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Becoming a Cosmetic Surgery Patient:

Learning to Discuss Aesthetic Concerns in a Medical Context

A dissertation submitted in partial satisfaction of the

requirements for the degree Doctor of Philosophy

in Sociology

by

Erika Lamoureaux

2024

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2024

ABSTRACT OF THE DISSERTATION

Becoming a Cosmetic Surgery Patient:

Learning to Discuss Aesthetic Concerns in a Medical Context

by

Erika Lamoureaux

Doctor of Philosophy in Sociology

University of California, Los Angeles, 2024

Professor John Heritage, Chair

Cosmetic surgery can be seen as a quintessential example of medicalization (Conrad, 2007; Dull & West, 1991; Sullivan, 2000), a process in which human conditions that were once merely considered problems with living are treated as medical conditions (Szasz, 2007), from baldness (Conrad, 2007) to the transformation of childbirth (Ehrenreich & English, 1978; Riessman, 1983; Wertz & Wertz, 1977). However, little has been studied on how doctors and patients take lifeworld issues such as cosmetic appearance and transform them into conditions worthy of surgical intervention.

With the exception of Julien Mirivel (2002, 2005, 2007, 2008, 2010), there has been little work done using face-to-face, real time interactions between cosmetic surgeons and patients, as opposed to post hoc perceptions (Dull & West, 1991; Davis, 1994, Gimlin, 2007; Brooks, 2004).

In doctor-patient interactions, most identity work and presentations of self occur early in the problem-presentations phase when patients disclose their concerns (Heritage & Robinson, 2006).

Videos of initial cosmetic consultations between 19 patients and one cosmetic surgeon in a Beverly Hills practice were examined through conversation analysis and ethnomethodological principles. Of particular focus were patients' language practices in performing the role of cosmetic surgery patient. Findings were supported with ethnographic observations.

The process of becoming a cosmetic patient, what Harvey Sacks calls "doing being a patient" (1984), is performative and involves an identity that is mutually co-constructed in the course of interaction. Interactional norms of medicine are actively being enacted and expanded to fit the commercial contingencies of cosmetic medicine. In this study, patients received medically relevant responses only when their concerns invited medical evaluation, delineating a clear boundary between patient and consumer. Through interaction with the surgeon, patients legitimized seeking intervention by transforming aesthetic desires into medical concerns. Patients were also socialized into the role of cosmetic surgery patient by acquiring the ability to discuss their appearance in a medically appropriate fashion through interaction with the surgeon. In order to be seen as viable surgical candidates, patients managed tensions between conflicting sets of interactive norms to perform "being a patient" in an environment in which issues of health were virtually absent.

The dissertation of Erika Lamoureaux is approved.

Steven E. Clayman

Tanya Jean Stivers

Stefan Timmermans

Candace West

John Heritage, Committee Chair

University of California, Los Angeles

2024

Dedication

As the saying goes, "it takes a village," and I am profoundly grateful for my academic village. I would like to extend my deepest appreciation to the members of my committee for their time, dedication, and invaluable guidance throughout this journey. My sincere thanks go to Steven Clayman, whose remarkable ability to take my fragmented thoughts and help shape them into something meaningful has been indispensable. I will never forget the parable about wrestling snakes that Stefan Timmermans shared with me the night before my proposal defense; it was a gesture of kindness that provided the strength I needed at a critical moment. Of course, I am also grateful for his sharp intellect and wicked sense of humor. I am deeply grateful to Tanya Stivers. Her work in doctor-patient interaction has played a substantial role in my analysis. I am thankful for the time and effort she invested in this dissertation; her contributions have significantly strengthened my work. Additionally, I am profoundly appreciative of Candace West, whose scholarly work has always been a source of inspiration to me. It is an honor that she not only served on my committee but also offered her friendship and acted as my personal cheerleader.

Above all, I am incredibly thankful to the chair of my committee, John Heritage. I really don't have the words to express how much his guidance, support, and friendship have meant to me. I remember sitting in your classroom on the first day you took over Manny's undergraduate class. That day changed my life. You inspired a love for conversation analysis, institutional talk, and especially doctor-patient interaction. It has been an immense honor to study under my academic hero and to receive his unwavering support throughout this process. The time we spent working together and analyzing data remains one of the most rewarding experiences of my life.

I am also grateful to Iddo Tavory, Julie Peggar, Lisa Kietzer, and Noah Grand—friends from the program who roamed the halls of Haines Hall with me during our time at UCLA. It is also important that I acknowledge this dissertation is complete, in large part, because Margaret Heritage refused to let me give up on myself, for which I will be forever thankful. Thank you, Margaret. I am also incredibly grateful for the support of Julie Haubner who was highly instrumental in helping me cross the finish line.

This work is dedicated to my parents, Lance and Carolyn Johnson, who instilled in me a passion for education; to David Cho and Erika Chau, whose boundless support and encouragement have been more than any graduate student could ever hope for; and to all of my students, past and present. My passion for teaching and my commitment to them gave me a reason and the strength to persevere.

Lastly, but certainly not least, I dedicate this dissertation to my wonderful, lifelong friend Tom Hammer. Though you are no longer with us, I know you have been with me in spirit, guiding me through this process. I wish you were here so I could tell you, "I finally did it!" I know that wherever you are, you are smiling.

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Vita

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Master of Arts, Sociology – August 2008
University of California, Los Angeles, Los Angeles, CA
Thesis: "Presenting Depression: Factors Impacting Physician Attention to Depression Presentation in Primary Care"

Bachelor of Arts, Anthropology, summa cum laude – June 2006
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- "Conversation Analysis: Methodology or Discipline?" – October 2012
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Teaching Assistant, University of California, Los Angeles, March 2006 – 2016

Research Interests

My primary research interests include conversation analysis, ethnomethodology, gender and medical sociology. Specifically, I am interested in exploring the ways in which communication between doctors and patients impact the quality of care patients receive.

Research Experience

Research Assistant, University of California, Los Angeles, May 2004 – August 2006

Performed research under Distinguished Professor John Heritage on how doctors' specific phrasing of opening inquiries impacts patients' willingness to disclose multiple medical concerns. Responsibilities included data coding, data entry, data analysis using conversation analysis, and light statistical operations using STATA.

Publications and Presentations

"Presenting Depression" – Presented at the annual meeting of The American Sociological Association, San Francisco, CA, 2009

Awards and Honors

UCLA Department of Sociology Excellence in Teaching Award, 2010

UCLA Department of Sociology Excellence in Teaching Award, 2013

Professional Memberships

American Sociological Association (ASA), member since 2008

Chapter 1 – Introduction

> Before the plastic surgeon and the patient ever get together, much has already happened in society and to them to structure that relationship. (Goldwyn, 1981, p. 3)

According to the American Society of Plastic Surgeons (ASPS), the number of Americans getting cosmetic procedures each year has been growing at an increasing rate since 1997.[1] Between 1997 and 2015, the number of women who elected to undergo surgical procedures rose a staggering 471%; during the same period, the number of men seeking cosmetic interventions rose 273%. In 2019, nearly 18.5 million cosmetic procedures were performed in the United States, at a cost of over $23 billion (ASPS, 2020). In April 2022, the Aesthetic Society released statistical data indicating that it is not only the numbers of cosmetic surgeries that are increasing, but also the cost of surgeries, which was rising by approximately 6% annually. Their study also showed that a staggering 94% of people who undergo cosmetic procedures are women (ASPS, 2022). Cosmetic surgery is a medical service that, by definition, is performed on healthy and functional body parts that fall within a range of what would be considered aesthetically "normal" as part of the patient's quest to more closely resemble some culturally derived standard of beauty.[2] Historically, cosmetic surgery has been perceived as a practice belonging primarily to the rich and famous; however, by the beginning of the 21st century it had moved well into the domain of mainstream society and is now a cultural practice commonly used by people from all walks of life.

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[1] 1997 marks the first year the ASPS started reporting statistics of the number of cosmetic procedures performed in the United States.

[2] If a body part were to fall outside of the range of normal, the procedure would be categorized as either "corrective" or "reconstructive" rather than "cosmetic."

Why is cosmetic surgery an important area of sociological inquiry? First, the shift of cosmetic medicine from a practice reserved for the wealthy and famous into something commonly performed in mainstream society, is due, in no small part, to active marketing done by cosmetic surgeons and their professional organizations. Cosmetic surgery has arguably been marketed longer and more intensely that any other type of medical practice (Sullivan, 2001). Accordingly, cosmetic surgery is an excellent example of what Conrad and Leitner (2004) have describe as a "private medical market," a context in which medical entrepreneurs market solutions for an ever-increasing breadth of human problems to patients who will pay out-of-pocket for medical services that are not covered by insurance (see also Conrad, 2007). In this context, medical services are treated and marketed like a commodity. Commodificaton is a social process (Appadurai, 1986) and commodification of medicine has been associated with a changing status of physicians and the services they provide. One of the factors that sits behind this transition is consumer driven biotech marketing, via direct-to-consumer advertising that targets people as "consumers," rather than as "patients." Rodwin (1994) takes this position even further. He argues that "medical care is a service, like any other, and that patients are consumers who can choose who should provide medical services, and even what kind of services to purchase." This shift away from the way medicine was practiced in the "golden age of doctoring" (McKinlay & Marceau, 2002), when advertising and direct profit from service provision were viewed as a violation of institutional norms (Parsons, 1951), indicates a shift in the structure of the institution of medicine itself. Because cosmetic surgery lacks a medical justification and is performed solely to meet a patient's desire, it is arguably, the most commodified area of medicine. Study in this area provides traction in understanding shifts within the institution of medicine as a whole.

A second area of importance is closely related to the first. Cosmetic surgery is an environment where a human body is treated much like "a car, a refrigerator or a house, which can be continuously upgraded and modified in accordance with new interests and greater resources" (Finkelstein, 1991, p. 87). As the practice of medicine becomes increasingly corporatized and commercialized, the nature of how doctors practice medicine and patients receive care has shifted to reflect those environmental changes, and those changes occur at the micro-level in doctor-patient relationships (Potter & McKinlay, 2005). Conrad (2005) has argued that, with increasing frequency, people assume the role of "consumer of medicine" rather than performing the more traditional role of "patient." One example of such a change is that, as medicine has become increasingly commercialized, doctors still act as gatekeepers but their role as such has become increasingly subordinate (Conrad, 2005). The commercialization of medicine has not only impacted the status of physicians, it has also had implications for the status of patients. Studying interactions between cosmetic surgeons and patients affords the opportunity to identify and observe how and where the performance of these roles changes. As an example, in what contexts are physicians inclined to relax some of the hold they have on the role of gatekeeper? Or what does "behaving like a consumer of medicine" rather than as a "patient" look like? By comparing cosmetic consultations to acute primary care interviews, the study of cosmetic surgery can provide a higher resolution understanding of the broad shifts in role performance suggested by Conrad.

If cosmetic surgery, particularly doctor-patient interaction in a cosmetic context, are important areas of inquiry for sociology, they tend to be underrepresented in the literature. Considering how prominent cosmetic surgery as a cultural practice has become, the lack of research in social science, and particularly in the sociological, literature is surprising. A large

portion of the existing work on the topic comes from contemporary feminist approaches. This literature reflects a critical cultural perspective (Blum, 2003; Dally, 1991; Elliott, 2011; Jeffries, 2000; Kaw, 1994), that presents surgery performed for vanity's sake as leaving "no space for interpretation as anything but subjugation" (Gimlin, 2000). However, from this perspective, the voices of the women who have had cosmetic surgery are largely absent. Views from the sociological perspective tend to be more varied. While often critical, they often tend to view cosmetic surgery as a savvy method of negotiating a patriarchal world where a woman's appearance is often correlated with avenues to success (Davis, 1995, 2002; Gimlin, 2000). These works are largely theoretical and based on interview data. Studies related to surgeon-patient interaction are even more scant, consisting primarily of a small body of work done by Julien Mirivel (2005, 2007, 2008, 2010, 2011) and a single project by Diana Dull and Candace West (1991). However, once again, this work draws largely upon data from interviews, in which patients deploy post hoc accounts of their motivations, conversations, and circumstances. In addition to their potential for inaccurate recollection, these studies highlight the post-operative rather than the pre-operative perspectives of patients, and give little insight into how these perspectives are concretely negotiated in conversations with clinicians.

My research differentiates itself from the existing literature in that it does not directly seek to characterize either the practice of cosmetic surgery, or the women who elect to undergo these procedures. Instead, I proceeded under the assumption that if the frameworks discussed in the areas listed above are valid, they will not only shape interaction between surgeons and patients, but they will materialize in observable and analyzable ways. As a means to achieving these ends I used conversation analysis, a method with a strong track record of analyzing role performance and of describing the social dynamics that occur during medical interaction, to

analyze videotaped interactions between surgeons and patients seeking cosmetic surgery. This area of inquiry is an important arena for the future of medicine because, as Sullivan observed as early as a quarter century ago, "cosmetic surgery may be at the cutting edge of commercial medicine but it is not out there alone" (Sullivan, 2001).

Background and Context

What is Cosmetic Surgery?

In the context of surgery, the term "plastic," contrary to what one might believe, does not mean artificial. The word comes from the Greek word "plastikos" meaning "to mold" or "to form." Unsurprisingly, plastics is a surgical specialty that is generally involved with appearance. However, not all plastic surgery is what we traditionally think of as cosmetic surgery. Plastic surgeons work with defects of body tissue of the face and body and address issues of both form and function. As a rule, plastic surgeons hold a degree from an accredited medical school and have completed a minimum of five years of graduate medical education: three years of general surgical training and two years of plastics. To be board certified by the American Board of Plastic Surgery, surgeons must have practiced in plastic medicine for a minimum of two years and they go through rigorous testing, a process that must be updated every 10 years. The profession and practice of plastic surgery has evolved across two lines of aesthetically related work: reconstructive and cosmetic. Although both sides of plastic surgery are concerned with the appearance of the body, reconstructive work is categorized as surgery that is done on some portion of the body that is considered to be abnormal. These abnormalities may be the product of trauma, infection, congenital or developmental abnormalities, disease, or tumors.

In most cases, reconstructive surgery is perceived as medically necessary and is almost always covered by insurance. In contrast, cosmetic or aesthetic plastic surgery is performed on bodies that fall within the normal realm of variation. These surgeries tend to be conducted strictly to improve or enhance appearance and are generally not covered by health insurance. Because there can be, and often is, overlap between what is purely cosmetic and what is considered to be reconstructive, if a surgeon can convince an insurer that a cosmetic patient's condition can be classified as reconstructive or medically necessary, it can be covered by insurance even if the patient is not seeking the surgery for any reason other than to enhance their appearance. For instance, a nose job can be classified as reconstructive if the patient's nose has been broken and is now crooked, they have a deviated septum, or they have difficulty in breathing through it. If the surgeon is able to document any of these circumstances, whether the patient specifically complained about breathing issues or not, the rhinoplasty would be considered medically necessary and could be covered by insurance. In this dissertation, I use the terms plastic, cosmetic, and aesthetic surgery interchangeably, to refer to elective surgery. On the rare occasion that I discuss reconstructive work, I reference it as such.

Medical Consumerism

During the "golden age of doctoring" (McKinlay & Marceau, 2002), doctors, for the most part, were autonomous and unaccountable to an organizational hierarchy. While they had to work within the boundaries of the law, the Hippocratic Oath, and the rules and regulations of the American Medical Associaton (AMA), doctors were largely self-employed in private practices and worked on a fee-for-service basis. In this model of medicine, doctors alone were responsible for their own medical decision-making. They were not subject to external institutions, nor were they accountable to them. The AMA was emphatic that no entity or person should stand between

a doctor and their patient (Starr, 1982). This structure is very similar to the context in which cosmetic surgery is practiced today. It is quite standard for surgeons to be self-employed and work in a private practice and on a fee-for-service basis. There generally is no employer or outside payer involved, so surgeons, relatively speaking, have complete autonomy in medical decision-making, how they run their practice, and how they set their fees.

During the latter part of the 21st century, the structure of medicine began to shift. Medicine went through a "purchasers revolt" (Quadagno, 2004), where insurance companies and others who routinely pay for medical services began to flex their collective muscle, and rein in medical decision-making in the interest of reducing costs. This influenced physician behavior in terms of the quantity of services they provided, as well as what they charged for those services.[3] Private practice gave way to health maintenance organizations (HMO), managed care, and the adoption of evidence based medicine (EBM). Suddenly the structure of physicians' pay shifted away from fee-for-service and the bureaucrats of managed care began to set fees and streamline the ways doctors practice (for a discussion see Starr, 1982) by using EBM or "cookbook medicine" to inform doctors' decision-making (Haug, 1976; Haug & Lavin, 1981; Timmermans & Oh, 2010). Suddenly, doctors were forced to attend to competing interests: "Is what my employer, my pharacueutical provider, or some insurance company pressuring me to do in my patient's best interest? If not, whose needs do I attend to?" On a good day, the patients' needs would win, but not all days were good.

---

[3] In response to some of the excesses in terms of what physicians were charging during medicine's "golden age," insurance companies and other organizations who paid for medical services banded together in an attempt to drive down costs associated with the care doctors were providing patients.

Since the late 1970s, doctors have become increasingly accountable to multiple entities, and their decision-making is necessarily influenced by the competing demands of those entities. The demands of powers located outside of the doctor-patient relationship have resulted in patterns of deprofessionalization (McKinlay & Stoeckle, 1988), and the proletarianization of medicine (Light, 2000). Over the past several decades, there has been systematic erosion in physicians' power, authority, and autonomy (Haug, 1976, 1988; Light, 2010; Light & Levine, 1988; McKinlay & Arches, 1985; McKinlay & Stoeckle, 1988). The Countervailing Power framework (Light 1995; Hafferty & Light, 1995) describes a process in which physicans are divested of power and authority over their work by market forces. These forces include government regulation, corporate interests, and mass media, among other sources, all of which have the power to sway physicians' decision-making away from what they believe to be best for their patient, and instead make decisions that are best for their patients within a field of what is also best in terms of some institution's financial bottom line. However, there is one additional market force that has been connected to deprofessonalizaton and that is patient consumerism, which according to Conrad (2005), has become an increasingly important force in the medical landscape over the past several decades.

The one of the major shifts away from the golden age of doctoring that has affected cosmetic surgeons is patient consumerism. Patient consumerism is a movement that started in the 1960s with patient advocacy groups and began to accelerate in the 1980s. Patients were being encouraged through media and advocacy groups to shop around and compare doctors, their skills (both in medicine and in bedside manner), and their prices (Hibbard & Weeks, 1987; Lupton et al., 1991; Timmermans & Oh, 2010). Compounding this trend was the notion of advertising medical practices directly to consumers, as discussed earlier. One of the upshots of medical

consumerism is that it challenges the traditional, patriarchal model of medicine where patients passively accept their doctors' advice unquestioningly. Patients became more educated, empowered, and depending upon the context, willing to assert themselves and challenge their clinicians and to shop for a doctor whose beliefs and care might be more in line with their own (Emanuel & Emanuel, 1992; Roter, 2000).

A doctor-patient relationship is a type of power relationship. Traditionally, this relationship has been defined around the notion of Parson's (1951) sick role. The patient is sick and the doctor is in charge, based upon familiarity with esoteric medical knowledge and patient dependency on medical support. It is the patient's responsibility to follow the treatment recommendations set forth by their physician. However, the consumerist movement in medicine has shifted the balance of power; to what degree is debatable, but it is most certainly situational. Patients have become more educated, and the internet has provided people with unprecedented access to information about their doctors, their education, and how those doctors are perceived by other patients. Patients' supercharged access to medical information helps them achieve greater understanding of medical problems they may be facing and available treatment options so they can make more informed decisions about their own care. It also affords them the ability to compare doctors, in terms of education, experience, and reputation. All of this information has facilitated the consumerist movement in medicine because patients now have enough information at their fingertips to shop for doctors in the same way they might shop for any other service provider. Patients may now consider multiple providers and ultimately select the one that best suits their goals and needs. They have changed the face of medicine where it is now treated as a "commodity" (Donaldson et al., 1991; Lloyd et al., 1991; Lupton, 1994, 1997; Lupton et al., 1991). Proponents of the market economy approach to medicine argue that it should be subject to

competitive market conditions, just like any other commodity, because in doing so, doctors will compete among themselves to maximize their income by providing the best medical services possible (Logan et al., 1996). There are, of course, some significant barriers to a fully competitive medical market: health care regulation, third party payers diminishing patients' incentive to be frugal, etc. Such restrictions result in something of a "halfway competitive market" (Altman & Rodwin, 1988; Rodwin, 1994). This halfway competitive market acts as a counterbalance in adding pressure to physicians to both maintain accountablity to their patients and contend with other outside forces mentioned earlier.

Starting in the late 1970s, a popular theme in the sociological literature is a debate concerning whether the practice of medicine is becoming deprofessionalized, or proletarianized (Haug, 1976; McKinlay & Arches, 1985; McKinlay & Stoeckle, 1988). Haug and colleagues (Haug & Levin, 1980; Haug, 1981) argue that a consumerist stance towards medicine is a clear challenge to physician authority. However, discussions of these processes tend to focus on medicine from a macro perspective. Power dynamics also play out on the level of the individual, in interactions between doctors and patients. Studies from the micro-perspective suggest that medicine is an institution in flux; but at the level of the individual, these changes might not be as profound as macro-level studies have suggested. Moreover, the studies that indicate shifts into a competitive medical market are not even across all contexts. In an interesting series of papers, Debra Lupton and her associates interviewed both doctors and patients to understand better how macro level shifts towards a more consumeristic medical marketplace are conceptualized and experiened by doctors and patients. They have shown that the tendencies for people to adopt a more consumerist stance – an orientation where patients are less deferential to their physicans and are more inclined to question and make demands of their doctors - does not distribute itelf

evenly across the population. People who are younger, more educated, and more affleuent tend to be less deferential towards their physicans than their counterparts at the opposite end of the spectrum (Lupton, 1997). Interestingly, another category that impacted patients' attitudes was the severity of their health concern. Patients whose conditions are more dire tend to be more deferential. She suggests the reason behind this might be that the more uncertain the patient's condition, the more likely they are to favor the more traditional role of patient, because they are more dependent on medical expertise for survival (Beck, 1994; Lupton, 1997). Rodwin (1994) drawing on Freidson (1973), has made an additional assertion that is particularly relevant for the present study: "[Medical consumerism] has great appeal and plausibility...when the choices patients make involve value issues or matters of taste rather than technical medical judgments."

While Lupton's findings support the argument that there is an increasing tendency for laypeople to embrace medical consumerism, her findings also suggest that lay attitudes towards the doctor-patient relationship are complex and varied. She suggests that ultimately laypeople are more likely to pursue both a "consumerist" and/or a "passive patient" stance toward their physician, based on context. Her findings echo those of Haugh and Lavin's (1981) study done 16 years earlier where they found that in terms of attitudes, a "substantial portion" of the 466 patients in their study were inclined to take a consumerist position by taking some responsibility for medical decision making, rather than leaving that process entirely in their physicians' hands. However, fewer than half of their patients indicated that they had ever actively questioned their doctors' authority: 30% reported a single instance of confronting their physicians, while 17% claimed to have done so more than once.

Surprisingly, there is not a lot of information about doctors' perceptions of the impact of consumerism. However, in a companion study to those listed above, Lupton (1997) interviewed

doctors to gain understanding of how doctors perceive and experience changes in the social position and status of the medical profession. Do they feel that their status has fallen or that patients have become increasingly demanding and confrontational? The doctors she interviewed frequently commented that as a profession, doctors were losing their “god-like status,” whereby doctors were not only immortal but infallible. One piece of evidence provided for this perception was that the doctors felt that patients were more likely to seek second opinions about their condition and its treatment. They attributed this trend to the notion that the general public was better educated and tendencies in the general public and the media to discuss medicine and doctors’ failings. Interestingly, many of her participants cited a belief that, in general, patients’ attitudes towards medicine had shifted; however, they had not noticed major changes in their own patients’ attitudes. Moreover, many of the doctors she spoke with claimed that, on an interpersonal level, there was a tendency for patients to expect them to retain an air of authority and formality, even in instances when the physicians tried to adopt a more friendly and informal stance. There was a tendency among doctors to perceive more consumeristic behavior of patients to be beneficial to medical outcomes because the new paradigm puts patients in a position where they are less likely to have unrealistic expections of what medicine can provide, while simultaneously asking them to see themselves as more responsible for their own health and health care decision-making. Some doctors suggested they felt that a more consumeristic environment where doctors are more likely to be more accountable to their patients and provide better medical services.

Overall, Lupton found “little evidence of hostility” towards the notion of consumerism in terms of patient’s behavior. However, this does not mean that there is not also an accompanying sense of alarm because commercialism has resulted in a trend of what doctors believe to be

excessively critical and demanding patients. However, most of these concerns are directed more towards loss of autonomy to macro sources, external to the doctor-patient relationship. The most significant concern with patient behavior is associated with patients' complaints, which doctors perceive as unwarranted and unfair (Annandale, 1989; Allsop & Mulcahy, 1998; Calnan & Williams, 1995; DelVecchio Good, 1995; Lipworth et al., 2013; Marjoribanks & Lewis, 2003; Watt et al., 2008).

Marketing Medical Solutions for Aesthetic Concerns

Evaluating one another in terms of appearance seems to be a favorite American, if not human, pastime. Individuals deemed beautiful are envied and are afforded social prestige, which in turn can translate into employment opportunity (Hamermesh, 2011; O'Connor & Gladstone, 2018). Conversely, being perceived as "unattractive" tends to act as a glass ceiling in the workplace (Toledano, 2012). Featherstone (1991) claims that "within consumer culture the body is proclaimed as a vehicle of pleasure: it's desirable and desiring and the closer the actual body approximates to the idealized images of youth, health, fitness, and beauty the higher its exchange value" (p. 177). Beauty, as an element of cultural prestige and exchange, is a notion not lost upon medical entrepreneurs who are ready, willing, and able to help people to more closely resemble idealized images. As noted by Adams (2013), "the boundaries between fashion, health, fitness, sexuality, personal identity, and the marketplace have collapsed upon one another as individuals are inundated with opportunities to 'improve' their bodies with some combination of fitness classes, equipment, pills, and procedures" (p. 375). In the "affluent West," there can be an expectation that the body is treated like as a project, something "which should be worked at and accomplished as part of an *individual's* self-identity" (Shilling, 2003); not only are we presented the opportunity to change our bodies, we are encouraged to take those opportunities. Virtually

any aspect the human body can cause an individual dissatisfaction, from baldness or lack of whiteness of one's teeth, to the size or shape of a nearly innumerable number of body parts. Consumers who are seeking to address concerns about their appearance can find a medical community which has been more than happy to oblige them in these processes. Surgery is one of many methods of improving one's appearance. It is also likely to be the most expensive, drastic, and arguably, the most effective.

Rise in consumer demand for cosmetic services did not happen in a vacuum. The proliferation of cosmetic surgeries performed starting in the latter portion of the 20th century is due, in no small part, to direct-to-consumer advertising of medical procedures and services. Advertising of medical services was a practice that was prohibited by the American Medical Association during the first half of the century, but this practice was systematically dismantled in the latter half. The "era of deregulation" began post World War II (Starr, 1982). Although the American Medical Association prohibited solicitation of patients and direct advertising to consumers, medical marketing was done through public relations and other less direct methods. One of the reasons the AMA opposed direct marketing to patient was an attempt to distinguish legitimate medical practices and practitioners from snake oil peddlers who would advertise their wares in print ads and in live presentations. They wanted to maintain the image of medicine as a noble profession which did not include peddling cures in a carnival atmosphere. Deregulation happened slowly and steadily through a series of legal wranglings and maneuvers (for a discussion see Starr, 1982; Sullivan, 2000), but the most notable of the changes happened in during the 1970s and 80s. In 1975 the Federal Trade Commission filed an anti-trust complaint against the AMA, declaring their ban on advertising violated the Sherman Antitrust Act of 1890. The AMA fought this assertion through the legal system but in 1982, the ruling was upheld by

the Supreme Court. This act allowed physicians to advertise their services directly to patients - a practice that was immediately and wholeheartedly embraced by American cosmetic surgeons. Suddenly cosmetic surgery was aggressively marketed directly to potential consumers in newspapers, glossy magazines, billboards, television advertisements and even on talk shows. This trend ushered in a new era of commercialization in American medicine, one that has continued to escalate across the decades into today's marketplace (Sullivan, 2000).[4, 5] The combination of individuals' decreased tolerance to suffer minor discomfort, in combination with entrepreneurial cosmetic surgeons who are now able to advertise directly to patients, has resulted in a rapid rise in the number of cosmetic surgeries performed annually.

Cosmetic Surgery as a Commodity

Every year the cosmetic surgery industry – doctors; pharmaceutical manufacturers such as Allergan, the makers of Botox®;[6] professional organizations such as the American Society for Aesthetic Plastic Surgery, and manufacturers of medical devices such as lasers with unique properties for resurfacing skin, or machines that heat or freeze fat cells in an effort to eradicate them – spend untold millions of dollars to drive patients into surgeons' offices.[7]. Doctors make appearances on talk shows to discuss the merits of the latest and greatest procedures in terms of

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[4] See Sullivan (2001) for an extended discussion of the processes leading to the commercialization of medicine in America.

[5] Only New Zealand and the United States allow pharmaceutical companies to advertise directly to consumers.

[6] Botox is a toxin that is injected into the face to freeze and relax facial muscles and in the process reduce or eliminate fine lines and wrinkles. Moreover, by freezing the muscles whose movement is responsible for creating lines and wrinkles, Botox is also associated with slowing the aging process.

[7] It is nearly impossible to determine the exact amount spent on advertising cosmetic services. Advertising is done by pharmaceutical manufacturers, professional associations, clinics, and individual doctors; moreover, it is done directly, or indirectly through "informative" talk show appearances, articles in fashion magazines, or television shows such as *Dr. 90210*, *Botched*, or *The Swan*.

creating a slimmer or more youthful appearance, Allergan takes out ads in magazines that show how Botox® or Juvéderm® can be used to address a myriad of signs of aging. All of this advertising is designed to shape consumer desire to change their appearance to meet some sort of cultural ideal. It also simultaneously encourages and empowers patients to seek medical treatment as a means to this end. There is a pattern in the way advertisements frame perception of cosmetic medicine. Broadly speaking, advertisements suggest that one's desire for a surgery is a matter of personal choice, and to obtain thinner thighs, larger breasts, or a more youthful appearance, all one must do is pick up the phone and schedule an appointment for a consultation:

> Choose a Lifestyle Lift[8]…Enjoy a More Youthful, Radiant You! (www.lifestylelift.com)

> The CoolSculpting[9] procedure is an innovative way to contour your body…With more than 3.5 million treatments performed worldwide people everywhere are getting a better view of themselves thanks to the one-of-a-kind CoolSculpting procedure. (www.coolsculpting.com)

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[8] Lifestyle lift is a trademarked facelift procedure. It is somewhat less expensive than traditional facelifts because it only tightens the skin along the neck and jawline, where in traditional facelifts the surgeon will also tighten the muscles that sit beneath the skin to create a taut foundation for the skin to lie upon.

[9] CoolSculpting is a trademarked procedure for fat removal. It is an alternative to liposuction that does not require cutting open the skin. Instead a cool laser is used to freeze problematic areas on the patient's body which allows the fat to be absorbed into the system and eliminated.

> If you are unhappy with the size, shape, or profile of your breasts it may be time to consider breast augmentation surgery…Dr. X can create perfect balance between your breasts and frame…(www. pasadenacosmeticsurgery.com)

> Beauty is a choice and the choice is yours. Are you ready to enhance your image, raise your confidence, enrich your life? Then call for a cosmetic consultation with the Cosmetic Surgery Specialist. (Composite ad, Sullivan, 2001, p. 145)

These advertising campaigns market surgery as a vehicle to achieve beauty and confidence. This message tends to be underscored by the use of images of happy, youthful and curvy women with impossibly clear skin. The message these advertisements send is clear: surgery can make you beautiful, happy and confident. All that stands between the patient and a new, brighter, more confident version of themselves is one phone call. These advertisements almost universally instruct patients to "call a doctor for a consultation." The word "consultation," hints at the notion that a medical evaluation of the patient is involved; however, surgery is presented as a matter of individual choice. Framing of the attitude of surgery as something "you choose to do for yourself," serves as an example of the subordination of physicians' role of gatekeeper that I mentioned earlier in this chapter (Conrad, 2005). However, although a patient may well "decide it's time to consider breast augmentation," in actual medical practice more is required to obtain surgery than mere desire. A surgeon will need to evaluate the patient to determine if surgery is appropriate and desirable. In in this regard, the surgeon's position as gatekeeper is still very much a reality. However, in advertising that is designed to bring

consumer-patients into surgeons' offices, this aspect of the surgeon's role is attenuated, almost to the point of invisibility.

Selling Surgery

Outside of a surgeon's office, sales, marketing and promotion of cosmetic surgery are done explicitly. However, traditionally these elements have been considered to be external to the practice of medicine. In fact, prior to 1979, the American Medical Association prohibited doctors from advertising their services (Starr, 1982). According to Parsons (1951), the division, or at least the perception of division, between medicine and profit is of great structural significance. So much so, that he considered the division between the work of doctoring and the idea that doctors might personally profit from providing medical recommendations, to be part of the bedrock on which the institution of medicine is built. Obviously in the realm or commerce, the name of the game is to realize a profit. In the business of commerce, profit is overtly celebrated as the institution's reason for existence; the greater the profit, the more successful the business.

Parsons argues the problem with the perception of doctors directly profiting from providing services or treatment recommendations is that it has the potential to erode patient ability to trust their doctors' recommendations. Because medicine is a specialized field, it is impossible for laypeople to possess the knowledge required to make truly informed decisions, on their own behalf, regarding their medical care. Therefore, patients have to look to experts—their physicians—to guide the decision-making process. In order for patients to comfortably surrender their judgment to the expert doctor, they need to be able to trust that their opinions are grounded in what they truly believe, to be in the patient's best interest. One of the reasons that the American Medical Association fought so hard to retain a ban on medical advertising is that the perception that doctors are

selling medical services suggests that they may be motivated by profit rather than the wellbeing of their patients. As a result, the credibility of the profession of medicine as a whole, not just the doctors who advertise, are jeopardized (Parsons, 1951; Sullivan, 2001). Quite obviously, cosmetic surgeons are highly skilled professionals, trained in medical schools, bound by the same sets of norms and responsibilities as any other physician. Likewise, they are entitled to the same set of rights, as any other medical specialty. However, one thing that sets cosmetic surgeons apart from most doctors who practice in other areas of medicine is that cosmetic surgeons also act as entrepreneurs, whose livelihoods depend on selling expensive surgeries to patients who act as consumers of a medical product (Mirivel, 2005).[10] Cosmetic surgeons, if they are to survive financially, are required to effectively market themselves to create a customer base for the range of services they offer (Adams, 2013).

Although cosmetic surgeons operate in a fee for service medical environment, in my experience, cosmetic surgeons tend to be reticent to talk about the topic of selling surgeries, However, whether surgeons want to talk about it or not, "closing the deal" is one of the central, institutional goal for cosmetic surgeons and the consultation is the primary vehicle for doing so (Mirivel, 2008) as Dr. Delmare describes below:

> I sell medicine every day. I have no bones about saying that I market it. I was trained as a general surgeon. I've operated on patients who are near death after a

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[10] I am not suggesting that cosmetic surgery is the only area of medicine where medical entrepreneurship is found. It is increasingly common to find general practitioners, fertility specialists, integrative doctors, and any other host of specialties where doctors stand outside of the larger medical system, work in private practice, market to patients and do not accept insurance payments. What does differ is in most areas of medicine, entrepreneurship is the exception, whereas in cosmetics it is more likely the rule.

> gunshot wound…now I don't. And cosmetic surgery can be criticized as marketing, but it's a business and it should be seen as that and anyone that doesn't realize that is really kidding themselves. (Mirivel, 2008, p. 156)

Despite Dr. Delmare's direct disclosure about cosmetic surgery being a business where the name of the game is selling medicine, his attitude toward selling is the exception rather than the rule. A nearly universal practice among cosmetic surgeons is to never discuss the cost of surgery with their patients. This hesitancy has been built into the structure of cosmetic consultations. At the conclusion of a consultation, the surgeon will tell their patients that they are going to step out of the room for a moment and that they will send the office manager in to discuss scheduling and financial issues.

Given that the profession of medicine's long-standing disdain for the practice of selling medicine, it is not surprising that most of the cosmetic surgeons I have spoken with, including my primary informant, insist that they shy away from engaging in any activities that are likely to be interpreted as selling surgery. The surgeon I worked with was very clear that he was not interested in "selling procedures." His strategy for selling is to sell himself. He says he does so by setting himself apart from his competitors by highlighting his training, competency and professionalism. His position is echoed by Dr. Evans, a surgeon who shares an office with Dr. Delmare:

> You know, uh, awkwardly enough, my strategy is not to sell [patients] a surgery. My strategy is to simply educate them. Educate the patient to what the surgery is

all about and as it relates to them individually. That's what my strategy for the first encounter is. (Mirivel, 2008, p. 156)

It is worth making a general observation about the landscape of cosmetic surgery as a practice. Outside of the four walls of a surgeon's office, as a profession and often as individuals, cosmetic surgeons act as entrepreneurs who actively, and often aggressively, engage in selling medical procedures to a consumer market that is thirsty for solutions to aesthetic problems. However, inside their offices in face-to-face interactions, the role of surgeon-as-entrepreneur recedes. Gone are the overt efforts to create a desire for surgery and drive patients into the office. Any mention of money or finances, is delegated to an office manager. As a matter of practice, surgeons adopt the social norms traditionally associate with the role of "doctor," and limit the scope of interaction with their patients to include only those things that have been traditionally associated with medical practice. The interaction is geared to provide patients with information. Information associated with making informed decisions, or to use more traditional medical terminology to give informed consent. That information might be related to the type of procedures that might best meet the patient's needs, or it might be associated with letting the patient know why he, or she, is likely to be the best candidate for the job.

Given the amount of time, energy and money that the profession of cosmetic medicine has put into marketing their services, it is not surprising that it is not only surgeons who are inclined to orient to cosmetic surgery as a commercial product. Adams (2013) has argued that patients also orient to cosmetic surgery as a commercial product and approach the process of contracting for surgical services in much the say way they would go about shopping for a car or

any other high-cost item. Patient-consumers tend to research the procedures that are of interest to them and then "doctor shop" by doing comparisons between doctors' credentials (Darisi et al., 2005), prices (Krieger, 2002), and personalities, then finding a comfortable compromise between best price and quality of the work. Another factor that contributes to patient perceptions of cosmetic medicine as a consumer good comes from cultural authority stemming from epistemic entitlement. Most people realize that they have primary authority in terms of determining how they wish to present themselves in society (Heritage, 2013; Heritage & Raymond, 2005; Pomerantz, 1984). A hairdresser, especially one who knows their client well, might give their opinion about a particular hairstyle, but ultimately it is the client's decision to determine if they would like long or short hair; to be a blonde, brunette, or a redhead; to present themselves as a sporty tomboy, a "girly-girl," a punk rocker, or a straight-laced corporate type. To a large extent, the same line of reasoning also applies to appearance and the outcomes associated with cosmetic surgery. Patients are inclined to liken getting a facelift or undergoing another form of cosmetic surgery to other, non-surgical, less invasive methods of creating change in the body: "I mean it's your body you want to have it done, why not? And if it helps your vanity, what is wrong with it?…Women buy makeup and have their hair done – what's the difference?" (Dull & West, 1991, p. 56). Just as it is not up to a hairdresser to make the determination that their client should change their hair color or style, it also outside the domain of a surgeon's area of professional authority and expertise to determine if a patient should get breast implants, or if they would be happier with B rather than a D cup bra size (Freidson, 1988). A cosmetic surgeon can tell a patient if their aesthetic goals are achievable through surgical methods; however it is the patient, not the surgeon, who ultimately determines their goals for their own appearance. It is this very sense of entitlement to make decisions about what they would like for their body that affords

individuals the opportunity to make claims about what they want from surgery in the same way they would if they were talking about changing hair styles.

In a medical marketplace that has become increasingly commercial over the last half-century, cosmetic surgery is likely to be the most commercial type of practice. For more than 40 years, cosmetic surgery has been treated as if it were a commercial product because it has been actively and aggressively marketed to the public, and the business of cosmetic medicine is structured very much as a commercial enterprise. However, it is not only the positioning of the surgeon that makes cosmetic surgery relevant in terms of studying the impact of commerce on the practice of medicine. For cosmetic patients tend to occupy demographics that Lupton and colleagues argued are most likely to adopt a consumerist stance towards medicine. By the very definition of cosmetic surgery, prospective patients are not facing uncertain or dire consequences with their health. They tend to be college educated (Schlessinger et al., 2010) and are also well informed about the benefits of procedures and surgeons in the area who have good reputations. They are likely to obtain this information though their social networks or via information they are able to find on the internet. The economic status of patients tends to run the gamut. In 2010 the mean annual household income per cosmetic surgery patient was $60,976 ± $38,553 (range, $17,958-$889,783), but generally are perceived as financially comfortable (Gordon et al., 2010). Finally, as the consumerist model of medicine predicts, patients seeking cosmetic surgery are well known for their propensity to “shop around” for doctors before making their final choice on which to use (Mirivel, 2005; Sullivan, 2001) and this is a trend that cosmetic surgeons are aware of (Goldwyn, 1981; Mirivel, 2005). Overall, it is hard to imagine a context more relevant in terms of studying power dynamics within the doctor-patient relationship in a consumerist medical context.

Feminist Critiques of Cosmetic Surgery

Before I transition into discussing cosmetic surgery from a more micro- perspective, as a type of doctor-patient interaction, I want to briefly discuss some of the major critiques of the practice and those who participate in it. Although these perspectives are not directly relevant to my research as my work does not attempt to address cosmetic surgery at the grand level of cultural discourse, they are important. These critiques are not some sort of occult, academic discussion. Although cosmetic surgery has become increasingly mainstream over the past four decades, it is far from unequivocally accepted by the culture that consumes it. Academic critiques, particularly those from the feminist perspective, have filtered into the culture as a whole, and cosmetic patients are part of the culture. These critiques act as a type of interactional background music to cosmetic consultations, or for that matter, conversations about cosmetic surgery in general. The critiques are not something participants tend to explicitly acknowledge, or orient to, yet they do shape the mood or the tone of many of the interactions. While some theorists claim that the practice of cosmetic surgery is being normalized in Western culture and that those who elect to have it are "proud of it" (Brooks, 2004), qualitative research consistently shows that women treat their desire for surgery as an accountable action. And, the accounts these women construct routinely pushback against the unflattering characterizations of "the type of women who seek surgery" that is prevalent within feminist discourse from the latter portion of the 20th century (Dull & West, 1991; Gimlin, 2000). Since these critiques seem to be of some importance to those who participate in cosmetic surgery, they are worth discussing briefly here.

Since an estimated 94% of cosmetic procedures are performed upon women (American Society of Plastic Surgeons, 2020), it is nearly impossible to conceptualize these practices as non-gendered. Not surprisingly, feminists and the feminist perspective, in particular, have been

quite vocal in their criticisms of cosmetic surgery, those who participate in it, and the culture in which the practice thrives. Perhaps the central concerns of feminist research revolve around the idea of agency in terms of what motivates women to seek cosmetic surgery. The perspectives of two feminist scholars, Susan Bordo and Kathy Davis, are relevant here. Both seek to answer the question, “Why do women seek plastic surgery?” but their answers to that question differ.

Bordo’s position draws on a Foucauldian model of normalization (Lawlor & Nale, 2014) conceptualizing the construction of an idealized notion of thought and behavior. The idealization acts as a form of social control in that those whose behaviors are in alignment with the norm are rewarded, while those whose behaviors deviate from that standard are punished. Cosmetic surgery is an extreme practice available for women to use to conform with patriarchal and oppressive ideals of youth, desirability and beauty (Bordo, 1993; Gillespie, 1996; Wolf, 1991). Lakoff and Scherr’s (1989) perspective folded notions of intersectionality, most notably, race and ethnicity into this perspective. What constitutes being “suitably feminine” tends to be strongly correlated with appearing white. They discuss the issues associated with Jewish women obtaining nose jobs to “pass” as non-Jews; Black women seeking to refine their noses or lips; or Asian women seeking to Westernize the appearance of their eyes. Bordo argues that extreme behavior in terms of women managing the appearance of their body – anorexia, bulimia (Bordo, 1993) and cosmetic surgery – are visible representation of pathologies in the culture. A culture in which images of perfect bodies bombard women to generate feelings of inadequacy and the belief that their own bodies are defective and in need of remedy in ways that conform to the ideas of a paternalistic, racist and anti-Semitic society.

Bordo acknowledges that the option of surgery is an individual choice. However, she argues that it is not fully a “free choice,” because of the subtle coercive mechanism that sit

behind the normalized practice of cosmetic surgery. Thus, the system in which these mechanisms operate should be considered oppressive. She suggests that, through the extreme efforts women will go to be in alignment with cultural expectations, we can identify the dilemmas women face, and use them to critique the society that creates such dilemmas (Bordo, 1999). However, Bordo's perspective is not simply a critique of the society, or even the practice of cosmetic surgery. Her critique extends to the women who elect to undergo these procedures. Those aligned with Bordo's position characterize women who seek cosmetic surgery in unflattering terms such as, narcissistic, psychologically unstable (Blum, 2003; Jeffreys, 2000), "fembots"[11] (Brooks, 2004) and cultural dopes.[12]

Kathy Davis takes a somewhat different position, not so much in terms of Bordo's characterization of the pathologies in a patriarchal society, but with Bordo's critique of the motivation and nature of women who seek surgery. Both perspectives, to differing degrees, problematize women's decision-making process because they argue women's perspectives of self and femininity cannot be separated from the culture that shaped them (Bartsky, 1990; Blum, 2003; Bordo, 1993; Davis, 1995; Gimlin, 2000; Haiken, 1997; Jeffreys, 2000; Morgan, 1991; Sullivan, 2001; Turner, 1984; Wolf, 1991). However, Davis problematizes Bordo's condescending position towards women seeking surgery, arguing that it does not take into

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[11] A term from "The Bionic Woman" used to describe constructed, mechanical, exact replicas of human females but decidedly non-human.

[12] It is ironic and worth noting that the (primarily female) authors of the more critical feminist perspectives routinely describe women who undergo cosmetic procedures with high degrees of hostility and contempt despite the fact that they consider them to be oppressed victims of a patriarchal society. Not only are they described as vain and shallow but in some cases less than human as evidenced by commentary by Brooks (2004): "I fear being the only human among a crowd of fembots, but I am more afraid of not being able to distinguish my humanness from technology" (p. 233). It is doubtful that such characterizations would be acceptable if applied to segments of other oppressed or marginalized populations.

account the voices of the group of people she is critiquing. Davis' interests are more focused on trying to understand "how cosmetic surgery might be the best course of action for a particular woman at a particular moment in her life" (Davis, 1995, p. 36). In this school of thought, cosmetic surgery is a vehicle that women can thoughtfully and consciously use to gain power in patriarchal system that places a great deal of value on feminine aesthetics (Davis, 1995; Dozal, 2010; Gimlin, 2007). Rather than adopting a stance where she positions herself as superior to those who elect undergo cosmetic surgery, Davis treats these "women as agents who negotiate their bodies and their lives within cultural and structural constraints of a gendered social order" (Davis, 1995, p. 42). From this perspective, women are conceptualized as rational social actors who have thoughtfully considered the costs and potential dangers associated with their actions (Bordo, 2009), and weighed them against the expectations of social, personal and professional success (Davis, 1995, 2002; Dolezal, 2010; Gimlin, 2000, 2007).

Looking back at the proliferation of cosmetic surgery across the cultural landscape, Bordo has expressed consternation about a society in which we have "gone from cosmetic surgery as a lifestyle of the rich and famous to breast implants as middle class graduation gifts" (Bordo 2009, p. 31). She also expresses extreme frustration about the impotency of the feminist cultural critique saying their work had no impact on the culture as a whole and likened her efforts, and those of her colleagues to expose cosmetic as suppressive and harmful, to "pissing in the wind" (Bordo 2009, p. 31). It is hard to imagine why Bordo is surprised that women interested in obtaining cosmetic surgery, the very group her message would need to reach in order to slow the rise of cosmetic surgery, would be at all receptive to receiving the message the feminist critique sets forth. Not only does their message condemn the practice, and the society in which it thrives, but also the individuals themselves. People are not generally inclined to listen to

a message where they are personally criticized, belittled, and insulted. However, the quantitative data does indicate that Bordo sells herself short. It shows that the feminist accusations about the character and motivations of cosmetic patients do cause patients moments of self-reflection. The result is that when cosmetic patients are interviewed about their motivations for surgery, they engage in a significant amount of emotional and interactional labor to distinguish themselves being from the vain, shallow fembots feminists have accused them of being (Dull & West, 1991; Gimlin, 2000). When cosmetic patients distinguish themselves from "other types" of patients whose motivations are perceived as frivolous, it seems to serve as a reflection of the critical feminist perspective – yet another layer of women evaluating the legitimacy of other women's motivations and decision-making processes. The feminist critique has not stopped the proliferation of cosmetic surgery, but it seems to have afforded women a context where they can scrutinize and evaluate one another, along with putting those who have chosen to have surgery feel, to varying degrees, vulnerable to attack for their decisions to do so.

My work builds upon the idea Kathy Davis has presented. It assumes that if one is to evaluate a group of people, be that group women, cosmetic surgery patients, or women inclined to have plastic surgery, their own words and actions should be taken into consideration in the evaluation. If we are to understand the meaning and relevance of cosmetic surgery to these groups, it is important to include their voices in the discussion. Issues of importance to the analyst may, or may not, be of any significance in the lives of those who want, or have had, cosmetic surgery. The body of qualitative work done by Davis, Gimlin, Dull, West and other researchers draws upon data collected in interviews. These works have provided rich details in terms of what they are willing to discuss, with a researcher, an individual who may well be perceived to be someone who stands outside of the margins of those who might be interested in

cosmetic surgery; or, even worse, might be hostile to it. It is almost certain, that to one degree or another, the "white coat effect" on the data they collect is in play. This does not, in any way, imply that the data they worked with lacks validity. However, it only addresses these issues from a certain vantage point. In the social sciences, context matters. The issues that are relevant to a pre-surgical patient, while talking with their surgeon, someone who is not likely to be perceived as critical of cosmetic surgery as a cultural practice, are quite likely to be different than those of a post-operative patient who is speaking with a researcher. My work provides this opportunity and adds to this body of literature by providing a preliminary look at women's attitudes about and motivations to seek cosmetic surgery from and entirely different perspective.

