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The Discourse of Distant Care: A Multimodal and Pragmatic Analysis of Medical Tourism Marketing and Its Sustainable Paradox.

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Abstract

This study explores the discursive construction of sustainability in the rapidly growing medical tourism sector. It investigates the pragmatic and multimodal strategies used to align the potentially contradictory concepts of luxury healthcare travel and ecological or social responsibility. Grounded in Multimodal Discourse Analysis and theories of Place Branding, the research examines textual and visual content from hospital websites, medical broker portals, and destination marketing materials for five key medical tourism hubs. The methodology employs a three-part analytical framework focusing on Interdiscursivity (blending of medical, tourism, and sustainability discourses), Spatio-Social Representation (how places and people are framed), and Pragmatic Politeness Strategies (addressing patient-tourist desires). The analysis reveals a prevalent strategy of green compartmentalization, where environmental claims are largely restricted to peripheral features like hotel accommodations, while the carbon-intensive travel core is linguistically backgrounded. Destinations are branded through a rhetoric of seamless efficiency, combining medical authority with touristic allure, while host communities are often visually and textually marginalized. The patient-tourist is addressed with exclusive, deferential politeness, constructing a hyper-consumer subject. Based on these observed patterns, the study suggests that current medical tourism discourse tends to obscure its socio-ecological footprint. It advocates for mandatory discursive integration of sustainability metrics, ethical codes of conduct centering host communities, and a reorientation towards a responsible mobility paradigm that transparently accounts for the costs of cross-border care.

Keywords: *Medical Tourism Discourse, Multimodality, Interdiscursivity, Place Branding, Pragmatic Politeness, Green Compartmentalization.*

1. Introduction

Medical tourism, the practice of traveling across international borders to access elective healthcare, has evolved from a niche phenomenon into a global industry. Driven by cost differentials, wait times, procedure availability, and sophisticated marketing, it represents a complex intersection of healthcare, commerce, and mobility (Wong et al., 2024; Connell, 2011). Concurrently, sustainable tourism has gained mainstream traction, advocating practices that minimise environmental harm, respect socio-cultural authenticity, and distribute benefits more equitably across host communities (Scott & Gössling,

2022; UNWTO, 2022;). Yet the convergence of these paradigms exposes a fundamental contradiction. Can an industry premised on long-haul air travel, resource-intensive medical facilities, and global health inequalities genuinely be reconciled with sustainability goals? Recent greenwashing scholarship suggests that such contradictions are often managed through selective disclosure and ethically ambiguous communication rather than substantive transformation (Santos et al., 2023; Ding et al., 2025).

This tension is not merely operational but profoundly discursive. Medical tourism is sold through texts, images, and narratives designed to reassure, allure, and persuade patients. These promotional materials, hospital websites, broker platforms, and healing-destination campaigns perform ideological work. They must mitigate the perceived risks of foreign healthcare, amplify destination appeal, and respond to consumer awareness of sustainability. Wellness tourism research shows that destination development depends on the interplay of infrastructure, community involvement, promotion, and visitor expectations, underscoring that discourse is central to how destinations are imagined and legitimized (Kebadie & Ullah, 2026). How this discursive negotiation occurs, and how sustainability is strategically incorporated, sidelined, or reshaped, is the central concern of this paper.

This study investigates how medical tourism marketing attempts to blend three distinct discursive registers: the clinical-scientific, emphasizing safety, technology, and expertise; the touristic-hedonic, emphasizing luxury, escape, and recuperation; and the ethical-sustainable, emphasizing responsibility and local benefit. This interdiscursivity reveals points of fracture, omission, and strategic compromise. The discourse constructs the "patient-tourist" as a privileged consumer while simultaneously creating the host destination and its community in ways that legitimize the industry's presence. This study addresses four objectives:

(i) To identify the dominant interdiscursive strategies used in medical tourism marketing to reconcile care with consumption and travel.

(ii) To analyze the multimodal representation of the destination's place, people, and environmental context.

(iii) To examine the pragmatic strategies used to address and construct the patient-tourist, with a focus on politeness and risk management.

(iv) To evaluate how, where, and in what form sustainability discourses appear within this promotional ecosystem.

