# **"Big eye surgery":** Understanding the ethical implications of medicalising Asian features in cosmetic surgery

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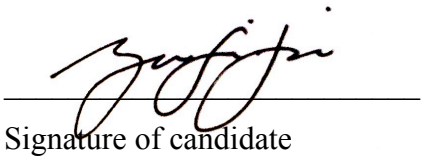
# Declaration of Originality

**Master of Research Thesis**

This is to certify that I, Yves Saint James Aquino, being a candidate for the degree of Master of Research, is submitting an original work to Macquarie University Higher Degree Research and has not submitted the same thesis for a higher degree to any other university or institution.

The sources of information used in this research include published materials such as books, articles, and online publications. The materials have been acquired through the help of the university library that offers physical copies of references or online access to digital copies. Some materials, such as books and journals, have been obtained from my supervisor, Prof Wendy Rogers. The references are properly acknowledged by including in-text citations within the body of the thesis, as well as a reference list at the end.

The research did not require an Ethics Committee approval.



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# Abstract

In East Asian countries, the ever-growing popularity of facial cosmetic surgery has generated various debates on the ethical implications of the practice. Ethical discussions are zooming in on the medicalisation of race-identifying facial features, such as Asian eyelids, in what has been referred to as Asian cosmetic surgery. In this study, I first posit that medicalisation in Asian cosmetic surgery can be interpreted in two forms: treatment versus enhancement forms. In the treatment form, cosmetic surgery is viewed as a remedy for "pathologised" Asian features. In the enhancement form, cosmetic surgery is seen as a form of improving the normal, albeit unwanted, racial features. Next, I present the findings from an empirical study that investigates medicalisation and its two forms in cosmetic surgery websites hosted in South Korea and Australia, as both countries are experiencing a growing number of aesthetic surgery clinics for Asians. Finally, I offer an ethical analysis of the consequences of medicalising racial features, mainly drawing from the findings of the empirical study. In particular, I describe how the practice influences individual autonomy and how it impacts on the traditional goals of medicine.

# Introduction

In recent years, there has been extensive news coverage of the dramatic rise of cosmetic surgery among Asian women in both Western and Asian countries. "Asian cosmetic surgery" has become a catchall phrase for cosmetic surgical procedures that are directed at racial features, such as the jawline, nose and eyelids. According to the International Society of Aesthetic Plastic Surgery, Asian eyelid surgery or blepharoplasty, in particular, is now one of the leading plastic surgeries performed worldwide (ISAPS, 2015). The latest report states that over 1.4 million eyelid surgeries, also referred to as "big eye surgery", were performed in 2014. South Korea, a popular destination for people seeking cosmetic surgeries like Asian blepharoplasty, is now considered by the media as the world plastic surgery capital. It has been estimated that as many as one in every three women in Seoul has gone under the knife (Marx, 2015). Australia is not too far behind, with increasing number of Asian-Australians deciding to undergo similar types of cosmetic surgery. The Australian documentary called "Change My Race" put a spotlight on this trend, referring to "de-racialisation" surgical procedures intended to make Asians look more Western (SBS, 2013).

Asian cosmetic surgery shares a number of general ethical issues with other types of cosmetic surgery. On the individual level, the practice may be criticised as a form of socialised oppression, with the issue primarily affecting women. On a societal level, there are questions as to whether cosmetic surgery truly promotes the goals of medicine, and if it is consistent with the duties of medical professionals.

In this research, I am particularly interested in framing ethical issues arising from Asian cosmetic surgery as an example of "medicalization", which refers to the process of viewing non-medical problems as medical (Conrad, 2005). Scholars have alluded to medicalisation in cosmetic surgery by describing how the practice depicts "ugliness as a form of disease" and beauty as the surgical outcome (Edmonds, 2013; p. 233). Further, medicalisation is considered a means for surgeons to justify the need to modify atypical features that deviate from time- and location-specific beauty norms (Gilman, 1999).

The medical framing in Asian cosmetic surgery creates specific ethical issues that are not as apparent in non-racial types[1] of cosmetic surgery. Medicalisation in racial cosmetic surgery is no longer just about framing "ugliness" as a disease, but specifically about depicting Asian features as seemingly pathological. In 1993, Kaw became one of the first scholars to articulate the criticism against cosmetic surgery in the US as a practice that medicalises racial features. Based on her ethnological research, she argues that the medical field uses scientific rationality and medical authority in order to promote negative racial stereotypes that bolster the need to conform to Caucasian standards of beauty. However, many scholars now criticise Kaw's interpretation. Some argue that Asian cosmetic surgery does not pathologise racial features, nor does it promote a Western ideal of beauty. Davies and Han (2011), for example, argue that in East Asia, cosmetic surgery is founded on a universal beauty ideal that is devoid of race. Dobke and colleagues (2006) claim that cosmetic surgery in East Asia is becoming a

[1] Non-racial cosmetic procedures may include breast augmentation or reduction, liposuction, and anti-aging injections, among others.

symbol of emancipation, rather than racial modification, reflecting the changing status of Asian women.

As with other conditions that have become medicalised, an important problem in racial surgery raised by critics is the "inappropriate" use of medical interventions for what is considered a social problem.[2] According to critics, medicalisation decontextualises social problems, if not completely ignoring them, only to re-frame them as medical problems that can be managed with medical interventions (Conrad, 1992). Conrad brings up medicalisation of domestic violence as an example, a process he argues that can distract from a focus on patriarchal values and gender oppression that promote aggressive male behaviour. Similarly, racial surgery can be seen as focusing on the individual without changing the social structures and expectations that motivate people to conform to certain standards of appearance. According to Parens (2013), critics of medicalisation argue that the process obscures our understanding of social sources of suffering. In this research, I am interested in applying this criticism to the medicalisation of racial features, to investigate how the practice impacts on psychosocial motivations behind cosmetic modifications, such as low self-esteem, racial discrimination, and gendered oppression, among others.

[2] Medicalisation is seen as appropriate and beneficial in conditions like epilepsy, which has been previously understood as a spiritual problem caused by bodily possession of evil spirits [Brown, P. (1995). Naming and Framing: The Social Construction of Diagnosis and Illness. *Journal of Health and Social Behavior*. Spec no. 34-52]. In other conditions such as pregnancy, medicalisation is arguably beneficial in order to improve maternal and child health through medical surveillance [Verweij, M. (1999). Medicalization as a Moral Problem for Preventive Medicine. *Bioethics*. 13(2):89-113.

To clarify the psychosocial motivations in Asian cosmetic surgery, it may be useful to think of two types of medicalisation depending on which type of society (Western or Asian) is being used as a context. The first type, treatment form, refers to framing racial cosmetic procedures as remedial or corrective, and is usually observed in Western societies with predominantly Caucasian mainstream society as shown in Kaw's (1993) ethnographic research. The second type, enhancement form, does not pathologise but rather seeks to improve racial features, and is seen in Asian countries like South Korea (Davies and Han, 2011). While both forms may be associated with oppression and discrimination based on physical appearance, the treatment model seems particularly problematic because the process of pathologisation is directed at a specific racial group.

The implications of the medicalisation of racial features have been studied in the past. However, much of the literature on Asian aesthetic surgery focuses on the psychosocial effects of aesthetic surgery based on the perspective of aesthetic surgery consumers (Edmonds, 2013; Reber, Schwarz, & Winkielman, 2004; Kaw, 1993). A substantial portion of the existing literature involves sociological and anthropological frameworks in understanding the issue, with little bioethical or philosophical debate on the subject. However, I believe that Asian cosmetic surgery is relevant to philosophical fields such as applied ethics and philosophy of medicine. For example, medicalised racial features can be understood and studied using bioethical concepts such as autonomy and authenticity. In philosophy of medicine, it would be useful to review definitions of health and the goals of medicine in understanding the legitimacy of Asian cosmetic surgery.

In this research, my main question is "What are the ethical implications associated with the different forms of medicalisation that occur in Asian cosmetic surgery?" To answer this question, I will provide three levels of analysis. In *Chapter 1*, I perform a concept analysis of medicalisation and argue that Asian cosmetic surgery is an example that occurs in two forms. In *Chapter 2*, I perform a descriptive analysis of medicalisation of racial features by engaging with empirical data. I analyse websites of cosmetic surgeons to identify recurrent themes and patterns in the text, images, videos and design. The Internet has become an important medium for cosmetic surgery, and is a potentially rich area for investigating marketing and communication strategies that may reflect the process of medicalisation in different forms. Finally, I offer an ethical analysis in *Chapter 3*, drawing mainly from the findings in my empirical research. The different levels of analysis of Asian cosmetic surgery can help improve our understanding of the impact of medicalised racial features, which in turn will contribute to wide debates about the conceptual, ethical, and social foundations of medical practice.

# Chapter 1: Conceptual analysis of medicalisation

Broadly speaking, the concept of medicalisation refers to the process of defining non-medical problems using a medical framework. It typically involves using medical language to describe a problem, adopting a medical perspective to understand the problem, or using medical or surgical intervention to "treat" it (Conrad, 1992). Therefore, medicalisation of a problem has to involve some if not most of the steps in the management of an illness, which include identification and labelling of a problem, diagnosis based on signs or symptoms, and/or the possibility of medical management.

Literature discussing medicalisation is extensive as well as varied, dating back to the early 1970s when the concept became a prominent term in academic discourse. The aim of this review is to provide a brief overview of what is meant by the concept of medicalisation, and how understandings of medicalisation have evolved over time. In addition, I will make an appraisal of the ethical issues that medicalisation raises, beginning with general ethical implications, and then followed by a specific discussion using two models of medicalisation that occur in Asian cosmetic surgery. This review takes into account the interdisciplinary nature of the concept by making use of studies across disciplines that range from sociological, to philosophical, to medico-surgical.

## *I. Medicalisation: a background*

With a concept as complex and as broad as medicalisation, it is important to clarify some of the major shifts in meanings and application of the concept. This section

provides a brief historical background of medicalisation and then a summary of its contemporary understandings.

## A. Medicalisation in a historical context

Since the 1970s, the concept of medicalisation has been "put forward in order to name, analyse and criticise the changing role of medicine in modern society" (Verweij, 1999; p. 90). Medicalisation in its early use by scholars such as Irving Kenneth Zola, Ivan Illich and Peter Conrad almost only had pejorative connotations.[3]

Zola (1975), one of the early influential scholars who described the concept, defines medicalisation as an "encroachment" of medicine into our socio-political life. On Zola's understanding, medicalisation refers to the phenomenon of using health or illness to explain a host of social problems, including but not limited to divorce, race riots, and juvenile delinquencies. He argues that the extensive use of a medical framework oversimplifies these social problems; instead of looking at a broader social cause, the individual is often blamed. According to Zola, this is problematic because once an issue is defined as medical, then the solution has to be medical as well, resulting in a problem-solution mismatch. He claims that one detrimental consequence is that the mismatch tends to preclude the option or possibility of other types of intervention (such as non-medical ones). Therefore, according to Zola, a social problem will persist when managed using a medical and individual solution while neglecting its social causes.

[3] Michel Foucault likewise criticised medicalisation as social control. See Foucault, Michel (1973). *The birth of the clinic: an archaeology of medical perception,* translated from the French by A.M. Sheridan. London: Tavistock.

Zola's (1975) interpretation of medicalisation attributes accountability to both the society and the institution of medicine even if both sides lack conscious intention of their role. Based on his accounts, both unwittingly drive medicalisation because society seeks medical experts to cure social ills, while medical experts are more than willing to perform the task.

In contrast, Illich (1976) claims that the responsibility of perpetuating medicalisation is attributable solely to the profit-oriented and "imperialist" nature of medicine. Unlike the shared, albeit unintentional, responsibility proposed by Zola (1975), Illich claims that the problem is one-way, with medicine's imperialist nature imposing itself upon society, which is a more or less passive recipient. He argues that industrialisation is the primary reason for the rise of medicalisation, which transformed medical practice into a profit-oriented endeavour, with doctors aiming to broaden their practice in order to sell more services to patients.

Illich (1976) argues that the industrialisation of medicine, along with the subsequent medicalisation of many aspects of our lives, has resulted in three levels of iatrogenesis[4]: the clinical, the social and the cultural. On his account, the first negative social consequence of medicalisation, clinical iatrogenesis, refers to the immediate harm to patients caused by medical professionals through (often unnecessary) medical or surgical treatments. Illich argues that such treatments may be motivated by physicians'

[4] Morrall (2009) and Illich (1975) define "iatrogenesis", a borrowed term from medicine, as harms unintentionally caused by medical intervention—which may involve medical technology, a procedure, or the doctor/surgeon.

desire to exploit patients for profit. The harms may be emotional damage or physical complications that are directly caused by medical treatments, or may refer to side effects or complications due to hospitalisation or surgery.

Social iatrogenesis refers to impairments that go beyond individual health and are usually in the form of the creation of unnecessary medical needs or stress-inducing medical bureaucracy, among other things. The last level, cultural iatrogenesis, is probably the most abstruse as it refers to how the medical enterprise "saps the will of people to suffer their reality" (Illich, 1976; p. 133). Illich argues that the most problematic social consequence of cultural iatrogenesis is the paralysis of healthy responses to suffering, impairment, and even death.

According to Illich (1976), the overall effect of these three levels of iatrogenesis is a two-pronged, self-perpetuating cycle. First, it makes medicine extremely powerful, turning it into a radical monopoly that prevents people from being free and autonomous. The second, a corollary of the first, is that medicalisation makes individuals excessively dependent on medicine. Instead of empowered and healthy citizens, Illich claims that patients are encouraged to become dependent consumers of curative or preventive types of medical services.

