EXPLORING LOCAL AND GLOBAL IDEALS OF BEAUTY IN TURKEY: DISCOURSES AND PRACTICES OF PLASTIC SURGERY PATIENTS AND PHYSICIANS

A Ph.D. Dissertation

by
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July 2008

To my father and mother, for the best of all reasons

EXPLORING LOCAL AND GLOBAL IDEALS OF BEAUTY IN TURKEY: DISCOURSES AND PRACTICES OF PLASTIC SURGERY PATIENTS AND PHYSICIANS

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I certify that I have read this thesis and have found that it is fully adequate, in scope and in quality, as a thesis for the degree of Doctor of Philosophy in Management.

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ABSTRACT

EXPLORING LOCAL AND GLOBAL IDEALS OF BEAUTY IN TURKEY: DISCOURSES AND PRACTICES OF PLASTIC SURGERY PATIENTS AND PHYSICIANS

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Intrigued by an increase in demand for aesthetic operations all over the world, this study offers an in-depth investigation of plastic surgery as a consumption phenomenon. First, it looks at how local and global notions of the beautiful are negotiated in Turkey through consumption and marketing of aesthetic operations. Second, it looks at the nature of a service relationship formed between the surgeon and the patient-consumer, and how this relationship is constructed and maintained. Gazi University Hospital was chosen as the ethnographic research site.

Results indicate that beauty is perceived as something that individuals improve, upgrade, and refine through time. Potential patients tend to have one of two ideals: The individual's own younger appearance or someone else's appearance. The ideal presented in the media is changing, making the target both difficult to achieve and difficult to catch. Here it is also possible to talk about a marketing process initiated and maintained by doctors and aesthetic medical companies at a global level. Neither the dominant logic nor the new logic of marketing can satisfactorily explain patient-consumers' behavior in this context, where boundaries for the product cannot be established and there is considerably higher risk compared to other purchasing situations. It is possible to talk about doctor branding in this context, where brand positioning and brand image cannot be static since doctors are also people. Moreover, patient satisfaction has longitudinal and interpersonal characteristics since it involves the approval of others.

Keywords: Beauty, Body, Plastic Surgery, Globalization, Service, Medicine

ÖZET

TÜRKİYE'DE YEREL VE KÜRESEL GÜZELLİK İDEALLERİNİN ARAŞTIRILMASI: PLASTİK CERRAHİ HASTALARININ VE HEKİMLERİNİN SÖYLEM VE DAVRANIŞLARI

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Tüm dünyada estetik operasyonlara olan talebin artmasından hareketle, bu çalışma, plastik cerrahiyi bir tüketim olgusu olarak ele alıp araştırmaktadır. Birinci olarak yerel ve küresel güzelliklik anlayışlarının, estetik operasyonların tüketimi ve pazarlanması yoluyla, Türkiye'de nasıl tartışıldığı incelenmektedir. İkinci olarak, cerrah ile hasta-tüketici arasında kurulan hizmet ilişkisinin özellikleri, ayrıca bu ilişkinin nasıl kurulup sürdürüldüğü incelenmektedir. Etnografik araştırma sahası olarak Gazi Üniversitesi Hastanesi seçilmiştir.

Sonuçlar güzelliğin bireyler tarafından geliştirilen, iyileştirilen ve düzeltilen bir kavram olarak algılandığını göstermektedir. Potansiyel hastalar iki tip idealden birine sahip olabilir: Bireyin kendi genç görüntüsü ya da başka birine ait görüntü. Medya tarafından lanse edilen ideal görüntü değişmektedir; bu da hedefi hem ulaşılması güç, hem de takip etmesi güç bir hale getirmektedir. Burada doktorlar ve estetik medikal şirketleri tarafından küresel düzeyde başlatılıp devam ettirilen bir pazarlama sürecinden de bahsetmek mümkündür. Ürüne ait sınırların çizilemediği ve diğer satın alma durumlarına göre çok daha fazla risk içeren bu alanda, pazarlamanın ne egemen mantığı, ne de yeni mantığı hasta-tüketicilerin davranışlarını açıklayamamaktadır. Bu alanda, doktorlar canlı varlıklar olduğu için marka konumlarındırması ve marka imajının statik olamayacağı bir çeşit doktor markalaşmasından bahsetmek de mümkündür. Ayrıca, hasta tatmini diğer kişilerin onayı ile ilişkili olduğu için, tatminin zamana bağlı ve kişilerarası özellikleri vardır.

Anahtar Kelimeler: Güzellik, Beden, Plastik Cerrahi, Küreselleşme, Hizmet, Tıp

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CHAPTER I

INTRODUCTION

Aesthetic surgery and related medical treatments have exploded in popularity over the past decade. People all around the world are having a greater number of cosmetic surgeries (Gilman 1999). Women in non-Western parts of the world are becoming obsessed with their appearances (Palmer 2005). In terms of cosmetic surgery applications, Turkish men are ahead of all European countries and the seventh in the world (Battal 2005). Medical tourism has become a big business, with various plastic surgery clinics specializing in attracting customers from around the world. Many doctors are now utilizing advertising to increase demand for their work. The examples given in the global media normalize the decision to have cosmetic surgery and present it as a socially acceptable practice.

Intrigued by these developments, this study offers an in-depth investigation of aesthetic surgery as a consumption phenomenon. Specifically,

the study examines two questions. First, it looks at how local and global notions of the beautiful are negotiated in Turkey through consumption and marketing of aesthetic operations. Second, it looks at the nature of a service relationship formed between the aesthetic surgeon and the patient-consumer, and how this relationship is constructed and maintained. The study focuses on aesthetic surgical operations involving pain, risk, and spending of time, energy, and money, and concern longer-term and deeper motivations compared to reversible beautification practices such as make-up (Warlop and Beckmann, 2001).

Globalization denotes increased interdependencies among societies due to more international trade, dissemination of technology, and intensified cultural exchange (Gilpin 1987; Albrow 1990; Harvey 1989; Robertson 1992; Waters 2002). While some authors argue that globalization is the pushing of a dominant hegemonic culture to the rest of the world (McLuhan 1964; Levitt 1983; Sklair 1991), others say globalization is the reflexive rethinking of one's own territory, so it cannot be homogenous all over the world (Appadurai 1990; Hannerz 1992; Bauman 1998; Featherstone 1995; Sassen 2001; Wilk 1995a, 1995b). There are also different accounts on how non-Western contexts adapt, change, or resist the global forces (Ger and Belk 1996; Ger 1999; Huntington 1993; Waters 2002).

Consumer culture in a globalizing world encourages people to discipline their bodies in the name of health (Featherstone 1982). Medical discourse, around the world, neutralizes requirements for a "healthy" and "fit" body, while the media reinforces this view by privileging and disseminating healthy and fit images of men and women. Accordingly, a cultural ideal, different from one's

own, may be interpreted as a look that is aesthetically pleasing (Bordo 1993; Thompson and Haytko 1997). Fashion, through fashion shows, magazines, and fashion models, influences the way people establish a standard about what is (fashionably) beautiful (Eicher and Sumberg 1995; Maynard 2004). Similarly, film industry (Mulvey 1975) and beauty pageants ((Wilk 1995a)) are contexts where ideal beauties are displayed and negotiated.

Aesthetic surgical operations are interesting because of their relationship to personal expressions and identity (Watson 1998). However, they have received scant attention in consumer behavior literature. Schouten (1991) studied different kinds of experiences people experienced before and after cosmetic surgery. Sayre (1999) studied her own motivations for undergoing a face lift. Askegaard, Gertsen, and Langer (2002) more recently studied cosmetic surgery and considered self-identity as a reflexive project. By examining the interaction of global and local forces and the nature of the service relationship, this study aims to extend knowledge on consumption and marketing of aesthetic surgeries.

The study utilized ethnographic methods. Gazi University Hospital was chosen as the ethnographic research site. I stayed in Gazi Hospital for a total duration of twelve months and participated in every stage, such as patient consultation, control visits, secretary's desk, surgeries, and patient visits after the operations, as well as weekly academic meetings in the department and other meetings in the hospital which involves all departments. The main method of data collection is a combination of in-depth interviews, projective techniques,

and systematic observation. Along with interviews, projective techniques were utilized with the intention of projecting some inner feelings (Branthwaite and Lunn 1985) and arrive at a thick description (Geertz 1973). Besides, reviews of secondary source data are conducted, along with content analyses of major newspapers and magazines throughout the years. For data analysis, the methodological logic of grounded-theory approach (Strauss and Corbin 1990) is followed. I came up with a list of codes by applying an open coding schema (Berg 1998). By making connections between themes and sub-themes, new categories were then developed beyond their intended properties and dimensions.

Results indicate that beauty is perceived as something that individuals improve, upgrade, and refine through time. This "beauty work" is triggered at some point, usually by an ideal image, by someone the patient knows, or by events and unique occasions. Patient-consumers might have conflicting thoughts and feelings during decision making process since plastic surgery is both valued and devalued in the society, so they usually "rationalize" their decision for surgery by explaining their motives in the form of a need, normality, transition towards another group, and a sense of empowerment. When they decide to go for surgery, they tend to have one of two ideals: The first one is the individual's own younger appearance and the other is someone else. The ideal presented in the media is always changing, making the target for informants both difficult to achieve and difficult to "catch". Here it is also possible to talk about a marketing process initiated and maintained by doctors

and aesthetic medical companies at a global level. Doctors share a collective pool of aesthetic surgery knowledge; and they apply these procedures to patients who seem to demand applications more and more similar each day.

Neither the dominant logic nor the new logic of marketing can satisfactorily explain patient-consumers' behavior in this context, where boundaries for the medical product cannot be established and there is considerably higher risk compared to other purchasing situations. The doctor is perceived as the key service provider; but the interaction is more "social" rather than "medical." One of the most peculiar features of doctor branding in this context is the fact that doctors are also people, so their brand positioning and brand image cannot be static. Moreover, patient satisfaction has longitudinal and interpersonal characteristics since it involves the "approval" of others, which often may occur weeks after the surgery.

Chapter Two, Three, and Four will discuss major theories of globalization, forces of globalization in the context of body-related consumption, and theories of body, especially from sociological and psychological perspectives. Chapter Five outlines the main methodological orientation. Chapter Six will present the main results in two parts: Beauty in Progress and Shopping for Beauty. Chapter Seven will discuss implications, and conclude with final remarks, limitations, and future research ideas.

CHAPTER II

GLOBALIZATION

Globalization is a term used to denote changes in societies due to more international trade and intensified cultural exchange. This results from decreased trade barriers and increased interdependencies among countries (Gilpin, 1987). A key aspect of globalization involves changes in and rapid dissemination of technology around the world (Albrow, 1997), specifically in transportation and communications, resulting in what is called “global village”. The term global village was uttered by McLuhan (1962) in his book “The Gutenberg Galaxy: The Making of Typographic Man”. What he meant by global village was how electronic mass media collapses space and time barriers in human communication, enabling people to interact and live on a global space. Space is compressed into time due to rapid technological advances such as the Internet (Harvey, 1989). *Compression* here denotes the interdependencies among different national systems, referring to an increasing level of

interdependence by way of trade, military alliance, and 'cultural imperialism' (Waters, 2002).

Robertson (1992) adds to this notion of globalization by arguing that it refers both to the compression of the world as mentioned above and the intensification of consciousness of the word as a whole. Intensification of a global consciousness relates to localization only in respective of globalization. Waters (2002) similarly argues that globalization is a social process in which people reflexively think and act, i.e. they compare themselves to economic, political, social, and cultural arrangements on a global basis. Therefore, globalization is a dialectic process (Giddens, 1990) and a social process (Waters, 2002), in which people become increasingly aware that they are receding and act accordingly. Although globalization is often defined as the spread of the Western culture across the planet, it is actually the reflexive thoughts made in reference to the Western culture. According to this view, not every corner of the world has to resemble the globalized culture; they can even be against that culture, but the process is always in reference to the West, which is termed relativization by Robertson (1992), where the results of relativization can be different for different cultures.

Although this definition of globalization as increased communication and economic and cultural exchange seems to represent a solid understanding of what globalization means, many people are more skeptical about what it means and what it brings to societies. Scholte (2000: 14) attempts to draw attention to this uncertainty by stating that "most of us are confused". Archer (1990: 14)

states that “all too often we encounter statements like globalization is the present process of becoming global. Globalization becomes a label to cover whatever strikes our fancy. Little wonder, then, that many skeptics have dismissed the emptiness of “globaloney” and “global babble”. Several critics also argue that globalization is not necessarily positive as it might lead to obliteration of cultural differences and commodified rationalization of life in which globalized products and services are automatically seen as positive and desirable (Belk, 1996). Ger and Belk (1996) argue that globalization brings division by “increasing social inequality, class polarization, consumer frustrations, stress, materialism, and threats to health and environment”.

Commodification (or commoditization) is considered to be another development that comes along with globalization, where any non-commodity can be turned into a commodity by assigning value. Different modes of commodification can be observed (Geertz, 1973) in different consumption contexts. It can even be observed in the area of one’s own body, allowing the body and self to be consumed in its strict sense. This commodification of self may lead to beauty contests, and in the extreme case, prostitution (Brannen, 1992).

As the above brief introduction to the concept of globalization implies, it is not a straightforward construct; and it is multi-dimensional, murky, amorphous, and not easily delineated. It is useful, at this point, to investigate what the “forces” of globalization are, i.e. its social and cultural elements, as well as the political, economic, and technological movements.

2.1. Forces of Globalization

The word 'global' is almost four hundred years old, and its common usage as intended here began to spread in the 1960s (Waters, 2002). Although it brings some controversial discussions as to what it means and what it brings to societies, many economists and sociologists now agree that globalization is under way. The concept has started to be discussed in academic writings only in the 1980s (Robertson, 1992), after which the usage of the term has become globalized, too. In this thesis, forces of globalization imply *both* an increasing level of business activity for global marketing *and* the uncontrollable and impersonal factors, such as the development of "Islamic fundamentalism as a response to the effects of Western modernization" (Waters, 2002: 3). However, these forces are not meant to be totally beyond human control and they are not transforming the entire world by spreading a homogenous Western culture and the values of capitalist society. Rather, these forces imply that every social arrangement in the world must establish its position in relation to the capitalist West, i.e. *relativize* itself against the Western cultures (Robertson, 1992).

The following section discusses political and economic, and then social and cultural forces in separate parts; however, they are not intended to represent independent, self-determining, and self-regulating movements. Rather, they influence each other in a continuous way, and for the most part, making it more and more difficult to distinguish one effect from the other.

2.1.1. Political and Economic Forces

Among the forces of globalization, political movements constitute an important part. The theme of 'mega-nations' has arisen, standing for relationships between nations and larger regional, supranational units (Robertson, 1992). Some empirical economists call for a triadic division of the world into Japan-centered East, Germany-centered Europe, and USA-centered West. Along with this triadic division, many accounts point to a process of states withering away, although many other accounts disagree by claiming that states and nationally organized societies still remain. Another account accepts the triadic division of the world, but furthers the discussion with the argument that each continent or subcontinent is becoming increasingly heterogeneous and complex in terms of ethnic and racial types, largely because of migration due to economic reasons, leading to the so-called 'world spaces' (Balibar, 1991).

Looking at globalization from a political perspective, one common notion conceives of globalization as internationalization. Here global refers to increasing relations between different countries and increasing amounts of exchange and interdependence among different nations. Another usage refers to globalization as liberalization, denoted by such terms as "borderless economies" (Sander, 1996), standing for the removal of government-imposed restrictions on movements between countries. A third conception equates globalization with *universalization*. In this usage, global means worldwide. Examples can be given

from the usage of the same calendar around the world or the same brands of products and services. Still another definition of globalization associates it with westernization or modernization, especially in the Americanized form (Spybey, 1996; Taylor, 2000). Globalization in this sense is sometimes described as an imperialism of McDonald's, Hollywood and CNN (Schiller, 1991). A fifth idea identifies globalization as deterritorialization (or a spread of supraterritoriality), which refers to taking control away from a territory that is already established.

Koçdemir (2002) argues that globalization is not observed in all parts of the world, therefore it is not a phenomenon that applies to each part of the world in an equal way. For example, only twenty percent of production in the world is international and only thirty percent of world population is integrated to world economy, where this integration involves only advanced economies, including OECD countries and a few more. Almost seventy percent of world trade is among the U.S., the E.U., and Japan. Therefore, not each country can be globalized as it requires minimum requirements in terms of infrastructure.

Consequently, another important aspect of globalization becomes this busy portrait of onrushing economic forces. Economic globalization can be described as the international integration of markets for goods, services, and capital (Rodrik, 1997). These economic forces demand integration and uniformity, and captivate people everywhere with fast music, fast computers, and fast food – MTV, Macintosh, and McDonald's – pressing nations into one homogenous theme park (Barber, 1996). Throughout the years, expansion of flows in the international arena and an increase in their velocity has led to what

Lash and Urry (1994) call “disorganized capitalism”. Speed and compression of space now invade cultures leading to instant consumption and flexibility in the application of labor (Waters, 2002). When we look at cultural economies, global success of Japanese companies challenged American and European domination. According to Dohse et al. (1985), important elements in Japanese organizational paradigm center on the themes of flexible specialization and accumulation. Images created by the media, as well as the viewers, cannot fit into bounds within local, national, or regional spaces (Appadurai, 2000). These forces are driven by an increasing scale of production and logic of marketization and commodification with an increase in the scale of consumption (Waters, 2002).

But this development is cultural, as well as economic, because it involves not only production but also consumption. International economic and political relations between nations are no longer the only links between societies. Economic relations should better be perceived as the social arrangements for production, exchange, distribution, and consumption. Similarly, political relations are the social arrangements for the concentration and application of power. The inter-societal linkages primarily focus on economic exchanges but also extend to tastes, fashions, and ideas (Waters, 2002). Therefore, besides the effects of political and economic aspects, social and cultural forces represent the effects created by interactions between and among societies and different groups of people from around the world.

2.1.2. Social and Cultural Forces

The expansion of the media of communication, such as the development of global television, new technologies of rapid transportation and communication, has made people all over the world more conscious of people in other places and of the world as a whole (Robertson, 1992). The 'instant' character of these new technologies raises the possibility of a general cultural shift in a globalized direction. Societies and regions become subject to cross-cutting of usually contradictory 'axes' of ethnicity and race. Social multiculturality is debated in reference to such themes as common cultures and identities; "while the theme of world order is much in the political air" (Robertson 1992: 186). This process is consolidated by global capitalism's tendency, more specifically, through the implementation of an extensive consumer culture (Featherstone, 1992; Sklair, 1991).

According to several scholars, globalization introduces a single world culture centered on consumerism, mass media, Americana, and the English language. This resembles a process of colonization of the non-Western world through the institution of new regimes of consumption. This is also termed as Coca-Colonization (Hannerz, 1992; Wagnleitner, 1994), where Coca-Cola is identified with the culture and ideals of the United States and promoted as a transcultural product. The term Coca-Colonization is used to imply the "invasion" of American values in other cultures. McDonaldization (Ritzer, 1993) and Disneyfication also refer to similar notions, where the former implies

a society with the characteristics of a fast-food restaurant (including efficiency, calculability, predictability, and control through nonhuman technology), and the latter conveys the idea that the principles of Disney theme parks are spreading throughout the world.

There are other notions which imply the similar notion of a single, homogenous world culture. For example, Americanization is another term used to denote the occupation of American cultural elements in other societies. Similarly, westernization implies a process where non-Western societies come under the influence of Western societies in several matters such as industry, lifestyle, law, language, and religion. Although westernization can be a two-way process, it is usually taken as the substitution of cultural elements in a non-Western context with the Western values and practices.

Also supportive of this position are the writings of McLuhan (1964) in global village, Levitt (1983) in global consumer demand homogenization, and Sklair (1991) in global culture-ideology of consumerism. In the words of Levitt (1983: 93), an early champion of global markets, "everywhere everything gets more and more like everything else as the world's preference structure is relentlessly homogenized". Many commentators (particularly those who conceive of globalization in terms of liberalization or westernization) have argued that the process brings a worldwide "cultural synchronization" (Hamelink, 1983; Tomlinson, 1991), where a global culture is being formed through the economic and political domination of the United States which pushes its hegemonic culture into all parts of the world. As Alden et al. (1999)

demonstrate, many brands in diverse national markets are positioned through television advertising as "signs" of membership in global consumer culture. The new communications technology is presented as producing a global *Gemeinschaft* which transcends physical space through bringing together disparate groups who unite around the common experience of television to form new communities (Meyrowitz, 1985). One problem with the homogenization thesis is that it misses the ways in which transnational corporations fit their advertising for various parts of the globe (Featherstone, 1995), where firms think globally and act locally (Ger, 1999).

Some diagnoses have linked globalization with enduring or even increased cultural diversity (Appadurai, 1990; Hannerz, 1992; Bauman, 1998). According to this perspective, there might be some convergences in the lifestyle and habitus of consumers but they are concentrated in various world cities such as New York, Tokyo, and London (Featherstone, 1995; Sassen, 2001). Appadurai (1990) argues that global situation is not singly dominated, but interactive. A single nation, such as the U.S. cannot dominate all cultural elements in the world; it is only a node in a complex transnational construction of imaginary landscapes. "The new global cultural economy has to be seen as a complex, overlapping, disjunctive order that cannot any longer be understood in terms of existing center-periphery models" (Appadurai, 1990: 50).

For Appadurai (1990), there are five dimensions of cultural flow that are navigated and negotiated by consumers: ethnoscapes, representing people who move from one place to another, technoscapes, the global configuration of

technologies and information that runs at high speeds, financescapes, the global system of financial transfers, mediascapes, the global distribution of media images and narratives, through which the audience constructs an "imagined Other", and ideoscapes, the global movement of ideologies and counter-ideologies. Appadurai (1990) stresses that through these flows globalizing and localizing processes feed and reinforce each other. These various "disjunctures" and interactions occur among different global cultural flows and provide the ways with which local cultures relate to global forces. They transcend national cultures to varying degrees. Rajagopal (2000) argues further that these flows are not neutral; rather, they involve power relations, resulting in different receptions of flows in different places. According to Rajagopal (2000), disjunctures in flows are used to the advantage of powerful parties in transnational networks.

Rejecting the notion of a single, homogenous global culture, many accounts thus support the idea that local consumptionscapes are influenced by a variety of forces in complex and multi-directional ways (Ger and Belk, 1996). Cultural artifacts, values, ideas, and aspects tend to transcend specific territorial boundaries (hence the term deterritorialization) making the global flows fundamentally in motion. Many social activities can take place irrespective of the geographical location of participants (Scholte, 1996). Television allows people to watch war news at home and the Internet allows them to communicate instantaneously with each other. Ties between cultures and places are weakening; and, in the process of globalization, cultures are simultaneously deterritorialized and reterritorialized in different parts of the world. Cultures

gain a special meaning in the new territory which they are taken into. Therefore, globalization spreads new forms of social activities without having to situate people in certain places (Scholte, 2000).

Some researchers argue for "creolization", where new meanings are assigned to new or foreign influences in the form of goods or ideas (Howes, 1996). It is the process of confluence of two or more cultures which interact in a center-periphery relationship (Hannerz, 1992). But this cultural process is not a simple pressure from the center towards the periphery, but a much more creative interplay. For example, Yoon et al. (1996) claim that individuals can be cosmopolitan (global) in one consumer domain but remain local in another. Creolization describes the cross-fertilization which takes place between different cultures when they interact. In this process, local participants select particular elements from the global culture, give different meanings, and create new forms. Appadurai (2000) gives the examples of terrorists modeling themselves as Rambo figures, housewives watching soap operas, and Muslim families listening to tapes of Islamic leaders, to demonstrate such resistance.

As Hermans and Kempen (1998) argue, there is fusion and intermixing of cultures. Sandıkcı and Ger (2002) also argue that "modernization" for consumers does not necessarily lead to global culture assimilation. It is now apparent that the notions of global and local cultures are relational (Featherstone, 1995). Echoing this position, Appadurai (1990) believes that global cultural forces tend to become indigenized in one way or another. This kind of a recontextualization of foreign goods and ideas in a mixed and complex

ways can be called hybridization (Hermans and Kempen, 1998; Pieterse, 1995). Hybridization concerns a desire to embrace elements of global culture and integrate them into the local culture (Hannerz, 2000). Hybridization can occur in art (Harvey, 1996), governance (De Rujiter, 1996), in restaurant menus (Warde, 2000), and in identities, consumer behavior, and lifestyle embodied in everyday practices (Pieterse, 2001). Pieterse (2001: 239) strongly points out that this boundary-crossing is not free for all. Hybridization involves a process of resistance and contestation where new meanings challenge the global meanings.

Taking a position in between homogeneity and various diversity perspectives discussed above, Wilk (1995a; 1995b), studying beauty pageants in Belize, was concerned with the idea of how replication of diversity can produce homogeneity. By trying to differentiate themselves from others, beauty pageants enter this structure of common difference, which is similar to the notion of global localities in Appadurai's (1990) terms. However, Wilk's (1995) notion of structure of common difference, i.e. a global network where common structures mediate among cultures, represents something more than a flow of things. "The connections between localities are created by widespread and common forms of content for the exercise of power over what to produce, consume, watch, read, and write" (Wilk, 1995a: 111). He contends further that only a few globalized systems are truly hegemonic in the sense of having been universally accepted. Globalization creates a kind of intimacy that validates the very categories of difference in dispute, i.e. structures of common difference. Perhaps another way to say this is that while different cultures continue to be quite different and

distinct, they are becoming different in very uniform ways. The new global cultural system promotes difference instead of suppressing it, but it selects the dimensions of difference. In the case of beauty pageantry, like other global competitions, standards are defined at the center (i.e. New York) rather than the periphery (i.e. Belize). Therefore, flows do not freely spring and move from one direction to another; they are affected by the powerful nodes in the network.

What does seem clear from this discussion is that it is not helpful to regard global and local as dichotomies separated in space or time. It seems that the processes of globalization and localization are inextricably bound together in the current phase (Kjelgaard and Askegaard, 2004; Askegaard and Kjelgaard, 2007). Societies might be converging in some respects (economic and technological), diverging in others (social and relational) and, in a special sense, staying the same in yet others (Baum, 1974). Besides the idea that globalization may not unify ideas and perceptions, there is also growing evidence that globalization brings resistance, selectivity, and agency in non-Western societies (Ger and Belk, 1996). In the last section, the major focus will be on how individuals experience these processes through personal consumption.

2.2. Globalization and Individual Identities

Consumption seems to be the dominant way of how everyday life is produced and reproduced for individuals (Slater, 1997). Consumer culture remains to be a

privileged medium for negotiating identity within post-traditional societies. Under consumer culture, consumption becomes the main form of self-expression and the chief source of identity (Waters, 2002). This has links to contemporary forms of consumption, and to what is perceived to be the "modern way of living". In a modern world, individuals are assumed to express their identities through consumption.

Characterizing modernity as an era of identity-crises connects to consumer culture in several ways. The modern self is required to construct a life through the exercise of (free) choice from among many alternatives. Consumer goods are part of the way in which people construct a sense of who they are, of their sense of identity through the use of symbols in consumption patterns (Kellner, 1992). It has been argued that one can feel and show different aspects of his/herself through the use of different products and services. For example, a person might communicate his/her status through the use of certain commodities; and a particular individual is a member of a particular group because he consumes particular goods (Baudrillard, 1998). Therefore, people can use consumption for having and maintaining aspects of self-concept (Hogg and Michell, 1996; Kleine et al. 1993) as well as facilitating identity change, such as discarding an aspect of identity like ethnicity (Kleine et al. 1995; Kleine and Kleine, 2000).

Symbolic meanings attached to consumption items affect modern consumers in buying different types of commodities (Bocock, 2001). This involves the purchase of goods and services not necessarily for their "use"

value, but because of the kinds of statements they make about the consumer (Howson, 2004). Indeed, consumer culture actively creates a particular kind of self and gives utmost importance to the creation and maintenance of self (Howson, 2004). Consumption is thus very much a social act where symbolic meanings, social codes and relationships, and in effect, the consumer's identity and self are produced and reproduced (Firat and Venkatesh, 1993: 235). Giddens (1991) argues that post-traditional (or modern) identity is not fixed; the individual negotiates multiple and contradictory identities each with different roles and norms.

Global processes affect the living conditions of people around the world, changing the way they live and their identities. In this sense, globalization might create new products and services, new forms of lifestyles, as well as new types of risks and vulnerabilities. People can now easily see what people in other parts of the world are doing, what they are consuming, and how they are consuming. In such a scene, none of the explanations or interpretations tells the whole story, because the phenomenon of identity politics is too complex for a simple explanation to suffice. We can, however, say that the centrifugal and fragmenting processes happen at the same time and together. Similar consumer segments created through globalization (Alden et al. 1999) together form a transnational consumer culture, which is depicted as a kind of freedom in which everyone can be a consumer (Slater, 1997). Globalization also creates, for a variety of reasons, the conditions for localization. Localization constitutes

different kinds of attempts to create bounded entities, such as countries, faith systems, cultures, or ethnicities.

The term 'glocalization', first coined by Robertson (1995), reflects the fact that globalization and localization happen simultaneously. Robertson (1992) provides a four-dimensional framework for globalization, which shows how individuals can compare themselves with respect to other people, institutions, and even ideas. The four dimensions that Robertson (1992) uses are selves, national societies, world system of societies, and humankind. In his conceptualization, individuals ('selves') interact with the other three components. For example, an individual might problematize himself/herself as an individual in the society, or relativize himself/herself as an element in the world system of all societies, or even think about himself/herself as a single yet complex identity in humankind. In an increasingly globalized world, there is a heightening of individual self-consciousness, even consciousness of globalization per se. In this respect, globalization involves the relativization of the individual with respect to what s/he sees around himself/herself. The perspective adopted in this study is similar to Robertson's view, i.e. individuals are consciously aware of their positions in the world and they are conscious of their differences with respect to other people.

Bartelson (2000) argues that after the intensification and exchange among different societies and a realization of differences, what follows is a *transformation* with changes emerging at the level of the local system. According to Featherstone and Lash (1995), these changes occur above the

heads of nation-states. In other words, 'nationally-determined' actors play a lesser role in this new world-society (Luhmann, 1997). However, these changes are not of a single type and they do not happen in the same way for each society or individual. Fragmentation is increasing (Friedman, 1995), and, as discussed above, there is creolization and hybridization of cultures, languages, and lifestyles (Ger and Belk, 1996). Therefore, realized differences are not interpreted in the same way, even for the same individual. Hybridization presumes an active consumer who negotiates his/her consumption process and imbues new, global products with localized and sometimes totally new meanings in a process of consumption creolization (Eckhardt and Mahi, 2004).

One explanation for how individuals respond to global flows is encompassed in the concept of desire. Desire is a means through which consumers fantasize, dream, and enjoy the discomfort of lacking an object (Campbell, 1987). Anything can be an object of desire and consumer desire never ends (Belk et al. 2003; Gould, 1991). Global images and depiction of foreign persona might result in consumers desiring certain products and services, as well as ideologies while consumers' tastes and preferences are also shaped by culture (Wilk, 1997). In terms of the effects of globalization, desire might have a transformative power (Belk et al. 2003), where individuals might desire a totally new self and a totally new life which shows the extremity of desire for otherness. The specific other might possess certain bodily features, like hair and skin color, body proportions, eye color, bone structure, height, weight, and so forth. The concept of desire will be discussed further in the next

chapter.

The question still remains, however, of how those who find themselves subjected to this process respond. There is not one single answer to this question; however, this thesis is an attempt to answer the question from one perspective: Body images and body practices. The next chapter describes one consumption domain, body, among many global consumption domains (including hamburgers, music, and clothing), by elaborating how forces of globalization interact with each other in the production and marketing of the notion of body.

CHAPTER III

BODY-RELATED CONSUMPTION IN A GLOBAL WORLD

Body is the physical material of a human being, which has historically been contrasted with his/her soul, personality, and behavior. It is perceived in connection with a person's appearance, which cannot be easily separated from his/her personality and other 'inner' characteristics. Variation in people's appearances is believed to be an important factor in the development of personality and the development of social relations. Some differences in appearance can be genetic, such as skin color; some are due to biological developments, such as aging or diseases; and some are due to personal adornments and irreversible, surgical interventions. Social factors in turn are believed to affect the physical appearance of a person so taking care of self through body maintenance cannot be free from social and cultural forces (Baudrilliard, 1998; Douglas and Isherwood, 2002 [1979]; Elliott, 1992; Mead, 1934). Increasingly, it cannot be separated from the global processes, too, which

affect and are affected by local notions and practices.

Body creates a vast array of consumption choices. Identity reflected in the body itself becomes a saleable commodity in modernity, creating a link among self, body, and consumption. Body becomes saleable because the image of an ideal body is largely displayed through the consumer culture (Featherstone, 1982). Images of healthy, beautiful, and young bodies illustrate all the positive attributes that anybody can and should achieve and maintain, and at the same time, reproduce ideas about what is "aesthetically normal" (Howson, 2004). People might feel rejected when their appearances do not correspond to the norms and standards that exist in their social group (DeJong, 1980). Being such an important factor in a person's development and social relations, physical appearance influences the way individuals imagine, act, and consume. Using consumption in the expression and negotiation of identities, body then becomes a site and a vehicle of self-expression and identity project (identity construction, reconstruction, and display) through a variety of techniques ranging from temporary to irreversible and dangerous, the latter being the focal point in this study. Body becomes especially interesting to study in a global marketplace because it represents a widespread issue of beauty with heavily commercial interests, where judgments of cultural value are both made and displayed.

In this chapter, relation of body to consumer behavior in a globalizing world will be discussed in further detail. Individual experiences of globalization can be reflected in the context of body. Individuals negotiate their identities

through their body-related consumption behavior in a globalizing (yet) local context. How body is used in expressing one's self will be investigated from different perspectives in Chapter Four.

3.1. Body Representation through Global Forces

This section will discuss discourses and institutional actors on global and local bodies in distinct yet, in effect, interrelated sections. The main topic is how the profession of medicine and the media, as well as the fashion industry, the film industry, and beauty contests can influence the production, marketing, and circulation of certain body images around the globe.

3.1.1. Medical Discourse

During the years before the war, in Western societies, asceticism tried to liberate the soul from its entrapment within the body. Asceticism was an early Christian term to denote practice and bodily exercise. It was an effort to achieve true perfection, gradually freeing a person's spiritual element from the body's demands. Body was seen as something threatening, something which should be governed to control irrational passions and desires.

These disciplinary practices in the Christian tradition existed to produce

the rational self, the network that Foucault (1988) has called the technologies of the self. According to Foucault (1988), there are technologies of production, technologies of signs, technologies of power, and technologies of self. Technologies of self are used to affect a certain number of operations on one's own body and soul, thoughts, and conduct by a person's own means or with the help of others, so as to transform himself/herself "to attain a certain state of happiness, purity, wisdom, perfection, or immorality" (Foucault 1988: 18).

In his other works, Foucault argues persuasively that the gradual rise of medical profession throughout Western history brought with it a different way of seeing the body. Illness was related to structural and personal spaces that individuals have. The sick other became an object to repair and modify. Under medical gaze, the birth of the clinic (Foucault, 1976) and an increase in the number of and attention given to scientific theories have led to a reduction in the power of religion to define and regulate bodies (Turner, 1982). This is often associated with secularization of social life, and with modernity (Shilling, 1993). Modernity reflects all post-medieval Western history and refers to a transition from relatively isolated local communities to a large-scale society. It is argued that the modern self is much more mobile and uncertain than the disciplined self described by Foucault (Beck, 1992; Turner, 1996).

In the nineteenth century, there have been important changes in scientific theories about nutrition. Some argue that behind the growth of nutritional science lay strong political and moral motives to regulate the working class (Crotty, 1995). By the 1880s, the scientific laws were being

applied to all living organisms, and everything started to be calculated in scientific units. There was a shift away from an eighteenth-century concern for long life as a religious value to the nineteenth-century concern for the efficient quantification of the body (Turner, 1982). The ancient moral language of diet has been transformed and replaced through time by more "neutral" and "scientific" language and nutrition (Turner 1996). In this way, medicalization won the social consent (Howson, 2004).

The expert forms of knowledge become dispersed through everyday communication and practices of both expert and lay people (Turner, 1997), where expert people set up the markers of compliance (Higgs, 1998). The result of these changes was to reify and objectify the body as an object of exact calculation. Science now regulates populations by taking a distinctive outlook on what is normal behavior within a system of *panopticism* (Foucault, 2003 [1969]). The term panopticism was used by Jeremy Pentham in 1787 in his book titled "Panoptican Prison". The idea was that a single, centered eye can observe all prisoners constantly, but the prisoners cannot see the observer. Since they are aware that someone is always watching them, they would behave like they were under continuous and relentless observation. The power of this architectural type lies in this constant existence and surveillance. Michel Foucault sees this architectural plan as an example of how electronic media monitor and follow people's behavior. Electronic inspection reduces individuals into data in the form of numbers and patterns.

Medicalization of knowledge and the associated social consent is also

and especially valid for advices about human body. As Featherstone (1982) contends, consumer culture encourages people to discipline their bodies in the name of health. One might further argue that health and beauty are very closely related; and both medicine and surgery are working for health and beauty at the same time (Gilman, 1999). The language used in ads for beauty products is quite technical and scientific (Sandıkcı, 1996), making the claims more believable. Hence the inclusion of physicians as medical authorities contributes to the "medicalization of appearance" (Sullivan, 2001).

Since body now can be measured in terms of height, weight, skin color, and proportions of body parts, it becomes easier and more feasible to communicate it globally in the form of numbers, statistical averages, and medical facts. Medical discourse is, around the world, neutralizes requirements for a "healthy" and "fit" body, while the media reinforces this view through such healthy and fit images of men and women. The next section will discuss this point further.

3.1.2. The Media

No other agent of consumer socialization has received more attention than the mass media (Moschis, 1987: 121), especially television. What appears on television, i.e. advertising and editorial or program content, provides people a certain kind of knowledge and guidance in their consumer behavior

development (O'Guinn and Shrum, 1997). It has been widely accepted throughout the years that television illustrates what products and services are available, how consumers can achieve them, how they can use them, and so forth (Goldberg et al. 1978). In other words, television is found to have a role in the construction of consumer reality (O'Guinn and Shrum, 1997).

Although a very important one with its broadcasting power, television is not the only one that is included in media discussions. There is also the print media, i.e. communication based on paper, including newspapers and magazines. Electronic media, in contrast to static media such as magazines, have the ability to utilize electronics energy for the audience to access the content. Nowadays, the most popular form of electronic media has become the Internet, a type of digital electronic media which connects worldwide, publicly accessible networks of computers that can transmit data in a second. Through advertising, one of globalization's powerful tools, one can simultaneously sense and touch events and objects that are great distances apart. With what McLuhan (1964: 185) calls "implosion", electronic communication and rapid transportation accelerate the effects of all kinds of experiences, including images of body and body maintenance activities.

