

SUN, SEA, SAND AND SILICONE

Mapping Cosmetic Surgery Tourism



Final Report 2014



PROJECT REPORT

SUN, SEA, SAND AND SILICONE

1. Executive Summary

This multi-site, mixed methods project charted the experiences of British, Chinese and Australian patients travelling abroad for cosmetic surgery. Cosmetic surgery tourism is a fast developing industry that incorporates novel forms of labour and organisational structures that cross national boundaries, as well as drawing together pre-existing medical and tourism infrastructure.

While medical tourism has often been characterised as wealthy patients from the global south travelling to the global north for high quality medical treatment unavailable at home, cosmetic surgery patients often travel from global north to global south, but these patients are on modest incomes. Despite this they can sometimes access upmarket private hospitals beyond their reach back home, made possible by favourable currency rates, cheap flights and lower labour costs outside the richest countries in the world.

UK and Australian patients travelled for surgeries that were popular back home – such as breast augmentation and uplift, ‘tummy tuck’, rhinoplasty and liposuction. Others travel regionally, for example within Europe, often also motivated by cost savings.

There are important exceptions to this pattern: Chinese patients travelling to South Korea access more expensive but high quality cosmetic surgery unavailable back home. Here patients from abroad often seek particular types of surgery prevalent amongst South Koreans, for example eye or jawbone surgery, or high tech surgery, such as breast augmentation using the patient’s own fat and stem cells.

Patients therefore travel from global north to global south, across regional borders, and many are also ex-patriates. UK patients in Spain were most usually already living in Southern Spain or Gibraltar.

Monitoring the movements of cosmetic surgery tourists is important in predicting health tourism in the future. As public healthcare systems are increasingly squeezed, patients become consumers in search of cut price procedures, taking on the risks of the choices they make. This research aimed to broaden understandings of surgical tourist experiences, the organisations involved, and the implications for globalized healthcare organised around consumption and markets.

2. Key Findings

Patients are ordinary people on modest incomes

They tend to spend as little time away from home and family as is possible/ recommended by their surgeon because want to get home to families/ friends.

Cosmetic surgery pathways often follow cheap flights

Clinics are often located at tourist resorts.

Different patients have surgery for different reasons

No-one in our sample wanted to look like a particular celebrity or achieve a perfect body.

Patients don’t make snap decisions

Most of our patients considered surgery for 5-10 years before they decided to have it. Once they made the decision they wanted surgery as quickly as possible to minimise the time spent dwelling on risks.

Patients lack knowledge of the places they travel to

Patients are mostly not well-travelled and have poor foreign language skills. Most have never visited their destination country prior to surgery.

Patients experience positive outcomes

97% of patients in our study were happy with the outcomes of their surgeries and would recommend their surgeon to a friend.

Agents are ‘brokers’ between surgeons and patients

Cosmetic surgery tourism agents or facilitators play a key role in patient experience of place and surgery and in ‘managing patient expectations’.

Surgeons are mobile

In addition to surgeons who are based in the destination country, many surgeons and other healthcare workers travel.

Cosmetic surgery and public healthcare

17% of our patients experienced complications from their surgeries. 9% received further treatment in the NHS or Medicare upon returning home. Most needed stitches replacing/ removing, infections treating with antibiotics, or seromas draining.

Private surgeons

Surgeons in home countries were characterised as aloof, inattentive, uncaring and as seeing patients as ‘walking cheque books’.

3. Study Methods

The project employed multiple methods in order to explore the size, structure, practices and flows of the cosmetic surgery tourism (CST) industry, focussing on patients travelling from the UK, Australia and China. 105 interviews were conducted with patients, 36 with cosmetic surgeons, 29 with cosmetic surgery tourism agents and 45 with other workers (nurses, tour guides, hospital and patient managers, translators and drivers). A full table is included below (see Table 1).

Patient interviews provided information on:

- Decision making
- Choice of destination
- Use of agents
- Experiences in their chosen destinations
- Post-surgical complications
- Overall satisfaction with their CST experience.

Interviews with surgeons explored:

- Career trajectories and motivations
- Issues they thought important for patients to consider
- The satisfactions and drawbacks of working in this field.

Interviews with other workers provided information on:

- Industry operations
- Patient numbers
- Employment opportunities for local workers
- Impacts on other branches of medicine and the public sector of CST
- The work experiences of employees.

In addition to the interviews, we followed patients from Australia to Thailand and Malaysia, from the UK to Poland, Tunisia, Belgium and Spain, and from China to South Korea. Researchers gained access to patients and staff in situ, observing consultations, pre-surgical tests and post-surgical check-ups, as well as some surgeries. The team followed patients to their apartments and hotels, on shopping trips and other tourist activities, and on evenings out. We accompanied some patients on their flights to and from their destination and met them weeks (in some cases months) after their trip to gather further reflections on their experiences.

We elicited photo diaries and video diaries from some patients who consented to use of images in the project. We took many photographs at destinations for illustrative purposes. An online questionnaire was also utilised, largely as a recruitment tool -- but some substantive findings from this have been used.



I went to a clinic in London and the surgeon came out of scrubbing up and he said, ‘Right I can have a quick consultation with you’. And I said ‘Can I just ask, you said you were scrubbing up, is there a patient waiting for you to operate?’ And he went; ‘Yeah, yeah but I have got ten or fifteen minutes that I can spend with you now’. And I said, ‘I am sorry but I don’t want you to do the same to me when there is a paying client in there. Sorry I won’t come to you, so I won’t waste your time’. So I just walked out. . . . I was just seen as a walking chequebook really. I felt like I was a number in a sales process”.

(UK Patient)



Accompanying patients inevitably raised ethical issues -- for instance patients asking researchers to help them negotiate with medical staff, or witnessing patients when they did not follow medical advice. These were all dealt with by researchers using good judgement at the time: assisting patients in negotiations when they thought it was necessary, and reminding patients about medical advice whilst not attempting to police behaviour. No issues of misconduct, medical or otherwise, were witnessed by the research team, although one patient we met was left for 20 hours without water because of miscommunication caused by language barriers. A small minority of patients underwent multiple (perhaps too many) procedures at one time, which, while not necessarily seen as dangerous by surgeons, created significant discomfort and disorientation for the patients.

These data were combined and coded into themes using NVivo. Analysis and writing up is on-going, although several strong conclusions have already been identified.