In comparing the discussions of Zola (1975) and Illich (1976), one can appreciate certain similarities and differences. For both authors, medicalisation refers to the encroachment of medicine into social issues. Both authors use examples such as mental illness,

allegedly deviant behaviour and various types of addiction, as well as death and dying. Their main difference concerns the parties responsible for medicalisation, whether it is only medical institution or whether responsibility is shared between society and medicine. Illich describes medicalisation as a result of an active dominion of medicine over society that results in the further impairment of citizens. For Zola, medicalisation is a result of shared tendencies between society and medicine: society searching for a cure to all its problems and medicine being willing to be the answer to that search. It is important to note that Zola does not seem to argue that either medicine or society is an active and intentional driver of the phenomenon.

## B. Contemporary understanding of medicalisation

Two major shifts occur in subsequent discussion of medicalisation: the first explains the softening of the initially pejorative connotation of the concept, and the second explores the role of the drivers of the process.

Verweij (1999), in discussing the moral problems of public health, argues that the derogatory use of medicalisation has been toned down. Using the example of preventive medicine, he claims that a growing number of authors contend that there are situations when medicalisation is necessary, leading to a more neutral view of medicalisation than that held by early authors. Instead of using the default negative preconception, Verweij argues that the concept can be understood as a phenomenon or a process that merely describes the change in discourse and perspective in understanding everyday concerns. The change in perspective may be the result of various developments in society, from

discovery of scientific and medical knowledge, to invention of new medical technology, to adoption of liberal ideologies[5].

Conrad (2005) discusses the second shift in understanding the concept of medicalisation, which involves the engines or drivers of the process. According to Conrad, social progress has decentralised medicine's influence on society, decreasing what Illich (1976) postulated as medical social control. Social progress can be attributed to major social trends such as patient and citizen empowerment, increasing patient rights, and consumer-driven health care systems. Conrad argues that such social changes have become important drivers of medicalisation. Progress has also changed the subjects of medicalisation from passive recipients of medical control, into empowered parties capable of redefining their own medical needs and even demanding some types of medical interventions. Thus, medicalisation can be seen as a "mutual construction" that intertwines the promises of medical services and the expectations of patients (Rose, 2007). This contemporary discussion differs from Zola's interpretation on two accounts. First, Zola seems to argue that society is an unwitting participant to medicalisation, while contemporary authors are more explicit in portraying individuals and societies as active drivers of medicalisation. In the article *The Shifting Engines of Medicalisation*, Conrad (2005) even argues that the "engines of medicalisation have proliferated and are now driven more by commercial and market interests than by professional claims-makers (physicians)" (p. 10). Second, Zola alludes to society in a more general manner,

[5] Although Conrad (1992) admits that the interface between medicine and religion is complex, he cites various historians who argue that secularisation and liberal ideologies lead to medicalisation. Conditions such as infertility or epilepsy used to be in the realm of "spiritual" or "religious" problems, but are now within the jurisdiction of medicine.

as opposed to contemporary discussion where Conrad (2005) and others specify particular elements of society, such as media, pharmaceutical corporations and managed care organisations.

In addition, Conrad (1992) argues that medicalisation can occur in varying degrees. At times, medicalisation may be restricted to the conceptual level, where medicalisation only involves the use of medical vocabulary to define a problem without necessarily offering an intervention. In other cases, medicalisation may develop to the extent that medical professionals themselves employ the medicalised framework. Conrad argues that such characterisation of the extent or degree is helpful in analysing specific applications of medicalisation, adding, "some instances of a condition may not be medicalised, competing definitions may exist or remnants of previous definition may cloud the picture. Therefore, rather than seeing medicalisation as an either/or situation, it makes sense to view it in terms of degrees" (Conrad, 1992; p. 220). Conrad argues that the importance of studying the extent is to clarify what contributing factors and which engines of medicalisation are involved.

Some authors, like Rose (2007), question the usefulness of medicalisation in contemporary discussions. Rose claims that the concept of medicalisation is not helpful in understanding how or why the expansion of medical authority has occurred. Rose, in fact, defends medicalisation as a wholly positive phenomenon that has shaped our society. He describes the innate social aspect of medicine, which allows it to manage human problems beyond mere pathology or disease, citing examples of the important

role of medicine in public health. Rose adds that the term medicalisation as a social critique of medicine is tired and meaningless:

> The term medicalisation obscures the differences between placing something under the sign of public health (as in the contemporary concern with childhood obesity), placing something under the authority of doctors to prescribe, even though not treating a disease (as in the dispensing of contraceptive pills to regulate normal fertility) and placing something within the field of molecular psychopharmacology--as in the prescription of drugs to alleviate feelings that would once have been aspects of everyday unhappiness (Rose, 2007; p. 701).

Because of the increasingly broad application of medicalisation, Rose (2007) argues that medicalisation has lost its meaning and may no longer be useful. I disagree with Rose's contention, since the evolving concept of medicalisation, rather than obscuring the differences among various examples of the phenomenon, has sensitised us in identifying other related and overlapping concepts. Contemporary analysis of medicalisation has in fact generated substantial discussions about related concepts such as healthism or healthicisation, geneticisation, and pharmaceuticalisation, all of which can be considered as subcategories of medicalisation. Pharmaceuticalisation is the process by which socio-behavioural or bodily conditions are treated with pharmaceuticals. Examples include pharmaceutical treatment of lifestyle problems such as obesity, or psychological problems like social anxiety. Geneticisation is the process of attributing genetic causes of medical conditions and non-medical problems, as well as determining the genetic basis of differences among individuals or groups (Maturo, 2012). Geneticisation can be considered under the banner of medicalisation, since research on the genetic basis of

medical conditions is usually associated with attempts to develop medical interventions on the genetic level. Although both concepts are not entirely new, the recent growth of medical industries, along with new marketing strategies and multi-media platforms revitalised discussions on these phenomena.

Healthicisation, which refers to increasing emphasis on healthy lifestyle, can be interpreted as a consequence of commercialisation of health. The emphasis on a healthy body (and healthy mind) has spawned lucrative industries that focus on fitness and healthy lifestyle, which have led to the emphasis on the "ideal", whether it be the overall way of life or particular concerns like physical features. Morrall (2009) cites cosmetic surgery as an example where un-healthiness is described as variation in human physiognomy from the ideal, and how this variation is considered an aberration. He explains that nowadays the body parts that are "absent, extra, have fallen out, are too blemished, too long, too short, too big, too short, too stiff, too wobbly, too taut, or too slack" can be replaced, modified or improved (p. 118).

Medical framing in cosmetic surgery suggests two possible ways of looking at the process of medicalisation. First, medicalisation can be understood as a form of treatment, where a condition not previously considered medical is portrayed as pathological and the intervention as remedial. Second, medicalisation can be understood as a form of enhancement, which accepts features or characteristics as normal but unwanted, and the intervention as a means to improve the undesirable characteristics. It is important to note that based on the general discussion of medicalisation, the

distinction between the enhancement and the treatment models of medicalisation has not been made explicit. Such distinction seems to arise particularly in the context of cosmetic surgery, which will be discussed in the next section of this chapter.

In summary, I have shown some key shifts in contemporary understanding of medicalisation that are relevant for my project in Asian cosmetic surgery. First, there is the softening of the pejorative connotation of the term medicalisation. An important implication is that medicalisation can be used to describe a phenomenon, instead of being merely a term to criticise alleged medical imperialism or society's over-dependence on medicine. This allows for an analysis of the concept in specific contexts prior to concluding that medicalisation is or is not problematic. Thus, the shift permits a balanced consideration of the positive and negative aspects of the phenomenon. Another change seen in contemporary discussion of medicalisation involves identifying the shift in the drivers of medicalisation. This benefits our present discussion because it points to other sources or influences apart from society and medical institutions. In the next section, I will further clarify how medicalisation is understood in the context of Asian cosmetic surgery.

## *II. Medicalisation in Asian cosmetic surgery*

In this section, I provide an overview of the development of plastic surgery, and then extend the discussion to explain how this has resulted in the trend of surgically modifying racial features in Asians. Next, I describe the two proposed forms of

medicalisation in Asian cosmetic surgery, namely the treatment and the enhancement forms.

## A. Development of racial cosmetic surgery

In the 19th century, plastic surgery was largely reconstructive and aimed at correcting physical deformities caused by infectious diseases such as syphilis, congenital disorders, and physical trauma (Gilman, 1999). In Europe, the end of World War I saw plastic surgery reaching unexpected heights, as surgical practice became necessary in treating facial wounds, burns, and other related deformities of soldiers who survived their injuries (Mazzola & Kon, 2010). Plastic surgery in the context of reconstructive function was considered to be consistent with the traditional medical model of treatment where a disorder, the disfigurement caused by injury or disease, is identified and a treatment, the reconstructive surgery, is offered. However, Gilman (1999) posits that early use of "aesthetic," "cosmetic" and "beauty" surgery labels may have been surgeons' attempts to justify "physical beauty" as a legitimate medical goal. In the 1930s, aesthetic plastic surgery (a term I will use interchangeably with cosmetic surgery) became a distinct practice focused on the surgical modification of a person's appearance toward some aesthetic ideal in the absence of deformities caused by birth defect, disease or injury.

With the continuous attempts at legitimising physical beauty as a medical goal, contemporary discussion of medicalisation in cosmetic surgery can be understood in a number of ways. First, medicalisation occurs when unwanted physical features are considered as source or cause of mental health problems (such as body dysmorphic

disorder), with surgical correction used as management to address the mental condition (Crerand et al, 2006). Second, medicalisation can be understood in terms of using surgical procedures to modify normal but undesired features, with the patient having no identifiable mental health problem. For the sake of clarity, this paper is concerned with analysing the latter form of medicalisation in cosmetic surgery.

In distancing itself from traditional medical causes of disfigurement, cosmetic surgical modifications became associated with arbitrary standards of beauty such as facial or physical variations associated with race. Gilman (1999) claims that eventually surgeons not only tried "to correct the ugliness that results from diseases such as syphilis, but they also tried to correct the 'ugliness' of non-white races" (p. 16). He cites the pejorative portrayal of African and Jewish noses as early examples of facial features targeted by plastic surgery, with surgeons describing such non-White races as, to some extent, pathological:

> According to the contemporary reading of [Dutch anatomist] Peter Camper (1722-89), the African nose was the least beautiful ... because he or she is closest to the ape in his or her physiognomy (Gilman, 1999; p. 87).

Similarly, Gilman (1999) claims Asians living in Western societies like the US have experienced derogatory portrayals based on their facial features. In the US, Gilman alleges that Asian-Americans were stereotyped as being short people who have flat faces and slanted eyes. The author argues that this portrayal motivated Asian-Americans to

seek aesthetic surgery to appear "less Asian." To appear less Asian, the eyes are the facial features commonly modified in cosmetic surgery. "Asian eyes" is the term applied to a characteristic absence of a crease in the upper eyelid; when the crease is present this is called double eyelid. Absence of the double eyelid, considered a 'deviant' feature, is made more apparent by thicker fat pad in upper lids of Asians (Bernardino & Rubin, 2003). Although it is difficult to provide a homogeneous definition of what generally constitutes Caucasian eyes, this term is understood in the literature to refer to wide-set eyes with double eyelids or a readily apparent upper-lid fold.

With the aim of investigating the process of medicalisation in the context of cosmetic surgery of Asian features, I postulate that the process can be understood as occurring in two forms: treatment and enhancement. Although the two forms may be considered overlapping, I describe certain distinguishing features and implications that can help in refining our understanding of the medicalisation of Asian features.

## B. Two models of medicalisation

Early discussions of racial cosmetic surgery were focused on Asians who migrated to western countries like the US. However, recent studies of cosmetic surgery involving Asians in their countries of origin (for example, Koreans in Korea) have offered an alternative perspective in understanding the phenomenon. The variations between the two geographical contexts serve as the foundation for proposing two models for the medicalisation of racial features in cosmetic surgery. Treatment medicalisation refers to the process in which Asian features are defined as pathological deviation from the norm,

understood in terms of Caucasian eyes/the Western face. Enhancement medicalisation, which does not involve pathologisation of Asian features, focuses on promoting cosmetic surgery as a chance to improve the self by the surgical modification of naturally occurring but undesired facial features.

## 1. The treatment model.

In a traditional medical framework, the treatment model refers to the clinical process of diagnosing, prognosticating and treating a condition (Laing, 1971). Typically, a medical condition or a problem is presented as a complaint (often by the patient), which usually prompts medical consultation with a physician. The physician takes the history of the medical complaint, performs physical examination, and investigates associated problems such as presenting signs and symptoms. Based on the findings, the physician develops differential diagnosis/es, to guide his or her intervention, from diagnostic to therapeutic management. Similarly, medicalisation understood as arising from the treatment model implies that a non-medical problem will be managed similar to a traditional medical condition, from diagnosis to medical or surgical therapy.

In the context of Asian cosmetic surgery, the treatment form is tightly linked to the Westernisation[6] of standards of beauty. In predominantly Caucasian communities, such as the US and Australia, scholars argue that the main motivation for Asian cosmetic surgery is to align to Western or Caucasian standards of beauty. The way that Asians are

[6] Westernisation is a broad phenomenon that refers to the process of adopting Western culture, traditions, lifestyle, or behaviour. This may manifest in speech (like having an American accent), clothing and fashion, diet and fitness, as well as economic and political ideologies, among others.

encouraged to seek the surgery is to portray Asian features, such as absent double eyelid, as a pathological deviation from the norm, with the norm being defined as a pair of wide eyes with upper lid folds. In fact, previous empirical studies have identified several stages in the treatment medicalisation model: use of medical terminologies in portraying the problem, emphasis on medical expertise, and use of a medical framework to describe the effectiveness of the intervention.

