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Feasibility of Self-Regulation on the Aesthetic Medical Field

A Research Based on the Practicing Medical Doctor's Perspective

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Abstract

Aesthetic medicine is a unique medical arena with great economic benefits, but it is also full of controversy. Whether the doctors in the field could enjoy the same degree of autonomy as in the therapeutic medical field, and retain the self-regulating management of the medical profession, has always been the focus of debate. Although various scholars have proposed arguments on this issue from the perspective of either patients or managers, discussions from the situated view of the regulated doctors are extremely rare. In this thesis the researcher takes the regulated practitioners as the research object and propose questions from three aspects, namely the power of professional knowledge, the establishment of specific private professional organization and the habitus of aesthetic medicine, and then draw conclusions from the answers of these questions. Based on the results, the researcher found that, in Taiwan, the aesthetic medical field is different from the therapeutic medical field and should not inherit same degree of self-regulation as in the therapeutic medical field; while the doctor's autonomy on technical level must be reserved through intensified legal interventions.

Key words: Self-regulation, Aesthetic medicine, Professionalism, Habitus, Field, Cultural capital, Symbolic capital

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1. Introduction

'Aesthetic medicine' is a unique medical arena, within which the doctors focus on improving people's cosmetic appearance and satisfaction rather than restoring the physiological rationality of human body or preventing disease. In Taiwan, due to the advances in technology and medical expertise, the aesthetic medical industry developed rapidly[1] in the past two decades and nearly one in seven clinics are involved in this emerging business[2]. For doctors, this lucrative industry provides them an arena to justly pursue personal economic interests with professional capabilities (Rees, 1991). Correspondingly, whether the doctors would make use of the self-regulation[3], which is a system long adopted in therapeutic medicine that medical professionals are regulated by themselves but not the statutes, to pursue their own interests in this lucrative field rather than to prioritize the wellbeing of the patients, become the focus of debate.

In Taiwan, the qualification for doctor to practice in aesthetic medicine was loosely stipulated under previous regulation. While in 2019, the provisions were tightened once through the introduction of the 'Regulations Governing the Application of Specific Medical Examination Technique and Medical Device', and the expansion of the industry was slowed down. But disputes are still heard frequently[4] and the calling for intensifying statutory intervention rather than retaining the self-regulation to the doctors in aesthetic medicine is elevated. Currently, based on the

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[1] 'Aesthetic medicine market size, share and trends analysis report by procedure type (Invasive Procedures, Non-invasive Procedures), by region (North America, Europe, APAC, MEA, LATAM), and segment forecasts, 2019 – 2026'. Available at: https://www.grandviewresearch.com/industry-analysis/medical-aesthetics-market, Accessed: 03 March 2020.

[2] 'Global analysis of current situation of aesthetic medicine'. Available at: https://kknews.cc/health/oajzxnp.html, Accessed: 03 May 2020.

[3] In professional field, self-regulation recognizes the maturity in handling the tasks of a profession. This regulating manner honours the special skills, knowledge and experience that a profession possesses. Besides, self-regulation means that the state has delegated its regulatory functions to those who have the specialized knowledge necessary to do the job. The granting of self-regulation acknowledges a profession's members are capable of governing themselves. Available at: 'Professional Self-Regulation', https://www.oct.ca/about-the-college/what-we-do/professional-self-regulation, Accessed: 20 May 2020.

[4] 'Ranked the 13th largest plastic country in the world, Taiwan medical beauty disputes frequently spread'. Available at: https://news.cts.com.tw/cts/general/201907/201907081966840.html, Accessed: 3 May 2020.

safety of consumers, the legitimacy of inheriting the self-regulating manner from the therapeutic field by aesthetic medicine is challenged (Parker, 2009, p. 211; Kmietowicz, 2014; Griffiths & Mullock, 2017; Davis, 1995); besides, the administrators around the world also propose to intensify the legal intervention on aesthetic medicine as a countermeasure to the inevitable infiltration of commercialism (Keogh, 2013; consumer council, HK 2016, pp. 73-82; Sari, Handayani & Pujiyono, 2018; Tan, 2007). However, situated opinions from the regulated practitioners to this issue are rarely discussed.

As a practicing doctor for 25 years, the researcher observed that the justification of doctor's self-regulation of aesthetic medicine is harshly challenged from several aspects. For example, the chance that patient's safety might be ignored for the doctor prioritizing his personal interests is a weak spot. Next, whether the doctor's judgments, which are based on professional knowledge, not to be overwhelmed or changed by patient's wish, is another controversial focus on whether the self-regulation can be maintained effectively. Moreover, doctors with varied training backgrounds compete for lucrative rewards within this arena might abdicate self-regulation.

Based on the aforementioned reality, the aim of this thesis is to investigate, through in-depth analysis of the interviewed data gathered from 13 random selected practicing doctors in Taiwan, the feasibility of adopting self-regulation in the aesthetic medical field. To fulfill this aim, following interlinked research questions are answered:

1. *How do doctors view the role and function of the medical knowledge in aesthetic medicine?*
2. *How do doctors consider the establishment of one private professional organization to be responsible for self-regulation?*
3. *How do doctors view the impacts on the competitions, the specialty credit and the ethical consideration, which are resulted from the changes of culture in aesthetic medicine?*

According to the research aim and questions, the purpose of this study is to explore how to maintain a delicate balance between the professional autonomy, which is reserved in the self-regulation, and the elevating strengthened legal intervention, in the specific regulation of aesthetic medicine.

1.1. Legal context on general medicine in Taiwan

Current regulation on Taiwan's general therapeutic medical professionals is a double-tiered system in which bureaucratic controlled mode and self-regulation posed in hierarchical manner. In this system, the state holds ultimate power in legitimizing doctor's identity, meanwhile medical professionals enjoy the reserved privileges and autonomy from the state. Although it inclines more to the idea of the *professionalism* proposed by Freidson (2001), it's not totally identical to that. Instead, this system is located in-between the spectrum of absolute bureaucratic control and total self-regulation, while the explicit influence of commercialism is scant because any commercial practice in medical affairs is prohibited by law in Taiwan.

1.1.1. *Statute*

The historical context for adopting current regulating approach is that Taiwan's legal system belongs to the civil law. Under relevant regulations, medical students, after receiving complete education and training in schools, must pass two stages of national examinations to obtain the license for legally implementing medical disposals within Taiwan's jurisdiction. While in the court, the existence of the government-issued license, which is stipulated in every law and regulation about the identity of doctor, is taken as the sole consideration for deciding whether a person is qualified to practice medicine. Besides, this legalized identity also provides the entitled exclusivity, which is backed by the state, in the labour market.

1.1.2. *Self-regulation: Technic bureaucrat, specialty system and soft law*

In addition to the statutory regulation, medical professionals are self-regulated in three aspect, within each the degree of self-regulation are varied. The first is the implicit self-regulation through the elite class of medical professionals being

recruited into relevant governmental institutions as technic bureaucrats. Although it's a formalized administrative manner, the essence of being regulated by the 'insider' remain unchanged (Baldwin & Cave, 1999; Kuhlmann, Allsop & Saks, 2009).

While the other part that embodies the function of self-regulation resides in the state delegating various responsible, private self-regulating medical organizations to issue the certification of specialties (Cohen, 1973) and legally link the system to the remuneration of medical disposals. According to current National Health Insurance Law of Taiwan, the payment of identical treatments would be varied depending on whether the performing doctor hold a specialist credential or not. For those who don't hold the relevant specialty titles, some disposals' remuneration will be lower or excluded from paying. In other words, the specialty credential is not only an honour endorsed through the advanced peers' recognition but also highly related to the remuneration received. That means, except to retain the prime power in determining the legitimacy of implementing medical practices, the state also draws on economic incentives to encourage the self-regulatory manner.

Finally, one more binding force of the non-statutory mechanism comes from the commitment to the professional ethics and the shared ideologies, both act as soft laws reside in the self-regulating manner, by the doctor. Generally, medical ethics are deemed as a mandatory attribute of medical cultures that cultivated through professional education (Olsson, Kalén & Ponzer, 2019; Bourdieu & Passeron, 1977; 1979). While the doctors' public revealing their commitment to medical ethics that listed in the Hippocratic oath[5] in the articles of medical private organization[6] (Campbell & Glass, 2001) is an apparent demonstration to concretize the binding force through a concept of social contract (Cruess & Cruess, 2008). Moreover, these

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[5] One of the oldest binding documents in history, the Oath written by Hippocrates is still held sacred by doctors: to treat the ill to the best of one's ability, to preserve a patient's privacy, to teach the secrets of medicine to the next generation, and altruism.

[6] Although, according to article 25.5 of the Doctors Act of Taiwan, a doctor guilty of violating medical ethics in his/her professional practice shall be disciplined by the Medical Association or the competent authority, this punishment is essentially executed through the private disciplines rather than the coercive power of the statute.

intangible disciplines are not only the moral requirement for the medical practitioners to abide by, but also have significant influence in court trials (Campbell & Glass, 2001).

1.2. Current management of aesthetic medicine in Taiwan

Currently, the doctors in aesthetic medicine are loosely regulated in Taiwan. Although the qualification restrictions for the practitioners were tightened once through the introduction of specific law[7], no specialty-related absolute exclusivity, which is backed by the state, is stipulated. That means, the state-issued doctor's license equates to the only prerequisite for people to practice most of the disposals in aesthetic medicine while the binding force that comes from self-regulating private organization barely exists. In addition, in this self-financed market, there is no room for the insurance system that supported by the state to operate. Therefore, generally speaking, it is a under-regulated situation.

2. Literature review

2.1. Self-regulation on medical professionals

Baldwin & Cave (1999) define regulation as,

> *in terms of the covering scope, can be narrowly considered as a set of specific orders in the form of rules, or broadly enough to refer to deliberate influences of government on behaviour through different instruments,*

and all types that go beyond the governmental agencies, such as the market mechanisms or the private organizations to exert social control or influence.

The tasks of regulation involve several aspects of the regulated objects, namely market entry, competitive practices, market structures, and remuneration (Moran & Wood, 1993). According to Baldwin & Cave (1999), to fulfil it's due functions, regulation must have several principles; firstly, a clear and legitimate purpose;

[7] Regulations Governing the Application of Specific Medical Examination Technique and Medical Device.

secondly, it should have an appropriate scheme of accountability, whether it's for the general public or for the regulated targets; thirdly, regulation must be accessible, consistent, open and fair; fourthly, regulation must be embarked through expertise; and finally, it must be efficient.

For regulating the medical profession, especially medical doctor, in terms of the involvement of the state, various democratic countries around the world adopted a two-tiered manner that combines bureaucratic control and self-regulation in tandem, while the balance between law and self-regulation is varied in each country (Freidson, 2001, pp. 133-41). However, even in the way that statute predominated, substantial self-regulation is retained through the relevant administrative units recruiting the elites within the professional group into government as technical bureaucrats (Kuhlmann, Allsop & Saks, 2009; ibid.). Hence, Collier (2012) denoted that

> *self-regulation is a basic tenet of all professions, and few professions value that principle as much as the field of medicine*.

Basically, there are several advantages for adopting self-regulation on medical professionals. Firstly, it is helpful to managing efficiency because professional knowledge and skill are esoteric and cannot be easily grasped by general administrative bureaucrats but can be dexterously handled by professional 'insider'. Secondly, this form contributes to the compliance of the regulated because of the unique culture of medical profession, which induce even more efficiency. Further, the adoption of self-regulation, which is operated with private strategies and mechanisms, can effectively reduce governmental financial burden. Finally, self-regulatory system is more flexible, reactive and adaptive to new problems (Baldwin & Cave, 1999; Baldwin et al., 2001; Baggott, 2002, p. 35).

However, scholars (Baldwin & Cave, 1999; Baldwin et al., 2001; Baggott 2002, p. 35) also argued that the self-regulation of the professionals has several innate shortcomings open to be challenged. First of all, due to lacking legitimacy, the effectiveness of self-regulating mechanism is often questioned by the general public for the long-criticized phenomenon of favouring the 'insider' in disputes. Secondly,

the situation that the agents might fail to effectively avoid conflicts of interest is another focus; especially when the regulated involve in economic interests, well-being or status, the public interest is often sacrificed while personal benefits are prioritized. Thirdly, the members of the group have to share high consistency in generating and operating self-regulatory system to assure the practical implementation of the disciplines won't be truncated. And finally, even with the self-regulation that run by private finance, the fact that these private organizations still need governmental funding and are not completely independent of the state's fiscal system will be taken as funnelling public funds into specific interested groups.

2.2. Medical ethics in aesthetic medicine

The aesthetic medical field is often regarded as a special, non-therapeutic[8] arena with the disposal's characteristics are different from those being defined by physiological rationality in therapeutic medicine (Sheldon & Wilkinson, 1998; Parker, 2009, p. 50). Meanwhile, this non-therapeutic feature is often regarded as the trigger point for scholars to debate whether the practitioners in this field are eligible to enjoy self-regulating management. Among these debates, the binding force of medical ethics on doctors in this field where interests commanded (ibid.), is bitterly questioned.

Cruess (2006) advocated that there is an invisible contract between doctors and society in general medicine. He argued that under this contract, which is embodied in the form of the self-regulation of the professionals, ethically, medical practitioners would self-demand their disposals to meet the expectation of the general public and keep surpassing throughout their careers. He also denoted that this continuous self-demanding is a commitment to society by the medical professionals (ibid.); while correspondingly, the general public rewards doctors with a stable working environment, relative opulent income and lofty social status. However, in contrast, Harris (2017) proposed that there are theoretical and

[8] Although there are many controversies about whether medical aesthetic treatments have curative effect, mainstream view regards them as non-physiological curative disposals. Therefore, for the reader's convenience, the researcher follows this fashion and categorize the treatments into the aesthetic and the therapeutic fields (Sheldon & Wilkinson, 1998; Parker, 2009, p. 50).

historical errors and omissions in the metaphor of social contract between medical professionals and general public; therefore, he argued that the concept of social contract should be abandoned under contemporary social context to let various topics of medical profession to be discussed in a broader perspective.

Maio (2007a) questioned the binding force of medical ethics in the aesthetic medical field by pointing out that the original appearance of medical profession, which has long been stereotyped already in therapeutic medicine, is changed in aesthetic medicine, because the role of doctors are transformed from a healer who cures disease to an entrepreneur who sells commodities in the aesthetic medical field. Likewise, scholars also questioned on whether the practitioners engaged in the lucrative and consumer-dominated aesthetic medical field can retain the essence of self-regulation, which guarantees the quality service effectively and efficiently, to ethically prioritize patient's wellbeing as in the therapeutic medical field (Parker, 2009, p. 211; Kmietowicz, 2014; Griffiths & Mullock, 2017).

Ferreira (2005) denoted the importance of medical ethics in aesthetic medicine because that the doctors face a consumer-led crisis in this field, therefore they must not only be qualified on skill and knowledge level but also have to pay more attention to ethical codes to win the trust from the patients, then their self-regulation can be retained. Similarly, callings from the medical professional groups also appeal the practitioners to address medical ethics squarely in order to continue to have a voice in this field rather than be led by the overwhelming willingness from the consumers (Marchac, 2007).

