 1991). These plans are traditionally limited in covering treatments and procedures that are categorized as elective (not medically necessary), not FDA-approved or experimental, or performed outside the United States. Patients pursuing elective, experimental, or medical tourism treatments generally do so with the understanding that public or private insurance coverage is not available and will need to rely on personal savings or alternative funding sources.

### **Provider Compensation and Reimbursement**

Current compensation methods for healthcare providers are incentive-based and can be understood through agency theory (Robinson, 2001). In this framework, a contract is formed between an individual or organization (the principal) and another party (the agent), whose actions are expected to serve the principal's interests (Ghemawat, 2010). In healthcare, agency theory helps explain how physicians often act as agents while patients

serve as principals. Since patients often lack the specialized medical knowledge to diagnose conditions and assess treatment options, they must rely on physicians to act on their behalf and recommend options that prioritize their health and well-being. This creates an inherent information asymmetry, giving physicians significantly greater expertise and control over clinical decisions than patients.

Therefore, agency theory suggests that patients must trust physicians to act in their best interests when recommending tests, procedures, and treatment plans. At the same time, the theory also recognizes that physicians work within larger healthcare systems that may introduce conflicting incentives, such as financial reimbursement models, organizational policies, or resource limitations. These factors can influence physician decision-making, creating a potential mismatch between the physician's incentives and the patient's best interests. As a result, healthcare systems often try to develop compensation schemes, professional standards, and regulatory oversight mechanisms that encourage physicians to serve as trustworthy agents for their patients while reducing conflicts of interest (Robinson, 2001; Ghemawat, 2010).

Physician reimbursement methods usually combine fee-for-service, capitation, salary, pay-for-performance incentives, and quality-based metrics (Houle et al., 2012). These various payment systems can influence physician behavior in different ways and may affect how care is provided. For instance, fee-for-service models reward the delivery of individual services, while capitation or salary-based models might promote efficiency and cost control. Pay-for-performance incentives and quality metrics are meant to better align physicians' decisions with patient outcomes and care standards. Together, these

strategies aim to create incentives that support the physician's role as a trusted agent acting in a patient's best interests.

Most clinicians in the United States are currently compensated through the relative-value unit (RVU) or similar performance-based systems modeled after the Harvard National Resource-Based Relative Value Scale (RBRVS; Schroeder et al., 2013), which was published in 1988 and adopted by the Centers for Medicare and Medicaid Services (CMS) in 1992 (Berger & Maher, 2011). The RBRVS assigns standard measures for "work performed" by a provider during clinical encounters, and many health systems, especially academic institutions, have widely adopted this concept to evaluate providers' clinical productivity and determine their compensation levels (Berger & Maher, 2011). Clinical performance tracking systems are increasingly built on electronic medical records (EMR) and calculate productivity using formulas based on contact time and effort level (Severance, 2016). Billing practices based on these compensation factors make it nearly impossible for patients to accurately plan for medical costs. This leads to millions of Americans risking the depletion of their savings, falling into debt, and being unable to afford necessities such as rent, food, and heat due to medical bills, even with some form of year-round health insurance coverage (Medical Tourism Association, 2019).

Recent implementation of quality assurance programs and formal grievance mechanisms is intended to ensure that healthcare facilities and practitioners meet acceptable standards of care. The accreditation process involves a systematic inspection of a healthcare facility and its programs, including assessments of staff qualifications and ongoing education, clinical and laboratory procedures, patient consent and disclosure practices, and documentation and record-keeping. In the U.S., hospital accreditation has

become a universal minimum standard because Medicare and Medicaid reimbursements are permitted only at accredited facilities, and some states have made accreditation mandatory for all healthcare facilities. This has led many private insurers to adopt the same requirement (The Joint Commission, 2019). In the US, accreditation standards are linked to better outcomes and generally allow patients to expect a certain level of quality and safety when choosing a facility. While many popular medical tourism destinations have not historically had these accreditation standards and infrastructure, increasing numbers of foreign medical facilities are seeking accreditation through the international branches of US certification agencies.

### **Healthcare Reform and Current Trends**

Recent healthcare reform in the US is designed to drive increased patient choice. In March 2010, the Patient Protection and Affordable Care Act (ACA), also known as Obamacare, was passed and signed into law. The primary goal of the ACA is to provide affordable healthcare coverage for everyone in the US. To achieve this goal, the ACA sought to stabilize the health insurance market by establishing exchanges, or "marketplaces," where individuals could shop for insurance. The underlying premise is that patients, as consumers of healthcare, will be able to identify the best healthcare plans for their unique needs (Johnson et al., 2013) and, in doing so, will stimulate price competition, leading to lower prices and better outcomes for patient-consumers (Kairies-Schwarz et al., 2017). The ACA also has specific standards for provider credentialing and requires facilities to comply with the Public Health Service Act (Kirkner, 2018).

The Affordable Care Act also restructured Medicare payments from volume-based to value-based with the goal of reducing costs, improving quality of care, and enhancing

the patient experience (Value-Based Care, 2018). To promote value-based reform, payment modifiers, bundled payments, and increased quality reporting requirements were introduced to link physician performance, quality, clinical services, facilities, and other health care entities to Medicare payments during an episode of care. When payments for such services are bundled, volume-based incentives are minimized, and efficiency, coordination, and quality are rewarded (VanLare et al., 2012; Mather & Bozic, 2013; Press et al., 2016). So far, most research indicates that cost is the primary driver for U.S.-based medical tourists, and the ACA would ideally lower healthcare costs through increased marketplace competition and patient participation. However, due to repeated legal challenges and appeals, the future and potential expansion of the ACA are unpredictable.

In addition to ongoing reform, emerging healthcare trends are impacting the US healthcare market. Patients, particularly younger generations, are becoming more engaged in their medical care and breaking with traditional healthcare practices to get the best value for themselves and their families. They are increasingly collecting health-related information from a variety of sources, including the internet; this is particularly true for patients interested in medical tourism. A 2017 survey by the Advisory Board of 4,000 consumers across the US shows that younger patients demonstrate lower loyalty to PCPs and are more likely to embrace innovative healthcare services, while baby boomers express higher levels of anxiety about rising healthcare costs (Table 1). The survey ultimately confirms that healthcare companies cannot rely on a standard insurance model or consumer strategy indefinitely. Instead, healthcare companies will need to address the varying needs of all age groups (The Advisory Board, 2019).

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**Table 1.***How Consumers' Health Care Preferences Vary by Age (Advisory Board, 2017)*

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<b>Baby Boomers</b>	<b>Generation X</b>	<b>Generation Y (Millennials)</b>
<ul style="list-style-type: none"><li>▪ Often Managing Multiple Chronic Conditions</li><li>▪ Want Access to Timely Care</li><li>▪ Quality over Cost</li><li>▪ Unlikely to Break a Referral</li><li>▪ Receptive to Virtual Care</li><li>▪ Disinterested in Travel, but cost sensitive about surgical care and making travel a possibility</li></ul>	<ul style="list-style-type: none"><li>▪ Cost Conscious</li><li>▪ Cost over Quality</li><li>▪ Deciding Care for Family (including Aging Parents)</li><li>▪ Willing to Break a Referral</li><li>▪ Increasingly Seeking Care which fits into Busy Lives</li><li>▪ Open to Virtual Care</li><li>▪ Travel is not Make-or-Break</li></ul>	<ul style="list-style-type: none"><li>▪ Cost Conscious</li><li>▪ Interested in Novel Options</li><li>▪ Convenience Seekers</li><li>▪ Referral Rebels</li><li>▪ Online Shoppers</li><li>▪ Reads &amp; Writes Reviews</li><li>▪ Most Likely to Travel</li><li>▪ Embraces Virtual Care</li></ul>

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Despite attempts to control healthcare expenses, the U.S. still spends more on healthcare services than any other nation due to administrative costs, defensive medicine resulting from high malpractice activity and premiums, and inappropriate utilization, all of which continue to drive up healthcare costs (De Law et al., 1992). Fear of malpractice claims is believed to induce medical practitioners to order unnecessary tests and services, thereby maximizing fee-for-service activity. For example, overutilization of costly and high-risk procedures, such as coronary artery bypass surgery, may result from fee-for-service incentives, a lack of communication and knowledge among medical professionals, defensive medicine, and patient demand (De Law et al., 1992). Over the next decade, healthcare spending in the US is expected to be primarily driven by trends in disposable personal income, rising prices of medical goods and services, and an aging baby-boomer demographic, leading to an expanding Medicare population. The patient demographic is particularly relevant as college-educated, White/Caucasian women between the ages of 45 and 64 with incomes between \$50 – 100k USD make up the

largest group of medical tourists. Consequently, cost-sensitive baby boomers, cost-conscious Generation Xers open to travel, and Millennials who are most likely to travel will likely drive growth in outbound international medical tourism going forward (Global Healthcare Resources, 2017).

### **Medical Tourism: History and Current Market**

Medical tourism and the international healthcare marketplace first emerged in the late 18th century, when patients from less developed parts of the world began traveling to major medical centers in Europe and the United States for medical care unavailable in their own countries. The medical tourism market has been growing in popularity due to globalization, the transnational circulation of money, goods, people, ideas, and information worldwide (Mittelman & Hanaway, 2012). This has ultimately led to the rise of outbound international medical tourism, where patients depart their home country by crossing an international border with the intention of receiving a medical treatment or procedure. Domestic medical travel is when patients travel within their own country to other towns, cities, or states to access medical care and does not qualify as medical tourism for the purposes of this research. It is also important to note that unplanned or emergency medical procedures occurring while an individual is visiting or traveling in another country are not categorized as medical tourism.

Despite the costs, effort, unfamiliar surroundings, working with unknown practitioners, and warnings about risks, patients from developed countries have become increasingly willing to travel outside their home countries to receive medical care (Carruth & Carruth, 2010; Fetscherin & Stephano, 2016). Medical tourist data suggest cost sensitivity primarily fuels travel of U.S.-based patients to South America, Central

America, and the Caribbean (Dalen, 2019) while medical tourism has increased among Canadians experiencing significant wait-times and delays in obtaining care (Turner, 2012). Another form of medical tourism, known as circumvention tourism, is characterized by patients using medical tourism to bypass domestic laws, administrative red tape, or social barriers that result in the desired or needed medical care being unavailable or limited within their home country (Jackson et al., 2018).

### **Medical Tourism Market Size and Industry Trends**

Patients traveling across borders for care, or medical tourists, can ultimately be divided into two categories: quality-sensitive (individuals who tend to be more affluent and are seeking better quality and more expensive care abroad) and price-sensitive (individuals with more moderate incomes seeking non-urgent procedures at reduced prices). Some nations do not offer or forbid certain medical procedures, which also motivates patients to travel elsewhere for care regardless of cost (Deonandan, 2015). With an increasing number of countries participating in the medical tourism industry, it is important to understand the industry's current size and growth potential. In 2017, there were approximately 14 – 16 million patients traveling across borders spending an average of \$3,800-6,000 USD per visit with care in the areas of oncology, orthopedics, fertility, cardiology, and neurology being the most sought-after services and highest revenue generators (Stackpole & Associates, 2010; Dalen, 2018). The global medical tourism market was valued at \$16.76 billion USD in 2018 and was estimated at \$41.75 billion in 2024. At one point, the market was expected to reach \$100 billion but has since been revised due to the impacts of COVID on travel and elective procedures. As the market recovers and travel resumes and healthcare systems in industrialized nations such as the

US and UK experience ongoing challenges, the market is now estimated to reach \$80 billion by 2032 (Grand View Research, 2024).

It is estimated that 1.4 – 1.9 million Americans travel outside of the US for medical care annually with the most popular destinations being India, Malaysia, Thailand, Turkey, Costa Rica, Mexico, Taiwan, South Korea, Singapore, and Brazil (AJN Reports, 2017; Patients Beyond Borders, 2019). According to Patients Beyond Borders (2019), inbound patient flow for medical tourists is highest into Costa Rica, India, Israel, Malaysia, Mexico, Singapore, South Korea, Taiwan, Thailand, Turkey, and the United States. India is currently a top cardiac care destination and Singapore is well regarded for complicated surgical procedures. Malaysia has also become another top destination in the medical tourism industry due to a well-developed healthcare infrastructure, affordable treatment options, and favorable government initiatives. Average cost savings realized in medical care across these destinations range from 20% to 90% compared with the United States (Medgadget, 2019). Prior to 2010, only a handful of hospitals and countries promoted themselves as medical tourism destinations whereas today, hundreds of healthcare facilities in over thirty different countries brand themselves as such (Saadatnia & Mehregan, 2014). Rising healthcare costs in developed countries in combination with globalization of communication and transportation technologies have created increasingly attractive opportunities for both patients and developing countries in the global healthcare market space (Fetscherin & Stephano, 2016). More recently, established agencies that accredit outpatient clinics, such as The Accreditation Association of Ambulatory Health Care (AAAHC) and The American Association for Accreditation of Ambulatory Surgery Facilities (AAASF) have also launched international initiatives that address ambulatory

care (Meidinger, 2015). Additionally, the Indian government actively supports medical tourism. To attract patients and further expand the industry, which is expected to bring in \$2 billion in revenue, it has introduced the M Visa for medical tourists which lasts up to 1 year and includes tax breaks to hospitals catering to tourists (Franzblau & Chung, 2013).

Globalization of the healthcare industry has influenced the perception of elective procedures where some medical services are viewed as commodities and patients act as consumers (American Society of Plastic Surgeons, 2013). According to a 2008 poll of American consumers, 39% would consider traveling to another country if the cost was half or less of what is charged in the United States as long as the quality was equal to or better. Additionally, some medical tourism facilities are marketing the ability to have such procedures performed in travel destination, resort-like settings and offering patients the opportunity to recuperate comfortably and privately (Jeevan, Birch, & Armstrong, 2011; Franzblau & Chung, 2013). Finally, the internet and ease of access to information about foreign hospitals, advertisements, and ability to book travel make the process very easy, much like shopping online for electronics and vehicles. This allows healthcare consumers to extensively research and compare before committing to a purchase (Franzblau & Chung, 2013). This also poses a significant risk and vulnerability for the medical tourism industry due to its high dependence on patient volumes supplied by international travel. For example, the travel and tourism sector suffered significant disruption due to the outbreak of a novel coronavirus in late 2019, which evolved into a global pandemic in 2020 (Business Insights: Global, 2020). More specifically, fly-in patient volumes fell by 62% during the last week of March 2020 due to COVID-19-related air travel bans (Dow Jones Institutional News, 2020).

Medical services range from complementary medicine and wellness therapies to more complex medical treatments and advanced surgeries (Treatment Abroad, 2018), but the most common types of procedures medical tourists seek are the following:

***Cosmetics and Dermatology***

According to a report from the American Society of Plastic Surgeons (ASPS), the number of surgical cosmetic procedures in the United States dropped by 16% from 2000 to 2012 due to the 2008 global economic crisis and rising malpractice costs. Cosmetic procedures tend to be elective and are not typically covered by health insurance; consequently, they are a commonly sought out procedure for medical tourists because inexpensive labor and practically nonexistent malpractice liability allows for less costly options outside the United States (Franzblau & Chung, 2013). For example, the cost of breast implants in the United States is approximately \$6,000 versus \$2,200 in India (Table 2).

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**Table 2**  
*Common cosmetic procedure pricing (US and select countries (in US \$)). (Franzblau & Chung, 2013)*

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<b>Procedure</b>	<b>USA</b>	<b>India</b>	<b>Thailand</b>	<b>Malaysia</b>	<b>Cuba</b>	<b>Hungary</b>
Rhinoplasty	4,500	2,000	2,500	2,083	1,535	2,858
Tummy tuck	6,400	2,900	3,500	3,903	1,831	3,136
Breast implants	6,000	2,200	2,600	3,308	1,248	3,871

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In many instances, patients can realize significant savings on cosmetic surgery by having a procedure done abroad, despite the costs of transportation and lodging (ASPS, 2013). Additionally, medical tourists with dermatologic skin conditions like psoriasis are known to seek out clinics situated near destinations associated with potential healing benefits such as the Dead Sea (Bryant, 2002).

### *Dentistry (General, Restorative, Cosmetic)*

Like other areas of medicine, the dentist-patient relationship is important, and a lack of trust can be a barrier to patients seeking care in a timely manner and potentially leading to lower patient satisfaction, greater patient anxiety, reduced compliance with practitioner directives, and less favorable patient outcomes. Despite evidence that most people trust their dentist, there are still concerns around dentist offices over-servicing patients to exploit fee-for-service models (Armfield, 2017). The American Dental Association (ADA) recommends regular dental visits, at intervals determined by a dentist based on the patient's current oral health status and history. Depending on the need for surgery or restorative procedures, dental care can be extremely costly. Consequently, more than 5 million patients traveled to destinations all over the world to obtain dental care in 2010 (Franzblau & Chung, 2013).

Most medical tourists seeking dental care outside their home country are prioritizing price and quality. Today, medical tourists can obtain both quality and cost savings in countries such as Costa Rica, Czech Republic, Hungary, Mexico, Thailand and South Korea where highly competent and skilled dentists can provide care at reduced prices (Figure 2) (Medical Tourism Association, 2026). Patients who live close to an international border form the majority of dental tourists. Approximately 800,000 US citizens, primarily living in Arizona, California, and Texas, crossed the border into Mexico and Costa Rica for dental care in 2010. Europeans near Hungary enjoy similar medical tourism opportunities. Hungary is home to more dentists per capita than any other country and can provide more extensive care, including cosmetic oral surgeries, full-mouth restorations, and implants. This type of dental work can be done in Hungary at

less than half the price a patient would be charged in the United States, including travel and accommodations (Patients Beyond Borders, 2011). Additionally, medical tourists can also find excellent dental care in Thailand where some dental facilities cater specifically to international tourists and are staffed by dentists who have received their degrees and training in the United States (Patients Beyond Borders, 2011).