In the first stage, medical terms or a medical framework is used in identifying or portraying the condition. Based on Kaw's (1993) ethnographic research, considered as one of the seminal empirical investigations in the topic of medicalised Asian features, cosmetic surgeons use words like "without" or "lack of", and "flat" or "dull" in pathologising the description of the Asian eyes. By using these terms, surgeons are indicating that the typical Asian eyes are problematic and should be corrected through cosmetic surgery. Kaw adds that some medical texts even went so far as associating Asian features with a person's poor intellectual and behavioural capacity to succeed in life. According to Kaw, Asian features have, for example, been connected to negative personality traits such as passivity, lacking in energy, or sleepiness by the dominant society. Further, the first stage of medicalisation is supported by the apparently scientific and objective description of the alleged problem. According to Sturm-O'Brien and colleagues (2010) cosmetic surgeons allegedly refer to ideal measurements and fixed ratios in order to "objectively" describe the supposed problem. The authors add that surgeons would usually draw from the so-called golden proportion based on Greco-

Roman ideals[7]. However, such golden proportions have been heavily criticised as Caucasian-centric (Sturm-O'Brien et al., 2010).

The second stage of medicalisation occurs when the intervention is described as an act that can only be performed by medical experts, in this case the cosmetic or aesthetic surgeons who have medical degrees (as opposed to cosmeticians). This implies that the requisite medical expertise involves "scientific rationality and technological efficiency" (Kaw, 1993; p. 75). The use of medical language and terminology connote scientific objectivity, implying that surgical practice is not based on arbitrary standards. Technological efficiency for Kaw seems to imply that the cosmetic surgery, with a focus on the diagnostic and surgical tools of the surgeon, offers "legitimate" results (that is, correction of features that deviate from the "norm").

Third, medicalisation involves presenting the intervention as medically sound and appropriate to treat the problem. The surgery is expected to "correct" the aesthetic deviation of the Asian feature, helping the patient appear more western. In turn, the presumption is that the patient is expected to experience improved integration with mainstream society given that he or she no longer looks "too different".

[7] The golden proportion has been used in Greek and Roman architecture. The use of the golden proportion in humans was heavily popularised by Leonardo da Vinci's drawing of the Vitruvian man, identifying ideal proportions of different parts of the human anatomy. [Naini, F. B., Moss, J. P., & Gill, D. S. (2006). The enigma of facial beauty: Esthetics, proportions, deformity, and controversy. *American Journal of Orthodontics and Dentofacial Orthopedics*, 130(3), 277-282.]

## 2. The enhancement model

In broad terms, enhancement is a process of providing interventions in the absence of disease to improve health beyond the "normal" state (Bostrom & Roache, 2007). Since the normal state is the baseline, the enhancement model in contrast to the treatment model does not depend on reframing a condition or feature as pathological.

Scholars who study cosmetic surgery in Asian societies argue against the framework of westernisation as the basis of Asian cosmetic surgery. Holliday and Elfving-Hwang (2012) for example, refute the claims made by scholars like Kaw, and claim that westernisation as a framework is too narrow when applied to Asians living in their countries of origin. From the perspective of patients, Asians living in Korea or Japan do not necessarily aim for a westernised face, given their strong sense of national identity. Holliday and Elfving-Hwang claim that instead of being passive followers of western standards of beauty, Asian consumers are empowered by cosmetic surgery to improve their features. The authors claim that the procedures are not meant to make women look normal (understood as western), but to make them look "more pleasing" and "more beautiful" in order to improve their chances in education, relationships and career.

Two defences are offered against the notion that Asians are adopting westernised standards of beauty. First, surgeons in Asia claim that Asian facial aesthetic surgery is founded on a universal beauty ideal that is devoid of race (Davies & Han, 2011). Instead of portraying these features as diseased in comparison to a western standard, authors argue that cosmetic surgery is marketed by emphasising the benefits of the procedure in

order to reach this universal standard of beauty. These benefits may include improvements in academic performance, career opportunities or chance at lasting romantic relationships. The second rationalisation is based on the idea that variations do exist in Asian population, with 50% having natural double eyelids (Motaparthi, 2010). Thus, some argue that the motivation is not towards an external western standard, but is consistent with internal variations that exist within a race, and that are considered desirable.

### C. The importance of the distinction between treatment and enhancement

Before I discuss the enhancement-treatment distinction in this research, I must clarify how it differs from the general bioethical debate on treatment versus enhancement. In the general debate, the distinction typically draws the line between services aimed at preventing or curing diseases or disabilities and services that improve a condition viewed as normal (Daniels, 2000). On one hand, some scholars like Sandel (2004) and Schwartz (2005) defend the distinction, arguing that treatments have high moral status as they accept the normal or natural, as opposed to enhancements that imply rejection of normal human life. On the other hand, Bostrom and Roache (2007) and Daniels (2000) argue that such distinction is difficult to draw and seems arbitrary. Bostrom and Roache claim that the line between therapy and enhancement is problematic for several reasons. One reason is that many interventions cannot be exclusively classified as curative, preventive or enhancing (such as vaccination, which is both preventive and enhancing). Another reason is the difficulty of defining the "normal healthy state," which is essential in identifying whether an intervention is a type of treatment or enhancement.

In the medicalisation of Asian features in cosmetic surgery, the ethical acceptability of enhancement and treatment forms appear reversed. The treatment form can be considered more ethically problematic than the enhancement form as the former strongly implies that Asian features need "treating". It can be argued that the oppressive implication of the treatment form involves a larger (racial) group, whereas the enhancement form focuses on an individual. As previously mentioned, some scholars (Holliday & Elfving-Hwang, 2012) argue that Asian cosmetic surgery should not be seen as pathologising Asian appearance, but rather a means of improving features towards a non-racial ideal (that may differ from one person to another). Thus, the enhancement type of medicalisation may not differ from other non-racial types of cosmetic surgery.

It is important to note, however, that the distinction between enhancement of normality and remedy of a pathologised condition is blurred given that what is 'enhanceable' today can become pathological in the future (Maturo, 2012). If we assume that cosmetic surgery in Asian region takes the enhancement form, Maturo argues that the trend would influence the society to the extent that it would create a new standard of what is normal, later on leading to pathologisation of features that are not aligned with this new standard. Thus, it can be said that the two forms of medicalisation result in two types of pathologisation: the treatment form implies a pathologisation of Asian features in reference to a Caucasian ideal, while the enhancement form entails a pathologisation of Asian features in reference to the latest standard of beauty within an Asian community.

In the next chapter, I investigate the distinction between the two forms of medicalisation as they occur in Asian cosmetic surgery. The empirical research involves a descriptive analysis of cosmetic surgery websites, which offer a medium to study various types of communications and marketing strategies that contribute to medicalisation of racial features. To allow for comparison of the two forms, the empirical study includes websites hosted in South Korea and Australia. This is based on my initial hypothesis that surgeons in Asia might tend to use the enhancement model, while surgeons in a predominantly Caucasian society might favour the treatment model of medicalisation.

# Chapter 2: Empirical investigation of medicalisation

This chapter on the empirical study is divided into two sections: the first contains the methodology and the second discusses the results. In the methods section, I describe the steps involved in the descriptive analysis of cosmetic surgery websites hosted in Seoul, South Korea and Sydney, Australia. These steps include sampling, data collection, and data analysis. In the results section, I describe how websites depict the medicalisation of racial features through cosmetic surgery, as well as describe the presence of the two forms of medicalisation.

## *I. Methodology*

The Internet has become an important advertising medium for plastic and cosmetic surgeons in addition to traditional media, such as print, radio and television (Nassab *et al.*, 2011). With secondary platforms such as Facebook, Twitter and other social networking sites, websites are enhancing accessibility and increasing interactions between consumers and cosmetic surgery providers (including private surgical practitioners and hospitals or clinics). Cronemberger and colleagues (2012) claim that a significant number of aesthetic surgery consumers rely on websites for information about procedures, and that they feel safe undergoing surgeries after studying online contents.

The poorly regulated status of advertising in cosmetic surgery and the borderless nature of the Internet offer an opportunity to study various types of communications and

marketing strategies in cosmetic surgery. According to the Australian Society of Plastic Surgeons (n.d.), there is very little enforcement of advertising guidelines for cosmetic surgeons. The specialty society recognises the danger that unregulated advertising inflates patient expectations while often ignoring or trivialising the risk involved in surgical procedures. The poorly regulated status of cosmetic surgery advertising is further aggravated by the borderless nature of the Internet, which also makes online marketing difficult to regulate. Unlike print, radio, or television marketing, online communications may be unpolished and may still include controversial claims that are usually policed in traditional media. For example, a study found that a significant amount of information on breast augmentation available online contains false or misleading information (Nassab *et al.*, 2011). At present, despite the rich nature and exponential growth of websites, there is minimal empirical research on Internet marketing communications in plastic surgery (Lunt, Hardey, & Mannion, 2010).

This part of the study investigates the two forms of medicalisation (enhancement versus treatment) in cosmetic surgery of Asian eyelids by performing a qualitative descriptive analysis of websites of aesthetic surgery hospitals and clinics in South Korea and Australia. The descriptive analysis also aims to investigate if there are substantial similarities and recurring themes among websites hosted in the same city/country. I compared Korean websites versus Australian websites based on my initial hypothesis that surgeons in Asia might tend to use the enhancement model, while surgeons in a predominantly Caucasian society might favour the treatment model of medicalisation. The empirical study is guided by the following research questions:

- How do cosmetic surgery websites portray Asian features as targets of cosmetic modification?
- What are the textual and visual representations that support either enhancement or treatment form of medicalisation?
- Are there similarities and differences between the Australian and Korean websites, and if so, what are they?

## A. Sampling and data collection

The study used search engine *Google* to identify websites for inclusion. I limited the search to Sydney and Seoul as representative cities of Australia and South Korea, respectively, that have substantial number of consumers and a strong presence of plastic surgery clinics.

An initial *Google* search using "Asian cosmetic surgery", with "Seoul" or "Sydney" as additional term limits, yielded over 1 million results that contained a mixture of clinic websites, blog posts and news articles. I browsed the results and listed potentially relevant cosmetic surgery websites based on the website address and website name. The websites were selected from a list that feature high up in early pages of the search results. The rationale behind this strategy is its consistency with the tendency of individuals seeking information to visit webpages that appear in early search results (Harvey, 2013). The chosen websites are listed chronologically according to their order in the *Google* search results. A total of 27 websites in Sydney and 15 in Seoul were

selected, including sponsored links (paid advertisements)[8] that appear before the list of results (*see Table 1*). The website whatclinic.com[9], which appeared in the initial results, was used to identify additional websites since *Google* results yielded far fewer Korean websites than Australian. Whatclinic.com yielded additional 9 websites for Korea and 6 for Australia, making the initial total 33 websites in Sydney and 24 in Seoul.

**Table 1: Selection process of websites**

| | Criteria | Sydney, Australia | Seoul, South Korea |
|---|---|---|---|
| **Inclusion** | 1. Initial Google search: "Asian cosmetic surgery" (with "Seoul" or "Sydney" as additional limits) | 27 | 15 |
| | 2. Additional search in whatclinic.com: "Cosmetic surgery" (with "Seoul" or "Sydney" as additional limits) | 6 | 9 |
| | **Initial total** | **33** | **24** |
| | 1. Removal of duplicates | -5 | -6 |
| **Exclusion** | 2. Excluded websites in language other than English; or without section on Asian blepharoplasty or Asian double eyelid surgery | -16 | -4 |
| | 3. Not analysed as saturation reached | -6 | -8 |
| | **Final total of websites analysed** | **6** | **6** |

After removal of duplicates, using the inclusion criteria of English language websites that incorporated a section on Asian blepharoplasty or Asian double eyelid surgery narrowed the number to 12 in Sydney and 14 in Seoul. Based upon initial descriptive analysis, saturation was reached after 6 websites for each city (*see Table 2*). Data saturation, a concept originally developed in grounded theory studies in the social sciences, refers to apparent completion of the data set based on replication and

[8] Sponsored links that appear as hypertext links above search results lists are usually related to the search terms. In this study, the sponsored links include websites of hospitals and surgical clinics.
[9] Whatclinic.com was founded in 2006 and operates in over 100 countries to help patients find, compare and book plastic surgery clinics online.

redundancy. Saturation is reached when additional data add nothing new (Bowen, 2008; Marshall *et al.*, 2013). Instead of aiming for representativeness, the goal of sampling qualitative research is to yield rich results: selecting apparently typical representative examples, selecting negative/disconfirming examples, and selecting exceptional or discrepant examples (Macnamara, 2005).

