THE CONTENT OF COSMETIC SURGERY MAGAZINE ADVERTISEMENTS AND

CONSUMER USE AND INTERPRETATIONS OF COSMETIC SURGERY ADVERTISING

by

HEIDI J. HENNINK-KAMINSKI

(Under the Direction of Leonard N. Reid and Karen Whitehill King)

ABSTRACT

Cosmetic surgery in the United States has experienced unprecedented growth, representing a $9.4 billion industry in 2005. Although increased marketing and promotional activity have contributed to this growth and physician advertising remains controversial, little is known about the content of cosmetic surgery advertising messages or its affect on consumers. This dissertation explores the manifest content properties of cosmetic surgery advertisements over a 20 year period, as well as consumer use and interpretations of such advertising, using social comparison theory and the Sarwer model as frameworks. Stage one of the study analyzes the appeals, physical characteristics, human model characteristics, physician characteristics, risk information and inducements within 1,857 cosmetic surgery advertisements placed in city magazines from 1985 to 2004. Among the findings: promotional activity increased significantly over time; most advertisements employed rational vs. emotional appeals; a surprisingly low percentage included risk information; the use of monetary incentives increased over time; and most ads responsibly portrayed before and after photos and avoided exploiting fears, anxieties or other emotional vulnerabilities. Stage two of the study involved in-depth interviews with women about their use of cosmetic surgery advertising, confirmation or disconfirmation of expectations set by advertising, and perceptions of cosmetic surgery advertising vs. to other types of physician advertising. The findings: cosmetic surgery advertising was used early in the information search and played a relatively minor role compared to other information sources; it was used primarily for awareness of physicians in their market, their credentials, and new cosmetic surgery procedures; and it helped set expectations for both process and appearance outcomes. Ads with before and after photos were considered the most persuasive while ads that ignored the impact of individual differences on appearance outcomes, made life-changing promises, or failed to disclose when a model was not a patient were considered to be unethical. In addition, participants neither recalled nor expected to see risk information in ads and had mixed opinions on how risk information might impact physician credibility. Methodological limitations are presented, followed by suggestions for advancing cosmetic surgery advertising research.

INDEX WORDS: cosmetic surgery advertising, cosmetic surgery marketing, physician advertising, appeals in cosmetic surgery ads, health communication and information, social comparison theory, Sarwer model

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For Cole

My gift, my joy, my inspiration

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CHAPTER ONE

INTRODUCTION

Cosmetic surgery in the United States has evolved from an enigmatic practice reserved for the rich, famous and aging to a menu of procedures familiar to even the very young. Fueled by cultural influences and societal perceptions of the ideal body image, an increasing number of adults, adolescents and children now undergo elective plastic surgery to alter their physical appearance (Gillespie, 1996; Sarwer, 2002; Sarwer, 2005; Wijsbek, 2000). The American Society of Plastic Surgeons (ASPS), which represents 97 percent of all physicians certified by the American Board of Plastic Surgery, reported that 3.4 million cosmetic surgery procedures were performed in the United States by licensed plastic surgeons in 2005, representing a 775 percent increase since 1992 and a 151 percent increase since 2000. When one includes cosmetic procedures performed by dermatologists, otolaryngologists (ear, nose and throat specialists) and general surgeons, the number of procedures performed in 2005 rises to 10.2 million, reflecting $9.4 billion in cosmetic surgery expenditures in 2005 (ASPS, 2005). Among the major drivers are: social and cultural standards of physical attractiveness, (Heinberg, 1996; Mintel, 2005; Pruzinsky, 1993; Sarwer, 2002; Sullivan, 2001); the quest for youth (Aaskegaard, Gersen and Langer, 2002; Haiken, 1997; Mintel, 2005); and increased marketing and promotional activity (Sarwer, 2005; Sullivan, 2001).

Physical appearance has long been a keystone of American popular culture. Mass mediated images can be a powerful source of socialization about appearance norms and since the mid-twentieth century, have helped establish the idealized images of beauty and attractiveness

that cosmetic surgery patients covet (e.g., Heinberg & Thompson, 1995; Lakoff & Scherr, 1984; Richins, 1991; Sullivan, 2001; Tiggemann, 2002). The media's influence on cosmetic surgery first became explicit when articles *about* cosmetic surgery as a way to attain these idealized images appeared in women's magazines during the post-war years and intensified with the diffusion of television (Davis, 1995; Haiken, 1997; Sullivan, 2001). While the quest for above-average physical appearance has been perpetuated over the years by popular magazines such as *Glamour, Vogue,* and *Maxim* that emphasize perfect bodies and youthful looks, today entire television shows such as ABC's *Extreme Makeover,* FOX's *The Swan*, and FX's *Nip/Tuck* have popularized the idea of cosmetic procedures. This momentum, and a perceived need for information about cosmetic surgery that is easy to understand, brought about the launch of a new magazine, *New Beauty,* in 2005. The publication is devoted exclusively to cosmetic surgery and provides information on cosmetic procedures and recommendations on how to find qualified surgeons.

Increased demand for cosmetic surgery also stems from the recognition of youthfulness as a marketable asset, both socially and professionally. Consumers are increasingly reluctant to accept signs of aging amidst a contemporary view of aging as a "partially curable disease" (Askegaard, et al., 2002; Haiken, 1997; Sayre, 1999). Against this backdrop, consumer research suggests that the old stereotype of cosmetic surgery as a vain enterprise is shifting toward a perception that looking good improves self esteem, fulfills personal needs, helps in the workplace, and therefore impacts quality of life (Mintel, 2005).

Increased levels of cosmetic surgery marketing activity also have contributed to the spike in demand. Cosmetic surgeons are engaged in aggressive marketing of their services due to an increasingly competitive field (Sullivan, 2001). This competitiveness first emerged when

medical schools produced a supply of plastic surgeons that exceeded the demand for reconstructive work (Brody, 1996). This initial impetus toward cosmetic work by plastic surgeons proved to be lucrative and soon attracted physicians from other areas of medicine, including dermatology, otolaryngology, ophthalmology, and general surgery (Haiken, 1997; Sullivan, 2001; Mintel, 2005). Given the fact that most elective cosmetic surgery is not covered by health insurance and relies heavily on consumer advertising to survive (Spilson, Chung, Greenfield & Walters, 2002), it is not surprising that the level of marketing activity has increased on behalf of a substantial number of service providers.

Cosmetic surgery is as controversial as it is popular. While supporters laud the physical, psychological and social benefits ascribed to those who elect to undergo the cosmetic knife, critics raise ethical, health and cultural concerns. In general, marketing by physicians has been controversial. This stems from concern that physicians might promote their own interests over that of the patient when marketing products and services, and that patients might experience subtle, but undue pressure when marketed to by doctors (Davidson, 1998; Padgett & Haas, 2004). If these things transpire, the American Medical Association is concerned about the negative impact this could have on the credibility of the medical profession. This concern is particularly salient for cosmetic surgeons, as cosmetic surgery practices rely heavily on consumer advertising to survive because the majority of cosmetic procedures are elective and therefore not covered by health insurance (Miller, Brody and Chung, 2000; Spilson, et al., 2002). In addition, advertising activity levels are further impacted as an increasing number of physicians from a variety of specialty areas compete for cosmetic surgery patients in a given market (Mintel, 2005; Sullivan, 2001).

Furthermore, cosmetic surgery puts healthy patients at physical risk for mere appearance enhancement. Some argue that this violates the physician's duty to "do no harm" while others maintain that cosmetic surgery is ethical as long as the doctor has fully disclosed risk information, including probability estimates (e.g., Davidson, 1998; Haiken, 1997; Morreim, 1988; Spilson, et al., 2002)[1]. At issue is whether consumers are making an informed choice. This concern is real against a backdrop of cosmetic surgery advertisements criticized by the Better Business Bureau (BBB) and the Federal Drug Administration (FDA) for the use of exaggerated or unsubstantiated claims, misleading statements about physician qualifications, or misleading information about financing options (Mintel, 2005) and television programs that perpetuate the misperception of cosmetic surgery as a medical treatment with "minimal risks and few side effects that produces a "Cinderella-like transformation in patients" (Sarwer, 2001, p. 343). As a result, consumers often forget it is *surgery* – with all the risks and potential complications of any invasive procedure.

The proliferation of cosmetic surgery also raises cultural concerns. First, cosmetic surgery may perpetuate wider social inequities. A substantial body of research demonstrates that physically attractive persons are more likely to benefit socially, psychologically and economically than unattractive persons (see Jackson, 2002 for meta-analysis of studies; Sullivan, 2001). To the extent that those with higher socioeconomic status are more able to afford surgery to improve physical appearance, existing inequities may be exacerbated. Second, cosmetic surgery may lead to homogenization of appearance both within the United States, as well as in

[1] While cosmetic surgery performed by legally licensed physicians with years of training and experience carries an inherent risk, two trends have further increased the risk of surgery. First, the lucrative nature of cosmetic surgery has attracted both physicians not trained or certified in specific cosmetic procedures to conduct such procedures, as well as unlicensed practitioners that perform procedures in offices, beauty salons and even hotel rooms, often with dire consequences (Helwig, 2000; Sullivan, 2001). Second, the movement of those practicing cosmetic surgery out of the hospital operating room and into the doctors office or ambulatory surgical centers for lower costs, greater convenience and privacy reasons also has increased the risks of cosmetic surgery (Sullivan, 2001).

other cultures that increasingly adopt Western ideals of beauty[2]. Finally, critics argue that cosmetic surgery promotes the misperception that happiness depends on a more perfect, youthful body (Davidson, 1998; Haiken, 1997; Sullivan, 2001) and creates the illusion that one can transcend age, ethnicity and even sex itself (Davis, 1995).

The increasing prevalence of cosmetic surgery and its areas of controversy justify the need for additional inquiry. While several studies have examined the relationship between the mass media and cosmetic surgery (Davis, 1995; Goodman, 1996; Haiken, 1997; Ring, 1999; Woodstock, 2001), and a body of research grounded in Social Comparison Theory has emerged around exposure to idealized beauty images through advertising in general, the study of cosmetic surgery advertising is virtually nonexistent. A review of the three existing studies suggests that the current understanding of cosmetic surgery advertising content is mostly anecdotal rather than empirical. Accordingly, the objective of this research is to fill that gap by systematically investigating the content of cosmetic surgery advertising, as well as interpretations by consumers of cosmetic surgery advertising, through a two-stage study.

The objective of the first stage is to empirically describe the manifest content properties of cosmetic surgery magazine advertisements placed in city magazines in the ten largest U.S. markets from 1984 to 2004. Content areas of interest include appeals, human model characteristics, risk information, promotional tactics, and physician characteristics. The research objectives for the second stage are to gain an understanding of how consumers use and interpret cosmetic surgery advertising as an information source. This second stage is key to understanding not just how the content of cosmetic surgery ads is used and perceived, but also

[2] This Western ideal of beauty – big round eyes, small waists, large breasts, blond hair and blue eyes – is increasingly adopted by members of other cultures who undergo cosmetic surgery to attain these ideals (Solomon, 2004). For example, South Korea has more than 1,200 plastic surgeons, the highest per capita in the world. According to Solomon, the newest craze in South Korea is a 'leg job' to reduce the size of thick calves as women seek the slender legs of Western supermodels.

serves as a first step in identifying the role cosmetic surgery advertising may play in bringing about individual, social or cultural effects. Shoemaker and Reese (1990) and Riffe, Lacy and Fico (1998) acknowledge the need to recognize the "centrality" of content and petition researchers to expand their content analytic work to systematically link content both to the forces that created it, and to its effects.

Obtaining an understanding of the content of cosmetic surgery magazine advertisements and the perceptions by consumers of cosmetic surgery advertising also may have theoretical implications. The Sarwer et al. (1998) model of the relationship between body image and cosmetic surgery considers physical, psychological and sociocultural influences on the development of body image, and addresses how thoughts and feelings about appearance may influence the decision to seek cosmetic surgery. He and his colleagues call for additional research to understand more fully the role of the mass media as a sociocultural influence in this process. Findings from this study may help illuminate the role that one specific form of mass mediated messages – cosmetic surgery advertisements – plays in that process.

In addition, while Social Comparison Theory (Festinger, 1954) has been used in marketing to investigate how consumers compare their own physical attractiveness to models in advertising *in general*, as well as outcomes of such comparisons (e.g., Martin & Kennedy, 1993; Richins, 1991), to date no studies have used social comparison theory per se to examine cosmetic surgery as a potential behavioral outcome. Nor has anyone employed social comparison theory to look at advertisements specifically *about* cosmetic surgery, messages that include an implicit efficacy message – that these idealized images actually are attainable via certain procedures. Accordingly, the findings from this study may suggest avenues for future research in this area.

The remainder of this study is organized in the following manner. Chapter Two provides the conceptual foundation for the study, beginning with a definition of cosmetic surgery and a brief history of cosmetic surgery advertising. It also introduces the two theoretical frameworks within which the study is situated: a cognitive-behavioral model of the relationship between body image and cosmetic surgery (Sarwer, Wadden, Pertschuk & Whitaker, 1998a), and Social Comparison Theory (Festinger, 1954), and presents the research questions for the study. Chapter Three outlines the methodology for both stages of the study, while Chapter Four presents the results of stage one and Chapter Five provides the results of the second stage of the study. Chapter Six provides the analysis and implications of the findings, along with the limitations of the study and suggestions for future research.

CHAPTER 2

REVIEW OF THE LITERATURE

The purpose of this chapter is to ground the reader in the concepts and theoretic frames that inform this work. First, "cosmetic surgery" is defined and a brief history of cosmetic surgery advertising in the U.S. is provided. Second, the two theoretical frames within which this study is grounded are reviewed. Third, the literature on the relationship between cosmetic surgery and the mass media in general and the limited research currently available about cosmetic surgery advertising are discussed. Research questions for the study conclude the chapter.

A Definition of Cosmetic Surgery

According to the ASPS, *cosmetic surgery* is performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem, while *reconstructive surgery* is performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. Reconstructive surgery is generally performed to improve functions, but may also be done to approximate a normal appearance (ASPS, 2004). Cosmetic surgery is elective and demand originates from marketing efforts and other sources of cultural pressure, as opposed to a patient's physical needs (Sullivan, 2001).

The field of reconstructive surgery crystallized during World War I in response to the severe head and facial wounds caused by trench warfare. After World War II, physicians trained in reconstructive surgery began to expand their practices to include cosmetic surgery for

a number of reasons, including an oversupply of surgical specialists[3] concurrent with a decline in demand for traditional non-cosmetic skills[4], as well as the attractive nature of an out-of-pocket, fee-for-service practice that did not require third party regulatory oversight (Sullivan, 2001). While many physicians initially wrestled with the ethics of elective surgery solely for physical gain, they soon found justification in the emerging science of psychology and psychiatry (Haiken, 1997; Sullivan, 2001). According to Straatsma, a mid-twentieth century plastic surgeon, cosmetic surgery was justified as a medical practice because of its ability to:

> …alleviate or remedy illnesses which in many cases are far more serious than bodily pain; namely mental anguish due to the patient's constant realization of the defect which in turn causes the development of an inferiority complex. (Sullivan, 2001, p. 64).

Thus, cosmetic surgeons came to see their work as facilitating a patient's total physical and mental health, rather than merely removing a distressing flaw. Physical appearance became recognized as crucial to mental health, in addition to social and economic success.

U.S. Cosmetic Surgery Statistics

Cosmetic surgery statistics are difficult to track in the United States. There are no official government statistics, most procedures are not covered by medical insurance and many procedures take place outside the hospital, thus rendering these traditional medical tracking methods incomplete. Data is only available from physician's professional associations that voluntarily collect information from a sample of members to project practice rates.

The ASPS is the sole source of cosmetic and reconstructive surgery statistical trends in the United States. The organization first began to collect and report the cosmetic work of its

[3] Plastic surgery is the only surgical discipline without anatomical boundaries. Plastic surgeons focus on skin and its contents, overlapping with other surgical specialties such as otolaryngologists, ophthalmologists, dermatologists and general surgeons. The number of medical doctors who self-designate plastic surgery as their primary area quadrupled from 1970 to 1996, yet only 62% are board certified in plastic surgery (Sullivan, 2001, p. 74).

[4] This decline resulted from the use of shatterproof glass in automobiles, increased seat belt usage, and a decline in the birth rate, which in turn reduced the number of cleft palates and other congenital deformities.

membership in 1992. Since 2000 the ASPS also began to provide a comprehensive estimate of cosmetic surgery procedures performed by ASPS member surgeons, as well as other physicians most likely to perform plastic surgery procedures who also are certified by the American Board of Medical Specialties (ABMS) recognized boards.

There has been a 700 percent increase in the number of cosmetic surgery procedures performed by ASPS members from 1992 to 2004 (see Figure 2.1). The ASPS also provides statistics about specific procedures performed, as well as demographic information about cosmetic surgery patients. 2-1 reflects the most frequently performed cosmetic procedures in 1994 and 2004. According to the ASPS, females have continued to comprise the majority of cosmetic surgery patients since it began to track this data (see Figure 2.2)[5]. The percentage of men undergoing cosmetic surgery each year ranged from a low of nine percent in 1998 to a high of 15 percent in 2002. Cosmetic surgery patients over the years have been predominately white (see Figure 2.3)[6], although there has been a slight increase in the percentage of Hispanic and black patients since 1994.

A Brief History of Cosmetic Surgery Advertising

At the turn of the century the American Medical Association desired to convince the public that medicine was a bona fide profession, deserving of special privileges because of special responsibilities, rather than just another commodity or trade. The AMA believed that explicitly commercial medicine would interfere with this quest for professional privilege and status and took steps to ban advertising by physicians (Sullivan, 2001).

The first AMA Code of Ethics in 1847 condemned advertising as both unethical and undignified and from 1957 to 1976 the prohibition read simply, "He [the physician] should not

[5] The ASPS first began to report patient sex statistics in 1992.
[6] The ASPS first began to report patient race breakdowns in 1994.

solicit patients." (Sullivan, 2001, p. 133). To this end, the AMA restricted physician advertising to include only factual information such as location, type of practice (e.g., plastic surgery), business hours, and contact information. In 1975 the Federal Trade Commission challenged this position on the grounds that such a prohibition constituted anti-competitive behavior and resulted in restraint of trade. In 1982 the Supreme Court upheld this judgment and the medical profession joined the pharmaceutical and legal professions in the ability to advertise.

Upon dissolution of the AMA's advertising ban, cosmetic surgery led the "medical marketing revolution" (Sullivan, 2001, p. 85). The first paid advertisements for cosmetic surgery by plastic surgeons appeared in California in the late 1970s on television, radio and print. By 1988, 48 percent of board certified plastic surgeons advertised in area Yellow Pages and some also advertised in newspapers, magazines, direct mail, television, and radio. Physicians from specialties other than plastic surgery also joined the marketing foray, exercising their new found freedom to call themselves "cosmetic surgeons" or facial plastic surgeons" as a result of the 1982 Supreme Court ruling. Marketing soon became a major priority for the ASPS, which established a formal marketing department in 1986 to oversee programs and assist members with marketing efforts. Given the limited geographic scope of a physician's practice, most cosmetic surgery advertisements were placed in local media. Full service marketing companies that specialized in commercial medical services also emerged in the mid 1980s. These companies provided packaged marketing plans, including advertising templates that could be used across markets, and also consulted with physicians on how to build their practices by marketing auxiliary services including spas, laser hair removal and skin care (Sullivan, 2001).

The medical profession remains concerned about physician advertising, particularly by cosmetic surgeons who seem to blur the lines between business and professional medical

practice (Miller, Brody and Chung, 2001). Several organizations address this concern in their respective codes of ethics.

Today, the AMA only restricts advertising that is false, deceptive or misleading and has developed a code of ethics to prevent such activity (Morreim, 1998). And while the American Board of Plastic Surgeons recognizes the role of legitimate advertising in the changing medical scene, it's Code of Ethics (2002) disavows advertising that "… leads to unrealistic expectations, is false or misleading, minimizes the magnitude and possible risks of surgery, or solicits patients for operations they might not otherwise consider." Furthermore, the ASPS has developed an even stricter code of ethics in an attempt to prevent its member physicians from engaging in deceptive advertising. The ASPS Code of Ethics prohibits the use of images of persons or facsimiles that falsely and deceptively create unjustified expectations of favorable results; unsubstantiated statements that indicate the physician possesses skills superior to other physicians with similar training; advertisements that appeal primarily to fears, anxieties or emotional vulnerabilities; and advertisements that contain a prediction of future success or guarantee that satisfaction or a cure will result from the performance of the physician.

Theoretical Frames

This research is situated within the context of two theoretical frameworks: a theoretical model of the relationship between body image and cosmetic surgery (Sarwer, et al., 1998a) and Social Comparison Theory (Festinger, 1954). More people than ever before are changing their appearance through cosmetic surgery. Because dissatisfaction with one or more physical features typically motivates pursuit of this surgery (Sarwer, et al., 1998a), the literature on body image is particularly salient. Most authorities believe that body image has multiple dimensions and, as such, should be reconceptualized as "body images" (e.g., Pruzinsky & Cash, 2002;

Thompson, 1990). Cash & Pruzinsky (1990) define "body images" as perceptions, thoughts, and feelings about the body and bodily experiences. As such, body images can be empirically assessed through thoughts, feelings and behaviors about the body (Sarwer et al., 1998). While body image has long been considered key to understanding the psychological profile of cosmetic surgery patients, empirical study of the link between body image and cosmetic surgery is relatively recent. Sarwer et al. (1998a) developed a model of the relationship between body image and cosmetic surgery that considers both physical and psychological influences on the development of body image, and addresses how thoughts and feelings about appearance may influence the decision to seek cosmetic surgery (see Figure 2.4).

According to the model, while the physical reality of one's appearance serves as the foundation for one's subjective body image, several psychological influences also play a role. *Perceptual influences* consist of an individual's ability to accurately assess the physical characteristics of a given body part; *developmental influences* stem from the contribution of childhood and adolescent experiences to adult body image (e.g., teasing about appearance); and *sociocultural influences* focus on the interaction of the mass media and cultural ideals for social norms and expectations about appearance. Finally, *self-esteem* also is thought to influence body image (e.g., Cash & Labarge, 1996; Fisher, 1990). The combination of these influences results in a two-dimensional body image attitude. Body image *valence* is the degree to which body image is important to an individual's self esteem, while body image *value* is the actual degree of satisfaction or dissatisfaction that individual has with his/her body. An individual's body image valence and body image value interact such that those with positive body image valence (i.e., whose self-esteem is dependent on physical appearance) and body image dissatisfaction are most motivated to undergo cosmetic surgery.

Sarwer et al. (1998a) posit that the *sociocultural* influences, particularly those related to the mass media, may indeed be the most pertinent to understanding the role of body image in cosmetic surgery. This position was first advocated in 1993 by Pruzinsky, who observed that the social and cultural standards of beauty portrayed in the mass media had directly impacted increased demand for cosmetic surgery. Accordingly, this study is intended to provide additional insight into the content dimensions and consumer interpretations of one specific type of mass media -- cosmetic surgery advertisements.

The second theoretical framework within which this research is situated is Social Comparison Theory, which serves to illuminate the *process* by which the mass media influence societal standards for physical appearance, as well as associated *outcomes*. Consumers are exposed to countless media images in the form of advertisements, magazine images, and television programs. Collectively, these media images present an idealized version of the perfect face and body. This is particularly true of advertisements, which often include highly attractive models in the hope of increasing the ad's effectiveness.

Social Comparison Theory originated with Festinger (1954) and has been used in marketing to investigate how consumers compare their own physical attractiveness to models in advertising, as well as the outcomes of such comparisons (e.g., Martin & Kennedy, 1993; Richins, 1991). The main propositions of social comparison as set forth by Festinger are these: 1) humans have a drive to evaluate their opinions and abilities; 2) in the absence of an objective basis for comparison, people engage in social comparisons with others; and 3) such comparisons will, when possible, be made with similar others (Martin & Kennedy, 1993). In the decades since Festinger's (1954) original work, the theory of social comparison has been substantially expanded and revised to include the evaluation of personal traits and circumstances (e.g.,

physical attractiveness) in addition to opinions and abilities (Wood, 1989), to include self-enhancement and self-improvement as additional motives for comparison (Martin & Kennedy, 1994; Wood, 1989), and to acknowledge that social comparisons may be automatic rather than intentional (Arrowood, 1986; Lyubomirsky & Ross; Wood, 1989). According to Richins (1995), "perhaps the most frequent social comparison in American culture, often unsought, is with media images" (p. 597). The idea is this: 1) consumers are exposed to idealized images of models which raise comparison standards for physical attractiveness; 2) dissatisfaction with one's physical appearance occurs as a result of the discrepancy between one's actual appearance and that of the standard; and 3) this dissatisfaction can impact self-esteem and body investment behaviors.