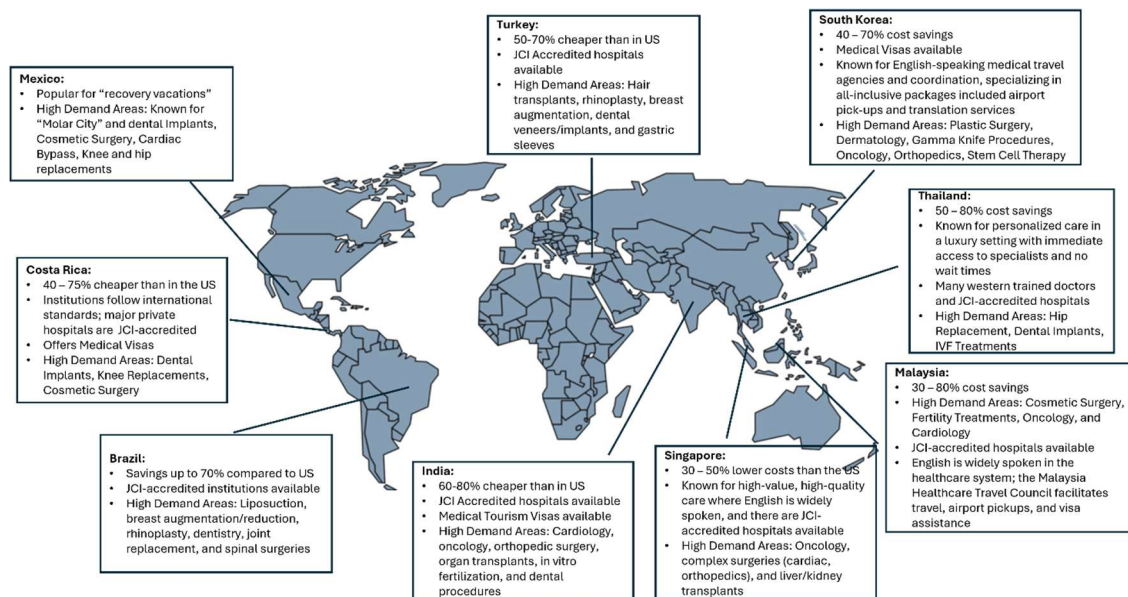


Figure 2. Top destinations, specialties, and expected savings for US tourists (Medical Tourism Association, 2026)

### ***Cardiovascular (Angioplasty, Coronary Artery Bypass Surgery, Transplants)***

Most studies examining trust in the practitioner-patient relationship have been conducted in primary care settings focusing on established relationships between patients and doctors. The nature of the relationship with a specialist, such as a cardiologist, is different in that care is generally received in the context of a life-threatening or chronic condition (Hall et al., 2002; Kayaniyil et al., 2009). Cardiovascular diseases are a leading cause of death worldwide and corrective procedures can be high risk and extremely

costly for patients. Kayaniyil et al. (2009) note that patients report a relatively high degree of trust in their cardiologists with previous studies showing 79% of patients reported complete trust in their specialist after only an initial visit; however, the high cost of cardiac care in the United States is the primary reason for patients seeking treatment options abroad (Andrei et al, 2014).

Countries such as Thailand, India, and Singapore offer cardiology services at significant savings to medical tourists (Table 3) (Lunt et al., 2011). Patients residing in the United States can save tens of thousands, and in some cases hundreds of thousands, of dollars on heart valve replacement, angioplasty, and bypass procedures if they obtain care at facilities in a variety of other countries such as India, Thailand, Singapore, Malaysia, Mexico, Poland, and Colombia. Additionally, many facilities now operate according to standards that are on par with American and European regulations and certified by accrediting agencies (Joint Commission International, 2018).

**Table 3.**

*Costs of cardiac procedures in popular destinations (in US \$) (Lunt et al, 2011)*

<b>Procedure</b>	<b>USA</b>	<b>India</b>	<b>Thailand</b>	<b>Singapore</b>	<b>Malaysia</b>	<b>Mexico</b>	<b>Poland</b>
Heart bypass	113,000	10,000	13,000	20,000	9,000	3,250	7,140
Heart valve replacement	150,000	9,500	11,000	13,000	9,000	18,000	9,520
Angioplasty	47,000	11,000	10,000	13,000	11,000	15,000	7,300

***Orthopedics (Joint and Spine; Sports Medicine)***

The invasive nature of surgery requires extraordinary trust in the surgeon on the part of the patient; however, changes related to the structure and financing of the health care system have placed unprecedented stress on the surgeon-patient relationship.

Although most patients continue to have faith in their surgeons, reports of excessive fees,

referral practices, and financial conflicts of interest have led patients to question the necessity of invasive surgeries, whether they are overpaying, or whether a less risky procedure is available (Axelrod & Goold, 2000). Consequently, there is an increasing trend towards patients traveling globally to receive surgical care.

The most common orthopedic procedures among medical tourists are hip replacement and resurfacing, knee replacement, arthroscopy and joint reconstruction, laminectomy and spinal decompression, and disk space reconstruction or disk replacement (Horowitz & Jones, 2007). According to the Medical Tourism Association (2026), orthopedic surgeries can cost more than five times as much in the United States as in other countries (Table 4). U.S.-based surgeons are pressured to discharge patients quickly, but orthopedic procedures outside the United States can be performed at lower cost and with greater comfort. Patients are allowed longer stays, with more time for recovery than many U.S.-based patients would achieve at home (Axelrod & Goold, 2000; Jeevan, Birch, & Armstrong, 2011).

**Table 4.**

*Costs of orthopedic procedures in popular destinations (in US \$) (Medical Tourism Association, 2026)*

<b>Procedure</b>	<b>USA</b>	<b>India</b>	<b>Thailand</b>	<b>Costa Rica</b>	<b>Mexico</b>
Hip replacement	35,000	8,500	10,000	12,000	12,000
Knee replacement	40,000	8,000	8,600	11,000	12,000

### ***Cancer / Oncology***

Hillen et al. (2011) found that trusting practitioner-patient relationships in oncology are strong overall and facilitate communication and medical decision making, a decrease in patient fear, and better treatment adherence. This is critical as trust is possibly

even more essential in oncology due to the life-threatening nature of cancer. However, the median monthly cost of branded cancer therapies is approximately \$8,700 for a patient receiving treatment in the United States while treatment for patients in the UK and Australia is \$2,600 and \$2,700 respectively (Crowe, 2017). This is likely due to pharmaceutical companies' abilities to take advantage of the U.S. free market system and the trend of health insurance companies continuously shifting a larger share of medical care expenses to patients through deductibles and other premiums (Crowe, 2017).

There is also the additional advantage of being able to access treatments that are not approved by the U.S. Food and Drug Administration (FDA) or offered in the United States. For example, Mexico has long offered non-traditional, holistic treatments for late-stage cancer patients (Fifth Season Financial, 2015), while various types of stem cell treatments are available in Israel, Russia, and China (MacReady, 2009). These factors have made seeking oncology care abroad more appealing, and sometimes necessary, for patients regardless of how positive and trusting the existing practitioner-patient relationship is at home in the United States.

### ***Reproductive (Fertility, IVF, Women's Health)***

The segment of the industry focused on reproductive medicine is also known as "cross-border reproductive care" or CBRC. Infertility is commonly associated with a high emotional burden including distress, anxiety, and depression; thus, effective communication, empathy, and understanding are essential to create a strong partnership within which interpersonal trust develops (Garcia et al., 2013). One of the fastest-growing categories of cross-border reproductive care is international surrogacy. Surrogacy is when a woman of childbearing potential (the surrogate) carries a pregnancy

to term for an individual unable (infertile) or unwilling to carry a pregnancy to term; it has become common practice to provide compensation for such arrangements (Deonandan, 2015).

In vitro fertilization (IVF) is another common procedure that patients seek out due to restrictive regulations, financing of the procedure, medication expenses, and associated wait times (Lunt & Carrera, 2010). For example, some countries restrict access to contraceptives and abortion procedures; therefore, some individuals travel to an accommodating neighboring destination for these services (Cohen, 2015). IVF remains expensive in the United States and research by Yildiz and Khan (2016) demonstrated that quality, cost, and procedure success rates in Turkish hospitals were found to be better than corresponding indicators in US hospitals. The cost difference between IVF services in the United States and Turkey is so significant that the overall cost of obtaining the procedure in Turkey remains lower even with additional expenses for travel and accommodation (Table 5).

**Table 5**

*Cost-effectiveness and sensitivity analysis of IVF services in Turkey & USA (US \$ per successful pregnancy) (Yildiz and Khan, 2016)*

<b>Assumptions about cost and effectiveness parameters</b>	<b>Success Rate</b>	<b>Turkey</b>		<b>Success rate</b>	<b>USA</b>	
		<b>Cost (USD)</b>	<b>Cost per successful pregnancy</b>		<b>Cost (USD)</b>	<b>Cost per successful pregnancy</b>
Average success rate based on patient age and average cost	37.7	8,500	22,546	25.5	12,400	48,627

### ***Weight Loss (LAP-BAND, Gastric Bypass)***

People considered overweight or obese are stigmatized and discriminated against by society throughout the United States and much of the Western world. This stigma also exists within the medical field and studies show that healthcare providers blame patients for their condition and demonstrate negative biases ultimately creating an impaired patient-provider relationship (Gudzune et al., 2011). The prevalence of obesity continues to rise around the world, prompting the continued search for successful weight-management strategies. An increasing number of individuals are seeking surgical intervention for effective and sustained weight loss (Kaser et al., 2009); however, weight loss surgery is an important decision that can have profound impacts on a patient's quality of life and long-term health (PR Newswire, 2014). Consequently, patients are required to meet specific surgical and preoperative evaluation criteria and expected to adhere to a strict post-procedure lifestyle (Kaser et al., 2009). Follow-up care is one of the most important stages of weight loss surgery, and patients need to be closely monitored and have easy access to their bariatric surgeon in the days, weeks, and months after the treatment (Medical Devices & Surgical Technology Week, 2016). Meeting practitioner expectations can be incredibly challenging and stressful for patients and medical tourism provides an alternative for patients who cannot or struggle to demonstrate they are good candidates for bariatric surgery in the United States (Jackson, 2018). The growth of the medical tourism industry has led to increasing numbers of patients from Canada and the United States circumventing the pre-operative evaluation and approval process and instead undergoing bariatric surgery in foreign countries (Birch et al., 2010; Jackson, 2018, Medical Tourism Association, 2026) where reduced wait times and significant cost

savings can be realized (Table 6). With patients primarily self-referring, foreign facilities have significantly increased web-based advertising for bariatric procedures targeting medical tourists to stimulate business (Lunt et al., 2011).

**Table 6.**

*Costs of gastric bypass surgery in popular destinations (in US \$)(Medical Tourism Association, 2026)*

<b>Procedure</b>	<b>USA</b>	<b>India</b>	<b>Thailand</b>	<b>Costa Rica</b>	<b>Mexico</b>
Gastric bypass	35,000	10,000	12,200	11,500	11,500

### ***Other Selected MT markets***

Other areas growing in popularity include transplants, gender reassignment surgery, and stem cell therapies. Transplant tourism is incredibly complex; patients travel for transplantation primarily because of organ shortages, inadequate facilities, and strict regulations in their home country (Franks, 2018). Stem cell treatments for a variety of medical conditions are also frequently advertised via the internet; however, most are clinically unproven. Despite warnings from scientists about the dangers of stem cell tourism, many patients take the risks, sometimes on more than one occasion (Peterson et al., 2013).

Thailand is a top destination for a variety of procedures and has also emerged as the hub for a niche, but growing sector of the MT market called gender reassignment surgery (GRS), also known as gender-affirming surgery in the transgender community (Aizura, 2010). A transgender person is an individual whose gender identity (appearance and behaviors) differs from what society traditionally expects based on their sex (biology and genitalia). Many GRS clinics target non-Thai trans women (people assigned a male sex at birth who later identify as female); consequently, Thailand receives hundreds of

transgender people from the United States, Europe, Asia, Canada, and Australia seeking the procedure (Aizura, 2010).

The relationship dynamics between practitioners and patients are unique in that they form and develop around the life and health of a patient. A practitioner's ability to obtain current and reliable information to provide the most accurate diagnosis depends on effective communication between the patient and the practitioner. Unfortunately, both patients and physicians can withhold or distort information which consequently impacts the doctor-patient relationship (Palmieri & Stern, 2009). In addition to discomfort or hesitation around discussing medical tourism in the practitioner-patient relationship, alternative care deliberately sought and received from a foreign provider, particularly when the patient wants the U.S.-based practitioner to resume follow-up and treatment upon return, may also strain the practitioner-patient relationship.

Many ethicists and practitioners express concern over foreign medical facilities misleading patients or unrealistically raising their expectations through exaggerated promises (Sangappa, 2012). The practitioner-patient relationship, particularly in the specialties described, will likely face new stressors as increasing numbers of patients engage in medical tourism. Learning more from practitioners and patients in these areas may provide some useful insight into how practitioner-patient relationships begin to evolve as medicine becomes more global and patients may engage in one or more medical tourism events.

### **Risks Related to Medical Tourism**

Medical tourism offers important cost savings and accessibility benefits; however, there are also challenges and risks patients may face while attempting to receive care

outside the US. Challenges can include language barriers, lack of local laws and regulatory oversight, travel documentation requirements, and coordinating follow-up care. Additional risks may include lack of adequate care, poor quality, infectious disease, pre- and postsurgical complications, counterfeit medication, antibiotic resistance, and medical errors (AJN Reports, 2017; CDC.gov, 2017). Long waitlists coupled with urgency have created a black market for organs procured through sale or deception and then sold to the highest bidder (Franks, 2018). Consequently, patients receiving organ transplants abroad may unknowingly receive organs obtained through the black market, infected with a disease, or both. There are additional concerns around informed consent, victimization of medical tourists and vulnerable patient populations, and political stability (AJN Reports, 2017).

In the event of complications, such as blood clots and medical errors, patients may not have any rights or effective mechanisms to seek damages for malpractice and may even go as far as spending additional money to purchase specialty insurance to cover such complications (CDC.gov, 2017; Dalen, 2019). United States practitioners may also be hesitant to resume or assume care of patients returning from medical tourism as the Medical Protection Society emphasizes the importance of doctors not acting outside their area of professional expertise and instead referring patients out to colleagues in relevant specialties as appropriate (BMA, 2013). As with most forms of integrative medicine, MT is not taught in any depth in medical school, resulting in a knowledge gap for most providers. Consequently, it may be difficult to find a specialist who feels comfortable caring for post-MT patients, especially those who have experienced complications.

## **Global Competition on Cost, Quality, and Safety**

To address concerns around adequate training and quality standards, there are now foreign medical facilities that obtain and maintain the same or equivalent accreditations through organizations like The Joint Commission (TJC). Accreditation is a helpful standard to guide medical tourists in choosing the best destinations and facilities for their needs. The Joint Commission launched an international affiliate agency in 1999, The Joint Commission International (JCI), in response to growing demand for universal accreditation standards. To secure accreditation by the JCI, an international hospital is required to meet the same rigorous standards as hospitals accredited in the US by TJC. To date, more than 1000 hospitals, laboratories, and special programs in 60 countries outside the US have earned JCI accreditation (Patients Beyond Borders, 2011). Additionally, many overseas healthcare facilities, particularly those targeting medical tourists, are staffed with healthcare practitioners educated and trained in US hospitals (Dalen, 2019).

Although traveling outside the US can make treatment or procedure possible for an uninsured or underinsured patient, continued growth and accreditation in the medical tourism industry have also led to insurance companies considering medical tourism as a cost-saving, quality alternative to the more expensive care in developed nations for patients with private insurance. Consequently, insurance companies such as Aetna, Cigna, United Healthcare, and BlueCross Blue Shield subsidiaries have experimented with limited coverage of medical tourism procedures. The standard policies offered by insurance and medical tourism companies generally cover healthcare complications, medical evacuation, trip cancellation, acute illnesses, and injuries that may arise during travel for the patient and a travel companion. However, the packages and coverage limits

are dependent upon the policy offered by each insurance company (Medical Tourism Magazine, 2018).

Patients often report that the care received during their MT experience was excellent with private room assignments, more personalized nursing support, and longer stays for recovery than what is allowed in the US. Medical concierge services have also been established in some host countries to match patients with facilities and surgeons as well as provide case management throughout the duration of the MT experience (Pashley, 2012). This has likely impacted patient perceptions of foreign practitioners as willing and able to dedicate more time to them at the bedside and has led to higher satisfaction with the overall value or level of care for the price paid. It makes sense for patients able and willing to travel internationally for medical care to do so, given many positive pull factors, but this means U.S.-based practitioners and health systems will struggle to compete for and retain patients, especially for higher-revenue treatments and procedures. At present, revenue generated for the US healthcare industry from inbound medical tourism still exceeds revenue lost to outbound medical tourism. However, some economists and industry experts have expressed concern that outbound medical tourism may affect the US healthcare market in ways similar to Japanese car manufacturers in the US automotive industry (Dalen, 2019). It is important to understand how such pressures may influence consumer, or patient, choice and the practitioner-patient relationship.

### **The Practitioner-Patient Relationship in the United States**

The relationship between practitioners and their patients has received philosophical, sociological, and literary attention since the time of Hippocrates. The topic is the subject of some 8,000 articles, monographs, chapters, and books in the modern

medical literature (Goold & Lipkin, 1999). A visit to a medical practitioner, also known as an encounter, is the foundation of the practitioner-patient relationship in the United States. Much of the medical encounter consists of a medical interview where the practitioner and patient are engaged in an exchange of information. The medical interview has three functions: gathering information, developing and maintaining a therapeutic relationship, and communicating information (Lipkin et al., 1995). Patients use an encounter to inform practitioners about concerns and developments in their health while acquiring and understanding relevant information about their health, treatment and management options, and possible progression over time. Practitioners use the information obtained during an encounter to guide them in diagnosing, prescribing, and making appropriate referrals (Adamson et al., 2018).

The patient has traditionally relied on the practitioner to be the knowledgeable party and take ownership over their care, and historically accepted practitioner decisions and directives. This paternalistic approach to treatment decision-making was the dominant practice in North America prior to the 1980s (Charles et al, 1999). The relationship dynamic is consistent with Bowlby and Ainsworth's Attachment theory, an evidence-based psychobiological theory of human development and relationships (Holmes & Elder, 2016). Although originally focused on parent-child relationships, the theoretical framework is applicable to people afflicted with illness. Patients seek out a wiser attachment figure, or secure base, for comfort and security (Holmes & Elder, 2016) and generally assume practitioners are competent and possess skill and knowledge beyond their own\*\*; patients also trust\*\* practitioners to be responsible for making optimal health-related decisions on their behalf (Tofan et al., 2013).

## **Trust and the Practitioner-Patient Relationship**

The ideal clinical relationship is one in which there is mutual trust and respect and the practitioner-patient relationship figures heavily into studies on trust, respect, communication, and decision-making (Diamond-Brown, 2016). The most expansive body of work on the practitioner-patient relationship ultimately revolves around the construct of trust, which is defined as an "assured reliance on the character, ability, strength, or truth of someone or something" or "one in which confidence is placed" (Merriam-Webster). Trust in healthcare has previously been measured using the Trust in Physician Scale, an 11-item, interviewer-administered measure assessing patient trust in physicians in the domains of dependability, confidence, and confidentiality of information, with all items fashioned in a 5-point Likert format, with a combination of positively and negatively worded questions (Anderson & Dedrick, 1990). Studies in orthopedics (Axelrod & Goold, 2000), cardiology (Kayaniyil et al., 2009), and dentistry (Armfield, 2017) indicate that patients have relatively high levels of trust in their physicians, which impacts overall patient satisfaction and compliance (Skirbekk et al, 2011). Trust is important in reducing anxiety and is highly correlated with patient satisfaction. Results from Thom and Campbell's 1997 exploratory study demonstrated that trust may be impacted by a variety of dimensions such as communication and respect (Table 7).