**Table 2: List of websites**

| | **Name of Website** | **Surgeon** |
|---|---|---|
| SYDNEY, AUSTRALIA | 1. Simply Beautiful Cosmetic Surgery & Laser Clinic<br>http://www.asiancosmeticsurgery.com.au/ | Dr. Peter Kim |
| | 2. Plastic Surgery Specialist Dr Kevin Ho<br>http://www.drkevinho.com.au/ | Dr. Kevin Ho |
| | 3. Advance Beauty Cosmetic Surgery<br>http://www.advancecosmetic.com/eng/ | Dr. Andrew Kim |
| | 4. Sydney Cosmetic Surgeon or Cosmetic Surgery International<br>http://www.cosmeticsurgeryint.com.au/ | Dr. Zion Chan |
| | 5. Sydney Plastic Surgery<br>http://www.drbarnoutisurgery.com.au/ | Dr Laith Barnouti |
| | 6. West Side Facial Plastics<br>http://www.drtsirbas.com/ | Dr. Angelo Tsirbas |
| | **Name of Website** | **Surgeon** |
| SEOUL, SOUTH KOREA | 1. ID Hospital<br>http://eng.idhospital.com/ | Dr Park Sang Hoon |
| | 2. TL Plastic surgery<br>www.tlplasticsurgery.com/ | Not specified |
| | 3. VIP International Plastic Surgery Center<br>http://www.beauty-korea.com/ | Dr Lee Myung Ju |
| | 4. Pitangui Medical & Beauty Center<br>http://www.pitanguiplasticsurgery.com | Not specified |
| | 5. Wonjin Aesthetic Surgery Clinic<br>http://wonjinbeauty.com | Not specified |
| | 6. The Line Plastic Surgery<br>http://thelineclinic.com | Not specified |

The web pages were accessed between April and July 2015. Most of the Australian websites and all Korean websites featured Asian surgeons. Although I made an effort to look for clinic and hospital websites with Caucasian surgeons for variety, I found that websites advertising the services of Caucasian surgeons do not have substantial descriptions or advertised expertise in Asian cosmetic surgery.

I limited the focus of the analysis to pages that describe Asian blepharoplasty, or upper eyelid surgery directed to Asians. This type of surgery is one of the most commonly requested procedures for Asians and may suffice to represent other types of cosmetic surgery involving race-identifying features.[10] This website section typically includes images, videos, text, anecdotal accounts of patients, and description of technique by a surgeon.

I saved the blepharoplasty section of the sample websites as 1) a collection of screenshots to preserve their design, and 2) PDF files for convenience when analysing the text. Because websites often change content, the saved pages were printed and date stamped.

Once the sample websites were collected, the next step was to organise and code the data, which included text, images, links and the overall design. The coding of data units of the webpage and the specific section on Asian blepharoplasty was guided by the descriptive research question "How do cosmetic surgery websites portray racial features, based on descriptions of Asian upper eyelid surgery?"

The main question is further subdivided into three parts. First, the analysis involved searching for visual and textual evidence of medicalisation of racial features; second, the

[10] Heyes (2009) points out that Asian blepharoplasty is often used as an example of ethnic cosmetic surgery. According to Heyes, one of the reasons is that cosmetic surgeons have effectively marketed this type of surgery as a distinctively ethnic procedure with its own anatomical, technical, and cultural challenges that makes it peculiarly visible.

analysis looked for evidence that websites employ either the enhancement or the treatment model of medicalisation; and third, the analysis compared the websites hosted in Sydney from those in Seoul. Initially, the first part contained three sub-sections: depiction of the racial feature as a pathology, portrayal of the patient evaluation as scientific and objective, and description of cosmetic surgery as either a treatment or an enhancement of the racial feature. However, detailed evaluation revealed that there were substantial overlaps among the three sub-sections that made the initial distinction unnecessary.

## B. Analysis of data

The analysis makes use of the descriptive framework of medicalisation offered by Conrad (2005). On Conrad's account, definitional components consist of "defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to 'treat' it" (p. 211). In addition, according to Conrad, the degree or extent of medicalisation may classify conditions as fully medicalised (such as death and childbirth), partly medicalised (for example menopause), or minimally medicalised (for example domestic abuse) based on certain factors. These factors may include support of the medical profession, availability of interventions, and coverage by medical insurance, among others.

Given Conrad's (2005) descriptive account of medicalisation, I searched for textual and visual representations that may support medicalisation. For the text, medical jargon in

the form of anatomical or surgical terms, and any references to medical technology were included. To explore the presence of two forms of medicalisation, both textual and visual representations were classified based on whether they appeal to aesthetics (for the enhancement form) versus health (for the treatment form). To compare the Australian with the Korean websites, websites were analysed individually and then as a group. Predominant themes and unique characteristics of either group were noted.

## *II. Findings*

Based on the research questions, the findings are divided into four major themes, namely A) types of ideal references; B) evidence of medicalisation that situates Asian eyes within the medico-scientific narrative; C) evidence of the two forms of medicalisation; and D) comparison of Australian and Korean websites.

### A. Medicalisation and the use of ideal references

In analysing the websites, I encountered various interpretations, some more explicit than others, of what constitutes "ideal eyes." This helps clarify the sources of insecurity or sense of inadequacy that cosmetic surgery clinics or cosmetic surgeons create and exploit in order to market cosmetic procedures. I believe understanding ideal references is important in explaining how Asian blepharoplasty, like other Asian cosmetic procedures, is founded on the social imperative of conforming to norms of physical beauty. Further, the interpretation of ideal eyes helps illustrate how institutionalised practices and values direct human behaviour, mirroring traditional medical practices that appeal to ideals of health.

Based on how websites portray Asian eyes, there are five possible "ideal" references that are used to explain the inadequacy of naturally occurring Asian facial features. This includes 1) Western or Caucasian eyes; 2) "other" Asian eyes with double eyelids; 3) celebrity eyes; 4) the natural look; and 5) the geometric ideal.

### 1. Western or Caucasian eyes as an ideal reference.

Although some scholars (Heyes, 2009; Holliday & Elfving-Hwang, 2012) argue against the westernisation model, it is still apparent since some websites describe Asian eyes in reference to Western eyes. Admittedly, these websites do not necessarily state that cosmetic surgery will transform the Asian eyelids into Western eyelids (in fact some websites clarify that that is not possible). However, the mere reference to Western eyes is perhaps sufficient to say that it is implied as an ideal. In addition, two interviewees in one website who reside in Australia explicitly allude to the desire to look "less Asian" and more like other Australians.

It is important to acknowledge that some of the websites showed an awareness of the race-oriented criticism against the practice, claiming that the procedure is not westernising. However, it is peculiar that some websites (for example, *Simply Beautiful*) claim that the procedure is not westernising but still refer to Western features as a reference in describing Asian eyes. In Australian websites, this ideal was also apparent in visual representations of female beauty by using Western-looking female models.

## 2. "Other Asians" as an ideal reference.

Many websites claim that 50% of Asians have double eyelids, and the claim is seen as a defence against the westernisation critique. According to some websites, this means that Asians who want to have double eyelid do not necessarily want to look Western, but they just want to like to look like the other 50% of Asians. This number has been cited by scholars (Kaw, 1993; McCurdy Jr, 2006; Motaparthi, 2010), but I could not find empirical studies that support it. It is also unclear whether "Asians" refer to the whole of Asia, including South Asia and Central Asia that have populations with facial features closer to the West. Asians in these territories have "big" eyes and "higher nasal bridge" that are different from the typical East Asian features.

## 3. The "celebrity look" as an ideal reference.

In South Korea, many celebrities are rumoured to have undertaken cosmetic surgical procedures. According to US news channel ABC, one in five South Korean women has had cosmetic surgery, and seems to "emulate the doll-like features of the [Korean-pop or] K-pop girls" (Chang & Thompson, 2014). These celebrity idols apparently do not look like the regular girl-next-door; they are described in the article as having double eyelids, v-line face, slim and with "big breasts." In Korean websites included in the study, many of the female Asian models featured are reminiscent of female members of popular K-pop idol groups like *Girls Generation* and *Wonder Girls* cited by the news article. Websites seem to use these celebrity images as an ideal reference in portraying "Oriental beauty". Such a phenomenon of "celebrity worship", the adoration of popular media personalities, has been conceptualised as part of identity-development in some

individuals (Swami, Taylor, & Carvalho, 2009). These women and the features they portray differ from the first two types of ideal references in that the Asian celebrity look is supposedly not external to Korean society.

### 4. The natural look as the ideal reference.

Some websites claim that the ideal surgical outcome should look "natural". However, there was no explanation what this natural look supposedly entails. In the literature, the term "natural" is used to describe surgical outcomes that retain an Asian facial appearance. For example, Holliday and Elfving-Hwang (2012) define "natural" as surgical outcomes that merely enhance Korean features, and "unnatural" as outcomes that look too Western. In Luo's (2012) study of cosmetic surgery websites in China, a natural look refers to the Oriental beauty constructed by cosmetic surgeons to preserve the "Chinese cultural identity."

### 5. The "geometric ideal" as the ideal reference.

The geometric ideal as a reference has been cited by websites such as *Wonjin Aesthetic Surgery Clinic* (hereafter *Wonjin*) and *ID Hospital.* They refer to the golden ratio and provide a detailed description, almost to a comical extent, of the geometric evaluation. *Wonjin* even goes as far as stating that "The ideal eye will have symmetrical eye lengths as well as length between eyes. This length ranges from 30mm-34mm" [http://wonjinbeauty.com]. As opposed to the "natural look", the "ideal proportion" seems to be more tangible, with websites offering objective and pseudo-scientific

methods of evaluating deviations. But like the "natural look", the standards of deviation seem to be highly dependent on the interpretation of the surgeon.

These types of ideal reference illustrate the spectrum of beauty norms that are used as basis for describing the inadequacy of a single upper eyelid crease. Some of these ideal references are more apparent in websites, while others are merely implied. Some references are also strongly associated with geography. Australian websites, for example, seem to be employing the Western ideal, while Asian societies use the local celebrity or Oriental ideals. In the next part, I will explain how cosmetic surgery websites situate some of these ideal references as part of a medico-scientific narrative.

## B. Medicalisation through medico-scientific narrative

Clarke and colleagues (2010) argue that techno-scientific discourse is one of the key components of medicalisation. According to the authors, "One overarching analytic shift is from medicine exerting clinical and social control over particular conditions to an increasingly techno-scientifically constituted biomedicine also capable of effecting the transformation of bodies and lives" (p. 65). In this analysis, the medico-scientific narrative can be summarised into three strategies: 1) description of Asian eyes as inadequate; 2) emphasis on objectivity; and 3) appeal to expertise.

### 1. Medicalisation by describing what makes Asian eyes "inadequate"

The use of medical narrative is apparent in online communication strategies that depict Asian features as "inadequate" or requiring surgical intervention. In this section, I

explain some of the specific ways websites use "ideal eye" references previously mentioned in portraying the inadequacy of the Asian eyes.

Australian websites often cite Western eyes as ideal reference, explicitly comparing Asian and Western eyelids (also referred to as Oriental versus Occidental eyelids). *Sydney Plastic Surgery* website identifies three main "problems" in naturally occurring Asian eyelids that are subject to modification: 1) a single eyelid crease; 2) prominent Mongolian folds or "excess skin" in the medial corner of the eye; and, 3) puffy or fatty eyelids. On the other hand, a Caucasian or Occidental eyelid is described as tapering closer to the eyelashes, with the fold going out laterally producing an "upside-down 'U' shape," as opposed to the typically straighter line formed by Oriental eyelids. The website adds that the Caucasian eyelid fold is also about 20% bigger than a naturally-occurring Asian eyelid fold. For *West Side Facial Plastics* website, the naturally-occurring eyelid crease in Asians differs from the Caucasian one in that the "shape and location of the [Asian] eyelid crease are lower and different than the occidental eyelid."

Sometimes, the patients themselves contribute to the discourse on the "inadequacy" of Asian eyes. *Advance Beauty Cosmetic Surgery* has a YouTube video embedded on the page that contains interviews with Asian patients living in Australia. The video follows two patients from their consultation with Dr. Andrew Kim, to the surgical operation, and after-surgery care. Despite the disclaimer of some websites that Asian double eyelid surgery is not about westernisation, the comments of the two patients resonate with the

racial critique behind the procedures.[11] One of the interviewees, a 20-year-old female patient, explains that she has suffered from racist comments due to her features:

> "They say 'chinky eyes', 'slit eyes' … or they pull their eyes (to the side). And it makes me feel like there's something wrong with me. I feel insecure when I go to (job) interviews and think, maybe they won't pick me because I look Asian, you know. Maybe if I look less Asian I will look more confident" [Source: http://www.advancecosmetic.com/eng/].

For the interviewee, her Asian eyes are problematic, as she believes that they are the reason why she is the target of racist remarks, and why she has not performed well in job interviews. Later on in the video, she expresses confidence that the Asian eyelid surgery will improve her looks and her self-esteem. Similarly, another interviewee, a male patient, expresses a sense of inadequacy with his typical Korean eyes. He hopes that the eyelid surgery will improve his social life in Australia.

> "I want to try to be similar like Australian [sic]. It's good if you look similar like them. ... No matter how well I speak my English ... or no matter how good of a sportsman I am, that doesn't really cover me being [sic] from Asia. I like being Korean, and I would like to stand tall, but I would like to be Australian" [Source: http://www.advancecosmetic.com/eng/].

Perhaps to balance this perspective, the same video shows another female interviewee who was not a patient of the clinic, but had previously undergone double eyelid surgery. She discloses that when she was 15 years old, her mother brought her to a cosmetic

[11] The experience and opinion of the two patients should not be generalised as fair representative of all Asian-Australians, or all Asians who seek cosmetic surgery.

surgeon to have her eyes "done". Even now, she still feels it was not necessary. She refutes the unrealistic expectations of eyelid surgery saying, "I don't think any amount of surgery is going to make me look Caucasian unless I have a face transplant, you know what I mean?" The statements of the three interviewees, whether for or against Asian eye surgery, affirm the idea that Western features are used to define the norm (or the ideal) that makes Asian features seem inadequate and subject to surgical intervention.

