Social Science & Medicine xxx (2014) 1–7

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

Brief encounters: Assembling cosmetic surgery tourism

Ruth Holliday [a], David Bell [a, *], Olive Cheung [b], Meredith Jones [c], Elspeth Probyn [d]

[a] University of Leeds, United Kingdom
[b] National University of Singapore, Singapore
[c] University of Technology Sydney, Australia
[d] University of Sydney, Australia

A R T I C L E I N F O

Article history:
Available online xxx

Keywords:
Cosmetic surgery tourism
Flow
Network
Assemblage

A B S T R A C T

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

© 2014 Published by Elsevier Ltd.

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

Sally travelled to Tunisia, along with two other British patients and their UK agent, and our researcher, for breast augmentation, eyelid surgery and neck lift, performed by two surgeons – one from Paris and one from the US – who were in Tunisia for one of their regular three-day clinics. Hospital facilities and post-operative care are much cheaper in Tunisia, and one surgeon was a Tunisian emigré with local contacts. The agent had promised a translator throughout the UK patients' stay, but they arrived to find he was no longer available. The agent explained that she had carefully vetted the hospital and chosen the best rooms for her clients. After three days both surgeons departed with suitcases full of cash, the only payment method they accepted. The surgeons ‘wined and dined’ the agent, who provided them – and surgeons in other destinations – with clients and ‘managed their diaries’ in exchange for a fee. The agent departed shortly afterwards, despite protests from Sally, telling us that Sally needed “tough love”, leaving her in the care of her two fellow travellers and the (non-English-speaking) hospital and hotel staff.

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

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

* Corresponding author. School of Geography, University of Leeds, LS2 9JT, United Kingdom.
E-mail address: d.j.bell@leeds.ac.uk (D. Bell).

http://dx.doi.org/10.1016/j.socscimed.2014.06.047
0277-9536/© 2014 Published by Elsevier Ltd.

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

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

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

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

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

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

1. Researching cosmetic surgery tourism

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

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

2. Assembling cosmetic surgery tourism

2.1. Cosmetic surgery tourism flows

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

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

Please cite this article in press as: Holliday, R., et al., Brief encounters: Assembling cosmetic surgery tourism, Social Science & Medicine (2014), http://dx.doi.org/10.1016/j.socscimed.2014.06.047

flows and 'scapes'. Appadurai identifies five nonisomorphic global flows: ethnoscapes (flows of people, both temporary and permanent), mediascapes (flows of images), technoscapes (flows of technology – high and low, mechanical and informational), finanscapes (flows of money) and ideoscapes (ideological flows). This remains a very productive analytical device for exploring global assemblages, though it is important to remember that assemblages are not reducible to flows. In our own research, we identified variations of each of these flows, and have begun to formulate our own, which we label *beautyscapes*.

In terms of ethnoscapes, or flows of people, the most obvious movements are of tourists themselves: medical and cosmetic tourism depends definitionally on movement from one place to another. Appadurai's discussion of people flows reminds us that some routes are relatively enduring – pilgrimages might be an obvious example – while others come and go, for various reasons. We found a similar mixture of well-worn routes, often mapping on to existing tourist itineraries (Australians travelling to Thailand), alongside newer pathways that have emerged specifically to tap into the cosmetic surgery market (some of the European destinations, such as those in Poland, to which British patient-consumers travel but which were not previously on the tourist trail). And it is important to note that even well-worn routes are re-inscribed, reinvented and subverted by surgical journeys (Thompson, 2011) – a previous tourist destination might become, over time, primarily associated with medical tourism, changing the meaning of a trip there. The deep attachment that Thailand holds in the Australian imaginary as a place of free-flowing hedonism is reworked when it becomes the site of physical transformation, and the construction of Marbella as a particular kind of glamorous resort in the British imagination readily combines with but also reshapes its image as a CST destination (Holliday et al., 2013).

Other people are on the move, too: we found doctors and medical staff travelling to clinics to perform surgeries; intermediaries, notably agents/facilitators, travelled to meet surgeons and scope new destinations, or to accompany patients. South Korean surgeons often perform consultations and surgeries in China; clinics in Spain host surgeons from Germany or Italy, and patient managers from Thailand hold seminars to promote surgery in various cities across Australia.