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**Table 7.**

*Categories of patient experience affecting practitioner-patient trust (Thom and Campbell, 1997)*

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<b>1. Thoroughly Evaluating Problems</b> Carefully reviewing history Demonstrating up-to-date knowledge Willingness to refer Searching for additional information Ordering tests Giving best effort	<b>4. Providing appropriate and effective treatment</b> Recognizing seriousness of condition Making correct diagnosis Achieving desired outcome Use of preventive services	<b>7. Demonstrating honesty / respect for patient</b> Admitting mistakes Honoring commitments Respectful, nonjudgmental
<b>2. Understanding patient's individual experience</b> Responding to patient's needs Knowing patient and family Taking into account patient / family preferences Avoiding assumptions Tailoring treatment for patient Treating patient as unique Considering "whole person"	<b>5. Communicating clearly and completely</b> Active listening Acknowledging patient's concerns Explaining completely and honestly Answering questions Direct communication Being sensitive Being relaxed and calm	<b>8. Predisposing Factors</b> Training Age, sex Recommendations of other patients Professional appearance
<b>3. Expressing caring</b> Concern for patient's comfort Expressions of concern/empathy Offering help Reassuring and comforting Being hopeful Prioritizing patients' interests	<b>6. Building partnership/sharing power</b> Providing options Treating patient as an equal Trusting patient Open to new ideas, flexible	<b>9. Structural / Staffing</b> Courtesy of office staff Messages to physician Obtaining laboratory results Access to physician On-call arrangements

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The authors surveyed trust experiences of 29 patients and ultimately identified the following nine categories of patient experiences positively or negatively affecting trust:

***Thoroughly Evaluating Problems***

The authors reported that over 60% of respondents surveyed shared experiences demonstrating how thoroughness of treatment generated trust. Specific experiences cited included the practitioner obtaining a comprehensive medical history, performing a physical examination, the practitioner seeking additional information on new treatments for the patient, and the physician ordering tests or making referrals.

***Understanding Patient's Individual Experience***

The authors found that for some survey respondents, trust was closely related to feeling personally understood by their practitioner. For example, a doctor showing interest in the patient as a person and how they feel about treatment was reported to increase trust by a patient.

***Expressing Caring***

The study concluded that the behavior of expressing caring provided the deepest sense of impact on patients positive or negative feelings related to trust in their practitioner. Respondents most cited expressions of empathy and actions taken by the practitioner to relieve pain or distress as positive influences on trust.

***Providing appropriate and effective treatment***

Patients ultimately seek out a healthcare provider to provide guidance on their health and the right treatment options for them. The authors found that patients believe good or bad outcomes in their care or treatment are a result of the actions taken by their practitioner. Examples cited by respondents to positively impact trust are the practitioner

seeing them in a timely manner upon communication concerning symptoms or obtaining a consultation from a specialist. Negative examples included delayed or failed action for a diagnostic procedure such as a blood test.

### ***Communicating clearly and completely***

The authors reported that good communication, attentive listening, and careful explanations are considered integral to the quality of care provided and consequently contribute heavily to building trust for the patient. Positive examples shared by patients include a physician actively listening as being an important part of communication to build trust and a practitioner explaining things in a way the patient understands. Negative experiences cited included a physician providing a serious diagnosis but telling the patient they were "lucky" with no additional context and the physician not allowing time for questions or not prioritizing time for questions as part of the encounter.

### ***Building Partnership/Sharing Power***

The authors concluded that physicians working with patients as partners and sharing power over their care were viewed positively by patients to ensure their preferences were considered and needs were met. Positive examples included physicians presenting treatment options for discussion and asking opinions of their patient while a negative example includes a physician who prefers a hierarchical work style or engaging in behaviors that project superiority.

### ***Demonstrating Honesty and Respect for the Patient***

The authors state there were no examples provided by respondents where honesty was cited as a factor increasing trust; however, the limited examples patients provided

describing experiences with dishonesty were particularly detrimental to trust, suggesting honesty is likely assumed and essential to trust.

### ***Predisposing Factors***

Predisposing factors are not based on a practitioner's behavior, but instead include their training, age, or sex, as well as recommendations from another patient. A recommendation or endorsement of a physician's training, professionalism, or bedside manner from another patient builds trust even before the referred patient sees the practitioner. Alternatively, reports of negative experiences with a physician would likely result in a patient avoiding scheduling appointments with that provider.

### ***Structural/Staffing Factors***

Structural and staffing factors include the politeness and accessibility of the staff, communication practices for the office, how easy it is to obtain information, or how long it takes to return phone calls. These factors are also not necessarily dependent upon the practitioner but may be influenced by them. For example, the authors reported that patients cited negative experiences of struggling to get past the front desk to converse with the practitioner, waiting for confirmation your records have been sent or received, and simply not knowing if your messages and concerns are being relayed to your provider.

In summary, Thom and Campbell (1997) researchers found that participants' trust levels are most influenced by their assessments of physician rapport, compassion, understanding, and honesty. Patient trust in physicians increases the likelihood of adhering to treatment recommendations and practitioner service performance is expected to positively impact patient trust (Crutchfield & Morgan, 2010). For example, a patient

will see a practitioner as caring if they show concern for a patient's comfort by making comforting gestures such as gently touching a hand and asking, "How are you today?" If a practitioner fails to exhibit such behavior, a patient will see the practitioner as disinterested or ignoring their needs (Thom & Campbell, 1997). When a practitioner performs well over repeated encounters, patients begin to expect, and trust, their practitioner will consistently do so in the future. As a result, patients place increased value on the relationship and are more likely to commit to maintaining an ongoing relationship into the future unless something changes. Historically, a patient maintained a relationship with a "family doctor" over many years and could even entrust the care of a family to them over many generations.

Research from the late 1970s also shows that patients often seek reassurance or information to ease their fears and concerns beyond merely receiving medical treatment (Stiles, 1979). Patients also look for signs of warmth and interest; however, practitioners are pressed for time in the modern healthcare industry and prioritize obtaining information from or imparting advice on to their patients. A practitioner being aware of his or her responses to patients can help ensure they demonstrate a compassionate demeanor and show they are a good listener and communicator that can be trusted (Stein, 2006).

Patients can also lose trust in practitioners if they feel a practitioner does not share relevant information about their health and options for treatment. Trust can also be lost if patients feel a practitioner's decisions regarding their care were motivated by personal gain for the practitioner, such as a financial incentive, rather than for the benefit for the patient (BMA, 2013). When the practitioner-patient relationship breaks down, patients

may begin to seek information outside of the relationship or transfer their care to another doctor. Alternatively, practitioners may also remove patients from their practice if they are non-compliant with a practitioner's professional boundaries, safety requirements for treatment plans, and payment schedules (Adamson et al., 2018, BMA, 2013). Regardless of whomever initiates relationship termination, the act and process can cause psychological, emotional, and physical stress (Bloom, Asher, & White, 1978). This supports the body of literature demonstrating that frequent and thorough communication and follow-up, respecting and including patients in decisions, offering reassurance, and having more time with patients will ensure the development of a lasting and profitable patient relationship. These practitioner actions are essential prerequisites for establishing a practitioner-patient relationship where an exchange of information can occur and patients feel practitioners respect and seek to understand their concerns without making assumptions (Crutchfield & Morgan, 2010; BMA, 2013).

Trust within the practitioner–patient relationship is reciprocal rather than unidirectional. Mutual trust requires not only that patients place confidence in their healthcare providers, but also that practitioners trust their patients. Historically, research has emphasized patient trust in healthcare professionals, while comparatively little attention has been given to the ways in which physicians experience trust, mistrust, or distrust toward patients (Rogers, 2002). In clinical practice, practitioners must rely on patients to provide accurate medical histories, participate honestly in examinations, adhere as closely as possible to prescribed treatment plans, and report changes in their health status truthfully and in a timely manner. Without this reciprocal trust, the effectiveness and safety of care may be compromised (Rogers, 2002). Medical tourism

(MT) introduces a structural disruption to the traditional, relationship-based model of care. It alters how trust is formed, maintained, and sometimes eroded by changing continuity, information flow, incentives, and expectations on both sides of the practitioner–patient relationship.

### **Shared-Decision Making**

Patients today are increasingly empowered through access to information, healthcare advocates, and multiple opinions to make informed decisions concerning their health. Patients are increasingly engaged in the direction of their care and can frequently choose from a network of practitioners, collect information from a variety of sources, often in the privacy of their home, and ultimately make a final decision to follow a practitioner's recommendations or instead, pursue an alternative. Increased patient engagement and access to information have caused the practitioner-patient dynamic to begin shifting away from the classic agency model and increasingly towards a shared decision model (Elwyn et al, 2012). As patient-centered care and shared decision-making have become new standards of practice, there has been a greater focus on these models in the literature as they relate to the medical encounter (Diamond-Brown, 2016).

Characteristics of the shared decision model require at least two participants – a clinician and a patient – and often involve more than one health care professional, such as a nurse, dietician, or pharmacist, as well as caregivers or relatives (Charles et al, 1999). Information sharing is an essential prerequisite for shared decision-making, where both patients and practitioners bring information to the encounter. The practitioner describes treatment options, expected benefits, and associated risks. Both parties are not required to be convinced that a selected treatment is the best choice, but instead, both parties agree

and endorse or customize a treatment option after some discussion and negotiation and then share responsibility for the final decision. These characteristics distinguish shared decision-making from other models of decision-making (Charles et al, 1999).

Medical tourism (MT) can introduce new dynamics into shared decision-making by expanding where, how, and with whom healthcare decisions are made by adding new actors, information sources, and decision points often outside the local practitioner's direct involvement. Unfortunately, very limited literature exists on how medical tourism specifically affects this relationship, and the few studies that do exist focus on the Canadian healthcare system or alternative medicine (Kelak et al., 2018). Although there is some overlap, alternative medicine differs in that patients are specifically seeking a more natural or holistic medical treatment than traditional Western medicine offers, whereas MT can offer the same or an equivalent procedure at a significant discount, a novel treatment, or even a locally restricted procedure. Applying the above body of literature on trust, respect, communication, and shared decision-making and the traditional clinical relationship will provide a framework to explore the dynamics of the practitioner-patient relationship when patients decide to pursue medical tourism.

## CHAPTER 2

### OUTBOUND INTERNATIONAL MEDICAL TOURISM AND THE PRACTITIONER-PATIENT RELATIONSHIP IN THE U.S.

This chapter reviews the literature on outbound international medical tourism and its potential effects on practitioner–patient relationships in the United States. The review begins with an overview of the U.S. healthcare system, including insurance structures, provider compensation models, and recent healthcare reforms that affect access, affordability, and patient decision-making. It then examines the rise and development of the global medical tourism market, covering its history, current trends, and the main reasons patients seek medical care abroad. By analyzing existing research across these areas, this chapter establishes the conceptual and contextual framework for understanding how medical tourism could influence practitioner–patient interactions within the U.S. healthcare system.

#### **Exploratory Study: Methodology, Data Collection & Analysis**

A qualitative research methodology has been applied for this study using descriptive phenomenology (Glaser & Strauss, 1967) based on semi-structured guided interviews with patients. A phenomenological study describes the common, or shared, meaning for individuals of their lived experiences of a phenomenon and reduces individual experiences to a description of the universal essence (Creswell & Poth, 2018). In other words, phenomenology uses subjects' personal experiences and how they interpret those experiences to draw conclusions about a phenomenon. Qualitative methods allow researchers to develop a more holistic and complete picture of a problem or phenomenon and include analysis of subject's stories, experiences, and personal

perspectives, which all contribute to a greater understanding of a phenomenon (Creswell, 2013). This makes the qualitative method the ideal technique to apply when studying a new area such as medical tourism. Data collection, coding, and analysis of data are ongoing throughout a qualitative study (Glaser & Strauss, 1967).

For this study, data collection consisted of interview notes and transcripts. Interviews, coding, and analysis took place during the Fall of 2019. The rationale for using this approach is that the phenomenological method is best suited for engaging research participants to discuss their feelings and further understanding of the lived experiences of MT patients and the U.S.-based practitioners that care for them. Although increasingly popular, MT is still a unique experience among a limited number of practitioners and patients who have an unusual, shared experience that can be difficult to discuss or revisit and understand without appropriate context.

### **Participant Recruitment**

Individuals were screened for participation in the study and recruited based on the following inclusion criteria:

1. U.S.-based practitioners able to give informed consent
2. U.S.-based practitioners with a patient who traveled overseas to complete a MT procedure
3. U.S.-based patients able to provide informed consent
4. U.S.-based patients who are post-MT procedure ages 18 and over

Participants were recruited through outreach to practitioners who were asked if they had cared for patients who traveled outside the United States to receive medical care. This included a list of pre-identified practitioners at the University of Pennsylvania.

Electronic email communications were sent to practitioners asking them to consider participation in the study as well. Practitioners were also asked to let their patients know about the study and provide them with recruitment materials if they were interested. Flyers were shared with outpatient clinical staff for patients to respond to if they were interested. The expectation was for the recruitment process to be considered complete once a minimum of three practitioners and three patients were interviewed, preferably matching practitioner-patient pairs. However, due to recruitment challenges with practitioners, the final interviews secured included no practitioners and 3 patients. Many practitioners contacted for interviews stated they were interested in the topic and outcomes of the research but were not aware of any patients in their own practice who had participated in outbound MT so they did not believe they would add value as intended. Two practitioners initially agreed to participate. One of these practitioners struggled with scheduling and eventually became unresponsive. The other preferred to only talk "off the record" and avoid signing consent for participation. This was also experienced with a few other practitioners who expressed concern that they would not be providing any identifying details about specific patients and did not understand why they would be asked to sign a consent for this type of research. For this reason, the study moved forward without securing any practitioner interviews as the patient perspective on the topic is still a critically important contribution to the knowledge base.

The study application was submitted to the Temple University Institutional Review Board (IRB) for expedited review. The application was assigned Temple IRB protocol number 25697 and was approved on March 25, 2019. Upon approval, recruitment, consent, and interviews of subjects began in April 2019 and remained

ongoing through November 2019. All participants provided written consent before participating in the research project.

### **Data Collection**

Data were collected from patient interviewees (n=3) (Table 8) via in-depth, individual, semi-structured interviews lasting approximately 45 minutes. Two research participants were multiple sclerosis (MS) patients recruited through professional affiliations at the University of Pennsylvania Neurosciences Center. One of the patients was known personally through previous employment at the University of Pennsylvania. A third patient was recruited through materials designed and approved by the Temple IRB for distribution to healthcare colleagues to further support recruitment efforts. A provider in private practice based out of Lancaster, Pennsylvania responded to the request in the recruitment materials and referred a patient the provider knew to have had multiple dental procedures and an eye surgery in countries outside of the United States.

**Table 8.***Patient / Interviewee Characteristics*

<b>Patient</b>	<b>Gender</b>	<b>Age Range</b>	<b>Race</b>	<b>Medical Condition</b>	<b>MT Treatment / Procedure</b>	<b>Motivation for Medical Tourism</b>	<b>Destination</b>	<b>Procedure Year</b>
1	Female	46 - 55	White	Multiple Sclerosis	Stem Cells & CCSVI Adipose Stem Cells	Treatment not available in US	India Bahamas	2014 2015
2	Female	36 -45	Black	Not Applicable	Lasik Surgery Dental Implants Dental Crown Repair	Cost Savings	Turkey Colombia Mexico	2008 2018 2019
3	Female	46 - 55	White	Multiple Sclerosis	Stem Cells	Treatment not available in US	Mexico	2017

A semi-structured interview guide was developed (Table 9) consisting of select separate sets of questions for practitioners and patients. Questions for practitioners were designed to gather information on practitioners' knowledge levels and trust-impacting behaviors, as defined by Thom and Campbell (1997), as they relate to medical tourism. Similarly, questions for patients were designed to explore experiences in which trust with their practitioner was positively or negatively affected. Due to the phenomenological nature of the study, there was no hypothesis or expected response from patients as this is a relatively new, previously uncaptured experience for U.S.-based patients; however, the previous work by Thom and Campbell suggests patients would cite practitioners' knowledge and awareness of MT or actions taken to search for additional information related to MT-related questions and a willingness to explore and discuss MT options with patients as important to establishing and maintaining trust.

The questions were designed with the intention of being tailored to either the practitioner or patient perspective, yet consistent enough to garner the relevant and consistent information from both sets of participants whether they were matched pairs or not. The questions were then mapped to the dimensions of patient experience affecting trust in the practitioner-patient relationship (Table 10).

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**Table 9.***Interview Guide – Qualitative Phenomenological Study*

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<b>Practitioners</b>	<b>Patients</b>
How would you describe your knowledge level about Medical Tourism (MT) prior to your MT patient? Post?	How would you describe your practitioner's awareness and knowledge of MT?
What did you think when you learned your patient was considering MT?	What was it like for you when bringing up MT for discussion with your US health practitioner?
What did you feel when you learned your patient was considering MT?	How would you describe your healthcare practitioner's reaction when you brought up your interest in MT?
What did you tell your patient when he/she shared they were considering MT?	What did your healthcare practitioner say about MT when you brought it up as a potential option?
What information did you share and provide to your patient inquiring about MT?	What MT related information did your practitioner share with or provide to you?
What did you think when your patient officially decided they were going to go forward with their MT procedure?	How much time did you spend discussing your MT plans with your US healthcare practitioner?
Can you describe the time, efforts, and resources you dedicate to MT patients?	How would you describe your practitioner's reaction when you told them you officially decided to have an MT procedure?
What do you think and feel about providing follow-up care to an MT patient after he/she returns to the US?	How would you describe your practitioner's involvement throughout your entire MT experience?
What do you think and feel about the outcome of your patient's MT experience?	How do you feel about the follow-up care you received or are receiving from your US healthcare practitioners post MT?
What do you think patients considering MT should know?	What do you think healthcare practitioners should know about patients considering MT?

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**Table 10.**  
*Interview Questions Mapped to Dimensions of Trust*

<b>Trust Category</b>	<b>Patient Perception of Practitioner Behaviors</b>	<b>Consequence</b>	<b>Question</b>
Thoroughly evaluating problems	Demonstrating up-to-date knowledge Willingness to refer Searching for additional information	Practitioners' demonstrating behaviors facilitates positive trust experiences while the absence of these behaviors creates negative trust experiences	How would you describe your practitioner's awareness and knowledge of MT? What MT related information did your practitioner share with or provide to you?
Understanding patient's individual experience	Taking into account patient preferences Avoiding assumptions Tailoring treatment for patients Treating patients as unique Considering "whole person"		What do you think healthcare practitioners should know about patients considering MT?
Expressing Caring	Expressions of concern/empathy Offering help Reassuring and comforting Being hopeful Prioritizing patient's interests		What did your healthcare practitioner say about MT when you brought it up as a potential option? How would you describe your practitioner's reaction when you told them you officially decided to have an MT procedure? How would you describe your practitioner's involvement throughout your entire MT experience?
Providing appropriate and effective treatment	Recognizing seriousness of condition Achieving desired outcome Use of preventive services		What do you think healthcare practitioners should know about patients considering MT?

**Table 10.**  
*Continued*

<b>Trust Category</b>	<b>Patient Perception of Practitioner Behaviors</b>	<b>Consequence</b>	<b>Question</b>
Communicating clearly and completely	Active listening Acknowledging patient's concerns Explaining completely and honestly Answering questions Direct communication Being sensitive		How much time did you spend discussing your MT plans with your US healthcare practitioner?
Building partnership / sharing power	Providing options Treating patient as an equal Trusting patient Open to new ideas Flexible		What was it like for you when bringing up MT for discussion with your US health practitioner? What did your healthcare practitioner say about MT when you brought it up as a potential option?
Demonstrate honesty / respect for patient	Admitting mistakes Honoring commitments Respectful Nonjudgmental		What was it like for you when bringing up MT for discussion with your US health practitioner? How would you describe your healthcare practitioner's reaction when you brought up your interest in MT? What did your healthcare practitioner say about MT when you brought it up as a potential option? How do you feel about the follow-up care you received or are receiving from your US healthcare practitioners post MT?