Cosmetic Consultations and Doctor-Patient Interaction

Now that I have situated cosmetic surgery into broader historical and cultural context, I will transition into a discussion of cosmetic surgery as an area of medical practice; more specifically in terms of interaction between surgeons and patients. Doctor-patient interaction is a form of institutional talk. Institutional talk is generally used to refer to the interaction occurs between a lay person and a professional, and these interactions are largely devoted to attending to institutionally relevant tasks. Generally speaking, these tasks are attended to in a particular order that gives that type of institutional interaction – a 911 call, a cross-examination in a courtroom, or a medical visit – a recognizable structure and shape. Heritage and Greatbatch (1991) suggest these trajectories serve as a type of institutional fingerprint that make a certain type of talk almost instantly recognizable. In this section I discuss interactions between cosmetic surgeons and their patients during cosmetic consultations, which, using the fingerprint analogy, is similar to but distinguishable from other forms of doctor-patient interaction. The differences in

the content and trajectories of these visits are related to differences in tasks that that need attention in the service of reaching that institution's goals.

I will start this section by explaining what a cosmetic consultation is and discuss some of its functions. Then, since within studies of doctor-patient interaction acute primary care medical visits tend to be treated as a sort of default to which other visits are compared, I will spend some time talking about the form and function of these visit as a basis for comparison. For the purposes of this research, I am primarily interested in the notion of identity and how it is constructed and performed during medical interactions. The roles in which I am most interested are those of doctor and patient, but more particularly the identities of "cosmetic surgeon" and "cosmetic patient," and what an appropriate performance of these roles looks and how these performances relate to the process of determining surgical candidacy.

Cosmetic Consultations. Before an individual can undergo cosmetic surgery, they need to set up a consultation with a surgeon. The cosmetic consultation is the first point of contact between patient and surgeon. The consultation can be summarized as an environment where the two participants exchange information that facilitates decision making as to (a) whether cosmetic surgery is a viable option for meeting the patient's desires for their appearance and (b) if this doctor and this patient wish to enter the undertaking together.[13,14] From a patient's perspective,

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[13] Sometimes a patient seeks a surgery that for whatever reason will not yield the desired results. One reason might be that their body isn't strong enough to risk anesthesia, so surgery isn't viable option. Or, a patient is concerned with a "droopy" bottom, but despite the existence of a surgery called a "Brazilian butt lift," there really isn't much that can be done to lift a bottom. They can put implants in to make it larger, and in doing so get a bit of a lift, but not enough to really "lift" the area as much as most patients will like. Joan Rivers often complained about the "hanging flesh" on the underside of the tops of her arms and discussed how she begged her doctors to get rid of it, even if doing so left a scar, but there isn't really a well-accepted surgery for achieving that goal.

[14] In terms of the two participants deciding to work together, surgeons might be concerned about working with the patient on the grounds they feel they may not be property motivated, or would not be likely to be pleased with their results because the cause of their dissatisfaction is more psychological than physical, or they might just not like the

first and foremost, most patients are primarily interested in determining how much the surgery they wish to undergo will cost. Surgeries that are too costly are a stumbling block for most patients.[15] If it turns out that the treatment they are seeking is beyond their comfort level, they will either table the idea of surgery or, as suggested by the model of consumer medicine, engage in the process of price shopping in the hopes that another surgeon might be more affordable. Patients also tend to be concerned about the level of post-operative pain they are likely to experience and how much downtime they should expect to have during recovery. Then there are the less tangible factors that are more intrinsically related to the surgeon, that feed into patient decision-making: Do they like this surgeon? Do they trust him or her? Do they feel comfortable with the practice as a whole and the way they do business? All of these factors, consciously or unconsciously, feed into patients' decisions as to whether they will undergo surgery, if they choose to do so, if they wish to do it with this particular surgeon.

Surgeons have a different set of goals for consultations. The first of which is, to sell surgery by distinguishing themselves as the best candidate for the job (Mirivel, 2008). However, there is a second, equally, if not more important goal for the consultation: to determine surgical candidacy. Not all who seek surgery turn out to be viable candidates for surgery. The consultation is intimately related to the processes of establishing candidacy if you are a patient,

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patient. Similarly, patients may choose to work with a different doctor based upon price, or any number of other reasons.

[15] Surgeons are aware of cost as a limiting factor on the path to surgery. There are several companies that are willing to finance patients' surgeries. It works much the same way lenders work with car manufactures to provide financing options to customers. In both cases, patients pay interest but at a lower rate than they would if they were to put the surgery on their credit card.

and, if you are a surgeon, determining if the person sitting in front of you is a good surgical candidate. But what, specifically, determines candidacy?

Just as patients are evaluating their surgeon, surgeons are also evaluating their patients. Robert M. Goldwyn (1981), clinical professor of surgery at Harvard Medical School and head of surgery, Division of Plastic Surgery at Beth Israel Hospital, is known for writing "the book" dedicated to teaching cosmetic surgeons the importance of cosmetic consultations In *The Patient and the Plastic Surgeon,* Goldwyn outlines specific goals a surgeon should achieve during the consultation, and how good communication skills are critical to achieving those goals and achieving successful medical outcomes. He describes the consultation as a context where the interactants construct a framework for communication and understanding. In turn, that framework becomes the basis of the entire surgeon-patient relationship. While patients' primary goal for the interaction tends to be determining costs associated with surgery, surgeons' primary goal is determining if the person sitting in front of them is a "good candidate" for surgery.

What constitutes a "good surgical candidate?" The criteria associated with determining candidacy are largely subjective and not necessarily well defined; however, according to Goldwyn, a "good surgical candidate" has physical, social, and psychological characteristics, which all need to be assessed in terms of how they relate to the three following questions:

1. Can I address this patient's concern medically?
2. Is this patient's desire for surgery properly motivated?
3. Is this patient psychologically sound enough to receive satisfaction from surgery?

Of the three, the physical component is arguably the easiest one to determine. First and foremost, it is of utmost importance that the patient is healthy enough to safely undergo surgery.

Another important determinant in establishing candidacy is to ascertain if the patient's goals can be achieved through surgical intervention. Not all concerns can be addressed surgically. As an example, if a patient wanted surgery to make them three inches taller, there are not many well accepted methods of achieving this goal through surgery.[16] In addition, it is also important to determine if the concern should be addressed. This determination is a bit more subjective. Just because a patient's request is technically achievable does not mean that it is likely to achieve what the patient is hoping for. As an example, a patient may want to have their "eyes done" in an effort to appear more youthful. However, the surgeon might determine that if they were to perform surgery on the eyes, and only the eyes, the result would be eyes that appeared incongruous with the rest of the patient's face. So, although technically, the surgeon might have fulfilled the request for an eyelid surgery, the surgery would not achieve the patient's overall objective. Instead of making the patient look more youthful, the surgery could make them look peculiar. In such an instance, although the surgery could be performed, it should not be.

Where the first component or determination is physical and largely relies on evaluations related to medical expertise and training, the latter two are related to information obtained through rapport with the patient. The issue of proper motivation is more of a psychosocial determination. Goldwin (1981) argues that, from an ethical standpoint, the surgeon should be able to determine that a patient's decision to undergo surgery is self-motivated, not because a boyfriend, spouse, or parent has decided that the patient would be more attractive with larger breasts or a smaller nose. The consultation also provides the

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[16] The Ilizarov procedure is a surgery named for its inventor. It is a cosmetic surgery used quite commonly used in China to increase a person's height. This is achieved through the process of lengthening bones, generally leg bones. Length is achieved by surgically breaking a bone, then allowing new bone to grow in the gap left by the gradually separating ends of broken bone. The procedure is almost never used in the United States. When it is used, it is almost exclusively performed for therapeutic purposes.

surgeon with the opportunity to determine whether this individual is psychologically well suited for surgical candidacy:

> Some patients should not have cosmetic surgery; their soma or psyche makes them unsuitable. As plastic surgeons, we justifiably place great reliance on technique; but contrary to the message in most surgical atlases and sex manuals, technique is not everything. A well-executed procedure does not necessarily produce a happy patient. (Goldwyn, 1981, p.37)

An example of the type of defect Goldwyn is discussing is that of a person who seeks unobtainable perfection from surgery. Another might be a person who seems to believe that small breasts or a large nose are the cause of unhappiness in their life: “If only I had bigger breasts, I would be able to find a husband and wouldn’t be so lonely.” Patients seeking medical solutions to address psychological concerns are fairly common in cosmetic surgery. Goldwyn explains that the ultimate success of a surgery is contingent on the patient’s perception of the result and concludes that patients with unrealistic expectations, improper motivations, or who are equipped with poor emotional constitutions are likely to be dissatisfied with their outcome. Dissatisfied patients can be costly financially or in terms of time and emotion. Dissatisfied patients do not refer their friends who are interested in surgery. A single negative review on Yelp can be tremendously damaging to a surgeon’s reputation and practice, and a lawsuit can be very costly in terms of time, emotion, and money. It is a well understood principle in the surgical community that patients deemed to be lacking in any of these areas should be rejected as viable

surgical candidates (Goldwyn, 1981; Gorney and Martello, 1999; Rohrich, 1999a) and the consultation is the structurally provided location to obtain this information.

From the perspective of the surgeon, if done properly, the consultation will afford them an opportunity to weed out potentially problematic candidates. It also allows them to lay the groundwork and assist in appropriately shaping a patient's expectations for the results they can reasonably expect from their surgery (Goldwyn, 1981, Dull & West, 1991);. Both of these functions are integral in trying ensure that a good surgical outcome does not go bad after surgery because the surgery was performed on an individual whose needs were not met through their surgical outcome.

Social Science Perspectives on Cosmetic Consultations. Social scientists, most notably ethnographers and other forms of micro-analysts, provide a similar but more nuanced take on what surgeons seek in a patient in the process of determining candidacy. Dull and West (1991) detail three factors that contribute to surgeons' decision-making processes. First, patients should display concern about the problematic feature that is proportionate to the nature of the feature. For instance, an otherwise beautiful woman who perceives a small blemish or bump as the defining feature of her face would constitute a poor candidate. The second factor Dull and West discuss is a more nuanced view that the patient should be properly motivated in their quest for surgery. They argue that this qualification is not without contradictions and draw the distinction that self-motivated does not equate self-generated. They report that the surgeons they interviewed had little concern about patients that seek enhancement for their career but are very concerned about those who attribute their desire to meeting the needs of a significant other. Finally, Dull and West identified a third area related to determining candidacy. The surgeons they interviewed considered a patient's ability to describe their condition in minute details, or as

Dull and West (1991) have termed it, to reduce their bodies into constituent parts, to be an important skill for patients to possess. So, rather than broadly glossing a concern as "My eyes look old," what a surgeon is looking for is precision in the description: "I don't like the wrinkles at the corner of my eyes, and my eyelid is getting droopy." According to Dull and West, precision is foundational to the process of determining what steps need to be taken to address the patient's concern. Equally as important is the notion that later those same descriptions act as a foundation on which postoperative results can be assessed.

Another study based on interviews of surgeons had a similar finding. The surgeons Mirivel (2007) spoke with claimed they looked for patients who are able to "grasp" the reason for the visit, expressing this in terms of an ability to discuss their concern at an appropriate level of detail. If the patient's description is too vague or ambiguous, it tends to be interpreted as a red flag. In addition, Mirivel also argues that surgeons must be able to actually see the concern their patient is presenting. If a person claims that their nose it "too big," the surgeon must be able to see the way in which their nose could be interpreted as "big." Cases in which the concern a patient is complaining about is not visible or discernable to others is considered to be a red flag for surgeons. This would be an example of an instance that would likely be interpreted as an indicator that the patient's concern is more likely to be situated in their psyche than their soma. The small body of literature dedicated to interactions between cosmetic surgeons and patients, particularly about determining candidacy, is dedicated to surgeons' perceptions of patients' behavior during consultations. However, patients' voices in relation to their goals for the consultation are absent. We can only guess as to patients' goals for the consultation might be. We also have little idea as to what characteristics patients believe would make them "good surgical candidates." In fact, we do not have any research that specifically indicates that patients

are aware that candidacy is a concern in an area of medicine that, after all, has been actively marketed as a commercial product available to those who, advertising suggests, have made the decision to live a fuller, happier life through the use of cosmetic medicine.

Doctor-Patient Interaction in Acute Primary Care Visits. When a patient steps into a doctor's office they bring their everyday knowledge of communication and practices for sense making into the consultation room with them. Rather than abandoning the communicative strategies they use in everyday life, they import the norms of the interaction order (Goffman, 1983) and ordinary methods of sense making (Garfinkel, 1967) into the medical visit and gently adjust the practices of everyday conversation to address the institutional contingencies associated with doctor-patient interaction. The goal of most medical interactions is for a doctor to provide their patient with medical evaluation and advice, in attempt to help the patient with whatever concerns she has brought to the interview to be investigated. This goal is normatively achieved, sequentially, through a six-part phase structure, where each phase is associated with a particular, institutionally relevant task.

Primary care medical visits begin with an opening sequence, then move through problem presentation, history taking, physical examination, diagnosis, treatment phases and finally a closing (Byrne & Long, 1976; Heritage & Maynard, 2006a; Robinson, 2003). Heritage (2010) describes the phase structure of primary care interviews as "fully institutionalized" in the sociological sense because it is taught in medical schools, and patients are initiated to the structure though multiple medical consultations starting in childhood. The basic tasks that are routinely accomplished during an acute primary care medical visit are associated with, and provide the backbone for, the phase structure of Byrne and Long's (1976) idealized medical visit. The first, medically relevant order of business is for the patient to let their doctor know why they

are there. As a means to this end, patients engage in a process of "problem presentation" (Heritage & Robinson, 2006; Robinson, 2006; Robinson & Heritage, 2005; Stivers, 2002b). Given a trouble, or some sort of medical problem, patients need to communicate this to their physician in the service of seeking assistance in dealing with that concern. So, not only are the patients engaged in a "problem presentation" but their tellings are simultaneously understandable as a request for medical help. The concerns patients present during the problem presentation phase of the visit are understood to set the official agenda for the visit (Heritage & Robinson, 2006). Ultimately, the goal of the rest of the interaction, is for the doctor to provide the patient with medical evaluation, advice and, where necessary a clinical intervention in attempt to help the patient with whatever concerns they brought to the interview to be investigated.

In cosmetic surgery the structure of the cosmetic consultations is clearly some version of this model that has been adapted to meet the contingencies of the institution. Just as with primary care visits, patients enter the consultation with a concern associated with their body; the difference here is that in this context the concern is not related to health or illness but rather to appearance. Since there is no illness to diagnose, the diagnosis phase of the visit does not tend to be present, and the consultation is dedicated to the processes of evaluating the patient's concern and discussing treatment options.

The phase structure is a useful tool for analysts because although a particular task – say the task of presenting a concern for a doctor to evaluate – is a standard part of most primary care interactions, there are an innumerable number of ways in which a patient can perform this action. They can use turn design and lexical choice to attend to the task at hand, presenting their concern, while simultaneously indicating an orientation or stance towards that project, or a just prior action. In a very insightful analysis that I will draw upon throughout this work, Heritage

and Robinson (2006) discuss how, in the course of the action of "presenting concerns" to physicians, as part of their turn-at-talk, patients will attend to the project of legitimizing the visit by giving reasons for their decision to seek treatment for a concern that might not initially appear to warrant medical interaction. The authors show how actions can be multi-valanced. In one turn at talk, a patient can present their concern, provide accounts for their decision-making, and do so in a way where they present themselves as reasonable rational people, thus distinguishing themselves from malingerers or drama-queens who are attending for inappropriate reasons. Accordingly, in these turns at talk, patients attend to three different tasks: providing medically necessary information; producing accounts for doing so; and engaging in face-work (Goffman, 1967) that allows them to be seen as properly motivated, and legitimate patients.

One notable difference between the experience of a primary care visit and that of a consultation for cosmetic surgery is that most of us have an understanding of the process of a primary care interview but cosmetic medicine has its own rhythm and mandates. Moreover, the contingencies surrounding cosmetic medicine are different from most other forms of medicine. The most immediately notable and relevant of these being, as previously mentioned, cosmetic medicine is a medical practice where notions of physical health or illness are not immediately relevant. This can create a conundrum for cosmetic patients, particularly for first-time patients who enter the interview with a minimal understanding of how to present their concern is legitimate and actionable, and hence to be perceived as properly motivated individuals and distinguish themselves from "other" patients who are "vain, shallow, or superficial."

Another dimension of institutional talk and doctor-patient interaction relevant to this study is the idea of asymmetry. Asymmetry is a classic feature of institutional talk. It occurs at multiple levels, including understanding of the institutional goals associated with the interaction;

the differences between lay-knowledge and that of the professional; and, the rights to knowledge (Heritage, 1997). Heritage and Robinson's (2006) study discusses the ways in which patients go about legitimizing their concern in a self-presentation where they project themselves as rational people with conditions worthy of medical intervention. It suggests that people tend to walk into their physician's office with a certain degree of understanding of what they are required to provide in the course of the interaction. However, the study also shows, that patient knowledge is accompanied by a level of uncertainty along those same lines and that the uncertainty can be stressful to patients. In contrast to the comparatively well-known requirements of primary care interactions, others are less clear cut. In some circumstances, like the visits to first time parents by home health workers (Heritage & Sefi, 1992), patients have had minimal, or no experience at all with the nature and purposes of the visit. For instance one study found that patients found interactions with medical social workers to be more elaborate and opaque than those with their physicians (Baldock & Prior, 1981), and Peräkylä (1995) discusses how in counseling sessions patients do not fully grasp what their counselor, or the institution itself, required from them, let alone why it is required. Cosmetic surgery, like these other circumstances, is an environment that places people in a medical circumstance that they may not have encountered before, and the new context requires these patients to somehow determine what the relevant requirements are, and appropriately perform them.

Issues of power within relationships are intimately tied to notions of asymmetry and doctor-patient relationships are no exception. The paternalistic model of the doctor-patient relationship is the one most commonly associated with the golden age of doctoring. Emanuel and Emanuel (1992) define this relationship in terms of decision-making power. The paternalistic model is one in which patients are perceived to lack the authority or medical knowledge to make

decisions about their own care and therefore are passive in terms of decision-making processes. A number of empirical studies have analyzed interactions between doctors and patients and found ways in which the structure and flow of interactions between doctors and patients work to reinforce the power gap created by asymmetrical levels of knowledge. One factor is that the medical interview is driven by doctor's questions. Questions inherently put the recipient in the position of responding to the topic and agenda put forth by question (Heritage, 2010). Patient contributions tend to be limited to questions as well as framed by them, and are not uncommonly subject to interruptions (Frankel, 1990, 1984; Mishler, 1984). Doctors do not generally display the need to account for the questions they ask, or the shifts in topic they might take (Mishler, 1984); and, while patients are producing information in response to their doctors questions, doctors tend to produce minimal continuative response tokens such as "uh huh" or "okay," which provide patients with little access to their underlying reactions (Frankel, 1984). The patient centered movement has exerted a notable amount of pressure for doctors to change their style of interaction, but empirical studies show that despite considerable efforts in training to change doctors' communication styles, asymmetry in interaction remains remarkably persistent and potentially even a functional aspect of doctor patient interaction (Pilnick & Dingwall, 2011).

Maynard (1991) has shown that one way physicians maintain a high level of control and power in interactons with patients is by controlling the topical agendas of visits. He suggests, following Mishler (1984), that doctors maintain professional dominance by routinely ignoring patients' lifeword experiences of illness. Since doctors' power and authority is rooted in their training in and understanding of biomedicine, by keeping the topic of the interaction confined to this area, they create an environment in which they can maintain epistemic authority. However, cosmetic surgery is an area of medicine where patients lifeworld experiences are fundamental

aspects of the interaction. This creates an environment where epistemic and deontic authority between the two types of interactants are notably more balanced. In surgeon-patient interactions the notion of doctors retaining a great deal of authority in diagnosing and treating disease are modified, In these interactions, it is more a matter of participants navigating "territories of knowledge" and authority (Heritage, 2011). It is significant that, in the world of elective cosmetic medicine, issues of health and illness are attenuated, almost to the point of invisibility. In terms of power and authority, this impacts two areas of medicine where where doctors' authority is paramount: epistemic (and to a lesser degree deontic) authority are central in the process of diagnosing medical conditions and determining treatment recommendatons. These two activities sit at the heart of the practice of medicine, but neither activity plays out in cosmetic medicine in quite the way they do in primary care.

Generally speaking, physicians have almost exclusive authority to diagnose illness (Freidson, 1970, 1988; Mishler, 1984; Parsons, 1951, though see Heritage, 2020 and Heritage & McArthur, 2019). It is within the realm of possibility for a patient to go into a medical interview and self-diagnose their illness, but in practice, self-diagnoses are rare (Gill, 1998; Heritage, 1997; Heritage & Robinson, 2006; Stivers et al., 2018). Not only do physicians have authority to diagnose illness, but empirical studies have shown that diagnoses do not require a response from the patient, and for the most part, diagnoses are generally uncontested (Heath, 1992; Peräkylä, 1998, but see Ijäs-Kallio et al., 2010; McArthur, 2024). Accordingly, patient non-responsiveness makes them passive recipients of their physicians' medically informed opinion about the nature of their concern.

Interestingly, the act of "diagnosing" does not translate well into a cosmetic environment. In cosmetic medicine there is indeed a concern that is topicalized and featured throughout the

interaction as the reason for the visit, but the right to evaluate the "problem" belongs exclusively to the patient. Outside the agenda set by this evaluation, the doctor's opinion in terms of what could or should be done to improve their patient's appearance is not only irrelevant, it is practically absent. Generally speaking, the only time a surgeon will contribute an unsolicited, albeit medically informed opinion about some area of the patient's body is if it is done in the service of achieving a patient's stated goals. Otherwise, the surgeon's opinion about their patient's appearance could create dissatisfaction where none existed previously (Goldwyn, 1981). So, in sharp contrast with primary care, it is the patient who has epistemic authority to assess their own appearance, and make declarations as to what the "problem" is, based on lifeworld considerations.

Stivers and colleagues (2018) have suggested that, while physician authority to diagnose is nearly absolute the same cannot be said about the act of prescribing treatment recommendations. The cultural authority to do so, like the act of diagnosing, is rooted in professional understanding of the body and possible medical interventions. However, in the act of proposing treatment, the deontic aspect of authority is nowhere near absolute. Physicians can make recommendations; however, it is ultimately up to the patient as to whether or not, and to what degree they are willing to follow through with those recommendations. In cosmetic medicine, the notion of "treatment recommendation" is also a territory that is shared. As often as not, patients enter consultation with a particular procedure in mind: a facelift, tummy tuck, nose job, or liposuction. It is unlikely that this is a coincidence. Not only are patients fully epistemically empowered to make decisions regarding the way they would like their bodies to look, but billions of dollars go into advertising specifically to empower patients to change their quality of life by undergoing one of these procedures. These procedures are, in reality, courses of

treatment. Stivers and colleagues (2018) have shown that doctors can express treatment recommendations in more or less authoritarian ways. The most common method used in the U.S. is a pronouncement, and it is also the most authoritarian: “I’ll start you on X.” What makes a treatment level more or less authoritarian is the extent to which its presentation allows the patient a role in decision making. “I’ll start you on X” is a method in which the physician assumes sole responsibility for the decision. However, Stivers and colleagues argue that the level of authority runs along a continuum, including proposals, suggestions, and offers which explicitly allow for patient input and decision-making.

Treatment recommendation, are a major and significant activity in cosmetic interactions. In fact, a good deal of the consultation is dedicated to a discussion about treatment. Just as in primary care, surgeon’s treatment recommendations are rooted in medical expertise. It is up to the surgeon to determine if the patient’s concerns can be addressed medically. Then, it is the surgeon’s responsibility to present the different medical options that can be employed to address the patient’s concern. It is also their responsibility to outline the merits and liabilities associated with each available option (Goldwyn, 1981; Sullivan, 2001). A rule of thumb regarding treatment is that the more invasive the treatment, the better the results will be, but these enhancements come at a larger cost in terms of finances, pain, and downtime. For example, signs of facial aging can be addressed with Botox® and fillers for a fraction of a cost of a facelift. In many instances a facelift is going to provide a lot more bang for the buck. In younger patients, a facelift might well be an option, but the amount of “improvement” the patient can expect might not be worth the associated costs. An interesting twist to the act of treatment recommendations and the authority they embody is, that it ultimately up to the patient*,* not the surgeon, to determine which option is the most appropriate (Goldwyn, 1981). This situation has interesting

implications in terms of authority, and the balance of power between surgeons and patients, because many of the contingencies surrounding patient decision-making are associated with lifeworld issues such as cost in relation to desire, issues that sit well beyond the boundaries of medical expertise or authority.

The influence consumer desire has on physicians' decision-making, particularly in terms of treatment, is a centerpiece in the argument that consumerist medical practice erodes physician authority and power, particularly the social authority associated with doctors' role as a gatekeeper (McKinlay & Marceau, 2002). The level of influence consumers have in terms of shaping doctors treatment recommendations is certainly not lost on pharmaceutical manufacturers who spend large amounts of money to get patients to ask their doctors if "Drug X is right for me" (Conrad & Leitner, 2008), a question that has been shown to have significant influence in doctor decision-making about treatment recommendations (Kravitz et al., 2005).

There is a fascinating body of literature that argues that patient desire for a particular form of treatment will influence what, and how often, a physician will prescribe (Kravitz et al., 2005; Stivers, 2002, 2007; Stivers et al., 2003). Stivers (2007) has shown that doctors' perception of a patient's desire for a particular treatment, regardless of whether that perception is accurate, is enough to influence decision-making, including prescribing antibiotics to satisfy perceived patient preferences despite their knowledge that the condition they are prescribing for is viral, and the antibiotic will be ineffective. Collectively, these empirical studies have shown that consumer desire, whether self-generated, or manufactured by Pharma, influence clinicians' decision-making in some profound ways.

The paternalistic model of medicine described by Emanuel and Emanuel (1992) is the idea that patients do not have the epistemic authority, or authority based upon knowledge to

evaluate their own conditions. At the other extreme, the Emanuels describe a model of medicine where physicians provide patients with all the information they need so that the patient can ultimately make a nearly autonomous decision regarding the course of action they wish to pursue in dealing with their condition. Both extremes are, at least to a certain degree, archetypes, but the interactions that occur in cosmetic interactions more closely resemble the latter. This is quite interesting since the business model behind cosmetic medicine is so similar to the way medicine was practiced during the golden age of doctoring, when the paternalistic model of medicine was understood to reign supreme (McKinlay & Stoeckle, 1988; Quadagno, 2004; Starr, 1982). What is it about the practice of medicine that creates this discrepancy? Is it the contingencies surrounding the nature of cosmetic medicine that provides patients a more authoritative role in the interaction? Or, is it that medical consumerism and a shift in the role of patient to patient as consumer can account for this shift? Or, as the studies by Rodwin (1994) and Lupton et al. (1991, 1994, 1997) suggest, is there a tendency for patients to defer authority to physicians, even when the context encourages them to take a more active role in terms of decision-making? Interactions between cosmetic surgeons and their patients provides a fertile environment to gain greater understanding of how the dynamics of the traditional relationship have changed in such a medically unique, and highly consumeristic context.

Drawing on Goffman's theory, what sort of norms are associated with appropriately performing the role of being a cosmetic patient; let alone a good surgical candidate? Are these behaviors the same as those associated with being a primary care patient? After all, through the process of medicalization, in cosmetic surgery, the margins of medicine have been extended to the point where notions of health and illness are virtually absent, and consumer desire for a

medical service is what drives patients into surgeons' offices.[17] Consultations provide a rich environment in which the abstract idea of "medicalization doesn't occur without social actors doing something to make an entity medical" (Conrad, 2005, p. 8), is enacted, in real time, through interactions between surgeons and their patients. It is in consultations where the interactional boundaries between norms associated with commerce and those of medicine are negotiated (Sullivan, 2001). The behavioral norms associated with cosmetic medicine are different than those in most other areas of medicine precisely because in many ways cosmetic medicine, although practiced for hundreds of years, is still very much a new frontier for medicine (Conrad, 2005). As a result, we can predict that, in these interactions, the participants will orient, to varying degree, to norms from both domains. What makes this especially interesting is that the values and norms associated with each of these domains tend to be conflicting and incompatible.

The methods of self-presentation in the role of patient in acute primary care visits do not necessarily translate into the requirements of cosmetic medicine. The dilemma cosmetic patients face is how adapt what they know about performing the social role of "patient" into a new context, but to so in a way that reflects and preserves the norms of doctor-patient interaction, in a context where notions of health and illness, the mainstays of most medical interactions, are no longer front and center. Traditionally, illness or the possibility thereof, serves as the basis for the social role of "patient" and is used by patients to legitimize their decision to seek medical intervention (Heritage & Robinson, 2006). However, without illness, or even the possibility thereof, how does one go about presenting oneself as a patient? How can a patient go about

[17] Generally, the only time health issues come into play in cosmetic consultations is when poor health is a barrier to cosmetic intervention. As an example, if a patient's health is such that undergoing anesthesia poses undue risk to the patient he or she will likely be deemed unsuitable as a surgical candidate.

presenting their desire for bigger breasts or to eliminate sagging jowls as a condition significant enough to warrant surgical intervention?[18] This is not a trivial concern, because theoretically, should a patient treat their own desire for surgery as reason enough for the doctor to provide it unquestioningly, the person seeking surgery is no longer so much a consumer-patient, instead they would be behaving as a customer who happens to be buying a surgery. In this context, doctors' role as gatekeeper is not just subordinated as Conrad (2005) suggests, it is obliterated.

The Present Study

In cosmetic surgery, the margins of medicine have been extended to the point where notions of health and illness are virtually absent, and consumer desire for a medical service is what drives patients into surgeons' offices. These and other contingencies come together in a way that arguably make cosmetic medicine the most commercial area in medicine (Sullivan, 2001). Consultations are the interactions where the patients' concerns are topicalized and discussed by the participants. The remedies to address these concerns are medical, but the surgical interventions available to meet the patients' aesthetic goals have been marketed in ways that are similar to the ways in which other commercial products are marketed (Sullivan, 2001).

Moreover, whether the surgeon is selling a surgery, or selling themselves, the notion of surgery as a commercial product, to one degree or another, is part of the context in which the interaction occurs. Peter Conrad has argued that, "medicalization doesn't occur without social actors doing something to make an entity medical" (2005, p. 8). Somehow this is enacted, in real time, through interactions between surgeons and their patients.

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[18] For a discussion on how patients legitimize their decisions to seek medical treatment, see Heritage and Robinson (2006).

My research builds upon previous studies of commercialization of medicine, and what it means to be a patient in a commercialized context. There has been vigorous debate as to the meanings of these changes. Rodwin (1994) has used the patient accountability model to suggest that the emergence of patients *qua* consumers creates an environment where patients are more likely to be active participants in the medical encounter. He argues that one of the strengths of this model that is that more active participants can create better medical outcomes because professionals are often not the best judge of what is in the best interest of the people they are serving. Cosmetic consultations are a rich environment to evaluate these assertions because in this area of medicine the boundaries between norms associated with commerce and those of medicine are negotiated (Sullivan, 2001).

As previously noted, a good deal of the existing literature in the social science addresses shifts in the profession of medicine from a theoretical perspective, or based on *post hoc* participant interviews. Although these works have provided great insights into the process at play in consumer-based medicine, none directly addresses the phenomenon that Conrad's statement addresses; what exactly are people doing in medicalized or commercialized context? How have these shifts impacted the behavior of participants? Equally as important is the notion of what participants, in situ, doing to make these shifts happen? These are not questions that can be adequately addressed by interviews. These questions require analysis of participant behavior in the context itself. To date, no such study exists.

My research operates under the assumption that cosmetic surgery occupies a liminal status between a commercial enterprise and medicine, and accordingly, the nature of how doctors practice medicine and patients receive care has shifted to reflect environmental changes, and that these changes are visible in doctor-patient relationships (Potter & McKinlay, 2005). I started my

research under the assumption many of the phenomena discussed in the literature will not only shape interaction between surgeons and patients, but also that they will also materialize in observable and analyzable ways. However, I entered the field to a certain degree as a tabula rasa. I did not want to superimpose my ideas concerning what might be important and relevant within these interactions. I wanted to remain open enough to be able to see what issues and tensions seem to be forefront for the participants. In the analysis chapters of this dissertation, I will discuss some of the ways in which my participants performed the role of being a patient in a highly consumeristic context, a context that was unfamiliar to many of them and one that posed challengers in terms of straddling the divide between commerce and medicine.

In chapter 3, the first analysis chapter of this dissertation, I discuss the opening moments of these interactions and the ways in which patients topicalize their concern; or, to use terms from primary care studies, engage in the activity of problem presentation. In more traditional forms of medicine this tend to be a relatively straightforward task. However, I show that in a more consumer based medical environment, the norms of medicine and commerce tend to be at play, and patients must negotiate their way through competing norms to present themselves as a cosmetic patient rather than a consumer of a medical product. I discuss how, when a patient miscalculates the line of demarcation between the two, with prompting and support from their surgeon, they recraft their request for help until its form indicates that the person has appropriately adopted the role of patient.

In chapter 4, I show that over the course of the consultation, patients are taught to see and discuss their bodies in institutionally relevant detail and explain how what constitutes institutionally relevant detail is associated with the commercial aspect of commercial aspects of medicine. I present quotes where postoperative patients discuss their appearance and surgical

goals and do so flawlessly from the perspective of a cosmetic surgeon. I then compare those quotes with the ways in which preoperative patients describe their concerns about their appearance. I argue that the postoperative patients' ability to discuss their appearance in institutionally relevant detail is a skill that they acquired by going through the process of having surgery. I show how surgeons, in the process of the consultation, socialize their patients in terms of how to conceptualize and discuss their bodies. I argue that, in effect, what surgeons require from their patients is not so much that they have the ability to see and discuss their bodies in relevant ways, as it is that their patients be able to learn to see**,** and discuss, their bodies in institutionally relevant detail. This distinction is subtle but meaningful.

In the final analysis chapter, I discuss the interactional work that people go through in terms of "doing being a patient" (Sacks, 1984). I show how patients import strategies for legitimizing their decisions to seek medical help, from those used in primary care. I argue that in these moments patients are actively engaged in the process of taking something that is not traditionally conceptualized as a medical concern and applying norms from doctor-patient interaction to feature those concerns as medically legitimate and worthy of medical consideration. In primary care, these strategies tend to be used when the patient is concerned that the medical legitimacy of their concern could be perceived as tenuous, and do so to keep from being perceived as a malingerer or a hypochondriac (Heritage & Robinson, 2006). I argue that cosmetic patients also are engaged in positive face-work (Goffman, 1967) when they use these strategies, but the negative labels they are trying to avoid are those attributed to them by the critical feminist perspective.

Across these three chapters, I discuss ways in which patients are engaged in performing, or rather learning to perform, what it means to be a patient in a medically commercial context, or

more specifically, as a cosmetic patient. While earlier studies related to cosmetic surgeon-patient interaction are either theoretical, or based upon surgeons' practical assumptions based upon years of practice or post-surgical interviews. While these studies have made significant and lasting contributions to our understanding of the practice of cosmetic surgery, they ultimately identify attitudes of self, gender and the meanings of cosmetic surgery that the participants bring to the interview, or explore how outcomes are integrated into post-surgical conceptions of self. They do not adequately reveal the social and interactional mechanisms through which desire, understanding, and indeed candidacy itself are negotiated directly, and mutually co-constructed within the medical interview. Nor do interviews provide any analytical traction in terms of how the participants attend to the shifting nature of the practice of medicine itself and how they integrate the competing demands and norms of medicine and commerce.

In an era of medicine that is progressively becoming more commercial, it has become increasingly important to understand the influence of this structural change on clinical interactions and vice-versa. By using actual doctor-patient interaction as data collected in this highly commercialized area of medicine, my research contributes to bridging the gap between macro level shifts and how they are enacted and realized in face-to face medical encounters. Cosmetic surgery is an ideal context in which to explore medicalization and the impact of consumerism on the doctor patient relationship because as a medical practice it is about as pristine example of each imaginable. As I have described, cosmetic surgery is a medical interaction and transaction that takes place between surgeons and patients with minimal outside influences of either employers or third party payers. It also a context where surgical solutions are marketed commercially and patients *qua* consumers have a high degree of epistemic license to assess their bodies and determine the changes they wish to achieve.

My work is dedicated to describing how patients in the opening minutes of a consultation perform being a patient (in contrast to a consumer of medicine) by adapting interactional norms from primary care visits into an environment where they are discussing aesthetic desires rather than issues of health and illness, and doing it in a way where they define what it means to be in a doctor-patient relationship in a medical context that is in flux. By studying interactions *in situ,* my work sheds insight on some of the apparent inconsistencies and contradictions mentioned in both medical and academic descriptions of surgeons' decision-making criteria cross this work I will argue that the lion's share of being a good surgical candidate is the consumer-patient's ability to successfully rise to the interactional task of performing being a patient, and not just any patient, not a primary care patient, or a patient who has undergone treatment for cancer, but a patient who can display that they have the requisite qualities that allow them to be a viable candidate for cosmetic surgery. In doing so, my work seeks to help bridge the gap between macro level shifts in the structure of medicine, and how they are enacted in face-to-face medical encounters.

One of the most interesting aspects of the dilemmas associated with cosmetic surgery is that they help to shed light on the normative practices of medicine and its evolving relationship to commerce. It is tempting to look at some of the issues cosmetic patients face as distinctive to the practice of cosmetic surgery; however, as the boundaries between commerce and medicine blur, illness and its treatment have become a competitive market where billions of dollars are at stake. Under such circumstances, it is better to consider many of the issues I see patients encounter in the realm of cosmetic surgery to be potentially present, in varying degrees, in all medical interactions but highlighted in cosmetic contexts. In an era of medicine that is progressively becoming more commercial (Potter & McKinlay, 2005; Sullivan, 2001), it

becomes increasingly important to understand the influence this structural change on clinical interactions and vice versa. This is an important arena for the future of medicine because as mentioned by Sullivan (2001), “Cosmetic surgery may be at the cutting edge of commercial medicine, but it is not out there alone.”

Chapter 2 – Research Design, Data Collection, and Methodology

> Are you kidding me? I wouldn't even consider a plastic surgeon that isn't in Beverly Hills…just because they're here doesn't mean that they're good, but your chances are better here…if they aren't good enough to afford the rents here, I can't trust them with my face!
>
> —Anonymous Transformations patient

At its heart, my research is an exploration of what Goffman (1959) calls "a presentation of self." More specifically, I examine how people use language practices in interaction to perform a particular role, that of "cosmetic surgery patient." One of the ways people go about performing roles, and likewise evaluate the performances of others, is by reference to sets of rules and norms that are related to the social roles which are relevant in a given context. In this work, the context I will be studying can be glossed as a "cosmetic surgery consultation." My work is an exploration of the ways in which individuals who are interested in finding surgical solutions for concerns with their appearance communicate them to their surgeons.

Cosmetic surgery is an area of medicine that is new to many, if not most, patients. In drawing upon norms associated with both commerce and medicine, this new type of medical context puts prospective patients in a position where they need to design their actions to navigate the boundaries between the two domains, in order to successfully perform "doing being" a patient (Sacks, 1984). Part of the performance of being a patient is associated with showing themselves to be normal and rational (Heritage & Robinson, 2006). In acute primary care visits, being normal and rational might be in opposition to being perceived as a worry wart or a hypochondriac. In cosmetic medicine, the negative stereotypes people seek to avoid are more contextually relevant so patients engage in efforts to distinguish themselves from a stereotyped image of a cosmetic patient who is likely to be perceived as shallow and superficial (Bordo, 1999; Davis, 1995, 2002; Dolezal, 2010).

One thing about role performance is that it is highly contextually bound and very precise. For example, what constitutes adequately performing the role of a cosmetic patient differs from the actions required to performing the role of an oncology patient. Taking that concept one step further is the notion that the interactions that I observed primarily occurred in a particular socio-geographical context: an upscale surgeon's office in Beverly Hills, California. In this chapter, I discuss my research design. First, I describe my research site, my primary informant, Dr. Dashanti, and the reasons why they were selected for this research.[19] I made these decisions for very specific reasons, which I discuss later in this chapter. In brief, I chose a research site that was most likely to resemble practices in more traditionally medical areas of medicine. After discussing the research site, I discuss how I recruited patients, and how the methods I used to do so impact the type of data I was able to collect. Finally, I talk about my methodology. In the last chapter, I spent a good deal of time providing background to many of the broader concepts related to cosmetic surgery and more specifically, processes associated with establishing surgical candidacy in this domain of medicine. In this chapter, I discuss conversation analysis, my primary method of research, and provide background information related to performing identity and doctor-patient interaction. I close by discussing some of the ways in which analyzing cosmetic consultations, using this most micro of methods, is relevant and important to understand the processes associated with cosmetic consultations, the relationship between surgeons and their patients, and that of doctors and patients.

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[19] "Dr. Dashanti" and all other names of people and places are pseudonyms. Also, to protect participants' privacy, I have also changed any significant markers of identity in ways that preserve the general importance associated with those characteristics, but do not put participant privacy at risk.

In order to focus on the intersection between traditional medical norms, aesthetic decision-making and commerce, I searched for practice contexts where the business model most closely approximates that of doctors who practice other forms of medicine in a private practice, or as part of a small, independent medical group, for example, a surgeon whose practice might resemble that of an upscale internist or specialist in integrative medicine.

Specifically, I sought these physician and practice characteristics. The practice was located in a medical building rather than a strip mall, a storefront type of structure, or any other location that would be better suited to retail business than medicine. The physician did not advertise directly to consumers in magazines, newspapers, or television. [20] The physician obtained new patients by referrals rather than appearances on reality television shows, the news, or talk shows. The practice's income was primarily derived through surgery and medical procedures, rather than quasi-medical procedures such as laser hair removal, facials, endermologie, [21] or through the sale of skin care, lotions, potions, or other retail items.

Because medical consultation and decision-making were the focus of this study, I did not attempt to recruit practices based on direct-to-consumer advertising. The latter has been shown to have a significant impact on how patient requests for a particular treatment influence doctors' decision-making processes (Kravitz et al. 2005). Patients who request a particular type of treatment, for instance antidepressants, are far more likely to get antidepressant medications than those who do not indicate a preference for a type of treatment regimen. Since it is reasonable to assume that the same phenomenon would hold true in cosmetic medicine, patients recruited

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[20] I considered practice websites on the Internet to be a standard mode of self-promotion, more akin to a business card or, back in the late 20th century, a yellow pages listing.

[21] Endermologie is an extremely deep sub-dermal treatment massage-like treatment that uses a vacuum device and claims to break down and remove cellulite.

using direct-to-consumer advertising could arrive with predetermined treatment preferences that would find support from practitioners. Similar considerations informed my decision to avoid practices that specialize in treating one type of cosmetic issue by using proprietary technology or patented treatment procedures, such as CoolSculpting®, that is widely marketed as a treatment for fat removal. When patients walk through the door with a particular process in mind, and their doctor can only provide that very treatment, the process of evaluating patient concerns to find the best treatment solution is largely eliminated. By eliminating the need for the surgeon to evaluate the patients concern to find the best possible method of treatment, one of the mainstays of physician professional authority is attenuated (Freidson 1988). As the need for medical evaluation of a patient's concern is minimized, the interaction becomes increasingly more consumeristic in nature. The aim of this research is to observe patient behavior in negotiating the norms of commerce and medicine in establishing themselves in the role of patients. So, an environment in which surgeon's roles are not necessarily limited by market forces, is preferable.

In addition, cosmetic surgery is about perception. The way patients perceive themselves, or the way they believe others perceive them, is what drives their interest in obtaining surgery to begin with. Since cosmetic surgery has traditionally been perceived as a luxury (or frivolity) for the rich and famous, it makes sense that there is a cultural perception that a "Beverly Hills plastic surgeon" is better than one who practices in Pasadena, Sherman Oaks, or any other upscale suburb of Los Angeles. In a manner of speaking, Beverly Hills is a bit like Mecca for cosmetic surgery. Many of the more well-known surgical innovators have their offices in Beverly Hills. Nearly all plastic surgeons featured in television shows are located in Beverly Hills. Quite frequently, even if the surgeon's office is not located in Beverly Hills, the production will reference it by featuring images of Rodeo Drive and the Beverly Hills sign in the show, while

downplaying the actual zip code in which the surgeon practices. Accordingly, since nearly all famous cosmetic surgeons are strongly associated with Beverly Hills, a “Beverly Hills plastic surgeon” has been marketed as being the gold standard of surgeons, through dozens of television shows over the past decade. Patient perception of a surgeon’s capabilities based upon their visibility in media cannot be underestimated. Kelly and Schwartz (2005) claim that patients often select physicians based upon limited information they receive indirectly. Although studies have shown that referral to a surgeon from another doctor is the strongest predictor of which cosmetic surgeon a patient will use, word of mouth, whether the mouth belong to a friend, or to a media outlet is a close second (Abraham, et al. 2011; Nowak and Washburn 1998). In Los Angeles, the surgeons people see on television tend to be in close physical proximity and readily available. The shows on which they are featured present these surgeons as highly skilled. Indeed, in these shows, these Beverly Hills physicians are often called upon to correct problematic surgical results a patient received from other, always unnamed surgeons.

Research Site

Under normal circumstances, the building in which a medical practice is housed would be irrelevant in determining the quality of a research site. However, in the world of cosmetic surgery, a practice’s location is extremely important. In the greater Los Angeles area, Beverly Hills, is perceived as “the” best place for cosmetic surgery. In reality, not all Beverly Hills surgeons are excellent and there are a number of outstanding cosmetic surgeons whose offices are located outside of Beverly Hills, but as mentioned above, perception and reputation are important in terms of selecting a surgeon. The phrase “Beverly Hills surgeon” holds enough weight with most cosmetic patients, that many surgeons are willing to pay a large premium to secure a Beverly Hills address. In the greater Beverly Hills area, there are two office building

complexes that stand out as the crème de la crème for cosmetic surgeons: the first is a large medical building that sits in the heart of Beverly Hills within walking distance of Nieman Marcus and the Chanel boutique. Although the building is not specifically dedicated to cosmetic medicine, it is home to more than its fair share of some of the area's more famous (and expensive) cosmetic surgeons. The second is Rodeo Towers,[22] a set of gleaming buildings that also house a high percentage of cosmetic surgeons that are commonly featured on television and those who have invented trademarked procedures. To those in the know, these structures are perceived as home to top of the line medical professionals and, perhaps most notably, top of the line cosmetic surgeons. Both buildings house a wide variety of medical practices, from physical therapists to fertility experts, to highly specialized oncology centers; however, a disproportionate number of the building's tenants are in some way related to cosmetic enhancement: cosmetic surgery, cosmetic dentistry, or anti-aging medicine. Similarly, a good number of physicians who practice in these locations, as a standard practice, do not accept payment from insurance. They are more likely to issue a superbill that a patient can submit to their insurance company to obtain reimbursement for their medical services. Rodeo Towers is conspicuously located on a street whose name is world renowned and intimately associated with wealth, power, and celebrity. The only signage on the face of the building is that associated with the practice of a surgeon who was prominently featured on one of the more popular reality television shows dedicated to cosmetic surgery. Chances are good that if a surgeon has been featured in a TV series, as a guest on a talk show, or if they have been interviewed in *Vogue* or another nationally distributed women's magazine, that surgeon's offices are located within the walls of Rodeo Towers. This building,

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[22] "Rodeo Towers" is a pseudonym.

and the attention that it has received in the media, particularly in the field of cosmetic surgery, gives medical practices therein an air of distinguished medical credibility and therefore an ideal location in which to locate a surgeon, or a practice, to work with.

The surgeon I worked with, Dr. Dashanti, who I generally refer to as "Dr. D," works in a practice simply called Transformations; a small but prestigious cosmetic surgery practice located within Rodeo Towers.[23] Transformations is owned by two surgeons who are leading experts in the field of facial reconstruction. The two owners are well known for their "nose jobs," and draw patients from around the world who are seeking rhinoplasty. In contrast to the glitz and glamour of the overall image Rodeo Towers projects, Transformations is not only small, but it is understated. Other than a small website describing the practice and their surgeons' turn down very lucrative appearances on television shows. They also and tend to shy away from interviews. One of Transformation's surgeons proudly told me:

> I want to earn my business the old-fashioned way, by word of mouth. All this publicity has the potential to create a lot of business, but I don't want my practice to be huge because a high-volume practice takes away from my ability to focus on my patients and give them the attention and the consideration they deserve. I'd rather have you come to me because your friend was happy with me and her results than because you saw me on TV. (Dr. Y, personal conversation, 11/2012)

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[23] To protect the identity of the participants to this study, all institutional and personal names are pseudonyms. Moreover, in a further effort to protect the privacy, descriptions of locations, professions, or any other details that could potentially be used to identify one of my participants have been altered but done so in a way where the meaning and essence of the altered details have been preserved.

One thing I quickly realized while spending time in this medical office is that word of mouth can be very powerful, because the reputation of the surgeons at Transformations extended far beyond the local area. Several of the patients in the waiting room had traveled from another state or a different country. One woman in her early 20s was sporting mildly black eyes and a bandage across her nose explained to me that she was there for a follow-up visit to have her bandages removed before she returned to Canada. During our conversation, she explained to me that as a Canadian she had access to rhinoplasty at, comparatively speaking, a very low cost through Medicare, Canada's national healthcare system. However, she did not "feel secure" dealing with anybody other than the two specialists at Transformations who she considered to be "the best" in terms of "fixing" noses. As a result, she spent a significant amount of money on airfare, lodging, and the full out of pocket cost of surgery itself, and in addition the time, effort and misery of travel, in order to have her surgery performed by doctors who have the reputation of being among the best in the world in terms of producing natural looking results.