Parker (2009, p. 211) questioned that the self-regulatory approach is full of problems and contradictions in aesthetic medicine, where market and medicine collides with each other, because the doctors have to stimulate demands and create consumers' expectations to obtain benefits; so, the practitioners inevitably either paradoxically cover up or downplay the risks and sufferings that the consumers must endure throughout the disposals, hence there is no space left for medical ethics. Moreover, Krieger & Shaw (2000) advocated that the aesthetic medical field is dominated by consumerism in accordance with the marketing force and the

attributes of patient are consumerism-oriented, so the doctors have to adopt themselves to commercial practices rather than ethical considerations. Conrad (2005) also pointed out that the aesthetic surgery embodies the pinnacle of coalescence of medicine and consumerism so the binding force of medical ethics will be weakened.

Adams (2013) and Gimlin (2000) believed that the legitimacy of self-regulation on aesthetic medicine is weakened because the behaviours of, not only the consumers but also the doctors, both superficially and substantially, have turned the beauty into a commodity; and these disposals, including the surgeries, have been promoted into a saleable product that can be picked and evaluated by personal interests, while the importance of medical ethics is easily ignored. While Pitts-Taylor (2007, pp. 28-9) pointed out that the aesthetic surgery has been actively developed and promoted by commercial practices as a medical resource that the consumer must seek for her lifetime, and this manipulation deteriorates the justification of the doctors' retaining autonomy because there are few spaces left for medical ethics. Latham (2010) also questioned the justification of self-regulation in aesthetic medicine; he proposed that based on the avoidance of conflicts of interests and to guarantee the safety of the consumers, the medical profession should withdraw from regulation, and independent organizations funded by the state should be set to be responsible for the registration and the regulation of the practitioners.

2.3. Medicalization of beauty and the consumers' characteristics

Another controversy about whether self-regulation is applicable to aesthetic medicine stems from the difference between the characteristics in this field, both of the disposals and the patients, and those in therapeutic medicine.

In terms of definition, scholars and researchers generally categorize the aesthetic medical disposals into 'non-therapeutic' medicine (Sheldon & Wilkinson, 1998; Parker, 2009, p. 50) and challenge the justification of the doctor's retaining of absolute autonomy because the doctor's focus in the disposals might be personal economic benefits rather than patient's wellbeing in this field. Miller and his team (2000) pointed out that the attributes of aesthetic medical intervention and

questioned '*is cosmetic surgery a medical privilege or an abuse of medical knowledge and skill?*'.

To defend this challenge, draw on the medicalization of beauty, doctors insist that the therapeutic effect of aesthetic disposals is critical in order to retain the autonomy through self-regulating mechanism (Kmietowicz, 2014). However, scholars questioned the justification of making use of medicalization to incorporate the desire of beauty. As Edmonds (2007) denoted, due to the intended promotion by the practitioners, aesthetic medical disposals are not only popularized in the countries or the social classes with relatively better economic condition, but also commercialized into accessible commodity in the lower class. Similarly, Neto & Caponi (2007) also argued that the doctors use strategies to have the medical discourses, which were originally limited to standardize the physiological rationalities, to be expanded to cover the patient's personal satisfaction in appearance, then 'medically' legitimize and justify these aesthetic disposals.

Parker (2009, p. 72) pointed out the injustice of this manner, because the doctors '*not only promote surgical alteration of women's bodies but are actively engaged with the socio-cultural system that objectifies those bodies.*' Sullivan (2001) made a similar claim and argued that by medicalization the medical profession is given the legal authorities to deal with aesthetic medical disposals in a systematic and constructive manner. Mirivel (2010) also proposed that the consumerism's entry into the aesthetic medical field has deteriorated the effect of self-regulation because it's difficult for the medical practitioners to communicate, persuade, and gain consumer trust with the evidence-based esoteric knowledge, which is the prerequisite of self-regulation, and further made the doctors' discretion relatively limited.

Besides, scholars suggested that the self-regulatory system may reserve too much autonomy to the professionals in aesthetic medicine, which induces the doctors to take the medicalization as a trick to effectively transform a normal appearance, which is with rational function, into a medical problem that needs to be redeemed through medical disposal, especially surgery (Dull & West, 1991; Sullivan, 2001).

Merianos, Vidourek & King (2013) also proposed that the combination of therapeutic terms and the promotion of self-esteem through marketing techniques is one of the practices commonly used to promote selective surgery; hence, under this manipulation, the self-regulation of doctors is reduced to a rubber stamp that provides doctors with legitimate reasons while actually is completely meaningless.

About the situation that whether to expand the scope of medicalization can truly protect female customers[9] while the doctors are self-regulated, Maio (2007a; 2007b) put forward his questioning and argued that the doctor would overdo for pursuing his/her own interests in the processes because those women who received the unnecessary aesthetic medical disposals are physiologically healthy. Besides, by justifying the application of 'the objectification theory' in explaining the behaviour of the female consumers who seeking aesthetic medical treatment, Vaugha-Turnbull & Lewis (2014) draw on this theory and questioned the actual goals of these aesthetic medical disposals is only to maximize doctor's benefits because the consumers are encouraged to be suffered from the oppression of objectifications.

For further discussing the necessity of these disposals, Pitt-Taylor (2009) put forward that the definition of the aesthetic surgery is semantically unstable and argued that the influence of the beautiful culture and the gender norms in society faced by the consumers must be thoroughly discussed first, rather than to ask the consumer to hastily relegate the autonomy of making decision of performing surgeries to doctor. Edmonds (2013) denoted that the so-called professional judgement is biased because medical practitioner use risk-benefit analysis as a convincing strategy to justify the legitimacy of the aesthetic disposals, which will make the consumers to underestimate the risk accompanied these disposals. Latham (2010) doubted the justice of the self-regulation in aesthetic medicine and claimed that even if there is comprehensive and sufficient informed consent between the doctor and the patient, the manner that depends on the doctor's discretion is,

[9] According to statistic (ISAPS, International Society of Aesthetic Plastic Surgery, international survey on aesthetic/cosmetic procedures, 2018), 87.4% of the consumers who received aesthetic medical interventions are female.

through the academic discourse of medicalization, just a statement that grants reasonableness and legitimacy to these medical treatments.

Finally, about the traits of the consumer in aesthetic medicine, Davis (1995) deemed these consumers are a group of victims in society who are vulnerable and under systemic oppression and denoted that the situation will be worsen under the self-regulation of doctors. Blum (2003) and Ensler (2004) also proposed that these patients who have the symptoms of Borderline Personality Disorder, such as self-harm and self-hate, cannot be 'cured' by scalpel; therefore, the justice of the self-regulatory system that always provide the practitioners green light to perform elective non-therapeutic disposals is questionable. In order to protect these women away from systemic oppressions, Davis (1995) argued that the substantive law must be promulgated to limit the autonomy of the professionals, and the codes related to these disposals must be explicitly defined.

3. Theoretical framework

In order to effectively discuss the feasibility of the self-regulating manner being inherited in the field of aesthetic medicine from the field of therapeutic medicine, there must be a set of systematic and rhythmic operational procedures. Indiscriminately pick any seemingly influential factor and omit the others to hastily put forward one-sided argumentation under poorly structured theoretical framework is not a reasonable approach. Therefore, it is important, at the first stage, to select suitable theories that can be used to thoroughly describe the behaviours of the practicing doctors in the field of aesthetic medicine.

On the one hand, Friedson's theory of professionalism provides the researcher a clear outline and a handy template to illustrate the doctors' behaviours as a whole from a macroscopic perspective. It can be used as the gauge in designing the questions for interviewing these doctors and to systematically find out whether their descriptions would reflect the typical elements of the professionalism and to what extent.

On the other, although the professionalism may be used to explain the macroscopic traits of these practitioners as a unified profession, it's insufficient in elaborating the microscopic distribution of the power between the state and the doctors in two different medical fields on the personal level. Therefore, for more in-depth analysis of the related legal issues, Bourdieu's theories of field, habitus and capital are used to elaborate these nuance differences of each interviewee's expressions on the aesthetic and therapeutic medical fields, and the new struggles faced by these practitioners in aesthetic medicine.

3.1. Professionalism

In addition to Freidson, there are also Larson and Abbott, who also put forward theoretical model to analyse professionalism. Larson (1977) took historical context as the background of his theory, discussed the special class identity and the status of the professionals in society. He focused on the returns of interests and analysed the reasons of the formation of professionalism, which is conducive to the depiction of the doctor's behaviours, especially the parts related to commercialism, in aesthetic medicine. However, due to his model was framed within the Anglo-American social context where liberalism is upheld, it is not suitable for a study focused on legal issue in Taiwan where the civil law is adopted. As for Abbott's theory, it is relatively idiosyncratic (Freidson, 2001, p. 6) and is not suitable for systematic analysis of the aesthetic medical field.

Although, there is a blind spot in Friedson's theory of professionalism, as Larson (1977, pp. 56-7) pointed out, that this model overemphasizes the importance of professional ethics, this model draws on professionalism as one regulatory manner for labour divisions while simultaneously mentions both free market competition and bureaucratic control as comparisons (Freidson, 2001), which provides a solid framework for this study. Therefore, the researcher chooses Freidson's theory as a start point to categorize scattered interviewed data into structured and descriptive analyses; and next, transfer these materials to the stage of interpretive analysis, which is performed by Bourdieu's theories, to obtain results.

3.1.1. *Professionalism as the ideal type*

Regarding to the self-regulation of medical profession, Freidson (1983; 1985; 2001) provided a set of explanations and summarized them into an ideal type named 'professionalism'. By proposing the professionalism to explain the task related to the professionals, Freidson (2001) claimed that the self-regulation of the professionals is established under several premises, and believed that the essences of the self-regulatory system, especially the one for medical professionals, is different from those based on either bureaucratic rationality or balance formed by the competition in free market. With their professional knowledge and commitment to ideologies and professional ethics, the medical professionals are self-regulated to provide quality service in line with the expectation of society under a unique fashion which prohibits outsiders to participate (ibid.). Besides, although the professionals are privileged to enjoy autonomy and discretion in their daily tasks, Freidson (2001) pointed out, that the esoteric knowledge is not the source of power. Actually, the power is gained through the persuasion between the professional groups and the state (ibid., p. 105).

Freidson (2001) believed that the conceptions of professionalism can be used to effectively describe the formation of the professional labour group. He also argued that it must take several elusive but practical factors into account, such as the esoteric knowledge, the commitment to professional ethics and values, the lengthy structured trainings, the unique habitus in working environment, and, last but not least, the social classes of the professional labour group, to have the traits of the professional group being thoroughly described (ibid., p. 17, 105).

Simply put, professionalism is, as Freidson (2001, p. 17) proposed,

> *'a set of institutions which permit the members of an occupation to make a living while controlling their own work,'*

and among them,

> *'two most general ideas underlying professionalism are the belief that certain work is so specialized as to be inaccessible to those lacking the required*

training and experience, and the belief that it cannot be standardized, rationalized'

or as Abbott (1991) puts it, *'it cannot be commodified.'*

3.1.2. *Role of the state*

Viewed from the traits of the professional labour, according to Freidson (2001), actors in the therapeutic medical field, especially doctors, who must retain high degree of discretion in handling their daily tasks, fit squarely with those characteristics of professionalism. This is the reason why the state inclines to delegate self-regulation, which is formed under a concept of re-stratification that the rank-and-file are regulated by the elite coterie within the 'like-minded' group (Freidson, 2001, p. 202), to the medical professionals to enhance the efficiency of management. Correspondingly, the medical professionals respond these privileged rights by providing quality services to meet the expectation of society and publicly convicting to professional ethics.

In terms of the power relegated from the state that involved in the regulation of the professional groups and the hierarchical design of governmental institutions, based on the framework proposed by Damaška (1986), Freidson divided the states around the world into four types, namely the reactive-hierarchical, activist-hierarchical, reactive-coordinate and the activist-coordinate type (ibid., pp. 135-8).

Within this typology, the UK's regulatory manner on the medical professionals is the typical 'reactive-coordinate' fashion. Under this design, various private professional organizations retain high degree of autonomy, while the state with coercive power acts only as a passive coordinator. Actually, the obtaining of the certificates that issued by respective medical schools in the UK is equal to the obtaining of the state's endorsement to legally perform medical practices. In other words, the entire privately organized training courses, internships, and certifications are all parts of the concrete manifestations of self-regulatory system. While the performance of these medical graduates in labour market contributes reversely to

the reputation of this self-regulatory system. Therefore, this system is strengthened by the operation of the market mechanism (Freidson, 2001, pp. 137-40).

On the other hand, the medical professionals' regulation in Germany belongs to the 'reactive-hierarchical' type within Freidson's (2001, pp. 135-8) typology. Under this manner, the state situates at a dominating position on the highest level that actively intervene in regulating professional group and meanwhile, delegates various private organizations, which situated at the lower level, to conduct self-regulation to improve the efficiency and flexibility of whole management. Practically, in Germany, medical students must pass four national examinations until they obtain the qualification of doctor. In this system, the power of the state is mainly demonstrated through these examinations. Although the professional groups seem to lose the autonomy within this regulatory manner, in fact, through the elite stratum being recruited into government and become the technical bureaucrats, the essence of self-regulation is retained (ibid., p. 141). While the situation in Taiwan, though not completely, inclines to this type of regulation.

3.1.3. *Key elements of professionalism*

The professionalism, as the ideal type for describing doctor's behaviours, has several characteristics needed to be clarified in advance.

First of all, the esoteric professional knowledge and skill, that formed barriers to shield the amateur from entering professional labour market, are the prime condition for the professionals to enjoy the highly autonomous self-regulation (ibid., pp. 138-41). According to Freidson (ibid., p. 157), there are three forms of knowledge, namely the descriptive forms, the prescriptive forms and arts, and the claim authority; while therapeutic medicine, which is based on science with the descriptive nature, represents the technical authority to the general public. Therefore, for managing efficiency, this nature provides the preliminary legitimacy for doctors to be delegated with self-regulating management by the state.

Another significant factor of professionalism is 'ideology'. According to Freidson (2001, p. 107), the ethical self-demands of the doctor act as the gatekeepers in the

self-regulating system. Freidson (ibid., p. 105) integrated the always emphasized altruism that prioritizes the patient's interests with '*the claims, values and ideas that provide the rationale for these institutions of professionalism*' into a term 'ideology' to represent the beliefs of the medical professionals. The commitment, especially explicitly, to the ideology, provide the second justification to the doctor's self-regulation.

Besides, the 're-stratification' within the professional group, that divides members into the elites and the rank-and-file, is another important factor for the self-regulation to be successful. Freidson (1984; 1985) argued that the 're-stratification' is conducive to the efficiency of management because the regulated show more compliance to the 'like-minded' elite members within same group. This approach is particularly efficient when it is used on the medical profession, because, traditionally, senior doctors have the rights to instruct younger generation in the general medical field, while the latter always obeys. In other words, though the regulated may not regard the general bureaucrats in government are 'professional' enough to understand their daily tasks, they deem the elite insiders in the self-regulatory system can hold empathy to their actions and effectively provide assistance (Freidson, 1983; Baldwin and Cave, 1999; Baldwin et al., 2001; Baggott, 2002, p. 35).