Table 1 – Interviews Conducted

Types	Number of interviews			
Agents	29	Australia (7), Korea (8), Malaysia (6), Spain (2), Thailand (1), UK (5)		
Patients	103	Destination	Male	Female
		Belgium	0	7
		Czech Republic	1	0
		India	0	1
		South Korea	4	20
		Malaysia	0	9
		Poland	4	16
		Spain	5	4
		Thailand	1	26
Tunisia	0	5		
Surgeons	36	Australia (2), Belgium (3), South Korea (8), Malaysia (2), Singapore (1), Poland (6) Spain (5), Thailand (8), Tunisia (1)		
Other workers	45	Patient Coordinator		5
		Marketing staff		11
		Others (Driver, Hospital owner, Hotel manager, Independent advisor, Interpreter, Lawyer, Nurse)		29

4. Context

We see cosmetic surgery tourism (CST) as emerging in the context of some major transformations, which we can characterise as being about

- Changing bodies
- Changing markets, and
- A changing world

Changing bodies refers to the practices and meanings of bodily transformation: while human beings have always changed how their bodies look and function, and changed what bodies mean, the scope of and access to practices of bodily transformation have never been greater. This is connected partly with technological advances, partly to the circulation of ideas about bodies, and partly with broad social and cultural, political and economic processes that are all reshaping our experiences of embodiment. Our bodies have never been more malleable, though any decision to make a change confronts us with choices and risks.

Changing markets refers first of all to healthcare, and to the 'marketisation' of healthcare – the very idea of a market in health is something that more and more people are being faced with. This connects to the privatisation of provision of services such as health, which has gathered pace in many countries – the extent to which 'market logic' has penetrated healthcare varies around the world, but nowhere is immune from the idea. But changing markets also refers to things like the employment market, and to the 'marketisation' of our lives and our bodies. So changing our bodies can be seen as an investment. Market logic reshapes our understanding of access to and choice in healthcare, but also refocuses issues of risk and even blame. As patients become consumers, we not only enter a healthcare marketplace, but are asked to calculate the costs and benefits of the choices we make.

A changing world refers to processes of globalisation. This does not mean that everywhere in the world is becoming more alike, but it does mean that everywhere is more connected to everywhere else. Transport and communications 'shrink' the world, for example, opening up new marketplaces for bodily transformation. So globalisation is reshaping the world, sometimes in predictable ways and sometimes in surprising ways. In this project, we have used terms such as flow, network and assemblage to explore how globalisation makes connections between places, people, things and ideas. And CST is one outcome among many of global processes – but also of regional and local processes, too.

4.1 Previous Research

As part of our work on this project, we carried out a systematic literature survey. CST is emerging as an interdisciplinary topic, studied from a number of different perspectives. Rather than run through the full literature review here, below we provide a typology of the academic literatures and highlight some of the key references:

Medical literature – often this is concerned with assessing either the risks associated with CST or the impact of CST on healthcare systems in both sending and receiving countries. We see in this category studies of infection rates, analysis of data from surgeons undertaking revision to surgeries undertaken abroad, commentaries from professional bodies on the impacts of CST, and attempts to quantify numbers of patients travelling abroad.

See: Birch et al (2007), Furuya et al (2008), Jeevan & Armstrong (2008), Miyagi et al (2012).

Health policy literature – here CST is viewed as one component of broader healthcare systems, often as a subset of medical tourism. Research has explored the benefits and costs of developing CST infrastructure, as well as issues such as accreditation schemes and cross-border or regional agreements and debates about the regulation of an increasingly privatised and marketised health system. Legal and ethical dimensions of CST are often debated in this literature.

See: Lunt & Carrera (2010), Lunt et al (2013), Snyder et al (2013), Turner (2007).

Tourism management literature – tends to view CST as a niche form of tourism, again often as a subset of medical tourism. This research explores both structural issues (resort development, branding) and experiential issues (how to market effectively, patients' decision-making, typologies of patients). It tries to quantify CST numbers, and to apply various multipliers to estimate the economic benefits of CST development. Research has also explored the roles played by agents and other intermediaries, and uses of online information and marketing materials in the CST context.

See: Castonguay & Brown (1993), Snyder et al (2011), Viladrich & Baron-Faust (2014), Wongkit & McKercher (2013).

Social science literature – this includes subdisciplines such as medical sociology, medical anthropology and medical geography, along with research in media & cultural studies. Here focus tends to be on the discourses and experiences of CST. This research has included ethnographic studies of patients in particular destinations, analyses of promotional materials read through critical discourse analysis, and attempts to theorise CST using social and cultural theory. This field also draws on the strong traditions of work in these areas exploring cosmetic surgery more broadly.

See: Ackerman (2010), Casanova & Sutton (2013), Enteen (2014), Turner (2012)

Our own research is informed by and seeks to contribute to academic debates across these literatures.

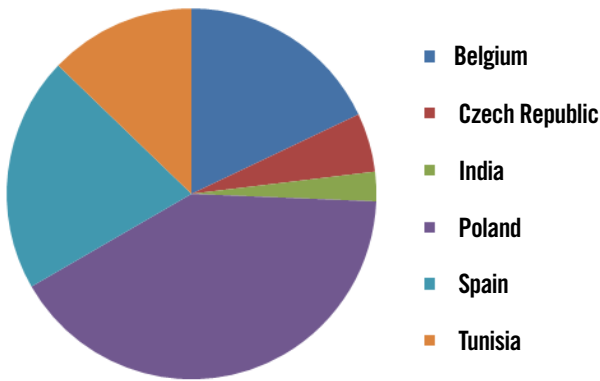
In addition to academic material exploring CST, **popular literature, press and media coverage, and social media** are very important, both as resources for research and as vital sites where CST is discussed, debated and framed. Guidebooks and websites provide detailed maps of the global reach of CST and advise would-be patients on the choices they are facing (eg Schult 2006). Press and media coverage often focuses on 'horror stories' but is also awash with tales of remarkable bodily transformation and its benefits. It is very important that those of us studying this field understand how CST is constructed, talked about, dreamed about or dismissed – and the popular media is a key site where this happens.