Recent work shows that images and information in the media can be interpreted in multiple and different ways, shifting attention from how advertising works to how advertising creates meaning (Firat and Schultz, 1997; Schroeder and Borgerson, 2003). Consumers can construct and perform their identities and try new roles and identities in collaboration with the consumer

culture (Solomon et al. 2002). Cultural codes and consumers' background knowledge seem to affect their relationships to advertising and mass media. The effects of media are not specific to a certain geographical location, either. By its very definition, media distributes images, knowledge, and information to large quantities of people. These people do not necessarily have the same characteristics in terms of race, ethnicity, age, or gender. Media are global and they should be contextualized with larger transnational processes.

Artz (2003) argues that globalization, media, and social class provide the necessary framework for understanding contemporary international communication. He sees media and communications technology as instrumental in the globalization process. Media make it possible to increase information flow, making production, distribution, and communication of global products easier. This requires media hegemony as an institutionalized, systematic means of educating and persuading particular cultural practices. Hegemony here is not control or domination; indeed the power of media lies in its participatory effectiveness. Consumption of the media commodities is a social practice, open to interpretations, and probably used beyond the intentions of the producer.

Media also have its mass distribution capacity for products, services, images, and information related to human body. Media have the potential for affecting health behavior (Robertson and Wortzel, 1978) and they act both as information sources and socialization forces to maintain or change health- and body-related behavior. As bodies have become projects to work on, contemporary body culture has become an example of narcissistic identity

seeking (Uusitalo et al. 2003), and people now widely assume that there is a strong link between body and social status (Joy and Venkatesh, 1994).

One of the most important arguments is that the advertising system establishes, proposes, and promotes an ideal appearance both for men and women (Richins, 1991). Happiness, according to this view, is achieved by achieving that ideal. People constantly compare themselves to images presented through the advertising system and strive to attain that ideal with diet, exercise, body building, clothing, make-up, hairstyling, and even cosmetic surgery because to ignore the cultural standards of beauty is to disengage form the society (Domzal and Kernan, 1993). Culture, not nature, dictates what is attractive. Realizing this, advertisers frequently appeal to consumers' selves, linking particular looks with products and services used to achieve those appearances. The imagery created and circulated in consumer culture places a premium on youth and beauty. The closer the body is to this idealized image, the greater is its exchange value and the more that the body can be used as a resource to gain access to a higher status.

Several studies have shown that Playboy magazine centerfolds and Miss America contestants continued to decrease in body size and got thinner throughout years (for example, Garner et al. 1980; Wiseman et al. 1992). As the years progressed, women started to appear with full-body depictions instead of only their faces, and consumers have been exposed to full-body shots in major fashion magazines (Sypeck et al. 2004). Media have the potential to contribute to the development and maintenance of body image disturbance and eating

dysfunction through the conveyance of thin-oriented norms and values (Garner et al. 1980). Through repeated exposure to thin models of beauty, women become more dissatisfied with their own bodies and engage in drastic means to lose weight (Stice et al. 1994). Hence, in consumer culture, the body can be transformed into a commodity.

Bordo (1993) is one of the most insistent figures claiming the existence of one-race, one-type beauty promoted in the media. She argues that the attraction of blonde hair and blue eyes is universal. She gives the example of a contact lens advertisement. In the ad, a woman was shown in a romantic fantasy, parachuting slowly and gracefully from the heavens. Bordo (1993) finds the ad racist, leading the viewers to think about only one kind of beauty. The male voiceover describes the woman in soft, lush terms (Bordo, 1993: 251): "If I believed in angels, I'd say that's what she was – an angel, dropped from the sky like an answer to a prayer, with eyes as brown as bark." After a significant pause, "No… I don't think so." At this point, the tape would be rewound to return us to: "With eyes as violet as the colors of a child's imagination." The commercial concludes: "DuraSoft colored contact lenses. Get brown eyes a second look."

Faced with a higher number of different images in alluring representations, consumers compare their bodies to those images and realize their differences at a global level. This comparison can be in the form of evaluating the physical characteristics of the body or forming and attempting to achieve a beauty ideal as presented. When local consumers compare their

bodies to images exported from other cultures, it becomes a globalization issue. This comparison may in turn result in a change of the notion of body, such as a change from "Body is given by God" to "Body can be changed", or result in a change of the notion of beauty, such as a change from 'I am beautiful' to 'I am not as beautiful as Angelina Jolie'. These changes in consumers' minds may change their body practices, and in the end, may lead them to surgically modify their body parts. But it does not necessarily mean that they will try to achieve the one-type beauty described by Bordo (1993) as there are various ways consumers can perceive and adopt foreign material.

3.1.3. Representation of Body in Different Global Contexts

In this section, particular attention will be provided to contexts which exist, move, extend, and continue at a global level. These contexts include, among others, advertising, the fashion industry, the film industry, and beauty contests.

3.1.3.1. Advertising

Effects of the media have already been investigated above; therefore there is no need to reiterate similar arguments for the effects of advertising. It has been discussed in consumer behavior literature that visuals are very effective in

conveying information (Phillips and McQuarrie, 2003), and celebrities are very effective in communicating advertising messages. Several studies have shown that as long as the celebrity is attractive and credible, s/he does not even need to be relevant in terms of the product category in order to convince consumers (for example, Friedman and Friedman, 1979). Interested readers can see Kahle and Homer (1985) for further discussion on source attractiveness and see McCracken (1989) for further discussion on celebrity endorsement. The general conclusion from above is that the advertising system illustrates ideal images both through products and services themselves (such as diet products and make-up tools) and through perfectly beautiful models and celebrities it employs for various categories of products and services.

3.1.3.2. Fashion Industry

One can define fashion as the current mode of consumption behavior in general or in a specific context like clothing or technology (Evans, 1989). It defines the style of styles being used at the time of question by consumers of clothing, food, ornaments, mobile phones, home decoration, and so forth. It involves many concepts of marketing, such as diffusion and adoption of innovations (theorized by Rogers in 1962, see Arnould (1989) for a consumer behavior example), opinion leadership, fads versus fashion, and product life cycle. In consumer behavior, consumers are believed to be provided with a plurality of interpretive

positions through fashion discourses (Thompson and Haytko, 1997). Rather than producing a single, hegemonic outlook of Western fashion, which is characterized by rapid changes and mass consumption of goods (Davis, 1992), consumers can play with a number of creative and proactive ways, a notion that is in line with the perspective of globalization presumed in this thesis.

The relation of fashion to the concept of body and body-related consumption behavior is quite apparent in consumers' desire to change their appearances, for shorter and longer durations and with various techniques, according to what is fashionable. There are a number of alternatives to choose from at a specific point in time and these choices involve various decision areas like make-up, clothing, hair style, and, in more significant situations, body proportions, size of body parts, shape of body parts, and even skin color. Many consumers express their desire to resemble fashion models and in many cases, just to look fashionable. Even women's desire to explicitly reject fashion ideals reflects their strong personal significance that they vest in fashion discourses (Thompson and Haytko, 1997).

In a globalizing world, people may establish similar or different, and most of the time, hybrid standards of beauty for themselves. Another cultural ideal, different from their own, may be interpreted as a look that is aesthetically pleasing. This look may become so fashionable across many cultures that it might create a collective mood (Thompson and Haytko, 1997) and thus a preference for a particular style or appearance. If we apply this concept to dress, a fundamental question is whether local styles are being wiped out in favor of a

generalized Americanization of appearance (Maynard, 2004), or in favor of a world fashion or cosmopolitan fashion (Eicher and Sumberg, 1995). Fashion in this sense might create a baseline against which consumers evaluate their appearances, especially to evaluate whether they look beautiful according to standards at that time.

For example, looking at fashion magazines, it has been found that there is a gradual increase in lip prominence among models (Auger and Turley, 1999). Currently, fuller lips are considered more beautiful (Peck and Peck, 1995) and lip augmentation procedures have become common in aesthetic plastic surgery. Bisson and Grobbelaar (2004), in a more recent study, investigated the same question, i.e. aesthetic properties of models' lips, and used model images in five magazine publications, namely Cosmopolitan, Vogue, New Woman, For Him, and Glamour. They compared models and non-models in terms of relative proportions of lips and found that consumers with thinner lips demand for lip augmentation procedures and surgeries more and more.

Continuing with the same example of face profiles and lip proportions, Nguyen and Turley (1998) evaluated the facial profiles of white and African American models and their respective "normal" counterparts to address the same question. The results confirmed that the African American profile displayed in fashion magazines has changed over time towards filler lips, which coincides with changes on Caucasian faces. Yehezkel and Turley (2004) later found that these changes in lip fullness for the African American model were

greatest during the period from the 1940s to the 1970s. They claim that with cultural barriers breaking and the disintegration of segregation during the 1960s and 1970s, public began to realize that facial attractiveness might have elements from different cultures, which indicates a change in Americans' view of the beautiful African American woman, as well as an acceptance of American facial features in the African American model.

The general conclusion is that fashion, through such a large-scale medium as fashion shows and fashion magazines, and basically fashion models, influences the way people establish a standard about what is (fashionably) beautiful. The same model can appear in different contexts and can be followed by people from around the world. We see striking examples of how consumers want to look like models that they see on television or on the cover pages of fashion magazines.

3.1.3.3. Film and Music Industry

Cultural products are believed to be embedded in movies and songs as an art form and as part of popular culture also represented by plays and novels (Friedman, 1985). Film and music represent other areas where consumers in different parts of the world might be exposed to "prevailing" norms of beauty through its practitioners, i.e. movie stars, singers, and other celebrities.

Motion pictures have been conceptualized as powerful vehicles of

socializing agents for consumers (O'Guinn et al. 1985). In consumer research, many accounts investigated films as carriers of the ideology of its creators and viewers, similar to other cultural artifacts (for example, Holbrook and Grayson, 1986; Hirschman, 1988). Regarding the representation of bodies and beauty notions in movies, depiction of women as spectacle – bodies to be looked at – (Mulvey, 1975) is much pervasive in Western culture and "it finds in narrative cinema its most complex expression and widest circulation" (De Lauretis, 1984: 4). Feminist attention to stereotyped images of women made cinema, especially Hollywood, a likely target for critique because movies depict women as objects to look (Mayne, 1985).

Wooden (2003) describes how women are depicted as anorexic, not eating, and denying food consumption in some films. According to her analysis, conspicuous food consumption by women in movies signals the 'bad' or ridiculous women. Fat characters are frequently depicted with little overt sexuality (Holmlund, 2002). Other women who watch these movies read and endorse visual cues of masculine desire (Mulvey, 1975), not as simple recipients of visual suggestions for behavior, but as women who judge and who imagine themselves being judged on thinness and attractiveness (Mason, 1998). This feminist perspective has been dominant in interpreting cinema and representation of bodies. In 1990s, scholars began to focus on the male body and constructions of masculinity, where the focus was still on the body's symbolic manipulation in cinema (Addison, 2002).

Links between excessive concern over attractive, thin, and sexy bodies

and cultural products such as music and cinema have not been studied much because its effects were perceived to be limited on consumer behavior. One of the much established theories is about celebrities, and as mentioned above, their power to attract many consumers. Each movie star or singer has a unique persona (Addison, 2002), something that exists apart from any particular film or song. Spectators usually seek information about the private life of stars, and their secrets and formulas of how to be thin and attractive. Stars are featured as experts in diet menus and beauty articles. Many of the ads, magazines, and news also promote stars, instead of films or albums, creating a whole system as a complex institution. These stars can be followed on a global basis. Both stars and their spectators can be Western or non-Western, creating a global interplay at the cultural level.

3.1.3.4. Beauty Pageants

Beauty pageants are another area of a visual discourse of identity and otherness that serves as a model for the way global and local cultural institutions articulate (Wilk, 1995a). Both local and international contests are carried out in almost the same format and structure, where several beautiful contestants demonstrate their faces and bodies wearing swimsuits to a group of people who are supposed to elect the most beautiful and to an audience who watch the contest in a show format at home or in the studio. These women are then eliminated step by step,

such as by asking a few questions and allowing them to demonstrate their personal skills and abilities. One of the remaining is then selected as the most beautiful, who, depending on the format, is sent to another (international) beauty contest to represent the country.

In this election, a major part of the selection criteria involves the physical attractiveness of the candidate, including her (and for male pageants, his) body proportions and how s/he walks. The judges of the event might be singers, movie stars, previous contestants, as well as 'authorities on beauty' (Latham, 1995). Looking at "Miss America" between 1940 and 1985, Mazur (1986) concluded that the height of the winner has increased, the bust has enlarged, the hips have got narrower, the waist has got thinner, and the weight has decreased slightly. In other words, bodily ratios have been exaggerated and the proportions have been dramatized throughout the years.

Where women selected at the local level are sent to another country for another contest, a global standard may become an internalized significant other by which the local is defined and judged. Recognizing that the global contest is the one to go for, members of the jury might look for attributes that are important for the international jury. In this respect, some authors argue that worldwide beauty pageants spread the universal standard of beauty (for example, Borland, 1996; McAllister, 1996).

As Wilk (1995a) argues, pageants provide regular institutions that link small communities of competitors and supporters together into larger and larger structures reaching upwards to a global level. Differences between local and

global become different standards within a single framework. Even if the locally selected woman stays at the local level, the very fact that women are selected on the basis of their outer appearances remains the same. This is called "structures of common difference" by Wilk (1995a). For example, the contest usually begins by contestants' high-heeled attractive walk shows. The winner usually receives gifts, some cash, or some merchandise prizes. In these and various other ways, the pageant is consumed by the audience and by the participants.

Beauty contests thus become places where local and global identities are implicitly or explicitly negotiated. For example, Thoma (1999) makes a narrative analysis of a novel and a film about "Miss Philippines" annual beauty pageant and its new queen Daisy Avila. Daisy becomes the new queen in spite of various sources of resistance, protests and governmental pressure. In a way, Daisy opposes the government in her country by being selected the beauty queen on a global level. Thoma (1999: 8) contends that:

> While it is obvious that beauty pageants are a tool of patriarchy and that much of what is being sold in beauty pageants via the cosmetics, clothes, body images, and competitions is a dominant European American standard of femininity for women, Hagedorn's novel, and the actual… protest against a Miss Philippines pageant which Hagedorn fictionalizes, make it clear that such contests are as much about racialized national identity as they are about gender stereotypes.

Thoma (1999) gives examples from beauty contests, too, to reflect the nature of local-global interactions, such as an Indian pageant who desired to express a non-European American ethnicity; and another Indian who was too scared to compete against American girls. Similarly, Schackt (2005) mentions

how beauty pageantry has been troubled by a tension between a folklorist type of orientation and a more politicized one in Guatemala. Russell (2004) contends that the popularity of contests in India has explanations from globalization thesis. Actually, as the beauty pageant stepped beyond its traditional borders, some started to view its Western standards of beauty emblematic of a kind of homogenized global culture (Whalen, 2003). In India, for example, there were protests in the months leading up to the event, as many people considered Miss World as a symbol of global consumerism and an affront to Indian culture, with one person in Delphi setting himself on fire in protest of Miss World.

We can therefore say that pageants are performances of identity within received categories of culture, gender, and nation (Zizek, 1989), but they are also places where elements of physical attractiveness dominate decision criteria. Pageants in this sense become cultural sites where different notions of beauty might be contesting, and where the hegemonic parameters of a Western identity for women can be negotiated, not entirely rejected or accepted, by the participants.

3.2. Desire for Otherness

Consumer desire in general can be defined as "a passion born between consumption fantasies and social situational contexts" (Belk et al. 2003: 327). Desires are different from needs since the former cannot be anticipated,

controlled, or planned. Desire addresses the interplay of the individual and the society because it is constrained by what Foucault (1984) calls *strategies of modern governance*. Furthermore, globalization promotes consumer desire and objects of desire, making desire itself a desirable thing (Ger and Belk, 1996).

In Belk et al. (2003) study, collages from projective exercises reflected desires which emphasize exotic and luxurious travel destinations, desirable people, and passionate activities, i.e. things that several participants do not normally engage in their everyday lives. These reflect the nature of a globalizing ethos in consumption. Commonalities among the objects of desire indicate a global consumer culture with a common imagery of what can be desired, although even such commonalities are culturally contextualized. Belk et al. (2003: 335) also state that "global modernities provide the common background for different emphases in the experiences of desire, as well as different constructions of otherness and moralities". Human potential for desire is channeled into images and objects of consumption through global flows and transnational connections.

The passion for some people may be intense because the desired object may promise a total transformation, a total escape for a better life, and an "otherness" of place and time. In Belk et al. (2003) study, the Other was Western for some Turkish consumers, which is linked to these consumers' negative feelings about their current existence. Reaching the object of desire can be difficult, but that just increases the pleasure the consumer gets, as long as there is hope. Imagination of what it would be like to obtain the object of desire

already gives pleasure because feeling desire itself is an affirmation of belonging in a globalizing consumer culture. There are consumers who state their desire to be like another person, which indicates the human connections and social nature of desires.

The connection of modernity and consumer culture to body and appearance is reflected mainly in an idealized image of body, which is desired and desiring (Turner, 1996). This image of an ideal body is proclaimed as a vehicle of pleasure, which is largely displayed in consumer culture (Featherstone, 1982). Images of beautiful and young bodies illustrate what is aesthetically normal (Howson, 2004). In trying to achieve this "normal" outlook, one should forgo some of his/her bodily urges. For example, in order to be beautiful, they engage in various forms of self-control, such as exercising and dieting.

Hence, with modernity, there has been a new emphasis placed upon bodily appearance. The general view is that through new technological advances, body can be endlessly modified. This distinct emphasis on appearance created a new consciousness among people related to how one looks and how others see him/her. For Featherstone (1982), this led to comparisons made between who we are and who we might become, which stimulates desire and heightens the importance given on body work. This may even lead to the modification of inner and unconscious drives (Elliott, 1992) as the ego now is shaped by the image projected by the culture industry. Once desire if fulfilled, it loses its ability to remain as desirable and the consumer may start to have

negative feelings about the once-beloved object or state being. This might explain the motive of several consumers to change their appearances frequently and plastic surgery patients to seek one operation after another.

One of the ways of obtaining the desired state would be, therefore, changing appearances. This "permanent" escape for consumers in the case of bodily desires and an admiration of other people is made "accessible" through the media and made physically possible by advances in aesthetic and plastic surgery. This escape is exemplified by Japanese consumers having eyelid operations, black people's whitening procedures, or Chinese consumers having a nose operation to resemble a Caucasian appearance and resemble a Western outlook.

Some scholars have observed that aesthetic facial proportions are different in different cultures (for example, Sim and Chan, 2007), whereas the standard of female beauty in the U.S. was restrained by an idealized image of Anglo-Saxon women (Lakoff and Scherr, 1984). A few studies have shown that cosmetic surgery procedures for non-Anglo-Saxon Americans are often attempts to become a part of the universal white population (Haiken, 1997), i.e. make themselves look less Jewish, less Asian, or less African (Kaw, 1993). For example, among the most commonly requested surgical cosmetic procedures for Asians is eyelid surgery, with which they intend to have a double eyelid as an average Anglo-Saxon person would have (Consulting Room, 2008). Man (2006) suggests that eyelid surgery is not compared to people of Arab or African descent, who also tend to have round eyes, but usually to American or

European people. Hodgkinson (2007) suggests that some Asian patients want to change characteristic flat Asian nose to a more prominent nose. Chose et al. (2004) similarly argue that an Asian face which is found to be attractive anthropologically approaches an average white American's face. Ashikari (2005: 87) maintains that globalization seems to be spreading "an image of universal beauty based on an idealized image of Anglo-Saxons; western institutions, such as the Hollywood film industry and the European/American big brand companies, contribute to this history of celebrating whiteness".

There are other studies made on the concept of whiteness in particular. The presence of dark skin in many societies has negative associations. There is found to be a high correlation between the tone of human skin of indigenous people and the average annual ultraviolet radiation available for skin exposure where the indigenous people live (Jablonski and Chaplin, 2000). The general inference is that urban people do not have dark skin because they do not work under the sun, but rather inside the buildings. Wagatsuma (1967) observed that there was a dichotomy in Japan between 'white and beautiful' versus 'black and ugly'. It has been observed that it is not simply about beauty, but also about race. The face-whitening practice of Japanese women is a widely observed social phenomenon in contemporary Japan (Ashikari, 2005). Caucasian models appear in the Japanese mass media as symbols of 'world culture' and 'universal beauty'. White skin appears as a symbol which enables the Japanese to feel that they are part of world culture.

3.3. Aesthetic Tourism

Effects of globalization have been showing its effects on tourism as well, such as in the case of a person's body tanned in a popular tourist place, or even on a broken limb encased in a plaster of Paris (Waters, 2002). Just like an individual is defined in a national society in relation to other societies, an individual's body is also exposed to images taken from other communities around the world. At the same time, medical tourism, or health care travel, i.e. traveling outside one's own country to obtain health procedures, is on the rise. Many of the news and articles written on this issue are about the ethical concerns regarding safety of medial practices and other issues concerning the travel and recovery period. Medical providers in the U.S. maintain that such a booming enterprise encourages opportunity and invites confusion and abuse (Cortez, 2007).

Globalization can be described as the circulation of goods and services in response to criteria of efficiency. The provision of health care services in this regard is often cited as one of the most rapidly growing markets in the world. The ease of seeking medical treatment and services overseas contributes to the growing worldwide spending on health care. The rise in health care spending on a global basis is supported by the existence of a global market for international hospital chains. Planning for a medical tourism trip is similar to planning a vacation using a travel agent (Burkett, 2007). Many of the hospitals in developing countries advertise themselves as equivalent to hospitals in the United States and Western Europe, usually by being accredited by the Joint

Commission International because it suggests that the hospital has earned the same quality and reliability.

Medical tourism presents many benefits to patient-consumers. For example, due to lower costs even with the cost of travel, medical tourism provides an economic benefit. It also offers a social benefit since decisions are relatively autonomous and do not become a community affair (Forgione and Smith, 2007). Lastly, it offers a legal benefit because some clinics apply procedures that are illegal in patient-consumers' home countries, such as sex change. Further, these clinics market themselves as romantic gateways, where patients can enjoy having fun in an exotic city (Lee, 2005).

Aesthetic tourism is a special kind of medical tourism which can be described as a marketing hook for travel agencies offering traditional, overseas vacations packaged with low-cost surgical or dental care (MacIntosh, 2004). Medical tourism is especially applicable and feasible in the case of plastic surgery because it is much less costly and much more convenient in countries like India and Thailand. Regarding aesthetic and plastic surgery, tourism and news coverage in the media have increased consumers' awareness and willingness about their options abroad. It is now very popular to apply for a procedure overseas. Sometimes the whole package is customized for the individual, including the visa procedures, traveling, being picked up from the airport, having the surgery preceded or followed by a holiday at the destination. It is usually possible to talk to the doctors over the internet, request an approximate price for the total package, and ask for financing options in the

host country. International healthcare accreditation of the plastic surgery clinic or the hospital becomes a major concern for patients.

Implications of this trend in aesthetic tourism patient-consumers are quite significant. Since cosmetic surgery is elective by definition, price becomes the major selling point of cosmetic surgery tourism. Although surgery and facility qualifications may not be available, many consumers might prefer to have a cosmetic operation abroad since it is cheaper. Also, the patient can combine surgery with a holiday and have an opportunity to visit exciting places. Lastly, the consumer is able to conceive that s/he had an operation.

Chapter Four will look at theories of body from different perspectives, as well as one specific body modification technique, plastic surgery in more depth.

CHAPTER IV

BODY AND PLASTIC SURGERY

Body has been one of the most studied areas in several disciplines. Perhaps the most important move in the reassessment of the body in literature was the critique of the mind/body dualism (Cranny-Francis, 1995). The individual has been theorized as conscious for most of the twentieth century, which reinforced the positive notion of mind and the negative valuation of body. As the work of Derrida (1976) illustrated, such a dualism operates by constructing body as the negative of but a necessary precondition for the mind. Bordo (1988) argues that this dualism leads to a notion of body which is alien to the mind and the true essence of self lies in the mind. Recently, however, theorists have replaced this notion of individual consciousness with an individual who participates in or resists to discourses and material practices that constitute the everyday real. These are embodied experiences, which must include an analysis of body inscription.

One of the earliest theories about the notion of how body is constructed discursively comes from the notion of a 'normal' body. The normal body tends to be male (Bordo, 1993), middle-class, heterosexual, and from an Anglo cultural background. The discourse on normal body is a technology for maintaining the social dominance of a particular positioning (Foucault, 1988). In real life, people can enact or resist their ideological positionings (Cranny-Francis, 1995). Postmodern understanding assumes that the body becomes the real material fact and it is reflected at the outset. People construct their "real" bodies in the image of bodies they see in the media (Owens, 1983). Then comes the question of the limits on body's sensory capacities beyond what we conventionally think of as "real", which involves the discussion of cyborg bodies (Venkatesh et al. 2002). Foucault talks about an artificial world and part-machine bodies because many of us rely on prosthetics for eyes (contact lenses), teeth (porcelain teeth), breasts (silicone implants), and so forth; and because we are connected to machines for much of the time (Danaher et al. 2000).

4.1. Body-Related Behavior

To facilitate a discussion on how body can be conceptualized, a categorization of body-related behavior is made in five groups to capture Sociology or Marketing literatures. These groups are not mutually exclusive or exhaustive, but only reflect how different epistemological approaches can investigate body.

4.1.1. Body Presented within Society

Goffman's (1969) dramaturgical model emphasizes that social life is similar to theatre where we are like actors, and our performances are like acts. The idea of body as social practice is central to Goffman's (1969) and Mauss's (1979) studies. Interpretation of bodily gestures and expressions depend on a shared vocabulary of understandings of what they mean, what Goffman calls a body idiom, which denotes physical gestures and conduct that are recognizable as conventional aspects of everyday life in Western culture (Howson, 2004). Body idiom in self-presentation enables people to classify information about people's conduct. Knowledge of what bodily gestures mean in turn influences how people present themselves in social encounters, hence symbolic interactionism. According to Goffman (1969), body idiom not only highlights the importance of bodily conduct in self-presentation, but also draws attention to the way body enters into and is used as a means of categorizing people.

4.1.2. Body across Social Classes

In contemporary sociology and anthropology, centrality of the body in everyday life practices has been expressed through the work of Bourdieu (1984) in his concern for the importance of the habitus. In the work of Bourdieu, we find

particular attention given to differences in the nature of body between different social and occupational groups. For Bourdieu (1984), body has a certain cultural capital which is expressed through practices, specifically directed at the outer body. Body modification techniques and bodily consumption patterns reflect the choices of not individuals, but of social groups. According to "classified body" view, body becomes a classifier itself. The political "unhappiness" of class comes to be experienced as the "unhappiness" found within the body. The body becomes central to social classification, a notion which Durkheim agrees (Bellah, 1973). Because bodily conduct has become an important way of socially classifying individuals, people spend a lot of time, effort and money on maintaining their bodies. "Taste", "fashion", and "lifestyle" are all terms which are connected to bodily performance and which become the key sources of social differentiation (Waters, 2002). For example, Veblen (1899) noted that middle-class women enhanced the upward mobility prospects of their men in the economic expansion of industrialization by imitating the ornamental function of upper-class women.

4.1.3. Body Constrained by Social Forces

Susan Bordo (1993, 1997) with a stricter perspective argues that prescribed body customs are actually sings of internalized cultural oppression. Therefore, leaving aside those who conform to cultural dictates through diets and cosmetic

surgery, even those who resist the culture with extreme body-related acts like piercing are actually having only simple achievements because they do not attempt to change and cannot change the culture itself as a whole. This perspective can be called structuralism, where a researcher tries to discover the tacit structure that is determining individual action. In the case of body-related practices, "controlled body" view argues that an individual has no agency in his/her behavior because s/he is bound up with predetermined social and cultural rules, norms, and standards. This view posits a problem because, according to several scholars, it is reductionist in the sense that human conscious action is reduced to the effects of structures. Human agency is either minimized or ignored. This view is challenged by the 'embodied body' approach, explained later.

4.1.4. Body Disciplined in Particular Ways

This view assumes that body is a site of power and a target of discipline (Howson, 2004). It assumes that individuals' consciousness have been manipulated by the powerful sources. Here, body becomes an object of power (Foucault, 1981a), which is identified, controlled, and reproduced. Social struggles actively shape knowledge and understandings of the human body, giving rise to what we call as 'poststructuralism'. Poststructuralism rejects the view that there is one, stable system behind the individual. Foucault takes this

claim further by arguing that the human body can be understood only through the structures and discourses that produce it. There is a new form of power in modernity which targets the human body with a gentler touch, but with a wider reach (Howson, 2004). In particular, sovereign power has been replaced by disciplinary power. This term denotes the way the human body is regulated to fit the requirements of modern capitalist societies.

4.1.5. Body Embodied by Individuals

This view assumes that individuals have agency over their bodies, taking a more anthropological stance by arguing that body has been constantly and systematically produced and presented in everyday life. After the rise of phenomenology in sociology, sociologists have more readily turned for tools to examine the "lived body" as a phenomenological reality. According to this view, we are in this world and our bodies are not objects, but simply us. Perception of the world begins from the body and we develop a sense of self via actions towards others and to the environment in which we are situated. This process of action in relation to others is referred to as intercorporeality, which posits that the body image is always the effect of embodied social relations. According to the concept of intercorporeality and the perspective of phenomenology, body images are multiple and dynamic.

This embodied view of body is preferred by most researchers in feminist

and gay/lesbian areas. Both areas tend to adopt an anti-foundationalist view of the body, which emphasize the changeable and contingent characteristics of embodiment in modern societies. Davis (1995) argues that women who opt for cosmetic surgery are not blindly applying the dictates of patriarchal ideology but are actively engaging with it, being aware of its benefits and drawbacks. Some even go further to advocate plastic surgery for feminist purposes. French performance artist Orlan in 1990, for example, produced her own blueprints for the surgeon to follow in order to convert plastic surgery from a mechanism of domination to a mechanism of reinventing her own body. As well as televising the whole operation, she also revealed details through photographs and provided "souvenirs" from her operations such as blood-stained gauze, bits of her bone, and fat removed through liposuction (Negrin, 2002). Although people usually want to display their surgically altered bodies as natural and try to disguise the effects of the surgery, Balsamo (1996) visualizes a surgical operation which openly presents itself to the public.

4.2. Different Body Imaginations and Practices

It is clear from the discussion above that body can be studied from different perspectives. Assuming we are looking at body from a certain perspective, we can come up with different factors that influence the individual realization of body and its performance. These factors are discussed in this section, with the

assumption that individual bodies are linked to societal dimensions. The body as such is a biological model, which is stable, predictable, objective, and hence, self-evident (Seymour 1998). But we cannot ignore the fact that even those biological states and acts are linked to values, norms, and any other collective sets of beliefs and practices.

There is growing consensus that body image, among other things, is highly shaped by social and cultural influences (Sullivan, 2001). Several definitions and categorizations of appearance and attractiveness are dependent on social contexts (Howson, 2004). Many studies point to the fact that radical changes of the body are highly interrelated with activities and ideologies in a broad range of social spheres. The effects of society are also evident in the fact that although ageing is totally biological and natural, people may try to mask, or masquerade (Biggs, 1993), their age by using cosmetics and clothes.

Clothing is one domain which is influenced to a great extent from culture. As one goes from Congo, represented as nature by Friedman (1994), to Paris represented as culture, s/he can observe how the rank order of dress differentiates. Each community develops its own way of shaping and marking individual bodies to indicate status changes or demonstrate social value (Falk, 1995). Paints, for example, are used in many cultures to communicate status through bodies but patterns and permanency of the paints vary widely across different cultures. For example, piercing in the West is a way of self-expression, while it denotes social traditions and rites of passage in non-Western societies (Howson, 2004). While it is “in” to be cut among gay circles in Germany, it is

"in" to be uncut in gay circles in New York City. These cultural differences are not static; and they change from one place to another and through time within the same location.

Many terms associated with consumption have become the basis for social differentiation (Bourdieu, 1984; Waters, 2002). A particular person is perceived to be a member of a certain group because s/he consumes particular products, and, equally, a consumer consumes particular products as s/he is a member of a certain group. This is the kind of reflexivity that Mead (1934) was referring to: The consumer is aware of himself/herself as against some others in his/her community. The self becomes most easily expressible when the person can associate himself/herself within a certain group. Similarly, models of competition draw attention to social dynamics, such as in "keeping up with the Joneses" (Douglas and Isherwood, 2002 [1979]) referring to a desire to imitate and stay better than our neighbors. Besides competition, there are models of conformity – it is not just any goods and services that we consume; they have some meaning with regard to a system of values (Baudrilliard, 1998). This strong relationship between group membership and consumption is highly evident in body-related behavior. The aesthetic impulse encouraged by consumer culture to construct identities by way of modifying the surface body is termed as "transvaluation" by Featherstone (1982), and such transvaluation also provides strong markers of social differences.

One of the "groups" that mark social differences has been theorized to be the sex and gender of a person. When we look at people around us, we can

discern their sex from their appearances, such as from their body size and shape, clothes, facial gestures, and body gestures (Howson, 2004). Once we decide that the person is a man or a woman by looking at his/her body (sex), consciously or not, we start to make expectations about his/her social roles (gender). For example, the "givenness" of the female body as weaker than the male body was used as evidence of women's inferiority in other areas (Howson, 2004). One of the most crucial indications for emphasis on female bodies is the gender-specific nature of anorexia. Anorexia, an eating disorder, is clinically almost entirely an illness specific to women (Turner, 1996). Women, according to traditional, anti-feminist thought, are inferior to rational men because they are objects, rather than subjects (Turner 1996), specifically, objects of the male gaze (Mulvey, 1975). This is evident in Berger's (1972: 48) observation that "Men act and women appear".

Second-wave feminism has challenged this construction of female body and called attention to women's embodied experiences. It is argued that sexual liberation, gay movements, feminist movements, associated with changes in laws regulating sex-related behavior have blurred differences between male and female identities. Butler (1993) discusses the concepts of sex and gender, and argues that body has a history of being affected by sexual difference and has not escaped the effects of sexism. She feels that norms materialize bodies in the sense that bodies are animated or contoured by norms.

According to several scholars, such as Turner (1996), this time, women have become the objects of consumerism as the beauty myth continues to live

by making women constantly monitor themselves and repair the flawed parts of their bodies (Howson, 2004). This myth actually shapes, reproduces, and intensifies what Ferguson (1983) calls the "cult of femininity". On the other hand, men became as much part of consumerism as women (Bocock, 2001). They, too, are now addressed as consumers of grooming, clothing, and accessory products. Men are also exposed to information and advice on how to make their bodies bigger and more muscular through diet, exercise, and cosmetic surgery (Sullivan, 2001). The term "metrosexuality" denotes a recent movement among men, including "real" men, bestowing their appearance as important as women's. Many men today are willing to shave unwanted hair, shape bodies, style eyebrows, wear make-up, get manicure and pedicure, and so on. What is different in advertising for appearance-related men products is that the gaze is also male, fostering more open eroticism and male narcissism (Mort, 1988).

Even if the gender gap for cosmetic surgery seems to be closing, aesthetic procedures are still associated with vanity, which is historically tied to women. A man who undergoes cosmetic surgery can be condemned as feminized. Hegemonic masculinity may still be prevalent, which favors heterosexuality over homosexuality. It privileges a certain kind of male body, which is muscular. This image of a "real man" influences self-identity of men and shapes their bodily conduct (Connell, 1995).

Preceding sections in this chapter discussed how body can be studied from different perspectives and the types of factors that could possibly affect

body imaginations and practices. However, there are many accounts which state that adornment, scarification, and body painting have their origins not necessarily in today's 'modern' societies but in the past or in tribal societies. From the time of the Ancient Greeks in the fifth century BC, the human form and appearance have been considered as important. Therefore, what is the historical process that brought us to the picture drawn in Chapter Three, where consumption was presumed to help consumers build and maintain their identities and where body came into play with an emphasis on ideal images?

4.3. Evolution of Contemporary Body

One of the first theories of beauty can be found in the works of early Greek philosophers who saw a strong connection between Mathematics and beauty. Specifically, philosophers argued that objects, including human body parts, are more attractive if they are proportioned according to the 'golden ratio'. This ratio appears almost everywhere in nature, including the basic geometric shapes, in leaf arrangements, in the spiral of seashells, and even in the spiral of DNA (Bashour, 2006). The ratio is actually the Phi ratio, which has been found in the faces and figures of statutes dating from ancient Egyptian and Greek periods. Marquardt (1997) theorizes that a prototypical face can be built entirely using the Phi ratio; and the so-called Marquardt mask is based on this ratio used for different areas of human face. A face that fits this mask is considered to be

beautiful.

History is full of examples where people living in ancient times were interested in beauty and tried to change their appearances. The first tattooed man was discovered on a mountain between Austria and Italy, at an approximate age of 5,000 years old. Primitive people found fat women more attractive and they treated the beauty of brides by sheer bulk. Moulding of skull and flattening a baby's hat by using trap-like cradles with two wooden boards were common among Mayan society. A Congo woman with a long and thin head was considered very beautiful. Chad women stretched their lips by using metal rings since their childhood. The women of Georgian high society looked beautiful only in their satins and silks, with their false teeth and false hair. Victorian females were wearing corsets to make their bodies have an unnatural hour-glass shape. A very small dainty foot was considered essential to make a Chinese woman eligible for marriage.

In other words, every historical era and each culture has its own ideas about eye-appeal (Eco, 2004), or about what is seen as beautiful. According to Duden (1991), historical conditions that shaped our 'modern' body perception did not emerge until the second half of the eighteenth century. Toward the end of the eighteenth century, the modern body was created as the effect and object of medical examination. As mentioned in Chapter Three, Foucault (1988) has described the discovery of a biological entity, body, as a unique creation arising from the interplay between the "medical gaze" and the material it examined and fabricated. The body was passive because it was medically examined, but it also

had the power to create new realities and constitute new objects because the gaze of the doctor was like a dissection and the sick patient was being treated in a way that had been conceivable only with dead bodies before.

This gaze turned the body and the patient into a new kind of discrete object. But the modern body was not only the result of developments in medicine. The modern body is also consistent with other aspects of the modern image of a man or woman (Duden, 1991). New medical insights contributed indirectly to the creation of a new physical-moral economy of the body in close interaction with social patterns. For example, what one eats, how one sleeps, how one rests, cleanses and dresses were all arranged from a clinical perspective and these studies were revealing the ways the physical and cultural environment could affect organisms (Jordanova, 1979). The doctor was helping people in cases of illness, but the individual was responsible to observe the 'non-naturals' himself/herself and arrange his/her life accordingly. These new rituals of a clean body and clean home became rituals of demarcation (Davidoff, 1979), where the new body assumed a central place in the self-image of the bourgeois classes. Therefore, the old body was replaced by a 'disciplined body' (see Foucault below), around which a new kind of society could be constructed. From the end of the eighteenth century, the body was used in new ways for the purposes of social stratification (such as men against women or rich against poor).