In other cases, Asian eyelids were portrayed as pathological without referring to Western eyelids as the norm. Some websites refer to the four other types of ideal references previously discussed, including "other Asians", the celebrity look, the natural look, and the geometric ideal. The "other Asians" approach is clear in *Advance Beauty Cosmetic Surgery* website's tagline: "Art of reshaping eyes while maintaining ethnic identity." However, the website offers no additional explanation anywhere in the webpage regarding ethnic or Asian identity. Other websites offer an anatomical description while avoiding reference to Western eyelids. *Simply Beautiful Cosmetic Surgery & Laser Clinic* (hereafter *Simply Beautiful*) describes Asian eyes as "small and slit-like," explaining that this is caused by an "absent" upper eyelid crease with a prominent Mongolian fold in the medial corner of the eye. The medico-scientific narrative is furthered by *Cosmetic Surgery International*, which goes as far as citing genetic causes, simply stating that, "unfortunately, due to our Asian genes, a lot of Asians lack the double eyelid genes." What is implied here is that the absence of double eyelid, regardless of its association to a particular race, is seen as a problem that can be addressed by medical professionals through cosmetic surgery.

## 2. Medicalisation by appealing to objectivity

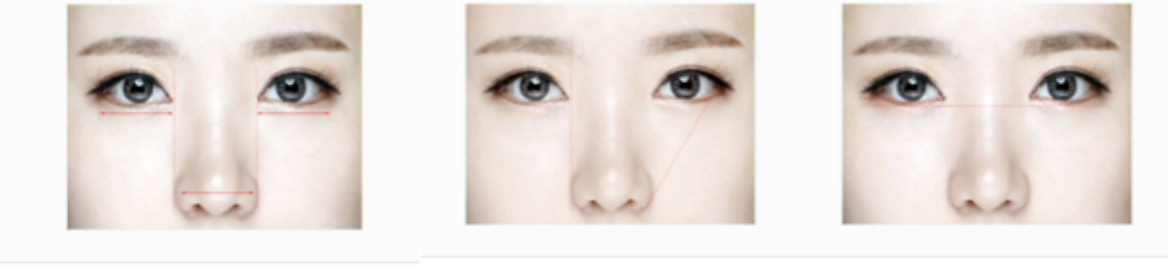
The use of medico-scientific narrative through the emphasis on objectivity is demonstrated in methods of evaluating Asian eye "problems". *VIP International*, in particular, emphasises the importance of "precise" measurement. The website claims that the design of the crease and the procedure to be performed depend largely on balancing the "eye condition" with the rest of the face. It adds that the surrounding structures, like eye muscles and upper lid fat "should be precisely measured".

Visual representations of the objectivity in evaluating eye problems are also apparent in some Korean websites. *Wonjin Aesthetic Surgery Clinic* and *ID Hospital* explicitly refer to the "golden ratio" as an objective basis of assessment. *Wonjin* clarifies that it is not the size of the eyes that is important, but the way the eyes fits the proportion of the face to create a "natural and beautiful" appearance. Explicitly referring to the term "golden ratio", the website describes the "ideal eye" (*see Figure 1*):

> (A) The ideal eye will have symmetrical eye lengths as well as length between eyes. This length ranges from 30mm-34mm. (B) The inner corner of the eyes should make a vertical line with the sides of the nose. The outer corners of the eyes should make a diagonal line with the corresponding nose side.[12] ... (C) The outer corners of the eyes should be slightly raised in relation to the eyes being on a level plane [http://wonjinbeauty.com].

[12] This description is unnecessarily specific as all types of eyes (save those with severe congenital malformation) would have a diagonal line that connects the outer corner of the eyes to the side of the nose.

**Figure 1: *Wonjin's* Golden Proportion**



| A | B | C |
|---|---|---|

Image source: http://wonjinbeauty.com/index.asp?inc=eyelid/Eyelid_Surgery

*ID Hospital* also claims that the "eye line" (used interchangeably with eye crease) should suit the entire face by "carefully considering the proportional ration [sic] between your forehead, eyebrows, nose, cheekbone and jaw line" (*see Figure 2*). The website asserts that any surgery that fails to consider an individual's "aesthetic aspects" will result in patients feeling a "sense of awkwardness." Thus, the website argues that the right method considers the various elements of the patient's eyes, including the size, shape and thickness of the crease, as well as the presence of fat deposits.

**Figure 2: *ID Hospital*'s Golden Proportion**

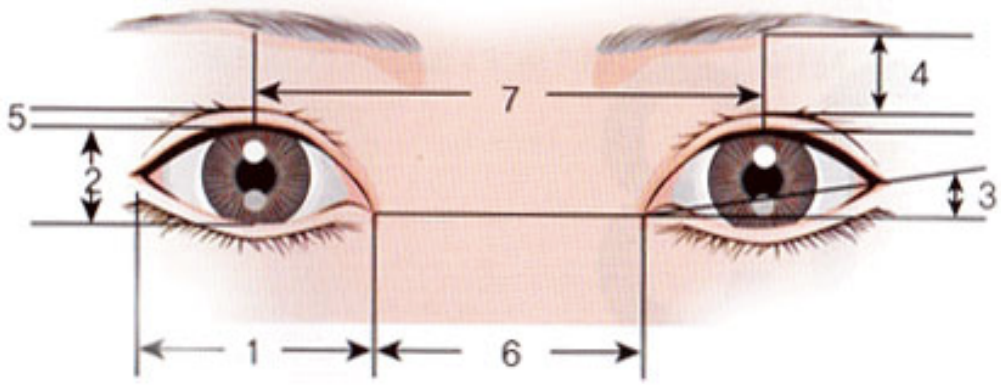



Image source: http://eng.idhospital.com/eye/eye0203.php

### 3. Medicalisation by appealing to expertise

The medical and scientific narrative can also be appreciated through the emphasis on expertise, which may refer to the skills of the surgeon or the presence of cutting-edge equipment.

Having the most elaborate depiction of cosmetic surgical procedures, *TL Plastic Surgery* mentions adherence to safety standards, the importance of professional expertise and use of state-of-the-art surgical equipment. The clinic's rhetoric on safety refers to the importance of safe anaesthesia and "systematic care throughout the surgery and after." According to the website, professional expertise means the clinic takes care of patients through its specialist team that includes the cosmetic surgeons, anaesthesia team and nursing team. Finally, the website shows various equipment specifically referred to as "TL Emergency System" that includes anaesthesia monitoring equipment, sterilisation system, cardio-respiratory monitor, cardioverter defibrillator and thryocicotomy equipment (*see Figure 3*).

Australian websites also mention, albeit briefly, the importance of consultation with the surgeon. *Sydney Plastic Surgery* states that comprehensive assessment is "vital" to determine the proper surgical procedure. *Cosmetic Surgery International* explains that the surgeon "will assess you and determine which technique is best for your eyes."

**Figure 3: *TL Plastic Surgery*'s Emergency System**


Image source: http://www.tlplasticsurgery.com/?page_id=230

Visually, surgical expertise is displayed through the use of images of medical professionals. The medical professionals are often shown wearing white laboratory gowns; while in other cases, the photos are of surgeons in the middle of an operation. In *TL Plastic Surgery, Pitangui Medical & Beauty Center (*hereafter *Pitangui)* and *Wonjin* websites, these photos are accompanied by texts that emphasise a surgeon-centred practice. *Wonjin* claims that "fully accredited surgeons" use the finest technique based on "19 years of numerous surgical experience." *TL Plastic Surgery* asserts that the clinic

has "highly experienced professionals with the wisdom to choose the accurate method for each individuals."

This descriptive analysis shows evidence of medicalisation through the use of medico-scientific narrative. Various types of medico-scientific discourse were identified. First, websites describe Asian eyes as anatomically inadequate necessitating surgical intervention. Second, websites emphasise scientific and medical objectivity especially in describing tools for evaluating anatomical inadequacy. Third, websites appeal to surgical or professional expertise to market cosmetic surgery services.

### C. Medicalisation as either treatment or enhancement

In order to investigate the presence of two forms of medicalisation, I identified both textual and visual representations and classified them based on whether they appeared consistent with either treatment or enhancement. Based on my descriptive analysis, the treatment form is associated with appeals to pathology, while enhancement is associated with appeals to beauty.

Some websites portray Asian eyes with single eyelids as pathological in line with the treatment form of medicalisation. *Sydney Plastic Surgery* uses terms such as "excess skin" or "fatty eyelids" that seem to result in a "deformed appearance" and can be remedied by cosmetic surgery. *The Line Plastic Surgery*, *Dr Kevin Ho* and *VIP International* websites even explain that some cosmetic procedures are specifically used to "correct" sleepy or droopy looks.

Other websites appear closer to the enhancement form of medicalisation by employing terms that seem to focus on beauty instead of pathology. *Wonjin* website emphasises the surgical outcome as "natural" and "beautiful"; while *Sydney Plastic Surgery, West Side Facial Plastics* and *TL Plastic Surgery* also refer to the goal of having a "natural-looking crease." Apart from appealing to what is natural, other websites (*ID Hospital* and *Simply Beautiful*) use terms to describe surgical outcomes, including "more attractive," "more receptive," and "more feminine," among others. *Pitangui* uses a dramatic tagline that exclaims, "You have [been] reborn through our operation! See how you beautifully transformed! (sic)" *Simply Beautiful* uses the famous quote "eyes are the windows to the soul," and implies that Asian eyelids with a single fold are unattractive by describing the advantages of double eyelids. In the same manner, *Cosmetic Surgery International* website claims that double eyelid gives "ladies" a better appearance, and that "female patients feel more confident about themselves."

The enhancement and treatment forms of medicalisation can also be appreciated in two types of visual depiction of Asian eyes based on the before-and-after photos. In one type, websites like *Simply Beautiful, The Line Plastic Surgery* and *Wonjin* show the full face of the female patient (*see Figure 4*). Apart from the outcome of the surgical procedure, some key differences in the "before" photo and the "after" photo can be identified. The before photo is usually emotionally neutral with no makeup, while the after photo has the patient smiling, typically with eye shadow and red lipstick. This type

of visual representation seems to be consistent with appealing to beauty and closer to the enhancement form of medicalisation.

**Figure 4: *The Line Plastic Surgery* before-and-after photo**

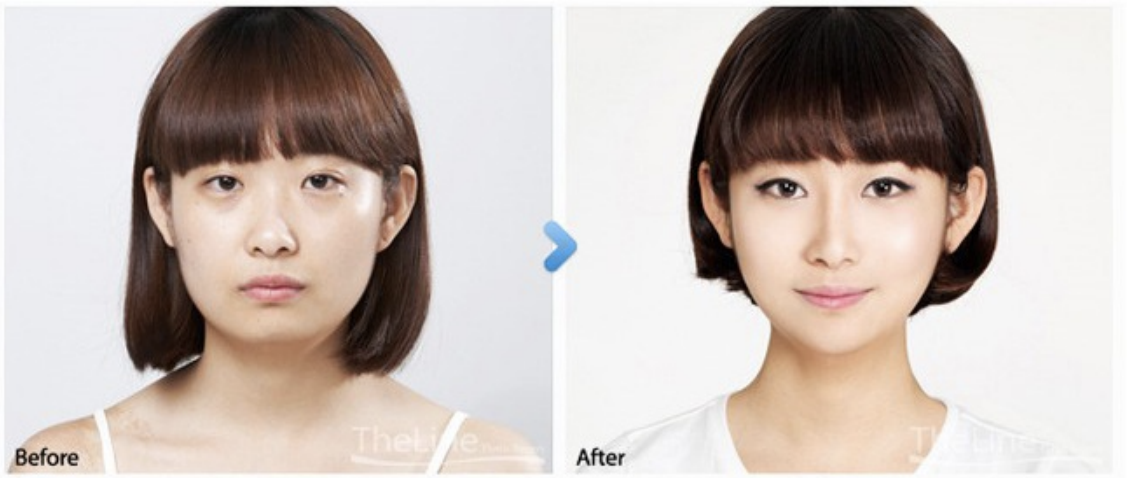



Image source: http://thelineclinic.com/wp/?page_id=87

In the second type of visual depiction, websites (*Advance Beauty Cosmetic Surgery, Cosmetic Surgery International, ID Hospital*) only show the disembodied eyes to highlight the changes made by the cosmetic procedure (*see Figure 5*). This type appears to be consistent with the treatment model, as it is reminiscent of how other medical conditions are visually depicted, which is often done by isolating the problematic part from the rest of the body.

## D. The extent of medicalisation

In this section, I discuss the extent of medicalisation that occurs in Asian eyelid surgery. This refers to the growing complexity of Asian eye characteristics that are being framed as problematic. Such complexity seems to be more apparent in Korean websites than Australian websites.

**Figure 5: *Advance Cosmetic Surgery* before-and-after photos**


Image source: http://www.advancecosmetic.com/eng/surgical/double-eyelid-surgery

For Korean websites, the portrayal of Asian eyes is very elaborate compared with the Australian websites. Unlike their Australian counterparts, Korean websites illustrate various eye concerns beyond just the upper eyelid. *ID Hospital* and *Pitangui* websites enumerate multiple eye issues, including "eyes with thin eyelids," "eyes with thick eyelids," "asymmetric eyelids," "sleepy eyes," "angry eyes," "sad eyes," "man's eyes," and "small eyes." *Pitangui* further differentiates vertically from horizontally small eyes. Other websites, like *TL Plastic Surgery*, offer a more general differentiation using only "very thin eyelid skin" and "puffy or droopy eyelids." Although Australian websites also refer to anatomical features of the Asian eyes, Korean websites provide a more detailed description. *VIP International* specifies that the upper eyelid is composed of

subcutaneous fat, orbicularis oculi muscle, orbital fat, tarsus, levator palpebrae superoris muscle, Muller's muscle and cornea, with each component playing a role in the shape of the eyes. The website claims that eyelid surgery requires "understanding fully such anatomical characteristic and physiological function of each component."

