AFTERWORD

Historical reflections on medical travel

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The terms ‘medical tourism’ and ‘health tourism’ cover many phenomena. Individuals able to afford the costs have frequently traveled great distances to consult with healers considered especially competent in their field. A reputation for expertise has, for the past century, been linked to technological capacity and those who can do so may prefer to travel to places such as the Mayo Clinic rather than relying on technology and expertise available locally. In Canada, there is something like a tradition that provincial Premiers with serious illnesses travel to the United States for their medical care. This is always controversial since Premiers are supposedly responsible for the quality of provincial health-care systems; if they don’t trust these institutions why should the rest of us? But despite occasional bursts of outrage, most Canadians understand the desire to obtain the best possible medical care even if it means traveling outside the country. What is unusual about the newest sort of ‘health tourism’ discussed in several papers in this issue is that technology and excellence are only some of the attracting features. Relatively low costs, desire to avoid waiting lists, access to procedures or facilities unavailable and possibly illegal at home, are often determining factors in individual decisions to travel for health care. One factor that is less than central is place. It just happens that the Mayo Clinic is in Rochester Minnesota, or the Cleveland Clinic is in Cleveland Ohio, or that the institutions discussed in these pages are located where they are. Location of course is not irrelevant. Not every locale can bring together the expertise, technology, capital, easy access and relative lack of political violence that turns a city into a medical destination. But there is nothing about these places that is intrinsically healthy or good for you. In many ways, ‘tourism’ is a catchy misnomer that simply means traveling long distances for medical care not dissimilar to what is available at home. While this phenomenon has relevance for medical care and global health and for the ways social scientists study them, such practices can best be seen as yet another example of the expanding global economy, another form of ‘offshoring’ goods and services, whose consequences have yet to be fully understood. It in no way diminishes the significance of this phenomenon to note that its application to health care is too recent for historians to have much in the way of a contribution to make to its discussion.

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There is, however, another form of medical tourism about which historians can say a good deal. It involves the close relationship between medical care and what is conventionally understood as ‘tourism’, which is closely tied to specific locations. That is to say, the therapy and the pleasures of tourism are inextricably linked and are intimately associated with specific places considered especially ‘healthy’ and, not inconsequentially, pleasant and attractive: the hilltop stations of colonial India; mountain tuberculosis sanatoria; and among the earliest examples, mineral waters spas. Many papers in this issue are about these latter institutions, which have received considerable attention from scholars, at least in part because of their rich hybrid character. Spas provided specific forms of therapy that were for many centuries part of mainstream medicine; here I need to distinguish mineral waters from other forms of hydrotherapy, like Vincent Priessnitz’s famous cold water system that was unquestionably ‘alternative’ rather than mainstream (Marland and Adams 2009). True mineral waters were very much connected with place and were frequently thought to lose their therapeutic powers if they were moved to another location, so people had to travel to them. In order to attract clients from afar to submit to sometimes unpleasant regimens and to keep them and accompanying families from running off to more interesting places, spas (or thermal stations as they are frequently called in France) have also been places of tourist leisure where walks, socializing, music, dance, theatre and even gambling became part of the healing experience. Movement has not been all in one direction. Jill Steward (2000) has suggested that some Austro-Hungarian spas began as resorts and only later added medicinal use of waters to their offerings because this attracted more tourists. The balance between the two functions varies significantly from one spa and one era to the next. In some cases I can say definitively that one or the other dominates. In many other cases, they coexist in permanent symbiosis or tension. In addition to being places of therapy, healing and pleasure, spas have also constituted social spaces in which individuals and social classes enact elaborate social rituals that have fascinated novelists and filmmakers. To some degree they reproduce normative social arrangements and distinctions, albeit in a uniquely intense and small-scale setting. At the same time they can be liminal spaces where normal rules of social life are relaxed; where nobility and middle class individuals can mingle; where, according to novelists and filmmakers, love affairs, licit and illicit, are possible and even incest seems like innocent fun (Le Souffle au Coeur by Louis Malle). They can serve as metaphors for a way of life, indeed a civilization, that is about to disappear (Badenheim 1939, by Aaron Applefeld).