By addressing these objectives through multimodal discourse analysis, this study aims to move beyond policy critiques of medical tourism's sustainability and provide a granular understanding of the persuasive mechanisms that sustain its growth and obscure its contradictions. In doing so, it responds to calls for more critical work on medical tourism marketing and destination management (Wong et al., 2024) while placing the ethical concerns raised in greenwashing research into direct dialogue with healthcare mobility (Ding et al., 2025; Santos et al., 2023). The findings are intended to inform regulators, healthcare ethicists, destination marketers, and consumers navigating this ethically complex terrain.

2. Literature Review

This study sits at the crossroads of four robust scholarly conversations: medical tourism as a global health and economic phenomenon, sustainable tourism, place branding, and critical discourse studies.

2.1. Medical Tourism: Scope, Drivers, and Critiques

Medical tourism encompasses a wide range of procedures, from cosmetic surgery and dentistry to complex cardiology and orthopedics. Key source countries include the US, Canada, and Western Europe, while leading destinations are in Asia (Thailand, India, Singapore), Latin America (Mexico, Costa Rica, Brazil), and Eastern Europe (Hungary, Turkey) (Connell, 2011). The drivers are well-documented: significant cost savings, avoidance of long wait times, access to procedures unavailable or unapproved at home, and the opportunity to combine treatment with a vacation (Crooks et al., 2011). However, a substantial critical literature highlights significant ethical and equity concerns: the potential for exacerbating a two-tiered healthcare system in destination countries by diverting resources to serve foreign patients (Turner, 2007); the brain drain of local medical professionals to the private sector serving

medical tourists; and the often-inadequate legal recourse for patients facing complications post-return (Snyder et al., 2011). More recent reviews, such as that by Wong et al. (2024), have called for a re-examination of medical tourism's impacts on destination management, emphasizing the need for a more critical lens on marketing practices. This body of work establishes the material contradictions at the heart of the industry.

2.2. Sustainable Tourism and Its (Mis) appropriation

Sustainable tourism is defined as tourism that takes full account of its current and future economic, social, and environmental impacts, addressing the needs of visitors, the industry, the environment, and host communities (UNWTO, 2022). The literature extensively documents greenwashing in tourism, where superficial environmental gestures such as towel reuse programs are promoted while core operations remain unsustainable (Gössling et al., 2019). Ding et al. (2025) have further explored the ethical consequences of such misleading communication, showing how it can erode stakeholder trust and conceal deeper environmental failings. Santos et al. (2023) provide a systematic overview of greenwashing, distinguishing it from related practices like selective disclosure and symbolic corporate social responsibility (CSR). The carbon footprint of travel, particularly aviation, is a central unsolved problem for tourism sustainability (Scott & Gössling, 2022). The application of this critical lens to medical tourism is nascent but growing, focusing on its high carbon intensity and questionable local economic linkages (MacNeill & Wozniak, 2018).

2.3. Place Branding and Destination Image Construction

Place branding theory examines how locations are strategically marketed to attract investment, tourism, and talent (Kavaratzis & Ashworth, 2005). For medical tourism, destinations engage in a specialized form of "therapeutic place branding" (Ormond & Sothern, 2012), crafting an image that combines clinical credibility with recuperative allure. This involves leveraging symbols of modernity (high-tech hospitals, JCI accreditation) alongside symbols of traditional care, relaxation, and natural beauty. The literature shows how destinations like Thailand brand themselves as the "Land of Smiles" with "world-class" medicine, while India emphasizes "ancient healing" traditions alongside cutting-edge surgery. This branding is a discursive project par excellence, yet analyses often lack detailed linguistic and multimodal scrutiny.

2.4. Critical Discourse Studies and Multimodality

Critical Discourse Analysis (CDA) investigates how language use in social contexts enacts, reproduces, or resists power relations and social inequalities (Fairclough, 2013). Multimodal Discourse Analysis (MDA) extends this to all communicative modes: image, layout, color, and video, understanding meaning as constructed through their interaction (Kress & van Leeuwen, 2021). In tourism, MDA has been used to analyze brochures and websites (Jaworski & Pritchard, 2005). Pragmatics, the study of language in use and context, offers tools like Politeness Theory (Brown & Levinson, 1987), which analyzes how language manages social relationships, and face wants (the desire for approval and autonomy). Applying these frameworks to medical tourism discourse is emerging; for example, analyzing how websites mitigate the "face-threatening act" of admitting medical risk (Guiry & Vequist, 2015).