Consequently, types of surgeries offered by websites also illustrate how medicalisation of Asian eyes has expanded beyond blepharoplasty[13]. Epicanthoplasty, also known as Mongolian fold surgery, seeks to decrease the size of medial epicanthal fold that is prominent in Asians. *Simply Beautiful* and *Sydney Plastic Surgery* also refer to this procedure as "big eye surgery" and, in a more technical terminology, "levator muscle tightening/shortening procedure." Brow lift is a surgical procedure usually done with blepharoplasty, as it involves removal of "excess" fat in the upper lid, creation of a double fold, and tightening of the muscles surrounding the area. Male eyeplasty, perhaps the only surgical procedure featured exclusively in Korean websites, refers to eye cosmetic procedures that are marketed to men. *Pitangui* does not explicitly refer to male eyeplasty, but lists "man's eyes" as one of the many possible eye problems for Asian patients.

[13] Among Korean and Australian websites, the labels "double eyelid surgery" and "blepharoplasty" are not consistently defined or used. For example, some websites (*Pitangui, ID Hospital, Cosmetic Surgery International,* and *Dr Kevin Ho*) seem to use "double eyelid surgery" synonymously with "eyeplasty" and "upper eyelid blepharoplasty." In other cases (*The Line Plastic Surgery* and *VIP International*) the term "upper blepharoplasty" is used to refer to brow lift, a surgical procedure that the website claims to correct "sleepy" or "droopy" eyelids. Some websites even differentiate various types of eye surgeries offered to Asian patients: upper blepharoplasty (double eyelid), lateral canthoplasty, epicanthoplasty, lower blepharoplasty, revision eyelid surgery, and sub-ocular brow lift.

Apart from the difference in the degree of medicalisation and extent of medical details employed, there is no substantial evidence that Korean websites are more inclined to employ the enhancement form of medicalisation, nor Australian websites to use the treatment form. In fact, I was able to observe the two forms simultaneously used in most of the websites.

### *Limitations of the study*

One of the limitations of the study involves language restrictions. First, the language criterion that limits inclusion to English websites may have precluded other popular Korean hospitals or clinics. Second, since the search was done using English terms, this might not reflect the search strategies of non-native English speakers seeking information from cosmetic surgery websites. For example, the Korean language has a specific terminology for "employment plastic surgery" and "marriage plastic surgery." In addition, the grammatical errors in some websites compromise the clarity of the message.

The analysis is also limited by website design, as well as the strategy to focus on Asian double eyelid surgery. The popularity of cosmetic modification in Korea, for example, involves other facial features such as the nose, chin, cheeks and jawline. Website design made it challenging to provide a clear comparison among websites. Different designs, such as the use of multiple tabs, hyperlinks, and videos are not consistent, and some useful information may be present but is unintentionally buried by the design of the

webpage. These limitations highlight the need for more in-depth and collaborative studies, as well as academic exchanges with local scholars.

## *Summary*

In summary, my analysis reveals that cosmetic surgery websites medicalise Asian eyes through the use of medico-scientific narrative. Material on the websites depicts Asian eyes as inadequate and in need of surgical intervention, emphasising the objective nature of evaluation and appealing to surgical and technological expertise. Further, my analysis shows that not only is the process of medicalisation present, but that it has expanded beyond the simple eyelid crease concern and Asian blepharoplasty as treatment. Cosmetic surgery websites include multiple potential eye problems, and in turn, offer additional cosmetic procedures to mage these problems. My analysis finds evidence of both forms of medicalisation. I observe that enhancement medicalisation is associated with textual and visual representations that appeal to improving beauty, while treatment medicalisation is associated with appeal to better health and welfare. In comparing the Australian and Korean websites, there is no clear pattern to support my initial hypothesis that one country might be strongly associated with one type of medicalisation (Australian for treatment form and Korean for enhancement form). In fact, the two forms of medicalisation often appear simultaneously in individual websites. In the next chapter, I draw from these empirical findings to discuss some ethical implications of medicalisation and its two forms as they occur in Asian cosmetic surgery. The ethical analysis involves discussion of medicalisation's impact on individual autonomy and the goals of medicine.

# Chapter 3: Ethical analysis of medicalised Asian features

In this chapter, I offer an analysis of the ethical implications of medicalising racial features in Asian cosmetic surgery. I focus on two major implications, namely 1) how medicalisation of racial features affects personal or individual autonomy; and 2) how medicalisation of racial features impacts upon the goals of medicine. For the first part of the chapter, I review the concept of autonomy and propose the use of feminist relational theories in evaluating the ethical issues that affect Asian women in particular. In the second part, I review the goals of medicine as articulated by Callahan (1996) as well as the internal morality of medicine espoused by various authors (Miller, Brody, & Chung, 2000). My intention in this analysis is to offer a discussion that specifically evaluates the impact of medicalising Asian features rather than a general discussion of the ethical implications of cosmetic surgery. I hope that my analysis will contribute to a growing literature on ethics and cosmetic surgery, where scholars like Gilman (1999), Kaw (1993), Heyes (2009), and Davies and Han (2011), among others, have laid strong foundations in exploring general problems associated with the ethnic surgical practice.

The discussion in this chapter is based mainly on the findings of the descriptive analysis of cosmetic surgery websites hosted in Sydney, Australia and Seoul, South Korea. The findings highlight some of the current trends in the online communications of Asian cosmetic surgery websites. Based on the website analysis, I was able gain insight into the process of medicalisation of Asian eyes, as well as investigate the presence of two forms of medicalisation: enhancement and treatment forms. In my analysis, the two

forms are present, but the distinctions are blurred and patterns unclear. One of the main delineating factors between the two forms is whether appeals are made to medicine or pathology (for treatment), or to beauty (for enhancement). The treatment form persists, although in a more subtle form than previously noted by Kaw (1993). For example, the term "correction" is still being employed, albeit sparingly. The use of the term is often interpreted as implying that the feature that needs "correcting" is a disorder, an unacceptable deviation from the norm. The enhancement model is also represented in text when websites use terms such as "more attractive", "more beautiful" or "more feminine", with visual and textual representations appealing to beauty. However, as described in my analysis, there is no mutually exclusive pattern. Both forms of medicalisation, the appeal to beauty and the appeal to health, are frequently employed simultaneously by most websites. The analysis does not support my initial hypothesis about the influence of geography, which postulated that treatment might be associated more with Western countries and enhancement with Asian countries.

Ultimately, I argue, as elaborated in succeeding parts of this chapter, that both forms of medicalisation end up pathologising naturally occurring Asian features, although in different ways. In discussing the two major ethical implications, I will try to compare and contrast the two forms, as I deem relevant, describing the problems resulting from medicalisation that appeals to health and that appealing to beauty.

## *I. The impact of racial cosmetic surgery on autonomy*

In this section, I discuss the impact of cosmetic surgery on autonomy in two parts. Firstly, I offer theoretical argumentation that identifies some of the shortcomings of the traditional definition of autonomy, followed by a discussion of autonomy as interpreted by feminist relational theories. I argue that relational autonomy is better suited than the traditional definition when it comes to evaluating the ethical implication of Asian cosmetic surgery, especially as a gendered medical practice. Second, in the practical level of argumentation, I argue that based on my findings in the descriptive analysis of websites, racial cosmetic surgery contributes to gender oppression and diminished autonomy.

### A. Autonomy as a relational concept

At its simplest, autonomy refers to self-rule that is free from external interference or internal limitations (Varelius, 2006). Philosophers and bioethicists also describe autonomy as having the ability to act according to one's own agency (Eyal, 2012). In bioethics, autonomy is associated with or is considered a requirement for informed consent, which refers to voluntary agreement of a competent individual in the context of medical decision making such as, but not limited to, agreeing to undergo a particular treatment. Beauchamp and Childress (2008), the authors who popularised the four principles of bioethics, define autonomy as the ability of an individual to act freely in accordance with a self-chosen plan. These definitions of autonomy, especially when it comes to the issue of informed consent, can be described as having two important elements, broadly categorised as either internal or external. Internal elements are the

necessary capacities that enable an individual to decide or deliberate; these capacities are typically associated with mental or psychological competences, maturity (age of consent), and/or rationality. External elements refer to the absence of or freedom from outside control.

Feminists have criticised traditional definitions of autonomy as overly individualistic (Mackenzie, 2010). In biomedical ethics, the individualistic interpretation that focuses on clinical encounters between a patient and a medical professional disregards complex psychosocial networks that go beyond the clinic. From my understanding, this means that the traditional interpretation simply looks at whether the internal and external requirements for autonomous decision-making are fulfilled at the minimum without considering how choices are influenced by social contexts. For as long as the person is capable (mature, rational or reasonable) and is free from external control, then that person can be considered autonomous. What this does is to limit the individual (and the individual choice) and isolate that individual from her environment, which consists of social relations and circumstances.

Given the noted limitations of traditional interpretations of autonomy, I argue, as has been done by other authors (Mackenzie, 2010; Sherwin, 1992), that autonomy should be understood as a capacity that develops in a social context. According to Mackenzie (2010), feminist relational theories recognise that the social context consists of power structures and social relations that influence individual preference and possibly shape self-identity. Mackenzie (2014) further identifies three axes or dimensions of relational

autonomy: self-determination, self-governance and self-authorisation. Self-determination refers to the freedom and opportunity to make and enact choices, identifying the external and structural (social and political) conditions for individual autonomy. Self-governance implies presence of skills and capacities necessary to make and enact choices, which are considered as internal factors that influence how individuals exercise autonomy. Self-authorisation refers to having the normative authority to be self-determining and self-governing, and is associated with three conditions that include accountability, self-evaluative attitudes and social recognition. Later in this section, I will argue that these dimensions (focusing on the first two) are harmed or diminished by racial cosmetic surgery.

The various axes of relational autonomy are premised on a social conception of the self, which states that identities are formed in social relationships within specific historical, political and geographical contexts that are influenced by social determinants such as race and gender (Mackenzie, 2015). This is in contrast to traditional conceptions of autonomy that focus on individuals who are self-sufficient and context-independent. Mackenzie (2015) argues that relational theories, instead of focusing on independence, respond to human existence as vulnerable and interdependent, to varying degrees. Understanding the degree or the manner by which social contexts influence vulnerability and promote interdependence can help us in uncovering whether social contexts hinder or empower the development of autonomy. For this reason, I believe that feminist relational theories, and relational conceptions of autonomy, encourage analysis of

individual choices in the context of power structures and opportunities that exist in relationships and organisation (Sherwin, 1992).

Next, I look at situations that undermine autonomy, which may facilitate our understanding of how some individual choices are shaped by gendered interactions. Here, I argue that women experience gendered norms that can be considered as sources of vulnerability, and I will discuss this on two levels, namely 1) in society in general, and 2) and in clinical encounters in particular. Further, I argue that gendered norms influence adaptive preference formation that tends to limit women's options, with the potential to undermine autonomy. This lays the foundation for my subsequent argumentation that Asian cosmetic surgery creates or exacerbates such vulnerability, further entrenching gendered oppression that diminishes the autonomy of Asian women.

First, on a general level, patriarchal society is a source of vulnerability for women. Despite social, political, and economic development in many societies, women continue to be vulnerable given widespread discrimination and violence against them. In analysing gender and trust in medicine, Rogers and Ballantyne (2008) claim that vulnerability can be broadly defined as the inability to protect one's interests, which may arise from either intrinsic or extrinsic factors. The authors claim that intrinsic factors reside within the individual, like having mental illness or belonging to extremes of age, while extrinsic factors are external to the individual, such as poverty or lack of education. In discussing sources of vulnerability for women, most discussions begin with extrinsic factors, specifically with gendered restrictions imposed by a patriarchal

society. Restrictions may take the form of gendered norms, which are powerful values and attitudes about gender-based social roles or behaviours (Keleher & Franklin, 2008). The norms are often preserved or caused by oppressive social structures through laws or policies that restrict participation of women in decision-making processes, deny women educational and other opportunities, and permit violence against women, among others. Some socio-political structures are more overtly restrictive than others. For example, Saudi Arabia prior to 2015 did not allow women to vote, significantly diminishing women's capacity to participate in political decisions (Watkins, 2015). In other cases, the oppression is more subtle, such as when women are paid less than men in similar jobs as happens in many developed Western countries such as the US[14] and Australia[15]. Regardless of the extent of restriction, gendered norms produced by oppressive social structures foster gender inequality that in turn limits choices for women.

Second, in health care or medicine as particular context, there is a rather specific manifestation of oppressive gender norms that contribute to or is a source of women's vulnerability. Rogers and Ballantyne (2008) argue that women are more regularly engaged in the health care system than men, specifically referring to the increasing medical surveillance of the female reproductive system. The authors claim that the trend of medicalising normal female physiology/anatomy has various consequences. First, this

[14] When Sony Pictures in the US suffered a cyber attack that exposed private emails of movie producers, it was revealed that female actors are paid less than their male counterparts. *The Washington Post* reports that women earn roughly 77 percent of what men earn. [Source: https://www.washingtonpost.com/posteverything/wp/2014/12/17/stop-denying-the-gender-pay-gap-exists-even-jennifer-lawrence-was-shortchanged. Accessed last 14 September 2015]

[15] Based on the latest figures from the Australian Bureau of Statistics, the full-time gender pay gap is 17.9%, with men earning more than $284 per week than women. [Source: http://www.abs.gov.au/ausstats/abs@.nsf/mf /6302.0]

reaffirms the notion that expertise on women's bodies lies with the medical profession and not with the woman herself. Second, the trend results in women being regularly placed in positions of physical exposure, which exacerbates already existing power inequalities. The discussion of physical exposure as a source of vulnerability resonates with what Foucault (1977) dubs as the "medical gaze". According to Young (2011), this gaze inevitably categorises patients into hierarchies, with the body being subjected to scales and degrees. The female body's constant exposure to the medical gaze seems to emphasise a one-way interaction, with the power mainly residing with the medical professional. In addition, Rogers and Ballantyne (2008) claim that gender stereotypes and oppressive habituation persist in medical interactions that portray women as passive and men as assertive; often women are the patients and men are the medical professionals. They argue that this puts women on an unequal footing with men, and that it might reduce women's ability or tendency to challenge or evaluate the competency of their physicians.

