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Of odysseys and miracles: A narrative approach on therapeutic mobilities for ayurveda treatment

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ABSTRACT

In the past two decades, health care has become a global market and transnational practice. An emerging body of literature examines the astounding variety of drivers, conditions, and experiences. However, the question of how traveling abroad for treatment emerges as an option and takes shape in people's illness trajectories has gained little attention thus far. This article attends to this gap by following the stories of people with chronic conditions who travel to India for Ayurveda treatment out of dissatisfaction with local biomedical health care. This study expands the focus of current research on transnational therapeutic mobilities in three ways: (1) by shifting the attention from *being* a foreign patient or medical traveler to *becoming* one, (2) by integrating quests for other-than-biomedical therapies, and (3) by applying a narrative approach to the field. Results show that apart from social, human, and financial resources, it takes certain patient-subjectivities to mobilize patients across borders and healing systems.

> Sooner or later, everyone is a wounded storyteller (Frank, 2013, XXI).

In the past two decades health care has become a global market. Hospitals in low- and middle-income countries attract patients from around the world for better and/or less expensive treatments (Connell, 2013; Kaspar et al., 2019; Rouland and Jarraya, 2020). Even from countries with sophisticated public health care people leave to find adequate treatment (Johnston et al., 2012). Patients leave because they are dissatisfied with or disenfranchised from health care in their place of living (Ormond and Lunt, 2020; Vargas Bustamante, 2020), they seek treatments or organs not available in their country such as experimental therapies (Scheper-Hughes, 2011; Song, 2010) or to circumvent waiting times at home (Crooks et al., 2012). The business of medical tourism has collapsed in 2020 and 2021 as a result of the COVID-19 pandemic but is expected to recover in the next years (Tatum, 2022). This article is about people with chronic conditions who travel from Europe to India for Ayurveda treatment. We follow Loïc's and Marco's[1] illness stories to learn about the circumstances that lead to transnational therapeutic journeys from affluent countries with cutting-edge biomedicine to middle- and low-income countries with traditional healing systems.

An expanding body of literature examines the growth and shaping of global health care markets. However, the question of how traveling abroad for treatment emerges as an option and takes shape in people's illness trajectories has gained little attention thus far. Scholars have been exploring the political economy of medical tourism and its effects on individuals and societies sending or receiving so-called medical travellers (Amodeo, 2010; Ormond, 2013; Reddy and Qadeer, 2010; Reisman, 2010; Whittaker et al., 2010; Wilson, 2010) as well as the subjective experiences of undergoing medical treatment in an unfamiliar place (Ackerman, 2010; Bell et al., 2011; Kangas, 2010; Kingsbury et al., 2012). Both strands focus on the specific phase of staying abroad, i.e. the time in between patients' entry into and exit from the medical destination. For that phase, they yield rich insights into the social and economic realities medical travel produces on various scales from the intimate to the global. However, little attention has been paid to what happens before and after international medical travel, i.e. to the *becomings* of medical journeys and the proceedings and consequences.

Drawing on a narrative approach (Hydén, 1995; Mattingly and Garro, 2000; Riessman, 1993) and the "growing body of literature on health and illness narratives" (Kokanović and Flore, 2017), we argue that the emergence and further development of the idea to travel abroad

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[1] All names of interviewed people in this article are pseudonyms to protect interviewees' identities.

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for medical treatment is not just a prelude of therapeutic mobility that explains *why* a person embarks. Rather, these becomings shape the sojourn at the medical destination (Abegg, 2017). Accordingly, in this article, we shift perspective from the sojourn at the destination to the question of how a destination far from home becomes a therapeutic option. This question demands for an understanding of therapeutic journeys as a component of people's illness biographies.

Working with people's illness biographies implies following their therapeutic trajectories. These trajectories might span across different healing traditions and hence imply mobility between countries as well as between medical systems. Our informants have travelled long distances to engage with Ayurveda, a distinctive, centuries-old medical system of Indian origin. Today, Ayurveda is not a coherent and fixed body of medical knowledge and practice but rather a multiplicity of practices evolving around healing and medical globalization (Pordié and Gaudillière, 2014; Meier zu Biesen, 2018; Banerjee, 2004; Warrier, 2011). It is commonly attributed as "traditional" or "alternative" or "complementary" medicine. These notions position Ayurveda within the medical landscape: either as senior to and more primitive than "modern" medicine or as subordinate 'other' to dominant biomedicine. Reverberating this positioning, undergoing Ayurvedic treatment could be seen as an act of resistance, criticism or despair from marginal(ized) positions. The presented illness narratives indicate that transnational therapeutic journeys from Europe to Indian Ayurveda clinics should be viewed as a desperate and at the same time dedicated response to disappointing therapeutic experiences and lack of answers in biomedicine.