Medical staff sometimes trade on past movement, in particular overseas education and training (often in western countries – a form of credentialising surgeons to reassure prospective patients; Casanova and Sutton, 2013). Prior migrations to departure countries also furnish staff in destination countries with the ability to translate both language and culture for patients. Medical tourists often travel with companions, if they can afford to – usually a family member or close friend. Most companions take on informal caring roles (Casey et al., 2013), and might also be the ones doing touristic activities (particularly if patient recuperation takes longer than planned).

Carla travelled to Malaysia for eyelid surgery and a facelift, and told us how important her companions were:

> "I think it was probably more supportive. Other than just security and stuff like that, you know, we were able to, well put ointment on each other, because, you know, your suture line went right up into the back of your hairline, so you're able to have somebody there that was able to help put your cream on, and then you'd put their cream on sort of thing. So in that regard, yes, support-wise I think it is very important" (Carla, Australia to Malaysia).

Some patients saw the trip as a holiday and got involved in holiday activities with their companions. Australian patient Dot travelled to Malaysia for breast augmentation, thigh lift and tummy tuck with the company of her girlfriend – she originally planned to travel with her partner but he could not join the trip. After 10 hour of surgery and five days later, Dot "did a 6 hour shopping trip still full of staples". She also did a few day trips. For her, the trip was not only about having surgeries but was also a holiday. Paul travelled abroad for rhinoplastry with his mother, and they were there for 10 days:

> "[I]t was quite good, because we were in Poland, the weather was really nice, Wroclaw is a – it's quite a medieval town and it was good to go with the old dear and have a bit of a holiday with her, we were having dinner every night in the restaurants and things" (Paul, UK to Poland).

A focus on ethnoscapes also reminds us of the importance of the actual practices of travel: flows are not abstract processes, but real events with real participants. Ormond (2013a) has discussed travel practices for medical tourists, attending to the embodied experience on planes, buses and taxis, as tourists undertake surgical journeys. We encountered some epic journeys – low-cost options that were also long-haul. Some Australian participants chose budget flights to Thailand with two stopovers that took four times as long as direct flights. One respondent, Helen, made the 20 hour, low-cost trip from Brisbane to Bangkok. Her luggage arrived two days after her surgery, and she opted to continually wear her only pair of knickers rather than risk what she thought would be the unhygienic consequences of washing them in the sink of her hospital room. CST was not a glamorous globetrotting experience for Helen.

In terms of technoscapes, quality markers like JCI travel and add 'international' recognition to hospitals.[2] We also encountered flows of medical devices such as implants – the migrations of defective PIP breast implants around Europe being a particularly problematic example that took place during our study – and flows of techniques and medical knowledge.[3] Again, the credentialising role of 'western' training is worth noting, as forms of skill (embodied in surgeons) travel. Given the emergence of global centres of expertise in particular cosmetic techniques, technoscapes do not always flow from the 'west'; the reputation of Brazil as a centre of expertise in cosmetic surgery makes it the origin point for some related technoscapes (Edmonds, 2010, see also Aizura, 2009 on Thailand). Sometimes, of course, there are blockages to particular flows; new techniques developed in one location might be prevented from travelling or from acting as attractors to other flows, such as of medical tourists (Cook et al., 2011).

In East Asia, a regional network has developed, with pioneering procedures flowing around and beyond the region. Local surgeons told us about the origins of cosmetic surgery in South Korea. Initially, they positioned popular surgeries such as blepharoplasty (eyelid surgery) as 'westernisation' and recounted the pioneering travels of early specialists to train in the US. After some discussion, however, they explained that US techniques were inappropriate to

[2] Joint Commission International (JCI) calls itself "the global leader in accrediting healthcare organizations" and offers a paid-for quality mark that is widely recognised as guaranteeing certain standards; see http://www.jointcommissioninternational.org/. In the medical tourism sector, JCI is a (contested) standard more relevant in Western contexts (see Ormond, 2013b).

[3] The 'PIP scandal' involved the use of non-medical grade silicone in the production of breast implants by the French company Poly Implant Prothèse (PIP). Around 600,000 women worldwide received defective implants that are more prone to rupture and migration and have been linked to health problems. The scandal revealed serious shortcomings in the regulation and testing of medical devices and the consumer rights of women with PIPs, who often had little course to legal address. PIP's founder was jailed for 4 years and fined 75,000 euros in December 2013.

Please cite this article in press as: Holliday, R., et al., Brief encounters: Assembling cosmetic surgery tourism, Social Science & Medicine (2014), http://dx.doi.org/10.1016/j.socscimed.2014.06.047

the 'Korean body' and that surgeons needed to 'rewrite' textbooks for the Korean context. They were careful to explain that removing too much fat from the eyelid created an 'unnatural' western eye not suitable for a Korean face.