Social comparison to idealized images in the mass media has been linked to a number of outcomes including lowered self-esteem (Irving, 1990; Martin & Gentry, 1997), lowered self-perceptions of and satisfaction with physical attractiveness (Martin & Kennedy, 1993; Richins, 1991), and body investment behaviors such as dieting, exercise, steroid use, and eating disorders (Botta, 1999; Morrison, Kalin & Morrison, 2004) (see Figure 2.5). Conceivably, social comparison theory could be integrated into the Sarwer et al. model (1989) to illuminate the process by which cosmetic surgery advertisements, a specific sociocultural influence, might influence the decision to have cosmetic surgery. Accordingly, the findings from this study may help guide future research in this area, ultimately expanding the repertoire of body investment behaviors explained by social comparison theory.

Previous Research about the Mass Media and Cosmetic Surgery

Several studies have examined the relationship between idealized images of women in the media and the mainstreaming of cosmetic surgery. For example, Goodman (1996)

hypothesized such a relationship and compared women's self-evaluations of their bodies with media depictions of women during their respective adolescent and early-adult years and found not only that they were consistent, but also that body-satisfaction decreased proportionately with age and that younger subjects were more favorable toward cosmetic surgery. Feminist researchers such as Woodstock (2001), Haiken (1997) and Davis (1995) also credit the media with creating an environment in which more and more women turn to cosmetic surgery to attain the perfect face and body. At the same time, Sarwer (2002) notes that little is known about the effect of sociocultural influences such as the mass media on body image and the resulting decision to seek cosmetic surgery. The limited research that links the media to cosmetic surgery focuses on idealized images of physical attractiveness in media and advertising *overall.* However, media influence also includes providing instruction on how to attain the ideal through advertisements, articles and programs *specifically about* cosmetic surgery. These cosmetic surgery messages potentially add another dimension, as they include an implicit efficacy message – that these idealized images actually are attainable via certain procedures.

Previous Research on Cosmetic Surgery Advertising

Only three studies to date have examined cosmetic surgery advertising. Sullivan (2001) dedicates a chapter to cosmetic surgery marketing. She compares a convenience sample of print ads (newspaper, magazine, brochures, programs) from the early and late 1990s to provide a general description of cosmetic surgery ads and found an increase in the number of references to affordability over this time period, as well as an increase in the use of sales promotion tactics. She also found consistency in the lack of risk information, emphasis on a single procedure, and references to physician credentials and experience over that time period.

Spilson, et al. (2002) examined whether consumers' perceptions of cosmetic surgery ads placed in the Yellow Pages of the ten largest U.S. cities during 1998 and 1999 were in conflict with the ASPS code of ethics. They found that participants believed that 25 percent of the ads used images of persons that falsely and deceptively created unjustified expectations of favorable results, that 22 percent of the ads appealed primarily to the layperson's fears, anxieties or emotional vulnerabilities, and that 17 percent of the ads contained unsubstantiated statements of physician superiority.

Ring (1999) conducted a comparative analysis of two Australian magazines *about* cosmetic surgery to assess the extent to which they displayed the expertise of individual physicians, as well as the convergence of editorial and advertising within each magazine. While the study focused primarily on editorial coverage, it also found that both magazines relied heavily on specific, named physicians as primary sources of editorial information and included a high occurrence of ads placed by those same physicians, suggesting a new definition of what constitutes 'advertising' by physicians.

While these studies are useful in providing initial insight into the content of cosmetic surgery, they make a limited contribution to a comprehensive understanding of cosmetic surgery advertising over time. The samples used in all three studies encompass limited time frames. Sullivan (2001) compared ads from the early and late 1990s, Ring (1999) examined ads placed in one issue of each of two magazines in 1999, and Spilson et al. (2002) focused on a sample of ads placed in the Yellow Pages by ASPS members from the ten largest U.S. cities over a two year period -- 1998 and 1999.

The studies also explore limited content properties. While the Sullivan study (2001) is arguably the most comprehensive of the three, the use of a convenience sample limits the

generalizability of her findings. Ring (1999) restricts her scope to only those advertisements placed by physicians who also author editorial content within two magazines, and looks at the size of such ads, the use of beautiful models and the incidence photos of service providers and before-after photos. Spilson et al. (2002) also address the extent to which consumers perceive that cosmetic surgery ads violate the ASPS ethical codes in terms of 1) using human images that falsely and deceptively create unjustified expectations of favorable results, physician characteristics; 2) making unsubstantiated claims of physician superiority as compared to other physicians with similar training; 3) appealing primarily to fears, anxieties or emotional vulnerabilities; 4) containing predictions of future success or guarantees of satisfaction; and 5) being objectionable in general. While this study has the soundest sampling methodology, its focus on Yellow Pages advertisements in and of itself limits the content properties available to assess. An emphasis on location/contact content and more basic production quality may serve as structural barrier to content properties that might appear in other print advertising formats, such as magazines, which could provide a richer medium through which to communicate the visual nature of cosmetic surgery.

Consequently, while these three studies touch on certain elements of cosmetic surgery advertising, they fail to do so in a manner or scope capable of systematically reflecting the evolution and current status of cosmetic surgery ads in the United States. Accordingly, this study provides an opportunity to fill that gap by examining the explicit portrayal in advertisements of cosmetic surgery as a conduit to achieving a face and body like that of models, as well as exploring the relationship of such messages to the motivations for, and expectations of, cosmetic surgery.

Research Questions: Stage One

Sample Characteristics

One of the objectives of this study is to provide a systematic view of general patterns in cosmetic surgery magazine advertisements since the ban on physician advertising was lifted in 1982. Sullivan (2001) suggests that the increased competition for cosmetic patients has intensified the level of commercialization over the years and this study provides an opportunity to look at advertising activity levels across ten markets within one type of advertising vehicle – city magazines. Accordingly:

R1: What is the overall frequency of placement of cosmetic surgery advertisements from 1984 to 2004 and what, if any, changes have occurred over time?

This descriptive profile is further developed by examining the topic and physical properties of cosmetic surgery magazine ads. Accordingly:

R2: What types of cosmetic procedures are advertised in city magazine? What, if any, changes have occurred over time?

R3: What are the physical format properties of cosmetic surgery advertisements, including size, production, type of illustration and placement?

Appeals

Within the advertising research literature, appeals in print ads typically are derived inductively from the major headline and visuals with the ad. Appeals are an indicator of the overall message strategy and executional components typically flow from that appeal. Generally speaking, advertising appeals are considered to be either rational or emotional and are used to attract the attention of consumers or to influence their feelings toward the subject of the advertisement. Rational appeals tend to be informative and focus on convincing consumers that

the advertiser's product or service has an attribute or gives a benefit that satisfies a need. Emotional appeals focus on the psychological or social needs for purchasing a certain product or service (Belch and Belch, 2004).

While advertising appeals in general have received extensive research attention, not much is known about the use of appeals within physician advertising in general, let alone in cosmetic surgery magazine advertisements specifically. Prior to deregulation in 1982, physicians were restricted to providing only general information about their practice. Nearly ten years later, Yavas and Riecken (2001) observe that doctors and dentists still perceive the most ethical messages/appeals to be informative in nature: area of specialty, location of practice, hours of operation and types of services offered. However, it is unlikely that the preponderance of cosmetic surgery magazine advertisements reflect only informational appeals. Haiken (1997) and Sullivan (2001) note that cosmetic surgeons came to see their work as not merely enhancing physical appearance, but also as a conduit to psychological health, as well as social and economic success. It is conceivable that advertising appeals may convey these as possible outcomes of having cosmetic surgery, thus appealing to the psychological or social needs of consumers. The ASPS expressed concern that cosmetic surgery ads placed by its members might push this boundary too far when it developed its code of advertising ethics. Spilson et al. (2002) gave further voice to this issue when they examined whether consumers perceived cosmetic surgery ads as appealing "primarily to the lay person's fears, anxieties or emotional vulnerabilities" and found that 22 percent of the ads were believed to have done so. Accordingly, this study asks:

R4: What types of advertising appeals are used in cosmetic surgery magazine advertisements? What, if any, changes have occurred over time?

Human Model Characteristics

According to Sullivan (2001), the majority of the several hundred print ads she reviewed from early and late 1990 contained pictures of patients or of models posing as patients. This is not surprising. Advertisements in general often include highly attractive models in the hope of increasing the ad's effectiveness (Richins, 1991), and the use of highly attractive persons in cosmetic surgery ads is arguably the most direct way to communicate a desirable outcome in terms of physical appearance. Study of the characteristics of human models within cosmetic surgery ads is of interest on two fronts. First, an understanding of the sex and race of human models may provide insight into the target market strategy of cosmetic surgeons. This approach has been used in other content analytic studies of advertising. Secondly, the manner in which the human models actually are portrayed is tied to ethical concerns.

In physician advertising, the Hippocratic Oath to "do no harm" extends to truth telling, informed consent and avoiding the build up of false expectations (Davidson, 1998). A highly attractive human image, whether an actual patient or a model representing a patient, can help set an expectation for the outcome of cosmetic surgery. Explicit disclosure of whether the human model or facsimile represented within an ad is an actual patient would assist in this endeavor. Furthermore, before and after pictures are commonly employed in cosmetic surgery advertising, though there have been recent efforts by some publishers to ban such techniques (Sullivan, 2001). At issue is the extent to which changes in physical attractiveness can be attributed to the results of cosmetic surgery as opposed to other ancillary effects, such as changes in hairstyle, lighting, pose and makeup. In essence, is the expectation outcome conveyed in the *after* photograph attributable solely to the results of cosmetic surgery, or are there other factors at play? Spilson et al. (2002) addressed this question when they asked respondents whether the

Yellow Page ads reflect use of "images of persons or facsimiles that falsely and deceptively create unjustified expectations of favorable results." In this study, respondents found that 25 percent of the ads sought to falsely create unjustified expectations. Accordingly, this study asks the following questions:

R5: What are the demographic characteristics of models portrayed in cosmetic surgery magazine advertisements, including sex and race? What, if any, changes have occurred over time?

R6: How are human models portrayed in cosmetic surgery ads, including identification of human models as actual patients, and the use of before and after photographs? What, if any, changes have occurred in these portrayals over time?

Risk Information

As pointed out in the first chapter, one of the criticisms of cosmetic surgery is that it puts healthy patients at physical risk for mere appearance enhancement. Some argue that this violates the physician's duty to "do no harm" while others maintain that cosmetic surgery is ethical as long as the doctor has fully disclosed risk information (e.g., Davidson, 1998; Haiken, 1997; Morreim, 1988; Spilson, 2002). The issue hinges on whether consumers have the information necessary to make an informed choice. While it makes sense that more detailed and client-tailored information about risks, potential side effects, and post-surgery downtime are more appropriately communicated during one on one encounters between physician and patient, there is a question as to what extent to such information is communicated within mediated messages. More than ever before, consumers are exposed to reality television programs about cosmetic surgery and marketing messages that emphasize positive outcomes and downplay risks. Some scholars have voiced concern that consumers may have lost sight of the fact that cosmetic

surgery procedures still carry all the risks and potential complications of any surgery (Sarwer, 2001; Sullivan, 2001).

In her review of print ads from early and late 1990, Sullivan (2001) notes that specific risks rarely are mentioned. And, in the few instances when they are mentioned, the references are indirect. For example, she cites an ad featuring a new procedure for liposuction in which the physician says the new procedure will cause "less bruising, swelling, and discomfort" (Sullivan, 2001 p. 148). She also notes the presence of unspecified risks such as warnings about selecting the "right" doctor – in most cases one who is board certified in plastic surgery. Potential risks also are associated with facilities. Since the 1980s an increasing number of procedures are conducted outside of hospital environments. While hospital environments are deemed to be the most safe because they must meet federal safety standards, similar safety accreditation is not mandated for professional surgical facilities or doctor offices, though some practitioners have submitted to accreditation procedures. Given these concerns, research questions for this study include:

R7: What potential risks, if any, are portrayed in cosmetic surgery magazine advertisements? What, if any, changes have occurred over time?

Inducements

Another area of interest is the extent to which cosmetic surgery ads include inducements to motivate a consumer to act (e.g., schedule a consultation, request more information). The idea, in essence, is to encourage consumers to continue down the path toward purchase. While such incentives are commonplace in product marketing messages, little is known about their application in the marketing of physician services. The use of inducements, however, has been studied in one medical area -- direct-to-consumer (DTC) prescription drug advertising. Bell,

Kravitz and Wilkes (2000) examined DTC ads and found that 17 percent of print ads included inducements. Their study revealed three general categories of inducements: 1) patient support services (e.g., assistance in finding a local support group for smoking cessation), 2) additional information (e.g., print brochures or video tapes) and 3) monetary incentives (e.g., rebates, discount coupons, free trial). Macias and Lewis (2005) adopted this taxonomy in their study of DTC prescription drug Websites and found that inducements most often involved monetary rewards, followed by offers to provide additional information.

When considering cosmetic surgery, the availability of financing options (including credit cards) may also be considered an inducement. Cosmetic surgery, by definition, is an elective procedure that is rarely covered by health insurance. As a result, the cost of the service is absorbed directly by the consumer. Recent consumer research has shown that disposable income is a significant barrier for many who desire to have cosmetic surgery (Mintel, 2005). Thus, the availability of financing options may serve as an inducement to undergo cosmetic surgery.

Medicine is considered to be a profession, rather than a trade. The foundation for this status rests in a service ethic that emphasizes the needs of others rather than personal gain. At the same time, cosmetic surgery has become a lucrative business that is dependent on marketing, somewhat blurring the distinction between medicine and other commercial trades (Sullivan, 2001). Creating demand for elective procedures through marketing is viewed as potentially compromising the reputation of the medical profession. Attitudes of physicians toward advertising have improved somewhat since deregulation, but Becker (1998) notes that moral resentment still remains and attitudes towards advertising may cease to grow more favorable.

Yavas and Riecken (2001, 1983) provide insight into certain advertising messages that inspire this resentment. On two occasions they surveyed doctors and dentists to assess their attitudes toward physician advertising overall and their opinions on the ethicality of various messages/appeals and found that competitive pricing strategies (e.g., special price offers and discounts), along with the use of patient testimonials, were among the least ethical messages employed in an effort to attract more business.

Sullivan (2001) investigates the use of such messages in her cursory review of print cosmetic surgery ads in the early and late 1990s. She notes that the presence of price information remains a rarity across the decade, but that discounts and other financial incentives begin to appear more frequently toward the end of the decade. The balance of the cosmetic surgery marketing literature is silent with regard to the use of inducements. Accordingly, this study asks:

R8: What, if any, inducements are present in cosmetic surgery magazine advertisements? What, if any, changes have occurred over time?

Physician Characteristics

As noted earlier in the chapter, the sheer competitiveness of the field of cosmetic surgery necessitates smart, if not aggressive marketing, and in such an environment state attorney generals and organizations such as the Better Business Bureau (BBB) and the Food and Drug Administration (FDA) have begun to scrutinize ads for misleading statements about physician qualifications and exaggerated or unsubstantiated claims (Mintel, 2005; Sullivan, 2001). The AMA code of ethics has a general prohibition on "false or misleading advertising" and the ASPS adopted its own ethical code of advertising for its members. Additional concerns have been voiced about what are perceived to be vague, unclear, or even misleading representations of

board certification and the influence such representations may have on more uneducated patients who might rely on institutional endorsements when making decisions about service providers. Several states have enacted legislation to try to restrict advertising claims of specialty status (Sullivan, 2001).

The previous research on cosmetic surgery advertising offers a cursory view of some aspects of physician characteristics. Spilson et al. (2002) examined the extent to which the lay public found cosmetic surgery ads placed in the Yellow Pages to be in violation of the ASPS code of ethics. Participants found that 17 percent of the ads included unsubstantiated statements of superiority and that 15 percent of the ads included a prediction of future success or satisfaction resulting from a physician's performance. Sullivan (2001) provides a general discussion of the results from her non-systematic comparison of several hundred print ads placed during the early and late 1990s. She notes that most ads included standard personal information about the physician, such as credentials and experience, and that a small number of ads included photos of physicians. She also observes the presence of some ads that do not specifically identify physicians, noting concern by some physicians about these facilities that are owned by non-physician investors. One of the objectives of the research is to provide a systematic profile of the how physicians are portrayed in cosmetic surgery magazine advertisements. Accordingly, research questions include:

R9: What are the characteristics of physicians represented in cosmetic surgery magazine ads, including type of practice, type of physician (M.D., D.O.), sex and race? What, if any, changes have occurred over time?

R10: What types of physician credentials are mentioned in cosmetic surgery magazine ads, including board certification, professional qualifications, and professional affiliations? What, if any, changes have occurred in these mentions over time?

R11: How often do cosmetic surgery magazine advertisements contain a claim of superiority by physicians other than board certification? What, if any, changes have occurred in these claims over time?

Comparative Questions

This study also examined a set of comparative questions to examine differences in the content of cosmetic surgery advertisements by physician gender and type of practice so as to better understand, and begin to make inferences about, the characteristics of advertising sources (i.e., cosmetic surgeons). Riffe et al. (1998) discuss the importance of systematically linking content properties to the forces that create that content, as well as the social, political, cultural, and economic factors that affect the context within which content is created. Accordingly, comparative research questions pertaining to physician gender include:

R12: What are the differences, if any, in the types of appeals employed in cosmetic surgery advertisements for male and female cosmetic surgeons?

R13: What are the differences, if any, in the ways male and female physicians are presented in cosmetic surgery magazine advertisements with regard to credentials (e.g., board certification, professional qualifications, and professional affiliations), the use of superiority claims, and the presence of physician photos?

R14: What are the differences, if any in the tendency of male and female physicians to include risk information in cosmetic surgery magazine advertisements?

R15: What are the differences, if any, in the tendency of male and female physicians to include inducements in cosmetic surgery advertisements?

Similarly, the following questions were asked with regard to type of practice:

R16: What are the differences, if any, in the types of appeals employed in cosmetic surgery advertisements for different types of practices?

R17: What are the differences, if any, in the credentials (e.g., board certification, professional qualifications, and professional affiliations), the use of superiority claims, and the presence of physician photos within cosmetic surgery advertisements for different types of practices?

R18: What are the differences, if any, in the presence of risk information within cosmetic surgery advertisements for different types of practices?

R19: What are the differences, if any, in the presence of inducements within cosmetic surgery advertisements for different types of practices?

Research Questions: Stage Two

A second objective of this study is to gain initial insight into how consumers interpret and respond to cosmetic surgery advertising. Findings from this stage may help illuminate the Sarwer et al. (1989) model of the decision to have cosmetic surgery. Accordingly, this study poses the following questions with regard to how consumers use the content of cosmetic surgery advertisements in general:

R20: When and in what vehicles do consumers recall encountering cosmetic surgery advertisements?

R21: How much attention do consumers pay to cosmetic surgery advertising in general?

R22: How do consumers use cosmetic surgery advertisements and what role do these advertisements play in their decision to have cosmetic surgery? At what stage of the decision-making process do they use cosmetic surgery advertisements?

R23: How important is cosmetic surgery advertising relative to other information sources in the decision to have cosmetic surgery?

As stated earlier in this chapter, physician advertising in general, and advertising by cosmetic surgeons specifically, has raised a number of ethical concerns, primarily grounded in medicine's stature as a profession, rather than a trade or commodity. One of the key concerns is that cosmetic surgeons might seek to falsely create unjustified expectations of outcome results. Accordingly, this study poses the following question:

R24: Do cosmetic surgery patients believe that the results of their cosmetic surgery met the expectations set by cosmetic surgery advertising?

Similarly, while physician advertising in general is controversial, it is all but required for cosmetic surgeons whose services are both elective and in keen competition with an ever increasing number of providers. Does this context influence the marketing strategies of cosmetic surgeons and do those strategies differ from that of other types of physicians? Clearly, consumer interpretations of advertising messages constitute a key venue within which to begin to assess such potential differences. Accordingly, this study asks:

R25: How do consumers view cosmetic surgery advertising as compared to other types of physician advertising? Do consumers perceive there to be an ethical line that cosmetic surgeons should not cross in their advertising?

A final area of inquiry probes more deeply into consumer perceptions of cosmetic surgeons and their advertising efforts, focusing on physician gender and type of practice. This

study poses two questions in an effort to better understand consumer perceptions of advertising sources:

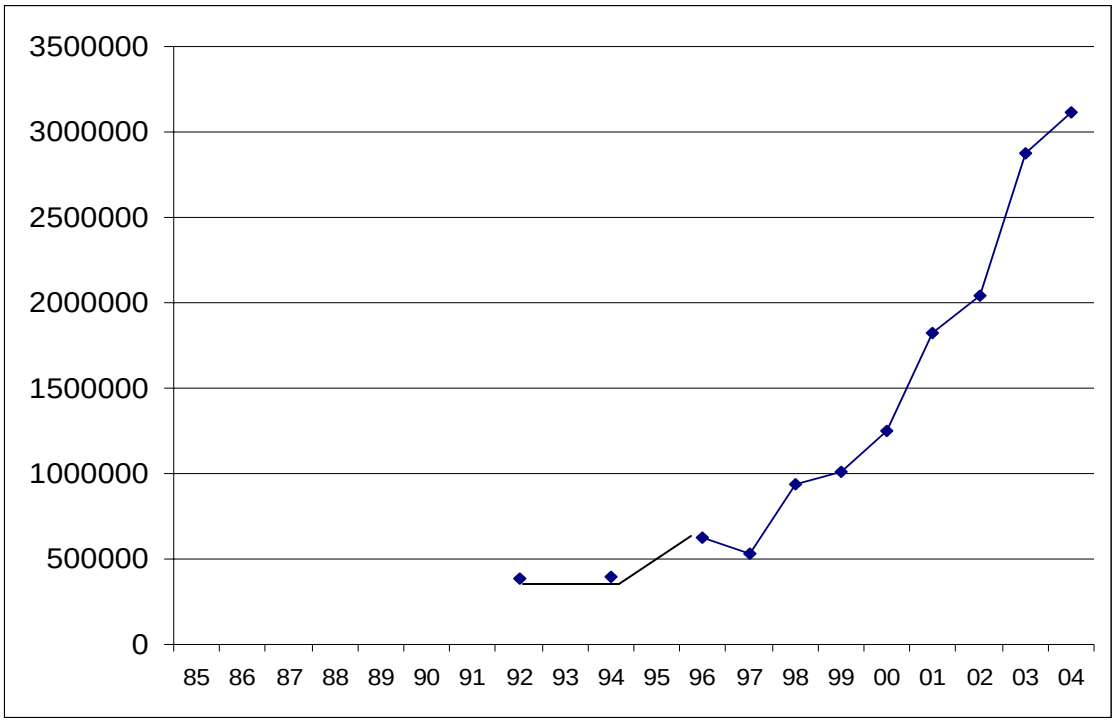
R26: How do consumers feel about male vs. female cosmetic surgeons and do they perceive a difference in the way male vs. female cosmetic surgeons advertise?

R27: How do consumers feel about different types of cosmetic surgeon practices (e.g., individual practitioners vs. group practices, vs. clinics) and do they perceive a difference in the way different practices advertise?