In the following, we provide a state-of-the-art of medical travel literature arguing for a two-fold expansion: (a) on the becomings of transnational therapeutic journeys that (b) integrate quests for other-than-biomedical therapies. We then present our data corpus of ethnographic research in an Ayurveda clinic in South India and explain the narrative approach we adopted to analyze the data. As part of the results, we present two pointed stories of therapeutic journeys from Switzerland to India: the therapeutic odyssey and the anticipated miracle cure, and elaborate the narrative elements travelogue, decampment, and uncertain future. We conclude that it takes a particular patient-subjectivity, aligned with social, human, and financial resources to mobilize patients across borders and healing systems: a subjectivity that views patients as deserving care in the absence of diagnosis and as having agency to consider alternatives in the presence of obvious treatment options. Decampment is the key (narrative) moment shaping the agency that patients require to leap.

1. Embedding therapeutic journeys in people's illness biographies

1.1. Transnational therapeutic journeys

The notion of medical travel or tourism has been used to aggregate manifold patterns, conditions, and drivers of transnational patient mobility as well as health care marketization. In this article, we use the notion of transnational therapeutic mobilities as suggested by Kaspar et al. (2019) to foreground a mobility, rather than a market perspective.

The desire to regain, improve and maintain health and wellbeing has been mobilizing people for centuries (Connell, 2006; Weisz, 2011). With decreasing traveling costs and eased information flow, traveling to access treatments elsewhere is becoming an option available beyond the affluent. Private and corporate hospitals around the world and particularly in Asia build on this development. Acknowledging the global need for effective, up to date therapies, hospitals have been transnationalizing their business activities in the past decades (Connell, 2006; Whittaker et al., 2010; Reddy and Qadeer, 2010). Rather than just attending to the local people in need of care, hospitals reach out and market their services at distant places in order to attract patients and generate more customers (Kaspar and Reddy, 2017). Often, these hospitals are supported by governments that wish to modernize the country and stimulate economic growth (Ormond, 2013, 2015; Reddy and Qadeer, 2010). As a result, a global trade in health care has emerged (Whittaker et al., 2010).

Medical travel research has thus far mainly been concerned with:

- foreign patients reaching and staying at transnational medical travel destinations, i.e. with the *modes of transnational access to health care* (Bochaton, 2015; Crush and Abel, 2015; Dewachi et al., 2018; Kangas, 2002; Kaspar, 2019; Kaspar and Reddy, 2017; Pian, 2015; Rouland and Jarraya, 2019),
- the *effects* of foreigners accessing health care in low- and middle-income countries on individuals as well as sending and receiving societies (Amodeo, 2010; Gupta, 2008; Hall, 2013; Lunt and Green, Stephen; Ormond, 2013; Penney et al., 2011; Reddy and Qadeer, 2010; Reisman, 2010; Whittaker et al., 2010; Wilson, 2011) and
- the *experiences* of undergoing medical treatment in an unfamiliar place (Ackerman, 2010; Bell et al., 2011; Cohen, 2011a; Kangas, 2010; Kearns et al., 2003; Kimport, 2022; Kingsbury et al., 2012).

More recently, therapeutic mobility is also understood as part of transnational livelihoods (Bell et al., 2015; Ormond and Lunt, 2020). There is little research, though, informing us about how medical travel becomes a potential pathway in people's illness biographies, i.e. how individual therapeutic journeys transnationalize, and what this means for patients and their families (but see: Boeger, 2020; Inhorn, 2015; Kangas, 2011, 2002; Pian, 2015). This assessment is similarly applicable to the field of research concerned with the somewhat separate branch of health or wellness travel/tourism that includes what is called traditional, complementary and alternative medicine (Cyranski, 2016, see e.g.; Meier zu Biesen, 2018; Pordié, 2013).

To better understand the role of illness (Frank, 2013; Kleinman, 1988) or migration (Hudson and Mehrotra, 2015; Ploner, 2017; Smith and Waite, 2019) in people's biographies, health and migration research have been using narrative approaches for decades. However, with respect to medical travel/tourism research, the potential of illness narratives as an analytical lens has yet to be fully explored (but see: Abegg, 2017; Kingsbury et al., 2012; Parry, 2015).

1.2. Illness narratives, therapeutic narratives, and the empowering effects of storytelling

Storytelling is an act of meaning-making, and hence an instrument to explain incidences to others and make sense of them to oneself (Charmaz, 1999; Riessman, 1993; Vindrola-Padros and Brage, 2017). In medicine, scholars have been advocating to use narratives to approach health issues holistically (Greenhalgh and Hurwitz, 1999; Kleinman, 1988), while in the social sciences and medical humanities, it has been used to generate insights into the social, emotional and psychological implications that come along with chronic illnesses' corporeal manifestations (Kokanović and Flore, 2017; Rushforth et al., 2021).

Particularly in the context of chronic and terminal illness, storytelling can work to:

- reconstruct a sense of order (Williams, 1984),
- re-claim control over one's life (Frank, 2013) against the backdrop of the chaos caused by disruptive incidents,
- maintain or build a sense of identity (Bury, 2001; Hillman et al., 2018; Lawson et al., 2017), as well as,
- re-claim agency against the objectification of the medical gaze and clinical protocols (Kleinman, 1988).