4.2 Further reading

- Ackerman, S. (2010) Plastic paradise: transforming bodies and selves in Costa Rica's cosmetic surgery tourism industry. *Medical Anthropology*, 29: 403-423.
- Birch, J., Caulfield, R., & Ramakrishnan, V. (2007) The complications of 'cosmetic tourism' – an avoidable burden on the NHS. *Journal of Plastic, Reconstructive & Aesthetic Surgery*, 60: 1075-1077.
- Casanova, E. & Sutton, B. (2013) Transnational body projects: media representations of cosmetic surgery tourism in Argentina and the United States. *Journal of World-Systems Research*, 19: 57-81.
- Castonguay, G. & Brown, A. (1993) "Plastic surgery tourism" proving a boon for Costa Rica's surgeons. *Canadian Medical Association Journal*, 148: 74–6.
- Enteen, J. (2014). Transitioning online: cosmetic surgery tourism in Thailand. *Television & New Media*, 15: 238-249.
- Furuya, E., Paez, A., Srinivasan, A., Cooksey, R., Augenbraun, M., Baron, M., & Granowitz, E. (2008) Outbreak of *Mycobacterium abscessus* wound infections among "lipotourists" from the United States who underwent abdominoplasty in the Dominican Republic. *Clinical Infectious Diseases*, 46: 1181-1188.
- Jeevan, R. & Armstrong, A. (2008) Cosmetic tourism and the burden on the NHS. *Journal of Plastic, Reconstructive & Aesthetic Surgery*, 61: 1423-1424.
- Lunt, N., & Carrera, P. (2010) Medical tourism: assessing the evidence on treatment abroad. *Maturitas*, 66: 27-32.
- Lunt, N., Mannion, R., & Exworthy, M. (2013) A framework for exploring the policy implications of UK medical tourism and international patient flows. *Social Policy & Administration*, 47: 1-25.
- Miyagi, K., Auberson, D., Patel, A., & Malata, C. (2012) The unwritten price of cosmetic tourism: an observational study and cost analysis. *Journal of Plastic, Reconstructive & Aesthetic Surgery*, 65: 22-28.
- Schult J. (2006) *Beauty from Afar: Medical Tourist's Guide to Affordable and Quality Cosmetic Care Outside the US*. New York: Stewart, Tabori & Chang.
- Snyder, J., Crooks, V., Adams, K., Kingsbury, P. & Johnston, R. (2011) The 'patient's physician one-step removed': the evolving roles of medical tourism facilitators. *Journal of Medical Ethics*, 37: 530-4.
- Snyder, J., Crooks, V., Johnston, R. & Kingsbury, P. (2013) Beyond sun, sand, and stitches: assigning responsibility for the harms of medical tourism. *Bioethics*, 27: 233-42.
- Turner, L. (2007) First world health care at third world prices: globalization, bioethics and medical tourism. *BioSocieties* 2: 303-25.
- Turner, L. (2012). News media reports of patient deaths following 'medical tourism' for cosmetic surgery and bariatric surgery. *Developing World Bioethics*, 12: 21-34.
- Viladrich, A. & Baron-Faust, R. (2014) Medical tourism in tango paradise: the internet branding of cosmetic surgery in Argentina. *Annals of Tourism Research*, 45: 116-131.
- Wongkit, M, McKercher, B. (2013) Toward a typology of medical tourists: a case study of Thailand. *Tourism Management*, 38: 4-12.

5. At a Glance ...

Destinations from the UK

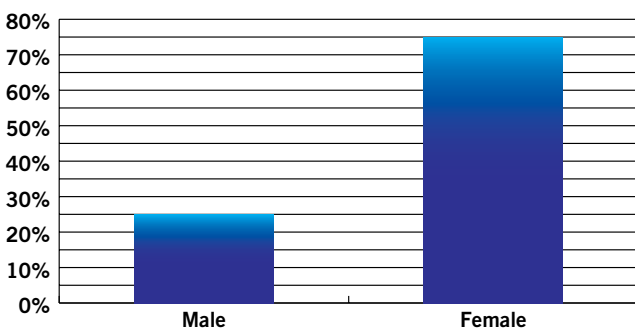
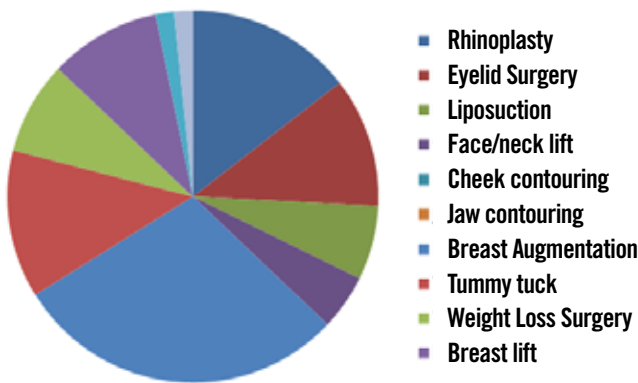


5.1 Most Common Procedure Choices

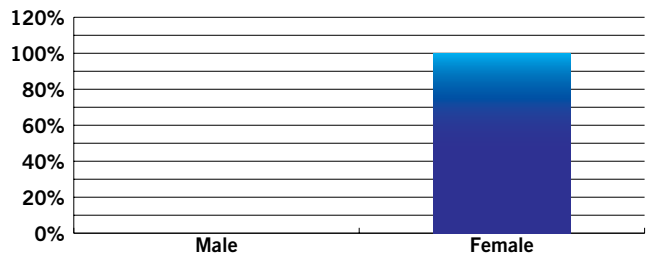
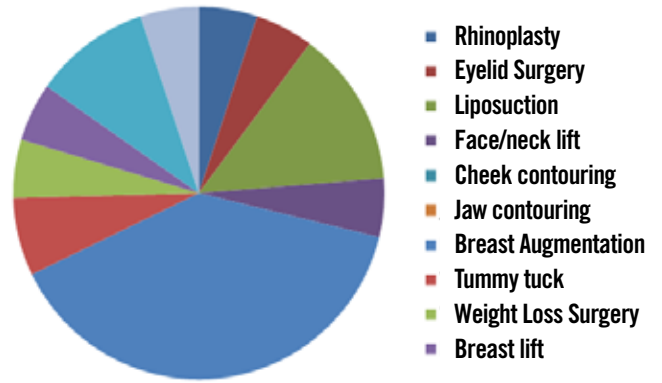
These graphs clearly demonstrate preferences for different procedures by different national groups travelling to different destination countries. Breast augmentations made up 44% of the British sample and 66% of the Australian sample, but were totally absent in the sample of Chinese patients travelling to South Korea, for whom eyelid, jawbone and nose surgeries made up 88% of the total. In addition, gender ratios varied considerably by departure country. No men were encountered travelling from Australia to Thailand or Malaysia, whilst male patients made up 24% of patients travelling from the UK to destinations in Europe.