At the same time, body was acquired through descriptions, drawings, instructions, and exercises. These separate textual layers have been learned by

children, where variant body images of different origins and differences in male and female bodies disappeared in a homogenous model (Joffe, 1948). Individuals could not find a way to express their personal body realities with these models. The power of medical gaze made individuals adhere to scientific rules; and thus the homogenizing forces of medicine made individuals express themselves only through clothing and other bodily practices, which would later involve cosmetic procedures and surgical applications. The modern body then has been created through the symbolic effectiveness of the nineteenth- and twentieth-century medical and hygienic practices.

Foucault (1981b) claims that the self is not natural. We construct our identities through the things that we do. We are thus products of discourses and power relations, and we take on different characteristics according to the range of subject positions that are possible in our socio-historical context (Danaher et al. 2000). The 'discursive norms' classify subjects according to their practices, and according to what they do with their bodies. These norms also depend on a series of coercive technologies and practices which ensure that only particular kinds of individuals are named as 'normal'. These technologies are called 'technologies of self', as explained in Chapter Three.

Starting with the nineteenth century, body styles started to shift faddishly every few decades and there was a growing passion for slimness (Stearns, 1997). The systematic concern about dieting was an important change in middle-class life, too, particularly for women but across the gender divine as well. Conflicting signals emerged from the world of fashion as the concern

about fat began to emerge in the 1890s, which is not surprising given its previous delight in plumpness. For example, upper class women were still trying to pad their clothes in 1895 to look more substantial than they were which has changed after thinness has gained popularity.

During the nineteenth century, further industrialization, urbanization, higher living standards, and an advance of rationality at the expense of mystic and religion ultimately resulted in an enhanced evaluation of beauty as an autonomous characteristic (Marwick, 1988). By the Victorian Era, several types of self-remedies for body and skin care were well-known and started to be distributed as recipes. The market began to expand partly due to the availability of drug stores and wholesalers. The 'natural' appearance started to be regulated (Black, 2004); for example, women started to use skin lighteners to present an appearance which signified a number of things, such as lack of physical labor and racial boundaries.

A French publication, *The Beauty Industry,* published in 1930, celebrated the achievements made by institutes of beauty since the first one had been founded in 1895. The book pointed out that the success of feminism has increased, rather than decreased the demand for beauty practices. An increasing number of advertisements began to appear for men, too. Everywhere there started to be an emphasis placed on exercise and physical culture. Many parts of the society started to embrace the importance given to beauty and physical appearance. Appearance of movie stars and singers were followed by close scrutiny (Marwick, 1988).

The contemporary beauty industry and commercialization of the modern body thus have their roots in the mid-twentieth century from which time we can trace advertising aimed at women and men (Black, 2004). Twentieth century encouraged a greater appreciation of human physical beauty with many social and technological changes. It is often claimed that the cultural norms of Western society were thoroughly American by the 1950s. Cultural transformations and flows, especially starting with the 1960s, became international (Marwick, 1988). It is this latter part of the twentieth century when the image of an ideal body is presented in consumer culture as desirable (Featherstone, 1982). Faced with a greater number of different images in more effective ways, in the global world, consumers now compare their bodies to those images and realize their differences.

The next section will focus on one area of body modification, surgical operations, and discuss it from different perspectives.

4.4. Surgical Operations and Plastic Surgery

The permanent alteration of the body is an extreme form of consumption. Body alteration is a catalyst to bring body in line with ideals. These (partially) irreversible operations are interesting because of their relationship to personal expressions and identity (Watson, 1998). They are used as a vehicle for human expression (Velliquette et al. 1998), but they are part of a domain larger than

temporary adornment (Rubin, 1988). The voluntary nature of these acts makes their consumption a more interesting issue because when one exerts control over something it becomes part of his/her self (Belk, 1988). Even a face lift, whose permanence diminishes as the person continues to age, lasts for seven to ten years (Meisler, 2000). Permanent decorative forms are associated with more enduring constructs like gender, group affiliations, and cultural norms and notions of beauty (Sanders, 1988). The name 'irreversible operations' were mentioned by Warlop and Beckmann (2001), but a systematic research has not been done on this category of consumer behavior.

Distinguishing from these reversible operations, irreversible operations (such as plastic surgery, teeth operations, eye laser operations, and permanent cosmetics operations) involve pain, risk, and spending of time, energy, and money, and concern longer-term and deeper motivations. These operations are considered irreversible, because they will change the body for longer durations compared to clothing and cosmetics use, and because the person's intention is to retain the modification for a longer time period. Nonpermanent forms are associated with specific social situations and stages in self-development. That is why a person who regrets what s/he has done to his/her body has to readjust his/her perceptions in order to regain psychological comfort (Sanders, 1985). Therefore irreversible operations involve a high degree of cognitive dissonance.

Most of these irreversible operations are carried out under anesthesia; therefore, they are also surgical operations. The two terms 'irreversible' and 'surgical' will be used interchangeably. In this thesis, one type of surgical

operations will be studied in full depth, which is plastic or aesthetic surgery, which denotes the application of surgical techniques to make body more in line with prevailing cultural standards or normal or attractive.

4.4.1. Plastic Surgery

The word plastic comes from the Greek *plastikos* which means to shape or to form. Cosmetic surgery, also referred to as plastic surgery, and rarely as aesthetic surgery, refer to surgical operations changing, transforming, reconstructing, and shaping the body, and adding or removing parts or organs of the body for aesthetic purposes. It includes operations on the face (such as cheek implants, chin augmentation, fat injections, ear pinback, eyelid tightening, face-lift, forehead lift, hair transplantation, nose job, scar revision, removal of birthmarks, scar tissue, and skin resurfacing) and operations on other parts of the body (such as arm lift, breast augmentation, breast implant removal, breast reduction, breast tightening, buttock-lift and thigh-lift, calf and other implants, foreskin reconstitution, liposuction, male breast reduction and enlargement, penile enlargement and implants, transgender surgery, and tummy tuck). In order to understand how plastic surgery evolved into its current situation, it is necessary to have a historical account of its development.

In ancient times, *The Sushruta Samhita*, written in approximately 600 BCE has the oldest known written account of nose reconstruction (Brown,

1986). The technique was quite primitive. In the 15th century, Serafeddin Sabuncuoglu authored the first known surgical textbook in the Turkish-Islamic literature (Dogan et al. 1997), in a period when the Catholic Church opposed operations on body on the grounds they interfered with Divine Will. During Renaissance time, the "Italian method", developed by Tagliozzi, was being used, though it was very grueling for the doctor and the patient. Patients had to endure several procedures on their bodies without anesthesia. For example, they had to immobilize their arms over their heads for many weeks to make the skin cut from the upper arms remain attached to the blood supply in the arm. In 1816, a German professor of surgery, Von Graefe, came up with the "German method" by combining the first three of Tagliozzi's steps to make a nose. By some authors, both Graefe and Tagliozzi are considered as the founders of modern plastic surgery because of the breadth of their reconstructive and cosmetic work (Sullivan, 2001; Rogers, 1988). There is also Dieffenbach with his "Indian method" (Sullivan, 2001). He is most famous for nose reconstruction in severely damaged faces. He constructed a complete nose on the patient's arm in a period of six weeks, then transferred it to the nose area, and immobilized the arm for two weeks, a shorter period than the Italian method. Still, during the eighteenth century, most practitioners did not professionalize on cosmetic surgery.

All efforts have been enhanced by the introduction of anesthesia and antiseptic techniques in the latter part of the nineteenth century. After the World War I, cosmetic surgery gained more respect and doctors have begun to

professionalize, specialize, and organize. The World War resulted in many people harshly damaged on their faces and on various body parts. The solution was to reconstruct the problematic area. Surgeries for more "aesthetic" purposes were usually done on noses, mostly by using Dieffenbach's method, to build up the "saddle noses" (Rogers, 1976). After the turn of the twentieth century, several methods have been developed, along with their own special problems. Technology has advanced to much higher levels compared to previous centuries.

The culture of plastic surgery has been changing, too. Good looks, rather than good works became the growing concern for adolescent girls (Brumberg, 1997) and a more secular consumer culture eroded the earliest negative perceptions about cosmetic surgery. Most cosmetic surgery in the first few decades of the twentieth century however were not done by respected doctors with formal training and experience in reconstructive and cosmetic surgery. It was done by "beauty doctors", many of which are deemed to be self-proud "quacks" (Sullivan, 2001), such as Charles Miller. While others talked about imperfections and corrections, Miller defined these body-related problems as deformities which have to be fixed. He even suggested that those deformities like wrinkles were more troublesome for women than the loss of a leg. John Taylor was another "quack", for example, in Edinburgh, who tried to remove scar tissue from the lower lid of a burn victim's eye. The pain was hurting, and the patient repeatedly shouted, "You hurt me, you hurt me!" to which Taylor replied, "Remember, Lady, Beauty! Beauty!" (Sullivan, 2001). In today's world

of advanced surgical techniques and a culture of people who are deemed to be more appearance-savvy, several surgeons are still considered as quacks.

Overall, between the world wars, the message about cosmetic surgery in the media was more complex but more tolerant. There was also a schism between those who accept cosmetic surgery as an academic field and those who do not. In later years, several small societies of cosmetic surgery practitioners were formed. Several significant developments in cosmetic surgery took place, especially after the 1950's. For example, breast augmentation was revolutionarized with the introduction of silicone breast implants. There have been numerous other cosmetic innovations, some of which still remain controversial.

Plastic surgery continues to grow at a rapid pace. There are numerous techniques and tools for innovative ways of modifying the body. One big controversy is in whether and how plastic surgery is different from other surgical operations on the human body. The distinction here is between "reconstructive" and "aesthetic" procedures, which is a blurry distinction (Gilman, 1999). The "father of plastic surgery", Dieffenbach, draws a line between a procedure having a real medical as opposed to an aesthetic function. Almost none of the insurance companies cover cosmetic surgery, just because of the fact that it is not critical for the survival of the "patient". Such surgery is elective by definition and aesthetic surgery patients are not really sick. Accordingly, one of the labels for cosmetic surgery in the society is that it is unnecessary, nonmedical, and that it is a sign of vanity. Reconstructive surgery

on the other hand is necessary as it restores a necessary function of the human body. Reconstructive surgery can be used following traumas, injuries, infections, tumors, birth defects, developmental problems, such as skin cancer or breast cancer. The goal in cosmetic surgery usually is to make the patient's appearance closer to the current ideal (Sullivan, 2001).

4.4.2. General Motives behind Plastic Surgery

The most general motivation for undergoing plastic surgery might be related to the individual's notion of his/her self. In general, one can argue that only appearance-savvy people would think about permanently altering his/her body (Meisler, 2000; Wan et al. 2001). According to Higgins' (1987) self discrepancy theory, our sense of self motivates our behavior by calling attention to such differences between who we are, who we would like to be, and how we think others see us. These discrepancies can lead us to feel depression, frustration, and guilt, but can also lead us to dream, imagine, and visualize. Moreover, different cultures have different values and norms which people feel obliged to, leading to different possible selves. The following grouping of motivations is not exhaustive and one can decide to commit irreversible operations for a combination of the reasons discussed below. These motives are derived from Sociology and Marketing literatures, although they may not represent the whole area.

4.4.2.1. Need

Many people who go through plastic surgery explain their motives in the form of a "need". There have been remarkable examples in history where the motive was considered to be a need because the reason was to make the body part function as before. For example, in the 1930s, Mussolini (1883-1945) ordered all officers over forty years of age to have an eyelid operation as he believed dropping upper lids impaired vision (Gilman, 1999). Reconstructive surgery usually is aimed at making a body part function properly, although the line between reconstructive and aesthetic surgery is blurred. Still many women's rationale for surgery is based on the fact that presentation and appearance can be crucial for their success at work, hence they "need" to look their best (Howson, 2004). In order to get rid of the unhealthy look due to imperfections on their bodies, people decide to change their body parts, such as teeth or eyes, to be a member of the healthy-looking and "employable" people.

By reducing a woman's breast size, aesthetic surgery can relieve stress on the woman's back muscles, but it also is supposed to boost her self-esteem. Therefore, it remains very difficult to find a point where the "real" need stops and the need to feel better starts. "Pathological" breast size and the acceptable aesthetic dimension were historically connected from the very beginning (Gilman, 1999). Whether or not vanity is a character flaw, the body-related problem can be the very center of the person's unhappiness, creating a "real"

need, and turning the person into a "real" patient. Some physicians even elaborate that these operations should be the facilitator of change rather than a basic change in the person's personality (Sullivan, 2001). Many people are said to lose their self-esteem and self-respect as they become obsessed for what they consider to be flaws on their bodies. People handle challenges to one aspect of the self by bolstering the self in another domain ("I am not smart but I may look nice"). This process is called compensatory self-inflation (Greenberg and Pyszczynski, 1985) or self-affirmation (Steele and Liu, 1983).

Needs can be diffuse and innate, but motives are more specific and learned (Markus and Wurf, 1987). Hence a man or a woman might be in need of intimacy, which is something internal (Murray, 1938), but s/he may or may not be motivated to have an aesthetic operation within a certain culture. Therefore, the progress from needs to motives, if at all, is not linear and automatic. A person who is in need of intimacy will not necessarily commit surgery. What interfere are the values, which are conscious and directly related to the behaviors people choose to do (McClelland, 1985). Using Foucault's (1981b) terminology, some people may find it "unethical" to commit surgery just to be more attractive. Most simply therefore, whether the person believes the specific operation is an acceptable choice or not will be one of the factors affecting his/her choice. This belief is affected by what is accepted to be 'normal' in the society s/he lives in, discussed next.

4.4.2.2. Normality

Sometimes the perceived flaw may involve a set if biases in the society. People may be stigmatized, i.e. assigned a marginal social status and excluded from full social acceptance (Howson, 2004). Failure to reflect the cultural embeddedness on our outward appearance and to modify it in pursuit of social and cultural beauty norms may result in various forms of social stigma and exclusion. For example, ageing women or obese men may be particularly vulnerable to discrimination in the society, making cosmetic surgery a quick way to fade out the stigma. An ancient but still vital link associates ugliness with bad character. Therefore, plastic surgery appears as an efficient way to get rid of the problem of social exclusion.

As stigmatization is about the norms that exist in the society, hence the word *norm-al*, the motivation behind such operations is to be normal, just like the other people on the street. It is about getting rid of a negative self that is devalued in the society (Banister and Hogg, 2001). Becoming invisible, seen but not seen, is the desire of the patient in this case. The greatest increase in the growth of nose surgery in the U.S. was in the 1940s, at a time when awareness of the dangers of being seen as a Jew was at its peak (Gilman, 1999). As another example, men are not supposed to have breasts “normally”. That is perhaps why a high percentage of breast reductions were done on men, as well as women.

The motivation to be normal can be explained by what Krueger (2002) calls introjection, the process whereby “people strategically align their own

responses with what they perceive to be the majority response" (Onotaro and Turner, 2004). There is also a process called projection, whereby people assume that others share their preferences, attitudes, and behaviors. When people feel that their preferences are not shared by others, they will possibly align their own situation to what others feel like normal. Normal for Turkish citizens, in the context of globalization, might relate to Western Europe or the U.S. (Fehervary, 2002), a point which will be explored further in the analysis part.

4.4.2.3. Ideal

While normal or average appearances (like the ones on the street) can be judged to be attractive, appearances judged to be exceptionally attractive are not necessarily average. If that appearance is what the person thinks is the ideal in a specific social context, then it most likely becomes his/her ideal, too. For example, the ideal male has a strong jaw and prominent eyebrow ridges, characteristics associated with male sex hormones and strength (Sullivan, 2001). The ideal female, on the other hand, has a higher forehead, smaller nose, fuller lips, and a smaller jaw, characteristics associated with youth and potential fertility. The female ideal, as embodied in 'Miss America' has become thinner throughout the years. Contemporary Westernized ideal of femininity stresses that the female body should be thin and firm, and skin must be smooth (Bartky, 1988). Being that much beautiful also has connotations with being erotic,

making the body both desiring and desired. The distance between the subject (the person) and the object (the ideal) is considered by Simmel (1978) to represent desire. We desire objects if they are not immediately available, as discussed in Chapter Three.

The discrepancy between different selves might lead to different types of discomfort (Markus and Wurf, 1987); for example, a discrepancy between actual and ideal selves is associated with depression (Higgins et al. 1985). If the discomfort is too high, the person might feel the need to have an operation. In consumer culture, the emphasis is on transforming the outer appearance of the body in pursuit of an idealized form. Consumer culture offers the perspective that the person can be modified towards the ideal. Hence operations' obvious attraction is in their potential to modify appearance to more closely approximate the current ideal. Although many breast augmentation patients were found to be motivated by their self-feelings about their breasts (Didie and Sarwer, 2003), their "self-feelings" are not isolated from what is appreciated in a society.

4.4.2.4. Passing

Besides willingness to be like others and to resemble the ideal, there is also the motive to "pass" to another category or group. By crossing the boundaries between groups, a person might become a member of another, or preferably, the desired group, where the surgeon can enable the patient to pass. This change is

not a quick, simple passage from one category to another, but a transition and a slow transformation of the individual.

Decisive categories of inclusion and exclusion are evident in historical examples. The nineteenth-century Jew wished to be a "German" assuming that "German" was a real category in nature rather than a social construct (Gilman, 1999). There has been a common theme in post-war novels and films that Nazi leaders disappeared by having their faces rebuilt so that they could pass, often as the sufferers. Some of the Asian-Americans seek cosmetic surgery in order to appear less Asian. Transition is thus moving into and becoming visible within the desired group, such as Americans, as opposed to becoming invisible among others in the group which the person already belongs to. So passing is not vanishing but merging with a very visible group. Multiple surgeries in this context may not be necessarily a sign of neurosis, but an indicator of the degree of transformation needed by the patient to pass. Cosmetic surgery can be a means of achieving upward social mobility, too (Gilman, 1999). It has been found that the motivation for cosmetic surgery among Asian American women was to improve social status, not mental health. Economic and social status of a certain group of people may trigger such a process in lower-level social classes.

One of the most visible changes in this category would be transgender surgeries, where a man can become a woman and vice versa. Cosmetic surgery enables the individual to pass into other cohorts, such as from male to female or from female to male. Transgendering is also associated with stigmas in the society as gay men and lesbians continue to experience discrimination (Evans,

1993). Miscategorization based on mere observation sometimes occurs, and there are many instances in which "corrective" surgery are requested to align the physical body with what the patient feels, i.e. the sex with the gender. Surgery is a real option for those who feel that they inhabit the wrong body. Transgendering or changing the sex of the individual involves many stages. For those who are referred to as "male femalers", this involves replacing the penis with the vagina, constructing breasts where none existed, and so on. For "female malers", the process involves removing breasts and having a penis through surgery. In such cases, the boundary between male and female is not only constructed but also reconstructed through surgery.

4.4.2.5. Rebellion and Control

Still another motivation for having a plastic surgery operation is the felt need to liberate oneself from social and cultural pressures. In general, as Mead (1934) argues, we want to distinguish ourselves from other people. There should be ways that the individual can express himself/herself, do something in his/her own, and take responsibility over that action.

Body is a good place for such individual expression as it is unique to the individual. Bodily practices offer a way to signal discontent with the modern social order and to confront categorical distinctions between normal and deviant. Those operations provide a means for the individual to transform

his/her appearance into something marginal, hence not normal. Compared to those who wish to be like the others, there are those who wish to be not like the others. This motive is what can be called "positive liberty" (Gilman, 1999) as these people liberate themselves and wish to be different from the rest. People who customize their bodies in extreme ways are not only rebelling against social constraints, but also trying to establish autonomy and reclaim control over their bodies (Sullivan, 2001).

One of the remaining motives for plastic surgery is thus to have control over what is happening to oneself. For example, all the motives that we discussed so far can be initiated by the individual's desire to control. Many people might be motivated by difference, discontinuity, and change, yet some people may want to remain the same. Therefore, providing a sense of continuity is another desire which is triggered by this sense of control. Eye laser operations, renewing teeth, and anti-ageing cosmetic surgery are all ways of controlling the change of body through time.

4.4.2.6. Plastic Surgery as Gift

Recent trends in plastic surgery coupled with increased availability and ease of payment, made surgery an attractive gift option for many people. Both in Turkey and in other parts of the modern world, plastic surgery has started to be given as gifts to young girls if they can pass their classes, as well as to wives

and lovers as anniversary and valentines gifts. Celebrities are offered different forms of plastic surgery for free if they accept to promote the surgeon's name. However, plastic surgery as gift does not automatically mean a self-motivated, well-informed person who needs plastic surgery to boost self-esteem, correct a bodily flaw, or make appearance more attractive.

4.4.3. Plastic Surgery Today

Today, technology for aesthetic surgery is much more advanced, coupled with changes in how doctors "market" their work. Full-service marketing companies offer public relations and advertising services for plastic surgeons (Sullivan, 2001). They can train staff, develop marketing plans, coach the physician for media appearances, track results, and conduct satisfaction surveys. The most common practice in cosmetic surgery ads is to have a picture of the physician, usually male, along with a picture of the actual patient, usually female. Almost none of the ads contain information about the costs or risks involved. Messages typically stress the ease of operations, the innovations (e.g. "Liposuction: A New Body Overnite") or the dominant cultural values (e.g. "All Limitations are Self-Imposed"). The patients pictured are typically Anglo females, except in hair loss treatment ads. Most usually, the ad contains the idea that the cost of plastic surgery is within the reach of middle-class individuals.

As discussed before, themes about physical appearance, beauty, sexual

appeal, and youth, as well as power and control, are presented as achieved rather than ascribed characteristics in the media (Bordo, 1993; Sullivan, 2001). Possibilities for bad results, health risks, and costs are downplayed. According to studies, fifty percent of people learn about cosmetic surgery from television and magazines (Agarwal, 2004). The tone of most articles and ads about plastic surgery is positive and sometimes lighthearted. None of them makes a promise that it will improve the person's life, solve his/her personal problems, or make the person reach his/her family or career goals. Yet some of them suggest that it can make a difference by giving examples from former patients who had undergone plastic surgery and improved parts of their lives. The examples and statistics given in media sources normalize the decision to have cosmetic surgery and present it as a socially acceptable way to change bodily appearance. No longer are patients only stars or the economically rich people; rather, young people or people with limited resources can also think about cosmetic surgery as an option to be more attractive.

CHAPTER V

METHODOLOGY

This study explores how notions and practices of body are created, recontextualized, and reflected in Turkey through the use of various types of aesthetic surgeries. Qualitative research methods suit better for this research because the aim is to understand experiences of patient-consumers who go through a cosmetic surgical operation, as well as experiences of aesthetic surgeons who perform these operations. The study aims to explore subjective meanings of "producers" (physicians, aesthetical medical companies, and the media) and "consumers" (patients and non-patients) who engage in different thoughts, feelings, and practices involving body-related behavior, surgeries, media applications, beautification rituals, and so forth. In other words, it would be impossible to quantify these experiences, feelings, and motivations since they are complex and interrelated on a global scale. Moreover, using quantitative methodology would pose problems since the topic is quite sensitive

and personal (Askegaard et al. 2002). With a naturalistic approach, qualitative research enables an understanding of the phenomenon in terms of the meanings people bring (Denzin and Lincoln, 1994). It brings out the experiential and socio-cultural dimensions of the study phenomenon, which are not directly accessible through experiments or surveys (Arnould and Thompson, 2005).

The methodology employed in this thesis is ethnography, which can be described as a qualitative inquiry that has a specific interest in a culture (Sarantakos, 1993), and the writing of a culture (Atkinson, 1992). Since the aim is to understand patient-consumers' notions, meanings, and practices, it is necessary to see the world through their eyes and document social interactions (Arnould and Wallendorf, 1994). Ethnography is used in this thesis since consumers communicate and negotiate culture in their consumption of medical services as well (Arnould and Wallendorf, 1994; Douglas and Isherwood, 1979). For the purposes of this methodology, I immersed myself into the hospital culture for a long duration, as I explain below.

This is thus intended to be an ethnographic study through an inquiry process of understanding a human and social problem (Cresswell, 1994). Ethnographic data collection method is chosen in order to understand a relatively 'unfamiliar world' (Van Mannen, 1988).This requires studying things in their natural settings (Denzin and Lincoln, 1994). In order to capture how the informants make sense of their beauty notions, and how these notions influence their surgical consumption processes, it is necessary to have an emic understanding of their feelings, thoughts, and behaviors. Following Patton's

(1990) argument, I aim to approach the fieldwork without being constrained by predetermined categories in order to have an open and detailed qualitative inquiry.

The methodological logic of grounded-theory approach (Strauss and Corbin, 1990) is followed in this thesis, which relies on close examination of the natural setting before a focused reading on literature. The goal is to develop a theoretical understanding from the ground. Theorizations are formed based on data, rather than extant literature (Strauss and Corbin, 1990). The idea is to avoid having preconceptions about the data or forcing the data to fit previous findings; instead the aim is to allow emergent themes to reflect the data and assure that research outcomes are not theoretically removed from the study subject (Hirschman and Thompson, 1997). Thus, the researcher is encouraged to collect data in all appropriate forms (Goulding, 2000) since the topic of interest has received relatively little attention in the literature (Goulding, 2002) and the project is undertaken in the spirit of exploration and discovery rather than justification (Hudson and Ozanne, 1988). Grounded theory and ethnography are highly compatible since ethnographic studies provide thick description necessary for grounding the work on data (Pettigrew, 2000).

On the other hand, I utilize a few sensitizing concepts, in order to guide my data collection and my understanding of consumer behavior. These sensitizing concepts provide a theoretical foundation for grounded theory work, rather than force data to fall into predetermined categories. They do not provide prescriptions to see, but rather suggest directions along which to look (Blumer,

1954). The sensitizing concepts in this thesis have been discussed in Chapters Two, Three, and Four, including theories for globalization and body-related consumption. These theories, especially ideas about globalization expressed by Appadurai (1990), Giddens (1990), Robertson (1992), Wilk (1995a; 1995b), Ger and Belk (1996), Rajagopal (2000), and Waters (2002); and ideas about bodily consumption behavior uttered by Featherstone (1982), Turner (1982), Foucault (1988), Bordo (1993), Gilman (1999), Sullivan (2001), and Howson (2004), serve as interpretive devices and starting points for this qualitative study (Glaser, 1978).

The open-ended and iterative nature of the research question has led to the development of a flexible and an interactive design process (Maxwell, 1996). Therefore it becomes a continual interplay between data collection and analysis to produce a theory about (global) consumption of surgical operations (Bowen, 2006). Themes emerge out of data analysis capturing the essence of meanings and experiences which are situated in a specific historical context. All data collection, analyses, and theory building processes stand in reciprocal relationship with each other, which are explained below.

5.1. Gaining Entry

In order to understand the culture of aesthetic surgery and arrive at thick description, it was necessary to "get in" to that culture. For this purpose, I made

contacts with two plastic surgeons for research purposes. One of them was working in a hospital far away from city center, and compared to the other surgeon, the number of patients was not very high. The second plastic surgeon (Doctor Ali) was working in Gazi Hospital, which is a university hospital in Ankara with a medical faculty working since 1979. I had chosen the second physician since the hospital was very close to where I live and the number of patients and the number operations carried out were very high. I made a quick "research" about the doctor from the Internet and from a friend of mine who knows him, and learned that he is very successful and also very open-minded about social issues and had a strong ethical perspective towards his patients.

After I made the contact, I made an appointment with the doctor to talk about my research objectives and the specifics of my ethnographic study. After he fortunately agreed on the research plan, I started to engage in departmental practices. The name of the department is "Plastic and Reconstructive Surgery", so there is both reconstructive surgery and aesthetic or cosmetic surgery being carried out in the hospital. There are a total of nine plastic surgeons working and twelve assistants who are majoring in plastic surgery.

It was a difficult process at the beginning to gain entry and get in to the daily routine of the department. I started to study in the department on a Monday, and as I have learned later, Monday is the most crowded and hectic days in the whole week. There is a departmental or academic meeting on Monday and Wednesday mornings. As soon as the meeting ends, doctors start to deal with their patients all at the same time and the whole area becomes very

crowded. On that Monday, too, assistants were running all over the place, doctors were talking to patients in inspection rooms, their own offices, or even in the corridor, children were crying, and the secretaries were trying to call people for inspection by screaming their names because it was too noisy.

At first, I was not able to make sense of anything because I was just observing without any guidance. I was so aware of my own presence everywhere so I was thinking about what to do about myself, rather than my research. Later I have decided that I should continue observing for a while, until I can get a sense of what is happening in the department in general. The period of "what am I doing here" soon ended within a couple of days and I was able to have a neutral posture and become invisible after a couple of weeks (Berg, 1998). Starting on the second day, I was given a table, a chair, and a telephone in Doctor Ali's office, so that I can easily take notes, read stuff, and talk to his patients. I was provided with an official permission letter from the medical faculty's Dean, as well as the department head, who also took a letter of application from the Dean of my own faculty of Business Administration.

I stayed in Gazi Hospital for a total duration of twelve months, almost all days during the week, sometimes working until late hours at night just like an assistant in the hospital, and sometimes coming to the hospital during the weekend in order to observe patients with different profiles. I usually went to the hospital in the morning at around 9 A.M., sometimes much earlier to participate in morning visits in patient rooms. I usually left the hospital in the evening at around 7 P.M. which changed according to the day's schedule of

events. I usually had to decide between whether to see a patient who can add a different bit of knowledge to my research or eat lunch; whether to inspect an "important" VIP patient who wanted to come at 9 P.M. because she did not want anyone to see her or go home and pack my luggage because I was traveling next morning. I was so much immersed in hospital life and just respected my research so much that I always have chosen the hospital over cinema and the patient over my mother who was also sick at home. The hospital life of one year is a period not only of an ethnographic research that I took very seriously, but also a year that I personally felt very lucky because I saw a different culture and a different world.

I participated in every activity in the department, most importantly, all patient consultations and control visits. I was introduced by Doctor Ali as a researcher from Bilkent University interested in aesthetic surgery patients. Sometimes patients were so surprised to hear that a social researcher makes research in a medical area; in those cases either Doctor Ali or I explained my research questions and my research methodology. During patients' first consultations, either the secretary or the polyclinic nurse, or sometimes I invited the patient to the consultancy (or inspection) room. When there are no patients left, when there is some spare time (which is usually not more than ten minutes), or when the doctor personally knows the patient, the patients were inspected in Doctor Ali's office. When I was at my table in the office, reading something or taking a note, some patients come to me to ask about Doctor Ali.

If I knew the patient from previous visits, I usually invited him/her in the office and chatted until the doctor comes.

During first consultation visits or control visits (one week, two weeks, one month, three months, or six months after the surgery), I was there with the doctor and the polyclinic nurse in the inspection room; did not directly participate in doctor-patient discussion, but usually observed, listened, and just answered questions about my research when appropriate. I helped the doctor when he needed something, such as giving his personal card, bringing him the camera so that he takes the photo of the patient's body part, or giving him colored pens so that he can draw the operation area on the patient's body. I also helped him by giving him the medical supply when he was taking out the nose plaster, taking out the blood drains from her breasts, or dressing a wound or the sutures.

When I thought I do not need to see another rhinoplasty patient that day, I stayed in the waiting area observing how people communicate with each other. I sometimes stayed in the secretary's desk to see how patients interact with the secretary or among themselves. There were a lot of conflicts at the secretary's desk as to whom the secretary has just called, why a particular patient is still waiting while all others were let inside the clinic, and so forth. Actually the secretary's desk was so crowded and busy all the time that after one secretary had to leave because of her pregnancy, the other secretary just resigned from her job because she could not deal with so many patients anymore, some of whom could very easily become unreasonable and rude. If I stood around the desk,

they were asking me a lot of questions, such as why he is still waiting even though the minister has called the doctor from his cell phone, or where she should go if she wants an X-ray of her arm, or where the out-patient facilities are. After a couple of months, I became able to answer several of those questions, but I tried to stay away from them I was afraid to give the incorrect response.

I was also officially permitted to observe the operations themselves, including both surgeries under anesthesia which are carried out on the third floor and surgeries with local anesthesia which are carried out in the clinic, the fourteenth floor. My first experience in the operation room was not scary at all, but very unusual. I did not know where to stand and what to do, and even how to explain my ethnographic methodology to anesthetists who were wondering about what I am doing there with my metal earrings and fluffy pencil box. The doctor was usually so busy with his patient and other things about the surgery, and he did not personally involve himself with my orientation. He taught me about sterile conditions and how to wash and dress myself, as well as how to let the operation nurse dress my operation gloves. Other than that, I learned where to stand and what to do in the operating room from assistants and mostly from the person who was in charge of preparing the operation room, bringing operation instruments, and adjusting the lights. Later during my stay, I got to know everybody, including anesthetists, operation nurses, and other staff. Operations were a necessary and interesting part of my research as I was able to talk to patients just before the operation, a critical time when they usually reveal

their intense feelings. I was able to listen to the conversation among nurses and doctors during the operation as well, where they stated their opinions about technical details such as the size of breast implants, as well as their personal judgments about the patient and the surgery.

Lastly, I attended weekly academic meetings in the department and other meetings in the hospital which involved all departments. The only activity that I did not participate was the emergency cases that involved plastic surgery, but since I was dealing with aesthetic patients, this did not pose a problem.

During my stay in the hospital, I was perceived as having a "professional eye from a different perspective" and everybody was so interested in my research. They even asked my personal opinion about what they should do when their patients did not like the results or how to "reject" a patient if they do not want to operate on him/her, although I tried not to answer these questions because of ethical concerns. My key informant, Doctor Ali, helped me do my research by introducing me to his patients and allowing me appear in all instances. He was a member check for my interview results so he spent considerable amount of time reading my findings and analyses (not interview transcriptions because the respondent identity was obvious even if I have changed all the names). He personally states that he was so surprised to see those findings about things he never thought before. He says he came to realize that he should not rely on what the patient says because it may not be true; and that the medical realities is only a minor portion of the whole story, as I will explain in subsequent chapters.

5.2. Data Collection

In order to capture the meanings and practices in a context with different Western and non-Western imaginations, data collection and analysis is designed to be both multi-method and emergent. Triangulation is achieved through the use of these multiple lines of sight (Berg, 1998). Data is triangulated (Denzin, 1978) by observing people at different times (morning, afternoon, evening, weekend, holidays, and so forth); investigators are sometimes triangulated by asking the assistants or doctors about specific patients to get their opinions about the same issue; theories are triangulated by taking different postures and letting different theories explain the situation; and finally, methodologies are triangulated by trying to collect data using different methods and analyzing them with different strategies. There are different methods of data collection, including in-depth interviews, systematic and participant observation, projective methods, as well as secondary sources of data, explained below. Data collection and analysis is emergent, which means that the study has an iterative design; therefore the methods can change with new data and added knowledge.

Before and during data collection, which also involves the analysis itself because of the cyclical nature of qualitative studies, I made my own assumptions and personal biases reflected at the outset to the extent possible, in order to show the ethnographer's hand (Altheide and Johnson, 1994). At the beginning, my assumption was that aesthetic surgery is only for those people

who are so much into their appearances that they cannot live with what they consider to be "flaws" on their bodies. Later, during data collection and analysis, I came to realize that anybody can apply for plastic surgery, regardless of their jobs, responsibilities, and even income. I also had the assumption that physicians can live very peacefully without thinking so much about their patients, and they have the "luxury" to answer patient questions according to their own wishes. I also saw that this is not the case, after I saw many physicians working until late hours at night, coming to the hospital during the weekend, arranging their lives according to the operation schedules, and thinking about their patients' well beings all the time. These two examples of my "subjective motivational factors" (Berg, 1998) illustrate that ethnographic study is subjective from the beginning, as in all other methodologies. Therefore, both data collection and analysis should be treated as social performances, explained below.

5.2.1. Sample

Since the aim in this study is not to generalize results to a large population, using random samples is not appropriate (Marshall, 1996). It is not possible to capture all possible variations through random sampling. Moreover, the purpose is to gain a deeper understanding of the phenomenon and facilitate the development of an analytical frame. Therefore, the sample size and the

informants chosen are decided based on whether I can adequately answer the research question, i.e. theoretical sampling (Glaser and Strauss, 1967). With theoretical sampling, data collection process is directed by evolving theory rather than predetermined clusters of population (Strauss, 1987). A new informant was thus chosen on the basis of what other informants have brought to data until that point. For instance, after I realized that aesthetic surgeons who work in their own private clinics work in different ways, educate themselves in other areas, and behave in different ways towards their patients, I went to Istanbul to carry out an interview with such a physician. It added a different perspective to my analysis and provided a different kind of knowledge. There are a total of thirty in-depth interviews conducted. The table in Appendix A summarizes the demographic characteristics of all informants. I stopped interviewing until theoretical saturation is satisfactorily reached (Strauss and Corbin, 1990), or when a single person has not added much to what I already knew regarding the research question, i.e. data saturation

I first started to conduct interviews with Doctor Ali's patients. I first chose patients having different types of operations, as each would bring new knowledge to my understanding of the phenomena. Later, I started to choose people with different characteristics, based on age, sex, and occupation, in order to arrive at thick description. While I was interviewing patients, I was also transcribing the taped interviews and taking theoretical notes, as I explain later. With a gradual theoretical enlightening, I also interviewed people who were against plastic surgery and people from the "production" side, i.e. doctors.

While I was talking to doctors and observing their behavior, I came to realize that they are not the only ones who "produce" plastic surgeries. Aesthetic medial companies are also making a significant contribution, so I conducted an interview with a representative selling aesthetic surgical material to hospitals and doctors. Later I realized that public relations managers are extensively involved on the production side, as they make doctors' names known in the public through television and newspaper exposure. Lastly, I conducted an interview with an insurance company representative as I realized that doctors had started to "insure" themselves against an increasing number of lawsuits initiated by patients who are not happy with surgical results, which I thought is an important detail.

5.2.2. Interviews

In interviewing, I followed the guidelines of McCracken's (1988) long interview, allowing my informants to lead the way raising issues that interest them. I had a guideline illustrating the essential questions I need to ask. These questions are provided in Appendix B. Total number of interviews conducted with doctor informants, as well as other people, who are considered to be the "producers" of plastic surgery, was ten. Duration of these interviews ranged from thirty-six minutes to a hundred and seventy-nine minutes, with a total duration of five hundred and sixty-four minutes, and an average of sixty

minutes. There were five female and five male informants, and average age was forty-one. In this group, there were six plastic surgeons, one aesthetic medical company representative, one insurance company representative, one person working in the media, and one Public Relations specialist.

Total number of interviews conducted with "consumers," i.e. patients and non-patients of plastic surgery, were twenty. Total duration of these interviews was one thousand, three hundred and sixty-three minutes, ranging from thirty-six minutes to a hundred and seventeen minutes, with an average of sixty-nine minutes. There were five male and fifteen female informants, and average age was thirty-one. One of these informants was Dutch who came to Turkey to have an aesthetic operation. Two of the Turkish informants currently live in the U.S., one in the Netherlands, and one in France. Two of the informants were against plastic surgery applications.