Therefore, for sufferers and survivors, storytelling can be an empowering act. Besides this, storytelling can work towards transforming illness from an individual incidence to a collective affection (Hydén, 1995). At the same time, it is shaped by power relations that

render some stories more tellable while silencing others (Bock, 2013; Garden, 2010).

Storytelling requires narrative work: incidents, experiences, and emotions have to be selected and arranged in a meaningful order, contextualized and related to relevant discourses, norms and events. Both context and content creation produce a story – and its subject (Lucius-Hoene and Deppermann, 2002).

2. Individual and group interviews with foreign patients receiving ayurvedic therapy

Findings are based on research encounters with 27 patients and three family caregivers[2] that took place in field visits organized by Sunita Reddy, Vandana Karuthodi Ravindran, and Ritika Kar to three different Ayurveda clinics in South India, in December 2017. Most of the research encounters were individual semi-structured interviews lasting between 20 and 70 min. Some interviews were conducted with two or three people, sometimes with people joining conversations. One conversation took place with a group of five persons who wished to be interviewed together. In individual as well as group interviews, research participants were invited to share their story about their pathway to the clinic where we were meeting. Interviews were conducted by Heidi Kaspar and Sunita Reddy. Most were held in English, some in German. When given consent, interviews were recorded, transcribed and translated by Vandana Karuthodi Ravindran and Christina Mittmasser and analyzed by Heidi Kaspar and Alwin Abegg. The background of Indian Health care service systems, corporatization of health care and the importance given to Ayurveda by establishing the Ministry of Ayush [3] in 2014 were foregrounded by Sunita Reddy. The authors report no competing interests.

Our sample consists of 16 persons from Switzerland, four from the USA, two from Germany and one from Latvia, Sweden, Italy, Malaysia, China, New Zealand, and India, respectively. This sample mirrors the breadth of regions patients come from. With respect to biomedical treatments, foreign patients travel to India from the Middle East, Africa, Central Asia and neighbouring countries, mainly (Kaspar and Reddy, 2017). With respect to traditional medicine, though, Europeans lead the rankings: Germany, France and Switzerland are the most frequent provenances of foreigners coming to South India for treatments in so-called alternative medicines (Cherukara and Manalel, 2008). According to our own interviews with clinic managers, patients from the Middle East constitute another major group of foreigners in Ayurveda clinics in South India. The over-representation of patients from Switzerland in our sample is owed to their over-representation in one clinic[4] and to a particular interest of the project as part of the Indo-Swiss research collaboration scheme. Ritika Kar discovered on her stay in Switzerland as part of that scheme that Swiss patients were traveling to South India for Ayurvedic treatment. This paper presents the analysis of two interviews that were selected as they are both exemplary – they share many commonalities with other accounts – while also indicating variety (see discussion).

A second sampling goal was to map the variety of health conditions that bring patients to Ayurveda clinics in South India. Interviewed patients were getting treatment for various health problems like enhancing metabolism, for mental and sleep disorders, injuries, cancer, heart problems, arthritis, pains due to trauma or unidentified reasons. Some came with a biomedical diagnosis, others with year-long experiences of seeking one. All reached out to the clinic for curative purposes, except one person who joined a family member and received preventive treatments.

We consider the generated information as reliable yet not representative. We relied on clinic managers and administrators to provide contact to patients. It is reasonable to assume that they made strategic choices when selecting patients. Consequently, our sample does not include disappointed or sceptic patients. One reservation needs to be considered when assessing the findings: patients depend on the people that treat them. We interviewed patients during their stay in the clinic. This might have restricted their capability to express criticism or doubt. Data analysis was conducted using Grounded Theory coding and memo writing techniques (Charmaz, 1999, 2006) to understand therapeutic mobilities from the perspective of patients. Methodologically, we focused on the reconstruction of the meaning patients make of their experiences and decisions. Thematically, we focused on patients' interpretations of events connected to and eventually leading to their stay in the Ayurveda clinic in India.

3. The field: three ayurvedic clinics in South India

Within the booming market of medical tourism, India is a leading destination (Bhattacharyya, 2020), while Kerala is the "'hot spot' of global Ayurveda" (Kannan and Frenz, 2019). Ayurvedic treatments are offered as cures for medical conditions as well as rejuvenating therapies and wellness treatments. The three clinics we visited were all located in one state of South India and oriented to treat patients. One has the AYUSH Hospitals Accreditation of the National Accreditation Board for Hospitals and Healthcare Providers (NABH).[5] As such, they differ and distance themselves from Ayurveda resorts geared towards wellness, leisure, and vacation, attending to guests and tourists who seek rejuvenation and relaxation, rather than cure. Apart from this commonality, the visited clinics vary in size (from 16 to more than 300 beds), years of business activity (from seven to over 100 years) and provenance of patients (focus on foreigners from Western Europe; foreigners from Western countries; local, national, and global provenance). The two small clinics consist of cottages arranged in a resort fashion while the larger is a classic hospital set-up with several large multi-storied buildings. One is a charity, two are private for-profit companies. We focused on private rather than public hospitals because transnational medical travel is driven by entrepreneurial private institutions. Therefore, they attract larger numbers of foreign patients. The three clinics were selected based on convenience sampling.