(Note: this is based on a small sample (105 patients) so is indicative only.)

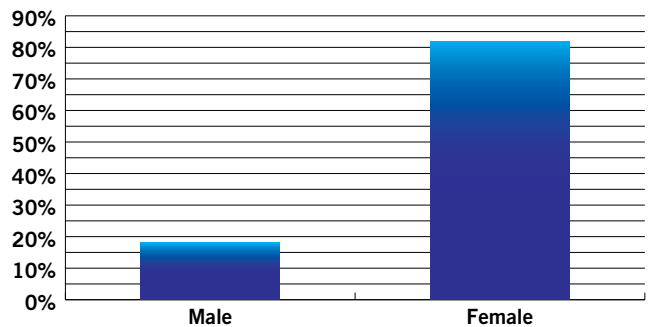
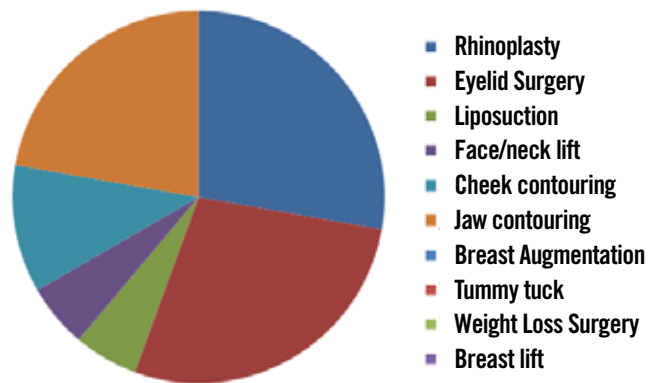
5.2 British Patients



5.3 Australian Patients



5.4 Chinese Patients



6.1 Why Travel?

For UK and Australian patients, cost was the biggest factor influencing decisions to travel abroad:

- A 'tummy tuck' in Poland (including travel and accommodation) is £3,000. The same operation is £6,000 in the UK.
- Average cost of breast augmentation in Australia is \$12,000 compared with \$4,000 in Thailand.

Surgical quality, technique and technology (not cost) were the primary drivers for Chinese patients travelling to South Korea.

UK and Chinese patients stayed in their destinations for the shortest time possible to minimise costs (5-7 days average).

Australian patients were more likely to combine surgery with a holiday and to stay longer in their destination country (10-15 days average).

Among our 'tourists' were expatriates, local cross-border travellers and migrants returning 'home' for treatments.

6.2 Who Travels?

Unlike their representation in much of the literature on medical tourism, our patients were not international 'jet-setters'. They were 'ordinary people' – administrators, nurses, care workers – who wanted to change one part of their body they didn't like. Patients from the UK and Australia travelled abroad for surgery because they couldn't afford it at home. Chinese patients were middle-class and sought better quality surgery than that available back home.

9% of our interviewees had a higher education qualification.

'Quality of Surgeon' was given as the main reason for choosing a particular destination; place was relatively unimportant (except Chinese patients who travel for high quality Korean surgery). Patients lack knowledge of the places they travel to. They are mostly not well-travelled and have limited foreign language skills.

Most patients said they simply wanted to look 'normal'.

"I didn't want to be massive, I was something like a 36A and I'm a 36 small D now, so I'm not like Jordan or anything like that, I just wanted to be normal, what I would call normal, and I feel a lot better in my clothes and a lot better in myself"

(UK Patient)

"I didn't want them ultra high - the really fake look like Victoria Beckham; like two high up circles. [I just wanted] 'moderate', which is just kind of the average, the standard one, so I thought that is fine"

(UK Patient)

"Yes I have still got some lines so that when I am out and my granddaughter is calling me 'Nan' I am not going to have people thinking 'freak show' because I didn't want to do that, I don't want to look younger than my daughter. So yes, I am very pleased with the surgery and I went there for cost effective surgery didn't I?"

(Australian Patient)

Chinese patients were middle-class and paid for their surgeries from savings. UK and Australian patients were more likely to use credit or small inheritances. Patients said they might otherwise have spent the money on home improvements or holidays.



6.3 Reasons for Surgery

Patients' stated reasons for CST generally fell into 4 groups (these reflect tendencies rather than discrete categories):

- 1. Correction** This group was mostly young people (men and women) seeking ear pinning, nose reshaping, breast surgery for symmetry, breast reduction for very large breasts or gynecomastia. They saw this as correction for 'abnormalities' that they were born with or that developed in puberty.
- 2. Investment** This minority group were seeking 'fashionable' surgeries. They consisted mostly of young women in UK/ Australian context who wanted 'boob jobs'. In South Korea blepharoplasty (eye widening), jaw reduction surgery and nose augmentation were commonly purchased by both women and men. These surgeries conveyed status and value and were linked with celebrity culture, especially the export of South Korean popular culture throughout East Asia (The Korean Wave). No participants said they wanted to look like a particular celebrity. But celebrities' body parts were used as a catalogue of desirable features that patients took to their surgeon (just like we sometimes take pictures to the hairdressers to indicate our desired style).
- 3. Repair** Women were the big majority in this group, which included people whose bodies had undergone trauma or change. Post pregnancy surgery including breast uplift and 'tummy tuck', vaginal 'rejuvenation' (often masking repair to episiotomy scar or prolapse). This group also included repair to other sudden bodily traumas, for example facial scar removal (from fighting) or sporting injuries to ears and noses.
- 4. Anti-ageing** This group was fairly gender neutral and sought face, neck or brow lifts, eyelid lifts (blepharoplasty) and hair transplants.

There was no single reason for surgery. The gender dynamics of surgery are quite complicated and tied as much to embodied processes like pregnancy and childbirth as to beauty cultures. In our sample cosmetic surgery was tied very strongly to age/ life-stage and anti-ageing.



6.4 Choosing a Destination

"It's not about Poland. It's not about tourism. To me it's about getting a good result from my surgery, and I would have gone anywhere for that. So it wasn't a holiday. I didn't view it as a holiday. I didn't base the decision on where the operation was. I based my decision on the reviews I'd seen, the patients I'd seen, the comments I'd seen, the results I'd seen. That was my decision. That was my decision; not that it was Poland. I couldn't care less that it was Poland. It wouldn't have matter to me if it was Africa."

(UK Patient)

"I've always wanted to go to Thailand and then when I knew that you could have boobs there, bingo, there was my opportunity. I think it was mainly because I'd always seen brochures on Thailand and I'd liked it so I think that was the main reason why."