The social aspects of the spa experience are so compelling that they have tended to overshadow discussion of their medical functions. The papers in this issue are a welcome exception to this tendency and remind us that spas have been, in the first instance, places of healing. The term itself is more complex than one might think. There is, first of all, the ‘medical’ as it has come to be understood: for example, physicians prescribing a growing variety of procedures based on waters seen as far more potent than normal tap water but gentler and more natural than most other therapies; other physicians supervising a therapeutic process that can have unexpected and expected side effects, such as fevers (thermal crises) that are thought to be beneficial but must be closely monitored. France certainly provides the most dramatic example of this sort of medicalized thermalism, largely due to the fact that responsibility for the nations’ spas fell to the premier institution of medical
research in nineteenth-century France, the Paris Academy of Medicine. But medical practitioners, in France as elsewhere, have frequently been ambivalent or even skeptical about the powers or water and in some countries – Germany is perhaps the prime example, but also Brazil as M.M. Quintela’s paper in this issue indicates (Quintela 2011) – mineral waters have been seen as a form of alternative or complementary medicine, a natural substitute for the practices of conventional medicine. Where alternative medicines are widely tolerated by health authorities, as is the case in Germany, water cures are reimbursed by the health insurance system.

In the United States where spas were for the most part almost purely commercial establishments, they have been seen mainly as a form of charlatanism. (During the 1920s and 30s, influenced by European models, Americans created medicalized spas, like those of Saratoga Springs, but the boom did not last long.) As forms of either orthodox or alternative healing, mineral water spas usually dealt with chronic illnesses of one sort or another and the goal was less often to cure than to alleviate symptoms and bring relief, which might well be temporary. Hence repeated trips to the spa were required.

Finally, and less frequently noted by scholars of the modern period – although this is a mainstay of scholarship of the ancient world (Galliou 2006) – waters could be a source of religious-based healing. The waters of Monchique were long a setting of religious healing as Cristiana Bastos shows in this issue (Bastos 2011). The spas of Pyrmont were originally devoted to miraculous healing before becoming centers of naturalistic water cures (Lempa 2008). To this day, the waters of Lourdes are thought to contain special spiritual properties that can produce miraculous cures. The Catholic hierarchy has been ambivalent about such miraculous cures and long ago set up an office to distinguish the small number of truly miraculous cures from fallacious claims (Szabo 2002). One cannot help thinking that the powers of even自然istically understood cures rest to some extent on the primordial qualities popularly attributed to water generally and especially those waters whose sources lies deep under the earth’s surface. The ritualistic regularity of spa life represents yet another link to its religious past.

Spas of course were not just places of healing. They were tourist destinations and social spaces. As tourist destinations they had to develop non-therapeutic infrastructures – railway lines, hotels, parks, casinos, which frequently financed therapeutic activities. These amenities were not just necessary to attract curists and the family and friends who might accompany them; they were an integral part of the cure. Even in France where water cures were seen as form of natural chemotherapy, no one doubted that leisure, relaxation, fresh air, and general escape from urban stress to natural rural beauty all intervened to intensify the therapeutic effects of waters. In other locales these aspects might be seen as the essential elements of the curing process with waters playing a secondary role. The relationship between tourist leisure and therapy was not without conflicts. Spa doctors frequently mistrusted the commercial propensities of proprietors and doubted their commitment to medicalized therapy. They complained bitterly about the heavy meals frequently served in expensive spa hotels. Above all, they feared becoming mere tourist sites. Nonetheless, doctors and entrepreneurs were inextricably bound together and, by the early twentieth century, spas were a recognized if highly specialized part of local tourist industries and were organized to maximize resources and efficiency in an increasingly competitive market. This meant, in particular, new and more
sophisticated forms of advertising but it also involved expanding leisure and tourist services as well as technologies for dispensing water cures. Aside from modernizing medical facilities, it was necessary to deliver healing waters in new ways, via vapors, pulverization, showers, mud baths or through previously ignored orifices. It might also mean expanding health activities beyond waters to include procedures such as massage and physiotherapy. In an intensely competitive environment, in which spas battled one another to attract clients, success in combining the latest medical innovations with the latest tourist amenities might mean the difference between institutional success and failure.

There have been interesting efforts to analyze the specific role that spa therapy played in the expansion of the tourist industry. It has been suggested that vacationing for the purposes of health was one of the first socially acceptable forms of leisure for the bourgeois, since its essential purpose – promoting health and vigor – was valued by the rising middle classes. It thus made leisure compatible with a bourgeois work ethic (Mackaman 1998). While such theories are stimulating, historians simply do not know enough about the early development of tourism to attribute so much importance to the role of health maintenance. It has been postulated that spas served other roles as well. In his book on French colonial spas, Eric Jennings (2006) speculates that local watering holes provided colonists with a dose of the French metropolis that was missing from the usual places of colonial social interaction and that periodic visits to the spas of France, notably Vichy, allowed officials and colonists from throughout the Empire to mingle and develop a common identity. Again, such ideas are plausible and deserve consideration, but scholars need to know far more about actual social interactions in such places in order to do more than speculate. Lauren LaFauci has taken a major step in this direction in her essay in this issue. Here she presents a dense and well-documented argument about the role of southern spas in developing southern identity and actually helping to consolidate support for slavery (LaFauci 2011). In a rather different vein, Steward (2002) has described how spas in the Austro-Hungarian Empire fostered local identities among ethnic groups such as Magyars, Poles, and the like. This was not just a case of people being more comfortable with their own kind. Nationalisms might be exploited to attract groups to specific spas in spite of powerful attractions drawing them to more cosmopolitan locations.