The clinic in question here is specialized in Ayurveda treatment, spanning a wide range of chronic illnesses such as cancer, narcolepsy, psychological disorders, arthritis, etc. The clinic is secluded, situated in the middle of a forest not far from a village in South India. It consists of several buildings, hosting doctor's offices, therapeutic rooms, guest rooms, yoga hall, kitchen, dining hall, shop, and library. Pharmaceuticals are prepared on site, with fresh herbs, rigorously overseen by the two managing doctors. Close to 30 therapists and several doctors work in the clinic, along with cleaning, kitchen, and administrative personnel. Patients are called guests; they stay in the clinic throughout the treatment period that typically lasts three to five weeks. Patients' daily routine includes seeing the doctor, receiving treatment, resting, and eating. As part of resting, socializing with other guests plays a key role.

[2] The data corpus consists of 26 interviews with patients, two interviews with family caregivers and one interview with a patient and his family caregiver together. On top of this, we interviewed nine Ayurvedic junior and senior doctors, four clinic managers and two international patient managers, but these interviews are not considered in this article.

[3] The Ministry of Ayush is part of the Government of India. Its purpose is to foster education and research as well as propagation of traditional healing systems in India including Ayurveda, Yoga and Naturopathy, Unani, Siddha, Sowa Rigpa, and Homeopathy. The Ministry had been upgraded from a Department after Hindu-nationalist party won the elections. It follows a "vision of reviving the profound knowledge of our ancient systems of medicine" (Ministry of Ayush n.d.).

[4] One of the selected clinics had a policy to favor Swiss patients, as one of the founders is an Indian living in Switzerland.

[5] See: https://www.nabh.c/frmViewAccreditedAyushHosp.aspx (10.10.2018).

The clinic is owned and managed by two Indian doctors, both having a Bachelor of Ayurvedic Medicine and Surgery (BAMS) degree. We meet Dr. T., a charismatic person who lives and treats patients in Switzerland and refers them to his clinic in South India, if required. According to him, providing Ayurvedic treatments in Switzerland is very limited, as requested fresh herbs are not available and importing them proved to be too complicated.

4. Two stories of therapeutic journeys to an Indian Ayurveda clinic

4.1. The therapeutic odyssey

> It is depressing when you are trying so many things. Each time there is hope. Each time, hope is disappointed (Loïc, interviewed 2016).

Loïc is a patient from Switzerland who has just arrived at the clinic. He is new to the place and to the people, but has made some first experiences, including a "welcoming oil massage." We meet him sitting on the veranda of the building that hosts the dining hall. As we ask him what has brought him here, he responds that his story starts with a disorder, "as probably all stories here do," and directly moves on to tell his therapeutic journey:

Four to five years back, problems with his stomach and intestines started and he went to see a general practitioner (GP). His GP could not find anything unusual and therefore referred him to a specialist in gastroenterology. This specialist too, did not find anything unusual. Loïc went to other GPs and to a variety of specialists. Later, skin problems occurred. The dermatologist could not identify the disease. Blood was tested, biopsies done, urine examined, tests to identify allergies or parasites, … – all negative.

After two to three years of seeing different biomedical GPs and specialists and still being left without an adequate response to his suffering, Loïc started his own search for answers off the referral track. Since biomedicine did not come up with any helpful leads, he took the quest to other healing systems. Loïc lists a long and varied series of therapies and diagnostics he has tried in the past two years: Traditional Chinese Medicine (TCM), particularly acupuncture, various kinds of teas, crude drugs such as medicinal mushrooms (German: "Vitalpilze"), a strict food regimen, dark field analysis (German: "Dunkelfeldanalyse"), bioresonance, numerology, astrology, some kind of aura-energy therapy … Some tests provided insights regarding the cause of his disorder and some therapies yielded improvement, but it did not last, others were detrimental. Despite all the testing and experimentation, diagnosis was still missing, while suffering continued to be substantial. In Loïc's own words:

> I never have pain, just discomfort, but it comes from deep within, deep in your bones there is a feebleness. You don't feel comfortable in your own skin. That comes from the intestines. It takes all your energy. It affects all your organs. Thinking becomes a challenge. (…). You don't feel like doing anything, the goal is to move as little as possible. Your organs are hurting, circulation causes problems, you feel the risk of blacking out. And people around you realize that something is wrong with you. With time, you don't even imagine how it is without all these problems, how it is to feel normal, to feel nothing.

Despite the continued irritation and fatigue, Loïc manages two jobs, one as an employee and one running his own business, but the disorder heavily affects his social and leisure life. At some point, his TCM-therapist tells him about Dr. T. and his clinic in South India. "And now I am here", Loïc concludes his story. After a year-long quest for answers a tip from a therapist has catapulted him into the present and put a tentative end to his odyssey. It took Loïc several months to get an appointment with Dr. T. in Switzerland, but when he met Dr. T., he immediately got a diagnosis: metabolism disorder.

