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Medical evacuations in French Polynesia: understanding the mechanisms that constrain or facilitate access to care, based on the experience of cancer patients

Alice SERVY
Lecturer in anthropology at the University of Strasbourg, attached to the laboratory "*Sociétés, Acteurs, Gouvernement en Europe*" (*SAGE*), researcher associated with the research division "*Mobilité, parcours et territoires*" of the National Institute of Demographic Studies (Condorcet Campus, Aubervilliers)

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Résumé

En Polynésie française, le dispositif d'évacuation sanitaire (abrégé « évasan ») permet aux personnes qui ne peuvent pas être soignées sur leur île de résidence d'être transférées vers des établissements de santé, situés sur l'île de Tahiti, en France métropolitaine ou en Nouvelle-Zélande. Chaque année, environ 27 000 évacuations sanitaires « inter-îles » ou « internationales » sont réalisées. La cancérologie représente l'une des principales causes d'évasan extraterritoriale. Aucune recherche approfondie en sciences sociales ne s'est cependant intéressée à l'expérience des évacuations sanitaires par les patients.

Cet article, fondé sur plus de deux mois d'enquête ethnographique, met en avant les mécanismes qui contraignent ou facilitent les évacuations sanitaires des personnes atteintes de cancer en Polynésie française. Après avoir présenté les représentations des patients autour des évasans, des pathologies cancéreuses et de leur prise en charge, j'analyse différentes dimensions des évacuations sanitaires qui influencent l'expérience des personnes évasannées. Ce travail met notamment en exergue le rôle des interférences spatio-temporelles dans le vécu de l'évasan.

Mots-clés : évacuations sanitaires, accès aux soins, mobilités thérapeutiques, cancers, Polynésie française.

Abstract

In French Polynesia, people who cannot be treated on their home island are transferred to health facilities on the island of Tahiti, metropolitan France, or New Zealand. Each year, approximately 27,000 "inter-island" and "international" medical evacuations (referred to as "medevacs") are performed. The treatment of cancer is one of the main causes of cross-border medical evacuations. However, there is a lack of in-depth social science studies on the medevac experience of these patients.

This paper, based on more than two months of ethnographic fieldwork, highlights the mechanisms that constrain or facilitate medical evacuations for cancer patients in French Polynesia. After presenting their perceptions of cancer, medical and non-medical care, and medical transfers, I have investigated several dimensions of medical evacuations that shape the experience of medevac patients. This work notably highlights the significance of spatio-temporal interferences in these patients.

Keywords: medical transfer, medical access, therapeutic mobility, cancers, French Polynesia.

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Introduction

French Polynesia is a French overseas territory in Oceania characterized by strong insularity. The 118 islands grouped into five archipelagos are dispersed over 2,500,000 square kilometers, an area equivalent to that of Europe[1]. The medical evacuation process (shortened to "medevac") provides that patients who cannot be treated on their home island of residence are transferred to the island of Tahiti, metropolitan France, or New Zealand. The Caisse de Prévoyance Sociale (CPS), responsible for managing social protection in French Polynesia[2], registers some 27,000 medevac patients annually, including 700 from outside the Polynesia[3].

In French Polynesia, the prevention and the screening of cancer, as well as patient care procedures (diagnosis, treatment, and follow-up) frequently involve inter- and extra-territorial travel. Although most islands have a health facility, oncology services (radiotherapy, chemotherapy) are primarily located on the island of Tahiti, which was home to more than two thirds (69%) of French Polynesia's 275,918 residents in 2017[4]. Along with cardiology, oncology represents one of the main reasons for so-called "international" medevacs. Polynesian patients can be evacuated to metropolitan France or New Zealand for surgery, brachytherapy, or a PET-scan, for example[5].

In 2018, the French Polynesian Assembly[6] conducted a fact-finding mission on the reception and care of Polynesian patients (and their accompanying person) who have benefitted from a cross-border medical evacuation.

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[1] https://outre-mer.gouv.fr/polynesie-francaise-geographie

[2] http://www.cps.pf/la-cps-et-la-psg/presentation-de-la-cps/presentation-de-la-cps

[3] ASSEMBLY OF FRENCH POLYNESIA. *Rapport mission d'information*. 2018, p. 26.

[4] Jérémie Torterat, Mathieu Bolduc. French Polynesia. Le ralentissement démographique se confirme, les jeunes continuent à émigrer. 2018.
http://www.ispf.pf/bases/Recensements/2017/Donnees_detaillees.aspx

[5] *Ibid.* p. 27.

[6] *Ibid.*

There are studies that have examined how medevac patients fit in the Polynesian health care system from a geographical or medical standpoint [7], and others have presented the perspective of health providers who look after patients transferred to the Paris region[8]. However, no in-depth social science research has been conducted in French Polynesia on the medevac experience of patients. From this perspective, my anthropological research project on inter- and cross-border medevac cancer patients is ground-breaking.

Research in the humanities and social sciences on the subject of ”therapeutic mobility” is currently expanding, as evidenced by the special issue of the journal *Mobilities* that was published at the end of 2019[9]. Therapeutic mobilities are defined in the introduction to this issue as "multiple transfers of people, including, but not limited to, nurses, physicians, patients, and includes health-related matters, personal accounts, medical data, and pharmaceutical products”[10]. Therapeutic mobilities can be cross-border or domestic (within nation state borders).

As part of my research in French Polynesia on inter- and extra-territorial medical evacuations, the use of the term, "mobility “, to denote the movement or potential movement to a location[11], serves to emphasize the spatio-temporal dimensions of moving. This term also helps to broaden the focus of medevacs by taking into consideration other people (parents, volunteers, professionals), as well as the things, ideas, and practices that are put into motion along with patients[12]. By using the concept of mobility, rather than that of "therapeutic itinerary”[13], for example, it is possible to highlight the fact that these transfers are not always one-dimensional nor clearly identifiable trajectories between the points of departure and arrival. Medical evacuations are often complex, multi-faceted, and diverse. Finally, the notion of therapeutic mobility makes it possible clarify the distinction between “medical tourism "[14] and “therapeutic immigration”[15]. This distinction, often brought up in the media, tends to refer to the host country’s (alleged) socio-economic status of its people and the legality of their cross-bordeur search for care[16]. Furthermore, these social categories do not reflect the

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[7] Emmanuel Vigneron, Vincent Simon, Fabrice Jeannette. *Problèmes de santé dans un territoire insulaire : les évasans en Polynésie française*. 1989.

[8] Alice Tellier, Bernard Rio. De l’hospitalité : prise en charge de patients polynésiens atteints d’hémopathies malignes. 2009.

[9] Heidi Kaspar, Margaret Walton-Roberts, Audrey Bochaton. Therapeutic mobilities. 2019.

[10] *Ibid*. p. 1.

[11] https://cnrtl.fr/definition/mobilit%C3%A9

[12] Juliette Sakoyan, Sandrine Musso, Stephanie Mulot. Quand la santé et les médecines circulent. 2011.

[13] Laurent Vidal. Itinéraire thérapeutique et connaissance de la maladie chez des patients séropositifs pour le VIH (Abidjan, Côte-d’Ivoire). 1992.

[14] Ara Wilson. Foreign Bodies and National Scales Medical Tourism in Thailand. 2011. Ruth Holliday, David Bell, Olive Cheung, Meredith Jones, Elspeth Probyn. Brief encounters: Assembling cosmetic surgery tourism . 2015.

[15] Anne Yvonne Guillou. Immigration thérapeutique, immigration pathogène. Abandonner le « parcours thérapeutique » pour l’expérience migratoire. 2009.

[16] Anaik Pian. Care and Migration Experiences Among Foreign Female Cancer Patients in France: Neither Medical Tourism nor Therapeutic Immigration. 2015. p. 651.

university of people who receive care outside their usual domicile[17], or the fact that people do not necessarily define themselves as "tourists"[18], "consumers",[19] or “migrants".

Studies conducted on the international mobility of patients in their search for health care, primarily emphasize their need for financial resources, social networks, and the knowledge of the host country[20]. However, little research has been conducted on the mobility of cancer patients[21], as Heidi Kaspar regrets[22]. Few studies have been carried out on patient mobility funded by a State or a government, as is the case of medical evacuations[23]. Ethnographic material gathered in the Pacific islands[24] is rare, and no research on domestic inter-island therapeutic mobility has ever been carried out, as far as I am aware[25]. However, it is a safe to assume that the nature of the disease, the mode of financing, and the unique characteristics of French Polynesia (administrative status, strong insularity, spatial deployment of the family, etc.) all have an impact on the delivery and experience of inter- and extra-territorial patient care.