There is a general view that spas in the eighteenth century were largely aristocratic destinations. This is somewhat oversimplified because it focuses on a handful of fashionable towns, such as Bath and Baden Baden, and ignores the large number of thermal sources with more modest ambitions and facilities. French spas of the early modern period were, in Laurence Brockliss’s account, spartan places (Brockliss 1990). But the few fashionable spas undoubtedly influenced popular stereotypes surrounding the spa experience. A corollary of this view is that spas with a strong aristocratic flavor became more middle class as the nineteenth century progressed. This was certainly likely as the middle classes expanded and more people were able to pay the considerable costs of the spa cure. But as a number of studies remind us, there was always considerable diversity among spa guests. One historian sees the German spa of the later eighteenth century as a space of bourgeois-noble interaction that helped create enlightenment culture (Kuhnert 1984). And such diversity increased over time. A historian of American spas sees them as spaces where national integration took place on a limited scale during the latter decades.
of the nineteenth century (Chambers 2002). Spas also divided social classes. David Blackbourn (2002) has emphasized the elitist character of certain fashionable European spas catering to an international elite that traveled from one fashionable spa to another. Steward (2002) suggests that such behavior repelled the middle of classes of Hapsburg Austria who preferred the simpler more regimen-based resorts such as Carlsbad or Gräfenberg.

If diversity characterized spas in their balance among social classes or emphasis on therapy as opposed to leisure, the same may be said about their success in attracting clients. In the US, spas were always fairly marginal institutions because, as suggested here, they were linked by the medical profession to charlatanism. But Britain had a vibrant spa industry in the eighteenth century, boasting world famous institutions like those of Bath, which gradually lost their popularity and luster in the second half of the nineteenth century. To explain this decline by appealing to changing fashions is a form of tautology (they became less popular because they became less popular) and ignores the fact that the appeal of continental spas increased dramatically during the period of British decline. To one analyst, it was the capitalist structure of the industries in the different countries that best explains their diverging histories. While English spas were primarily private sector speculations, those of Germany were part of a system of state-managed capitalism that produced resource-rich, innovative and attractive resorts (Bacon 1997).

Much the same can be said of French spas that also expanded dramatically during this period with the help of significant state (national and local) funding and regulation. Whether this explanation is correct or not, it is always nice to be reminded that private enterprise has its limitations and state intervention its uses.

However, resources and facilities tell only part of the story. There is also the science of mineral waters, which has been surprisingly understudied. Explaining the way waters operated therapeutically has traditionally been the province of medical science. For much of the nineteenth and twentieth centuries, efficacy or lack thereof have been perceived as matters of empirical fact (see Weisz 2001). The task of science was to explain how these waters actually worked. Chemistry was the chief instrument in performing this task. Analyzing chemical composition (a sophisticated scientific activity in itself) served as a basis for classifying waters and suggested theories of physiological mechanism. Such theories changed regularly as new scientific tools made new entities (such as radiation) visible but the goal of explaining mechanisms remained primary. In France, a second and linked goal was to use knowledge of mechanisms to permit increasingly specialized use of waters for specific ailments in a manner that approximated the most modern therapeutics. While it was understood that the rest, relaxation, and the beauty of the countryside had a role to play in therapy, it was the chemical composition of the waters that normalized human physiology. One could represent the encounter as one between two complex liquids with one adding to or drawing from the other specific elements. In the words of the second professor of hydrology at the Paris Faculty of Medicine, Maurice Chiray, ‘[m]ineral waters are, like the liquids of the organism, a complex electronic milieu, and the infinitely small [elements] of one can act on the infinitely small [elements] of the other, either by way of the exchanges of certain elements, or by way of the addition of others which the humors are partially or totally lacking’ (Chiray 1938).