Loïc reflects on his decision to try yet another therapy: "Coming here to this place is the most radical thing I have ever done." It is a radical decision, because it involves traveling to a distant and unfamiliar place and because it implies leaving home and work and breaking with daily life for a couple of weeks. For Loïc, it involves a professional risk as he must leave his business. It also implies additional strain on his health as traveling causes him great discomfort. He would have preferred to stay in Switzerland. But the references have been so good for this clinic that he feels that there was no other option than coming to India. He adds: "In fact, coming to this clinic is my last resort."

Loïc's hope is that here, he can learn how to handle his irritable bowel syndrome, to control the heat in his stomach and the surges on his skin. With teas, medicinal mushrooms, pro-biotics and such, small achievements have been made. Now, he hopes he can get a little deeper with his healing, reaching the core of his condition.

We call Loïc's story the therapeutic odyssey because his itinerary to the Indian Ayurvedic clinic very much resembles the endless, daunting journey of Odysseus for whom the only motivation to continue was to finally put an end to the journey by arriving at his destination. It is a long journey with a clear destination, but hardly any orientation to guide his path.

4.2. The anticipated miracle cure

Marco's diagnosis came unexpected. He had never been suffering from anything during the 54 years of his life, but eventually started to have some undefined joint pain. More out of curiosity, he wanted to find out what it was and after three years received the diagnosis: a rare kind of blood cancer. Marco was given a very clear verdict: treatment might curb cancer over 10 or 15 years, but not heal it. From then on, things went fast and fierce: after being told on a Monday, Marco was on chemotherapy on Friday. "Doctors fast as lightning took me by surprise and started chemotherapy right away." Chemotherapy worked well in the beginning, drastically improving his measures while showing manageable adverse side effects. The therapy was continued when, suddenly, the lingering pain in his legs and feet "exploded." Walking and standing was barely possible, anymore. That is when he said to himself:

> That's it. Basically, I had not been suffering before, my measures improved. What are they [the doctors] up to? Finish me off completely? (…). I had always been the guy who would try alternative things. So, we quickly started looking around.

While he searched extensively for a cure online, Marco also had informed all his friends to enlarge his chance to find an adept treatment for his condition. One day, he heard from a friend:

> His father had a condition like mine. He was about to start chemotherapy when he heard of a doctor in (…) Switzerland. He went to see this Dr. T. and Dr. T. said to him: 'Don't worry. You surely don't have to start chemotherapy.' He told him to drink some sort of powder and to come to his clinic in India for therapy as soon as possible. He went there three times. After the third stay he went back to oncology and told doctors to take his measures. They did all the measurements, and everything was gone. That is what he told me. I went to oncology and told the doctors to stop everything, the whole chemotherapy. They said: 'Are you sure?', and I: 'Completely sure! I don't want to waste the rest of my life on chemotherapy. And I have the opportunity to go to India.

Marco soon gets an appointment and meets Dr. T. in Switzerland. He is impressed by Dr. T., who, after a short check, tells him: "I am not sure that I can heal you. But I give you a good chance that you can heal yourself." Dr. T. urges him to not lose any time and a little later Marco arrives at the clinic where we meet.

The past three weeks have been exhausting and Marco feels weak: This morning he tried to take a walk in the forest but "had no juice." Dr. T. has told him that the treatment he gets is "one of the hardest." The

pain in his legs and feet is the same as it had been in Switzerland. Despite the absence of palpable progress, Marco is confident about his future; he completely trusts in Dr. T.:

> I have to say, I've rarely heard a person like this, where I feel energy like this in the first moment. I have never seen that. Just this morning, as the door opened [and Dr. T. entered] – an amazing energy! There is something amazing radiating from him. I am eager to find out what he can do with me. I just have a good feeling. You see, my whole thinking has gone away from the illness. I'm having it, period.

Marco was about to return home the day after next when we met. Dr. T. told him to immediately go to the hospital to take measures and let him know. He seems to be genuinely interested, but also needs the information as a basis to prepare the medicine for Marco, as back in Switzerland, the therapy will be continued.

We call Marco's story the anticipated miracle cure, because throughout the interview he was "radiating" that compelling and somehow contagious confidence that he will be fine. He never explicitly said so. In fact, quite the contrary: instead of mentioning signs of progress, he notices that he currently is not managing a stretch that he could easily walk when he arrived at the clinic. However, Marco does not question the therapy nor his decision to come to the clinic but maintains a firm faith in Dr. T's treatment. Marco had been introduced to us by another guest at the clinic as an "incredible story." However, his incredible story has not materialized, yet. The "incredible story" is a preceding story that concerns another man. While Marco has set out to repeat the miracle cure, his confidence anticipates the realization of it while the two stories coalesce.