To better understand the mechanisms that constrain or facilitate the medical evacuations of cancer patients in French Polynesia, I will mainly describe here the experiences of my respondents who were evacuated for medical reasons. After presenting the research methodology used, I will examine the feedback of my respondents regarding their cancer, the administration of their care, and the medical evacuation itself. I will then return to the key points that medevac patients emphasized in their testimonies, namely: the administrative procedures, transfers, accommodation, money, clothing, information and communication technologies, family relationships, interactions with other patients and medevac personnel. We will see that the ways in which cancer patients experience medical evacuations are primarily impacted by spatio-temporal interferences.

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[17] Sandra Perez. Health and Interfaces. 2010. Meghann Ormond, Neil Lunt. Transnational medical travel: patient mobility, shifting health system entitlements and attachments. 2019.

[18] Laurent Pordie. Se démarquer dans l’industrie du bien-être. Transnationalisme, innovation et indianité. 2011. p. 5.

[19] Heidi Kaspar. Searching for therapies, seeking for hope: transnational cancer care in Asia. 2019. p. 123.

[20] Audrey Bochaton. Cross-border mobility and social networks: Laotians seeking medical treatment along the Thai border. 2015. p. 366. Dominique MATHON, Philippe APPARICIO, Ugo LACHAPELLE. Cross-border mobility and therapeutic itinerary of Haitians in the Ouanaminthe region. 2019, p. 24-25.

[21] Anaik Pian. Care and Migration Experiences Among Foreign Female Cancer Patients in France: Neither Medical Tourism nor Therapeutic Immigration. 2015. Sylvain BESLE, Solenne CAROF, Emilien SCHULTZ. Les parcours de soins des enfants en rechute de cancer. Un objet multi-situé au croisement de la sociologie et de la médecine. 2019.

[22] *Ibid*. p. 121.

[23] Juliette Sakoyan. *Un souci « en partage » : Migrations de soins et espace politique entre l’archipel des Comores et la France. 2010. Christian Fleury. Île-frontière et santé. Jersey et Saint-Pierre-et-Miquelon, deux exemples en décalage*. 2010.

[24] Evelyn Marsters. A Transnational Syndemic: Cook Islanders and their experiences of TB and diabetes. 2013. Patricia Fifita. *Siu I Moana: Navigating Female Cancer Experience in the Kingdom of Tonga*. 2016. p. 272.

[25] Christian Ghasarian. Mobilité trans-insulaire et réseaux d’entraide à Rapa (îles australes). 2014. p. 4.

Methodology

This study, which is a component of the ATOLLs project[26], was conducted using an inductive methodology that alternated between fieldwork and theoretical research. Since my fieldwork was “multi-sited”;[27] I was able to track the progression of cancer patients beginning from suspected cases and diagnosis to treatment, remission, or death, and get a better understanding of the complexities of medical evacuations.

As part of my postdoctoral year funded by the French Red Cross Foundation, the National Institute for Demographic Studies and the Scientific Interest Group (GIS) Gender Institute, I gathered data at two sites: the urban area of Tahiti, where French Polynesia’s main hospital has a cancer department, and the Paris region, to which most cross-border medevac patients are transferred. Due to the COVID-19 pandemic, I was able to conduct only one two-month mission in French Polynesia (the second having been cancelled), plus one week of data collection (out of the eight weeks initially planned) at a reception center in Paris for Polynesian patients.

Between October 2019 and January 2020, I met 83 people involved in medevacs and cancers in French Polynesia to varying degrees: members of volunteer associations dedicated to helping medevac patients, volunteers from cultural associations, political figures, researchers, social workers, healthcare personnel and managers, etc. I carried out non-directive interviews with these people, inquiring about their activities, the structure of their work, the basis for their commitment, their viewpoints on the issues, and their experience with cancer and medical evacuations (given that some had themselves been patients or had accompanied patients). Materials related to their activities (maps, reports, brochures) were also collected.

These people introduced me to 32 patients with whom I conducted one or two non-directive interviews. The two main inclusion criteria for respondents were met if they were or had been cancer patients and had been medically evacuated to Tahiti, New Zealand, or metropolitan France. Among the 32 cancer patients (22 women and 10 men), 11 had lung cancer and 12 breast cancer. At the time of the interviews, 29 respondents out of the 32 had already been evacuated at least once: 16 from their island of residence to Tahiti, 15 from Tahiti to metropolitan France, and 9 from Tahiti to New Zealand. These people came from various socio-professional backgrounds (retired, employed, executive, etc.). They identified themselves as "Polynesian" or "mixed" (26 of them), "Chinese" (1), "French" (4), or "New Zealander" (1). Their average age was 56 (with a standard deviation of 13). My respondents mainly spoke to me about their treatment program, their medical evacuation, their reaction to cancer, their relationship with relatives, and their interactions with volunteers from healthcare associations.

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[26] https://polynesie.site.ined.fr/fr/ANR-ATOLLs/

[27] George Marcus. Ethnographie du/dans le système-monde : L’émergence d’une ethnographie multisituée. 2010 [1995].

After having obtained permission from the managing director and medical staff of Taaone Hospital (the French Polynesian hospital center) to record my observations and conduct interviews, I spent many hours in the pulmonology and radiotherapy departments, as well as in the day hospital where chemotherapy is administered. There, I was able to observe the interactions between patients and hospital staff (as related to the delivery of healthcare, announcement of diagnoses, consultations, time in waiting rooms), as well as with volunteer associations and visiting relatives.

My written notes from these observations and interviews were selectively transcribed into digital format, coded by keywords, and saved in thematic Word files. Along with this cross-interview thematic classification, I created an analytical interview spreadsheet on Excel, on which I recorded each interviewee's identifying information, elements showing how our meetings were progressing, and excerpts taken from interviews and broken down by theme.

Results

My research began with the assumption that the ways people perceive illnesses and their treatment influence healthcare practices. I focused not only on the perceived ideas and experiences that cancer patients had of their medevacs, but also on their view of cancer itself and its treatment.

Perception of cancers and their treatment

Terms used

Aside from French, Polynesian and Chinese are two other languages primarily spoken in French Polynesia. The Tahitian Academy uses the expression *māriri 'aita'ata*[28] to designate cancers, but few of my respondents were familiar with this term. A woman in her thirties from the Tuamotu Islands explained to me as follows: "For Polynesians, cancers do not exist, but there is a very serious disease comparable to it called *ma'i rahi*. Paracetamol and light medication have no effect on this disease. The Tahitian Academy has translated the word 'cancer' into Tahitian, but for us [in Apataki], we say 'major illness' to designate AIDS, cancer, etc." (C. 35 years of age, daughter of F. 62 years if age, metastatic thyroid cancer).

During the interviews conducted in French, terms referring to animals were also used by my respondents when referring to their illness, such as "crab", *fe'e* ("octopus" in Tahitian), or *heke* ("squid" in Marquesan). However, the most frequently used word was "cancer".

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[28] http://www.farevanaa.pf/dictionary.php

Cancer development

Cancers are viewed as dangerous diseases by my respondents. They most often consider their illness to be irreversible once the diagnosis is made. Most of my respondents (including those with metastatic cancer) however indicated, at the time of the interview, that they no longer associated cancer with death. A 42-year-old woman told me: “I've had this disease for seven years. In my family, nearly all the women have cancer, they feel fine, they no longer have chemo. I'm the only one still on chemo. Even when I relapsed, I took it well. Now the disease, I take it as mild flu” (D. 42 years old, metastatic breast cancer).

All my respondents view cancer as a disease that interferes with the functioning of their body. Some speak of cancer as an entity that gnaws at them from the inside. One patient told me: “It's to exterminate these beasts that they do this [surgery]” (A. 46 years old, sinus cancer). Others, on the other hand, make a point about the inherent nature of cancer: “Cancer is something that is already in you when you are born and, at some point, it appears” (L. 79 years old, breast cancer).

Causes

Numerous respondents blame their illness as being due to certain behaviors – socially and scientifically speaking – that are considered harmful for the maintenance of good health: the excessive use of tobacco, alcohol, drugs, etc. They point to their own individual responsibility in the development of the disease. A few women wondered if their illness was not linked to a divine punishment, or they told me about remarks from people who affirmed that it was linked. Some interviewees (all women) considered that their cancer resulted from a psychological injury, a family quarrel, the death of a relative, marital infidelity, or a professional misstep. None of them considered cancer to be a disease of the mind, of the living spirit, or of the spirit of the dead[29].