Dr. D is not a partner in Transformations; he actually leases office space from the other two surgeons. The association works well because Dr. D specializes in tummy tucks and body work; however, he also routinely does work on faces. One area he is particularly passionate about is working with patients interested in gender reassignment where again, he is known for his body work, especially chest modification for female-to-male patients. Most patients walking in the door of Transformations would assume that Dr. D was part of the larger practice: not only do the three doctors share physical space (waiting room, consultation rooms, operating room, and office space), they also share a receptionist, and their patient coordinator/office manager.[24]

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[24] About a year after I completed my data collection Dr. D left his office at Transformations and opened a solo practice in another medical building in Beverly Hills. The split was an amicable one.

Participants

Surgeon: Dr. Dashanti

Dr. Dashanti did his undergraduate work at an Ivy League School where he graduated magna cum laude and was named a member of Phi Beta Kappa. He then attended a highly respected medical school in the U.S. and completed full General Surgery training at Cleveland Clinic Foundation. He then honed his plastic surgery skills at the top tiered program in the Midwest. Upon completion of the program, he was awarded an advanced aesthetic fellowship under Dr. Bogner, a Beverly Hills cosmetic surgeon.[25] Dr. Dashanti is certified by the American Board of Surgery, The American Board of Plastic Surgery, and the American Society of Plastic Surgeons. He also practices plastic/reconstructive surgery for West Los Angeles Medical Center, where he is also the medical director for their Center for Wound Management and Hyperbaric Medicine. He claims that he continues his work at the Medical Center to balance his practice, stating, "Working with patients who have medical needs, often which are quite pronounced, has a different set of rewards than those you get when working with cosmetic patients...Balance is important" (interview 12/12/16). Unlike many of his competitors, Dr. Dashanti's promotional materials do not feature images of beautiful young women in exotic locales wearing bikinis. Instead, Dr. Dashanti's promotional literature emphasizes his training as it relates to his skill as a cosmetic surgeon. On his website, he indicates that he is double board certified, and references other areas of his education and credentialing. He also talks about being an artist and a sculptor

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[25] It is worth noting that Dr. Bogner was a cosmetic surgeon who, in the late 1970s and early 1980s, after the American Medical Institution's ban on physicians marketing their services to consumers was found to be in violation of anti-trust laws, was among the first to start aggressively marketing cosmetic services, most notably breast implants directly to consumers through a popular, free newspaper, *The L.A. Weekly*. More than a decade later, cosmetic surgery became a popular topic for reality television, and Dr. Bogner was right there, being featured in the first of these early shows.

prior to being a surgeon and how that training makes him uniquely qualified as a surgeon. He also cites his reputation for providing outstanding care, before, during, and after surgery, as the basis for his consistently high patient satisfaction ratings, and the high rate of referrals he receives.

Although it is unlikely that Dr. D is familiar with Talcott Parsons' description of the normative structure of the institution of medicine in "The Social System" (1951), through his statement he positions himself clearly in the normative framework Parsons suggests is critical for medicine to exist as a functioning institution; namely he explicitly states that his patients needs always take precedence over the possibility for his own financial gains. He insists that he does not "sell surgery"; instead he claims he assists patients in deciding the best ways to achieve their aesthetic goals. Dr. Dashanti's stance towards his practice disavows the notion that he is "in it for the money" and says that patient satisfaction is what motivates his decision-making processes. It is worth noting that Dr. Bogner, the surgeon Dr. Dashanti worked under during his fellowship, offered Dr. D and one of the other fellows an opportunity to be featured on the reality show he was associated with. Dr. D passed on the opportunity citing that he wished to grow his business the "old fashioned way," through word of mouth. The other member of the cohort was featured on the show and had a rather meteoric rise in terms of his reputation and the growth of his business.

By claiming that selling surgery goes against his personal "core beliefs," Dr. D tacitly acknowledges the concerns many people have about medical markets and doctors as entrepreneurs; concerns about doctors, particularly cosmetic surgeons selling unnecessary or unwanted services to their patients (Blum 2003; Bordo 1993, 1999; Brooks 2004; Davis 1994; Miravel 2008). He also clearly positions himself within the "medical" realm on the continuum

between “commerce” and “medicine” by dismissing any concerns a patient might have that he is going to “sell” them surgeries in which they have no interest. It is exactly Dr. D’s adherence to traditional medical norms, values, and practices that made him an ideal subject for my research. Because of his explicit dedication to the practices and norms of medicine, his patients are far more likely to be inclined to fully perceive their interaction with him as a medical consultation rather than merely a means to merely find out how much he charges to perform the procedure of their desire.

Patients

Data for this research were drawn from a total of 19 unique interviews between Dr. Dashanti and prospective patients. I collected 21 interviews, but I pulled two patients from the study because they were English language learners. Although they both spoke English very well, they had a substantial amount of difficulty with English in a medical environment so the flow of the conversation and the scope of ideas that could be discussed were quite limited. In terms of demographics, of the 19 remaining interactions, 18 were women and one was a man. Participants ranged in age from 31 years of age up to 73. Not all patients elected to provide their age, but two of the patients are 31 years old, the male and one female patient are 49, another is 50, two patients are “pushing seventy,” and one patient is 73 years; the ages of the other patients are unaccounted for. With the exception of one patient who came to see Dr. D. for a second opinion about reconstruction of her breast, all my participants were interested in addressing some signs of facial aging. One patient was interested in signs of facial aging, but her primary concern was addressing sun damage (spots) on her arms and legs. In terms of social status each participant, without exception, would be best classified as falling in the middle to upper middle-class range. Two participants worked in the beauty industry (a hair stylist and a makeup artist), four were

homemakers, three were writers/journalists, four identified as management, one was a business owner, and the final five were unknown. In total, I collected nearly 45 hours of video in which 19 patients discuss approximately 51 concerns.[26]

Recruiting Patients

Prior to recruiting patients, I submitted my data collection protocols to the UCLA Human Subjects Protection Committee. They approved my recruitment, consent and assent procedures. Once my study was approved, I began to recruit participants. To be eligible for this study, participants must have met the following criteria:

1) Be actively seeking information from a plastic surgeon regarding a cosmetic procedure;
2) Be at least 18 years of age;
3) Speak English fluently.

Patient Recruitment Protocol. As is the tradition within medical communication research, I recruited participants from individuals who were in the surgeon's office, waiting for their consultation. To afford individuals privacy, Dr. D's staff introduced me to their patients as a researcher from UCLA. The participants were informed that I was collecting video data for a study to determine how conversational practices between doctors and patients impact medical decision-making. Subsequently, if the patient expressed interest in hearing more about the

[26] The number of concerns discussed is not as easy to quantify as one might imagine. As an example a patient might be concerned about her "eyes looking old and tired" which would be one concern, but over the course of the interaction that concern is likely to be broken down into upper eyelids, lower eyelids, drooping brows, circles under the eyes, and crow's feet. Some of the fractionalized concerns could be referenced but not discussed as particularly relevant. In terms of calculating the total number of concerns I tried to count the number of concerns that were not only referenced but were actually discussed in a reasonable degree of depth.

research, to protect the potential participant's privacy, a member of the office staff took us into a private office area where I told them about the study in greater detail.

During these interactions, I told patients about my study and the requirements for participation. If an individual expressed interest in participation, I provided them with written copies of the study's protocols, and discussed each section of the document with them in the process of obtaining informed written consent. While presenting the study, I emphasized that their participation was not mandatory, and that if they elected not to participate that it would not impact the cost of their surgery. Patients were also informed that if they elected to participate, if at any point during the consultation with their surgeon they became uncomfortable, they could request to have the camera turned off, or have a cap put on the lens to protect their privacy. No participants requested that the camera be turned off, and only one patient (a woman interested in having her breast reconstructed) requested that the lens cap be put on the camera at the point she disrobed. Participants were also informed that, at any point after their consultation, if they changed their mind about participation, they could withdraw from the study by contacting me, by phone or email, and requesting to be removed. In such cases their video data would be destroyed in their presence. I did not have any patients withdraw from the study after the fact. In addition, since Dr. D.'s office staff, although technically not part of the study, was unavoidably being observed and would likely appear in my analysis, I also obtained written consent from them.

Data

Video recording

There is a long-standing tradition of collecting videotaped, rather than audiotaped, data for studies that use conversation analysis as a methodology. Video captures paralinguistic

communication such as gesture, gaze, and body position. I anticipated that video would be especially important in a context where participants would be discussing details of appearance. In any conversation, non-verbal modes communications are rich resources of communication, but in cosmetic surgery, which is inherently visual in nature, participants' need to use multi-modal forms of communication, particularly gesture, is magnified. Take for instance the description "big"; how large does something have to be to allow it to be termed big? It is a term that gains much of its relevance from context. A person can describe either a pimple or a skyscraper as "big" and obviously, these two items are vastly different in terms of their objective size. Quite frequently when people use a descriptive term such as "big" it is accompanied by a gesture which either indexes the actual problem so the recipient can actually see just how big the problem is, or the gesture can actually approximate just how big the term "big" might be (e.g., a little kid saying "I love you this:::: much" while flinging her arms open wide to gesturally approximate a huge amount).

In sum, to refine the meanings of terms like big, small, a little bit, dark, falling, drooping, sagging, etc., or terms associated with appearance, people commonly resort to gesture to give greater descriptive power than words alone, or sometimes even words at all, can provide. As such, the non-verbal behavior of participants as they negotiated what aspects of the patients' anatomy was perceived to be problematic and what might constitute a viable solution would be immediately relevant to the study itself. Overall, these interactions were so dependent on non-verbal communication strategies that this study would have been impossible to conduct without visual, videotaped access.

To collect observational data, whenever possible, I tried to set my camera up in a consultation room prior to patients' arrival at the office. This was important because I wanted to

be as unobtrusive as possible. I did not want the process of setting up my camera to be disruptive to the normal flow of business in Transformations. Neither did I wish to risk the possibility of my camera making patients who had not signed up for the study uncomfortable. The last thing I wanted was to risk hurting the business of surgeons who had gone out of their way to help me.

Camera placement was an important issue, both in terms of capturing the data my research requires, but also doing it in a way that was not disruptive to Dr. Dashanti or the flow of the visit. I spent some time talking with Dr. D and we came up with what we felt would be an ideal placement. The camera sat approximately 12 feet in front of the chair that patients sit in during the consultation and a bit to the side. This placement allowed direct visual access to patients' faces, as well as ¾ degree angle of Dr. D, except when he would walk around the patients to see them from different angles or walk around the room to obtain items like a mirror, a bottle of Botox and a syringe, or a notebook filled with "before and after" pictures. An additional benefit of having the camera positioned directly within the patient's field of vision is that it affords them a visual cue that the camera is indeed there, with a black piece of fabric taped to the lens and flipped up so that it does not cover the lens. I wanted there to be a reminder to the patient that, if for any reason they became uncomfortable, they could cover the camera lens. During these observational recordings I was not present, unless the patient requested otherwise.

Most interviews ran anywhere from 50 minutes to an hour and a half, based upon how many concerns a patient presented, the number of surgical options to address the patient's concerns were available, or if the patient elected to receive Botox® injections at the end of the consultation. The longest interaction was also the most medical in nature: a woman seeking a revision for botched mastectomy. Breast reconstruction falls under the definition of reconstructive surgery when the goal of the surgery is to restore a more natural looking form to

some area of the body that has gone through trauma. This patient's consultation included a significant history-taking segment, in which they discussed the treatment protocol for her cancer, the processes associated with her mastectomy, and infection and problematic healing associated with her previous reconstruction, and how she needed to fully heal before they could determine which, if any, of the possible reconstructive procedures would be right for her. It lasted 1 hour and 47 minutes.[27]

Transcription

After I procured video data, I immediately set to the task of transcribing it using conventions developed by conversation analyst Gail Jefferson (Jefferson 2004; Sacks, et al 1974: 731-73). Jefferson's system of transcription is used to produce detailed transcripts that record verbal and non-verbal communication, including intonation, gaze, posture, and,perhaps most importantly in terms of this research, gesture. This level of detail was essential to analyzing the processes by which patients went about describing their aesthetic concerns to their surgeon. Multi-modal communication is always an important aspect of communication (Mondada, 2009), but perhaps even more so in cosmetic consultations, where in contrast to many other environments, so many of the physical features and phenomena affecting those features do not lend themselves well to verbal description. In fact, in chapters 3 and 4, I discuss the difficulties patients have in appropriately articulating their concern and how gesture and other strategies are used in contexts where appropriate verbiage or terminology is absent or elusive.

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[27] When I mentioned the length of this patient's appointment, Dr. D told me that given what she had been through, they anticipated that she would have quite a bit to say and scheduled her for a late afternoon appointment when Dr. D could give her all the time she needed without risking keeping another patient waiting.

Ethnographic Observations and Fieldnotes

Throughout this work I use my ethnographic observations to supplement, underscore, or contrast with phenomena found in the videotaped data. I started taking field notes when I began recruiting patients in October 2011. I took detailed notes when speaking with prospective participants before and after their consultations. When I was engaged in face-to-face interactions, I avoided making notes until the patient had left. During phone conversations, I took notes on a scratch pad or my computer. I sought and was granted permission to use these conversations.

It should be noted that I was in the examination room with all of my participants setting up the camera. In each instance, the patients were notified when the camera was turned on. I engaged in conversation with my participants, on camera, until Dr. D entered the room. Sometimes, I remained in the room engaged in conversation with my subject and Dr. D. I was able to transcribe these conversations. Since my conversations with these patients are not part of the medical interview, in this dissertation I treat these conversations as fieldnotes, although they were recorded and transcribed.

As I started to talk about the work I was doing in my day-to-day life, I realized people and their friends had a lot to say about cosmetic surgery. I found that when I told people that I was working in a plastic surgeon's office, they were eager to provide me with information about the type of procedures that they were interested in or had already had done. Again, I sought and was granted permission to use these conversation fragments. These casual, completely off-the-cuff conversations were a rich source of information because they occurred outside of a medical environment or context. The observations and snippets of conversation I was able to capture from these conversations became particularly salient in comparing the way potential patients talked about their appearance or their reason for the visit in the waiting room or to other

laypeople, in contrast to the ways they talked to their surgeon. I continued taking these informal fieldnotes through May 2024.

Methodology: Conversation Analysis

The analytic methodology relied upon in this study is conversation analysis (CA). CA is a large and diverse field (Sidnell and Stivers 2013) that resists easy summary. It has become a prominent methodology in the study of doctor-patient interaction and medical communication more generally (Heritage and Maynard 2006b; Parry and Barnes 2024). Its central animating question is "Why that now?" (Schegloff and Sacks 1973). For every turn at talk this question can be raised in many forms: why that action, why that grammar and vocabulary choice, why that intonation, body posture, gaze direction, etc. In responding to these questions, conversation analysts have developed research on turn-taking (Sacks, Schegloff and Jefferson 1974), sequence organization (Schegloff 2007), repair (Schegloff, Jefferson and Sacks 1977), ways of referring to persons (Enfield and Stivers 2007), among many other topics. When applied to medical encounters, CA has found wide application in all the elements in the primary care consultation and many aspects of secondary care, including oncology, pediatric neurology, and the mechanics of surgery among many others.

The tools of conversation analysis are a major resource for analysts to determine "why that now" for every utterance by reference to the sequence in progress. And, in the course of analyzing interaction as it unfolds, moment-by-moment, across turn constructional units (Sacks, Schegloff & Jefferson, 1974), turns at talk (Schegloff, 1996), sequences (Schegloff, 2007), and sequences of sequences (Schegloff 1990, 2007), one can observe how participants to the conversation mutually co-construct, shape, modify, and perform identities relevant to the task at

hand; in this instance, the identities being doctor, and, more notably in terms of this research, patient.

Conclusion

This project does not make any claims of being representative of interactions between all types of cosmetic surgeons and their patients. In fact, this work is not intended to be generalizable to all cosmetic surgeons in the United States, or to all surgeons in Los Angeles, or even to all surgeons in Beverly Hills. This research has been designed to provide an initial glimpse into interactions between cosmetic surgeons and their patients. In this research I am primarily interested in patient behavior and how their identity as a cosmetic patient is worked-up during the consultation. Because this study emphasizes patient perspectives and behavior, I wanted to capture similarities and variation across patients, and not have variation across surgeons or practice types act as confounding factors. Most of my participants were seeing a cosmetic surgeon for the first time and had little understanding of what to expect from the visit. The asymmetry between patient knowledge of the trajectory and the goals of the consultation is striking. Obviously, surgeons are extremely familiar with the process. They conduct multiple consultations each week and have had formal explicit training on what should occur during these meetings. Because Dr. D. has received approximately the same formal training as his counterparts, I have every reason to believe that my selected field site is representative of a "typical" high end, board certified, Beverly Hills plastic surgeon.

The variations in patient behavior that I capture in this pilot study are not exhaustive. However, it is reasonable to surmise that the dilemmas faced by patients in this single location are likely shared by most patients during an intake interview, and the the interactional strategies I identify to address these dilemmas are also shared. My findings can be considered a baseline set

of patient behavior which subsequent research can build upon in both breadth of strategies individuals use to address contingencies that are inherent to the process of becoming a cosmetic patient, as well as in work that makes comparisons across behaviors in different types of practices.

Chapter 3 – Commerce Versus Medicine: "What Am I Supposed to Say?!"

> I'm getting kinda nervous. I don't know what to say. What exactly should I say to him? I mean, do I just come out and say, 'I want laser resurfacing?' [laughing nervously] or what?"[28]
>
> —Alexia, 32

This chapter is dedicated to examining some of the ways in which prospective cosmetic patients, many of whom have never been in a cosmetic surgeon's office, negotiate the conflicting norms of commerce and medicine. I show how patients, through the way they present their aesthetic concerns to their physicians, project a particular identity and orientation to the interaction. The problem that patients tend to face is that, outside the realm of their surgeons' offices, cosmetic surgery tends to be conceptualized and talked about in terms of types of procedures: "I need a facelift." I talk about why this frame is inappropriate in a medical context, and why translating a desire for surgery into something more medically appropriate can be difficult. I then show how, in instances where patients are not able to project the appropriate identity, the interlocutors collaboratively modify the presentation to the point where the patient presents as a patient, rather than as a consumer of cosmetic medicine.

Most people walk into a cosmetic surgeons' offices with a particular surgery in mind. Some want a facelift, others a nose job, and some are interested in getting a tummy tuck. When I first mentioned to Alexia, the woman quoted above, that I was working with a cosmetic surgeon for my dissertation she perked up, looked at me, and specifically asked, "Does he do laser resurfacing?" She explained to me that in a few weeks, she and her husband were going to Las

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[28] Alexia is the pseudonym of a personal acquaintance who, when she heard about the research I was doing, wanted to talk to the surgeon I was working with about having a procedure done. Once in the office, as with all my participants, I provided her with the opportunity to give informed consent to enroll as a participant in this study and she signed on as a participant.

Vegas with several of their friends. She went on to say, “I wanna get laser resurfacing done so I can look extra good for the trip” (Fieldnotes Doc1 Pat3, 03/24/2012). I gave her Dr. D’s phone number and within moments she was on the phone with his office scheduling an appointment. Alexia’s desire for a particular treatment does not seem to be unique. The participants I worked with walked into Dr. D’s office with an idea of a surgical procedure they wished to obtain. In pre-consultation interactions I had with my participants they, almost universally, expressed those desires to me clearly and directly:[29]

I wanna get some laser resurfacing done – Alexia, 32 32 (Doc1 Pat3)
I want a facelift – Billy, 49 (Doc1 Pat2)
I need a [breast] reduction – Ellen 50 (Personal Conversation 12/20/2011)
It’s time for me to have a facelift; past time, actually – Marsha (age unknown) (Doc1 Pat6)
I have fatty knees, so I’m going to go in to get lipo – Angelica 34 (Personal Conversation 12/02/2011)
After having the boys my body is a mess. I need a “Mommy Makeover,” you know a tummy tuck, a boob job with a lift – Sandra 27

As common as Alexia’s direct-method of discussing her desire to obtain a medical procedure might be, the nervous laughter that accompanied the notion of “just coming out and saying, ‘I want laser resurfacing’” indicates that on some level she is acutely aware that there is something inapposite about the format of her request (Haakana, 2001; Jefferson, 1984). Alexia is not alone with her discomfort. Virtually every patient I worked with, while they were in the waiting room just prior to their appointment, with varying degrees of nervousness, asked me some version of the question, “What should I say to him?” This creates an interesting question. If these statements are representative of the way people tend to topicalize their desire for cosmetic

[29] Quotes were taken from pre-consultation conversations with my participants and were recorded in my daily field notes.

surgery, why is Alexia nervous and uncertain about just coming out and saying "I want laser resurfacing," to her surgeon?

The short answer to my proposed question is that there are a nearly infinite number of ways that one can make a request; but not all request formats are created equal. Cosmetic procedures may well be marketed and discussed in everyday conversation as if they are commercial products that are available for the asking. However, when potential patients sit down to talk to their surgeons, they find themselves in an interaction with a doctor, not a salesclerk. Request formats have the capacity to index distinct social roles (Curl & Drew, 2008; Ervin-Tripp, 1976). Alexia's proposed request for help, "I want laser resurfacing," is a format that is well suited to a retail environment – "I want a pepperoni pizza" – but violates the norms of doctor-patient interaction. Through this form of request, she indicates an orientation to the interaction as a customer rather than as a patient. In cosmetic consultations, would-be cosmetic patients are called upon to transform their desire for surgery into a format that indicates that they are orienting to the process at hand as a patient rather than a consumer; a process that is neither easy nor intuitive.

A cosmetic consultation is similar, in terms of shape and function, to an acute primary care medical interview. In both contexts, patients come see their physician about a situation associated with their bodies that they find troubling and the rest of the interview is dedicated to determining what, if anything, can be done about the patient's concern (Byrne & Long, 1976; Heritage & Maynard, 2006; Robinson, 2003; Ruusuvuori, 2000). Patient presentations of their concerns normatively occur in response to their physician's opening inquiry, and are generally constructed from an amalgamation of descriptions of physical symptoms, explanations of their illness experiences, and accounts for their decisions to seek help (Heritage & Robinson, 2006;

Roberts, Sarangi, & Moss, 2004; Stivers, 2001; ten Have, 2001). In the context of a medical consultation, these descriptions amount to a request for their doctors' expert opinion about their medical concern and its treatment. The patient's request is granted when their clinician performs the requested action (Heritage & Maynard, 2006; Ruusuvuori, 2000). Because aesthetic concerns tend to be conceptualized and talked about in terms of the procedures used to address a problem, rather than the problem itself, this method of requesting service creates an interactional dilemma for people seeking cosmetic surgery.

The phrase "I need a facelift" serves as an umbrella term for a number of different concerns associated with facial aging. However, these concerns do not have symptoms, at least not in the traditional sense, because aging is not a disease. Of course, there are signs of aging, which could be conceptualized as "symptoms," but they do not readily lend themselves to any sort of concise description. Accordingly, this group of aging related concerns can be easily glossed (Jefferson, 1986) as "I need/want a facelift." Normatively patients do not enter medical consultations proposing a treatment for their concerns. However, presentations in which patients produce a candidate diagnosis as part of their presentation, physicians tend assume their patient is proposing treatment (Stivers, 2002b; Stivers et al., 2003). Requests for service made in the declarative "I want/I need x-treatment" format are problematic in doctor-patient interaction, because in the process of naming a medical treatment – a specific surgical procedure (e.g., laser resurfacing, a facelift, a reduction, or Botox) - patients have also reached a diagnostic decision, and pre-empted the socially sanctioned epistemic and deontic rights of doctors to diagnose and determine safe and effective medical treatments (Freidson, 1970; Parsons, 1951; Starr, 1982). A request for medical service that circumvents doctors' culturally sanctioned right to propose treatment based on medical expertise, would be an example of the erosion of authority predicted

by medical consumerism (Altman & Rodwin, 1988; Freidson, 1973; Haug, 1976, 1988; Haug & Lavin, 1981; Rodwin, 1994).

It is highly unlikely that Alexia could articulate the exact difficulty with "I want laser resurfacing" as a method of topicalizing her goals for the consultation. However, the giggles that accompany that proposition indicate that she realizes that something about it is improper. Yet, her in anxiety about what she should say in lieu of that inquiry – "I'm getting kinda nervous. I don't know what to say. What exactly should I say to him?" (Fieldnotes Doc1 Pat 3, 04/03/2012) – she explicitly states that she is having trouble translating her desire into a request that is more medically appropriate. In this chapter, I argue that, in the act of presenting their concern to their physician, patients are making a request that indicates a particular social identity and an orientation to the visit. On one end of a spectrum sits the identity of "patient," at the other end a "customer" who happens to be purchasing medical services. In practice, both ends of that spectrum are ideal types. Most patient presentations suggest an orientation to the interaction that sits somewhere along that spectrum. I show how the identity of "patient" does not occur naturally. A would-be patient's social identity is fluid, malleable, and worked up during the presentation itself. Furthermore, I suggest that a person's ability to present themselves as a patient is the first step in the process of being perceived as a viable candidate for cosmetic surgery.

Requests

As Curl and Drew (2008) noted, "making a request, be it for an object, assistance, or information, is a basic and ubiquitous activity in human interaction" (p. 130). We make requests of one another all day long: "Please pass the butter; How do you get to San Jose from here?; Could you pick me up on your way home from work?" More often than not these requests come

and go virtually unnoticed, unless our interlocutors have used the wrong question format. When an interlocutor makes a request using a design that is not quite right for the context, it can feel insulting, prickly or burdensome. We have all heard someone tersely respond to a request by snarling something along the lines of, "A 'please' would be nice!" In such cases, the requester has likely used a format that is more hearable as an "order" or a "demand" than a request. However ubiquitous the act of requesting might be, the methods we use to produce those requests are anything but mundane. In terms of sequence structure, a request is a first pair part, or an initiating action, which makes some subsequent action, or second pair part (e.g., "granting" or "rejecting") an accountably relevant next action (Sacks & Schegloff, 1973, Sacks et. al., 1974; Schegloff, 2007). Analyses of request formats have shown that social relationships, power structures, and identities are quite precisely expressed and enacted through the syntax of individual requests (Brown & Levinson, 1987). Whether a request is made in everyday conversation, or it is made in an institutional context such as doctor-patient interaction, the format selected by the speaker is relevant; not just to analysts, or even in the first place to analysts, but to the others participating in the interaction.

The act of requesting can be accomplished through a variety of linguistic forms. Some of the most basic forms of request range from simply naming the object being requested. At the dinner table, "salt" or "salt, please" would be readily understandable as a request for someone to pass the salt. Of course, the act of requesting can also be more complex. Constructions such as an imperative or a declarative ("Pass me the salt" or "I need the salt") are more formal and explicit methods of making a request (Curl & Drew, 2008). Requests are a subcategory in a classification of "directives" which are "utterances designed to get someone to do something" (Goodwin, 2006 p. 517, see also Drew & Couper-Kuhlen, 2014; Floyd et al., 2020; Kendrick & Drew, 2016).

Ervin-Tripp (1976) produced a hierarchical typology of different types of directives, that range in the level of assertiveness from a "hint," to an "imperative" or a "need statement" that place more of a demand on the recipient to conform with the directive. Ervin-Tripp argue that speakers choose between the following alternatives based upon the relative levels of power between speaker and addressee. Ervin-Tripp's typology would predict that a hint, or one of the other more indirect methods of building a request, would be more likely to be used in a context where an individual of relatively lower social status or power were making a request of someone who they perceive to have higher status, or more power. This idea of differences in social status resulting in how requests are constructed is further explored by Brown and Levinson (1987) who argued that speakers tend to select indirect request formats to avoid engaging in a face threatening activity, particularly to avoid threatening their recipient's "negative face" (cf. Goffman, 1955), the human want to avoid imposition by the demands of others.

One notable deviation from the body of literature that states speaker's choices in selecting request formats are driven by the interplay between politeness, social distance and power inequities is the work done by Curl and Drew (2008). They did not directly dispute the notion that speakers consider power inequities or social distance as guiding premises when selecting a request formats; however, they argue that the request formats can also yield information more concretely related to the speakers understanding of the context they are in. More specifically Curl and Drew discuss the ways in which request formats indicate how entitled the speaker feels to make that particular request, from their interlocutor, in that particular context. By comparing requests made in two sets of phone calls – one made up of everyday conversations, the other of patient calls to doctors for "after hours" assistance – Curl and Drew found that sometimes peers make requests of one another in ways that index a high level of "politeness" whereas patients

who are making special requests of physicians in after hours calls can do so quite directly. They explain this deviation from what politeness theory predicts by arguing that speakers formulate requests in unique environmental contexts and the format of request a speaker chooses indexes their evaluation of what they feel reasonably entitled to request of their interlocutor given the specific circumstances present within the interaction.

Curl and Drew's research shows that there tends to be an inverse relationship between contingencies associated with granting a request and a speaker's sense of entitlement to make the request. So, a speaker who feels highly entitled to make a request uses a format that does not acknowledge that there may be pronounced contingencies associated with having their request granted. Conversely, speakers who believe that there is a great deal of contingency associated with granting their request are more likely to use a request format that displays a low degree of entitlement. The specific roles "entitlement" and "contingency" play in requests made in service encounters is discussed in significant detail across the next section of this work, but for now suffice it to say that in order to adequately perform "being a patient" through a request, the request's format should acknowledge medical evaluation as a contingency associated with obtaining medical service. This differs from many other service encounters (e.g. a retail store, restaurant, or a hairdresser) where a "customer" can reasonably expect to make a purchase or contract for a service without having the provider assess their request to determine if the customer is legitimately entitled to make the request in the first place.

Requests In Service Encounters

In everyday conversations the act of making a request has been characterized as a dispreferred social action because it places some degree of obligation on the recipient to fulfill that request. Dispreferred social actions in everyday conversation tend to be produced later rather

than earlier in the conversation, and to be constructed in ways that attenuate the directness of the request (Pomerantz & Heritage, 2013; Schegloff, 2007). This is quite a different stance towards a request than those made in service encounters. Merritt (1976) defines a service encounter as:

> …face-to-face interaction between a server who is "officially posted" in some service area and a customer who is present in that service area, that interaction being oriented to the satisfaction of the customer's presumed desire for some service and the server's obligation to provide that service. (Merritt, 1976, p. 321)

In retail service environments requests are not treated as burdensome; instead fulfilling customers' requests is the primary objective of the businesses. In these encounters, customers are expected to produce their request as a first order of business, rather than the last, because the request sets the trajectory for and the official agenda of the entire interaction (Kuroshima, 2010; Vinkhuyzen & Szymanski, 2004, p. 92). Furthermore, in retail service environments customers are not called upon to justify their decisions (Kuroshima, 2010; Lee, 2009, 2011). Accordingly, one could rightly assume that, in the context of a retail based service encounter, most customer requests are constructed in way that indicate a high degree of entitlement in terms of having the right to make a request and to have that requests fulfilled: these requests tend to direct, explicit and brief (Curl & Drew, 2008; Merritt, 1976).

Although Merritt (1976) describes a "service encounter" as an interaction between a service provider and a person using the services of that provider, her definition might better suited to describing commercial service encounters. Not all services are available purely upon the whim of person who is seeking them. Sometimes service providers act in the capacity of a gatekeeper, whose job it is to make sure that only those people who are legitimately entitled to

receive them. In these environments, individuals making requests are held accountable for presenting themselves, and the situation for which they are seeking help, in ways that afford the service provider an opportunity to evaluate the condition and determine whether or not the request should be granted.

In contrast to commercial service encounters, calls to 911 call centers are contexts in which the individuals providing the service are also in charge of ensuring only those who are legitimately entitled to receive services do so. Similar to doctors, 911 operators are in a position where they are expected to help the person seeking the service, but they also have a responsibility to society. They are expected to provide help to those who need it, but also to ensure that only those people who are legitimately entitled to receive the services they provide can get them. As gatekeepers, emergency service operators evaluate incoming calls to determine whether or not any given situation meets the institutional definition of what constitutes an emergency (Bergmann 1993; for a comprehensive discussion see Heritage & Clayman 2010). Once an ambulance or a police car has been dispatched, it is no longer available to help others who may be in dire need of assistance, so an operator's ability to assure that potentially lifesaving services will only be dispatched when the specifics of a given situation legitimately warrant it (Bergman, 1993; Heritage & Clayman, 2010; Sharrock & Turner, 1978; Whalen & Zimmerman, 1990; Whalen, Zimmerman & Whalen, 1988).

Requests for service that are made in contexts where the service provider concurrently acts as a gatekeeper are grammatically more complex and present a decidedly different stance than their retail counterparts. In these interactions those seeking the service spend a great deal of effort in appropriately formatting their request for service in ways that both respect the norms of the institution, and in ways where they display themselves as viable candidate who are entitled

to, and worthy of the service (for full discussion see Heritage & Clayman, 2010). One of the common strategies used to achieve this is to construct the requests in such a way that it gives the gatekeepers an overview of the situation. The overview gives the gatekeeper *qua* service provider the opportunity to evaluate the situation as a whole before making a determination. "Fully entitled" requests, or those in which the individual making the request does not provide the service provider with enough information to evaluate the request, are routinely treated as incomplete, precisely because they do not include the information necessary for the provider to make the determination as to whether the 'customer' is entitled to receive service.

```
[MCE: 12 – 1:34]
1    911:      Midcity Emergency.
2    Clr:      .hhh Yes. (.) would you (send) th'police: (.)
please to:
3                 thirty four twenty two Jones north .hhh
downstairs.
4    911:      Whatsa problem ma'am.=
```

```
[MCE 21:12-1:22] (Heritage & Clayman, 2010, p. 69)
1      911:       Midcity emergency
2      Clr:       Ye::s uh if you gotta squa:d care could you
send one
3            ccover to Wake Street and Lowen Avenue?
((keyboard))
4      911:       Whatsa problem there.
```

The callers in the fragments above are both requesting police cars, but neither caller has provided the reason a police car is needed. Without knowing why the police car is needed, it is impossible for the 911 operator to determine if the events being called about legitimately warrant police help. While these bald requests for service might well be at home in a retail environment, they are ill suited in the context of 911 calls because they do not provide the call takers with institutionally required information; namely specification for why the car is needed (Whalen & Zimmerman, 1990; Whalen, Zimmerman & Whalen, 1988). Without a description of the events

that motivated the call, call takers are unable evaluate if the events in question are legitimate emergencies that are entitled to help. Predictably, rather than grant or reject the callers' requests, the operators in both of these fragments ask their callers to provide an overview of the situation. Ultimately that information can be used to determine if emergency services should be dispatched.

Medicine is another context where speakers, though the format of their requests for help, must show an understanding of and deference to institutional contingencies. It may be okay to directly ask for tuna sushi (Kuroshima, 2010), or suggest that you want to book a flight (Lee, 2009), but it is not okay to phone a surgeon and say, "I think I'd like to book an appointment for an appendectomy." In sum, "I need X" or "I'd like Y" are request formats that are well suited to a retail environment, but their directness make them woefully inadequate in the context of 911 calls or medicine because these frame requests circumvent the professional's duty as a gatekeeper and frame the speaker's desire as reason enough for to provide help. In social contexts where a service provider also acts as a gatekeeper, a person's ability to describe the situation they are in as a method of formulating a request is not a social nicety but an institutional requirement that allows for the appropriate allocation of the goods or service being provided.

Service Requests in Medicine: Doing "Being a Patient"

Patient requests for medical help tend to differ from service encounters and even requests for emergency services in that they tend avoid directly asking their clinicians for what they want. When doctors ask their patients "What can I do for you today?" patients usually respond, not by telling the doctor exactly what they want, but instead they describe. signs and symptoms and experiences of illness they've been struggling with. In doing so, they are presenting their concerns in ways that allow their doctors to evaluate the information they've been given using

their professional expertise and ultimately propose a diagnosis and treatment regimen. When patients present their concerns to their clinician in this way, they are using the norms of medical interaction to simultaneously present themselves as being properly motivated patients and legitimate candidates for the service they are requesting. Heritage and Robinson (2006) have shown that patients, especially in instances where the medical legitimacy of the concern they are presenting may not be fully apparent (for example a bug bite, a sniffle, or other concerns that might be likely to be perceived as innocuous), are inclined to put a significant amount of effort into "legitimizing their concern" while constructing their problem presentation. By attending to the project of presenting themselves and their concerns as legitimately in need of treatment, patients display some degree of understanding that their doctor, alongside the role of healer, also acts as gatekeeper to medical resources and knowledge. While physicians have a professional responsibility to help their patients to heal, they are also entrusted with the responsibility of assuring that only those who are legitimately ill receive costly medications, time off from work, or other secondary gains associated with being sick (Parsons 1951).

The Medical Interview Summarized as Single, Hypothetical Adjacency Pair

Grossly speaking, an acute care primary medical interview is an extended sequence that is structured around a single adjacency pair: a request and a response. Within this sequence the first action of the adjacency pair is "the request." But what exactly is it that patients request when they walk into primary care visits and talk to their doctors? Are they requesting help? A treatment? Both? Neither? Traditionally acute care visits medical visits, in their entirety, have been likened an extended service request sequence where patients request medical evaluation by describing signs and symptoms of illness to their physician, and accordingly those requests are understood to be granted at the point where the doctor diagnoses the illness and provides a

treatment recommendation (Heritage & Maynard, 2006; Ijas-Kallio et al., 2010; Robinson, 2003; Ruusuvuori, 2000).

Patient requests for help are normally produced in the problem presentation phase response to a doctor's opening inquiry (e.g., "How can I help you today?"; for a discussion of soliciting inquiries see Robinson, 2006). In the hypothetical example provided above, the patient does not explicitly request "medical help"; instead they produce a description of troublesome signs and symptoms:

> 1st pair part: I've had a fever and a sore throat for the last several days . . .
> (Request)
> 2nd pair part: I think what you're experiencing is strep, so I'm going to start you on a round of antibiotics
> (Granting the request)

When a patient describes their illness experience to their doctor, like the 911 callers discussed earlier, they do so in a way that provides the doctor with information in a way that allows him or her to bring their professional judgment to determine if the patient's concern is worthy of medical evaluation, and subsequently to determine what should be done to address it. In the hypothetical example above, the patient's request is granted when the doctor produces a diagnosis of 'strep' and recommends antibiotics. However, diagnosis and a treatment recommendation are not required for the concern to be treated as legitimate. Sometimes patients bring symptoms to their doctor that turn out to be benign, yet they were still worthy of medical evaluation and attention. Of course, my description of how patients formulate their problem presentations (requests for help) is massively oversimplified. There are innumerable ways that patients can go about producing a request. Requests can be brief and merely enumerate a list of symptoms, or the patient might elect to describe their condition in an extended narrative that begins with the first discovery of a symptom (Heritage & Robinson, 2006) and ends with their

current illness experience (Heritage & Clayman, 2010). Whether long or short, patients' problem presentation during the presentation packages can attend to several projects beyond merely presenting a concern to be evaluated during the medical interview. Through the information they bring forward, they can indicate whether their problem is new or recurrent: or in cases where the medical nature of the concern is tenuous they can justify their motivations for seeking help (Heritage & Robinson, 2006); they can also use their descriptions to indicate that they are reasonable and rational by showing an appropriate level of concern about their conditions (Halkowski, 2006); and, among other things, patients can frame their request so it is understandable as "seeking medical evaluation" or as "seeking treatment" (Stivers 2002, 2007). The number of projects to which patients can attend are likely to be as numerous as the variation of presentation styles used to make them.

In a study of pediatric visits Stivers (2002b, 2007) found there to be two general forms of requests patients use to request help from their physicians. She found that while formulating request for medical help, patients can construct their problem presentation with two types of information: descriptions of symptoms or candidate diagnoses:

Symptoms Only Problem Presentation

```
1  DOC:     O:kay: Robert.
2           (0.5)
3  DOC:     What's up.=
4  BOY:     Uhm I have these little red s:pots
5           all over my body.
6           (0.5)
7  BOY:     An:' – we don't know what they are: (really
            (Stivers 2007: p. 25)
```

Candidate Diagnosis Presentation

```
1  DOC:     Al:ri:ght, well what can I do
2           [for you today.
3  MOM:     [(°hm=hm=hm=hm°)
4  MOM:     .hhh Uhm (.) Uh- We're- thinking she might
```

```
5             have an ear infection? [in thuh left ear?
6   DOC:                             [Okay.
7   DOC:      Okay.
              2007: p. 28)
```

In symptoms-only presentations patients enumerate their symptoms, but in the course of doing so they avoid naming their illness or explicitly hypothesizing about its nature. By contrast, candidate diagnosis presentations are ones in which patients explicitly name the illness they believe they are suffering from. The little boy in example 1 describes his concern in terms of the symptoms he is experiencing: "little red spots all over my body" (lines 4-5). Through the construction of his problem presentation, he creates a context where the act of naming of the illness (i.e., the diagnosis) is left to the physician. Alternatively, the mother of the patient in example 2 makes a diagnostic claim when she proposes that her daughter might be suffering from an "ear infection" (line 5). These two methods of presenting a concern convey notably different orientations towards the purpose of the medical visit. Because in "symptoms only" presentations patients remain agnostic in terms of the specific nature of their illness, they convey that the reason for the visit is to receive medical evaluation (Stivers, 2007). However, in candidate-diagnosis presentations, patients show that they presume to know the exact nature of the illness and therefore frame their reason for the visit is not to be medically evaluated, but rather to seek treatment, perhaps even a specific treatment, for a known condition.

Although laypeople can, and do, have diagnostic hunches about the nature of their own illnesses, only physicians have been granted social license to officially name disease (Freidson, 1971): "I may believe that I have bronchitis, but it only officially becomes bronchitis when my doctor says that's what it is." When patients propose a diagnosis while presenting a concern it is problematic because diagnosing illness is an activity that sits at the core of the profession of medicine, and one that doctors are exclusively licensed and charged with the right to perform. As

a result, when patients diagnose their own illnesses they tend to get pushback, or a mild reprimand from their physician (Heritage & Robinson, 2006).

Role Performance and the Medical Interview

When a patient either self-diagnoses or proposes a treatment, in a sense they render the work of physician unnecessary because they have already performed the activities in the phase structure are usually reserved for the physician. However, as a reminder, Figure 1 is an overview of the standard phase structure.

Figure 1. Phase Structure of a Primary Care Consultation

The medical portion of the visit occurs in phases two through five, and each of the phases are ordered as tasks that must be accomplished during the interaction. Each of the phases correlates with a task, or a responsibility that is associated with one of the participant's role performance. I have designated patients' responsibilities in black and those of the physician in red. Figure 2 shows that the medical interview is doctor-centric as most of the tasks needing to be accomplished during the interview are the doctor's responsibility.

Figure 2. Normal Flow of Diagnostic Activities and Division of Responsibility

In an acute care visit the patient's initial responsibility is to present a list of signs and symptoms of illness that will a become topical agenda for the interaction. If in the problem presentation phase, a patient were to produce a "candidate diagnosis" rather than a list of symptoms she eliminates. Furthermore, if the doctor were to unquestioningly accept their patient's diagnosis, it would eliminate the need for a second of the physician's three tasks: data gathering. After all, if a diagnosis has already been made there is no need to gather data to achieve that end. Suddenly now two out of the three responsibilities assigned to the physician are eliminated. Figure 3 illustrates that all that is left for the doctor to do is to write a prescription based on the patient's assessment of their own condition.

Figure 3. The Impact of Patient Self-Diagnosis on the Phase Structure

Of course, if a doctor were to accept their patient's candidate diagnosis without assessing the patient's condition, they would be medically remiss. After all, just because a patient hypothesizes that their chest pains are indicative of an incipient heart attack, this does not mean that it is actually a heart attack. It is critical that the doctor verify that the patient's hypothesis is well grounded before suggesting heart treatment. Absent this process of evaluation, the doctor's areas of authority are completely attenuated and the physician becomes little more than a prescription writer, Since the act of "self-diagnosing" violates the norms of doctor-patient interaction it is not surprising that patients tend to be hesitant to do so (Gill 1998, Gill & Maynard 2006, Ijas-Kallio 2010; Stivers 2007). When they do, their efforts are likely to be met with pushback from their physicians (Heritage & Robinson 2006a). Technically, if the doctor

were to accept the patient's assessment of his condition, the only professional activity left to perform would be for the doctor to evaluate the available courses of treatment, advise the patient of alternative treatment strategies and the strengths and weakness associated with each, and then, if warranted, write a prescription.

If we take this line of reasoning a step further, if in a problem presentation a patient were to propose a particular treatment**,** as is common in cosmetic surgery, determination of a treatment is not related to a particular diagnosis. Since there is no need to make a diagnosis, there is no need to gather data, and now the last of the physician's socially granted responsibilities (i.e., decisions about treatment) has been usurped. Figure 4 shows that in cases where patients begin the visit by requesting a particular treatment the role of the doctor in the phase structure has been rendered nearly non-existent.

Figure 4. The Impact of Patient Proposal for Treatment on the Phase Structure

In sum, if in the response to an opening question like, "What can I do for you today?" the patient were to propose a treatment, whether it be "I want laser resurfacing," or "I need an antibiotic for my bronchitis," the doctor's responsibilities of data gathering are made irrelevant because the patient has diagnosed their own illness, and has predetermined the treatment. Quite literally, all there is left for the physician to so is provide the appropriate treatment. It is difficult to see how this method of requesting, from a medical perspective, could be considered anything but inappropriate, because in doing patients assume all of the medical responsibilities afforded doctors. The only function remaining for her surgeon would be to agree to perform the laser

resurfacing, or in a more traditional medical context to write the prescription. In other words, when taken to a logical conclusion, in instances where patients propose a treatment as the reason for their visit, the doctor's role in the interaction is relegated to nothing more than a paper pusher whose only role is to facilitate their patient's goal. Given that patients' self-diagnoses and treatment recommendations detract from the rights and responsibilities of physicians, it is not surprising that they are relatively rare. Patient presentation packages that are constructed using self-diagnoses are relatively uncommon in acute primary care visits accounting for an estimated 8% of all adult acute primary care visits, and 16% of pediatric visits (Stivers 2007). However, presentations where patients proffer a treatment recommendation as the reason for their visit are virtually unheard of (J. Heritage personal communication, November 2014).

Problem Presentations in Cosmetic Consultations

In the beginning of this chapter, I suggested that outside of the medical realm people tend to conceptualize and discuss cosmetic surgery in terms of the procedures they wish to have (e.g. *I want a facelift)*. I have also argued that referencing a specific treatment is malapropos in the context of medicine because it strips away the rights and responsibilities afforded to physicians, and renders the doctor as little more than a clerk who peddles medical services. This mismatch of between how cosmetic surgery is discussed in everyday life, and how it needs to be discussed to align with the norms of medicine creates an interactional dilemma for patients. Thus, cosmetic patients are called upon to somehow translate their desire for surgery into a problem presentation package that avoids making a diagnostic claim or proposing a course of treatment.

The process of translating desire for surgery ("I want a facelift") into a medically appropriate problem presentation requires that the patient describe their condition in terms of signs and symptoms. Cosmetic surgery, by its very definition, is medicine practiced in a context

that is devoid of disease or pathology. So, without disease what exactly is "a symptom?! A patient who is interested in constructing their presentation in a way that seeks medical evaluation must find a way to build a "symptoms only" presentation in a context where symptoms are not readily identifiable. What are the "symptoms" of less than glowing skin, breasts that are too large, or wrinkles around the eyes? For many patients this task of describing "symptoms" for their doctor to evaluate proved to be quite daunting. I want to take a moment to note that most of my participants expressed some concern about "what they should say" to their doctor. Generally, about five minutes after entering the waiting room they would look at me and whisper, "What should I say to him?" or "What am I supposed to say to him?" On average, patients would spend 20- 30 minutes in the waiting room before being called into meet with Dr. D. Even after a reasonable amount of time to think about how to resolve the difference between how they were accustomed to talking about cosmetic surgery outside of the context of medicine – "I need a facelift" – my patients, displayed varying degrees of inability to present their concerns in a medically appropriate way once they were sitting in front of their surgeon. Where some patients struggled under the weight of this task, others came up with creative ways of dealing with the issue.

In the previous section I discussed Stivers' (2002) "symptoms only" versus "candidate diagnosis" problem presentation formats. These are concepts I continue to draw upon in discussing cosmetic patient presentation packages, but to do so their definitions must be slightly modified to allow them to be descriptive of the phenomenon in the context of cosmetic medicine. In terms of the current research the most important aspect of Stivers' (2002, 2007) system of classifying presentation types is the function each of them serve: where "symptoms only" is a style of presentation that seeks medical evaluation, and a "candidate diagnosis" format is used to

request treatment. However, in the context of cosmetic medicine, “diagnosing” tends to be subjective. As an example, if a patient were concerned about the size of her breasts, a “diagnosis” of the patient’s condition might sound something like “your breasts are too small.” Because the patient’s concern is not a medical condition but an aesthetic preference, the act of declaring some area of the body as a medically relevant concern, is the prerogative of the patient. Determining if that concern is treatable and the appropriate course of action would fall in the domain of the surgeon. When patients propose treatments as a way to topicalize their concern, the actual physical issue that is causing them grief tends to remain unnamed. “I need/want a facelift” tacitly proposes that some unnamed issue with the face is problematic, but the unspoken diagnosis is conflated with and referenced by an articulated treatment proposal (a facelift). In this context, a rough equivalent of Stivers’ “candidate diagnosis,” would be a “request for treatment.” However, while a candidate diagnosis is understandable as a request for treatment, a “request for treatment” performs that action directly.