There are a total of twenty other interviews conducted, which are not intended to be in-depth interviews. Some of them were conducted when there is a specific instance important for the research, such as when the patient came for a six-month control visit, but s/he does not have time for an interview. In these cases, I asked a couple of important points such as motivations for surgery, whether s/he is satisfied with results, or if there is an ideal someone else for the individual. Sometimes the person did not want to engage in a full interview, but stated that she can go through a couple of questions. Some of these interviews were actually intended to be full interviews, but at the end of the interview, I realized that it did not add much critical information to existing knowledge, or

that the person could not express himself/herself sufficiently. For all these interviews, the dialogue was recorded with the permission of the individual, but they were not transcribed. I only listened to these interviews on the computer and made notes about the specific data. Total duration for these interviews is nine hundred and four minutes, ranging from seven minutes to a hundred and twenty minutes, with an average duration of forty-five minutes. There were two male and eighteen female informants in this category, and the average age was thirty-seven.

The interviews were semi-structured and semi-formal, with pre-defined questions provided in Appendix B and additional probing questions determined according to the flow of the formal conversation. Probing was very important because it was necessary to understand informants at a deeper level. Almost all interviews were recorded and saved into the computer using Power Voice II program. Some informants did not want me to tape the meeting, some without explaining why and some stating that they would not be comfortable with their voices being recorded. All interviews were then transcribed by myself using DocShuttle Express and Bytescribe WavPlayer programs.

Interviews with patients were conducted either before the operation when they were already alert about their surgery decision, or after the operation if they think they would be more comfortable after everything is over. Interviews with doctors, aesthetic medical and insurance representatives, PR specialists, and people working in the media were conducted in their offices at a time specified by themselves. I prepared myself before each interview, by

repeating questions to myself, rehearsing the projective studies, and getting ready in terms of necessary equipment such as pencil and paper, tape recorder, and projective materials. It was much easier and effective to conduct the interview with this self-conscious performance. I also prepared myself by learning about the informant's language; for instance, before interviewing doctor informants, I learned some of the medical terms and classifications in order to effectively word the questions (Berg, 1998).

5.2.3. Projective Techniques

Along with the interviews, projective techniques were utilized with the intention of projecting some inner feelings (Branthwaite and Lunn, 1985) and arrive at thick description (Geertz, 1973). I found that informants are much more expressive in relation to a stimulus (re: Levy, 1985), such as pictures, photos, and videos, as they better articulate their feelings and thoughts in discussing such an abstract concept like beauty.

One of these projective techniques was the critical incident technique (Flanagan, 1954), where the informants was asked to remember the first critical event or an occasion when they think about a specific concept, such as "defects" on their bodies. This was especially useful because I needed to come up with a good theory that links the life-time beauty work of these individuals, as explained later in Chapter Six. This technique provides more details about a

specific issue, such as when they have decided for surgery or when they became so much concerned with their breasts or noses. Once the critical incident is described by the informant, it becomes easier to probe further questions.

A second technique was helping informants express their feelings by showing them photographs (such as a celebrity or an infamous person), or making them choose among the photographs if they were to date or marry one of them. These pictures are provided in Appendix C. The photos were numbered on the computer so it was easy to communicate with the informant especially if s/he does not know who is in the picture, and it was easy to analyze results afterwards. Besides, a video illustrating tribe people's beautification practices helped improve the ease of explanation and increase amusement. Lastly, word association technique was utilized that would capture the personal, idiosyncratic responses (Branthwaite and Lunn, 1985). When I asked them "What comes to your mind when I say brain surgeon?" and "What comes to your mind when I say plastic surgeon?" where responses reflected the unconscious thoughts and feelings of responses as they did not have the time to think about their ideas and present them in "socially appropriate" ways.

5.2.4. Systematic Observation

A key advantage to using qualitative data collection techniques in this study was that participants were often interviewed and observed in their natural settings

regarding their surgeries. Thus, they can more conveniently participate, they may be able to more accurately answer questions about their settings, and the researcher gets a firsthand look at the settings as the participants describe them. For this purpose, informants and non-informants were systematically observed in the hospital before consultation (such as interactions with the secretary, conversations among themselves while waiting for their appointments), during their consultation and medical examination (interactions with the physician, language used, their space usage and kinetic behavior), before the operation (their behavior towards the doctor, emotional reactions to events and people such as nurses), and after the operation (interactions with family, visitors, doctors, and other personnel). The strategy followed in observation was to focus on a group intentionally (plastic surgeons and patients) and purposefully observe those who naturally fall into that group (Adler and Adler, 1994).

There were four major modes of observation carried out (Gold, 1958): Firstly, I was a *complete observer* during the operations. I usually read an article or wore sterile clothing and gloves in order to watch the surgery without participating in the operation itself. I talked with doctors and assistants performing the operation, with anesthesia personnel, with nurses and other personnel who deal with the organization of lighting and surgical material. At first, it was difficult to interact with doctors as I was a "stranger"; but as people get to know what I am doing as a researcher, they get used to my presence.

I was an *observer as participant* during patients' first consultation or control visits. Doctor Ali introduced me as the researcher from Bilkent

University, and the patient knew I was conducting a study on plastic surgery. Usually I stood next to the doctor and did not behave judgmental so the patient did not feel uncomfortable. Actually, several patients stated their hopes, desires, fears, and angers to me without even asking them such as when the doctor was not yet in the consulting room.

I was also a *participant as observer*, when I stood in the secretary area just like a person working in the hospital or when I sat in the doctor's office studying. People did not know I was observing them, but they usually ask me questions about where the doctor is or other things about hospital stuff. I also helped doctors in the department, such as calling their patients and helping them inspect their female patients since it was easier for them to communicate with a female. Doctors encouraged me to participate in academic meetings so that I can inform both plastic surgeons and other doctors in the hospital about "consumption" issues and how psychological and social expectations of patients shape their satisfaction from the service. With their encouragement, I wrote a review article with Doctor Ali, describing how doctors can see their patients in different ways.

At the same time, I was an observer outside of the hospital, where I was able to participate in the event, and at the same time observe what I am doing and what others are doing. One of these events is the Nineteenth Congress of the International Society of Aesthetic Plastic Surgery in Melbourne, Australia. I had two electronic papers presented on computer terminals, and I was able to listen to paper presentations, academic discussions, casual conversations among

doctors, and talk to representatives in medical company stands. I also made a speech on an international radio program in Melbourne, about possible patient motivations in plastic surgery. In all these instances, I was able to observe and take notes about the prevailing "culture of plastic surgery" on doctors' side at an international level.

I also attended an academic circle gathered in İzmit, where the doctors carried out a couple of surgeries for educational purposes and made presentations on medical issues. I myself made a presentation about how doctors tend to see patients and how studies of consumer behavior might approach them in a different way. I also attended a presentation made by a large aesthetic medical company in a hotel Ankara, in order to listen to presentations and conversations made between doctors and company personnel. I attended another presentation in another hotel in Ankara, which was held to educate e companies' sales representatives. I attended two beauty and aesthetics fairs in Ankara to see in what ways patients and non-patients are interested in beauty issues and how plastic surgery might be related to other beautification practices in general. Lastly, I participated in a national symposium in İstanbul named "Türk Kültüründe Beden," and without any presentations, I was able to observe how Turkish social theorists approach the issue of beauty in Turkish culture.

Besides being a complete observer, an observer as participant, and a participant as observer, I was also a *complete participant* in a botox session. Just to learn about how patient-consumers feel and how they would interact with the hospital personnel, I personally asked the doctor to make an operation

on myself, and we decided that the application of a minimum amount of botulinum toxin on an area between my eyebrows is the best solution, as the effects would be temporary and the application is relatively less risky. During this minimally invasive procedure, I asked the doctor several questions just like a patient, and he answered my questions. I totally participated in the event, as the doctor was trying to decrease my tension, the nurse holding my hand during the application, and I was asking the same questions over and over again.

I took field notes for the whole period of stay and observation, although it was sometimes difficult to leave the patient and go to a room to write something so that I do not forget it later, or take a note while the patient is watching me in return. I tried to write everything in the form of detailed descriptions, times, durations, names, places, as well as my own feelings and opinions. It was also very beneficial to write "verbatim quotations" from patients (Silverman, 1993) as they helped me to connect analysis results to patients' everyday behavior.

5.2.5. Unobtrusive Measures

I also utilized secondary sources which are publicly available, such as the Internet, newspapers, and magazines. Recognizing that these sources are prepared for purposes other than my research question and that they have editorial biases (Berg, 1998), they were still useful when I needed data which is

biased in a specific way. For example, news about plastic surgery in the media, advertisements which use human bodies or web sites of aesthetic surgeons served as primary data at several points during this research. An example of a newspaper article is provided in Appendix D.

In addition, medical documents and surgical apparatus were useful as they were items from the material culture I was investigating (Hodder, 1994). These items were contextually interpreted where they were helpful in making abstract concepts be visualized and give them a substance. Appendix D contains an example of a medical document.

5.3. Data Analysis

Following the discovery oriented aims of grounded theory, analysis sought to identify conceptual categories and themes. Data analysis has in fact started during data collection. As described before, data collection and data analysis were not consecutive since rules of collecting new data and sampling procedures were established according to the level of theorization achieved and characteristics of the theory.

After a few interviews were conducted, I started to transcribe the taped conversations. While transcribing and reading the transcriptions, several themes have started to emerge. I took a note of every theoretical issue that arose during data collection and transcription. Interview transcripts, field notes, current

information that I gathered from the media were all sources of data. After all interviews were conducted and transcriptions were made, I read all transcriptions over and over again until I arrived at a list of concepts which were unorganized and which have only loose connections to other forms of data.

Therefore, I first came up with a list of codes by applying an open coding schema (Berg, 1998); frequently interrupting the coding by writing a theoretical note (Strauss, 1987). For instance, while I was coding "perception of plastic in society", I took a note of the ways patient-consumers can explain how their friends and family members can perceive plastic surgery in general and the specific patient's decision for surgery. there were other codes that later supported this theoretical note, such as perception of the plastic surgeon, "necessity" for plastic surgery, and people/ideas against plastic surgery. Another example is related to the effects of media on people's decision making. I coded the data by such labels as beauty icons, effects of media, TV programs watched, and magazines purchased. The theoretical note was related to how people can shape their pre-operation decision making and post-operation satisfaction; and subsequent coding was affected by this theoretical note. Later, I coded the newer interviews by new codes (for the media effects) in addition to the ones above, such as searching for a plastic surgeon, one-type beauty, sections read in newspapers/magazines, norms and standards, expectations before the surgery, and normality, all reflecting how patient-consumers decide to go for surgery and decide on the specific of the operation.

This open coding was in fact disordered and unstructured. There were a total of one hundred and seven codes reflecting all relevant and irrelevant data in unorganized form, and associated theoretical notes which did not display meaningful patterns. Still, however, they represented links between the original, raw data and the sensitizing concepts that I utilized since the beginning of this research (Coffey and Atkinson, 1996). This was followed by some elimination of irrelevant or redundant data according to emergent relationships between codes and with data in other forms. This elimination resulted in an effective simplification of data into chunks that share a common code.

With this classification system, I was able to simplify the complexity of reality into a manageable organization of all data (Patton, 1990). This was also useful in selecting the next informant for further investigation or for observing same things in different ways. For instance, the theme of "taste" has appeared to be important, which reflected a special kind of knowledge on beauty issues and on the "right" kind of operations chosen. The size of breast implants or the shape of the nose is reflected this notion of taste. After realizing this, I started to interview people from different economic and social backgrounds in order to learn their opinions and meanings on this issue. I started to ask different questions on the issue of taste, and concentrated more on this aspect during projective studies by asking respondents such questions as why they did not like a specific woman in the projective picture.

Then I started to "play with" this segmented data by further exploring the codes and their contents. Spending more time on data and further reading on

established theories resulted in some patterns and themes, showing properties of similarities or contrasts. Some of the codes appeared to be very much related to each other and they usually formed a theme. For example, the role of doctors in patient's decision making processes emerged as an important theme, and the codes labeled doctors as friends, doctor's role in decision making process, communication with the patient, trust, marketing of plastic surgery, doctor's vulnerabilities, operation from the doctor's perspective, doctor's patient selection, things that doctors should do other than the operation, doctor's satisfaction from the operation, doctor as brand, and doctor public relations together formed this theme. Some of the codes remain redundant since they were not related to any of the themes, although they may still be important. For example, although the notion of personality and internal characteristics and the related code "inner beauty, other beauty components" are important in understanding a person's perception of what is considered beautiful, this node was disregarded from further analysis since I was not interested in the psychological aspects of beauty, such as how one's personality might affect his/her appearance and the perception of others.

Linking related codes together and creating themes was then followed by creating sub-titles under each theme in order to ensure a richer understanding. Data was read over and over again, codes were organized in new and different ways, and themes were reordered several times until a satisfactory composition of data in terms of themes and sub-themes was reached. In order to enhance theoretical sensitivity, who, when, where, why, and how questions

were asked to see the analytical depth and link it to existing literature (Strauss and Corbin, 1990). Moreover, my making connections between themes and sub-themes, which can be described as a process of axial coding, new categories were developed beyond their intended properties and dimensions.

For instance, the codes labeled good examples, beauty icons, people as brands (women), ideal (women), men's beauty, ideal, bad examples (women), bad examples (men), femininity, one-type beauty, norms and standards, and normality were initially categorized under the theme "beauty standards." However, comparing codes and themes with each other revealed that norms and normality were also sub-themes for "progress in beauty," because these norms set the ideal standard for beauty work; as well as for the theme "rationalization of plastic surgery", since people stated their desire to feel "normal" by having an aesthetic operation and correcting their physical flaws. In other words, several codes which were united under a specific theme were disintegrated and used to create another theme. This meant integrating data at a more abstract level and uncovering patterns that naturally exist in data through constant comparison of incidents applicable to themes and sub-themes (Lincoln and Guba, 1985).

There are several strategies undertaken in order to increase the trustworthiness of this research. In order to increase credibility, prolonged engagement in the hospital with persistent observation was accomplished and multiple data gathering techniques were utilized in order to avoid systematic biases (Maxwell, 1996). In addition, member checks were conducted with the

first analysis report read by the key doctor informant in order to see if there are disagreements in terms of descriptions and interpretations (Wallendorf and Belk, 1989). Transferability of results was limited because the ethnographic study was carried out in one hospital, which might be argued to have a certain patient profile. However, visits to several other hospitals and interviewing doctors working in other hospitals enriched data and increased its transferability as well. Moreover, the emergent nature of study design made the results more transferable due to several refinements made along with new data and new results.

Dependability of results was made possible through data collection at various times and observation through a long period of time which captures all seasonal changes. Confirmability was attained through field notes and reflexive journals. Personal diaries made it possible to uncover biases as I took note of everything including my own worries, pleasures, and tempers. In addition to these criteria, I also strived to maximize the integrity of this research by trying to engage in a good interviewing technique and by self-analyzing myself in an honest way. Informant identity was safeguarded to the highest extent; all names have been changed; and each patient has been notified about my research interests and the fact that I am in that consulting room because of my research.

CHAPTER VI

FINDINGS

News and trend analyses all over the world indicate that the importance of physical appearance is highly recognized and there is an accompanied rise in demand for aesthetic surgery. Today, beauty industry is a multibillion dollar business that influences the viability of cosmetics companies, pharmaceuticals, plastic surgeons, department stores, salons, spas, beauty parlors, magazines, and books (MacInnis and De Mello, 2005). In the specific area of plastic surgery, major developments have taken place after the World War II, in order to cure the traumatic body dysfunctions of soldiers in particular. Since then, both in Turkey and in the world, major developments have occurred in plastic surgery knowledge and technology, accompanied by changing needs and desires of plastic surgery patients.

Given this picture, it becomes especially important to look at how people perceive and change their bodies; and the relationship between dynamics

of globalization and body-related discourse and practice. Turkey is a very interesting site not only because it is a non-Western country, but also because various religious and cultural negotiations occur frequently. Satellite television and state deregulation over broadcasting in the 1990s were major developments; and "under the deepening impact of global consumerism," sexuality was transformed into a form of public spectacle (Öncü, 2002). Widely available products have been displayed more and more attractively in shops, which stimulate consumer desire (Ger et al. 1993).

One of the recurring themes among informants in this study was the idea that beauty is something good because it provides someone a positive image about his/her personality and improves his/her credibility. In this study, attractive people are perceived to be more advantageous because people look at, listen to, and behave nicer to beautiful people. Sales people pay more attention. Even without saying a word, attractive people are one step ahead in all aspects in life. Informants state that a person can be "naturally" beautiful but it does not mean anything if s/he cannot enhance that beauty by make-up or skin care. They think this "natural" beauty should be upgraded to the highest level possible by using various beautification practices in order to get attention and emphasize that the person is chic and trendy. All informants engage in several of those practices including hair care products, skin care products, shower gels, make-up tools, as well as manicure, pedicure, removal of hair, sporting, dieting, and hair coloring. They think plastic surgery is a very effective beautification tool; however, it requires time, energy, and money. It is also risky and painful.

Results from the qualitative analysis of data will be discussed in two parts in this chapter. The first part, titled "Beauty in Progress," will investigate how the concept of beauty is perceived as progress among informants, rather than as a state of being or as something achieved. The second part of the analysis, titled "Shopping for Beauty," will deal with how plastic surgery is negotiated and commercialized around the world through doctors, advertising agencies, aesthetic medical companies, and other interested organizations.

6.1. Beauty in Progress

Body-related consumption, i.e. purchasing different products and services related to body, and associated beautification practices, have been discussed in much depth in the literature, as mentioned in Chapters Three and Four. One of the assumptions in consumer behavior studies is that beauty is something to achieve, a state-being, or a situation (for example, Askegaard et al. 2002; Schouten, 1991). In contemporary body culture, however, bodies are taken as projects to work on (Uusitalo et al. 2003). It is widely believed that people constantly compare themselves to images presented in advertising (Richins, 1991) and strive to attain that ideal. Therefore, viewing beauty as a state, rather than an ongoing work, disregards the life-long practices and "beauty work" of many individuals, and ignores the ongoing beautification practices of those who are already considered to be beautiful by society, such as celebrities.

For informants in this study, achieving beauty is a practice, a progression and almost a way of living. People may decide to go for surgery because of a change in their lives and because their selves are in transition (Schouten, 1991); but beauty work does not stop with that surgery. Hayal (39F) tells that happiness caused by surgery is temporary, so beauty work continues for her. Even if her nose is fixed, Derya (25F) thinks she will continue looking at her photographs to see whether she is now more beautiful. Esma (32F), after breast reduction surgery, continuously checks whether her breasts are getting bigger or not. This continuous effort to achieve beauty or remain beautiful is typically exemplified by dieting and exercising.

Almost all informants are continuously engaged in these activities even when they think they are closer to their ideal. They literally state that they "constantly" diet, "always" weigh themselves several times during the day and using different scales, and "regularly" watch what they eat. The words "always" and "all" are cues that the informant is describing idealized goals (Arnould and Price, 2000), in an effort to participate in something that everybody does. Yonca (27F) states that she is always dieting and exercising, just to be better in shape. Hayal (39F) says that she is in constant effort to become ever more beautiful:

> Actually I don't eat much. But having a scale is essential, I have a scale at home and at work, actually I have three scales at home, in the bathroom, in the bedroom, and another one in the small room. I always weigh myself using one scale after another… I am constantly weighing myself.
> **… What is your weight and height?**
> My height is 174 centimeters and my weight is 52.

Yok hiç asla [çok yemem]. Tartı ama çok önemli, mutlaka iş yerinde ve evde tartı var, hatta evde üç tane var, banyomda, yatak odamda ve bir küçük oda var, orda, hatta birinden çıkıp birine sürekli gezerken... sürekli tartılma halindeyim.
… Boyunuz kilonuz kaç?
Valla boyum 1.74, kilom da şimdilik 52.

Some informants who have gone through an aesthetic operation have future plans for other operations, indicating the same progress in beauty. Their plans include having liposuction after pregnancy, having breast augmentation after giving birth to at least one child, having an abdominoplasty after breast reduction, and so forth. Even the order of operations becomes an issue within this never-ending beauty work. Consider Hazan's (28F) example below:

After the accident I was obsessed with my foot, you know, when I was coming to the doctor's office for my foot, I've started to examine myself physically in front of the mirror... my nose was also twisted... 'cause it was really broken bad... I thought if I cannot make my foot done then I might have my nose done, and then that turned into an obsession, I felt like I had to make it done, and then one day we came to Doctor Ali's office, and I showed my foot to Doctor Ali, and he said no [Next, she explains how she decided to go for a nose operation instead of an operation on her legs].
Would you consider having operations for other parts of your body in the future?
Hmmm I would consider, I would definitely consider, I know myself.
Like where for example?
Where... I would go for a face lift if my skin gets too wrinkled. Other than that, I would go for soft tissue fillers, you know, in order to look younger I would definitely do it, what else, for example if my legs go... [pause] have cellulite, you know very wavy and if there is a cure for that, I would do it as well.

[Kazadan] sonra işte bu ayağıma falan taktım ben işte, ona falan gelirken işte tabii kendimi sürekli incelemeye falan başladim ben aynada falan... e burnum da yamuldu... yani burnum da eğrildi çünkü... e bari ayağımı yaptıramayacağım işte burnumu yaptırayım diye öyle bir fikir oldu ve sonra saplantı oldu bende, illa yaptırmak istiyorum diye ondan sonra işte bir gün Ali Hoca'ya geldik, ondan sonra ayağımı gösterdim

olmaz dedi [Daha sonra bacaklarında yapılacak bir operasyon yerine burnunu yaptırmaya nasıl karar verdiğini açıklıyor].
Peki ileride başka yerlere de operasyon yaptırmayı düşünür müsün?
Mmm düşünürüm ben düşünürüm, ben kendimi biliyorum.
Mesela neler?
Ne... yüzüm çok kırışırsa gerdirebilirim. Ondan sonra dolgu yaptırabilirim yüzüme işte hani daha genç görünmek için uğraşırım kesinlikle, ne olabilir mesela atıyorum bacaklarım çok... [duraksıyor] çok selülitli böyle girintili çıkıntılı bir hal aldı ve bunun bir çaresi bulundu yaptırırım yani.

Hazan's narrative exemplifies how an individual plans his/her journey towards ideal beauty and makes an order of operations. This process on deciding and changing opinions about what is beautiful and then applying available procedures to reach that beauty is like a game, where patient-consumers can choose among beauties and among operations. If this thought to become more and more attractive each day becomes very strong, they may even start to think in terms of the operations themselves. It is not unusual for a patient-consumer to come and ask the doctor "what operation should be applied to me at this time?" or "what operation do you think I need the most?" This progress in beauty starts in informants' lives at various points and based on various motives. The next section will talk about how the progress starts.

6.1.1. Activation of Beauty Work: "Only if My Nose was a Bit Smaller"

There is usually a starting or a "trigger" point that makes informants aware of their physical appearances and perceive "deformities" on their bodies.

Deformity of a body part remains as a problem to be solved along the way towards ideal beauty. Although not necessarily intended to be solved with a surgical operation at the time of the interview, deformities mentioned by interviewees can be about excess weight, insufficient weight, short height, poor skin, visible vessels, big breasts, small breasts, saggy breasts, big nose, deviated nose, large ankles, large forehead, deformed teeth, excess eyelid skin, excess fat around the belly, and even brown eyes.

When these individuals come to see the doctor, they talk in such a way as if the deformity is something to be objectively analyzed. Although there are medical rules and measurements that "objectify" the deformity, the patient talks about the deformity as if it is a disease or a defect that can be cured through medicine with pre-established rules. They use such words as "this," "that," "these," and "those" to refer to their body parts. For example, they say "I want to make these smaller" talking about their breasts or "this part of this thing is too big" talking about their noses. Sometimes they directly ask the surgeon "what do you think my problem can be?" or "isn't it clear what I came for?" thinking that their defects are so objectively obvious that the doctor can easily see what the problem is. Although they do not feel at ease when they first show their breasts to the doctor during the first consultation, they become much more comfortable after the operation as their breasts become objects having been medically treated. In fact, many informants state that they show their breasts to anyone who asks about the operation because they feel proud of themselves.

Although the "defect" is objective, when I ask informants about how

they started to consider it as a problem, they usually talk about their friends, family members, or specific experiences. So the starter of beauty work is usually not the deformity itself, but an ideal image, a person, an event, or an occasion. When this trigger occurs through an ideal, "to-be" patient starts to criticize his/her body and compare it with the ideal. As I will elaborate later, the ideal is usually a Western person or a foreign celebrity, which does not resemble an average Turkish person in informants' minds.

The informant may decide that the "problem" needs to be solved when his/her friends or family members talk about those problems as deformities, like in the case of Yaprak (18F) whose uncle made fun of her because of her nose. She also mentions that her mother has always tried to convince her to have a nose job because that would make her more beautiful:

> All the times since my childhood, my mother used to tell me "your face is very beautiful," "your nose could have been more like this" or "like that," I think that was in my mind since that time [pause].
>
> *Küçükkenden beri işte annem "yüzün çok güzel," "burnun da şöyle olsa," "burnun da böyle olsa" falan derdi, zaten öyle öyle kafamda yer etmiş bir şekilde [duraksama].*

Melih (22M) also mentions about her mother, who actually made the decision for him.

> My mother [laughing]… She is really dominant, my mother was so… you know… my… I mean I was telling her that it's not that important, but she was like "do it" all the time, "you should do it," after a certain point it turned into the sword of Damocles, we arranged for it, got an appointment with Doctor Ali… she said "you'll do it." Ok then, I'll do it! [laughing]

Annem [gülerek]... Baskın eleman, annem çok şey yaptı artık… benim… ya ben diyordum işte önemli değil, yaptırmasam da olur falan derdim, o işte "yaptır," "yaptır" işte "yaptıracaksın," işte bir yerden sonra artık adalet kılıcına dönüştü, tam ayarladık işte Ali Hoca'dan gün aldık... "olacaksın" dedi. E olayım bari! [gülüyor]

Other informants also give similar examples where their relatives, friends, or significant others criticize the person's physical appearance by referring directly to a specific body part, such as nose or belly. One of the patients observed mentions that her best friend told her to go through a nose operation by telling her: "Your face is very beautiful, your hair is no nice, only if your nose were a bit smaller."

Besides the activation of beauty work through an ideal or through other people's criticisms, appearance-related problems can also arise after specific events, such as pregnancy or accidents, which alter their bodies. The idea of having plastic surgery can develop through time, which might be triggered with just one critical instance. Therefore, not a particular person but a certain event can activate beauty work.

Selin (28F) mentions that she has started to think about having plastic surgery on her breasts after she saw a little girl playing in her apartment. The girl's breasts were moving fast while she was jumping all over the place, and Selin thought she should have those "moving" breasts that even a child has. Mine (28F) talks about the moment that she became aware of an idea that her breasts need reconstruction. She mentions that she was doing yoga, and she suddenly started to consider plastic surgery.

> Breasts for example, especially making them firmer and steeper, I mean more… I mean definitely making them steeper… in terms of its form… I thought about it for example, especially when I was practicing yoga yesterday, very interesting actually, it just came to my mind suddenly…
>
> *Göğüs mesela, özellikle dikleştirme yani daha böyle… yani kesinlikle daha böyle şey dikleştirme şey… form açısından… onu düşündüm mesela, özellikle dün yoga yaparken mesela çok enteresan, bir anda çaktı yani…*

Unique occasions constitute another triggering factor which starts beauty work. There were many patients observed who wanted to have an aesthetic operation to appear more beautiful for special occasions. One of these patients wanted to have breast augmentation before her wedding so that she could be more attractive for her husband without telling him about the surgery. Another patient wanted to have rhinoplasty before her wedding because she thinks she would look better during the wedding ceremony and in her wedding album. Still another patient wanted to undergo a nose surgery before her graduation party. Her examinations would be over by then, and she would be rewarded by her family for her graduation from college. Yet another patient wanted to have a nose job for her high-school class party at the end of the year. Another informant wanted to have a series of minimally-invasive procedures on her face, as well as a brow-lift, before she starts her new job as speaker in a TV channel. All these patients were trying to arrange their surgeries according to their time tables so that they would look good for the specific occasion.

Plastic surgery as gift is also another unique occasion where people start to think seriously about having an operation. For example, there are a lot of examples from high-school graduates, for whom the surgery would be a gift

both for their graduation from high school and for their eighteenth birthday, as part of a celebration that they are now grown-up people. There were several patients observed who come to the doctor's office with the gift already provided by their families, such as rhinoplasties and breast augmentations. These to-be patients usually come with their families, so the party who provides the present also appears in the gift-giving situation. Ajda (37F) gives the example of another person she knows, who went through a facelift operation as present for her husband's birthday. There are examples in the media representing aesthetic surgery as gift, such as Ministry of Justice having surgery as gift for informers of malpractice in Turkey, the U.S. army having liposuction as gift for women soldiers (known as G. I. Jane soldiers), and women having vaginal reconstruction as gift for their husbands.

Therefore, what starts this beauty work is not the specific beautification practice or the surgical operation, but rather it is the fact that the person becomes aware of his/her own appearance and decides that s/he needs improvement. In fact, many individuals decide to go for surgery after many years of a decision making process entailing many thoughts and interactions. So it becomes the individual's responsibility (Askegaard et al. 2002; Thompson and Hirschman, 1995) to carefully observe own body and go to the doctor if there is problem, just like when s/he has pain or a dysfunction. It is about self-control and self-discipline (Foucault, 1980).

One interesting point is that this activation does not make them think they are ugly, but that they need improvement (ASPS, 2007). Contrary to the

assumption in several studies that all people who decide to go for plastic surgery are in need of boosting their self esteem (for example, Askegaard et al. 2002; Schouten, 1991), many informants in this study were proud of their appearances even before the operation. They describe their physical appearance as "God has created me in a special way," "God save me," and "I think I'm more beautiful than Jennifer Lopez," but they just need to work more on their beauties and become more attractive. The difference between their actual and ideal selves does not create depression (Higgins et al. 1985), but the ideal self serves as an object of desire (Belk et al. 2003) and the desired change would facilitate other changes in the person's life (Sullivan, 2001). For example, Hayal (39F) previously had nose operation, teeth treatment, breast augmentation, and recently had her breast implants removed through another operation. She just loves her body and likes to talk about her own beauty at all times.

> My breasts are 88, waist is 59, and my hips are 86. So... I mean I have exactly the same standards that a European model has. I mean my physical appearance is just perfect, even though I'm 39. I shouldn't be modest about it, should I? [Laughing]
> **Why did you want to remove your breast implants?**
> Well because they made me so attractive and noticeable. Because I already have a very nice body, when my breasts were like bombs, you know… it was so noticeable. But later this started to bother me, because I didn't want to be that noticeable.
>
> *Göğüslerim 88, belim 59, kalçalarım da 86. Yani… Demek istediğim aynen Avrupalı bir mankenin ölçülerine sahibim. Yani 39 yaşımda olmama rağmen görüntüm mükemmel. Alçak gönüllü olmama gerek yok, değil mi? [gülüyor]*
> ***Göğüs protezlerini neden çıkarttırmak istedin?***
> *Yani çünkü beni çok fazla güzel ve dikkat çekici yaptı. E benim zaten çok güzel bir vücudum var, e göğüslerim de bomba gibi olunca, anladın mı… çok dikkat çekici oldu. Fakat daha sonra bu beni sıkmaya başladı çünkü o kadar dikkat çekmekten hoşlanmadım.*

These consumers think they already look beautiful, yet they still continue to work on their beauties. Ideal beauty is desired as it is reachable but not immediately available (Simmel, 1978 [1900]). The next section will discuss how activated work of beauty might result in a decision for having an aesthetic operation, even for those who think they are already beautiful. This decision making entails information search and evaluation of alternatives, which involve discourses in general public about aesthetic operations and their representation in the media.

6.1.2. Deciding for Plastic Surgery

After trying other ways such as using padded bras or wearing large clothes, the person might decide that surgery is the only option that would totally satisfy her. Since surgery is usually not a frequently purchased item and it entails a risky decision, patient-consumers are expected to engage in extensive problem-solving before making a decision (Solomon et al. 2002). During this thinking of whether to have the operation or not, patients sometimes feel like they might be humiliated by others since it usually becomes visible that they had gone through an aesthetic operation. Many informants have the idea that plastic surgery resembles luxurious consumption in a medical sphere, described by such words like “unnecessary,” “money wasted,” and “doesn’t worth risking your life.”

Plastic surgery is sometimes degraded as a practice only appearance-savvy people would undertake, who are in need of constant appreciation for their beauty, who have nothing else to do, or who have extra money to spread. Some patients, such as Hayal (39F), feel like their personality and behaviors are evaluated on the basis of the plastic surgery they went through:

> When I had the implants, I hated the way people stared at me… Even people I don't know, I don't talk, I don't even say hello were coming and asking me those stupid questions like "is it comfortable?" stuff and nonsense… ummmm all those words, again someone I don't know, someone I just say hello might come and say "did your silicones explode?" and so forth, of course in years I heard other things from other people as well, for example the looks irritated me, especially the looks…
>
> *Ya protez varken göğsümde insanların tepkileri hoşuma gitmiyordu... E tanımadığım, konuşmadığım, selamlaşmadığım biri yanıma gelip, "kullanımı rahat mı" abuk sabuk, bilmem ne işte... uuuu laflar, yine hiç tanımadığım, sadece merhaba dediğim bir insanın gelip "silikonların mı patladı kız" demesi falan, yani tabii yıllar içinde başka laflar da duydum, mesela bakışlar beni çok rahatsız etti, özellikle bakışlar...*

On the other hand, plastic surgery is so much appreciated as it can provide relief for someone who has been suffering from a cosmetic problem or else it can make someone happier as s/he can feel more attractive for their spouses or friends. For example, the term aesthetic marvel (*estetik harikası*) is used frequently by many informants to refer to such people who have undergone plastic surgery with very good results, such as Deniz Akkaya, who, according to many patients, deserves to be beautiful after that much labor is exerted.

With these two conflicting viewpoints, some patients are in serious doubt about whether to have the operation or not. Some even state that they felt

embarrassed in the waiting area because there were people who really were in need of surgery, such as people without arms or babies with congenital abnormalities. Patients may have to consider different points of view for the same operation; for example, a woman's husband may think that she would be more attractive with bigger breasts, but her mother may not approve this decision. That woman may have to "balance" these different viewpoints and weigh carefully the pros and cons of plastic surgery, and how to make her appearance more beautiful in such a way that it does not look too appealing or inviting.

With the idea of having an operation in mind, informants usually start to collect information. They rely mostly on television as an information source, especially magazine and paparazzi programs. Other than providing a common language, the media also have the power to influence informants' way of thinking. For instance, fashion channels and beauty contests are good sources where people can see vivid examples of perfect beauty and obtain "valid" information about what is considered beautiful (McAllister, 1996; Stice et al. 1994). Internet is another source where they can easily search and find information on beauty, plastic surgery, tactics to look thinner, make-up tips, and the rest. Magazines, especially health, fashion, and women magazines constitute another important source for this kind of information. Since the representation of surgical operations in the media is usually positive, these fantasies of perfect beauty become more pleasurable since the imagined consumption is realized to be within the realm of possibility (Ger, 1997). Doctors state that when patients

only see the before and after photos in the media, they do not think about what actually happened in between, and the pain and complications that those celebrities might have experienced, because they are not publicized in the media.

This is also one of the reasons why plastic surgery is perceived to make someone beautiful in a miracle way. News and articles in the media "promise" the readers or the watchers that they will get the ideal they want. Some examples in newspapers promise that legs which are out of shape become columnar with surgery and that one can have aesthetic teeth within a couple of hours before one's job interview. Some catchy terms are used like slogans for plastic surgery in newspapers and magazines, where they are especially used as headings, such as "aesthetic break during lunch time" and "large and firm breasts in two hours." Some of the news might minimize the surgical content of aesthetic operations and talk about them in an entertaining, fun language:

> You know those operations which make your nose get trimmed, your ankles thinner, your chin roundy and nice, and your breasts supported with mini silicones; for those who are afraid of these operations, there are other "retouching" operations… Painless operations, in other words! Like make up… (Newspaper clipping, 2005)
>
> *Hani şu burun kırptırma, ayak bileği inceltme, çene kemiğini topicik topicik yapma ya da memişleri minik silikonlarla destekleme operasyonlarından korkanlar için daha "rötuş" kıvamında operasyonlar var ya... Acısız operasyonlar yani! Makyaj gibi...*

Informants do not only read local newspapers or follow Turkish TV channels as they are more conscious of other people all over the world, and of the whole world as a whole (Robertson, 1992) through foreign television

channels, magazines, and the Internet. Any image or news on TV or the Internet has an "instant" character; so anyone can learn about the same news at the same time with other people around the world. Therefore, media images and narratives are globally distributed (Appadurai, 1990). Informants watch foreign channels such as MTV, Turkish version of foreign channels such as CNBC-e, or Turkish version of foreign programs such as *Beni Baştan Yarat* (originally, Extreme Makeover).

They can even participate in this "global" dialogue such as by joining discussion groups on the Internet by talking among themselves about what they see on TV, looking at these celebrities' web sites, and reading news and interviews on magazines. They can sometimes vote for "who is more beautiful" on the Internet; vote for "who is more famous"; choose which of their friends look good (such as "My Sexy Friends" application on some web sites); or play with their own appearances (such as "Likeness" application on some web sites where you would find which celebrity you resemble). Therefore, the ideology that one has to be good-looking is spreading very rapidly (Appadurai, 1990). According to informants, even if one does not have the natural beauty (*güzel*), s/he can at least try to be pretty (*bakımlı*).

It is also found that informants are more likely to observe other people during every day life, such as what they wear and how they look. Some informants are really interested in knowing everything about body and beauty, so their receptors are open to new information from any source, exemplified by Gaye (37F) below.

> I buy all the books I find about this subject… my acquaintances… books, television channels, newspapers, magazines, sometimes high society magazines… ummm… aestheticians [aesthetic surgeons], I talk with all aestheticians I know, I gather information from normal doctors…
>
> *Valla bulabildiğim bütün her yerdeki kitapları alıyorum, bu türde bulduğum... yakın tanıdıklarımda, çevremde... kitap, televizyon kanalları, gazete, dergi, bazen sosyete dergilerinde... eee... estetikçiler, tanıdığım bütün estetikçilerle konuşuyorum, normal doktorlardan bilgi alıyorum...*

During information search, word of mouth and the power of influence groups become particularly important. Patients in the waiting area talk to each other and share all they know. They ask previous patients about their experiences, even though they do not know them in advance. For an example of how a patient can turn into a consumer of plastic surgery who can invite others for surgery, one can look at the web site of Cindy Jackson, who went through several aesthetic operations and became satisfied with her appearance at the end. It is observed that relatives and friends become important sources, where mothers seem to be one of the strongest influencers in this study. Many informants state that their mothers were making strong suggestions about having an operation. Bilge (25F) talks about a mother who brought her son to the hospital for a nose job:

> A very interesting simple example is something I came across lately and I was shocked. A little boy who was 13 years old, he had a small bone on his nose, his mother just takes him to my office, saying "make his nose", the boy doesn't have such a desire, he's not even in a position to recognize his physical appearance, his… he doesn't have that maturity or consciousness, his mother was like "he will be excluded" etc, etc, "make his nose"…

En basitinden mesela cok enteresan birsey, geçen karşılaştım ve şok olmuştum. Onüç yaşında bir erkek çocuk, burnunda ufak bir kemer var, annesi bunu sürüklüyor benim odaya, bu çocuğun burnunu yapın diye, çocuğun kendisinin böyle bir isteği yok, daha kendisi dış görünüşünü hani algılayabilmiş durumda değil, o er... erişkinliğe veyahut da o bilince sahip değil, annesi diyor ki bu çocuk ilerde dışlanır, bilmem ne olur, şu olur, bu çocuğun burnunu yapın...