On both levels (societal and in the clinical encounter), gendered norms and oppressive habituation can be so entrenched that they lead to adaptive preference formation. Adaptive preferences are formed when individuals (in this case women) submit to gendered choices limited by social structures, even accepting these choices as their own (Levey, 2000). Adaptive preferences can be related to what Benson (1991) refers to as feminine gender socialisation. Specifically, the author discusses how gender socialisation attaches great significance to physical appearance, especially towards women as visual objects for men. In this case, Benson argues that gender socialisation is

exceptionally powerful, as it tends to lead to women internalising societal standards of beauty. In the long term, the process of internalisation no longer depends on clearly coercive processes or external pressures in convincing women that their value depends on their physical appearance. Benson argues that we have reached a point where women find it reasonable and are satisfied to submit to societal standards of feminine beauty. Women are convinced that submitting to such standards are necessary components of their major life plans, or are a constitutive part of their self-realisation. According to Benson, autonomy is undermined when the internalised standards lead to false conceptions of women's personal value, and consequently, resulting in a misunderstanding of the motivations behind their actions.[16] Thus, adaptive preference formation is problematic as it masks gendered choices as empowering when in truth these preferences result from ongoing oppressive socialisation that reduces women's choices, self-worth, and ultimately, autonomy.

In this section, I explained the advantage of understanding autonomy as a relational concept, in contrast with the traditionally individualistic interpretation. A relational conceptualisation takes account of the power structures and social relations that surround autonomy and individual preferences. In particular, I described the influence of power

[16] For Levey (2005), a preference being adaptive is not sufficient to undermine autonomy. In using the context of gendered labour, Levey argues that gendered preference adaptation is similar to other types of preference-formation resulting from social, cultural and religious contexts that influence legitimate options. Instead, Levey believes that the wrongness in gendered preferences lies in their distribution. The author claims, for example, that women choosing to be primary caregivers are not inherently problematic. Rather, the problem is that socio-political structures systematically accord this gendered choice with less respect, that is primary parenting is not even recognised in most workplace laws. Gendered socio-political structures also affect men; such as when they are not accorded equally substantial paternity leaves to give them opportunity to care for the newborn.

structures and relations in promoting gendered norms that lead to adaptive preference formation. I argued that women especially are vulnerable and are subjected to adaptive preference formation, especially in attaching significance to their physical appearance. Moreover, I argued that this is problematic as it leads women's internalisation of societal standards of feminine beauty—a process that seem to unfairly reduce women's value to mere visual objects. In the next section, I describe communication strategies in cosmetic surgery websites that may contribute to adaptive preference formation, and in turn potentially undermine autonomy.

## B. Asian cosmetic surgery and diminished autonomy

In arguing that Asian women seeking Asian cosmetic surgery may have compromised autonomy, I extend the general claim about sources of vulnerability to women by describing how the medicalisation of normal female physiology/anatomy occurs in the practice of modifying racial features. First, I argue that enhancement medicalisation, by appealing to beauty, further displaces women's control over their own body. Second, I argue that the treatment form, by appealing to health, limits women's value as defined mainly by their physical appearance.

### 1. How appealing to beauty displaces women's control over their own bodies

Based on my descriptive analysis of websites, the enhancement form of medicalisation appeals to beauty by using medico-scientific narratives to depict the objectivity of evaluating physical features in terms of deviations. Such deviations are based on various ideal references which I identified in my analysis, including the Caucasian standard,

"other Asians" standard, celebrity look, natural look, and geometric ideal. In Western societies, like Australia, the Caucasian standard of beauty as the ideal remains pervasive. On Australian websites, cosmetic surgery clinics mainly use Caucasian models and describe Asian eyelids in reference to Caucasian eyelids. Some websites even illustrate specific parts of the eyes, such as the upper and lower lids, medial and lateral canthi, and overall shape as bases of comparison. This online communication strategy contributes to what Young (2011) describes as the practice of a minority being defined by the dominant (Caucasian) culture as "the Other." Young argues that this practice often constructs the bodies of "the Other" as "ugly, dirty, defiled, impure, contaminated, or sick." Medicalising Asian features is very far from correcting this notion, and instead perpetuates the idea that Asian women are deficient in that they do not conform to the Caucasian ideal.

In Asian societies like Korea, there seems to be a shift from Caucasian standard to standards normally seen in Asian pop celebrities as well as what has been considered as geometric ideals based on the golden proportion. Based on the findings of the descriptive analysis, websites claim that there is an objective way of evaluating deviations by referring to golden proportions. This is often accompanied by visual illustrations that offer specific measurements of eye features to depict deviations that can be managed through cosmetic surgery. What cosmetic surgery does is to reject the naturally occurring Asian feature, which is a single upper eyelid.

In both cases, whether discussing Asians in Western countries or Asians in their countries of origin, the implication is that cosmetic surgery has a medico-scientific way of rejecting naturally occurring eyelids, claiming that surgery is an appropriate intervention. This is consistent with what Rogers and Ballantyne (2008) discussed as the medicalisation or pathologisation of female anatomy/physiology as a source of vulnerability. Asian cosmetic surgery reaffirms the notion that women are not considered to be the best judge of their own physical appearance, and that the objective evaluation of their physicality lies with the cosmetic surgeons as experts on beauty. Thus, such practice leads to the displacement of women's control over their own body, significantly restricting the way they value themselves.

## 2. How appealing to health promotes oppressive socialisation of female appearance

In this section, I argue that the treatment form of medicalisation that appeals to pathology reinforces the oppressive notion that women's value is based on physical appearance. Women are often bombarded by beauty products and services emphasising the importance of physical appearance. In advertisements made by the beauty and fashion industry, women are advised what brand of makeup to buy or which clothes to wear. Some beauty and fashion advertising can be persuasive enough that they do influence women's choices. However, in cosmetic surgery, the persuasion is framed in the context of medical advice, and thus carries significant authority compared with obviously commercial advertising.

In the treatment form of medicalising Asian features, the medico-scientific narrative used by websites offers a normative framing to the recommendation of modifying appearance. What the normative framing implies is that modifying one's appearance is not a matter of a fashionable trend; rather it is a matter of necessity. This implication is based on societal views about medicine as the standard of norms (usually interchanged with health) that is legitimised by scientific and medical knowledge. The value of a woman's physical appearance is no longer just tied to beauty, it has been intertwined with the concept of health. I think the danger here is that such a "recommendation" can be viewed as something that needs to be taken seriously, as if it's an obligation or pressing health need. For example, when Asian cosmetic surgery identifies the "ideal" pair of eyes and labels naturally occurring single eyelids as problematic, it does not seem to imply that correction is a matter of free choice, but rather seems to create an obligation on the part of the subject to correct the alleged pathology.

Linking this back to a relational understanding of autonomy, cosmetic surgery may be seen as a social institution that imposes its own standard on women. In a way, cosmetic surgery undermines what Mackenzie (2014) refers to as the self-determination axis of autonomy. Cosmetic surgery becomes a source of constraint that interferes with women's choices about what to value, who to be and what to do. This occurs when cosmetic surgery highlights ideal references, and uses a medico-scientific narrative that turns recommendations into normative judgments. Further, cosmetic surgery also harms the self-governance axis by shaping cosmetic modification as an authentic choice for women. In some cases, not only does cosmetic surgery push surgical modification as

necessary, it is also depicted as common and normal, and to some extent, a way to achieve a better life (by becoming "more attractive").

The supposed benefits of cosmetic surgery, as well as the culture that strongly endorses them, result in adaptive preference formation. This means that the choice to have surgery, even if freely chosen by women, seems to be problematic. Women are already being told that their appearance is naturally deficient and deserves some form of modification. Such aesthetic modification can be in the form of exercise, wearing makeup, tanning or whitening skin, fashion, or surgery. According to Benson (1991), "Many women are brought up to believe that constructing a feminine appearance is indispensable to their personal worth" (p. 387). Benson argues that this limits how women view themselves in terms of their strength and value by making them believe that their physical appearance is extremely important. The author adds that the so-called "socialisation of female appearance" reduces autonomy by systematically instilling in women a false sense of personal value (prioritisation of physical appearance), leading to misunderstanding of reasons for their choices. The misunderstanding may be in the form of a false belief that what they are doing is for themselves; or that such choice is an act of empowerment, when in reality, the choice has been created by a patriarchal society that primarily judges them based on how they look (Gillespie, 1996).

Thus, given the context of patriarchy, Asian cosmetic surgery gives us grounds for concern as a source of vulnerability that potentially undermines autonomy. First, cosmetic surgery seem to transfer women's control over their own bodies to cosmetic

surgeons, limiting how women value themselves. Second, cosmetic surgery tends to reinforce the oppressive notion that women's value is based on physical appearance, which influences how they make choices in terms of their education, career, and relationships.

## *II. The impact of racial cosmetic surgery on the goals of medicine*

In this section, I discuss a second implication of medicalising racial features by describing how Asian cosmetic surgery leads to the perversion of goals of medicine. First, I provide a brief summary of and commentary on the traditional goals of medicine as espoused by Callahan (1996) in "The Goals of Medicine: Setting New Priorities" (hereafter *Goals of Medicine*),[17] in conjunction with the internal morality of medicine (Miller et al., 2000). Then, I will argue that there are two interrelated ways by which Asian cosmetic surgery leads to the perversion of medicine, namely 1) "perversion by misdirection," or how Asian cosmetic surgery puts primacy on commercial interest over the health of the patient; and 2) "perversion by expansion," or how hyper-specialisation creates additional "physical problems" that can be surgically modified.

### A. Goals and internal morality of medicine

According to the *Goals of Medicine*, medicalisation—along with driving factors such as technological developments, changes in cultural attitudes and social expectations, and

[17] Other scholars have offered various interpretations of the goals of medicine. However, the interpretations are quite similar in emphasising health goals, as opposed to purely cosmetic goals. See Brülde, B. (2001). The Goals of Medicine: Towards a Unified Theory. *Health Care Analysis*, 9(1), 1-13; or Nordenfelt, L. (2001). On the Goals of Medicine, Health Enhancement and Social Welfare. *Health Care Analysis*, 9(1), 15-23.

pharmaceutical developments—is putting pressure on the nature of medicine. For this reason, the report aims to respond to such developments by reformulating the goals of medicine. The aim is to create a practical approach to guide future priorities in biomedical research, the design of health care systems, and physicians' training. Although these goals are not necessarily complete, they are by far the most discussed and clear ones I have encountered. The four goals articulated by the report are: 1) the prevention of disease and injury and the promotion and maintenance of health; 2) the relief of pain and suffering caused by maladies; 3) the care and cure of those with a malady and the care of those who cannot be cured; and 4) the avoidance of premature death and the pursuit of a peaceful death.

In addition to the *Goals of Medicine*, I also draw elements from the internal morality of medicine as discussed by Miller and colleagues (2000). Specifically, I refer to the clinical virtues that are meant to guide medical professionals in the context of clinical medicine (not public health or research). The authors claim that the virtues refer to "dispositions of character and conduct facilitating excellence in pursuit of the goals of medicine and the performance of professional duties" (p. 354). One of the specific professional duties formulated by Miller and colleagues I find relevant in my discussion refers to "refraining from the fraudulent misrepresentation of medicine as a scientific practice and clinical art" (p. 354).

It is important to note that *Goals of Medicine* classifies cosmetic surgery under "acceptable non-medical uses of medical knowledge". The report acknowledges that

there are situations when medical knowledge and skills are not used to achieve goals directly related to health. They offer a few reasons that such uses may be deemed acceptable, which I find unconvincing. First, the report claims that the practice of improving a person's appearance apart from repair of injury or deformity has long been accepted. I believe that this is not sufficient to justify the practice solely as a matter of historical precedence. Ethically, the fact that a practice is widespread is not an automatic justification for its acceptability; socio-cultural and scientific developments can change the societal as well as the moral value of a certain practice. Some mainstream medical practices that enjoyed widespread use in the past, such as the application of lobotomy to treat some mental conditions, were banned once society and medicine became concerned with the safety and ethics of the practice. Second, *Goals of Medicine* claims that the practice does not pose any threat to the general welfare, and is often paid for personally. This completely misses the point, since the general welfare can include issues that involve racial discrimination, which is arguably fostered by at least some forms of cosmetic surgery. In addition, the fact that the procedures are paid for personally does not invalidate the wider societal effects of the choice to undergo the surgery. It is ironic that the same report admits that one of the sources of stress or pressure that challenges the goals of medicine is how Western societies are treating bodily health as a type of religion that aims to "hold on to youth and beauty and a perfectly functioning body" (p. S3), which I have to admit seems like a popular understanding of the goals of cosmetic surgery. In contrast to *Goals of Medicine*, I argue that cosmetic surgery, at least in the context of procedures aimed at modifying race-identifying features, perverts the goals of medicine.