Interviews began with a general question about MT knowledge to help establish rapport, confirm and collect relevant background information, and ease into the more specific interview questions focusing on information pertinent to the practitioner-patient relationship. The intention was to begin a conversation with the practitioner or patient, allowing for a comfortable, flexible flow of information in which questions could be answered in any order that was comfortable for the participant and conducive to the progressive flow of the session, while the interview guide was used to redirect the conversation as needed. Respondent answers could also trigger the researcher to ask additional questions to clarify or further explore a topic. Interviews were conducted via telephone, audio-recorded with participants' consent, and supplemented with field notes, all of which were transcribed.

### **Data Analysis**

The audio-recorded interviews were transcribed using the transcription application, NVivo 12 Plus, a qualitative data analysis software program designed to support data coding, organization, and thematic analysis of text-based and multimedia data. NVivo has been widely used by academic, government, health, and commercial researchers across diverse disciplines since its initial release in 1997 (Dhakal, 2022). Its established credibility and analytic capabilities made it well suited to support the organization and analysis of the unstructured text generated from semi-structured interviews addressing sensitive topics, including trust, medical tourism, and the practitioner-patient relationship.

Each transcript was reviewed by the interviewer while listening to the original audio recording and corrected as needed to enhance transcription accuracy and support

analytic rigor (Morrow, 2005). Following verification, transcripts were uploaded into NVivo 12 Plus for analysis. During the analytic process, each transcript was summarized to identify themes related to medical tourism and participants' perceptions based on their lived experiences.

Analysis began with systematic organization of the raw interview data by interview question. A series of tables was developed consisting of three columns: Column 1 identified the interviewee; Column 2 documented the corresponding response, including relevant direct quotations; and Column 3 provided a concise summary of the response. For the first interview question ("How would you describe your practitioner's awareness and knowledge of medical tourism?"), each transcript was reviewed in full, and relevant excerpts were identified and extracted into the table. This process was repeated for each interview question.

Coding was organized around themes that emerged within responses to each question. For example, responses concerning practitioner knowledge of medical tourism ranged from "knowledgeable" (n = 1) to "limited knowledge" (n = 2). Applying the trust framework proposed by Thom and Campbell (1997), practitioners who demonstrated up-to-date knowledge and a willingness to seek additional information about emerging treatment options were perceived more favorably. Conversely, limited knowledge was described as potentially diminishing trust in the practitioner's guidance regarding medical tourism decisions.

A single investigator served as the primary coder, with a research advisor providing interpretive consultation as needed to enhance analytic consistency. Participant accounts were accepted as accurate representations of their lived experiences. Medical

records were not reviewed, as the study focused on perceptions, feelings, and interpretations regarding the impact of medical tourism experiences on the practitioner–patient relationship rather than on verification of clinical details.

Efforts were made throughout the research process to minimize the influence of personal perspectives, assumptions, and potential biases. The researcher had a prior professional relationship with practitioners at the University of Pennsylvania, where recruitment occurred. To address potential concerns related to insider positioning, reflexive journaling was conducted during both the interview and analysis phases. In addition to participant review and confirmation of statements, the researcher maintained ongoing written reflections to critically examine assumptions and reactions. This reflexive process, consistent with qualitative methodological guidance (Strauss & Corbin, 2015), was intended to mitigate potential bias associated with previous employment and established professional relationships.

For example, reflective notes following the interview with Patient 1 revealed that, despite prior familiarity with aspects of the patient's medical history through professional interactions, the researcher had limited knowledge of the patient's medical tourism experiences, including one event that had occurred since their last professional contact. Similarly, reflections following the interview with Patient 3 highlighted assumptions formed based on familiarity with a specialist involved in the patient's care. However, during the interview, the participant emphasized experiences with a different specialist and their primary care physician. These reflections helped distinguish between prior assumptions and data grounded directly in participant narratives, thereby strengthening analytic credibility through deliberate reflexivity.

## Results

Five primary themes – skepticism, uncertainty, support, research, and accessibility – emerged from the interviews. Participants described a range of reactions from primary care providers, general practitioners, and medical specialists, with responses spanning from supportive to strongly opposed to the pursuit of medical tourism.

Interviewees also provided detailed accounts of practitioner statements, conversations, and behaviors, offering important contextual insight into how discussions about medical tourism and related treatment experiences influenced their trust in their practitioners. The identified themes and their corresponding frequencies are summarized in Table 11, followed by illustrative commentary to contextualize and interpret the findings.

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**Table 11.**  
*Substantive Reference Counts*

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Theme	Reference Count
Skepticism	7
Uncertainty	7
Support	13
Research	13
Accessibility	32

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### *Skepticism*

The perception of practitioner skepticism emerged early in all interviews. Terms or references of skeptical/skeptic, leery, devil's advocate, lack of information, expected efficacy, or ability to cause harm as they relate to a medical tourism treatments or procedures were captured 7 times. For example, when asked "How would you describe your practitioner's awareness and knowledge of MT?" Patient 1 was the only interviewee

who perceived their practitioners as having high levels of awareness and knowledge about medical tourism, stating,

*Oh, they were completely aware. My neurologist was skeptical. Well, with my neurologist being skeptical, it wasn't the most comfortable thing, but for the sake of honesty, and the best treatment I could get, I wanted them to be honest.*

Patients 2 and 3 both perceived their practitioners' knowledge of MT to be limited.

Patient 2 summarized her practitioner's knowledge and awareness of medical tourism as,

*Not very extensive. And it's funny, because I had my first set of x-rays before I went to Columbia, and then I got the six months X-rays after I'd gone, my first round. So they're like, "Oh, you got a lot of work done since we last saw you." I was like, "Yeah, I got it done [in] Columbia," but I live in Maryland, so there's a town called Columbia in Maryland, so I think they probably thought I meant that. So I was like, "No, Columbia, the country," and so they were like, "Oh," and they were a bit leery. They're like, "They don't use the same grade of materials and it may not last as long." So they really kind of tried to discourage or try to make me second guess my decision to go there.*

Patient 3 shared similar skepticism from their practitioner and stated,

*When I had mentioned, especially going to Mexico, he really frowned upon it. I guess because it's Mexico, there are I guess a lot of connotations that it's not a very clean place, you're not going to receive the best care, and things like that. And it was not at all like that. But, yeah, I don't think he is on top of the newest things, quite honestly. I feel like anytime I would ask him about different things, like I said, years ago, that stem cell transplants or stem cell in general, even research on remyelination, it's like I bring up something and he turned around to his computer and types it in and just reads me whatever's online. And I'm like, dude, I can do that. I have done that. So it just to me, doesn't seem like he is very knowledgeable on a lot of the newer things, especially patients traveling to go to different countries.*

*He very much was against it and was trying to talk me out of it. The whole point of the stem cell treatment is to halt progression. And I don't know if he felt like I was already too far gone. My type of MS, since it's progressive, felt like it wasn't really going to help me. So, no, he didn't*

*offer any kind of new information, or a supportive word. I mean he just kind of basically said it's not going to help you, but he didn't have any reasons behind his blanket statement. It just kind of was like, okay go ahead, but you're not going to get anything out of it. And, he didn't have research. And, I know it is new and there isn't a lot of facts, but it's not like he was saying that because he knew that. He was just generally saying that because almost like he was trying to write me off and didn't want to discuss it any further.*

Additionally, the question, "What did your healthcare practitioner say about MT when you brought it up as a potential option?" produced consistent themes of skepticism (focusing on negatives) from practitioners. Patients were consistent across all interviewees in perceptions that their specialists focused particularly on the negatives about MT treatment options. As shown in the narratives above, Patient 1 reported her neurologist as "playing devil's advocate" and Patient 2 recalled that her dentist chastised her, citing concerns that foreign dental providers, "don't use the same grade of materials [that] may not last as long." Patient 3 summarized her neurologist's response as follows:

*I have my neurologist that I had been seeing since I was diagnosed in 2001. And I had been to other doctors for second opinions and different things like that. But I have kept the same neurologist since 2001 through now. And before I had gone, several years when we first started hearing about stem cells, I had asked him his opinions and his response was pretty much, it was too new. He's not real familiar. Basically, told me I was probably going to die. But he agreed that yes, he would see me afterwards as he has up through the years.*

*It was pretty much a slap in the face, that it just hurt that he wasn't going to support my decision. I mean when he flat out told me, "Yeah, you're probably going to die," I was just like, "Thanks a lot." So, I mean I kind of thought he would be more supportive, but I wasn't surprised based on some of my research I had done previous to going because there were several people in our Facebook group that had said their neurologist didn't support it. There were very few people out of the thousands that are on this site that said that their neurologist was for it, or supportive, or*

*interested in learning more of that kind of thing. So I wasn't surprised at all by his reaction.*

### ***Uncertainty***

The theme of uncertainty also emerged from answers to the question, "What was it like for you when bringing up MT for discussion with your US health practitioner?" Patients described their desire for reassurance that they could continue to be medically managed by their U.S.-based practitioners once they returned. Knowing this would offer peace of mind and be sure they remained medically stable after their MT event. Similar references to uncertainty were mentioned 7 times across interviews.

Patients 1 and 3 raised the topic for discussion with their practitioners prior to their medical tourism event and asked their practitioners if they would continue to see and treat them once they returned. Patient 3 described approaching her practitioner by sharing the following:

*And when I actually approached him about going to Mexico for the stem cell transplant, when I had pretty much already made up my own mind I was going, to ask his opinion, not really his blessing, but to ask what he thought of it, and, of course, would he treat me when I returned, he was not in support of me going, and said it was too new.*

Patient 1 cited a concern that her practitioner's skepticism might influence their willingness to see her after an MT event and explained,

*Well, I have heard stories of doctors that afterwards refused to see the patients because they, I don't know, I guess because there's not enough research in the area of, at least with the stem cells. I asked him straight up. I was like, 'Well, if I do this, are you going to still see me? He's like, "Of course I am." I was like, "Okay, just wanted to make sure.*

Patient 2 opted not to disclose her plans prior to her MT event, but shared the following:

*I asked the dental hygienist lots of questions. I mean, issues with cavities, whatever. Just for my own peace of mind to make sure that things are still fine. I've been to that dentist...like twice since I started going to get work done and come here and they have no issues.*

### ***Support***

Support was a strong theme with a total of 13 references across all 3 interviewees; however, it is important to note that most references were specific to the perceived lack of it (n = 9). The question, "How would you describe your healthcare practitioner's reaction when you brought up your interest in MT?" revealed diverging themes related to support between primary care physicians versus specialty practitioners. All interviewees distinguished between practitioner specialty or medical office staff and further commented on potential motivations such as self-interest like billing revenue, which revealed themes of skepticism again. For example, Patient 2 felt her dental work completed abroad did not elicit any opinions from the hygienist she regularly saw for maintenance care, but shared the following thoughts about the dentist and billing representative,

*Honestly, the only people I really got pushback from [at] the dentist office, were the dentists themselves and maybe the billing person who had something to try to chime in for because they have an economic incentive. So yeah. But otherwise, the follow-up care's been fine and I haven't had any complications at all.*

Patients 1 and 2 both stated their neurologists were either skeptical or not supportive respectively; however, Patient 1 reported, "My primary care physician was absolutely supportive 100%." Similarly, Patient 3 reported that her primary doctor's office where she sees a nurse practitioner or physician assistant, and shared,

*Now, my primary, I always see a nurse practitioner, or a physician's assistant, and before I went, they were like, great, good for you. We'll help*

*you whatever way we can when you come back. We'll do your monthly blood test or whatever you need. And they have. They were very supportive, more so than my regular neurologist.*

Diverging experiences between primary care and specialty practitioners were noted when interviewees were asked, "How much time did you spend discussing your MT plans with your US healthcare practitioner?" Patients 1 and 3 could not provide relative quantities but were able to describe their practitioner's efforts and supportive behaviors or lack thereof. Patient 1 explained,

*When I discussed it with my primary care physician, she was just excited and supportive. That made things really easy, getting information and some signatures from her. I needed to get a letter [and] I didn't ask my neurologist for it simply because my primary care was so much more into it and it was easier, and she's local for me. I basically needed a letter stating that I had multiple sclerosis and that I was in her care, and how long I had been under her care.*

Patient 1 has a practitioner who was willing to spend time discussing and even prioritizing her MT-related needs. This is consistent with the positive support theme (n = 4) identified and associated with altruistic primary care practitioners.

The following two questions, "How would you describe your practitioner's reaction when you told them you officially decided to have an MT procedure?" and "How would you describe your practitioner's involvement throughout your entire MT experience?" reveals practitioners adjust their behavior once the patients confirmed and began preparing for their MT event. Patient 1 explained her neurologist "*didn't tell me not to do it*" while Patient 3 describes a sort of resignation to the idea of MT on the part of her neurologist in quoting his statement to her, "*You've always been very opinionated and if you're going to go, go.*" Additionally, all three interviewees reported no involvement, coordination, or communication from their specialists while receiving their

medical treatment or procedure outside the United States. The theme of support re-emerged again for the noted lack of involvement throughout the process.

### ***Research***

Research was a core theme across all MT experiences discussed (n = 13). When asked, “What MT related information did your practitioner share with or provide to you?” patients stated there was no information provided by their practitioners and detailed how they conduct their own patient-initiated research on treatment opportunities in the US and other countries. For example, Patients 1 and 3 heavily leveraged internet searches, Facebook discussion groups, interviews with foreign medical facilities, and conversations with post-procedure MT patients. The patients stated that beyond their own research, no MT related information was provided or shared by practitioners; however, Patient 1 reported her PCP “offered to give me immunizations in case I needed them,” but she knew they were not required to go to India, so she declined. Patient 3 did not disclose plans for MT prior to travel so the question was not applicable, but like the other interviewees, she conducted her own research and leveraged available sources to fill information gaps not addressed by their U.S.-based practitioners. Additionally, Patient 2 is currently researching options for a breast reduction in India where she can opt for a liposuction procedure instead of the more invasive surgical procedure with significant pre-approval requirements in the United States.

### ***Accessibility***

Finally, the theme of accessibility as it relates to costs savings and limitations for novel treatment opportunities in the US, such as stem cells, was referenced considerably (n = 32). Interviewees were asked, “What do you think healthcare practitioners should

know about patients considering MT?” and all patients stated that some aspect of the care they needed was limited or inaccessible in the United States due to cost or lack of availability. Patient 1 explained,

*When a patient resorts to medical tourism, it's because they're desperate and they don't feel like they're getting what they need here [in the US]. And, it's not to be derogatory to the particular doctor, but in my case, I couldn't get stems cells here or the kind that I felt I needed at the time. And, I don't know if doctors feel like, if they take it personally when you go. I don't know. But, I would hope that they don't. But their hands are tied. It's nothing personal.*

Similarly, Patient 3 asked, “*Why doesn't the United States have this type of thing?*” And Patient 2 stated, “with dental procedures becoming more expensive, it's just when people who have the means to do so, I think [medical tourism] it's inevitable.”

Interviewees were also asked, “How do you feel about the follow-up care you received or are receiving from your US healthcare practitioners post MT?” to better understand how they perceived any changes in the practitioner-patient relationship post-MT experience. All interviews reported that they resumed the normal routine with their practitioner upon return. Patients 1 and 3 used the phrase “pretty much the same” as before their MT event to summarize their post-travel visit schedule and approach to treatment with their U.S.-based practitioners. Patient 2 similarly described her dental visit schedule and routine as 6-month visit intervals for dental maintenance just as it was before her MT event. The return to normalcy supports patients' beliefs of needing to seek out more desirable options for themselves as things will remain status quo in the United States and they would regret not seizing the opportunity.

## **Discussion**

Due to inability to recruit practitioners to interview for this study, it was not possible to determine if U.S.-based practitioners have similar desires to support patients seeking treatment abroad and instead act out of concern to limit liability. Many practitioners contacted for interviews stated they were interested in the topic and outcomes of the research, but were not aware of any patients in their own practice who had participated in outbound MT. Consequently, they did not believe participating in the study and providing an interview would add value. Crooks et al (2015) also confirmed it is difficult to get practitioners to discuss this phenomenon as they are not convinced it applies to them. Despite the inability to secure practitioner interviews, patient interviews provided several insights into the impacts of outbound MT on trust in the practitioner-patient relationship. Patients' statements were analyzed against the categories of trust and subsequently summarized.

### ***Thoroughly Evaluating Problems***

Patients place greater trust in practitioners who demonstrate up-to-date knowledge, search for additional information to help them, and give their best effort to treat the patient. If a practitioner is limited in what they can do for the patient, the patient wants the practitioner to be willing to recommend and refer them to where they can access additional options or a higher level of care. Study participants articulated initiating their own research efforts to learn about outbound medical tourism options. When they sought to discuss what they read or learned with their specialists, two patients shared that their practitioners did not demonstrate current knowledge of medical tourism. Patient 3 reported the practitioner looked up the treatment during their clinical encounter but

simply read aloud what was posted on the internet. The interviewee was already familiar with this information based on her own research and felt that the practitioner added no value to her consideration for treatment abroad. For the interviewee, this signaled a lack of knowledge and interest in current treatment options for their specific health needs.

When asked about practitioners' knowledge level regarding medical tourism, the interviewees noted practitioners' "skeptical" or "leery" nature toward MT. If practitioners are not mindful of how they express skepticism, even when justified, a patient's trust and confidence in their practitioner's knowledge may be adversely impacted. Knowledge determines the quantity and quality of information a practitioner is likely to provide, and both Patients 1 and 2 reported that their practitioners offered no information. Practitioners should be aware of patients' perceptions as they may not trust their practitioner's ability to search, gather, process, and relay up-to-date information. This may result in patients not communicating their intentions, questions, or interests with their practitioner and lead to trust issues for both the practitioner and patient, which are counterproductive to the therapeutic relationship.

### ***Understanding the patient's individual experience***

A patient will place greater trust in a practitioner's therapy recommendations if they believe the practitioner understands and considers their unique circumstances related to their condition, family situation, and treatment preferences. This requires the practitioner to limit assumptions, look at the patient as a "whole person" as opposed to their diagnosis and symptoms, and tailor treatment to a patient's specific needs.