I use Stivers’ “symptoms only” term for cosmetic patient problem presentations that do not include a treatment proposal. However, in cosmetic medicine this method of presentation also is modified to address contingencies associated with cosmetic surgery. It is rare for a would-be cosmetic patient to directly reference any body part, or physical symptom associated with the problematic body part. Interestingly, in many cosmetic problem presentations, when naming a body part or a concern about some aspect of that part of the body, patients have the tendency to literally stop speaking and resort to paralinguistic strategies to index the specifics of their concerns. While talking with their surgeon, they frame concerns about their physique in terms of lifeworld concerns (Barry, Stevenson, et al., 2001; Husserl, 1970; Mishler, 1984): how their appearance impacts their abilities to live the life they wish to live. In the context of cosmetic

medicine, a “symptoms only” presentation and a “request for treatment” are methods of requesting help from their surgeons that index distinctive orientations to the incipient interview that distinguish the orientations and goals of cosmetic surgery from types of medical interactions.

Symptoms Only Presentations in Cosmetic Medicine

“Symptoms only” presentations are the method of presentation most frequently used in acute care visits (Heritage & Robinson, 2006a; Ijas-Kallio et al., 2010; Stivers, 2002b), because patients tend to be hesitant to enter their doctor’s epistemic domain by articulating their diagnostic hunches (Drew, 2006; Gill, 1998, Gill & Maynard, 2006, Heritage & Robinson, 2006a). I have discussed how in acute care visits a “symptoms only” presentation as one that offers only a description of what the patient has been experiencing (Stivers, 2002). When patients construct this style of presentation package, they use physical symptoms (e.g., cough, spots, rashes, fevers, etc.) as the foundation of their complaint. Merriam-Webster defines “symptoms” as “subjective evidence of disease or physical disorder; by contrast illness is manifested in the disease associated with being sick that patients experience during day-to-day life. As Eisenberg (1977) observes “physicians diagnose and treat disease where patients suffer illnesses” (see also Cassell, 1976; Engel, 1977; Kleinman, 1980; Mishler, 1984). Illness need not be associated with physical disease alone. There may be no blood tests or biological markers for mental illness, yet there is suffering nonetheless. Sometimes illness is a result of psychological process or it can also be from lifeworld considerations. There is a close, sometimes inseparable relationship between the mind, the body and one’s lifeworld surrounding, and the notion of “illness” relates to all three.

Cosmetic surgery, by definition, is medicine practiced on healthy bodies so there is no disease; however, cosmetic patients do experience psychological disease, which translates to an

illness experience, that is often quite pronounced. Sometimes patient dissatisfaction is as simple as "I don't like X (my nose, breasts, jawline, etc.); but, as I show, when talking with their surgeons, patients often suggest that problems they have with their physique is related to some problem with living. Accordingly, their lifeworld issues, rather than physical concerns, are treated as the symptoms of the "illness," the day-to-day disease patients experience as a result of their aesthetic "condition." When a patient constructs their concern by describing the lifeworld issues surrounding living with a bodily condition, they frame their condition in terms of illness; and the lifeworld "symptoms" of illness are fully subjective, sit squarely within the epistemic domain of the patient, and are not vulnerable to being hearable as a encroaching on their surgeons epistemic domain by making diagnostic claim (Barry, Stevenson, Britten, Barber, & Bradley, 2001; Stivers, Mondada, & Steensig, 2011). In cosmetic surgery, the general format of a "symptoms only" presentation takes the form of verbal descriptions of some lifeworld difficulty in combination with a gesture to indicate which part of the body is of concern, and to specify what about that body part is problematic.

Billy. The first patient I use to illustrate a "symptoms-only" presentation is Billy. Prior to his consultation, Billy told me that the reason for his visit was, that he wanted to get a facelift (fieldnotes Doc1 Pat2, 02/06/2012). I start with him because he is one of the few patients who was able to present his concern in terms of the physical symptoms of facial aging, without drawing on lifeworld symptoms, but he did so wordlessly. Billy is a well-known Hollywood makeup artist. His profession qualifies him as somewhat expert on the aesthetics and structure of the human face. If anybody should be qualified to adeptly discuss the details of their own appearance, it would be Billy. After all, it is his job to scrutinize the minutiae of his client's faces and then, using the miracle of makeup, enhance what is there by playing up the positive and

minimizing the appearance of less than desirable features. In some ways, the work of a makeup artist could be likened to that a plastic surgeon, except that the makeup artist uses brushes rather than a scalpel to achieve their goals.

When Billy entered the consultation, he did not present his desire for a facelift as a direct request for service (i.e. "I'm interested in getting a facelift"). Instead, he was able to translate his desire for "a facelift" into a more medically appropriate format complete with a 'description' of those aspects of his face that were causing him consternation. However, what was notable about his presentation is that, although he was able to deftly communicate several issues on his face that he believed to be problematic, he did so without verbally articulating any of the key descriptive elements. Billy begins his description of his concern, in earnest, at line 173.

Billy Problem Presentation

```
156   DOC:   So, how can I help you today?
157   PAT:   tch Well do you have a mirror?= Can I use that
158          mirror?
159   DOC:   Do I have a mi:rror?
160   PAT:   Ah he huh he
161   DOC:   Huh huh
162   PAT:   (          ) isn't very active (over) is is she
163          recording now?
164   DOC:   I::: would imagine so
165   PAT:   Does she want us to wait for her?
166   DOC:   No, I don't think she's coming in.
167           ((doc gets up to check the camera))
168   DOC:   You're on.
169   PAT:   Okay.
170          (9.2)
171   DOC:   You take a look at (your face) an tell me what
172          (.) bugs ya.
173   PAT:   Well here's the things these- ((reaches up and
174          starts touching/pinching the flesh under his chin))
175          this thing is getting a little- (1.8)
176          No:w (0.2) I'm (0.2) jest (.) gonna be starting
177          a diet soon?
178   DOC:   Mmhmm
179   PAT:   A Clean Diet, [are you familiar with the clean
180          diet?
181   DOC:                 [Mmhm
182   DOC:   Mmhm
183          ((Pat's phone rings))
184    PAT:  I'm sorry ((standing up, fumbling for phone))
185   DOC:   Nah that's fine.
((Patient answers phone, excuses himself, and leaves the consultation room
momentarily))
```

The surgeon initially launches this problem-presentation sequence with an opening inquiry, “So, how can I help you today” (line 156). Billy does not immediately provide the information sought by the surgeon’s question. Instead, he presents the surgeon with a counter-inquiry, “Do you have a mirror?=Can I use that mirror” (line 157-8). Billy’s response to Dr. D’s inquiry is interesting. Schegloff (2007) has shown that counter-inquiries tend to occur when for some reason an interlocutor is unable to appropriately respond to the just prior question. Billy’s request for a mirror is a method of obtaining an instrument which he can use to help him provide Dr. D with the information he is looking for. Using his image in the mirror as a reference, Billy ‘describes’ both the facial location of his concern as well as the problematic phenomena associated with that location without explicitly articulating either of them. In fact, he doesn’t articulate much of anything. The lexical portion of his presentation is limited to: “Well here’s the things these- . . .this thing is getting a little-” (lines 173-175). The verbal portion of his presentation is devoid of descriptive specificity. He does not name the part of his body that is causing him distress, and he stops short of saying what that part is doing to cause the distress. Instead, he resorts to gesture to achieve those ends.

The “thing” Billy is referencing is an area of flesh under the chin. The technical term for this part of the body is the submandibular triangle, a completely occult reference term, not readily available to most laypeople. Just at the point where a description of what “these things” might be, he cuts off his speech and uses gesture (see Figure 5) to indicate the specific area of his face by reaching up and lightly pinching an area of loose skin just under his chin.

Figure 5. Billy Manipulating Loose Skin

Image produced from study data.

By using gesture, rather than a description, Billy can reference the exact area of his face that he is dissatisfied with. In addition, he also uses gesture to illustrate the nature of the problem. He does not merely point to the problematic area; he lightly pinches the area multiple times. Through this action, is able to animate his body to show *exactly* what it is about that area of concern that is problematic to him. Each time he pinches the area, the pressure of the pinch on his flesh works to make the area of loose skin more visibly pronounced, and when he releases the pressure of the pinch the skin moves back into place. This is ingenious, because every time he pinches the skin it expands in a way that mimics and exaggerates how, over time, what used to be taut is filling out and dropping.

Remember, when Billy began his presentation, “Well here’s these things” he suggested that he had more than one area of concern. Upon the completion of the under-chin pinch, he fluidly shifted the positioning of his hand and extends the reach of his fingers to the skin along the jowl line and lightly pokes at those fleshy areas so they are included in his gestural presentation (see Figure 6).

Figure 6. Billy Jowl Inclusion Gesture

Image produced from study data.

Again, as Billy pokes and releases the small fleshy masses along his jawline, he again indexes precisely the area of his face that concerns him, while animating his flesh in a way that indicates that area of skin has drooped or fallen from some previous position. In this way, he is able to precisely locate the areas of concern for his surgeon, indicate exactly what issues he has with those areas, and to do so without saying a word.

Across the presentation as a whole Billy was able to use gesture to indicate, quite exactly and efficiently, the locations on his face that were of concern to him. He was also able to equally efficiently communicate quite specific and nuanced descriptions of physical occurrences – or symptoms (*i.e.* sagging or drooping)—associated with those areas. His presentation clearly falls into the classification of a symptoms only presentation because, in the truest sense he is talking about the ways his body is behaving and how those behaviors are distressing to him. So, just as the little boy talking to his pediatrician described his concern as "having little red spots all over his body, " Billy, by presenting a list of symptoms for the surgeon to evaluate, used a descriptive, 'symptoms only' presentation to allow the doctor to understand the problem and propose the

treatment of his desire, without having to articulate it himself. In doing so, Billy was able to appropriately perform the role of patient, by constructing his request for help in a way that acknowledged medical evaluation as a contingency in obtaining cosmetic surgery.

Letitia. Letitia, the next patient whose presentation I discuss, also used gesture to describe her concern, but she also used lifeworld issues as "symptoms," of her concern. Letitia is a Latinx patient in her late 60s who is interested in having a facelift. Prior to entering her consultation, she told me that she wanted to meet with Dr. D to find out how much a facelift would cost. She was concerned that surgery in the U.S, might be too expensive compared to what it tends to cost in Mexico. She also mentioned that she might be interested in finding out a little bit more about Botox, fillers or something non-surgical that could "make me [her] look a little younger" (fieldnotes, Doc1 Pat5, 04/19/2012) Again, although Letitia entered her consultation aware of what she wanted, a facelift and/or injectables, she did not directly request those services. Instead, she constructed the cosmetic version of a 'symptoms only' presentation, which afforded her surgeon the opportunity to evaluate her condition and determine how it should be treated.

<u>Letitia: Problem Presentation</u>

```
220    DOC:   Wull what's what's bugging you about about yer
face?
221 → PAT:   Mostly- ((pointing at area above the mouth)) okay
that
222           (0.2) I'm dating and going with somebody that's
fifty
223           nine,
224    PAT:   There's starters?
225    DOC:   Okay?
226    PAT:   Although they all say that he doesn't look any
younger
227           than me >thank god<? .hhh He's a- he's a wrinkled
white
```

```
228           guy, eh he he anyway thi[s- I- go(h)d it really
bugs me
229           this right here.=
230 →                                [((gesturing to the same
area
231           above the mouth))
232    PAT:   =I mean ((moving hand up to crow’s feet area))
obviously
233           you can see m[e, you're the professional
234    DOC:                [(mmhm) yeah.
235    PAT:    I would think for pushing seventy (.) cuz see
236            in (.) in-
237    DOC:    Lemme ask you a question.=do you- have you ever
238            smoked?
```

Letitia’s surgeon opens the consultation by asking her to tell him “what is really bugging you about your face” (line 220). Letitia begins to launch a verbal presentation by saying, “Mostly–”, but then cuts herself off. Rather than naming her concern she uses her index finger to point to the area of her face located immediately above her upper lip (line 221) and lightly traces the area where if she were a man, a moustache would be (see Figure 7).

Figure 7. Letitia’s Gesture to Her Upper Lip

Image produced from study data.

Through this gesture, she directs her surgeon's gaze to a localized area of her face. In doing so she tacitly invites her surgeon to evaluate that area and draw his own conclusion about the nature of her concern. Because she uses gesture as the workhorse to reference a particular location of her body, she can use the lexical portion of her presentation to explain why she is concerned about the yet unarticulated problem associated with the skin on her face.

While she is gesturing towards her upper lip, she dedicates the verbal portion of her presentation to presenting lifeworld issues associated with her concern: "I'm dating and going with someone who is fifty nine [approximately 10 years younger than she is] . . . although they all say that he doesn't look any younger than me, thank God, . . . it really bugs me, this right here" (lines 222-229). Thus far in her presentation Letitia has couched her concern in terms of social expectations associated with dating and relationships. She explains that "what is bugging her about her face" is that she is in a relationship with someone who is nearly a decade her junior; a state of affairs that deviates from normal dating patterns where a woman is expected to date a man of her own age, or a bit older. She underscores the notion of their age difference being problematic by expressing gratitude that the difference in their ages is not readily evident: ". . .they all say that he doesn't look any younger than me, thank God!" (lines 226-7). But, she indicates, the lines on her face jeopardize her ability to continue to pass as approximately the same age as her boyfriend. Patients may not have the authority to propose treatment, but they do have the authority to know and talk about what makes them unhappy or uncomfortable in their day to day lives (Pomerantz, 1978; Stivers, Mondada, & Steensig, 2011). So, through this presentation she is able to talk about her concerns in a way that avoids stepping into her surgeon's professional domain.

After Letitia presented her concerns associated with her upper lip, she expanded the scope of her complaint by sweeping her hand up to the outer corner of her eyes and made an up and down motion; a gesture that includes her "crow's feet" as part of her overall complaint (line 232-3). Again, she relies upon gesture to do the lion's share of the work (see Figure 8).

Figure 8. Letitia's Gesture to the Area Around Her Eyes

Image produced from study data.

While gesturing toward her eyes she dedicates the lexical portion of her turn to explicitly defer evaluation to Dr. D's professional authority: "I mean [moving hand up to crow's feet area] obviously you can see me, you're the professional" (lines 232-233). Over the course of her turn she has avoided "naming the problem." Instead, she frames the problems she is experiencing as self-evident to a medically trained eye.

Over the course of her presentation as a whole, Letitia is able to present the areas of her body she finds to be problematic (the lines around her mouth and eyes) without actually articulating either of them. In doing so she tacitly instructs Dr. D where to look and to evaluate

the situation himself and to arrive at his own medically informed conclusions about the nature of her concern. In doing so, Letitia has built her presentation so that it only includes information about those aspects of her concern that she is entitled to know, evaluate, and discuss. Between her use of gesture, presentation of lifeworld difficulties as "symptoms" of her physical state she fulfills her obligation to present her concern. Although Letitia never explicitly refers to a problem with her body, a symptom, or anything that on its surface seems to be even remotely medical, her presentation is constructed in a way that it fully performs the role of "being a patient."

Both Billy and Letitia found elegant solutions in terms of presenting concerns without naming them, or proposing treatments. In the act of framing and presenting concerns with their appearance, using strategies that are in alignment to those used by primary care patients, they were able to appropriately perform the role of patients in immediate response to Dr. D's soliciting inquiry. However, not all patients are able to present themselves and their concerns so seamlessly. In the next section I discuss patients whose presentations miss the mark in terms of transforming their concerns into a presentation package that appropriately performs the role of patient.

Direct Requests for Treatment

In this section I discuss patients who present their concerns to their surgeons as a "direct request for treatment," meaning in ways that indicate they are seeking a particular service rather than medical evaluation. The hallmark characteristics of this presentation type are:

a) They propose a specific form of treatment as the reason for their visit.
b) The initial presentation does not include symptoms or other features that afford their surgeon the opportunity to evaluate their condition.

In this section I show that in instances where patients produce direct requests for treatment, their presentations are treated as incomplete. Most notably, these problem presentations do not elicit medically relevant uptakes. When a doctor responds to a patient's presentation in a medically relevant way, it indicates the request provided the information necessary for the interview to move forward (Heritage and Clayman 2010). Conversely, if a patient's problem presentation does not elicit a medically relevant response, it is understood to suggest that there is an issue with either the content or the form of the presentation. In my data, when patients' presentations did not elicit an interactional "go-ahead" from their surgeon, patients responded to it as a cue to incrementally build their presentation so that it conformed with the norms of medicine. It is only when the patient's presentation indexes the identity of "patient" rather than "customer" that Dr. D will respond to their presentation in way that is readily recognizable as medically relevant.

Direct requests for services can encompass a range, as evidenced by these three presentations. We return to Alexia, the patient who hypothetically proposed that she should come out and tell her surgeon that she "wants" laser resurfacing. However, in this analysis I discuss what she actually did in her interview, rather than her musings about what she should do. The second patient is Danica who makes a bold request for an outcome; and the third and final patient I discuss is Marsha who, through her presentation, literally tells her surgeon what needs to be done to her face. I show how, in each case, their medically inappropriate requests for help are worked up, arriving at a presentation that more closely aligns with the norms of medicine.

Alexia. Throughout this chapter I have discussed Alexia's pre-consultation anxiety and musings regarding what she "should say" to her surgeon to open the visit. From the time she initially proposed "I want laser resurfacing" as a preposterous way to open a medical visit, she had approximately 20 minutes to ponder the problem before she actually went into the

consultation room. When she entered the exam room, I was still in the process of setting up and adjusting the camera and caught her anxious plea for help on video:

<u>Alexia</u>*: "How do I start this thing out?"*

```
09   PAT:    ((Whispering to researcher)) How do I
10           start this thing out?
11   RES:    Oh: (.) you'll figure it out. ((smile voice))
12           (0.2)
13   RES:    I can't tell you, (h)
14           (4.0)
```

A few minutes thereafter the surgeon entered the consultation room and posed the question: "So what can I help you with, Alexia?" (line 150). After more than 20 minutes of struggling to come up with a medically appropriate substitute for "I want laser resurfacing" Alexia produced an only slightly modified version:

<u>Alexia: Problem Presentation</u> *"I'm looking to do laser resurfacing"*

```
150    DOC:   So what can I help you with Alexia?
151    PAT:   Okay. So:: (0.2) I'm (.) looking to: (.) do laser
152           resurfacing on my face?
153    DOC:   Okay?=
```

In the actual consultation, Alexia modified her initial request for service by replacing "I want" with "I'm looking to do" laser resurfacing. The meaning of what was initially a bald statement of desire for a specific procedure ("I want laser resurfacing") shifted slightly in the force of the request. "I'm looking to do" still proposes her desire for treatment, and "laser resurfacing" is still a treatment proposal. However, "looking" is a gerund that frames achievement of her goal as an ongoing process, rather than as a forgone conclusion. By framing her quest as an ongoing process, Alexia dampens the level of entitlement embodied in her request because it leaves room for the possibility of addressing some sort of contingency (Curl & Drew, 2008). She produces

her turn using a fully rising "question intonation," and comes to a full stop at the end of her turn constructional unit, a move that signals that her presentation thus far is possibly complete and that she is willing to yield the interactional floor to the surgeon. However, rather than responding to Alexia in any substantive way, Dr. D merely says, "Okay?" (line 153) a continuer produced with upward intonation, which is a response that hedges between moving forward in the interview, or inviting Alexia to provide more information. (Beach 1993; Heritage & Clayman 2010, see also Betz et al. 2021).

Before I move on to discuss how Alexia incrementally builds her turn from a presentation that treats laser resurfacing as a consumer good into something that more closely resembles a viable problem presentation, I'd like to discuss the interactional context that Alexia's statement has created, and its ramifications for how the surgeon can respond. One interesting aspect of requests is that they set agendas in terms of what would constitute an appropriate next action. Ideally, the recipient of any first pair part (i.e. a request) should produce a next action that is responsive to the question just produced (Schegloff, 2007; Schegloff & Sacks, 1973). In terms of a request the appropriate next action would be to either "grant" or reject" the request (Drew and Couper-Kuhlen 2014). Or, another less desirable way to come off as responsive would be to respond to the topical agenda by building their response around the topic. In this case the topic of Alexia's request is 'laser resurfacing " So, for Dr. D to be responsive to be responsive to Alexia's request, his response must either (a) grant or reject the request for laser resurfacing embedded in her presentation or (b) respond to the topical agenda by building his response upon the idea of either "laser resurfacing" or "her face" because these are the only two items of Alexia's utterance that could conceivably be construed as topics.

However, Dr. D does not do either; he avoids responding by using “Okay?” which treats Alexia’s problem presentation as incomplete and invites her to continue and provide more information:

Alexia: *I’ve had it done before…*

```
150     DOC:   So what can I help you with Alexia?
151     PAT:   Okay.  So:: (0.2) I'm (.) looking to: (.) do laser
152            resurfacing on my face?
153 →   DOC:   Okay?=
154 →   PAT:   =>I've had it done< before.
155 →   DOC:   How long ago?
156 →   PAT:   Uh:mm (.) tch. I had it done >a’million
157            times actually.< The last time I had it
158            do:ne was (.) probably last summer?
159     DOC:   Okay?
160     PAT:   And u:h:m:, (0.2)
161     DOC:   Do you know what kind of laser it was?
```

Alexia’s initial presentation is “So, I’m looking to do laser resurfacing on my face” (lines 121-152). She had already indicated to me that there is something untoward about proposing a treatment to a surgeon, and indeed Dr. D’s continuer indicated that this presentation was insufficient. Alexia did not miss a beat and moved forward by building her turn upon her just prior utterance. She was able to extend her request by adding a second turn constructional unit, “I’ve had it done before” (line 154) which is hearable as an expansion of her previous utterance. Her expansion is quite interesting because a patient’s prior experience with a condition or treatment is something that affords patients a higher degree of authority to diagnose disease or propose treatment.

Medical knowledge is the foundation of of medical authority. When patients have previous experience with a problem or its treatment, it allows them to speak about their condition more definitively. So, Alexia’s disclosure of previous experience with laser resurfacing acts as evidence for her ability to make a definitive statement about what would be an appropriate

treatment for her yet-undisclosed concern with her skin. Accordingly, in the process of resorting to "previous experience" with the condition, Alexia mitigates her faux pas by claiming previous experience and, by extension, expertise about her condition or at least a similar one. With this move, Alexia draw upon a strategy used in other medical contexts to bolster her legitimacy in making the determination that laser resurfacing is the appropriate course of action to meet her undisclosed physical concerns (Heritage & Robinson, 2006).

Her strategy was met with some success. Dr. D responded to her modified presentation with a medically relevant history taking question, "How long ago?" A physician's first history taking question is understood to be a formal transition point out of the problem presentation phase of the visit, and into the next phase: history taking (Heritage and Clayman 2010). This action marks the patient's presentation as adequate or complete. So, when Alexia displays that she has medically appropriate grounds on which to make her request, Dr. D's response indicates that she has now appropriately assumed the role of patient, rather than treating the encounter as a commercial transaction. However, as Heritage (2010) has observed, the transition from one phase of medicine to the next is not always clean. It can be likened to the passing of a baton in a race. In this case, the interactional baton was not passed cleanly. Rather than using her turn at talk to respond to "How long ago?", she moves to upgrade her sense of entitlement to propose treatment, by stating that she has had laser treatments not once, but "a million times" (lines 156-157). Through this short series of moves, she was able to indirectly suggest that on multiple other occasions some unnamed doctor or doctors have evaluated her skin and determined laser resurfacing to be the appropriate treatment to address the concerns that she has not yet named in the course of this visit. Across her turn she indirectly builds her turn to account for her faux pas by suggesting that it is the previous clinician's authority, not her own desire or sense of

entitlement, that informs her ability to propose a course of treatment for her still unarticulated concern with the condition of the skin on her face, and in doing so, displays that she has appropriately adopted the role of cosmetic patient.

Danica. The next patient I discuss is Danica. Her presentation differs from Alexia in that, rather than requesting a treatment in her problem presentation package, she directly requests, or demands, a particular result. In the world of cosmetic surgery, reconstructive work, which fixes deformity (congenital or a deformity caused later in life through accident or trauma), can undoubtedly be considered the most inherently medically legitimate of all cosmetic concerns. Where some might have concerns about someone's desire to go under the knife to have a slimmer waist or shapely bottom, few would begrudge an individual who has experienced trauma and deformity to have surgery to restore a more standard appearance and function to the damaged area of the body (Garfinkel, 1967). Curl and Drew (2008) suggest that one's level of entitlement to make a request and have it granted inform the format of the request itself. In the world of plastic surgery, reconstructive patients may be allowed the highest degree of entitlement in terms of assuming that their desire for surgery would be reason enough to legitimate their request for treatment. So it unsurprising that Danica, the only reconstructive patient in my data set, is also the patient that produced the most entitled and direct request for surgery. However legitimate the desire reconstructive work may seem outside of the realm of doctor-patient interaction, the legitimacy of wanting reconstructive surgery does not translated into unequivocal entitlement to get that surgery.

Danica is a patient who, prior to showing up in Dr. D's office, had recently undergone a bilateral mastectomy and then breast reconstruction. The latter procedure was successful in one breast but not in the other. On her patient intake form, she described the reason for her visit as,

"to get a second opinion" about future reconstructive efforts on her breast. Danica's problem presentation sequence is unusual because, rather than taking place near the beginning of the medical interview, it occurs almost 25 minutes into the interaction because the first 25 minutes of the visit was dedicated to telling Dr. D about her medical history from the time she was diagnosed with breast cancer up to her most recent reconstructive surgery. Throughout this discussion, Danica indicated that she was aware that her breast was still healing from the last surgery, and that she knew that would need to wait a minimum of six months before she could even consider having another procedure. In fact, she was so early into her healing process from the last surgery that during her consultation with Dr. D., she still had stitches in her body and an active infection. This set of physical circumstances would render Danica a poor surgical candidate because her body was not in any condition to safely undergo surgery. This was a point that Dr. D made repeatedly during the interaction, because as often as Danica indicated that she was aware that she would have to wait to have her next surgery, it was also clear that she desperately wanted to go back under the knife sooner rather than later.

Dr. D's "opening inquiry," the point that marks a transition to the medical business at hand, not only occurred at a non-standard time (25 minutes into the visit), it was also a non-standard form of a soliciting inquiry: "Uh, as mean as far as I saw on the intake form, yihknow that you wannid a- a second opinion."

Danica: Problem Presentation "*I want a new boob . . .*"

```
879              (0.8)
880   DOC:       Uh: I mean as far as I saw on on the intake form
(0.2)
881              yihknow that you wannid a- a second opinion
882   PAT:       Right.
883   DOC:       I do think that uhm=
884   PAT: →    =I want a new boo:b.
885   DOC: →     Right.
886   PAT:       An' I don't know how to get one
```

```
887   DOC:     Right,
888            (0.4)
889   DOC:     What I would need to do is to do an examination.
Okay?
890            (0.2)
891   DOC:     I could tell you if I think you'd be a candidate
for a
892            deep flap. Yihknow.
892   PAT:     Yeah, you can- I'll give you an examination
884   DOC:     Yeah
894   PAT:     Do an examination,
895   DOC:     Yeah,
896   PAT:     That's what expected you'd wanna look at it.
897   DOC:     Right.  Right.
898            (0.2)
```

When crafting his soliciting inquiry, Dr. D. incorporated the words Danica wrote on her intake form, "to get a second opinion." By presenting this understanding, he creates an environment that constrains relevant responses to either "confirming" or "rejecting" his understanding. His inquiry exerts a notable amount of pressure to keep the focus of the visit to "a second opinion" about her future options, rather than affording her latitude where she might be likely to reframe the reason for her visit as a desire to discuss the viability of a new surgery.[30] In line 882 she solidly confirms his understanding that "a second opinion" is her reason for the visit by producing a simple, straightforward "Right." Because she has confirmed that her reason for the visit is a second opinion, and they have just concluded an extended conversation about the specifics of her current condition, she has just given Dr. D a green light to render his opinion about the information her prior surgeon had given her. However, after her confirmation, he begins his next turn by saying, "I do think that uhm" (line 883), an utterance that appears to suggest that he is producing an opinion about her future options. Danica cuts him off and

[30] Leter in the interaction, Dr. D. tells Danica that, at this point in her healing, it is impossible to tell if a subsequent surgery is a viable option, let alone which reconstructive process might best meet her needs. He explained that all future actions were contingent upon how her current surgery healed.

changes the entire dynamic of the presentation by making a bold and bald declaration that radically changes the nature of her request, “I want a new boob” (line 884).

When she declares that she wants a “new boob,” Danica accomplishes two tasks. First, by inserting her declaration into the interaction just at the point that Dr. D appears to be beginning to render his opinion, she blocks his incipient utterance and precludes him from rendering any opinion at all. Second, Danica’s utterance, “I want a new boob,” shifts the dynamic of the interaction from a request for a medical evaluation regarding her future options, to a demanding direct request, for a new breast. Her request, presented as a desired goal, creates an environment where the next logical step, under normal circumstances, would be for the surgeon to either “grant” or “reject” Danica’s request. Quite obviously, as much as Dr. D, or anybody else, might be sympathetic to her desire for a new breast, granting her request for a new one without giving the current breast time to heal was a medical impossibility and utterly out of the question.

Rather than producing a substantive response to Danica’s request for a “new boob,” Dr. D withholds a substantive response. Instead, he produces, “Right” (line 885), an acknowledgment token that is responsive to her just prior utterance, but in a way that is fully non-committal. Interestingly in this instance, “right” is simultaneously hearable as aligning with the patient’s desire for a “new boob” while remaining non-committal in terms of the request itself.

When Danica’s request for a “new boob” does not elicit a substantive response from Dr. D, she continues by using an “and” in first position; a move that allows this turn to be heard as a continuation of her prior turn at talk, “and I don’t know how to get one” (line 888). This move is quite elegant because it serves to recalibrate her request. Now, rather than seeking a “new boob,” she has reframed her goal for the visit as a request for help in determining how she should go

about get a “new boob,” a project that is once again in alignment with “getting a second opinion.” Once Danica had indicated that, once again, she was aligned with the project of getting information, Dr. D tacitly marks her request as medically acceptable by transitioning into a new order of business, a physical examination. “What I would need to do is to do an examination” (line 889). In a move similar to the one made by Alexia after her interactional faux pas, Danica responds to the idea of a physical examination in a way that grants his request, but she also frames the examination, an act that is done to obtain information on which a medically informed decision can be made: “That’s what [I] expected you’d wanna look at it” (line 896). By framing an examination as something she expected all along, she seems to mitigate the transgression of directly requesting “new boob,” by claiming that she had assumed that medical evaluation of her breast’s current condition was never in question. So, like Alexia, Danica uses what is left of the problem presentation sequence to incrementally adapt her request so that it conforms more closely to a medical protocol, while also attending to the project of cleaning up the mess caused by that transgression.

When patients initially present their concern as request for a service, with very little prompting from their surgeon, they self-correct by strategically adapting their presentations so that they acknowledge medical evaluation as a contingency in the process of obtaining their surgical goals. Alexia and Danica’s presentations show that incursions into the domain of cosmetic surgeons can be intentional or unintentional. Some patients, such as Alexia, seem to inadvertently wander into physicians’ domain because of uncertainty regarding how they should present their cosmetic concern; others, like Danica, appear to go there intentionally. Intentional or not, patient excursions into surgeons’ realm of professional authority tend to be brief, and patients modify their presentations to more closely approximate behavior associated with

performing doing “being a patient” than that of behaving like a customer. Dr. D did not need to explicitly sanction his patients, nor did he direct them in how to behave “like a patient”; what he did do was withhold substantive response to their disclosures, which in turn allowed them the space to modify their requests for help into something more closely aligned with the norms of medicine.

Where most patients in my data set quickly fell into line and modified their presentation, other patients could not, or would not, appropriately modify their requests. These cases tended to be notably more complex and occupy extended sequences. As an example of just such a situation I discuss the case of Marsha, a patient who ultimately presented two concerns. In her presentation of her first concern, Marsha, even after several turns at talk, was unable to modify her request in a way in which she assumed the role of patient. Accordingly, her concern does not elicit medically relevant uptake from Dr. D. It is only through her second concern that she is able to appropriately perform that role to the point that the interaction can move out of the problem presentation phase of the visit.

Marsha. Marsha is a 58-year-old patient who, prior to her consultation, explained to me that she had already had consultations with “a couple” of other surgeons (fieldnotes Doc1 Pat6, 05/12/2012). The interaction between Marsha and her surgeon was analytically interesting because she presented two unique sets of concerns to her surgeons: a set of conditions associated with a face/neck lift (lines 44-82); and a second, comparatively incidental condition of a small “indentation” in the skin of her face (lines 45-125). When viewed in terms of surgical interventions the former condition can be considered major because it would require a $15,000-$20,000 surgery as a correction; whereas the latter would only require a quick injection of a $500 cosmetic filler to correct. In terms of sequential ordering Marsha began her presentation by

presenting her major concerns, those associated with her lower face and neck. In doing so she used the relative structural locations or the two concerns to feature her concerns with her face/neck lifts as the primary reason for her visit. By holding her presentation of the "indentation" in her face until second position, its subordinate structural location framed the indentation as ancillary to her primary concern.

In this interaction, while discussing her concerns about her face and neck she oriented to the interaction as a customer and her presentation did not receive medically relevant uptake from Dr. D. However, when she shifted into a discussion of her smaller concern, the indentation in her cheek, she used a presentation format that indexed an orientation to the process as a patient, rather than a customer. Even though the treatment for the former is more medically extensive and expensive, it is the smaller of the two concerns that Marsha used to appropriately perform "being a patient." As I discuss, Dr. D. only responded to Marsha's presentation in a medically significant way when she used the norms of medical interaction to describe her concern with the indentation on her face. It was the transition from orienting to the interaction as a customer to a patient that opened the door for Dr. Dashanti to engage in talk about both of Marsha's concerns; because in her presentation of the second condition she afforded him the status of "doctor" with all its associated rights and responsibilities.

Because Marsha's presentation is relatively complex and extended, I am providing a fragment that covers the entire interaction. An overview of where the conversation goes will likely facilitate understanding of what is happening in the individual sequences. I have included a line of demarcation between lines 82 and 83 because that is the point where the sequence transitions from Marsha's presentation of her concerns about her neck into the presentation of the

“indentation” in her cheek. Over the remainder of this chapter, I break down and analyze this problem presentation sequence into its constituent parts.

Marsha: ‘*so that needs to be tightened and fixed’*

```
44   DOC:     So I went through yer intake form (0.4)
45            ah::: last- that you filled out last
46            week,
47            (.)
48   DOC:     And ah:: since I saw what (.) was kinda
49            bothering you but I want'chu to kinda
50            tell me in your own words.
51            (.)
52   DOC:     .hhhh what er the issues that ri:lly
53            bug you about (.) mainly about yer face?
54          → (0.2) ((during this pause patient gestures to her
face and neck))
55   DOC:     .hhhh ah:::m you you pointed kinda all
56            up and down yer face.
57           (.)
58   DOC:     Bet,
59   PAT:     No:. Not really it's jest- It's cuz of
60            the neck.
61   DOC:     Mmhm?
62   PAT: →  that I'm having an issue with.
63   DOC:     Okay,
64   PAT: →  So that needs to be (0.4) tightened and
65        →  fixed.[ Nothing
66   DOC:           [Right.
67   PAT:     Nothing makes someone look older than
68            their (0.5) nec[k,
69   DOC:                    [(       ) neck
70   PAT:     Ah [ha ha ha ha ha
71   DOC:        [Right          right. En especially
72            when there's a disconnect between their
73            face and their neck [too.
74   PAT:                         [Right.  Because I
75            I look pretty good for my age [yihknow,
76   DOC:                                   [Right.
77   PAT:     I mean I'm fifty-eight.
78   DOC:     That's great,
79   PAT:     Yihknow,
80   DOC:     That's great.
82   PAT:     Nobody thinks that (yihknow) thank God.
```

(Bold in original: lines 59–60 "it's jest- It's cuz of the neck."; line 62 "that I'm having an issue with."; lines 64–65 "So that needs to be (0.4) tightened and fixed.")

--------------------PROBLEM #2 (Cheek indentations)--------------------

```
83   DOC: →  And you were mentioning some other things
84           like ah::m like indentations in yer cheek
85   PAT:    [tch Yea:h yiknow when I'm slee:ping now
86           it's the weirdest thing I can wake up
87           in the morning and they'll be like (0.2)
88           I don't know if you could se- cuz I cover
89           it up (.) pretty good with ah::m (0.3)
90   DOC:    With makeup?
91   PAT:    Makeup. .hh but (.) there's like a liddle dark
92           spo:t: [yihknow
93   DOC:→          [Do you see it right now?<C[uz I s:ee:
94   PAT:                                      [Here cuz it's a
liddle
95           weirded out the:re I dunno en- or it [might
96   DOC:                                         [Right there?
Okay.
97   PAT:    Yeah right here. .h En then at night see-
98           I never have this- (.) I get these liddle
99           u:h:m (0.7) tch (.) ah (.) creases.
100          (.)
101  PAT:    Never had that.
102          (.)
103  PAT:    Ev[er.
104  DOC:      [At night (.) you mean (0.2)
105  PAT:    When I wake up[ in the morning I have
106  DOC:                  [ (           ) it's gone,
107          it's
108  PAT:    No I have like this liddle crease en then
109          I fill it wi:th th- uhm (0.2) tch ah::
110          that ah collagen filler,
111  DOC:    Oh okay.
112  PAT:    Pain in the a:ss?
113  DOC:    Hehehe
111  DOC: → Yer taking a page out of my book?
112  PAT:    I am?
113  DOC:    A liddle filler her[e and there?
114  PAT:                       [Yeah.
115  DOC: -> .hhh (wh[en didju)
116  PAT:             [Yeah. And the
117  DOC  -> start noticing that?
```

In this extended excerpt, Dr. D opens the problem presentation phase by requesting that Marsha tell him "in her own words what the issues [are] that really bug her about her face"(lines 52-53). Marsha begins by glossing her concern in an extremely loose fashion, using a fast, broad

gesture where she waves her hand over the area between mid-chest to the top of the head, in a way that suggests that she finds everything between her chest and the top of her head problematic. When Dr. D begins to object to her response's lack of specificity (line 55) she backs away from the implication that everything from her chest to her hairline was of concern, and begins to verbally articulate the concerns she has with her neck and face. She builds her presentation which incrementally over five turn constructional units:

i: "It's cuz of the neck." (line 60)
ii. "That I'm having an issue with." (line 62)
iii. "So that needs to be (0.4) tightened and fixed." (lines 64-5)
iv. "Nothing makes someone look older than their neck," (line 67)

Marsha begins to unpack her gestural gloss verbally, although better, her presentation, "It's cuz of the neck." (line 60), still lacks specificity. A "neck "is part of one's anatomy but it is not a doctorable concern; it is merely a body part. Because Marsha's description does not include details, such as sagging, wrinkles, issues of skin texture or coloring, some indication of trouble that Dr. D. could observe or analyze, realistically he cannot interpret her "neck" as a 'doctorable' concern. Physicians routinely treat descriptions produced at an insufficient level of granularity as incomplete (Heritage & Clayman 2010). In response Dr. D produces, "Mmhm?" a continuer designed to encourage her to "unpack the gloss" (Jefferson 1986) by providing more detailed information about what the problem with her neck might be.

When Marsha's "neck" presentation does not elicit a medically relevant response, she builds her turn by adding an increment, '*that I'm having an issue with'* (line 62). This increment is ostensibly designed to clarify that her neck is the issue she'd like to have addressed. She builds this increment using the word "issue," the word used by the surgeon in his opening inquiry, "What are the issues that really bug you?" In doing so she frames her utterance as responsive to

his inquiry by suggesting her neck is the thing she is “having an issue with” (Clayman, 2001). In doing so she tacitly suggests that she has already produced the information her surgeon requested in his opening inquiry. However, this increment does not present any new information, all this inclusion accomplishes is to renew her “neck” as the issue she would like to discuss. Once again, her second attempt at presenting “the neck” as the reason for her visit elicits nothing more than a continuer, “Okay,” (line 63), which frames the presentation, thus far, as still incomplete.

When she proceeds deeper into her problem presentation, she changes her strategy. Rather than producing a description of her problem, she makes a treatment proposal: “*so that needs to be tightened and fixed”* (lines 64-5). As discussed earlier in this chapter, this move is extremely problematic. Marsha is not just proposing a treatment, through her presentation, she is telling Dr. D what needs to be done. Her directive pre-empts any opportunity or need for Dr. D to evaluate her face, let alone to make treatment recommendations about the yet unnamed problem Marsha is experiencing with her neck. Quite obviously, the way her utterance is framed creates a context where is difficult for Dr. D. to respond. If he agrees with her assessment, he abdicating all his medical responsibilities to her. If he rejects her assessment, he suggests that the concern she is presenting does not exist. If he were to do that, there would be no need to continue with the interaction, because he would have rejected the doctorability of the concern. Unsurprisingly, with no readily available options for a viable response, he once again resorts to, “Right” (line 66).

When once again her presentation still doesn’t elicit a medically relevant response from Dr. Dashanti, Marsha attempts to close her presentation and elicit a more substantive response from him by producing an ‘aphoristic’ assessment (Drew and Holt 1998): “Nothing makes someone look older than their neck” (lines 67-68), which is hearable as an attempt to close the

current sequence (Drew & Holt 1998; Schegloff & Sacks 1973). At this point, Marsha's presentation has come to a point of hearable completion, so a history-taking question that targets the problem(s) with her neck*,* would be the next relevant action on the part of Dr. D. However, for reasons previously discussed, he cannot readily do so without abdicating his medical responsibilities and acting as a medical order-taker who will grant a neck lift, without evaluation or consideration, merely because Marsha said that it needed to be done.

Marsha, in the absence of a medically relevant uptake to her repeated attempts to topicalize her neck as a medical concern, engages in a series of self-assessments about her overall appearance; each of which receives acknowledgment tokens from the surgeon (lines 75-82). At this point, more than 30 lines of talk have been dedicated to Marsha's presentation of her neck as a concern, but at no point does Dr. D respond to her concern in a medically relevant way. Medically speaking, this is the equivalent of "*if a tree falls in the woods and there's nobody there to hear it, does it make a sound*?" But in this case, if a patient presents a concern, but their doctor does indicate that they hear it as doctorable concern, does it actually exist as a concern within the interaction? In this instance the answer to this ethereal question is, "No". Because Dr. D. has avoided acknowledging Marsha's complaint in any medically recognizable way that furthers the interaction, her concern is effectively sidelined. Ultimately the sequence devoted to Marsha's presentation of the concerns she has with her neck comes to an end when Dr. D abandons the project of getting information about Marsha's neck and issues a new soliciting inquiry that seeks information about Marsha's second concern: "*and you were mentioning some other things like indentations on your cheek?"* (lines 83 -4).

Because the problem with Marsha's neck is left unacknowledged in any medically relevant way it has been "sequentially deleted" (Sacks, Schegloff & Jefferson 1974, Schegloff

1987), or at least temporarily so, because the question of whether it would ultimately become a legitimate topic for the interview was left to be decided at some later point in the consultation. It only becomes part of the topical agenda for the visit quite a bit later in the interaction.

Concern #2: "Cheek indentations"

The second concern topicalized during the problem presentation phase of Marsha's visit were "indentations" or "creases" in the skin on her face. This relatively minor concern became a topic of conversation when the surgeon closed the topic of Marsha's neck by producing a soliciting inquiry about another concern she had listed on her intake form: *"And you were mentioning some other things like indentations on yer cheek*" (lines 83-84). However in this instance, Marsha's response to her surgeon's inquiry conveys a vastly different stance toward her problem and indeed the interaction itself. In this instance, Marsha describes her condition as a mystery, or a puzzle, and presents it as such to the surgeon so it can be analyzed, and hopefully addressed during the consultation. In other words, in contrast to her previous presentation, this one invites evaluation.

Marsha: *It the weirdest thing. . .*

```
83   DOC:    And you were mentioning some other things
84           like ah::m like indentations in yer cheek
85   PAT:    [tch Yea:h yiknow when I'm slee:ping now
86           it's the weirdest thing I can wake up
87           in the morning and there'll be like (0.2)
88           I don't know if you could se- cuz I cover
89           it up (.) pretty good with ah::m (0.3)
90   DOC:    With makeup?
91   PAT:    Makeup. .hh but (.) there's like a liddle dark
92           spo:t: [yihknow
93   DOC:→          [Do you see it right now?<C[uz I s:ee:
94   PAT:                                          [Here cuz it's a
liddle
95           wierded out the:re I dunno en- or it [might
96   DOC:                                              [Right there?
Okay.
97   PAT:    Yeah right here. .h En then at night see-
```

```
98              I never have this- (.) I get these liddle
99              u:h:m (0.7) tch (.) ah (.) creases.
100             (.)
101  PAT:       Never had that.
102             (.)
103  PAT:       Ev[er.
```

This presentation is notably different than the one she used for her "neck.". While describing the "indentations" Marsha is quite cautious about making any specific claim about the location or the nature of the indentation. She begins by producing a narrative that proposes a causal link between sleeping and the "indentations" on her face. In her description, she classifies it as completely puzzling by describing it as "the weirdest thing" and gesturing in a linear pattern down the length of her cheekbone (lines 85-87). She then moves into a display of "troubles resistance" (Heritage & Robinson 2006) by explaining that she has tried to deal with this relatively innocuous concern on her own but, despite her best efforts, has not been able to successfully deal with it (lines 88-9). Through her presentation, she invites him to examine the area on her face by gesturing to indicate the problematic area, and she underscores the invitation for him to look at the problematic area by verbally suggesting that he might be able to see the problem about which she is speaking ("I dunno if you can se-") (line 88). She brings her turn to a possible point of conclusion by producing an account for why he might not be able to see the problem she is referencing: "I cover it up pretty good . . ." (lines 89-90). At this point the surgeon engaged with the presentation and aligned enough with her to produce the word "makeup" (line 90) as a "collaborative completion": a move that is strongly affiliative (Sacks, Schegloff, & Jefferson 1974, Lerner 2004).

Since the analysis of Marsha's presentation has been extensive, it is worth summarizing the events of her presentation as a whole. She began the interaction by producing a request that tells the surgeon what needs to be done rather than asking him. Through this method of problem

presentation Marsha displays orientation to the process more as customer of cosmetic services rather than a patient. Because Dr. Dashanti was unable to get Marsha to present her concern in alignment with the norms of medical interaction, her concerns with her neck were temporarily tabled. However, at the point that Marsha moved into her presentation of the indentations on her face, her method of presentation shifted into a narrative that included descriptions of physical 'symptoms' she was experiencing; a format that fully allows the doctor to evaluate her concern and make diagnostic conclusions and subsequently treatment recommendations. The shift in the types of identity Marsha projects through the two different request formats is procedurally consequential. They indicate different presentations of self, or orientations to the incipient interaction. One suggests that Marsha intends to enter the interaction in the role of 'customer' with the rights and responsibilities associated to a retail customer. The other indicates that she is donning the role of 'patient.' Each method of presentation elicits a notably different pattern of response from Dr. D., and it is only when she appropriately performs the role of patient that he responds by treating her as one.

Conclusion

This pattern of responses is not restricted to Marsha's two concerns, it was a recurrent pattern throughout my data. I found that without exception, when patients could produce their concern to their surgeon in a format that invites evaluation of the conditions for which they are seeking treatment, their presentation packages were treated as legitimate and complete by eliciting a medically relevant response, usually in the form of a history taking question. However, as I have shown in this chapter, not all patients are able to translate their desire for surgery into a descriptive presentation, and again, without exception, surgeons withheld producing substantive response until patients built their presentations in ways that acknowledged

medical evaluation as an integral in the process of obtaining cosmetic surgery. Without this acknowledgement patients treat surgery as if a retail service where surgery, the object of their desire, is available upon demand for anybody who is willing to pay. What determines the social identity of patient and differentiates it from that of customer is quite literally the way cosmetic surgery is requested, right up front, during the problem presentation phase of the visit in response to the opening inquiry.

This chapter has been an exploration into a context where the interactional norms associated with medicine are actively being enacted and expanded to fit the environmental contingencies associated with the practice of cosmetic medicine. Perhaps at its most basic level what I have discussed in this chapter is the ways in which boundaries between commerce and medicine are enacted during cosmetic interviews. This positioning creates a context where interactions between surgeons and patients are likely to embody the often conflicting and mutually exclusive norms of commerce and medicine. In an earlier chapter of this dissertation, I noted Deborah Sullivan's assertion that cosmetic medicine sits at the intersection between commerce and medicine (1999). Where many patients automatically orient to the consultation in ways that suggest they have oriented to the process as patients, when they do not, they are held to performing to that standard. In this chapter I have looked at how the methods patients use to go about requesting help from their surgeons index dramatically different perceptions about the nature of cosmetic surgery, and how those formulations establish institutional identities. I have also shown how, when necessary, those identities are co-constructed and modified in real time so that the identity expressed through the request is that of a patient rather than a consumer. I have argued that when a patient is initially unable to adequately perform "doing being a patient" surgeons can readily resist by merely withholding medically relevant responses. In doing so

surgeons can hold their patients accountable for behaving as such. In doing so, surgeons create an environment where presenting in the role of patient through the construction of a request for help is quite literally the first task associated with becoming an appropriate surgical candidate. In the process of withholding medically relevant responses from patients who behave like customers rather than patients, surgeons engage in interactional skirmishes to defend the margins of their epistemic domain, and through these little skirmishes patients are tacitly being socialized into the process of how to perform being a patient of cosmetic medicine.

Chapter 4 – Legitimizing the Concern

> The individual comes to doings as someone of particular biographical identity even while he appears in the trappings of a particular social role. The manner in which the role is performed will allow for some "expression" of personal identity …There is a relation between persons and role. But the relationship answers to the interactive system—to the frame—in which the role is performed, and the self of the performer is glimpsed. Self, then, is not an entity half-concealed behind events, but a changeable formula for managing oneself during them. (Goffman, 1974, pp. 573-74)

When a potential patient enters a consultation with a cosmetic surgeon one of the first tasks, they face is also the most fundamental: presenting – or describing -- their concern(s) to their surgeon. In the last chapter, I argued that patients can either present themselves as a 'customer' or as a 'patient'. In this chapter I move a little bit deeper into the identity work that is accomplished when patients present concerns. People have a choice in how they go about describing things, and have multiple building blocks at their disposal that they can use to produce a description: names, formulations, characterizations, excuses, explanations, and justifications for the circumstances they choose to describe, and the words they use to construct those descriptions situate the events into a unique social framework (Heritage 1984; 134-137). Through descriptions people disclose how they are oriented to an event. A description can provide information in terms of how the speaker is related to the event. Are they a participant or a bystander? Descriptions often indicate how the person feels about what they are describing. Do they think is funny or frightening? (Sacks, 1984; Zimmerman, 1992). Descriptions can also indicate a psychological disposition towards what is being described (Heritage & Robinson, 2006a). On some level, we know we are being evaluated on the way we respond to, and describe life events. We tend to consciously construct our descriptions of some object, event or state of affairs, in ways that project a particular identity. When patients describe their concerns, cosmetic

or otherwise, to their doctors they are providing information about their conditions but they are also unavoidably engaged in doing identity work through their descriptions.