Table 2.1. Cosmetic Surgery Procedures Performed in 1994 and 2004

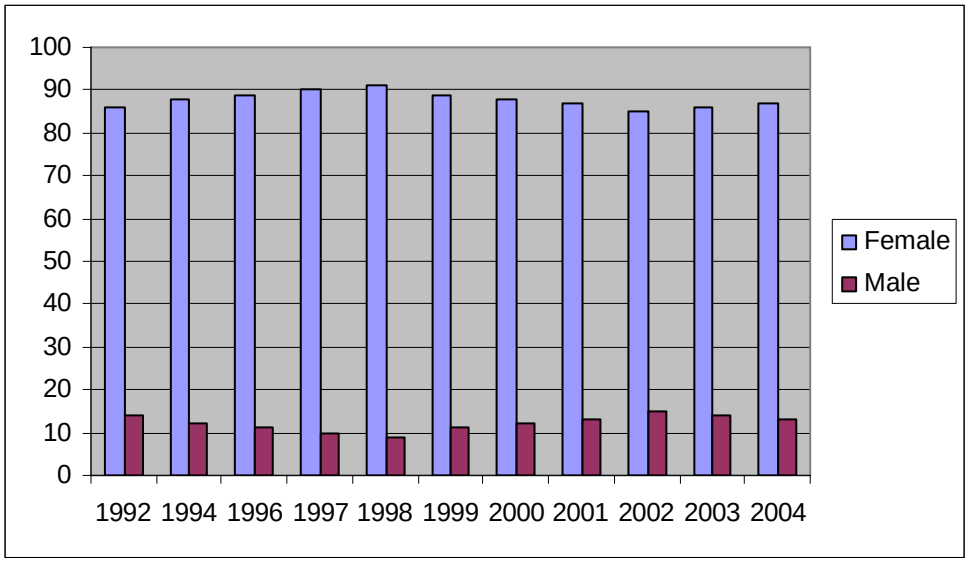
Cosmetic Surgery Procedure	1994 Rank	1994 Frequency	2004 Rank	2004 Frequency
Liposuction	1	51,072	7	32,4891
Eyelid surgery	2	50,838	10	23,3334
Breast Augmentation	3	39,247	9	26,4041
Soft tissue fillers	4	36,432	2	1,097,046
Nose reshaping	5	35,927	8	305,475
Facelift	6	32,283	12	114,279
Chemical peel	7	29,072	3	1,090,523
Breast implant removals	8	28,655	19	35,208
Retin-A Treatment	9	20,875	29	0
Tummy tuck	10	16,829	13	107,019
Forehead lift	11	13,182	16	54,993
Dermabrasion	12	10,100	17	54,018
Breast Lift	13	10,053	15	75,805
Ear surgery	14	4,684	21	25,915
Male Breast reduction	15	4,416	23	13,963
Chin augmentation	16	3,632	22	15,822
Cheek implant	17	1,136	25	9,318
Thigh lift	18	1,098	27	8,123
Upper arm lift	19	633	24	9,955
Butt lift	20	314	28	3,496
Botox	n/a	0	1	2,992,607
Cellulite treatment	n/a	0	18	44,569
Laser hair removal	n/a	0	5	573,970
Laser skin resurfacing	n/a	0	11	164,451
Laser vein treatment	n/a	0	14	103,460
Lip augmentation (non-injectable)	n/a	0	20	26,730
Lower body lift	n/a	0	26	8,926
Microdermabrasion	n/a	0	4	858,867
Sclerotherapy	n/a	0	6	544,898

[1] ASPS statistics based on procedures performed by ASPS Member Surgeons certified by the ABMS.
[2] ASPS statistics based on procedures performed by ASPS Member Surgeons certified by the ABMS as well as other physicians certified by ABMS-recognized boards.



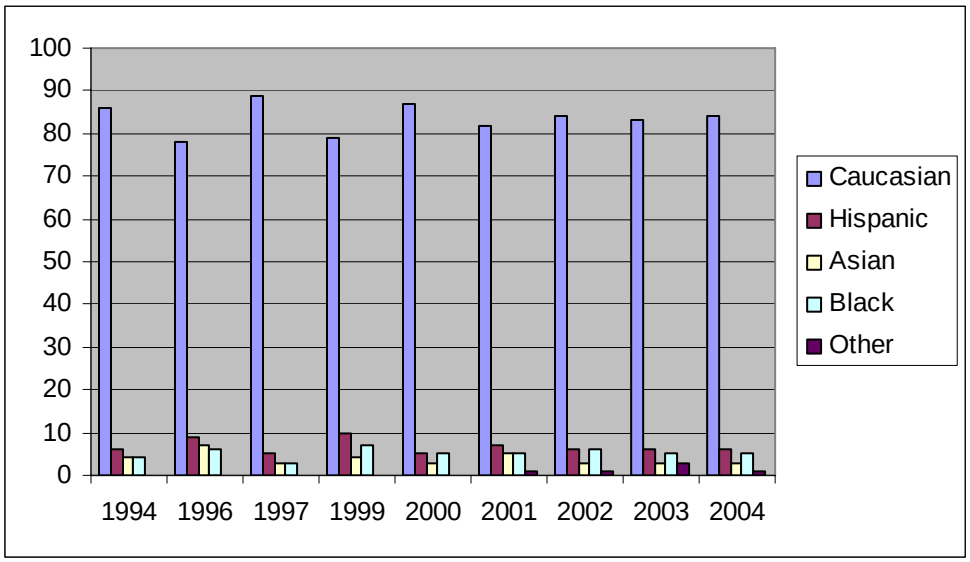
Source: ASPS Procedural statistics

Figure 2.1. Frequency of Cosmetic Surgery Procedures



Source: ASPS Gender Quick Facts
Note: 1992 – 1999 statistics reported for ASPS members only, while 2000-2004 statistics reported for ASPS members and other physicians certified by the American Board of Medical Specialties-related boards.

Figure 2.2. Percent of Cosmetic Surgery Patients by Gender



Source: ASPS Race Quick Facts
Note: 1994 – 1999 statistics reported for ASPS members only. 2000 – 2004 statistics reported for ASPS members and other physicians certified by the American Board of Medial Specialties-related boards. Statistics not available prior to 1994 nor for 1995 or 1998.

Figure 2.3. Percent of Cosmetic Surgery Patients by Race

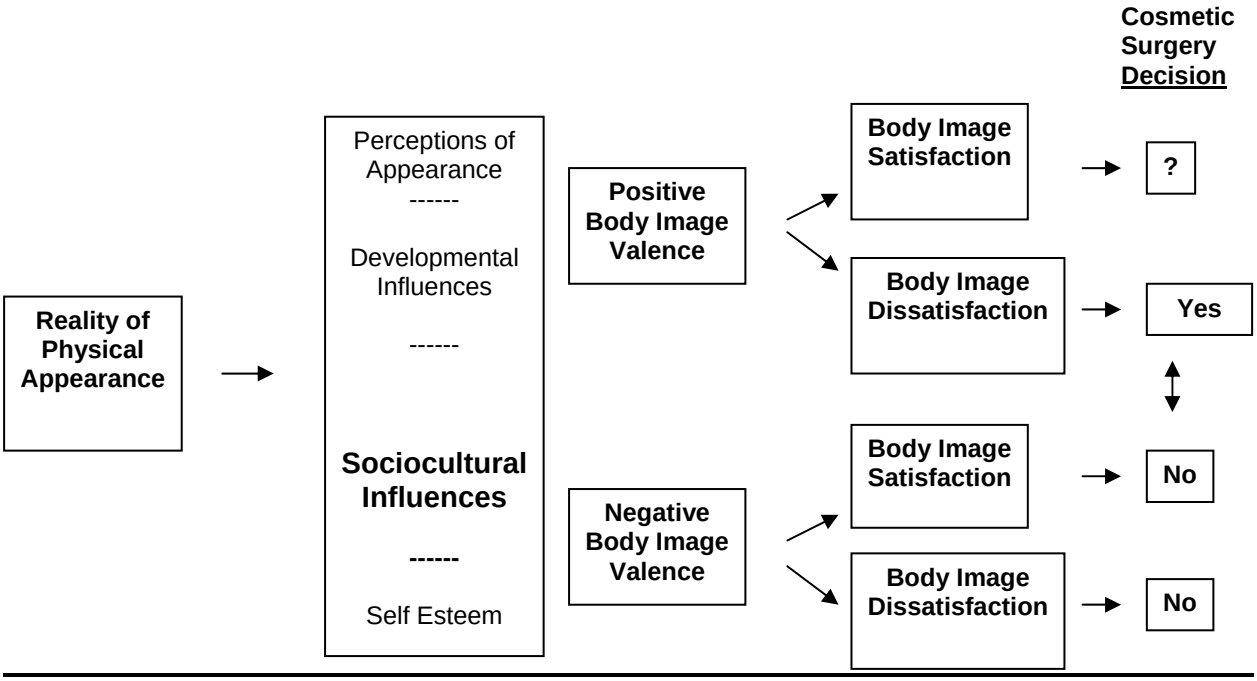


Figure 2.4. A Model of the Relationship Between Body Image and Cosmetic Surgery (Sarwer et al., 1998)

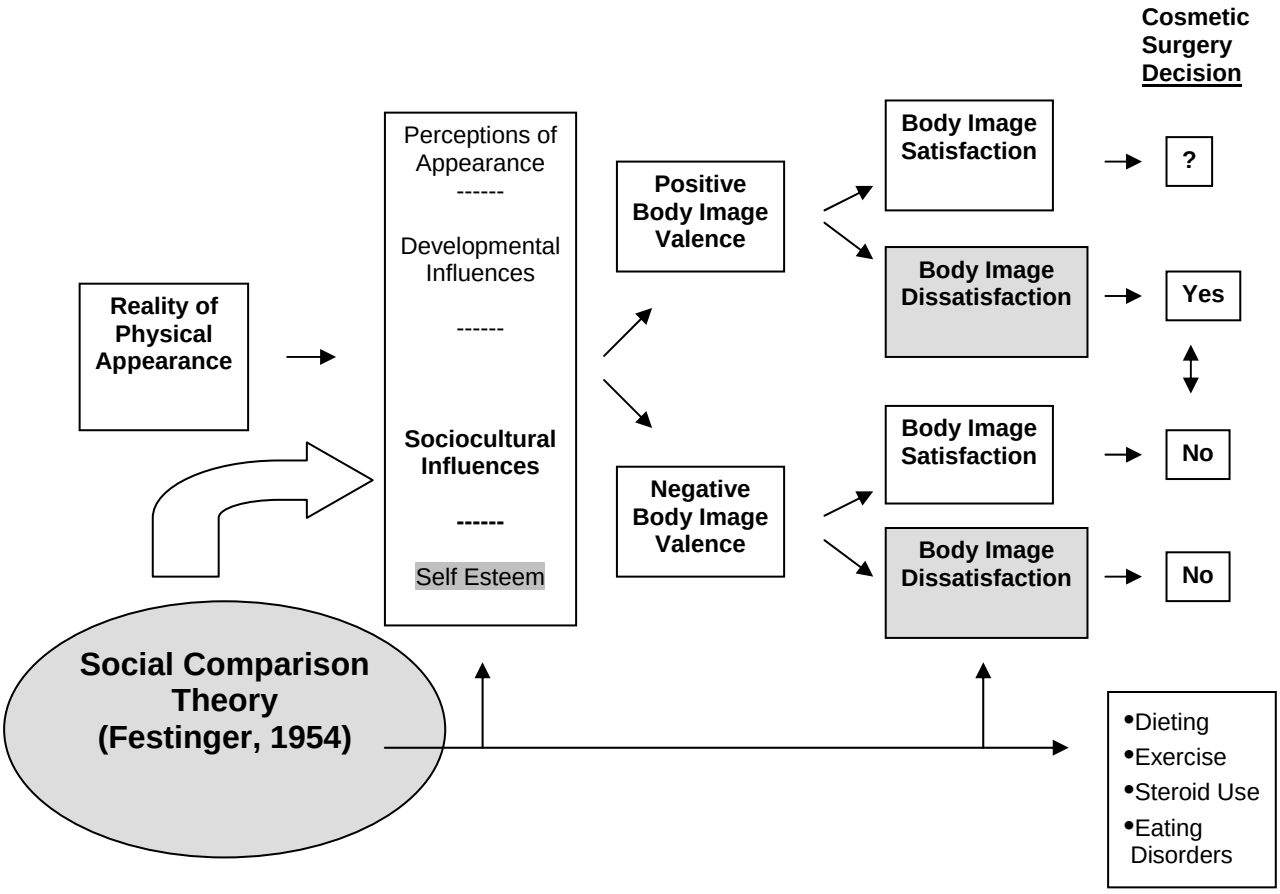


Figure 2.5. Overlap of Social Comparison Theory Outcomes and the Sarwer Model

CHAPTER 3

METHOD

This chapter describes the method for each phase of the study. Stage one is a content analysis to address content-based research questions and stage two consists of in-depth interviews with women who have had, or who are planning to have, cosmetic surgery in order to gain insight into their use and interpretations of cosmetic surgery advertising.

Stage One Method:

The first stage of this study consists of a content analysis of the properties of cosmetic surgery ads placed in city magazines from 1985 to 2004. Content analysis is a useful method for establishing whether patterns support existing theories or research propositions and is a standard analytical tool for advertising studies (Kolbe and Burnett, 1991). It also has been used in other research to examine trends in medical advertising (e.g., Macias and Lewis, 2004; Prather, 1991; Roth, 1996).

Sample

This study employed a systematic random sample of cosmetic surgery advertisements placed within ten city magazines in the United States from 1985 to 2004. As described later, the analysis focused on unduplicated ads yielded by the sampling procedure. City magazines were selected due to the local nature of physician advertising and the similarities between the age and income demographics of city magazine subscribers and the profile of cosmetic surgery patients as outlined by the ASPS on its website (see Exhibit A in the Appendix). Furthermore, print advertising in magazines, newspapers and telephone books has been established as some of the most popular media used to advertise cosmetic surgery practices (Finch, 1999; Sullivan, 2001).

The sampling frame consisted of U.S. metropolitan markets within which a city magazine is published. The intent of this study was to focus on metropolitan markets under the assumption that they would yield the greatest number of advertisements to examine. As a result, the ten largest metropolitan markets as defined by the 2003 census (see Table 3.1)[7] were selected from the sampling frame, a definition that has precedent for the study of cosmetic surgery advertising (Spilson, et al., 2002). This approach yielded the following markets and respective city magazines: *Los Angeles Magazine* (Los Angeles/Long Beach), *New York Magazine* (New York), *Chicago Magazine* (Chicago), *The Washingtonian* (Washington D.C), *Philadelphia Magazine* (Philadelphia), *Detroit Ma*gazine and *HOUR Detroit* (Detroit), *Atlanta Magazine* (Atlanta), *Inside Houston* (Houston), *Boston Magazine* (Boston/Lawrence/Lowell/Brockton), and *D Magazine* (Dallas). However, *Phoenix Magazine*, from the 11th ranked metropolitan market of Phoenix, replaced *Inside Houston* in the sampling frame, as all known archival copies of *Inside Houston* magazine from 1985 to 1997 were destroyed in a flood.

The 1985 to 2004 timeline was selected for two reasons. First, although the Federal Trade Commission first challenged the ban on physician advertising in 1975, the Supreme Court did not uphold this challenge until 1982. As a result, 1985 represents a reasonable year to initiate the study, as it allows for a three-year start-up period for cosmetic surgery advertising campaigns. Second, this timeline permits comparisons between two ten-year time spans, 1985 to 1994 and 1995 to 2004.

[7] In 2004 the Census Bureau replaced its ranking of Metropolitan Markets with Core-Based Statistical Areas (CBSA). In many cases these CBSA's combine a number of separate metropolitan cities, with the effect of elevating the ranking of cities with lower populations. For example, in 2003 Miami ranked 22nd as a metropolitan market but under the new system adopted in 2004, Miami is combined with Ft. Lauderdale and Miami Beach to become the 6th ranked CBSA. This intertwining of distinct metropolitan cities confounds the sample of city magazines; thus, this study relies on the 2003 metropolitan market rankings to establish the sampling frame.

A systematic sampling procedure using a random start was employed to select issues from which to generate the sample of advertisements. The goal was to ensure seasonal representation and to minimize duplication. Nine of the ten magazines in the sampling frame publish monthly and for these magazines one issue from each quarter (January – March; April – June; July – September; October – December) was selected for each year, yielding a total of four issues per year per magazine. A die was rolled to randomly select the start month within each quarter for 1985, where a "1" or "4" would result in selecting the first month for each quarter (e.g., January, April, July, October), a "2" or a "5" would result in selecting the second month for each quarter and a "3" or "6" would result in selecting the third month for each quarter. The roll yielded a "4" and resulted in a selection of the January, April, July and October issues for 1985. A rotation schedule was followed for the balance of the years, where the second issue for each quarter was selected for 1986, the third issue for each quarter was selected for 1987, and so on (see Table 3.1). For *New York Magazine,* which publishes weekly instead of monthly, the first weekly issue was selected for each month. This approach has been used in other content analysis studies that examined advertisements placed in weekly magazines (e.g., King, Reid, Moon and Ringold, 1991).

This process should have yielded four issues per year for twenty years for a total of 80 issues for each of the ten magazines, and a grand total of 800 issues for the study overall. However, *D Magazine* (Dallas market) did not publish from July 1993 to November 1994, yielding 74 instead of 80 issues for that market. The Detroit market also was atypical. *Detroit Monthly* was the city magazine of record from 1985 until it closed in 1996. *HOUR Detroit* initiated publication in 1996 and continues on as the city magazine of record for metropolitan Detroit. As a result, the two Detroit publications overlapped in 1996, with *Detroit Monthly*

publishing 13 unique ads and *HOUR Detroit* publishing three unique ads during the months sampled for that year. An examination of the ads revealed that there was no duplication between the ads placed in the two magazines that year. Thus, all sixteen unique ads were retained in the unduplicated sample.

Libraries holding the above designated issues for the magazines were located using the WorldCat database. In one case (*HOUR Detroit*) library holdings were incomplete and the researcher had to contact the publisher for permission to access their private archives for data collection. The primary researcher traveled to the libraries and manually searched bound copies of magazine issues for the presence of cosmetic surgery advertisements. Such ads were digitally scanned and stored on CDs.

Unit of Analysis

Given the focus of this project on elective cosmetic surgery procedures conducted by physicians, ads from the issues were included in the sample if they met three criteria: 1) the ad contained the word "cosmetic surgery", "plastic surgery", "aesthetic surgery", or referenced any of the specific elective cosmetic surgery procedures (including non-invasive) listed by the ASPS on its website; 2) the ad contained a reference to a physician, doctor or hospital, either by name or in general; and 3) the ad was not dedicated exclusively to hair replacement treatment or reconstructive surgery. This sampling procedure yielded a total of 3,491 ads from all ten markets, which were then reviewed to eliminate duplication.

Each scanned ad was given a unique identifier and a hard copy was printed. Hard copies of the ads within a market were then manually compared by the researcher and the first instance of an ad was identified and counted in the "unduplicated" sample. An ad was considered unique if it was different in any manner from the other ads in a given market, including a change in size,

a change in headline, or a change in tagline. Hard copies of unique ads by market were then organized in three-ring binders and subsequent instances of those ads (i.e., duplicates) were stapled to the unique ad to allow an analysis of total ad frequency counts, in addition to unique ad frequency counts. This process identified a total of 1,857 unique cosmetic surgery ads for content analysis.

Coding Categories

The manifest content of 1,857 cosmetic surgery ads was coded on a number of dimensions. As this is the first systematic content analysis of cosmetic surgery, no templates existed for the coding sheet. Accordingly, content areas of interest emerged from the literature discussed earlier and included, though were not limited to, variables that were addressed in the three prior studies of cosmetic surgery advertising. A random sample of 10 percent of unique ads from the Atlanta and Houston markets were reviewed on the content dimensions of interest to ensure that coding categories adequately captured the content. A training manual was then developed that included descriptions of rules, procedures and definitions (see Appendix B). According to Kassarjian (1977) and Kolbe and Burnett (1991), these are necessary to ensure valid findings and to make further research replications possible. The resulting coding sheet was extensive in scope and contained 286 variables across seven broad categories: physical/format characteristics, visual characteristics, model characteristics, physician characteristics, verbal characteristics, risk information, and appeals (see Appendix C).

The training manual categories were crosschecked in several ways. First, accuracy was assessed for certain medical information. For example, a plastic surgeon was contacted by phone to confirm the coding schema for board certification and memberships within professional organizations relevant to the field of cosmetic surgery. Similarly, a media relations

representative for the ASPS was contacted to verify the taxonomy of cosmetic procedures mentioned with ads and the appropriate official ASPS procedural category within which it should be assigned (e.g., if an ad references "endermology", it should be placed within the official procedure category of "cellulite"). Second, face validity was assessed by providing the coding sheet and two sample ads to three doctoral students who were not official coders for the study. These students confirmed that they were able to complete all sections of the coding sheet for both ads based on the definitions provided in the training manual.

Coding Procedure & Pilot Study

Eight female graduate students in mass communication or speech communication at the University of Georgia for whom English was their native language were employed as paid coders. Coder training is essential to objectivity and improving inter-coder reliability (Kassarjian, 1977). Coders participated in an initial 3-hour training session. The goal of the session was to familiarize the coders with the content, which was often technical in nature (e.g., medical procedures, medical affiliations), guide them on how to approach reading and evaluating an ad, and to warn them against coder fatigue (Neuendorf, 2002). The training session consisted of a review of the 19 page manual outlining operational definitions for variables in the coding sheet, followed by a group discussion where the coding sheet was applied to a sample of cosmetic surgery advertisements. Advertisements for this part of the training session were drawn from *Inside Houston*, a publication not included in the sampling frame, to ensure judge independence and to avoid sensitizing the coders to the actual data set. One-third of the ads from *Inside Houston* (n= 14) were used during the initial training session. At the conclusion of the session, the coders were given another one-third of the *Inside Houston* ads (n=14) for an initial pre-test to identify troublesome variables and determine focal points for the second training

session. A two-hour follow-up training session was conducted after which the remaining one-third of the *Inside Houston* ads (n=14) was distributed for the official pre-test.

The official pilot study was conducted to check inter-coder reliability and the clarity of the coding sheet, rules and definitions. A pretest is critical in content analysis to establish reliability. Inter-coder reliability was assessed for the official pretest using the percentage of agreement method (Kassarjian, 1977). All but one variable exceeded the acceptable 80 percent level (Riffe, Lacy & Fico, 1998). This variable focused on classifying the outcome of the procedure advertised as "restorative" or "transformative" in nature. Based on the pretest, this variable was excluded from the study. Although exceeding the 80 percent threshold, three variables posted percent of agreement in the low 80s and were deemed to require further attention prior to beginning coding of the study sample.

Percentage of agreement for the variable "ad size" was just 82 percent, not surprising given the fact that magazine ad sizes often fall outside of traditional categories of "quarter" and 'half" page increments. Coders were advised to judge ads more carefully on this dimension and were given some examples of typical magazine ad sizes and their corresponding category on the coding sheet.

Percentage of agreement for the variable "degree of nudity/attire" was just 83 percent. Additional analysis of the pre-test data showed that most disagreement occurred between the "demure" and "suggestive" categories. Coders were alerted to this discrepancy and the operational definitions for what should constitute "suggestive" attire were underscored.

The final variable falling between the 80 to 85 percent range was "call to action: call physician for information", which posted a percentage agreement of 82 percent. Follow up discussions with coders revealed an intermingling of this response with other call to action

responses. Some coders were selecting "call physician for information" whenever the verb "call" was used, even when it was used in conjunction with consultations or brochures (e.g., call to schedule a consultation, call for a free brochure). As a result, coders were instructed to focus on the most *specific* aspect of the "call physician" response (e.g., select "request brochure" category if ad states "call to receive one of our free brochures instead of selecting both "call physician for info" and "request brochure").

Three coders were then assigned to each market, with each coder independently judging every unique ad within that market. To guard against order bias, each coder received CDs containing digital .pdf files of the ads for that market placed in a different sequence (King et al., 1991). To further assure judge independence, coders were instructed not to discuss the ads with one another, but to rely on the information in the training manual or their training notes when completing the coding sheets.