It is also probable that the media answers individual questions, where doctors can reply questions through e-mails. Patients ask opinions of people whom they like and trust in the media, such as a person whom they call Sister, who replies letters from readers.

Dear Sister, I'm a young and beautiful woman and everybody likes my appearance. My only problem is that my breasts are small. I want to have breasts that are beautiful and firm just like famous artists and photograph models in the magazine world. I think those models also have gone through aesthetic operations on their breasts. Clothes really fit them and they are very good looking in terms of their physical appearances. What do you say, should I go through a surgery to have bigger breasts? I want to act according to your suggestions because I really trust you.
Dear Daughter, I wish I had a chance to show you a letter from Germany that I got a few days ago… One of the valves on her breast implant exploded, and I think one implant was not in accordance with the other implant. At the end, she said "I wish I hadn't gone through the surgery, I wish I had my smaller breasts back". Maybe it's her bad luck, maybe not everyone goes through the same thing. (Newspaper Clipping, 2007)

Sevgili Abla, ben çevresi tarafından çok beğenilen, genç ve güzel bir kadınım. Benim tek sorunum göğüslerimin küçük oluşu. Ben magazin dünyasının ünlü mankenleri, fotomodelleri gibi güzel ve diri göğüslere sahip olmak istiyorum. Sanırım bu mankenlerimiz de göğüslerinden estetik ameliyat geçirmiş. Gerçekten de giydikleri yakışıyor ve fiziksel özellikler açısından görünümleri çok hoş. Ne dersiniz, göğüs büyütmek için estetik ameliyat olayım mı? Sizin düşüncelerinize güvendiğim için fikrinizi almak ona göre hareket etmek istedim.
Sevgili kızım, keşke imkan olsaydı da sana bundan birkaç gün önce, Almanya'dan aldığım bir mektubu okutabilseydim… Bir göğsünün silikonun subapı patlamış, diğerinde ise sanırım bir uyum bozukluğu olmuş. Sonuçta, "keşke ameliyat olmasaydım, göğüslerim küçük

kalsaydı çok pişmanım" diyor. Belki bu biraz onun şanssızlığı. Herkeste bu tür sonuçlar ortaya çıkmayabiliyor.

The answer contains misleading information and creates an image that people might think that they know technical details about the surgery and discuss the risks among themselves even though they do not have the necessary training.

Conflicting thoughts and perceptions in "media sources" such as television, newspapers, magazines, Internet, and "people sources" such as previous patients and relatives, it becomes a difficult process for patients to process all this information and come to a decision. Since the attributes of interest for consumers are imprecise and unknowable in advance (before the surgery), it becomes a difficult task for them to evaluate the doctor alternatives (Kotler, 2003), too. Some patients choose a hospital and then choose a doctor in the hospital, which resembles going to a shopping mall and searching several stores to decide. Some people directly search for a plastic surgeon and make an appointment with him/her, which resembles choosing a specific brand. Some patients contact the secretary of a plastic surgery department and ask for the surgeon with the highest number of appointments, or they just sit in a chair and observe doctors to decide, which resembles looking at a magazine and searching for the most fashionable or popular brand. Some other patients already know about a doctor, so they just go to the same doctor without searching for another plastic surgeon, which resembles brand loyalty. The brand (doctor) in this case is really an active partner (Fournier, 1998), not only because the connection is

ongoing with the brand contributing to the relationship, but also because the brand in this case is a human being. Brand personality (Aaker and Fournier, 1995) thus coincides with the doctor's personality traits, such as his/her physical appearance and friendliness, and academic performance such as perceived level of knowledge and results of previous operations.

Patients can also decide on the surgeon by talking to strangers, too, indicating that people may trust previous patients more than other sources. Ali (39M) talks about one such example, where a tourist hears two people talking about a plastic surgeon in a good way, and she decides to go for surgery based on what she hears.

> And then this Dutch woman went back to Holland, she only had my name and surname; she doesn't even know where I work; and she applied to the Turkish Embassy in Holland telling them that she wants to reach me, and the embassy found after some research that I'm working at Gazi University, and then, after this much effort she went through [laughing] she came from Holland to have the surgery, I mean all of these are not rational attempts according to my own logical thinking [laughing] so I looked at it… I listened to it with surprise.
>
> *Sonra bu Hollandalı kadın Hollanda'ya geri dönmüş, ama benim adım soyadım var, fakat çalıştığım yer dahi yok, Ankara Hollanda Büyükelçiliği'ne başvurmuş, ben bu doktora ulaşmak istiyorum, büyükelçilik de bir arştırma sonucunda benim Gazi Üniversitesi'nde olduğumu bulmuş, onun üzerine böyle bir çabadan sonra kadın [gülerek] Hollanda'dan atlayıp gelip ameliyat oldu, yani bunlar tabii benim kendi mantık silsilem içerisinde doğru hamleler olmadığı için [gülerek] şaşkınlıkla bak... dinliyorum tabii.*

Therefore, as in the case of impulse purchasing, decisions can be quick and decision criteria may not be "rational." Observation results revealed that patients can come to the doctor's office in a mood very much determined about

the plastic surgery decision, even though they have other health problems. Some patients literally state that they do not want to think about the operation decision since any new information would confuse their minds. These patients directly ask the physician, without talking about the specific details or possible complications, "can you give me a date for breast augmentation, please?" so that s/he would not think about his/her decision anymore.

Patient-consumers with these intricate thoughts and feelings engage in discourses with people they know, with people they do not know, and with themselves. They watch and read news and talk to each other about plastic surgery. They negotiate medical and psychological questions and uncertainties. Different views in society and medical realities provided by the physician all become parts of a complex decision. Results show that patients who have already decided to undergo surgery resolve the tension they feel by rationalizing their decision.

6.1.3. Rationalization of Plastic Surgery

During interviews, or during consultations and control visits, patients come up with several legitimizations for why they need surgery (Ger and Belk, 1999). They try to come up with good excuses, and in a way defend themselves, for their decision. Although the surgery is a highly established medical performance with many standard rules, it is transformed by individuals into

individualized experiences with personal meaning. In other words, they are trying to communicate the idea that they are not like those who misuse surgery for the mere purpose of becoming more attractive; and they state they do not want to display the good work by revealing their breasts or other parts of the body. They try to form the whole experience as an individuated possession (Arnould and Price, 2000) and by linking it to a self-narrative so that the surgery for them is a personal performance.

6.1.3.1. Perceived Necessity: "I Really Need Surgery"

Some informants explain their decision for having surgery in the form of a need. The idea of "having to have" the surgery is especially valid for people with deviated noses and big breasts. People with deviated noses have difficulties in breathing and sleeping. They usually "prove" that they have problems by illustrating that they cannot breathe well. People with considerably large breasts also have several health problems including aches in shoulders, back pain, and rash under breasts. These patients usually complain for several minutes explaining all these problems in a moody and afflicted manner. Actresses and people in military service are required to adhere to specific appearance-related attributes defined by law; for instance, they should not have scars on face. It is at this point where the line between reconstructive and aesthetic surgery becomes very thin (Gilman, 1999) because although the surgery would be

defined as having aesthetic concerns, results would also improve patients, quality of lives by solving several health problems. Moreover, when they need to reduce the size of their breasts due to health problems, they also want them to be tighter, higher, and firmer. When they have to fix the deviation of the nose, they also want the exterior to be done. Almost all nose patients literally state their motivation for rhinoplasty as "let's make the exterior since we're making the interior done."

It is also common among patients to describe their motivations in the form of needs when they think they would not go through surgery if the conditions were otherwise, as Sayre (1999) pointed out in her study. For example, women with small breasts think that they "need" the operation because bras with extra pads and wires are so uncomfortable. Some patients think that they need to look better because their job necessitates having a young, attractive outlook (Howson, 2004), like Ödül (35F) who wants to be offered better roles in theater. It is observed that females can apply for surgery only to please their male partners (Cahill, 2003). In one such instance during a consultation, a wife and a husband came to the doctor's office. The female asked for breast reconstruction because she thought her breasts have lost their attractiveness after pregnancy. On the other hand, her husband wanted her breasts to be bigger, too, although she was demanding no such request. At the end, she went for both breast augmentation and reconstruction surgeries; and as she explains later, she needed to look good for her husband.

6.1.3.2. Search for Normalcy: "I wanna Wear Skirts like Everybody Else"

Some informants feel like a deviated nose or a big tummy is not normal hence they want to get rid of the problem in order to feel more "average" and standard. Even though the body-related problem is not necessarily visible from outside (such as when the patient wears padded bras or when she covers her tummy with large clothes) and although the problem is not actually a physical handicap which requires medical intervention, patients still do not feel normal. Medical science and the media seem to be the two major sources of establishing the normative standards (Joy and Venkatesh, 1994), through which patients first "problematize" and then normalize (Thompson and Hirschman, 1995).

To claim a normal identity, they go through a surgical operation, or a specific technology of the self (Foucault, 1988); and they regulate themselves (Foucault, 1981b) by monitoring their bodies not only because they want to look good but also they want to be healthy (Foucault, 2003 [1969]). Patients do not consider themselves to be "healthy-looking" when their breasts are too big or when they feel like they cannot breathe well even though the deviation is not too large. They consider themselves to be not healthy-looking even when their legs are too wide, when their eyes have excess skin, or when they are bald, which makes the medicalization of appearance even more effective (Gilman, 1999; Sullivan, 2001). In other words, they feel "normal" only after the surgery they "need," not only for their appearance but also for their health.

Therefore, it is getting more and more difficult to define what is "normal". There is a historical example illustrating how beauty and normalcy are related. By the early part of the twentieth century, some industries began to make widespread use of practical anthropometry. Anthropometry is the measurement of height, weight, and other dimensions of human beings to compare body parts of different people, different sexes, and different races. At that time, all measures have been recorded in statistical tables so that standardized measures of the "average" body can be used by clothing industries. However, what began as a table of statistical averages soon became a means of setting ideal norms (Urla and Swedlund, 1995). Records have shifted from statistically "average" weights to becoming a guide to "desirable" weights that were notably below the average weight for most adult women. This points us to the socially adjustable nature of human biology, i.e. its completion by culture. Therefore, "Norm and Norma, the average American male and female" were more than statistical averages; they were ideals.

In this study, informants do not feel normal until they reach the physical appearance they strive for. They illustrate examples where excess fat becomes visible in everyday clothes, their bellies get out of their t-shirts as if they are pregnant, or their breasts do not fill the bra they want to use in order to fit the dress they would like to wear. In other words, normalcy is defined from outside through fashionable clothes and perfect images, where informants find excesses, shortages, or deformities that do not fit the clothes or images. Interview results show that making breasts medium-size, round, and firm is now perceived as

making them closer to “normal”, more than making them sexier (Thompson and Hirschman, 1995). Bilge (25F) states that one can talk about a line of beauty where, on the one end, there are those people with noticeable deformities and those without such abnormalities on the other end.

> What we do in general is to make the ugly beautiful, and make the beautiful very beautiful, and make the very beautiful very very beautiful, this is what we do according to patient expectations. In reconstruction what we do is that we do the first step that I described, make the ugly beautiful or make it acceptable. Reconstructive patients don’t demand too high, they don’t aim for the very beautiful, they actually demand the things that they deserve as human beings… They only want to be normal, you know, making the ugly beautiful or nice or acceptable. For aesthetic patients, they’re already beautiful, nice people [laughing], they want to be much nicer, much much nicer, well, I respect them too.
>
> *Bizim çok kabaca genelleyecek olursak yaptığımız şey, ya çirkini güzel yapıyoruz ya da güzeli daha güzel yapıyoruz ya da daha güzeli daha daha güzel yapıyoruz, işte insanın beklentileri doğrultusunda böyle birşey yapmaya çalışıyoruz. Rekonstrüktifte nispeten yaptığımız iş ne oluyor, bunun ilk basamağı kötüyü güzel yapmaya çalışmak ya da kötüyü kabul edilebilir yapmaya çalışmak oluyor, dolayısıyla hastanın ne oluyor, beklentisi aslında normal olmak oluyor, rekonstrüktif vakalarda çok aşırı güzeli hedeflemiyor, çok aşırı şeyi hedeflemiyor, aslında son derece insani hakkı olan şeyleri istiyor... zaten onların tek isteği normal olmak, işte yani kötüyü güzel yapmak ya da iyi yapmak ya da kabul edilebilir yapmak. Estetik vakalarda zaten genellikle hepsi güzel hoş insanlar [gülerek], daha hoş, çok çok daha hoş olmak istiyorlar, ona da saygım sonsuz.*

The critical point here is that these people can be regarded as having the same “interest” in beautification. Those with more noticeable abnormalities, such as those without arms or legs (Sherry, 2004), and those with more “cosmetic” requests, such as those who come for breast augmentation or face lift, can be considered as having similar requests as people in both ends attain to be more normal by having the surgery done, where the definition for normal

changes among people. They actually use the word "normal" a lot during interviews. Hayal (39F) thinks that aesthetic surgeons can form "normal" noses through surgery; Hazan (28F) wants to have "normal" ankles through a surgical rasping procedure; and Esma (32F) says she was not able to wear "normal" shirts at work like her "normal" friends. These patient-consumers, therefore, have a certain "desire" (Belk et al. 2003) to achieve normalcy. It is also interesting to see that what is defined as "normal" by informants usually refer to a person with Western physical characteristics (Fehervary, 2002), as discussed later in this section.

6.1.3.3. Transition towards the Better: "I Want to Look Like Them"

Some people want to resemble people in different groups, social classes, or different races. For example, Derya (25F) lives in Chicago working as a network specialist. She frequently comes back and forth between Turkey ands the U.S. and she says she felt like the only one with a big and bony nose as all others had nice noses because of their genetic makeup.

> Especially when I went to the U.S. it was very [obvious] because everyone in the U.S. has very nice noses, I mean… Their noses are not like the ones in Turkey… because their genetic things are better, I mean… their noses are really much nicer I think. Since I was there for a year, I've got this nose thing [idea], you know everybody has a nice nose but mine is a bit, it has a bone here and it is low here and this thing developed, this desire, and that's why I wanted to have it [the operation].

Özellikle Amerika'ya gittiğimde bu çok şey oldu çünkü Amerika'da herkesin burnu çok güzel yani, şey... Turkiye'deki burunlar gibi [değil]... onlarin genetik şeyi daha iyi olduğu icin, şey... burunları cidden daha güzel, sanırım, hani son bir yıldır orda olduğum için bu burun olayı daha çok ilerledi, hani herkesin burnu güzel benimkinde bir şeylik var, kenar var işte, şurada bir düşüklük var falan bu daha çok böyle ilerledi bu istek o yüzden [ameliyat] olmak istedim.

Turkish people who temporarily work outside of Turkey or who travel among countries explain how their appearance can become a problem in different contexts in a foreign country. What they describe as personal problems related to 'looking Turkish' is also prevalent in other contexts. Ethnic differences in appearances affect which operations are carried out more frequently in different countries. For example, doctor informants gather a diverse breadth of knowledge in different countries where demand varies. They state that due to differences in racial features and geographic conditions, Turkish people are shorter and they have bigger breasts, bigger thighs, and bigger noses, so they go through breast reduction, liposuction, and nose surgeries more often than in other countries. In Nordic European countries, however, people are taller and thinner, and they have small noses, making them candidates for breast augmentation more than other surgeries. Moreover, their skin is lighter and more sensitive, which makes them grow old sooner and apply for face lift and eye lid surgeries more often than people living in southern places. In Far Eastern countries, there are many nose operations carried out; however, the form of surgery is different. In China, Japan, and Malaysia, physicians try to fill the space on the nose using filler materials or gristle from ears to make it look more Western, hence Western standards become the

implicit standard and the 'normal' (Fehervary, 2002). Similarly, people in Far Eastern countries are small and short, therefore big breast implants do not look good on their bodies. They also go through eye lid surgeries in order to create a second lid on their eyes like in the U.S. and Europe. All of these experiences are important for doctor informants because they train and develop themselves, as well as provide education, according to the "demand" that "naturally" varies in different countries. This may indicate a desire for the Western appearance at a more general level.

The imagined transition can also be among different social classes in the same society. Hacer (18F) is a high-school graduate, who wants to take the university exam and study further. She wants to become a policewoman as she thinks it is easier to get that job. Her father works as a cleaning person in a university in Ankara, but she preferred to describe him as a "person working in the university" with a large circle of friends and co-workers, disguising his real job. She explains her motives in the form of a need, as her nose is deviated and she has difficulties breathing. But further probing and subsequent analysis revealed that she wants to be included in the society, especially higher social classes. She thinks she can be one of those beautiful women who are married to men with good jobs and nice looks. So she implicitly assumes that the operation will give her a chance to achieve upward social mobility (Gilman, 1999). She wants to marry and she thinks her appearance would help her find and maintain someone.

> Women haver it in their nature, woman is beautiful, I mean with her physical appearance, her face, especially if she's married she should be much more well groomed, why, in order to make the marriage go well, I mean not to make her husband look at other women, in order to be satisfying for her husband, it's the same thing for a boy friend, it's the same thing, I mean a woman, with her grooming, nice smell, make-up and you know, her eyes with sürme [a special make-up dye that darkens the eyelids], with her nice cherry lips, she should be able to satisfy her husband, I mean the other things that she does, she should do it for herself.
>
> *Hani kadının zaten doğasında vardır, kadın güzeldir, hani fiziğiyle olsun, yüzüyle olsun, hele bir de evliyse hani daha çok bakımlı olmalı, niye hani evliliğin düzgün gitmesi açısından, hani kocasının gözünün en azından başka bir kadına bakmamasından, doyurucu olmasından, bu erkek arkadaşı da olsa farketmez yani, hani bir kadın bakımıyla, güzel kokusuyla, makyajıyla veya hani sürmeli gözüyle, güzel kiraz dudaklarıyla falan bir erkeğini doyurmalı bence, hani onun dışında yaptıklarını öncelikle kendi için yapmalı.*

Therefore, surgery can facilitate bodile changes, which facilitates changes in other aspects of life. Hazan (28F) talks about an incident that she experienced when she started to work as teaching assistant. She was wearing casual clothes to school until when the department head sent a note criticizing her clothing style. Hazan (28F) knew that they had the blonde girls in the department in their minds as examples of good appearance, and she describes those girls wearing fashionable clothes, mini-skirts, and high-heel shoes. This stays as one of her motivations to go through plastic surgery to have her legs more in shape and attractive. Hazan (28F) literally states that she wanted to look like other girls in school. So the person may want to have the surgery in order to wear the clothes s/he wants, which can be reflected in a patient's words: "Now, my body fits the clothes!" (Gimlin, 2000)

6.1.3.4. Sense of Empowerment: "I Like It and That's It"

A remaining group of patient-consumers just do not legitimize their decision for having surgery by telling this is what they want and that is the whole explanation. Some patients come to doctor's office just because they want to concentrate on themselves and do something about their appearances. When the physician asks "how can I help you," they usually respond by saying "you can make me happy" or by joking about their problems and laughing at their jokes. On the very same day, they could as well go shopping to reduce pressure and anxiety they feel about life in general. For example, they state "*I felt so down at home so I came here just to feel better*" or "*I forget about my problems when I talk with the doctor here about my beauty.*" Hazan (28F), after the accident, wanted to feel better about her physical appearance, although there were no major injuries or abnormalities. Similarly, Hayal (39F) is aware that she is going through all those operations just to feel better in life.

> It was around 1996 or so, I was more beautiful than now as I've shown you in photos, my nose was smoother, just average, straight, you know like yours… [pause] and then I got divorced and I thought I should do something, I was unhappy, I asked myself what I should do, I thought I can make my nose done. [I've decided that] I'll make my nose done. Everyone was like there is nothing wrong with your nose… no, no, I though I should do it, you know, something different, a wish to be happy, you know, like I did in the past, if I do something [like this] I would be happy and this happiness would spread to other people…
>
> *1996 gibi falandı, yine fotoğraflarda gösterdiğim gibi bence bundan daha güzeldim, düzgün, sıradan, dümdüz, seninki gibi bir burundu benim burnum... sonra [duraksama] eşimden ayrıldım ve bişi*

yapmaliyim dedim, çünkü mutsuzum, ne yapmalıyım, dedim burnumu yaptırayım, burnumu yaptırıcam, ya burnunda birşey yok herkes [böyle söyledi]... yok yok yaptırıcam, yani değişiklik, mutlu olma isteği işte, daha önce olduğu gibi, birşey yaptırırsam mutlu olurum ve başkasına da benim mutluluğum geçermiş gibi…

Informants state that they feel better about themselves when they do something about their bodies. One patient makes a joke about it by saying "I have surgeries done in my spare time" (*Boş zamanlarımda ameliyat oluyorum*). Bodies are their *own*, bodies are *only their* own, and bodies are *them*. Patient-consumers in this study have expressions of empowerment when they decide to go for surgery on their own, have an operation that they had wanted for several years, imagine their beauty after the operation, and even lie about the operation to their fathers and brothers. They want to control their own destinies, go for surgery for their own pleasure, and even have fun in the hospital. It is also usual for some people to try their own solutions before coming to the hospital. For instance, some tried to create their own botox mixtures and died as soon as they have injected those solutions into their skins. Another person injected an animal's fat on his face and almost died as his face got inflamed. Another person injected gearbox oil into his penis to make it larger and had serious complications afterwards. There are many people who tried to make their ears look smaller by gluing them on the back of their heads.

According to doctor informants, it is generally considered inappropriate to go through a face lift operation after the age fifty or sixty in Turkey, because at that age, people are considered to be retired from life, too, so they should sit at home, relax, take care of their grand children, and do other things for their

families. Many patients who come to the hospital considering an operation say they are ashamed since they are now considered elderly. For some informants, therefore, going through a face lift also means proving themselves and others that they are still alive. Especially after the age fifty, patients state their willingness to show their friends and family members that they exist. There are several examples where patients want to prove that they will "look good when they die."

A similar feeling of empowerment exists among patients who think that they regulate themselves by way of surgery. For example, almost all liposuction, breast reduction, and abdominoplasty patients promise themselves that they will not gain weight ever again. They feel the surgery gives them the power to continue living as a person who controls his/her own life. Surgery also empowers individuals when it is seen as a reward (such as for finishing high school) or a punishment (such as for eating too much), because in these cases individuals feel like they have decided for surgery on their own. Many patients use the sentence "it's my own decision" (*bu benim kararım*) to refer to this kind of empowerment.

6.1.4. Laboring for the (Fashionable) Ideal

With such legitimizations explained above, patient-consumers can decide to go for surgery. The important point here is that even after correcting the body

"flaw," beauty work does not stop. Even the ambiguity around their decision might continue since a similar set of social and cultural forces remain after the surgery. Patients continue to negotiate their identities in a culture intermingled with different discourses on religion, income, and patriarchy. Even though all informants have an idea about perfect beauty, none of them said they achieved their ideal.

There are two types of ideals for these individuals. The first one is a kind of beauty which is more self- and past-oriented, where they want to recapture the look they used to have in the past. Leyla (44F) states that she wants to be "old her," and her ideal is her younger self. A few other informants also state that they used to be very happy about their appearances, but since they are aging, they now feel like they are losing their attractiveness. Gaye (37F) depressingly talks about her aging and how she wants to be herself with her younger skin and pre-pregnancy body.

Many of the informants appreciate how celebrities remain so young and beautiful through the use of non-invasive techniques and surgical operations. They harshly criticize celebrities who do not utilize available techniques of plastic surgery to make their appearances younger and more appealing. They do not find old people attractive and when they talk about aged people they only refer to their appearances they used to have in the past. For instance, Hayal (39F) thinks that youth gives someone beauty.

> This [Harrison Ford] used to be handsome, but now he's too old, it would be nonsense if I say he's handsome. Brooke Shields was very beautiful in the past, but now I'm much beautiful than her. Really!

Bu [Harrison Ford] eskiden yakışıklıydı, şimdi çok yaşlı, yakışıklı demem saçma olur. Brooke Shields eskiden çok güzeldi, ama şimdi ben daha güzelim ondan. Vallahi bak!

Moreover, attractiveness is a concept that applies to young people according to Hazan (28F). So it would be nonsense to talk about an aged person's physical appearance since other people would not be interested in him/her.

> The third one [David Beckham], I don't know, I mean the third one is too old for me I mean if I were to choose [him] to be my boyfriend, I couldn't even touch him, he's too old.
>
> *Ya üçüncü [David Beckham] ne bileyim ya üçüncü böyle çok yaşlı falan geldi bana yani sevgili olarak seçeceksem ben o adama kesinlikle dokunamam, çok yaşlı.*

Some informants do not focus on themselves, but on others. The ideal in this case is not the individual himself/herself, but someone else. Patient-consumers who are "other-oriented" in their plastic surgery conception are found to be more involved in celebrities' appearances and their lives, in terms of what they do, where they go, what they wear, and so forth (Austin and Vancouver, 1996), which creates a yearning for the achievement of that ideal state even if it is unrealistic (Danaher et al. 2000). Even if patients do not approve lives of celebrities, they still have good knowledge of what is going on. They state that they at least look at the pictures and photos – clothes, hair, or make-up – without reading the news. When they are waiting for their appointments and even during consultations, they talk about how celebrities wear, how they apply make-up, and they give examples from celebrities as they

think celebrities' beautification practices are already fashionable and trendy.

The ideal beauty is sometimes abbreviated using the words "Russians," "Moldavians," "Norwegians," "Polish," "Germans," or "North Europeans", meaning that people living in those countries are already "proven" to be beautiful so by resembling a Russian person, one can guarantee his/her own beauty. They literally use the word "Russian" or "North Eurpoean" to refer to their ideal beauties. They may say things like "skin like a Russian" (*Rus cildi gibi)* to refer to a light-colored, smooth skin and "has a Eurpoean look" (*Avrupai bir havası* var) to refer to a non-fat, thin and tall body. Many informants give examples from Russians and Moldavians who come to visit Turkey especially during summer. Those women who physically move from one country to another (Appadurai, 1990) look so nice and attractive that informants start to question their own beauty and these tourists can become role models (Ger et al. 1993). Mine (28F) says that these foreign women set high standards of beauty for Turkish women, implying that Turks need to change their appearances if they want to be attractive like a Moldavian or European.

> Those women who come from abroad, I don't know, like Moldavians, you know those Latinos… not the Latinos but… I don't know, these men especially during summer, they go to those places and [Turkish] women, rightfully I mean, I don't know… they have to make concessions, maybe they won't go for it [surgery], but just for that reason they go for it.
>
> *Bu yurt dışından gelen kadınlar, ne bileyim Moldovyalılar [Moldovalılar], eee işte bu Latin... Latinden ziyade... ne bileyim yani bu erkekler özellikle daha çok yaz dönemlerini de o şekilde değerlendirip oraya gidiyorlar ve [Türk] kadınlar haklı olarak artık bilmiyorum... kendilerinden ödün vermek zorunda kalıyorlar, belki [ameliyat] yaptırmayacaklar ama sırf onun icin yaptırılabiliyor.*

Besides foreigners who come to Turkey for various purposes, Turkish informants who go to other countries also compare themselves to foreign people. As mentioned in the "transition" discussion above, Gamze (20F) is extremely concerned with the way she looks as she believes appearance is very important for success, as she is currently working on an album. Duygu (F25) works in Chicago and she feels threatened when people in her office look very attractive, modern, fit, healthy, and shiny. Those who want to work outside Turkey have to reconsider how they look not only in terms of being healthy and attractive but also in terms of looking more Western. Duygu (25F) says Turkish people are easily distinguished from their European or American counterparts, so they may consider having plastic surgery, such as make their noses smaller. Altay (34M) who works as a taxi driver in San Francisco states that the issue of physical appearance is very important as people have strong attitudes towards different races in the U.S.

On the other hand, informants use the words "Chinese," "Pakistani," or "Far Eastern" to refer to unattractive people. When informants were shown a video about African cultures' notions of beauty and beautification practices, such as the tradition of Thailand women to coil their necks, ears, and lips with rings and dishes, informants were disgusted by these practices and expressed such terms as "horrible" (*iğrenç*), "I'm feeling faint" (*fena oluyorum)*, "disgraceful" *(rezalet)*, "torture" *(işkence)*, "stupid" *(aptal)*, "nonsense" *(saçmalık)*, "it's nasty" *(pis birşey)*, "I'm disgusted" *(tiksindim)*, "poor woman"

(zavallı kadın), "idiot" *(geri zekalı)*, and "very bad" (*çok kötü*). They stated that these practices are totally out of any considerations for beauty, and that no one in this world, other than people living in that region in Thailand, would be content with such an understanding of beauty.

When informants talk about an ideal body, they mostly give examples from singers and film stars not only because they are physically attractive, but also because they are presented as ideally attractive. In other words, they do not have to physically see their ideals as the media already makes them available. Hayal (F39) literally states that she is very much affected by women that she sees on TV, especially in celebrity news and fashion shows. She admires models on Fashion TV and she tries to look like them. She explains that she made her teeth re-made to resemble Harika Avcı, a formerly popular Turkish singer and actress, because the "bunny look" with two teeth in the front was very popular at that time. Nalan (18F) states that she used to look at celebrities' noses all the time until she decided to go for nose reconstruction surgery. It was like choosing a nose from a catalog. She came to the doctor with several pictures of the same model, showing her "perfect" nose from different angles.

There are many patients who brought pictures of their ideals, in order to physically show the physician whom they want to resemble. These pictures are almost always the pictures of foreign celebrities, mostly European and American. One patient brought several pictures of Monica Cruz (whom she wants to resemble) and Tori Spelling (whom she does not like), showing good and bad examples from famous people. Another male patient brought pictures

of Brad Pitt saying that he wants to look exactly like him. Another patient brought pictures of Demi Moore for her noses, by also stating that she wished she would totally resemble her in all body parts. There are other pictures brought by patients, but the interesting point is that none of these pictures was a Turkish celebrity.

When informants were asked about the specific characteristics of their ideal appearance, features of the female ideal are big and round breasts, a thin, proportional body, no fat, especially no belly, a small and lifted nose, blonde hair, long and lifted eye brows, not-prominent ears, colored and big eyes, full lips, light-colored skin, and no wrinkles. These specific features actually correspond to a Western or European outlook as informants refer to these characteristics as not Turkish but Western and European (*Batılı* or *Avrupai*). For instance, in a projective study, informants were asked to compare people from different nationalities and cultures. Informants chose the one who is blonde, who has a "Caucasian" nose according to medical definitions, and the one with lighter skin, usually not even considering the Chinese and black people as candidates for beauty. Moreover, all doctor informants state that no single patient has ever wanted to look like an Arab or a Japanese, as they always want to resemble someone with a lifted nose (usually a characteristic of Europeans, according to doctors), no-fat body, and light skin.

There are a variety of emic terms that informants use to refer to these characteristics. For instance, the term *Rus gibi* (like a Russian) is used to refer to thin, tall bodies with blonde hair and colored eyes. They use the term *Avrupa*

standartları (European standards) to refer to tall women with perfect proportions, such as 90-60-90. They use the term breasts like bombs (*bomba gibi göğüsler*) to refer to breasts which are not too big like Anatolian women, but not too small, and which are firm and round, like the ones they see in fashion channels and the ones that bikini models have. They say that these bikini models are usually from North Europe and they claim everybody in this world has already accepted that North Europeans have very nice bodies and faces. These models have teeth like pearls (*inci gibi dişler*) when they smile and have young body like a stone (*taş gibi vücut*) as they appear when they pose in a beach. Emic terms for bad characteristics include mass production (*seri üretim*), same model (*aynı model*), like a transvestite (*dönme gibi*), artificial (*yapay*), engine (*motor)* to refer to promiscuous women, ornate (*kokoş*) to refer to very fancy women, like cloned (*klonlanmış gibi*), monkey (*maymun*), dead fish (*ölü balık*) to refer to the strange look that people with too much botox can have, which connote negative attributes of going through "faulty" surgeries or going through many surgeries one after another. These performances could be interpreted as making the individual move away from his/her "true self," "his/her individual existence," and "who s/he really is" (Arnould and Price, 2000); something that further increases alienation of the individual from his/her inner self (Gimlin, 2000) and from the community.

Examples given by informants serve as people-brands, where they can refer to these famous names and can safely assume that other people know what s/he is talking about. These recognized singers or film stars are usually foreign,

as stated before. The female examples are Angelina Jolie, Milla Yoyovich, Princess Stephanie, Lucy Liu, Liv Tyler, Nicole Kidman, Beyonce, Elle Macpherson, Vanessa Hessler, Jennifer Lopez, Catherine Zeta Jones, Sharon Stone, Madonna, Meg Ryan, and Elizabeth Hurley. A few Turkish female examples include Ajda Pekkan, Deniz Akkaya, Yeliz Yesilmen, and Petek Dincoz. Bad examples include Cher, Pamela Anderson, Deniz Akkaya, Tanyeli, and Ajda Pekkan.

It is interesting to see that such examples as Ajda Pekkan can serve as both good and bad examples for female beauty. This also reflects the ambiguity around the concept of plastic surgery, which is both degraded and appreciated. Even Handan (35F), who is against plastic surgery, thinks that Ajda Pekkan "deserves" to go through the operations because she thinks Ajda Pekkan intends to make herself sexier for her job performance. Hayal (39F) says she adores Ajda Pekkan because she can keep her sexy appearance. Hazan (28F) says Ajda Pekkan is her idol, and thinks that even though she obviously went through aesthetic operations, she is still beautiful. Gaye (37F) thinks even though she looks a bit artificial, she had achieved perfect beauty. When informants compare Ajda Pekkan with Cher, who also went through a series of cosmetic surgeries, they all prefer Ajda Pekkan since she looks more Western and more "modern" in their own words, while Cher is a bit *kıro* (slang for a bumpkin, unstylish person).

In other words, even though Cher is a foreign star, Ajda Pekkan is liked more by all informants as she looks more Western, modern and stylish. She can

be described as a Turkish representative of the ideal global image that informants strive to attain. This idea leads to a discussion about whether there is an established "one-type" beauty accepted in the world. As discussed by many scholars in the area and literally stated by many informants in this study, the media "pumps" a certain ideal image as the beautiful and the sexy, therefore people, especially younger people, try to achieve the same appearance. A particular image may become aesthetically so pleasing across cultures that it may create a "collective mood" (Thompson and Haytko, 1997). A Turkish person is described by informants as having darker skin, brown eyes, hairy faces, more fat around belly and hips, and breasts that are too big. The ideal, on the other hand, has lighter skin, colored eyes, a thinner and taller body, and full lips. Cenk (25M) talks about his experiences in the U.S. as a "loser" in terms of romantic relationships although he thinks he looks attractive in a natural way. He states that a Turkish guy does not have a "universal charisma" that he can utilize wherever he goes.

It can be argued at this point that the common theme in self-oriented and other-oriented beauty work is the existence of an ideal (Wilk, 1995a). Specific characteristics of the ideal might be different in different places and they might also be different through time. Therefore, the target is not only difficult-to-achieve, but also moving. One newspaper title says: "Latest model Hande Ataizi" (*Son model Hande Ataizi*) (A newspaper clipping, 2002) implying that a star like Hande Ataizi, whom people admire in terms of her physical appearance, is also changing. Articles in magazines and newspapers explain

these changes and provide suggestions to catch up with fashion even though what is presented as beautiful and fashionable can be unrealistic (Byrd-Bredbenner et al. 2005). News frequently suggest that one needs to change his/her appearance in order not to be outmoded, with such slogans as "Renew yourself" (*Kendinizi yenileyin)* (A newspaper clipping, 2005).

Looking at winners of the beauty contest "Miss World" reveals that the winner has almost always been a white Caucasian, with smaller breasts, larger thighs, and chubbier legs in the past. Appearances have got thinner with larger breasts over the years with more prominent lips and eyes, indicating that there is fashion in beauty changing over time. In another study, looking at Playboy centerfolds revealed that the waist-to-hip ratio has changed over the years; and claiming that the notion of beauty stays the same in history is only an "academic urban legend" (Freese and Meland, 2002; Tooby and Cosmides, 2000). Plastic surgery is an effective way to construct or maintain the kind of beauty chosen. Hazan (28F) talks about a trend in her college that in the past four or five years, there has been an increase in the number of people with operated noses. Some of the patients come to the doctor's office demanding noses which obviously look operated. One of the doctors interviewed works in Germany and states that it is now fashionable to wear nose plasters even without surgery.

Moreover, plastic surgery as an industry, including doctors, practitioners, hospital managers, clinic owners, and aesthetic medical companies (that supply the necessary apparatus and devices to surgeons, such as implants for breast augmentation, bandages for face lifts, and plasters for nose

jobs), seems to follow the demands of patients and what is fashionable. Bilge (25F) describes, for example, that bigger breasts were more popular in the past while the size of breasts has decreased over the past ten years. Selim (52M) mentions about the fashion of having a "size zero" body, equivalent to wearing a size of 32-34. Onur (47M) says that in the past, patients used to prefer much smaller and lifted noses while today patients prefer more natural noses. It is also evident that patients might follow new, more fashionable techniques in plastic surgery, which is also promoted by the media. For example, since liposuction became popular, techniques specific to liposuction have been improved.

Therefore, informants who want to resemble someone else often turn to other people presented by the media for establishing their ideals, making the moving target even more difficult to achieve. The fact that surgery is painful and risky makes the journey more joyful than it already is, while physicians implicitly convey that without taking all the risks and going through the whole painful operation process, patients can never achieve the look they want. Even though this "beauty in progress" work is hard, especially when there is a surgical operation involved, the process is still enjoyable.

6.1.5. General Implications of "Beauty in Progress"

Informants work on their beauties, therefore a specific surgery is not necessarily the beginning or the end of their progress in beauty. The progress can be

experienced for the same body part through time or for the perception of general beauty, which makes it easier for patients to cope with "failures." The ideal serves as the symbolic end point, although it is very difficult to achieve that beauty according to patient-consumers, since it usually involves a foreign celebrity who does not resemble an average Turkish person.