> "And doctors are smart – very smart. They always experiment for new things to develop, which is why cosmetic surgery in Korea is evolving so fast… Even with cosmetic surgery, nowadays double eyelid operations, and things involving the eyes and nose are basic stuff. Every day surgeons are thinking of new ways of making money, so they develop new types of operation" (Kim Seong-Ho, South Korea).

Cosmetic surgery is a source of great national pride in South Korea and surgeons felt they were at its international forefront. This reputation bore up in what patients told us: Chinese tourist Dandan spent 5.5 million Korean Won (around £3200) on jaw bone reduction surgery to make her face more symmetrical. The procedure was one to two times more expensive in South Korea than in China, but Dandan chose the former because she "would rather play safe" and chose what she "trust[ed] most". So technologies flow into countries, are adapted and flow out again. Clinics in China import not only techniques and medical knowledge, but also models of management and equipment designed and manufactured in South Korea. In the context of cosmetic surgery, 'South Korea' itself is like a brand name, representing advanced techniques and knowledge.

Perhaps more than other forms of medical tourism, CST is intricately entwined with mediascapes (Jones, 2008). In fact the (especially US) media is frequently cited as the 'cause' of cosmetic surgery, either in de-mystifying and promoting its practices via makeover TV (Jones, 2012) or in promoting the bodies of (western) celebrities as a new (global) norm. There is no doubt that 'fashions' in cosmetic surgery exist, and that these fashions travel. There is evidence that surgical fashions are popularised via mediascapes such as the Korean Wave (*Hallyu*) and K-pop, which, combined with Japanese Manga, have popularised a particular facial shape for women and men in many countries in East Asia. Narrow jawlines, wide eyes and augmented nose tips create a 'Korean look' whose procedures Korean surgeons have developed into an internationally recognised specialism, and for which aspirant youths from neighbouring China as well as those from the Korean diaspora are more than willing to travel (Holliday and Elfving-Hwang, 2012).

Mediascapes also include news media, with its often sensationalised accounts of surgery-gone-wrong (Casanova and Sutton, 2013) – which we do not have time to discuss here – and the media that emanate from within CST itself. The latter category includes professional and trade publications, travel guides and assorted online resources – websites, online forums and social media. It is a truism that without the internet, medical tourism would probably not exist in its current form – online information is a vital resource for travellers, and those offering services have developed sophisticated online information and guidance (and advertising – often these boundaries are blurred). CST websites communicate particular images and messages to potential clients: of exoticness, of beautifully transformed bodies, of surgical excellence, messages favourably comparing the standards offered with those at home, and reassurances about outcomes (Holliday et al., 2013).

Guidebooks are often written by former tourists, and offer 'insider' accounts and travelogues as well as narratives centred on choice and possibility and on the 'doability' of medical tourism (Ormond and Sothern, 2012). Obviously, these media have a vested interest in promoting certain images and discourses of CST. As Appadurai (1990) notes, mediascapes and ideoscapes can have greater isomorphism than some other global flows – but it is important not to simplify this as western ideologies assuming global hegemony. While there are undoubtedly global flows of beauty ideas (and related products, technologies, styles, practices) that is not the same as saying that one ideal of beauty is globally dominant – the global and the local mix, reworking each other, producing new transnational hybrids (Faria, 2013). Our discussion of beautyscapes below attends to this particular set of flows.

Flows of money in CST – finanscapes – means tracking both the direct transactions as patients pay for treatment (such as the suitcases of cash we saw surgeons leaving Tunisia with) and the interrelated impacts of global financial markets on changing the contours of affordability for prospective patient-travellers. The ripples of financial crises have produced disparate effects on medical tourism, in some cases leading to the opening up of new tourism markets where economic problems have diminished domestic uptake in private medicine (for example in Thailand and Malaysia; Bochaton, 2013; Ormond, 2013). Favourable economic conditions, whether through exchange rates or incentives (such as package deals or subsidies) mean that cosmetic surgery tourists are enabled by finanscapes, at the same time they are constrained by their effects in other contexts (the instability of global finance makes this a particular turbulent 'scape'). As noted earlier, in the majority of cases cosmetic tourists are paying out-of-pocket for procedures and are not, we should reiterate, high-flying and high-spending elites (even though, in some cases, they are able to experience 'luxury' and private healthcare for the first time when they travel abroad). Given the centrality of affordability, it is no surprise that cost is frequently cited as a primary factor affecting decision to travel, and the decision about where to travel. Like many others in our research, Iman said that she was motivated by the comparatively low cost of travel abroad: "It was cost, it was completely cost, because I just saved quite a lot of money, I probably saved half or more, so that was why really" (Iman, UK to Tunisia).