Finally, as Freidson (2001, p. 107) pointed out, the above-average remuneration, especially are backed by the state, plays a key role in the success of self-regulatory system. Due to the governments of the advanced democratic countries gradually regard the health of citizens as an important issue related to human rights, the doctors in therapeutic medicine are regarded as a vital public asset that the state needs to carefully cultivate. Therefore, in addition to autonomy, the guaranteed, above-average economic rewards, which is backed by the state-run health insurance system and used to strengthen the self-regulating mechanism, is another elementary incentive for the doctors to stay in the therapeutic medical field.

3.2. Field, habitus and capital

Compared to Freidson, Bourdieu did not agree with using the term 'profession' to encompass all members of certain occupation into an 'imagined' group to be discussed about, and he believed that to use this term 'profession' in sociological research is an ideological approach because it smuggles certain ideas into this imagined title 'profession', and then, making the research loses its critical stance (Noordegraaf & Schinkel, 2011). Besides, Bourdieu also believed that the concept of 'profession' is dangerous due to its neutral-looking appearance (Bourdieu & Wacquant, 1992, p. 242). Therefore, Bourdieu strongly advocated that the concept of profession should be replaced with 'field' in order to illustrate a domain for specific actors to struggle within and argued that only with this manner the deviations caused by ideologies can be avoided (ibid.).

Although Bourdieu's critique of the concept of 'profession' is potent, it is also one-sided and biased (Noordegraaf & Schinkel, 2011). That means, it is not optimal to discuss thoroughly about the doctors' opinions on the aesthetic medical field by using Bourdieu's theories alone when the doctors are treated as group as a whole. However, Bourdieu's theories of field, habitus and capital provide the researcher an effective and complementing theoretical framework for the analysis with a comprehensive view to interpret the struggles of these agents in aesthetic medicine from the microscopic level, which is Freidson's theories hardly touched. Therefore, with these theories, the researcher can analyse the actor's capital and power acquisition between different fields and within each field, and between the doctors and the state, to infer the feasibility of the agents' intention towards the self-regulation.

3.2.1. *Field*

According to Bourdieu (1993, p. 162), field is a social space with its own unique rules of operation. The boundaries of any specific field are elusive and hard to be defined (Carlhed, 2007). However, though it may be difficult for the outsiders to clearly recognize the outline of a specific field, the insiders, such as the practicing doctors, are well acknowledged their locations are within the specific field, i.e.

aesthetic medicine, or not. Because, the field is well apprehended by them as the context in which they have to struggle to occupy better status (ibid.); while for outsiders, it's only a continuum of regular space without any importance.

Besides, within a field, the agents struggle for different forms of capital, such as cultural, economic, social or symbolic capitals, to gain the prestige required to be successful (Brosnan, 2010; Bourdieu & Wacquant, 1992, p. 120). Reversely, the prestige owned also enhances the agent's competitiveness to gain more capitals. Vertically, this manner operates reciprocally to let the holders to move upward to better positions; while horizontally, different capitals within specific field are also interlinked and transformable between each other (Bourdieu, 1986). Luke (2003, p. 55) explained this idea further and proposed that this concept of field could also be applied to the medical domain for its unique culture. That means, to be more precisely, the doctors fight over the capitals in the aesthetic medical field to attain the attractive positions, i.e. to be more competitive, can be regarded as their struggle.

Viewed from an even broader perspective to discuss the agent's position, various fields might be interlinked and hierarchical with each other (Bourdieu & Wacquant, 1992, p. 109). The agents compete within one specific field and struggle upwards might join into another field or situated in two related fields, such as the holistic medical and the aesthetic medical fields, simultaneously. Moreover, the social space in which the field is located can also be regarded as a field. Bourdieu called it the 'field of power', which refers to a structural space in society that has the ability to allocate capitals and determine the social structure (Bourdieu, 1993, pp. 37-40). Furthermore, varied fields, such as the therapeutic and the aesthetic, though might be interlinked superficially, within this field of power are independent relatively. This independence is embodied when the external factors try to exert influences on a specific field, while these influences can only be shown through the rule of conversion of this specific field (ibid., p. 164).

That means, the capital, such as the esoteric knowledge owned by doctors, must go through the conversion mechanism in the aesthetic medical field, i.e. to be deemed powerful by all members, which includes the consumers, to exert influence

(Bourdieu, 1993, p. 164) and provide the holder the dynamics to move upward. In other words, the 'former' capital is powerful or not, depends on whether the conversion, which is decided according to the rules of the new field, is successful or not (ibid.). Simply put, whether something is 'capital' is not absolute, but will change with the field in which it is located.

3.2.2. *Habitus*

Habitus is '*an acquired system of the generative schemes objectively adjusted to the particular conditions in which it is constituted*' (Bourdieu & Passeron, 1977). Collyer and his team (2015) elaborated this idea further and describe habitus

> '*is an explanatory tool that shows how our actions are always historical, for our individual history shapes our thoughts and actions into "durable dispositions" that guide future behaviour*'.

Therefore, habitus can be regarded as a product of history (Bourdieu, 1990, p. 54), such as medical students constantly evolve, transform, or maintain their own way of thinking, habits, and the resulting behaviours through the lengthy process of socialization, which includes the educational and clinical training process, then become rational doctors with medical habitus. That means, the educational system plays a particular role in developing habitus throughout doctor's lifetime (Bourdieu & Passeron, 1977; 1979). Besides, habitus is also highly linked with the field a person belongs, hence it should not be considered absolutely unchangeable (Olsson, Kalén & Ponzer, 2019).

In medical field, the habitus has influences not only on the level of doctor's skills, tastes (McDonald, 2014) and preferences, but also on their adherence to medical ethics (Mitchell, 2013). During the daily tasks, the doctor embodies the moral habitus in the relationships with their patients. The education in medical school has influence in shaping students' habitus (Balmer et al., 2017), while reversely the habitus provides a means of understanding students' abilities and limitations within the medical field (Olsson, Kalén & Ponzer, 2019). Besides, habitus interacts with

the medical field and ultimately shapes the dispositions and preferences of doctors (Luke, 2003, p. 55).

One important point is that the hierarchical conception of the medical habitus, which act as symbolic violence (Bourdieu, 1990) to all agents within the medical field, especially therapeutic medicine, provides the concrete reason in explaining junior doctor's obedience to senior mentors after they accomplished their trainings of the specialty in medical centres, then, strengthen the self-regulation of the medical profession. Besides, the professionalism, which is embodied in the specialty credentials that are capable to exert influences on patient (Noordegraaf & Schinkel, 2011) as a form of symbolic capital held by the doctors in the therapeutic medical field, is also conducive to strengthen the self-regulation.

3.2.3. *Capital*

According to Bourdieu (1991), capital is one's resources, both material and immaterial, related political, personal, functional, professional, linguistic, intellectual, and scholastic power for one to struggle upwards and gain better position in specific field. Bourdieu (1986; 1997, p. 47) delineated three fundamental types of capital, namely *economic* capital (money, property), *cultural* capital (knowledge, skills, educational qualifications), and *social* capital (connections, membership of a group) in his articles and books. However, he also argued that these forms of capital, no matter any single one or combined with each other, can be viewed as symbolic capital that specific related to honour or prestige (Bourdieu, 1986). In other words, all of the other forms of capital might funnel into the domain of symbolic capital that an agent possessed (Ihlen, 2018). For instance, social capital alone can be regarded as symbolic capital, since it is 'governed by the logic of knowledge and acknowledgement' (Bourdieu, 1986, p. 257).

Therefore, symbolic capital can be deemed as but one of many forms of capital that social actors can possess. It is a comprehensive display of all available capitals that one can exert. As Swartz (2013, p. 112) put, symbolic capital is the overarching and most coveted form of capitals, i.e. a form of 'meta-capital'.

The credential that embodies the professionalism of doctor, either the legalized identity or the issued specialist titles by the self-regulating organization, though their essences are the cultural capital, can still be deemed as symbolic capital (Noordegraaf & Schinkel, 2011), which can exert influences both in the therapeutic medical field and the society, of these practicing practitioners for them to struggle upwards. Meanwhile, the promotion and the image-packing that attained by commercial practices in the aesthetic medical field are also treated as symbolic capitals in this study. With this manner, the researcher is provided a handy tool to analyse the difference of dynamics in the respective medical field, i.e. the therapeutic and the aesthetic.

4. Methodology

4.1. Methodological considerations

With this thesis, the researcher intends to explore the practitioner's opinions and expectations on current and future regulating manners of aesthetic medicine, and then to understand whether the long-adopted self-regulating mode in managing the therapeutic medical profession could be inherited in this emerging field. To study this issue, it is necessary to understand the factors such as the attitude of the doctors on aesthetic medicine, the influence of their training background, the general image to the establishment of specific responsible organization, the awareness of medical ethics, and the views on current medical regulation, both on therapeutic and aesthetic medicine. It covers a complex range of aspects and contents.

Prior to collecting data, although the researcher has pondered as thoroughly as possible about the contents to ensure the interview questions cover most of the parts related to the research issue, the range of the information required couldn't be clearly defined because the aforementioned complexities. To make matters more complicated, the doctors who are trained in different medical specialties have different habitus of expressions in terms, metaphors, and degree of explicitness on same issue even they received identical curriculum in university, while the field of

aesthetic medicine is exactly this environment where the doctors with various training backgrounds coexist. In other words, the attempt to investigate this issue with a unified questionnaire is full of obstacles.

Therefore, in deciding whether to use qualitative or quantitative research designs, the researcher first ponder various parts that are difficult to be overcome. If the researcher adopts quantitative analysis, the formatted questionnaire used must be lengthy and copious enough to cover all aspects. Any truncation or omission due to ill-considered design may impair the integrity of the result. But, lengthy questionnaire for quantitative design might decrease the participants' willingness to reply (Bryman, 2012, pp. 234-5). On the contrary, the qualitative study by interview with semi-structured questions could avoid these shortcomings. Besides, the fact that the researcher shares identical medical habitus with the interviewees is also conducive to collect data as comprehensive as possible, such as to identify the implicitly mentioned but important content throughout the interviews by the doctors, in qualitative analysis. This is another advantage why the researcher decides to use qualitative design.

4.2. Data and analytic method

4.2.1. *Empirical data*

The empirical data of this thesis are gathered from two rounds in-depth of interviews with 13 random selected practicing doctors in the aesthetic medical industry situated around Taiwan through online real-time dialogues. Then, these data are analysed with the theories of Friedson and Bourdieu to obtain situated argumentations of the regulated.

The discussions and conclusion of this study will be presented as qualitative research design. Even quantified data may be used throughout the process, no quantitative description will be presented. In addition, due to the researcher shares identical medical habitus with these interviewees, the process is conducted as a dialogue between peers of different specialties within medical field. This manner is conducive to encourage the participant to express as much as possible and to

understand the implicit, subtle and nuanced meanings throughout the interviewee's speech.

Before proceeding the interview, the researcher formulated the interview guideline first, but the interviewees are not restricted to discuss only the issues listed within it throughout the process. The purpose of the guideline is to provide a framework and ensure that the research topics set at the beginning are indeed touched, but not to delineate concrete restriction of the contents to be expressed. Next, the time of the interview is limitless. The respondents can extend any question at any time freely according to their own style, rhythm and depth and breadth involved. At the end of the interview, the interviewees are enquired whether they'd like to supplement any topic to make sure that they fully expressed their opinions. Finally, the interview will be conducted in Chinese and recorded throughout and, later, the researcher will personally transcribe the recording data and translate the parts that to be excerpted into English according to the content's needs.

4.2.2. *Design of interview questions*

The interview questions are designed in the open-ended and semi-structured formulation. In accordance with the design of Bryman (2012, pp. 471-4), the interview guideline is prepared in advance and the questions are divided into three parts to correspond to the priori themes, which are used in the analysis later, to make sure the aspects that related to the research questions are touched.

The first part involves personal motivations of choosing to work in the so-called 'non-therapeutic medical' field and the views on the difference of the traits between therapeutic medicine and aesthetic medicine. The doctors are inquired about whether the aesthetic medical field have any strong incentive, such as lucrative economic rewards, brighter future, or relaxed lifestyle, for them to join. Then, the interviewees are enquired about the distinct difficulties encountered in the aesthetic medical field, whether there are consumers related or technic oriented. On the one hand, through this part, the researcher hope to get an image of the expectation and perception of these medical professionals on the field of both therapeutic and aesthetic medicine to distinguish the nuance difference of respective habitus in

these two medical fields; and, on the other, to clarify how and to what extent the consumerism involves in the aesthetic medical field and affects the interaction between the doctors and the consumers within.

The focus of the second part is to understand the doctor's subjective attitude towards professional medical organizations, and to explore the influence of medical habitus, especially the traditions of mentoring and apprenticeship, which is unique to the medical profession throughout the training in the therapeutic medical field. This part will touch the self-regulatory mechanism, such as the training courses, the responsible organization and the background of the therapeutic medical specialty. Through the elaboration of the doctor, the researcher hope to explore, from the doctor's perspective, whether the self-regulatory fashion of the existing medical specialties can be inherited in aesthetic medicine, and to understand whether the doctor's existing medical specialty training constitutes a boost or resistance in the aesthetic medical field at this stage. And more importantly, the development of medical ethics during their training process. Moreover, the interviewees are requested to express their views on the functions of existing specialty medical organizations. Next, regarding to the establishment of a specific medical organization that to be responsible for the tasks related to aesthetic medicine, the doctor will be consulted on, both from the ideal and actual aspects, whether it is helpful, no matter for collective promotion or for the management of, to aesthetic medicine.

The aim of the third part is to understand whether the doctors have any awareness or perception about relevant laws and regulations on aesthetic medicine in Taiwan, and to understand if a stable regulated environment, no matter it is structured under statutory or self-regulatory fashion, is a must to these doctors. Furthermore, to what extent do these doctors prefer to the involvement of statutes, such as the qualification to practice and the commercial practices, i.e. the advertising and marketing restrictions. The interviewees are also encouraged to comment on any deficiencies or paradox in current laws and regulation for the researcher to problematize the current legal environment. Besides, the doctors are enquired to

comment on the legal restrictions encountered by Taiwan's aesthetic medical industry when their business goes to international domain.

Finally, the interviewees are encouraged to put forward any other opinion and view on any aspects about aesthetic medicine beyond the listed questions to make the data collected in interview more complete.

4.3. Ethical considerations

Prior to the interview, the respondents will be provided with the outline, aim, purpose and the scope of this research, and required to sign an informed consent document. Due to this thesis will be written in English while the interviews are performed in Chinese, specific tasks related to translation will be noted. This research will follow ethical principles, in the sense that the participants possess the rights to decide whether they want to participate this research or not (Bray 2008, pp. 313-4). Besides, the participants will be informed that they have the right to cancel the interview at any moment and to choose not to answer some of the questions (Bryman, 2012, pp. 131-3; Denscombe, 2011, p. 197).