While the above fields provide essential context, a significant gap exists in a holistic, critical discourse analysis that systematically integrates the multimodal, interdiscursive, and pragmatic dimensions of medical tourism marketing, specifically in relation to the emergent discourse of sustainability. Existing critiques of the industry's unsustainability are largely external; few studies examine how the industry internally discursively manages or evades this critique within its own promotional materials. Therefore, this study fills that gap by providing a comprehensive discourse-analytic map of how medical tourism sells itself in an era of growing ecological and social consciousness, revealing the precise textual and visual mechanisms of obfuscation and legitimization.

3. Theoretical Framework

This study is guided by an integrated theoretical framework that combines Multimodal Discourse Analysis (MDA), Interdiscursivity, and Pragmatic Politeness Theory, all viewed through the critical lens of Place Branding and Spatial Semiotics. This framework allows for a holistic examination of how medical tourism destinations are semiotically constructed, how different discourses are woven together to achieve persuasive ends, and how the relationship between the consumer and the provider is linguistically managed.

3.1. Multimodal Discourse Analysis (MDA) as the Foundational Lens

Drawing on the social semiotic approach of Kress and van Leeuwen (2021), this study treats all communicative modes in promotional materials as meaning-making resources. Key analytical concepts include: representational meaning, interactive meaning, and compositional meaning. Representational meaning deals with what is depicted. In images, this involves analyzing whether participants (people, places) are represented as conceptual (generalized, symbolic) or narrative (engaged in actions). Interactive meaning deals with how the design addresses the viewer/reader through contact (eye contact or its absence), social distance (close-up vs. long shots), and point of view (angle implying power or equality). Compositional meaning deals with how elements are arranged to create coherence through information value (placement), framing (connection or disconnection), and salience (what draws attention).

3.2. Interdiscursivity as the Strategy of Blending

Interdiscursivity refers to the mixing of different discourses, genres, or styles within a single text (Fairclough, 1992). Medical tourism marketing is fundamentally interdiscursive, blending four discourses. Firstly, clinical/medical discourse is characterized by technical terminology such as "minimally invasive," "board-certified," and appeals to scientific authority. Secondly, tourism/hospitality discourse is characterized by hedonic vocabulary ("luxury," "paradise," "rejuvenation") and visuals of beaches and spas. Thirdly, corporate/business discourse is characterized by terms like "value," "package," and "world-class service." Finally, sustainability discourse is characterized by terms like "eco-friendly," "responsible," and "green." The analysis focuses on how these discourses are hybridized, which one dominates in which context, and where they conflict or are kept strategically separate.

3.3. Pragmatics and Politeness Theory as the Relational Engine

Brown and Levinson's (1987) Politeness Theory is used to analyze how websites and brochures address the potential patient-tourist's face wants. Seeking medical care abroad involves significant face-threatening acts (FTAs): it admits one cannot afford or access care at home (threat to positive face) and involves ceding autonomy to an unknown foreign system (threat to negative face). Promotional discourse employs two strategies to redress these threats. Positive politeness attends to the patient's desire to be approved of and valued, including compliments, claims of in-group membership, and optimism. Negative politeness attends to the patient's desire for autonomy and freedom from imposition, including deference, hedges, and impersonal constructions.

3.4. Place Branding and Spatial Semiotics as the Contextual Frame

This analysis is situated within the understanding that medical tourism marketing is an act of therapeutic place branding (Ormond & Sothern, 2012). It draws on spatial semiotics to examine how the destination is linguistically and visually constructed as a heterotopia (Foucault & Miskowiec, 1986): a simultaneously real and mythic "other space" that resolves the contradictions of illness and vacation, risk and safety, foreignness and comfort. The framework addresses questions such as: How is the geography of care mapped? How are local people positioned within this branded space?

3.5. Synthesis: The Diagnostic Framework

To operationalize this framework, Table 1 outlines the coding categories used in the analysis, linking each theoretical concept to specific research questions and evidence types.