Several of my respondents claimed that their cancer was due to environmental problems. Nuclear testing came first, then pesticides, household products, glass dust, open fires, etc. Several people mentioned nuclear testing as a possible cause of their cancer. However, two men who had worked in Moruroa (a Tuamotu atoll where 138 nuclear tests occurred from 1966 to 1996) told me that nuclear tests were the sole cause of their illnesses. In general, few people could pinpoint the exact cause or causes of their cancers, and most of them gave different interpretations during the interview.

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[29] Simone Grand. *Tahu'a, tohunga, kahuna: Le monde polynésien des soins traditionnels*. 2007.

Biomedical and non-biomedical therapy

I met most of my respondents suffering from cancer at the Taaone hospital, and they all told me that were being administered "biomedical" therapy during their stays, such as surgery, radiotherapy, chemotherapy, immunotherapy, or hormone therapy. Biomedical therapy is based on biomedicine, that is, on the biological sciences. Most respondents said that were being treated with biomedical therapy that had been recommended to them and that they trusted their health providers and their prescribed treatment. A few respondents, however, expressed mistrust. A 72-year-old man with oral cancer and who was awaiting diagnosis for his lung and prostate cancers told me: “Fortunately, I discontinued my chemotherapy and radiotherapy. If I had waited for the *taote* [doctor] to tell me: ‘You’ve completed all the sessions, now go home’, I'll would have died. I would have been burned by up to 100%. If I have lung cancer and I have six chemotherapy sessions to do, I will refuse to have them all during one hospital stay and will ask to be allowed to travel back to the Marquesas between sessions. Three months is too long for me. I won't let myself be taken like the other time. I plan to go back and forth and take *Tahiti rā'au* [medicines] at the same time, because the two medications go together. I'm looking [to cure myself] too” (M. 72 years old, oral cancer, lung and prostate cancers diagnosed).

Twelve of my 32 respondents indicated that they had used *rā'au Tahiti* [medicines] (or more broadly Polynesian *rā'au*). Some of my respondents had used Polynesian *rā’au* before a doctor diagnosed them with cancer. Others have used *rā'au* to counter the side effects of biomedical therapy. Very few respondents reported directly treating their cancer using Polynesian *ra'au*. Most do not favor combining Polynesian medicine with biomedicine. While some healthcare providers advise my respondents not to combine biomedicine and *Tahitian ra'au*, others support more integrative medicine.

Several of my respondents, primarily women, emphasized the significance of diet in their fight against cancer. A modified diet was put forward mainly to counteract the side effects of biomedical therapy. A few respondents who were among the most educated (and mainly of Chinese or metropolitan French descent) also indicated having tried other forms of therapy (Chinese, Ayurvedic, etc.).

Many respondents also brought up God’s intervention on the progression of the disease[30]. They say that they pray at home more frequently than in a place of worship. Two women also said that they had attended a spiritual retreat in an effort to rid themselves of their cancer.

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[30] Of the 32 surveyed, 17 declared themselves Catholic, 7 Protestant, 2 from the Church of Jesus Christ and Latter-day Saints (Mormon Church), 1 Seventh-day Adventist, 1 from the Community of Christ (Sanito), 1 agnostic, 1 non-Church. Only 2 respondents are atheists.

The effects of cancer and therapy

My respondents drew attention to the impact of cancer and its therapy on their bodies and in their social lives. Most of them stressed how important the beauty of the body is to them. Many (almost all women) expressed concern to me that they would lose their hair after receiving biomedical treatments. Hair is associated with beauty, femininity, and perhaps most importantly Polynesianness. Nine of the twelve respondents with breast cancer had undergone a mastectomy. The Polynesian respondents nevertheless seemed to be less impacted than their *popa'ā* counterparts [white foreigners] by partial or complete breast removal. Weight loss related to illness or therapy was viewed differently depending on the respondent's starting weight and representation of ideal weight. Most viewed their weight loss positively when they thought of themselves as having been overweight. However, being “too thin” is considered as a sign of poor health, particularly among my male respondents.

My respondents defined good health in various ways. Good health was described as having no disease, as a state of well-being, or as the absence of pain. Several respondents, all having been under treatment for more than a year, and who see good health as a state of well-being or one without any pain, stressed the fact that they do not feel sick, or that they are not even sick. Almost all respondents, however, admitted that they had already felt some pain brought about by their illness (painful symptoms or side effects of treatments), even if they did not necessarily report this to hospital staff. One patient explained to me: “I have tingling pain in my joints, in my back, in my chest, as if I had been stabbed with a knife, as if I were burning inside. I tell the nurses that it's always the same. I have tingling and fatigue. To the doctor, I simply say that I am tired” (D. 42 years old, metastatic breast cancer). Several health providers told me about the differences between Polynesians and *popa'ā* [white foreigners] when it comes to pain management: "Polynesians don't have the same perception of pain. If they tell you that they are in pain, it's because they are really in great pain” (M. 25 years old, nursing staff).

For most respondents, their illness had a positive or negative influence on their character or their morale. A 50-year-old woman with metastatic breast cancer told me: “The disease makes me tougher. I'm more confident. I feel stronger. In the past, I was never sure of myself. Now when I say no, it means no” (J. 50 years old, metastatic breast cancer).

Several patients also told me that their illness has helped them reinforce their ties with those close to them, especially with their children and their parents. But their illness has also sometimes caused them to grow apart from some of their friends.

Many respondents (20 out of 32) were no longer engaged in any professional activity, because they were retired or were receiving a disability pension, for example. Some of the others, voiced their desire to resume studying or working as soon as possible.

According to my respondents, the division of household chores is very “gendered”. Women are typically in charge of cooking and cleaning. Right after an operation or a session of radiotherapy or chemotherapy, husbands and children often offer to "help" with these chores over the long term, yet the division of roles remains unchanged.

Perceptions of medical evacuations

Fear of the medical evacuation

Most of my respondents spoke about their fear of a medevac, whether it be inter-island or cross-border. For example, a 64-year-old lung cancer patient told me: “My wife is afraid that I will die in New Zealand. That's why she said no to a medevac [for a PET scan]. As if she were the one who's sick. She would much rather watch over me at home. I would have already left for New Zealand, if my wife hadn’t been here” (G., 64 years old, lung cancer).

The level of fear varied, however, depending on the medevac patient’s destination (whether it was distant or not), state of health (whether the cancer was at an advanced stage or not), family ties (whether single status or had dependent children), prior experience abroad with or without family members (vacationing in New Zealand, studies in France, prior medevacs). My respondents were not only afraid of dying far from their home (in a distant country far from their relatives), but also expressed concern about not being able to care for their family and their property (house, garden, animals) due to the distance from home.

More advanced care

Despite their anxiety for medical evacuations, and particularly for cross-borders ones, respondents who had gone through a medevac believed that they received a more accurate diagnosis and more advanced care. A resident of the Parisian reception facility for Polynesian patients told me: “I went through four chemotherapy cycles [in Tahiti]. My cancer is receding. But it can only disappear if I have a transplant here in France” (M. 55 years old, myeloma).

Three of my respondents (including two *popa'ā women*) chose to receive treatment in France without going through a medevac so that they could get the treatment that they deemed that was the most appropriate at the time. One of them explained to me: “There was a rumor that you get radiation burns when you have your radiation therapy done in Tahiti. My husband told me that it was out of the question to get it done here. ‘You're leaving!’ But I went through radiation therapy here again in August due to the metastases. I didn't think of that… I could have been treated with CyberKnife [robotic manipulator for radiosurgery] in France, but I don't want to leave here.” (C. 44 years old, metastatic breast cancer).

Discovering or rediscovering a location elsewhere

Some respondents see a medical evacuation to France or New Zealand as an opportunity to discover or rediscover other places. A 48-year-old woman with breast cancer told me: “In April, they sent me back to New Zealand for a PET scan to monitor my condition. New Zealand is not so bad. It's a vacation spot. I have no worries, not even about cooking. I went there alone. There was always someone there to look after us. I shopped. I bought a young-looking bra to cover the prosthesis. I went out with Polynesian families. I recently went out with an elderly woman who had been there for a month. I bring back stuff for the children, school supplies and clothes. It's combining business with pleasure” (M. 48 years old, breast cancer).