Based on our extensive fieldwork, we firmly dispute the model of the cosmetic surgery tourist as wealthy westerner. Instead, patients in our study were on modest incomes and could not afford procedures 'at home'. An agent highlighted the difference between Thailand and Australia in terms of cost:

> "[L]ots of women take loans out for their surgery and even when they go overseas with us, a breast augmentation might be $4000 roughly. Some people still take a loan to pay for that, but it's much more manageable at $4000 than $15,000. But I think maybe more Australians are doing it because it is affordable now. Because most people wouldn't pay $15,000, but if it's only $4000 they really feel, 'Oh, well maybe I can afford that; maybe I will do it'" (Barb, Australia).

Examining CSTs as flows departs from more static 'postcolonial' models showing that those who travel are wealthy elites from poorer countries or poorer patients from wealthy countries (Buzinde and Yarnal, 2012). The cash transactions of these travellers flow to the clinics or hospitals in destination countries and then beyond, to the countries of residence of their staff. Some of these flows may remain intact and some may shift if, for instance, the destination point changes as clinics move to take advantage of currency exchange rate fluctuations, which small clinical assemblages seem prone to do.

In South Korea small clinics are more permanent and concentrated in particular places – such as the Gangnam and Apgujeong districts of Seoul – and are usually 'owner-managed' by surgeons working alone or in pairs. Here clinic size often directly reflects a surgeon's personal wealth. At the other end of the scale, Bumrungrad International Hospital in Bangkok is deeply embedded in more globalised capital flows, owned by a conglomeration: shareholders

Please cite this article in press as: Holliday, R., et al., Brief encounters: Assembling cosmetic surgery tourism, Social Science & Medicine (2014), http://dx.doi.org/10.1016/j.socscimed.2014.06.047

ARTICLE IN PRESS

include a number of subsidiaries of Bangkok Bank PCL; the wealthy Sophinpanich family (founders of Bangkok Bank) and the Government of Singapore Investment Corporation. In Tunisia, major destination hospitals are owned by the family of the deposed president Ben Ali, who reigned from 1987 until the Arab Spring in 2011. The current finanscapes of CST are therefore deeply embedded in local and global networks of capital backing major international hospitals, the small-scale entrepreneurialism of surgeons or agents, credit industries that patients draw on, circuits of cash and currency as well as historical and political conditions that generate specific, local capital accumulations.

As noted above, we have begun to explore the notion of beautyscapes as an addition to Appadurai's framework. We see beautyscapes as in part specific articulations of the flows already discussed – beauty flows along mediascapes, ethnoscapes, technoscapes, finanscapes and ideoscapes – but we also use it to draw attention to a more complicated, nonisomorphic, disjunctive notion of 'global beauty' than we often currently encounter in academic, professional and media accounts. In place of accounts that see global beauty as homogenising, westernising, modernising – all flows pointing in one direction – we argue the need to see beautyscapes working at (and across) different scales, moving in many different directions, producing more variegated outcomes.

The idea of beautyscapes (note: plural) makes us look closely at flows, and at what happens when flows 'land' in places; these flows shows us how beauty practices, ideas, and ideals shape and are shaped by encounters with particular locales; CST is one powerful manifestation of this heterogeneity. For example when we encounter and seek to understand the idea of a 'Korean look' that has become popular across the East Asian region, described above, what we are observing is a particular beautyscape – a mixing of flows of people, things, ideas and more – that coalesces in the here-and-now of early twenty-first century East Asia (Holliday and Elfving-Hwang, 2012). To be sure, it travels beyond the region, and to some extent 'goes global'; but it is also very much *located*. The idea of beautyscapes also draws attention to questions of translation: as destinations become associated with particular procedures and even particular looks, so patients are drawn to them with particular expectations, and surgical outcomes might not quite match. Dandan, the respondent noted above who had chosen a Korean surgeon because of safety and quality, was extremely unhappy with her result. She thought she looked "cute and sweet" (typical of the 'Korean look') after the surgery but wanted to look "mature and independent". She expressed her distaste for the 'Korean look' that she felt she had been given:

> "I don't like Korean-style facial features… I saw a lot of Korean girls there. I get bored when I look at them… they all look the same. Their clothes, faces and make-ups are similar. They look like a clone army … I read some beauty magazines and couldn't tolerate them. For some reason I got really tired of the Korean beauty. It makes me feel uncomfortable, as if I eat some greasy food" (Dandan, Chinese national, travelled from France to South Korea).