This study used three coders on every unique ad. Data from all three coders for a given market were entered into an SPSS file, yielding three records for each variable for each ad. These were then reviewed and distilled into one response when there were two or more coders in agreement for that variable. Thus, a variable response for a given ad was considered "correct" if at least two of the three coders agreed on a response. There were 88 instances across all ads where at least two of the three coders did not agree on a variable. In those cases, a meeting was scheduled with the three coders so that the disagreement could be discussed and resolved. During the meeting, the researcher identified the areas of disagreement and reviewed information in the training manual. The three coders then worked out the differences amongst themselves. This procedure was followed to achieve as much objectivity as possible (Kassarjian, 1977) and the results were posted to the SPSS file *after* the inter-coder reliability index was calculated.

Once the final SPSS file for unduplicated ads was complete, a master file for duplicated ads was constructed. Binders containing the hard copies of the ads were reviewed to count the number of instances a unique ad was repeated within a given market and the corresponding record in the SPSS file was copied the appropriate number of times to reflect duplication. The month and year of the duplicate ads were also reflected in the unduplicated master file to permit detailed frequency analyses.

Inter-Coder Reliability

A review of the content analysis literature reveals several inter-judge reliability measures that can be used. This study adopted Perrault and Leigh's (1989) reliability index measure. The reliability index (I_r) has been identified by a number of researchers (e.g., Kolbe and Burnett, 1991; Rust and Cooil, 1994; Taylor and Stern, 1997) as the best measure for nominal data, largely due to its ability to take into consideration the number of category options for a given variable when accounting for chance agreement.

A systematic random sample of 134 ads was selected from the master file of 1,857 unique ads. The sample size was calculated according to the guidelines laid out by Lacy and Riffe (1996) for nominal content categories. Their formula is intended to generate samples with confidence intervals that ensure that the minimal acceptable reliability figure has been achieved. This sample size is based on an acceptable minimal level of agreement of 85 percent and a 95 percent level of probability (sampling error is ≤ 5% for the assumed population level of agreement):

$$\text{S.E.} = \text{SQR}\ \frac{\text{PxQ}}{n\text{-}1} \times \text{SQR}\ \frac{N\text{-}n}{N\text{-}1}$$

where P = percentage of agreement in population, Q = (1-P), N = the population size, and n = the sample size.

Two dice were rolled to determine the starting point for selecting the 134 ads for the reliability sample, yielding a "7". A two-digit random of numbers was then referenced (Wimmer and Dominick, 2003) and the seventh number was "77". The 77th ad became the starting point, and every fourteenth ad was sampled from that point on, wrapping around to the first ads within the database. Data for these 134 ads were then transferred into an Excel file and PRAM (Program for Reliability Assessment with Multiple Coders) was run to determine the overall percent agreement among the three coders for each variable. The overall percent agreement was then used to calculate the reliability index (I_r). The estimated reliability indexes, as well as 95 percent confidence interval for each variable, including those not addressed in this study, are reported in Table 3.3.

The reliability indexes for all but seven variables exceeded the critical value of .85, as suggested by Perrault and Leigh (1989). Two variables associated with the indoor setting of the advertisements, "photo studio" and "indoor setting can't be determined," did not achieve an 85 percent level, nor did the variable "other procedures". Coders also did not achieve satisfactory reliability when coding for explicit verbal references to "helpful staff", "physical attractiveness in general" and "physical attractiveness – slimming". The variable "physician specialty" also did not achieve a satisfactory reliability level, largely due to the fact that most ads stated a mixture of specialties. For example, one ad for a board certified plastic surgeon had the term "cosmetic surgery" in the name of the practice but referred to "facial cosmetic surgery" in the body copy. These seven variables were dropped from the analysis.

Data Analysis

Data for stage one were then analyzed in the form of descriptive statistics and chi-square analysis, given the categorical nature of the data. Results are reported in Chapter Four. Figure 3.1 summarizes the research procedure for stage one of the study.

Stage Two Method

To augment stage one of the study, in-depth interviews were conducted with a convenience sample of twelve consumers with the objective of describing and understanding how consumers interpret and respond to cosmetic surgery advertising in general. This second stage is an important first step in identifying the role cosmetic surgery advertising may play in bringing about individual, social or cultural effects. Shoemaker and Reese (1990) and Riffe, et al. (1998) acknowledge the need for researchers to extend their content analytic work to systematically link content to both the forces that created it and to its effects.

Criteria for Participant Selection

Participants were selected based on five criteria: sex, age, household income, cosmetic surgery history/intent and exposure to some form of cosmetic surgery marketing communication materials. Demographic criteria were set in an effort to approximate the readership profile of city magazines. As a result, participants were women between the ages of 35 and 55 with household incomes of $55,000 or higher. Participants also were required to have undergone one or more of the cosmetic surgery procedures listed on the ASPS website, or to be planning to have cosmetic surgery within the next twelve months. Finally, participants were screened for exposure to some form of cosmetic surgery marketing communications.

Recruitment of Participants

Participants were recruited from the greater Detroit, Grand Rapids, and Atlanta markets using snowball sampling, a technique recommended when it is necessary to engage people on a sensitive topic (Lindlof and Taylor, 2002). Colleagues and friends from both markets were contacted either by email or in person and asked if they knew of women who either already had had cosmetic surgery or were planning to have cosmetic surgery in the next 12 months, and who were between the ages of 35 and 55 with household income greater than $55,000. If they did know of someone, they were asked to make initial contact to find out whether that person would be willing to speak with the researcher about participating in the study. If the response was affirmative, the researcher was provided with the prospective participant's preferred means of contact (phone or email) and a convenient time to reach them. Prospective participants were then contacted by the researcher, who provided background information on the study and confirmed that all criteria were met, including the ability to recall some form of cosmetic surgery marketing communication materials (recruitment scripts are available as Appendix D).

If all criteria were met and the prospective participant was willing to be interviewed, a date, time and location for the interview was established based on their preference. An email reminding them of the interview was sent one week in advance, along with a copy of the consent form to allow the participant the opportunity to review it in detail prior to the interview. Upon completion of the interview, participants also were asked to provide referrals to others who might qualify as participants. Because this stage of the study was not designed to be projectable, recruitment of participants continued until redundancy was reached, suggesting that the research questions had been rigorously and thoroughly examined (McCracken, 1988). This process

yielded a total of twelve participants, a number deemed acceptable based on reaching redundancy and in light of the supplemental role the interviews played in this project.

Interview Format and Protocol

Interview Guide. An interview guide was developed following the guidelines for a semi-structured interview as outlined by Kvale (1996). This format allows the researcher to uncover specific information about key topics while at the same time providing opportunities for other relevant content to emerge and for participants to explain and discuss their responses. Interviews began with a grand tour question, *"Can you recall when you first encountered information about cosmetic surgery in the mass media? What were the sources of that information?"* If participants did not mention advertising in their response, they were prompted with*, "What about advertisements? What can you tell me about those sources of information about cosmetic surgery?"* While the interview guide (see Appendix E) was used to begin initial exchanges on key topics of interest and ensure that all issues were covered as intended, the conversation was allowed to flow naturally. Areas of inquiry included the use of cosmetic surgery advertising (i.e., when used, topical areas of interest, relative importance to other sources of information), perceptions of cosmetic surgery advertising vs. other types of physician advertising, confirmation or disconfirmation of expectations created by advertising, and differences in perceptions of advertising by male vs. female cosmetic surgeons, as well as between different types of practices.

Pilot Study. Pilot studies are an important component of the qualitative research process because they help to determine whether the interview protocol will uncover the desired information (Kasper, 1994). An initial draft of the protocol was tested during a pilot interview with a thirty-eight year old woman from Athens, Georgia who is contemplating having cosmetic

surgery. Minor adjustments were made to the wording of some sections of the protocol based on the results of the pilot study.

Analysis. All interviews were tape recorded and transcribed by the researcher. Transcripts were then reviewed for emergent themes relative to each of the stage two research questions. Throughout the process of analysis, the researcher maintained analytic memos noting themes and patterns to assist in the later construction of results (Miles and Huberman, 1984). To validate the interpretations, six of the twelve participants were contacted and asked to review the results section of the manuscript vis a vis their respective interview transcript. These member checks are essential to obtaining trustworthy and accurate representations in qualitative research (Mariampolski, 2001). The results of this qualitative analysis are reported in Chapter Five. Figure 3.2 summarizes the research procedure for this stage of the project.

Table 3.1. Metropolitan Market Rankings

Rank	Metropolitan Market	Population (000)	City Magazine	Circulation[1]
1	Los Angeles/Long Beach	9,911.5	Los Angeles Magazine	153,398
2	New York	9,468.6	New York Magazine	438,101
3	Chicago	8,489.5	Chicago Magazine	182,140
4	Washington DC	5,187.8	Washingtonian	161,062
5	Philadelphia	5,150.9	Philadelphia Magazine	119,916
6	Detroit	4,468.2	Detroit Magazine HOUR Detroit (1996+)	N/A 45,000
7	Atlanta	4,456.7	Atlanta Magazine	67,071
8	Houston	4,440.2	H Texas Magazine (formerly Inside Houston)	
9	Boston/Lawrence/ Lowell/Brockton	4,059.6	Boston Magazine	124,140
10	Dallas	3,800.9	D Magazine	60,465
11	Phoenix	3,552.7	Phoenix Magazine	50,000

Source: Sales & Marketing Management Survey of Buying Power, 2003
[1]2004 Rate Cards

Table 3.2. Sample Issues by Year

Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
1985	January	April	July	October
1986	February	May	August	November
1987	March	June	September	December
1988	January	April	July	October
1989	February	May	August	November
1990	March	June	September	December
1991	January	April	July	October
1992	February	May	August	November
1993	March	June	September	December
1994	January	April	July	October
1995	February	May	August	November
1996	March	June	September	December
1997	January	April	July	October
1998	February	May	August	November
1999	March	June	September	December
2000	January	April	July	October
2001	February	May	August	November
2002	March	June	September	December
2003	January	April	July	October
2004	February	May	August	November

Table 3.3. Intercoder Reliability Index (I_r)

Variable	# (K) of Categories	Percentage of Agreement	Estimated Reliability (I_r)	95% Confidence Lower Limit of I_r
Physical Characteristics				
Ad Production	4	96.0	.97	.96
Ad Size	11	89.3	.95	.94
Ad Illustration	4	92.5	.95	.94
Ad Placement	7	89.3	.93	.93
Advertising Topic				
Cosmetic Surgery	2	96.5	.96	.95
Facial Cosmetic Surgery	2	99.5	.99	.99
Plastic Surgery	2	98.0	.98	.97
Specific Procedures				
Botox	2	95.5	.95	.94
Breast Augmentation	2	94.5	.94	.93
Breast Lift	2	94.0	.94	.93
Butt Lift	2	95.5	.95	.94
Cellulite	2	94.5	.94	.93
Chemical Peel	2	94.5	.94	.93
Chin Surgery	2	90.0	.89	.88
Dermabrasion	2	96.0	.96	.95
Ear Surgery	2	96.5	.96	.95
Eyelid Surgery	2	91.0	.91	.90
Face Lift	2	91.5	.91	.90
Facial Implants	2	91.0	.91	.90
Female Breast Reduction	2	92.0	.92	.91
Forehead Lift	2	94.0	.94	.93
IPL/Fotofacial	2	96.5	.96	.95
Laser Hair Removal	2	95.3	.95	.94
Laser Skin Resurfacing	2	91.0	.91	.90
Liposuction	2	94.5	.94	.93
Male Breast Reduction	2	95.0	.95	.94
Microdermabrasion	2	95.0	.95	.94
Nose Surgery	2	93.0	.93	.92
Permanent Makeup	2	96.5	.96	.95
Soft Tissue Fillers	2	94.0	.94	.93
Thermage	2	95.5	.95	.94
Thigh Lift	2	95.5	.95	.94
Tummy Tuck	2	95.5	.95	.94
Upper Arm Lift	2	95.0	.95	.94
Vein Treatments	2	93.8	.94	.93
Other Procedures	2	85.2	.84	.82
Physician Characteristics				
Practice Type	6	96.5	.98	.97
Physicians Named	8	98.0	.99	.99

Variable	# (K) of Categories	Percentage of Agreement	Estimated Reliability (I_r)	95% Confidence Lower Limit of I_r
Physician Photo	2	98.0	.98	.97
Physician Type	3	96.0	.97	.96
Physician Male	8	92.5	.96	.95
Physician Female	8	97.0	.98	.97
Physician Sex Can't Determine	8	94.5	.97	.96
Physician White	8	91.5	.95	.94
Physician Black	8	98.0	.99	.99
Physician Asian	8	98.0	.99	.99
Physician Hispanic	8	98.5	.99	.99
Physician Multi-Racial	8	98.5	.99	.99
Physician Other Race	8	98.0	.99	.99
Physician Race Can't Determine	8	91.5	.95	.94
Physician Specialty Area	10	73.5	.84	.82
Physician Credentials				
Board Certification	2	97.5	.97	.96
Board Certification Type	7	93.3	.96	.95
Professional Affiliations	2	99.0	.99	.99
Professional Qualifications	2	90.0	.89	.88
Superiority Claims	2	87.1	.86	.84
First/Only Physician	2	97.0	.97	.96
Human Model Characteristics				
Human Model Present	2	99.5	.99	.99
Model as Patient	2	98.5	.98	.97
Model Male	8	97.0	.98	.97
Model Female	8	95.0	.97	.96
Model Sex Can't Determine	8	98.0	.99	.99
Model White	8	81.1	.89	.88
Model Black	8	99.0	.99	.99
Model Asian	8	99.0	.99	.99
Model Hispanic	8	99.0	.99	.99
Model Multi-racial	8	99.5	.99	.99
Model Other Race	8	99.5	.99	.99
Model Race Can't Determine	8	84.1	.90	.89
Before/After Photo Present	2	98.0	.98	.97
Before/After Lighting	3	97.5	.98	.97
Before/After Hairstyle	3	97.0	.98	.97
Before/After Makeup	3	97.5	.98	.97
Before/After Pose	3	96.5	.97	.96
Before/After Clothing	3	95.5	.97	.96
Appeals				
Assurance	2	92.5	.92	.91
Anti-Aging	2	98.5	.98	.97
Economic Benefit	2	1.00	1.00	1.00
Health	2	1.00	1.00	1.00

Variable	# (K) of Categories	Percentage of Agreement	Estimated Reliability (I_r)	95% Confidence Lower Limit of I_r
Humor	2	97.5	.97	.96
Information	2	92.5	.92	.91
Psychological Benefit	2	1.00	1.00	1.00
Self-Determination	2	99.0	.99	.99
Physical Attractiveness	2	94.0	.94	.93
Sociability	2	1.00	1.00	1.00
Threat	2	99.5	.99	.99
Weight	2	98.5	.98	.97
Affordability	2	99.5	.99	.99
Other Appeal	2	1.00	1.00	1.00
Sexual	2	93.5	.93	.92
Sexual Attractiveness	2	92.5	.92	.91
Sexual Behavior	2	92.5	.92	.91
Sex Esteem	2	89.1	.88	.87
Sex Decorative	2	93.0	.93	.92
Risk Information				
Risk Info Present	2	99.0	.99	.99
General Risk	2	99.0	.99	.99
Anesthesia	2	99.5	.99	.99
Allergic Reaction	2	99.5	.99	.99
Bleeding	2	99.5	.99	.99
Bruising	2	99.5	.99	.99
Physician Selection	2	99.5	.99	.99
Pain/Discomfort	2	99.5	.99	.99
Puckering/Dimpling	2	99.5	.99	.99
Infection	2	99.5	.99	.99
Recovery Period	2	99.0	.99	.99
Swelling	2	99.5	.99	.99
Scarring	2	99.5	.99	.99
Other Risk	2	99.5	.99	.99
Inducements				
Financing by Physician	2	98.0	.98	.97
Financing by third Party	2	98.0	.98	.97
Financing Source Not Specified	2	97.5	.97	.96
Credit Cards Accepted	2	97.5	.97	.96
Schedule Free Consultation	2	89.6	.89	.88
Request Video	2	91.5	.91	.90
Request Print Material/Brochure	2	92.0	.92	.91
Sales Promotion Present	2	98.0	.98	.97

$I_r = \{[F_o/N-(1/k)][k/(k-1)]\}^{.5}$ for $F_o/N \leq 1/k$, where F_o is the observed frequency, N is the sample size and F_o/N is the percentage of agreement.
Limits = I_r +/- Z_c $[I_r(1-I_r)/N]^{.5}$, where Z_c is the critical value for the c percent confidence interval and N is the sample size (Perrault and Leigh, 1989).

Formulation of Research Ouestions

⇩

Selection of Sample

1. Identification of Population:
   - Cosmetic surgery advertisements placed in city magazines.
2. Identification of Sampling Frame:
   - City magazines in the ten largest metropolitan markets
   - Time frame: 1985-2004
   - 4 issues per year (rotating one issue from each quarter)
   - Yield: 10 markets x 20 years x 4 issues/year = 800 issues
3. Identification of Unit of Analysis
   - Cosmetic surgery ads (unduplicated n=1,857; duplicated n=3,491)

⇩

Construction of Coding Categories
(Appendix B & C)

1. Creation of coding sheet and training manual.
   a. 7 categories
   b. 286 variables
2. Review by researcher of random sample of 10% of unique ads from Atlanta and Houston to ensure coding categories adequately captured content.
3. Cross check of coding categories
   a. Medical terminology reviewed with plastic surgeon
   b. Taxonomy of cosmetic procedures reviewed with ASPS media relations department.

⇩

Coder Training & Pilot Study

1. Coder recruitment (8 female graduate students, English as first language)
2. Initial training session
   a. Review of training manual and coding sheet
   b. In-session application and discussion of 14 cosmetic surgery ads
3. Unofficial, independent pre-test to identify problem areas (n = 14 ads)
4. Review and tabulation of unofficial pre-test results; revisions to codebook
5. Second training session to review problem areas and revisions
6. Official, independent pre-test (n = 14 ads)
7. Reliability check and exclusion of problem variable (below 80% agreement)

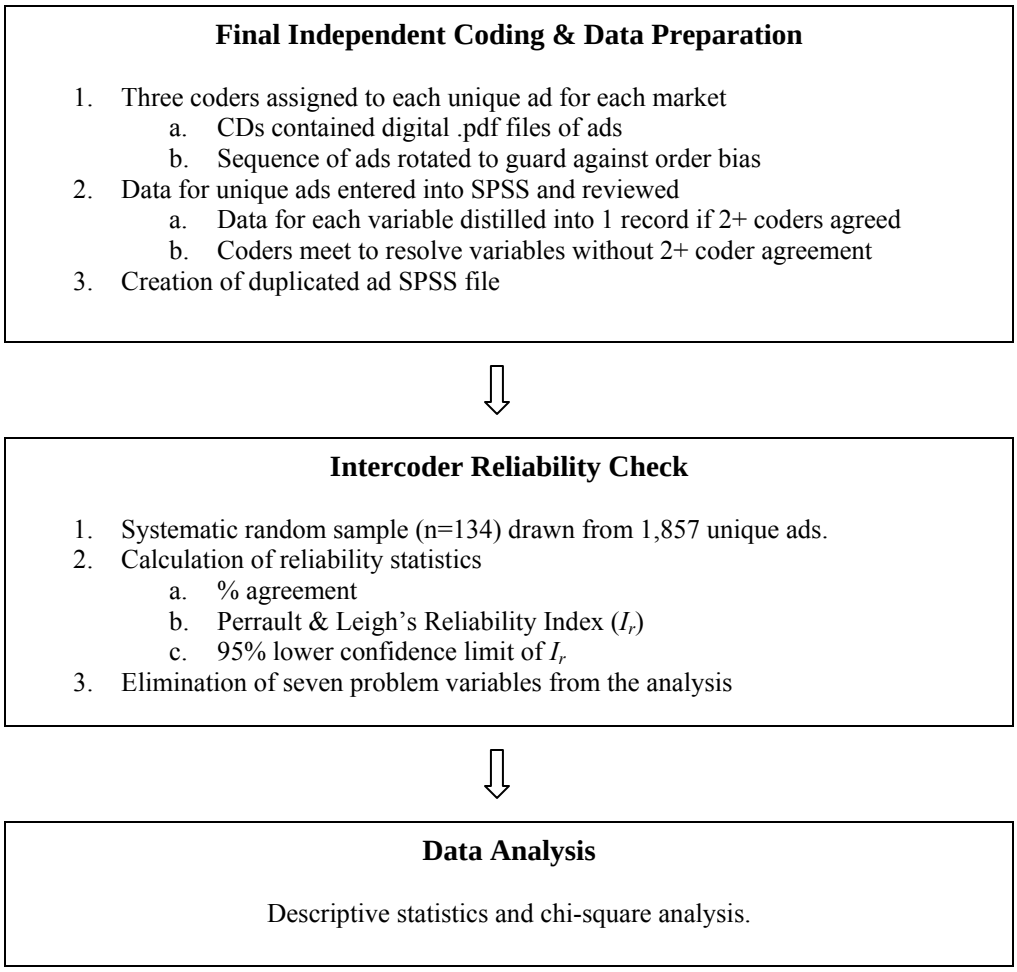


Figure 3.1. Summary of Research Procedures for Stage One

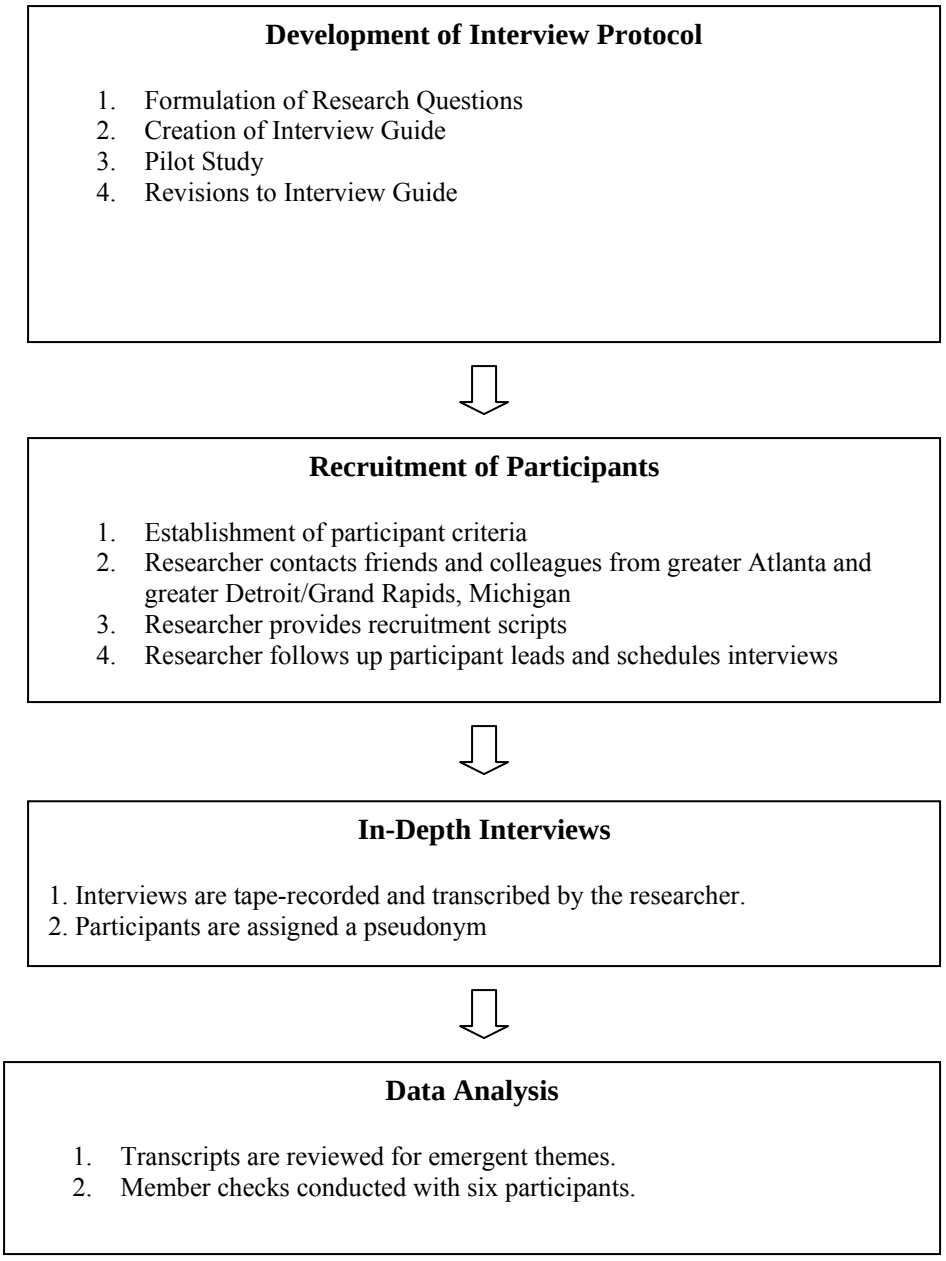


Figure 3.2. Summary of Research Procedure for Stage Two

CHAPTER FOUR

RESULTS: STAGE ONE

This chapter will report the research findings of this study. First, a summary of the sample characteristics, including physical properties, will be provided. Results will then be reported for appeals, human model characteristics, risk information, inducements, and physician characteristics, including chi-square analysis to analyze differences across the two decades for each of these variables. The final section of this chapter provides an analysis of these variables vis a vis physician gender and practice type.