Table 1. Analytical Framework for Medical Tourism Discourse

Analytical Dimension	Sample Research Questions	Data Sources & Coding Evidence
Interdiscursivity	• Which discourse is dominant? • Where do discourses clash or blend? • How is sustainability terminology deployed?	Thematic coding of all textual content; page/section headers. Example: A homepage headline like "World-Class Surgery in Paradise" blends clinical ("surgery") and touristic ("paradise") discourses.
Spatio-social representation (Multimodal)	• How are hospitals, landscapes, and people depicted? • What is the visual relationship between medical and touristic spaces?	Homepage banners; destination image galleries; staff photos; testimonial videos. Example: An image of a smiling doctor in a crisp uniform with a direct gaze was coded as "demand" for interactive meaning, establishing a pseudo-relationship.
Pragmatic address	• How are patient anxieties addressed? • How is trust built linguistically? • How are prices and risks framed?	FAQ text; consultation request forms; "Contact us" phrasing; testimonial narratives. Example: Use of "you may consider" instead of "you should consider" was coded as a negative politeness hedge.

4. Methods

This study employed a qualitative, multimodal critical discourse analysis of a purposively sampled corpus of medical tourism promotional materials from five established destination countries.

4.1 Site Selection and Corpus Construction

Five countries were selected to represent geographical and branding diversity: Thailand, India, Mexico, Turkey, and Costa Rica. Thailand was chosen because it is long-established, combining advanced hospitals with resort tourism. India was selected because it is a cost leader and emphasizes high-tech and traditional medicine. Mexico was considered due to its proximity to the US market and its dental/cosmetic focus. Turkey was chosen because it is a rising hub for hair transplants and cosmetic surgery. Costa Rica markets itself as an "eco-medical" destination.

The corpus was constructed in the fourth quarter (Q4) 2023 and archived using browser screenshots and PDF downloads to ensure consistency. For each country, three types of digital promotional materials were collected: The first corpus was hospital/clinic websites**:** The official international patient portals of two leading, internationally accredited hospitals per country were considered (total: 10). Each entire site was archived, generating approximately 350 pages. The second corpus was medical tourism broker/agency websites: Two major international broker platforms, MedicalTourism.com and Health-Tourism.com, and one leading national broker per destination country (e.g., HealthToursThailand.com) were selected. This yielded a total of 7 broker sites and approximately 120 pages. The third corpus involved destination marketing organization (DMO) materials: The "medical tourism" section of the official national tourism authority website for each country was selected (total: 5), contributing approximately 30 pages.

The total corpus comprised over 500 web pages, including text, images, videos, infographics, and downloadable PDF brochures. This broad corpus was used for thematic coding. For the detailed multimodal analysis, a smaller, purposive sub-corpus was created, consisting of three key pages (homepage, "why choose us," and "patient testimonials") from each of the 22 sources (10 hospitals + 7 brokers + 5 DMOs), resulting in 66 pages analyzed in depth.

4.2. Analytical Procedure

A three-stage, iterative analytical procedure was followed, aligned with the theoretical framework.

Stage 1: Interdiscursive Mapping and Thematic Coding.
All textual content from the 500+ pages was imported into NVivo software. Through repeated close reading, codes were developed to identify the presence and mixing of the four key discourses: Clinical, Touristic, Corporate, and Sustainability. A codebook was created to define these codes and ensure consistency. For example, "Sustainability Discourse" was coded for any mention of "green," "eco," "responsible," "community," "carbon," or "local benefit." This stage identified broad thematic patterns and lexical choices.

Stage 2: Multimodal Analysis of Key Pages.
For each of the 66 pages in the sub-corpus, a detailed multimodal analysis was conducted using a structured protocol adapted from Kress and van Leeuwen (2021). The analysis documented: images (subject matter, composition, gaze, social distance, angle, color scheme), layout (information architecture, navigation), and verbal-visual cohesion (how text relates to images).

Stage 3: Pragmatic and Micro-Linguistic Analysis.
This analysis focused on specific textual genres within the sub-corpus: the "welcome message," procedure descriptions, FAQ sections, and contact forms. This process involved:

(i) Pronoun analysis: tracking the use of "we," "you," "our," and "your."
(ii) Modality analysis: analyzing modal verbs (can, will, may, should).
(iii) Politeness strategy coding: identifying instances of positive politeness (e.g., "you deserve") and negative politeness (e.g., "we would be honored").
(iv) Transitivity analysis: in success stories, identifying who the actors are and what processes they are engaged in.

A constant comparative method was used across the five destinations to identify both universal strategies and destination-specific nuances.