5. Therapeutic mobilities narratives: travelogues, decampments, and uncertain futures

The presented stories are different and share instructive commonalities. We present four narrative elements that are common to all stories in our sample except one and use Marco's and Loïc's stories to elaborate on the varying characteristics. The observation of symptoms, i.e. **(a) appearance of a disorder** is a common beginning for illness narratives. Loïc and Marco start off with rather diffuse somatic experiences that feel wrong. The observation of symptoms can be followed by various emotional and practical reactions, ranging from denial, downplay or neglect to acknowledgment, surrender or resignation, to a dedicated search for diagnosis and therapy as in the presented stories. In our interviews, the search for diagnosis and adequate therapy is narrated as a **(b) travelogue**, consisting of a few or countless stations extending to years. In this part of the story, actions and events occur as subsequent stages on a therapeutic journey whose destination is a status of regained or at least improved health. As the presented stories show, pace of succeeding stations as well as pattern and length of the journey vary considerably.

The presented stories furthermore entail marked turning points, and even **(c) decampments** from the current track. In our sample, decampments occur as departing from

- conventional to alternative medicine *and*
- from intimate to distant and often unfamiliar places.

The singular character endows it with the power to constitute a narrative element that sets the moment apart from the stations of the travelogue. After a decampment, another travelogue might follow – or the end of the therapeutic story.

For our interlocutors, the tentative end of the story is the present, i.e. the arrival and sojourn at the Ayurvedic clinic in India. Yet, this present might not be the end of their therapeutic quests as the effect of the therapy has yet to materialize itself. **(d) Uncertain futures** imply that the endings of the presented stories are pending. This ambiguity deprives the storyteller of one of the most creative powers: telos. Usually, stories are told retrospectively, and they strive towards an ending envisaged by the narrator (Mattingly, 1994). Narrators of therapeutic-journeys-in-the-making might be confident, but they can never be sure. Instead of being creators of their stories and mastering the telos of their story, they must deal with the future's contingency and might have to fundamentally re-craft their story as future unfolds. While the appearance of a disorder is generic to illness biographies, and an uncertain future applies to storytellers telling their biographies while illness is still unfolding, travelogue and decampment are particular, though not exclusive, to transnational therapeutic journeys to so-called alternative treatments. There is one exception in our sample that does not generate a decampment and travelogue element. It stems from non-resident Indians who were well acquainted with the place and the medicine and hence constitute a different type of medical traveler: migrants returning to familiar places and healing systems for treatment.

5.1. Therapeutic decampment as an articulation of agency

The departure from a therapeutic path suggested by medical authorities is an essential element in the therapeutic odyssey and miracle cure narrative. The departure takes place in two steps: 1) Acknowledgment that the current path does not lead to the targeted destination. 2) Action to create alternatives, a bifurcation in the path. Decampments are coined by agency and an orientation towards the future. In social sciences, agency is understood as a person's ability to act within a context of facilitating and restricting social and material structures (see e.g. Wanka and Vera, 2018).

In Loïc's story, there are two decampments, one is more marked: traveling to India to surrender to a three-week long treatment as "the most radical thing" he has ever done. The first decampment happens two to three years after the onset of his disorder, when he decides to see other-than-biomedical healers. Marco had always been in touch with complementary and alternative medicine. At the integrative medicine department at the Swiss hospital, he was doing curative eurythmy. Engaging with Ayurveda therefore is not a decampment for Marco per se. Stopping chemotherapy altogether and traveling to India, however, constitutes a turning point in his story. Here, decampment is marked by Marco's dedication as well as by the response of doctors who, working with an integrative medicine department were comfortable in collaborating with "complementary" medicine but reacted with disbelief to the announcement of stopping biomedical treatment.

For both Marco and Loïc, decampment is an articulation of agency. It is a tactic to counteract the potentially colonizing power the illness wields over their lives and to re-gain control over therapeutic decisions as well as their subject positions. To counter the overwhelming embrace of the illness, Marco prevents of what he perceives is a path of increasing pain and disability and decreasing control over his life in which therapy might cure one illness but evidentially provokes others. Loïc's decampment is a dedicated, perhaps desperate, action to finally end his odyssey in a positive, beneficial way, rather than surrender to illness and arrange his life around the suffering.

Marco experienced the oncological treatment as over-powering and harmful, hence threatening, a cure that comes with pain and disability. Biomedical professionals assign Marco a compliant patient-subjectivity that surrenders to treatment and its side-effects and hands control over to physicians. For Marco, decampment is an articulation of agency to re-claim participation in therapeutic decisions including the tolerability of treatment effects and the goal of treatment. His departure to the Ayurvedic clinic can also be understood as clearance from the biotechnical embrace and an escape from the clinical narrative (Del Vecchio Good, 2007).

Loïc on the contrary, is not caught but abandoned by biomedicine. For him, to counter the overwhelming embrace of the illness implies insisting on a disease and the need for therapy where medical experts cannot provide a diagnosis. It implies insisting on a patient-subjectivity

and deservingness to care against the backdrop of a system that continues telling him that "everything is fine" and hence denying his suffering and eventually a patient-subjectivity. For Loïc, decamping is an articulation of agency, too. Agency here consists of rejecting the assigned subject position by holding on to a patient-subjectivity and demanding care. Decampment is a means to perform that agency. Loïc describes that surrendering to illness and arranging a life with it is a lingering temptation, but his family supports him in insisting and continuing the quest.