Moreover, the researcher is going to give to the participants confidentiality, which means all participants are guaranteed anonymity in this thesis. Next, when any interviewed content is excerpted in this article, the interviewee's original titles will be replaced with arbitrary coded alias to prevent any retrograde identification of the interviewee's gender, age, and precise geographical location. Furthermore, the participants are noticed that the collected information will only be used for the purpose of this research, stored in a safe location, and deleted after the thesis is completed (Bryman, 2012, pp. 131-3).

4.4. Analytic method

The data collected after the interviews will be qualitatively analysed in a bottom-up fashion in line with the template analysis (King, 2012, p. 426).

According to Bryman (2012, pp. 578-9) and King (ibid.), template analysis is a style of thematic analysis and

‘It is not a complete and distinct methodology, but rather is a technique that may be used within a range of epistemological positions’ and can be used both in ‘the kind of realist qualitative work that accepts much of the conventional positivistic position of mainstream quantitative social science’, and within “a ‘contextual constructivist’ position” as researcher’s attempt in this thesis (King, 2012, p. 427).

Central to this analysing technique is the development of the coding template that is constructed on the basis of a subset of collected data. With the developed template, the researcher may apply it to further data, then revise and reapply according to the need in the analytic process. That means, among the analysis of the interview contents of different interviewees, the template will be readjusted repeatedly until it becomes a suitable formulation.

The flexibility of coding is a unique and handy characteristic of the template analysis for this research. Indeed, through the rigorous and structured procedures of the traditional thematic analysis, that the descriptive empirical data is converted into the codes of the interpretive themes for analysis, can prevent the inexperienced researchers from rushing into the interpreting analytic result with insufficient analysis at too early stage. However, it may be difficult to clearly differentiate the interpretive and the descriptive coding during the analytic processing, and the norm of a three-level hierarchy coding will restrict researchers from finding meaningful content in the empirical data during the analysis (King, 2012, p. 429).

While with the template analysis this limitation can be overcome because this method provides the researcher the flexibility to move between these two stages of analysis. But this is not to say that the hierarchical coding is totally abandoned in template analysis. Instead, it avoids the strict of fixed number of levels of coding hierarchy and explicit distinction between the descriptive and the interpretive themes, because it ‘*encourages the analyst to develop themes more extensively where the richest data are found*’ (ibid.).

Therefore, three main axes, which the interview questions are structured in line with, will be taken as priori themes in the initial stage of the analysis rather than one

specific hierarchy for coding to make the great use of the collected data. According to these priori themes, other sub-themes will be derived from the interviewed materials. One thing important while converting the empirical data, which is obtained from the three parts used to support the researching topic in the interview questions, into the themes that can be analysed is that certain aspects in the expressions, such as repetitions, indigenous typologies or categories, metaphors and analogies, transitions, similarities and difference, linguistic connectors, missing data, and theory-related material, must be considered to enable a systematic analysis (Bryman, 2012, p. 580; Ryan & Bernard, 2003).

Another important characteristic of the template analysis is that it permits parallel coding of

> *'segments of text, whereby the same segment is classified within two (or more) different codes at the same level' (Bryman, p. 432).*

Moreover, sometimes, especially in interviews with the professionals, such as doctors, there are subjects that are not explicitly expressed lurking throughout the participant's statement. This undercurrent, such as the impact of consumerism in aesthetic medicine, that spans throughout the entire paragraph is important, but it cannot be easily identified and presented in general coding process. For sorting out this information, the *integrative* theme (King, 2012, p.431-6) of the template analysis can be an effective tool. Through the researcher's own knowledge of the research topic and the use of the integrative themes, the undercurrent can be converted into specific concrete data that are ready to be analysed, which helps the researcher to make use of the empirical data comprehensively.

Finally, unlike most thematic approaches which require the researcher to carry out each step of the analysis on each transcript, the use of an initial template based on a sub-set of the data changes the process and progresses through '*an iterative process of applying, modifying and re-applying the initial template*' in the template analysis (King, 2012, p. 430), is also a flexible technique for the researcher to efficiently analyse the overall collected data.

4.5. Analytic template

At the beginning of the work, based on the theories of Freidson's professionalism, the initial analytic template used for the analysis was designed. As the transcription proceeded, the scattered data obtained from the interviews are categorized, in comply with the research questions, into three aspects, namely the power of the esoteric knowledge, the establishment of single responsible private organization, and the impacts result from specific habitus of aesthetic medicine. Next, the initial analytic template, which cover these three aspects, will be used as a starting point for analysis in order to obtain the initial descriptive materials. After that, these materials will be analysed mostly based on Bourdieu’s theory of field, habitus and capital to obtain the interpretive analysis for discussion.

The analytic processes are not proceeded unidirectionally that from the descriptive to the interpretive analysis but move back and forth between the two stages. As the analytic process progressing, the template is revised repeatedly until the collected data can be mapped exactly to all the analytic themes set at the beginning. At the same time, as the frequency of analyses has increased, the gradually surfaced undercurrent of other important information beyond the originally planned themes are codified into sub- or integrative theme (King, 2012, p.431-6), such as the impact of non-doctor roles or the influence of consumerism. With this fashion, the scope of the analytic template is repeatedly expended to enclose all newly identified information. That means, beyond the scope of these priori themes, the analytic template is updated continuously with the function to identify undercurrents in the data gathered of every interviewee one by one to make the most use of the data.

5. Analysis and discussion

Based on the analytic template, the analysis and discussion are performed from three aspects, namely the esoteric knowledge, the specific private organization and the medical habitus in the aesthetic medical field, in accordance with the priori

themes that set at the initial stage. While several sub-themes are added as the analysis progressing as the titles in the paragraphs.

5.1. Esoteric and institutionalized knowledge

5.1.1. *A devalued cultural capital*

The professional knowledge cannot be easily understood by lay people, is the primary reason Freidson (2001, pp. 17-8) believed that the doctors must retain considerable discretion in their daily tasks. To be specific, externally, these institutionalized knowledges are viewed as cultural capitals (Bourdieu, 1986) by the doctors to support the legitimacy for them to retain the autonomy because no others, even the state, can judge their service quality (Freidson, 2001, p. 17); and internally, it strengthens the self-regulation by consolidating the community consciousness among the 'like-minded people' (ibid., p. 202). Although the popularization of knowledge has shaken the professional authority in recent years, these challenges are launched on the shared scientific bases that both the patients and the doctors accept rather than the arbitrary feelings of either party. That means, in Bourdieu's words, the status of the professional knowledge as a valuable cultural capital to give the doctors a great advantage for retaining the class difference (Bourdieu, 1986) remain unchanged. However, this condition is quite different in the field of aesthetic medicine.

<u>*Invalidated medicalization of beauty*</u>

Through expanding the academic field of the plastic surgery to amass the satisfaction of patient's psychological wants, the medical elites draw on medicalization to annex 'beauty' within the scope of the academic discourses by standardizing beauty with the quantified scales as they always did physiological diseases (Neto & Caponi, 2007). Essentially, this manipulation, which introduces the therapeutic medical habitus into aesthetic medicine through the academic strength, is a strategy to gain a conversion mechanism (Bourdieu, 1993, p. 164) to try to retain the knowledge's power. But this strategy fails because the consumers of aesthetic medicine don't deem the professional knowledge as a guide in judging

the success of the disposals. Frankly, they don't passively accept their self-financed demands to be judged by the medicalized rationality, instead, under neo-liberal ethos, they actively demand the service quality to meet their elusive, psychological 'wants' just like picking luxury goods as calculating customers in boutiques (Leve, Rubin & Pusic, 2011; Fraser, 2003; Adams, 2013). Further, this subjective demand is initiated in a cyclic process of the constant picking and the ensued satisfying from self-considered improvement to fully display their pleasure in consumer culture (Featherstone, 1991, p. 177). Simply put, in the aesthetic medical field, patient's arbitrary judgement is everything, while the original authority of the knowledge that provides the justification of self-regulation is harshly challenged.

Doctor Huang[10] illustrated these consumers' psychological motives:

> *Such facelift is way too convenient for her. So, she may sit in front of mirror all day long to observe her face and check where could be changed further. A patient like this, I think she would only appear in aesthetic clinic. Because no one would go to clinic to have her/his healthy organ checked repeatedly. But in aesthetic medicine, even if it (face or body figure) is fine, she would have it checked and modified again and again.*

Doctor Wang also denoted the beauty-seeking desire and curiosity of his friends, especially women, even outsides the clinic:

> *Once they (friends) knew that I am a practicing aesthetic doctor, they will enquire and show great interests ... Everyone is eager to be better looking.*

<u>Dominating will of consumers</u>

Next, within the field of aesthetic medicine, the relative proportion of patient's feeling and scientific base are reversed. Implicitly, this reversion changes the habitus that the doctors are accustomed to because their disciplinary behaviour can no longer be unified with those in the therapeutic field (Bourdieu, 1986, pp. 83-4) and, explicitly, the practical situation makes them to prioritize the consumer's psychosocial feelings rather than use the professional knowledge to persuade during

[10] All interviewees mentioned in the article are represented by pseudonyms.

whole treatment. This trend not only reveals the direction and dynamics that are hardly seen in therapeutic medicine, it's also bizarre in the evidence-based modern Western medicine because the unified behaviours (ibid.) that are guided by quantified guidelines are replaced by elusive feelings.

Doctor Sun expressed his experiences of this supersession:

> *(In aesthetic medicine) you cannot exclusively use quantitative data to persuade patients. Their judgements to the result are very subjective. It's a big difference from the general (therapeutic) medicine.*

Doctor Lin also pointed out similar feelings:

> *Our score comes from consumers. Even though we score our performance only eighty or ninety, if the consumer is very satisfied throughout the process and thought we deserved fully scored, then it will be one hundred points (a concept of full scored in Taiwan). Conversely, once she isn't satisfied, no matter how well we have done, she will make trouble and put forward complaints.*

Besides, this sense of powerlessness is even more contrasting while the doctors compared their current situation with the former one in therapeutic medicine.

Doctor Sun pointed out the difference between these two fields:

> *Treatment in hospitals were focused at diseases. As long as the disease is cured, then everything would be fine. It's less controversial. There is no 'semi-cured'. But the problem within aesthetic medicine is that the determination of quality is more abstract and up to the customer to decide ... This sometimes makes me difficult to handle ... you think you have done well, but the patient just told you that she is not satisfied. She felt bad.*

While Doctor Chen presented the emptiness of losing the authority of professional knowledge, and, instead, having to serve these 'guests' emotionally:

There is a feeling that I will never wear a white robe anymore (and I am no more a real doctor) in this new field … Moreover, since that moment, there were no more 'patient' to me (in my career), they are 'guests'.

The dominance of the consumer does not only encroach the power of the professional knowledge as a cultural capital but also makes the practitioners confused because the behaviour of 'to follow consumer's will' is against their knowledge-based digitized medical system of dispositions (Bourdieu, 1990, p. 54).

Doctor Liu revealed his confusion about this trait:

Like rating hotels, it's clear what facilities should a hotel have for a five-star rating, and what for a three (star) to be called. Right? But there has not such criteria for the aesthetic disposals.

<u>*Unorthodox non-knowledge-based strategies*</u>

Moreover, the doctors are forced to pay disproportional attention to the communications with the consumers to avoid medical disputes (Patel & Morrison, 2013; Bismark, Gogos, McCombe, Clark, Gruen & Studdert, 2012). This situation led the doctors focus more on the consumer's satisfaction that resulted from the subjective cognition rather than the quantitative evidence when she enters clinic or operating room (Neto & Caponi, 2007).

Doctor Wang denoted the importance of alternative strategies in running business:

We have to pay more attention to customer service, (concern) the feelings of customers ... caring, rhetoric and attitude are very important ... even at midnight, customers might page you and complain something trivial, you just have to respond immediately …

In other words, within the aesthetic medical field, the doctors have to transform themselves from professional workers who hold a powerful cultural capital, i.e. the esoteric knowledge, to service providers that have to satisfy the consumers' feelings.

Doctor Sun illustrated this situation practically:

In some situations, we may argue that the results are within the normal range and some patient accept. But, somehow, you would face some very subjective people and it's useless to discuss rationality with them.

While Doctor Wang draw on a practical case to depict the irrationality:

Although it's quite normal there is swelling around the operation site within one week after the disposal, she (customer) might keep complaining about what is done badly and scolded us. But one month later, all the swelling is gone, she will be very happy and satisfied with the outcome …

In summary, the professional knowledge, which is deemed as the elementary prerequisite for the self-regulation in therapeutic medicine, is neither concerned by the consumers nor powerful to be used as a criterium in deciding the quality of the services by the practitioners anymore. Moreover, the strategy that attempts to medicalize beauty to retain the authority have failed because of the knowledge's inability to produce the conversion functions (Bourdieu, 1993, p. 164) in the aesthetic medical field. As the practicing doctors lose the authority that comes from the esoteric knowledge, they have no choice but to seek other capitals to struggle upward. Although legally the professional knowledge is still used as a guide for judgment in the court, it loses power in persuading the consumers in the clinics.

5.1.2. *Non-institutionalized education of specific knowledge*

According to Bourdieu (1986), the institutionalized knowledge that embodied in the forms of professional credentials, no matter it's issued by the state or the private organization, is a cultural capital. For the professionals as a whole, it can be used reversely to persuade the state to delegate them with the self-regulation for better managing efficiency (Baldwin & Cave, 1999); while for personal, it is an easy route to gain economic capital (Bourdieu, 1986). Besides, the monopolization of the formalized knowledge by the elite stratum in the professional groups is a key factor to consolidate the self-regulation (Freidson, 2001, pp. 29-32, pp. 83-4; 1986, pp. 1-2). Likewise, general medical education in Taiwan, within which doctors are trained

at the schools and then in medical centres to gain the specialty titles, is academic and institutionalized. But there are very different ways in aesthetic medicine.

Non-institutionalized education and training

Like other specialties, the practitioners in aesthetic medicine also have to go through lengthy trainings because the knowledges are specific and esoteric. However, in Taiwan, the professional knowledge of aesthetic medicine is not transferred from an institutionalized system, but from a variety of coexisted sporadic and scattered channels inside or even outside the field. This impairs the very element of the self-regulation because the re-stratification insides the group hardly emerges (Freidson, 2001, pp. 29-32; 1984; 1985).