Heritage and Robinson (2006a) have shown that in acute primary care visits, through the process of describing physical concerns, patients orient to framing their condition as legitimate and worthy of medical evaluation (i.e. 'doctorable'). Through this process they also attempt to present themselves as reasonable rational human beings, who are reliable evaluators of their own bodies. Those who fail at this task run the risk of being perceived as a worry wart, or a malingerer. The same is true in cosmetic interviews. Patients, through descriptions of their physical concerns, attend to the project of describing their condition in a way that the condition itself will be perceived as legitimate and worthy of medical attention. In doing so, they can frame themselves as a rational person whose desires for self-improvement are reasonable and properly motivated; qualities commonly associated with being perceived as a "good candidate for surgery" (Goldwyn 1981). In the realm of cosmetic surgery, a poorly constructed description can cause the patient to be perceived as improperly motivated, shallow, vain, or a perfection seeker; obviously, less than desirable qualities for a viable cosmetic patient.

I want to make the point that as a conversation analyst, I am not a mind reader. I have no way of knowing what is actually occurring in a person's head. I can make no claims as to what a subject is actually thinking or feeling. What I can analyze is what patient descriptions of their concerns project that they are thinking or feeling. Goffman (1959) argues that individuals project a definition of any situation when they appear before others, and that it is the obligation of each participant to table their own "immediate heartfelt feelings" in favor of conveying an impression of the situation that is acceptable and in alignment with co-present others. So, people are likely to construct descriptions in ways that they feel will project a culturally appropriate attitude or

perspective. For instance, a patient may feel that their face “looks horrible” (Doc1 Pat3), or that the lightly sagging skin along their jawline makes them “look like a shar-pei” (Doc1 Pat2): but, in truth, most of the aesthetic issues patients present to their cosmetic surgeons are relatively minor. They are conditions that in day-to-day life would likely go unnoticed by others because these features fall within the normal range of human variation, or represent normal signs of aging. These small “flaws” may feel like a big deal to patients. However, to perform being a rational person, and therefore a good candidate for surgery, patients tend to describe their concerns to their surgeons, in ways that indicate that they understand, in the bigger scheme of things, that their “flaws” are actually rather nominal and mundane. They avoid dramatic descriptions of their concerns, in favor of a downplayed version that better reflect the physical realities of their bodies.

One of the fundamental issues patients face when presenting a concern, particularly one whose medical legitimacy is tenuous, is how to go about describing it in a way that shows that the symptom or condition is troublesome enough to warrant medical intervention without over-describing it. It is a fine line. If the condition is not presented as significant enough, the person risks appearing as if they are the type of person to waste their doctor’s time to evaluate a non-significant condition. Conversely, should the patient make much ado over something innocuous, the are inclined to be perceived as a hypochondriac, who sees a mountain in a molehill (Heritage & Robinson, 2006a). The same is true for patients of cosmetic surgery. If the patient describes their concern as small and nearly innocuous, it would beg the question, if your issue is so small, why would you spend thousands of dollars and risk going under anesthesia to have it addressed? And, in instances where patients display a significant degree of concern about their appearance that is incongruent with the relative non-severity of the issue, surgeons are likely to perceive the

individual as a “perfection seeker” (Goldwyn 1981). Moreover, the size or severity of an aesthetic issue is readily visible. This inconvenient fact makes it problematic for a patient to puff or exaggerate the magnitude of the condition in order to increase its magnitude in an effort to make a relatively small concern big enough to warrant surgery. So, emphasizing the magnitude of a condition may be a risky way for a patient to legitimize their concern. Either way, miscalculation in describing the magnitude of one’s condition, or indicating an inappropriate level of concern about their condition, can result in a patient projecting an identity that can be judged as less than ideal for surgical candidacy (Goldwyn, 1981).

So, if making a proverbial mountain out of an aesthetic molehill as a method of presenting the concern as legitimately warranting surgical intervention is off the table as a strategy, how can a patient go about legitimizing their desire to seek medical intervention for their cosmetic concern? This is the general question I provide the answer to in this chapter.

Background: Legitimization Strategies in Problem Presentation

By the time we reach adulthood most of us have learned how to talk to doctors and appropriately navigate the pathway to assuming the “sick role” and becoming a patient (Parsons 1951). We are familiar with the overall structure of primary care visits and how to go about presenting troublesome symptoms or concerns to our physicians (Gill, 1994, 1998, Gill & Maynard, 2006, Heritage & Robinson, 2006a). Moreover, we have been socialized to understand the types of symptoms that are considered pronounced enough to seek medical intervention versus those that are merely bothersome. For instance, a run of the mill stubbed toe, although it may be painful, does not normally warrant running to the doctor for medical assistance. Conversely, most of us are aware that a mole, although most likely innocuous, might well warrant going to the doctor to have it checked out to eliminate the outside possibility that it

might be cancer. People who cannot appropriately make the determination between "doctorable" conditions, or conditions worthy of medical evaluation even if they do not ultimately need treatment (Halkowski, 2006, Heritage & Robinson, 2006a), and mundane experiences of bodily discomfort are vulnerable to being perceived as slightly unbalanced, hypochondriacs, or malingerers. However, what constitutes "being sick" is not always straightforward or clear cut. In cases where the severity of patients' symptoms or condition can be perceived as ambiguous, they tend to extend a notable amount of effort to frame their decision to seek treatment as legitimate.

Generally, in acute care visits, when patients talk to their doctors, they present a list of symptoms to be evaluated during the visit, and ultimately the doctor will make a formal diagnosis. Some physical symptoms, such as heart palpitations, vomiting, trouble breathing, or a gunshot wound are universally understood to be markers of some sort of condition that is unquestionably 'doctorable' or worthy of medical evaluation (Halkowski, 2006, Heritage & Robinson, 2006a). In such cases patient presentation packages tend to be devoid of efforts to legitimize their decision to seek treatment:

Ex. 1 Bronchitis

```
1  DOC:  What can we do for you toda:y? What brings ya i:n.
2  PAT:  Uh:=I wanna get rid=a this: stuff in my
3        lu:ng[s
4  DOC:       [O:kay, >.hh< how long have you been sick for.
5        (0.5)
6  PAT:  Four (weeks.)
```

(Heritage & Robinson, 2006, p. 64)

In this excerpt the patient's presentation is short and to the point. He presents lung congestion as an unambiguously doctorable concern. His bald description of the congestion in his lungs indicates that he perceives "stuff in my lungs" to be a symptom that is fully worthy of medical attention. The doctor's first history taking question, "How long have you been sick for?"

explicitly states that she has accepted “stuff in my lungs” has qualified the patient as being “sick.” However, the doctorability of other symptoms and circumstances are often not as readily evident as having “stuff” in your lungs (Jefferson, 2015). Heritage and Robinson (2006a; see also Heritage & Clayman, 2010) have shown that when patients enter a medical consultation with symptoms that are vulnerable to appearing innocuous (e.g., a bug bite, mild cold symptoms, low-grade aches and pains, etc.) they are preoccupied with describing their symptoms in ways that legitimize their decision to seek treatment. In such cases patients tend to describe symptoms in ways that seem to say, “this may not look like a big deal, but it is actually more troublesome that it might initially appear.” When patients bring vague, mild, or seemingly medically innocuous symptoms into their doctor for evaluation, they display “overt preoccupation” (Heritage & Clayman, 2010) with describing their problem in a way that shows their decision to schedule a medical appointment was properly motivated and legitimate. To do so they must ward off the possibility of appearing to be a malingerer, a hypochondriac, or a member of what doctors sometimes call, “the worried well.”

In a study of patient problem presentations made in acute primary care visits, Heritage and Robinson (2006a) identified several discursive practices used by patients in circumstances where the inherent doctorability of their concern is not readily transparent. One method of legitimizing the decision to seek medical assistance is to indicate that some third party (e.g., a friend, a spouse) suggested that the patient seeks medical evaluation. In doing so the patient indicates that at least one other person also felt that their condition was significant enough to warrant medical evaluation. Another method of legitimizing a concerns is for a patient to frame themselves as “troubles resistant.” Troubles resistant is a term coined by Gail Jefferson to describe a person’s ability to preserver in a trying circumstance (Jefferson, 2015). Heritage and

Robinson (2006a) extended this terms into the realm of doctor patient interaction to refer the type of person who does not run to the doctor for every itch or scratch. Troubles resistance can be shown in a couple of notable ways:

1) The patient can explain that the condition has lasted an inordinate amount of time. By living and suffering with a condition long enough that a reasonable person would assume that it would have resolved itself, a patient can mitigate the appearance of being unduly cautious. In doing so they frame their otherwise mundane symptoms as peculiar and thereby worthy of medical attention.

2) Patients can indicate that they have tried unsuccessfully, on at least one occasion, to treat the condition on their own. In doing so they indicate that going to a doctor was not their first line of defense, but despite their best efforts their condition remains unchanged – or worse

By explaining that they have dealt with their condition for longer than one might expect, or that self-treatment has been ineffective, patients can appear stoic while suggesting that their symptoms are likely more problematic than they might originally appear. In doing so they ward off any chance of being perceived as a Nervous Nellie who has little tolerance for discomfort or risk.

A third method discussed by Heritage and Robinson (2006a) is for patients to suggest a possible link between their minor symptom and a more severe condition. As an example, a patient may be concerned that a skin blemish that doesn't seem to heal may be an early indicator of cancer. Although patients seldom overtly make this connection in their initial presentation of their concern, by framing their seemingly innocuous condition as behaving differently than one would expect it to, they have created a context where they can later rationalize their decision to seek treatment based on "worst case" anxieties (Heritage & Robinson, 2006a). So, if a blemish turns out to be nothing more than a mere blemish, the patient can give the impression of being conscientious, rather than a hypochondriac, by claiming "that's what I thought, but I was

concerned it might be cancer." Through these discursive practices, patients can weave together a problem presentation that portrays their seemingly mundane condition as something that is potentially more troublesome than it might otherwise appear.

In the excerpt below, the patient has decided to see the doctor for help with what he originally believed to be a "bug bite." Although it is a bothersome condition, most of us do not run off to the doctor every time we get bitten by a bug. In fact, under normal circumstances an individual who would run to the doctor for a mosquito bite might well be perceived as hysterical or high strung. However, in this instance the patient is concerned because his experience with this particular bug bite deviates from what one would generally expect. If he were to maximize or overstate his symptoms by describing them so that they are larger than the physical facts bear out (e.g., "I have a huuuge bug bite on the back of my neck that is so enormous and itchy that I can hardly stand it..."), he runs the risk of looking like a catastrophizer (Robson et al., 2012): conversely if he merely states he is seeking treatment for a bug bite he also looks a bit off psychologically because most people would either put calamine lotion on a bite and wait for it to pass. In this instance, the patient is called upon to engage in a balancing act, the goal being to describe this concern in a way that does not take unnecessary liberties with the reality of physical symptoms, but to also explain them in ways that maximize the troublesome nature of their condition so it can be differentiated from more mundane experiences of a bug bite:

Ex. 2 [Ringworm: Heritage, 2009]

```
1  Pat:  Oh I got_ (.) what I thought_ (.) in June (.)
2        Uh was an insect bite=in thuh back of my neck
3        Here.
4  Doc:  Okay,
5  Pat:  An' I (0.2) you know became aware of it 'cause
6            It was itching an'=I (.) scratched that,
7        (0.2)
8  Pat:  An' it persisted fer a bit so I tried calamine
9        lotion,=
```

```
10 Doc:  =Okay,
11       (0.2)
12 Pat:  An' that didn't seem to make it go away
13       completely , an' it=stayed with me,=w'l its
14       he still with me. Thuh long and thuh short of it.
15 Doc:  [Okay.      ]
16 Pat:  [Cut to thuh] chase is its- its still with
17       me (0.3)but (its) got a welt associated
18       °with it.°
19 Doc:  Okay,
20       (0.5)
21 Pat:  It got a welt that's (.) no:w increased in
22       size to about that big=it was very (.) small
23       [like a dime] initially you know, an' now
24 Doc:  [Okay,      ]
25 Pat:  it's (0.3) like a (.) bigger than a half dollar
26       (I bet [it's like-)] [(     )-]
27 Doc:         [     So you] [sit it's] no:longer
28       Itchy.  Is [that correct.]
29 Pat:             [Occa:        ]sionally.
```

Most of this patient's presentation is devoted to legitimizing his reasons for seeking medical intervention, not the condition itself. First, he explains that initially he interpreted his condition as most people would, as a banal and commonplace "insect bite" (line 2). In doing so he shows himself to be rational, rather than someone who jumps to the worst case conclusion. Once he has grounded his initial interpretation in the mundane, he proceeds by systematically distinguishing the symptoms he is experiencing with those that one would normally expect to experience with a bug bite:

1. He mentions that he first noticed the problem "in June," or approximately 11 weeks prior to the consultation (lines 1 -2, and 13-14).
2. He goes on to suggest that his self-treatment efforts have not been successful (lines 8-13)
3. And then explains that over time, and despite his best efforts that rather than getting better his condition is worsening by claiming that now it is "bigger" than it was 11 weeks ago and is surrounded by a welt (lines 15-25).

Over the presentation as a whole, he dedicated a notable degree of interactional effort to frame his condition is more unusual than it may initially appear. In doing so he legitimizes his

decision to seek help for a condition that, upon first blush, could be perceived as commonplace. Taken individually or collectively the practices this patient used maximized the medical import of a condition with questionable doctorability.

Like their primary care counterparts, cosmetic patients are also called upon to describe their concerns in the problem presentation phase of the visit, but there are subtle differences between the two contexts that create problems for cosmetic patients. First, in cosmetics medicine, pathology and illness, medicine's *raisons d'êtres,* are absent. Without the specter of disease or pathology, it is a little more difficult for the patient to legitimize their concern as the beginnings of a potentially severe or life-threatening illness. In cosmetic medicine, what is visible to the naked eye is the problem, not a symptom of it. So, if a patient is concerned about the size of her thighs, the problem is the size of her thighs, nothing more, nothing less. Therefore, the option of maximizing the meaning of the condition by framing it as evidence of some more insidious condition is out of the question. The other method a patient could use to maximize their concern would be describing their concern, say the size of their thighs as "huge." However, this move could be risky, unless the patients thigh's were unquestionably huge. Cosmetic patients need to find a way to strike a balance between reporting their concerns in ways that do not over inflate their physical realities, and in ways that frame their conditions as sufficiently bothersome or distressing to warrant seeking medical help.

Throughout this work, I have suggested that because cosmetic surgery is not medically necessary, and instead is driven completely by a patient's desire to alter their appearance in a way they believe to be more aligned with cultural preferences. However, health and illness are medicine's *raisons d'etres*. Accordingly, the institution of medicine and norms of medical interaction are designed to facilitate providing medical care to those who are in need of medical

advice or care. Doctors are service providers but they also perform the role of gatekeepers whose job it is to keep people from taking advantage of secondary gains associated with being sick or engaging in behavior that might be harmful to their health or society as a whole (Parsons, 1951). These facts make it difficult for people seeking cosmetic surgery to perform the role of being a patient. In a medical world that deals in appearance and desires, rather than symptoms and illness, how do you go about performing the role of patient? In the last chapter, I showed that Dr. D withheld medically relevant responses until his patients, through their request for help, oriented to the interaction as patients, rather than as consumers. In this chapter I continue down the path of the identity work done by patients. The acts of “legitimizing the concern” and in doing so “legitimizing the decision to seek medical intervention” discussed by Heritage and Robinson (2006a) are intimately related to identity work. It is also worth noting that, in instances where people are inclined to legitimize their decision-making, they inherently acknowledge that they are in a less than fully entitled position to have their desires for treatment fulfilled (Curl & Drew, 2008).

The strategies used by primary care patients to seek medical intervention for potentially innocuous problems lend themselves nicely to cosmetic consultations. One of the issues that patients face framing their concerns as if they are medically warranted, is that cosmetic surgery is not medically necessary. The legitimization strategies that Heritage and Robinson have identified are contextually, not medically, based. For this reason, these methods of legitimization provide a framework from which cosmetic patients can use to legitimize medical interventions for non-medical concerns. I argue that by incorporating these methods of legitimizing concerns into cosmetic presentations and discussions about aesthetic concerns, patients are engaged, not

just in a presentation of self as a “patient,” but they are showing themselves to be a sound, properly motivated surgical candidate.

Perceptions of Cosmetic Patients

Shallow, vain, superficial, and “bitchy” are stereotypes that permeate the way women who seek cosmetic surgery are commonly conceptualized in everyday life (Macgregor, 1967; Pearl & Weston, 2003) media (Pearl & Weston, 2003) and feminist discourse (Davis, 2002; Haiken, 1997). Feminist scholars such as Bloom (2003) and Jeffries (2002) have gone as far to interpret cosmetic surgery to be an act of pathological self-hatred. In popular parlance, these labels, and accordingly the people to which they are applied, are often associated with maladjustment and psychological disorder (Macgregor, 1967; Pearl & Weston, 2003). It is somewhat ironic that these negative conceptualizations of cosmetic patients are not purely exogenous to the practice of cosmetic surgery. Patient selection, or perhaps more specifically, care in patient selection is considered to be extremely important in cosmetic surgery. Not all patients who have good surgical results are happy with those results, and unhappy patients can make life miserable for their surgeons. Worst case scenario is that an unhappy patient brings a lawsuit against a surgeon. Even if the patient does not win, it still costs the surgeon time and legal fees. Dissatisfied patients also give negative reviews; rather than giving referrals to their friends, they give warnings (Goldwyn, 1981).

Young cosmetic surgeons are immediately taught to be on the lookout for unduly “vain,” “narcissistic,” and “perfection seeking” patients because they tend to be psychologically maladjusted individuals that should be ruled out as viable surgical candidates. The perception is that it is difficult, perhaps impossible, for these personality types to be satisfied with their surgical results, no matter how good the results might be (Goldwyn, 1981; Gorney & Martello,

1999; Rohrich, 1999). Since these unflattering conceptualizations of cosmetic patients seem to be ubiquitous across American culture, it is not surprising that potential patients might be inclined to do image work to distinguish themselves from their "superficial" counterparts. The negative stereotypes associated with cosmetic patients place individuals interested in cosmetic surgery in a dilemma similar to the one faced by primary care patients. However, cosmetic patients, rather than being concerned about being labeled as a hypochondriac or a malingerer, must somehow figure out a way to describe their concerns to their surgeon in a way that they do not come off as being unduly vain, preoccupied with their appearance, or chasing some unobtainable notion of perfection.

"Normal": Departures From the Normative Baseline of the Patient's Own Biographical Experience

Harvey Sacks (1984) argues that "being ordinary" is a "job." He suggests that "being ordinary" is not a natural state, rather it is achieved by doing ordinary things. However, what it takes to perform "being ordinary" varies across time, from culture to culture (Geertz, 1973), and across social categories. The "job" of being ordinary is done by following a set of "rules" or norms associated with a set of social identities and circumstances; in other words, the behavioral norms associate with any given role motivate individuals to act in socially prescribed and approved ways (Coleman, 1990; Durkheim, 1950, Hechter & Opp, 2001; Parsons, 1937; Parsons & Shils, 1951). How does one go about appearing ordinary? Since what it takes to perform "being ordinary" is intimately tied to social roles and contexts, in the broadest sense to be ordinary one should "spend their time in usual ways, have usual thoughts and usual interests" (Sacks, 1984, p. 415). In terms of how a cosmetic patient should perceive their "flaw" or "blemish," ideally they should respond to it as any other normal, ordinary person would.

How can a patient go about presenting a concern about their body so that the problem seems significant enough to warrant surgical intervention but does not convey that they are making much ado about nothing? In comparison to their primary acute care counterparts, cosmetic patients are disadvantaged because where most of us have learned to have a basic understanding about the type of corporeal experiences that warrant seeking medical intervention; the same cannot be said for aesthetic experiences. This leaves a cosmetic patient in a position where it is up to them to determine what type of flaw or blemish would be considered distressing enough to warrant seeking medical attention, not to mention spending thousands of dollars and assuming the physical risks associated with going under the knife: "I don't like what is going on with those dark circles under my eyes, they make me look old and tired. Overall, I think I look pretty good, this makes me miserable. Am I being too picky or is this something that would bug most people?" Interestingly, one of the ways patients go about performing being a reasonable rational patient is by tacitly suggesting that some aspect of their appearance has historically been normal for them, and then contrasting their current appearance with that description of normal.

A prospective patient's ability to be "normal," or at least perceive and describe their bodies in a way that is in line with the way most other people would, is a concept that is important to surgeons in terms of determining candidacy. One of the main qualities that surgeons look for in the process of determining a patient's viability as a good surgical candidate is that the patient's level of concern is appropriate to the size of the "flaw," and the flaw's relationship to the whole of the patient's appearance (Dull & West, 1991). In fact, Goldwyn (1981) describes patients who display "maximal concern about a minimal deformity" as the "worst type of patient" (p. 41). Surgeons' concerns with patients who display levels of distress that are disproportionate to the nature of the problem center on the possibility that, if the individual is

inclined to perceive a molehill as a mountain, they will likely fixate on some minor aspect of their post-surgical results and be just as unhappy as they were before entering surgery.

Since successful practices are built upon patient satisfaction, a patient's capacity, or lack thereof, to appropriately assess the realities of their body and be happy with their surgical results is of utmost importance (Dull & West, 1991; Goldwyn, 1991). Relatedly, if the same patient came in and were to describe their condition in minimal terms that might more closely approximate the reality of their physique, it is also a potential problem. This sentiment is nicely articulated by a surgeon interviewed by Dull and West (1991) who explicitly states that someone who is seeking surgical intervention for too small of a concern is a poor surgical candidate:

> Say some absolutely gorgeous woman has some eeny-teeny wrinkle right here and she has invested her whole life to getting that wrinkle away—well, I know almost one hundred and ninety nine percent that no matter what happens to that little wrinkle, she's going to fix on something else to uh go after. And those are real tough patients to help out. (Unknown surgeon quoted in Dull & West, 1991, p. 61)

If a patient were to produce a minimized description of their condition, even if the description is well in line with the physical reality of the appearance of their face, their description makes them appear to be a "perfection seeker." In these circumstances Goldwyn advises surgeons to ask themselves "why, if this patient's concern is so minimal, are they so distraught that they are willing to go under the knife?" Again, this patient is less likely than others, to be satisfied with their post-surgical results. Goldwyn (1981) suggests that there are two types of patients who invest a disproportionate amount of energy to their concerns, either by talking about a concern in a disproportionate way, or fixating upon a nearly imperceptible flaw.

He warns that these types of patients would be better off being treated by a psychiatrist than a cosmetic surgeon, though of course, what constitutes "a disproportional amount," is a matter of judgement.

It is worth noting that nearly all of the participants in this study presented concerns that were insignificant enough that they would likely go unnoticed by others, unless the patient specifically pointed the "problem" out. In fact, the patients in this study routinely acknowledged the concerns they were presenting were, at least in that moment, relatively small and incidental. But, they do so in the service of engaging in a presentation of self where they appear to be rational, and capable of appropriately evaluating their condition. Once they have portrayed the ability to properly assess the physical realities of their condition, they can then go about the business of explaining why a seemingly small issue warrants seeking medical intervention.

Karen

The first patient I discuss is Karen, a 73-year-old woman who is quite youthful in appearance. She enjoyed a longstanding relationship with Dr. D who, several years earlier, had performed a facelift on her. Over the years, Karen continued to see him several times each year for Botox injections. On this particular visit, Karen was interested in exploring non-surgical options (e.g., fillers, Botox, or lasers) to address fine lines and wrinkles above her lips, and general issues with the tone of the skin located around her mouth, a situation that many people would call the beginnings of "smoker's lines," except in this instance Karen hasn't smoked a cigarette in her life. It is worth noting that the area around the mouth is something she considers to be new to her.

Ex. 3 Karen: *I was priding myself on the fact that I wasn't getting any lines…*

```
21  DOC:    What's buggin' you?
22          (0.2)
23  DOC:    If [you want I can give you a mirror too?
24  PAT:       [Uh:::m:::
25          (0.4)
26  PAT:    You know- you know I'm seventy three now,<right?
27  DOC:    Mmhm,
28  PAT:    [ ((patient brings fingers up and traces across her
29              upper lip along the moustache area))
30          [Fer yea:rs I was (.) priding myself on the fact
31          that I wasn't getting any (.) lines across here.
32  DOC:    Mmhm?
33  PAT:    No:w I see 'em coming.
34  DOC:    They' startin' to come?
35  PAT:    Yeah.
36  DOC:    Okay
```

One of the most notable things about Karen's presentation is that she initially avoids explicitly naming or describing the problem for which she is seeking treatment; a recurrent phenomenon across nearly all of my cases. The surgeon opens the problem presentation by asking Karen, "What's buggin' you?" (line 21) and Karen begins her presentation by mentioning her age: "You know I'm 73 now, right?" (line 26). Initially this might seem to be a rather circuitous way to begin her turn, since her age does not seem to directly responsive to the question, "What's buggin' you?" However, what Karen is doing by declaring her age is establishing a state of normal, a longstanding one at that: 73 years to be exact. After laying the groundwork by establishing a state of normal, Karen then produces the meat and potatoes of her presentation. Rather than verbally articulating "what's bugging her," she places her index finger to her upper lip and begins to trace the area along the top of her upper lip while explaining, "For years I was priding myself on the fact that I wasn't getting any lines across here" (lines 28-31).

As mentioned in chapter 3, using gesture to index a concern is a way to avoid articulating anything that might be vulnerable to being heard as a diagnostic claim. In addition, by using

gesture, Karen avoids describing what she finds objectionable about her face, especially since "smoker's lines" isn't exactly flattering, and even worse in Karen's case it would be a misnomer. She continues into her turn by claiming "for years I was priding myself on the fact that that I wasn't getting *lines* across here." The beauty of her brief presentation is that she suggests that "lines" around the mouth are something that for 73 years she did not have. In addition, by stating that not having the lines is "a source of pride," she underscores her ability to accurately and appropriately interpret what is occurring by tacitly acknowledging that such lines on a person's face are an occurrence one can reasonably expect to have at 73. Once she has established a long-standing state of normal in terms of the state of her face, she could lower the boom in terms of presenting her concern, "Now I see 'em *coming* [emphasis mine]." (line 33). By using a gerund, "coming" to describing her condition, she frames it emergent. By doing so she indicates that currently the problem is small, but the implication of her statement is that the condition is progressive. By intimating that the lines are a nascent and therefor relatively minor, she shows herself to be "normal," reasonable, and rational because her perception of the condition is not out of line with the physical realities of her face. However, because the lines are "coming," it suggests that the lines will likely become bigger and more pronounced with time. Her presentation acknowledges the minimal nature of the condition, but it also suggests that she wishes to preemptively address the issue before it becomes larger and more problematic at some point down the road. At the same time, given that she has lived without "lines" around her mouth for 73 years she establishes a personal norm. She is then able to tacitly claims that her condition is doctorable based upon the fact that these lines are a deviation from what has always been "normal" for her, rather than what might be normal for another woman of her age.

In contrast to Goldwyn's (1991) concern about a patient who displays "maximal concern about minimal deformity," Karen has managed her presentation so that it indicates moderate concern about a minimal deformity based in the idea that the condition is progressive, and a deviation from a long standing, previous state of normal; one that she was happy with. In doing so she avoids appearing to be vain or a perfection seeker because she is not attempting to look "better" than usual, she merely wants to look the way she has always looked.

Billy: Size Matters

Billy, the patient discussed in the last chapter, is a well-coiffed 50-year-old patient who was interested in getting a facelift. By typical standards Billy would be considered quite youthful looking in face, physique, and style of dress. According to his partner, for months before he scheduled his consultation Billy often discussed the condition of his face and his desire for surgery and his assessments of his appearance were seldom subtle: "Ugh, I'm starting to look so old!!!", "My face is falling forward, I look like a Shar-Pei!" (fieldnotes for Doc1 Pat2 De, 02/02/12).[31] Despite his exaggerated descriptions of his appearance outside the treatment room, when Billy entered the consultation he presented his concerns with his appearance in a far more circumspect manner. Instead of producing a description that maximizes the magnitude of the condition of the skin on his face, like Karen he opts to use a version that expresses the problem in minimal way.

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[31] Billy used a similar description of his face his interaction with his surgeon: PAT: I'm turning into a sharpei (line 567). However, he produces this assessment well into the interaction after he has established a rapport with his surgeon.

Ex. 4 Billy: *This thing is getting a little-*

```
171  DOC:     You take a look at (your face) an tell me
172            what (.) bugs ya.
173  PAT:   → Wel[l here's the things these- this thing is=
174                [((reaches up and starts touching/pinching the
175            flesh under his chin))
176         →  =getting a little:- (1.8) No:w (0.2) I'm (0.2)
jest
177            (.) gonna be starting a diet soon?
178  DOC:      Mmhmm,
179  PAT:      A Clean Diet, [are you familiar with the clean
180            diet?
```

In the last chapter I discussed how Billy expressed interest in signs of facial aging along his jawline and under his chin but managed to communicate his desire exclusively through gesture. In cosmetic surgery, size matters, and for the most part, the phenomena associated with facial aging are best measured in millimeters. In Zimmerman's (1992) terms, the issues Billy is experiencing are not easily codable. A description of what that area is doing, for example, "sagging," at least on Billy's face, would be likely to be an overstatement of the problem at hand, yet there are not many other descriptors he could use. The other associated terms are even more severe: a wattle, a turkey gobbler, or a double chin. Not only are these terms unflattering and self-deprecating, as can be seen in the sketches of Billy, they would grossly overestimate the magnitude of the problem is presenting. In the process of using gesture rather than vocabulary to index what is bothering him he is able to circumvent all the potential issues associated with selecting descriptive terms.

Billy, like Karen, through gesture is able to avoid verbally characterizing his concerns. What he does achieve verbally is to frame his concern as emergent and progressive. As Billy is talking, he reaches up, touches, and manipulates the area under his chin he states, "This thing is getting a little–" (line 173 & 176). In his utterance he calls the problematic area a "thing," a loosely descriptive term that frames the problem as something inanimate, or something that lies

outside of himself that has suddenly inflicted itself upon him. He is able to underscore the progressivity of his condition by pinching the loose skin, causing the condition to become more pronounced. Where the specifics of Billy's presentation are achieved by dint of gesture, he uses gerunds in the verbal portion of the presentation to indicate that his condition is something nascent and emergent; as if to say, "What I'm showing you may be small now but it is a process and will continue to get bigger." Overall, Billy's presentation is designed so that it presents a clear, accurate and non-inflated description of the concern he has with the appearance of his face.

Just as with Karen's claim that she sees wrinkles around her mouth "coming," when Billy uses the phrase "getting a little" he can indirectly evoke a sense of an impending trajectory. Not only does this allow him to avoid using a potentially problematic or unflattering descriptive term, but the indirectness of the claim suggests that the fact that the bigger problem is not in the present but at some point down the road.

It would be difficult, if not impossible, to argue that the signs of aging that Karen and Billy find distressing are out of the ordinary in the general population for people of their respective ages. However, Billy and Karen present their concerns in ways that suggest that the issues that are bothering them are deviations from their personal sense of what is "normal" for them. In these presentations Karen and Billy recalibrate "normal signs of aging" to be abnormal because they are deviations from what has been a normal appearance for them. In doing so, they subtly take a routine biological process of aging, and reframe it into something quasi-pathological, and accordingly worthy of treatment. Although a surgeon is considered an expert in signs of facial aging and determining if something "needs" to be done, patients are experts in their own appearance history in a way that is irrefutable, even by a medical expert.

When patients describe their concerns in terms that are vague but progressive, they are able to achieve several related goals. First, they can describe their concern in a way that does not overestimate the physical reality of their condition. This is important because in the process of appropriately assessing the condition of their face they show their surgeon that they are reasonable people. In these descriptions the problem is not attributed to the size and magnitude of the concern, but rather that the current condition is going to become progressively more pronounced. Accordingly, it becomes difficult to perceive either Karen or Billy as perfection seekers who desire surgical intervention for a relatively unnoticeable condition. Rather, through their accounts, they show that they are not attempting to look more beautiful, they are merely interested in maintaining their physical status quo. In terms of a presentation of self, like their primary care counterparts who might be concerned that a blemish, bug bite or a small mole might be cancer, cosmetic patients can present themselves as conscientious persons seeking to address a situation while it is small and manageable, rather than waiting for it to progress.

Performing Normal: Departures from Normative Gender Ideals and their Lifeworld Implications

Patients like Karen and Billy ground the legitimacy of seeking surgical intervention in the fact that the problem they are experiencing is a deviation from the baseline of their own normative experience. Others, however, legitimize their desire for surgery by indicating that their current physical condition prohibits them from living their lives in a way that they can comfortably and appropriately perform in line with social expectations. In circumstances where cosmetic patients explain the condition of their bodies as having lifeworld implications, they frame their condition as socially problematic rather than a matter of mere aesthetic preference. In doing so, they make claims, often gendered ones, that suggest an entitlement to go about their

lives in the same ways others in their social category would. By explaining how their cosmetic concern negatively impacts their ability to live their lives appropriately, they translate an aesthetic condition into an illness experience and in turn present their concern as doctorable and worthy of medical attention.

Shereen

The first case I discuss is that of Shereen, a blonde woman in her late forties. Shereen scheduled a consultation with her surgeon because she was interested in having her legs treated with a C02 laser to remove multiple brown sunspots. Shereen's presentation is similar to Karen's and Billy's in that she too avoids initially naming or explicitly describing the area of her body she finds problematic. She does not describe the spots by name, but instead, like Billy, she describes them as "these things" (line 70), a term that frames the spots as somehow exogenous. Shortly thereafter she glosses her concern as "sun damage on the body" (line 73), which is a description that provides a causal theory about the origins of the problem, but leaves the actual type of damage – wrinkles, spots, broken capillaries, redness, etc. – unnamed. And once again, like Karen and Billy, she dedicated the verbal portion of her problem presentation to legitimizing her desire to seek treatment for a somewhat innocuous concern.

Ex. 5 Shereen *My primary concern is that summer is coming. . .*

```
59  DOC:    So:: (0.2) whaddu you wanna talk about
60          today?
61  PAT:    Well?
62          (0.6)((shifts gaze downwards and focuses on her
            legs))
63  PAT:    My primary concern is summer is coming,
64  DOC:    Mmhm?
65  PAT:    And it's Southern California so any
66          day of the week it can happen that you
67          need to put something on,
68  DOC:    Right.
69  PAT:    that ah shows yer legs and (0.2) I've
```

```
70            developed all th[ese things in the last
71            few years,<it's on my arms as well.
                              [((punctuating the rhythm
              of her speech by pointing at individual spots on her
legs))
72  DOC:      Mmhm.
73  PAT:      So the sun damage on the body is a rilly
74            big deal to me,
75  DOC:      Okay,
76  PAT:      There's no artificial tanning that covers
77            that cove:r:s tha:::t, uhm (0.8)
78  DOC:      Right. Right.
79            (.)
80  DOC:      Anywhere else face neck chest? that sorta
81            area?
```

Dr. D opens the problem presentation phase of the visit by asking her, “Whaddu want to talk about today?” Of course, the goal of this inquiry is to get her to produce a concern to be discussed over the course of the interview. In turn initial position she explicitly frames her response with “My primary concern is . . .” (line 63); however, rather than continuing her utterance producing a description of some characteristic of her body, she begins an extended turn at talk by saying, “. . . summer is coming, and this is Southern California.” Quite obviously, a primary concern is normally a symptom, an injury or an illness, not a season. However, as Shereen speaks she shifts her gaze down to her legs, and Dr. D’s gaze follows. She explains that her “primary concern” (line 63) is that “summer is coming and at any point of time *you* [emphasis mine] can be called upon to put something on that shows your legs, and I’ve developed all these things in the last few years” (lines 65-71). As she states “all these things” she begins to touch several of the individual spots on her legs (see Figure 9).

Figure 9. Shereen's Gesture to the Spots on Her Legs

Image produced from study data.

Shereen's use of the word "you" is interesting because she does not frame the obligation of wearing a dress as something unique to her – '… so any day of the week *I* might need to put something on that shows *my* legs. . ." – instead she uses "you," a generalized pronoun, which functions like "one" and indicates some universal instruction or truth ("You should never curse in church," "Eating vegetables is good for you.") Through this utterance she has suggested that, "putting on something that shows your legs" is a general responsibility of summer living in Southern California. More importantly, she also tacitly suggests that the brown spots on her legs prevent her from fulfilling her socially mandated obligation of showing her legs during the summer. By prefacing her next turn constructional unit with "so" she indicates that what she is about to say is a result, or upshot of what she said earlier: "So the sun damage on my body is a really big deal to me" (line 73-74). Interestingly, Shereen frames her inability to show her legs, not the spots themselves, as her primary concern. In doing so she causally links the sun damage

on her legs to her problematic life experience of not being able to put on a dress, bathing suit or pair of shorts at the drop of a hat (Gill & Maynard, 2006).[32]

Across her presentation, she provides her inability to meet a gender normative social obligation, rather than vanity, as her reason for seeking help. As she moves towards concluding her presentation, explains that she has tried to deal with the sun damage herself using self-tanners (line 76). This is significant because failed attempts at self-treatment are also a strategy patients in primary care use to legitimize their decision to seen treatment for seemingly innocuous claims (Heritage & Robinson, 2006). By doing so, she positions laser surgery as a reasonable, and perhaps the only viable option, to correct the issue that has kept her from performing her socially normative summertime obligations.

Alexia: I Just Don't Wanna Wear So Much Makeup…

Alexia, the next patient I discuss, is the patient from the last chapter who was interested in laser resurfacing. Like Shereen, Alexia also grounded her desire for surgical intervention in lifeworld circumstances; however, she did not do so during the problem presentation phase of the visit where, she merely stated, "I'm looking to do laser resurfacing on my face. . . I've had it done before" (Doc1 Pat3, lines 151-4). Instead, the following excerpt occurs near the end of a dramatically extended problem presentation sequence in which Dr. D, unsuccessfully, tried to get Alexia to specify they type(s) of problem(s) she wished to address with laser resurfacing. Where Karen, Billy and Sheeren all, quite literally, pointed out their concerns in early in the interaction,

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[32] This is the reverse of a phenomenon discussed by Gill and Maynard (2006). They have shown that in primary care visits patients can explicitly mark that they are accounting for their symptoms by using "attributive linkage proposals" such as 'because' or 'so' to connect a symptom to a life world experience, but in these instances it is the circumstance that has caused the symptom; not vice versa (e.g., I think I get depressed because I'm not getting sleep).

Alexia did not. After 379 lines of dialog Alexia seemed unable, or unwilling, to specifically state what type of problem she was experiencing with the skin on her face.

The following fragment represents one of Dr. D's efforts to get Alexia to provide some sort of detail of what issue(s) she might like to address. Although CO2 laser resurfacing can be highly effective for specific issues, there are problems for which it is inappropriate. In order for him to determine if the laser would actually provide Alexia with the outcome she wants, he needs to know what the problem actually is. In an effort to elicit the nature of her complaint he asks her to compare the current condition of her skin with what was happening in 2009. 2009 is significant because earlier in the interaction claimed to have had laser resurfacing in that year.

Ex. 6 Alexia:

```
379  DOC:   What's going on no:w with your skin?
380         versus back in oh nine?
381         (0.6)
382  DOC:   Is it something worse?  Or is it jest the
383         same things that were going on in oh nine.
384  PAT:   Uh::m:: (.) lemme see.  (0.2) Okay, my
385         skin tone is horrible. It takes a lo::t of
386         makeup tah make my skin tone even.
387  DOC:   You mean it's- it's not uniform.
388         (.)
389  DOC:   It's::: blotchy?
390  PAT:   Very blotchy, its ver:y (0.8) .h u:hm:
391         tch I have like ac- if I get a pimple it
392         scars immediately so I jest (.)I jest
393         wanna (.) have- I don't I don't wanna
394         wear makeup all the time,=
395  DOC:   =Ri[ght
396  PAT:      [Like when I go:- when I'm hiking er if I'm
397         doing .hh gonna go work out I don't wanna wear so
398         much makeup on (my face cuz) my skin is so uneven.
399  DOC:   Okay,
400  PAT:   Yihknow that's m:- (.) ultimately that's
401         what my go:al is.
```

Rather than providing Dr.. D with some symptom or description, "I have lots of little brown spots or that treatment got rid of the brown spots, but they're coming back and I've got

some lines," she produces accounts for her desire to seek treatment. Her account is somewhat different than Shereen's. Where Shereen indicated that the spots on her legs prohibited her from fulfilling social obligations, Alexia suggests that her unnamed condition causes her to engage in socially dispreferred behavior: wearing an inappropriate amount of makeup at inappropriate times and places. For simplicity's sake, I've streamlined Alexia's presentation by removing the dysfluencies in her turns at talk and am rendering it as a continuous presentation:

> Okay, my skin tone is horrible. It takes a lo:t of makeup to make my skin even. . . I just wanna have- I don't wanna wear makeup all the time. Like, when I'm hiking er when I'm gonna go work out I just don't wanna wear so much makeup on my face because my skin is so uneven. You know that's m- ultimately that's what my goal is. (lines 384-481, summarized)

She begins by producing her turn in a way that indicates she is responding to Dr. D's inquiry by repeating the word "skin" that was a part of Dr.D's question (Clayman, 2001), asserting that her skin tone is "horrible" (line 385). Because the adjective seems to be incompatible with the physical realities of her skin which appeared flawless, it was important for Alexia to unpack the meaning of "horrible." Across the rest of this fragment she subtly unpacks and fleshes out the meaning of this description, but she does so primarily in terms of lifeworld concerns. She does indicate that she has concerns about the evenness of its appearance: "It takes *a lot of make-up* [emphasis mine] to make my skin tone even" (lines 385-86). She then expands by explaining the lifeworld consequences of living with uneven skin. Generally, wearing "a lot" of makeup is considered to be excessive and undesirable, and tends to be associated with people who have low social standing. So, she tacitly suggests that the unevenness of her skin is bad

enough that she is better off wearing too much makeup than letting people see the problems that sit underneath it.

Alexia indirectly indicates that the condition of her skin is bad enough that it causes her to engage in behavior- wearing a lot of makeup - which under different circumstances most women would not been keen to do. Since wearing "a lot of makeup" is a socially undesirable action, suggesting that her condition is severe enough that she is compelled to engage in socially problematic behavior, she is making a claim about the legitimacy of her concern. She also includes a partial description of the physical nature of her problem; she feels her skin tone is uneven. Dr. D gives supportive acknowledgement tokens (395, 399) that seem to accept her problem characterization, and indicate a willingness to move on. As Alexia continues with her presentation, she expands upon the intensity of the problem of wearing an inappropriate amount of makeup by indicating that she is currently compelled to wear make-up "all the time" (line 394) including when she goes hiking or to the gym (lines 396-7). This is an interesting move because she is suggesting that it is not just the amount of makeup which is problematic, she also feels she has to wear it in places where "a lot of makeup" is not appropriate. The gym, hiking and perhaps going to the beach or swimming, are arguably the most inappropriate places to wear makeup because, when engaged in these activities, one should be focused on the athletic activity in which they're engaged, not upon the way they look. In fact, a woman who wears a full face of makeup to the gym is very likely to receive eye rolls and negative assessments from those around her, because make-up in athletic environments is understood to indicate that their priority is to "look pretty" in a context where their priority should be exercise, or having fun with their friends. In short, their makeup causes them to be perceived as shallow and vain. At the close of Alexia's presentation, she summarizes her position by stating that her "ultimate" goal is for laser

resurfacing. She does not say that having clear, even skin is her goal, instead she takes the position that she does not want to have to continue wearing so much makeup on her face is (lines 397-401), a disclosure in which she prioritizes the social discomfort of violating gender norms, over the physical aspect of her condition.

Since the lion's share of Alexia's presentation emphasizes the lifeworld discomfort associated with living with and managing "uneven skin," she frames the physical aspect of her concern as subordinate to her condition as a problem with living. The condition's severity is implied by the notion that it is pronounced enough to cause her to engage in socially undesirable behavior that, if it weren't for the condition of her skin, she would never engage.[33]

Shereen and Alexia both described their primary concerns as lifeworld issues where because of the condition of their skin they felt as if they were unable to appropriately perform gender roles. In both cases they take skin conditions that sit well within the realm of normal and present them as barriers to adequately performing responsibilities associated with being a normal, everyday woman with everyday responsibilities. Rather than maximizing the severity of the condition, an act that might well make them appear to be the type of person who makes a big deal about a relatively small flaw, these women opted to highlight lifeworld consequences associated with their concerns. By using these strategies both women strongly but subtly legitimize their decision to seek surgery. By displaying a desire to be merely be ordinary, or as Sacks (1984) says, to do ordinary things in customary ways, cosmetic patients circumvent the idea that they are vainly in quest of seeking perfection with an eye on making themselves

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[33] In this sequence Alexia has characterized her skin as "horrible," "blotchy," and implied that she has acne scars. However, late Dr. D indicates that he is having trouble seeing Alexia's concerns. He asks her to remove her makeup, but she refuses. He then says that he is going to need to put on his "X-ray glasses" and asks her to "please help me out, would you say that there is brown discoloration under the makeup?" (lines 876-878).

extraordinary.[34] Through these accounts a patient can claim entitlement to undertake relatively drastic measures (i.e. surgery) in pursuit to being merely normal

Performing Normal: It's Time!

> *There is a certain natural order to things* [emphasis added]. A person who is twenty-five years old does not need a facelift, but they need a breast augmentation. – Well, "need" is relative, obviously, but for purposes of discussion . . . there's a certain order of what you go through psychologically and what you might need. (Anonymous cosmetic surgeon, Dull & West, 1991, p. 56)

Dull and West (1991) suggest that one-way post-operative cosmetic surgery patients account for their surgery is by framing their desire for it as "normal and natural pursuit." This is a different take on the concept of "normal" from that of the patients I have discussed. Karen and Billy's version of normal can be translated as maintaining a status quo; an appearance that has been normal for them. Sheeren and Alexia's version of normal is a desire to participate in activities in gender appropriate way. In this section the concept of "normal" takes a different bend. This set of patients portrays normal signs of aging, sometimes in combination with an age, as somewhat objective indicators that "it's time" to start considering cosmetic surgery to attend to what is happening to their bodies.

> At about 45 your eyelids start to come down. And that's when you start to notice you're losing elasticity and you get the fold in your upper eyelid . . . *by the time*

you get to be my age, it was certainly time to do it [emphasis mine] (Dull & West, 1991, page 57).

The patient in this interview by Dull and West describes the condition of the skin of her eyelids as something predictable in woman of a "certain age." Note, this patient also uses "you/your" as a generalized pronoun; so, in effect, what she is saying is that at about 45 years old everybody should expect that their skin will start to lose elasticity and that they will get a fold in their upper eyelid, and that "you," no matter who you are, when you get to be her age will almost certainly want surgery to address that fold in your eyelid. In her statement, she frames surgery as a normal predictable response that anybody would be likely to consider to address aging eyelids. An additional feature of this statement is she implies that she, like the patients from Heritage and Robinson's (2006) study I discussed earlier, is "troubles resistant." This patient indicates that she has stoically lived with this condition for an unspecified yet significant amount of time; the span of time between 45 and her undisclosed age. Not only is this a different use of the concept of normal, it also sits in contrast with the other cases I have discussed, where the patients treat their conditions as emergent rather than matured. Although Dull and West's data came from interviews of post-operative patients, the same method of normalizing the decision to seek surgery is used by some pre-operative patients who are seeking cosmetic interventions.

Margo: I Feel Like I'm Getting At That Age Now…I'm Turning 32 Next Month

Margo is a 31-year-old patient who is interested in laser resurfacing, and possibly Botox to address fine lines and wrinkles, particularly those around her eyes. Thirty is an interesting age. It has notably different meanings for people depending on which side of the age they are on. In

1964 Jack Weinberg (Daily Planet) is known for having said, “Don’t trust anyone over 30.”[35] For most people younger than 30, the age seems to mark an almost terrifying transition point from youth to adulthood or even middle age. However, for those where 30 has come and gone, the age seems fresh and youthful.

Ex. 7a Margo: ***I feel like I’m getting at that age . .***

```
18  DOC:   So what's goin' o:n?
19  PAT:   Wu:[l
20  DOC:      [It's funny I- I noticed a couple of things
21         bags under the eyes and then (0.2) yihknow (.) “a 
bunch
22         of lines” ((reading from her intake form))
23         [(               )
24  PAT:   [Hehehehe ((tossing hands up and cupping them over 
her
25         nose and lowerface))
26       → >Yeh: a bunch of l(h)i:(h)nes he he< I feel
27       → like I'm getting at that age now, ahm
28  DOC:   Okay,
29  PAT:→  um turning thirty two next month
30  DOC:   Ye:ah it's all over.
```

Dr. D begins the consultation by asking Margo “What’s goin’ on” but just as she begins to answer, he looks down at her intake form, reads for a moment, overlaps her and says, “It’s funny, I noticed a couple of things, bags under the eyes, yihknow, a bunch of lines” (lines 20 - 22) The word “funny” frames what he is seeing as either unusual, puzzling, or comical. From the perspective of anyone looking at Margo, “bags under the eyes and a bunch of lines” would likely be considered to quite an overstatement in terms of the magnitude of her concern. The first place she goes to construct an account for her desire to have her “bags and wrinkles” medically addressed is to provide her age as if it is a well-known fact that once you reach your 30s your

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[35] Don't trust anyone over 30, unless it's Jack Weinberg". *Berkeley Daily Planet*. 2000-04-06. p. 1. Retrieved 2015-04-06.

face falls apart: “I feel like I'm getting at that age now, ahm um turning thirty-two next month.” However, Margo’s account for her desire for treatment is also good naturedly problematized by Dr. D who responds by saying “Yeah it’s all over now.” It’s not unusual that Dr. Dashanti would give her a bit of a good-natured ribbing about her claim, given the discrepancy between the magnitude of the problem in her presentation with the appearance of her face. Although his comment is produced with a playful tone, it is also hearable as problematizing her concern.