5. Findings and Discussions

The following section presents the findings organized by the three analytical dimensions. To provide a descriptive overview of the thematic coding, the word cloud in Figure 1 visualizes the most frequent terms from the corpus after removing common stop words. This serves as a preliminary indicator of the dominant lexical landscape.

Figure 1. Word Cloud of Medical Tourism Marketing Corpus

5.1. Interdiscursivity: The Rhetoric of Seamless Efficiency

The dominant interdiscursive blend was a clinical-touristic-corporate hybrid, creating a rhetoric of seamless efficiency. Medical authority provided credibility, touristic allure provided motivation, and corporate professionalism promised a hassle-free experience. This blend was identified across 94% of homepage texts in the sub-corpus. For instance, a hospital website in Thailand states:

> *Our JCI-accredited surgical team provides world-class orthopedic care, after which you can recuperate in a private suite with panoramic views, followed by curated wellness therapies. Our concierge handles everything from airport transfer to post-operative luxury tours.*

This verbatim blends clinical discourse ("JCI-accredited," "orthopedic care"); touristic discourse ("recuperate," "panoramic views," "wellness therapies," "luxury tours"); and corporate hospitality discourse ("world-class," "private suite," "concierge").

Sustainability discourse was conspicuously absent from core value propositions. The analysis showed that when it appeared, it was compartmentalized in two ways. First, spatial compartmentalization: it was largely limited to separable parts of the "package." Of the 28 instances where environmental claims were made across the entire corpus, 22 (78.5%) related to hotel accommodations ("green certification," "eco-toiletries," "energy-efficient lighting") rather than to medical travel or the procedures themselves. Second, sectional compartmentalization: sustainability content was confined to dedicated "CSR" or "Green Policy" pages, entirely separate from main treatment and destination pages. Among the 22 sources, 15 had a sustainability or CSR page, but only 3 had any mention of environmental responsibility on their main treatment or homepage sections. The language used on these pages was generic, borrowed from corporate sustainability reports.

5.2. Multimodal Construction: The Therapeutic Heterotopia

Visually, destinations were constructed as pristine, orderly therapeutic heterotopias, a pattern observed across all 66 pages analyzed. This covered two spaces: hospital and recuperative. Hospital spaces were depicted through gleaming, futuristic architecture (exterior shots resembling luxury hotels), minimalist interiors, and advanced equipment close-ups. Staff were shown in crisp uniforms, often smiling directly at the camera (demanding gaze, establishing a pseudo-relationship), or in staged "action shots" during consultations (narrative representations of care). Recuperative spaces involved images seamlessly transitioning to serene beaches, lush rainforests, or tranquil spa settings. These were predominantly conceptual representations; empty beaches, untouched nature implying exclusive access and purity.

The erasure of context was profound. In the sub-corpus of 66 pages, only 12 images (representing 5% of all images analyzed) showed local people not in a service role. The host community was represented only through two narrow frames: the medical professional (authoritative, smiling) and the hospitality worker (uniformed, serving). No images depicted the surrounding urban reality, local traffic, or non-tourist-facing areas of the destination. This visual strategy performs a symbolic sanitization, divorcing the clinical-touristic bubble from its geographical and social context.

Table 2. Multimodal Representation in Medical Tourism Marketing

Represented Element	Dominant Visual Mode	Linguistic Framing	Discursive Function
Hospital/Clinic	Futuristic architecture; clean interiors; advanced technology.	"State-of-the-art," "internationally accredited."	Establish clinical credibility and safety.
Medical Staff	Portraits with direct gaze; staged consultation shots.	"US/UK-trained," "board-certified."	Personalize and legitimize expertise; build trust.

Represented Element	Dominant Visual Mode	Linguistic Framing	Discursive Function
Recuperative Setting	Empty beaches; pristine rainforest; infinity pools.	"Paradise," "tranquil," "rejuvenating escape."	Provide hedonic motivation; frame recovery as a vacation.
Patient-Tourist	Post-operative, smiling, relaxed in scenic settings.	"Guests," "valued patients."	Model the desired outcome and address the consumer.
Local Community/ Context	Largely absent. If present: service staff or cultural "performers."	"Warm hospitality," "friendly culture."	Provide an exotic backdrop without complexity.
Environmental Features	Generic "green" nature shots (palms, water).	"Lush," "natural," "eco-friendly" (for hotels).	Append aesthetic and vague "green" appeal.