Doctor Chen narrated his experience as an apprentice at clinic:

> *This is a different arena … the technics or the operation of instruments are totally new to me, and I have to learn all over again … at first, managers sent me to follow a senior doctor for three year … I was already V5 or V6[11] then, but I still followed him, kind of, like an intern doctor in medical centre.*

Doctor Lin describes his experience of learning abroad:

> *I went to South Korea to learn ... I spent lots of time there. I learned from the doctors there, then I came back to Taiwan and perform operations myself.*

While Doctor Huang put his experience of receiving education provided by some related pharmaceutical companies:

> *A company happened to invest Taiwan (at the time I joined the aesthetic medical field). At that time, they encouraged ophthalmologists to receive education and learn some treatments … These are part of a set of education course exclusively for the users of their products (drugs) … some doctors are not invited to participate because he/she didn't use that company's products.*

[11] A senior status of doctors, usually it takes 10-12 years to be that for a medical student after he/she graduated from school in Taiwan.

For lacking the formalized training route, the doctors have to make themselves an advantage with their own resources. Although their personalized trainings are the advantages that they can use to struggle, this is not conducive to the self-regulation for the members as a whole. Because the general quality of the services is difficult to be assessed by the self-regulating manner within a field glutted with various learning routes (Freidson, 2001, p. 17). Next, the situation that the power of the cultural capital of the institutionalized knowledge no longer exist (Bourdieu, 1986) also pushes the doctors move away from the self-regulation further.

Knowledge as business secret

Another key figure, which is conducive to the self-regulation, lies in the formalized sharing of knowledge among members for the overall benefit of the organization. According to Freidson (2001, p. 202), this feature that the knowledge is approved and shared among the peers will induce the members belong to same profession to constitute a consciousness community. Meanwhile, this consistent consciousness, as a collective cultural capital, provides a powerful evidence for the medical professionals to prove their capability in providing quality services under self-regulation. However, in the aesthetic medical field, harsh competitions between the doctors, either for financial interests or personal reputation, weaken the belief of the knowledge sharing. As Freidson (ibid., p. 219) pointed out that '*secrecy is anathema to the growth of knowledge and technique, preventing independent testing and validation by other, creating a destructive and divisive form of collegial competition*.' But, taking specific knowledges or skills as business secrets, i.e. as personal capital, to remain competitive is universal in the aesthetic medical field.

Doctor Lin pointed out this trait frankly:

> *The experienced doctor is unwilling to share (his expertise). He is so content in his advantage, why should he teach (share)? As far as I am concerned, some people are willing to spend NTD 500,000 for participating my single surgery ... however, I just don't want to teach others ... because I neither want to take the responsibility of his learning nor to sell the techniques that I have*

learned ... I have gone through bitter processes and experienced lots of complications to have myself mature as I am today, I don't want to sell it.

Doctor Chen also expressed that the self-exploration, rather than been taught by mentor, is commonly seen in aesthetic medicine and stressed that himself was very lucky to have a senior doctor as mentor at the first beginning of his career:

I was lucky. Someone led me at the beginning ... Generally, the training is less standardized (in this field) ... I think some people have advantages because their teacher in medical centre is doing (aesthetic disposals). But, when I was in the (medical) centre, my teacher wasn't. So, I had to learn by myself. Learning by oneself is sporadic and scattered. You may go to learn by yourself or go (pay) to see other people's demos, but it's just a brief visit. Next, you have to explore by yourself.

<u>Intrusion of powerful non-medical outsiders</u>

In addition, various medical symposium, conferences and seminar etc. in the field of therapeutic medicine are both the effective channels for members to receive new knowledge and the opportunities for the publishers to gain reputations. By incorporating these studies into the re-validating assessment of the private issued specialty title as a part of the institutionalized learning, the self-regulatory mechanism can be effectively consolidated. However, in the field of aesthetic medicine, due to the intrusion of non-doctor actors with jurisdiction, (Freidson, 2001, p. 186), especially the instrumental or pharmaceutical businesses, the doctors have been deprived of the authority to formulate institutionalized knowledge. Under the disguise of academic lectures, these intruders turned these occasions, that originally provide advanced education, into commodity exhibitions. This not only reduces the willingness of doctors to participate, but also makes the overall trend of the field move towards commercial operations. It is unfavourable to the generation of self-regulating mechanism because those non-medical actors, who gained dominant positions in the matters related to education, weaken the prestige of the elites within the system and reduce their credibility; and, further, while they

conducting self-regulation, make the fairness of the elites (Baldwin & Cave, 1999) being questioned by other members.

Doctor Huang expressed his reluctance to participate in the educational courses due to the harmful manipulation of the non-doctor actors:

> *A lot of lectures hosted by some aesthetic medical associations are actually the occasions for salesmen to promote their products. I think they are all about marketing. There are relatively few academic gains. In fact, probably more than half of them, are talking only about machines now.*

Doctor Sun also questioned the educational function of the medical association:

> *When I was younger, I would pay to participate (the lectures). Though it is more expensive for non-members, but I am okay … While recently, I rarely gone … there is nothing new. They are all continuously repeated, again and again. If there really is something new, I will read it first in the journal. I don't have to participate these seminar or symposium.*

In summary, there are full of informal learning channels in the aesthetic medical field, which result in the level of the doctors in the field, no matter on skill or knowledge, varied greatly. Although, from the perspective of monopolizing the knowledge, personal capital might be improved to remain competitive in the aesthetic field, the collective promotion of the group as a whole, i.e. the shared reputation as the collective symbolic capital (Noordegraaf & Schinkel, 2011), is sacrificed. This situation is detrimental to the applicability of self-regulation.

5.2. Deficiency of consensus on specific private organization

The state-endorsed specialized organization, which is responsible for the self-regulating tasks, is also an important factor to self-regulation (Freidson, 2001, pp. 141-6). For professionals, externally, this organization acts as a portal, with which the state can communicate; while internally, its existence embodies the self-regulation through the re-stratification within the professional group. Both roles are conducive to stabilize the self-regulation.

In Taiwan, various specialized medical associations act this role. This is a development in line with the accumulation of the professional knowledge and a regular phenomenon that various medical specialties form sub-fields within the boundaries of holistic medical field (ibid., p. 58) while those related and partially overlapped sub-fields, with their own cultural capital, compete with each other (ibid., p. 186). As time progresses, the allocation among overall resources of the whole field are stabilized. Further, the ensued delegation of self-regulation to respective association strengthens this arrangement. That means, the establishment of this single responsible organization, which similarly acts as a portal for aesthetic medicine, become critical point to the feasibility of self-regulation.

A fragmented field

Several factors, which are related to the objective conditions and the conflicts between various existing specialties, hinder the setting of one single responsible organization in the aesthetic medical field. The first critical factor is the fragmented and chaotic status quo of the field. According to the information issued by the state on August 2019, instead of only one, there are more than 12 private self-regulating organizations are related to aesthetic medicine in Taiwan and all of them are legalized to provide training programmes. This fragmented status is detrimental to the creation of a single organization because, according to Freidson (2001, p. 202) it impairs the formation of community consciousness among the practitioners.

Doctor Lin pointed out the diversity from the perspective of the interest-led traits of these organizations:

> *The vision of running an academic association is supposed to improve everyone's ability and reduce complications ... However, the 'wants' of aesthetic medicine could be 'created' ... it's a strategy for amassing more benefits. As I said, when it comes to interests, there is nothing fair. Every association is selfish. The 'created wants' are always monopolized.*

While Doctor Liao also showed his disagreement for setting single responsible organization:

I don't agree with the establishment of single responsible association. I think the mechanism of free market will do better job.

Conversely, Doctor Huang argued the establishment of the responsible organization is helpful to those 'rookie' practitioner:

I think it is necessary to establish such a medical association. Because there are some doctors who want to get started. He (rookie doctor) still needs a general idea at first, like some basic techniques.

These varied perceptions embodied the obstacles for the doctors to reintegrate their varied previous habitus into new one. In other words, the inconsistency among the interviewees is the denial of the self-regulating system shown by the interviewees.

Diversified and scattered knowledge

Besides, extensive scope of the professional knowledges involved in aesthetic medicine are scattered within various already re-professionalized specialties with varied standardized trainings. The idea of the operating approach of identical disposals are different from each other because no unified habitus is shared among the practitioners (Bourdieu & Passeron, 1977; 1979). Hence there are difficulties to encircle all aesthetic disposals within one autonomous professional arena. Although similar situation sporadically occurred in therapeutic medicine, this overlapping is ubiquitous in aesthetic medicine, which makes the specialty categorization under current laws and regulations unable to exert due functions in this field.

Doctor Hsu explicitly expressed his opinions on this aspect:

The scope of medical beauty is very large. Will the training of aesthetic specialist be the mixture of plastic surgery, dermatology, ophthalmology and otolaryngology? I don't think it is possible to have such a comprehensive training to cover all, nor do I think it need to train such all-round doctors.

This points out that it's not only disadvantageous objectively, i.e. one specific specialized training course is impossible to be formulated; but subjectively, the practicing doctors also deem the comprehensive training is meaningless in

application. That means, the establishment of one single responsible organization for managing is a redundant action to these practitioners.

Interest-oriented organizations

The other factor, which involves the conflicts among various specialties in the field of aesthetic medicine, is an even more harsh issue to be handled. In this emerging field, which full of competition and lucrative rewards, specific groups are unwilling to share their advantageous capitals to remain competitive. Like those who have the plastic surgery training background, though this title is of no benefit for them in competition, are always regard themselves the 'only legalized and qualified doctors' to engage in aesthetic disposals, and actively influence the formulation of the relevant laws to benefit themselves with exclusive rights.

Doctor Lin vividly pointed out the very core of this issue:

> *The disputes between plastic surgery and non-plastic surgery are bitter ... Their stances separate widely ... plastic surgeons argued that most operations can only be performed by them (legally) ... To be honest, for other doctors, they are capable to do these operations also. Then, why can you say I am not qualified to do it?*

Omnipresent inconsistency

Moreover, through the interview process, the function of the single self-regulatory organization is always questioned by the interviewees. They believe this organization might be nothing more than a field of power (Bourdieu, 1993, pp. 37-40) to legalize themselves to grasp interests. While the due functions of the professional organization, such as to provide helpful education or to promote overall benefits, are ignored.

Doctor Tsai pointed out the dilemma of the establishment of single responsible organization:

> *I think it is necessary for better managing (by government). However, I find it's difficult on practical level. Because every medical society has political*

power to backup, which means there are interests. If they have money, they will be able to dominate in formulating regulations and provisions.

Doctor Lee put forward opinions on the practical situation:

Does it make any sense even if it is really established? In the past, plastic surgery and dermatology were doing this, but no one joined them except their own member. Even if that unique association is really established, will everyone join and follow its rule? When the interests of those who do not follow the rules are blocked, they will find another way to attain their goals ... it didn't make any sense.

While Doctor Sun expressed more frankly:

Ophthalmology, plastic surgery, dermatology, everyone wants to dominate. So, are they willing to join others? ... You are here to compete with me, then why should I join you and help you to be strong? In my opinion, no one in the world would establish this 'thing'.

These conflicts between the existing related specialties in the field, by defending their own interests for monopolizing the market, result to the decline of consensus among members for generating self-regulatory mechanisms (Baldwin & Cave, 1999; Baldwin et al., 2001). Besides, in terms of the power of the capital, the emergence of the single organization that facilitates the self-regulation is tantamount to reduce personal advantage of some privileged people.

Doctor Tsai vividly described the scruples of these people:

If there are common interests, everyone can stand together. But when everyone's focus is different, it will be difficult. Like many famous medical aesthetic doctors, they are not plastic surgeons, nor any specialists. If they join this specific organization, then their power of speech may be reduced. That's why he is reluctant to (join).

Deterioration from the state

Finally, the state, which is supposed to provide an anchoring point through coercive power, carries out a regulation full of loopholes and making it's common for some doctors to obtain the practicing qualification through relative relaxed routes. This further deepens the inconsistency and distrust among the practitioners.

Doctor Wang put forward his views on this:

> *For example, training period of family medicine is relatively short, it takes only four years. But it may take six to seven years to earn the certificate of plastic surgery… Somehow people just look for easier route and skip necessary trainings ... many doctors will take the shortcut.*

In summary, the respondents expressed pessimism about the establishment of a single responsible organization. Meanwhile, according to the interviewees, not only practically the institutionalized comprehensive education is impossible, the bitter struggle among various specialties also complicates this situation. This condition weakens the justification of the ensued self-regulation because the re-stratification (Freidson, 2001, pp. 83-4) in the field is hardly to appear. Moreover, this deficiency of one specific organization makes the state has no portal to communicate further prohibits the state from delegating self-regulation to the practitioners.

5.3. Habitus in aesthetic medicine

5.3.1. *Commercial practices as new capitals*

According to Bourdieu (1991), capital is one's resources, both material and immaterial, for one to struggle upwards in a specific field. The devaluation of the economic capital by the better-than-average remuneration, which is backed by the state, in therapeutic field, motivates the professionals to compete for the reputation among their peers rather than selling their professional labour just for living (Freidson, 2001, p. 203). Hence, the room for commercialism to operate in the therapeutic medical field is restricted. Practically, to promote the social status of the professional groups as a whole, the *'professions attempt to limit potentially divisive economic competition among their member by promulgating rules designed both to temper the spirit and substance of intra-professional competition.'*

(Freidson, 1994, p. 175), while this collective promotion of the group reversely acts as a symbolic capital to the members (Noordegraaf & Schinkel, 2011). Current situation of the therapeutic medical field in Taiwan follows this suit. Within it, the agents comfortably struggle for the cultural capital under a habitus of collective, enduring and disciplinary manner (Bourdieu, 1977, p. 84) of the self-regulation.

<u>*Economic capital*</u>

In aesthetic medicine, this privileged economic interest from the state no longer exists. The consumers must self-financed to receive the medical services and bureaucratic system excludes these treatments from the claim of the state-run health insurance system. From political view, this approach offers the effective means in regulating country's overall limited medical resources. However, this preclusion results in losing the power of the economic incentives that can be utilized to strengthen the self-regulation; hence the neoliberal economic model, which is based on the consumerism, could permeate into and dominate this emerging field (Lupton, 1997; Conrad, 2005). That means, economic capital regains its value to be competed for (Bourdieu & Wacquant, 1992, pp. 105-7) in aesthetic medicine.

Doctor Wang concisely pinpointed out the reasons for entering the aesthetic medical field and the eager to be an entrepreneur resolutely:

> *It certainly about financial rewards! It's my 'own' clinic.*

Doctor Tsai also put forward his paradoxical experience for investing in aesthetic medicine:

> *Will I miss my previous identity (as an attending plastic surgeon in medical centre)? Yes, sometimes I do. However, my current income and life quality are really incomparable (better) with the previous ones.*

While Doctor Lin put forward an implicit but affirmative statement:

> *Because, you know, the health insurance (in terms of doctor's remuneration) is not good (to doctors) in Taiwan. In the self-financed market, it will be better.*

For the doctors, the attachment to the state guaranteed incomes is decreasing. Instead, they move towards a field to look for better economic rewards, although new capitals are needed in this field.

Departing from the therapeutic medical habitus

Viewed from another aspect, the practitioners invest into an emerging field where the academic-oriented habitus is changed due to the ubiquitous harsh competition while the cultural capital used previously to compete in the therapeutic field has diminished its value. And most importantly, the trend within the aesthetic medical field goes against the development of the self-regulation, because no collective promotion could be expected (Freidson, 1994, p. 157). Moreover, both the demanding academic pressures and the annoying hostile struggles between factions in therapeutic medicine, which are the avatar of the medical habitus, also make the practitioners to switch their runway. According to Bourdieu (1977, pp. 83-4), it is a breakaway from the previous self-regulating medical habitus.