Sample Characteristics

Frequencies were run in order to determine the general characteristics of the sample and to address the following research questions:

R1: What is the overall frequency of placement of cosmetic surgery advertisements and what, if any, changes have occurred in the frequency of placement over time?

R2: What types of cosmetic procedures are advertised and what, if any, changes have occurred in the incidence of those procedures over time?

R3: What are the physical format properties of cosmetic surgery advertisements, including size, production, type of illustration and placement?

Unduplicated and Duplicated Ads

There were a total of 3,491 ads for the entire 20-year period. Of these, 1,857 were unduplicated ads. For the unduplicated sample, 24.6 percent (456) of the ads were from the first decade (1985 to 1994) and 75.4 percent (1,401) of the ads were from the second decade (1995 to

2004). For the total sample, including duplicate ads, 27.1 percent (947) of the ads were from the first decade and 72.9 percent (2,544) of the ads were from the second decade (see Table 4.1).

Frequencies were plotted over time for both the unduplicated and total samples, revealing a similar distribution pattern for both samples, in that advertisement frequencies for both samples increased from 1985 to 1988, and then declined slightly through 1993 (see Figure 4.1). Placement levels began to increase again in 1994 and this increase continued through 2004 with the exception of slight declines in 1999 and 2002. A chi-square analysis was conducted on the frequency distribution by year and revealed no significant difference in the distribution patterns of the total and unduplicated samples ($\chi^2 = 20.301$, $df = 19$, $p = $ NS).

As noted by Reid, King and Kreshel (1991), content analysis can be used to examine all ads, whether duplicate or not, or it can examine just the unduplicated instances of ads. This decision is driven by the research objectives. When the researcher is assessing matters of audience exposure or "opportunities to see" estimates, the use of the total sample is appropriate. However, when the objective is to better understand source characteristics or other considerations, as is the case in this study, including all ads can bias the results. Accordingly, the subsequent research questions were addressed using the unduplicated sample of cosmetic surgery advertisements.

Procedures Advertised

The overwhelming majority of ads (84.6%) were for one or more specific cosmetic surgery procedure, while just 15.4 percent of the ads made general references to cosmetic surgery, plastic surgery, facial plastic surgery or facial cosmetic surgery (see Table 4.2). Furthermore, the number of ads for specific procedures increased significantly from 76.1 percent in the first to 87.3 percent of the ads in the second decade ($\chi^2 = 141.086$, $df = 2$, $p \leq .001$).

Over half the ads that mentioned a specific cosmetic surgery procedure included liposuction (53.5%). Liposuction plus breast augmentation (38.8%), facelift (38.5%), eyelid surgery, (37.8%) and nose surgery (33.4%) represented the five most frequently advertised procedures during the 20-year period, followed by soft tissue fillers (31.9%), laser resurfacing (28.5%), Botox (26.6%), vein treatments (23.3%) and breast lift (22.2%). During the first decade, liposuction (59.8%) was the most frequently advertised procedure, followed by breast augmentation (47.7%), facelift (46.8%), nose surgery (46.0%) and eyelid surgery (42.8%). During the second decade, liposuction remained the most frequently advertised procedure (51.8%), followed by eyelid surgery (36.4%), breast augmentation (36.3%), facelift (36.1%) and laser resurfacing (35.4%). Table 4.3 presents the breakdown in advertisements by procedure.

All five of the procedures most frequently advertised over the twenty-year period (liposuction, breast augmentation, facelift, eyelid surgery, nose surgery) were among fourteen procedures that experienced a significant decline in the second decade. For example, liposuction was present in 59.8 percent of the ads that mentioned specific procedures during the first decade, but it appeared in just 51.8 percent of the ads in the second decade ($\chi^2 = 6.991$, $df = 1$, $p \leq .01$). Similarly, breast augmentation significantly declined from being present in 47.7 percent of the ads in the first decade to 36.3 percent in the second decade ($\chi^2 = 14.815$, $df = 1$, $p \leq .001$). By contrast, eleven procedures experienced a significant relative increase in advertising presence. For example, ads for laser resurfacing increased from four percent in the first decade to 35.4 percent in the second decade ($\chi^2 = 131.058$, $df = 1$, $p \leq .001$) and references to Botox increased from less than one percent in the first decade to 34 percent in the second decade ($\chi^2 = 155.135$, $df = 1$, $p \leq .001$).

While there is not much of a change between the two decades in terms of what procedures are advertised most frequently, the relative percentage of ads within which they appear does decline as new, usually less invasive procedures (e.g., Botox, laser skin resurfacing) are introduced. This likely reflects the constant evolution of the field of cosmetic surgery, as well as possible changes in the interests of patients.

Physical Properties

This section describes the physical characteristics of the sample and then compares and contrasts these characteristics by decade. Table 4.1 presents a breakdown of the physical characteristics of the 1,857 ads.

Ad Production. While more than half of the ads placed during the 20-year period were black & white (59.5%), there was a significant increase in the use of color from the first to the second decade. During the first decade, 83.1 percent of the ads were in black & white, followed by color (13.6%) and combination b&w and color (3.3%). In the second decade, the use of both color (42%) and combination b&w and color (6.2%) increased, while the percent of black & white ads decreased to 51.8 percent in the second decade ($\chi^2 = 141.086$, $df = 2$, $p \leq .001$). Despite this shift, black and white production still accounted for the majority of ads placed in the second decade, perhaps a function of the ability of the magazines to handle color advertising over the time period examined. Alternatively, it is possible that this reflects a more serious tone and/or cost factors.

Ad Size. More than half of the ads across the 20-year period were ¼ page to ½ page in size (52.8%), followed by ¼ page or smaller (21.6%) and full page or larger (15.8%). However, there was a significant change in ad size between the two decades, as the percentage of ads ¼ page or less in size increased from 7.2 percent to 26.3 percent and the number of ads larger than

½ page but less than one page decreased from 16.7 percent to 6.9 percent (χ^2 = 109.577, df = 4, $p \leq .001$). In general, the size of ads decreased over time.

Ad Illustration. More than half of the ads across the entire 20-year period used photos (67.7%), followed by artwork (14.8%), combination of artwork and photos (11.0%) and all copy (11.0%). There were some significant changes between the two decades. While the use of photos remained high, advertisements containing artwork decreased significantly from decade one (24.3%) to decade two (11.7%), and the use of a combination of artwork and photos increased from 5.5% to 12.8% over the same period (χ^2 = 109.577, df = 4, $p \leq .001$).

Ad Placement. Nearly three-fourths of ads over the 20-year period were display ads placed throughout the magazine (72.4%), followed by ads placed within special themed advertising sections (21.7%) and ads placed in the classifieds section (1.5%). Ad placement changed significantly between the two decades, as display ads decreased from 93.6 percent to 65.5 percent and ads placed in special themed sections with the magazine increased from 4.6 percent to 27.3 percent (χ^2 = 136.393, df = 3, $p \leq .001$). This may be a reflection of magazines creating more special health, beauty and top doctor sections as a form of value-added advertising packages. These packages are designed to provide the advertiser with additional benefits beyond the advertising space purchased and, in the case of city magazines, could include editorial features, conferring "top doctor" status, or complementary Internet links. Classified ads were seldom placed in either decade.

Advertising Appeals

As discussed in Chapter 2, deregulation of physician advertising in the early 1980s allowed physicians to move beyond providing mere contact information in their advertising. In addition, an emphasis on the potential economic, social and psychological, as opposed to mere

physical benefits of cosmetic surgery may also have had an impact on the use of certain types of appeals in advertisements (see Appendix G for examples of appeals). Accordingly, the following research question was posed:

R4: What types of advertising appeals are used in cosmetic surgery advertisements and what, if any, changes have occurred in the use of these appeals over time?

Four appeals (physical attractiveness, assurance, informational, and sexual) appeared with the greatest frequency over the 20-year period (see Table 4.5). Straightforward physical attractiveness (56.5%) was the appeal most frequently employed over the entire 20-year period, as well as for each of the two decades, followed by assurance (34.4%), informational (22.2%), sexual (20.0%), humor (9.6%), self-determination (8.4%) anti-aging (7.6%), weight loss (5.7%) and psychological benefit (5.3%). Of the ads utilizing a sexual appeal, 85.7 percent implied that cosmetic surgery would improve sexual attractiveness, 59 percent suggested that cosmetic surgery would make one feel sexier, and 12.9 percent contained a promise of increased sexual activity.

Two appeals, assurance and self-determination[8], significantly increased in presence from decade one to decade two. The percentage of ads using an assurance appeal increased from 27.4 percent to 36.6 percent ($\chi^2 = 12.924$, df = 1, $p \leq .001$) while the percentage of ads using a self-determination appeal increased from 4.4 percent to 9.7 percent ($\chi^2 = 12.660$, df = 1, $p \leq .001$). Assurance appeals were defined as having the intent to give the audience a sense of confidence in the physician or the procedure and ads employing assurance appeals tend to emphasize the credibility of the surgeon or the safety of the procedure. Self-determination appeals were

[8] Assurance appeals were defined as having the intent to give the audience a sense of confidence in the physician or the procedure. Ads employing this appeal tend to emphasize the credibility of the surgeon or the safety of the procedure. Self-determination appeals were defined as having the intent to encourage the audience to undergo surgery for themselves, not others, thereby taking control of their physical appearance and destiny. These and the definitions of other appeals are further explained in the coder training manual, Appendix B.

defined as having the intent to encourage the audience to undergo surgery for themselves, not others, thereby taking control of their physical appearance and destiny. Just one appeal, weight loss, decreased significantly in presence from decade one (9.9%) to decade two (4.4%) (χ^2 = 19.436, df = 1, $p \leq .001$).

Human Model Characteristics

While the representation of human models in cosmetic surgery ads potentially can provide insight into targeting strategies, these representations also play a role in establishing expectations of cosmetic surgery outcomes. To provide a systematic view of the representation of human models in cosmetic surgery magazine advertisements, the following research questions were asked:

R5: What are the demographic characteristics of models portrayed in cosmetic surgery magazine ads, including sex and race? What, if any, changes have occurred in these characteristics over time?

R6: How are human models portrayed in cosmetic surgery advertisements, including identification of human models as actual patients, and the use of before/after photos? What, if any changes have occurred in these representations over time?

Table 4.6 presents a breakdown of these characteristics, including the presence, sex and race of models, and whether the model was explicitly identified in the copy as an actual patient. In addition, the section identifies the use of before and after photos of human models and reports the extent to which these photos held visual characteristics other than surgery results constant between photos. Model presence is reported for all unduplicated ads (n=1,857), whereas model sex, model race, and presence of before/after photos are reported for only those ads in which a

human model was present (n=1,391). For the purposes of this study, physicians and/or members of their staff were not considered to be human models.

Human Model Presence

Three-fourths of the ads over the 20-year period (74.9%) included a human model. While the presence of human models remained high, there was a significant decrease in the percentage of ads that included human models between the two decades, from 81.4 percent during the first ten years to 72.8 percent during the second ten-year period ($\chi^2 = 13.393$, df = 1, $p \leq .001$). This shift may be related to an increase in the number of ads placed within "top doctor" special advertising during the second decade, as discussed earlier in this chapter.

Human Model Demographics

Over the 20-year period, 94 percent of the ads containing human models featured one or more female, while just 12.7 percent of the ads featured males. Model sex could not be determined for 4.8 percent of the ads. The percentage of ads featuring female models remained high for both decades, increasing slightly from 91.6 percent to 94.8 percent ($\chi^2 = 4.787$, df = 1, $p \leq .05$) There was no significant change in the percentage of ads that featured male models between the two decades ($\chi^2 = .029$, df = 1, p = NS), nor in the ads for whom model sex could not be determined ($\chi^2 = .001$, df = 1, p = NS).

Advertisements predominately featured white models across the 20-year time span (69.6%). Black, Hispanic and Asian models combined appeared in just 2.1 percent of the ads over the 20-year period and race could not be determined for one or more models in nearly one-third (31.8%) of the ads. This may in part reflect the difficulty coders had in identifying race, particularly that of Hispanics. The percentage of ads that included white models increased significantly from decade one (64.7%) to decade two (71.4%) ($\chi^2 = 5.741$, df = 1, $p \leq .05$), while

ads for whom model race could not be determined decreased from 36.9 percent to 30 percent (χ^2 = 6.015, df = 1, $p \leq .05$).

Human Model As Patient

Just 7.3 percent of the ads over the entire 20-year period that featured a human model explicitly named that model as an actual patient and there was no significant difference in this approach between the two decades (χ^2 = 37.235, df = 1, $p \leq .001$). While this number might increase if one were to assume that the presence of before and after photos tacitly implied that the model was an actual patient, such instances were not assumed to be an indication of patienthood in this study.

Use of Before and After Photos

Before and after photos were employed in 17.3 percent of the ads that included human models over the entire 20-year period. Furthermore, the prevalence of this approach remained consistent across decades. Although the percentage of ads that featured before and after photos decreased from 19.9 percent in decade one to 16.3 percent in decade two, the difference was not significant (χ^2 = 2.569, df = 1, p = NS).

Generally speaking, the majority of ads that included before/after photos appeared to hold photographic production qualities constant. More than three-quarters of the ads over the entire 20-year period that included before/after photos featured the model in a similar pose for both photos (80.8%) and held lighting constant (79.2%). More than half of the ads using before/after photos held makeup (56.3%) and hairstyle (51.7%) constant and 45 percent of the ads showed models wearing the same clothing in both photos.

The tendency to hold before/after photographic production qualities constant remained consistent across both decades for pose, lighting, and makeup. However, there was a significant

decrease in the percentage of ads holding hairstyle (from 63.5% to 46.4%) and clothing (from 55.4% to 40.4%) constant ($\chi^2 = 6.013$, df = 1, $p \leq .05$ and $\chi^2 = 4.680$, df = 1, $p \leq .05$, respectively).

Risk Information

As presented in Chapter Two, some researchers have voiced concern that consumers have lost sight of the fact that cosmetic surgery procedures are indeed *surgery* and carry potential risks and complications. As a result, the following research question was asked:

R7: What potential risks, if any, are portrayed in cosmetic surgery advertisements over time and what, if any, changes have occurred in those portrayals over time?

Over the 20-year period an overwhelming majority of cosmetic surgery ads (91.5%) did not make reference to risks, nor was there a significant difference in this absence between the two decades ($\chi^2 = .225$, df = 1, $p \leq .05$) (see Table 4.7). Of those ads that did present risk information, references to recovery period was the most frequent for the overall 20-year period (43.3%), followed by physician selection (24.8%), pain (22.3%), swelling (19.7%), bruising (17.2%), scarring (16.6%), and bleeding (14.0%). Just one category of risk information – recovery period – changed significantly from decade one to decade two, with the percentage of ads referencing duration of recovery period increasing from 26.8 percent to 49.1 percent ($\chi^2 = 6.140$, df = 1, $p \leq .05$). The percentage of ads citing the risk of choosing the wrong doctor remained relatively s over the two decades ($\chi^2 = .118$, df = 1, $p \leq .05$). And, while the percentage of ads that referenced pain, swelling, bruising and/or bleeding all increased from decade one to decade two, none of these shifts were significant ($\chi^2 = .248$, df = 1, $p \leq .05$; $\chi^2 = .3.494$, df = 1, $p \leq .05$; $\chi^2 = .975$, df = 1, $p \leq .05$; $\chi^2 = 2.065$, df = 1, $p \leq .05$). Finally, scarring was the only category of risk information whose frequency actually decreased between decade

one (24.4%) and decade two (13.8%), but this decrease was not statistically significant (χ^2 = 2.462, df = 1, $p \leq .05$). This may perhaps reflect decrease in scarring as new, less invasive procedures are developed.

Inducements

As previously noted, physician marketing efforts often are viewed through a different lens than are ads for non-medical products and services. One issue is the extent to which physicians may be creating demand rather than responding to it. One potential form of coercion might be including additional response mechanisms intended to move consumers closer toward making a purchase decision. Accordingly, the following research question was asked to assess the use of such tactics to motivate consumers to act:

R8: What, if any, inducements are present in cosmetic surgery advertisements and what, if any, changes have occurred over time in the use of such inducements?

Table 4.8 presents a breakdown of inducements by decade. The presence of inducements is reported for all unduplicated ads (n=1,857), whereas the percentage of specific inducement types is reported for only those ads for which an inducement was present (n=893). While nearly half of the ads over the 20-year period (48.1%) included an inducement, the use of inducements decreased over time, with inducements present in 60.3 percent of the ads during the first decade, but only 44.1 percent of the ads in the second decade (χ^2 = 36.148, df = 1, $p \leq .001$). Opportunities to obtain additional information were the most frequently used type of inducement, appearing in 84.5 percent of ads over the 20-year period, followed by financing options (15.1%), monetary incentives (11.2%) and the acceptance of credit cards (6.5%).

Only the use of monetary incentives increased between the two decades, climbing from 1.8 percent in the first decade to 15.4 percent in the second decade (χ^2 = 21.993, df = 1, $p \leq$

.001). Although the percentage of ads with invitations to solicit additional information remained high, their presence decreased significantly from 90.5 percent in the first decade to 81.9 percent in decade two ($\chi^2 = 48.586$, df = 1, $p \leq .001$). The percentage of ads mentioning financing options and the acceptance of credit cards also decreased between the two decades ($\chi^2 = 6.054$, df = 1, $p \leq .05$; $\chi^2 = 4.387$, df = 1, $p \leq .05$).

Physician Characteristics

As discussed in Chapter Two, the marketing efforts of physicians often raise concerns distinct from other types of products and services. In an effort to better understand the characteristics and portrayals of physicians in cosmetic surgery advertisements, the following research question was asked:

> R9: What are the characteristics of physicians portrayed in cosmetic surgery advertisements, including the type of practice, type of physician (M.D. or D.O.), sex and race? What, if any, changes have occurred in these representations over time?

Tables 4.9 and 4.10 present a breakdown of these characteristics by decade. Type of practice and whether or not one or more physician is named is reported for all unduplicated ads (n=1,857), whereas the balance of the characteristics (physician type, sex, race and photo presence) are reported for only those ads where one or more physician was actually named (n=1,522).

Practice Type

Just over two-thirds of the ads over the 20-year period feature an individual practitioner (67.6%), followed by Institute/Center (16.4%), a group of practitioners (13.3%), hospital (5.5%) and other (.9%) (see Table 4.9). While individual practices remained the most frequent type of practice, the percentage of ads featuring Institute/Centers decreased from 28.1 percent in the first

decade to 12.6 percent in the second decade, while the percentage of ads featuring a group of practitioners increased from 6.6 percent to 15.5 percent ($\chi^2 = 77.421$, $df = 2$, $p \leq .001$).

In order to count as an individual practice or group practice an ad had to mention physicians by name. Over the entire 20-year period, 82 percent (1,522) of the ads included the name of one or more physician and there was a significant increase in the percentage of ads that named physicians from decade one (69.5%) to decade two (86%) ($\chi^2 = 63.289$, $df = 1$, $p \leq .001$). In addition, 25.5% of these ads overall included a photo of one or more physician and this increased significantly from 15.8 percent in the first decade to 28.0 percent in the second decade ($\chi^2 = 19.916$, $df = 1$, $p \leq .001$). The increase in the use of physician names and photos may perhaps reflect growing acceptance of physician advertising since it was first legally recognized in 1982, as well as an increase in the use of "top doctor" special advertising sections in the late 1990s and early 2000s.

Physician Type

The majority of ads (87.7%) that named physicians also referenced whether the physician was a medical doctor (M.D.) or an osteopathic doctor (D.O.) (see Table 4.9). Medical doctors accounted for more than three-quarters of these ads (85.7%) as compared osteopathic doctors (2.0%), and there was no statistically significant change in this representation between the two decades ($\chi^2 = .436$, $df = 2$, $p =$ NS).

Physician Gender

Physician gender was determined based on visual (photo) and/or verbal (name) cues. As shown in Table 4.10, ads including male physicians (78.3%) outnumbered female physicians (17.6%) four to one, and physician sex could not be determined for 11.4 percent of the ads. While the percentage of ads featuring one or more male physician remained high, there was a

decline from decade one (86.1%) to decade two (76.2%) ($\chi^2 = 14.563$, $df = 1$, $p \leq .001$). At the same time, the percentage of ads featuring female physicians increased from 9.5 percent to 19.8 percent ($\chi^2 = 18.308$, $df = 1$, $p \leq .001$).

Physician Race

The majority of ads over the 20-year period included physicians for whom race could not be determined (79.4%), followed by ads that included white physicians (18.8%) and Asian physicians (1.7%). In addition, the number of ads that included white physicians increased significantly from 10.7 percent in the first decade to 21 percent in the second decade ($\chi^2 = 17.301$, $df = 1$, $p \leq .001$), corresponding to a decline from 88 percent to 77.2 percent of ads for whom physician race could not be determined ($\chi^2 = 18.034$, $df = 1$, $p \leq .001$). And, while the number of ads including Asian doctors increased slightly from 1.3 percent in decade one to 1.8 percent in decade two, the increase was not statistically significant ($\chi^2 = .475$, $df = 1$, $p \leq .05$). Race historically has been a difficult variable to measure in content analyses, so the inability of coders to discern physician race in the majority of ads is not surprising. Interestingly, 92.8 percent (1,122) of the ads for which physician race could not be determined (1,209) did not include a physician photo while the majority of ads for which coders identified white doctors (97.5%) and Asian doctors (61.5%) did include physician photos. This may suggest that visual (photo) cues may be more useful in determining race.

Physician Credentials

As discussed previously, physician advertising is under scrutiny, particularly in the competitive field of cosmetic surgery, for the use of misleading statements of claims of physician credentials. Accordingly, the following research questions were asked:

R10: What types of physician credentials are mentioned in cosmetic surgery magazine advertisements, including board certification, professional qualifications, and professional affiliations? What, if any, changes have occurred in these mentions over time?

R11: How often do cosmetic surgery magazine advertisements contain a claim of superiority by physicians other than board certification? What, if any, changes have occurred in these claims over time?

Tables 4.11 and 4.12 present the extent to which cosmetic surgery advertisements referenced physician credentials, including board certification, membership in professional organizations, and other types of qualifications such as number of years in practice and medical school affiliation.

Board Certification

More than half of the ads (58.3%) over the 20-year period referenced physician board certification. Furthermore, the number of ads referencing board certification increased significantly from 49.8 percent in the first decade to 61.0 percent in the second decade (χ^2 = 17.897, df = 1, $p \leq .001$).

Board certification in plastic & reconstructive surgery was the most frequently mentioned type of board certification for the entire 20-year period (46.2%), followed by generic references to board certification (15.9%), dermatology (9.3%), both general surgery and plastic & reconstructive surgery (4.0%), cosmetic surgery (3.4%), ophthalmology (2.7%), both cosmetic surgery and facial plastic surgery (2.6), and general surgery (2.4%). In addition, the type of board certification mentioned changed significantly between the two decades (χ^2 = .56.804, df = 8, $p \leq .001$). References to board certification in plastic & reconstructive surgery increased

from 42.3 percent to 47.3 percent while references to board certification in dermatology increased from 3.5 percent to 10.9 percent. However, generic references to board certification decreased from 20.3 percent to 14.7 percent. References to all other types of board certification also decreased from the first decade to the second decade.