This discussion of flows and 'scapes' takes us part way towards assemblage thinking; certainly, flows are important elements in assemblages, and assemblage is the coming together of flows. Now we want to add one more element to this assemblage; the network.

2.2. Cosmetic surgery tourism networks

Adding networks to flows gives a sense of the nodal points that flows travel to and from, and a sense of connectivity – flows do not hover above us; they converge and make connections, bring things together or keep them apart (Pordié, 2013). Some connections are short-lived, intermittent, ephemeral; others are enduring, consistent, 'solid'. While flows have the capacity to switch and swerve, places have varying capacities to attract some and repel other flows – though this capacity does not simply map onto core/periphery or global/local distinctions. Nevertheless, networks of connectivity provide an important focus, and there have been two prominent ways of thinking networks in relation to medical travel and CST. The first, most obvious, relates to the internet: as noted above, the internet is a vital enabler for medical tourism and a site for various experiences of connectivity, as well as a stimulus for the engagement with travel itself. It also enables forms of imaginative travel (to new places and to a 'new me') and provides opportunities to engage with our second form of network thinking: social networks. Here we need to consider both online social networking – through the use of platforms such as Facebook – alongside (and increasingly inseparable from) forms of 'offline' social networking (face-to-face contact with family, friends or fellow tourists, for example).

Extending discussions of the various forms and functions of social networks/communities among cosmetic surgery tourists (Jones et al., 2014), we want to reiterate here the vital importance of understanding networks *relationally*. Social networks are drawn upon throughout the surgical journey, from discussions with family and friends in the decision-making stage to consulting past recipients of procedures via online forums – accessing forms of 'warm expertise' that might offer counternarratives different from those available via clinic websites – and then on through the journey itself, whether that means 'keeping in touch' online with family and friends or sharing experiences with others recuperating on-site (Ackerman, 2010). The use of Facebook before, during and after surgical tourism is particularly interesting, and ubiquitous. Social media accessed via mobile devices means that patients frequently document their entire journey, sharing their experiences and building a strong sense of community with others (Jones et al., 2014). Shared social media narratives and images become a collective resource for patients and would-be patients:

> "The support on Facebook through [the agent], through people that are Facebook friends with [the agency] who've done it, everybody on there is either interested in surgery or they've had it. So there's a common theme there … people that have been through it, different procedures, it's great. They put pictures up and you can see the before, see the after, and you know they're genuine, true people because genuine, true people are making the comments. I'm there with a tummy tuck and I'll say, 'Yeah, that's me. I've had this. It was like this, this, this, and this'. You know what I mean? It's phenomenally good" (Paul, UK to Poland).

One issue that emerged in our research was a blurring of the understanding of the role and remit of Facebook, especially between patients and agents. The latter clearly viewed social media as an important marketing tool, and so made heavy use of Facebook-based discussion with patients and prospective patients as a way to convey particular messages about the service they were offering, as well as to share the load of 'emotional labour'. Patients, on the other hand, did not recognise (or refused) the 'marketing' definition of agents' Facebook pages, and saw them instead as open forums for discussion, which included critical commentary. For patients, Facebook was 'freer' than commenting on clinic websites, where they knew that negative posts might be removed, and its 'real time' correspondence provided 'authenticity', especially as they closely monitored each others' real-time journeys through travel, consultation, surgery, recovery and return. But the familiarity of Facebook – and the in-between status of agents, who are both fellow-

Please cite this article in press as: Holliday, R., et al., Brief encounters: Assembling cosmetic surgery tourism, Social Science & Medicine (2014), http://dx.doi.org/10.1016/j.socscimed.2014.06.047

travellers and friends but also businesspeople – meant that there was sometimes conflict over how Facebook could (or should) be used.