Several of my medevac respondents, however, spoke to me about feeling homesick. A 79-year-old woman living on the island of Huahine who was receiving breast cancer treatment in Tahiti told me: “During my prior visit, I stayed six weeks in Tahiti with my husband far from coconut trees and the lagoon. It was too long of a stay. We are too attached to the colors of plants, of coconut palms” (L. 79 years old, breast cancer). Some of my respondents stressed how important Polynesian food was for them, and how hard it was to find some during the medevac.

Medical evacuation experiences

Administrative procedures

An inter-island or cross-border medical evacuation entails administrative procedures. Evacuation is programmed or triggered (in the event of an emergency) by the patient's attending physician and approved by the medical adviser of the Caisse de Prévoyance Sociale (CPS). In the case of a scheduled inter-island medevac, a return transport voucher (valid for six months) is issued to the attending physician who submitted the request. The patient makes his own flight reservation with Air Tahiti. In an emergency, the physician does this. However, to my knowledge, every inter-island medevac of my respondents has been programmed.

For a cross-border medevac, the patient (or one of his relatives) must go to CPS’ "one-stop shop" in Tahiti to carry out all formalities required for his medevac to France or New Zealand. A CPS social worker told me: "Since 2001, we have handled the administrative part [determination of entitlement, passport application, purchase of tax stamp], as well as the social part of the medevac process [family considerations, seasonal clothing]. People often lack the proper clothing and the money to buy the tax stamp for their passport. Europe Assistance [Oceania] issues an emergency passport [as per the Directorate of Relations with Municipalities] and makes flight reservations. According to the tax code, a tax stamp costs 1,500 XPF [13€] for the disadvantaged, instead of 12,000 XFP [101€], but some people are still unable to pay 1,500 XFP…” (J. 60 years old, social worker).

Travel

When a patient is medically evacuated to Tahiti, France, or New Zealand, the Caisse de Prévoyance Sociale (CPS) covers transportation and accommodation costs. When the patient is a beneficiary of the French Metropolitan Social Security system, the CPS advances these costs. However, the CPS does not cover certain expenses even for cancer patients. A 42-year-old woman with metastatic breast cancer told me: "Transportation between Tahiti and Moorea to undergo a scan or an MRI is not covered, while travel to undergo radiotherapy or chemotherapy is (D. 42 years old, metastatic breast cancer). A medevac aid volunteer told me: “Inter-Island travel for mammograms should be covered, and mammograms should be prescribed at the same time as other examinations when a medevac is required. Women here don't see their gynecologist every year” (P. 60, member of an association).

My respondents who reside outside of the island of Tahiti have all been medically evacuated several times during their therapy. A 46-year-old woman with breast cancer and uterine cancer explained to me: “I have been living in Maupiti for five years. And I travel back and forth every six months to see my gynecologist, undergo radiotherapy, etc. The hospital is my home. […] I am leaving for France in a week for brachytherapy. But I won't have the time to see my husband in Maupiti before leaving [tears]” (G. 46 years old, breast and uterine cancer).

Dates (and destinations) of medevacs are sometimes discussed between patients and healthcare providers and between healthcare providers and CPS staff. My 72-year-old respondent, suffering from oral, lung, and prostate cancers, told me: “I spent three and a half months in Tahiti getting treatment for my oral cancer. I had enough. I went to see the *taote* [doctor] four times to have him sign the paperwork so that I could be released” (M. 72 years old, oral cancer, cancers of the lung and of the prostate being diagnosed).

Travel on the island of Tahiti can also be problematic for some of my respondents, depending on where they are lodged and the means of transportation available to them. During a consultation, a patient said to the doctor following her case: “I’m going to undergo a radiotherapy session every day, but how will transportation be handled? I can't ask my son [who lives on the Taiarapu peninsula] to take me there every day” (L. 79 years old, breast cancer).

Accommodation

Not all medical evacuations require the patient to be sheltered on site. Some respondents residing on islands that are easily accessible and close to Tahiti (such as Moorea and Bora Bora) can go and return the same day. My respondents (and the person accompanying them) who have been evacuated to a cross-border location or to Tahiti (for longer than a day) are housed either with a relative or in a CPS-approved facility.

Accommodation for beneficiaries of the French Metropolitan Social Security is not covered during the medevac. In Tahiti, there is a “host-hotel network for short stays” [31], called l’Hospitel, as well as six authorized pensions. The two main subsidized hostels in Paris are La Croisée and Le Rosier Rouge.

The main reason given by my respondents for not being hosted by a relative is the dread of disturbing their hosts. One of my respondents told me: “During the first medevac, I was staying with a friend, a former teacher colleague from the Marquesas. But when I returned in September, I came here, to l’Hospitel, because my friend had left Tahiti. I prefer being here, I don't bother anyone. I don't care what my girlfriend thinks. I prefer this arrangement because I’m not bothering anyone. When you stay with people too long, you think it will bother them. We have everything we need here. We are well housed, well fed. L’Hopitalet is fantastic: you have your privacy, your meals are ready, its clean, staff are friendly. We’re treated like royalty! I can walk to the hospital [700m away], but they give us drivers too! (I. 67 years old, breast cancer).

Several respondents stated how important it was for them to pay for accommodation. Lacking the resources to pay for these expenses was an additional factor for choosing to be housed in a CPS-approved facility. In Tahiti, as several generations can live under the same roof, the large size of households dissuaded some of my respondents from being hosted by their relatives. My 72-year-old respondent, who has three cancers, explained to me: “I don't like living in Fa'a'ā under the same roof with my children, since their in-laws are there. I don't want to bother them, and I prefer to be on my own. When I'm at l’Hospitalet, I find peace and quiet. I take the bus to go to town” (H. 72 years old, oral cancer, cancers of the lung and of the prostate being diagnosed).

Money

When a person has a cancer-like "long illness", the CPS issues the patient a "Red Notebook" (health journal with a third-party payment system), which exempts the patient from having to advance treatment costs (i.e., appointments for chemotherapy, radiotherapy). Many of my respondents also told me that people close to them (family, church members, co-workers) have given them financial aid (or food) before or during their medevac. Volunteer associations (specifically, the *Ligue Contre le Cancer*) has also occasionally given financial aid to the most disadvantaged patients who have been evacuated outside of French Polynesia.

The Department of Solidarity, Family and Equality (DSFE) provides various types of aid (food, clothing, household appliances, economic integration planning, grants for disabled adults known as "COTOREP"), which are not reserved solely for medevac patients, but which, in half of the cases, are paid to people who have been evacuated to Tahiti.

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[31] http://www.chpf.pf/2018/07/18/hospitel/

The DSFE also helps patients get housing relief from the Polynesian Housing Office (OPH). A 50-year-old man suffering from esophageal cancer told me: “Social Services gives you a voucher worth 20,000 XFP [168€] for food. I want to the Hyper U supermarket, and I only bought meat. Boxes full of meat: lamb, chops, boneless chicken thighs, heart, pork, etc. 20,000 XFP of meat! The cashier thought I had a restaurant where I live [laughs]! Absolutely not. It's welfare! I stored it in my grandmother’s and my aunts’ freezer [in Tahiti]. When I began feeling better, I began eating the meat in small helpings at a time. The *taote* [doctors] prescribed three months of rest [without treatment]. I returned to Raiatea with three months of meat, and I left the rest in the freezer” (M. 50 years old, esophageal cancer).

Clothing

In the case of inter-island medevacs, patients and the people accompanying them seldom have trouble acquiring clothes. The Department of Solidarity, Family and Equality can nevertheless provide good clothing to the disadvantaged who have been evacuated to Tahiti. After receiving food relief, my respondent said: “Social Services gave me a voucher for 30,000 XFP [251€] to buy clothes. They said to me: ‘Go to the Social Services store, they will know. They gave me a shopping cart for me to pick out what I needed. The first time, I was unaware that I was going to be hospitalized. I left Raiatea with just two items of underwear, two shirts, and two shorts” (M. 50, esophageal cancer).

In the case of cross-border medevacs, there is a clear divide in the acquisition of warm clothing between people who are accustomed to traveling to countries with temperate climates and those who are not. A 60-year-old man receiving treatment for a thymoma told me: “I already had warm clothes for the medevac to New Zealand, because for ten years, we went skiing there every year” (N. 60 years old, thymoma).