Professional Qualifications

While not as common as mentions of board certification, references to other kinds of professional qualifications such as number of years of experience and medical school affiliation were frequently found in cosmetic surgery ads. Over the 20 years, 40 percent of the ads mentioned one or more physician qualification other than board certification. The percentage of ads referencing such qualifications increased significantly from 27.9 percent in the first decade to 44.0 percent in the second decade ($\chi^2 = 37.235$, df = 1, $p \leq .001$).

Superiority Claims

Physicians also made explicit claims of superiority over other practitioners such as, "best educated", "first or only to offer procedure" and "it takes a woman to understand a woman's body". Over the 20-year period, nearly one-third (30.1%) of the ads contained superiority claims other than board certification and the use of such claims increased significantly from 20.2 percent in the first decade to 33.3 percent in the second decade ($\chi^2 = 28.307$, df = 1, $p \leq .001$).

Professional Affiliations

Over the entire 20-year period, just over one-fourth (27.8%) of ads referenced one or more professional organization to which physicians belonged (e.g. Academy of Dermatology, American Society of Plastic Surgeons, Lipoplasty Society of North America). In addition, the number of ads mentioning professional affiliations increased significantly from 19.3 percent in the first decade to 30.6 percent in the second decade ($\chi^2 = 21.954$, $df = 1$, $p \leq .001$).

Advertisement Characteristics by Physician Gender

In an effort to further understand source characteristics, a series of comparative questions were asked to identify potential differences in cosmetic surgery advertisements based on physician gender and practice type. The questions posed with regard to physician gender included:

R12: What are the differences, if any, in the types of appeals employed in cosmetic surgery advertisements for male and female cosmetic surgeons?

R13: What are the differences, if any, in the ways male and female physicians are presented in cosmetic surgery magazine advertisements with regard to credentials (e.g., board certification, professional qualifications, and professional affiliations), the use of superiority claims, and the presence of physician photos?

R14: What are the differences, if any in the tendency of male and female physicians to include risk information in cosmetic surgery magazine advertisements?

R15: What are the differences, if any, in the tendency of male and female physicians to include inducements in cosmetic surgery advertisements?

For this comparative analysis, ads where one or more physician was either named or pictured (n=1,522) were grouped into three one of three categories: 1) those featuring only male physicians, 2) those featuring only female physicians, and 3) those including both male and female physicians or ads where physician sex could not be determined.

Appeals

Advertisements for male versus female physicians differed significantly in the use of four types of appeals: physical attractiveness, assurance, informational and humor (see Table 4.13).

Ads for female physicians were more likely to include assurance appeals as compared to males (χ^2 = 7.381 df = 2, $p \leq .05$). This trend also held for informational appeals, employed in over one-third of ads for females (36.5%) but just one-fifth of ads for male physicians (20.8%) (χ^2 = 23.539, df = 2, $p \leq .001$). Conversely, the percentage of ads employing a physical attractiveness appeal was higher for male physicians (56.0%) than for female physicians (38.9%) (χ^2 = 24.293, df = 2, $p \leq .001$), as was the case for humor appeals (11.2% vs. 3.0%) (χ^2 = 16.332, df = 2, $p \leq$ .001). Ads utilizing economic, threat, sociability, affordability, and health appeals did not appear with enough frequency to be incorporated into this analysis. 4-14 presents the results for the balance of advertising characteristics analyzed by physician sex.

Physician Credentials

On the whole, advertisements for female physicians tended to include credentials more than did ads for male physicians. For example, three quarters of ads for female physicians referenced board certification as compared to 60.9 percent of ads for male physicians (χ^2 = 15.999, df = 2, $p \leq .001$). This was also the case for references to professional affiliations (42.9 percent vs. 31.8 percent; χ^2 = 16.322, df = 2, $p \leq .01$). Although ads for female physicians were slightly more likely to include references to professional qualifications (48.8%) than were ads for male physicians (46.6%), the significant difference for this variable is most likely attributable to the fact that only 33.8 percent of ads featuring both male and female physicians or where physician sex could not be determined (χ^2 = 13.467, df = 2, $p \leq .001$). Furthermore, while ads for female physicians were slightly more likely to include a claim of superiority (36.9% vs. 34.9%), this difference was not statistically significant.

Physician Photos

More than half of the ads for female physicians included a photograph of one or more physician as compared to less than one quarter of the ads that included a male physician (χ^2 = 132.759, df = 2, $p \leq .001$).

Risk Information

As noted earlier, the presence of risk information was scant in all advertisements over the 20-year period. However, it is still interesting to note that a significantly higher percentage of ads for male physicians included risk information (11.2%) than did ads for female physicians (2.5%) (χ^2 = 16.038, df = 2, $p \leq .001$).

Inducements

Nearly half of ads featuring male physicians included some form of inducement (49.3%) as compared to just over one quarter of ads for female physicians (26.1%) (χ^2 = 38.424, df = 2, $p \leq .001$).

Advertisement Characteristics by Practice Type

The following questions were posed with regard to differences in type of physician practice:

R16: What are the differences, if any, in the types of appeals employed in cosmetic surgery advertisements for different types of practices?

R17: What are the differences, if any, in the credentials (e.g., board certification, professional qualifications, and professional affiliations), the use of superiority claims, and the presence of physician photos within cosmetic surgery advertisements for different types of practices?

R18: What are the differences, if any, in the presence of risk information within cosmetic surgery advertisements for different types of practices?

R19: What are the differences, if any, in the presence of inducements within cosmetic surgery advertisements for different types of practices?

For this analysis, ads were grouped into four categories of practice type: 1) individual practitioners, 2) group practice (more than one named physician), 3) institute/center (no named physicians, and 4) hospital/other. Significant differences by practice type were reported for all variables, with ads for institutes/centers being the least likely to include additional information about physicians.

Appeals

Four appeals appeared with enough frequency across the practice categories to be included in the analysis: physical attractiveness, assurance, informational, and sexual, and all four differed significantly by practice type (see Table 4.15). A physical attractiveness appeal was employed most frequently for all practice types, with two-thirds of ads for institutes/centers and more than half of the ads for each of the three other categories utilizing this type of appeal ($\chi^2 = 19.733$, df = 3, $p \leq .001$). The high incidence of institute/center ads for this appeal could perhaps reflect a diminished appeal repertoire for such practices, who may find it difficult to leverage other appeals more closely tied to a bona fide physician persona (e.g., psychological benefits, assurance).

The use of assurance appeals ranked second among all four practice types, but was significantly less prevalent in ads for institutes/centers than for other categories, appearing in just 24.3 percent of the ads ($\chi^2 = 17.480$, df = 3, $p \leq .001$). This may reflect the difficulty of establishing assurance in a practitioner or procedure without a focus on a specific physician.

Informational appeals were ranked third in use for all types of practices, but were more prevalent among ads placed by hospital/other practices. Such appeals appeared in just 16.1 percent of ads for institutes/centers ($\chi^2 = 10.263$, df = 3, $p \leq .05$).

Sexual appeals accounted for less than 10 percent of the ads in any of the practice types. However, ads for institutes/centers employed sexual appeals for a significantly higher percentage of ads (8.9%) than did individual practitioners (2.5%), group practices (1.6%) or hospital/other, for which there were no ads using sexual appeals ($\chi^2 = 34.586$, df = 3, $p \leq .001$). Table 4.16 presents the results for the balance of advertising characteristics analyzed by type of practice.

Physician Credentials

Generally speaking, individual practitioners were most likely to reference physician credentials in their ads, followed by group practices, hospital/other and institutes/centers. For example, nearly two-thirds of both individual practitioners (63.2%) and group practices (61.5%) mentioned board certification in their advertisements as compared to 44 percent for hospital/other and 37.7 percent for institutes/centers ($\chi^2 = 70.798$, df = 3, $p \leq .001$). This pattern held for references to professional affiliations and qualifications. One-third of ads for individual practitioners and one-fourth of ads for both group practices and hospitals/other referenced affiliations with professional organizations as compared to just 7.5 percent of ads for institutes/centers ($\chi^2 = 84.477$, df = 3, $p \leq .001$). Nearly half of ads for individual practitioners and 40.5 percent of ads for group practices referenced professional qualifications, as compared to 34 percent of ads for hospitals and 15.4 percent of ads for institutes/centers ($\chi^2 = 97.294$, df = 3, $p \leq .001$). The consistent fourth place showing of ads for institutes/centers is not surprising, given the fact that procedures in such practices are often performed by visiting physicians rather than full-time physicians dedicated exclusively to a practice.

Superiority Claims

More than half of the ads for hospitals/other contained claims of superiority, followed by ads for individual practitioners (32.5%), group practices (31.2%) and institutes/centers (15.7%) ($\chi^2 = 44.898$, df = 3, $p \leq .001$). The high percentage of hospital/other ads may reflect the fact that in some markets city level chapters of the ASPS undertake ad campaigns to persuade consumers that board-certified plastic surgeons are the safest choice for cosmetic surgery.

Physician Photo Present

Ads for individual practitioners included more physician photos (27.1%) than did other types of practices, followed by group practices (17.8%) and hospitals/other (8%). Not surprisingly, no ads for institutes/centers included a physician photo ($\chi^2 = 9.675$, df = 3, $p \leq .01$).

Risk Information

While the percentage of ads including risk information was less than 15 percent for all practice categories, hospital/other tended to present risk information most frequently (14%) as compared to group practices (10.1%), individual practitioners (9.1%) and institutes/centers (3.6%) ($\chi^2 = 12.777$, df = 3, $p \leq .01$). The higher incidence of ads for hospital/other may perhaps reflect a tendency of hospitals to encounter risks more frequently than do physicians solely providing cosmetic surgery services.

Inducements

There also was a significant difference in the use of inducements across practice types. Over half of the ads for group practices (61.5%) and individual practitioners (53.4%) included some form of inducement, followed by hospital/other (44%) and institute/center (39.3%) ($\chi^2 = 30.814$, df = 3, $p \leq .001$).

Table 4.1. Magazine Advertisements by Year

Year	Percent of Unduplicated Ads	Unduplicated *n*	Percent of Duplicated Ads	Duplicated *n*
1985	1.5	28	1.2	43
1986	2.4	44	2.3	79
1987	2.7	51	3.0	105
1988	3.7	68	4.2	148
1989	2.9	53	3.5	121
1990	3.1	58	3.4	117
1991	2.0	38	3.2	110
1992	2.2	40	2.1	75
1993	1.7	31	1.9	66
1994	2.4	45	2.4	83
Total Decade 1	**24.6**	**456**	**27.1**	**947**
1995	4.4	82	3.9	135
1996	6.8	126	5.4	187
1997	8.1	151	6.7	235
1998	7.2	133	7.3	255
1999	6.5	120	6.8	239
2000	7.9	146	8.7	303
2001	8.5	157	8.6	301
2002	6.9	128	7.0	245
2003	9.0	168	9.2	321
2004	10.2	190	9.3	323
Total Decade 2	**75.4**	**1,401**	**72.9**	**2,544**
Total	**100.0**	**1,857**	**100.0**	**3,491**

$\chi^2 = 20.301$, df = 19, $p \leq .001$

Table 4.2. Advertising Topic by Decade

	Total		1985- 1994		1995-2004	
Topic	Percent	*n*	Percent	*n*	Percent	*n*
Ads for Specific Procedures	84.5	1,570	76.1	347	87.3	1,223
Ads for General Cosmetic/Plastic Surgery	15.5	287	23.9	109	12.7	178
TOTAL	100.0	1,857	100.0	456	100.0	1,401

$\chi^2 = 33.017$, df = 1, $p \leq .001$

Note: Percentage figures are calculated based on the total number of unduplicated ads in each decade.

Table 4.3. Specific Procedures Advertised by Decade

	Total		1985-1994		1995-2004				
Procedure	Percent	*n*	Percent	*n*	Percent	*n*	χ^2	*df*	*p*
Liposuction	53.5	841	59.8	208	51.8	633	6.991	1	.01
Breast Augmentation	38.8	610	47.7	166	3.3	444	14.815	1	.001
Facelift	38.5	605	46.8	163	36.1	442	13.095	1	.001
Eyelid Surgery	37.8	594	42.8	149	36.4	445	4.764	1	.05
Nose Surgery	33.4	525	46.0	160	29.8	365	31.687	1	.01
Soft Tissue Fillers	31.9	501	27.3	95	33.2	406	4.664	1	NS
Laser Resurfacing	28.5	447	4.0	14	35.4	433	131.058	1	.001
Botox	26.6	418	.6	2	34.0	416	155.135	1	.001
Vein Treatments	23.3	366	14.4	50	25.8	316	19.946	1	.001
Breast Lift	22.2	348	27.3	95	20.7	253	6.868	1	.05
Laser Hair Removal	21.3	334	.6	2	27.1	332	114.262	1	.001
Chemical Peel	20.8	327	22.1	77	20.4	250	.467	1	NS
Female Breast Reduction	18.9	297	27.9	97	16.4	200	23.452	1	.001
Tummy Tuck	18.7	293	16.1	56	19.4	237	1.929	1	NS
Forehead Lift	15.3	240	13.5	47	15.8	193	1.083	1	NS
Chin Surgery	12.0	189	22.1	77	9.2	112	43.053	1	.001
Microdermabrasion	11.8	186	.3	1	15.1	185	57.155	1	.001
Facial Implants	11.0	173	15.5	54	9.7	119	9.259	1	.05
Skin Surface Treatments	9.4	147	4.3	15	10.8	132	13.424	1	.001
Neck Lift	9.1	143	13.8	48	7.8	95	11.887	1	.001
Ear Surgery	8.1	127	13.8	48	6.5	79	19.608	1	.001
Dermabrasion	5.7	90	11.5	40	4.1	50	27.513	1	.001
IPL/Fotofacial	5.5	87	0.0	0	7.1	87	26.207	1	.001
Cellulite Treatment	5.2	82	2.6	9	6.0	73	6.266	1	.05
Permanent Makeup	4.3	68	8.6	30	3.1	38	19.888	1	.01
Tattoo Removal	3.9	61	1.1	4	4.7	57	8.949	1	.01
Thigh Lift	3.1	48	2.6	9	3.2	39	.332	1	NS
Butt Lift	2.9	46	1.7	6	3.3	40	2.280	1	NS
Male Breast Reduction	2.9	45	4.9	17	2.3	28	6.560	1	.01
Thermage	2.0	32	.3	1	15.1	185	57.155	1	.001
Upper Arm Lift	1.6	25	.9	3	1.8	22	1.518	1	NS

	Total		1985-1994		1995-2004				
Procedure	Percent	*n*	Percent	*n*	Percent	*n*	χ^2	df	*p*
Mesotherapy	1.0	16	0.0	0	1.3	16	4.6	1	.05
Other[1]	2.0	38	3.2	11	2.2	27	.025	1	NS

[1]Procedures with less than ten mentions were classified as "other" and include male surgery, calf lift, vaginal surgery, cesarean scar revision, pectoral implants, permanent makeup removal, implant removal, ethnic surgery, skin tag removal, knee lift, and post obesity lift.

Table 4.4. Physical Characteristics by Decade

	Total[1]		1985-1994[2]		1995-2004[3]	
	Percent	*n*	Percent	*n*	Percent	*n*
Ad Production:						
Black & White	59.5	1105	83.1	379	51.8	726
Color	35.0	650	13.6	62	42.0	588
Combination	5.5	102	3.3	15	6.2	87
$\chi^2 = 141.086$, df = 2, $p = \leq .001$						
Ad Size:						
¼ page or less	21.6	402	7.2	33	26.3	369
> ¼ page to ½ page	52.8	981	62.9	287	49.5	694
>½ page <1 page	9.3	173	16.7	76	6.9	97
1 page or larger	15.8	293	12.5	57	16.8	236
$\chi^2 = 108.208$, df = 3, $p = \leq .001$						
Ad Illustration:						
Photos	67.7	1258	61.4	280	69.8	978
Artwork	14.8	275	24.3	111	11.7	164
Combination	11.0	204	5.5	25	12.8	179
None/All copy	6.5	120	8.8	40	5.7	80
$\chi^2 = 62.333$, df = 3, $p = \leq .001$						
Ad Placement:						
Display	72.4	1345	93.6	427	65.5	918
Special Ad Section	21.7	403	4.6	21	27.3	382
Classified	1.5	28	.4	2	1.9	26
Other[4]	4.4	81	1.3	6	5.4	75
$\chi^2 = 136.393$, df = 3, $p = \leq .001$						

[1] Percentages calculated based on total number of unduplicated ads (n=1,857)
[2]Percentages calculated based on unduplicated ads in first decade (n=456)
[3] Percentages calculated based on unduplicated ads in second decade (n=1,401)
[4]Other placement includes advertorials and practice announcements.

Table 4.5. Appeals by Decade

Appeal	Total	1985-1994	1995-2004	χ^2	*df*	*p*
Physical Attractiveness[1]	56.5% (1050)	58.8% (268)	55.8 (782)	1.222	1	NS
Assurance[1]	34.4% (638)	27.4% (125)	36.6% (513)	12.924	1	.001
Informational[1]	22.2% (413)	21.9% (100)	22.3% (313)	.034	1	NS
Sexual[1]	20.0% (371)	19.5% (89)	20.1% (282)	.080	1	NS
Sexual Attractiveness[2]	85.7% (318)	91.0% (81	84.0% (237)	2.683	1	NS
Sex Esteem[2]	59.0% (219)	66.3% (59)	56.7% (160)	2.554	1	NS
Sexual Behavior[2]	12.9% (48)	9.0% (8)	14.2% (40)	1.621	1	NS
Humor[1]	9.6% (179)	10.5% (48)	9.4% (131)	.546	1	NS
Self Determination[1]	8.4% (156)	4.4% (20)	9.7% (136)	12.660	1	.001
Anti-Aging[1]	7.6% (142)	5.9% (27)	8.2% (115)	2.549	1	NS
Weight Loss[1]	5.7% (106)	9.9% (45)	4.4% (61)	19.436	1	.001
Psychological Benefit[1]	5.3% (99)	6.4% (29)	5.0% (70)	1.267	1	NS
Affordability[1]	3.4% (63)	2.2% (10)	3.8% (53)	2.654	1	NS
Social[1]	1.4% (26)	1.1% (5)	1.5% (21)	.404	1	NS
Threat[1]	1.2% (23)	1.8% (8)	1.1% (15)	1.315	1	NS

Note: Frequencies are in parentheses.
[1]Percentages are calculated based on the total number of unduplicated ads (n=1,857).
[2] Percentages are calculated based on total number of unduplicated ads with sexual appeal present (n-371).

Table 4.6. Human Model Characteristics by Decade

	Total	1985-1994	1995-2004	χ^2	*df*	*p*
Model Present[1]	74.9% (1391)	81.4% (371)	72.8% (1020)	13.393	1	.001
Model As Patient[2]	7.3% (102)	7.5% (28)	7.3% (74)	.034	1	NS
Model Sex[2]						
Female	94.0% (1307)	91.6% (340)	94.8% (967)	4.787	1	.05
Male	12.7% (176)	12.4% (46)	12.7% (130)	.029	1	NS
Can't Determine	4.8% (67)	4.9% (18)	4.8% (49)	.001	1	NS
Model Race[2]						
White	69.6% (968)	64.7% (240)	71.4% (728)	5.741	1	.05
Can't Determine	31.8% (443)	36.9% (137)	30.0% (306)	6.015	1	.05
Other[3]	2.1% (29)	1.1% (4)	2.5% (25)	2.512	1	NS
Before/After Photo Present[2]	17.3% (240)	19.9% (74)	16.3% (166)	2.569	1	NS
Pose held constant[4]	80.8% (194)	75.7% (56)	83.1% (138)	1.837	1	NS
Lighting held constant[4]	79.2% (190)	81.1% (60)	78.3% (130)	.238	1	NS
Makeup held constant[4]	56.3% (135)	62.2% (46)	53.6% (89)	1.520	1	NS
Hair held constant[4]	51.7% (124)	63.5% (47)	46.4% (77)	6.013	1	.05
Clothing held constant[4]	45.0% (108)	55.4% (41)	40.4% (67)	4.680	1	.05

Note: Frequencies are in parentheses.
[1] Percentage figures are calculated based on the total number of unduplicated ads by time period (n=1,857).
[2] Percentage figures are calculated based on number of unduplicated ads with model present (n=1,391).
[3]Other races include black, Hispanic, Asian, and multi-racial.
[4]Percentage figures are calculated based on number of unduplicated ads with before/after photo present (n=240).

Table 4.7. Risk Information by Decade

	Total	1985-1994	1995-2004	χ^2	*df*	*p*
Risk Info Present[1]	8.5% (157)	9.0% (41)	8.3% (116)	.225	1	NS
Risk Info Type[2]						
Recovery Period	43.3% (68)	26.8% (11)	49.1% (57)	6.140	1	.01
Physician Selection	24.8% (39)	26.8% (11)	24.1% (28)	.118	1	NS
Pain	22.3% (35)	19.5% (8)	23.3% (27)	.248	1	NS
Swelling	19.7% (31)	9.8% (4)	23.3% (27)	3.494	1	NS
Bruising	17.2% (27)	12.2% (5)	19.0% (22)	.975	1	NS
Scarring	16.6% (26)	24.4% (10)	13.8% (16)	2.462	1	NS
Bleeding	14.0% (22)	7.3% (3)	16.4% (19)	2.065	1	NS
Other[3]	9.6% (15)	7.3% (3)	10.3% (12)	.321	1	NS

Note: Frequencies are in parentheses.
[1] Percentage figures are calculated based on the total number of unduplicated ads by time period (n=1,857).
[2] Percentage figures are calculated based on number of unduplicated ads with risk present (n=157).
[3] Other risk information includes general reference to risks, risks associated with anesthesia, and puckering.

Table 4.8. Inducements by Decade

	Total	1985-1994	1995-2004	χ^2	*df*	*p*
Inducement Present[1]	48.1% (893)	60.3% (275)	44.1% (618)	36.148	1	.001
Inducement Type[2]						
Additional information	84.5% (755)	90.5% (249)	81.9% (506)	48.586	1	.001
Financing Options	15.1% (135)	16.4% (45)	14.6% (90)	6.054	1	.05
Monetary Incentives	11.2% (100)	1.8% (5)	15.4% (95)	21.993	1	.001
Credit Cards Accepted	6.5% (58)	7.6% (21)	6.0% (37)	4.387	1	.05

Note: Frequencies are in parentheses.
[1] Percentages calculated based on total number of unduplicated ads (n=1,857)
[2] Percentages calculated based on total number of unduplicated ads for which inducement was present (n=893).

Table 4.9. Physician Characteristics by Decade

	Total		1985-1994		1995-2004	
	Percent	*n*	Percent	*n*	Percent	*n*
Practice Type[1]						
Individual Practitioner	67.6	1255	61.4	280	69.6	975
Institute/Center	16.4	305	28.1	128	12.6	177
Group of Practitioners	13.3	247	6.6	30	15.5	217
Hospital[2]	1.8	34	2.6	12	1.6	22
Other[4]	.9	16	1.3	6	.7	10
$\chi^2 = 77.421$, df= 2, $p \leq .001$						
Physician Type[3]						
M.D.	85.7	1305	84.6	269	86.0	1036
D.O.	2.0	31	2.2	7	2.0	24
Other[4]	12.2	186	13.2	42	12.0	144
$\chi^2 = .436$, df = 2, p = NS						

[1]Percentages calculated based on total number of unduplicated ads (n=1,857), unduplicated ads in decade one (n=456) and unduplicated ads in decade two (n = 1,401).
[2]Variable includes ads placed by hospitals that both did and did not mention the name of a physician.
[3]Percentages calculated based on number of ads that mentioned the name(s) of a physician (total n=1,522; decade one n=318; decade two n=1,204).
[4]Other includes ads where a physician name was mentioned but type could not be determined, and ads placed by physician groups with both M.D.s and D.O.s.