While online networks were of vital importance to patients in our study, they also overlapped with face-to-face networks, particularly for groups of patients who travelled together and then stayed in touch. Meeting online before travel, they had already developed friendships by the time they met either in transit or at the destination, and they stayed close throughout their trip. Once back home, they kept in touch via Facebook and, in some cases, continued to meet up. Social networks allow prospective patient-travellers to access forms of warm expertise and peer knowledge which has higher 'value' than marketing messages from clinics – interventions of agents notwithstanding – but they also enable patients to be producers of that expertise and knowledge. However, it is not just online that the use of social networks as trusted sources of information blurs with marketing – Bochaton (2013) discusses the 'recruiting' of Laotian shopkeepers and other key social figures by Thai hospitals keen to encourage cross-border medical travel, who then encourage others to consider making the trip to. In a relatively new market, where health, bodies and in some cases life itself is at stake, friendly advice from trusted figures is vital – hence the desire of at least some agents to position themselves this way, trading on their own past experience as capital.

An agent based in Australia highlighted the importance of being supportive to the medical tourists, especially when they are aboard:

> "[S]ome of [the questions] are just really stupid. Sometimes they'll say, 'It's a really stupid question, but...' And – but you've got to be on call to them and that's what I feel is the most important thing. That's what I do. I'm not saying that everybody else does that, but that's what I do, because that's what I missed out on. And talking to the ladies that I talk to over here and that one that I told you in particular, she actually ended up being a very good friend of mine and she's been over twice since then, with me. Yeah, so it's – I don't know – basically they need somebody – some people do, some people don't, but most of them, even the young girls, first time out of the country, or first time to an Asian country, or something like that, having a boob job, they need reassurance every now and then. They might want to ask a specific question, but it's really just to talk to you, or, 'Oh, she's still there!' You know what I mean? So you earn your money, or I do anyway, that's for sure" (Beverley, Australia).

For medical tourists, having a facilitator who takes on the role as 'friend' can make a difference to their travel experiences, as Mandie recounts about Melissa, the facilitator she travelled with: "I think when you come on your own you can tend to hide away a bit. [Melissa] used to take us out for morning and afternoon tea, so wherever you were we would all gather and meet at one spot and we'd have morning and afternoon tea and we would all get to know each other" (Mandie, Australia to Malaysia).

It is not only patients that form networks in the context of CST. Professional bodies and trade associations may be nationally-based, but their reach extends well beyond national borders. Tourism agencies have their own networks and outposts, while individual hospitals might have overseas consulting rooms and representatives. Forms of accreditation, such as JCI, function in a network-like way, connecting those facilities that meet the required standard (or pay the required fee). And on the ground, agents and other intermediaries are densely involved in forms of networking, especially in bringing together the diverse flows that allow a cosmetic surgery journey to take place. Agents arrange trips, consult with surgeons, recommend destinations, handle logistics, sometimes travel with patients, and build networked businesses (often upon very modest foundations). They are arguably the quintessential networkers, in both senses of the word: they network relentlessly across borders and time-zones with all the other players to build a network with the agent at the centre.

3. CST as assemblage

We want to draw the issues raised above together by turning to the notion of assemblage now. It is partly to provide a more nuanced account of globalising processes that assemblage thinking has been popularised. Here, we draw on four disciplinary contexts where assemblage thinking has proved helpful, and draw together some of these insights with our discussion of empirical findings on CST. We are using assemblage as a way to combine flows and networks and to capture those things that flows and networks potentially leave out conceptually.

First, in science and technology studies (STS), assemblage thinking has been productively utilised to theorise the coming together of heterogeneous people and things (see Latour, 2005). For example, Anderson (2002) uses assemblage to rethink technoscience in relation to globalisation, rewriting the globalisation narrative away from a straightforward westernisation/modernisation model. This allows us to see more clearly 'the mutual reorganization of the global and the local [and the] increasing transnational traffic of people, practices, technologies' (Anderson, 2002, p. 643). Second, in anthropology assemblage has been used to think 'the *actual* global' as it is encountered, experienced, and lived (Ong and Collier, 2005). Summarising anthropological assembling, Marcus and Saka (2006, p. 101) name its concerns as 'the ephemeral, the emergent, the evanescent, the decentered and the heterogeneous'. Third are assemblings in critical human geography. Here, too, assemblage is deployed for its emphasis on contingency and emergence, and for thereby allowing scholars to reframe globalisation as messy, contingent coalescings that can (and do) dissolve or disband and then regroup in different ways. Geographers have also stressed that assemblages can be grounded or placed, that the term implies both territory *and* relations (McCann et al., 2011). This does not mean 'fixing' assemblages; they are always in a state of emergence and flux. Finally, we are guided by the feminist insistence of the embodied nature of flows and attachments (Gatens, 1996). This is to give full weight to how flows and networks are gendered, raced, sexed and classed – in short to how they are continually re-embodied.