## B. Asian cosmetic surgery and perversion of medical goals

Drawing from literature on the internal morality of medicine, I contend that despite not directly violating medical goals, Asian cosmetic surgery is problematic in two ways. First, the practice itself is mainly geared towards commercial interest and not the health of the individual (perversion by misdirection). Second, with the attempt to justify the practice, there is an effort on the part of cosmetic surgery to portray racial features as if they are maladies (perversion by expansion).

### 1. Perversion by misdirection

In this section, I argue that Asian cosmetic surgery leads to the perversion of the goals of medicine by misdirecting the aim of medical intervention from health to commercial interests. This criticism appears to be more aligned with the enhancement type of medicalisation. In this case, perversion occurs when, instead of the goals of health (such as cure, care, or prevention espoused by *Goals of Medicine*), commercial interests become the primary concern of the medical practice. According to Miller and colleagues (2000), cosmetic surgery becomes unethical when marketing strategies contain deceptive or misleading claims, as well as creating unrealistic expectations that appeal to layperson's fear and emotional vulnerabilities. They add that cosmetic surgeons often trade on "glamour and dreams" without sufficiently discussing risks and complications associated with the surgical procedures. Further, cosmetic surgery threatens professional integrity when it stimulates demands for invasive surgical procedures that are not medically indicated, and downplays the risk and complications of such procedures.

In my website analysis, findings show that some marketing strategies can be considered as evidence of the entrepreneurial nature of Asian cosmetic surgery. For example, *Simply Beautiful* website lists "affordability", along with expertise and experience, as one of the reasons why the clinic is a top choice for Asian blepharoplasty. *Cosmetic Surgery International* website includes a statement "$2500 All Inclusive" at the top of the web section on Asian double eyelid surgery. However, it is not clear which procedures are included. Some websites have a widget or a button for price consultation. Others highlight "free consultation" to increase engagement with potential patients. Instead of focusing on objective facts about medical conditions, including side-effects and unwanted outcomes, these communication strategies focus on cosmetic procedures as "consumable lifestyle options" (Adams, 2013; p. 381). With allusions to prices and affordability, the websites are excellent examples of how cosmetic surgical procedures are depicted as commercial products rather than a healthcare intervention.

The findings support the claim that cosmetic surgery practice draws heavily on a market system that aims to increase demand. Relating this to *Goals of Medicine*, Callahan (1996) claims that one of the stated reasons behind the reformulation of the traditional goals was to respond to the threat that medicine will eventually lack coherent direction and purpose, generating discrete, unrelated objectives in the name of market freedom or special interest groups without any clear direction that clarifies how medicine can contribute to "individual flourishing." I contend that the threat is already apparent as the aim to increase demand drives the perversion by misdirection. The misdirection harms

patients in the short term by de-emphasising side effects and unwanted outcomes, and in the long term by allowing profit-oriented interests to overshadow the goal of protecting and promoting patients' health.

## 2. Perversion by expansion

In this section, I argue that medicalisation, specifically the treatment form, in Asian cosmetic surgery leads to perversion of the goals of medicine by expanding or creating new problems that cosmetic surgery can supposedly manage. I contend that one of the effects of medicalisation is hyper-specialisation, which is possibly driven by the need to increase demands for cosmetic surgery.

Historically, the benefits of specialisation were considered organic and evolutionary, associated with positive consequences (Barrett, 2014). The benefits include developing knowledge and skills for physicians and improved health outcomes for patients. However, according to Barrett, the present trend of sub-specialisation (in the context of neurosurgery), is "driven by a number of outside factors, often by non-surgeons or by surgeons with aims that are not medical or surgical, but political" (2014; p. 293). In cosmetic surgery, the driver from surgeons (or non-medical owners of cosmetic surgery clinics) seems to be commercial interest rather than political.

The website analysis revealed the phenomenon of hyper-specialisation and its consequences. Findings show that websites have "created" new potential eye problems that can be managed by cosmetic procedures. In the literature, the eye problem is limited

to the lack of upper eyelid crease. However, my analysis showed that Asian eye concerns are no longer so simple, and now include "eyes with thin eyelids," "eyes with thick eyelids," "asymmetric eyelids," "sleepy eyes," "angry eyes," "sad eyes," "small eyes," and, strangely, "man's eyes." As a consequence, these new eye problems have led to the development of additional types of procedures that can be offered by cosmetic surgery clinics. Some websites differentiate blepharoplasty from other surgeries such as epicanthoplasty, lower blepharoplasty, revision eyelid surgery, and sub-ocular brow lift. Male eyeplasty is an odd sub-category of eye surgery that seems to comprise most of the other surgeries altogether; the only difference is the surgery is directed to male patients.

It appears as though the more one specialises in something, the greater the incentive to "discover" or perhaps "create" new problems that can then be corrected. According to Heyes (2009), this focus on sub- or hyper-specialisation may be due to surgeons wanting to add new niche markets to distinguish their services from those of "less qualified or skilled competitors" (p. 201). The author adds that the "large clinical literature on Asian blepharoplasty is written by specialist surgeons who are at pains to represent themselves as skilled in understanding both the technical and cultural needs of their patients" (p. 201). Thus, it is no longer enough to be a qualified plastic surgeon as a foundation for success. It seems that for a cosmetic surgeon to succeed, he or she needs to focus on expertise that leads to hyper-specialisation, expanding armaments, procedures, and techniques to identify, and then correct more 'problems' in more patients.

Hyper-specialisation is problematic for both patients and the medical profession. For patients, this trend increases the sources of anxiety or insecurity that they might have with their appearance. Even if they are only concerned with the upper lid crease, for example, the identification of other problem areas may influence patients into believing that there are more eye problems they should deal with. For the medical profession, it is also problematic as some scholars fear that any kind of sub- or hyper-specialisation will hinder growth and development in the long term (Watkins, 2005). In the long run, Lončarek (2009) argues, perhaps in exaggeration, that physicians who "have total knowledge about infinitely small area will use totally useless and infinitely expensive medical technology to treat totally healthy and infinitely wealthy patients" (p. 85).

Further, Miller and colleagues (2000) argue that based on the internal morality of medicine, physicians should "not be involved in the deliberate creation of disease just so that they can expand their practices and increase their earnings" (p. 361). Thus such is the ultimate danger of the perversion by expansion, which is interrelated to the commercial motivation behind perversion by misdirection. Danger lies with the tendency of surgical practice to hyper-specialise, which encourages creation of disease or sub-categories of disease that can eventually prove harmful to both patients and the medical profession.

**Summary**

In this chapter, I have argued that there are two negative ethical implications of medicalising racial features in Asian cosmetic surgery. First, I claimed that Asian

cosmetic surgery leads to diminished autonomy. I used a feminist relational conception of autonomy in discussing how cosmetic surgery contributes to gendered norms and adaptive preference formation. I argued that cosmetic surgery leads to diminished autonomy by displacing women's control over their bodies, and by reducing women's value to physical appearance. Second, I discussed the negative impact of the surgical practice on the goals of medicine. I argued that despite not directly violating goals stipulated in the *Goals of Medicine*, cosmetic surgery leads to perversion in two ways. Perversion by misdirection refers to the tendency of cosmetic surgery to prioritise commercial interest over the health of the patient; while perversion by expansion refers to the tendency of the practice to hyper-specialise, leading to the expansion of the suite of alleged cosmetic problems that can be managed by surgery. I explained that these features of Asian eye surgery encourage the deliberate creation of new disease or conditions to expand practices and promote profit-oriented interests. Given the two negative implications that affect both the patients and the medical professionals, I posit that medicalisation of Asian eyes, as well as other racial features, is ethically problematic. In the concluding chapter, I will provide a brief commentary on what these findings and discussion mean to the legitimacy of cosmetic surgery as a medical practice. Further, I will offer potential directions for further research, such as the value of aesthetic goals as legitimate goals of medicine.

# Conclusion

In this research, I initially set out to explore the implications of medicalising racial features in Asian cosmetic surgery. The intention was to lay the groundwork for further understanding how cosmetic surgery impacts on individual autonomy and the goals of medicine. First, I offered a conceptual analysis of medicalisation and how it occurs in racial cosmetic surgery. Second, I carried out a descriptive analysis of cosmetic surgery websites to investigate the presence of the two types, enhancement and treatment forms, of medicalisation. Third, I performed an ethical analysis of cosmetic surgery, as a practice that medicalises racial features, drawing mainly on my empirical findings. In this concluding chapter, I intend to summarise important key findings in my research, as well as explore some practical implications and make recommendations for future research.

In my conceptual analysis, I hypothesised that two forms, treatment and enhancement medicalisation, are present in Asian cosmetic surgery. In the treatment model, cosmetic surgery is a remedy for pathologised Asian features; while in the enhancement model, cosmetic surgery is a way to improve—not cure—normal but unwanted racial features. I argued that distinction is important in identifying oppressive or discriminatory surgical practice on the level of racial groups (treatment model) or on the level of individuals (enhancement model). In addition, the distinction may help to explain how socio-cultural as well as geographical locations influence medicalisation in the context of Asian cosmetic surgery.

My empirical investigation, which focused on Asian double eyelid surgery, confirmed the presence of medicalisation in cosmetic surgery websites hosted in South Korea and Australia. Findings showed the use of a medico-scientific narrative that emphasises scientific objectivity and medical expertise in situating racial features as medical concerns. One key finding is that procedures are no longer limited to blepharoplasty and have expanded to include others modifications of Asian eyes. In terms of the two forms, the distinction lies with whether communication strategies appeal to health (treatment form) or beauty (enhancement form). However, websites did not necessarily exclusively conform to one type, and in fact often appear to simultaneously use both.

In the ethical analysis, I argued that there are two general negative implications of medicalising Asian features in cosmetic surgery. First, using feminist relational theories, I discussed how the practice leads to diminished autonomy. I argued that cosmetic surgery weakens autonomy by displacing women's control over their bodies and by reducing women's value to physical appearance. Second, I discussed the negative impact of the surgical practice on the goals of medicine. I argued that the practice misdirects medical goals by prioritising commercial interest over the health of the patient; and, because of the need to hyper-specialise, the practice expands the suite of alleged cosmetic problems that can be managed by surgery.

My findings have potential implications for the way that we think about Asian cosmetic surgery. On the one hand, we might want to suggest that cosmetic surgery should be

removed from medical practice. Although I do not necessarily call for the banning of the practice, I have to ask whether medical professionals should still perform cosmetic surgery. I base this view, which I admit might be extreme, on the discussion that the practice perverts the goals of medicine. Specifically in the context of Asian cosmetic surgery, it seems that the practice highlights racial differences, even depicting racial features as pathological in order to market cosmetic procedures. This is problematic because commercial interest seems to obscure the goal of promoting the well being of individuals. Further, the fact that cosmetic surgery is a form of medical practice (specifically surgery) seems to reinforce the need to medically frame racial features as, intentionally or otherwise, pathological. Perhaps this contributes to the vicious cycle of socialised oppression, the one that puts unfair significance on physical features as the basis of one's self-worth. It might be better in the long run for cosmetic surgery to identify itself as purely commercial endeavour outside medicine, and align itself with other commercial entities in the beauty industry.

In addition to undermining the goals of medicine, the implications of Asian cosmetic surgery for diminished autonomy support, at the very least, supports the idea that we should view cosmetic surgery with caution. Although proposing specific regulatory mechanisms is beyond the scope of this chapter, and this study as a whole, I believe it is important to consider ways that we can ameliorate the psycho-social effects of depicting racial features as a medical problem. I do not wish to stereotype all cosmetic surgeons as malicious, and I believe there are those who are aware of the criticism against the practice. And maybe some are warning potential patients against the risk of the surgery,

even to the point of discouraging them. However, it is important to institutionalise policies that promote social harmony without resorting to surgically removing physical reminders of ethnic differences, and using medical scientific narratives to defend such strategies.

It is important to note that my ethical analysis is based on the findings of my empirical research on websites. As a consequence, the study has a number of limitations that should be considered. First, websites do not always reflect behaviours and motivations of cosmetic surgeons and consumers or the cultural background of host societies. In particular, because of the English language inclusion criteria, it is possible that some Korean websites—as well as Korean empirical and theoretical studies—that could have offered a varying perspective have been excluded. These limitations highlight the importance of encouraging collaboration with researchers from Asian countries. In terms of methodology, future research can expand the criteria in this study by analysing the whole website, or by including websites hosted in other countries. Interdisciplinary research can also explore how online communications are translated into real-world practice by employing methodologies developed in the social sciences.

The scale of the ethical issues arising from Asian cosmetic surgery is both extensive and multi-faceted, and this study is just the groundwork for future philosophical research. In particular, it would be interesting to look into the intersection of aesthetics and health. Exploring aesthetic theories of beauty may facilitate our understanding of cosmetic goals as potentially legitimate goals of medicine. It would be interesting to investigate how

complex theories of beauty—whether it is an objective reality or a subjective experience—can inform our understanding of the equally complex interpretations of health and disease. In particular, interdisciplinary research can explore the social and cultural aspects of aesthetic judgments and their influence on social constructivist or normative accounts of health. Moreover, since existing accounts of health and aesthetics in mainstream literature remain Western-oriented, it might be helpful to explore or compare those conceptualisations specific to Asian context.

In conclusion, my conceptual analysis and empirical investigation showed that medicalisation of Asian features is apparent in cosmetic surgery, and is associated with important ethical implications concerning autonomy and the goals of medicine. I have shown the contribution of this research to larger issues of medicalisation and cosmetic surgery by analysing the medico-scientific narratives used in online communication strategies. Although this project illuminates a mere fragment of various important issues, my study identifies an encouraging field of research that affects our understanding of the conceptual, ethical, and social foundations of medicine.

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