Table 4.10. Physician Characteristics by Decade (Continued)

	Total	1985-1994	1995-2004	χ^2	*df*	*p*
Physician(s) Named[1]	82.0% (1522)	69.5% (317)	86.0% (1205)	63.289	1	.001
Physician(s) Photo[2]	25.5% (388)	15.8% (50)	28.0% (338)	19.916	1	.001
Physician Gender[2]						
Male[4]	78.3% (1191)	86.1% (273)	76.2% (918)	14.563	1	.001
Female[5]	17.6% (268)	9.5% (30)	19.8% (238)	18.308	1	.001
Can't Determine	11.4% (174)	10.7% (34)	11.6% (140)	.198	1	NS
Physician Race[2]						
Can't Determine	79.4% (1209)	88.0 (279)	77.2 (930)	18.034	1	.001
White	18.9% (287)	10.7% (34)	21.0% (253)	17.301	1	.001
Asian	1.7% (26)	1.3% (4)	1.8% (22)	.475	1	NS
Other[3]	1.8% (27)	1.6% (5)	1.8% (22)	.089	1	NS

[1]Percentages calculated based on total number of unduplicated ads (n=1,857), unduplicated ads in decade one (n=456) and unduplicated ads in decade two (n-1,401).
[2]Percentages calculated based on only those ads that mentioned the name of a physician (total n = 1,522; decade one n=317; decade two n=1,205).
[3]Other races include black, Hispanic, and multi-racial doctors.
[4] Includes in which only male physicians were present (n = 1,100) and ads in which both male and female physicians were present (n=59).
[5] Includes ads in which only female physicians were present (n=203) and ads in which both female and male physicians were present (n=59).

Table 4.11. Physician Board Certification by Decade

	Total		1985-1994		1995-2004	
	Percent	*n*	Percent	*n*	Percent	*n*
Board Certification Mentioned[1]	58.3	1082	49.8	227	61.0	855
$\chi^2 = 17.897$, df =1, $p = \leq .001$						
Board Certification Type[2]						
Plastic & Reconstructive Surgery	46.2	500	42.3	96	47.3	404
Generic "board certified"	15.9	172	20.3	46	14.7	126
Dermatology	9.3	101	3.5	8	10.9	93
Both General Surgery and Plastic & Reconstructive Surgery	4.0	43	4.8	11	3.7	32
Cosmetic Surgery	3.4	37	5.7	13	2.8	24
Ophthalmology	2.7	29	2.2	5	2.8	24
Both Cosmetic Surgery and Facial Plastic Surgery	2.6	28	5.7	13	1.8	15
General surgery	2.4	26	6.6	15	1.3	11
Other[3]	13.5	146	8.8	20	14.7	126
$\chi^2 = 56.804$, df = 8, $p = \leq .001$						

[1]Percentages calculated based on total number of unduplicated ads (n=1,857)
[2] Percentage figures are calculated based on the total number of unduplicated ads mentioning board certification (n=1,082).
[3] Other types of board certification include otolaryngology, both dermatology and plastic & reconstructive surgery, facial plastic & reconstructive surgery, both otolaryngology and plastic surgery, and cosmetic surgery, plastic surgery and otolaryngology.

Table 4.12. Physician Credentials by Decade

	Total[1]	1985-1994[2]	1995-2004[2]	χ^2	*df*	*p*
Professional Qualifications[3]	40.0% (743)	27.9% (127)	44.0% (616)	37.235	1	.001
Superiority Claims	30.1% (559)	20.2% (92)	33.3% (467)	28.307	1	.001
Professional Affiiliations[4]	27.8% (517)	19.3% (88)	30.6% (429)	21.954	1	.001

[1] Percentage figures are calculated based on the total number of unduplicated ads (n=1,857).
[2] Percentage figures are calculated based on the total number of unduplicated ads in each decade (n=456; n=1,401).
[3]Professional qualifications include references to number of years of experience in general or in a specific procedure, medical school or residency affiliation, undergraduate or masters school affiliation, number of procedures performed, number of patients, academic affiliation (e.g., professor, trainer, instructor), chief of staff at hospital, continuing education, Ph.D., or inventor/holder of medical patent.
[4] Professional affiliations include membership in the Academy of Cosmetic Surgery, Academy of Dermatology, American Academy of Facial Plastic & Reconstructive Surgery, American Society of Aesthetic Plastic Surgeons, American Society of Plastic Surgery, Lipoplasty Society of North America, American College of Surgeons, American Society of Laser Medicine Surgery, American Society of Liposuction Surgery, American Society of Ophthalmic Plastic & Reconstructive Surgery, International Society of Cosmetic Laser Surgeons, and state and city level professional organizations.

Table 4.13. Appeals by Physician Gender

Appeal	Male[1]	Female[2]	Both/Can't Determine[3]	χ^2	*df*	*p*
Physical Attractiveness	56.0% (616)	38.9% (79)	60.7% (133)	24.293	2	.001
Assurance	36.2% (398)	42.9% (87)	30.1% (66)	7.381	2	.05
Informational	20.8% (229)	36.5% (74)	24.7% (54)	23.539	2	.001
Sexual	19.0% (209)	15.8% (32)	21.9% (48)	2.594	2	NS
Humor	11.2% (123)	3.0% (6)	6.4% (14)	16.332	2	.001
Self-Determination	8.6% (95)	8.4% (17)	7.8% (17)	.183	2	NS
Anti-Aging	8.1% (89)	3.4% (7)	7.8% (17)	5.417	2	NS
Weight	6.7% (74)	3.4% (7)	4.6% (10)	4.186	2	NS
Psychological Benefit	5.3% (58)	4.9% (10)	4.1% (9)	.523	2	NS

Note: Frequencies are in parentheses
[1] Percentages based on total number of unduplicated ads with only male physician(s) (n=1,100)
[2] Percentages based on total number of unduplicated ads with only female physician(s) (n=203)
[3] Percentages based on total number of unduplicated ads with both male and female physician(s), or where physician sex could not be determined (n=219).

Table 4.14. Advertisement Characteristics by Physician Gender

	Male[1]	Female[2]	Both/Can't Determine[3]	χ^2	*df*	*p*
Physician Credentials						
Board Certification	60.9% (670)	75.4% (153)	60.3% (132)	15.999	2	.001
Professional Qualifications	46.6% (513)	48.8% (99)	33.8% (74)	13.467	2	.001
Professional Affiliations	31.8% (350)	42.9% (87)	24.7% (54)	16.322	2	.001
Claim of Superiority	34.9% (384)	36.9% (75)	28.3% (62)	4.299	2	NS
Physician Photo Present	23.3% (256)	55.7% (113)	87% (19)	132.759	2	.001
Risk Information Present	11.2% (123)	2.5% (5)	7.8% (17)	16.038	2	.001
Inducement Present	49.3% (542)	26.1% (53)	41.6% (91)	38.424	2	.001

Note: Frequencies are in parentheses

[1] Percentages based on total number of unduplicated ads with only male physician(s) (n=1,100)

[2] Percentages based on total number of unduplicated ads with only female physician(s) (n=203)

[3] Percentages based on total number of unduplicated ads with both male and female physician(s), or where physician sex could not be determined (n=219).

Table 4.15. Appeals by Practice Type

Appeal	Individual Practitioner[1]	Group Practice[2]	Institute/Center[3]	Hospital/ Other[4]	χ^2	*df*	*p*
Physical Attractiveness	53.9% (676)	57.9% (143)	67.5% (206)	50.0% (25)	19.733	3	.001
Assurance	36.9% (463)	33.6% (83)	24.3% (74)	36.0% (18)	17.480	3	.001
Informational	23.9% (300)	20.2% (50)	16.1% (49)	28.0% (14)	10.263	3	.05
Sexual	2.5% (32)	1.6% (4)	8.9% (27)	0.0% (0)	34.586	3	.001

Note: Frequencies are in parentheses.

[1] Percentages based on total number of unduplicated ads for individual practitioners (n=1,255).

[2] Percentages based on total number of unduplicated ads for group practices (n=247)

[3] Percentages based on total number of unduplicated ads for institutes/centers where specific physician not referenced (n=305).

[4] Percentages based on total number of unduplicated ads for hospitals where specific physicians were/were not referenced, or ads for city professional organizations (n=50).

Appeals that did not appear with enough frequency across the four categories to be included in the analysis are anti-aging, economic, health, humor, psychological benefit, self-determination, sociability, threat, weight, and affordability.

Table 4.16. Advertisement Characteristics by Practice Type

	Individual Practitioner[1]	Group Practice[2]	Institute/Center[3]	Hospital/ Other[4]	χ^2	*df*	*p*
Physician Credentials							
Board Certification	63.2% (793)	61.5% (152)	37.7% (115)	44.0% (22)	70.798	3	.001
Professional Qualifications	46.1% (579)	40.5% (100)	15.4% (47)	34.0% (17)	97.294	3	.001
Professional Affiliations	33.5% (421)	24.7% (61)	7.5% (23)	24.0% (12)	84.477	3	.001
Claim of Superiority	32.5% (408)	31.2% (77)	15.7% (48)	52.0% (26)	44.898	3	.001
Physician Photo Present	27.1% (340)	17.8% (44)	0.0% (0)	8.0% (4)	9.675	2	.01
Risk Information Present	9.1% (114)	10.1% (25)	3.6% (11)	14.0% (7)	12.777	3	.01
Inducement Present	53.4% (670)	61.5% (152)	39.3% (120)	44.0% (22)	30.814	3	.001

Note: Frequencies are in parentheses.
[1] Percentages based on total number of unduplicated ads for individual practitioners (n=1,255).
[2] Percentages based on total number of unduplicated ads for group practices (n=247)
[3] Percentages based on total number of unduplicated ads for institutes/centers where specific physician not referenced (n=305).
[4] Percentages based on total number of unduplicated ads for hospitals where specific physicians were/were not referenced, or ads for city professional organizations (n=50).

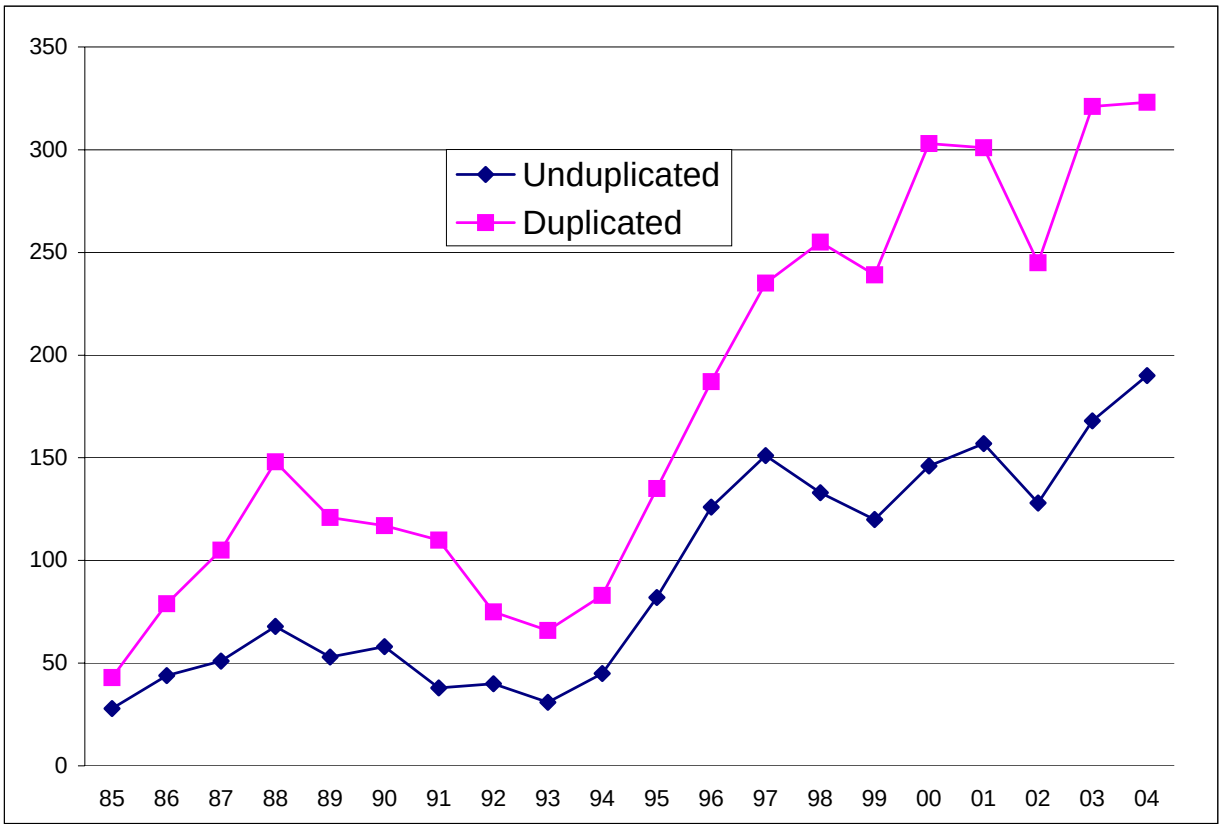


Figure 4.1. Advertisement Frequencies by Year

CHAPTER FIVE

RESULTS: STAGE TWO

The objective of this stage of the research was to explore consumer use and interpretations of cosmetic surgery advertising *in general* rather than seeking out responses to any specific advertising stimuli derived from Stage One of the study. This chapter presents the findings from the participant interviews, including use of advertisements, confirmation or disconfirmation of expectations set by advertising, perceptions of cosmetic surgery advertising versus other forms of physician advertising, perceptions of advertising for male versus female cosmetic surgeons, and perceptions of advertising for different types of cosmetic surgery practices.

Participant Characteristics

Participants were all Caucasian females, with ages ranging from 34 to 52; the average age of participants was 45. Eleven of the participants worked full-time outside the home. Four participants worked in the medical field, four were in sales, and two worked in marketing communications. Two participants were from the greater Atlanta area while ten were from the greater Grand Rapids or Detroit, Michigan areas. There were no differences found in participant responses based on location.

Ten participants had already undergone elective cosmetic surgery while two participants, Samantha and Faith, were scheduled to have their first elective surgery within the next year. Of the ten women who had already had cosmetic surgery, three had had three or more procedures and seven had had two procedures. Nine of these women were planning to have more cosmetic

surgery within the next year, while just one had no intention of further surgeries (see Appendix F for participant profiles).

Encounters with Cosmetic Surgery Advertising

Exposure to cosmetic surgery advertising in any form was a condition of participation in this study. In an effort to understand the extent of their encounters with cosmetic surgery advertising, participants were asked the following question:

R20: When and in what vehicles do you recall encountering cosmetic surgery advertisements?

Participants recalled encountering advertisements on television, radio, the Internet, city and national magazines, newspapers, yellow page ads, billboards, direct mail, and in brochures distributed at trade shows and in doctor offices. Interestingly, participants typically had difficulty parsing out advertisements and other marketing materials from print editorial content and television programming about cosmetic surgery. The most frequently recalled mediums were television, magazines, radio, newspapers, and brochures/displays in doctor offices.

On the whole, participants did not recall encountering cosmetic surgery advertisements prior to the late 1990s. While eight of the twelve participants underwent one or more cosmetic surgery procedure in the 1990s, just two of these participants, Jennifer and Cheryl, recalled seeing cosmetic surgery advertisements prior to their first surgeries. Even then, they each recalled only one source for advertisements. For example, Jennifer recalled seeing an ad in *Atlanta Magazine* for a plastic surgery consultant prior to her eyelid surgery in 1996 and Cheryl, who had an eyelid lift in 1999, did so in response to brochures posted in her dermatologist's office. Conversely, all participants recalled multiple vehicles through which they have been exposed to cosmetic surgery advertisements since 2000. For example, according to Margeaux:

> [Since 1998] it's a whole different story. Things have really exploded. So there are several different offices and businesses in our area that are doing all types of procedures. They are promoting in so many different ways – every possible form of advertising. And informational seminars that you can go to – and you learn about those through ads as well.

Cheryl makes a similar observation:

> Well, it seems like there are a lot more [ads] in the past three to five years. Almost anything you pick up now has something in it. And it seems that that trend started about five years ago or so.

Use of Advertising

A series of questions were asked to better understand how and when women used advertising in their search for information about cosmetic surgery. These questions captured information about attention, purpose, information categories of interest and the relative importance of advertising versus other information sources.

Attention

While the ability to recall the presence of cosmetic surgery advertising and the channels through which such ads were communicated provides some insight into the marketing environment, it says little about the salience of such messages to consumers. To gain such insight, the following question was asked:

R21: How much attention do you pay to cosmetic surgery advertising in general?

Participant responses fell into one of two categories. The majority of the women said they consistently paid a high level of attention to all forms of cosmetic surgery advertising and expressed fascination and intrigue with the topic in general. Furthermore, this perspective was shared both by women who had had, and who were planning to have cosmetic surgery. For example:

> **Diane, 49, philanthropist**: I always look at cosmetic surgery ads. I pay a lot of attention because I am always curious. And I think every woman is. We just

want to find out what's up and coming and new. There's all kinds of new things coming out all the time, techniques, procedures, products.

Patrice, 48, nurse technician: I pay a lot of attention to them all the time. I really do. My interest in piqued, it really is!

Samantha, 39, title insurance escrow officer: I pay a lot of attention. I am very intrigued by every ad I see.

Alternatively, some participants shared that their level of attention was conditional, based on whether or not they perceived a specific need at the time they encountered the advertising. Their approach to cosmetic surgery ads was more purposive in nature.

Cheryl, 52, media production entrepreneur: I would say that I am mildly interested [in cosmetic surgery ads]. Unless I am at a point in my life where I am not feeling good about how I look. Then I am more interested in ads for that procedure because I would want to see what they are saying about it.

Janet, 35, real estate agent: I just don't pay a lot of attention now. I did before, because I needed a very specific procedure done. My gut said get a [breast] lift. So I was looking. And as I age I will probably have more done and will pay more attention to ads again then.

There is an indication that these two approaches are not mutually exclusive. One of the women interviewed began with a purposive approach to cosmetic surgery advertising but her level of attention intensified post-surgery as she became more aware of and interested in cosmetic surgery as a topic. This shift may have been propelled by expanded coverage in the mass media of cosmetic surgery overall.

Paula, 41, nurse. I didn't pay much attention before I had my surgeries. I did it because I had so much extra skin and my clothes weren't fitting. But now I think, "Oh, wow, they can do *that?"* There are so many different things they can do.

Role of Advertising: Purpose & Topics of Interest

Recalled exposure and attention levels do not necessarily convey how consumers actually *use* cosmetic surgery advertisements. What types of information are they seeking out? What

content is most salient to them? Where do they use ads in their decision-making process? To better understand the role that cosmetic surgery advertisements play, participants were asked the following questions:

R22: How you use cosmetic surgery advertisements and what role do these advertisements play in your decision to have cosmetic surgery? At what stage of your decision-making process did you use the advertisements?

Participants unanimously indicated that they used advertisements at the early stage of their decision-making process, using terms such as "upfront", "a beginning tool", "a starting point", "at the beginning", and "early on". Furthermore, all participants shared that the key role cosmetic advertising played was to create awareness of procedures and practitioners – what the latest procedures are and who does them in the area. And while they acknowledged the role that advertising played in identifying potential providers, participants across the board were quite emphatic about the limited role that advertising played in their final selection of a physician. For example:

> **Cheryl, 52, video production entrepreneur**: I'll tell you what I think it did. I think it piqued my interest. It got me thinking about it and it moved me to the point of looking to a credible source. I don't think that beyond that … it didn't close the deal. It was something that got me down the path to say, "Oh, that could be an option. I could look at that". I don't think the advertising closes the deal on something as personal as this. It just makes you aware.
>
> **Margeaux, 51, sales manager:** I think it's just a very beginning tool to find out who's out there and what they do. I guess if I saw an ad I was really impressed with that I thought was conveyed really well, it might color my decision whether to go with a specific physician. But no, all it does is tell me who is out there and what their capabilities may be so I can do further research.
>
> **Janet, 35, real estate agent:** I've seen these cheesy ads on TV. And I always thought, who on earth would select a physician, a doctor from a TV ad?

Another participant shared that she used the advertisements, along with other mediated sources of information, to educate herself and to prepare to interview physicians.

> **Stephanie, 51, sales representative:** The ads, articles and TV shows all help because they cued me in on what questions to ask when I interviewed the doctor, but the ads didn't make my decision on who would do the surgery.

Interestingly, physician selection was the dominant topic across all interviews, even for participants who indicated that they would return to the same physician for future work. Those participants who were happy with their surgery outcomes said they no longer looked to advertising to identify potential providers, but continued to seek out information in the ads about procedures. This may suggest that cosmetic surgery advertisements need to play a dual role, targeting first-time patients by emphasizing physician contact information and credentials, but simultaneously featuring additional procedures and offerings for return patients. This latter strategy might best be served using direct mail or other forms of relationship marketing, rather than city magazines.

> **Diane, 49, philanthropist**. Now that I have a doctor, that part [of the ad] isn't as important. I'm more interested in information about procedures.
>
> **Janet, 35, real estate agent:** I can't imagine I would ever go anywhere else.
>
> **Daria, 39, interior designer:** Information about doctors will matter less for future surgeries, because I'll go back to the same surgeon because he did a good job.
>
> **Renee, 39, dietician:** I don't use ads anymore to source a doctor. I will probably go back to the same place. I was very happy with everything, so I won't use ads to find a doctor for future surgery. It may be more expensive, but I'll go there.

The women interviewed also mentioned several other types of information they actively looked for in cosmetic surgery ads, including physician credentials, patient testimonials, and the relative importance of advertising vis a vis other sources of information about cosmetic surgery.

Physician Credentials. Physician credentials also were mentioned by participants as a key piece of information they sought out in advertising. Credentials of interest included board certification, years of experience, education/training, area of specialty, and hospital affiliation. Board certification was mentioned most frequently, and most participants were adamant about only considering board certified plastic surgeons. This preference was attributed to articles highlighting the importance of using board certified plastic surgeons, or, for those participants who work in medical-related field, a self-proclaimed understanding of the superior training and education associated with plastic surgeons.

> **Cheryl, 51, video production entrepreneur:** You know what, I look for "board certified plastic surgeon" because I've seen enough stories that say you should look for a board certified plastic surgeon. And I look to see what hospitals they are affiliated with, because I know that I give more credibility to some hospitals than others. I also look at the length of time the practice has been in the area and where they are located.

> **Paula, 40, nurse:** I look for whether they are board certified in plastic surgery, how long they've been in practice, and where they did their schooling and residency – if it's a top plastic surgery area. If it's not mentioned in the ad there's a place you can actually check to see what their certification is. And you need to. That's extra schooling, extra fellowships, extra classes for board certified plastic surgeons. And each year they have to be updated and they are always getting training. And you want them to be trained.

For one participant, the salience of board certification and other physician credentials was so strong that, when searching for a plastic surgeon, she recalled specific copy points from an ad she had seen three years earlier.

> **Janet, 35, real estate agent:** So in retrospect, where I had originally found the ad for the doctor's office that said they were board certified and recognized for year after year after year, that was where I should have gone first. It was assuring. And they won awards and they were recognized for so long. The credentials were key, because not every office that was listed [in the magazine] had the credibility that they did. And that information stayed with me so long. I remembered it years later when I needed to find someone to fix the first botched job. I should have gone to them in the first place.

Some participants also looked to advertising and other information sources to communicate a level of specialization beyond board certification type and expressed frustration with their inability to uncover which surgeons were doing which procedures most often with successful results. For example:

> **Faith, 49, legal assistant:** It matters what they specialize in. But sometimes it's hard to tell, especially in ads. They tend to list everything but you don't know if they specialize in liposuction or breasts. They'll tell you board certification, but not more.

> **Patrice, 48, nurse technician:** I think there are certain surgeons who are better at some things than others, so you have to look carefully. But it's tough to know who is a specialist at what procedure. They all seem to say they do everything. Jack-of-all-trades. Even when you ask their office people on the phone. They are reluctant to suggest one doctor over another in the practice. But at a minimum it has to be a board certified plastic surgeon.

Testimonials/Before & After Photos. One additional type of information participants sought out was testimonials, often in the form of before and after photographs. Overall participants seemed to feel that such visuals added credibility to the physician and helped them visualize a successful outcome for themselves, perhaps providing a form of efficacy. For example:

> **Stephanie, 51, sales representative:** I look for information about doctors and procedures in the ads, but what really draws me in are the testimonials. And then when you go to see the doctor, they have even more photos and stories of people who have had the surgery. And those are very impactful.