Doctor Lee vividly described the dilemma he faced:

> *There is heavy stress in the medical centre. The regulations require you to submit two SCI thesis each year. I don't have such expertise about that. I think myself am more clinical prone … in medical centre, most of time you just work (do the research or write article) for your mentor but not yourself.*

While Doctor Wang accounted his disgust to the scramble for resources between the factions that commonly seen within medical centre:

> *I really don't like the atmosphere of the struggle between factions in the medical centre. So, my initial setting was to leave medical centre one year after I fetched my specialty certificate.*

Because they are tired of the habitus in the therapeutic field, they complied themselves with the habitus in the new field, i.e. adjusted themselves towards commercialism, to survive.

New habitus in aesthetic medicine

Therefore, in the aesthetic medical field, the doctors draw on other means, such as commercial practices (Rufai & Davis, 2014), to remain competitive in the struggle for economic capital. The interviewees collectively agreed that the advertising is an inevitable and useful strategy at the first beginning of their investing in aesthetic medicine, because under the deficiency of any former reputation and the consumer's negligence about their academic background, commercial propaganda is an efficient strategy.

Doctor Sun proposed his reason for this manipulation:

> *You may rely entirely on words of mouth (in running business). But, will it work in this era? … even a website of such a high visibility as "Mobile01" (a well-known on-line forum in Taiwan) has to buy ads on Facebook, while our own popularity cannot be compared to it … what will people think of when they mention about you? This is very important. You got to have a special feature that allows people to recognize … I happen to be a plastic surgeon, I mean, I am a skilful person, so, I entitled myself "the aesthetic craftsman."*

Doctor Lin proposed similar opinions:

> *they (the disposals of aesthetic medicine) are "developed" need. It is a self-financed market. Patient does not have to be treated and all the surgeries and disposals are elective. So, how do you make patients come and receive treatment? This requires advertising and marketing.*

Doctor Wu denote the commercial tint of aesthetic medicine directly:

> *(In aesthetic medicine) lots of clinics are run by merchants. Of course, they will operate by commercial practices … Some medical clinics alwyas encourage customers to receive disposals as soon as they enter the clinics … for the purpose of making money.*

Involvement from the semi-professional outsider

In addition to advertisements, another commercial manipulation that is commonly seen is to insert a semi-professional role, i.e. the consultant, between the patient and the doctor to carry out the promotion and inflict the 'inherited' symbolic violence

on the consumers (Bourdieu & Wacquant, 1992, pp. 110-3). In this way, the advertising effect could be multiplied because the doctors' prestige can be retained as a symbolic capital (ibid.) as it was in the therapeutic field. However, this trick might be a double-edged sword to the practitioners. On personal level, this may retain the doctor's personal symbolic capital; however, the justification of the self-regulation for the whole members, which is based on the group's quality-assurance, become debatable.

Doctor Wang described this division and cooperation:

> *We hire consultant in our clinic … it's quite natural for her to tout about our doctors.*

Doctor Wu elaborated the deviation towards commercialism in the aesthetic medical field:

> *Some (clinics) are dominated mainly by consultants … they are all trained to be skilful in promoting. They are very good at selling things. Once consumers come in (clinic), they will be encouraged to buy a lot of commodities (treatments and related material products) ... of course, it is good for business, right? … Sometimes, they (consultants) will push doctors to implement the disposals they already sold. So, if doctors are interest-oriented, then they (consultant and doctor) are complementary with each other.*

Commercialized academic titles

Except the advertisement, packaging oneself with piles of academic titles are deemed another commercial marketing trick in the name of professionalism by the interviewees. It is believed that these manipulations, which act as symbolic violence (Bourdieu & Wacquant, 1992, pp. 110-3), might be powerful tricks to lay people in the aesthetic medical field, while for these professionals, this packaging instead highlights the disadvantaged position of those actors for their lacking something basic.

Doctor Lin expressed his views:

Participating in those societies? I think it's actually for advertising only. The more associations I join, the more senior I seems to be, right? ... it's very convincing ... to outsiders.

Doctor Wang disdained explicitly:

He collects these stamps (of various relevant associations) merely to prove that he is also a qualified doctor.

In summary, the operation of commercialism has become a unanimous linkage in the managing practices and the competitiveness for these practitioners in the aesthetic medical field. This trend decreases the justification of the self-regulation of aesthetic medicine in terms of the collective promotion (Freidson, 1994, p. 175). Inevitably, any capital jointly owned by the group loses its value in the field of aesthetic medicine where the members compete fiercely with each other. For survival, the doctors have no choice but draw on the commercial manipulation for improving personal competitiveness. While for the state, this situation makes it difficult to treat these practitioners as a whole and appoint the elites within to conduct self-regulation because there are full of conflicts of interests.

5.3.2. *Inconsistency on specialist credential as symbolic capital*

In self-regulating system, the regulated must share consistency in generating and operating the system to ensure its function won't be truncated (Baldwin & Cave, 1999; Baldwin et al., 2001). The existing specialties system in therapeutic medicine in Taiwan follow this suit. In Bourdieu's words (1990, pp. 120-1; 1986), the institutionalized specialist titles, which are issued by the self-regulating organization, are powerful cultural and symbolic capitals in therapeutic medicine; while to the patients, these credentials, according to Freidson (2001, p. 79), are useful market signals because in professionalized domain, which is based upon esoteric knowledge, the trustworthy signal is needed to reduce the probability of failure in choosing services. Both of them could be regarded as powerful evidences for the success of the doctors' self-regulation. However, this is not necessarily the case in aesthetic medicine.

Devalued specialty title

General public often intuitively equates plastic surgery as aesthetic medicine. However, whether this connection could exert influence, even a specious one, on this particular consumer group, so that the practitioners might deem this certification of plastic surgery a workable market signal, or, a symbolic capital, for them to be privileged, is debatable.

Doctor Lee, a doctor with such a background, hold an uncertain attitude towards this perception and put forwards his feelings:

> *Actually, title of plastic surgeon has no special appeal (to the customers). I think ordinary people seem to think the title "beauty specialists" that shown in the advertisements of pharmaceutical companies are more powerful.*

Doctor Chen has similar opinions:

> *In terms of competitiveness, the title of plastic surgeon is actually not as advantageous as imagined. It seems that your business will be better than the average clinic for holding the certification of plastic surgeon, I don't think it's true. …… In terms of the patient's choice, I think the difference is not so obvious.*

In addition, the consumers' arbitrary judgments of the results, which based on personal feelings, further depress the doctors on the psychological level and make them believe that the specialty certification as credit (Bourdieu, 1992, p. 120) weights far less than the patients' feelings.

Doctor Lin shared his experience:

> *I don't think there is any difference (for holding the title of plastic surgery specialist or not), because, in fact, customer still judge by whether you can perform the disposal or not ... and most importantly, it is your works decide everything. So, I think it seems superficially there is difference, but there is not essentially ... for a very famous doctor, who cares what specialty he graduated from? Besides, you may be a certified plastic surgeon, but you just cannot operate at all and have nothing (works) to show, then you are nothing.*

Doctor's persistence in specialty training

Contrast to the powerlessness in facing consumers' arbitrary judgments, on the experiential and knowledge level, the plastic surgeons are still full of honour, confidence and superiority. They believe that the specialty training does provide them a solid foundation of knowledge and skills to be relatively dexterous in handling the demands of consumers. In other words, they still hold the training a valuable asset and deem it a powerful cultural capital because they are benefited from the specific reputable self-regulating organization (Bourdieu, 1990, p. 121).

Doctor Tsai expressed this stance proudly:

> *In terms of surgical techniques and the application of (soft) tissues, I think the training of plastic surgery has helped me quite a lot. Because, for both surgery and treatment, I can proudly say that we (plastic surgeons) are certainly familiar with soft tissues all over human body.*

Doctor Wang stated even more practically about their 'legalized' status:

> *Because we are ministry-endorsed specialists, our professional training is very solid. You know in this industry some paediatricians are performing operations, and some physiatrist are also performing. But when we see some of their finishing touches, we can tell that their basic trainings are insufficient.*

Doctor Liao also showed his confidence and said:

> *I am glad to let patients know about my original training background (of plastic surgery). It is a boost in most aesthetic medical scenarios.*

Chaotic appraisal to specialty training

Obviously, the appraisal of the specialty of the plastic surgery is bifurcated among the practitioners, according to whether it is viewed from the angle of the market function or the professional ability. However, if the scope of the specialty training is expanded to cover all kinds of specialists, the situation will be more complicated. Generally, it is believed that the specialty training not only aims at the unique skills for some specific field, but also enhances the doctor's ability to handle all relevant

medical complications. In other words, it is deemed by the practitioners as the prerequisites of becoming a 'legitimate' doctor.

Doctor Wu propose his opinion on the necessity of specialist training profoundly:

> *Since it's a state-endorsed specialized department, you must be trained in a large hospital (medical centre), right? So, you will be familiar with whole hospital, whether it is medical or surgery, ... However, you join (aesthetic medicine) as early as you graduated (from school), and you only perform Botox (injection) ... Why do you want to study in medical school for such a trivial trick? ... Of course, you can devote to aesthetic medicine as soon as you want, and you can do well if you really, really concentrate. But after all, you haven't experienced a lot of complications, nor you are honed to deal with most of relevant issues, then it is difficult for you to handle anything unexpected.*

But, to those doctors, who want to invest in aesthetic medicine directly after graduated from school, the specialty training is an unnecessary process, because the prime agents in the field, i.e. the customers, don't think the specialty title an effective market signal. Hence, this negation from the customers provides these doctors a justification to escape, or devalue, these trainings. Furthermore, their deficiency of the training of specialty also equates to the shortage of the medical habitus of the therapeutic field (Bourdieu & Passeron, 1977; 1979).

Doctor Lee put his opinions towards this:

> *They skip these trainings because they think these trainings are not important, so, they go outwards directly (after graduated from medical school and join aesthetic medicine). Those people just look at the return of business performance (and focus on the economic benefits).*

Doctor Wang also shows his views:

> *... their learning stops at the moment of graduating from medical school and had not been trained in specialist system. They ... are not complete trained and without experience in dealing with various complications. They are very*

lacking (in everything) ... it requires in-depth training before you become a complete doctor.

Doctor Sun put his stern views explicitly:

Now, many, many young doctors, after they get PGY[12] *training, they hop into aesthetic medicine. They have never been resident (doctors) ... All they want is making big money.*

<u>*Adverse impact from the state*</u>

Besides, current regulation, that take the doctor's identity as the only prerequisite to practice in the aesthetic medical field, also has adverse impact to the power of specialty title. That means, the law[13] not only fails to achieve the purpose to restrict the operator's qualifications, but also makes the specialist system more devalued within the aesthetic medical field by explicitly stipulating various specialties are qualified to conduct identical intervention. Superficially, through legal intervention to re-posit the agents, who have different cultural capitals, on an equal basis and let them compete for economic capital freely (Freidson, 2001, pp. 137-41), the state further deteriorates the self-regulating mechanism; while essentially, due to the state blocks the conversion mechanism to work in the aesthetic medical field (Bourdieu, 1993, p. 164) by intensifying statutory involvement, the value of this cultural capital is reduced.

Doctor Lee put his opinions on this chaos results from the intervention of law:

At least it (the Regulations Governing the Application of Specific Medical Examination Technique and Medical Device) introduce some restrictions ... But it also has lots of loopholes. Basically, I think it provide no control at all. However, at least for those who have not yet stepped out of the (medical) centre, there may be a little more time for them to consider. But for those who are already in the field, it makes no difference to them.

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[12] A legalized and formalized process of medical education for students who are just graduated from school in Taiwan. It is a prerequisite for students to apply for any specialty training.

[13] Regulations Governing the Application of Specific Medical Examination Technique and Medical Device.

This further enlarges the inconsistency of the acknowledgement on the specialty title as a symbolic capital (Bourdieu, 1990, p. 121) due to the inclination towards personal benefits rather than collective credits of the members. Hence, the perception that specialist training is optional but not necessary for practicing in aesthetic medicine becomes a convincing fashion.

Doctor Hsu expressed his attitude towards this issue:

> *It's OK for those weird (non-surgical related) specialties to participate in this field ... I think they should be OK if they feel confident.*

Doctor Lin put similar views:

> *I won't object (the participation of those doctors with non-surgical related specialty), that is to say, not only dermatology or plastic surgery can perform these (aesthetic) treatment. I think everyone can do it ... I hold positive attitude toward this issue.*

Obviously, except to the consumer's intervention degrades the self-regulation in the field of aesthetic medicine, the legal power also compressed the space that the self-regulation can operate. That means, internally these practitioners lack consensus towards the training of specialty and this lacking is deteriorating to self-regulation; while externally it's even more difficult for the professionals to be delegated to self-regulation by the state because the practitioners show no unified belief in the already concretized self-regulating mechanism, i.e. the specialty system.

5.3.3. *Decreasing commitment towards medical ethics*

According to Bourdieu (1977, p. 83), habitus makes the agents incline to show similar disposition in different fields. Therefore, the habitus, which is built through the process of socialization in university and medical centres, allows the junior doctors to maintain the same tendency, quality and preference for doing things in the future (Bourdieu & Wacquant, 1992, pp. 123-6; Olsson, Kalén & Ponzer, 2019). Although the awareness of the medical ethics are enlightened through standardized education in university, the training process of becoming a specialist is even more

critical to the younger generation for the cultivations of the medical habitus and the adherence to the medical ethics because by learning through the cooperation and supervision between peers, the younger generation accustomed themselves to become rational and legitimate doctors (Bourdieu & Wacquant, 1992, p. 129; Brosnan, 2014).

Besides, according to Freidson (2001, pp. 214-5), the professional knowledge and skills do not inherently have power, instead, the "*professionals gain their protected status by a project of successful persuasion, not by buying it or capturing it at the point of a gun.*" In other words, the professionals gain the trust of the state by clearly appealing to medical ethics and then, retain autonomy in self-regulation. While facing the outsiders questioned their priority in conflicts of interests, the explicit declamation of professional ethics is used to defend that they won't benefit themselves even they are self-regulated. Therefore, Freidson (ibid.) proposed whether the self-regulation is acceptable by the general public depends on the doctors' commitment to medical ethics, and strongly advocated the legitimation of the self-regulating system, ultimately, must rely on the persistence of medical ethics.

Diluting effect from the 'half-done' doctor

To the interviewees, those doctors who have only received the education in university then immediately join aesthetic medicine after obtaining the statutory identification of doctor, are deemed as 'half-done' in terms of the habitus of the therapeutic field (Bourdieu & Wacquant, 1992, p. 129; Brosnan, 2014). Explicitly, this deficiency is shown in their poor technic abilities in handling medical issues; while implicitly, the cultivation of their awareness to medical ethics is also regarded relative scarce.

