



## Brief encounters: Assembling cosmetic surgery tourism



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### ARTICLE INFO

#### Article history:

Available online 26 June 2014

#### Keywords:

Cosmetic surgery tourism

Flow

Network

Assemblage

### ABSTRACT

This paper reports findings from a large-scale, multi-disciplinary, mixed methods project which explores empirically and theoretically the rapidly growing but poorly understood (and barely regulated) phenomenon of cosmetic surgery tourism (CST). We explore CST by drawing on theories of flows, networks and assemblages, aiming to produce a fuller and more nuanced account of – and accounting for – CST. This enables us to conceptualise CST as an interplay of places, people, things, ideas and practices. Through specific instances of assembling cosmetic surgery that we encountered in the field, and that we illustrate with material from interviews with patients, facilitators and surgeons, our analysis advances understandings and theorisations of medical mobilities, globalisation and assemblage thinking.

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“I hadn't slept the whole time I was there, I only slept one night, because of the morphine and because of the anaesthetic and I was hallucinating as well and I was so uptight and paranoid about the cleanliness and because I was so hungry, all I thought was, ‘oh my god ... if I don't die of starvation in Tunisia I am going to die of an infection’, and to me I really, really was. And then it was so noisy at night, because another thing; the hospital was also being used for the overflow hospitals in Libya for the war-torn ... maybe they don't know that at night you can hear them screaming in pain” (Sally, UK to Tunisia).

Sally travelled to Tunisia, along with two other British patients and their UK agent, and our researcher, for breast augmentation, eyelid surgery and neck lift, performed by two surgeons – one from Paris and one from the US – who were in Tunisia for one of their regular three-day clinics. Hospital facilities and post-operative care are much cheaper in Tunisia, and one surgeon was a Tunisian emigré with local contacts. The agent had promised a translator throughout the UK patients' stay, but they arrived to find he was no longer available. The agent explained that she had carefully vetted the hospital and chosen the best rooms for her clients. After three days both surgeons departed with suitcases full of cash, the only payment method they accepted. The surgeons ‘wined and dined’ the agent, who provided

them – and surgeons in other destinations – with clients and ‘managed their diaries’ in exchange for a fee. The agent departed shortly afterwards, despite protests from Sally, telling us that Sally needed “tough love”, leaving her in the care of her two fellow travellers and the (non-English-speaking) hospital and hotel staff.

The hospital was also treating Libyans caught up in civil war, who were highly distressed, having been injured or lost loved ones in the conflict. In the lobby of the nearby holiday hotel where medical tourists recuperated (taking advantage of out-of-season rates), a Libyan patient slashed at his wrists, whilst staff tried to wrestle a knife away from him. The UK patients knew nothing about the Libyan conflict, or their proximity to it. They thought they were in ‘the Mediterranean’. Shocked at the severity of the wounds and emotional trauma of the patients in the adjacent ward, some reflected on the ‘triviality’ of their own surgeries and desires for a better life in the light of the Libyans' experiences. At the time of the last interview with these patients, two were still texting the Libyan friends they had made, and were sending small amounts of cash to help out when they could afford it.

This vignette describes our encounter with one field site, but it captures perfectly the themes and issues we focus on in the discussion below. In one clinic, on one visit, we became entangled in multiple global flows – those directly collected and connected in the network that brought doctors, nurses, agents, patients, money and medical practices together in a clinic in Tunis, and those that for very different reasons coexisted in the same space: war casualties brought for treatment due to cross-border medical

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agreements between Tunisia and its neighbour Libya (Lautier, 2008). The clinic is a 'space of connectivity' (Pordié, 2013) – a site where things come together. Sometimes, it is a site of 'throwntogetherness' (Massey, 2005). Researching cosmetic surgery tourism (hereafter CST) brings us into contact with broader debates – those around cosmetic surgery and around medical tourism (Sobo, 2009; Wilson, 2011) – as well as reminding us of the importance of attending to the specificity of the places, people, things, practices and ideas that come together when someone travels abroad to access a procedure to enhance their appearance – and when someone is on hand to facilitate that access, whether directly (a doctor, a clinic) or indirectly (a blogger, an agent).

The main aim of our discussion is to refocus attention in CST research on the detail of these flows and networks, to map how CST is composed of interconnected circuits at different spatial scales. CST has tended to be reduced to 'globalisation' and aligned with ideas about core-to-periphery, west-east or north-south movements, for example in discussions of an emerging global beauty ideal shaped around western cultural norms. We aim to reveal a much more complex and variegated cartography. Our attention to flows, networks and assemblages gives us a new conceptual toolkit for analysis of the experiences of CST uncovered in our research.