The CPS issues clothing vouchers for those who lack the money or the opportunity to acquire warm clothing before their cross-border medevac. Volunteer associations, such as Te Rima o te Here, also provide warm clothes before patients are medically evacuated abroad, or on location once they arrive, depending on supply and volunteer availability. Obese patients, however, find it harder than others to find warm clothes that fit them. A social worker explained to me: “The CPS issues vouchers to purchase warm clothes at Juliette and Aqui von Faut’s store. But Juliette does not sell clothes larger than a size 2XL. Aqui von Faut sells larger size hunting clothes, but they lack style. The Red Cross also has warm clothes available, but it is mainly the *popa'ā* who donate warm clothes, but they are all small-sized! (J. 60 years old, social worker).

Information and communication technologies

The use of information and communication technologies is a great advantage for medevac patients because mobile telephones and the Internet allow them to stay in touch with their relatives.

A respondent with esophagus cancer told me: "My *vini* [cell phone] is important. I use it when I felt unwell. In the past, I had no use for it. An uncle I hadn't seen for ten years bought me a *vini*. The phone becomes your best friend. I am happy when someone calls me. I send my uncle a message when my credits run out and he puts 5,000 XFP [42€] on my phone" (M. 50 years old, esophageal cancer). A woman living in Paris in a home for Polynesian patients explained to me: "Volunteers come to check if I have a telephone and a chip. They collect the SIM cards of those who return [to Tahiti] and pass them on to new arrivals [in Paris]. They came a week and a half after my arrival. But I could hardly wait to buy a phone and a SIM card. I bought them with the money my daughter gave me at the airport. […] At first, I didn't have a phone and I cried all the time because I couldn't talk to my children. A woman from Réunion Island [who lives with me in the home] lent me her phone so that I could call them. I hadn't had time to put a router at home before leaving. I couldn't talk to them with the Internet. Now the kids say they're *fiu* [tired] of talking to me. […] I try to call them two to three times a day" (A. 46 years old, sinus cancer).

It can be difficult to choose whom to talk to and how to communicate. A 16-year-old girl with leukemia told me: "My grandma says there's no point talking to my family on MSN because they just want money and don't give anything in return. It is better that I speak with people who help us, like the volunteers of the association Te Rima o te Here" (T. 16 years old, leukemia).

Internet and mobile telephones also keep my medevac respondents occupied when they are bored. A good number of them (mainly the younger ones and the more educated) have access to the Internet which gives them information on illnesses and their treatment.

Family relationships

The family can act as a hindrance or a facilitator during a medevac. As already noted, my respondents thought that it was important to consult with their relatives before deciding on a medevac or a specific course of treatment. A 67-year-old woman treated for breast cancer explained to me: "The *taote* [doctor] of Taaone told me: 'I'm going to operate on you right away'. I told him no because I wasn't well. He said that I have cancer cells, and that he was going to remove three lymph nodes to check if the cancer had spread elsewhere. I told him: 'No, no, I need my family to get their advice. I don't want to be touched. […]' When I returned to Nuku Hiva, I met other women who had cancer in the same part of the breast. That convinced me. I decided to go back to Tahiti. I didn't want to have surgery, because I knew how serious my case was. I thought it was too late. My girlfriends in Nuku Hiva told me: "But no…" (I. 67 years old, breast cancer). While most of my respondents do discuss their illness with members of their extended family, others (mainly men) prefer to talk about it only within their immediate family or refrain from talking about it at all with their relatives (as in the case of men living alone).

Most of my respondents emphasized how important it was for them to have a person close to them (most often their spouse) accompany them during a medevac, especially in the case of a medevac to France. When the medevac patient is a minor or is not independent (has trouble getting around, hearing, speaking), the CPS covers the transportation and accommodation costs of the family plus a medically authorized accompanying person. Few of my respondents were able to benefit from an accompanying person that the CPS paid for. Some people, however, had sufficient financial means or had received the social benefits to afford the cost of one or more non-approved person to accompany them.

A medevac can also be an opportunity for some of my respondents to see relatives living in Tahiti, New Zealand, or metropolitan France. However, my respondents were more concerned about those whom they had left behind at home, especially if they had young children. A woman living in Paris in a reception center for Polynesian patients explained to me: “I made the decision to regularly check on my husband and my three children. I was supposed to be away for two months and now I've been here [in Paris] for four. I made the decision to ask my nephew to take care of the children. My husband didn't say anything, because he doesn't know how to manage children. He leaves at 3:30 a.m. and gets home at 6 p.m. I did the shopping for my nephew before leaving. My husband has never done the cooking, shopping, or anything else. My daughter has a Red Notebook because she has asthma. When she coughs, I make her go see her attending physician right away. My nephew told me: ‘Don’t worry’. I really know that there is someone who takes care of the children, who prepares the *mā'a* [meals], who picks them up from school, who does the housework, who does the children's laundry. My nephew reassured me: “Don't worry. Just leave. Don't think about the house”. But every day, I speak to my daughter and the younger one. The older one is fine, I've already taught him how to wash his clothes, cook eggs, and so on” (A. 46 years old, sinus cancer).

Interactions with other medevac patients

Several of my respondents told me that they had been medically evacuated to Tahiti or Paris with other Polynesian patients. Many of my respondents, including those living alone, spoke about how important it was to have other Polynesian patients around them during the medevac to France or Tahiti. A 55-year-old man treated for a myeloma told me: “We were five Tahitians arriving in Paris. Our hosts greeted us very warmly at La Croisée. A., J., and Mama C had already arrived. We were not greeted with leis (garlands) and wreaths, but with an *Ia ora na* [hello]! After a week there, it was party time. Every day is party time. Fortunately, we all get along very well. We play the guitar, we sing. A bit of alcohol is served right and left. Volunteer associations come to liven things up a bit in the living room. When I got here I had back pain. G. does my shopping. G. helps everyone. He just had a broken shoulder, not cancer. G. used to take care of everything in the past, but now he’s returned home. A. picks up my medication at the pharmacy now. […]

When we are hospitalized, someone comes to pick up our dirty laundry. We spend the time visiting friends in hospitals" (M. 55 years old, myeloma).

Several of my respondents emphasized the importance of sharing communication codes. A social worker explained to me: "In my culture, speaking in the familiar form is important. It creates closeness. We can identify people from the same community. It's the same with a New Caledonian. We recognize each other as islanders. We create ties. Older Tahitians take me for a Cambodian. When I say, "*Ia ora na* [hello]', it's settled, they know I'm Polynesian. Facial expressions, and eyebrows raised to say, "Go away", or "I'm *fiu* [tired]", are signs that show that we are Polynesian" (N. 32 years old, social worker).

Medevac professionals

On several occasions, my respondents emphasized the role that health providers play for motivation and support, both before and during the medevac (especially those going to France). A 60-year-old woman who had been treated for uterine cancer several years back told me: "I didn't want to go to France. The doctor said: 'Would you rather live or die?' My husband didn't want me to leave. But the doctor convinced me to go" (V. 60 years old, uterine cancer).

My respondents brought up the Caisse de Prévoyance Sociale (CPS), the Department of Solidarity, Family and Equality (DSFE), and several volunteer associations that help medevac patients, such as Te Ramepa ora, Te Rima o te Here, A Tauturu ia na, and the Ligue Contre le Cancer. These associations mainly provide moral support (visits to the hospital or to the place of accommodation, planning of outings), material aid (clothing, SIM cards), and sometimes financial aid to medevac patients. A 70-year-old volunteer explained to me that: "In the past, Polynesians were dropped off in a hospital in Paris in cold weather, in a foreign country far from their families. The islanders did not speak French. It was awful. The human aspect was not taken into consideration. The human aspect is not like a machine that is sent in for repair. Thanks to the social coverage [introduced in 2001], we were able to plan something decent. […] We fought to humanize medevacs (I. 70 years old, member of an association). However, it's sad that some patients and accompanying persons have abused the system. A second volunteer told me: "We go to France to get treatment, not for a vacation. The accompanying persons sometimes want us to take them shopping. That makes me angry. […] There are some who don't dare tell the CPS social worker that they don't have any money and others who exaggerate. They want to leave the country as a group, they don't want to eat hospital food, and they ask us for more money" (P. 60, member of an association).

Some church groups provide medevac patients with financial relief or clothing and intercede when it comes to accommodation and hospital stays. My respondents spoke less often about church involvement in medevacs than that of caregivers and associations.