Margo can respond to Dr. D’s jocular response to her problem presentation in one of two ways. She can back away from her concern and align with the notion 32 is not that old and that her “bags and lines” are not really very bad after all. However, in this case she risks looking irrational, and could potentially forfeit the opportunity to have her concerns addressed. A second option would be to defend her concerns with her appearance as valid and legitimate. She does the latter. Originally Margo had suggested that moving into one’s thirties and finding the associated fine lines and wrinkles means it is objectively time to start considering cosmetic medicine as a method to keep the wolves from the door. When Dr. D did not appear to align with her stance, she began the process of distinguishing what she is experiencing from the routine signs of aging others her age might experience.

Ex. 7b Margo: *I feel like I’m getting at that age . . .*

```
29  PAT:   um turning thirty two next month
30  DOC:   Ye:ah it's all over.
31  PAT:→ I know but yih know what,=it is fer me?
```

After Dr. D teases her about the idea that 32 is “that age” where one should start thinking about wrinkles, she subtly shifts the emphasis from a general sense of age being an objective indicator, to age being an objective indicator for her**.** She responds to Dr. D’s response that rejects the notion that 32 years old marks some sort of entry into the world of lines and wrinkles,

by acknowledging the validity of his rejection. In turn initial position she produces “I know,” which acknowledges that, chronologically, the age of 32 is not problematic for most people. She then moves forward by setting the groundwork to differentiate herself, and her condition from that of other 32 year olds: “but you know what? It is for *me* [emphasis added]” (line 31). In doing so, she starts to differentiate the difference in the significance of age of 32, for her, versus for other people. Through this effort she provides a foundation on which she can build her claim that it is indeed time to start being concerned.

Ex. 7C Margo: *I feel like I’m getting at that age . . .*

```
29  PAT:    um turning thirty two next month
30  DOC:    Ye:ah it's all over.
31  PAT:→  I know but yih know what,=it is fer me? Ah I'm
32          fer one (          ) my face I'm having like some
33     →    major skin issues lately, cuz I have rosacea so
34          I've been dealing with like derm- my dermatologist
35          en .h so I'm kinda expanding other options on how
36          to deal with my skin uhm so (        ) been up
37          close looking at m(h)yself a l[ot more lately
38  DOC:                                  [ Right       Right
39  PAT: →  Uhm an: fer one my mom when she turned thirty
40          thirty three all of a sudden (.) like out of
41          nowhere she got these hu:ge puffy bags under her
42          eyes?
43  DOC:    Mmhm?
44  PAT:    She was stressed around the same time I am now
45          and I’ve been noticing like like I wake up in the
46          morning, and I have these bags that don’t go away?
47  DOC:    Right?
48  PAT:    that’s kinda concerning to me?
```

After acknowledging Dr. D’s comment that problematized the age of 32 being a concern, Margo goes on to explain why, in her case, this age might be significant for her. Through explicitly telling him that “it is for me” she has set the groundwork to explain why the age of 32 is significant, but she switches gears for a moment, to use the opinion of another medical authority to help support her claim. She tells Dr. D that she has been working with a

dermatologist to deal with "rosacea and major skin issues" (lines 33-37). This disclosure couches "issues with" her skin as medically legitimate, because they have been diagnosed by another medical authority, another strategy used by patients in primary care to legitimize tenuous concerns (Heritage & Robinson, 2006).

Margo also able to use "rosacea and skin issues" as an account: "So [I've been] up close and looking at myself a lot more lately" (lines 36-37). Generally, scrutinizing one's own face is an action that, if she were not experiencing a legitimate medical concern with her skin, could be interpreted as being vain or narcissistic. Margo seems to indicate that self-scrutiny tends to be perceived as problematic because she drops a laugh particle in the word "myself," a feature of talk associated with strategically marking something as slightly inappropriate or untoward (Haakana, 2001; Jefferson, 1985). This move is also potentially hearable as serving an additional function: minimizing the magnitude of the concerns she has presented. By indicating that she has been "up close looking at herself," she is able to recalibrate the degree to which her concerns are noticeable. Initially, "bags and a bunch of lines" give the impression that the concerns they index are rather pronounced, but through this reframing they are now something that was noticeable to her because she claims that she was scrutinizing her face in an effort to understand and deal with a medically legitimate concern. This is interesting because she has started to transition away from the "it's time" method of legitimizing her concern and instead working towards the "it may be small now, but it's a deviation from what is normal for me, and I anticipate that the condition is progressive" method used by other patients I have discussed in this chapter. However, she does not fully abandon the idea of being in her early 30s as an expected and appropriate time to seek surgery.

She continues in her turn by providing an account for why the age of 32 is more relevant for her as a harbinger of problems to come than it would be for another 32 year old:

Ex. 7d Margo: ***I feel like I'm getting at that age . . .***

```
36          . . . so (        ) been up
37          close looking at m(h)yself a l[ot more lately
38    DOC:                                [ Right      Right
39    PAT:→ Uhm an: fer one my mom when she turned thirty
40          thirty three all of a sudden (.) like out of
41          nowhere she got these hu:ge puffy bags under her
42          eyes?
43    DOC:  Mmhm?
44    PAT:  She was stressed around the same time I am now
45          and I've been noticing like like I wake up in the
46          morning, and I have these bags that don't go away?
47    DOC:  Right?
48    PAT:  that's kinda concerning to me?
```

In this fragment, Margo expands her problem presentation by drawing a parallel between her current experience and that of her mother when she was the same age (lines 39-46). Through this declaration, Margo suggests that the "bags" below her eyes should not be evaluated in the same fashion one would use to assess someone else in their early 30s. Instead, her presentation suggests that her circumstance is unique and associated with unusual genetic predispositions. By explaining that her mother experienced the same phenomenon at approximately the same age (33 years old), under a similar set of circumstances (under a lot of stress), and with a sudden and unanticipated onset ("all of a sudden like out of nowhere she got these huge puffy bags under her eyes"), she invokes the notion of genetic predisposition as a legitimizing factor both for her concern about the puffiness she is experiencing as doctorable and her decision to seek treatment for something that otherwise might appear to be mundane and innocuous. Through this revelation, Margo's revelation serves to distinguish her situation from what other 32 year olds might expect to experience. Where most people can anticipate to age at some baseline rate of a

normal progression and speed, Margo suggests that because of her genetics, her own aging process is likely to be accelerated and happen "all of a sudden." So, across her turn, Margo's presentation legitimizes her decision to seek treatment, and in doing so, she reframes herself as a person with good reason to be concerned about whatever signs of aging might be associated with being 32 years old; even if at the moment those signs are not particularly pronounced.

Across this inferentially dense portion of her turn, she has accomplished multiple tasks. She has suggested that, in contrast to what Dr. D might think, the condition of her skin is worthy of medical treatment, as evidenced by the diagnosis of rosacea that she received from her dermatologist. She has also framed her condition as small but visible when she looked closely at herself in the mirror, but suggests that her scrutiny was prompted by her rosacea, not vanity. And, in conjunction with the notion that her condition is beginning to surface at 32, an age she indirectly suggests is the time people start to notice signs of aging, the implication is that it will continue to get worse. She then provides her mother's experience at roughly the same age to legitimize her perception of her condition and her decision to seek help in addressing it now, rather than waiting until later. In each step of this presentation, she moves away from the notion that 32 years old is a natural time to start paying attention to and seeking medical attention for visible signs of aging, into a presentation where she frames her experience as outside of the normative experience of aging. In the end, Margo was able to convince Dr. D that her concerns were legitimate because at the close of the visit he gave her Botox injections to address the fine lines around her eyes. He also discussed the possibility of doing a lower eyelid surgery, but he presented it more as a possibility for down the road and Margo agreed with his assessment.

Where, at least initially, Margo used her age to suggest one's early 30s could be objectively understood as a legitimate time to start considering cosmetic medicine, patients who

used their age to suggest that "it's time!" for cosmetic surgery tend to be notably older. Dull and West (1991) interviewed post-operative patients and many of them tended to link physical changes in their face to a certain age:

> "In your late fifties and sixties, you start to get a lot of "crepeyness in your neck. Just all of a sudden it's there . . ."
>
> "At about 45 [your eyelids] start to come down . . ."

By referencing their age as part of their problem presentations, patients treat chronological age as well as the physical concerns associated with the age as "objective indicators" of the need for surgery (Dull & West, 1991). By creating a timeline that reflects a natural order in the processes of aging, an environment is created where patients like Margo may be considered too young to be a viable surgical candidate; after all, "a twenty-five-year-old does not need a facelift." However, once a person has reached a certain age there is virtually no cutoff point provided the patient's general health will allow for surgery. As an anonymous cosmetic surgeon said, "You're never too old for it...I've done a facelift on a ninety-three-year-old." (Dull & West 1991, p. 58). Although our culture has a unique understanding of age and how the physical processes of aging are indicators of an objective "need" for surgery, patients do not tend to produce age alone as a legitimizing factor. Instead, they tend to produce it in combination with a positive self-evaluation.

Although one's age may well be a sign that a potential patient is within an appropriate age range to be a viable candidate for surgery, one's age is not a doctorable concern, nor does age explain why a patient is seeking surgical intervention now as opposed to 5, 10, 15, or 20 years ago. Disclosure of age, rather than being framed as the problem itself, is a mechanism that can be used to indicate troubles resistance. By explaining that they are 58, or 73, they indicate

that they did not run off to their doctor at the first signs of aging, rather they have waited, watched and lived with the signs of aging for a significant amount of time and have managed to live just fine with the normal expected signs of aging.

Marsha: *I think I look good for my age I mean I'm 58*

```
64 PAT:     So that needs to be (0.4) tightened and
65          fixed.[ Nothing
66 DOC:           [Right.
67 PAT:     Nothing makes someone look older than
68          their (0.5) nec[k,
69 DOC:                    [(       ) neck
70 PAT:     Ah [ha ha ha ha ha
71 DOC:        [Right         right. En especially
72          when there's a disconnect between their
73          face and their neck [too.
74 PAT:                         [Right.  Because I
75       →  I look pretty good for my age[ yihknow,
76 DOC:                                  [Right.
77 PAT: →    I mean I'm fifty eight.
78 DOC:     That's great,
79 PAT:     Yihknow,
80 DOC:     That's great.
81 PAT:     Nobody thinks that (yihknow) thank God.
```

***Karen*:** *You know I'm 73 now, right?*

```
15  PAT:      °What's going on,° (2.6)((removing her glasses))
16  PAT:   I th::ought I'd ask you about some refinishing= ((turning
17           face towards surgeon and leaning towards him to allow him
18           to clearly see her face))
.
.
.
23           (0.2)
24  DOC:     If [you want I can give you a mirror too?
25  PAT:        [Uh:::m:::
26           (0.4)
27  PAT: →  You know- you know I'm seventy three now,<right?
28  DOC:     Mmhm,
29  PAT:     [ ((patient brings fingers up and traces across her
30            upper lip along the moustache area))
31           [Fer ye:a:rs I was (.) priding myself on the fact
```

```
32              that I wasn't getting any (.) lines across here.
33   DOC:       Mmhm?
34   PAT:       No:w I see 'em coming.
```

When the patient associates their chronological age with a positive self-assessment "I think I look pretty good for my age" (lines 75-77), or like Karen who was 73 and priding herself on the fact that she didn't have any lines around her mouth, "older" patients are making a claim that the condition that they are currently seeking to address is different from all the other signs of aging they have encountered in the past, the implication being that they have been troubles resistant because they have experienced any number of small changes in appearance and have done so stoically and are even able to assess themselves positively (e.g., "I think I look pretty good for my age") regardless of the changes that come with age. However, there is something about the current condition that is pronounced enough that it has the potential to discredit and call into question their otherwise youthful appearance. In other words, there is an incongruity between their youthful overall appearance and their chronological age, where the area that is of concern to the patient belies their true age. They have waited long past times that others might have run in to their surgeon's office to get help and rose above it all and aged gracefully, but now this condition, whatever it might be, has just proved to be too much.

By invoking the image of what a woman of a certain age are "supposed" to look like, patients can make claims about the significance of their concern by tacitly suggesting that they have been living with plenty of little changes that occur with age without running to the doctor but they have finally reached a tipping point where the changes in their face have the potential to discredit the youthful look they have always enjoyed. Just as with the other patients and strategies that I have discussed, patients' use of chronological age is used to indicate that their condition is more radical deviation from some previous state of normal than they are comfortable with. By using this strategy, they obviate the possibility of being perceived as vain for seeking

surgery to address a physical change in the body that is generally perceived as a normal, natural part of aging.

Self-Treatment and Troubles Resistance

When a patient details self-treatment efforts in their problem presentation package, they frame their concern as more problematic than it appears on the surface. Patients use self-treatment attempts to show that they initially evaluated their concern as something innocuous that they could treat at home. Failed self-treatments are a mechanism patients can use to distinguish their current condition from their more mundane counterparts. When primary care patients describe their conditions as persistent over a significant degree of time and resistant to self-treatment, their claim for the condition's entitlement to medical evaluation is linked to its seeming inability to heal on its own (Heritage & Robinson, 2006a). In cosmetic surgery, a reasonable person would not anticipate their condition to get better with time or heal on its own. However, there are any number of resources available, particularly to women, that are designed to help combat or conceal signs of aging. So the “failed self-treatment” method for legitimizing one’s decision to seek medical intervention used in primary care imports quite nicely into cosmetic consultations. Marsha’s presentation of her second concern, “a little indentation and creases,” provides a nice illustration of this.

Ex 9b **Marsha** *'. . .it's the weirdest thing. . .'*

```
82  DOC:     And you were mentioning some other things
83           like ah::m like indentations in yer cheek
84           [(               )
85  PAT:     [tch Yea:h yiknow when I'm slee:ping now
86           it's the weirdest thing I can wake up
87           in the morning and they'll be like (0.2)
88         → I don't know if you could s- cuz I cover
89         → it up (.) pretty good with ah::m (0.3)
90  DOC:   → With makeup?
91  PAT:   → Makeup.
92  PAT:     .hh but (.) there's like a liddle dark
93           spo:t: yihknow
94  DOC:     Do you see it right now?<Cuz I s:ee:
95  PAT:     Here cuz it's a liddle wierded out the:re
96           I dunno en- or it [might
97  DOC:                       [Right there? Okay.
98  PAT:     Yeah right here. .h En then at night see-
99           I never have this- (.) I get these liddle
100          u:h:m (0.7) tch (.) ah (.) creases.
101          (.)
102 PAT:     Never had that.
103          (.)
104 PAT:     Ev[er.
105 DOC:       [At night (.) you mean (0.2)
106 PAT:     When I wake up[ in the morning I have
107 DOC:                   [ (             ) it's gone,
108          it's
109 PAT:     No I have like this liddle crease en then
110        → I fill it wi:th th- uhm (0.2) tch ah::
111        → that ah collagen filler,
112 DOC:     Oh okay.  (              )
113 PAT:   → Pain in the a:ss?
114 DOC:     hehehehehe
115 PAT:     Huh?
116 DOC:     Yer taking a page outta my book?
117 PAT:     I am?
118 DOC:     A liddle filler here and there?
```

While presenting the indentation on her face, Marsha describes it as something small enough that it may not be immediately evident to the naked eye: "I don't know if you could s- [see it]" [lines 88-9]. She describes her problem in minimal terms, which reflects the physical

reality of her indentation. Her condition's diminutive size is potentially problematic because, it begs the question, "If it's so small that it can't even be seen, why are you seeking treatment for it?" This ties back to the vanity issue. One does not want to be perceived as the type of person who is so vain that they would seek medical intervention for a nearly invisible concern. However, immediately after disclosing the near invisibility of the condition, she then provides a possible account for the reason her concern might not be visible to the doctor, the fact that she covers the indentation with makeup: ". . . cuz I cover it pretty good with makeup" (lines 88-91). Not only does makeup account for the reason her concern might not be readily visible to Dr. D, it is also indicates that she has been trying to manage the condition on her own. Later in her turn, she mentions a second, possibly related concern: "I've never had this- . . . I get these little creases" (lines 98-100). By explaining that "these little creases" are something she has not had before, she invokes the shift away from the status quo method of legitimization I discussed earlier. She then further elevates the legitimacy of her desire to have her "creases" medically addressed by explaining that managing her condition is a "pain in the ass" (line 113). Although she does not unpack the meaning of "a pain in ass," the process is presented as a lifeworld version of a symptom, in terms of the hardships associated with living with the indentation and creases.

Across her turn Marsha has used multiple strategies to show herself and her seemingly small concerns as being legitimate and worthy of medical intervention. First, she has shown that she can reliably assess the condition of her skin by describing the concern as "little" (lines 92, 95 & 99). She then shows that she has been troubles resistant both in terms that she is 58 and has not sought surgery before, but also by letting her doctor know that she has been trying, unsuccessfully, to manage her condition using makeup and filler for some undisclosed amount of

time. Her final claims for her condition's doctorability is achieved by explaining that the effort required to manage her conditions are burdensome and only marginally successful. As previously noted, two of the qualities surgeons look for in a "good surgical candidate" is that the patient is able to appropriately assess their own appearance, and that their level of concern about their condition is roughly proportional to the size of the blemish itself (Goldwyn, 1991), and in her presentation about the indentation and creases Marsha has been able to do both. [36]

For another example of self-treatment as an attempt to legitimize seeking treatment for a relatively minor concern I return to Alexia. Alexia and her surgeon engage in a sequence that is quite like the one between Marsha and her surgeon; however, Alexia's occurs much later in the medical interview during the history taking sequence, but also at a point where Alexia is describing a small physical concern that might well go unnoticed. Describing a flaw as so little that it may well go unnoticed by others is a disclosure that may well reflect the physical realities of the concern, but is also a point in the interaction where patients are vulnerable to being perceived as vain or hyper-critical because they are distressed enough to seek surgery by a flaw that is only marginally visible. Like Marsha, in this instance Alexia uses her age as a method of legitimizing her concern; like Margo, she is in her early thirties, but she also talks about her use of makeup and over the counter serums in an attempt to address her concerns.

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[36] It is worth mentioning that in the last chapter I discussed how Marsha, in her presentation of her desire to have her neck "tightened and fixed" was unable to formulate her request for help in a way that afforded Dr. D the opportunity to evaluate her condition and make treatment recommendations, and was therefore sequentially deleted, and the condition was left unexplored. However, since Marsha was able to present these concerns in a more medically appropriate way, it opened the door for Dr. D to begin to perform a history taking and begin an overall evaluation of her face. As a result, he was also able to work his way in to evaluating her neck and lower face without compromising his medical responsibilities by acknowledging that her neck indeed needs to be "tightened and fixed" (see previous chapter for analysis of her earlier presentation).

Ex. 11 Alexia: *I treat my face with serum*

1166 PAT: Like (.) all of thi- I I touch
1167 my skin it doesn't fee::l (0.7) that bad,
1168 under? But I feel it I feel like liddle
1169 bumps. And I see it it's like it's like
1170 I'm not a **thirty year old shouldn't have**
1171 all these (.) spo:ts en [stuff en yihknow
1172 DOC: [Right
1173 PAT: I jes- you see that? ((Leaning forward and tilting her head))
1174 DOC: Mmhm?
1175 PAT:→ **you see how dark- I mean that's with**
1176 → makeup on. Can you imagine without
1177 → makeup on, it looks re:ally bad.
1178 DOC: But it's not a depression right? It's a
1179 (.) color darkness:.
1180 (.)
1181 DOC: Cuz I don't see it (0.3) sinking in. I
1182 don't see it
1183 PAT: No:: it's jest dark
1184 DOC: Right.
1185 PAT: Yihknow.
1186 (2.0)
1187 PAT: → **That- and that's cuz I I treat my face**
1188 → with serum. Because the serum in the
1189 →daytime and serum at night has helped a
1190 **lot.**
1191 DOC: So if you hadn't been using that it
1192 could have been- who would know what
1193 it would look like right now?
1194 PAT: (Oh) it'd look horrible.

Alexia opens this sequence by explain that she has "little" (line 1168) bumps and spots on her face and suggests that these skin dysfluencies are outside the norm for a 30 year old. (lines 1169-71). She suggests that bumps and spots may well be normal for people in a different age range, but for her they are out of the ordinary and therefore not as mundane a condition as one might think. The problem with Alexia's description of her concern is, like Marsha, the problems she is presenting is small enough that she appears to be concerned that Dr. D may not even see the spots and bumps, so she follows up her description by gesturing to the area of her face in question and asking the surgeon, "You see that?" (line 1173). As discussed with Marsha,

running to the doctor to get medical intervention for a condition that is nearly invisible has potential costs in terms of presentation of self. In order to keep from being perceived as a perfection seeker, she needs to somehow find a way to balance the notion that her condition is nearly invisible with other information that makes it pronounced enough to warrant medical intervention.

When Dr. D provides a token "mmhm," an utterance that indicates that he does indeed see the blemishes she is concerned about, she begins to upgrade the magnitude of her concern; "you see how dark- I mean that's with makeup on. Can you imagine without makeup on, it looks really bad [emphasis added]" (lines 1175-77). Through this utterance she was able to almost magically shift a concern that was "little" and nearly unnoticeable into something that is "really bad" by suggesting that the amount of makeup she's wearing mitigates the appearance of the blemish. It is probably worth mentioning that the reason Alexia provided for seeking treatment for her concern, was that she was uncomfortable having to wear too much makeup "all the time." As the surgeon inspects her face, he acknowledges that he sees something, but it is not a wholehearted endorsement. He provides a candidate understanding for confirmation, "it's not a depression, right? It's a color darkness. . . I don't see it sinking in" (lines 1181-1182). Alexia responds by claiming that the reason he cannot see her blemish is because she has been treating it with both a day and a night serum. The implication of this disclosure is that the serum has been instrumental in keeping the problem from becoming more pronounced but has not corrected the issue. She tells him that has been diligent about applying serums, morning and night, to treat her spots and discoloration. By doing so, she suggests that the failure of the serum to resolve this issue is not related to her efforts. This is a sentiment that Dr. D's next comment acknowledges, "So if you hadn't been using that it could've been- who knows what it would look like now"

(lines 191-193), a musing that affords Alexia a chance to make a rather grandiose statement about a currently innocuous concern, “Oh, it would be horrible” (lines 194).

So, like Marsha, in a context where a patient’s concern is small enough to be nearly invisible to the naked eye, Alexia incorporates troubles resistance into her presentation. By doing so, these women change the emphasis of their presentations to focus on their efforts to address their concerns on her own. They also frame their efforts to do some as troubling, not in a physical sense, but in the realm of the lifeworld. The medical legitimacy of their concerns are not found in their size or severity of their conditions, rather in the fact that these patients have exploited the over-the-counter treatment options available to them, which make medical intervention a reasonable, rational next step.

There’s an old humorous but wise saying that goes, “Don’t sweat the small stuff. . . It’s all small stuff.” There is arguably no place in the medical world where nearly every condition discussed could fall into the category of “small stuff” more than cosmetic surgery. In the world of aesthetics, there is often only a millimeter or two difference between perfection and a concern. In cases associated with visible signs of aging, not only are these changes minute, but they are also normal, commonly experienced signs of aging. In the beginning of this chapter, I argued that one of the dilemmas patients face is how to present their concerns to be significant enough to warrant seeking surgery. Furthermore, they need to do so in ways in which they do not present themselves as someone who is inordinately preoccupied with their own appearance, and making a mountain out of a molehill. Outside of the presence of a cosmetic surgeon, someone in everyday conversation can gloss over this problem by simply stating that they want or need a particular treatment; but for reasons discussed in chapter 3, that method is not available in a cosmetic consultation.

Given the diminutive size and appearance of most patients' concerns, particularly since there are no health risks associated with these concerns, patients who seek cosmetic surgery are burdened with determining how to discuss their condition with their surgeon. They must do so in ways that present the condition as significant enough to warrant going under the knife or the needle while not overstating the physical reality of the condition itself, and to do so in a way that is not vulnerable to being perceived as being narcissistic, hyper self-critical, or vain. In the last chapter I showed how patients, through the design of their request for their surgeon's help, establish themselves as alternatively a patient seeking medical advice or a consumer of cosmetic surgery. In this chapter I showed how, in the moment, through interaction, patients use strategies from primary care medicine to legitimize their reasons for seeking medical intervention for their concern. They achieve legitimization by applying interactive strategies from the medical world, and in doing so, transform an aesthetic desire into a medical concern.

Peter Conrad (1992) defines medicalization as "a process by which non-medical problems become defined and treated as medical problems, usually in terms of medical disorders" (p. 209). Although much has been written about the encroachment of medicine into nonmedical areas of life (Szasz, 2007), from baldness (Conrad, 2007) to the transformation of childbirth, a process that was historically handled in the home rather than the hospital (Ehrenreich & English, 1978; Riessman, 1983; Wertz & Wertz, 1977), little if any work has been done on how doctors and patients, in real time, take lifeworld issues, such as preferences for one's appearance, and transform them into conditions that are worthy not only of treatment, but surgical intervention; a treatment where a patient assumes the risks, up to and including death, that are associated with being put under anesthesia. My work takes this line of inquiry a little bit deeper into the world of micro analysis of face-to-face interaction and details some of the ways

that people, through interaction, actively take a non-medical problem and then define it and treat it as medical. So, when patients like Sheeren describe their concern as, “My primary concern is that summer is coming…so any day of the week it can happen that you need to put something on that shows your legs” (lines 64-69), they treat their problem with living as a symptom associated with their physical condition, and in doing so they engage in the process of medicalization…one concern at a time.

Chapter 5 – Describing the Problem: The Devil is in the Details

> There's two groups of people. Ones that will come in and say, "Make me beautiful" – those are poor candidates. And somebody [who comes in] and says, "I don't like my nose." And if you say, "What don't you like?" And he says, "Well I don't like the lump and it's too long" – if they can describe what bothers them, and you know it can be surgically corrected, then those are excellent candidates for surgery.
>
> —Unidentified cosmetic surgeon (Dull & West, 1991, p. 62-63)

Over the last two chapters I have discussed ways in which people who are interested in having cosmetic surgery present and discuss their concerns with their surgeon in order to be seen as viable surgical candidates. They do so by formulating their problem presentation in ways that draw upon problem presentation packages commonly used in primary care visits: first, by formulating their presentation as a request for medical evaluation rather than treatment; and second, by featuring their concern as something that is significant enough to be worthy of medical treatment. In both of these endeavors, they perform the interactional labor of transforming dissatisfaction with some aspect of appearance into a doctorable concern.

The surgeon quoted above suggests that one of the most important qualities surgeons look for in the process of determining surgical candidacy is a patient's ability to describe their concerns with their appearance in detail. Cosmetic surgeons are taught that patients, like the hypothetical one discussed in the quote above, who conceptualize and discuss concerns with their body using broad brush strokes should be avoided because they lack the appropriate psychological attributes required for surgical candidacy (Goldwyn, 1981). This sentiment is echoed in study after study, including one done by Dull and West (1991) in which they interviewed surgeons and determined that from a cosmetic surgeon's perspective a good surgical candidate will have "well-honed abilities to reduce their bodies into parts" (p. 63). Surgeons, whether it be the anonymous surgeon quoted, or Robert Goldwyn, the cosmetic surgeon who is

arguably best known for teaching other cosmetic surgeons what to look for in selecting patients who are "good surgical candidates," discuss a patient's ability to describe what bothers them in detail as if it is an ascribed rather than achieved skill. I found this to be anything but the case.

In this chapter, I show how, through the interaction that takes place during the consultation, surgeons are able to socialize potential patients to see and discuss their concerns in medically appropriate ways. In the last chapter, I showed that the patients in this study universally struggle to find the appropriate words to describe their dissatisfaction with their bodies. I argued that rather than articulating their concerns, they tend to use gesture to indicate an area of concern and then build their presentations to feature their concern as sufficiently problematic to warrant seeking medical intervention. These presentations are a far cry from presentations at an institutionally appropriate level detail. In this chapter I show that most patients, particularly those with little to no prior experience with cosmetic surgery, enter the consultation with a layperson's understanding and ability to describe the concerns they have with their appearance. I describe how a patient's ability to discuss their anatomy in institutionally relevant detail is a skill that a surgical candidate acquires over the course of the consultation, rather than one they possess when they walk through the door. In other words, I argue that patient's ability to evaluate and discuss their own appearance in a medically appropriate fashion is an achieved skill that patients acquire through interacting with their surgeons. "Good surgical candidates," at least in terms of discussing their concerns, is as much, if not more, a matter of socialization as it is a patient's psychology.

Professional Vision

Goodwin (1994) defines “professional vision” as a “socially organized way of seeing and understanding events that are answerable to the distinctive interests of a particular social group” and posits that “the ability to see a meaningful event is not a transparent, psychological process but instead a socially situated activity accomplished through the deployment of a range of historically constituted discursive practices” (606). In any profession, there is inherently an asymmetry in knowledge and know-how between the professional and a layperson (Drew, 1991, 1992; Drew & Heritage, 1992; Heritage, 2005, 2013; Heritage & Clayman, 2010), doctors and patients (Heritage, 2005; Maynard, 1991), 911 call takers and individuals calling in with an emergency (Whalen & Zimmerman, 1987, 1990), and even between callers and hosts on talk radio (Hutchby, 2013).

Professionals, by definition, are experts in their field; again, by definition, laypeople are not. Because a professional has likely spent years studying and practicing within their occupational field, they have been socialized to see and distinguish nuanced phenomena within that field. Moreover, through formal and informal educational practices professionals are trained to a specialized way of viewing phenomena within their field, and those ways are common and recognizable to others who do similar work and have the same training. Professional “vision” is not only a more precise way of looking at a certain aspect of the world, but what is seen by professionals is interpreted in very specific ways; ways that are relevant to the work of the professional. Professional vision stands in contrast with untrained lay vision and is part of the underpinning of professional competence.

The number of things that can be seen and interpreted in any perceptual field is nearly boundless. Charles Goodwin initially discussed the notion of “professional vision” using the

example of dirt and people's perception of it (1994). He suggested that you and I might look at a mound of dirt and be able to categorize it in a handful of possible ways: dirt, sand, silt, or mud. He contrasts that with the way archaeologists see the nuances of dirt where to a trained eye slight changes in the color or consistency of "dirt" can be indicative of a posthole, or an area in the dirt that is stained from what was once a post rotted in the ground. Similarly, a farmer might look at a field of "dirt" and be able to determine different properties about the nature of the soil as it relates to farming. Goodwin discussed the ways in which the practices of coding, highlighting, and the production of graphical representations are used by professionals to see, and in turn can be used to train others to allow them to see the phenomenal objects of interest in their profession. Coding, which is the process of highlighting, deliberately demarcating, and ultimately naming relevant elements in a perceptual field, is part of being human. The ability to do so acts as an informational buffer that allows the brain to process only those aspects of an environment or circumstance that are relevant to the current environment or the task at hand. After all, what is of interest to an archeologist is not likely to be of any relevance to a farmer, and vice versa; so, one is usually only taught to see and talk about details that are relevant to the needs of their own particular profession. Accordingly, Goodwin demonstrated that one's ability to "see" with professional vision is neither a property of the eye nor the brain; rather it is a property of discursive practices that professionals use to demonstrate competence in their practice.

Professional Vision and Cosmetic Surgery

Cosmetic surgeons have been taught to analyze anatomical structures in terms of whether they can be modified using surgical means and, if so, what procedure can be used to address each of their patient's issues. In cosmetic consultations the immediately relevant task for cosmetic surgeons is to determine if a patient's desires for their appearance can be achieved through

surgery. To make this determination surgeons need to know precisely which areas of the body their patients find problematic, and what about that particular feature is causing the patient distress. Then, and only then, can the surgeon determine if that problem can be addressed surgically. To a surgeon a "face" is conceptualized of distinct regions: lower face (jaw line region), upper face (brow line and above), mid-face (area across the cheeks), eyes, brows, mouth, etc. As specific as these regions may seem, they are not quite specialized enough to align with available treatments. For instance, eyes and lips can be further reduced to upper and lower regions; and in the case of eyes even further reduction is common (lower lid, tear trough region etc.)

Potential signs of aging are varied: one can have laxity of the skin (sagging/drooping), wrinkles, skin discoloration, puffiness (fat pads), or dullness (lack of "luminosity") of the skin; and treatment for these issues are not a one size fits all prospect. Broadly speaking wrinkles and lines are best addressed by Botox; however, deeper lines such as marionette lines, the deep lines that run from the corner of the nose to the corner of the mouth, are best addressed by fillers; sagging by surgery; and dysfluencies in the color or texture of the skin by laser.

It is also important to note that a single area such as the tear trough (the area under the inside corner of the eye where people commonly get "dark circles") may require more than one procedure to achieve desired results. "Dark circles" are often the result of thinning skin, which allow the vascular structure beneath the skin to appear, but the same area may have laxity of the skin that could require surgical intervention. While surgery has the capacity to remove excess skin, in many cases it would not address the darkness of the area and in some cases, could make the circles worse. There are a bewildering number of potential facial concerns and possible interventions available to treat a given condition. For a surgeon to discuss viable options for

treating a patient's concern he or she must be aware exactly what aspects of their face the patient would like addressed. So, when a patient comes in and says, "My eyes look old," their description does not yield the specificity the surgeon needs to make appropriate recommendations. Is it the fine lines and wrinkles the patient finds troublesome? The darkness under the eyes? Or, perhaps it's the hooded eyelids? Or maybe is it that their eyebrows have started to drop?

Since most of us understand the goals and objectives of cosmetic surgery from a lay perspective I think it is important to provide a glimpse into the level of detail associated with understanding the signs and symptoms of facial aging. Figure 10 provides an illustration of the level of specificity that surgeons ideally require from their patients. Please note that Figure 10 is only a partial illustration of concerns that can be addressed via medical intervention. It only includes those concerns that can be addressed with injectables (e.g., Botox or fillers); it does not include surgical interventions (e.g., face lift, nose job, blepharoplasty, etc.) or concerns that can be treated with lasers (e.g., brown spots, dull skin, fine lines). All told, there is a bewildering number of distinct concerns associated with facial aging that can be addressed medically.

Figure 10. Partial List of Medical Terms to Describe Facial Treatment Areas

Image courtesy Proactive Medical Aesthetics.

Most lay people, particularly those with little or no experience with cosmetic medicine, are unaware that small details such as "bunny lines" on the bridge of the nose, "hollowing temples," or "dimpling on the chin" are phenomena associated with aging. So, it is highly unlikely that a patient is going to notice that their temples are hollowing, let alone ask for treatment for it, yet a surgeon will often propose filling those hollows as a surprisingly effective method of addressing a gaunt and aging face.

Institutional Relevance of Specificity

In aesthetic medicine one practical concern associated with a patient's ability to clearly and concisely express which parts of their body they are dissatisfied with is a question of subjective preferences. Just as people have different opinions about what is beautiful, they have unique understandings of what facial features could be considered a flaw. Most of the symptoms patients are inclined to present in acute, primary care visits (e.g., pain, congestion, heart palpitations, etc.) can almost universally be categorized as undesirable states of being. However, the same cannot be said for cosmetic medicine, where beauty is in the eye of the beholder. The subjective nature of what constitutes an undesirable physical feature is a reality that shapes what a surgeon can say or do during the initial moments of a consultation. They cannot look at a patient's face and assume that some aspect of their patient's face is inherently problematic, as that feature may be something that does not bother their patient – or even worse, it might be a feature that the patient likes about themselves. So, if a patient cannot clearly stipulate those aspects of their face that they find problematic, the surgeon is left in a position where they have to assume what the problem might be. This context is less than desirable because if the surgeon guesses wrong, they risk upsetting or insulting their patient.

In everyday conversation calling attention to the specifics of another's anatomy can be problematic, particularly if that body part can be perceived as undesirable or unattractive. In some social circles a large rear end is the epitome of sensuality, while in others it is quite undesirable. Commenting that a woman has "a big butt" can be a compliment or an insult depending on the unique perspectives of both the speaker and the recipient of the utterance. The same principle applies in cosmetic surgery. Laxity or fullness in the skin that sits between the upper eyelid and the eyebrow is a phenomenon that naturally occurs in the process of aging; such

a situation is often referred to as "droopy" eyelids. Many people who have "droopy lids" perceive them as causing the eye area to appear old and tired. However, as the following fragment indicates, laxity in the same area can also be perceived as desirable: the marker of ethnic identity, or as the key component of aesthetically desirable "bedroom" eyes.

Brigitte Bardot Eyes [01:06]

```
((this discussion is about her eyelids. The "top an the bottom"
in line 310 is referring to eyelids))
309 PAT:  ah all all the surgeons I talk to o:h:::
310       they wanna do the top an' the bottom.
311       (.)
312 PAT:  .hhh a[:n:
313 DOC:        [(okay/yeah) that's right? (    )
314 PAT:  this'z the way my eyes 'av been ferever.
315       (.)
316 PAT:  and it's like (0.2) if I s:- s- cha::nge
317       that look
318 DOC:  It's gonna make you look (.) too
319       different.
320 PAT:  Oh yeah. Ever[ybody's gonna go "Oh:?"
321 DOC:               [Yeah.
322 DOC:  (It's just like) Brigitte Bardot had an
323       upper eyelid, yihknow she was known
324       fer her upper ey[e
325 PAT:                  [Yea:h it's- m- me too?
326 DOC:  Claudia Schiffer too . . .
```

One of this patient's primary concerns is the laxity in the tissue of her lower eyelids. This patient is pleased with her upper eyelids and does not wish to have them altered despite the fact that they are "hooded." In this interaction with Dr. D, as she starts to share her concerns about the ways her eyes are aging, she expresses her frustrations with other surgeons she has spoken with who all suggested that she also surgically address her "hooded" or "heavy upper lids" in an attempt to make her look more youthful. However, this patient does not find her hooded lids problematic. Instead, she sees them as part of her identity. She describes the heaviness of her

upper lids as “having been [there] forever” (line 314), which precludes it from being a result of aging, and in doing so implicitly suggests it is part of an anatomy she is content with.

When a surgeon’s assessment of their patient's body diverges from that of the patient, it creates a context where the surgeon’s professional evaluation might impact the way the patient perceives their own appearance and the surgeon’s “professional opinion” could potentially create dissatisfaction where there previously was none. This situation is ethically problematic, and it runs against physicians’ creed which states, “First, do no harm.” In this instance, the evaluation of Marsha’s previous surgeon did not change her opinion about her “hooded” eyes, but his efforts to convince her to “fix” a part of her anatomy she likes and considered to be an integral part of her identity may well have cost him a patient. Dr. D did not make the same mistake. Rather than aligning with the perspective that doing the patient’s upper lids is important in terms of making her look more youthful, Dr. D. collaboratively completes her utterance for her (Lerner 2004). She is in the process of talking about what it would mean to change a structure that had been part of her face “forever” (lines 314-317), when he summarizes the point: “It’s gonna make you look too different” (line 318). He then continues his turn by diverging even further from the perspective of the other surgeons by explaining Brigitte Bardot and Claudia Schiffer, two great beauties who not only have hooded lids but are also made more beautiful by them.

Another related concern cosmetic surgeons have about patients’ inability to fully articulate their concerns is that the patient may well not have any idea about the specifics they seek to address, and instead are electing to have surgery to correct a general sense of not feeling attractive. In a work written to instruct cosmetic surgeons about the perils and pitfalls of selecting patients, Goldwyn (1981) warns against taking on patients who use “vague descriptions.” He summarizes such patients as “indecisive, or unaware of what body feature

really disturbs them." He claims that a patient's inability to clearly articulate their concern creates a context where the doctor must do it for them and warns, "If you make the decision for them, she can blame you for any later dissatisfaction, saying that you talked her into an operation" (41).[37] Goldwyn's trepidation about a patient's inability to name their concern and therefore putting the surgeon in the position where they are forced to do it can be found throughout the literature (Gorney and Martello 1999, Malick et al. 2008, Rinker et al., 2008, Rohrich 1999, Napoleon 1993, Wengle 1986a,b). Patients who are unable to communicate the specifics in terms of what they dislike or would like to be changed about their body are likely to be perceived as questionable in terms of being considered as viable surgical candidates.

Professional Vision in Patients as a Post-Operative Achievement

Dull and West (1991) interviewed post-operative cosmetic surgery patients and found one commonality between them is that they display the ability of "reductionism," or the capacity to reduce the body into parts and discuss their concern in terms of symptoms associated with each constituent part:

> "I had a very Roman nose, straight, kind of broad. I mean, it was perfect, but it was kind of big." (Dull & West, 1991, p. 63)
> "I am very pleased with the results. Sometimes I fluctuate on wondering if I should have chosen an even larger size in breasts, but I inevitably return to the same conclusion: that this is perfect proportionately. I see no scar on the left nipple; there is a slight trace of the scar on the right nipple, but I don't think anybody else would notice, it is so slight." (Dull & West, 1991, p. 63)

From these quotes Dull and West concluded that these patients "display an orientation to reductionism in their descriptions of their activities." They also claim this orientation is a quality

[37] By "making the decision for them," Goldwyn suggests a context where it is the surgeon, not the patient, who initially articulates what the problem might be. Using the quote from the beginning of this chapter, an example of Goldwyn's notion of "making the decision for them" would be if it were the surgeon rather than the patient who was the one to suggest "the lump" and "it's too long" as the problems with the patient's nose.

that surgeons look for when selecting good surgical candidates. They contend that reductionism plays an extremely important role in managing a patient's expectations because the ability to do so is mandatory in the process of allowing the surgeon and the patient to jointly evaluate the parts of the body that require "correction." By discussing a patient's concern in highly nuanced ways, surgeons and their patients are able to establish a mutual basis for evaluating the patient's chief complaints, what should be done about them, and assessing post-operative results. As an example, if a patient complained about their eyes "looking old," it would be difficult to come to some relatively concrete agreement as to what an appropriate solution for that might be. After all, it is not realistic, or even desirable to expect a 64 year old to have the eyes of a 24 year old as a post-operative result. So, what would the results of a successful surgery look like?

However, if the patient expressed their concern about lines around their eyes, dark circles and bags under the eyes, the surgeon can shape the realities of their patients' expectations: "With some Botox injections we can virtually eliminate the lines around your eyes. We can greatly reduce the bags under your eyes by surgically removing the fat pads that cause the 'bags' and then tightening the excess skin. The trade-off is that once we remove those pads the dark circles are going to appear more pronounced because the darkness is due to thinning of the skin in the under-eye area. So, without the fat, I expect that the area will become about 10% darker." Thus, through discussions of very specific details, the surgeon can communicate what post-surgical, "younger looking" eyes will actually look like; mostly wrinkle free, without bags, but the dark circles will not only remain but likely look a little bit worse. The greater the detail in the description of what the patient wishes to achieve, the less the likelihood for some sort of mismatch between what a patient expects, and the realities of what results surgery can actually deliver. The ability to talk with precision about what can, and cannot, be achieved via surgical

intervention is a critical element in the participants' ability to ensure intersubjectivity in terms of (a) establishing the specific features of the face that the patient seeks to address via surgery, (b) what the patient expects to achieve through surgical intervention, (c) to what degree the patient can expect to achieve their goals for surgery, and perhaps most importantly (d) as a mechanism to assess post-operative results to determine whether or not the surgery was a success.

I do not dispute that the patients Dull and West interviewed do indeed display a well-honed ability to assess their pre- and post-operative appearance. Nor do I dispute that a patient's ability to discuss their concerns with their appearance at this fine-grained level of detail is extremely important in terms of achieving intersubjectivity to shape understanding and expectations. However, I would like to suggest that these patients' ability to do so, and to do so fluidly, is the result of going through the surgical process, rather than a prerequisite for it. One patient I worked with had no idea her "hollowing temples" caused her face to show its age. However, after she received treatment for it, she is the first one to tell her friends how filling in the "hollows at my temples, makes my face look fuller, my skin thicker, and makes me look like the me from 10 years ago" (Personal conversation, November, 2016). In a post-operative interview, she would give the impression of having a keen ability to compartmentalize her concern and discuss it in nuanced detail. However, it was likely a skill she acquired through interaction with her clinician. In fact, not a single patient in my data set was able to present their concerns to their surgeons at the level of clarity and specificity displayed in the statements from Dull and West's post-operative patients. In contrast, virtually all the patients in my data displayed a distinct inability to describe the physical aspects of their concern; partially because even individuals who are inclined to scrutinize their own face have not been trained to do so in

the same way surgeons are, and also because quite often laypeople are unaware that particular conditions, let alone treatments for them, even exist.

In this chapter I show that the consultation is an interactional environment in which a patient is asked to elevate their "lay vision" to something that aligns more closely with the detail-rich perception associated with "professional vision." Through the interaction, surgeons take their patients' initially vague descriptions of their concerns, work them up as part of a medical evaluation, and in doing so repackage the same concerns in institutionally relevant detail. Thus, they socialize their patients to conceptualize and discuss their faces at the level of detail that allows them to be perceived as "good surgical candidates."

Lay Vision

I have only one example where a patient can analyze and articulate his face in anything close to institutionally relevant terms. By "institutionally relevant terms," I mean a presentation where both a specific location on the body is featured as problematic, and the presentation includes a description of what the problem with that body part might look like. The following example is the final concern that Billy presented during the problem-presentation sequence of his interview. After indicating concern about his jowls and the area under his chin, at the very last moment, almost as if it were an afterthought, he presented his "eyes" as an additional concern.

Billy: *Oh my God, your eyes look old!*

236 PAT: =Oh an then you can look at my eyes but (0.4)
237 I think my eyelids look pretty good.
238 DOC: Ok[ay
239 PAT: [Although I notice that when I wear contacts
240 DOC: Mmhm
241 PAT: **I'm like "Oh my god you- yo- y- your eyes look**
242 **ol:d."**
243 DOC: **Now you're talking about yer upper eyelids or the**
244 **lower eyelids.**
245 PAT: Well I don't think- I don't think my lower eyelids
246 hhhhh (2.3) look bad at all. I mean they're a
247 little like (0.3) yihknow I could probably do a
248 little fill[er here but it's- it doesn't bother me,
249 [((pointing at an area underneath the eye
that
250 is commonly associate with dark circles))
251 DOC: Mmhm
252 PAT: It's not necessary<and I have no puffiness.
253 DOC: Right.
254 PAT: And I have no dark circles.
255 DOC: R:ight.
256 PAT: Uhm, (2.0) These are (2.5) my eyelids (.) are
257 uneven? ((shifts gaze from mirror to doc))
258 (3.0)
259 DOC: Yeah yer
260 PAT: See there- one is (.) ah:: (1.0
261 DOC: Is higher. The left is highe[r than the right
262 PAT: [This one's higher
263 (0.2)
264 PAT: than this one?
265 DOC: (Well maybe-) close your eyes (0.3) real (.)
264 slowly.
265 (1.5)
266 PAT: Slowly?

There are two notable things about his description. First, it occurred only after the surgeon prompted him to talk about his concern in greater detail: “now you’re talking about yer upper eyelids or the lower eyelids” (lines 243-244). Second, Billy produced detailed descriptions of symptoms that he was not experiencing. Initially he described his eyes as “looking old.” Although “looking old” is most certainly a problem that cosmetic surgeons address, the description did not provide institutionally specific detail. Billy’s surgeon responded

to the assessment “my eyes look old” by asking a follow-up question that was designed to elicit more detail about Billy’s concern with his eyes: “Now you’re talking about yer upper eyelids or the lower eyelids?” (line 243-4).

Once prompted, Billy produced a description of his lower lids that is a surgeon’s dream. He started with a macro assessment of his lower lids, “I don’t think my lower lids look bad at all” (lines 245-6) before drilling down and describing them in terms of the possible problems that could be associated with lower eyelids. He began by pointing to the hollow area under the eye near his nose and acknowledged that he “could use a little filler” to address the area of hollowness, an assessment that his previous experiences with filler give him the epistemic authority to make (Heritage and Robinson 2006). But then he ruled that area out as a problem by claiming that the hollowness did not “bother” him. He then went on to rule out “puffiness” and “dark circles,” the other major problems associated with the lower eyelid area.

Once he assessed his lower eyelids in terms of specific concerns that could be associated with that area of the body, he shifted his attention to his upper eyelids. He ruled in his upper lids as possibly needing some sort of intervention by producing a micro description of the exact nature of his concern by claiming that his eyelids are uneven, and that the crease in his left eyelid sits higher than the right, a claim that the surgeon investigated more closely by having Billy slowly open and close his eyes. While moving forward in the trajectory of the visit by shifting from the problem presentation to a physical examination of the problem just presented, the surgeon marked Billy’s presentation of his concern with his eyelids as sufficient and complete (Heritage & Robinson, 2006).

Billy’s ability to describe his eyes in institutionally appropriate detail, like the post-operative patients Dull and West interviewed, is associated with first-hand experience in

assessing faces. Both his profession, and quite likely his previous experience with cosmetic medicine, massively contribute to his ability to see and discuss his eyes in institutionally relevant detail. As a Hollywood makeup artist, it is Billy's job to identify less than flattering components of his clients' faces and then to attenuate their visibility with makeup. In a manner of speaking the "professional vision," or the way makeup artists have been socialized to see and perceive faces is like that of cosmetic surgeons. Where a cosmetic surgeon makes their patients more visually appealing using a scalpel or a syringe, a makeup artist uses cosmetics to highlight their clients' best features and to attenuate the appearance of problematic ones. Billy told his surgeon: "I'm a makeup artist so I pay very close attention to people's faces" (lines 349-50).