We opened this paper with a vignette from one place and time. It's true we chose one of the more 'dramatic' experiences from our research, rather than describing chatting in hospital rooms in provincial Poland or unglamorous journeys on low-cost airlines. Our encounter in Tunisia has its unique elements – we did not end up in close proximity to war casualties anywhere else (at least not to our knowledge). But it is also *typical*: Tunisia is one of many countries developing an export market in health services – indeed, its agreement with Libya is part of this strategy (Lautier, 2008). Like many other places around the world, then, Tunisia is being assembled as a medical tourism destination. In our encounter, this not only meant opening up to patient-travellers; it also meant opening up to medical professionals and, as Lautier (2008) shows, to transnational flows of images and ideas.

Moreover, the patients we met in Tunisia were typical cosmetic tourists, by which we mean they were ordinary people, not jet-setting elites. They were shocked by the conditions that surrounded their stay and by the situation they had landed in of. Some were unaware of the geopolitical context, or even of basic geography. Tunisia was made 'accessible' to them because of cost

Please cite this article in press as: Holliday, R., et al., Brief encounters: Assembling cosmetic surgery tourism, Social Science & Medicine (2014), http://dx.doi.org/10.1016/j.socscimed.2014.06.047

ARTICLE IN PRESS

and ease – a short hop on a low-cost carrier – but its 'reality' was obscured by the mediascapes they chose to access (and those they didn't) in planning their trips. The Tunisian example is typical in that there is a 'beautyscape' in formation here, too: our patient-travellers were motivated to travel there in part with an idea of how they wanted to transform their bodies, as well as with an expectation of what that transformation would achieve for them. The networks of information that brought the patients there carried along with them particular messages, constructing Tunisia and the clinic as hopeful.

This example shows CST as assemblage; indeed, one of the features of assemblages concerns how 'new and unpredictable directions develop when assemblages encounter novel perturbations' (Anderson et al., 2012, p. 182) and how parts of one assemblage 'can be disconnected or plugged into a different assemblage in which their interactions are different' (p. 181) – in Tunisia both of these shifts are clearly observable, as the CST assemblage meets with the Libyan conflict, itself another kind of assemblage. These assemblages demonstrate powerfully that the flows of various scapes are always deeply historical, produced by and productive of raced and gendered bodies and agents. The clinic is plugged into both assemblages at once, and becomes a site of concentrated connectivity as well as 'throwntogetherness'. These observations also remind us of the emergent temporality of assemblages; what we found in Tunisia was a very particular time as well as place. And that place is both territorial – located nationally, regionally and locally – and relational, formed out of particular entanglements. Such assemblages are emergent wherever CST takes place and makes place.

Finally, we should remark on the work of assemblage that takes place in the research process and in our ongoing work to conceptualise CST. By turning our attention to flows, networks and assemblages, and by conducting detailed and wide-ranging empirical work, we are able to track and trace the emergence of CST as a particular form of both medical mobility and of socio-technical assemblage. Our study thus contributes to debates in the study of transnational healthcare, where its focus on 'medicalised beauty' and beautyscapes produces new insights that are distinctive to this field of medical mobility; it also contributes to assemblage thinking and to theories of globalisation by turning attention to specific articulations of places, people and things, to the assembling of particular flows and networks, and to experiences of CST as a complicated, multi-scalar, transnational and glocal phenomenon.

Acknowledgements

The research for this paper was funded by the Economic & Social Research Council (Grant Reference RES-062-23-2796). Additional data collection and analysis was carried out by Almudena Casas, Ji Hyun Cho, Kate Hardy, Emily Hunter, Marcela Koscianczuk, Hannah Lewis and Jacqueline Sanchez Taylor. Thanks to the anonymous referees for their insightful comments, which helped refine our discussion. Thanks too to all the participants in our research.