Their decision to go for surgery involves a very difficult and complex process as there are a variety of discourses and meanings prevalent in the society. The media provides illustrations of perfect beauty and presents plastic surgery as a feasible solution to achieve the same look that celebrities have. This miraculous perception of aesthetic operations complicates the decision making process and alters the perception of surgical results. Word of mouth circulates in various ways spreading both correct and incorrect information and shaping consumer expectations, which also affects consumers' choices towards a specific surgeon.

Doctors are implied to know about patient expectations although the communication between the doctor and the patient may not be established effectively, as will be elaborated in more detail in the next section. Doctors are assumed to know about the prevailing discourses in beauty and what is considered to be the ideal physical appearance, as if it is also a medical construct with perfect proportions and ideal images.

6.2. Shopping for Beauty

Plastic surgery is becoming more and more popular not only because it is perceived as an effective beautification practice but also because it became a popular topic to discuss. It is quite common nowadays to hear jokes, tales, funny stories, and rumors on television and in magazines about plastic surgery. A daily fortune-teller in a newspaper suggests that "Libras should not go through any aesthetic operations this month until the fifteenth," illustrating how aesthetic operations can be perceived as part of daily lives, as ordinary, natural, and common.

It was discussed in the previous section that being attractive and beautiful is almost a never-ending process. For informants, journey is at least as joyful as the destination since a new destination can easily be created within a master plan of being fashionably and continuously attractive. At first sight, beauty is something non-saleable because it is a concept or an idea rather than a product or service. However, when we look at the whole range of products and services in the beauty industry, especially including plastic surgery, we can realize that beauty is something scarce and exchangeable, and it requires special knowledge for appropriate consumption (Appadurai, 1986). In this part of the analysis, focus will be on how doctors, media, and firms together constitute a (global) system of interactions with patient-consumers. The next section will elaborate how aesthetic surgery is perceived (differently) among doctors themselves.

6.2.1. Medical Discourse

As stated before, plastic surgeons are actually "aesthetic, plastic and reconstructive surgeons." All types of tissue and bone injuries, burns, congenital abnormalities such as cleft lips and cleft palates, developmental abnormalities, infections, diseases, skin cancers and tumors are included in this area. Aesthetic surgery is actually only one part of the whole area, although it is perceived to be the only relevant job of the plastic surgeon. Some physicians interviewed complain about news and articles in the media that represents plastic surgery as miracle and aesthetic surgeons as magicians. Even patients refer to their doctors as having "magical hands" and call the doctor's office "the magic room." In addition, doctor statements on TV can be manipulated to emphasize the entertainment content, which creates an easy and fun image of plastic surgery.

Surgery as perceived by doctors themselves is a profession where medical rules still apply to their fullest extent, although perceived more like a beautification tool by the society in general, reflected by the term "aesthetician" (*estetikçi* or *estetisyen*). For doctors, if a person wishes to become more beautiful through surgery, this desire makes them potential patients for plastic surgeons. Turan (39M) states that "if a person doesn't have breasts, what's the difference from a person without an arm, in terms of the entirety of the body, or from a person without a finger or without a nose?" Another doctor makes a similar comment in a newspaper by saying "then we might say the same thing

for a person with a heart disease, we can say 'let's leave it there 'cause God created that way'" (A newspaper clipping, 2002). Also consider Ali's (39M) idea that each operation has an aesthetic component, even though it is not an aesthetic operation.

> You perform a very successful [gallbladder] operation but you stitched her abdomen like "çarsamba pazarı" [slang for bad, messy, all mixed up]. Now, can you expect this person to be happy even though she got the necessary treatment concerning her health? No, you can't. Therefore, for every surgery, for every treatment, you need to think about the aesthetic side, if you want the patient to be happy… So beauty and function, beauty and disease, treatment, reconstruction and aesthetic, [these] can't be separated easily; this is something we force to create… The disease affects the everyday life of the person with a gallbladder problem through pain and ache; but the worry that a patient has, whose breasts couldn't develop enough and who needs breast augmentation affects the person without pain, but it creates psychological pain and social pain, instead of physical pain.
>
> *Çok iyi bir [safra kesesi] ameliyatı yapmışsın ama çarsamba pazarı gibi dikmişsin kadının karnını, e şimdi bu hastanın o ameliyattan sağlıkla ilgili tedavisini iyi almasına ragmen mutlu olması beklenebilir mi, beklenemez... dolayısıyla her ameliyatta, her tedavide işin estetik kısmını düşünmekle yükümlüsün, karşıdaki kişinin belli bir mutluluk seviyesine ulaşması için… Dolayısıyla güzellik ve fonksiyon, güzellik ve hastalık, tedavi, rekonstrüksiyon ve estetik birbirinden ayırt edilemiyor, bu bizim yapay olarak yaratmaya çalıştığımız birşey… Safra kesesi hastalığı olan kişide hastalık veya sıkıntı ağrı yaparak günlük yaşantıya etki ediyor, memesi yeterince, yeteri kadar büyümemişş olan, 'augmentasyon'a ihtiyacı olan bir hastanın sıkıtısına ağrı yapmadan etki ediyor, ruhsal bir ağrı yaratıyor veya sosyal bir ağrı yaratiyor, fiziksel bir ağrı yerine.*

In medicine, therefore, doctors perceive each person applied as a patient who is in need of surgery in order to boost his/her self image and to be happier in life. They think plastic surgery patients may demand unnecessary surgery, but doctors have the obligation and the right to refuse to perform the operation.

According to doctor informants, plastic surgery deviates from other

areas in medicine from several perspectives. First of all, plastic surgery is "elective" by definition. In other words, there is no vital disease or an important medical necessity for such surgery. Patients are not patients in the usual sense, because they do not have a disease that gives unbearable physical pain or other health concerns. There might be a lot of psychological and social worries that bother patients, but there are minimum or no physical problems. Secondly, since plastic surgery deals with the external body, people can more easily observe surgical results and make comments both for themselves and for others. All patients observed and interviewed in this study came to the doctor's office with their problems defined beforehand, diagnosis made by themselves, and sometimes the necessary treatment already specified.

Bilge (25F) thinks the beauty of plastic surgery comes from the fact that no patient is the same as another because their biological states and expectations are different. Ali (39M) similarly thinks that plastic surgery requires constant thinking about what you are doing, constant learning and upgrading in terms of knowledge, skills, and technology, and an on-going process of improvement. As medical practice, plastic surgery deviates from other specialties because each patient requires unique consultation and treatment. For breast augmentation, for instance, doctors inspect individual characteristics, such as the base length and projection of breasts, the volume of breast skin, and the overall height and weight of the patient. These characteristics guide the decisions for the type and size of breast implants, as well as the specifics of the operation, such as where to put the implants (areola, underarms or under the breasts).

It is possible that doctors have disagreements on several issues. For instance, some doctors believe that people before the age 20 should not go through an aesthetic operation; whereas some doctors claim that there is no need to wait if the young person has psychological problems because of the body flaw. Doctors also "negotiate" with people from other areas and disciplines. For instance, they are in relationship with the courts since the court requests "expert opinion" from doctors in several cases, where disagreements may arise. They also engage with the military and the police on occasions where a suspect is accused of having plastic surgery, who is a patient for the doctor and who still bears patient rights. They may engage in discussions, such in television programs or newspapers, with religious authorities some of whom do not approve aesthetic surgical operations.

According to observation results, besides this medical discourse among doctors in the presence of patients and the public in general, there is another level of discourse among doctors themselves, where they think they know and understand each other. For example, they think that even though they work for long hours, they are appreciated neither by the hospital management nor by patients, or by the society in general. People may think they earn high amounts of money with minimum effort, and they sometimes risk patients' lives by convincing them to have surgery. When doctors come together and talk about these "misperceptions," they generally get depressed and frustrated since they are not appreciated as much as other physicians, although they have the same education and training, and most of the time, more training and expertise

compared to other specialties.

Similarly, they may have the attitude that it is the patients who make them engage in such beautifying practices, and doctors should not be blamed for their behavior. For instance, in one of the sessions in the international congress of aesthetic surgery in Melbourne, a woman was selected from the audience and has been "criticized" for flaws on her face. The representative physician from the sponsoring company then offered solutions to this lady using several products that the company sells. The conversation between the woman and the doctor started by the doctor's comment that he has been following the same strategy towards patients for years by first asking them "From what part of your body are you most uncomfortable with?". The woman selected replied "Nothing, actually". Under normal conditions the doctor is expected to stop there since the patient does not demand anything from the plastic surgeon. But the doctor replied "Yes I know that! Every woman says that she does not need anything, but you apply everything on your face and body, everything that is possible." This was a moment where everybody started to talk to each other whispering that the doctor's reply was inappropriate. The reply actually reflected what doctors may think about and approach patients.

Doctors, too, can thus humiliate patients and criticize their behavior. They use such terms like "professional patient" to refer to patients who always demand more beauty in whatever way possible and who are never bored of coming to the hospital. They may interrupt patients in a furious way when they ask "stupid" questions or demand unrealistic things. They may reply by joking

and can tell about these patients to their co-workers. They may say things like "how am I supposed to make that woman beautiful, she is just ugly!" or "if you see a wrinkle when you go like this [mimicking the patient's gesture] then don't do that!" These examples illustrate that doctors can sometimes complain about patient requests. In contrast to what patients believe in general, they may not want to make the operation since they know the results would be unsatisfactory for the patient, however satisfactory the medical results can be. The next section will elaborate on personal interactions between patients and physicians.

6.2.2. Interactions: Surgery as a Special Service Relationship

Surgery is similar to a service relationship where the customer interacts with a service provider on the basis of his/her expectations and personal relations. Resembling other service situations, for example, some patients try to decrease cost by bargaining with the doctor. One of the patients observed during an abdominoplasty consultation literally stated that "this surgery is too risky at this price", indicating that if the price was a little bit lower, she would take the risk and have the operation. Different from conventional service situations, however, patients do not only lose money, but can risk their very existence. In contrast to a typical buyer-seller situation, where the seller tries to sell, the doctor may try to convince the patient not to go through the operation. Patients cannot just purchase surgeries one after another because they have to wait for at least six

months to have another operation.

Notion of a service relationship is getting more and more widespread among doctors, too. A plastic surgery textbook by Nahai (2005: 5), for instance, states that plastic surgeons "are not selling a product" but they "are providing a service- a service that is personal and customized to each patient, one that carries risks unlike those encountered at the beauty salon or spa."

The following parts will elaborate on expectations from the service provider, as well as the interactions and close relations formed with the doctor.

6.2.2.1. Expectations from the Doctor

Plastic surgeons are perceived in different ways by patients interviewed. They are perceived as physicians just like in other medical specialties; they are perceived as artists since they give shape to human body; and they are also perceived as acquaintances or social contacts since they are intended to be involved in patients' lives almost forever. During in-depth interviews with patient consumers, a projective study was carried out by asking "what comes to your mind when I say brain surgeon?" and "what comes to your mind when I say plastic surgeon?" Comparing plastic surgeons to brain surgeons in this projective study revealed that the former is all about appearances while the latter deals with "important stuff". Answers for the brain surgeon varied from brain to brain salad, head, scalpel, and hospital; while answers associated with

the aesthetic surgeon were beauty, nose, breasts, and implants. One of the patients could not think of anything at all for a plastic surgeon.

Doctors interviewed in this study want to approach their patients with a medical perspective also because they want to correct the "misunderstanding" about plastic surgeons, exemplified by the projective study described above. Turan (39M) below explains how he approaches his own patients.

> I define them as patients, I see them as patients and I approach them as patients. Why, because [pause] as I see it, there is a misunderstanding or deficient perception in society about what we do. There are two main things that we do, or who are we first of all, we're plastic and reconstructive surgeons, when you say plastic and reconstructive surgery, there is 6-7 years of education, after 6 years, there is majoring for another 7 years, you learn microsurgery here, you perform microsurgery, I mean arm breaks and leg breaks [where they are split from body], this is our job, you learn burn surgery, maxillofacial, head traumas, head and face bones surgery… you learn face surgery, you know, you learn skin tumor surgery, you learn hand surgery, you also learn aesthetic surgery, and after you finish, everybody wants to perform in one of these areas, some only focus on jaws, some only do aesthetic surgery, some only do hand [surgery], well I focus on the aesthetic area.
>
> *Ben onları hasta olarak tanımlıyorum, hasta olarak görüyorum ve hasta olarak yaklaşıyorum. Eee niye böyle çünkü [duraksama] hani benim gördüğüm kadarıyla bizim yaptığımız işle ilgili toplumda ciddi bir yanlış ya da yetersiz algı var, şimdi bizim yaptığımız işlerin iki ayağı var, daha doğrusu öncelikle biz neyiz, biz plastik ve rekonstrüktif cerrahiyiz, plastik ve rekonstrüktif cerrahi dediğimiz zaman, işte 6-7 senelik bir ihtisastır, 6 sene üzerine 7 senelik daha bir ihtisas dalından bahsediyoruz, burda mikrocerrahiyi öğreniyorsunuz, mikrocerrahi yapıyorsunuz, yani kopan kollar bacaklar, bizim işimiz, yanık cerrahisini öğreniyorsunuz, maksillofasiyel, kafa travmaları, kafa yüz kemikleri cerrahisi… yüz cerrahisi öğreniyorsunuz, işte deri tümör cerrahisi öğreniyorsunuz, el cerrahisi öğreniyorsunuz, estetik cerrahi de öğreniyorsunuz, ondan sonra bitirdikten sonra zaten herkes bunun bir tarafına kayıyor, kimisi sadece çeneyle uğraşıyor, kimisi sadece estetik yapıyor, kimisi sadece el yapıyor, ben bu işin estetik kısmıyla uğraşıyorum.*

Therefore, doctors are also trying to keep their "physician" identity by (re)shaping their communication with their patients in a special way. With diverse and sometimes conflicting perceptions, doctor informants state that they have difficulties in understanding what is really expected of them. Indeed, they are expected to do things other than the surgery itself (Vargo and Lusch, 2004). For example, they are expected to give advice on how to make the patient more attractive. Some surgeons around the world have actually started to do it in more professional ways by including these tasks in the service they provide to their patients. For instance, an American plastic surgeon was giving a lecture in the nineteenth International Society of Aesthetic Plastic Surgery, and he explained this part of his job as "massage and make-up after the operation, and I can go somewhere else to do other things."

Doctors state that they also have to deal with patients' psychological and social well-beings, as well as their physical health, which is not expected in other medical areas as much as in plastic surgery. According to doctor informants, the disease and the treatment are perceived to be more "objective" in other specialties. Whether the patient has deeper expectations about the treatment does not play as much significant role as in plastic surgery. For example, when a patient demands an inappropriate operation from the plastic surgeon, the doctor may not just ignore the request, as demonstrated in Bilge's (25F) expression below, talking about one of her patients who was very thin but who still wanted to go through a liposuction surgery:

> Well, it is first of all very important to understand patient motivations here… both would be getting rid of the patient, going like "OK I did, I had the fat pulled away "fışfış" [slang for the sound of soaking the fat through liposuction]" would be getting rid of the patient, saying "go and come back when you gain weight" would be getting rid of the patient, in this case it is useful to explore patient motivations, and if necessary it would be useful to work in a multi-disciplinary way and include psychiatry in this process.
>
> *Yani şöyle birşey var tabii ki hastaların bir kere motivasyonunu anlamak çok önemli burda... ikisi de başından savmak, çünkü alırsın, "aman hadi yaptım iki fışfış çektim yağı bitti" de sallamak olur ya da "sen azıcık git şişmanla öyle gel" demek de hani başından savmak olur, böyle bir durumda hastanın motivasyonunu araştırmakta fayda var ve gerekirse multi-disipliner calışıp psikiyatriyi de işin içine sokmakta fayda var bence.*

Plastic surgeons, in other words, are implicitly assumed to consider the psychological and social conditions of their patients, although these factors are not directly associated with the medical application. When doctors are expected to deal with patients' deeper motivations and "real" expectations, this requires an approach that is different from the application of "objective" medical procedures. It is this characteristic of plastic surgery that makes the communication between plastic surgeons and patients much more important than in other medical areas. A different type of language, a different approach to the same body, and a different understanding of the problem may create two different conceptions between patients and doctors. The section below talks about the specific interaction between the doctor and the patient during the patient's consultation or control visit.

6.2.2.2. Intense Relations with the Doctor

One observation result is that patients live in their own worlds of ideal appearances, whereas doctors have their own measures, rules, calculations, and estimations that an average patient would never understand. For example, a patient may come to the doctor's office with a complaint about her big breasts; however, if the excess fat tissue is lighter than 300 grams, her breasts are not big enough from a medical standpoint. Similarly, when the patient comes with a complaint about saggy breasts, she cannot decide on how her breasts would look like because the doctor makes specific measurements that would indicate the new position and size of breasts. For example, the distance between the lower part of the neck and the tip of the nipple should be around 20 centimeters to talk about firm breasts.

With many sources of information about plastic surgery and an increasing number of people going through these operations, plastic surgery patients can now make comments about their problems or deformities, criticize the physician for his/her treatment, and interfere with technical details since they are more readily available in the media although they are not necessarily correct. They sometimes "test" the surgeon's knowledge by asking questions that they learned from the Internet. They sometimes come up with requests which are not attainable, such as "can you snap these two sides together?" talking about excess skin on her face or "can we just cut this piece out and sew it?" talking about an area of several small spots on skin.

In these instances, doctor informants usually try to explain medical rules in a language that the patient understands. They use examples, metaphors, and graphical representations so that the patient can visualize what the doctor is talking about. Doctors also try hard to follow the "fashion" that is prevalent in terms of appearances so that they would better understand what their patients want. For example, they read the news and watch some TV programs because they think it is easier for them to come close to the patient than wait for patients to learn about medical rules and procedures. They sometimes listen to the dialogue among patients themselves in order to learn the "language" shared among patients, rather than interrupting their conversation, which is in fact not directly related to the application itself.

One of the differences in language appears when the patient wants to see the exact result before the operation. In every consultation and during every medical examination, the doctor tries to make sure that the patient understands that the results of the operation may not coincide with what they imagine in their minds; and operation results depend on the patient's physical characteristics and healing factors. Patients want to see results on the computer beforehand, not only because they believe the image is surgically obtainable (Agarwal et al. 2007), but also because the inclusion of technology in such an abstract concept like beauty impresses patients, and they think the conversation is more scientific and even more medical when the computer is involved. In reality, using computers to illustrate possible results would be misleading. Ali (39M) prefers not to show any computer images at all. He claims that doctors

cannot copy the computer image and carry out the exact operation, and no computer can simulate what doctors actually do since the program cannot copy human physical characteristics and cannot simulate the healing period.

Sometimes patients can be very confused when the doctor does not respond in the intended way at the moment of actual exchange (Kopytoff, 1986); and they may be so fixated on the expected response that they may repeat the question until the response is close to their expectations. Some patients can be problematic in the sense that they may have unrealistic expectations or they may not even know what they want. They may never be satisfied since they are not sure about what to expect. If the doctor realizes that the patient is not a good candidate, s/he may refuse to perform the operation. S/he might direct the patient to a psychiatrist so that the patient can better understand his/her actual problem, if any. All doctors interviewed, such as Ali (39M), said that if the patient has unrealistic expectations, they should either refuse to make the operation or instruct the patient appropriately.

> [When an average Turkish man in his 20's wants to resemble Brad Pitt] I crash this person's desires [to resemble Brad Pitt] immediately and sharply, because you should make him stop dreaming about it… For this reason, without any question marks or hesitations, you should be able to communicate that it's not possible, in a very harsh, clear, net, abrupt, hard-hearted and cruel way so that he won't come back two days later saying "but you said it's feasible" or "but when you said blah blah I thought this is possible" and so forth… I mean the person should be disappointed at the beginning, rather than later.
>
> *[20 yaşlarında ortalama bir görüntüye sahip erkek bir Türk, Brad Pitt'e benzemek istediğini söyleyince] Bu kişinin bu doğrultudaki ümitlerini anında ve sert bir şekilde kırıyorum, çünkü hayali ettirtmemek lazım… O nedenle soru işaretine veya tereddüte hiç fırsat vermeden, çok sert, net bir şekilde bunun mümkün olmadığını, bütün açıklığıyla, bütün*

çıplaklığıyla, bütün sertliğiyle, bütün vicdansızlığı ve acımasızlığıyla ortaya koyabilmek lazım, ki iki gün sonra kişi diyemesin ki "ya aslında ama siz olabilir dediydiniz" de "demediydiniz" de vesaire, "ben ama siz öyle deyince şöyle umit etmiştim" de gibi... yani yaşayacağı hayal kırıklığını kişi sonradan değil baştan yaşaması lazım.

Simlarly, Turan (39M) approaches his patients in a way that, potentially, they may not be self-aware of their expectations and needs.

> Part of our job is to differentiate these [people]. I mean if the person really needs a nose job, doing it, and if the person doesn't need a nose job, not doing it, is the physician's problem, not the patient's. Therefore we come to the same point, I mean my… well your… well my patient that went out before you came here, she came here to fill this area [nasolabial tunnels], but we said "you don't need it" and we made the patient go back, if you can do this, then you can be able to see the person as a patient.
>
> *Bunları ayırmak bizim işimizin bir parçası. Yani eğer birinin gerçekten burun ameliyatına ihtiyaci varsa onu yapmak, birinin burun ameliyatına ihtiyaci yoksa onu yapmamak hastanın problemi değil, hekimin sorunudur. Dolayısıyla yine aynı yere geliyoruz yani orda benim... evet buna sizin... evet benim sizden once gelen hasta işte buralarını [dudak kenarlarındaki olukları] doldurmak icin geldi, "hayır sizin buna ihtiyacınız yok" deyip hastayı gönderdik, bunu söyleyebiliyorsanız, o zaman hastayı hasta olarak görebiliyorsunuz.*

Since the doctor cannot control everything during the surgery, or control recovery characteristics of the patient, sometimes results can be less than perfect. The patient may get the feeling that the doctor did not perform well because s/he did not care enough. Even if the results are satisfactory from a medical point of view, the patient can still be unhappy due to reasons other than the surgery itself. So doctors express their feelings of vulnerability when patients personally focus on the doctor. Doctors also state that still another group of patients has psychological problems, such as body dsymorphic

disorder (or body image disorder) which is a disease that makes individuals view their own bodies in a totally negative way and think that they are ugly, fat, unattractive, and old. According to doctors, this group of patients is more inclined towards suing the doctor for unsatisfactory results; and on very rare instances, some patients threaten to kill doctors. All doctor informants agree that if the patient is a single, over-expectant male with narcissist personality characteristics, he can be potentially dangerous. Ali (39M) states that he tries hard to eliminate those patients since they would be problematic sooner or later.

> You try to differentiate, because you know that they will become a problem later, the foremost reason for American plastic surgeons' unnatural death is being shot by male rhinoplasty patients, for example, because if they have tendency for crime, if he is persecuted towards that, if he thinks there is a problem and if you are involved in it and if the problem can't be solved, you directly become the target, suddenly everything becomes connected to you, he gets divorced, he runs out of money, and then you become the person who triggers all of those, so it's important that you differentiate those patients.
>
> *Ayıklamaya çalışıyorsun yani çünkü biliyorsun ki o hasta başına bela olur, Amerika'da plastik cerrahların doğal olmayan ölüm sebeplerinin başında erkek rinoplasti hastaları tarafından vurulmaları geliyor, mesela, çünkü eğer suça eğilimliyse hasta, oraya perseküte olduysa, bir sorun var diye düşünüyorsa ve sen ona müdahele olduysan ve sorun çözülmediyse, direkt hedef sen haline geliyorsun, herşey sana bağlanıyor bir anda, karısından ayrılıyor, eşinden ayrılıyor, parası bitiyor, bütün yani olayı tetikleyen adam sen oluyorsun, o nedenle hastayı iyi ayıklamak gerekiyor.*

Importance of communication between the patient and the doctor is demonstrated especially when the doctor is perceived as a friend rather than a medical doctor. It is generally much less common for a doctor and a patient to become friends in other medical spheres, but since plastic surgeons are seen as

experts on beauty, they are also seen as companions along the way towards ideal physical appearance. It is frequently observed that patients hold the doctor's hands with worship and say things like "I love these magical hands" or hug the doctor when they see him/her outside of the hospital and say such things as "You are my hero" or "You created a miracle." Some of them even romanticize this relationship and say things like "I fell in love with his art" and "I really like the way he holds the scissor." They share their personal stories and secrets as they see the doctor as a close friend who would solve his/her personal problems. One patient felt so close to the doctor that she wanted to share about her reasons for nose surgery– that she was beaten by her husband who broke her nose and hit on her forehead causing a facial deformity. This close sympathy and feelings of friendship can spread, and different patients can talk to each other while waiting for their appointments, or after the operation in patient rooms, making them close friends with each other. Some of them describe this friendship with such terms as "followers of Doctor Ali" (*Ali Hoca'nın müritleri*) and "botox fellowship" (*botoks kardeşliği*).

One patient, who recently had a nose job, called the doctor from his cell phone, and told him that "I know there is nothing wrong with my nose or anything but I am bored at home, can I come to your office?" This is an example of how patients can see this whole process of plastic surgery as an adventure and something they do for pleasure and fun. They can come to the doctor's office just as they would go to a shopping mall to look around and kill time. This also resembles a typical service situation where, more and more each

day, providers are supposed to "manage the hearts" of their clients (Hochschild, 1983; Kang, 2003).

Trust is established when patients feel that the doctor understands their needs and expectations. Almost all informants state that it is very important to trust the doctor because your new appearance will "depend on" the doctor's knowledge and abilities. Besides medical knowledge and experience, doctor's individual characteristics, such as honesty and friendliness, plays a very important role in building trust (Casielles et al. 2005). Derya (25F) says she trusts her doctor because he said he would make a nose that fits her face, instead of a much lifted nose that celebrities have. Selin (28F) says he heard about Doctor Ali, and after she got to know him after a few visits, she trusted him and decided to undergo surgery. When friends and family members tell good things about a specific doctor, there is trust established even before coming to the doctor's office. Informants say that when they trust the doctor, they totally trust him/her on various aspects of the surgery, such as in terms of the size of breast implants and shape of their noses. Tutku (39F) says she left almost everything to the doctor since she trusted him.

> Well I told him everything very clearly and I told him that I need it [breast augmentation], but of course only if he agrees. I told him I would go for it if he agrees to do it. He said "yes, we can do it," he showed me all implant types one by one. He said "this is the right one for your body" and that was it, I haven't… I haven't interfere with anything, like do this or do that, I left everything up to him because I was very certain that everything will be fine. I mean, trust [I trusted him]…
>
> *Yani ben ona herşeyimi açık ve net anlattım ve böyle birşeye ihtiyaç duyduğumu [meme büyütme], ama kendisi onaylarsa tabii ki, hani birşeyler onaylarsa yaptırabileceğimi söyledim, "evet" dedi*

"yapılabilir," işte "dışarıdan bulduğumuz işte şu silikon vardır, bu silikon vardır," hepsini bana tek tek gösterdi. "Sizin" dedi "vücudunuza olabilecek bu" ve öyle yani hiç ben... birşeyine karışmadım, illa şu olsun bu olsun herşeyi kendisine bıraktım çünkü ben bu kadar eminim herşeyin çok güzel olacağından. Yani güven[dim]...

Doctors also think that trust is very important in this service relationship. Loyalty grows as the patient and the doctor continue to understand each other more and more, as discussed in the first section. Selim (52M), depending on his many years of experiences, tells that trust is very important both for the patient and the doctor.

> That [trust] is extremely important, if the patient doesn't trust the physician, even if the physician performs extremely perfect, the patient wouldn't like the results, but if there is trust established, and if the patient agrees to have the operation or the treatment from that doctor, if there are minor problems, since surgery means complication, believe me, the patient doesn't care about those. But if you were not able to establish that trust, and if there is a flaw with a chance of one in ten thousand or something like a minor imperfection, the patient can easily make it a big problem, so trust is very important.

> *O [güven] inanılmaz önemli birşey, eğer hasta hekimine inanmazsa, hekim ağzıyla kuş tutsa, en mükemmel şeyi de yapsa hastaya beğendiremez, ama arada cok ciddi bir güven ortamı sağlanmışsa, hastanın aklında hiçbir kuşku olmaksızın hekime ameliyat ya da tedavi olmayı kabul etmişse, arada sorun çıksa bile küçük ufak tefek, çünkü cerrahi demek komplikasyon demek zaten, hasta bunu önemsemiyor inanın, ama o güveni verememişseniz onbinde birlik bir kusur olsa ya da kusur gibi birşey olsa hasta bunu problem edebiliyor, güven çok önemli.*

Therefore, with some level of trust established, patients accept vulnerability in and "forgive" failures in doctor's performance (Soderlund and Julander, 2003). There are several characteristics of this service relationship where the doctor can be perceived as the service provider and the patient as the

consumer. As in other consumption contexts, the doctor may have to build a network of individual patient-consumer relationships (Parasuraman et al. 1985), instead of waiting in the office for patients to come. "Relationship" in this context becomes the key variable to build long-term, mutually satisfying relations (Berry, 1983). However, the relationship may "fail" to provide satisfaction for the consumer; and the following part will elaborate on this issue further.

6.2.2.3. "Failure" of the Service Relationship and Patient Satisfaction

Medical failures are not perceived the same way by patients, or patients may not like surgical results even though there are no complications. When the progress is not achieved or when the surgery "fails" to make the needed change, respondents engage in coping strategies while their "responsibility" for beauty work still continues. According to observation and interview results, there are two ways of coping with this failure. In the first one, patients do not see this as complete failure but as an obstacle in their way towards their ideal. Whether they want to achieve a younger self or the appearance of someone else, they already seem to have been ready for this difficulty, which makes their progress more difficult but not less enjoyable. When their breasts are not "big enough" even after the surgery, or when they feel like they did not achieve their imagined beauty, they do not feel depressed because they see this as another

necessary step to be taken as they are constantly working towards beauty. The desire to attain the ideal still continues (Belk et al. 2003). Even when their breasts are not as perfect as they imagined, they tolerate this problem; because the important thing is that they did what they were supposed to do, and that is what counts. Therefore, the first coping strategy for operations that "fail" to satisfy the requested beauty is to consider it as another problem to be solved since they are already "working" for their beauty. In other words, it was their individual responsibility to solve the body problem at the first place; now it is still their responsibility to solve this problem. The progress continues.

Post-operation conversation between patients and doctors reflects a second coping strategy, which is asking the doctor about what to do and thus transferring the burden to the doctor. When patients look at their noses after the plaster is taken out, they sometimes say things like "my nose is too big!" or "I feel like this nose is not mine!" In these cases, patients usually imply that the operation was unsuccessful because it resulted in something they did not ask for. In these cases, they usually cope with failure by directly asking the doctor whether there is a way to revise, refine, or remake the body part. This reflects the authority of a medical entity, in this case, the doctor, which reflects further medicalization of beauty since the failure is resolved with another medical intervention. Sometimes patients directly ask for a secondary operation to make their noses a "little bit more" lifted or their bellies a "little bit less" fatty. The flaw of the body now becomes the flaw of the surgeon and the surgery. The immediate tension that arises due to an incomplete fulfilling of consumption

needs (Solomon et al. 2002) is reduced by asking many questions to the doctor and making sure that there is a scientific way to "correct" the flaw of the surgery.

Whether the failure of service provided by the doctor can be perceived as the failure of the brand depends on how strong the "brand equity" is. This partly depends on the "feasibility" of patient expectations before the surgery and the effective communication and trust built between the patient and the doctor. According to informants, physician's perceived level of knowledge, his/her communication abilities, as well as the quality of service provided in the hospital are all determinants of their satisfaction; therefore, they see the brand as the whole combination of what they think and feel before, during, and after the operation. For instance, informants frequently mention the behavior of nursing staff and meals as components of their total experience (Boschoff and Gray, 2004).

Therefore, even though an aesthetic operation can be considered as an experience good (Keller, 2003), where the performance of the physician can be experienced only after the operation (and sometimes never), brand loyalty continues to exist even when the service fails to meet expectations if trust is established. Brand fails only when trust is gone, i.e. the doctor cannot respond to the patient's psychological and social desires, which is different from other cases where brand loyalty depends on repeated performance of the product/service. In our case, patients engage in a high-contact, customized service relationship; and they state greater satisfaction from relational

components of the service relationship (Kinard and Capella, 2006). The next section will continue by further investigating how doctors can increase demand for their work and engage in various types of marketing activities in a medical area.

6.2.3. Doctoring Beauty

In the specific case of plastic surgery, we can talk about "doctoring of beauty". Being a very unique branch in medicine, plastic surgery is neither perceived to be "pure medicine" because of its distinguishing characteristics from other medical areas as discussed before, nor as "pure adornment" since it involves a profession, a medical doctor with many years of education and practice, and more importantly, a surgery and associated complications. Nevertheless, engaging in aesthetic operations is becoming less like a risky and painful activity and more like an ordinary beautification treatment, not necessarily as the "last, desperate option" (re: Gimlin, 2000). Some of the patients mention that they sometimes think of their physicians as doctors who just love to operate on people, who would try to convince non-patients to be patients, and at an increasing rate, try to boost the number of patients (Sullivan, 2001). They think a plastic surgeon would like to "cut" people and give form. There are extreme examples of patient persuasion in the U.S. For example, there was a contest for free breast augmentation hosted by a local radio station in Dallas (Rohrich,

2001). The marketing strategy was to entice young women to expose their breasts on the radio station's web site so that they could be judged as the person most in need of surgery.

The rising interest in plastic surgery and an increase in the number of plastic surgeons, accompanied by a unique "commoditization" process, bring about a development of global communication and exchange practices on both economic and social levels. The next section will discuss this global phenomenon.

6.2.3.1. Global Communication of Plastic Practices

Although medicine is a largely regulated area making its globalization difficult (Fraser and Oppenheim, 1997), it is possible to talk about a global communication among patients, doctors, and aesthetic medical companies. For example, physicians try to excel at their performance, and in pursuit of this excellence, they educate themselves through other doctors in other parts of the world who are assumed to know better (Rohrich, 2000). Turkish doctors may stay in foreign countries temporarily or permanently, and when they come back to Turkey, they basically transfer their knowledge. Plastic surgeons in more developed countries have opportunities to teach those in less developed regions throughout the world (Zbar et al. 2001). As a result, doctors engage in various activities for academic exchange of knowledge through conferences and

seminars (Appadurai, 1990). Turan (39M) is one of the doctors who continuously engage in that kind of information sharing and academic exchange.

> The first thing I do is becoming better in what I do. I make serious investment to achieve that, what kind of an investment, I go to as many conferences as possible, I make contacts with people I appreciate or whom I find interesting, I go to where they live, I spend time and effort to do these. I mean seriously, I go abroad for a week each month, I mean each week in four weeks I'm in a foreign country, to educate or to be with someone else, because I also provide education, in botox for example, I go to several places around the world [clears his throat].
>
> *Benim ilk yapmaya çalıştığım sey işimi daha iyi yapmak, bunun için ciddi yatırımda bulunuyorum, nasıl yatırım, olabildiğince çok kongreye gidiyorum, gittiğim kongrelerde beğendiğim, ilginç bulduğum adamlarla ilişkiye geçiyorum, onların yanlarına gidiyorum, vakit ve para harcıyorum bu iş için, yani ciddi ben her ayın ortalama bir haftası yurtdışındayım, yani dört haftanın bir haftası ben yurtdışındayım, eğitim vermek amacıyla ya da hani birilerinin yanında olmak amacıyla, çünkü bir eğitim de veriyorum ben, belli başlı bu askı konusunda, botox konusunda filan, dünyada orda burda eğitim veriyorum [boğazını temziliyor].*

Similar to doctors, machinery, technology, and software can move very easily in the case of plastic surgery. All kinds of medical knowledge, equipment, pharmaceuticals, and all kinds of tools can be imported and exported with minimum trouble across different countries. Sertap (30F), a sales representative of a medical company, mentions that many doctors prefer neither Turkish nor Chinese aesthetic surgery materials, because they are of very low quality. Many materials used, particularly the breast implants and nose plasters, are of American origin. Public relations agents can participate in these movements as they publish news about advances in technology along with

doctors' profiles. Developments and advances in knowledge become even more remarkable because many people in the world have a similar interest of becoming more attractive.

As part of the analysis made here, the number of aesthetic surgeries has been compared between Turkey and the U.S. The U.S. has complete statistical figures after the year 2000 (ASPS, 2008). Gazi University Hospital is taken as a proxy for Turkey in terms of the number of operations since there are no records for the country. According to results, the rate of increase in the number of operations is quite similar in two countries implying that they experience similar trends. If we look at the coefficient between the U.S. and Turkey, it is getting smaller and smaller, reflecting that the two countries resemble each other more and more each year. Assuming that Turkey and the U.S. have similar "rates of production" measured by the number of operations, one can also suggest that social trends are the same. Bilge (25F) comments on this point below.

> I mean all patients… they are all rich, I mean those who come from Africa- they're also [laughing] they're not coming from the middle of a refugee camp [laughing], they're also rich, and they want to have surgery.
>
> *Gelenlerin hepsi yani zaten... durumu iyi olanlar geliyor öyle söyleyeyim, hani Afrika'dan da hani böyle [gülerek] mülteci kampının göbeğinden çıkıp da gelen hastamız yok [gülerek], hani durumları iyi olan, ameliyat olmak isteyen hastalar geliyor genelde.*

Bilge (25F) also mentions that plastic surgeons are also similar across countries.

> I don't see my clinic as worse than others [in the world], what I mean is that we're at the same level in my opinion, I can't speak for Turkey as a whole but in terms of international publications and following innovations… Of course it's better in some countries because the facilities are better, but we're not behind them.
>
> *Ben kendi kliniğimi farklı bir yerde görmüyorum, yani şöyle söyleyeyim, yani birebir aynı seviyedeyiz diye düşünuyorum, ama Turkiye'nin geneli için konuşamam fakat gerek yurtdışı yayınlar olsun gerek yenilikleri takip etmek olsun… E tabii ki yurtdışında birazcık daha fazla, olanaklar daha iyi, ama bence biz de geri kalmış değiliz.*

Therefore, even though the types of operations are different, the types of people who go through surgical operations and the types of behavior doctors maintain are quite similar. It can be inferred from this analysis that doctors supply and patient-consumers demand a similar service around the world, despite various differences, creating an unspoken plastic global consumer culture over and above societies. Hence "beauty" becomes the universal language for all people and we can talk about a special kind of interdependence among these firms, doctors, and patients all around the world (Robertson, 1992; Waters, 2002). Marketing is part of almost all medical applications, utilized by doctors, plastic surgery clinics, PR agencies, and medical companies.

It makes it easier to communicate this way and opens up opportunities for medical travel as well. This global culture of plastic surgery is exemplified well in the so-called "aesthetic tourism," a type of medical tourism where patients around the world can go to different places for medical treatments at

cheaper prices. Usually, this medical treatment is accompanied by a holiday package, hence the term "aesthetic vacation" (*estetik tatil*), with which the individual enjoys the whole period of stay. Besides, patients do not have to explain their friends and coworkers about their surgery. Prices can be in the form all-inclusive packages, including surgery, hospital costs, and an accompanying holiday package, similar to the notion of "all included" packages that travel agencies promote. There were several patients, such as David (56M), who came to Turkey for the purpose of going through an aesthetic operation, at a much lower cost than their own countries, with similar quality of healthcare, and an added opportunity to travel to an authentic, Eastern city.