5.3. Pragmatic Address: Hyper-Politeness and the Sovereign Consumer

The linguistic address to the patient-tourist was characterized by an excessive, hyper-deferential politeness strategy, constructing them as a sovereign consumer. Pronoun analysis across the sub-corpus revealed a ratio of "you/your" to "we/our" of 3.5:1, emphasizing the individual client's needs and agency. Positive politeness was evident through ubiquitous affirmation (e.g., "you deserve the best health") and claims of shared goals ("we are here to make your dream a reality"). Negative politeness was most pronounced in risk communication. Complications were not denied but framed as rare events managed by a vigilant system, using heavy hedging. Here is a verbatim example from an FAQ section of a Mexican hospital:

> *While all surgical procedures carry some inherent risk, our rigorous pre-operative screening and board-certified anesthesiologists work to minimize any potential for complications. You will be fully informed of all possible outcomes during your comprehensive consultation.*

This response acknowledges risk but immediately surrounds it with professional safeguards ("rigorous," "board-certified," "minimize"). The modality is softened through phrases like "carry some" and "potential." Responsibility is shifted to the future consultation, respecting the patient's current autonomy.

Pricing, a key driver, was handled through a strategy of delayed imposition. Specific prices were rarely listed on main pages; instead, the language invited a "free, no-obligation quote," framing cost not as a barrier but as personalized information to be respectfully requested. This pattern was consistent across all 22 sources, with none providing specific package prices on their main treatment pages.

In light of the available literature, these findings illustrate and extend existing critiques. The green compartmentalization strategy is a specific instance of the greenwashing tactics documented in general tourism (Gössling et al., 2019; Ding et al., 2025), now tailored to the medical context. This concept refines greenwashing by specifying the spatial and thematic displacement of sustainability claims away from the industry's core carbon-intensive activities. The erasure of local context and the construction of a therapeutic heterotopia align with place branding strategies that commodify and simplify places for consumer appeal (Kavaratzis & Ashworth, 2005). The hyper-politeness strategy provides a linguistic mechanism for managing the profound face-threatening acts inherent in medical tourism, constructing the patient-tourist not as a patient within a health system, but as a client purchasing a bespoke health experience.

5.4. Discussions, Conceptual Framework and Limitations

The findings indicate that medical tourism marketing reconciles care with consumption by producing an interdiscursive language in which clinical authority, touristic desire, and corporate service are made to appear mutually reinforcing rather than contradictory. What emerges is not a neutral mixture of registers but a persuasive arrangement that normalises medical travel as efficient, safe, and desirable. The clinical

lexicon secures legitimacy through references to accreditation, expertise, and technological competence, while the touristic lexicon supplies pleasure, comfort, and escape; corporate discourse then binds both into a promise of seamless coordination. Read through Fairclough's notion of interdiscursivity, this is an ideological simplification rather than a mere stylistic blend, because it suppresses the material frictions of long-distance care and converts them into a marketable narrative of convenience (Fairclough, 1992, 2013). In that sense, the study extends Connell's (2011) account of medical tourism by showing that the industry's expansion depends not only on cost and access, but on the discursive manufacture of legitimacy. It also supports Wong et al. (2024), who argue that medical tourism research requires a more critical engagement with destination management and marketing.

The multimodal evidence strengthens this argument by showing that destinations are visually composed as therapeutic heterotopias: spaces where illness, recovery, leisure, and exclusivity are brought together within a carefully sanitised frame. Hospitals are depicted as sleek, futuristic, and internationally credible, while surrounding landscapes are rendered serene, pristine, and restorative. Using Kress and van Leeuwen's (2021) framework, these images are not decorative supplements to verbal claims; they are central semiotic resources through which trust, aspiration, and spatial order are produced. Foucault and Miskowiec's (1986) idea of heterotopia is especially apt here, because these promotional environments present a world apart: clinically advanced yet emotionally soft, foreign yet familiar, luxurious yet morally untroubled. What is most telling, however, is the patterned erasure of local complexity. Host communities are largely absent except as smiling professionals or service staff, while ordinary urban realities and socio-economic unevenness disappear from view. This confirms broader critiques in place branding and tourism discourse that destinations are often reduced to consumable signs rather than represented as lived social worlds (Kavaratzis & Ashworth, 2005; Jaworski & Pritchard, 2005).