Others' therapeutic stories work as powerful decampment drivers in both Loïc's and Marco's story. The pivotal role of circulating testimonials and word-of-mouth in mobilizing patients as been described in medical travel literature (Connell, 2015; Kaspar and Reddy, 2017; Yeoh et al., 2013). In the presented stories, the power of circulating experiences is accentuated. Marco creates tight parallels between his friend's father's story who has been miraculously healed in India and his own therapeutic journey. They started off with very similar diseases, diagnosed by the same oncologist. By following his therapeutic path to the Ayurvedic clinic in South India, Marco aspires to repeat the miracle cure.

The testimonial mobilizing Loïc is less elaborated in his story but invested with similar power: The references he received for this doctor and clinic were so clear that he could not ignore this option. In both stories, circulating narratives are invested with hope. Both testimonials are stories within stories that suggest that hoping to be healed is adequate and the efforts and risks of decamping justified.

5.2. Narrative tactics to handle uncertain futures

Both stories end by arriving in an ambiguous present. For Marco, it is the end of his sojourn at the clinic, for Loïc the beginning. The present is ambiguous as various indications towards further developments co-exist or are missing. Marco has experienced treatment but not yet improvement; his treatment will be continued back home. Loïc has not yet started treatment. For both, the present is invested with hope while there is no evidence, yet. Marco and Loïc have to close their stories in the face of an uncertain future, i.e. while the end of their journeys is contingent.

Therefore, Marco's and Loïc's position as storytellers is precarious. Decampment positions them as self-responsible patients reclaiming agency and control over therapeutic decisions while working towards regaining or at least improving their health. They have taken health risks and invested money, time, and hope. The outcome of this therapeutic journey is critical, yet unknown. Will it bestow an auspicious end or tragic plot twist on their therapeutic journeys?

How does this uncertainty shape the story? Loïc and Marco have different narrative tactics to handle contingency. Loïc moderates his hopes, Marco invests in the future. Building on a history of disappointed hopes, Loïc avoids high expectations. His modest hope is to reach a stable state and learn to handle his condition. The outcome is nevertheless critical. Since this therapy is his "last resort" it constitutes the termination of his therapeutic journey. The ending will lead towards healing or result in abandoning the patient-subjectivity eventually and surrender to a life coined by suffering.

While the contingent end in Loïc's story is mediated by his therapeutic past, the contingent end of Marco's story is shaped by its anticipated future. In the absence of an already manifest miracle cure, Marco narratively produces it. He followed the therapeutic pathway of his reference story, and his story anticipates reproducing the ending. Building perfect parallels between his own future story and another person's testimony, Marco's story works as a performative act that provides no prognosis but neither leaves any doubt that there will be a miracle in the end.

However uncertain the health outcomes of their therapeutic journeys, decampment worked for both regarding agency. Marco has successfully decolonized his life from the disease. While the disease lingers in his body it does not dominate his thoughts anymore. He has learned that he might have been living with the disease for decades and might continue doing so and has stopped constantly thinking about it. And Loïc has received a diagnosis and is about to receive therapy, hence is being treated as a patient.

6. Discussion

Re-gaining health is the common goal of transnational therapeutic mobilities. It is also the telos of "restitution narration" described by Frank (2013). The restitution narration follows a threefold storyline: (1) health, (2) illness and (3) (envisioned) return to health, whereas everyday life before the onset of illness is articulated as normality (1), illness as it's disruption (2) and the efforts and pathway to restore health and normality as a goal (3). Therapeutic mobilities stories can therefore be understood as restitution narration.

The results of this study indicate that the combination of illness narratives and therapeutic mobilities yields novel insights. The narrative analysis of therapeutic mobilities stories allows to examine what "regaining health" means for transnationally mobile patients, rather than assuming it. Marco's and Loïc's stories teach us that envisioned health as a telos is malleable and shaped by respective illness biographies. Too many disappointments block Loïc's hope of being completely healed, and Marco has learnt on his therapeutic journey that he might have been living with cancer for the past 30 years, turning the health that preceded the onset of disease into a delusive state and not necessarily a desired one (see also Thomas-MacLean, 2004).

The therapeutic odyssey narrative resonates with many other stories we have encountered in our empirical research in India and with findings from other studies that indicate that national therapeutic mobilities often precede international ones and that going abroad appears as an option after many others have been tried and proved ineffective (Kaspar and Reddy, 2017; Vindrola-Padros, 2019). The anticipated miracle cure narrative on the contrary is particular for Ayurveda medical travel narratives. While it is common for patients and their families to express amazement and gratitude towards doctors' skill and competence at the destination (Kaspar 2021; Kaspar and Reddy, 2017), for Ayurvedic doctors or treatments, this is even more pronounced. People become witnesses or living proofs of something they had almost lost hope for, and that they have been told would not work.

The presented narratives result from specific contexts: patients' mobilities between places and medical systems. We assume that our findings generally apply to mobilities between dominant biomedical and 'other(ed)', i.e. subordinated medical systems such as Traditional Chinese, European etc. medicine, as the same power dynamics cause barriers to access such treatments. Yet, further research will have to provide evidence. The presented narratives also result from specific narrative positions: they are told as the ending is still unfolding. Our interview partners were all hopeful to experience the success of their treatments. We expect narratives told from an ending of manifested failure to differ starkly.