By contrast with this element of Billy's presentation, as well as the descriptions of Dull and West's post-operative patients, the other patients in the present study were remarkably incompetent in presenting the institutionally relevant details of their concerns. As noted in chapters 3 and 4, they are extraordinarily vague in comparison to the detailed fluidity of post-operative patients' analysis of their faces. Where post-op patients can discuss their appearance in terms of physical detail, pre-operative patients, as we have seen, enter their consultations with a strong tendency to present their concerns in terms of lifeworld difficulties, physical details are left unspecified and instead are tacitly indicated by dint of gesture. Alternatively, concerns are referenced by proposing remedies, such as laser resurfacing, but without identifying what the remedy is to address.

Some patients provide more specific detail than others. Broadly speaking, most concerns are made up of two interrelated pieces of information: the part of the body on which the problem is located, and the problem itself: as an example, "I have a rash on my leg." Where some patients fail to describe the nature of the problem but only its location, others articulated the problem

without directly naming the associated part of the body. For example, Ellen, the patient below, is concerned about loose skin around her neck and along her jawline. In her presentation, she codes the type of problem she is experiencing as "dropping" (line 101) although the part of the body on which the "dropping" is occurring is indicated with a loose gesture rather than words.

Ellen: *This is dropping....*

```
100 DOC:  Allright, what have you seen different with yer face?
101 PAT:  This is dropping .hh an[d-
102 DOC:                           [The neck?
```

Here Ellen provides her surgeon with the symptom she would like to have corrected, but the surgeon is left to analyze what he sees and determine which area(s) of her face are "dropping" and could be perceived to be problematic.

Comparatively speaking the contrast between the way my participants describe their concerns to their surgeon, and the way Dull and West's interviewees describe their concerns during an interview are quite pronounced. Recently my friend Melinda told me that she wanted to go see a cosmetic surgeon to have her eyes done because, "I look old and I can barely see out of these eyes, they're sagging so much" (notes from personal conversation 1/22/2016). Several days after her consultation we spoke again, and she told me that she was going to go in for surgery on March 21. When I asked if she was going to get her "eyes done" she displayed an ability to describe her concern at a significantly higher level of granularity than in our previous, pre-consultation, conversation:

> Well, actually I'm only getting the uppers done. My doctor doesn't think I need the lower done because I don't really have any extra skin down there like I do up on the top. I mean the lowers [lids] are crepey but he says that a laser will get rid of that, so I'll be getting laser done the day after my surgery. Not only will he get rid of that crap on my eyelids, but my whole face will be all even and glow-y. He also said that thinks a bit of filler here (pointing) in my cheeks might be a, "nice touch" to finish everything off. (02/25/2016)

It is my contention that whether it be Melinda's ability to describe her concerns with her eyes in terms of discrete regions (e.g., upper and lower lids) and distinct phenomena (e.g., sagging versus crepey), or the similar level of ability Dull and West's post-operative interviewees displayed in terms of evaluating their appearance, a cosmetic patient's ability to fluidly discuss their condition in relevantly detailed ways is not something that patients bring with them into their consultation. Instead, it is a skill that is acquired by participation in the consultation and subsequent interactions with a cosmetic surgeon.

Achieving Professional Vision: The Devil is in the Details

The surgeon quoted in the beginning of this chapter suggested that "If they [patients] can describe what bothers them, and you know it can be surgically corrected, then those are an excellent candidate for surgery" (Dull & West 1991: p. 62-3). What this doctor is seeking in an appropriate surgical candidate is an individual who not only has the capacity to see their own body in terms of its constituent parts, but also an individual who has the capacity to communicate their ability to "see" at a professional level. What is interesting is that he suggests that the ability to "see" is an innate trait. However, as he continues with his example, he indicates that at least initially, his patient does not display this trait. His hypothetical patient initially framed her concern as, "I don't like my nose," an assessment that glosses the patient's concerns about the appearance of her nose under a single heading. It is only after his follow-up question, "what don't you like?" prompts her to unpack the details of her gloss that she discloses that she attributes her dissatisfaction with her nose to its "lump" and its length, both conditions that can be addressed surgically.

Accordingly, the situation this surgeon describes is one in which his hypothetical surgical candidate describes her dissatisfaction in the type of detail that makes her an "excellent" surgical

candidate after he uses a follow-up question to elicit further details from her. What this surgeon's description leaves unstated is that there is a process involved in getting a patient to discuss their concern at a level of detail that makes them a viable surgical candidate. Perhaps more accurately, these follow-up questions are designed to gain enough detailed information that the surgeon is not put into a position where (s)he must venture an educated guess as to what might be bothering their patient. In addition, the type of information the surgeon's follow-up questions elicited was produced at a level of granularity that allows him to determine if the concern can be addressed surgically.

While getting their patients to conceptualize and talk about their concerns at a higher degree of granularity, surgeons effectively help their patients repackage their presentations to provide information in institutionally relevant detail. As patients parse descriptions of their appearance into more detail, they are increasingly likely to produce descriptions of their concerns that align with the contingencies associated with "professional vision" (Goodwin 1994).

Goodwin's (1994) notion of professional vision is predicated upon an individual's ability to parse a perceptual field into professionally relevant categories, but quite often the phenomenon that needs to be classified is not represented in everyday speech. The ability to see and talk about the world through the lens of a given profession is largely the result of informal acculturation and apprenticeship (Goodwin 1994, 2007; Grasseni 2004; Koschmann et al. 2007; Lymer 2009). Earlier I mentioned that laypeople and archaeologists are likely to "see" and talk about the relevant details of dirt differently. Before moving into a discussion of surgical patients, and how they are taught to "see" in institutionally relevant ways, I would like to take a moment to provide a bit more detail about Goodwin's assertions.

In his study of archaeologists, Goodwin (1994) shows how newcomers to the field are taught to understand and classify extremely subtle variation in colors and qualities of dirt using a Munsell chart. For intersubjectivity to exist there must be a meeting of minds in terms of a given set of meanings and definitions associated with a given situation. Goodwin posits that within a given profession the ability to see the world through a detailed framework is both the result of being socialized into a profession, and simultaneously one of the elements that distinguishes professionals within the field as such. He illustrates this concept by showing now novice archaeologists are taught the relevant details of learning to see and interpret relevancies in dirt using the Munsell chart. The Munsell chart is a tool that helps professional achieve uniformity to when referring to a particular color and or quality of soil by giving definition to a color and quality of dirt that might otherwise be indescribable. Using this tool, archaeologists can shape the way they see and perceive dirt in ways that are consistent across the profession.

The problem of description worsens when discussing the nuances of dirt, or obscure body parts or other things that are located outside the realm of general knowledge and are situated more squarely in the nuanced domain of some sort of profession. This is why visual aids like the Munsell chart that helps code the colors of dirt into standardized, discussable terms are so important.

Like the color and texture of dirt, some bodily structures and features lack appropriately descriptive vernacular terms. Although cosmetic patients are not training to be surgeons, during the consultation they do become a sort of apprentice who is expected to become familiar with the ways in which surgeons see and discuss relevant corporeal phenomenon. In some instances, like the interaction with Billy discussed above or the hypothetical interaction with the patient who "didn't like her nose," surgeons can use a simple follow-up question to get their patient to

discuss their conditions at the requisite level of detail; however, in my data such situations were rare. Instead, surgeons have come to rely upon a simple tool to facilitate achieving a state of intersubjectivity, and that tool is a simple hand mirror.

Look in the Mirror and Tell Me What's Bothering You

Although surgeons require their patients to be able to describe their concerns in terms of discrete, operable conditions, there is wide gap between their ideal and the type of information their patients are able to present during the problem presentation phase of the visit. Since patients, at least initially, either indirectly index their concern by referencing a particular type of treatment (e.g. *I'm looking to do laser resurfacing on my face),* or expressing their physical concern in terms of lifeworld issues (e.g. *My primary concern is that summer is coming . . . so any day of the week you can be called upon to wear something that shows your legs)*, surgeons find themselves in a position where, they need to assist their patients' descriptive abilities. In every case I looked at, up to and including that of a woman seeking surgery to reconstruct a breast that did not respond well to post-mastectomy construction, a mirror becomes the means to achieving this end.

A mirror, like the Munsell chart, is a tool that affords a patient and their surgeon to circumvent descriptive terms and ensure that that their attention is coordinated upon a singular area of the body. The first step in establishing intersubjectivity between the participants of an interaction is assuring that both parties are focused on, and discussing, the same phenomenon. Comparatively speaking, in everyday conversation this process is quite easy because we use commonly understood reference terms to index the topic of conversation. As an example, if interlocutor A tells interlocutor B, "My stomach is too big," because B understands the term "stomach" as well as the word "big," (s)he can achieve a reasonable understanding of the

information A is trying to convey. The shared understanding A and B achieve is facilitated by a common understanding of these terms.

If commonly understood reference terms are not readily available, the task of creating a shared field become notably more complex and the process is often dependent upon gesture and visual cues. As an example, during his presentation Billy was unable to name either the part of the body that was of concern to him, or describe what that part of the body was doing: “Well here’s the things these- this thing is getting a little- (1.8)” (lines 173-5). Without a gesture and a shared visual field his description of his concern would be unintelligible; however, because he reaches up and pinches two areas of skin near his jawline during his utterance, “this thing,” a previously non-specific reference term, is imbued with referential specificity and meaning.

When the surgeon puts a mirror in a patient’s hand, he facilitates the process of establishing a shared field of vision and understanding. The mirror creates an environment where the surgeon and the patient concurrently have visual access to the patient’s face during the interaction. While the patient gazes into the hand mirror they have full visual access to their own face. Normally, surgeons position themselves in front of their patients while they present their concerns. While the patient is gazing at their own reflection in the mirror, the surgeon’s gaze is directed to the patient’s face. Through this positioning of their bodies both parties have visual access to one another, as well as the facial phenomena the patient is discussing. Quite often when the interaction transitions into the physical evaluation of the patient’s concern, Dr. D positioned himself in close physical proximity to his patient (see Figure 11).

Figure 11. Surgeon Positions Himself in Front of Patient

Image produced from study data.

This position allowed him closer visual access to their patient's face, and it also provided the opportunity to touch and, upon occasion, manipulate the patient's face if necessary. Of course, during this process, once again the mirror allows the patient visual access to what their surgeon is seeing and doing (see Figure 12).

Figure 12. Mirror Allows Patient Visual Access to Surgeon's View

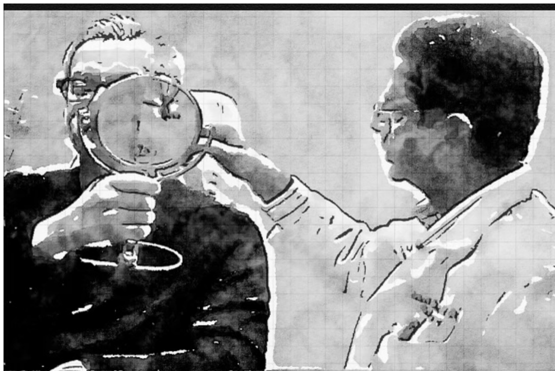

Image produced from study data.

Not only does this position allow the surgeon to gaze upon his patient's face directly, since he is positioned next to the patient, he can shift his gaze so that he can see exactly what the patient sees in the reflection of the mirror.

As a rule, the lay vision of human anatomy does not afford patients the ability to discuss details of their faces at the micro level of detail cosmetic surgeons require. Even as a make-up artist with training in the anatomy of a face, Billy still has difficulty naming his concerns. However, Billy's training did provide him with was an understanding of how a mirror can facilitate a discussion about appearance:

Billy: *Do you have a mirror?*

```
156 DOC:  So, how can I help you today?
157 PAT:  tch Well do you have a mirror?= Can I use that
158       mirror?
159 DOC:  Do I have a mi:[rror? ((swiveling in his chair to
160       get the mirror to hand to Billy))
161 PAT:                 [Ah he hu[h he
162 DOC:                          [Huh huh
```

The surgeon's, "So, how can I help you today?" (line 156) is an opening inquiry, and a first pair part that is designed to elicit Billy's goals for the visit. However, rather than providing the appropriate second pair part (i.e. a description of his concern), Billy produces an insertion sequence by requesting a mirror, another first pair part produced in the service of getting a tool to help him respond appropriately to his surgeons just prior inquiry. Once he received the mirror Billy was easily able to locate and point to the minor areas of sagging along his jawline, and through his gestures he could flesh out the meaning of "Well here the things these- this thing is getting a little - " (lines 173-5) a description that he was unable to describe moments ago.

Although Billy had the wherewithal to ask for the mirror as assistance in describing his concern, usually the task of getting a mirror into the patient's hands falls upon the surgeon. In

most cases, it was the surgeon who offered the patient a mirror. Karen, the patient in the fragment below is one of Dr. D.'s long term patients and over the years the two have developed a friendly relationship that is warm enough that while greeting one another they hugged while saying hello:

Karen: *I was priding myself on the fact that I wasn't getting any lines…*

13 DOC: So. What's going on?
14 PAT: (h)e What's going on?
15 PAT: °What's going on,° (2.6)((removing her glasses))
16 PAT: I th::ought I'd ask you about some refinishing= ((turning
17 face towards surgeon and leaning towards him to allow him
18 to clearly see her face))
19 PAT: =Whaddaya think?
20 DOC: He he he Wu::ll luh- let me s:ee (.) I'll s:t- I'll start
21 by asking yo[u the question, What's buggin' you?
22 PAT: [Arright,
23 (0.2)
24 DOC: **If [you want I can give you a mirror too?**
25 PAT: [Uh:::m:::
26 (0.4)
27 PAT: You know- you know I'm seventy three now,<right?
28 DOC: Mmhm,
29 PAT: [**((patient brings fingers up and traces across her**
30 upper lip along the moustache area))
31 [Fer ye:a:rs I was (.) priding myself on the fact
32 that I wasn't getting any (.) lines across here.
33 DOC: Mmhm?
34 PAT: No:w I see 'em coming.
35 DOC: They' startin' to come?
35 PAT: Yeah.
36 DOC: Okay.

After the greetings ended Karen transitioned into the business portion of the visit by telling her surgeon that she was interested in "refinishing" and then turned her face towards him and asked for his opinion (line 17-8). Cosmetic surgeons are taught that their job is to determine if a patient's concerns can be treated by surgical intervention, not to decide whether an

intervention is necessary. So, Dr. D does not respond to Karen's inquiry as to what his thoughts might be about "refinishing" her face. Instead, he reverses the direction of the inquiry, where now she, not he, is in the position to talk about her face by asking, "What's bugging you?" (line 21). Karen does not immediately respond to his soliciting inquiry. There is a noticeable 0.2 second delay (line 23), which her surgeon responds to as if the pause was an indication that Karen was having difficulty finding a way to articulate her concern. To help her, Dr. D offers her a mirror, ostensibly to facilitate her ability to talk about what is bothering her, and it is effective. She looks in the mirror and although she does articulate "lines" as the problem she is interested in treating, she mentions them as a negative, or something that she *hadn't* experienced up until now. As she gazes in the mirror at her reflection, she relies upon gesture to indicate where on her face the "lines" that were of concern to her were located.

In both Karen and Billy's cases, a mirror was topicalized early in the interaction at a point where one, or the other, of the interlocutors anticipated some degree of difficulty in describing facial "flaws." Billy requested a mirror prior to describing the features of his face that were of concern to him; and the surgeon offered Karen a mirror at a point in her presentation that indicated that she might be having trouble describing what was "bugging" her about her face. In both instances the mirror is introduced as a tool allows the patient to circumvent naming parts of the body or the nature of their concerns by pointing precisely at the problematic areas.

A mirror's ability to assist a patient in describing their concern is only one function it plays during the interview. It also is a tool that assists surgeons in the process of helping their patients to understand appearance in terms of what can and cannot be done surgically to address their concerns. Moreover, it allows the surgeon to show the patient what he sees as he evaluates their appearance. As the surgeon goes about the task of sharing his understanding of his patients'

concerns his talk is formulated from a surgeon's perspective, and it is constructed using medically informed vocabulary. By using a mirror during the explanation, a surgeon can precisely index specific aspects of their patient's appearance by pointing, touching or even pinching, lifting or otherwise mobilizing areas of interest to illustrate phenomena associated with the face during the ongoing stream of talk. It is extremely important that the surgeon is able to create a context of mutual understanding with his patient. The patient needs to be able to see exactly what it is their surgeon is talking about. For instance, when Dr D was talking about how surgery could address Billy's upper eyelids that are beginning to drop, he took a Q-Tip like swab and use it to gently move the lax skin into a position that surgery would be able to achieve.

This type of effort is extremely useful in helping a patient understand what results they can realistically achieve during surgery, and the mirror is the tool that allows them the visual access they need to accomplish this mutual understanding. It is not enough that Dr D can see what is happening with his patient's face, it is essential that the patient simultaneously has visual access to what minute aspects of their anatomy their surgeon is seeing and discussing. So, when surgeons evaluate their patients' faces, patients are tacitly instructed in how to see and discuss their faces with "professional vision." Accordingly, since a patient's ability to compartmentalize their concern is one of the criteria associated with determining surgical candidacy, in the process of providing patients with new way of seeing and discussing their face, surgeons also engage in the process of teaching their patient what they need to know to perform being a "good surgical candidate."

Online Education

"Online communication" is talk that is produced by physicians 'online' during physical examinations. Heritage and Stivers (1999) have identified two main types of online communication: *online commentary* and *online explanations.* The former is talk produced by the physician that describes and or evaluates what (s)he is seeing, feeling or hearing during the physical exam, and the talk is used to give patients access to the basis of their clinician's reasoning, and more significantly, to foreshadow their diagnosis; particularly when the diagnosis conflicts with what the patient believes about their own state of health (pp. 1501-02). The latter, online explanations, are quite obviously, explanations of medical procedures. Online explanations are designed to "reducing mystification, enhancing the patient's medical knowledge, and communicating respect by involving the patient in the care process" (Billings & Stoeckle 1999, pp. 58-59, in Heritage and Stivers 1999, pp. 1502). Mirivel (2008) extended the notion of online communication to include the non-verbal communications. He has termed movements, gestures, and manipulations of patient bodies "visible commentaries" (pp. 159) and has suggested that this form of communication is instrumental in terms of projecting the value of surgical intervention, allowing the surgeon to attend to the institutional goal of "making surgery relevant without directly selling it" (pp. 154). In this section I show how a combination of talk and gesture are used to facilitate achieving another goal: assuring the patients understand and can discuss their condition in institutionally relevant detail.

Mirivel (2008) has also suggested that during an examination, when surgeons mobilize their patient's bodies to illustrate the phenomenon they are discussing, they do so to justify their diagnostic evaluation and to promote the desirability of their recommended treatment. Moreover, he suggests that the manual activity is done to allow the patient to "see and experience" the true

physical nature of their concern firsthand.[38] Through physical manipulation of their patient's bodies surgeons can turn their patient's aesthetic concerns, into an embodied phenomenological experience. Alternatively, when evaluated through the lens provided by Dull and West (1991), surgeons' illustrative manipulations serve to shape their patients' expectations for surgical results, and in the process, lay the groundwork for evaluation of the results of the surgery. These two perspectives are not mutually exclusive, but to promote the desirability of surgery, or to lay groundwork for subsequent evaluation of surgical outcomes, the patient must first be taught how to perceive their concerns through a framework that includes sufficient detail to convert an aesthetic understanding of the body into an objective medical phenomenon. A mirror becomes the tool that, in the absence of relevant reference terms, ensures that surgeons and their patients have mutual access to, and understanding of, the phenomena being discussed.

The process of working up patients' concerns from the way they are originally presented into institutionally appropriate detail is, often, an extended process. Rather than providing multiple examples across multiple patients I dedicate the majority of my analysis to the interaction between Letitia and her surgeon, and show how her initial presentation was translated into operable concerns over the course of the medical interview. Before discussing the transformation, it is necessary to look at the starting point. For comparison's sake, I quickly review Letitia's initial problem presentation:

1a) Letitia's initial problem presentation.

```
220 DOC:  Wull what's what's bugging you about about yer face?
221 PAT:  Mostly- ((pointing at area above the mouth)) okay that
```

[38] Mirivel discusses a surgeon's manipulation of the body in association with a case of breast implants, so the patient had visual access to her surgeon's movement without a mirror. Patient's who are concerned about facial phenomenon require a mirror to be able to observe the results of their surgeon's manipulations of their body.

```
222        (0.2) I'm dating and going with somebody that's fifty
nine,
223        (.)
224 PAT:   There's starters?
225 DOC:   Okay?
226 PAT:   Although they all say that he doesn't look any younger
than
227        me >thank god<? .hhh He's a- he's a wrinkled white
guy,
228        eh he he anyway this- I- go(h)d it really bugs me this
229        right here.
230        ((gesturing to the same area above the mouth))
231        (.)
232 PAT:   I mean ((moving hand up to crows feet area)) obviously
you
233        can see me, you're the professional.
```

As discussed in a previous chapter, Letitia constructs her presentation in a way that highlights the endemic epistemic asymmetries between doctors and patients. Where doctors are imbued with the "cultural authority" of medicine (Starr, 1982), which allows them epistemic authority to look at and evaluate bodies to determine what, if anything, should be done in terms of treatment; patients are fully licensed to understand how they experience life in their own bodies, and how those experiences make them feel. Through this presentation Letitia tacitly acknowledges the line between the personal and physical experiences of aging by explicitly discussing lifeworld difficulties, problems that are situated in her epistemic domain, while using deictic gesture to indicate the physical aspects of her concern; aspects that belong in the epistemic domain of Dr. D.

Although Letitia is presenting "smoker's lines," or fine wrinkles that run perpendicular to the upper lip, as her primary concern, the lexical portion of her presentation is dedicated to explaining her discomfort from what Pomerantz (1980) termed a "type 1 knowable," or something that the speaker is entitled to know from her own first-hand experience. She explains that what's "bugging" her is that she is dating a man nearly 10 years younger than she is. By

explaining her concerns in terms of lifeworld difficulties, Letitia can avoid making diagnostic claims (e.g., "I need a facelift," "This needs to be tightened and fixed," "I have smoker's lines") or otherwise encroaching upon her surgeon's epistemic domain. In fact, she explicitly acknowledges the physical aspect of her concern as falling within Dr. Dashanti's area of epistemic authority of her surgeon when she brings her presentation to a possible completion by telling him, ". . .obviously you can see me, you're the professional" (line 233).

Although Letitia's presentation masterfully avoided encroaching upon the epistemic domain of medicine, cosmetic surgeons operate on bodies not lifeworld circumstances, and in cosmetic surgery the decision of what constitutes a "flaw" is the responsibility of the patient, not the surgeon. Thus, in order to be able to communicate her problems in a professionally relevant way, Letitia's description of her concern needs to be reworked so that it includes the detailed information the surgeon needs to be to discuss her body in terms of possible treatments.

In her initial problem presentation Letitia indicates the vertical lines above her mouth and the lines around her eyes as her primary concerns, but she does so with gesture and therefore leaves the physical aspect of her turn completely unspecified. She does not indicate which aspects of her face she feels give away her age, instead she treats her concerns about aging as self-evident, at least to a "professional" eye (line 233). At the point her presentation is hearable as complete, her surgeon transitions into the information gathering phase of the visit by asking follow-up questions designed to elicit information about the possible causes of the lines around Letitia's mouth:

1b) Letitia (cont.): *vertical lines*

```
236 DOC:  Lemme ask you a question do you- have you ever
237       smoked?
238       (0.3)
239 PAT:  When I was like- like eighteen. No. I'm not-=
240       =Do I have like smoker lines?
```

```
241 DOC:  Wull do you drink from a straw a lo::t
242 PAT:  No I don't do any of tha(h)t.
243 DOC:  Okay,
244 PAT:  I drink from the bottle of water.
245 DOC:  Yeah I mean (0.3)
246 PAT:  They're very pronounced. I=
247 DOC:  =These vertical lines (0.2)[smokers can have em
248 PAT:                             [I think they're more
249       pronounced than everything else I have (.) goin on.
250 DOC:  Tch uh:m yeah but they I: can see them you've
251       got certain areas that that are you know (0.2)
253       more obvious then others,
254 PAT:  What do you think are more obvious? Yihknow
255       it's like you look at what you look at (    )
256 DOC:  Wull there are different things becuz there are
257       some things that can be treated with-
258       non surgically an there are some things that er
259       going on that c'n only be treated surgically.
```

The first follow-up question the surgeon asks is whether Letitia smoked cigarettes (lines 236-7). In her response Letitia seems to reject smoking as a cause for a yet unnamed problem by explaining that she only smoked when she was 18 years old. She then, for the first time, articulates "lines" as the problem that "really bugs" her (1a line 228). When she does so she provided a candidate label "smoker's lines" (see Figure 13) but she does so as a question, "Do I have like smoker's lines?" (line 240).

Figure 13. Smoker's Lines

Image in the public domain.

By framing her response as a question, Letitia is able to finally articulate "smoker's lines" as a concern, but because her response seeks information from Dr. D, she puts him in the position of having to apply the label to the lines on her lips. This is an interesting move on her part because the vernacular term to lines above the lips is "smoker's lines," and most people associate the lines with smoking cigarettes, but one does not have to smoke to get them. It is worth noting that Dr. Dashanti provides "vertical lines" as an alternate, less colloquial and pejorative description of the lines on her face. Moments later Letitia acknowledges that hers are more prominent, although she still is not using a label to describe what she does not like are "very pronounced . . . more pronounced than anything else I have going on" (line 246 & 248-9). It is worth noting that when Letitia acknowledges that her lines are "very pronounced" she is aligning with his assessment; the patient has not actually used a descriptive term. She is still indexically dependent on linguistic categories he proposed.

Given that "lines" are her primary concern, why does she pose the question, "Do I have like smoker's lines?" to Dr. D, and seemingly resist articulating her problem? One possibility is

that the term “smoker’s lines” is not a particularly flattering one; moreover, in this case it is not accurate because Letitia was never really a smoker. It can be psychologically uncomfortable to attribute a negative label to one’s self. In fact, in everyday conversation, if a person were to apply a self-deprecating label to themselves, the socially preferred response of the recipient is to reject the negative assessment (Pomeranz 1978). However, in a cosmetic surgeon’s office, surgeons are in a position where they really cannot deny their patient’s reality.

If Letitia does indeed have lines around her mouth, it would not be a wise move for Dr. D to deny his patients reality; one cannot fix what does not exist. So, if Dr. D were to say, *you don’t really have lines around your mouth,* it could suggest that Letitia were making a mountain out of a molehill by suggesting medical intervention might be needed to address a ‘non-problem.’ Equally important is the notion that, if she does indeed have lines, by denying them he would send her away untreated, and if Dr. D frequently denied that patients’ legitimate concerns were worthy of treatment in order to preserve their feelings, he would have no business left. It is likely that Letitia has some awareness that if she labels her condition as “smoker’s lines,” a less than flattering term, then it is likely that Dr. D would let that description stand, and that could be emotionally uncomfortable. Thus, by dancing around the term, her concern can be discussed without directly applying a pejorative term to describe it.

When Dr. D produces an alternate description, “vertical lines.” he eliminates the causal implication of the lines associated with “smoker’s lines.” Also, “vertical lines” is a more straightforward description that is perhaps a less evaluative description of the condition of the skin above her mouth Now, keep in mind that surgeons’ professional ideology states that patients are supposed to articulate the aspects of their face that they perceive as problematic. However, in this instance, over a small number of turns at talk, Letitia’s condition has been worked up from a

gesture, to a lifeworld concern (the issue associated with dating a younger man). Then Dr. D indirectly suggested the term "smoker's lines" and then reframed the problematic condition to "vertical lines". Letitia has aligned with Dr. D's description of her concerns, but he, not she, has been the one to articulate it. Not only that, he then tells her that he sees her lines, but feels that certain areas of her face are more "obvious than others" (line 251-253). He then transitions into an analysis of the features of her face he thinks detract from a youthful appearance and an explanation of what can be done, surgically and non-surgically to address them (lines 250-3 & 256-9). This is in many ways a lesson in how to see, and discuss, her condition in appropriate ways. Letitia has now been provided the vocabulary to talk about having the vertical lines around her mouth addressed, a far more precise description than a quick gesture.

When the surgeon shifts the topic of the conversation to address what he feels are Letitia's more "obvious" areas of concern he ventures into an area where he is providing his own assessment of Letitia's face. Theoretically this violates the notion that it is the patient who should disclose their concerns to assure that surgeons do not create concerns in the patient's psyche that were not there before. However, the observations that Dr. D is to disclose can be classified under the heading of other aspects of an aging appearance, described under the auspices of medical expertise. And, more importantly, sometimes surgeons really do know what is best in determining how to go about achieving the patient's goals; in this case the goal being, not looking older than one's younger boyfriend. Sometimes, the things that patients fixate on in terms of their appearance, are not the things that most people who look at them would see as the most problematic, or aging, aspect of their face. As he moves into an analysis of her face, he, in effect, is helping Letitia unpack her concern of "appearing older than her boyfriend" by detailing the ways in which age has manifested itself in her face.

1c Letitia (cont.):

```
260 PAT:  W'll right now I'm looking for non-surgical
261       [I'm working for eighteen more months
262 DOC:  [So
263 DOC:  Yeah.
264 PAT:  An then I'm (.) then I'm (gonna start to) take better
265       care of myself.
266 DOC:  Right. I think let's start surg- ah let's talk
267       about the non-surgical stuff.
268 PAT:  Okay,
269 DOC:  To do that (0.2) I'm gonna grab a mirror so (.)
270       it's always easier for me tah [kinda show you=
271 PAT:                                [Yeah.
272 DOC:  =while you're looking at yourself.
273 DOC:  Ahm. (clears throat) so I'm gonna have you
274       hold thi:s,
275       (0.2) ((doc begins handing a mirror to his patient))
276 DOC:  and [(1.7) en so now jest start top down okay?
277 PAT:  Okay.
278           [((during the 1.7 second pause she takes the
mirror,
279       brings it up, and positions it where she has a good
view
280       of her face))
281 PAT:  Okay.
282 DOC:  Do you wear yer hair like this all the time?
283 PAT:  Bangs?
284 DOC:  Bangs.
```

In this sequence Letitia's surgeon indicates his intent to begin an analysis of her face in terms of non-surgical treatments that can be done to address signs of aging. However, before he begins his analysis of her face, he momentarily deviates from the topic of her face so he can get a mirror into her hands. He explicitly states that the process of analyzing her face and explaining what can be achieved through medical intervention is easier when the patient is given the opportunity to view themselves in the mirror while he is discussing the specifics of their face (lines 269-71). It is only at the point that Letitia has the mirror in her hand and her gaze is directed at her own reflection in the mirror that he returns to the project of evaluating her face starting "at the top" and working his way down (line 276). In this sequence he is beginning the

process of socializing her in how to see, and talk about, her face in institutionally relevant detail. Dr. D's descriptions of the aging characteristics of Letitia's face, and what can be done about them, recalls to Dull and West's post-operative patients' descriptions of themselves: "I got what I wanted. A clear forehead, no heavy eyelids and bags under my eyes (my eyes weren't too bad to begin with [but] my forehead was heavily lined). No furrows around my mouth. No wrinkles. Neck is great." The laundry list of qualities that Dull and West's patient was able to produce differs dramatically from Letitia's initial ability to describe her concern in anything other than lifeworld terms but sounds very similar to the detailed way Dr. D. discusses Letitia's face.

1d) Letitia (cont.): *forehead lines*

```
341 DOC:  =So fer instance if we were talking about'chur
342       forehead,
343 PAT:  Mmhm,
344 DOC:  Raise yer eyebrows up? .hhh Se[e you have these
345       lines that go a:l:l the way here.=
346                                       [((Running his fingers
along
347       her forehead while she watches the movement of her
face
348       and the movement of his hand in the mirror))
349 PAT:  =°MM[m°
350 DOC:      [I would leave those alo:ne, Why:? Because (.)
351       one you won't be able to move yer eyebrows at al[l=
352 PAT:
[Right.
353       Right.
354 DOC:  =two it's gonna drop yer eyebrow like this, ((using
his
355       thumb to gently push her brow down towards her eye
while
356       she watches in the mirror))
357 PAT:  Yeah which most people get [(.) brow lifts don't they?
358 DOC:                              [An then you're gonna get-
359       (0.2) An so;- so if your forehead lines bothered you I
360       would s- jest do from here. Up.=
361       ((using his little finger to gesture from a line on
her
362       forehead up towards her hairline))
```

```
363        =And that'd sti:ll give you yihknow (.) the ability to
do
364        your eyebrows=
365 PAT:   =Right
366 DOC:   .h an:d it wouldn't drop (0.2) yer brow
367 PAT:   Right.
368 DOC:   The only difference is you'd prolly still have
369        these (.) lines down here. ((gesturing from a line on
370        her lower forehead downwards))
372 DOC:   .h but everything else would be very smooth.=
373        ((the entire time he's talking he is pointing to and
374        tracing different line trajectories on her face))
375 PAT:   =Okay.
376 DOC:   That's besides the point because we're not gonna talk
about
377        the forehead.
378        (0.2)
```

Figure 14. Lines Across Letitia's Forehead

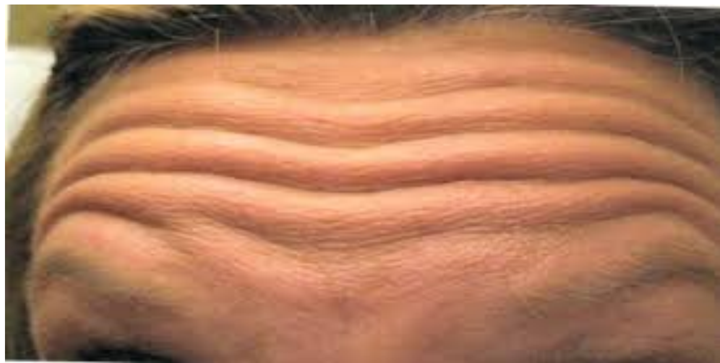

Image produced from study data.

Dr. D begins the discussion about the lines across Letitia's forehead (see Figure 14) by asking her to raise her eyebrows (line 344). When a person raises their eyebrows the lines across their forehead become more pronounced and therefore easier to discuss. Dr. D began his assessment by parsing the lines on Letitia's forehead into two categories: lines that are not treatable (lines 346- 357) versus those that are treatable (lines 358-375). He began his is explanation by using two fingers to point at two lines that ran all the way across the lower portion of her forehead -- the two lines positioned closest to, and just above her eyes -- and

explained that he would not be able to treat those two lines because in doing so she would lose all motion in her brow (line 351) and therefore the capacity to change expressions. Moreover, he goes on to explain that one of the reasons some of her forehead lines were not treatable is because of a risk of having her eyebrows drop (line 354); a phenomenon that, though he does not articulate it, would risk making her look older and angry.

To illustrate the potential problem associated with treating the lines on her lower forehead he took his thumb and gently pushed the eyebrow area downwards. So, not only is he showing her how to assess what her face currently looks like, but he is also mobilizing her face so she can understand the contingencies associated in addressing that area of her face. In the process of explaining the lines on her face that he would be able to treat, he is working to set his patient's expectations so if she moves forward and gets treatment, she does not expect that each and every line on her forehead would be gone. This is extremely important because a patient who expected a completely wrinkle free face would not be unhappy with their result. As Dr. D is manipulating her face Letitia leans in to get a closer view of herself, and as she does so she scowls slightly to maximize the downward motion of her brows the doctor initiated with his thumb. In doing so, she tacitly suggests that she both hears and understands what he is telling her.

After Dr. D rules out the possibility of treating the lines on the lower portion of her forehead, he shifts direction to explain which lines he would be able to address by using Botox. While explaining what he can do, he can use her face as a reference to illustrate what can be achieved.

Figure 15. Surgeon Uses Gesture to Differentiate Between Treatable and Untreatable Lines

Image produced from study data.

As shown in Figure 15, as Dr. D talks about what he can do to treat her forehead lines, he takes his little finger and placed it on the end of one of the lines below the center of her forehead, and lightly sweeps his fingers up towards her hairline in a gesture that suggests that all the lines between his finger's starting point and her hairline could be addressed and smoothed out using Botox injections (lines 359-62). As he continues with his explanation, he again uses gesture to indicate the delineation between lines that are treatable versus those that are not, as he verbally reiterates that the lowest two lines would not be treated because of having her brow drop.

At the point, he has completed his explanation of what can and cannot be achieved in terms of mitigating the appearance of the lines on Letitia's forehead. He has given her a notable degree of education in terms of how to view her forehead as a professional. Although Letitia did not specifically mention her forehead as an area of concern, one can reasonably expect that prior to coming into the office she would perceive the lines on her forehead the way most of us do, as a collection of forehead lines; nothing more, nothing less. Through his explanation he provided her the opportunity to perceive the terrain of her forehead area in a more nuanced fashion. By

having her raise her eyebrows he has instructed her in a technique that allows her the opportunity to magnify the appearance of the lines on her face and in the process, she can see how movement has contributed to the creation of the lines on her face, and in turn enabling her to see how freezing those same facial muscles would help attenuate the appearance of those same lines. In addition, he has taught her that all lines are not created equal, some lines and movement are associated with facial expression, and are therefore desirable; and as mentioned earlier some lines respond well to treatment whereas others do not and treating them has the potential to create new problems.

Figure 16. Crow's Feet

Image in the public domain.

In keeping with his stated agenda of "starting at the top" of her face and working his way down, after Dr. D. brought the discussion of the lines on Letitia's forehead to a close, he shifted into a discussion about her periorbital lines (crow's feet), as shown in Figure 16. He tells Letitia that the wrinkles around her eyes are, in his opinion, the most pronounced lines on her face (lines 380-385). By topicalizing her periorbital lines, he, like so many of his patients, can circumvent naming the lines by using gesture to indicate the exact area of her face he is focused upon:

1e) Letitia (cont.): *These are the lined that I notice more than anything else.*

379 DOC: That's besides the point because we're not gonna talk

380 about the forehead. **Where I re::ally notice it (.) in you**

381 **is here, ((pointing to and tracing the lines around her**

382 **right eye))**

383 PAT: Right.

384 DOC: **These are the lines that I I actually notice more**

385 **than anything else (.) Line-wise [In your face.**

386 PAT: [Okay. You really

387 do? Okay. **((Squinting her eyes, pulling the mirror closer**

388 **to inspect that area of her fac**e))

389 DOC: Uhm.

390 PAT: Yea:h I see it.

391 DOC: Usually because you usually smile a lot or

392 s[quint a lot.

393 PAT: [I do. I do.

394 DOC: **The great thing about Botox is it works (.)**

395 **really well with lines that are still there**

396 **when you're no:t doing that expression. So, even**

397 **when your face is relaxed I still see the lines ((pointing**

398 **at, and tracing down the lines)) yihknow (.) so Botox is**

399 **great fer th[at-**

400 PAT: [Okay so that's not- that wouldn't be

401 Restaylane then huh?

402 DOC: Mm mm. Ne:ver inject Restaylane and in these lines

403 ((gesturing to the crow's feet area on his own face))

404 PAT: Really? Okay.

405 DOC: Never.

406 DOC: Uhm. Restaylane wi[ll

407 PAT: [Is it fer thi:s? ((shifting her gaze

408 back to the mirror and gesturing along the marionette line

409 area on her face))

410 DOC: Yeah. Exactly. Exactly.

The area around her eyes was one of the areas Letitia pointed to as an area of concern in her problem presentation. However, she presented the lines around her mouth from her point of view, as her biggest concern. So, Dr. D's assertion that, from his perspective, the lines around her eyes are the most notable signs of age is at odds with her assessment, at least in terms of

what is being treated as a top priority. Accordingly, she treats Dr. D's assessment as news. "Okay. You really do? Okay." (lines 386-387). She then squints her eyes, a movement that like the forehead intensifies the visibility of the lines around her eyes and leans closer to the mirror to inspect the area he has just topicalized. After a moment she acknowledges that she can see what he sees by uttering, "Yeah, I see it" (line 390). So, once again, although Letitia was not the one to describe her concern in institutionally appropriate detail, her responses, both in word, intonation and gestures, suggest that she has the ability to understand his detailed assessment of her face, although she was not the one to articulate it.

In a pattern like the one Dr. D used to discuss the lines on her forehead, Dr. D uses his description to help shape Letitia's understanding about the outcomes of treatment. After drawing Letitia's attention to her periorbital lines, he explains to her what expressions are responsible for creating those lines: smiling and squinting (lines 391-2). During his explanation Letitia's gaze is still directed at her own reflection in the mirror, but she has relaxed the muscles she had used to squint up her eye to intensify the lines. Again, he uses her reflection in the mirror to discuss the potential outcomes of treatment in minute detail. When Letitia relaxes her smile and the associated squinting of her eyes, the muscles around her eyes relax. Dr. D can use this opportunity to shape expectations about treatment outcomes. He provides an explanation about the types of lines that are treatable with Botox. Although he does not explicitly discuss what constitutes an untreatable line, he suggests that treatable lines that are those visible during expression and movement He explains treatable lines as those that are "still there when you're not doing that expression" (line 396). Finally, Dr. D linked his explanation of treatable lines to the realities of her face by suggesting that although her face is relaxed he can still see lines, and

while he's talking he uses gesture to direct Letitia's gaze to three areas so that she can see exactly what he is seeing (lines 394-9), and know that Botox will not eliminate this set of lines.

During this sequence, Letitia is taught a basic lesson about how injectables are used. One extremely common mistake new patients make is they think that "fillers" (e.g., Restalyne) are used to "fill in" fine lines and wrinkles. Letitia expresses surprise that Dr. D. would treat her crow's feet with Botox rather than Restalyne (lines 400-01), a hypothesis that Dr. D. quickly corrects. The term "filler" is somewhat misleading as fillers are used to add volume to the face, not to be used like spackle to fill in lines.[39] If a doctor were to try to "fill" a patient's lines their face would have small raised areas that would resemble tiny speed bumps running along the outside corners of their eyes. The belief that filler is used to fill in lines is a mistake that is so basic and common among people who have never used injectables that, when I hear someone talk about wanting "filler" for their wrinkles, I become instantaneously aware that they have little, if any, experience with or exposure to cosmetic medicine. However, Letitia is able to use this opportunity to show that she is a quick learner. She may have made an error in her assumption that crow's feet are addressed with filler, but she asks a follow up question, "Is it [Restalyne] for this?" (line 407) while pointing to her "marionette lines" or nasolabial folds (the depressions that run from the side of the nose to the corners of the mouth), which is one of the more common uses for filler. Her follow-up question indicates that she is gaining the ability to differentiate the type of "lines" on a face and the appropriate forms of treatments required to address them.

---

[39] "Spackle" is a putty like substance that painters and construction workers use to fill small holes or cracks in a wall to give it a smooth appearance before it is painted.

As the sequence transitioned from the topic of Letitia's periorbital lines to the proper uses of Restylane, Dr. D. mentioned that he tends to use it in cases when patients' under eye areas appear gaunt and hollow (see Figure 17).

Figure 17. Patients' Under Eye Areas Appearing Gaunt

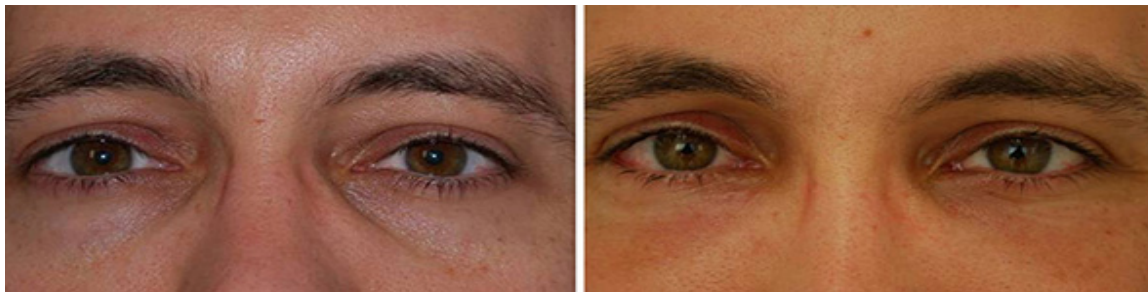

Image in the public domain.

Dr. D.'s reference to the lower eye region occasioned Letitia to gaze into the mirror and evaluate the area beneath her own eyes. She responded to his comment by laughing and saying that "hollowness" is not her problem; rather, if anything, she had the "opposite problem" (lines 412-3). As the conversation transitions away from her crow's feet, the eye area remains the broad topic of conversation, yet the participants are engaged in the process of parsing the eye into regions, and the individual regions into a collection of treatable concerns:

```
407 DOC:    . . .Sometimes I do it here. ((pointing at his
own
408         under eye area)) fer people who have hollowness
409         under their eyes,
410 PAT:    Uh huh,
411 DOC:    Ahm
412 PAT:    ((patient moves mirror closer to her face and touches
the
413         area under her eyes)) I don't have hollowness I have
the
414         opp[osite
415 DOC:       [You've [got a liddle bit of a bags
```

416 PAT: [**They're not really baggy they're jest (.) I**
417 **mean there's no puffy- there's no like water in**
418 **there it's different,**
419 DOC: **No it's it's a liddle bit of fat an some loose skin.**
420 PAT: Yeah,
421 DOC: But can you, (.) and I didn't wanna bring it up
422 cuz it's not a- it's a surgical procedure b't
423 yihknow f- fer **your lower e[yes I would recommend=**
424 **[((reaching out and touching**
425 **the area under her eyes in a way that pulls and flattens**
426 **the area mimicking what surgery would do))**
427 **=a lower eyelid (.)[surgery,**
428 PAT: [Yeah see that's what I'd that's
429 what I would want.
430 DOC: **To remove a liddle bit of that fat an then [jest**
431 **a li:ddle bit of skin to tighten it a bit. ((using his**
432 **fingers to tighten and lift the flesh around her eye))**
433 PAT: [lift it jest
434 a liddle bit right?
435 DOC: Yeah. Yihknow=
436 PAT: =Would that get rid of like here? ((Pointing to a
437 slightly higher area around her eyes while still gazing
438 in the mirror))
439 DOC: Yes.

In response to Dr. D's disclosure about using Restylane to address hollow areas under the eyes Letitia inspected her own under eye area and determined that she did not have hollowness and described the problem with the area beneath her eyes as "opposite" (Line 414) of being hollow. As she is formulates her assessment of her eyes, Dr. D renders his own diagnosis of "bags" in overlap just as she is claiming that she doesn't have bags (lines 415-16). While continuing to look in the mirror she continues assessing the appearance of her under eye area in terms of what it isn't: "there's no puffy- there's like no water in there" (line 417)." Her

assessment is a bit off. “Bags” are accumulations of fat that poke through muscle; they are not created by water.

Figure 18. Bags Under Eyes

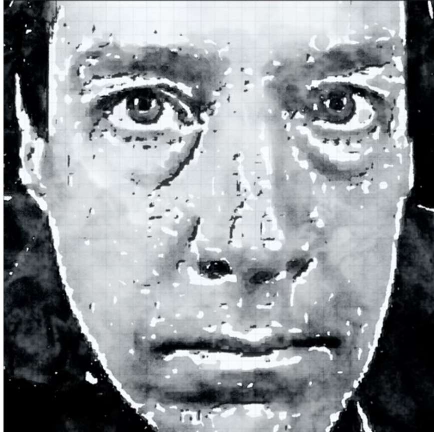

Image in the public domain.

After her assessment Dr. D. goes back and explains his assessment of “a little bit of bags” and explains the look of the area under her eyes in greater detail. Patients are intimately familiar with the topography of their face, and casually familiar with the topography of faces in general, but surgeons have been educated in terms of what goes on underneath the skin to cause a face to look the way it does. So, since Letitia has indicated that she does not have a grasp on what a “bag” is, let alone what causes it, Dr. D is able to educate her about the cause of the dysfluencies of the skin around her eyes. He explains that the appearance of bags is caused “a little bit of fat and some loose skin” (line 419).

The surgical correction for “bags” underneath the eyes is a two-part process: removing the protruding areas of fat, and then tightening the loose skin surrounding the area. As Dr. D explains that the appropriate treatment for this condition would be a “lower eyelid” surgery he is simultaneously able to illustrate how surgery would address both conditions; yet another move

where he is providing instruction in terms of how to perceive her face in institutionally relevant ways. During his turn at talk he reaches out, places his finger on the outer third of the fatty area underneath her eye, pushes down slightly to mitigate the appearance of protruding flesh, while simultaneously gently pulling the area up and out in a way that the area's loose skin is pulled taught. He subsequently provides a verbal iteration of his action when he tells Letitia that what he would do is, ". . .remove a little of that fat and then jest a little bit of the skin to tighten it a bit" (lines 430-31).

At the point the discussion of Letitia's lower eye area comes to an end. Dr. D. and Letitia have discussed concerns and treatments associated with what surgeons refer to as the "upper face" area, which starts at the top of the cheeks and extends to the hairline. Although Dr. D constrained his analysis of her face primarily to aspects of her appearance that can be treated using injectables, he covered quite a bit of territory. Before moving to the mid- and lower sections of her face he briefly summarizes his just prior analysis and treatment recommendations.

Letitia (cont.): *You don't have any lines here, but then boom . . .*

```
448 DOC:   You don' wanna do that, but uhm but yeah, I think
Botox
449        fer here ((tracing the area on her face)) would be a
450        rilley good thing to do [cuz it'll- you don't rilley
have
451        any lines=
452 PAT:                               [Okay.
453 DOC:   =here ((pointing mid face)) but then boom yer hit
with
454        lines here ((pointing near her eyes)), en then no
lines
455        right here. ((pointing slightly higher on her face))
456 PAT:   An thi:s is rilley bothering me ((still gazing in
mirror
457        and pointing to 4 distinct areas on her mouth and
then
```

458   drawing a circle around the whole mouth area), everything
459   around my mo[uth is what bothers me the most.
460 DOC: [Yeh.