The importance of both detaching from a traditional model of medical travel based on 'west-goes-east' or 'north-goes-south', and of paying attention to the local, contingent and contextual is also highlighted by Ormond (2013b) in her study of Malaysia, which embraced the 'deterritorialisation' of healthcare after the Asian financial crash severely curtailed its booming private healthcare industry. However, deterritorialisation has not produced homogeneously globalised medical economies based on equivalent standards of care and travellers' abilities to pay: Malaysia's 'Muslimness' is exploited to attract wealthy Saudis for lengthy stays, while Indonesian patients are heavily regulated and quickly turned around, providing value to the Malaysian healthcare industry only in terms of patient volumes, and patients from Singapore are encouraged, via pre-existing free trade and travel agreements, to seek cross-border healthcare. Ormond also reminds us that not only people travel in medical flows; so do ideas, policies, technologies, etc. – all of which are invested with their own geopolitics.

While Ormond's work highlights key issues across the medical tourism sector, two key elements of the definition of CST in its specificity are significant for the analysis that follows. The first is the 'electiveness' of cosmetic surgery. This classification specifically 'positions' CST within the broader understandings of contemporary healthcare: electiveness conveys choice, lending itself to arguments that focus on the 'consumerisation' of health practices, even contesting the label 'health' as useful for considering elective bodily transformation at all. In practice, electiveness means that even in situations where public health systems provide medical care, those deemed elective fall outside its reach, and can often only be accessed via private providers. Similarly, in situations where private health insurance underwrites medical bills, elective procedures may also be excluded from insurance cover. In most cases, then, cosmetic surgery patients pay out-of-pocket for their procedures. This inevitably brings a particular nuance to the purchase of cosmetic procedures, at home or abroad.

Second is the 'tourismness' of cosmetic surgery tourism (Bell et al., 2011). Within the medical tourism literature there is debate regarding whether the term 'tourism' is appropriate at all (Roberts and Scheper-Hughes, 2011). In the case of elective procedures, the electiveness and the tourismness become mutually reinforcing, doubly trivialising the practices of cosmetic surgery tourists. These two terms drown out the 'surgery' in between, and this issue hangs over professional, lay, media and academic discussion of CST.

Certainly, the electiveness and tourismness of CST give its global and local forms a particular 'shape'.

In the next section we present a brief overview of the research project and research methods that underpin our analysis in this paper, before moving on to develop the conceptual approach through a discussion of flows, networks and assemblages that draws out key examples from our fieldwork to build a new understanding of how CST 'works'.

## 1. Researching cosmetic surgery tourism

We draw on empirical material collected over two and a half years of intensive fieldwork carried out by a multi-disciplinary team of researchers working in diverse locales. The main regional focal points for our project were (i) patients travelling from the UK to destinations in Europe and its environs (a focus which ended up taking us to Tunisia, as described in the opening vignette), and (ii) patients travelling from Australia to destinations in East Asia – a focus which led us to explore in more detail various regional flows around East Asian countries including Thailand, South Korea, Malaysia and China. We undertook interviews and ethnographic fieldwork, travelling and talking with patients (who were sometimes travelling alone, sometimes in groups or with partners and families), doctors and healthcare workers, as well as other key players in the industry such as agents/brokers/facilitators, translators and drivers. Altogether, we interviewed 213 people, as well as collecting photo and video diaries from some patients, observing and participating in social and clinical environments at different field sites and in social media forums associated with CST, and in latter stages of the research hosting stakeholder events to bring together key participants for broad-ranging discussion.<sup>1</sup>

Our mixed methods and mixed disciplines enabled the project team to explore CST in different contexts and through many conceptual lenses, producing deeper and more complicated accounts of this emerging phenomenon. While some of the conceptual tools we outline below have resonance and usefulness beyond CST, our discussion focuses on specificity: what happens in CST is a particular form of coming-together (and sometimes throwing-together). The particularity of CST is in part related to issues discussed above: the electiveness and monetised nature of the transactions, changes in the local and global landscapes of healthcare provision (including issues of both regulation and deregulation), the 'consumerisation' of at least some aspects of healthcare, and the issue of 'tourismness'. These issues have at times led to over-simplistic 'analysis' which collapses CST with homogenising globalisation, cultural (and medical) imperialism, and neoliberalism. Our dissatisfaction with such easy accounting for CST, combined with the richness of our empirical material, pushed us to produce a more nuanced analysis, one that listened carefully to how real participants accounted for their own experiences and actions, and that scouted more widely for ways to conceptualise CST. We shy away from overgeneralisation, and begin our own act of assemblage by considering the diverse flows that together make up CST.

## 2. Assembling cosmetic surgery tourism

### 2.1. Cosmetic surgery tourism flows

In considering the flows that constitute CST, we draw on Appadurai's (1990) discussion of globalisation's disjunctive global

<sup>1</sup> For more information on the project, see [<http://www.ssss.leeds.ac.uk/>].

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