(Australian Patient)

All of our patients put the quality of the surgeon as their primary reason for choosing a specific destination. The reputation of surgeons was judged mostly by personal recommendation, although Australian patients were more likely to consider surgical qualifications. The clinic and destination country was of secondary importance, though Australia to Thailand was a path already very well established for tourism.



6.5 The Industry

Facilities varied from large ‘international’ hospitals (e.g. Bumrungrad in Thailand) to small clinics occupying one floor of a tower block with two recovery beds (the most usual model in South Korea).

Some hospitals were permanent with their own staff on contract. Other hospitals rented space to different medical teams who leased them just for a few days each month.

Surgeons and other staff were also sometimes ‘medical tourists’ travelling abroad to conduct surgeries and consultations.

Over half of our patients used the services of a specialist agent to arrange their trip.

Agents are often former patients who have made the same journey, now running single-person businesses from their own homes.

Agents network with a variety of other workers – patient co-ordinators, drivers, translators, hotel managers – to provide a package.

Agents filter prospective patients, and also keep the more commercial aspects of the industry remote from surgeons.

Budget airlines have a major role to play in popularising specific destinations. CST pathways often follow cheap flights, and clinics are often located at tourist resorts.

The internet is key to this industry, providing information on surgeries, destinations, surgeons’ qualification and patient testimonies.

Websites often provide direct price comparison and emphasise quality of care and hygiene.

Social networking sites were used extensively to facilitate mutual support and group travel for patients.

Social media are also used by agents to market their services – sometimes giving rise to conflicting understandings of their purpose.



6.6 Surgeons

Some surgeons are based in and work in a single country, but many are highly mobile, living in one country and operating in others. Some surgeons travel to departure countries to give seminars or consultations then operate back home or in a third destination country. If a surgeon conducts any part of their business in a departure country the patient from that country has more rights to take legal action if something goes wrong. Destinations countries where operating theatre rentals and healthcare staff are cheap allow discounts to be passed on to patients without compromising surgeons’ salaries.

There is much debate over the pros and cons of medical tourism for national healthcare systems and whether CST encourages medical staff to migrate from public to private healthcare or if instead it encourages medical staff to remain in their home country rather than forming part of a medical ‘brain drain’ to richer countries. These debates assume that money is the driving force behind the migration of surgeons, yet our research found that care was a key issue.

Surgeons often cited the conditions in overstretched public healthcare as making caring for patients impossible. Moving to the private sector enabled surgeons to implement an ethic of care they were unable to actualise in the public sector. Surgeons also moved from other areas into cosmetic surgery. These surgeons cited artistic orientation, variation of techniques and new technologies as key motivations for entering the sector. Surgeons were unhappy that cosmetic surgery is not always taken seriously.

“[The surgeon in Poland], he went out and got me a DVD. Who’s going to do that here? He went out to get me a DVD. He’d seen a DVD that he thought I’d like because it was a comedy and it was funny and he went out and got it for me. He went to somewhere to get me a DVD ... that I could watch on my laptop. Now, you try and find a surgeon here that will do that. I would imagine they’re very rare ... He’s a lovely, lovely man. A lovely guy and not just a good surgeon, but a nice guy ... Yeah, he was somebody I could have been friends with, you know”

(Patient, UK to Poland)

“Well I am very happy, and I enjoy my work. There is no right answer, as cosmetic surgery is ... not a matter of fixing something definitively, like an illness, but about reconstructing something. As a result you can to some extent incorporate your own styles to create something new, and that is what I find intriguing about my work ... I think that’s why it’s so enjoyable for me ... it’s about discovering new things. Also I like to make others happy ... I feel proud of myself when I finish an operation and a patient would come up to me and say thank you”

(Surgeon, South Korea)

“Throughout the year it is very rare to perform the same type of surgery – it is always different. So compared to other branches of medical surgery, where the types of operations you perform are very similar and generic, cosmetic surgery is a lot more fun”

(Surgeon, South Korea)

“Maybe I shouldn’t say something like that but I feel sometimes like a creator or maybe not really creator but a magician! I change ugly things into beautiful ones”

(Surgeon, Poland)

“Of course, there are those who think of cosmetic surgeons highly, and even envy us for our access to creativity, and the relative lack of monotony in our field of work. However there are also those who think of us lightly . . . and consider our work as a part of beauty and cosmetics, and not so much on the medical front. They underestimate us, almost as if we are pseudo-doctors”

(Surgeon, South Korea)

6.7 Agents

Cosmetic surgery tourism agents act as ‘one stop’ solutions to finding, arranging and organising treatment abroad. They are typically women and are often former patients who have made the same journey they now arrange for others. Agencies are largely unregulated and rarely consist of more than a single-person business; most are freelance while some are formally connected to hospitals or clinics. Most of the agents we interviewed were working class, with little if any tertiary education. Their previous jobs had been as beauty therapists, estate agents or

administrators. They were generally dealing with between one and thirty clients per month. Some require a fee from the patients direct, others take commission from hospitals and travel agencies.

Many agents saw themselves as performing an important community service:

“I want to be there to be able to morally and emotionally support people and educate them to the best way of doing things abroad”

(Agent, sending patients from UK to Poland)

In addition to patients and surgeons, agents network with a variety of other workers and businesses – airlines, hotels, patient co-ordinators, drivers, translators, hotel managers – to provide a package.

Agents filter prospective patients, in some cases deciding not to take them on. In this way they benefit surgeons by keeping away those patients who might be problematic in terms of having unrealistic expectations or being at high risk of complications. In addition, agents often keep the more commercial aspects of the industry remote from surgeons. This allows surgeons freedom to work untainted by direct monetary discussions with clients and thus to maintain a certain degree of perceived care and medical professionalism beyond money.

We found that agents perform a high degree of emotional labour: they are involved in reassuring clients, hugging them, holding hands after operations, providing extra pillows. They are also called on to constantly share their own cosmetic surgery tourism experiences. Many used the surgeons they referred clients to themselves, and some were recovering from their own treatments as we interviewed them.

Agents also perform aesthetic labour, presenting their own transformed bodies as templates/examples to clients. Thus their own appearances are of the utmost importance, and it is crucial that the results of their own cosmetic surgeries are seen as positive and enhancing.