Interviewees explained that they resort to MT for affordability, greater treatment options, and hope in desperate situations. Patients may choose MT because of financial pressures

in the US and foreign medical facilities offering clear and transparent pricing that make it easy for them to compare and plan for their treatment. Patients were also pursuing MT because they are desperate to get better or slow advancement of their condition and this should not be considered an insult to a U.S.-based practitioner. The experiences of Patient 1 and Patient 3 demonstrate the lack of insight practitioners may have into the thoughts, concerns, and anxieties of their patients. For example, while recalling the discussion with her neurologist to confirm he would still be her doctor after the MT treatment, Patient 1 explained, "He looked at me like I was crazy. He's like, 'Of course I am.'" Based on the interaction described by the patient, the practitioner was surprised by the question. Although most practitioners may intend to continue medically managing and maintaining an ongoing practitioner-patient relationship post-MT events, it is important to acknowledge that both Patients 1 and 3 were unsure if they would be welcome back to the practice. This is likely the case for many MT patients as Patient 1 reported, "there was a Facebook page for the folks that went to India, and to hear some of their stories and how they were then turned away by their neurologists because they had gone overseas to get stem cells. I couldn't believe it." Patient 3 also belongs to a Facebook group and stated, "there were several people in our Facebook group that had said their neurologist didn't support [the stem cell treatment in Mexico]." Practitioners should be aware that the internet is heavily leveraged by patients interested in medical tourism and social media platforms enable patients to communicate and share experiences and information. An ongoing challenge with social media sites is the access to persistent chat and discussion posts that may contain and highlight sensationalized "horror stories" or even misinformation with no fact-checking or disclaimers. Patients may also become doubtful

if they encounter multiple stories reinforcing narratives of practitioners refusing to continue managing the care of patients who pursue medical tourism. Couple that with practitioners showing skepticism or not volunteering any reassurances, and patients are sure to experience uncertainty. Despite the topic being uncomfortable for patients, they are still taking the initiative to ask the difficult question to remove the added uncertainty. This suggests practitioners might be making assumptions about the mutual expectation for the clinical relationship post-MT; however, patients are not making the same assumptions, and it is important for the two parties to be clear to either reestablish or maintain trust.

### ***Expressing caring***

Practitioner demonstration of empathy, offering help, and being hopeful is important to patients. Patients feel more at ease with a practitioner who they believe cares about them. A practitioner who cares will consider and share news of advancements or new treatment possibilities with patients. Study participants' experiences reveal an incredible opportunity to nurture increased trust in the practitioner-patient relationship. When sharing what their practitioners said about medical tourism, all the interviewees reported they experienced a practitioner focusing on the negatives. This may be due to a practical approach by practitioners in discussing risks. It is important to note that the two multiple sclerosis patients who traveled outside the US to receive stem cell treatments both rely on wheelchairs and a practitioner may feel stem cell treatments are unlikely to reverse the level of disability accumulated up to this point; however, Patient 2 perceived her practitioner's comments as chastisement while Patient 3 perceived the attitude of the neurologist to be apathetic when he told her "okay go ahead, but you're not going to get

anything out of it." Practitioners should understand that patients want practitioners to prioritize behaviors of caring, expressing empathy, or being hopeful because patients are balancing potentially negative aspects of MT with hope and a commitment to finding treatment options that align with their interests. Another important aspect of caring is offering help. All interviewees reported no involvement from their practitioners while traveling for their MT event. Patients 1 and 3 reported receiving support from primary care offices with pre- and post-travel activities; however, none of the interviewees' primary care or specialists offered to reach out and have a conversation with the foreign medical providers. Although not required or standard of practice, the offer to help would have been appreciated by these patients. For example, Patient 1 shared, "I don't know how much time the doctors would be willing to spend trying to communicate [with foreign medical providers], but it would be very beneficial, I think." Patient 1 also reflected on the experience and stated, "Had I had the experience [or knowledge], I would have said, 'Hey, would you be willing to talk to the people in India?'" A practitioner's lack of involvement may be motivated by the practitioner's perceived increase in risk for both themselves and the patient. For example, a study found that domestic Canadian physicians desire to provide patients with information to support them in making an informed decision regarding medical tourism treatments, but they avoid participating in the decision-making process to limit increased liability. However, the more the home physician is involved, the more likely it is that there will be a better medical outcome for the patient (Crooks et al., 2015). Practitioners can pull insights from the study participants' experiences to better understand how they can offer to help and support patients once they have decided they will pursue an MT procedure or treatment.

### ***Providing appropriate and effective treatment***

Patients seek out and maintain clinical relationships with practitioners because they trust they will receive effective treatment for their health care needs. In the case of Patients 1 and 3, none of their previous therapies had produced desired results and they later became interested in more innovative and aggressive treatment options. The patients found stem cell treatments for multiple sclerosis (MS) that were not available in the US and considered their reliance on wheelchairs a factor in determining that the potential benefits outweighed the risks; thus, classifying the treatments as appropriate for their individual circumstances that they wanted to discuss with their U.S.-based practitioners.

For Patient 2, the appropriate and effective treatment was available in the US and would have likely required the patient to take on significant debt. The dentist and billing representative likely did not recognize how cost prohibitive the \$16,000 quote was for the patient. Without the dentist offering appropriate alternatives, the patient sought out and found equivalent care at an accessible price appropriate for her individual circumstances.

It is also important to note that the interviews shed light on an incredibly interesting concept of trust and faith not just in practitioners, but also in the US healthcare system. They all saw their pursuit of medical tourism as an opportunity to access novel or affordable care that they do not believe is accessible in the US and were willing to take the chance and place that trust in other countries and international practitioners to provide a novel and innovative therapeutic option or simply equivalent care for a low cost, flat fee provided upfront of the service.

### ***Communicating clearly and completely***

A practitioner's willingness to listen, answer questions, and engage in honest discussion about a patient's concerns is essential to trust in the practitioner-patient relationship. It is important for practitioners to listen, explain completely and honestly their reasons for wanting to include or exclude treatments for consideration. Patient 3 explained that her attempt to discuss stem cell treatments with her neurologist was met with the practitioner citing a lack of information on the treatment and suggesting the treatment likely would not help her. Patient 3 perceived the practitioner's response was simply a result of not wanting to discuss the topic of medical tourism any further due to their skepticism.

Active listening, sensitivity, answering questions, and thorough and honest explanations are important for communication to foster and maintain trust in the practitioner-patient relationship. The experience of Patient 3 demonstrates a lack of good communication at a critical time in her medical care. Consequently, the study participant may be unlikely to seek future opportunities for open and efficient communication with her neurologist about medical tourism or other significant treatment opportunities as she perceives the practitioner as "writing her off" and any topics she raises for discussion unworthy of his time or attention.

### ***Building partnership/sharing power***

Building a partnership and sharing power is another important element of trust in the practitioner-patient relationship and not only requires that the patient trust their practitioner, but also that the practitioner demonstrates trust in the patient. Additionally, patients' expectations of practitioners are evolving, and they want practitioners to engage

them as equal stakeholders in decision making when discussing treatment options. Patients want practitioners to be flexible and open to new ideas. This is particularly important for patients considering MT. A strong partnership between a practitioner and patient creates an environment to openly discuss alternative treatment options and the potential for the U.S.-based practitioner to collaborate with a foreign provider for the benefit of the patient.

***Demonstrating honesty/respect for patient***

A practitioner's respect for their patient is critical to sustaining a relationship as patients feel they entrust their livelihood to the practitioner and live with the benefits and consequences of any action or lack of action related to treatment. Patients understand there may be bad news but want their practitioners to share honest concerns and objective, evidence-based information over opinionated judgements. Patient 3 described a concerning encounter when she informed her practitioner about her plans to travel to Mexico for stem cell treatment. She perceived her neurologist as frowning upon medical tourism in Mexico because of the perception that it's not a very clean place, as opposed to the practitioner providing any clinical data demonstrating evidence of poor or concerning outcomes.

Responses from study participants bring up important considerations for the medical industry related to standards and professionalism. All patients perceived differences in the way practitioners responded to their medical tourism plans and experiences. A practical explanation for these differences is that some practitioners provide preventative maintenance care such as PCPs or hygienists versus specialists who manage more complex conditions and care like neurologists and dental specialists; thus,

they may feel more is at stake with MT and are more skeptical. Nevertheless, practitioners' projection of judgment or non-judgment is an important component of demonstrating respect for the patient. Furthermore, any perception of negative responses and unsupportive behaviors as motivated by financial incentives could seriously erode trust in the practitioner-patient relationship. For example, Patient 3 cited a financial incentive as potential motivation for her being chastised. She chose to have dental work done in Colombia to save approximately 50% on the cost quoted to her by a U.S.-based dentist for the work she required. She explained the following:

*The only people I really got pushback from, from the dentist office, were the dentists themselves and maybe the billing person who had something to try to chime in because they have an economic incentive. But most of the time I spent in the office itself was with the dental hygienist. So, I just made sure that I asked him lots of questions. Just for my own peace of mind to make sure that things are still fine. I've been to that dentist, I mean, like twice since I started going to get work done and come here and they have to no issues. So, everything's fine. They check the, actually the implants. Like I did my job correctly so, and my teeth look okay.*

Additionally, patients are finding medical tourism treatment options online via patient discussion boards and social media sites and communicating and informing each other about medical tourism procedures. One of the MS patients shared that treatment protocols are accessible online and available to review. Patients want practitioners to approach these treatment protocols with the same mindset they would with any U.S.-based treatment protocol.

## **Conclusion**

Since the late 18th century, patients have been crossing international borders to receive medical care. Historically, patients from underdeveloped countries traveled to developed nations to access modernized healthcare services; however, high costs and

long wait times in developed nations have led to patients increasingly taking advantage of medical and technological advances in emerging, lower cost markets. This has led to the current medical tourism phenomenon which is gaining in popularity among emerging markets aiming to target patients from developed nations and achieve buy-in from insurance companies. As increasing numbers of U.S.-based patients explore treatment alternatives through medical tourism, the foundation and dynamic of the US healthcare business model built on the practitioner-patient relationship faces the potential for significant alteration. Instead of U.S.-based practitioners providing patient care from start to finish, including extensive workup of the patient, performing the procedure, and providing follow-up care, a practitioner may now spend a significant amount of time working the patient up, only to have them complete the highest piece of the value chain across borders and then return for follow-up care.

The standard guidance is still for patients to receive treatment stateside in the name of better quality, ethics, and regulations; however, MT will likely continue to gain popularity as emerging markets can offer competitive pricing alternatives and cuts to the Affordable Care Act over the last decade threaten to increase the number of uninsured Americans. Consequently, practitioners will find themselves in an increasingly familiar situation of being expected to support patients preparing for an MT procedure and then resume management of the patient's care upon their return. Therefore, it is essential to educate practitioners, health administrators, and insurance companies about medical tourism and the lived experiences of U.S.-based patients and practitioners respectively seeking and providing care before and after an MT intervention. Findings from this study

are intended to add to the limited knowledge on the practitioner-patient MT relationship and contribute to the industry in the following ways:

1. Describe the medical tourism experiences of patients and their providers
2. Understand practitioners' current level of knowledge about MT and how they advise patients pursuing this increasingly popular option
3. Develop a better sense of the time and resources required by practitioners to counsel and care for patients pre and post MT procedure and opportunities for reimbursement or value creation
4. Help practitioners better understand the patient's perspective and experience when seeking advice and support in their MT journey
5. Suggest or propose ways the healthcare industry can evolve to better serve and support practitioners and patients regarding MT

Advancing knowledge in one or more of these areas may substantially improve the pre- and post-MT experience for both practitioners and patients. This was a small, exploratory study intended to identify any new themes related to the impact of outbound MT on US healthcare dynamics. Patients interviewed for the study effectively articulated a variety of ways in which practitioner behaviors impacted trust in their clinical relationship. It is important that practitioners, healthcare administrators, and government agencies understand connections between trust, the therapeutic relationship, and MT as it poses unique challenges to the US healthcare landscape and sustainability.

Ideally, research findings can be utilized to educate practitioners about MT trends in their industry and how to talk to patients about MT. Additionally, the findings may provide insight on how to encourage patients to engage their practitioners in their MT

process earlier. Finally, these findings also have the potential to contribute to the identification and/or development of sustainable strategies for both practitioners and healthcare systems that could be implemented as the medical tourism industry continues to evolve and expand.

Some interesting and unexpected findings were related to reliance on primary care physicians (PCPs) for support related to MT, practitioner lack of knowledge, and patient consideration of future MT procedures. Study participants reported their PCPs were more supportive of their medical tourism interests than their specialists. This resulted in them engaging their PCPs for more specialty related care. On one hand, engagement of PCPs this way could be good for their practice but may also risk placing greater burden on PCPs when specialists are better positioned to review and discuss potential MT procedures and protocols with patients.

Considering how practitioner knowledge levels impact trust and sustainability of the practitioner-patient relationship, medical schools should consider adding medical tourism to the curriculum so that practitioners understand motivations for it, evolving treatment landscapes outside the US, and how to actively listen and discuss MT-related topics with patients. Healthcare administrators can consider similar measures regarding implementing best practices for patients considering MT based on guidance provided by professional organizations such as the American Medical Association (AMA). Although the media highlights a number of concerning stories about MT where outcomes are negative, patients are also having good experiences. Two of the patients in this study had more than one MT experience and one patient is considering going for a third procedure, a breast reduction.

Finally, some additional thoughts to consider are that patients' increased reliance on social media and websites for novel or more aggressive treatment options, and patient testimonials may place them at risk for being exposed to privacy or financial scams. Additionally, the dental patient also shared an emerging trend she learned about where U.S.-based practitioners are starting to travel abroad to take advantage of the simplified fee structure, which translates to a simplified reimbursement or payment structure for practitioners. This could potentially have a significant impact on an already difficult provider availability issue in the US and exacerbate existing disparities in accessibility of care.

It would be a gross over-simplification to categorize patients' reactions, feelings, thoughts, and perceptions of how a medical tourism event impacts the practitioner-patient relationship as positive or negative. Patients are experiencing, processing, and categorizing practitioner reactions on a very thoughtful level and drawing informed, experienced-based conclusions that the US healthcare community should pay careful attention to. Patients are disappointed by negative reactions, but expect such reactions based on other patient stories they encounter while researching medical tourism options on the internet and communicating with other patients via social media platforms or patient discussion boards. Healthcare administrators and practitioners have a unique opportunity to leverage insightful feedback directly from post-MT patients as the medical tourism phenomenon continues to grow.

### **Limitations**

Phenomenological research is highly dependent on the researcher; consequently, efforts to eliminate avoidable biases in the data analysis process were implemented

including recording and transcribing interviews. To ensure the experience of participants was captured as intended, research participants were provided with a copy of their transcript to verify the accuracy and "trueness" of the data. Another researcher also assisted with data analysis and comparison of findings to ensure reasonable consistency.

Phenomenological research also presents ethical considerations for subject confidentiality. The researcher intends to eventually share pooled, generalized findings within the academic community and healthcare industry among a variety of stakeholders including practitioners, patients, medical associations, and health systems. The researcher will exercise caution to reduce the likelihood of disclosing participants' personal identifying information by converting physical documents to electronic records whenever possible and shredding any paper records that are not necessary. Electronic files were also maintained on a password-protected device. Additionally, the researcher dedicated time to speaking with participants and educating them specifically about how their data and the information would be shared, which was intended to help participants grasp the potential outcomes of their involvement in the research (Kaiser, 2009).

Additionally, there are limitations with sample size and diversity of the patient sample. The study set out to interview both patients and practitioners but was only successful in securing interviews with patients. As a result, the sample size is too small and limited in the desired diversity required to apply generalizations from findings to larger patient populations. All interviewees were female between, aged 36 - 55; consequently, the findings do not offer insights into any potential differences in the experiences of male, non-binary, or transgender patients and other age groups. The interviewees consisted of 2 White and 1 Black patient; thus, the perspective of other

racial groups is absent, and the sample size does not allow for generalizations to either the represented groups or any other racial groups.

The patients' experiences captured a limited range of medical tourism procedures with interviewees focusing on stem cell therapies and dental work. There was a significant exploratory element to the study as patients were not limited to discussing their experience with one practitioner as modern medical care often involves multiple practitioners, but this added variation in patients sharing experiences and thoughts on a range of providers including primary care physicians, neurology specialists, dentists, hygienists, nurse practitioners, and office staff / billing specialists.

Many of the practitioners contacted for participation in the study stated that they were not aware of any of their patients traveling outside the US for care, so they did not believe they would add value as intended. They acknowledge that they have had patients inquire about medical tourism, but nothing further resulted from the conversations. This was unexpected considering practitioners were recruited from a variety of locations and specialties and the large estimates for outbound MT activity from the US over the past few years. Two practitioners initially agreed to participate; however, one of these practitioners struggled with scheduling and eventually became unresponsive. The other preferred to only talk "off the record" and avoid signing consent for participation. This was also experienced with a few other practitioners who expressed concern that if they would not be providing any identifying patient details, they should not need to sign a consent. For this reason, the study moved forward without securing any practitioner interviews and consequently, no practitioner-patient matched pairs.

Future studies addressing similar research questions require more robust sample sizes including increased representation for racial groups, gender and non-gender conforming groups, age groups, and medical tourism treatments and procedures to better understand the implications of this phenomenon on the practitioner-patient relationship. Future studies should also develop methodologies accounting for practitioner variability as philosophy of care differs among practitioners based on their training, specialization, credentials, and personal approach. Finally, further research is needed to better understand how many U.S.-based practitioners are talking to patients about MT versus seeing and actively managing care for MT patients after they return to the US. It would also be very beneficial to understand if practitioners widely screen for location of treatments and surgeries versus primarily focusing on just the treatment or surgery, date, complications, and outcome. This would provide insight as to why it is difficult to identify practitioners that have MT patients in their care. And most importantly, the opportunity to receive input from practitioners via a survey or interviews will be incredibly important for understanding if and how medical tourism impacts their approach to care, resource consumption, and relationship dynamics including their level of trust in patients as most studies focus only on patient trust in practitioners.

## CHAPTER 3

### DENTAL TOURISM KNOWLEDGE AND EXPOSURE IMPACTS U.S.-BASED CLINICAL DENTAL PRACTICES

#### Overview

Results from an initial phenomenological study using semi-structured interviews with a small sample of three medical tourism patients (Temple IRB number 25697; approved on March 25, 2019) demonstrated that medical tourism does impact the practitioner-patient relationship. Interviews with study participants revealed that patients place greater trust in practitioners who demonstrate up-to-date knowledge, search for additional information to help them, and share information and treatment decisions with the patient. Patients are gathering significant information on their own by browsing websites and patient discussion boards, as well as by speaking with other medical tourism patients, third-party medical tourism companies, and foreign clinicians. Patients also vary greatly in their willingness to engage their local practitioners in discussions about medical tourism. In some cases, practitioners are a trusted and vital source of support for patients pursuing medical tourism, while in other cases, patients do not notify their practitioners of their medical tourism intentions until after they have traveled and completed a procedure. Additionally, patients have chosen to pursue medical tourism despite their local practitioner's advice against such procedures.

Insights from the dental patients in the study further support the opportunity to examine the unique connection among dentists, patients, and the medical tourism industry. The patient in the pilot study regularly visits her local U.S.-based dental provider for routine hygiene appointments and has an ongoing relationship. However, she

required more significant and costly dental procedures at two different times, and she chose to travel outside the United States to receive high-quality yet affordable dental care. She reported being satisfied with the services she received both times, despite being reprimanded by the dentist and the office's billing manager. She believed this reprimand was motivated by financial incentives rather than her best interests as the patient and customer, even though she continued returning to that practice for her routine care. Her experience indicates that practitioners and staff may also perceive or be influenced by dental tourism, which could affect their relationships and interactions with patients, potentially impacting trust. Therefore, further research involving dentists seems promising, especially given the frequency of routine care and the established dental tourism industry. Focusing on dental tourism will enable more targeted studies on this specific sub-specialty.