The linguistic construction of the patient-tourist follows the same logic of reassurance and control. The discourse repeatedly positions the prospective traveller not as a vulnerable patient entering an uncertain transnational medical system, but as a sovereign consumer whose preferences, anxieties, and dignity must be carefully managed. Brown and Levinson's (1987) politeness theory helps explain this pattern. Positive politeness appears in affirming formulations that flatter the traveller's worth and entitlement to excellent care, whereas negative politeness is evident in hedged language around surgical risk, pricing, and decision-making. Yet these strategies do more than preserve face; they commercialise reassurance itself. Risk is acknowledged only to be quickly enclosed within a rhetoric of expertise, vigilance, and personalised consultation. This finding refines earlier work on trust, mediation, and patient experience in medical tourism (Crooks et al., 2011; Snyder et al., 2011) by showing that trust is not merely established interpersonally but pre-scripted discursively. The patient-tourist is thus fashioned as a consumer-subject who is both courted and governed through language.

The treatment of sustainability is perhaps the sharpest finding of the study. Sustainability discourse appears neither absent nor fully integrated; it is compartmentalised. Environmental and ethical claims are displaced onto peripheral features such as accommodation, toiletries, landscaping, or generic CSR pages, while the carbon-intensive core of medical travel remains conspicuously backgrounded. This pattern is better understood not as incidental omission but as strategic discursive management. It aligns closely with the greenwashing literature, where selective disclosure, symbolic responsibility, and rhetorical substitution conceal structurally unsustainable practices (Santos et al., 2023; Ding et al., 2025). In tourism more broadly, climate research has already shown that aviation remains one of the sector's unresolved contradictions (Scott & Gössling, 2022). The present findings show how medical tourism attempts to evade that contradiction linguistically and visually. Seen in this light, "green compartmentalisation" is a useful refinement of existing debates because it identifies the precise mechanism through which sustainability is aestheticised without being allowed to challenge the industry's core mobility model. That tension also resonates with wider destination-development debates in wellness tourism, where local legitimacy and sustainability claims often exceed substantive practice (Kebadie & Ullah, 2026; UNWTO, 2022). These interconnected findings are synthesised visually in Figure 2, which summarises the study's conceptual framework.