6.8 The Internet

Websites are key to this industry, providing information on surgeries, destinations, surgeons' qualifications, and patient testimonies. Hospitals, clinics and agents advertise online, providing direct price comparisons and emphasising international accreditation and hygiene. Agents' websites emphasise personal care and the unique service that can only be offered by someone with experience and expertise in cosmetic surgery tourism.

Most website splash pages feature images of models rather than actual patients, although many do include galleries of before/after pictures. Most also have information about attractions and tourist activities in the destination, and some include booking links.

Social networking sites such as Facebook are also very important and are often set up by agents for marketing and promotion. They are also widely used by patients to share information and experiences.

Patients use online media in several ways:

Before surgery patients are likely to conduct research by searching the websites of surgeons, hospitals and agents as well as reading social media:

"I compared, I looked at before and after photos of that doctor and researched his work and then I looked at other surgeons as well ... I'd researched the implants which were meant to be the best ... I'd read lots of testimonials, not just from [the agent's] website but on forums"

(Patient, Australia to Malaysia)

We found that cosmetic surgery tourists are generally not content with the advertising of hospitals and clinics, and like to discuss surgical techniques and the results of particular surgeons with each other, via social media.

During their trips patients told us that social media was a way to access support.

"You got all this support from all these people that are on Facebook ... that are commenting, that's making you feel you're not completely alone. It is nice. It's a lovely thing that ... although I couldn't speak to anybody because there was nobody really out and about that spoke English, it was nice being able to go on Facebook and being able to just make comments"

(Patient, UK to Czech Republic and Poland)

While away, some travellers put up pre- and post-surgery images of themselves and write in detail about their experiences. They do this to share information with other patients and to reassure family and friends.

After surgery patients may share and compare their transformations and recoveries via social media. Some of those who suffered complications were able to find support and information online that was not available elsewhere. Some patients continue to blog or upload videos about their cosmetic surgery tourism experiences for years afterwards.

6.9 Treatment Back Home

1 in 6 of our patients experienced complications from their surgeries. Fewer than 1 in 10 needed treatment in the NHS or Medicare upon returning home.

Most were small complications such as needing stitches removing, antibiotics for infections, or seromas draining.

The structure of healthcare back home made it ill equipped to deal with these minor complications. Two serious cases resulting in major complications were treated with very different levels of sympathy and compassion. In one case the patient was blamed for her decision to go abroad and she felt that treatment was given grudgingly.

6.10 Clean Hospitals

Many patients remarked on the clean facilities, and the visible cleaning work that they saw struck them as extraordinary when compared with UK or Australian hospitals, though they were most often referring to public hospitals back home:

"I wouldn't have no worries going abroad because I've never known such a clean hospital as what that was where I was, the room I was in, they came in 3 to 4 times a day and cleaned that room, you know, I mean the floors and everything, 3 and 4 times a day, it was spotless, it really was spotless"

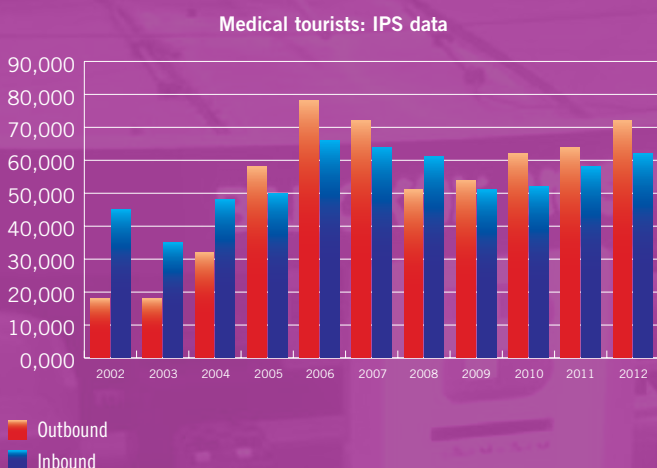
(Patient, UK to Poland)



7. The problem of numbers (an example from the UK)

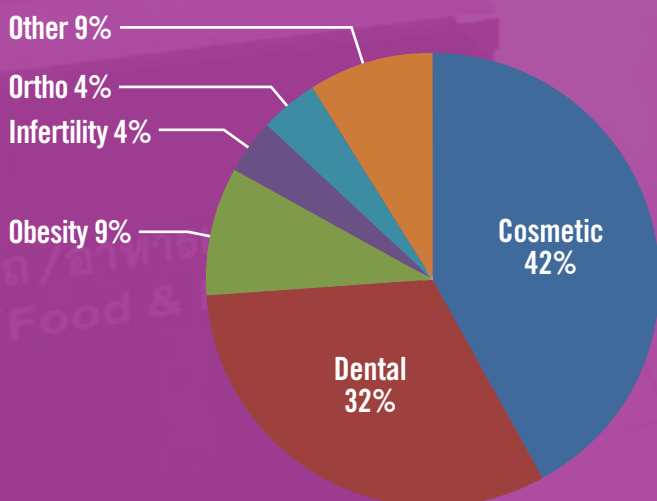
No reliable figures exist that show the numbers of people travelling abroad for cosmetic surgery. The International Passenger Survey monitors the reasons people give for travelling abroad when they leave or enter the UK from airports, ports and by rail. The following graph shows annual extrapolations of people travelling for medical treatment.

Fig 1: Inbound and Outbound Medical Tourists (UK) From the International Passenger Survey



A survey of 1000 patients travelling abroad for medical procedures conducted by Treatment Abroad shows the kinds of treatments that patients travel for. Much dental treatment is cosmetic and there are also grey areas between health and appearance in the use of obesity surgery. This survey would therefore place cosmetic procedures at as much as 60-70% of all medical tourism.

Fig 2: Most Popular Medical Tourism Procedures (from Pollard, 2013)



The dangers of flying home too soon after surgery and of other complications are often stressed in the medical literature (Birch et al 2007; Furuya et al 2008; Handschin et al 2007; Jeevan et al 2008; Jeevan et al 2011; Miyagi 2012) though data on complication rates is patchy (Melendez et al 2011), and widely cited figures are based on small sample sizes. For example, BAPRAS conducted a survey to which

203 (62%) of 326 UK consultant members responded. 76 (37%) respondents reported having seen patients with complications or concerns following cosmetic surgery abroad (Jeevan et al 2011). In another survey conducted in eleven NHS plastic surgical units of the pan-Thames region, 35 out of 65 consultants responded; 60% of them had seen complications from patients who had travelled overseas (Birch et al 2007).