Since the first study, the coronavirus (COVID-19) pandemic significantly impacted the medical tourism industry between 2020 and 2022 due to travel restrictions, delays in elective procedures, and strain on local economies and hospitals. Additionally, the literature on medical and dental tourism remains limited in its focus on patient volume, demographics, destination of care, therapeutic areas, and potential risks or ethical considerations, while a gap persists regarding how outbound international medical tourism impacts clinical practices in U.S.-based clinics. Consequently, there is a need to better understand the current state of U.S.-based practitioner experience, particularly as it relates to knowledge about outbound international dental tourism, to understand the following question:

*How does U.S.-based dental practitioners' knowledge of and exposure to outbound international dental tourism affect clinical screening practices?*

### **Dental Practitioner Knowledge**

Trust is a key component of the practitioner-patient relationship for both patients and clinicians. Thom et al (2011) developed and validated a measure of physician trust in the patient as part of a study of prescription opioid treatment of chronic, nonmalignant pain. Patient trust in physicians was measured by a patient's perception of a provider's ability to thoroughly evaluate problems, understand the patient's individual experience, express caring, provide appropriate and effective treatment, communicate clearly and completely, build partnership and share power, demonstrate honesty and respect for the patient, staffing, professionalism, and infrastructure of a provider's practice, and other factors such as training, demographics, and recommendations.

Grob et al (2019) state that limiting measurement of physician trust in patients to a list of providing accurate information, answering questions honestly, and adhering to physician guidance is short-sighted, and the foundation of the relationship must move beyond patient adherence to a collaborative partnership reflecting the patients' values, preferences, and abilities. These researchers believe practitioners can demonstrate trust in their patients by paying careful attention to verbal and nonverbal communication, using the shared decision-making model, and addressing implicit bias that may affect patient care.

Sousa-Duarte et al (2020) provide a literature review of healthcare professionals' trust in patients, but more explicitly focus on distrust. An asymmetric flow of information between a practitioner and patient may result in distrust and uncertainty. The authors also

recognize the role of implicit bias in physician distrust, as healthcare professionals may perceive risks in trusting certain patients or patient populations, stemming from past breaches of trust and a sense of vulnerability to medico-legal complaints or liabilities.

Tiwari et al (2023) specifically investigated trust in the Patient-Dentist Relationship using an 11-item Dental Trust Scale, employing both quantitative and qualitative methods. They noted that a dentist's relationship and trust with the community rely on provider competence, compassion, reliability, and dependability, similarly to the relationship between patients and practitioners discussed in the first study. Tiwari et al. (2023) also note that trust between a dental practitioner and their patient can significantly affect patient utilization of care, satisfaction, and compliance with treatment; therefore, providers must understand how to develop and maintain trust with patients across cultural, socioeconomic, language, and insurance comprehension factors. These factors may be relevant to practitioners with limited knowledge of dental tourism, who are skeptical of it due to poorly informed biases, or who have treated patients with negative dental tourism experiences.

### **Dental Tourism since COVID**

Dental tourism is an ideal sub-specialty for studying the impact of medical tourism on the practitioner-patient relationship, given the duration and frequency of interactions between a patient and their dentist. The American Dental Association (ADA) recommends regular dental visits, at intervals determined by a dentist based on a patient's current oral health status and history; consequently, patients are typically seen twice a year for preventative hygiene appointments and check-ups, or more frequently if needed. This may result in a stronger relationship dynamic than in other healthcare sub-

specialties, as visits with primary care physicians are recommended only every 1 to 3 years, and most doctors spend an average of 13 – 24 minutes per visit, depending on their specialty. However, similar pain points for dental care around costs, inadequate insurance or a lack of insurance coverage, complex billing, and wait times have been compelling some U.S.-based patients to consider dental tourism. In 2010, more than 5 million patients traveled to destinations worldwide to obtain dental care (Franzblau & Chung, 2013).

The dental care model in the US is primarily designed around preventive (recommended bi-annual dental hygiene visits, annual x-rays) and restorative treatment (replacing missing or damaged teeth with crowns, bridges, etc.); however, dental care can become complex when considering that additional levels of care can range from purely cosmetic (teeth whitening, straightening/braces) to oral surgery (requiring surgical incisions into the gums to remove decay, perform extractions, or place implants). Additionally, patients continue to exercise greater control over the direction of their dental health with easy access to information on the internet and multiple providers / second opinions. Increased patient engagement, access to information, and dental care costs have shifted the practitioner-patient dynamic towards a shared decision-making model (Elwyn et al, 2012). The shared decision model requires the dentist and patient to exchange information (medical history and patient prognosis/diagnosis), and the practitioner then describes treatment options, expected benefits, associated risks, and costs/payment options. What is important is that both parties agree to pursue a selected or customized treatment option after engaging in discussion and negotiation and then share responsibility for the final decision (Charles et al, 1999). To expand upon the results of

the first study, which aimed to understand how medical tourism impacts the practitioner-patient relationship, a questionnaire was adapted from a New Zealand survey of dentists to focus on a subgroup of dental practitioners in the United States.

A questionnaire from a 2018 study (Lovelock, Lovelock, and Lyons) focusing on the impact of outbound medical tourism on the generating region (New Zealand) included questions to understand how medical tourism affects the practitioner-provider relationship. The first section of the survey established dental practitioners' knowledge of dental tourism. The second section focused on practitioners' perceptions of dental tourists, the circumstances in which survey participants encountered dental tourists, the types of treatments patients expressed interest in or presented with, and related information. That section also asked questions about how practitioners' encounters, discussions, and relationships were impacted by patients' interest or choice to participate in dental tourism. The third section surveyed perceived issues arising from dental tourism and how it impacted practitioners, patients, and their relationship. The final section collected information on participants' demographics, including age, gender, ethnicity, and professional background.

## **Methodology & Survey Development**

### **Survey Design**

To provide an easily accessible solution for data collection with the targeted dental practitioner population, a 20-question survey, created in Qualtrics, was distributed via email to a random sample of U.S.-based dentists to assess dentists' knowledge of the dental tourism phenomenon and its impact on their practices and patient engagement.

Qualtrics offers a cloud-based platform for creating and distributing surveys. Advanced logic for questions and security can be designed into the survey.

The consent form and survey questions were designed to take no more than 10 minutes to complete; however, since most survey respondents will view the survey on their mobile devices, the content may feel lengthy to scroll through. To reduce survey fatigue, inattention, and cognitive overload, the survey was made short and avoided long or repetitive questions. The design also included different question order options to help ensure respondents stayed attentive.

The survey begins with a consent document explaining why survey respondents are being invited to participate in the survey and the goal of the research, how many questions are in the survey, the types of questions in the survey, how long the survey is expected to take, how the data collected in the survey will be used, who may see the data, how many people were expected to participate, what potential risks may be involved, opportunities to enter a raffle for compensation, and who to contact if they have questions or concerns. This consent was followed by a radio button selection asking individuals if they agreed or declined to participate.

The remainder of the questionnaire is divided into 3 segments: Patient Demographics, Dental Tourism Knowledge and Experience, and Dental Clinic Practices related to dental tourism. The Patient Demographics section contains eight (8) questions to gain insight into the socio-demographic characteristics of respondents, as these may impact their exposure to dental tourism and their trust-facilitating behaviors regarding the phenomenon. The Dental Tourism Knowledge and Experience section contains seven (7) questions to assess practitioner comfort, knowledge, and experiences related to dental

tourism, while the Dental Clinic Practices section consists of five (5) questions to evaluate how the dental practitioners are screening patients for interest in dental tourism and engaging in trust-facilitating behaviors with patients. These two sections of the survey utilize Likert scales.

The Likert scale is widely recognized as an easy and reliable scaling technique for measuring and understanding respondent perception (Tanujaya, 2022). A 6-point Likert was chosen to reduce neutral responses and push respondents to lean towards either a positive or negative position, rather than the 5-point Likert, which can lead respondents to repeatedly select the neutral middle option. Each Likert question has 6 options (6-point Likert), and the respondent marks their response via a sliding scale that registers a selection labelled from 0 to 5, with 0 indicating the least engagement/knowledge and 5 indicating the most engagement/knowledge (Tables 12 & 13).

**Table 12.**  
*Dental Tourism Knowledge & Experience*

0	1	2	3	4	5
<b>What is your comfort level discussing and answering patient questions about dental tourism?</b>					
Discomfort	Slight Discomfort	Neither Comfort nor Discomfort	Somewhat Comfortable	Moderate Comfort	Fully Comfortable
<b>What is your knowledge level regarding dental tourism?</b>					
None	Minimal	Basic	Moderate	Good	Expert
<b>To what extent have you encountered dental tourism in the media you interact with?</b>					
No coverage	Minimal Coverage	Intermittent Coverage	Moderate Coverage	Regular Coverage	Significant Coverage
<b>To what extent have you read research / professional articles about dental tourism?</b>					
Never	Minimal (one article)	A few related articles	Intermittent review of related articles	Moderate review of related articles	Significant review of related articles
<b>To what extent have you discussed dental tourism with colleagues?</b>					
Never	Minimally	Intermittently	Moderately	Regularly	Frequently
<b>To what extent have you encountered medical tourism information in professional and/or industry settings such as attendance at conferences, workshops, or lectures?</b>					
Never	Minimally	Intermittently	Moderately	Regularly	Significantly
<b>How many patients over the past 2 years have asked you about dental tourism?</b>					
0 patients or unsure	1 – 5 patients	6 – 10 patients	11 – 20 patients	21 – 50 patients	Over 50 patients

**Table 13.**  
*Dental Clinic Practices*

0	1	2	3	4	5
<b>To what extent do you screen your patients for past engagement in dental tourism?</b>					
Never Screen	Rarely Screen	Intermittent or occasionally	As needed based on patient or exam	Regular Screening	Always Screen
<b>To what extent do your intake forms and process include questions about dental tourism history?</b>					
No Questions	At least 1 question about location of past dental care	More than 1 question about location of past care	At least 1 question specifically about dental tourism history	More than 1 question specifically about dental tourism history	Specific dental tourism questions and follow-up discussion during consultation
<b>To what extent do you engage in a patient's interest in dental tourism?</b>					
Never	Rarely	If patients ask about it	Same as patients asking about another dental provider	Research dental tourism info to support discussions and decision making at no extra cost	Research dental tourism info to support discussions and decision making for an additional fee
<b>To what extent do you or your dental office engage with the dentists from dental tourism destination countries?</b>					
No engagement	Same as when patients see another U.S.-based dentist	Engagement depends on request from patient	Engagement depends on outreach from dentist in destination country	Additional engagement with dentist from destination country at no additional cost	Additional engagement with dentists from destination countries for an additional fee
<b>To what extent do you perform remedial or corrective work on dental tourism patients?</b>					
Never or unsure	Minimal or very little	Intermittently or occasionally	Moderate number of patients / not uncommon	Regularly / normal to see patients seeking such work	Frequently and / or seeing an increase in these cases

## **Survey Security**

The survey link included in the email is not restricted to enable easy access for potential respondents. The unrestricted link also allows survey recipients to share the survey with eligible colleagues to help counter the anticipated low response rate for healthcare professionals. To mitigate this risk, the survey design included CAPTCHA (Completely Automated Public Turing test to tell Computers and Humans Apart) (von Ahn, L., et al, 2004).

## **Survey Sample**

The survey targeted U.S.-based dental practitioners, including general and pediatric dentists, dental surgeons, endodontists, exodontists, orthodontists, periodontists, and prosthodontists. Participants were provided with a description of the study and its eligibility criteria, followed by an informed consent to participate and complete the survey. An incentive was offered, which included the option to share survey results if requested and a raffle for two randomly selected respondents to win a \$300 gift card. Respondents remained anonymous to the researcher, and the gift card winner was chosen randomly regardless of their survey responses.

## **Survey Testing**

The survey was pilot tested by researchers, non-dentists, and a small sample of dentists to ensure that the questions were interpreted appropriately by the intended audience, that the average time to complete the survey was as expected, and to identify and correct any technical issues. The pilot testing was conducted in two rounds with four U.S.-based general dentists in Pennsylvania who had a professional connection to the researcher and agreed to provide feedback. Test survey respondents were asked to try

different responses each round to confirm whether the survey logic and flow were working correctly. The respondents provided the following feedback via discussion:

- **Consent:** Two test survey respondents believed the consent form was probably more detailed than necessary for a survey that did not ask for any personal or patient-related information, and that just a sentence or two would have saved a minute or two. Overall, it was straightforward and made sense.
- **Ease of viewing questions:** Only one pilot respondent took the survey on a computer/laptop, while the others took it on their mobile devices. Feedback indicated that some questions were difficult to view and should be further condensed for mobile devices to make them easier to read and require less scrolling. It was assumed that most practitioners who opt to participate in the survey will complete it on a mobile device for convenience, and the intention is to optimize the survey for mobile completion.
- **Likert scale questions:** The feedback revealed that some technical adjustments were required to the rules for Likert-scale questions. One respondent reported not being able to submit answers for selecting the (1) to indicate an absence or limited engagement with medical tourism on a question. The slider starts in that position and is required to be moved before returning to that position or slide it to another selection for the answer to be accepted. The survey rules force an answer to the question. The respondent eventually figured out they had to move the slider to other

answers but suggested adding instructions to the question to avoid extra time and frustration for survey respondents. This issue can be eliminated by removing the requirement for a response, but the researcher has prioritized reducing the risk of non-response or accidental response, so instructions will be incorporated to move the slider at least once before a final answer can be accepted.

- **Survey advancement to raffle entry:** Two areas were identified where survey flow issues occurred. The first was that 2 test survey respondents selected "No" to the question about whether they were a U.S.-based dentist and still advanced to complete the survey, even though the survey should have terminated. Respondents also complete a separate set of questions to provide their email address to enter a raffle for a gift card. All respondents identified an issue with advancing to or accessing the final question to provide their data to enter the raffle. The survey flow instructions in both cases were not correctly assigned, but the logic was corrected and is now functioning properly.

After the survey was adjusted based on test respondents' feedback, the survey was retested to ensure it was functioning reliably and then distributed to the randomly selected practitioners on Monday, August 18, 2025.

### **Survey Distribution & Data Collection**

Data collection was conducted via a Qualtrics survey. Qualtrics is an online survey tool used to develop and distribute surveys, collect responses, and analyze response data. The survey was distributed to a random sample of dentists obtained from

the US Business Data Repository. The repository includes data on approximately 34,000 dental practitioners, including their names, dental practices, locations, and email addresses. Email addresses were used to distribute the survey, targeting a sample size of 68 responses with a 90% confidence interval and a 10% margin of error. Using an expected response rate of 20%, the survey was initially distributed to 340 dentists.

The list from the repository data was screened to select only dental practitioners with an email address and either DMD or DDS credentials. DMD and DDS credentials are used to help differentiate potential survey respondents from other professionals, such as dental hygienists, who may have also been included in the database. This narrowed the list down to 1,031 dentists. From there, a random sample of practitioners was selected for survey distribution using the Excel "RAND()" function. The method is ideal for selecting a random subset of items from a list, such as the US Business Data repository. The function generated a random number between 0 and 1 for each email. The random numbers were then sorted with the corresponding email addresses (ascending order), and a sample of 340 email addresses was selected for survey distribution.

After the initial distribution, 92 invalid email addresses were identified from undeliverable email notifications, and one (1) email address was identified as duplicate. To ensure adequate sample size, an additional 93 emails were selected to replace invalid and duplicate addresses. These email addresses were selected on 11SEP2025 and included in a second round of emails on 12SEP2025 to support continued recruitment of potential survey respondents. On September 15, 2025, survey responses totaled 8 for a response rate of approximately 2%. Of the 8 responses obtained, Qualtrics had not detected any duplicate responses or surveys completed by bots. The response rate to date

is very low, but surveys of health professionals typically have low response rates. Recruitment in waves or stages improves participation (Funkhouser et al., 2024).

By September 25, 2025, the response rate remained very low with only 11 survey responses received. However, participation was assumed to eventually improve with additional rounds or waves of survey distribution (Funkhouser et al., 2024). Additionally, email addresses from the US Business Data Repository resulted in 260 invalid, returned, or duplicate email addresses. Given the persistently low response rate, a variety of ideas were considered to increase it. The following actions were decided upon and implemented:

1. Revised introductory email to emphasize the purpose of the research and appeal to dental health professionals for their insights to improve industry practice, the week of September 29, 2025.
2. Reached out to dental associations and professionals via websites and email, and on October 15, 2025, confirmed a co-sponsor (a respected industry professional or trade association) local to the Greater Philadelphia area to support credibility and further distribution. The co-sponsor distributed the survey with the revised introductory email and a message to colleagues to contribute and complete the survey on October 17, 2025.
3. Looked for alternative distribution channels to identify current email contacts for U.S.-based dentists, including Prolific, Reddit, dental school and dental office directories, and LinkedIn. Created and published the survey on Prolific on October 15, 2025, to a targeted audience of 63 professionals pre-identified as U.S.-based dentists. Finally, a list of dentist emails was compiled from

dental school directories throughout the United States between October 20, 2025, and October 21, 2025, including University of California, Los Angeles, UTHealth Houston, University of Florida, Virginia Commonwealth University, Howard University, The Ohio State University, Meharry Medical College, University of Minnesota, and The University at Buffalo.

While responses plateaued in the first 30 days, the above interventions helped progressively improve response rates (Table 14) over the following 2-month period.

By October 22, 2025, the response rate improved significantly, and a total of 47 responses were collected, 9 of which were incomplete, while two were identified as potential bot activity. Overall response quality was 95%, with the majority of surveys submitted by general dentists (53%). An additional email was sent out the following week, on Friday, October 31, 2025, to encourage continued participation, which was effective in generating additional responses. By November 5, 2025, total responses had reached 92, with 11 responses incomplete. The number of surveys identified as potential bot activity remained at only 2; the majority of respondents continued to come from the general dentistry specialty (64%), and respondents were majority male (58%) vs. female (42%). Overall response quality was 96%.

A final round of email reminders went out to dental practitioners on Thursday, November 6, 2025. By Sunday, November 23, 2025, a total of 104 responses had been received, with 74 suitable for data analysis to achieve the necessary 90% confidence interval and a 10% margin of error. The survey was closed, and submission of survey responses was disabled on Tuesday, November 25, 2025.

**Table 14.**  
*Data Response & Quality Progression*

Date	Total Responses	Incomplete or Failed Responses*	Usable Responses	Response Quality	
August 18, 2025					1st distribution Aug 18, 2025
September 15, 2025	8	2	6	100%	
September 25, 2025	11	3	8	100%	
October 22, 2025	47	11	36	95%	Revised introductory email Sept 29, 2025. Identified co-sponsor to endorse email and encourage colleagues to participate October 15, 2025. Directed emails to dental networks / directories October 21, 2025.
November 05, 2025	92	23	69	96%	
November 23, 2025	104	30	74	96%	
November 25, 2025	104	30	74	96%	Survey closed

\* Incomplete or failed responses include unfinished surveys and potential bot activity

## **Data Cleaning & Preparation**

The survey instrument consisted of twenty (20) questions delivered via a web-based platform, designed to capture demographic information, professional exposure to dental tourism, patient interactions, and self-reported knowledge and comfort levels regarding the topic. Responses were collected using a combination of categorical demographic items and ordinal Likert-type scales (0–5), which allowed for descriptive statistical analysis of practitioner perspectives. A total of 104 survey responses were collected.