Spatio-temporal interference

Medical evacuations involve spatial displacements over time in an "uninterrupted movement whereby the present becomes the past”[32]. My research led me to take a particular interest in temporal dimensions (as they relate to the different types of individual and social apprehension, and passages of time,[33]), as well as in the environments that influence and shape the medevacs of cancer patients. How my respondents experienced their medical evacuations depended on spatio-temporal interferences. On the one hand, the spatial dimensions (of a hospital in Tahiti, a reception center in Paris, etc.) and the temporal dimensions (of the medevac process, scheduling, timing, duration, frequentness, etc.), and, on the other hand, spatial and temporal dimensions related to other aspects of their personal and social lives (particularly those involving their cancer, therapy, family life, and economic activities).

Medical evacuations

The temporal dimensions of medevacs varied significantly depending on my respondents’ experience. Some respondents were transported from their home island to the island of Tahiti, others from Tahiti to metropolitan France or New Zealand. Their medevac experience therefore varied as a function of the distance to their destination (from about twenty kilometers from Moorea to Tahiti to nearly 16,000 kilometers from Tahiti to Paris), the transport time (ranging from a few minutes to about twenty hours), and the ease of travel (frequency of departures of boats and planes, for example). My respondents were medically evacuated on different schedules (times of the year, stages of cancer, etc.), or at a different pace (number and frequency of medevacs, waiting time, speed of decisions and execution, etc.).

All my respondents left their usual place of residence when they were medically evacuated, and, for their therapy, they were eventually sent to the island of Tahiti, where cancer treatment is centralized. They also proceeded through certain medevac stages involving planning, waiting time, and travel. For example, a patient told me: "The first time [that I was in New Zealand to carry out a PET-scan], I wasn’t ready. The second time, no problem, and now I’m in line for my third medevac [big smile]. Just for fun, I would like once to take a plane! (D. 42 years old, metastatic breast cancer).

Cancers

In addition to the temporal dimensions attributed to medevacs, my respondents spoke about their cancerous pathology.

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[32] https://www.larousse.fr/dictionnaires/francais/temps/77238

[33] André Akoun. Temporalités. 1999. p. 532.

Biomedicine distinguishes several cancer stages depending on the size of the tumor, invasion of the lymph nodes, and the presence of metastases in the body[34]. The pace at which the disease evolves towards death or remission greatly varies according to the type of cancer, the patient, and the therapeutic advances that may or not be curative. A physician from the Taaone hospital told me: “We no longer know the lifespan of cancer patients. Some can now survive for ten years with lung cancer! (E. 65 years old, nursing staff). Health providers point out that in addition to these different stages of cancer, are associated temporal phases, such as those related to emergencies, therapeutic follow-up, recurrence, or palliative care[35].

Health providers and their patients, however, do not always perceive the temporal dimensions of cancer (stage, evolution, etc.) in a uniform manner. Some of my respondents already see themselves in the terminal phase, when health providers say that there is still time to eliminate the tumor from their bodies. Others, on the other hand, hope for a remission, even when they are undergoing palliative care.

Due to these conceptual differences, some of my respondents consider that the temporal dimensions of the medical evacuation (prescribed by the physician who believes that the medevac can help improve the patient’s condition) conflicts with the temporal dimensions of the cancer itself (as felt by the patient). Several of my respondents spoke of their fear of being evacuated to metropolitan France or New Zealand at a stage of the disease when they had a high probability of dying.

In addition, they often consider (at least at the beginning of their biomedical care) that a medevac is reserved for critical cases. A patient told me: “The first time, I didn't want to go to New Zealand. I wasn't ready. For me, when you are medically evacuated to New Zealand, it’s because something serious is happening. But the oncologist explained that it's because there is no PET-scan here [in Tahiti]” (D. 42 years old, metastatic breast cancer). For my respondents, they must not die during a medevac. An association volunteer told me: “I tell the doctor not to have the patient transported to France if there is only a tiny chance of survival. The dead must absolutely be present here to be touched, to be felt. In our country, we have no fear! […] It is very important [also] to be well dressed in the coffin, to wear a white robe. We prepare this a long time in advance. To look beautiful, even on the last day. […] But when the person dies in France, the coffin is returned to us sealed” (P. 60, member of an association).

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[34] https://www.e-cancer.fr/Patients-et-proches/Les-cancers/Cancer-du-sein/Les-stades-du-cancer

[35] Gustave-Nicolas Fischer. *L’expérience du malade. L’épreuve intime*. 2009. p. 69-70.

Care management

Research in the humanities and social sciences has demonstrated the complexity of the temporal dimensions related to the management of cancer pathologies[36]. In France, Marie Ménoret[37] notably made a point of emphasizing the “splitting” of cancer time (due to the abundance of people, services, and locations), the “reduction” of biomedical caregiving time (linked to shorter hospital stays), and the “sustainability” of this time (patient follow-up spanning many years). In addition to the issue of the temporal dimensions of biomedical care, there is also the one of spatial dimensions, which may be ambiguous, as in the case of patients who are migrants[38], or multiple, as in the case of children whose cancer has relapsed [39].

In French Polynesia, the testimonies of my respondents on the biomedical management of their cancer also shed light on the spatial dimensions. Patients pass through various health facilities and services and can receive treatment at home, as in the case of drug hormone therapy, for example.

The cancer management of my respondents is also characterized by a series of short time spans. Their lives are structured around the schedules, the pacing, and dates of consultations, examinations, hospitalizations, radiotherapy sessions, chemotherapy cycles, etc., as well as by the temporal dimensions of the health facilities (opening hours, staffing shifts, departure of caregivers on fixed-term contracts, etc.). My respondent suffering from esophageal cancer explained to me: “It's the first time in my life that I've been ill. I had my first injection, it was my first admission to a hospital, my first sight of a doctor or a nurse. I had only seen all that on TV. In the last six months, I've seen it all. I must arrive on time, and in the evening, they connect you [to chemotherapy]” (M. 50 years old, cancer of the esophagus).

Medical evacuations are processes implemented in the biomedical management of patients. The temporal dimensions of medevac patients (as they experience them) do not always coincide with those of consultations, examinations, and biomedical treatments (which often take longer than desired). A woman who was evacuated to Tahiti from the Marquesas Islands told me, for example: “I went with a friend to get the test results at the Paofai clinic, and we waited all day. […]

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[36] Marie Ménoret. Les Temps des cancers.1999. Alex Broom, Philip Tovey. Exploring the Temporal Dimension in Cancer Patients’ Experiences of Nonbiomedical Therapeutics. 2008. Gustave-Nicolas Fischer. L’expérience du malade. L’épreuve intime. 2009. p. 69-82. Jean-Luc Lory, Mathieu Lory, Jeanne Both. Le temps. Le passé et le futur au présent, les malades du cancer et leur monde. 2010. Lionel Pourtau, Agnès Dumas, Philippe Amiel. Les individus face à l’événement «cancer». 2011.

[37] *Ibid.* p. 29.

[38] Anaik Pian. Care and Migration Experiences Among Foreign Female Cancer Patients in France: Neither Medical Tourism nor Therapeutic Immigration. 2015.

[39] Sylvain Besle, Solenne Carof, Emilien Schultz. Les parcours de soins des enfants en rechute de cancer. Un objet multi-situé au croisement de la sociologie et de la médecine. 2019.

My *taote* [doctor] said to me: “Go for a stroll around Papeete, we don't have the results yet.” I said, “No [I don't have time to wait]! You call me! Get that in your head, I don't live here! I'm from the Marquesas!” (I. 67 years old, breast cancer).

The temporal and spatial dimensions of medical evacuations can also interfere with those of other therapeutic practices (Polynesian *rā'au*, Chinese medicines, diets, spiritual retreats, etc.). Many of my respondents told me of their intent not to use Polynesian and biomedical treatments at the same time, or in some cases, lacked the necessary resources (plants, understanding) at the medevac location. A woman who was evacuated to Tahiti from Maupiti explained to me: “I heard that two [men] in Maupiti took *rā'au Tahiti* for liver and lung cancer and the cancer regressed. You take a sea cucumber. You split it in half. You boil it. You drink sea cucumber water once for three days running. I tried this twice after my first biopsy, but this didn't work. It depends on the disease. They told me to try soursop too, but I haven't tried that yet. I'm waiting for the chemo to end [and my return home after the medevac]” (I. 43 years old, breast cancer). In some cases, medical evacuations may instead encourage the use of non-biomedical therapies. A *popa'ā* woman who was evacuated from Tahiti took advantage of her stay in metropolitan France to consult a fire cutter recommended by a physician who could treat her radiation burns (C. 68 years old, breast cancer).