6.2.3.2. Plastic Measurements

Communicating plastic surgery knowledge and spreading technology becomes easier also because there are numbers and measurements that creates an "objective", easy, and understandable language that is common across countries. For example, the so-called "golden ratio", representing the number 1.6180339887, is the ratio of the longer side to the shorter side, which is believed to be aesthetically pleasing for over 2,400 years (Wikipedia, 2008). According to scholars, golden ratio exists everywhere in nature, so it is preferred to have the same ratio on human face and human body. It is medically called a "beautiful, orthognatic face" (Gülşen, 2008) with proper nasofrontal,

nasomental, nasofacial, and mentocervical angles.

Although none of the Turkish doctors interviewed uses the Phi ratio to measure the "objective" attractiveness of a patient's face, the common ideal characteristics chosen by informants reflect these standards. There are various applications of the number Phi, such as Phi-mask, which illustrates the mask of a male or female face with perfect proportions. The creator of the mask actually states that "the mask can be used to plan the surgical correction of the face or its specific components to more closely approximate the configuration of the perceived ideal facial form" (Marquardt, 1997).

As another example, the well-known body mass index dictates that an average, normal body weight should be in proportion with height, where an ideal body should have an index between 20 and 40 (Fisher and Voracek, 2006). Another common measurement is about whether a woman's body has the ideal hour-glass shape or not, quantified by the size of breasts, belly, and thighs, which ideally should be 90, 60, and 90 centimeters respectively.

These standards make physicians' jobs easier, too, because it is easier to have a well-accepted, common measurement to apply and convince patients in that way. For example, one of the doctors in the world plastic surgery congress presented a study where he came up with a measure of "perfect face angels" for female patients. He explained that he calculated this ratio by looking at models and actresses who are acknowledged to be attractive and sexy by the general public. He calls it the "universal angle of beauty" according to which one should have a voluminous and three-dimensional, well-defined mid-face with a

gentle S-curve from eye lids to upper lips. He came up with a perfect angle calculated by several distances and volumes on the face. These measurement scales are preferred by aesthetic surgeons because they form the basis on which to compare surgical results, quantify aesthetic interventions, and identify patients who are unlikely to benefit from the surgery (Ching et al. 2003).

Measurements in the form of numbers make it easier for physicians to apply procedures and for patients to follow since numbers are "objective" and tell the truth. Dissemination of plastic surgery technology and communication of beautiful images around the world creates a global environment in which those images and scientific knowledge can be effectively shared by everyone who participates in this plastic global consumer culture. Doctors can also use medical measurements that cannot be understood by other people. For instance, the ideal brow position has been a matter of some debate among plastic surgeons (Booth et al. 2004). A "simple" concept of the ideal brow position was described by a medical doctor in the following way (Westmore, 1975):

> The medical brow should begin on the same vertical plane s the lateral extent of the nasal ala and the inner canthus, and that it should end laterally at an oblique line from the most lateral point of the nasal ala and the outer canthus.

This actually may not mean anything to a "lay person" who does not understand the medical jargon. It entails a special medical language only an specifically-trained medical doctor would understand.

Therefore, these flows create a global culture of plastic surgery among doctors, as well as patients. Doctors can now share knowledge and attract

foreign patients as well as local patients. They can make their names known in a global network and in their home country. More and more each day, they start to think that they should pay attention to other factors besides their scientific performance, such as creating ways to satisfy patients in ways other than surgery itself, building "doorways" for potential patients to enter, and sometimes successfully converting people into patients. The following section will specifically discuss how doctors can utilize marketing tools to advertise and brand their work.

6.2.3.3. Doctor Imaging and Public Relations

Plastic surgeons engage in marketing practices, either through small-scale activities, such as personal attempts to convert people into patients, or through larger-scale practices such as employing public relations (PR) specialists. With increasing demand for plastic surgery, doctors may also try to differentiate themselves and build a brand around their names within in medicine where many legal restrictions apply. For example, many of the patients interviewed state that Doctor Ali's noses look so natural that they can now recognize his patients. Similarly, they would also recognize his breast implant operations since he tries to remain on the natural side by using medium size implants even if the patient insists on bigger breasts. Ali (39M) tries to be careful because, even if not patients, other physicians would think of them as bad performers.

> Sometimes there is a noticeable problem [on the nose] and I don't want people to say "Doctor Ali did it", so I tell the patient "come on, let's do it, it doesn't look good, let's not make you walk around like this, it'll be better" and I use my power to persuade, I try to increase my persuasiveness, I try to persuade. Because that bad result… each good result is positive prestige and each bad result is negative prestige, even though the patient is not aware.
>
> *Bazen bariz olarak [burunda] beğenmediğim bir kısmı oluyor ve hani "Doktor Ali bunu böyle yapmış" denilsin istemiyorum, o zaman diyorum ki hastaya, "gelin bunu yapalım, düzeltelim, çok iyi durmuyor, hani böyle dolaştırmayalım sizi, daha iyi olacak" deyip o zaman inandırıcılık şeyimi, katsayımı artırmaya gayret ediyorum, ikna etmeye çalışıyorum. Çünkü o yani her kötü... her iyi sonuç nasıl ki pozitif prestij, her kötü sonuç da negatif prestij hasta farkında olsa da olmasa da.*

If the doctor has a private clinic, his/her may appear in clinic brochures and web sites. In other cases, doctors can have their own, personal web sites. Web sites typically give information on procedures, doctor resumes, costs, and locations. It is illegal in Turkey to provide patients' before-and-after photos, but in other places, especially in some states in the U.S., web sites illustrate photos of the best work of plastic surgeons. After-photos usually depict the "beautified" and happy patient (Gilman, 1999) with make-up, nice clothes, nice hair, and a similing face. Some doctors also try to increase demand for plastic surgery in general by talking about aesthetic operations in a positive way. They can also increase demand by operating consumers for free either for educational purposes or as a bonus. For example, if the patient goes through breast reduction operation, she can get liposuction on some parts of her body for free.

Some doctors use personal web sites and public relations companies to introduce themselves to the public, improve their image as physicians, and

sometimes increase the number of patients. In the U.S., doctors are allowed to make advertisements for their work, but the American Society of Plastic Surgeons has developed a code of ethics for its physician members (Goldwyn, 2002). In Turkey, however, it is completely illegal for doctors to advertise themselves or say things like "I am a better surgeon" either on television or in magazines and newspapers. Instead, they usually engage in "covered" or "camouflaged" advertising (Şahin, 2004). Without providing contact information, doctors can answer questions on the radio, provide information on TV, or write articles for newspapers and magazines on any plastic surgery issue. This makes surgical operations a unique kind of commodity as their "distribution" is controlled in various ways (Appadurai, 1986). An informant, Gonca (40F), who works as a public relations manager, describes that instead of applying conventional marketing principles, doctors rely on their public relations managers to advertise themselves in the media within legal constraints.

> For example we invite them as guests on television, we use our relations with TV channels, about the topic, like if it's about botox we call for a botox [doctor] or if the doctor deals with cardiology, we direct him/her for those programs, we use our relations with those programs and we invite the doctor to that program. We make news for newspapers, but of course this happens in legal restrictions, not like the doctor advertises himself/herself, but as if the doctor is talking about a subject, we use a famous person to create news about the doctor, and we use those news, or for instance there is a new laser stuff the doctor brought, something technological, we make a connection from there and create a news or prepare a workshop, and then we invite the press, we make illustrations, and there we inform them about the doctor, his/her name, what s/he does, and we organize press releases about it. These are all PR work.
>
> *Örneğin televizyonlarda konuk olarak çıkartıyoruz, o ilişkilerimizi kullanıyoruz televizyon kanallarında, işte konuyla ilgili, atıyorum botokssa botoksla ilgili istiyoruz ya da işte kalple ilgiliyse doktorumuz,*

kalple ilgili programlara yöneltiyoruz, o programlardaki ilişkilerimizi kullanıp onu konuk olarak oraya davet ettiriyoruz, onu yapıyoruz, gazetelerde haber çıkmasını sağlıyoruz, e tabi bu yine yasal çerçevelerde oluyor, doktor çok reklam yapıyor gibi değil de sanki bir konuyla ilgili konuşturuyoruz, fikir alma, danışmanlık yapma tarzında oluyor, onları yapıyoruz, ya da işte ünlü birini kullanıp haber yaratıyoruz doktorla ilgili, o haberi kullanıyoruz, ya da yeni bir atıyorum lazerle bilmem ne getirmiş doktor, teknolojiyle ilgili, onla bağlantılı yapıp, haber yapıp ya da workshop hazırlatıyoruz ona işte başını oraya davet ediyoruz, uygulamalı göstertiyoruz, orda da doktorun adı, kendisi, işte yaptığı işle ilgili bilgi veriyoruz, bunlar için de basın toplantıları falan düzenliyoruz, bu tamamen PR calışmaları oluyor.

PR agents can also give additional advice to plastic surgeons, such as where to appear, how to dress and how to behave in a television program, as well as marketing suggestions about how to specify and reach a target group and how to approach patients in this group. The assumption is that even though the doctor is academically knowledgeable in medicine, s/he also needs to be charming in order to "sell" this knowledge. The doctor should be able to make people listen to him first. Among the advices that PR agents give concerning a TV program are making jokes where appropriate and speaking in a challenging and entertaining way, typically creating some sort of "agitation."

Aesthetic surgeons are more appealing for public relations specialists, too, because they have more interesting material that can turn into exciting news. Since people are attracted to beautiful men and women, these news have more place in television programs aimed at women, including morning programs such as *Sabahların Sultanı* (Seda Sayan's TV program) where celebrities are invited or afternoon programs such as *Kadın Olmak* (Berna Laçin's TV program) where cooking and knitting are the most common topics;

as well as evening news, where a supposedly new technology of plastic surgery is introduced accompanied by images of beautiful women usually in their bikinis. Doctors suit well in TV programs as women can ask all kinds of questions to learn the "secrets" of how to be beautiful.

Gonca (40F) tells further that aesthetic surgeons are usually very busy; so they do not have time to introduce themselves or announce their national and international achievements, so it is becoming more and more common among plastic surgeons to come to terms with a PR agent and "market" themselves through that agent. Moreover, using PR specialists is advantageous because PR companies have more and stronger connections with TV channels and print media owners; and they can more effectively organize media exposures.

Gonca (40F) expresses that there are many examples where the physician is actually an "average" surgeon in terms of his/her endeavors but s/he became known through PR efforts, especially for a specific kind of plastic surgery. The media contains examples where the doctor's name is covertly pronounced along with the news, where the news which are usually "created" (*haber yaratmak*) by PR agencies. Consider the examples provided below, although they are not proven to be created by PR agents. These news appear in various newspapers, where doctor names appear along with the news. Doctor and organization names are disguised. Doctor names are abbreviated as "X" and organization names are abbreviated as "Y".

Table 1 Doctor and Organization Names That Appear Along with News

Doctor Names That Appear Along With The News	By making a special contract with a bank for the first time in Turkey, Aesthetic and Plastic Surgeon Op. Dr. X, who wants to increase his patient potential, has started the "Beauty with Credit – Beauty in Installments" period for those who want to be better, more beautiful and better in shape, but who don't have enough money. (2004) *Türkiye'de ilk kez bir bankayla özel bir anlaşma yaparak, mevcut hasta potansiyelini artırmak isteyen Estetik ve Plastik Cerrahi Uzmanı Op. Dr. X, parasını denkleştiremeyen, ama kendisini daha iyi, daha güzel ve daha bakımlı hissetmek isteyenler için "Kredili Güzellik - Taksit Taksit Güzellik" dönemini başlattı. (2004)*
	X, new popular plastic surgeon of high society, recreates his patients from top to toe with his 1.5-month packet program. The "beni baştan yarat" [A saying for a wish to transform into a physically new self] packet program cost starts from 70 thousand Euros… After this packet program, which is applied in Y and which lasts for 1.5 months, even the patients can't recognize themselves. (2005) *Sosyetiklerin gözde plastik cerrahı X, 1.5 aylık paket programla hastalarını tepeden tırnağa yeniliyor. "Beni baştan yarat" paket programının bedeli 70 bin Euro'dan başlıyor... Y'de uyguladığı ve yaklaşık 1.5 ay süren bu paket program sonunda hastalar bile kendilerini tanımakta zorluk çekiyormuş. (2005)*
	Hande Ataizi was a young lady with small, plumpy, potato cheek, thin lips, and an arched nose. Hande Ataizi with lemon breasts has gone through a series of aesthetic operations. CHEEKS, Date: 1997, Doctor: Prof. Dr. X. NOSE, Date: 1998, Doctor: Prof. Dr. XX. Secondary Operation: 1999 / Prof. Dr. X. BREASTS, Date: 1998, Doctor: Prof. Dr. XX. Secondary Operation: 1999 / Prof. Dr. X. TEETH, Date: 2000, Doctor: Dr. XXX (operation continues). (2002) *Hande Ataizi, birkaç yıl önce küçük tombul patates yanaklı, ince dudaklı, kemerli burunlu bir genç kızdı. Limon göğüslü Hande Ataizi, tepeden tırnağa estetik ameliyatı oldu. YANAKLAR, Tarihi: 1997, Doktoru: Prof. Dr. X. BURUN, Tarihi: 1998, Doktoru: Prof. Dr. XX. İkinci ameliyat: 1999 / Prof. Dr. X. GÖĞÜSLER, Tarih: 1998, Doktoru: Prof. Dr. XX. İkinci ameliyat: 1999 / Prof. Dr. X. DİŞLER, Tarih: 2000, Doktoru: Dr. XXX (operasyon devam ediyor). (2002)*

Table 1 (cont'd)

Doctor Names That Appear Along With The News	By the way, we shouldn't be unfair towards Turkish doctors. X, who made Ajda Pekkan and Gönül Yazar keep the same appearance for years, is as successful as his European colleagues. His foreign colleagues admire and appreciate Prof. X's operations. (2004) *Bu arada Türkiye'deki doktorların da hakkını yememek gerek. Ajda Pekkan'ı, Gönül Yazar'ı yıllardır aynı görüntüde tutmayı başaran X, en az Avrupalı meslektaşları kadar başarılı. Prof. X'in gerçekleştirdiği operasyonlar, yurtdışındaki meslektaşları tarafından da hayranlık ve takdirle karşılanmakta. (2004)*
	"Breasts that I make are like balls without silicones"… European celebrities wait for one year's list in order to have an operation done by Turkish aesthetic surgeon X who lives in Germany. (2004) *"Yaptığım memeler silikonsuz top gibidir"… Avrupa'nın ünlüleri, Almanya'da yaşayan Türk estetik cerrah X'e ameliyat olmak için bir yıl sıra bekliyor. (2004)*
Orga-nization Names That Appear Along With The News	Y promises that just before the new year, you'll get rid of excess weight through liposhaping, be younger through botox, and have a better appearance through hair transplantation. There is a chance for Y Card holders to have a 15 percent discount on cash payments, 10 percent discount on payments in installments, and an option to pay in 3 installments for purchases of 50 million TL or more… The "Botox" application, which is 450 dollars in Y, is discounted for 300 dollars for those who bring a friend. (2001) *Y,yılbaşı öncesi liposhaping'le fazla kilolardan kurtulmayı, botox'la gençleşmeyi, saç nakliyle havalı görünümü vaat ediyor. Y Card sahiplerine nakit ödemede yüzde 15, taksitte yüzde 10 indirim, 50 milyon üzeri ödemede 3 taksit imkânı veriyor… Y'de 450 dolar olan "Botox" uygulaması, arkadaşıyla gelene 300 dolara iniyor. (2001)*
	There is also "Alo Aesthetic" as counsel line. Y has started to provide 24-hour service to people with aesthetic concerns. X told that "Alo Aesthetic Counsel Line" will be provided this month on the web site "Y" and "those who send photos of their flaws can see the results after aesthetic [surgery] on the computer". (2001) *Telefonla danışma hatlarına "Alo Estetik" de katıldı. Y, kurduğu danışma hattıyla, estetik kaygısı olan kişilere 24 saat hizmet vermeye başladı. X, "Alo Estetik Danışma Hattı" hizmetini, bu ay içerisinde internette "Y" adresindeki web sitesinde de vermeye başlayacaklarını anlatarak, "Böylece kusurlu yerlerinin fotoğraflarını web sitemize gönderen kişiler, bilgisayarda estetikli halini görebilecek" dedi. (2001)*

Table 1 (cont'd)

Idea Beauty Defined And Calculated	Based on preferences made by one thousand patients last year, Y manager Dr. X and Dr. XX have listed the characteristics of an ideal woman: Nicole Kidman's nose, Winona Ryder's eyes, Kim Basinger's lips, Sandra Bullock's chin, Jennifer Lopez's cheeks, and Selma Hayek's body. An attempt to attain all of these or a series of operations from top to toe costs 35 thousand dollars. (2003) *Y yöneticilerinden Dr. X ve Dr. XX, geçen yıl bin kadın hastanın tercihlerini esas alarak idealdeki kadını şöyle sıraladılar: Nicole Kidman'ın burnu, Winona Ryder'ın gözleri, Kim Basinger'ın dudakları, Sandra Bullock'un çenesi, Jennifer Lopez'in yanakları ve Salma Hayek'in vücudu. Bunların hepsine birden sahip olmayı denemenin ya da tepeden tırnağa estetiğin bedeli ise 35 bin dolar. (2003)*

6.2.3.4. Aesthetic Medical Companies

Using marketing tools and applying an overall strategy of marketing is becoming more and more common among aesthetic medical firms, too. These firms come to doctors' offices marketing several of these products and informing doctors about the latest technologies and news from around the world. Bilge (25F) thinks that these companies are very clever applying several marketing tactics.

> Our sector is a very dynamic one, and it's open for improvement. This sector is very open to cosmetic things and stuff, therefore, willingly or not, we become the intermediaries here. There is a new product, usage of this product, there is a new cream, this cream, miraculous botox, I mean at least the canalization of these for the society is carried out by us or at least carried out by us most of the time; of course the capitalist society is there and the consumer society, so they are trying to invest on us [the doctors] for this reason, you know all those creams and stuff, botox, mezotheraphy, liposculpture, and everything, they're first

introduced to us, and they're trying to brainwash, and then we orient our patients in that way…

Bizim sektörümüz çok şey, hem dinamik, hem de ilerlemeye, işte kozmetik şeylere falan çok açık bir sektör, dolayısıyla ister istemez biz de burda şeyiz aracıyız. İşte yeni bir ürün var, bunun kullanılması, yeni bir krem var, bu krem, mucizevi botox, en azından bütün bunların şeyi, nasıl söyleyeyim topluma kanalizasyonu bizim tarafımızca gerçekleştiriliyor ya da en azından çoğunlukla bizim tarafımızla gerçekleştiriliyor, e tabii kapitalist toplumu da düşünürsek, tüketici toplumu, dolayısıyla bizim üzerimize [doktorların üzerine] çok yatırım yapılmaya çalışılıyor bu açıdan, yine bütün işte bu kremler, şunlar, cartlar, curtlar, botokslar, mezoterapidir, liposculpture'dır, hepsi öncelikle bize şöyle bir güzel şey yapılıyor, zihnimize kazındırılmaya çalışılıyor, daha sonra biz de hani hastamızı bu şekilde yönlendirerek…

Another company promotes a product of photography by sending e-mails to doctors who have attended the last ISAPS congress held in Australia. The e-mail contains the following expressions:

> Increase patient satisfaction and practice revenue with Y mediscope 2007! Y is the proven, worldwide tool for medical photo documentation. The new mediscope 2007 sets benchmarks for standardized before and after photography! Whether you perform face lifts, fillers or body contouring – Y's outstanding images demonstrate the success of your treatments and impress patients with customized skin reports. Thanks to brilliant before and after photos your patients will be convince that more treatments pay off. Thus Y increases the number and frequency of treatments per patient and your practice revenue! Sell more aesthetic treatments! Optimize your imaging workflow!

E-mail from another company, which provides professional marketing advice to doctors, gives the "secrets" to making patients "choose you":

> Hundreds of thousands of dollars are spent on aimless advertising, and bad practice advertising is the worst thing your practice can do. It's almost a criminal waste of your time, money, and precious human resources. Next Wednesday, take an hour to learn the secrets of building your brand, making your advertising dollars work, and converting new

> patients. We'll cover topics like: Designing a practice logo that works, examples of the best medical marketing out there, 45 seconds to a better website, 6 secrets to great graphic design, copy that sells your services, the most powerful headlines ever written, working with creatives - designers and copywriters, the real goal of all your practice marketing, making the best ads in your market, branding your practice… There is no better way for you and your marketing director to get your arms around your practice advertising.

All of these practices and examples offer that aesthetic surgeons engage in marketing practices; they try to increase their "sales," create "brand recognition," and improve "brand image."

6.2.4. General Implications of "Shopping for Beauty"

As the media presents aesthetic operations as easy and almost miraculous, patients may perceive surgery as yet another tool to beautify themselves. With different and usually incorrect perceptions about what surgery and surgeons can and cannot do, patients communicate with doctors as if they are friends, rather than physicians. This new service relationship brings a newer logic in marketing since the context provides characteristics which are not seen in other consumption contexts, such as the condition of unconsciousness during actual service delivery (surgery), lack of a concrete product with features established beforehand, and considerably higher risk of dying during service delivery.

Communication between the doctor and the patient becomes very important, and it shapes and directs pre-surgery expectations and post-surgery

satisfaction in dramatic ways. Trust is built in ways different than other consumption contexts, such as through personal bonds between the patient and the doctor and the perception that the doctor, by operating on the patient, can solve his/her personal problems in other aspects in his/her life. The concept of "brand loyalty" applies to the medical consumption context as doctors utilize marketing tools to convert patients, increase demand, and establish a long-term reputation around their names.

CHAPTER VII

DISCUSSION AND CONCLUSION

Results obtained in this study illustrate that beauty is not a state of being, but a progress that may continue throughout one's life, which thus requires time, energy, and money. Like a car or a refrigerator, beauty can be "continuously upgraded and modified in accordance with new interests and greater resources" (Finkelstein, 1991: 87). In the context of plastic surgery, the customer engages in an ambiguous, risky decision making process and the doctor is in a serious, long-term relationship with the patient with a cautioned interest in selling. In this new context, consumer decision making shows characteristics which are different from conventional decision making processes used to explain consumer behavior in other product/service encounters. Decision making process is shaped and modified through various discourses in the society, the media, and the medicine.

This playing through life-long beauty work gives informants pleasure.

As described in Chapter Six, they enjoy being "less beautiful" than they can be. Being more attractive may only be possible through an aesthetic operation; but this is not a hopeless situation since surgery is now available more conveniently. Since the ideal beauty reflects non-Turkish characteristics, the fantasies of being a citizen of another culture, such as Europe, is also pleasurable and fun (Campbell, 1987), and even more so because it is possible to attain a similar physical appearance. Therefore, plastic surgery enhances an individual's sense of power, and gives him/her an opportunity to partake in another group. In other words, fantasizing "myself as I could be" is itself desirable (Belk et al. 1996). These thoughts and feelings are already pleasurable for informants; imagining oneself having a different appearance is perceived as fun, hopeful, and empowering (Belk et al. 1997).

Therefore, medicine, which has been regarded as the place only for the sick, emerges as a new consumption area. Patients consider plastic surgery as another beautification practice and doctors utilize marketing tools. Although aesthetic surgery is a medical specialty, information is more easily exchanged and it can be more easily distorted in the local and global media. People can more easily comment on surgical results. The idea of going through surgery and surgical tools and knowledge are being globalized through doctors and aesthetic medical companies. Through numbers and measurements, surgical techniques are being objectified. Hospital is becoming a place to have fun, just like a shopping mall, where patients enjoy talking to the doctor about beauty issues and discussing alternative methods of "treatment." Mallification of hospitals is

reflected also in hospital managers' efforts to turn consultation rooms and doctor offices into more pleasant places for the patients. Patients are no longer sick, but just in need of a medical treatment to enhance their beauty.

In this chapter, the implications of the findings will be discussed in three parts: The first part will discuss the newer service logic in marketing by considering the characteristics of this new consumption context and different discourses that shape consumer concerns and decisions. The second part will look at whether and how patient-consumers can potentially become satisfied. The last part will discuss branding implications of plastic surgeons' medical and marketing orientations, and how it is possible to talk about people as brands. After this discussion, concluding remarks will be presented along with limitations of this study.

7.1. Newer Logic in Marketing: A Medical Service Relationship

A general conclusion from this study is that even in medical sphere where knowledge is more "objective" and rules are stricter both locally and globally, flows of information and images can still be filtered into different social classes and groups, and "leak" through boundaries such as religion, patriarchy, and cultural norms. It is a "silent" trade being experienced because both local and foreign actors agree on the dimensions of commodity exchange (Price, 1980). One difference of plastic surgery from other beautification practices is that

patients cannot change the form of surgeries or create new surgical techniques; only doctors can. In this case, the product *has to* be taken as it is by consumers since not the product (surgery) per se, but the ways of using it and the knowledge that produces the product can be changed.

We can look at plastic surgery decision making process from a new perspective which brings a newer logic for products and services (re: Vargo and Lusch, 2004). The so-called "dominant logic" in marketing assumes that all commodities are manufactured outputs which have tangible properties. The new dominant logic presumes that provision of service, rather than products, is the main unit in economic exchange (Vargo and Lusch, 2004). Results in this study exemplify this new dominant logic in marketing, because it is not the surgery alone that consumers purchase.

However, this context is not typical of many product or service situations; therefore it may require even a newer logic in marketing. First of all, the product is not is not a concrete, certain thing; and it is not only the surgery itself. It involves the physician's knowledge and skills, where surgery becomes the transmitter of this knowledge. This is in contrast to other contexts, where the product characteristics are clear, such as for newspapers or hamburgers; and even for service contexts such as banks or schools. In plastic surgery, the boundaries for the product and service are not clear. This is one of the reasons why patients expect too many different things from their doctors and doctors cannot be sure of what they are supposed to do. There is not a fixed sequence for their jobs to follow and their responsibilities can easily jump into areas other

than medicine as they are expected to know about current styles, how to make patients more fashionably beautiful, and even touch a woman's soul.

The patient-consumer, too, does not have a clear idea about what the product is. Product characteristics, such as physical results on the tangible body part or cost of the surgery, and service characteristics, such as the doctor's attitude or service quality in the hospital mix together in ambiguous ways. The idea of the product can be different for each patient-consumer; it can be beautification, becoming sexier, freeing oneself from bodily constraints, or having the luxury to wear new, fashionable clothes. It is not clear in consumers' minds themselves what to expect from the surgery and the surgeon. Moreover, the specific surgery itself can be a single phase in beauty progress, further complicating what the product is. The consumer cannot touch or even feel the product and think about its features. The tangible results of the surgery do not have clear attributes which can be determined or discussed beforehand.

Therefore, patient-consumers cannot clearly determine what the product is, and doctors cannot set clear specifications of what they will accomplish, in contrast to all consumption contexts discussed in consumer behavior studies, where the consumer actually knows what s/he is paying for. Although the patient is the co-producer of the surgery in a strict sense, s/he is unconscious during the actual delivery of the service (surgery) because of anesthesia. The consumer cannot interfere with the process, but only see its results afterwards.

A second important difference of plastic surgery from other consumption contexts is that the service is much riskier. The risk involves not

only psychological risks such as when the patient does not like the part's new shape and lose his/her self esteem and social risks such as when other family members or friends do not "approve" the person's new physical appearance and the person actually loses his/her standing and respect at work, at home, and in the society; but also health-related risks such as complications of the surgery, side effects of anesthesia and the possibility that the body part may lose its function. The nature of this risk is also different because consumers not only risk their time and money, but also their very existence. Therefore, the term "risk" is not in its everyday usage here and it actually refers to serious medical complications and the risk of death.

Context is risky also because the results of surgery are almost irreversible in the sense that a reduced breast or a re-shaped nose can never be returned back to their original forms because of medical constraints. The doctor may perform another surgery in an attempt to re-shape the body part, but the results may not be necessarily in line with what the patient desires. Moreover, although it is possible to increase consumption of products and services by just purchasing more, due to biological limitations, it is not possible to "purchase" surgeries one after another by paying more. Even if it were possible to go through several surgeries one after another, there would be no guarantee that the patient would attain the desired physical appearance, although it is usually possible to find the perfect color of lipstick, or the perfect brand of a computer, or the best dress for the party, just by trying different brands and purchasing more.

In the context of plastic surgery, an uncertainty exists because patients cannot see the results of surgery beforehand. The doctor cannot guarantee that there will be no complications or that the patient will exactly get the desired outlook. Although the physician uses the same medical applications and employs the same tools and facilities, the results might differ from one person to another. Even if the results are the same, different patients may or may not like the very same results. In other words, although the application is medical, and hence, "objective", the results are subjectively evaluated. Reliability of information gathered from the media and through word of mouth is not assured, which further increases the ambiguity involved. Since there is no medical disease involved which has to be prevented or cured such as breast cancer (Wong and King, 2008), the individual takes the risk even though s/he might live without surgery, which further increases the perceived level of risk.

The risk involved, therefore, necessitates a newer logic because expectations from an extraordinary hedonic experience cannot explain patient-consumers' decision making behavior and relations with the service provider. In contrast to a hedonic experience such as river rafting (Arnould and Price, 1993: 24), evaluation of the outcome is not solely dependent on the "narrative" experienced by consumers as it also depends on whether expectations are satisfied or not, although both expectations and satisfaction criteria are vague. Moreover, the risk is not a joint risk shared by the *communitas* produced by all people involved in the experience; but rather, the risk is completely particularized to the individual person. In other words, the others involved in the

whole experience are not necessarily "team players" (Arnould and Price, 1993: 42) and there is nothing much the individual can do to reduce the risk in advance.

A third distinguishing factor in terms of the context characteristics is the service provider himself/herself. The physician does not illustrate the conventional characteristics of other service providers. First of all, the doctor is not necessarily interested in selling the service. Depending on interview and observation results, the doctor sometimes tries not to sell since s/he thinks the "dream" in the patient's mind is not possible to attain and the patient may not be satisfied. The doctor does not engage in advertising or promotion activities as in other service contexts where the main orientation of service companies is to increase sales. In a strict sense, competitors exist for a specific physician, but it is not sufficient to explain their competitive behavior by looking at their "sales" or "promotion activities." Lastly, there is no substitute for surgery at home or in the market, so it is not possible for patients to "resist" the prevailing ideological discourse (re: Thompson, 2008) about plastic surgery as there is no other way to physically change the body part, which makes the service provider in this context much more powerful compared to other cases.

Related to the characteristics of the service provider, is the nature of the service relationship itself. This is a high-contact, customized service (Bowen, 1990; Kinard and Capella, 2006) which makes communication very crucial for the relationship between the doctor (service provider) and the patient (consumer). Every time a patient contacts the service provider, a service contact

is said to occur (Bitner, 1995); therefore, service relationship does not only entail the surgery, but also pre-operation and post-operation interactions. Both doctors and patient-consumers try to build long-term relationships with each other. Service encounters are at the same time social encounters; therefore, they might be considered *both* as conventional purchase situations where patients try to get knowledge about the surgery and decide whether to purchase the service or not *and* as a social interaction where they want to trust the physician, usually with a mind already decided for surgery. Repeated interactions between a doctor and a patient result in the development of professional *and* personal bonds (Czepiel, 1990), as discussed in Chapter Six.

These three distinguishing characteristics together, namely, product vagueness, a different risk nature, and a different nature of the service relationship, create a newer logic in marketing. For instance, the dominant logic assumes that people exchange tangible products where the new logic claims that people exchange specialized knowledge and services (Vargo and Lusch, 2004). The newer logic proposed in this study claims that it may not be clear what people actually exchange. The total package may include tangible results of intangible services, creating a special mix, whose ingredients cannot be specified beforehand as it changes from one patient to another. Accordingly, the consumer is not solely an operand resource (dominant logic), but s/he is not solely an operant resource (new logic), either, since the patient can participate in production but there are various medical restrictions that prevent the patient interfere with the production process.

7.2. Longitudinal and Interpersonal Characteristics of Satisfaction

One of the most important findings in this study is the notion of "beauty in progress", which represents continuity of beauty work towards an ideal, who can be the person's younger self or someone else, usually a foreign celebrity. The narratives and practices of patient-consumers in this study suggest that people do not think they are beautiful "enough" and stop engaging in beautification. They think they are already beautiful but they can be more beautiful since the ideal is beyond instant reach and the changes in beauty fashion may necessitate renewal and modification of physical appearance. There are different types of beauties, so patients can freely choose among those types by deciding on the type of operation; so it is the individual's responsibility to be fashionably and continuously beautiful. Beauty in this sense is actually a never-ending process towards some "perfection." The perfection can involve the specific body part (such as having large breasts and maintaining their steepness through time) or the physical appearance in general (such as achieving a younger look, and then becoming more "European" with a thin body, which may continue in this way towards the ideal).

One of the implications for the notion of beauty in progress is that patient-consumers decide on an operation according to where they are on this progress and the kind of beauty "needed" by the person. Moreover, since patients are determined to continue working on their beauties, they can cope

with failures when they do not attain the ideal appearance or when there are some "mistakes" such as having breasts smaller than targeted or a lowering of noses weeks after the rhinoplasty surgery. This coping strategy is usually shared with the doctor because doctors are perceived to be the scientific authorities on the issue of beauty and as friends of patients. Therefore, service failures do not necessarily result in dissatisfaction.

Still another conclusion is the lack of a visible, concrete product, not only because the good in this context is a service that includes both tangible and intangible components, but also because the product being served by doctors (surgery) and the actual product that consumers have in their minds (beauty) do not coincide. A major part of doctors think they are serving customers on the basis of operations, although informants talk about a variety of complex and overlapping motivations leading to expectations which are sometimes unattainable. For instance, informants talk about their ideal clothes in order to describe the perfect beauty in their minds, where it is almost impossible for doctors to understand how those clothes can turn into medical "realities." Therefore, the difficulty of achieving perfect beauty is accompanied by an uncertainty of what perfect beauty means, accompanied by changes in what is considered beautiful.

In this context, satisfaction from the medical service cannot be explained by using previous theories of satisfaction. For example, expectation disconfirmation model assumes that consumers are satisfied if their expectations are exceedingly fulfilled by the product or service (Van Raaij, 1991). Patient-

consumers, however, are not able to set clear expectations because surgical results cannot be replicated on a model or pre-determined by the computer, and also because consumers themselves may not be aware of their own expectations from the surgery. Moreover, it becomes difficult to verbalize expectations on abstract concepts such as beauty, sexiness, or attractiveness; and even more difficult to communicate it to the doctor, which further impedes an adequate explanation for satisfaction.

SERVQUAL model measures service quality based on tangibles, reliability, responsiveness, assurance, and empathy (Parasuraman et al. 1985). Although there are applications of this model in a clinical setting (Headley and Miller 1993), it may fail to capture the whole experience of plastic surgery patients which starts outside of the hospital and many years before the surgery. Satisfaction from an aesthetic operation is not shaped at the specific point of surgery. Although quality perception is very important in shaping consumer satisfaction from a hospital service (Zeithaml et al. 1996), according to informants' interpretations of their own beauty and their vague but several expectations from the operation, satisfaction becomes a very complex and multifaceted construct that cannot be explained only by looking at the patient's experience in the hospital. Satisfaction can start even when the person starts to collect information, when s/he makes an appointment with the doctor, or when she purchases a mini skirt that she can wear after the surgery.

Therefore, satisfaction is only understandable as a gestalt, not as perceptions of quality for single attributes in the hospital (Chao, 2008).

However, this does not mean that perception of hospital services does not affect satisfaction; but rather, the share of hospital services in total satisfaction and/loyalty is not clear. Some informants who were complaining about tasteless food or uncomfortable beds were very satisfied with the overall experience. Some informants with good surgical results from a medical standpoint were not totally satisfied because of poor conditions in the hospital and other factors.

Furthermore, satisfaction is not necessarily linked to surgical results and it does not necessarily coincide with medical surgical performance (Bragg et al. 2007). Satisfaction in its strict sense may never occur since beauty is an endless work. According to doctor informants, medical success of an operation usually involves applying the procedures successfully, no bleeding, no infections, no complications, and basically, an alive patient who survives the anesthesia. The patient, on the other hand, often does not know anything about the medical procedures. Therefore, satisfaction in this context cannot be explained by looking at satisfaction from surgical results, although the common tendency in consumer behavior is to explore satisfaction by looking at the consumption transaction.

Therefore, satisfaction from this medical service cannot be explained without exploring what others say about surgical results, because patients interviewed state their need to be "approved" about the surgery and their desire to be liked and admired concerning their new physical appearances. All these attributes bring out the longitudinal and interpersonal characteristics of satisfaction, which relaxes the prevailing assumption in consumer behavior

studies that the consumer is satisfied or dissatisfied alone and based on product/service performance. Although beauty attempts have almost always been discussed in terms of social and psychological practices, satisfaction has not been discussed from an interpersonal perspective. Satisfaction or dissatisfaction is not solely dependent upon surgical results, nor is it established right after the operation. Satisfied patients may later be unhappy because of negative feedback they receive from their friends and relatives, and unhappy patients may later become delighted. The surgery itself, although it is the core service being sold, is not actually experienced by the patient since s/he would be unconscious during surgery.

Therefore, satisfaction is shaped according to the quality and goodness of feedback received, which implies that satisfaction in this context is not a personal but a shared, communicated, public, communal, and longitudinal construct. Decision making process of Turkish informants involved in this study implies that they need to "balance" local and foreign ideas and meanings. For instance, they go through a breast augmentation surgery, but they do not intend to show their breasts by wearing revealing clothes or use their breasts to get the attention of men, both of which are against traditional Turkish values and Islamic rules in their opinion. Therefore, their satisfaction is also shaped by these discourses, norms, and values. It is not only the interpersonal features of information search or the interpersonal atmosphere of doctor-patient dialogue; the formation of satisfaction itself is interpersonal, i.e. shaped by other people's opinions, expectations, and priorities, as much as the patient's. The others in

this context can be Turkish or foreign, and they do not have to physically communicate as discussed in Chapter Six.

As mentioned before, surgery is like an adventure, which also reflects the interpersonal character of satisfaction, similar to hedonic experiences that many individuals seek out (re: Arnould and Price, 1993). If this is the case, then results of the specific surgery may not necessarily affect whether patients are satisfied or not. Informants actually call the surgery as having magical attributes; so satisfaction does not stem from the service attributes per se, but it is embedded in the total experience of deciding and having the surgery with doctor, who becomes the service provider and a close friend. This experience is characterized by high levels of emotional intensity (Kang, 2003) and expectations are vague. Reactions to surgical outcomes involve a longer-term process, rather than being specified at brief moments of exchange.