Doctor Chen expressed opinions about the correlation between the environment throughout specialty training and the medical ethics:

> *It always has something to do with the background (of your training). You come from this environment, seriously, it's not easy for you to change too much (of the adherence to the ethics).*

In fact, the join of considerable amount of the non-specialist agents in aesthetic medicine have great impacts on the aesthetic medical field and inevitably makes a diluting influence on the habitus that inherited from the therapeutic field, then lowers the justification of the self-regulation (Freidson, 2001, pp. 214-5). Even if some members insist on following the professional ethics, this dilution somehow weaken this commitment shown by all members.

Doctor Wang expressed the influence of this trend worriedly:

> *This ratio is getting higher and higher. Many people enter this market even without graduating from PGY. They pour scorn on the idea of specialist training ... they just want to make money ... Of course, there might also be some people who want to perform surgery and make money after accomplishing specialist training. But, at least, we are equipped with solid and standardized trainings. We well understand which parts (tissues) can be touched (incised or removed) and which cannot ... But, if you don't have this kind of training, what you see is only money.*

While being asked, 'Will the commitment to the medical ethics to be less in those who has not been trained in a medical centre and joined directly in aesthetic medicine?'

Doctor Lee put his affirmative answer:

> *I believe it is for sure ... if this boundary (of ethical considerations) within their mind is obvious, then they won't be so eager to skip (specialist training) at the first beginning.*

Doctor Sun have similar view on the 'eccentric' young generation:

> *Now many young doctors, after they got (accomplished) PGY training, they participate aesthetic medicine immediately. They have never been a resident. They also have no idea about medical ethics ... For them, medical ethics has no restraint (as soft law). I think they are much worse than the previous ones. Of course, there were also someone outrageous in the past, but at least they dare not to be so presumptuous. Now everything (outrageous) is there.*

Changed medical habitus

According to Bourdieu (1977, p. 83), habitus is the homologous relationship and the unifying principle of the activities of the agents existing in different fields. However, due to harsh commercial competition and overall dilution of the commitment to medical ethics, which are both intensified by the 'half-done' doctors' join, the original medical habitus is forced to change in the aesthetic medical field. Callings from the medical personnel for seriously addressing the ethical issues provide evidences for this trend (Marchac, 2007; Ferreira, 2005; Atiyeh, Rubeiz & Hayek, 2008). Likewise, the concise answer '*No*' provided by the interviewees while being enquired about whether medical ethics is an important binding force in the aesthetic medical field, also embodies this change of the medical habitus.

Doctor Lee put forward his worry about himself:

> *The longer you stay in the field, the more the hue of medical ethics will gradually be faded away ... I still uphold medical ethics because, maybe, that I have not being joined this field long enough.*

Doctor Chen hold similar view, though he regarded himself a doctor with highly ethical adherence. While being asked 'Is medical ethics emphasized by those who are trained in medical centre under apprenticeship?', he expressed the subtle shift:

> *At least I think there will still be a little influence. However, some people may not treat it seriously. Perhaps the influence of the market is greater than the influence of medical ethics.*

This movement weakens the justification of self-regulation in aesthetic medicine, no matter from the perspective that this system must ultimately resort to medical ethics or the adherence to the professional "ideologies" (Freidson, 2001, pp. 105, 122-3), or in terms of the habitus that are no longer identical in the therapeutic field as Bourdieu proposed (1977, pp. 83-4). Faced with the fact, the practitioners turned to seek more powerful means, i.e. the coercive power of the law from the state, to further involve in this field, so that they can attain the legalized dignity of the professionals, rather than follow the accustomed self-regulating mode.

Doctor Hsu put his opinions:

> *So as long as I make sure that I haven't violated the law, I don't care about the rest.*

While Doctor Sun made a brief but affirming note of this situation:

> *You cannot expect to use medical ethics to effectively regulate everyone (in the field of aesthetic medicine).*

6. Conclusion and future works

6.1. Research questions answered

The aim of this thesis is to investigate the feasibility of adopting the self-regulation in the aesthetic medical field in Taiwan. For fulfilling this aim, three research questions were proposed. After completing the analysis and discussion of the gathered empirical data, these aforementioned research questions are answered below.

> RQ1: *How do doctors view the role and function of the medical knowledge in aesthetic medicine?*

Based on the results, the researcher found that the role and function of the esoteric knowledge, which is the preliminary elements of the professionalism and acts as both a powerful cultural capital and symbolic capital to maintain the difference between different classes in therapeutic medicine, are deemed impaired in aesthetic medicine by the practicing doctors. Because it is weak in deciding the success of the disposal in aesthetic medicine and the other powerful actors, i.e. the consumers, no longer passively receive the medicalized scale in their active judgement to define beauty. Instead, personal elusive psychological feelings become the dominant factor in deciding the quality in this field. That means, the knowledge is no longer a powerful capital to exert influence in aesthetic medicine because the conversion mechanism does not work.

Besides, mainly because objectively the knowledge involved in the field is too complex, there are full of scattered and extremely personalized learning channels rather than the formalized and institutionalized educational system. That means, the mechanism used in the therapeutic medical field, as shown by the re-stratification (Freidson, 1984; 1985) in which the medical elites have strengthened the self-regulation through the institutionalized educational system, such as the specialty training, barely exists in the aesthetic medical field.

RQ2: *How do doctors consider the establishment of one private professional organization to be responsible for self-regulation?*

Based on the results, the researcher learned that there is lots of inconsistency among the members to the establishment of a single responsible organization to be responsible for the self-regulating tasks in the aesthetic medical field. First of all, the interviewees hold varied, even contrasting, opinions to the necessity of the establishment of this organization. Generally speaking, they did not believe that the existing medical organizations, which are more than 12 and relevant to the provisions of the training courses, could actually provide any educational function, that are supposed to have, to meet their needs and promote the group's status. On the contrary, the practitioners deem that the purpose of these organizations is only for interests, no matter to personal or specific interested sub-group.

Next, the setting of holistic training under a single specific specialty to cover all aspects of relevant aesthetic disposals are deemed impractical by the interviewees because there is neither suitable existing facilities nor need to train all-round doctors to do so. Besides, the situation that these practitioners, especially between the doctors with and without the training background of the plastic surgery, hold a general attitude of despising to each other, because the former, those who are situated at the already privileged stance, want to be backed by the power of the law to exclude the rights of other doctors to practice, further impairs the consensus among the members.

RQ3: *How do doctors view the impacts on the competitions, the specialty credit and the ethical consideration, which are resulted from the changes of culture in aesthetic medicine?*

Based on the results, the researchers identified that the practitioners believe that the changes in culture in the aesthetic medical field have caused the original academic-oriented habitus, which is long adopted in therapeutic medicine both by the medical profession and the general public, is no longer applicable; hence they must turn to commercial practices and accustom themselves towards harsh competition to remain competitive, while this situation reversely moves the habitus in aesthetic medicine to commercial practices, such as enticing advertising manipulation or the accumulation of quasi-academic titles, even more.

Next, the training of the existing specialty system, which issues the specialty title and is the avatar of the self-regulation in therapeutic medicine, is viewed as an optional process for them to survive by the interviewees, because its function as the effective market signal is impaired in the aesthetic medical field.

Finally, due to the increasing number of those doctors who never received the therapeutic medical clinical trainings, i.e. the specialty training, in the field, the habitus of aesthetic medicine is highly commercialism-tinted and the general adherence to the medical ethics among the practitioners is diluted.

6.2. Conclusion: A field which self-regulation is unfeasible

Summing the answers of these RQs, the researcher puts forward a concise conclusion that in aesthetic medicine it is fundamentally difficult to follow the adoption of the self-regulation as in the field of therapeutic medicine; while the intensifying of bureaucratic intervention for promoting the consumer's safety and retaining the doctor's technical autonomy, which is in line with the legal system adopted in Taiwan, will be a plausible countermeasure.

To be more detailed, the situation that there are various inconsistencies among the members within the aesthetic medical field is the first obstacle that hinders the formation of the self-regulatory system from the very beginning. Next, the aesthetic

medical field has unique habitus, especially those related to commercial practicing, that is different from the counterpart in therapeutic medicine and the nature of the capitals that the doctors can use within the field are also distinct. It decreases the legitimacy of applying the self-regulatory management system to the field. Furthermore, the elementary requirements for maintaining the necessity of the self-regulating management such as the esoteric knowledge and the specialty credential lose their power as capitals in the aesthetic medical field is another deciding reason. Although it is believed that the doctors have to retain considerable autonomy to make correct decisions technically as expected, in the field of aesthetic medicine the justification of overall retaining of the autonomy as that in therapeutic field is untenable. Finally, the distinct habitus in aesthetic medicine also makes the application of self-regulating manner unfeasible.

Therefore, the researcher argued that if the self-regulating mechanism is to be adopted in the field of aesthetic medicine in Taiwan, at least for now, its scope has to be restricted and the legal intervention should be intensified. In other words, according to Freidson (2001; 1994), when the feasibility of the self-regulatory management declines, in order to meet the practical demands, the managing mechanism will move to the other two directions, i.e. either free market or bureaucratic control; while the latter is a plausible choice for its compliance with the civil law system adopted in Taiwan.

6.3. Future works

Due to the limited time and number of research samples, as well as the identity of the research object, some important issues related to the regulation of aesthetic medicine have to be discarded in this paper. Therefore, the researcher here proposes several suggestions for the researchers who are interested in conducting research in this area as a reference.

First of all, it is recommended to limit the research object to the doctors who have only received university education but not received any specialty training. Because, as found in this paper, the difference between their habitus and those in the field of therapeutic medicine is a factor that may cause a decline in the adherence to medical

ethics, and thus make the self-regulatory management lose its justification. Moreover, the fact that the number of the actors with this status is gradually increasing make it an issue necessary to be studied. However, there is neither specific research on the doctors with this identity nor any about their situated opinion is discussed, which causes an academic gap in the professional legal management of the aesthetic medical field. Therefore, the researcher suggests that future research can move in this direction.

Secondly, the consultant, who never exists in therapeutic medicine, could be another candidate of further research. In the field of aesthetic medicine, in addition to the doctors and the consumers, the omnipresent consultants in various clinics is another identity that might be powerful to affect the behaviours of the doctors and the consumers throughout the treatment process. However, under current situation in Taiwan, there is neither specific law nor official stipulation to regulate their qualifications, certifications and work contents, nor there is law regulates the relative responsibilities and penalties of the services provided during the disposal. Due to the limitation of time and space, this paper cannot discuss this identity too much. But, for the field of aesthetic medicine to be fully managed to maintain consumer's safety, the research on the consultants is necessary.

Finally, a further quantitative research on this issue is feasible for those researchers who have better time and financial resources that beyond the scope of this study. Taking this study as a piloting research, the approximate issues that the practicing doctors in the field of aesthetic medicine concern about have been achieved to a clearer outline. Therefore, it is less obstructive to design a precise questionnaire that can be used in a quantitative study to analyse the behaviour of practitioners more accurately. In that, the respondent's willingness to answer the questionnaire can be improved because of the lean and concise formulation. This makes it more feasible for the researchers to conduct large-scale study and then carry out quantitative analysis and discussion. Moreover, this transition from qualitative analysis to quantitative research can, on the one hand, retain the bottom-up research design that observed from the perspective of the regulated doctors; while on the other, more

quantitative information can be obtained for generalization and inference of the study result and make the research more credible.

Reference

Abbott, A.L. (1991). The Future of Professions: Occupation and Expertise in the Age of Organization. *Research in the Sociology of Organizations, 8*, 17-42.

Adams, J. (2013). Medicalization and the Market Economy: Constructing Cosmetic Surgery as Consumable Health Care. *Sociological Spectrum, 33*(4), 374-89.

Atiyeh, B., Rubeiz, M., & Hayek, S. (2008). Aesthetic/Cosmetic Surgery and Ethical Challenges. *Aesthetic Plastic Surgery, 32*(6), 829-39.

Baggott, R. (2002). Regulatory Politics, Health Professionals, and the Public Interest. In Allsop, J. and Saks, M. (Eds.), *Regulating the Health Professions* (pp. 31-46). London: Sage.

Baldwin R. and Cave, M. (1999). *Understanding Regulation: Theory, Strategy and Practice*. Oxford: Oxford University Press.

Baldwin, R., Hutter, B. & Rothstein, H. (2001). *Risk Regulation, Management and Compliance: A Report to the BRI Inquiry* (unpublished report).

Balmer, D. F., Devlin, M. J., & Richards, B. F. (2017). Understanding the Relation Between Medical Students' Collective and Individual Trajectories: An Application of Habitus. *Perspectives on Medical Education, 6*(1), 36–43.

Bismark, M.M., Gogos, A.J., McCombe, D.B., Clark, R.B., Gruen, R.L., & Studdert, D.M. (2012). Legal Disputes Over Informed Consent for Cosmetic Procedures: A Descriptive Study of Negligence Claims and Complaints in Australia. *Journal of Plastic, Reconstructive & Aesthetic Surgery: JPRAS, 65*(11), 1506-12.

Blum, V.L. (2003). *Flesh Wounds: The Culture of Cosmetic Surgery.* Berkeley, California: University of California Press.

Bourdieu, P. (1997). The Forms of Capital. In A. H. Halsey et al. (eds.), *Education: Culture, Economy, and Society* (pp. 46-58). Oxford & New York: Oxford University Press.

Bourdieu, P. (1993). *The Field of Cultural Production: Essays on Art and Literature.* Cambridge: Polity Press.

Bourdieu, P. (1991). *Language & Symbolic Power* (G. Raymond & M. Adamson, Trans.). Cambridge, UK: Polity.

Bourdieu, P. (1990). *The Logic of Practice.* Stanford, California: Stanford University Press.

Bourdieu, P. (1986). The Forms of Capital. In J. G. Richardson (ed.), *Handbook of Theory and Research for the Sociology of Education* (pp. 241-58). New York, NY: Greenwood.

Bourdieu, P., & Passeron, J.-C. (1979). *The Inheritors: French Students and Their Relation to Culture.* Chicago: University of Chicago Press.

Bourdieu, P., & Passeron, J.-C. (1977). *Reproduction in Education, Society and Culture.* London: Sage.

Bourdieu, P., & Wacquant, L. J. D. (1992). *An Invitation to Reflexive Sociology.* Cambridge, UK: Polity Press.

Bray, Z. (2008). Ethnographic Approaches. In Porta, D. and Keating, M. (eds.), *Approaches and Methodologies in the Social Sciences: A Pluralist Perspective* (pp. 296-315). Cambridge: Cambridge University Express.

Brosnan, C. (2014). Medical Education and Pierre Bourdieu. In William C. Cockerham, Robert Dingwall and Stella R. Quah (eds), *The Wiley Blackwell Encyclopedia of Health, Illness, Behavior, and Society*, 1361-6. Chichester, UK: John Wiley & Sons, Ltd.

Brosnan, C. (2010). Making Sense of Differences between Medical Schools through Bourdieu's Concept of 'Field'. *Medical Education, 44*(7), 645-52.