If we were to accept these figures above uncritically this would demonstrate very little burden on the NHS as a result of complications arising from CST. Another study designed to investigate the costs and benefits of medical tourism to the NHS presents similar results (Hanefeld et al 2013) though this study draws data from just 17 cosmetic surgery tourists.

It could also be argued that some savings to the NHS result from CST – for example from patients who go abroad for surgeries that have been scheduled in the NHS but where the patient wants to avoid long to waiting lists, or in terms of reduced medication use and higher levels of economic participation resulting from improved wellbeing, and some treatments and consultations were offered free of charge by clinics abroad to make patients fit for surgery that might otherwise have been undertaken in the NHS. These questions, however, are beyond the scope of this study. There is an urgent need for further research, especially in the production of more accurate figures unaffiliated to any particular interest groups.

References

Birch J, Caulfield R, Ramakrishnan V. (2007) The complications of 'cosmetic tourism' - an avoidable burden on the NHS. *Journal of Plastic, Reconstructive & Aesthetic Surgery*, 60: 1075-7.

Furuya EY, Paez A, Srinivasan A, Cooksey R, Augenbraun M, Baron M, et al. (2008) Outbreak of *Mycobacterium abscessus* wound infections among "lipotourists" from the United States who underwent abdominoplasty in the Dominican Republic. *Clin Infect Dis*, 46: 1181-8.

Handschin AE, Banic A, Constantinescu MA. (2007) Pulmonary embolism after plastic surgery tourism. *Clin Appl Thromb Hemost*, 13: 340.

Hanefeld J, Horsfall D, Lunt N, Smith R. Medical Tourism: A Cost or Benefit to the NHS? (2013) *PLoS ONE*, 8.

Jeevan R, Armstrong A. (2008) Cosmetic tourism and the burden on the NHS. *J Plast Reconstr Aesthet Surg*, 61: 1423-4.

Jeevan R, Birch J, Armstrong AP. (2011) Travelling abroad for aesthetic surgery: Informing healthcare practitioners and providers while improving patient safety. *J Plast Reconstr Aesthet Surg*, 64: 143-7.

Melendez MM, Alizadeh K. (2011) Complications from international surgery tourism. *Aesthet Surg J*, 31: 694-7.

Miyagi K, Auberson D, Patel AJ, Malat CM. (2012) The unwritten price of cosmetic tourism: an observational study and cost analysis. *J Plast Reconstr Aesthet Surg*, 65: 22-8.

Pollard K. *Cosmetic Surgery Abroad*. (2013) Presentation at: Stakeholder Event; June 24, Leeds, UK.

8. Issues and Recommendations

The industry is unevenly regulated and poorly documented

Better regulation is vital to protect patients. Surgeons and clinics should be accredited and inspected. The quality assurance of medical devices needs to be tightened. This regulation must be transnational not national, for example organised around the EU or ASEAN.

Patients find legal redress difficult to access if surgery goes wrong

It is currently very difficult to sue across national borders. Legislation could be introduced to facilitate this; however, with each country having different legal systems, even within the EU, this seems a long way off. Voluntary codes and standards for overseas treatment are a possibility, but discussions to this end have yet to travel over from the US.

Patients should be very wary of clinics and surgeons that offer 'lifetime guarantees' and other guarantees as many clinics close after a few years. Patients must establish where to take a complaint or claim if treatment fails -- to the clinic or the surgeon. The contract will normally be made with the clinic with which negotiations have taken place. All too often, clinics have no insurance cover, and refer claims to the surgeon who again may also be uninsured. Some surgeons do carry professional liability insurance to cover claims against them and patients should check this before going ahead.

Cosmetic surgery tourism sits uncomfortably between healthcare and consumerism

In the private sector responsibility for risk is transferred from doctor to patient – it becomes a 'patient choice' or a consumer purchase. Consequently if things go wrong the patient is blamed for making a bad choice. For patients used to more directive nationalised healthcare services, negotiating risk is extremely complicated.

GPs are reluctant to advise patients thinking of travelling abroad

GPs are largely unsympathetic to patients who want cosmetic surgery. In countries with nationalised healthcare such elective surgeries are seen as indulgent and unnecessary. Many uncritically

accept a media discourse associating cosmetic surgery with celebrity culture. Almost all of our patients strongly rejected the idea they wanted to look like celebrities, referring instead to problems with or negative changes to their own bodies. In addition, GPs are very wary of liability being transferred to them from the surgeon through being seen to recommend a surgery or destination or becoming involved in patients' post-op care.

Distance from surgeons makes complications difficult to deal with

Unlike surgery in home countries, surgery abroad makes treatment of complications much more difficult. Patients should stay in their destination for the full recommended time as most complications arise within days of surgery. Patients should bear in mind that if revisions are needed later they will have to find money to travel back to the destination country.

Complications insurance, though unfit to cover all losses and expenses that can be incurred from failed overseas treatment, seems essential. The take-up of these policies, however, has not fulfilled earlier promise. Legislation could be changed to facilitate this.

Complications insurance often lasts only a year from the date of surgery, and surgeons often recommend letting surgery heal for a year before the final result can be seen. Thus insurance can run out before revisions are done.

Larger hospitals often have better facilities for emergencies

Should anything go wrong during surgery, big hospitals often have better facilities than small clinics. For instance, large hospitals have emergency departments and crash teams. In the event of cardiac arrest in a small clinic surgeons may have to call an ambulance and transfer the patient.



Patient medical records are often unavailable to medical staff in destination countries

Patients sometimes have underlying medical conditions that are only discovered at the point of surgery or pre-surgical tests. Most surgeons refuse to treat a patient with a serious health condition (e.g. high blood pressure or diabetes) so patients can be returned home without surgery. In some cases health problems may not be discovered until there is a problem during surgery. Medical records should be made available to overseas medical personnel.

Patients don't always follow medical advice

Some patients drank alcohol soon after their surgery. Others failed to rest sufficiently. Some failed to take their prescribed medicine – e.g. because they didn't like swallowing pills – and some removed bandages or medical support garments too early. For best results patients should follow their surgeons' advice more carefully, even when it is uncomfortable or inconvenient and disclose all pre-existing medical conditions before their surgeries.

Language barriers and lack of geographical knowledge can make communication difficult

Patients sometimes travel to destinations that are not at all what they expected. They can be shocked by the poverty in their destination, get caught up political protests or even wars, or cause offence by failing to observe important religious or cultural customs. On a more local level many patients don't like the food in destination countries, especially when they are feeling ill after surgery. Relatives may find it difficult to contact them if they have to go through hospital switchboards and communication with healthcare staff about treatments can be difficult. Even negotiating the type of surgery desired can be tricky.