As the century progressed, interpretations centering on the nervous system as the regulator of physiological terrain became more common. By the early twentieth
century, the French were doing more than speculating. A network of university chairs devoted to thermalism was created and financed by the waters industry and produced a growing literature on the physical effects of waters. Little of this research was clinical. Not only was efficacy presumed, but clinical research had little status in the early twentieth century. The hallmark of science was laboratory experimentation and French university laboratories went energetically about the business of testing the effects of different waters on animals or isolated organs. Such work could say little about clinical efficacy but it produced a large literature demonstrating that waters produced physiological effects. It was a leap but not a huge one to attribute therapeutic effects to such physiological effects. By the 1940s, the network of academic chairs and laboratories had become so visible and had produced a large enough body of scientific literature that few questioned thermalism’s place in French medicine or its reimbursement by the social insurance system that was introduced following the Second World War.

However, this golden age did not last. In the first instance, medical science provided a host of therapies that worked more quickly and consistently (although not necessarily more cheaply) than did mineral waters. In the second, health insurance systems quickly found themselves in financial trouble. It was tempting to try to save money by cutting back on reimbursement of services that appeared increasingly old-fashioned. Finally, definitions of scientific validity changed. Even before the ‘evidence-based medicine’ movement turned such ideas into scientific orthodoxy, there was increasing disenchantment with a purely experimental approach that justified therapies by appealing to presumed underlying physiological mechanisms corrected by waters. The demand here, as throughout medicine, was for proof of therapeutic efficacy via double-blind, randomized clinical trials, sufficiently numerous to permit meta-analysis. This was a difficult jump for spa industries to make, even in places such as France and Portugal where they were highly medicalized. Some spas thus jumped into the alternative medicine camp, which did not at that time demand randomized clinical trials to demonstrate efficacy. One could even abandon water and find new therapeutic modalities, although few institutions that changed their orientation displayed the inspired creativity of the Ayurvedic spa described by Harish Naraindas in this issue (Naraindas 2011). Another option was to move into the ‘wellness’ business and provide essentially healthy people with services that make them feel good or better, everything from massages, to perfumed baths to facials. This strategy had the advantage of not requiring the total abandonment of medicalized waters but merely adding new services to existing water treatments. As Cristiana Bastos and Amy Speier demonstrate in this issue, such hybrid institutions can work fairly well, quite possibly because they do – in a more expansive and targeted way – something that successful spas have always done: add pleasure and well-being to an essentially medical enterprise (Bastos 2011, Speier 2011).

French spas have also experimented with the provision of such services in an effort to deal with declining interest and funding. Those of the Jura (in the mountainous east of the country) now distinguish between two types of clients. In 2002, those taking traditional thermal cures accounted for about 25% of the economic benefits of the industry and were usually over 60 years of age, excepting those visiting several spas that specialize in children; such cures lasted the canonic 21 days. In addition, about 10% of revenues was due to a much larger group of visitors seeking a return to form
(remise en form) during stays lasting about 6 days (which explains why they generated less revenue) and who were characteristically between 40 and 60 years of age.\(^1\) A national study in 2002 found that 95% of all days spent in spas were devoted to medical cures while 5% were devoted to remise en form.\(^2\)

If movement toward this wellness orientation continues to occur at the local level, and even famous spas like Aix-les-Bains push this aggressively in their online advertising, it is largely absent from political and medical discourse. In fact, most such rhetoric has to do with adapting mineral waters to new criteria of evidence-based research. The impetus, it is true, has come from the French government, which gave notice in 2000 that it would not continue to reimburse cures unless the industry was able to justify not just the efficacy of its practices, but the efficacy and economic advantages over other forms of therapy. By 2002, an accord had been signed to this effect and the spa industry – as it had in the 1920s and 1930s – intervened, financially allocating over a million euros annually for research. A new research organization AFRETH (Association Française pour la Recherche Thermale) was set up in 2005 and by the end of 2009, had financed 23 research projects, studying the effects of waters on such varied conditions as thrombosis, otitis, anxiety and obesity.\(^3\) A recent clinical trial has apparently demonstrated that water cures are significantly more effective than a standard anxiolytic, paroxetine, for reducing the symptoms of anxiety (Dubois et al. 2008). Thermal-station and university laboratories have also engaged in research using local funds. Spending a little over €1,000,000 annually on such research hardly puts AFRETH in the same league as the French INSERM, let alone the National Institutes of Health. But as a symbol of willingness to adapt to new scientific and political imperatives, it says much about the French determination to keep mineral waters if not in the mainstream then at least within the margins of contemporary biomedicine.

Notes


References


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