Existent literature is indicative of further therapeutic mobilities narratives such as the notion of medical pilgrimage in Song's (2010) research on people with incurable neurodegenerative conditions traveling abroad to access experimental stem cell therapies. Her interlocutors describe their risky journeys as transcendental acts; they hope to improve their own health, but simultaneously contribute finding new cures for everyone with similar conditions. Transnational medical travel as an act of family care and expression of affection or cultural belonging (Inhorn, 2011; Kangas, 2011; Kaspar, 2019) is another notion that could be further investigated as a therapeutic mobilities narrative.

Research on therapeutic mobilities has gained a certain level of attention over the past decades in the social sciences. The results of this study might inspire future research beyond the field of therapeutic mobilities for the relevant sub-disciplines of health geography and medical anthropology. For example, the narrative element of decampment might prove useful in medical anthropology to better understand

the contexts in which unconventional or even radical therapeutic decisions become an option. And the narrative element of travelogues might help to examine the connections between disparate places of health care in health geography. Understanding health care behavior through patients' stories might furthermore be fruitful to (a) identify commonalities and differences between places of health care provision that are distant yet connected through patient mobility as well as to (b) see beyond obvious factors and begin to understand why some patients set off on a journey across the globe and medical systems and others in similar situations do not. To both sub-disciplines, the narrative element of uncertain futures might serve as useful analytical lens to pay attention to the contextuality of data production and the precarious subject position "patients as narrators" find themselves in when providing information on therapeutic journeys with contingent endings.

7. Conclusion

Before the COVID-19 pandemic, medical tourism was a booming market. India's health travel market registered an 18% growth just before the pandemic outbreak (Bhattacharyya, 2020). The COVID-19 pandemic slashed the industry (see e.g. Tsai, 2021), but experts expect it to recover (Tatum, 2022). The pandemic has been a health crisis that prompted an economic crisis. This shock on both health care and the economy might even mobilize more people across national borders to seek medical treatment (see Yeginsu, 2021).

This paper expands the focus of current research on international medical travel in two ways: by shifting the attention from *being* a foreign patient or medical traveler to *becoming* one, and by integrating, rather than separating quests for *other-than*-biomedical therapies. Furthermore, it offers a methodological innovation by applying a *narrative* approach. A narrative approach to illness dates to the mid-20th century (Kokanovic and Flore, 2017) and is common in migration studies but is new in the field of transnational therapeutic mobilities. The results presented in this paper indicate that a narrative analysis is a fruitful instrument to yield novel insights on how patients become transnational.

Despite the emerging field of research on therapeutic mobilities, scientific knowledge on how traveling abroad emerges as an option in people's illness biographies is still limited. Commonly listed drivers include differentials between places regarding cost, quality, legality, and availability. In some places, traveling abroad for treatment has become a commonly known option or even an obvious choice (Kaspar and Reddy 2018; Knoll, 2017). In other places, people learn about medical travel at some point during their therapeutic quests.

Our analysis of therapeutic mobilities stories from people with chronic conditions traveling from Western Europe to South India for Ayurveda treatment has shown that medical travel is becoming an option when people feel the need to divert from current therapeutic paths. We have identified decampment as the key narrative element describing this bifurcation and we have highlighted that decampment is an act of agency that manifests resistance to local healthcare. In the presented stories, interlocutors deemed it necessary to depart from their home and familiar medicine to keep in control of therapeutic decisions and to continue the quest of healing. The industry evokes patients as customers on a global health care market and praises medical travel as a savvy choice (see Ormond and Sothern, 2012). Our results, however, indicate that therapeutic mobility is not a choice of *where* to go, but a decision to depart, i.e. to abandon ineffective routes and find alternative ways.

Our results furthermore show that therapeutic mobility becomes an option when trusted testimonials are so convincing that ignoring them feels like foreclosing the chance for a healthy future. Calculating the best benefits among transparent offers is quite a different 'choice'. Evoking patients as customers who take well-informed choices might refer to a small sub-set of medical travelers, but it does not relate to the realities of many patients.

In a place where health care is enacted as a state responsibility and where biomedicine is the dominant form of medicine, traveling abroad for so-called alternative treatment can be read as a manifestation of biomedicine that failed to meet patients' needs. This implies a tacit criticism of the government for not meeting its responsibilities (see Kangas, 2007). At the same time, decampment might impede the formation of political claims, as stakeholders exit the national system (see Ormond, 2015). Yet, traveling to seek therapy elsewhere is an option reserved for those who can afford the extra expense or have a government covering it. It therefore cannot be practiced without increasing health inequalities. This paper presented two exemplary stories from people who were abandoned or overwhelmed by local health care that prides itself to be world-class. Decampment might prove a useful analytical tool to disclose insufficiencies in local health care, where due criticism is not articulated as politically effective claims.

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Data availability

The data that has been used is confidential.

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