Bryman, A. (2012). *Social Research Methods*, *4th ed.* Oxford: Oxford University Express.

Campbell, A.H., & Glass, K.C. (2001). The Legal Status of Clinical and Ethics Policies, Codes, and Guidelines in Medical Practice and Research. *McGill Law Journal, 46*(2), 473-89.

Carlhed, C. (2007). *Medicinens lyskraft och skuggor: om trosföreställningar och symbolisk makt i habiliteringen 1960-1980* (The Glow and Shadows of the Medicine: Doxa and Symbolic Power in the Area of Services to Young Children with Disabilities 1960-1980). Dissertation, Uppsala University.

Cohen, H.S. (1973). Professional Licensure, Organizational Behaviour, and the Public Interest. The Milbank Memorial Fund quarterly. *Health and Society, 51*(1), 73-88.

Collyer, F. M., Willis, K. F., Franklin, M., Harley, K., & Short, S. D. (2015). Healthcare Choice: Bourdieu's Capital, Habitus and Field. *Current Sociology, 63*(5), 685-99.

Conrad, P. (2005). The Shifting Engines of Medicalization. *Journal of Social and Health Behavior, 46*(1), 3–14.

Denscombe, M. (2011). *The Good Research Guide: for Small-scale Social Research Projects. 4th ed*. Berkshire: Open University Press.

Collier, R. (2012). Professionalism: The Privilege and Burden of Self-Regulation. *CMAJ: Canadian Medical Association Journal (journal de l'Association medicale Canadienne), 184*(14), 1559-60.

Cruess, S.R., & Cruess, R.L. (2008). Professionalism and Medicine's Social Contract with Society. *The Virtual Mentor: VM*, 6 4.

Cruess, R.L. (2006). Expectations and Obligations: Professionalism and Medicine's Social Contract with Society. *Perspectives in Biology and Medicine, 51*, 579-98.

Damaška, M. R. (1986). *The Faces of Justice and State Authority: A Comparative Approach to the Legal Process.* New Haven: Yale University Press.

Davis, K. (1995). *Reshaping the Female Body: The Dilemma of Cosmetic Surgery.* New York: Routledge.

Dull, D., & West, C. (1991). Accounting for Cosmetic Surgery: The Accomplishment of Gender. *Social Problems, 38*(1), 54-70.

Edmonds, A. (2013). Can medicine be aesthetic? Disentangling Beauty and Health in Elective Surgeries. *Medical Anthropology quarterly, 27*(2), 233-52.

Edmonds, A. (2007). 'The Poor Have the Right to Be Beautiful': Cosmetic Surgery in Neoliberal Brazil. *The Journal of the Royal Anthropological Institute, 13*(2), 363-81.

Ensler, E. (2004). *The Good Body.* New York: Villard Books.

Featherstone, M. (1991). ‘‘The Body in Consumer Culture.’’ In M. Featherstone, M. Hepworth, & B. S. Turner (ed.), *The Body: Social Process and Cultural Theory* (pp. 18-33). Thousand Oaks, CA: Sage.

Ferreira, M. (2005). Who Is in Control of Aesthetic Surgery? *Aesthetic Plastic Surgery, 29*(6), 439-440.

Fraser, S. (2003). The Agent Within: Agency Repertoires in Medical Discourse on Cosmetic Surgery. *Australian Feminist Studies 18*, 27-44.

Freidson, E. (1983). The Reorganization of the Professions by Regulation. *Law and Human Behavior, 7*, 279-290.

Freidson, E. (1984). The Changing Nature of Professional Control. *Annual Review of Sociology 10*, 1-20.

Freidson, E. (1985). The Reorganization of the Medical Profession. *Medical Care Review 42*, 11-35.

Freidson, E. (2001). *Professionalism: The Third Logic*. Chicago: University of Chicago Press.

Gimlin, D. (2000). Cosmetic Surgery: Beauty as Commodity. *Qualitative Sociology, 23*, 77-98.

Griffiths, D., & Mullock, A. (2017). Cosmetic Surgery: Regulatory Challenges in a Global Beauty Market. *Health Care Analysis 26*(3), 220-34.

Harris, J. (2017). It Is Time to Cancel Medicine's Social Contract Metaphor. *Academic Medicine, 92*(9), 1236-40.

Ihlen, Ø. (2018). Symbolic Capital. *The International Encyclopedia of Strategic Communication*. ([online] Available at: https://onlinelibrary.wiley.com/doi/epdf/10.1002/9781119010722.iesc0190 [Accessed: 30 April 2020]).

Keogh Report: Review Committee, *Review of the Regulation of Cosmetic Interventions: Final Report*. (Department of Health, 2013).

King, N. (2012). Doing template analysis. In Symon, G. & Cassell, C. (ed.), *Qualitative Organizational Research: Core Methods and Current Challenges* (pp.426-50). London: Sage.

Kmietowicz, Z. (2014). Surgeons Condemn UK's Lack of Action on Regulating Cosmetic Treatments. *BMJ, 348*, g1577.

Krieger, L. M. & Shaw, W. (2000). Aesthetic Surgery Economics: Lessons from Corporate Boardrooms to Plastic Surgery Practices. *Plastic & Reconstructive Surgery, 105*(3), 1205-10.

Kuhlmann, E., Allsop, J., & Saks, M. (2009). Professional Governance and Public Control: A Comparison of Healthcare in the United Kingdom and Germany. *Current Sociology, 57*(4), 511-28.

Larson, M. S. (1977). *The Rise of Professionalism: A Sociological Analysis.* Berkeley: University of California Press.

Latham, M.J. (2010). A Poor Prognosis for Autonomy: Self-Regulated Cosmetic Surgery in the United Kingdom. *Reproductive Health Matters, 18*(35), 47-55.

Leve, M., Rubin, L.R., & Pusic, A.L. (2011). Cosmetic Surgery and Neoliberalism: Managing Risk and Responsibility. *Feminism & Psychology, 22*(1), 122-41.

Luke, H. (2003). *Medical Education and Sociology of Medical Habitus: "It's not about the Stethoscope!"*. Dordrecht: Springer.

Lupton, D. (1997). Consumerism, Reflexivity and the Medical Encounter. *Social science & medicine, 45*(3)*,* 373-81.

McDonald, R. (2014). 'Bourdieu', Medical Elites and 'Social Class': A Qualitative Study of 'Desert Island' Doctors. *Sociology of Health & Illness, 36*(6), 902-16.

Maio, G. (2007a). Medicine on Demand? An Ethical Critique of a Wish-Fulfilling Medicine: The Example of Aesthetic Surgery. *Deutsche Medizinische Wochenschrift, 132*(43), 2278–81.

Maio G (2007b) Is Aesthetic Surgery Still Really Medicine? An Ethical Critique. *Handchirurgie Mikrochirurgie Plastische Chirurgie, 39,* 189-94.

Marchac, D. (2007). Aesthetic Surgery and its Future. *Aesthetic Plastic Surgery, 31*, 211–2.

Miller, F., Brody, H., & Chung, K. (2000). Cosmetic Surgery and the Internal Morality of Medicine. *Cambridge quarterly of Healthcare Ethics: CQ: The International Journal of Healthcare Ethics Committees, 9*(3), 353-64.

Moran, M. and Wood, B. (1993). *States, Regulation and the Medical Profession*. Buckingham: Open University Press.

Merianos, A. L., Vidourek, R. A., & King, K. K. (2013). Medicalization of Female Beauty: A Content Analysis of Cosmetic Procedures. *The Qualitative Report, 18*(46), 1-14.

Mitchell, C. Ben (2013). Medical ethics and moral habitus. *Ethics & Medicine: An International Journal of Bioethics*, *29*(2)*,* 69-70.

Mirivel, J.C. (2010). Communicative Conduct in Commercial Medicine: Initial Consultations Between Plastic Surgeons and Prospective Clients. *Qualitative Health Research, 20*, 788-804.

Neto, P.P., & Caponi, S. (2007). The 'Medicalization' of Beauty. *Translated by Silvana Polchlopek, from Interface - Comunicação, Saúde, Educação, Botucatu, 11*(23), 569-84.

Noordegraaf, M., & Schinkel, W. (2011). Professionalism as Symbolic Capital: Materials for a Bourdieusian Theory of Professionalism. *Comparative Sociology, 10*(1), 67-96.

Olsson, C., Kalén, S., & Ponzer, S. (2019). Sociological Analysis of the Medical Field: Using Bourdieu to Understand the Processes Preceding Medical Doctors' Specialty Choice and the Influence of Perceived Status and Other Forms of Symbolic Capital on Their Choices. *Advances in Health Sciences Education, 24*(3), 443-457.

Parker, R. (2009). *Women, Doctors and Cosmetic Surgery: Negotiating the 'Normal' Body*. Palgrave Macmillan: London.

Patel, A.J., & Morrison, C.M. (2013). Opportunities to Reduce Plastic Surgery Claims through an Analysis of Complaints Data. *Journal of Plastic, Reconstructive & Aesthetic Surgery: JPRAS, 66*(4), 455-9.

Pitt-Taylor, V. (2009). Becoming/Being a Cosmetic Surgery Patient: Semantic Instability and the Intersubjective Self. *Studies in Gender and Sexuality, 10*(3), 119-28.

Rees, Thomas D. (1991). The Surgery of Aesthetics: A Modern Dilemma. *Aesthetic Plastic Surgery, 15,* 99-104.

Rufai, S.R., & Davis, C.R. (2014). Aesthetic Surgery and Google: Ubiquitous, Unregulated and Enticing Websites for Patients Considering Cosmetic Surgery. *Journal of Plastic, Reconstructive & Aesthetic Surgery: JPRAS, 67*(5), 640-3.

Ryan, G. W., and Bernard, H. R. (2003). Techniques to Identify Themes. *Field Methods, 15*, 85-109.

Sari, S.D., Handayani, I.G., & Pujiyono (2018). Government and Aesthetic Beauty Clinic's Responsibility in Fulfilling the Citizens' Constitutional Right to the Service of Aesthetic Beauty Clinic in Indonesia. *SHS Web of Conferences 54*, 02003.

Sheldon, S. & Wilkinson, S. (1998). Female Genital Mutilation and Cosmetic Surgery: Regulating Non-Therapeutic Body Modification. *Bioethics, 12*(4), 263-85.

Sullivan, D. (2001). *Cosmetic Surgery: The Cutting Edge of Commercial Medicine in America.* New Brunswick, NJ: Rutgers University Press.

Swartz, D. L. (2013). *Symbolic Power, Politics and Intellectuals: The Political Sociology of Pierre Bourdieu*. Chicago, IL: Chicago University Press.

Tan, H.B.K. (2007). Aesthetic medicine: a health regulator's perspective. *Clinical Governance: An International Journal, 12*(1), 13-25.

Vaughan-Turnbull, C., & Lewis, V. (2015). Body image, objectification, and attitudes toward cosmetic surgery. *Journal of Applied Biobehavioural Research, 20*(4), 179-96.

Appendix: Guideline of interview

1. Personal background and Perception on aesthetic medical field

1.1. What is the reason for you to join the field of aesthetic medicine? Is this your personal decision? Have you been influenced by any suggestion/advice provided from others, e.g. your parents, spouse, or peers (including seniors or younger generations, or mentors since the age of internship or residency) when you made this decision?

1.2. What is your reaction while you are inquired about the content of your current job by non-medical personnel? Can you recall their initial responses and what is followed?

1.3. Have you personally or your co-working doctor, if there is any, encountered any difficulty that is specific belong to aesthetic medicine, e.g. patients, technique, remuneration, promotion of business or even dispute? How different are they from those happened in the therapeutic medical field?

1.4. When did you make up your mind to join the aesthetic medical field? Is there any boost/shortage from your prior job, e.g. workload, academic pressure, impact on personal/family life, unacceptable income or future?

1.5. When providing patient consultation or promoting your business, would you simply state that you are a doctor, or would you describe yourself with the name or title of ‘artist’, ‘body sculptor’, or ‘master of XX’ etc.? If yes, what is the reason? Is it purely because they sound professional, or is it something else?

1.6. What and why is the reason that patients trust in you? Advertising rhetoric or medical capability? or anything else? Is there any variance in different group of patients, e.g. repeated, recommended or alien?

2. Relevant to professional specialty

2.1. Are you happy to let patients know your original training background? This refers to regular specialties, such as obstetrics and gynecology, pediatrics, dermatology, surgery, and so on. Does this status provide any assistance in

business promotion or competitiveness in the field of aesthetic medicine? How does it work?

2.2. Have patients ever inquired directly about your specialist training? If so, in your judgment, what is their motivation? How do you respond?

2.3. Do you think joining a specialist medical association (here, any medical association not related to the classification of health care benefits) will provide in helping your business, skills, market share, and future? If so, how and in what way?

2.4. The membership of the Medical and American Medical Association does not seem to be related to legitimate practicing qualifications within aesthetic medicine. What are the selection criteria for joining the Medical and American Medical Association? Is the number of members an important factor? Or, does the leader, or chairmen affect whether you join or not?

2.5. If possible, do you agree to the establishment of an exclusive and unique aesthetic medical association to be responsible for training, licensing, and further education and other related tasks to maintain the rights of doctors in the overall field of medical aesthetics? Why? And what is the reason for you to think so?

2.6. If there is a single department of aesthetic medicine as described in the previous question, what function do you want it to provide? Such as defending for the exclusive right of practicing status, market expansion, education and training, or lobbying to revise the law for relaxing advertising restrictions, or anything.

3. Legal issues

3.1. What would you describe as a medical disposal in the field of aesthetic medicine? Medical behaviour? consuming behaviour? Commercial activity? Or any other name? Do you think it is necessary to distinguish between therapeutic and non-therapeutic medical behaviours? why?

3.2. Do you think that non-invasive medical treatment can be placed by non-doctor personnel under the supervision of doctor? For example, trained nursing staff. Why? Can you provide any practical case?

3.3. There are special laws that regulate, at least roughly, medical aesthetics-related legal management issues, such as the identity of practitioners, the scope and content of executables, etc. Do you think this law is appropriate? Why? If not, what parts and how do you think should be changed to meet the needs of the actual job?

3.4. Some feminist and consumer groups advocate that the income from aesthetic medical services, compared with other business, be levied the value-added business tax. Do you think this claim is reasonable? Why? If this tax is really imposed in the future, how will it affect you under your speculation?

3.5. Would you hire or cooperate with a ‘beauty consultant’ to promote the business? Are these ‘beauty consultant’ qualified registered nursing staff or belong to other medical fields? or totally outsiders previously? What is the content of their jobs?

3.6. Do you use any media, including social media, such as Facebook, Twitter, etc. to market your services? How effective?

3.7. Do you think celebrity’s endorsements, though it is currently not allowed by law, are helpful for business development?

3.8. Do you think Taiwan's aesthetic medical industry is going to the international market? How to do? Does the forming of a professional organization to build a collective brand, just like that well-known fame of Taiwan’s plastic surgery, help?