Collective events

Temporal and spatial dimensions of medical evacuations can conflict with those of social, cultural, political, governmental, or historical collective events. Some respondents told me that the spatio-temporal aspect of their medevac was marked by a political election, a cultural festival, a legislative change, or an attack. Such collective events can result in having the location or the timing of the medevac changed. A 44-year-old woman with metastatic breast cancer told me: “The PET scan was scheduled for November in New Zealand. But they didn't issue me a visa. This happened to ten of us. They no longer issue emergency visas for PET scans. They suggested that I apply for a tourist visa, but in that case, you must pay for everything yourself” (C. 44 years old, metastatic breast cancer). Another patient told me: “During my third medevac, the flight had to go through Hong Kong [instead of the United States], because I left on September 11, 2001 [the day of the attacks in New York and Pennsylvania] (F. 62 years old, metastatic thyroid cancer).

In addition, the way certain collective events unfold can influence a patient’s medevac experience. Medevac patients may want to advance or postpone the dates of their departure or return (even if it means having to wait a long time), in order to attend or avoid attending a particular event. For instance, during a consultation at the Taaone hospital, a patient who had been evacuated to Tahiti from the Marquesas Islands asked the doctor to advance his immunotherapy session (administered at the day hospital as an intravenous infusion), so that he could return home before the Marquesas festival began and not end up stuck in Tahiti due to the influx of tourists filling the planes (M. 72 years old, oral cancer, lung and prostate cancers being diagnosed).

Economic activities and transactions

The planning and timing of economic activities and transactions that enable my respondents to obtain money or goods occasionally run into conflict with the spatio-temporal constraints of medevacs. Some patients attempt to schedule their medevac so that they can maintain their economic activity, go on vacation, follow the growth cycles of their vegetable garden, pay back a loan, receive an inheritance, or benefit from social welfare or retirement money. A 64-year-old woman with metastatic breast cancer explained to me, "I was aware that I had something in my breast that was the size of a grain of rice. I had a mammogram in March or April 2014. I got chikungunya in late 2014, which caused the tumor to grow to the size of a ping pong ball. The doctor knew what it was and told me I needed therapy. But I had to work, because otherwise I'd be unable to pay back my debts and I had to take care of my granddaughter. I waited until the vacation in July for my granddaughter to return to Moorea, for my retirement to begin, and for the start of my supplementary health insurance before seeing a doctor. I didn't think of getting treatment before then. I didn't want to depend on anyone. I had the operation on July 7, 2015. Before that, I didn't have the money to treated during my illness" (S. 64 years old, metastatic breast cancer).

On the flip side, other respondents, told me that the timing and the locations of the medevacs sped up their business dealings and transactions. A 48-year-old woman suffering from metastatic bladder cancer told me: "I asked the *taote* [doctor] to prescribe a medevac for me every 24th of the month and that way, I could do my shopping far from home [because she accuses her children and their spouses living with her of emptying the fridge]. I come to the hospital with my own money [adult disability payment]" (R. 48 years old, metastatic bladder cancer). A man residing in the Marquesas Islands told me: "I'm used to coming to Tahiti. […] I take advantage of it here to change my glasses, to buy hardware for the brushcutter. It's half price here! » (M. 72 years old, oral cancer, lung and prostate cancers being diagnosed). Another patient explained to me: "My adoptive grandparents bought me a lot in Raiatea so that I could build a house. But my [biological] parents are jealous. Fortunately, I was sick! I went to fill out the paperwork to show that I own the land. […] I also took the opportunity to complete the OPH file [for the Polynesian Housing Office]. The *taote* [doctor] gave me a medical certificate to speed up the procedure. And look [he hands me a letter with a big smile], I got 2,000,000 XPF [16,760€] in subsidies to build a house! (M. 50, esophageal cancer).

Family life

The testimonials of my respondents frequently reveal interferences between how family life is organized and the medevac process. For example, pregnancies, availability of childcare, dates schools are in session, birthdays, weddings, preparation for end-of-year celebrations, family reunions, and religious conversions can be impacted by the temporal dimensions of medevacs. One of my respondents, treated in Paris for a myeloma, told me: "My wife and I got married at the hospital in October 2019 in a religious and civil ceremony [shortly before being evacuated to Paris].

She became a Catholic to support me. She was a Protestant in the past. But we were very involved in our professional lives. We didn't have time to get married" (M. 55 years old, myeloma). A patient who was evacuated from the island of Maupiti to Tahiti explained to me: "The teacher said that since I have been sick [and left home], my [10-year-old] son's grades have dropped. But the teacher insists that he must be left in Maupiti. You shouldn't take him to Tahiti, because he likes fishing. He get bored [if he comes] to Tahiti"; (I. 43 years old, breast cancer).

At the same time, the scheduling and planning of medical evacuations (as well as of the therapy) can be impacted by family life. A respondent I met in Paris in a reception center for Polynesian patients, said: "At the beginning, I didn't want to be evacuated [to metropolitan France], because I had no one to leave my children with" (A. 46 years old, sinus cancer). A 40-year-old woman treated for metastatic breast cancer said: "I wanted to have a child at all costs. I stopped taking the treatment when I got pregnant. I informed the *taote* [doctor]. Otherwise, there's no point to life! If I don't have children, what's the use of struggling?" (A. 40 years old, metastatic breast cancer).

Conclusion

My research indicates that inter-island and cross-border medical evacuations of cancer patients in French Polynesia are constrained or facilitated by several reasons. My research focused on my respondents' representations of medical evacuations, cancers, and their treatment, as well as on various aspects of medevacs that have impacted their experience. My research emphasizes the significance of spatio-temporal interferences in their medical evacuation.

Medical evacuations are carried out as part of a process of patient biomedical healthcare. My responders agreed to be medically evacuated because they understood, to some extent, the evolution, causes, effects, and treatment of cancer explained to them by their biomedical health providers. My respondents are aware that cancer impacts how the body functions, and that it is not, for example, a curse caused by a spirit. My respondents have a certain level of faith in their healthcare providers and in the biomedical therapies they receive. They also accept, to a certain extent, the after-effects of their therapy (inability to work, hair loss, etc.), even though this does not dispel their doubts or prevent them from seeking alternative types of care. The role of both healthcare providers and the patient's support network is crucial for the development or alteration of these notions.

Medical evacuations frequently elicit fear, most often one of dying far from home. For a patient to agree to be medically evacuated, he must see the hope of receiving care or undergoing examinations that are not available in Tahiti or on his home island. Some patients also view medevacs as an opportunity to discover or rediscover a place different from the one where they live. However, there are strong disparities in relation to the fear of medical evacuation. The level of fear significantly varies depending on the patient's (subjective) state of health (whether he believes he will die soon or not), his family situation (whether he has children or not), the duration and location of the medical evacuation (France, New Zealand, Tahiti), his prior experiences (as a tourist or as a student) at the medivac destination, and the possibility of being able to afford the trip of an unapproved accompanying person.

Through their testimonials, medevac patients speak about the various aspects of medical evacuations: administrative procedures, transportation, accommodation, money, clothing, information and communication technologies, family relationships, interactions with other patients and medevac professionals. Their accounts make it possible to analyze medical evacuations as therapeutic mobility. In fact, during medevacs, not only patients (and their accompanying person) are transported, but also the knowledge and practice of therapeutic, culinary, artistic, social, and recreational activities that are shared through get-togethers, the exchange of addresses, and the provision of mutual aid. Also shared in the process are material products (clothing, mobile phones, telephone chips, food, body oils) and communication codes (speaking in Tahitian, use of facial expressions). However, the speed and the timing of these exchanges and the people involved can either be harmful or beneficial to the well-being of medevac patients and can impact the care they receive. Not having a mobile phone to contact family back in Tahiti after being recently evacuated to Paris, can, for example, be a patient’s source of profound distress.