Therefore, consumers in this study may experience free imagination and actively participate in an imagined (global) community, and get pleasure from a never-ending availability of progress. Satisfaction is shaped largely by a fun and pleasure element in the whole experience, and by the feeling that they are progressing towards perfection. Interpersonal characteristics of satisfaction bring out notions of interdependent demand and communal decision making, having effects on individual bodies. Physical bodies become sites for expressing a collective mood, which in turn shapes advances in plastic surgery technology. Therefore, doctors can manipulate consumer satisfaction not necessarily by improving surgical techniques but by playing with other parameters of

satisfaction, such as perception of the relationship between the doctor and the patient or convincing patient's relatives and friends about the success of surgical results. The next section will talk about different roles doctors can play in this whole experience and attempts of branding themselves.

7.3. Doctor Branding

The notion of beauty in progress has implications for doctors as well. Patient-consumers and doctors may want to maintain enduring relationships because beauty work does not depend on one single purchase, but a long-term series of several purchases, even for the same body part. Doctors can attempt to attract, maintain or enhance their customer relationships (Berry, 1983) because a fixed transaction on the basis of surgery in exchange for money cannot develop into mutually satisfying relations and profitable returns in the long run.

This is one of the reasons why communication and trust are extremely important in this area (Casielles et al. 2005), where some trust must be established even before the purchase decision (re: Soderlund and Julander, 2003). As different from other consumption contexts, patients may come to the doctor's office with a prepared mind about the surgery decision and with a level of trust already established towards a specific doctor, i.e. pre-relational trust (Ekici and Sohi, 2000). Many patients observed talk about how they trust the physician in advance, even without knowing much about the doctor and even

when they know that the doctor's performance may vary from one operation to the next.

As discussed in Chapter Six, doctors are expected to do more than surgery. At the individual level, they are expected to understand patients' deeper, underlying motivations and desires so that both the patient and the doctor can become satisfied with surgical results. Since adverse effects of the surgery are directly related to one's health, as well as his/her appearance, trust becomes much more important than in other service contexts. This kind of trust is similar to trust that patients would have towards other people in life, more than trust that they would have for a company or a brand. In other words, trust in this context is similar to trust that we feel for our friends, rather than for an organization. The company here is also the person himself/herself.

At a more general level, patients expect doctors to know about prevailing norms of ideal beauty. They expect doctors to differentiate between modern, Western beauty and more traditional, local type of beauty. They also expect doctors to know what is fashionable not only in terms of physical appearance but also in clothing, accessories, and hair style. In medical sense, trends in fashion and general demand for specific surgeries can make doctors learn about relevant techniques. New technologies and advances in surgical procedures are developed in areas where patients demand the most. Therefore, medical advancements and fashion trends follow each other. At an imaginary level, doctors are expected to create a miracle. This makes doctors not only physicians, but also artists, friends, and beauticians. This miraculous role is

reflected especially when patients wake up from anesthesia with their new breasts, new noses, or new faces. The physician is supposed to create a pleasurable surprise when the patient first sees himself/herself following the procedure. This "wow effect" can actually be created not necessarily through surgical achievements but through psychological conditioning of the patient and by creating trust and a strong, long-term relationship.

All these roles expected from doctors are actually not related to their area of expertise. These expectations require a different kind of training and a different perspective in life. Many doctors, on the other hand, utilize these medical and non-medical service characteristics as attributes of their brands. Brand personality has been described as the process of attributing human characteristics to brands (Aaker, 1997). Characteristics of brands, such as sincerity, excitement, competence, sophistication, and ruggedness, also exist for people (as brands). But they still fall short of explaining how doctors can possibly brand themselves.

"Personal branding" has actually been in use since the 1990s. The term was first used to refer to a process whereby people and their careers are marked as brands (Peters, 1997). But its applications and consumer responses to personal branding have not been investigated in consumer behavior. In contrast to other service relationships, doctors cannot advertise the results of operations they performed or promote free surgeries in a hospital. In this regard, doctors can be perceived as only performing medical applications and treating patients. It is in fact illegal in Turkey for doctors to advertise themselves, but many

doctors start to engage in "marketing" their work in other ways, usually in the form of "covert" advertising, constructing web sites, and hiring public relations specialists to organize television and print media exposure. Some doctors engage in serious attempts to make their names known by utilizing PR specialists on a long-term basis.

Concerning doctor-branding, this study is a first attempt to investigate the concept in more detail and link it to other consumer behavior concepts, such as brand loyalty. There are a few articles studying consumers' relationships with their brands (for example, Fournier, 1998); nonliving products and services having human attributes (Aaker, 1997; Fournier, 1998); and celebrities' use of marketing concepts and tools (Levine, 2003). However, these studies only look at relationships where the brand is built around a physical product/service with a specific company's marketing efforts. In this study, the brand is also the company that is marketing it; and it is not necessarily interested in selling the product. In the context of cosmetic surgery, the doctor becomes both the product and the marketer; moreover, s/he is not a celebrity and s/he cannot advertise himself/herself using conventional methods.

Positioning image of the surgeon becomes a difficult task because the image should be appropriate for both patients and physicians, and on both local and global levels. In this context, doctors can choose their patients; accept and maintain patients who match the target group, and reject those who do not match. Doctor branding implies that doctors can focus on personal characteristics which are not related to their medical performances or scientific

achievements. The most common characteristics that are observed among Turkish doctors include international reputation, scientific discoveries, and successful performance of aesthetic surgeries. But there are other non-medical characteristics that doctors can utilize in brand positioning, which includes friendliness, talking style, closeness to the patient, availability and accessibility, good physical appearance, sociability, responsiveness, kindliness, sympathy, sensitivity, warmth, thoughtfulness, hospitality, and helpfulness.

The relationship perspective in branding is very fruitful in understanding interactions between consumers and brands (Aaker et al. 2004; Fournier, 1998). But this perspective is useful because brands stand for products and services which are nonliving things. By bringing the perspective that consumers actually communicate with their brands and that brands can have personality traits, we can better understand firms' branding strategies and consumer behavior. According to this view, consumers can form a stronger relationship with brands which are congruent with their self-concepts (Sirgy, 1982). However, in our context, the brand is already a person, so the relationship perspective is not as helpful in understanding consumer-brand relationships.

Consequently, one of the most peculiar features of doctor branding is the fact that doctors are also people, so their brand positioning and brand image cannot be static. Doctors talk to their patients before and after the surgery; and the service relationship is intended to continue for a long period of time, as discussed before. The interactions between doctors and patients can help or impede a particular brand image since the results of branding activities are

immediately visible at the time of interaction, which is not the case in most purchasing situations. Therefore, brands are co-created by doctors and patients through various interactions that occur before, during, and after the service relationship, which is not necessarily a single surgery. In other words, the consumer has a more direct role in building a brand. For instance, the doctor can shape his/her behavior according to the feedback s/he receives during a consultation. S/he can appear in different television programs in order to change his/her positioning among his/her patients. Or s/he can use strong aspects of his/her personality, which might be considered as brand "enhancing" rather than brand "building."

With doctors being co-branded with patients, the resulting brand image has implications for both the doctor and the patient. Assuming that a brand has been constructed, the relationship perspective becomes more useful in explaining the consumer-brand interactions. For instance, the doctor can maintain the current positioning or reposition his/her brand according to circumstances. Patients, on the other hand, can become so proud of their doctors that the brand image reflects their identities. They can even form a special kind of brand community as they would understand each other and know what they went through the course of the surgery, where the doctor (or the brand) plays a key role during the whole experience. There are instances where patients praise their doctors to other patients in the waiting area and "defend" them on discussion groups on the Internet.

7.4. Managerial Implications

Characteristics of a newer logic in marketing, nature of satisfaction, and doctor branding have implications for doctors and hospitals as well. One of the key conclusions is that planning the operation based on what patient-consumers say is not wise because what they say does not coincide with what they really think; and worse, they may not be sure about how they feel or not be aware of their expectations. They may also feel shy about expressing their real motivations and expectations, such as their desire to be attractive or sexy. It is also possible that they see the doctor as an "authority," so s/he already would know about what the patient means, and it would be rude to tell the doctor what to do. Moreover, the terms used by patients may not necessarily match what they mean in medical terms. For example, there are instances where patients state that they want a natural nose which does not look operated. But the doctor may or may not realize later that they actually wanted a nose which is much lifted.

A brief professional consultation by the doctor, therefore, may not be enough for understanding patients' deeper motivations and for satisfying their social needs, as well as their "physical" needs. The patient expects a social interaction with the doctor, even though it is not essential for the effective delivery of the specific service (consultation or surgery). This study illustrates many examples where patients do not act like they demand a professional hospital service but they behave like they are "shopping for beauty" in a

"hospital mall." This forces doctors to constantly repeat what they can and cannot do and what the service includes, in order not to leave it to the patients' imagination. These roles and responsibilities that a plastic surgeon has to entail are not actually included in his/her education in medical school. S/he is educated just like other doctors in terms of style and types of knowledge, except for the specific content of the medical area. This has implications not only for plastic surgeons who are already working in the area of plastic surgery, but also for medical schools which educate new medical students.

Another consequence of this is that without participating in scientific endeavors or without improving surgical techniques, doctors can increase the number of their patients and make them more satisfied with surgical results. Patients do not know about technical details and they would not understand the specifics of the operation even if they were provided with the information either by the surgeon or through the media. Therefore, they become receptive to other types of information about plastic surgery, such as types of operations available or the results that celebrities achieved. And for this reason, patients become more receptive to how the hospital treats patients or how the doctors communicate with patients, even including the color of the consultation room or whether the secretary serves them coffee while waiting. The media disseminates information that (potential) patients can analyze; and doctors can concentrate and improve themselves on areas such as personal organization of appointments, communication skills, close relations with the patient, spiritual satisfaction of patients, and continuity of the relationship after the surgery, and

even in terms of his/her own physical appearance.

Another implication is about patients' ideals. The results indicate that Turkish patients' ideal male or female has characteristics of a Western person, and usually a celebrity. What patients consider as "natural" and "normal" is not actually common and ordinary in Turkey. What doctors have to consider as normal, therefore, is only normal in Europe, but not in Turkey. According to doctor informants, this Western ideal is quite pretentious for the morphological characteristics of a typical Turkish person. Therefore, doctors may have to think more or ask the patient about the specific characteristics of their ideals, and consider whether that ideal can be achieved using contemporary surgical techniques, and act accordingly.

Results also indicate that the media shapes and alters (potential) patients' ideals and their beliefs about what plastic surgery can do to achieve that ideal. On the other hand, word of mouth seems to be one of the most powerful sources of information that shapes patient demand. Therefore, many of the sources that initiate and shape demand for plastic surgery cannot be controlled by any one individual, and not even by doctors. Since information which circulates through the media and word of mouth can often be incomplete or incorrect, as discussed in Chapter Six and in this chapter, it might be necessary that individual doctors, hospitals, and governmental and non-governmental health organizations can take necessary action in order to inform and educate potential patients. This would make the correct type of information to disseminate and shape demand in more accurate ways.

7.5. Concluding Remarks

Two general conclusions from this study are (1) the global interdependence among patient-consumers, plastic surgeons, aesthetic medical companies, and the media represents a special network with increasing relationships and, (2) consumption of aesthetic surgery represents a special service relationship with distinguished characteristics from other consumption contexts, which have important implications for both consumer behavior researchers and practitioners. Inclusion of both the consumer (i.e. patients) and the producer (i.e. doctors, media, and aesthetic medical companies) sides enriches this understanding by investigating specific interactions between the service provider and the patient-consumer. The substantive domain of plastic surgery, which is considered as another area of contribution (Ladik and Steward, 2008), provides important implications for patients and doctors, as well as for the society as a whole, as the increase in demand of and supply for cosmetic operations is very high in both affluent and less affluent nations in the world. The multi-discipliner nature of the research question (medicine, sociology, psychology, marketing, and consumer behavior) and an accompanied diversity in references is an important asset to understand the phenomenon from different perspectives (Deighton, 2005).

There are several limitations in this study. For instance, although informants are found to engage in a continuous effort to beautify themselves,

the study lacks a longitudinal analysis of how informants situate the specific surgery in their lives. Since each beautification practice represents a part of the progress along the way towards ideal beauty, it may be more meaningful to look at the surgery decision along with other beautification practices through time. Beauty ideals can change, too, as there is also a notion of beauty fashion prevalent in many modern societies. Longitudinal data, tracking how consumers engage in life-time beauty work, how they become socialized into a shared knowledge and culture about body and plastic surgery, and the corresponding self-conceptions (Thompson and Arsel, 2004), would improve the overall comprehension of the concepts. Post-operation data, i.e. what informants feel and what they do after the surgery, would thus enrich the understanding of "beauty in progress", as well as how (dis)satisfaction evolves. This would enhance the "macro perspective" in consumption, which attempts to look at consumption processes at a broader level, such as by investigating post-purchase behavior (Belk, 1987).

Moreover, the study lacks a fully adequate global interpretation, which could have been made possible by investigating the meanings and practices of different people in different cultures, and their notions of ideal beauty. A more useful research design in this regard would be "multi-sited ethnography" (Marcus, 1995) where many interviews would be conducted in different places, which would make the results more "relational" rather than territorial (Kjeldgaard et al. 2006).

The study also lacks in-depth information about people who changed

their minds for surgery, people from rural areas, male patients, aged patients, as well as the patient's friends and relatives, which would enhance the understanding of beauty notions and the concept of satisfaction. Therefore, while the conclusions drawn from this study appear credible within the context of the informants' experiences, their broad applicability to other persons or other contexts should not be presumed. Focus groups would also reveal interactions among patients and/or non-patients, which would convey more knowledge about the characteristics of interpersonal satisfaction and communal decision making.

Moreover, patient-physician interactions can be investigated in more depth in a future study, where important implications can be made about patient acceptance, patient rejection, and patient retention by utilizing the exchange model. Lastly, the notion of quality of life is worth examining in future studies, exploring such concepts as how patients feel surgery has affected their lives in general, and more specific effects on work, love, and family lives. Similarly, patients' interactions in the hospital system, including not only doctors but also nurses, secretaries, and assistants, would expand knowledge on the share of hospital service quality on overall satisfaction and the special case of relationship marketing in the hospital, although data from Gazi Hospital would remain as the only particular setting for such knowledge.

In conclusion, once again, contemporary consumer culture is marked by a dialectic between self-discipline for normal physical appearance and a hedonic pursuit of pleasure from achieving a better outlook. Cosmetic surgery may be an

ongoing part of our biological adaptation. Or it might be a technological extension of makeup. The crucial point here is that even our physical bodies, which have long been assumed to be given and fixed, are now included as another consumption sphere. Bodies are now flexible. They are liable to change according to circumstances. Since people have started to change the size, shape, and color of their bodies, we have nothing left to modify for symbolic consumption.

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APPENDIX A

INTERVIEW INFORMANTS

"Producers" of Aesthetic Surgical Applications

Ali: Male, 39, Turkish, lives in Ankara, married with a child, plastic surgeon. 179 minutes.

Bilge: Female, 25, Turkish, lives in Ankara, single, plastic surgeon. 50 minutes.

Cansu: Female, 59, Turkish, lives in Ankara, married with two children, works for TRT. 51 minutes.

Gonca: Female, 40, Turkish, lives in İstanbul, single, works as PR specialist. 54 minutes.

Onur: Male, 47, Turkish, lives in Ankara, married with a child, plastic surgeon. 54 minutes.

Pelin: Female, 35, Turkish, lives in Ankara, single, insurance company representative. 40 minutes.

Selim: Male, 52, Turkish, lives in Ankara, married with a child, plastic surgeon. 55 minutes.

Sertap: Female, 30, Turkish, lives in Ankara, single, works as medical firm representative. 35 minutes.

Toygar: Male, 39, Turkish, lives in Izmit, married with two children, plastic surgeon. 36 minutes.

Turan: Male, 39, Turkish, lives in İstanbul, married with a child, plastic surgeon. 50 minutes.

"Consumers" of Aesthetic Surgical Operations

Altay: Male, 34, Turkish, lives in San Francisco, single, taxi driver, had several nose operations. 68 minutes.

David: Male, 56, married with three children, lives in the Netherlands, works as project manager in underdeveloped regions of the world, had eye-lid and face-lift operations. 72 minutes.

Derya: Female, 25, Turkish, lives in Chicago, single, works as a networker, had a nose operation. 46 minutes.

Eda: Female, 37, Turkish, lives in Ankara and England, single, assistant professor, against plastic surgery. 117 minutes.

Esma: Female, 32, Turkish, lives in Ankara, married with a child, insurance sales representative, had breast reduction operation. 52 minutes.

Gamze: Female, 20, lives in the Netherlands, single, student, works as waitress and singer, had nose operation. 42 minutes.

Gaye: Female, 37, Turkish, lives in Ankara, married with a child, works as tourist agent manager, had nose operation, liposuction, fat injection. 89 minutes.

Hacer: Female, 18, Turkish, lives in Ankara, single, unemployed, had a nose operation. 53 minutes.

Handan: Female, 35, Turkish, lives in İstanbul, interview carried out in the U.S., single, works as professor, against plastic surgery. 94 minutes.

Hayal: Female, 39, Turkish, lives in Ankara, sports trainer, single, previously had nose and teeth operation and breast augmentation, recently removed her breast implants. 76 minutes.

Hazan: Female, 28, Turkish, lives in Ankara, research assistant, divorced, had nose operation, fat injection on legs. 72 minutes.

Kader: Female, 34, Turkish, lives in Ankara, divorced with a child, works, had abdominoplasty and liposuction. 46 minutes.

Melih: Male, 22, Turkish, lives in Ankara, single, master's student, had nose operation. 93 minutes.

Mine: Female, 28, Turkish, lives in Ankara, single, works in a bank, had nose operation. 47 minutes.

Musa: Male, 22, lives in Ankara, single, student, had chin operation. 36 minutes.

Nalan: Female, 18, Turkish, lives in Ankara, student, had nose operation. 42 minutes.

Selin: Female, 28, Turkish, lives in Ankara (has plans to go to Antalya), single, medical representative, had breast augmentation operation. 42 minutes.

Serdar: Male, 31, Turkish, lives in Ankara, single, works as instructor, had nose operation. 110 minutes.

Tutku: Female, 39, lives in Ankara, divorced and widow with a child, works as a belly dancer, had breast augmentation and liposuction operations. 73 minutes.

Yonca: Female, 27, Turkish, lives in Ankara and France, single, master's student, had teeth operation. 93 minutes.

Other Interview Informants

James: Male, 35, American, lives in the U.S. (Sausolito), married to Ebru, software engineer, had eye laser surgery. 33 minutes.

Ebru: Female, 32, Turkish, lives in the U.S. (Sausolito), married to John, computer engineer, had eye laser surgery. 73 minutes.

Rain: Female, 63, American, lives in the U.S., divorced, real estate agent, had nose, teeth, and breast reconstruction operations. 35 minutes.

Sevil: Female, 44, Turkish, lives in İstanbul, divorced, architect, had nose operation. 35 minutes.

Cenk: Male, 25, Turkish, lives in Bursa, had lived in Berkeley, single, industrial engineer, had eye laser surgery. 120 minutes.

Gelin: Female, 30, Turkish, lives in the U.S., New Jersey, single, manager, had

nose and cheek bone operations. 60 minutes.

Kerime: Female, 38, Turkish, lives in Ankara, married, works in a bank, had abdominoplasty operation. 7 minutes.

Ödül: Female, 35, Turkish, lives in Diyarbakir, Ankara and İstanbul, single, had nose operation, minimally invasive patient, player. 11 minutes.

Birsen: Female, 24, Turkish, lives in İstanbul, single, had breast augmentation. 15 minutes.

Münire: Female, 27, Turkish, married without child, lives in Ankara, had prominent ear operation. 17 minutes.

Okşan: Female, 26, Turkish, single, lives in Ankara, had breast augmentation and prominent ear operations. 21 minutes.

Linda: Female, 42, American, lives in San Francisco, single, works as personal public relations manager. 28 minutes.

İnci: Female, 24, Turkish, lives in Ankara, single, works in a bank, had breast reduction and eye laser operations. 30 minutes.

Ceyda: Female, 44, Turkish, lives in Ankara, married with a child, retired from Aselsan, now manages her own restaurant, had breast augmentation and nose operations, had her silicon implants changed for a bigger pair. 32 minutes.

Nazan: Female, 21, Turkish, lives in Ankara, single, medicine student, had breast reduction. 36 minutes.

İpek: Female, 36, Turkish, lives in Bay Area, CA, married (now with a child), assistant professor but does not work at the moment, against plastic surgery. 53 minutes.

Deniz: Female, 26, Turkish, lives in London (interviewed in Berkeley when she was an exchange student at UC Berkeley), single, masters student, had nose operation.58 minutes.

Funda: Female, 19, Turkish, lives in Ankara, single, Sociology student, had breast reduction. 66 minutes.

Sevim: Female, Turkish, lives in Germany, married with, housewife, had abdominoplasty. 40 minutes.

Feride: Female, Turkish, lives in Ankara, had breast augmentation surgery. 49 minutes.

Nermin: Female, Turkish, lives in Ankara, had breast augmentation surgery. 65 minutes.

Yeliz: Female, Turkish, lives in Ankara, previous beauty contest winner, had minimally invasive procedures. 20 minutes.

APPENDIX B

INTERVIEW GUIDE

Consumer Interview Questions

GENERAL QUESTIONS AND BEAUTY IDEALS

- Yaş, evli/nişanlı/bekar, okul/iş, nereli, boy/kilo …
- Bana güzel bir kadını tarif eder misin? (Herşeyiyle) Sence saçları / burnu / gözleri / vücudu kime benziyor? Sarışın mı esmer mi? Mavi gözlü mü siyah gözlü mü? Küçük popolu mu büyük popolu mu? Küçük göğüslü mü, büyük göğüslü mü? Küçük burunlu mu büyük burunlu mu? …
- Bana yakışıklı bir erkeği tarif eder misin? (Herşeyiyle) Traş olmuş mu? Saçları uzun mu kısa mı? Elleri manikürlü mü? Kaşları alınmış mı? Vücudu kaslı mı zayıf mı? …
- Kime hayransın? Ona benzemek ister miydin? Neden?

- Vücudundaki her yeri değistirebilme imkanın olsaydı neler yapardın? (Saçtan ayağa kadar, detaylı) Birine benzeme imkanın olsaydı kime benzemek isterdin?
- Çevrendeki ailen ve arkadaşların seni güzel bulur mu? Nereni beğeniyorlar? Neler söylüyorlar?

(Break if needed, before going to the second part)

LIFE STYLE AND OPINIONS ABOUT PLASTIC SURGEONS AND PLASTIC SURGERY IN GENERAL

- Tipik bir günün nasıl geçer? Boş zamanlarında neler yaparsın?
- [Görüntüyle ilgili] Sabah kalktığın andan itibaren dışarıya çıkmadan önce neler yaparsın? Bir düğüne veya partiye giderken neler yaparsın?
- Televizyon izler misin? En sevdiğin program hangisi? Başka hangi programları izlersin? Yabancı kanallara erişiminiz var mı? Hangi kanallara, programlara, dizilere bakıyorsun?
- İnternete girer misin? Hangi sitelere?
- Gazete okur musun? Hangisi? En çok hangi kısımlarını okursun?
- Dergi alır mısın? Hangisi? En çok hangi kısımlarını okumayı seversin?
- Ameliyat yaptırmış diger aile bireyleri, arkadaşlar kimler? Neler yaptırmışlar? Bu konudaki onların ve kendisinin duyguları, düşünceleri ...
- Alışveriş yapmayı sever misin? Ne alışverişi yaparsın? Nerelere gidersin? Modayı takip eder misin? Bakımını yapmak ya da güzelleşmek için ne gibi

ürünler satın alıyorsun? (şampuan, sabun, cilt bakım ürünleri, kremler, losyonlar, parfüm...)

- Diyet yapar mısın? Spor yapar mısın?
- (*Projective)* Beyin cerrahı deyince aklına ne geliyor? Plastik cerrah deyince aklına ne geliyor?
- Sence günümüzde insanlar dış görünüşlerine göre mi değerlendiriliyorlar? Sence güzel/yakışıklı birisi daha kolay mı iş buluyor? Daha çabuk mu evleniyor?
- Karısının/kocasının veya sevgilisinin isteğiyle estetik ameliyat yaptıran bir kişi hakkında ne düşünürsün?

(Break if needed, before going to the third part)

PROJECTIVE PICTURES

- Birini seçmen gerekseydi hangisi olmak isterdin? Sevgilin/eşin hangisine benzemeni isterdi?
- Birini seçmen gerekseydi hangisiyle evlenmek isterdin?
- İki resimde neler farkli?
- Hangisi daha guzel?
- Hangileri birbirine benziyor? Nereleri benziyor?
- Beğendiğin/beğenmediğin yerler – tek tek.
- Bu kişiler hakkında ne biliyorsun? Filmlerini, programlarını izledin mi?

HABERCİ BELGESEL: Burada gösterilen kadınlar sence güzel mi? Ankara'da bu takı / çizgi / kıyafetle dolaşan birini görsen ne düşünürdün?

(Break if needed, before going to the fourth part)

SPECIFIC SURGERY

- Ne ameliyatı olacaksın?
- Burnunu... beğenmiyor muydun? Neden beğenmiyordun? Bununla ilgili kötü bir anın var mı?
- Ameliyat olmaya nasıl karar verdin?
- Ameliyata karşı çıkan oldu mu? Kimler destekledi? Kötü tepkiler aldın mı? "Dinimize göre estetik ameliyat günahtır" diyenlere katılıyor musun?
- Ameliyat ücretini kim karşıladı? Borç aldın mı?
- Doktoruna nasıl karar verdin? Birisi mi tavsiye etti? Doktorun hiç bu ameliyatın gereksiz olduğunu söyledi mi?
- Burnunun... nasıl olmasını istiyorsun? Bu şekle nasıl karar verdin? Doktorunla şekli konusunda konuştunuz mu? Elinde bir resim var mı(ydı)? Doktoruna istediğin şekli nasıl tarif ettin?
- Ameliyat olduktan sonra sence hayatında neler değişecek?
- İleride baska yerlere de operasyon yaptırmayı düşünür müsün? Nereye? Neden?

PROJECTIVE PICTURES (Karışık Hollywood ünlüleri). Hangilerini tanıyorsun? Nereden hatırlıyorsun? (Film, magazin haberi, gazete, dergi...) Hangilerini beğeniyorsun? Hangilerini beğenmiyorsun?

Doctor Interview Questions

GENERAL QUESTIONS

- Kişisel bilgiler, yaptığı iş, ünvanı, nerede çalışmış, uzmanlık alanları...
- Plastik ve rekonstrüktif amelıyatlar arasında ne farklar var?
- Plastik cerrahi ile göz lazer operasyonları, diş estetik operasyonları arasında ne gibi benzerlikler/farklılıklar var?

(Break if needed, before going to the second part)

"PRODUCTION" OF SURGERIES

- Muayene ve operasyonlarda kullanılan standart oranlar var mı? Bu oranlar neye göre belirlenmiş? Zaman içerisinde değişikliğe uğramış mı? Bu oran değişik ülkelerde farklı olabiliyor mu? Hastaların istekleri ile bu oranlar örtüşüyor mu?
- Sizin hastalara gösterdiğiniz resimler veya oönekler oluyor mu?
- Hastalar genellikle aynı şekli mi tercih ediyorlar? Değişik talepler oluyorsa, bu talepler neye göre değişiyor?
- Plastik cerrahi alanının size göre iyi ve kötü yanları neler?
- Diğer doktorlarla kendinizi karşılaştırdığınızda kendinizi ne yönde farklı görüyorsunuz?
- Türkiye, diğer ülkelerden teknoloji olarak farklı mı? Doktor sayısı? Hasta sayısı? Felsefe olarak?
- Meslek hayatınızın en yıpratıcı yönü nedir? En zevk aldığınız yönü nedir?

- Başınızdan geçen hastalarınızla ilgili iyi/kötü/ilginç deneyimleriniz var mı?
- Yaptığınız ameliyatı kendinizin beğenmesi de önemli midir?
- Yaptığınız bir ameliyatı, hasta memnun olduğu halde, sizin hiç beğenmediğiniz oldu mu?
- Hasta sayısının çokluğu kariyeriniz veya mesleğiniz açısından önemli midir? Bu sayıyı artırmak için uyguladığınız yöntemler var mı?
- Mesleğinizde kendinizi uygulamakla yükümlü hissettiğiniz etik kuralların neler olduğuna inanıyorsunuz?
- Medya sizin mesleğinizi nasıl ve ne yönde etkiliyor? Medyanın hastalarınıza direkt etkileri olduğunu düşünüyor musunuz, bunun etkilerini siz nasıl görüyorsunuz?
- Kültürlerarası iletişim sizing gözlemlerinize göre hastaların taleplerini etkiliyor mu? Ne yönde etkiliyor?

(Break if needed, before going to the third part)

PATIENT-CONSUMERS

- Kimler, ne ameliyatı oluyor? Belirli grup hastalar belirli tip ameliyat mı istiyor?
- Sizin gereksiz/yanlış bulduğunuz talepler oluyor mu? Bunları geri çeviriyor musunuz? Nasıl geri çeviriyorsunuz?
- Üst üste değişik veya aynı yerden operasyon geçiren hastalarınız oluyor mu?
- Tibben mümkün olmayan isteklerle karşılaşıyor musunuz?

- Ameliyat olma nedenlerini sizinle paylaşmaları gerekiyor mu? Geçersiz neden diye birşey söz konusu olabilir mi? Size yalan söylediklerini düşündüğünüz oluyor mu? Bunu nasıl anlıyorsunuz? Etrafından gizli olarak operasyon geçiren oluyor mu? Sizden de saklamanızı istiyorlar mı?
- Operasyon geçiren veya geçirmek isteyen kadın ve erkek hastalar arasında ne gibi farklar var?
- Ekonomik olarak gücü ameliyata yetmeyen hastalarınız oluyor mu? Bunlarla ilgili bir yönlendirme yapıyor musunuz?
- Birine benzemek isteyen, ya da birine ait bir burun/göğüs/popo şekline sahip olmak isteyen oluyor mu? Kime benzemeye çalışıyorlar? Ellerinde kesilmiş resimlerle geliyorlar mı? Bu resimler kime ait oluyor? Siz bu talepleri karşılıyor musunuz? Kişiyi o resme benzetmeye çalışıyor musunuz? Hasta ile nasıl bir karar verme süreci yaşıyorsunuz?
- Kız ve erkeklerde yaş farkına göre istekler değişebiliyor mu? Çok küçük yaşta kız veya erkekler ameliyat olmak istiyor mu?
- Sağlığı açısından operasyonun riskli olduğu hastalarınız oluyor mu? Ameliyattan vazgeçirme girişiminiz oluyor mu?
- Yabancı ülkelerden gelen hastalarınız oluyor mu? Bunlarda ne gibi farklar gözlemliyorsunuz?
- Ameliyat için gelen kapalı hanımlar oluyor mu? Hangi operasyonlar için?
- Aklına koyduğu halde sizinle görüstükten sonra ameliyattan vazgeçen hastanız oldu mu? Aklında olmadığı halde buraya geldikten sonra başka bir ameliyata karar veren hastanız oldu mu?

APPENDIX C

PHOTOGRAPHS USED IN PROJECTIVE STUDIES

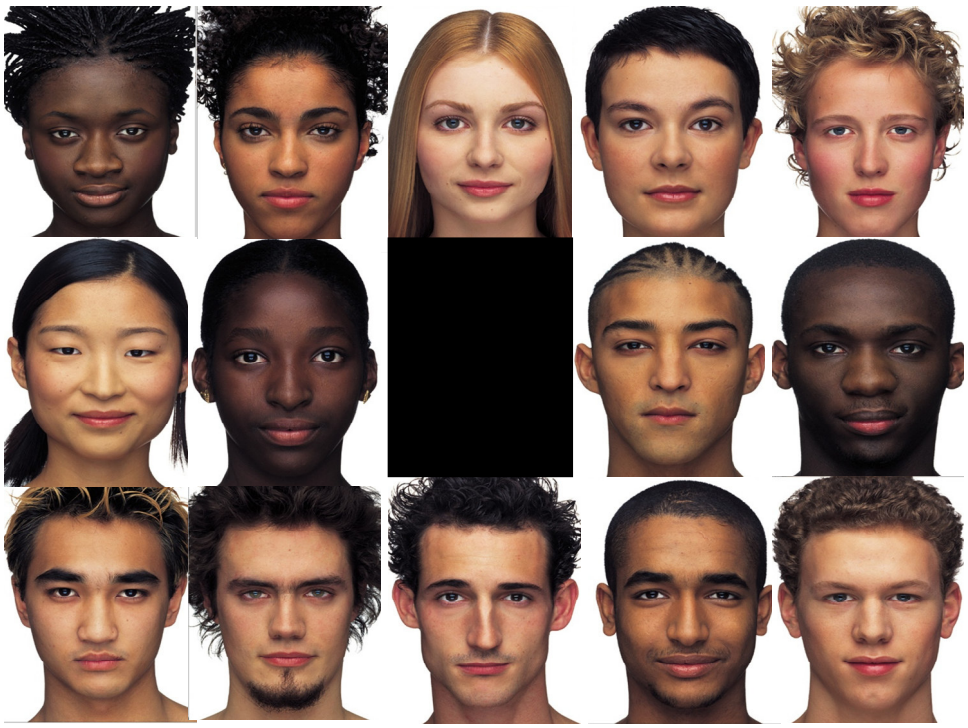

Figure 1 Projective Photographs

Figure 1 (cont'd)

Figure 1 (cont'd)

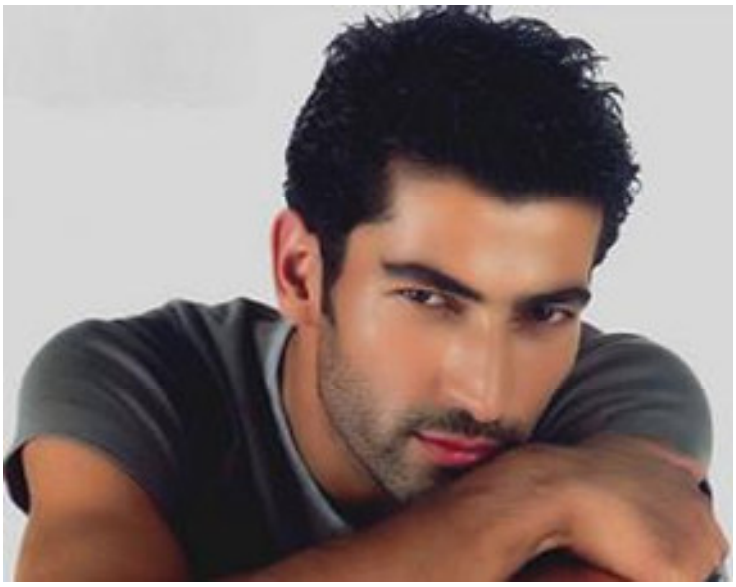

Figure 1 (cont'd)

Figure 1 (cont'd)

Figure 2 Celebrity Photographs

Figure 2 (cont'd)

Figure 2 (cont'd)

Figure 2 (cont'd)

APPENDIX D

EXAMPLES OF UNOBTRUSIVE MEASURES

Dudaklarınızla büyüleyin

Eğer dudaklarınızın şeklinden memnun değilseniz siz de kendinizi uzmanlara teslim edin. Hayalleriniz gerçekleşsin

Artık istediğiniz dudaklara sadece 1-2 dakikada kavuşabilirsiniz...

Lokal anestezi altında üst veya alt dudağın iç yüzüne yapılan kesiler ile dudak dışa doğru itilerek kalınlaştırılıp inceltilebiliyor... Ancak uzmanlar, günümüzde yeni uygulanan bir yöntemi tercih ediyor. Lokal anestezi ile yapılan bu yöntem, vücudun başka yerinden alınan yağın dudağa enjekte edilmesiyle gerçekleşiyor. Yağın bir kısmı derin dondurucuda muhafaza edilip daha sonra tekrar kullanılabiliyor. Kendi yağınız kullanıldığı için de hiçbir alerji riski taşımıyor ve en iyi sonuca ulaşılıyor.

DAHA ÇEKİCİ OLABİLİRSİNİZ...

Dudak ile birlikte dudak çevresindeki kırışıklıklara ve yüzdeki diğer bölgelere de yağ enjekte edilebilir. Elmacık kemikleri üzerine verilerek bu bölgede sağlanan dolgunluk, yüze büyük oranda canlılık ve çekicilik verir. Enjekte edilen yağın yüzde 40-50'si eridiğinden, 3 ay sonra tekrarlanması sonucu kalıcı hale gelir.

Dolgu maddeleri

DUDAKLARI ve yüzdeki kırışıklıkları doldurmak için dolgu maddeleri geliştirilmiştir. Bunlar içinde en zararsız olanı ve en çok uygulananı, hiyoluronik asitten (Juvaderm, Restylane, Hyaliform) elde edilen maddelerdir. Bu maddeler 1-2 dakika içinde enjekte edilerek dudaklara dolgunluk verir ve kırışıklıkları düzeltir. Etkisi 6 ay ila 1 yıl arasında devam eder.

Figure 3 A Newspaper Article

Farklı Tekniklerde Postoperatif Meme Ölçümlerinin Değerlendirilmesi

Hastanın:
Adı/Soyadı: Yaş:
Dosya No: Tel:
Ağırlık:……..kg Boy:……..cm BMI:
Sutyen ölçüsü:

Operasyon: Cerrah:
Tarih:
Teknik:
Ameliyat süresi:
Çıkarılan doku miktarı: sağ:……..gr sol:……..gr
Drenaj miktarı sağ:……..gr sol:……..gr
Postoperatif komplikasyon:

	Preop	Plan	PO 3 gün	PO 1ay	PO 3 ay	PO 6ay
Nipple-notch						
Nipple-IMF						
Nipple-nipple						
Sutyen ölçüsü						
Skar N-İMF						
Skar İMF						

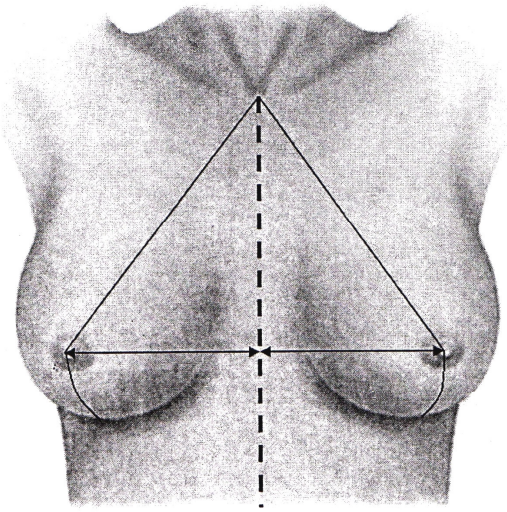

Figure 4 A Medical Document