The data were reviewed for completeness, duplicate entries, and bot/data integrity. First, incomplete surveys were identified and removed, reducing the dataset to 89 valid responses. Next, duplicate entries were detected and eliminated, leaving 88 unique responses. To further safeguard against automated or fraudulent submissions, responses with ReCaptcha scores below 0.5 were excluded, resulting in 85 high-quality responses. Finally, the dataset was refined to include only complete responses from U.S.-based dentists, yielding a final count of 74 usable responses for analysis. This systematic data cleaning process ensured that the dataset retained only authentic, complete, and relevant responses, thereby strengthening the validity of subsequent statistical analysis and interpretation (Table 15).

**Table 15.**  
*Data Cleaning Steps*

Step	Description	Responses Remaining	Percent of Total
1	Total responses collected	104	100%
2	After removal of incomplete surveys	89	85.6%
3	After removal of duplicate responses	88	84.6%
4	After removal of ReCAPTCHA scores below 0.5	85	81.7%
5	Final count of complete responses suitable for analysis	74	71.5%

### Results

The final sample consisted of 74 U.S.-based dental practitioners, with no missing data across study variables. Respondents represented a range of specialties, geographic locations, and years of professional experience (Tables 16 – 19). Composite variables were created for dental tourism knowledge, exposure, and clinical practice behaviors based on theoretically informed item groupings. Internal consistency reliability was assessed for each composite measure using Cronbach's alpha, and item-level diagnostics were examined to confirm scale adequacy. Descriptive statistics were then calculated to summarize respondent characteristics and central tendencies of the primary study variables. Bivariate relationships among key constructs were evaluated using Pearson product–moment correlation analyses. Finally, a two-step hierarchical multiple regression analysis was conducted to examine the unique and combined contributions of demographic characteristics, dental tourism knowledge, and exposure in predicting clinical screening practices. The results of these analyses are presented in the following section.

## Descriptive & Correlation Analyses

Demographic analysis revealed that most respondents reported substantial professional experience, with the majority practicing dentistry for 20 years or more (67.6%, n = 50), followed by 10–14 years (17.6%, n = 13). Smaller proportions reported fewer than 10 years of experience. Participant age ranged broadly, with the largest age groups being 56–65 years (28.4%, n = 21) and 66+ years (28.4%, n = 21).

**Table 16.**  
*Age Range of Survey Respondents*

<b>Age Range</b>	<b>Count</b>
56-65 years	21
66+ years	20
36-45 years	16
46-55 years	9
26-35 years	8
<b>Grand Total</b>	<b>74</b>

**Table 17.**  
*Respondents Years Practicing Dentistry*

<b>Years as a Dentist</b>	<b>Count</b>
20+ years	50
10-14 years	13
15-19 years	4
0-2 years	3
5-9 years	3
2-4 years	1
<b>Grand Total</b>	<b>74</b>

Gender distribution included both male and female respondents. The sample was predominantly male (58.1%, n = 43), with females comprising 41.9% (n = 31) (Table 18). General Dentistry was the most common specialty represented, followed by Pediatric

Dentistry, Periodontics, Oral Surgery, Prosthodontics, Orthodontics, and Endodontics  
(Table 19).

**Table 18.**  
*Breakdown of Survey Respondents by Gender*

<b>Gender</b>	<b>Count</b>
Male	43
Female	31
<b>Grand Total</b>	<b>74</b>

**Table 19.**  
*Breakdown of Survey Respondents by Area of Dental Specialty*

<b>What is your primary area of dental specialty?</b>	<b>Count</b>
General Dentistry	47
Pediatric Dentistry	6
Periodontist or Gum Specialist	5
Prosthodontist	4
Oral Pathologist or Oral Surgeon	4
Endodontist or Root Canal Specialist	3
Orthodontist	3
General Dentistry, Pediatric Dentistry	1
General Dentistry, Oral Pathologist or Oral Surgeon, and Prosthodontist	1
<b>Grand Total</b>	<b>74</b>

Geographic representation for location of primary dental practice among the survey respondents spanned 24 states. The heat map (Figure 3) illustrated the distribution of responses across the country with 27% of responses coming from Pennsylvania (11) and Texas (9), while the remainder came from Ohio (6), New Jersey (5), California, Virginia, and Florida (4), Puerto Rico, Alabama, Minnesota, Michigan, Nebraska, Utah, and Colorado (3), and Washington, Oregon, Nevada, Oklahoma, Illinois, New York, Massachusetts, Tennessee, South Carolina, and Georgia (1).

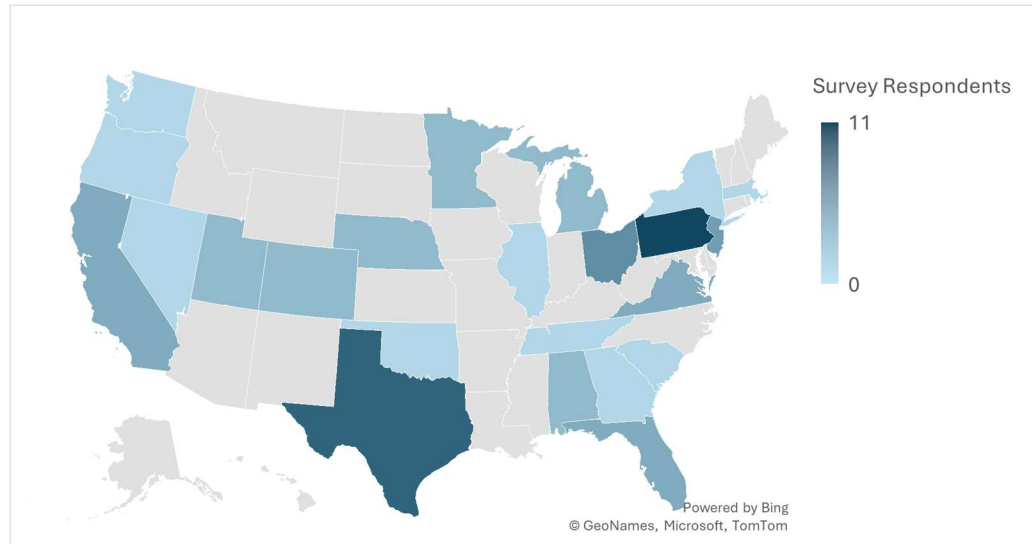


Figure 3. Geographic Distribution of Survey Respondents

Descriptive analyses were conducted for the three domains: Exposure, Knowledge, and Clinical Practice. The Knowledge domain comprised two items: respondents' self-reported comfort discussing dental tourism with patients and their perceived level of knowledge regarding dental tourism. The observed mean score for comfort discussing dental tourism was high ( $M \approx 4.16$ ), whereas self-rated knowledge was moderate ( $M \approx 3.01$ ). That self-reported comfort was rated higher than knowledge may indicate that respondents generally perceive themselves as capable of engaging in conversations with patients about dental tourism, even though their assessment of their underlying knowledge is less elevated. The difference between comfort and knowledge suggests that dentists may rely on general clinical experience, professional judgment, or patient-initiated dialogue rather than formalized training or structured informational resources when discussing dental tourism. From a descriptive standpoint, this asymmetry reflects a form of practical communicative readiness that does not necessarily coincide with extensive subject-specific expertise.

The Exposure domain included four items addressing respondents' encounters with dental tourism through media, scholarly or professional literature, discussions with colleagues, and formal professional education such as conferences or workshops. Mean scores across these items ranged from approximately 1.24 to 2.07, indicating consistently low levels of exposure. Among these indicators, exposure through conferences, workshops, or lectures was the lowest, while discussions with colleagues demonstrated slightly higher engagement. This distribution suggests that dental tourism is more frequently encountered through informal professional interactions than through institutionalized educational or scholarly venues. The low levels of exposure across multiple channels indicate that dental tourism may not occupy a prominent position within mainstream professional discourse or continuing education environments at the time of data collection.

The Clinical Practice domain encompassed six questions addressing patient inquiries, screening practices, intake documentation, engagement with patient interest, office-level engagement with destination countries, and provision of remedial or corrective care to dental tourism patients. Mean scores in this domain were generally low, with several items falling below a mean of 1.0. The inclusion of dental tourism history in intake forms exhibited the lowest observed mean ( $M \approx 0.51$ ), indicating minimal formal documentation of dental tourism within routine clinical processes. Screening for dental tourism history and active engagement with patient interest were also limited. In contrast, the provision of remedial or corrective care demonstrated a higher mean ( $M \approx 2.18$ ) relative to other clinical practice indicators. This pattern suggests that dental tourism is more commonly encountered as a post-treatment clinical issue rather than as a factor

integrated into preventive assessment, planning, or patient counseling workflows. From a descriptive perspective, clinical involvement appears to be episodic and reactive rather than systematic or standardized.

Descriptive statistics for the three primary variables, Exposure, Knowledge, and Clinical Practice, were summarized in Table 20. These values indicated that respondents reported moderate levels of perceived knowledge regarding dental tourism, comparatively lower levels of exposure, and low engagement in dental tourism–related clinical screening and practice behaviors.

**Table 20.**  
*Conceptual Domains of Dental Tourism Engagement*

Domain	Survey Item	Mean (0–5)	Descriptive Level	Mean Likert	Standard Deviation
Knowledge	Comfort discussing dental tourism with patients	4.16	High	3.60	1.08
	Knowledge level regarding dental tourism	3.01	Moderate		
Exposure	Encountered dental tourism in media	1.92	Low	1.69	0.87
	Read research/professional articles	1.47	Low		
	Discussed dental tourism with colleagues	2.07	Low– Moderate		
	Exposure via conferences/workshops/lectures	1.24	Very Low		
Clinical Practice	Patients asking about dental tourism (past 2 years)	1.70	Low	1.32	0.80
	Screening patients for dental tourism history	1.53	Low		
	Intake forms include dental tourism history	0.51	Very Low		
	Engagement with patient interest in dental tourism	1.19	Low		
	Office engagement with destination countries	0.80	Very Low		
	Remedial/corrective work on dental tourism patients	2.18	Low– Moderate		

Individual survey questions that measured similar ideas were grouped together to form overall scales for knowledge, exposure, and clinical practice behaviors as they related to outbound, international dental tourism. Combining related questions facilitates the measurement of more complex relationships as opposed to relying on a single question. The consistency of each scale was then evaluated using a statistic called Cronbach's alpha, which indicates how well the questions within the scale work together to measure the same concept (Cronbach, 1951).

Dental tourism knowledge was measured using a two-item composite scale that assessed practitioners' self-reported knowledge regarding dental tourism and their comfort level in discussing and answering patient questions about dental tourism. Internal consistency reliability for the Knowledge scale was evaluated using Cronbach's alpha. The scale demonstrated acceptable reliability for a brief, exploratory measure, with Cronbach's  $\alpha = .647$  (standardized  $\alpha = .647$ ). Although this value falls slightly below the conventional .70 threshold, it is considered acceptable given the two-item structure and the exploratory nature of measuring an emerging construct within U.S. dental practice research. The two items comprising the Knowledge scale were moderately and positively correlated,  $r = .479$ , indicating that while the items are related, they capture distinct but complementary dimensions of dental tourism knowledge and communication confidence.

Exposure to dental tourism was measured using a four-item composite scale assessing the extent to which practitioners had encountered dental tourism through media exposure, research or professional articles, discussions with colleagues, and professional or industry settings (e.g., conferences, workshops, lectures). The Exposure scale

demonstrated good internal consistency, with Cronbach's  $\alpha = .764$  (standardized  $\alpha = .764$ ) across the four items. Inter-item correlations ranged from .310 to .572, indicating moderate associations among items while avoiding redundancy. The strongest association was observed between media exposure and discussions with colleagues ( $r = .572$ ), while the weakest association occurred between media exposure and professional conference exposure ( $r = .310$ ).

Clinical screening and practice behaviors related to dental tourism were measured using a six-item composite scale assessing frequency of patient inquiries about dental tourism, screening for prior dental tourism engagement, inclusion of dental tourism questions in intake processes, engagement with patient interest in dental tourism, office-level engagement with dentists in destination countries, and performance of remedial or corrective work for dental tourism patients. The Clinical Practice scale demonstrated good internal consistency, with Cronbach's  $\alpha = .768$  (standardized  $\alpha = .783$ ) across six items. Inter-item correlations ranged from .125 to .592, indicating acceptable variability in item relationships. The strongest correlation was observed between intake process inclusion and engagement with patient interest ( $r = .592$ ), while weaker correlations were observed between office-level engagement with destination dentists and other screening behaviors. Corrected item-total correlations ranged from .335 to .596, suggesting that all items contributed adequately to the construct. Cronbach's alpha values if item deleted ranged from .719 to .774, indicating no substantial reliability improvement through item removal.

Descriptive and correlational analyses were conducted to understand how the variables were related to one another. A Pearson correlation analysis was used to examine

whether increases in one variable tended to be associated with increases or decreases in another, without suggesting that one causes the other. Additionally, hierarchical multiple regression analysis was used to examine how dental tourism knowledge and exposure are related to clinical screening practices while accounting for characteristics such as age and years in practice. This approach provides insight into which factors are most strongly associated with clinical behavior when multiple influences are considered simultaneously (Cohen et al., 2013).

As expected, years in practice and age were strongly positively correlated,  $r = .841, p < .001$ , indicating substantial overlap between variables; however, neither years in practice ( $r = .053, p = .656$ ) nor age ( $r = .091, p = .441$ ) was significantly correlated with clinical screening practices. Dental tourism knowledge was significantly and positively correlated with clinical screening practices,  $r = .406, p < .001$  and Exposure,  $r = .416, p < .001$ . Dental tourism exposure also demonstrated a strong positive association with clinical screening practices,  $r = .635, p < .001$ . These results indicate that greater knowledge and exposure are both associated with increased screening behaviors, with exposure exhibiting the strongest relationship.

### **Hierarchical Regression Analysis**

A two-step hierarchical multiple regression was conducted to examine whether dental tourism knowledge and exposure predicted clinical screening practices after controlling for demographic characteristics (Table 21). The dependent variable was Clinical Practice / Screening. The demographic variables of age, gender, and years in practice were entered as predictors for clinical screening practices. This model was not statistically significant,  $R^2 = .033, F(3, 70) = 0.788, p = .505$  and none of the following

demographic predictors were statistically significant (Years in practice:  $\beta = -.153$ ,  $p = .498$ ; Gender:  $\beta = -.168$ ,  $p = .207$ ; Age:  $\beta = .154$ ,  $p = .480$ ); however, knowledge and exposure were then added, resulting in a statistically significant improvement, with the model explaining 45.1% of the variance in clinical screening practices,  $R^2 = .451$ , adjusted  $R^2 = .410$ . The change in explained variance was substantial and significant,  $\Delta R^2 = .418$ ,  $F$  change (2, 68) = 25.858,  $p < .001$  (Table 22). Exposure was a strong and significant predictor of screening practices,  $\beta = .624$ ,  $t = 5.844$ ,  $p < .001$ . At the same time, knowledge was not a significant predictor when exposure was included ( $\beta = .097$ ,  $t = 0.894$ ,  $p = .375$ ), and demographic variables remained non-significant (Table 23).

**Table 21.**  
*Correlations*

		How long have you been a dentist?	What is your age?	Knowled ge	Exposu re	Clinical Practic e
How long have you been a dentist?	Pearson	1	.841**	.258*	-.178	.053
	Correlation Sig (2-tailed)		<.001	.027	.129	.656
What is your Age?	Pearson	.841**	1	.257*	-0.35	.091
	Correlation Sig (2-tailed)	<.001		.027	.768	.441
Knowledge	Pearson	.258*	.257*	1	.416**	.406**
	Correlation Sig (2-tailed)	.027	.027		<.001	<.001
Exposure	Pearson	-.178	-.035	.416**	1	.635**
	Correlation Sig (2-tailed)	.129	.768	<.001		<.001
Clinical Practice	Pearson	.053	.091	.406**	.635**	1
	Correlation Sig (2-tailed)	.656	.441	<.001	<.001	
** Correlation is significant at the 0.01 level (2-tailed)						
* Correlation is significant at the 0.05 level (2-tailed)						

**Table 22.**  
*Analysis of Variance <sup>a</sup>*

Model		Sum of Squares	df	Mean Square	F	Sig
1	Regression	1.507	3	.502	.788	.505 <sup>b</sup>
	Residual	44.646	70	.638		
	Total	46.153	73			
2	Regression	20.794	5	4.159	11.151	<.001 <sup>c</sup>
	Residual	25.359	68	.373		
	Total	46.153	73			

a. Dependent Variable: Clinical Practice

b. Predictors: (Constant), Age, Gender, Years as a dentist

c. Predictors: (Constant), Age, Gender, Years as a dentist, Exposure, Knowledge

**Table 23.**  
*Regressions*

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	R Square Change	F Change	df1	df2	Sig. F Change
1	.181 <sup>a</sup>	.033	-.009	.799	.033	.788	3	70	.505
2	.671 <sup>b</sup>	.451	.410	.611	.418	25.86	2	68	<.001

a. Predictors: (Constant), Age, Gender, Years as a dentist

b. Predictors: (Constant), Age, Gender, Years as a dentist, Exposure, Knowledge

**Table 24.**  
*Coefficients <sup>a</sup>*

Model		Unstandardized B	Coefficients Std. Error	Standardized Coefficients Beta	t	Sig
1	(Constant)	1.78	.615		2.898	.005
	Years as a dentist	-.092	.134	-.153	-.681	.498
	Gender	-.269	.211	-.168	-1.274	.207
	Age	.089	.126	.154	.710	.480
2	(Constant)	-.021	.553		-.038	.970
	Years as a dentist	.111	.109	.185	1.015	.314
	Gender	-.140	.166	.087	-.846	.401
	Age	-.059	.098	.102	-.596	.553
	Knowledge	.072	.081	.097	.894	.375
	Exposure	.570	.098	.624	5.844	<.001

a. Dependent Variable: Clinical Practice

This study examined how U.S.-based dental practitioners' knowledge of and exposure to outbound international dental tourism influenced their clinical screening practices. The correlational findings provided clear evidence that both knowledge and exposure were meaningfully associated with clinical practice; however, the magnitude of these relationships differs significantly. Exposure demonstrated the strongest relationship with clinical practice ( $r = .635$ ), indicating that experiential contact with dental tourism, through patients, professional contexts, or information sources, was closely linked to practitioners' screening and related behaviors. Knowledge, while also significantly related to clinical practice ( $r = .406$ ), showed a comparatively weaker association. The positive correlation between exposure and knowledge ( $r = .416$ ) suggested that these constructs are related but distinct. Practitioners who encountered dental tourism more frequently tended to develop greater knowledge and comfort discussing it; however, the stronger link between exposure and clinical practice suggested that experience was more influential on clinical behavior than awareness alone. This pattern supported the interpretation that knowledge functioned as a supportive or enabling condition, whereas exposure served as the primary mechanism through which dental tourism becomes salient enough to influence routine clinical behavior.