Patients were keen to tell us this is no holiday

The label cosmetic surgery tourism was rejected by many patients because of its whimsical connotations of beauty and relaxation. They pointed out that surgery is serious and painful. There were no beaches and bikinis in our study, though most patients undertook shopping and visits to local attractions as they began to feel better.

Public hospitals back home are not equipped to deal with aftercare as outpatients

Public healthcare systems 'back home' are keen to point out the 'burden' of medical tourism when the patient returns home and a complication emerges. Although most complications are minor, healthcare systems are ill equipped to deal with them. Seromas cannot usually be drained as an outpatient procedure for instance, and doctors back home do not like resolving emerging problems for fear of transfer of liability. More cost effective outpatient systems with legal protection for 'home' doctors could keep costs of medical tourism to a minimum as this practice inevitably grows.

Cosmetic surgery tourism is less risky than most people think

Whilst we have highlighted important notes of caution above, the circulation of horror stories about cosmetic surgery in the media gives the impression that CST is much riskier than it actually is. Home country surgeons' organisations are also keen to point out the risks of CST as they don't want to lose patients to overseas competitors. However, whilst our research demonstrates low risk (17% had complications but only 2% of those were serious) and largely positive experiences, it was based on hospitals, clinics and agents who openly participated in our study, potentially skewing our results towards more positive outcomes. Some clinics and surgeons we contacted refused to grant us access, possibly in some cases because of problematic practice or pending complaints.

All cosmetic surgery carries risks

Whilst our study encountered only one patient who developed serious life-threatening complications as a result of their surgery, two deaths of cosmetic surgery tourists were reported to us during the course of our more general enquiries. This is a stark reminder that cosmetic surgery is never without risks – especially when many invasive procedures are performed together. We remain unable to compare the risks of surgery abroad with the risks of surgery at home because no data on risks at home exists and there is no reliable information on the numbers of patients travelling abroad for cosmetic surgery.



9. Outputs

9.1 Academic

Holliday, Bell, Cheung, Jones & Probyn Brief Encounters: Assembling Cosmetic Surgery Tourism, *Social Science and Medicine*, DOI: 10.1016/j.socscimed.2014.06.047, 2015.

Holliday, Bell, Jones, Hardy, Hunter, Probyn and Sanchez Taylor, 'Beautiful Face, Beautiful Place: Relational Geographies and Gender in Cosmetic Surgery Tourism Websites', *Gender, Place and Culture*, DOI:10.1080/0966369X.2013.832655, 2013.

Jones, Holliday, Bell, Probyn, Sanchez Taylor, 'Facebook and Facelifts', in Lean, Staiff and Waterton (Eds) *Travel and Transformation*, Ashgate, 2014.

Holliday, Hardy, Bell, Jones, Probyn and Sanchez Taylor, 'Beauty and the Beach' in Botterill, Pennings and Mainil (eds) *Medical Tourism and Transnational Health Care*, Palgrave, 2013.

Bell, Holliday, Jones, Probyn and Sanchez Taylor, 'Bikinis and Bandages: an Itinerary for Cosmetic Surgery Tourism', *Tourist Studies* 11 (2), 2011, 137-153.

9.2 Press

Sarah Boseley, Cosmetic surgery tourism on rise as satisfied customers spread the word, *The Guardian*, 22.06.13, available online at: www.theguardian.com/lifeandstyle/2013/jun/21/cosmetic-surgery-tourism

Catherine Jackson, Whose body is it anyway? *Therapy Today*, 01.07.13, available online at: www.therapytoday.net/article/show/3835/

Holliday, Bell, Jones and Cheung, Clinical Trails: Exploring Cosmetic Surgery Tourism, *Discover Society*, 01.06.14, available online at: www.discoversociety.org/2014/06/03/clinical-trails-cosmetic-surgery-tourism/

Holliday, Cosmetic surgery boom not a sign of economic health, *The Conversation*, 01.02.14, available online at: <https://theconversation.com/cosmetic-surgery-boom-not-a-sign-of-economic-health-22796>

The project has also been referenced on BBC News, Real People and the Mail on Sunday.

9.3 Television

Change My Race (TV documentary) Special Broadcasting Service, Australia, Prospero Productions, 03.12.13, available online at: www.sbs.com.au/documentary/program/1335

The Nip Tuck Trip (TV documentary) TV3 New Zealand, available online at: <http://tpiltd.com/content/nip-tuck-trip-1-x-45-minutes>

Insight: The Beauty Race (TV current affairs) Special Broadcasting Service, Australia, 29.8.11, available online at: www.sbs.com.au/insight/episode/watchonline/422/Beauty-Race

9.4 Radio

BBC R4's *Thinking Allowed* (Holliday and Sanchez Taylor, 11.01.12)
ABC's *Body Sphere* (Jones, 13.01.13)
ABC's *Life Matters* (Jones, 26.02.13).
BBC Radio 5 Live *Victoria Derbyshire* (Holliday 27.06.13)

See also:
www.ssss.leeds.ac.uk/publications/

9.5 Policy

Findings relating to PIP implants presented to Ministers and MPs from the Health Select Committee in Portcullis House on 02.07.12.
Presentation on Cosmetic Surgery Tourism to PIP Patient Information Group, Royal College of Surgeons (Holliday, 2.07.14)

9.6 Events

We co-hosted: 'Transnational Healthcare: A Cross-border Symposium' in Wageningen (NL) and Leeds (UK), at which we presented findings in June 2013. The conference brought together leading academics working in the field.

A stakeholder conference brought together leading academics, patients, agents, surgeons, lawyers and policymakers. This was the first event to initiate discussion between stakeholders on medical tourism, its costs and benefits to both patients and the NHS. Findings of two major projects were announced, presentations given by MEP for Yorkshire and Humber, Linda McAven, Laurence Vick (Michelmores Solicitors), cosmetic surgeon Christopher Stone (C. A. Stone Medical and Legal). Representatives from British Association of Plastic, Reconstructive and Aesthetic Surgeons, Department of Health, Nuffield Council on Bioethics and Spire Healthcare also contributed. A separate stakeholder event in Sydney also brought together patients, agents and surgeons for discussion.

See also:
www.ssss.leeds.ac.uk/events/

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