Perhaps the most interesting thing about Dr. D's summary is that his description, along with providing instruction on how to compartmentalize the concerns associated with her face, also is constructed using the same strategies patients do to legitimize their concern (see discussion in previous chapter). Dr. D has broken her "upper face" into three distinct regions. He suggests that one of the three areas has lines and wrinkles, but that area is sandwiched between two areas devoid of wrinkles: you don't really have any lines [here], then boom, you're hit with lines here, and then no lines here" (lines 450-455). Through this description, Dr. D. describes a situation where the need for treatment is grounded in the notion that the area with wrinkles is anomalous with the rest of her face. It is not the severity of the wrinkles, or Letitia's desire to look more youthful that serve to legitimize the treatment of the lines around her eyes, rather it is that the lines are visually inconsistent with the surrounding areas and are therefore a deviation from normal. So, in this brief summation he not only provides indirect instruction in how to perceive and talk about her concerns, he also provides her with a method of legitimizing her concern in something other than vanity or desire.

At the point Dr. D's summary assessment of Letitia's upper face area comes to a point of possible completion, Letitia renews attention to her mouth, the area of her face she provided as her primary concern during the problem presentation phase of the visit. However, this time she does a better job in terms of presenting her concern in terms of its constituent parts:

Letitia (cont.): . . . *everything around my mouth is what bothers me the most* . . .

456 PAT: An thi:s is rilley bothering me ((gazing in mirror and
457   pointing to 4 distinct areas on her mouth and then

```
458         drawing a circle around the whole mouth area)),
459         everything around my mo[uth is what bothers me the
most.
460 DOC:                              [Yeh.
461 DOC:    So we'll get there.
462 PAT:    Plus this- I used to have like fa:t lips. ((pinching
her
463         upper lip))
```

Originally when Letitia presented the area surrounding her mouth as her primary concern she pointed to the area above her upper lip and made a quick back and forward sweep- across motion to indicate her entire upper lip area as a problem. In this fragment, Letitia tries to re-topicalize the area around her mouth, but this time the mirror allows her descriptive gestures to be far more controlled and specific. This time while she describes her concerns about the region surrounding her mouth, her gaze is fully fixated in the mirror as she states, “This is really bothering me” (line 456). While she is speaking, she takes her index finger and places it at the center at the top of her lip and sweeps out to the left corner or her mouth; she then repeats the same movement, but this time sweeps out to the right corner of her mouth. With these two gestures, she has once again indexed the “smoker’s” lines around the top of her mouth. She then continues by pointing at her right nasolabial fold (marionette line), an aspect of her mouth that was not indicated in her first presentation, and traces it from the side of her nostril to the corner of her mouth, and again repeats the same gesture on the other side while verbally stating, “everything around my mouth is what bothers me most” (line 459).

As she continues to gaze in the mirror, she gently pinches her lower lip while verbally including the volume of her lips as an additional are concern associated with her mouth area. The concern that she originally glossed as an entire area, has now been broken down into three distinct, and treatable, areas: smoker’s lines, marionette lines, and reduced lip volume. In doing so she has followed the lead set by her surgeon and indicated an ability to evaluate and discuss

her appearance in terms of its constituent parts. Although she does not have the vocabulary or the ability to evaluate the appearance of her mouth in the same fluid way as her surgeon would, her detailed description displays a shift in the way she is analyzing her appearance. Suddenly she is evaluating and discussing the physical, rather than the psychosocial aspects of her condition; moreover, by describing her concern in terms of its constituent parts (lip lines, nasolabial folds, and lip volume) she is indicating ability to elevate the way she perceives her condition from that of a layperson into something that more closely resembles the way her surgeon evaluated her upper facial area. Within just a few minutes of interaction she has gained considerable capacity in terms of how to discuss her appearance using the lens of professional vision, and by employing a range of linguistic and embodied practices to render that vision into communicable form.

Conclusion

As small children, we are taught to conceptualize and discuss our bodies at a particular level of granularity or detail. The ability to talk about the world in increasingly detailed terms is a general feature of language learning. Children are taught language at a mid-range level of descriptive granularity It is not uncommon to hear a parent playing instructive "games" with young toddlers where they are asked to locate body parts: "Where's your nose? Can you show me your nose? Good. What about your eyes, where are your eyes?" Quite obviously as we get older our ability to name and identify parts of the body becomes more detailed (Brown, 1958). As an example, "eyes" come to be understood as a collection of smaller parts; an eyeball, eyelids, eyelashes and perhaps eyebrows, but much of the topical geography of one's face and body has no name at all, or at least not one that is known to laypeople. Our ability to perceive our bodies in terms of small, discrete parts or regions is only slightly more refined as adults than it

was when we are children. Yet when potential patients enter cosmetic consultations they are asked to step-up their "name and assess the individual parts of the body" game to the level of a medical professional who has spent years being explicitly taught to conceptualize and discuss the body in terms of its constituent parts.

I'd like to return for a moment to the statement made by one of Dull and West's (1991) post-operative patients. Keep in mind that these interviews were not only produced after the intake interview, but post-operative patients also go through extended conversations with their surgeons in pre-operative consultations. Pre-op consults tend to take place about a week before surgery, and in these consultations surgeons tend to reexamine their patients bodies, discuss their current condition, what they plan on doing during the surgery, how long the procedure will take, what the patient can expect in terms of healing processes and post-operative results. Then after the surgery there are usually at least two, sometimes many more, post-operative consultations. In post-operative consults it is not uncommon for surgeons to pull out pre-operative photos and compare them against post-operative results. In doing so they remind patients about undesirable features that have been either attenuated or eliminated surgically.

> I got what I wanted. A clear forehead, no heavy eyelids and bags under my eyes (my eyes weren't too bad to begin with [but] my forehead was heavily lined). No furrows around my mouth. No wrinkles. Neck is great. (Dull & West, 1991, p. 63)

This woman's evaluation of her appearance includes details that are far more specific than any of the information the patients in my data set provided in their consultations with Dr. D. This is a far cry from what Letitia, or any other patient I have discussed in this dissertation, in terms of fluid ability to discuss the nuances of one's own face. But after careful examination of the interaction between Letitia and Dr. D, we can see that in the process of explaining what can,

or cannot be done surgically, Dr. D provided Letitia a lesson in "professional vision." More importantly, during the same interview, Letitia repeatedly displayed increased understanding about her face and surgical processes, and also a greatly enhanced ability to discuss her concerns at a tighter level of granularity. In keeping with this line of thinking, it is easy to see after several pre- and post- operative interviews, not to mention undergoing surgery itself, why a post-operative patient is able to display the high degree of competency surgeons look for in determining "good surgical candidates." Letitia and Dr. D have provided ample evidence that that a patient's "ability to break her appearance down into constituent parts" is not inherently the product of a person who is psychologically stable as Goldwyn (1981) suggests, rather it is the result of socialization that occurs within the course of the interview. Through interaction, patients are either intentionally or inadvertently taught to "see" their bodies in institutional detail. This is a phenomenon that I suspect occurs in lay conversations as well as medical interactions.

Yet as Goldwyn's warnings to novice surgeons indicate, issues about a patient's ability to discuss their aesthetic concerns or goals in institutionally relevant detail are well founded, because as Dull and West (1991) have suggested and this study confirms, patients' detailed descriptions of their concerns become the basis for mutual evaluation of what can or should be done in terms of achieving their aesthetic goals. However, the contrast between the level of detail patients can reasonably be expected to use when they walk into the interview and the level of detail required by the surgeon is a dilemma that the surgeon must be able to help their patient resolve for the person in question to become a viable surgical candidate.

In this chapter I have shown that the ability to discuss one's concerns in institutionally specific detail is a skill that is collaboratively acquired and achieved during the interview itself. Most patients, particularly those who are new to the world of cosmetic medicine, enter the

consultation and display a significant amount of difficulty articulating their concerns. Disclosure of detail is something that is facilitated by the surgeon, either in the form of follow-up questions that encourage the patient to take a general complaint such as, "My eyes look old," and break it down into more specific details about the nature of the skin on the eyelids and which of these specifics are perceived by the patient to be areas might be problematic. This task is nearly always facilitated using a mirror, which circumvents the necessity for vernacular terms for body parts or phenomenon associated with those body parts (e.g., sagging, laxity, etc.). Thus, educating and socializing potential patients into viable surgical candidates by directly, or indirectly, teaching them how to see, evaluate and discuss their own bodies is a critical and integral aspect of the cosmetic consultation.

Chapter 6 – Conclusions

> An anonymous plastic surgeon supposedly commented, "When patients go to a plastic surgeon they want to know only two things: can he or she do it and how much will it cost?"…In the long run (and is not a medical career like a marathon) we, the plastic surgeons, will wither on our professional vine unless we extend ourselves to be more than vendors of services, dispensers of a narrow skill. (Goldwyn, 1991, p. 299)

In this study I have focused my attention on the problem presentation phase of intake interviews between a cosmetic surgeon and individuals who are interested in undergoing cosmetic surgery. In the past three chapters I described a range of interactional practices that patients, often with the help of their surgeon, use to present themselves as reasonable rational people who are likely to be considered viable candidates for cosmetic surgery. I argued that the process of becoming a cosmetic patient, or what Harvey Sacks would call, "doing being a patient" (1984), is performative and involves an identity that is achieved, or perhaps better described as mutually co-constructed, in the course of interaction. In the beginning of this dissertation I noted that one of the values of my study is that with the exception of the small but significant body of work by Julien Mirivel, there is little social scientific research devoted studying cosmetic surgery as a medical practice. In concluding this dissertation, I begin by bringing together some of the main themes from the previous chapters and bring attention to what I achieved by studying face-to-face interactions between a surgeon and potential cosmetic patients. I then consider some of the implications of my findings. Most notably I discuss the implications of face-to-face interactions between doctors and patients in terms of the role micro interactions play in establishing and maintaining a delicate balance between the norms and expectations of medicine and those of commerce. I conclude by discussing the limitations of this study and suggesting directions for future research in this area.

Summary

This research was conducted in Beverly Hills, California at Transformations, a cosmetic surgery group that is located in Rodeo Towers and my primary informant for this research was Dr. Dashanti, a double board certified cosmetic surgeon. I used conversation analysis as my primary research method; however, I have also included ethnographic observations as support for my arguments. I argued that one of the values of my study is that there is little social scientific research that looks at the practice of cosmetic surgery. Moreover, the research that does exists tends to look at cosmetic surgery from a macro level (Sullivan 2000), or from the feminist tradition in which the work is primarily concerned with characterizing cosmetic surgery as an instrument of a patriarchal society, cosmetic surgeons as professionals who profit from that society, and women as cultural dopes (Bartsky, 1990; Blum, 2003; Bordo, 1993; Davis, 1995; Gimlin, 2000; Haiken, 1997; Jeffreys, 2000; Morgan, 1991; Sullivan, 2001; Turner, 1984; Wolf, 1991). To date there has been little ethnographic work done, and the work that has been done has tended to use interviews with surgeons and post-operative patients (Dull and West 1991, Davis 1994, Gimlin 2007, Brooks 2004). With the exception of work done by Julien Mirivel (2002, 2005, 2007, 2008, 2010), there is little, if any, work done that has examined actual interaction between surgeons and their patients, rather than post-hoc perceptions of those interactions and relationships.

As primary data I used videotapes of naturally occurring interactions that occurred between Dr. D and potential patients during cosmetic consultations, which are usually the first point of contact between surgeons and potential patients. In these interviews, patients present their concerns to their surgeon, and across the interview the patients' concerns with their appearance are evaluated. Normatively the surgeon will make treatment recommendations and

explain the strengths and liabilities of each of those options. Dr. D, like most other surgeons, did not discuss price with his potential patients. Instead, once the consultation has ended, potential patients are taken to the office manager, who will discuss cost and other financial considerations with patients. In this study I focused almost exclusively on the problem-presentation phase of the medical visit because this phase normatively occurs early on in the visit and it is a phase where a significant amount of identity work is achieved (Heritage & Robinson, 2006a, Drew & Heritage, 1992, Heritage & Maynard, 2006, Heritage & Clayman, 2010).

One of my initial observations became the starting point for my research. After spending some time in the field, I realized that, outside of the medical realm, people have very little difficulty talking about and expressing specific concerns about their bodies and their desire to undergo particular surgical procedures to address those concerns. However, without exception, each patient I worked with expressed a sense of anxiety about "what they should say" to their surgeon, or how they should go about expressing their concerns and desires to them. I argued that this anxiety is rooted in the notion that, in everyday contexts, people talk about their desire for cosmetic surgery in terms of their desire for a certain type of treatment: "I need a facelift" or "I want a boob job." These formulations work perfectly well in day-to-day life, but they do not translate well into the realm of medicine because "I want/need X" request formulations directly propose and request a particular treatment, and in doing so eliminates the need for their surgeon to evaluate the patient's condition and subsequently to propose treatment based upon medically informed evaluation. As a result, the "I want/need X" format of request putatively pre-empts the need for medical evaluation and thus treats cosmetic surgery as a commodity, similar to most other retail products or services that are readily available for the asking. I argued that this method

of request is problematic in most medical contexts, but it is particularly so in the context of cosmetic surgery.

Academics and laypeople alike tend to perceive cosmetic surgery as sitting at "the intersection between commerce and medicine" (Sullivan, 1999). Critics of cosmetic surgery frame the practice of cosmetic medicine as an environment where surgeons are likely to be more concerned about profitability than their patient's needs, and are therefore inclined to emphasize the act of selling as much surgery as possible, regardless of whether it is in a patient's best interest. When a patient directly requests a procedure, they indicate that they are approaching cosmetic surgery as a commercial, rather than a medical, enterprise. If the surgeon were to simply and unquestioningly grant such a request, the interaction would no longer be recognizable as doctor-patient interaction. It would more closely resemble something that one would expect to hear in a salon or a spa. When patients propose treatment, they encroach on the rights and responsibilities afforded the medical profession. A surgeon can abdicate those rights and responsibilities, but in doing so they would also abdicate the larger part of what it means to be a doctor. So, to reclaim their rights and responsibilities, they need to engage in interactional practices that secure their socially granted right to assess their patient's condition and propose treatment based upon that evaluation. The use of these practices does not need to be overt or assertive, because as my participants' anxiety indicated, they had concerns about proposing treatment, but seemed to be unable to find a way to topicalize their concerns in medically appropriate ways. By withholding medically appropriate responses to improperly formatted requests, Dr. D tacitly held his patients accountable for requesting help using the norms of medicine, and afforded them the opportunity to produce more talk which usually resulted in the

patient being able to backdoor their way into a more medically appropriate problem presentation package.

Accordingly, it appears as if one of the most fundamental aspects of being perceived as a good surgical candidate is orienting to the process as a patient. My findings act as a counterbalance to the commonly held belief that cosmetic surgeons favor the entrepreneurial side of the intersection between commerce and medicine, because they are assumed to be ready, willing, and able to perform surgery on anybody and everybody who asks for it. In chapter 3, I suggested that in the process of developing the cosmetic consultation by letting the norms and values of medicine shape the way the participants discuss desires, goals, and possible outcomes, the participants actively engaged in institutional identity-work by interacting as "doctor" and "patient," rather than "customer" and "service provider." Thus, doctors and patients, *in situ,* through face-to-face interaction, engage in the process of medicalizing problems with one's appearance.

As it turns out, it is not enough to perform merely being a patient of cosmetic surgery. The notion of being a certain type of patient, a "good surgical candidate," is something that both surgeons and patients orient to; however, the two sets of participants had different emphases. In chapter 4, I argued that one of patients' preoccupations for their presentation package is legitimizing their decision to seek treatment by presenting themselves as reasonable, rational people, whereas in chapter 5 I showed that surgeons were more concerned with ascertaining that their patients have the ability to reduce their bodies into constituent parts. Patients' preoccupations with performing in ways that make them a good surgical candidate is, at least in part, related to the notion of being a legitimate patient in any arena. The foundation of this need has been concisely summarized by an anonymous physician:

> In order to have the privilege of talking to your doctor you must fulfill the essential precondition of being sick. Then you may go to him and ask him if he will perform his professional services upon you. (Byrne & Long, 1976, p. 20; Heritage & Robinson, 2006, p. 48)

In primary care, being a legitimate patient requires that an individual either be sick, or at minimum, they should be suffering symptoms that are likely to be interpreted by rational people as worthy of medical evaluation. Otherwise, they risk being perceived as a hypochondriac or a malingerer. Since cosmetic surgery is medicine without illness, the process of legitimizing one's desire for surgery can be difficult. Overall, my participants indicated an awareness that some people seeking cosmetic interventions are, or at least should be, rejected as surgical candidates. Almost always, the issue laypeople mention when discussing the possibility of being rejected as a surgical candidate is related to the potential patient's concerns about a seemingly small issue that is treated as a non-issue: "Susie is complaining about her 'fatty knees.' Can you believe it? Fatty knees at 6 feet tall and I dunno, what? 130 lbs. That doctor better throw her out and tell her that she needs a psychiatrist, not a plastic surgeon" (private conversation 1/22/2018). People tend to be quick to diminish the legitimacy of small and seemingly aesthetically unimportant details that plague others. This becomes problematic for potential patients because most cosmetic concerns are indeed small; bigger concerns that are likely to tend to be perceived as "needed" tend to fall under the heading of reconstructive, rather than cosmetic, surgery. So, when patients talk with their surgeons, they devote quite a bit of interactional labor into distinguishing themselves from those patients who, because of their concern about a seemingly small physical issue, should see a psychiatrist rather than a surgeon. Unsurprisingly, cosmetic surgeons are trained to watch for people whose level of concern is disproportionate relative to the magnitude

of the problem. Patients' concerns about being rejected because their problem is too insignificant are more pronounced than they should be. Most patients come in concerned about a relatively minor issue, and few patients are rejected as candidates. One of Dr. D's patients asked him if he thought there was something "wrong with her" because she had undergone multiple procedures. He looked genuinely puzzled and said "no." She went on to say that it was her understanding that surgeons were concerned about people who get too many surgeries or are concerned about the "little stuff." He responded, "I can see the issues you're complaining about. They don't have to be big, they just have to exist to be valid." This mindset was evidenced in his responses to most patients in this study. His responses to their efforts to legitimize their decisions to seek treatment were nearly universally agnostic. It appears as if, unless a potential patient's concern about their appearance was completely over-the-top, or off base, surgeons, or at least this surgeon, was not inordinately concerned about their patients being vain or concerned about small and often nearly imperceptible, at least to other laypeople, changes in their faces.

What does seem to be a matter of concern to surgeons is that a patient displays an ability to understand and discuss their appearance in terms of its constituent parts. Dr. D's behavior indicated he is far more interested in practical aptitude rather than moralistic or psychologically based assessments. Rather than making some paternalistic judgment about the reasoning informing his patients' desire to undergo surgery, he devoted far more energy into the project of training his patients in the ability to see and discuss their faces at an institutionally relevant level of detail. Presumably, what his evaluation of his patients in terms of candidacy is hierarchical. Presumably one of the more basic levels is proper motivation. Dr. D disclosed to me that he is leery of taking on young, quiet patients who come in with their boyfriends, and during the consultation the boyfriend, rather than the patient, is the one who talks about the girls' desires for

implants or a nose job. Goldwyn discusses extreme situations where, to use Dr. D's words, a patient comes in inordinately upset about some perceived flaw that is not visible, but these types of situations, although they most certainly occur on a regular basis, are not the norm. Unfortunately my data set did not contain an instance where a patient was rejected on the basis of being improperly motivated, but it is my hypothesis that, if a potential patient does not immediately trip the most basic motivational wire and draw attention to themselves in that way, surgeons can move outside of the psychological realm to evaluate their patient on the more practical level.

Dr. D's emphasis in discussing his patients' faces and appropriate treatments in great detail is absolutely done in the service of achieving what Goldwyn (1991) calls "informed consent," meaning that the surgeon provides as many relevant details as possible to facilitate patient decision-making process. But, as Dull and West (1991) argued, the process of breaking a face down into operable components provides a platform on which surgeons can discuss the patient's body in terms of treatments and provide detailed information as to what sort of outcomes patients can expect from the procedure. When Dr. D told Letitia that some of her lines were "treatable" while others were not, he was doing more than merely providing resources for informed consent, he was actively working to shape his patients' expectations about their surgical outcomes. Patients certainly benefit from this activity, but it is equally and arguably even more important for the surgeons. In the process of helping patients to understand what they can and cannot expect in terms of a surgical outcome, they attenuate the possibility of a disappointed post-operative patient.

Across this study, I documented some of the practices patients used to present their concerns and themselves to their cosmetic surgeon. I also discussed some of the problems,

challenges, and dilemmas potential patients and surgeons encounter in the process of problem presentations, and showed how, when necessary, surgeons are able to help, or redirect patients so that they are better able to present themselves in ways that allow them to be perceived as viable candidates for surgery. I now consider limitations of this study and make suggestions for future avenues of research.

Study Limitations and Directions for Future Research

The scope of my research was limited in several ways. First, and most importantly, my data were collected from one doctor in the Beverly Hills and his interactions with 19 patients. Although my findings were largely compatible with the findings of other qualitative studies, (Dull and West 1991, Mirivel 2005, 2007, 2008, 2010), it would not be prudent to assume that all cosmetic surgery practices, let alone surgeons, are created the same. In the opening chapter I discussed how some cosmetic surgery practices are set up to specifically feature a trademarked procedure such as a Lifestyle Lift, and these types of practices are becoming increasingly popular. In these practices the range of services is narrow, and often the trademarked service is all they offer. In these contexts, the need for surgeon evaluation is mitigated. While the surgeons still need to evaluate the patient to assure that the procedure is appropriate in terms of achieving the patient's goals, in such an environment the nature of the treatment a patient is likely to receive is a foregone conclusion. Similarly, in the world of people interested in cosmetic surgery, tales abound of cosmetic surgeons who use heavy-handed, high pressure sales tactics, to load patients down with multiple procedures they had never considered. These contexts are similar in that both would seem to be medical environments where some of norms and values associated with more traditional aspects of medicine are tabled in an effort to sell a surgery, or a certain type of surgery. This begs the question, in an environment that leans more heavily into the

commercial aspect of cosmetic medicine, do the patterns that I found hold true? Or are direct requests for treatment more tolerated? If so, what are the implications for doctor-patient relationships as the medical context leans more heavily into the commercial side of Sullivan's, "intersection between medicine and commerce"?

Another limitation with my study is the number of patients, and accordingly the type of surgeries that they were seeking from Dr. D. First, it is worth mentioning that my patients were all Angelenos, all middle to upper middle class, all of them were Caucasian, and all but one were female. In addition, all but one patient were concerned about visible signs of aging on the face. Cosmetic surgery on the body in many ways is easier to discuss because we tend to have more vernacular terms for the body parts, and the range of what people want done with those parts of the body tend to be more streamlined. Whether we are talking about breasts, thighs, a behind, or even a nose, people are inclined to either want that body part larger or smaller, or higher or lower, so the ease one might be able to discuss their concern might have an impact in the way patients discuss their concerns. However, most body work is done on sexualized areas of the body: breasts, thighs, bottoms, and stomachs. In addition, while my patients were able to frame themselves as trying to maintain a sense of preserving what has historically been "normal" for them, it is far more likely that someone interested in body work is trying to enhance something they have never liked about their appearance. It would be interesting to see if, in such a context, patients are more or less inclined to legitimize their desire for surgery. Since in everyday life there seems to be a certain level of morality issues associated with breast implants, "butt lifts," and very likely liposuction, it would be interesting to see how morality concerns, if many, are managed in the discussion of such procedures.

Appendix A: Recruitment Scripts

1.0 Patient Recruitment

Oral Script to Recruit Cosmetic Surgery Patients

Hi, my name is Erika Lamoureaux and I'm a student at the University of California, Los Angeles. I'm doing a research project on interaction between cosmetic surgeons and patients and I was hoping you would participate. You are eligible to participate if you are at least 18 years of age, speak English fluently and are interested in obtaining information about a cosmetic (non-reconstructive) procedure. I am doing this study to help doctors learn about what you as a patient expects when you come to see them.

If you agree to participate your consultation will be videotaped. I will not be present in the room during your consultation. Approximately 2 weeks after your consultation you will be contacted by phone for a brief interview about your experience in the consultation.

It's absolutely up to you; you're under no obligation to participate and if you agree, you will have full access to the camera and can turn it off at any point during the consultation. Additionally, your information will be kept confidential and your surgeon will not have access to either the videotapes or the information obtained from your interview. You may withdraw from the study at any time in which case your video will be destroyed in your presence.

Your participation would be very helpful both to us and the doctor and staff in this practice. If you are willing to participate I will give you a formal written consent form.

Thank you for your consideration, would you be interested in participating in this study?

2.0 Patient Recruitment

Recruitment Letter and/or Oral Script to Recruit Cosmetic Surgeons

**NOTE: *****Whether initial recruitment of surgeons is done by letter, phone or face-to-face contact the same script will be used. There will be no additional presentation materials for presentation. Any follow up meetings would be initiate at the request of the physician to answer any questions or address any concerns they might have.* **

Hello Dr. [NAME}

My name is Erika Lamoureaux and I am a graduate student at University of California, Los Angeles. Dr. [NAME] suggested I contact you to see if you might be willing to participate in a research study on communication between cosmetic surgeons and their patients. More specifically my study is (a) looking at patients' preferences and motivations for cosmetic procedures and how physicians can facilitate those preferences and (b) looking at medical decision-making processes.

To conduct this study, I would like to videotape ten initial consultations with potential patients in your practice. This would involve a video camera being set up in one corner of an examination room. I would not need to be in the room since the camera could essentially be left running. In the event that there was a patient who had agreed to participate but changed his/her mind for any reason during the consultation, the camera could be turned off or removed entirely. I anticipate that, if you agree to participate, my work should take 5-14 days depending on the number of patients available within the given time frame.

As far as what I would be asking of you, I would like for you to:

- Permit me to explain the study to patients in your waiting room and ask for their consent to participate in the research. Alternatively, when the patient phones in to make their appointment, your receptionist could tell the patient that your practice is working with a researcher from University of California, Los Angeles and ask if they would mind if the researcher approached them and explained the study prior to their consultation.
- Allow the visits with your consenting patients to be taped. The videotaping will take the amount of time you spend with each study patient and the researcher will not be present during the interaction.
- Immediately following the end of the consultation, you will be asked (on tape) for your assessment of the patient's surgical candidacy.

Unless you elect to have your office staff mention the potential presence of a researcher, your staff will not be asked to do anything special other than coordinate with us on alerting you as to which patients have agreed to be in the study.

Studies of doctor patient interactions using videotaped data have been done in a variety of medical settings in the U.S. and Europe and there is usually less than a 10% refusal rate.

Both the patients and you, as the physician, can ask that we erase any particular consultation. If for any reason you feel uncomfortable about a particular encounter I am happy to delete it (or destroy the tape).

Thank you for your consideration.

Appendix B: Consent

2.0 ***Physician Consent***

SURGEON CONSENT TO TAKE PART IN A RESEARCH STUDY

TITLE OF STUDY: **Assessing Decision Making Processes in Cosmetic Surgery Intake Interviews**

PRINCIPAL INVESTIGATOR: ERIKA LAMOUREAUX
UCLA
Department of Sociology
264 Haines Hall
375 Portola Plaza
Los Angeles, CA 90095-1551
(626) 588-7033; elamoure@ucla.edu

This consent form is part of an informed consent process for a research study and it will give information that will help you to decide whether you wish to volunteer for this research study. It will help you to understand what the study is about and what will happen in the course of the study.

After all of your questions have been answered, if you still wish to take part in the study, you will be asked to sign this informed consent form.

The study principal investigator will also be asked to sign this informed consent. You will be given a copy of the signed consent form to keep.

If you have questions at any time during the research study, you should feel free to ask and should expect to be given answers that you completely understand.

You are not giving up any of your legal rights by volunteering for this research study or by signing this consent form.

Why is this study being done?

The purpose of this study is to examine how individuals seeking cosmetic surgery and their surgeons make decisions about treatment options. This study is interested in how patients and surgeons talk about different options and how they decide on which treatments to be pursued.

Why have you been asked to take part in this study?

You have been asked to participate in this study because you are a board-certified surgeon who specializes in cosmetic work. You routinely facilitate or participate in treatment decision-making conversations with patients.

Who may take part in this study? And who may not?

You MAY participate in this study if:
● you are a health care provider who does cosmetic work
● you speak English fluently

You may NOT participate in this study if:
● you are not a health care provider who does cosmetic work
● you do not speak English fluently

How long will the study take and how many subjects will participate?

Approximately 5 surgeons and 50 individuals who are interested in having cosmetic work done will participate in this study, along with any companions they bring with them. Surgeons may have staff accompany them during visits. If you decide to participate, you will be asked to allow for the videotaping of at least 10 treatment decision-making conversations (i.e., 10 different patients). Additionally, you will be asked to participate in a brief (i.e., 5 minute) on camera interview about your impressions of the patient after their consultation.

What will you be asked to do if you take part in this research study?

If you decide to participate in this study, you will be asked to allow at least 10 visits to be videotaped, and engage in a 5 minute on camera interview immediately following the patient's consultation about your impressions of the patient and their surgical candidacy.

What are the risks and/or discomforts you might experience if you take part in this study?

There are at least three risks for health care providers. First, because your conversations will be videotaped, you might experience mild nervousness, embarrassment, or emotional discomfort. Transcripts and images of your conversation may be used for teaching and research purposes. Second, there is the potential for disgruntled participants to later request copies of recorded visits for legal purposes. To address this, Certificates of Confidentiality from NIH will be requested to protect both you and your patients from possible subpoenas of taped data. Third, there is the risk that information concerning how you conduct your medical practice is revealed to your colleagues, patients, or the public at large. To address this, the research team will not be providing any individual-level information on health care providers participating in this study to anyone within or outside their practices. Results will only be supplied in aggregate form. In the rare event that such a breech were to occur, the PI will immediately inform you and the UCLA IRB, and take all possible action to minimize the negative consequences resulting from the breech.

Are there any benefits for you if you choose to take part in this research study?

There are no direct benefits to your participation. Your participation will help us have a better understanding of communication between patients and their surgeons, and of how surgical decisions are made.

What are your alternatives if you don't want to take part in this study?

There are no research alternatives available. Your only choice is not to take part in this study.

How will you know if new information is learned that may affect whether you are willing to stay in this research study?

During the course of the study, you will be updated about any new information that may affect whether you are willing to go on taking part in the study. If new information is learned that may affect you after the study or your follow-up is completed, you will be contacted.

Will there be any cost to you to take part in this study?

There will be no cost to you.

Will you be paid to take part in this study?

You will not be paid to participate in this study.

How will information about you be kept private or confidential?

Your personal identity, that is your name and other identifiers, will be kept confidential. You will have a code number and your actual name will not be used. Only the study primary investigator will be able to link the code number to your name.

By taking part of this study, you should understand that the study collects demographic data on your patients. This data will be recorded by the study investigator who may store and process their data with electronic data processing systems. Because the information from the tapes may be used in multiple studies, and because the completion dates of those studies cannot be predicted in advance, the tapes will be kept indefinitely.

Your data may be used in scientific publications. If the findings from the study are published, you will not be identified by name. Your identity will be kept confidential. The exception to this rule will be when there is a court order or when a law exists requiring the study doctor to report certain information. It is possible for confidentiality to be breached if someone recognizes your voice from your video image.

The study doctor/investigator will be allowed to examine the data in order to analyze the information obtained from this study, and for general health research.

If you do not sign this approval form, you will not be able to take part in this research study.

You can change your mind and revoke your approval at any time. If you change your mind after completing the study and leaving the office, you must revoke your approval in a written request to Erika Lamoureaux. If you revoke your approval, all of your data will be destroyed.

What will happen if you do not wish to take part in the study or if you later decide not to stay in the study?

You may choose not to be in the study. If you do choose to take part in the study, it is voluntary. You may refuse to take part in the study, or pull out of the study, at any time. If you do not participate, or if you pull out of the study, your relationship with the study staff will not change, and you may do so without penalty and without loss of benefits to which you are otherwise entitled.

Who can you call if you have any questions?

If you have any questions about taking part in this study, or if you feel you may have suffered a research related injury, you can contact the principle investigator (see contact information on page 1, above).

Additionally, if you have any questions about your rights as a research subject, you may contact the IRB Administrator UCLA: University of California Los Angeles, 10945 Le Conte Avenue, 2107 Peter V. Ueberroth Building, Box 951694, Los Angeles, California, 90095-1694. Tel: (310) 825-5344. Email: GCIRB@OPRS.UCLA.EDU.

What are your rights if you decide to take part in this research study?

You have the right to ask questions about any part of the study at any time. You should not sign this form unless you have had a chance to ask questions and have been given answers to all of your questions.

Consent for Videotaping, Tape Recording, etc. for Educational and Research Purposes

You hereby authorize the principle investigator to make videotapes, tape recordings, or photographs of your visit with the surgeon. Furthermore, you hereby authorize the principle investigator to show, play, or retain such videotapes, movies, tape recordings, or photographs, with explanatory text if desired, in the interest of teaching/education (e.g., training surgeons or teaching students) and research (e.g., scholarly conferences and publications in journals, books, or other educational media).

Your consent is given subject to the condition that:

The name of the patient and their companions will not be identified in the videotapes, movies, tape recordings, or photographs.

The videotapes, movies, tape recordings, or photographs will not be used for commercial or public media purposes.

This authorization is expressly intended to release from liability and hold harmless the state of California, as well as University of California, its staff, officers, employees, and agents from any and all liability, which may result from the taking, printing, retaining, and using of said videotapes, tape recordings, or photographs.

This authorization and release are expressly intended to be binding upon the undersigned, his heirs, executors, administrators, successors, and assigns.

You have read and understand the above and do hereby agree to procedure to be undertaken.

Subject Signature ___________________________________ Date ____________________

AGREEMENT TO PARTICIPATE

I have read this entire form, or it has been read to me, and I believe that I understand what has been discussed. All of my questions about this form or this study have been answered.

Subject Name:____

Subject Signature:__________________________________ Date:___________

FUTURE USE OF DATA

Please check the appropriate box below and initial:
______I agree to have my data stored for future use by the Principal Investigator and/or research team.
______I do not want my data stored for future use by the Principal Investigator and/or research team.

Signature of Investigator/Individual Obtaining Consent:

To the best of my ability, I have explained and discussed the full contents of the study including all of the information contained in this consent form. All questions of the research subject and those of his/her parent or legal guardian have been accurately answered.

Investigator/Person Obtaining Consent:___________________________________

Signature:__________________________________ Date: ________________

PATIENT CONSENT TO TAKE PART IN A RESEARCH STUDY

TITLE OF STUDY: **Assessing Decision Making Processes in Cosmetic Surgery Intake Interviews**

PRINCIPAL INVESTIGATOR: ERIKA LAMOUREAUX
UCLA
Department of Sociology
264 Haines Hall
375 Portola Plaza
Los Angeles, CA 90095-1551
(310) 968-1474; elamoure@ucla.edu

This consent form is part of an informed consent process for a research study and it will give information that will help you to decide whether you wish to volunteer for this research study. It will help you to understand what the study is about and what will happen in the course of the study.

After all of your questions have been answered, if you still wish to take part in the study, you will be asked to sign this informed consent form.

The principle investigator will also be asked to sign this informed consent. You will be given a copy of the signed consent form to keep.

If you have questions at any time during the research study, you should feel free to ask and should expect to be given answers that you completely understand.

You are not giving up any of your legal rights by volunteering for this research study or by signing this consent form.

Why is this study being done?

The purpose of this study is to examine how individuals seeking cosmetic surgery and their surgeons make decisions about treatment options. This study is interested in how patients and surgeons talk about different options and how they decide on which treatments to be pursued.

Why have you been asked to take part in this study?

You have been asked to participate in this study because you have scheduled an appointment with a cosmetic surgeon to explore the option of cosmetic surgery.

Who may take part in this study? And who may not?

You MAY participate in this study if:
● you are seeking information from a surgeon about cosmetic surgery
● you speak English fluently
● you can complete a short questionnaire without assistance before and after your visit with the surgeon
● you are at least 18 years old
● all of your companion(s) is/are at least 18 years old
● all of your companion(s) give informed consent

You may NOT participate in this study if:
● you are not seeking medical intervention for a cosmetic concern
● you do not speak English fluently
● you need assistance with filling out questionnaires
● you are younger than 18 years of age
● any of your companions are younger than age 18
● any of your companions do not give informed consent

How long will the study take and how many subjects will participate?

Approximately 5 surgeons and 50 individuals who are interested in having cosmetic work done will participate in this study, along with any companions they bring with them. If you decide to participate, you will be asked to complete a short survey (about 5-10 minutes) before your visit with the surgeon, and to allow the visit to be videotaped. The videotaping will last as long as you, your companions, and the healthcare providers are discussing treatment options, and until everyone exits the room. This conversation usually lasts between 30 minutes and 1 hour. Finally, you will be contacted, by telephone, by the principal investigator approximately 15-30 days after your consultation to be interviewed about your current stance towards your desired surgery(ies).

What will you be asked to do if you take part in this research study?

If you decide to participate in this study, you will be asked to complete a short survey (about 5-10 minutes) before your visit with the surgeon, and to allow the visit to be videotaped. The surveys will ask general socio-demographic questions.

What are the risks and/or discomforts you might experience if you take part in this study?

Because the conversation will be videotaped, you might experience mild nervousness, embarrassment, or emotional discomfort. Transcripts and images of your conversation may be used for research and teaching purposes.

Are there any benefits for you if you choose to take part in this research study?

You will receive no direct benefit from participating in this study. Your participation will help us have a better understanding of communication between patients and their surgeons, and of how surgical decisions are made.

What are your alternatives if you don't want to take part in this study?

There are no research alternatives available. Your only choice is not to take part in this study.

How will you know if new information is learned that may affect whether you are willing to stay in this research study?

During the course of the study, you will be updated about any new information that may affect whether you are willing to go on taking part in the study. If new information is learned that may affect you after the study or your follow-up is completed, you will be contacted.

Will there be any cost to you to take part in this study?

There will be no cost to you or your companion(s) to participate in this study.

Will you be paid to take part in this study?

Participants in this study will not receive financial compensation.

How will information about you be kept private or confidential?

Your personal identity, that is your name and other identifiers, will be kept confidential. You will have a code number and your actual name will not be used. Only the primary investigator will be able to link the code number to your name.

By taking part of this study, you should understand that the study collects demographic data. This data will be recorded by the study investigator who may store and process your data with electronic data processing systems. Because the information from the tapes may be used in multiple studies, and because the completion dates of those studies cannot be predicted in advance, the tapes will be kept indefinitely.

Your data may be used in scientific publications. If the findings from the study are published, you will not be identified by name. Your identity will be kept confidential. The exception to this

rule will be when there is a court order or when a law exists requiring the study doctor to report certain information. It is possible for confidentiality to be breached if someone recognizes your voice from your video image.

The study investigator will be allowed to examine the data in order to analyze the information obtained from this study, and for general health research.

If you do not sign this approval form, you will not be able to take part in this research study.

You can change your mind and revoke your approval at any time. If you change your mind after completing the study and leaving the office, you must revoke your approval in a written request to Erika Lamoureaux. If you revoke your approval, all of your data will be destroyed.

What will happen if you do not wish to take part in the study or if you later decide not to stay in the study?

You may choose not to be in the study. If you do choose to take part in the study, it is voluntary. You may refuse to take part in the study, or pull out of the study, at any time. If you do not participate, or if you pull out of the study, your relationship with the study staff will not change, and you may do so without penalty and without loss of benefits to which you are otherwise entitled.

Who can you call if you have any questions?

If you have any questions about taking part in this study, or if you feel you may have suffered a research related injury, you can contact the principle investigator (see contact information on page 1, above).

Additionally, if you have any questions about your rights as a research subject, you may contact the IRB Administrator UCLA: University of California Los Angeles, 10945 Le Conte Avenue, 2107 Peter V. Ueberroth Building, Box 951694, Los Angeles, California, 90095-1694. Tel: (310) 825-5344. Email: GCIRB@OPRS.UCLA.EDU.

What are your rights if you decide to take part in this research study?

You have the right to ask questions about any part of the study at any time. You should not sign this form unless you have had a chance to ask questions and have been given answers to all of your questions.

Consent for Videotaping, Tape Recording, etc. for Educational and Research Purposes

You hereby authorize the principle investigator to make videotapes, tape recordings, or photographs of your visit with the surgeon. Furthermore, you hereby authorize the principle investigator to show, play, or retain such videotapes, movies, tape recordings, or photographs, with explanatory text if desired, in the interest of teaching/education (e.g., training surgeons or teaching students) and research (e.g., scholarly conferences and publications in journals, books, or other educational media).

Your consent is given subject to the condition that:

The name of the patient and their companions will not be identified in the videotapes, movies, tape recordings, or photographs.

The videotapes, movies, tape recordings, or photographs will not be used for commercial or public media purposes.

This authorization is expressly intended to release from liability and hold harmless the state of California, as well as University of California Los Angeles, its staff, officers, employees, and agents from any and all liability which may result from the taking, printing, retaining, and using of said videotapes, tape recordings, or photographs.

This authorization and release are expressly intended to be binding upon the undersigned, his heirs, executors, administrators, successors, and assigns.

You have read and understand the above and do hereby agree to procedure to be undertaken.

Subject Signature ___________________________________ Date_____________________

AGREEMENT TO PARTICIPATE

I have read this entire form, or it has been read to me, and I believe that I understand what has been discussed. All of my questions about this form or this study have been answered.

Subject Name:____

Subject Signature:_____________________________________ Date:_____________

FUTURE USE OF DATA

Please check the appropriate box below and initial:
______I agree to have my data stored for future use by the Principal Investigator and/or research team.
______I do not want my data stored for future use by the Principal Investigator and/or research team.

Signature of Investigator/Individual Obtaining Consent:

To the best of my ability, I have explained and discussed the full contents of the study including all of the information contained in this consent form. All questions of the research subject and those of his/her parent or legal guardian have been accurately answered.

Investigator/Person Obtaining Consent:______________________________________

Signature:______________________________________ Date: __________________

Appendix C: Transcription Conventions

TRANSCRIPT SYMBOLS

1. Temporal and sequential relationships

A. Overlapping or simultaneous talk is indicated in a variety of ways.

[[Separate left square brackets, one above the other on two successive lines with utterances by different speakers, indicates a point of overlap onset, whether at the start of an utterance or later.

] Separate right square brackets, one above the other on two successive

] lines with utterances by different speakers indicates a point at which two overlapping utterances both end, where one ends while the other continues, or simultaneous moments in overlaps which continue.

// In some older transcripts or where graphic arrangement of the transcript requires it, a double slash indicates the point at which a current speaker's utterance is overlapped by the talk of another, which appears on the next line attributed to another speaker. If there is more than one double slash in an utterance, then the second indicates where a second overlap begins, the overlapping talk appearing on the next line attributed to another speaker, etc. In transcripts using the // notation for overlap onset, the end of the overlap may be marked by a right bracket (as above)
* or by an asterisk.

So, the following are alternative ways of representing the same event: Bee's "Uh really?" overlaps Ava's talk starting at "a" and ending at the "t" of "tough."

```
Ava:        I 'av [a lotta  t]ough cou:rses.
Bee:              [Uh really?]

Ava:        I 'av // a lotta t*ough cou:rses.
Bee:        Uh really?
```

= B. Equal signs ordinarily come in pairs -- one at the end of a line and another at the start of the next line or one shortly thereafter. They are used to indicate two things:

1) If the two lines connected by the equal signs are by the same speaker, then there was a single, continuous utterance with no break or pause, which was broken up in order to accomodate the placement of overlapping talk. For example, TG, 02:18-23:

```
Bee:        In the gy:m? [(hh)
Ava:                     [Yea:h. Like grou(h)p therapy.Yuh know
            [half the grou]p thet we had la:s' term wz there en we=
Bee:        [ O h : : : . ]˙hh
Ava:        =[jus' playing arou:nd.
Bee:        =[˙hh
```

Ava's talk is continuous, but room has been made for Bee's overlapping talk (the “Oh”).

2) If the lines connected by two equal signs are by different speakers, then the

second followed the first with no discernable silence between them, or was "latched" to it.

(0.5) C. Numbers in parentheses indicate silence, represented in tenths of a second; what is given here in the left margin indicates 5/10 seconds of silence. Silences may be marked either within an utterance or between utterances, as in the two excerpts below:

```
Bee:    ˙hhh Uh::, (0.3) I don'know I guess she's aw- she's
        awright she went to thee uh:: hhospital again tihda:y,
Bee:    Tch! .hh So uh I don't kno:w,
                 (0.3)
Bee:    En:=
```

(.) D. A dot in parentheses indicates a "micropause," hearable but not readily measurable; ordinarily less than 2/10 of a second.

((pause)) E. In some older or less carefully prepared transcripts, untimed silences may be indicated by the word "pause" in double parentheses.

2. Aspects of speech delivery, including aspects of intonation.

. ? , ?, ¿ _ A. The punctuation marks are not used grammatically, but to indicate intonation. The period indicates a falling, or final, intonation contour, not necessarily the end of a sentence. Similarly, a question mark indicates rising intonation, not necessarily a question, and a comma indicates “continuing” intonation, not necessarily a clause boundary. In some transcript fragments in your readings you may see a combined question mark and comma, which indicates a rise stronger than a comma but weaker than a question mark. Because this symbol cannot be produced by the computer, the inverted question mark (¿) is used for this purpose. Sometimes completely 'level' intonation is indicated by an 'empty' underline at the end of a word, e.g., "word_".

: : B. Colons are used to indicate the prolongation or stretching of the sound just preceding them. The more colons, the longer the stretching. On the other hand,

graphically stretching a word on the page by inserting blank spaces between the letters does not necessarily indicate how it was pronounced; it is used to allow alignment with overlapping talk. Thus,

```
            Bee:       Tch! (M'n)/(En ) they can't delay much
lo:nguh they
                       [jus' wannid] uh-˙hhh=
            Ava:       [ O h  :  .]
            Bee:       =yihknow have anothuh consulta:tion,
            Ava:       Ri::ght.
            Bee:       En then deci::de.
```

The word "ri::ght" in Ava's second turn, or "deci::de" in Bee's third are more stretched than "oh:" in Ava's first turn, even though "oh:" appears to occupy more space. But "oh" has only one colon, and the others have two; "oh:" has been spaced out so that its brackets will align with the talk in Bee's ("jus' wannid") turn with which it is in overlap.

\- C. A hyphen after a word or part of a word indicates a cut-off or self-interruption, often done with a glottal or dental stop.

word / word / WOrd D. Underlining is used to indicate some form of stress or emphasis, either by increased loudness or higher pitch. The more underlining, the greater the emphasis. Therefore, underlining sometimes is placed under the first letter or two of a word, rather than under the letters which are actually raised in pitch or volume. Especially loud talk may be indicated by upper case; again, the louder, the more letters in upper case. And in extreme cases, upper case may be underlined.

° / ° ° E. The degree sign indicates that the talk following it was markedly quiet or soft. When there are two degree signs, the talk beween them is markedly softer than the talk around it.

F. Combinations of underlining and colons are used to indicate intonation contours, as follows:

_: If the letter(s) preceding a colon is underlined, then there is an "inflected" falling intonation contour (you can hear the pitch turn downward).

: If a colon is itself underlined, then there is an inflected rising intonation contour (i.e., you can hear the pitch turn upward).

So, in

Bee: In the gy:m? [(hh)
Ava: [Yea:h. Like grou(h)p
therapy.Yuh know
[half the grou]p thet we had la:s' term wz
there en we=
Bee: [O h : : : .]˙hh
Ava: =[jus' playing arou:nd.
Bee: =[˙hh
Bee: Uh-fo[oling around.
Ava: [˙hhh
Ava: Eh-yeah so, some a' the guys who were bedder
y'know wen'
off by themselves so it wz two girls against
this one guy
en he's ta:ll.Y'know? [˙hh
Bee: [Mm hm?

the "Oh:::." in Bee's second turn has an upward inflection while it is being stretched
(even
though it ends with falling intonation, as indicated by the period). On the other hand,
"ta:ll" at the end of Ava's last turn is inflected downward ("bends downward," so to speak,
over
and above its "period intonation."

G. The up and down arrows mark sharper rises or falls in pitch than would be
↑ be indicated by combinations of colons and underlining, or may mark a whole shift,
↓ or resetting, of the pitch register at which the talk is being produced.

> < H. The combination of "more than" and "less than" symbols indicates that the talk
< > between them is compressed or rushed. Used in the reverse order, they can indicate that
a stretch of talk is markedly slowed or drawn out. The "less than" symbol by itself indicates
< that the immediately following talk is "jump-started," i.e., sounds like it starts with a rush.

hhh I. Hearable aspiration is shown where it occurs in the talk by the letter "h" -- the
more h's, the more aspiration. The aspiration may represent breathing, laughter,
(hh) etc. If it occurs inside the boundaries of a word, it may be enclosed in parentheses
in order to set it apart from the sounds of the word (as in TG, 02:12-13 below). If the
˙hh aspiration is an inhalation, it is shown with a dot before it (usually a raised dot).

Bee: [Ba::]sk(h)etb(h)a(h)ll? (h)(°Whe(h)re.)

J. Some elements of voice quality are marked in these transcripts. A rasping

#	or 'creaky' voice quality is indicated with the "#" sign. Similarly a 'smile voice' - a voice quality which betrays the fact that the speaker is smiling while speaking is normally
£	indicated with the "£" sign.

3. Other markings.

(( )) A. Double parentheses are used to mark transcriber's descriptions of events, rather than representations of them. Thus ((cough)), ((sniff)), ((telephone rings)), ((footsteps)), ((whispered)), ((pause)) and the like.

(word) B. When all or part of an utterance is in parentheses, or the speaker identification is, this indicates uncertainty on the transcriber's part, but represents a likely possibility.
( ) Empty parentheses indicate that something is being said, but no hearing (or, in some cases, speaker identification) can be achieved.

(try 1) C. In some transcript excerpts, two parentheses may be printed, one above the other;
(try 2) these represent alternative hearings of the same strip of talk. In some instances this format cannot be printed, and is replaced by putting the alternative hearings in parentheses,
separated
by a single oblique or slash, as in

```
Bee:        °(Bu::t.)=/°(Goo:d.)=
```

Here, the degree marks show that the utterance is very soft. The transcript remains indeterminate between "Bu::t." and "Goo:d." Each is is parentheses and they are separated by a slash.

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