The consistent, positive associations among all three constructs highlight a gap between emerging global patient behaviors and formalized clinical practice structures. Without standardized education or institutional guidance, screening practices appeared to be shaped largely by individual experience rather than professional norms. These findings underscore the need for proactive educational and policy interventions that integrate dental tourism considerations into routine patient intake and screening processes, rather

than relying on reactive, exposure-driven learning. The analyses demonstrated that U.S.-based dental practitioners' engagement in dental tourism–related clinical practices was significantly associated with both knowledge and exposure. However, exposure exhibited the strongest relationship, reinforcing the conclusion that clinical screening practices were driven primarily by experiential factors rather than knowledge alone.

## **CHAPTER 4**

### **DISCUSSION AND FUTURE RESEARCH**

#### **Discussion**

This study examined how U.S.-based dental practitioners' knowledge about and exposure to outbound, international dental tourism related to clinical screening practices. Building on the earlier phenomenological pilot study suggesting that medical tourism could influence trust and relational dynamics, such as when patients disclose travel intentions and perceptions of clinician response, the present study shifted to dental practice as a more frequent relationship-based care setting. By using a targeted survey approach adapted from prior work in New Zealand, this study sought to clarify if, and how, dentists were encountering dental tourism patients and understand if dental tourism was being incorporated into routine U.S. dental workflows, or whether it was largely encountered as a concept and in discussions around safety and quality, or only after the fact through remedial care. Overall, results indicated a consistent pattern: dental tourism was present in practice, but it was not systematically institutionalized in screening and intake processes. Additionally, although knowledge and exposure were both positively associated with screening behaviors, exposure emerged as the dominant predictor when both were considered simultaneously.

A notable descriptive finding was that practitioners reported high comfort discussing dental tourism yet, only moderate self-rated knowledge. This "comfort > knowledge" pattern suggested that many dentists felt able to communicate with patients about dental tourism even when they did not view themselves as highly informed about

the topic. This was consistent with broader relationship-centered care frameworks, which emphasize that trust is influenced not only by technical expertise but also by interpersonal behaviors such as listening, clear communication, shared power, and partnership-building (Charles et al., 1999; Elwyn et al., 2012). The finding implied that dentists may have been drawing on general clinical communication competencies rather than formal training on dental tourism to navigate patient questions. In practice, this could mean that patient encounters were handled on a case-by-case basis, shaped by individual clinician style and experience rather than standardized guidance.

The earlier qualitative pilot work suggested that patients placed heightened trust in practitioners who demonstrated up-to-date knowledge and actively sought information to support patient decision-making. The present results indirectly align with that premise: dentists may have been willing to engage, but the system may not have been equipping them with structured knowledge resources to do so consistently. Comfort may have facilitated patient dialogue, but without topic-specific knowledge and standardized workflows, discussions risked being uneven, which potentially reinforced variability in trust experiences depending on the individual dentist or practice and the patient's expectations.

Exposure scores were consistently low, especially at conferences / workshops / lectures, with slightly higher (though still low) exposure in discussions with colleagues. This pattern suggested that dental tourism was not widely embedded in continuing education or formal professional discourse. Instead, it was encountered informally through peers, through sporadic media exposure, or in occasional patient-driven discussions. This is relevant because professional norms and standardized clinical

behaviors are often strengthened through formal channels such as professional guidelines, continuing education (CE) programming, institutional training, and peer-reviewed dissemination. When a topic remains informal, it tends to become experience-dependent, with clinicians learning about it only through very direct and specific channels they engage with. In the case of dental tourism, the landscape was experiencing a unique period where patient behavior was globalizing faster than professional education and clinical infrastructure were adapting, ultimately creating a gap between what patients do and what intake/screening protocols routinely capture.

Across the clinical practice items, the lowest mean was for including dental tourism history in intake forms, followed by low screening frequency and low engagement with destination providers. In contrast, remedial / corrective work showed the highest mean within the clinical practice domain. Taken together, this pattern supports an interpretation of reactive clinical involvement, in which dental tourism is not routinely documented or screened as part of baseline risk assessment, and practitioners are more likely to encounter it after procedures have occurred. Consequently, this resulted in encounters having a higher chance of including post-dental tourism complications, follow-up needs, or corrective work.

Bivariate correlations showed that knowledge, exposure, and clinical practice were all positively related. This supported the general expectation that practitioners who knew more and encountered dental tourism more often were also more likely to screen and engage in related clinical practices. The hierarchical regression results further refine this picture by demonstrating that demographics (age, gender, years in practice) did not significantly predict screening behaviors. When knowledge and exposure were added, the

model explained a substantial proportion of variance in clinical screening practices, but exposure was the only significant unique predictor. Exposure may function as a mechanism through which practitioners developed applied, situation-specific knowledge that actually translated into practice changes. In this sense, exposure is not simply "contact," but also a pathway to experiential learning.

Traditional knowledge–attitude–practice frameworks propose that professional behaviors are mainly influenced by acquiring knowledge that then shapes attitudes and clinical decisions. However, the current findings show that in the context of dental tourism, practice adaptation may be driven more by experiential exposure rather than formal knowledge pathways. This indicates that practitioners might respond to patient-driven globalization of healthcare through situational learning and case-based encounters instead of structured educational or institutional mechanisms.

### **Trust as a Clinical and Relational Outcome**

The literature reviewed emphasizes that trust is built through competence, communication, partnership, and respect (Thom et al., 2011; Grob et al., 2019), while distrust may arise from uncertainty, lack of or inconsistent information, or perceived risk/liability (Sousa-Duarte et al., 2020). In dentistry specifically, trust influences satisfaction and engagement with care (Tiwari et al., 2023). Results showed that dentists felt comfortable discussing dental tourism, which could support shared decision-making and partnership behaviors; however, minimal screening and intake integration could undermine relational continuity because patients may have perceived that the topic was not a priority, not understood, or not open for discussion, especially if they anticipate

judgment or financial conflict as reflected in the pilot patient experience of feeling chastised.

When dental tourism is primarily addressed through remedial care after complications arise, interactions may have become more emotionally charged by pain, dissatisfaction, cost, blame, or uncertainty. This context could heighten distrust on both sides. Patients may have interpreted corrective care conversations as judgmental; clinicians may have experienced uncertainty about prior treatment quality, materials used, documentation, and medico-legal risk (Sousa-Duarte et al., 2020). Consequently, the absence of routine screening may have inadvertently increased the likelihood that dental tourism emerged in high-stakes moments, where trust was hardest to maintain.

Age and years in practice were strongly correlated, which was expected, but neither predicted screening behaviors. Gender was also non-significant. This suggested that dental tourism-related screening was not simply a function of seniority or generational differences. Instead, screening appeared more contingent on whether a practitioner is exposed to dental tourism through patients, professional conversations, or information channels. Educational interventions should take a broader approach, emphasizing consistent screening norms across all career stages from recent graduates to the most tenured practitioners.

### **Implications for Medical and Dental Education, Clinical Practice, and Policy**

The dissertation's central research question, how medical tourism affects practitioner-patient relationship dynamics in the United States, was explored across two studies, with the second study focusing on dental practitioners as a more tractable and

data-rich population. The dental findings, however, carry meaningful implications well beyond dentistry.

The core finding that exposure, rather than formal knowledge, is the primary driver of clinical screening behavior is almost certainly not unique to dental practice. Practitioners in fields like primary care, orthopedics, and neurology face the same dynamic: patients arrive having already sought or completed procedures abroad, yet intake forms and clinical workflows rarely account for this. Just as dental practitioners were found to engage with dental tourism reactively, most often through remedial or corrective work, physicians in other specialties are likely to encounter post-MT patients due to aftercare needs or complications rather than at the point of planning. The dental study lends empirical weight to what the qualitative pilot study had already suggested anecdotally: the U.S. clinical system is not systematically prepared for a patient population that is globalizing faster than professional education and intake protocols are adapted.

Practitioners' comfort in discussing dental tourism, despite limited formal knowledge, also resonates beyond dentistry. In fields like oncology and neurology, where the pilot study's patients experienced dismissiveness or apathy from their specialists, this same gap between conversational ease and substantive knowledge may explain why those practitioners were willing to comment but not in ways patients found meaningful. The dental findings suggest that comfort alone, without topic-specific knowledge embedded in clinical workflows, yields inconsistent, often reactive encounters rather than the trust-building, shared decision-making interactions patients need.

Relating these findings to the original objective of understanding how medical tourism impacts practitioner-patient relationship dynamics, the dental study provides quantitative confirmation that the relational disruptions documented in the qualitative pilot are structurally grounded. Medical tourism is not merely an uncomfortable conversation topic; it is an unmeasured variable in clinical workflows across specialties, one that surfaces most visibly when things go wrong. The absence of screening means practitioners across medicine are likely underestimating how frequently their patients engage with global healthcare markets, which, in turn, limits their ability to maintain the continuity, trust, and shared decision-making that define the contemporary, functional practitioner-patient relationship. Hence, the dental findings do not narrow the dissertation's contribution; instead, they anchor it empirically and point toward an intervention framework applicable across the broader U.S. healthcare system.

Exposure through conferences and formal settings was low, indicating an opportunity for continuing education modules addressing dental tourism trends, common treatment types sought abroad, and typical post-treatment follow-up scenarios, as well as training on practitioner communication aligned with shared decision-making to support nonjudgmental, trust-building dialogue. Practitioners might also appreciate content on risk management (documentation, continuity of care, and informed discussion) to reduce uncertainty that can lead to clinician hesitancy or distrust.

Inclusion of questions on intake forms is a practical and actionable intervention opportunity to incorporate brief, standardized screening items into medical and dental history workflows. Adding neutral questions about dental care received outside the U.S. within a defined timeframe could normalize disclosure and reduce stigma. Standardizing

this practice also supports shared decision-making by ensuring the topic is addressed consistently and early, rather than only when complications arise. Furthermore, professional associations and insurers could also play a role by providing guidance on continuity-of-care expectations, documentation standards, and how to approach remedial care when treatment has occurred abroad.

### **Limitations**

The findings of this study should be interpreted in light of several methodological and contextual limitations. The study relies exclusively on self-reported survey responses, which capture participants' perceptions rather than directly observed behaviors or objectively verified clinical practices. Respondents may differ in how they interpret survey items, particularly those related to more abstract constructs such as knowledge, engagement, or exposure to dental tourism. As a result, reported scores reflect subjective assessments rather than standardized measures of competence or practice.

The use of a six-point Likert scale provides an efficient means of capturing gradations in respondents' experiences; however, such scales do not convey the depth, frequency, or complexity of engagement. For example, items addressing remedial or corrective care do not differentiate between isolated, low-complexity interventions and repeated or resource-intensive clinical management. This limitation constrains the granularity of interpretation. Additionally, the analysis is constrained by the Knowledge scale, which consists of only two items with an alpha slightly below .70, which is common in short exploratory measures but may limit precision.

It is also important to acknowledge the alternative expectation of knowledge driving clinical practice over exposure. This school of thought would suggest that

exposure to dental tourism should primarily influence clinical behavior indirectly through the primary driver, development of practitioner knowledge, and subsequent shifts in attitudes toward screening and risk management. The finding that exposure, rather than knowledge, emerged as the dominant predictor may reflect limitations in how knowledge was operationalized, such as reliance on self-reported familiarity rather than applied or clinically actionable knowledge. It is also possible that unmeasured attitudinal factors such as perceived risk, professional responsibility, or openness to medical tourism mediate the relationship between knowledge and practice, thereby lessening the direct statistical effect of knowledge in the regression model. However, the persistence of exposure as a significant predictor, even when controlling for knowledge, suggested that in the context of dental tourism, experiential encounters may have functioned as a more immediate driver of practice adaptation than formal knowledge acquisition alone. This pattern may reflect the emergent and patient-driven nature of dental tourism, where clinicians are prompted to modify behaviors in response to real-world cases rather than through established educational or institutional pathways.

The study is also limited to capturing responses at a single point in time. Consequently, the data are not appropriate for examination of temporal changes in knowledge, exposure, or clinical practices related to dental tourism, nor do they reflect how practitioner engagement may evolve in response to broader trends in healthcare globalization or patient mobility.

While the sample includes dentists from various backgrounds and practice contexts, the sample size is small, and most respondents primarily practice general dentistry; consequently, the recruitment approach limits the extent to which the findings

can be viewed as broadly representative across the dental industry or other healthcare industries. The results are best understood as descriptive of the participating practitioners rather than indicative of the U.S. dental population and industry as a whole. Finally, the scope of this study was intentionally limited to the provider perspective, excluding patient-reported experiences, outcomes, or motivations related to dental tourism. This focus constrains the analysis to how dental tourism is perceived and managed within dental practices, without addressing its broader implications for patient decision-making or continuity of care.

### **Future Research**

These findings carry several implications for future research. Patient-centered studies are needed to explore motivations, satisfaction, and outcomes of dental tourism, complementing practitioner perspectives. Specialty-specific analyses could reveal whether certain fields, such as prosthodontics or oral surgery, are disproportionately affected by corrective work related to dental tourism. Regional analyses may uncover whether dentists in border states or metropolitan areas experience higher patient inquiries. Educational and policy-oriented research could assess whether dental schools and professional associations should incorporate dental tourism into curricula or continuing education programs. Finally, longitudinal studies would be valuable to track changes in practitioner attitudes and patient demand over time, particularly as dental tourism continues to expand globally.

Building on the descriptive findings and acknowledged limitations of this study, several directions for future research are warranted. Future studies may incorporate qualitative methodologies, such as semi-structured interviews or case-based inquiry, to

explore how dental practitioners interpret dental tourism, navigate ethical considerations, and manage clinical challenges associated with care received abroad. Qualitative data could provide contextual depth that complements survey-based findings.

Longitudinal research studies could examine changes in practitioner knowledge, exposure, and clinical practices over time. Such approaches may be particularly useful for understanding how emerging trends in global healthcare access, digital health information, and international travel influence professional engagement with dental tourism. Future research could also examine variation across dental specialties, practice settings, and geographic regions, thereby enabling a more nuanced understanding of how dental tourism intersects with different areas of clinical practice. Qualitative follow-up with dentists to explore why intake forms rarely include dental tourism questions would help clarify perceptions of relevance, time burden, liability concerns, and comfort levels in discussing dental tourism. Studies that specifically focus on cost and financial impact to U.S.-based practices are also an option. Additionally, future studies could assess the role of institutional and educational structures, including dental school curricula, continuing education programs, and professional guidelines, in shaping awareness and preparedness related to dental tourism. Such work may clarify how formal educational pathways influence practitioner engagement. Finally, mixed-methods research designs that combine descriptive quantitative measures with qualitative inquiry may offer a particularly effective approach for capturing the complexity of dental tourism, including its clinical, ethical, and systemic dimensions.

Ultimately, the findings from this study suggest that U.S. dental practices were adapting to outbound international dental tourism, driven primarily by practitioner

experience, in a more reactive than proactive manner. Dentists may be comfortable discussing dental tourism, but low formal exposure and minimal integration into intake workflows mean screening practices are not standardized. Exposure appears to be the primary driver of whether dental tourism becomes operationalized in practice. This creates a meaningful opportunity for professional education, clinical screening standardization, and guidance development to support earlier identification, stronger shared decision-making, and more consistent trust-facilitating clinical engagement with patients navigating dental tourism.

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**APPENDIX A**  
**SURVEY QUESTIONS**

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Consent (Select 1)

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Yes, I agree to participate

No, I decline participation

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Practitioner Profile / Demographics

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Are you a US-based dentist?

No (end survey)

Yes

What is your primary area of dental specialty?

- General Dentistry
- Pediatric Dentistry
- Orthodontist
- Periodontist or Gum Specialist
- Endodontist or Root Canal Specialist
- Oral Pathologist or Oral Surgeon
- Prosthodontist

Where did you attend dental school (location)?

Where is your dental practice located? (city, state, and country)

How long have you been a dentist?

- 0-2 years
- 2-4 years
- 5-9 years
- 10-14 years
- 15-19 years
- 20+ years

What is your Gender?

- Man
- Woman
- Nonbinary
- Other – please specify
- Prefer Not to Say

What is your Age?

- 18-25 years
- 26-35 years
- 36-45 years
- 46-55 years
- 56-65 years
- 66+ years

What is your Nationality?

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Dental Tourism Knowledge	0	1	2	3	4	5
What is your comfort level discussing and patient questions about dental tourism?	Discomfort	Slight Discomfort	Neither Comfort nor Discomfort	Somewhat Comfortable	Moderate Comfort	Fully Comfortable
What is your knowledge level regarding dental tourism?	None	Minimal	Basic	Moderate	Good	Expert
Dental Tourism Exposure	0	1	2	3	4	5
To what extent have you encountered dental tourism in the media you interact with?	No Coverage	Minimal Coverage	Intermittent Coverage	Moderate Coverage	Regular Coverage	Significant Coverage
To what extent have you read research/professional articles about dental tourism?	Never	Minimal (one article)	A few related articles	Intermittent reading	Moderate reading	Significant reading
To what extent have you discussed dental tourism with colleagues?	Never	Minimally	Intermittently	Moderately	Regularly	Frequently
To what extent have you encountered medical tourism information in professional and/or industry settings such as attendance at conferences, workshops, or lectures?	Never	Minimally	Intermittently	Moderately	Regularly	Frequently
How many patients over the past 2 years have asked you about dental tourism?	0 patients or unsure	1 – 5 patients	6 – 10 patient	11 – 20 patients	21 – 50 patients	Over 50 patients
Clinical Practices	0	1	2	3	4	5
To what extent do you screen your patients for past engagement in dental tourism?	Never Screen	Rarely Screen	Intermittent or Occasional	As needed based patient or exam	Regular Screening	Always Screen
To what extent do you think your intake forms and processes include questions about dental tourism?	No Questions	At least 1 question about location of past care	More than 1 question about location of past care	At least 1 question specifically about DT history	More than 1 question specifically about DT history	Specific DT questions and follow-up discussion during consult
To what extent do you or your dental office engage with the dentists from the destination countries?	Do not engage	Same as when patients see another US dentists	Engagement depends on requests from patient	Engagement depends on outreach from dentists in destination countries	Additional engagement with dentists from destination countries as needed at no extra costs	Additional engagement with dentists from destination countries for an additional fee
To what extent do you engage in a patient's interest in dental tourism?	Never	Rarely	Engage if patients ask about it	Same as patients ask another US dental provider	Research DT info to support decisions and decision-making at no extra costs	Research on DT info to support decisions and decision-making for an additional fee
To what extent do you perform remedial or corrective work on dental tourism patients?	Never or Unsure	Minimal/ Very little	Intermittently/ occasionally	Moderate number/not uncommon	Regularly normal to see patients needing such work	Frequently and/or seeing increase in these patients

**APPENDIX B**

**GIFT CARD SELECTION SURVEY**

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Gift Card Drawing (Select 1)

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If you are interested in being entered into a drawing for a \$300 gift card, please enter your email address:

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