References

Ackerman, S., 2010. Plastic paradise: transforming bodies and selves in Costa Rica's cosmetic surgery tourism industry. Med. Anthropol. 29, 403–423.
Aizura, A., 2009. Where health and beauty meet: femininity and racialisation in Thai cosmetic surgery clinics. Asian Stud. Rev. 33, 303–317.
Anderson, B., Kearnes, M., McFarlane, C., Swanton, D., 2012. On assemblages and geography. Dialogues Hum. Geogr. 2, 171–189.
Anderson, W., 2002. Postcolonial technoscience. Soc. Stud. Sci. 32, 643–658.
Appadurai, A., 1990. Difference and disjuncture in the global cultural economy. Theory, Cult. Soc. 7, 295–310.
Bell, D., Holliday, R., Jones, M., Probyn, E., Sanchez Taylor, J., 2011. Bikinis and bandages: an itinerary for cosmetic surgery tourism. Tour. Stud. 11, 139–155.
Bochaton, A., 2013. The rise of a transnational healthcare paradigm: Thai hospitals at the crossroad of new patient flows. Eur. J. Transnatl. Stud. 5, 54–75.
Buzinde, C.N., Yarnal, C., 2012. Therapeutic landscapes and postcolonial theory: a theoretical approach to medical tourism. Soc. Sci. Med. 74, 783–787.
Casanova, E., Sutton, B., 2013. Transnational body projects: media representations of cosmetic surgery tourism in Argentina and the United States. J. World Syst. Res. 19, 57–81.
Casey, V., Crooks, V.A., Snyder, J., Turner, L., 2013. Knowledge brokers, companions, and navigators: a qualitative examination of informal caregivers' roles in medical tourism. Int. J. Equity Health 12, 94 (online).
Cook, P.S., Kendall, G., Michael, M., Brown, N., 2011. The textures of globalization: biopolitics and the closure of xenotourism. New. Genet. Soc. 30, 101–114.
Edmonds, A., 2010. Pretty Modern: Beauty, Sex, and Plastic Surgery in Brazil. Duke University Press, Durham NC.
Faria, C., 2013. Styling the nation: fear and desire in the South Sudanese beauty trade. Trans. Inst. Br. Geogr., 318–330.
Gatens, M., 1996. Sex, gender, sexuality: can an ethologist practice genealogy? South. J. Philsophy 25, 1–9.
Holliday, R., Bell, D., Jones, M., Hardy, K., Hunter, E., Probyn, E., Sanchez Taylor, J., 2013. Beautiful face, beautiful place: relational geographies and gender in cosmetic surgery tourism websites. Gend. Place & Cult. http://dx.doi.org/10.1080/0966369X.2013.832655 (online first).
Holliday, R., Elfving-Hwang, J., 2012. Gender, globalization and aesthetic surgery in South Korea. Body Soc. 18, 58–81.
Jones, M., 2008. Skintight: an Anatomy of Cosmetic Surgery. Berg, Oxford.
Jones, M., 2012. Cosmetic Surgery and the Fashionable Face. Fash. Theory 16, 193–210.
Jones, M., Holliday, R., Bell, D., Cheung, O., Hunter, E., Probyn, E., Sanchez Taylor, J., 2014. Facebook and facelifts. In: Lean, G., Staiff, R., Waterton, E. (Eds.), Travel and Transformation. Ashgate, Aldershot, pp. 189–204.
Latour, B., 2005. Reassembling the Social: an Introduction to Actor-network Theory. Oxford University Press, Oxford.
Lautier, M., 2008. Export of health services from developing countries: the case of Tunisia. Soc. Sci. Med. 67, 101–110.
Marcus, G., Saka, E., 2006. Assemblage. Theory, Cult. Soc. 23, 101–106.
Massey, D., 2005. For Space. Sage, London.
McCann, E., Ward, K. (Eds.), 2011. Mobile urbanism: Cities and Policymaking in the Global Age. University of Minnesota Press, Minneapolis.
Ong, A., Collier, J. (Eds.), 2005. Global Assemblages: Technology, Politics, and Ethics as Anthropological Problems. Wiley-Blackwell, Oxford.
Ormond, M., 2013a. En route: transport and embodiment in international medical travel journeys between Indonesia and Malaysia. Mobilities. http://dx.doi.org/10.1080/17450101.2013.857812 (Online first).
Ormond, M., 2013b. Neoliberal Governance and International Medical Travel in Malaysia. Routledge, London.
Ormond, M., Sothern, M., 2012. You, too, can be an international medical traveler: reading medical travel guidebooks. Health & Place 18, 935–941.
Pordié, L., 2013. Spaces of connectivity, shifting temporality: enquiries in transnational health. Eur. J. Transnatl. Stud. 5, 6–26.
Roberts, E., Scheper-Hughes, N., 2011. Introduction: medical migrations. Body Soc. 17, 1–30.
Sobo, E., 2009. Medical travel: what it means, why it matters. Med. Anthropol. 28, 326–335.
Thompson, C., 2011. Afterword: science as a vacation? Body Soc. 17, 205–213.
Wilson, A., 2011. Foreign bodies and national scales: medical tourism in Thailand. Body Soc. 17, 121–137.