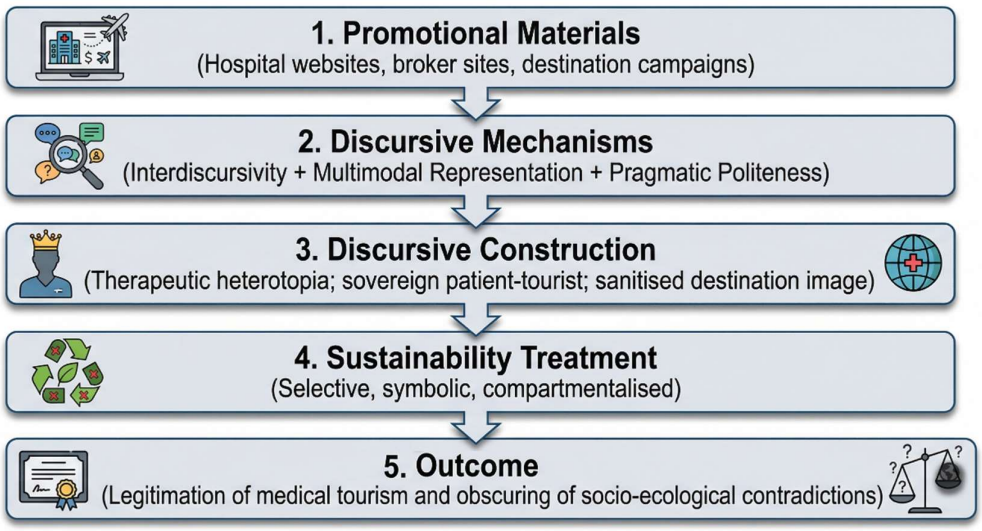

Figure 2. Conceptual Framework of Medical Tourism Marketing Discourse

Figure 2 conceptualises medical tourism marketing as a discursive system in which promotional texts and images work together to legitimise cross-border care by fusing medical credibility, touristic desire, consumer convenience, and selective ethical signalling. At the input level, the framework begins with promotional discourse drawn from hospital websites, broker platforms, and destination marketing materials. These materials mobilise three central meaning-making mechanisms: interdiscursivity, multimodal representation, and pragmatic address. Interdiscursivity explains how clinical, touristic, corporate, and sustainability discourses are blended; multimodal representation captures how places, people, and environments are visually and linguistically framed; pragmatic address shows how the patient-tourist is reassured, persuaded, and positioned through politeness, hedging, and trust-building strategies. Together, these mechanisms produce a branded image of the destination as a therapeutic heterotopia: a space that appears safe, luxurious, efficient, and morally acceptable. However, the framework also shows that sustainability is not fully integrated into the core logic of medical tourism promotion; rather, it is often compartmentalised into peripheral or symbolic claims. The overall outcome is a discourse that normalises medical tourism, constructs the patient-tourist as a sovereign consumer, marginalises host-community realities, and obscures the socio-ecological contradictions of long-distance care.

These findings should, however, be read in light of the study's limits. Because the corpus consists of producer-generated English-language promotional materials, the analysis captures how the industry represents itself rather than how those representations are interpreted, negotiated, or resisted by actual patient-tourists. Future research should therefore combine discourse analysis with reception studies, interviews, and digital ethnography of patient forums. It should also widen the corpus to multilingual content, influencer media, video-based platforms, and longitudinal comparisons across crises or policy shifts. Just as importantly, the discursive patterns identified here ought to be paired with empirical work on carbon emissions, health-system effects, labour relations, and host-community outcomes. That broader agenda would allow scholarship to move from identifying how medical tourism legitimises itself to demonstrating more fully what its persuasive language and imagery help to conceal.

6. Conclusion and Recommendations

This multimodal and pragmatic discourse analysis has deconstructed the sophisticated persuasive machinery of medical tourism marketing. It has revealed an industry that speaks in a polished, interdiscursive language of seamless efficiency, constructing therapeutic heterotopias that are clinically credible and hedonically alluring. Within this discourse, sustainability is not integrated but compartmentalised, reduced to a marketing add-on for peripheral services, while the jet fuel for the essential journey is absent from the narrative. Host communities are visually marginalized, and the

patient-tourist is constructed as a sovereign consumer through a hyper-polite address. This discursive regime has consequences; it facilitates the continuation of an unsustainable model by making its externalized costs less visible and its immediate, personalized benefits hyper-visible. To foster a more responsible and transparent medical tourism sector, the following recommendations are proposed based on the observed discursive patterns:

(i) For Destination Marketing Organizations (DMOs) and National Health/Tourism Ministries: Develop and enforce mandatory discursive guidelines for medical tourism promotion. These should require:
- Integrated Carbon Disclosure: Promotional materials for treatment packages must include a standardized, estimated carbon footprint for the travel and medical stay component.
- Contextual Transparency: Dedicated sections detailing the hospital's contributions to the local health system and its local employment and supply chain practices.
- Visual Ethics: Guidelines encouraging the inclusion of images that represent the destination in a more holistic, non-erasive manner.

(ii) For International Accreditation Bodies (JCI, ISQua): Expand accreditation standards to include ethical communication and sustainability reporting. Hospitals seeking medical travel accreditation should be required to publish an annual impact report detailing environmental metrics and socio-economic impacts on the local community.

(iii) For Medical Tourism Facilitators and Hospitals: Move beyond greenwashing to adopt a Responsible Mobility communication framework. This involves offering carbon-neutral pathway options and showcasing genuine, measurable community partnerships within core promotional narratives.

(iv) For Researchers and Consumer Advocates: Develop discursive literacy toolkits for potential medical tourists, teaching them to critically read medical tourism websites: to identify green compartmentalization and to question erasures of local context.

In retrospect, the industry has built a formidable bridge of words and images to promise seamless care across great distances. It is now imperative to reconstruct that discursive bridge with the materials of transparency, equity, and ecological accountability. Only then can medical tourism begin to align its powerful narrative with the imperative of genuine sustainability.

Declarations

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Conflict of Interest

The authors declare no conflict of interest.

Ethical Approval and Informed Consent

Informed consent was obtained from all subjects involved in the study.

Data Availability

The data supporting the findings of this study are available from the corresponding author upon request.

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