In French Polynesia, the Caisse de Prévoyance Sociale or the French Metropolitan Social Security covers a large part of medevac expenses (transportation and accommodation). Every person must therefore be able to benefit from a medevac if the prescribed test or therapy is unavailable on his home island. However, cancer medevacs require specific “know-how-to-do” and “know-how-to-be” skills, which are not evenly found in the general population. These skills can be administrative (knowing how to book accommodation or a plane ticket, making a medical appointment, applying for social welfare), related to logistics (adhering to treatment schedules and appointment times, taking public transportation, reading a map, finding one's bearings in a city, organizing one's family and professional lives while away, finding warm clothes), social (staying in touch with family, joining a volunteer association, residing in a community reception center, negotiating a date for a medevac), technological (using a mobile phone, surfing the Internet, chatting on a patient forum), language-related (speaking French in metropolitan France, English in New Zealand), or even biomedical (understanding and using a specialized dictionary, undergoing a scan, taking prescription medication, undergoing radiotherapy). Furthermore, a patient’s mobility during a medevac assumes that other people will either be unable to relocate (such as relatives who housesit or care for his children in his absence), otherwise they can travel to another country or another island.

These “know-how-to-do” and “know-how-to-be” skills vary not only according to the patient's level of education, socio-economic status, and social network, but also according to age, physical stature, state of health, family situation, and the medevac patient’s prior experience that impact the acquisition and practice of these skills.

My research revealed that the people who find a medevac to be the most difficult to manage are women with dependent children (especially single-mother households with young children to raise alone), women who are obese (because they have trouble getting into a scanner, sitting on a plane, finding warm clothes), those who are the most disadvantaged (as they have never visited a medevac location or cannot afford the cost of an unlicensed accompanying person), as well as advanced cancer patients.

The uneven distribution of these "know-how-to-do" and "know-how-to-be" skills for a medevac has nevertheless been addressed by several professionals. In particular, my study emphasizes the extent of the work performed by medical staff, volunteer associations that help medevac patients, the Caisse de Prévoyance Sociale (CPS), the Department of Solidarity, Family and Equality (DSFE), churches, family members, and other patients.

Although research in the human and social sciences as related to cancer has emphasized the significance of temporal dimensions[40], little work has been done, to my knowledge, on therapeutic mobility that delves into the types of individual and social apprehension and of time[41]. And no study has addressed spatio-temporal interferences. My case study incorporates temporal and spatial dimensions to medical evacuations for cancer. Medevacs break up the time spent by patients (and by those around them). However, for these people, they bring further uncertainty and spatio-temporal constraints.

According to my research, the medevac event and experience are significantly impacted by the interferences caused by the temporal dimensions (planning, scheduling) and the spatial dimensions as they relate to the multiple aspects of patients' lives. A patient's time does not strictly revolve around the planning of medical evacuations and biomedical care. The lives of my respondents are impacted and positioned by non-biomedical care, family life, social interactions, economic activities, and business transactions. Depending on his scale of priorities, a patient might, for instance, place the care of his children or his financial independence ahead of the biomedical care provided by a medical evacuation.

As patients adapt to the institutional planning of cancer treatment[42] and medical evacuations, my research shows that institutions (hospitals, the CPS, the DSFE, volunteer associations) also provide, to a certain extent, for adjustments to prevent spatio-temporal interferences that would lead to the discontinuing of a specific therapy or the cancellation of an medevac, for example.

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[40] Marie Ménoret. Les Temps des cancers.1999. Alex Broom, Philip Tovey. Exploring the Temporal Dimension in Cancer Patients' Experiences of Nonbiomedical Therapeutics. 2008. Gustave-Nicolas Fischer. L'expérience du malade. L'épreuve intime. 2009. p. 69-82. Jean-Luc Lory, Mathieu Lory, Jeanne Both. Le temps. Le passé et le futur au présent, les malades du cancer et leur monde. 2010. Lionel Pourtau, Agnès Dumas, Philippe Amiel. Les individus face à l'événement «cancer». 2011.

[41] Juliette Sakoyan. Deuil du retour et oubli empêché. L'expérience temporelle des mères migrantes avec un enfant autiste. 2007. Anaik Pian. Care and Migration Experiences Among Foreign Female Cancer Patients in France: Neither Medical Tourism nor Therapeutic Immigration. 2015.

[42] Marie Ménoret. *Les Temps des cancers*.1999. p. 70.

My work also disproves the idea that Polynesians are unable to project themselves in the future[43], yet some *popa'ā* health professionals still use this myth to justify the non-compliance of their patients[44].

My research has been limited primarily by the duration of this field survey. A second trip to French Polynesia and additional data collection in Île-de-France (or even New Zealand) would allow me to gather further data and broaden the range of respondent profiles. It would therefore be interesting to speak at greater length with people who have objected to medevacs, as well as with the family members of patients and the staff at the Taaone hospital. I would also be able to better observe the interactions of my responders with the people around them in the locations where they reside, are cared for, or work, in order to better understand the family ties that exist during medevacs.

The interviews I conducted with 32 cancer patients have already enabled me to gather a large quantity of data on the mechanisms that constrain or facilitate medical evacuations. Some of these mechanisms have appeared in qualitative research on the cross-border therapeutic mobility of patients (the weight of financial resources, the role of the family, the prior experience of the medevac location)[45], or on multi-site care management (transportation problems, accommodation, childcare)[46]. In my case study, some constraints were minimized, others increased. Focusing on the specificities of my expertise, my research dealt with the issue of temporal and spatial dimensions that condition and shape therapeutic mobility.

My respondents who suffer from cancer, a so-called “long illness”, are often treated with several cycles of radiotherapy or chemotherapy. For my respondents, this entails many round trips between locations over several years. Their temporal experience of this travel is therefore different from that of people staying a few days abroad to undergo a cosmetic operation, for example[47].

My research on therapeutic mobility was funded and coordinated by third parties: primarily the CPS and the Taaone hospital. I have emphasized the significance of financial resources and family networks in the medevac process in French Polynesia.

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[43] Bernard Rigo. *Lieux-dits d'un malentendu culturel. Analyse anthropologique et philosophique du discours occidental sur l'altérité polynésienne. 2003. p.33. Bruno Saura. Tahiti Mā'ohi : Culture, identité, religion et nationalisme en Polynésie française.* 2008. p. 266.

[44] Antonin Roussey. *Culture polynésienne et maladies chroniques : une étude qualitative des déterminants de santé culturels dans la prise en charge des maladies chroniques*. 2018. p. 80.

[45] Audrey Bochaton. Cross-border mobility and social networks: Laotians seeking medical treatment along the Thai border. 2015. p. 366. Dominique Mathon, Philippe Apparicio, Ugo Lachapelle. Mobilité transfrontalière et itinéraire thérapeutique des Haïtiennes et des Haïtiens de la région de Ouanaminthe. 2019, p. 24-25.

[46] Sylvain Besle, Solenne Carof, Emilien Schultz. Les parcours de soins des enfants en rechute de cancer. Un objet multi-situé au croisement de la sociologie et de la médecine. 2019.

[47] Ruth Holliday, David Bell, Olive Cheung, Meredith Jones, Elspeth Probyn. Brief encounters: Assembling cosmetic surgery tourism. 2015.

However, these elements appear less significant when therapeutic mobility is fully supported by the patient and his family, as in the case of transfers between Central Asia and India that was examined by Heidi Kaspar[48]. Some of my respondents, who are relatively poor, were evacuated without any moral or financial support from their relatives. The significant work of volunteer associations and aid institutions for medevacs was also emphasized in my case study.

In conclusion, my research focuses on French Polynesia. Through partnership agreements with the Taaone hospital, cross-border medical evacuations from the island of Tahiti mainly go to metropolitan France, and more specifically to the Paris region. These medevacs are among the most expensive and geographically the most distant in the world. Medevac patients therefore must deal with additional constraints, such as adapting to differences in climate, getting a supply of their usual foods, finding warm clothes, dealing with a major jet lag that makes communication with relatives problematic, paying high transportation costs for unlicensed accompanying persons, etc. Such difficulties do not exist, for example, in the case of medical evacuations between the island of Jersey and Great Britain that were examined by Christian Fleury[49].

My fundamental research on the factors that constrain or facilitate the medical evacuations of cancer patients in French Polynesia nonetheless highlights the significance of existing operations and systems (finances, administration, clothing, psychological aid, etc.). It also sheds light on some areas needing improvement, such as the availability of warm clothing for obese persons and CPS management of inter-island medevacs for patients needing mammograms, scans, and MRIs.

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[48] Heidi Kaspar. Searching for therapies, seeking for hope: transnational cancer care in Asia. 2019.

[49] Christian Fleury. Border island and health. Jersey and Saint-Pierre-et-Miquelon, two out of step examples. 2010.

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