> **Cheryl, 52, video production entrepreneur:** I guess I'm looking to see if it's a testimonial, a before and after, or something like that. I'd be interested in what the person had to say, although I'm a little leery of some of that because there is always the disclaimer that results may vary. But I guess I'm looking for a visual, some credibility, some information.

> **Daria, 39, interior designer:** I look for success factors in ads, and the best way to tell is with before and after photos. You get a sense of how successful your surgery might be.

> **Patrice, 48, nurse technician:** I always look at the before and afters. There should be more before and afters … that's what's best to see, an actual patient. They are helpful because you can identify with them more. You can say, "My stomach looks like that, but look how she looks now".
>
> **Paula, 40, nurse:** I always pay most attention to the people in the ads. And I want to know if they are everyday people or just models. People that are models have natural beauty. That's their job. Everyday people that work to get to where they look good, they should be in that ad because they've had it done. They've had to work through all those other issues. They weren't born beautiful. They weren't born with great skin and everything else. It's important to know because it makes it real. When you see their before and after photos you can figure out what's changed. But if it's just a model you have no idea. I would like to see the every day person. I want to know some of the story. You know, working in the hospital, you like to see the before and after. With the beautiful model it's hard to know what's changed.

Like Paula, Patrice also discussed the ability to parse out what exactly had changed in the before and after photos, further testament to the advertising literacy of the participants.

> **Patrice, 48, nurse technician:** I think I'm a good judge of what has been added so I still like to see before and afters. And I can look at the photo and say, "Right. I know what happened there." You have to read between the lines. I mean, it's advertising. And the buyer needs to beware.

Role of Advertising: Relative Importance

Cosmetic surgery advertising represents just one source of information that consumers use when contemplating cosmetic surgery. As indicated above, participants shared that advertising plays a role early on in the decision-making process. To assess the relative importance of advertising in comparison to other sources of information, the following question was asked during the interviews:

R23: How important is cosmetic surgery advertising relative to other information sources in your decision to have cosmetic surgery?

In addition to advertising, participants mentioned several other sources of information about cosmetic surgery, including information on the Internet, consultations with cosmetic

surgeons, interviews with former cosmetic surgery patients and even reality television programs. Invariably, participants indicated that these sources of information played a more significant role than advertising in their decision to have cosmetic surgery, as well as who would perform that surgery.

> **Diane, 49, philanthropist:** For me it would have to be more than the advertising. People matter more. I would need to have more first hand referrals for people who have actually gone to that person. I asked for referrals from my internist, my OBGYN, and others who have had surgery by the doctor. That's what probably sold me on him the most – that my OBGYN's wife actually used the same doctor.

> **Janet, 35, real estate agent:** [Ads were] kind of a low priority. My biggest deal was let me talk to you and find out what your experience was with that doctor. And if it was okay with you, then what about the next person and the next person. That was way more important than any advertising. Because anyone can put an ad in a magazine or on television.

> **Faith, 49, legal assistant:** Well the biggest decision in all this is who to go to. And I rely more on the consultation with the physician than on ads. And I talk to other people who have had it, and I get all the information from the Internet that I can.

> **Stephanie, 51, sales representative:** I look at the ads, then I go to the doctor website. But to actually choose the doctor, it's more of a referral from others, and then interviewing the doctors myself. The ads were a first step. I mean, I scoured them madly for information, but once I got into meeting the doctors, understanding their process and speaking to their references, that's what swayed me. I would say that the little nuggets of information in the ads helped, but talking to people, including the doctor, played the biggest role.

While conversations with former patients and physicians were considered to be more important information sources than advertising, utilization of the Internet to research additional information was also a common theme. Eleven of the twelve participants indicated that they used advertising and the Internet in combination.

> **Renee, 39, dietician**. I used the print ads to determine which physicians I was interested in and if they did the procedure. Then I go to the web to gather data and make a final decision.

> **Stephanie, 51, sales representative:** [I use ads] at the very start. I never knew anything about [tummy tucks] and I saw something in a TV ad that interested me. So I went to the Internet to check it out more, then called the office to schedule a consultation and ask for a list of patients who are on the reference list who would talk to me.
>
> **Samantha, 36, title insurance escrow officer:** Advertising suggests an idea to me and sometimes tells me where to look on the Internet. And I usually go to a neutral source, like WebMD or ASPS to get more information about doctors.

A common search for information sequence profile emerged during analysis of the transcripts. For many participants, exposure to advertising was followed by additional research on the Internet, which resulted in a short-list of doctors to interview, followed by reference checks with former patients, and then final selection of a cosmetic surgeon. For example:

> **Cheryl, 52, video production entrepreneur:** Well, I rely a lot on information from the Internet. Places like WebMD and the ASPS website. I mean, after seeing the ads I went online to those neutral sources and read about tumescent liposuction. And then I made a personal visit to the physician's office. And for me it's really about whether I connect with someone and whether I feel like I'm getting a straight story or not. That's the critical thing.

Interestingly, several participants included reality television programs about cosmetic surgery in their list of important information sources.

> **Samantha, 36, title insurance escrow officer:** It's more important to me to talk to people and get more detailed information about their experience. And of course, the television programs like *Extreme Makeover* give you all kinds of good information.
>
> **Margeaux, 51, sales manager:** Seminars, people who've had it, and television shows about cosmetic surgery, like *The Swan"* are the most important. The only thing that makes the advertising important is that it tells who I may want to talk to.

Another participant acknowledged that the importance of advertising as an information source might vary based on the complexity or invasiveness of the procedure, suggesting that the issue has several layers of complexity.

> **Jennifer, 50, freelance copywriter:** Advertising would make the most difference for something like Botox. [The places that do it] are all pretty much the same, so pricing would be very important, and you could communicate that in ad fairly well. If they had a special of the month and said $50 off or something like that, yeah, that could influence me.

Risk Information

Although none of the participants mentioned, unprompted, that they looked for information about risks when encountering cosmetic surgery advertisements, the researcher asked whether participants had encountered such information and whether they expected to encounter such information, in cosmetic surgery advertisements.

The presence of risk information in advertising was rarely recalled, nor was it expected by most participants. Only one of the interviewees recalled seeing any reference to risks in cosmetic surgery advertisement and even then, the reference was general and positive:

> **Stephanie, 51, sales representative:** Ads are usually very vague about [risk information], or they portray it in a positive manner. Things like "virtually no swelling or downtime". It's all very general.

Nearly all the participants indicated that they would not expect to see references to risks in advertisements. In fact, most participants were quite matter of fact about why such information might not be included in ads, perhaps indicating a certain savvy about the persuasive nature of advertising -- even advertising by physicians, a source typically accorded a high degree of credibility and trust.

> **Renee, 39, dietician:** They don't want to scare you off. They want to lure you in. And then, when you sit down with them, they talk about it so they are covered from a legal standpoint. But I've never seen an ad that has ever said anything negative.

> **Patrice, 48, nurse technician:** I wouldn't expect to see risk info. It's not pretty enough. It won't sell. They are trying to sell the concept, the idea, the results. Even with bariatric surgery ads all you see is, "I lost 100 pounds and now I play with my kids." They never tell you that two out of every ten patients die, that

four out of ten have serious complications and that 70 percent of the people who have it done regain the weight. They leave that chapter out.

Jennifer, 50, freelance copywriter: I don't recall seeing a lot of risk information in ads. I think that's something they avoid. They don't want you thinking about that. They want you to think about the positive end outcome. I would personally be interested in that information and would seek it out on my own, but I haven't seen it much in ads.

Samantha, 36, title insurance escrow officer: I haven't and don't expect to see risks. They want to make it seem really great and beautiful and glamorous. But it's just like a diet. You don't just get there. It doesn't happen overnight. I think the ads make it seem instantaneous, but the reality is that it doesn't happen that way. Anytime you do something like that to your body it doesn't recover right away.

Daria, 39, interior designer: You typically don't see that in ads. I haven't, because that would be promoting something bad. And if it *is* there, it's in fine print.

Janet, 35, real estate agent: I would probably have more respect for a doctor who included that information, although you probably don't see too many ads with that there. But I understand. That would be like putting a real estate ad in the paper and saying, "Oh, yeah, and by the way, the basement flooded once. But they cleaned it up." And they haven't even looked at the house yet! So I can see why they don't do it.

Alternatively, one participant attributed the lack of risk information to the inevitability of an advertisement to accurately communicate the type, probability, or severity of risks at the individual level, rather than a deliberate, strategic intent to emphasize the positive over the negative:

Paula, 40, nurse: That wouldn't be in the ad. That would come when you go to the doctor. It's all individual. Because they check your skin to see how you are going to heal. They look at other scars you have to see how you might do, and they check out whether you smoke or not, how healthy you are, and if you eat right. I mean they ask a ton of questions that I didn't think they would ask. It's a given that any type of invasive procedure is going to have swelling. There will be issues and there will be risks. I mean, it's a given unless people aren't in the real world.

To probe this construct more deeply, participants were presented with a hypothetical situation in which they were asked about their impressions of two ads and the cosmetic surgeons who placed the ads. Participants were told that the two ads were identical, except that one ad contained a reference to a two week recovery time and the chance of temporary swelling and bruising. Some of the participants conferred greater credibility upon the physician who included the risk information. For example:

> **Faith, 49, legal assistant:** I've seen no risk information in ads, none at all. But I would probably lean toward an ad that had that information. I'd trust them more. They are willing to put it in the ad.
>
> **Stephanie, 51, sales representative:** I think ads with that information have more credibility. And that's ultimately why I went with the doctor I went to. Because he was very frank about what to expect … he gave me the ugly side.
>
> **Diane, 39, philanthropist:** I would respect an ad that did that. There's too many out there that just show you the positive side. I'd rather get the real information -- that would be very helpful.

However, this was not the case for everyone. Some participants felt that risk information would be a turn-off and would actually dissuade them from considering a physician who included such information in an ad. For example:

> **Patrice, 48, nurse technician:** Even if I saw an ad with risk info, I wouldn't go to [that doctor]. To me it would be like those, "Try this new blood pressure medication. It may cause dizziness, drowsiness, stomach ache, ulcers, blah, blah, blah" ads. It would be a turn off. Now, if I was researching it on the Internet, I would want to know. But not in an ad.
>
> **Daria, 39, interior designer:** I think it would be a turn off at that stage, because if I was going for elective surgery I would want to be excited to start investigating! Something I wanted to improve upon and I can learn about it later. Besides, I would never rely on an ad for anything. Not even a coupon. I don't believe in it until I actually get the 50 cents back!

One participant shared that while the presence of risk information might not be a turn off, she would not put much credence in either the utility of the ad or in the integrity of the physician:

> **Cheryl, 52, video production entrepreneur:** I think the fine print of ads has become so prevalent that we almost don't look at it. I think there are so many disclaimers that you see in the advertising about "side effects may vary", "individual results may vary", and "you may experience this," … it's become so pervasive that I almost think I discount it. I almost think that when it comes to risk, I don't trust the ads to tell me what really is the appropriate level of concern I should have.

Another woman felt that risk information in advertising was irrelevant:

> **Paula, 40, nurse:** No, [it doesn't make a difference]. Because once it's in your head that you want to have it done, it doesn't really matter. You are already focused on what you are going to have done.

In summary, the interviews indicate that although risk information is salient to these women, they do not expect to see it in advertisements. Furthermore, participants differed in their perceptions of physicians who did or did not include risk information in hypothetical advertisements. The response of one participant acknowledges this difference in preference by individual:

> **Samantha, 26, title insurance escrow officer:** I would go for the doctor who gives you the full story because he's not trying to pull the wool over your eyes. He's going to tell you everything you need to know and not just the pretty stuff. But that would be for someone who is looking for information about reality. Anyone else who wants to focus on the dream might just go for the dream without thinking of the consequences.

<u>Confirmation/Disconfirmation of Expectations</u>

As mentioned in Chapter Two, the ASPS developed a code of ethics to guide the marketing endeavors of its members in an effort to preserve the reputation of the profession. One component of that code involves the intent to falsely create unjustified expectations. Accordingly, this study asked the following question of interview participants:

> R24: Did the results of cosmetic surgery meet the expectations set by the information presented in cosmetic surgery advertising?

Interestingly, during the interviews the participants had difficulty parsing out expectations generated by advertising alone. This required the researcher to ask several follow up questions in an effort to isolate advertising influences, particularly from expectations that were grounded in dialogue with physicians prior to the surgery. Even then, the researcher was unable to secure responses to this question from three of the women. This difficulty is further illustrated by the following quote from Janet, in regard to her second surgery to repair the mistakes made during her breast augmentation.

> **Janet, 35, real estate agent:** Yes, my expectations were absolutely met. He fixed it and I look great. And I should have gone with my gut instinct -- I should have gone to him in the first place. But I can't say that all of my expectations came from the ad, because I know who is paying for the ad. So it's tough to focus just on that alone. And then talking to people time and time again … I kept hearing that the surgeon I had chosen, my new surgeon, was repairing [my first surgeon's] work. It was almost taking over his practice.

Over the course of the interviews it became evident that participants defined "expectations" in two ways: 1) outcome expectations about appearance and 2) process expectations, including recovery period and side effects. Many of the women discussed both appearance and process expectations in the interview, while others focused exclusively on either appearance or process, largely reflecting their experiences. Interestingly, none of the women made any reference to outcome expectations other than straightforward physical appearance (e.g., changes in lifestyle or self esteem). For example:

> **Cheryl, 52, video production entrepreneur:** My expectations were met for results, but not for process. I can look at a before and after picture [of myself] and say, "That's really a good result." But in terms of process and procedure, I think the ads make it sound like it's a lot easier than it is in terms of recovery. The duration or recovery and what you look and feel like.

> **Diane, 49, philanthropist:** To some degree [they were met]. Although I don't think they showed downtime or side effects quite to the degree they should in the ads. Because it's major surgery. I don't think that … even though they tell you in

> the consult about the downtime and discomfort it's not as real until it happens to you. On the other hand, the aesthetic result matched perfectly.

The inclusion of process expectations in response to this question is particularly interesting given that most respondents did not recall seeing, nor did they share expecting to see, any references to risk information in cosmetic surgery advertising. This ambiguity also may reflect the difficulty participants had in separating the various factors that influenced their expectations. Alternatively, it may suggest that the absence of risk factors and/or side effects contributed to an expectation that there would be no such effects.

Participants discussed both types of outcome expectations (e.g., appearance and process) in relation to either physician selection or portrayals of human models in ads. Several participants attributed the meeting of their expectations to their choice of doctor. In doing so, they placed the responsibility on the consumer to make an informed decision about the provider, rather than placing trust in the advertising content per se. For example:

> **Margeaux, 51, sales manager:** The augmentation did [meet my expectations from the ad], definitely. The liposuction, because they took a lot out of my thighs, it left some dimpling, so not as much there. But I believe the work I'll have done in the future will meet what I've come to expect. I think [what's promised in the ads] is attainable if you go to the right people. You have to be really careful about their qualifications. You can't take the ads at face value. You have to go in with both eyes wide open and research everything.

> **Faith, 49, legal assistant:** Yes. I think that if the ad says it will be this, then I would expect that it will turn out that way. But that's if I pick the right surgeon. And I always do my research. I mean, they're doctors who are advertising, so their reputation is important to them.

Alternatively, many of the women discussed their expectations specifically within the context of the human models in the ads. This reference was not surprising, as the use of human models represents one of the most direct ways to communicate positive appearance outcomes. Many participants expressed setting realistic outcome expectations, recognizing that it was

unlikely that their results would align perfectly with those of the models in the ads. Some participants attributed this healthy skepticism to individual differences. For example:

> **Daria, 39, interior designer:** (hasn't had yet). I don't expect to look exactly like the people in the ads. I mean, just like anyone who takes a picture into a hairdresser and says, "I want that haircut because then I will look like that," and then they walk out and they look terrible because it's the wrong cut for them! So my expectations aren't set that high and I believe they will be met because I'm realistic.

For others, this realism was grounded in an understanding that advertisements typically reflect an idealized standard of beauty, usually unattainable by the average person. For example:

> **Samantha, 36, title insurance escrow officer:** Well, most ads don't use real people, so my results probably won't look like that, and I understand that. You're not going to look like that person. They wouldn't put a normal person in there for breast implants who got a size C. They'd put someone in who got a size D. It would be exaggerated to some degree. Super thin or totally perfect picture of someone perfect and beautiful. Most ads don't put a normal person in there.

Cosmetic Surgery Advertising vs. Other Types of Physician Advertising

As discussed in Chapter Two, cosmetic surgery is elective and demand originates from marketing efforts and other sources of cultural pressure, as opposed to a patient's physical needs. At the same time, cosmetic surgeons remain a part of the medical profession, charged with a responsibility to promote patients' interests over their own, even in the face of an increasingly competitive landscape. This begs a preliminary question -- are the marketing endeavors of cosmetic surgeons different from those of other physicians, and if so, how? While Stage One of this study identifies advertising weight and content properties of cosmetic surgery ads, it falls short of capturing consumer perceptions of cosmetic surgery advertising. As a result, participants in this study were asked:

R25: Do you think there is a difference in how cosmetic surgeons advertise as compared to other types of physicians? Do consumers perceive there to be an ethical line that cosmetic surgeons should not cross in their advertising?

Virtually all the women interviewed believed that ads for cosmetic surgery were distinct from other forms of physician advertising, and differences were perceived in three areas: degree of aggressiveness, message and style/tone. Several of the women remarked about the sheer volume of advertising messages as compared to other forms of physician advertising, and linked that volume to the intent to create demand. For example:

> **Paula, 40, nurse:** Oh, yes. There's a big difference. [Cosmetic surgeons] put it out there more. I mean, you don't hear about a general practice on the radio. And monthly they send stuff to your home and once you have something done they send you an offer to bring in a friend. So they are actively searching for clients.

Furthermore, some of these women went so far as to approve, if not endorse, this aggressiveness.

> **Patrice, 49, nurse technician:** Oh, yeah. Huge difference. I think cosmetic surgeons are trying to create demand. I mean, it's an industry that has just skyrocketed. And I'm the first one to tune into *Dr. 90210* or *Extreme Makeover*. And I love the before and afters. It's a huge industry! But I don't think there's any harm in it.

> **Margeaux, 51, sales manager:** Big difference. They are out there more. And as a business person I think it's awesome. I think when you work so hard to develop a skill and an education that you should have the ability to market and promote yourself just like anyone or anything else. I think it tells you something about their approach to things if they have a strong marketing program to get the word out. I think it shows an aggressive individual who really wants to do well, and therefore maybe that attitude spills over into his approach to surgery and his techniques. Maybe someone who is looking to advance more in technology and be more involved in what is happening. Who isn't just laid back and happy with the status quo, but wants to push forward and move on and use all the tools that are available.

However, not all participants were as positive about what they perceived to be aggressive advertising by cosmetic surgeons, and several women hinted at an innate tension that they couldn't quite define:

> **Stephanie, 51, sales representative:** I think the cosmetic surgeon is out there a lot more. And sometimes I resent it, even though I'm a big advocate of cosmetic surgery. But I'm not quite sure why. I think we have to be careful with that.
>
> **Cheryl, 52, video production entrepreneur:** I think there are some things … I think there's some stuff that cosmetic surgeons shouldn't advertise. But maybe I'm just being old fashioned. And I can't quite put my finger on why I think that.

Participants also perceived differences in advertising messages. Several of the women interviewed felt that cosmetic surgery ads emphasized benefits beyond mere health or improved physical appearance more so than did ads for other physicians. For example:

> **Stephanie, 51, sales representative:** [Cosmetic surgery ads] don't just talk about changing how you look – the physical change from surgery. And most other physicians just talk about the physical ramifications. But for plastic surgery it's about changing your life.
>
> **Patrice, 48, nurse technician:** Cosmetic surgeons are more like, "We can make you look better than you did before." Heart surgeons don't give you that guarantee. They say, "We have the best facility and equipment and will do our absolute best to treat you." Plastic surgeons seem to promise without any caveat.
>
> **Daria, 39, interior designer:** Definitely there's a difference. I think ads play on the whim of people more than the need. Catching people at the moment that they are at their weakest. Well, maybe not their weakest. But you may be thinking about the surgery for a while and all of a sudden, for whatever reason, circumstances change and you want to investigate it more. You might have broken up with a boyfriend. You might have divorced; you might be going through your change. You might want to look younger or see yourself the way you remember yourself. And cosmetic surgery ads try to play into that … to catch you when you're ready and make you think they can help change your life.

These references to "life-changing" were somewhat surprising, given that none of the women mentioned outcomes other than a change in appearance when asked whether expectations created by cosmetic surgery were met.

Interestingly, one participant did not perceive any real difference in the messages used for cosmetic surgery ads and those placed by other types of physicians:

> **Janet, 35, real estate agent:** They all provide a safe service, whether you need a new heart or you need your boobs lifted back up to where they belong. Truly, I

> think that is probably the same thing. So the message, regardless, is usually about "Enjoy life, live longer, be happy, be healthy".

At the same time, this woman recalled a radio advertisement she heard the morning of the interview and acknowledged the expanding repertoire of message strategies.

> **Janet, 35, real estate agent:** I actually heard an ad for liposuction this morning as I was leaving the gym. It was a television ad and it said, "Don't stop working out, just make it go further" or something along those lines. And I thought, "Well, isn't that clever?" So it's interesting that they now go so far as to tie it to the workout. Who knows where it will go from here?

Other participants focused on differences in tonality. Many of the woman interviewed felt that ads for cosmetic surgery had more style and glamour while other types of physician advertising tended to be more serious and stoic.

> **Cheryl, 52:** Oh yes. A big difference. I think that I could describe it as a car. The cosmetic surgeons are more like a Mercedes or a cool sports car and the physicians who are performing other services are more like a reliable Ford. Other physicians tend to be more traditional. Cosmetic surgery ads tend to be softer, more glitzy. There's a different feel to it. It's higher design … it's going for a better look. It's more artsy and snazzy. It's a different look than the physician standing there in the more traditional ad.

> **Patrice, 48, nurse technician:** So you see it [for both types], but it's the tone that's different. For other doctors, the tone is serious. It's a serious ad with factual information.

> **Samantha, 36, title insurance escrow officer:** Well, [cosmetic surgeons] are a lot more showy. They want to show a beautiful image. I think a regular doctor would show a family kind of picture or something. And cosmetic surgeons show a gorgeous babe kind of person, you know? Not normal life sort of stuff. They try to create an experience for you. It's the whole package … a beautiful resort type environment and a perfect life after that.

In summary, participants were virtually unanimous in their belief that advertisements for cosmetic surgery differed from other types of physician advertising.

Participants also were asked to envision what might constitute an ethical line that cosmetic surgeons should not cross when advertising. The objective here was to capture what

might actually be considered to be unethical advertising from the perspective of the consumer, rather than to identify such infractions in real life. As with the query about confirmation or disconfirmation of expectations, some participants had difficulty separating their experiences with cosmetic surgery advertising from interpersonal exchanges with physicians. This required the researcher to ask a series of follow-up questions to encourage the participants to focus in on advertising messages alone. As a result of this focus, two primary themes emerged, misrepresentations in ad copy and visuals and targeting youth. Participants spoke of two kinds of misrepresentations -- over promising results and featuring a model who was not an actual patient without disclosing so.

For some women, over promising was grounded in the fact that every person's body reacts differently to cosmetic surgery procedures, making it impossible to assure a specific, tangible result.

> **Cheryl, 52, video production entrepreneur:** I think, and I don't know what peer review is like on this stuff, but they have to be careful not to promise to deliver results. Because every person is different. And although I joke about "results may vary", I think they have to be very careful about not over promising. And to me, when I look at something and it sounds too good to be true, I've been raised that if it sounds too good to be true, it just is. It's not going to happen. But other people might not think that way.
>
> **Patrice, 49, nurse technician:** They sometimes make it seem like everyone is a perfect candidate and we can fix this, no problem. The ads almost make a guarantee.
>
> **Paula, 40, nurse:** Sometimes they make it seem that everyone can have it done. And that's not true. It's so individual.

For other women, professional ethics were challenged by the promise of life-changing results beyond physical appearance enhancements. For example:

> **Stephanie:** I think it should be more results-driven than emotional. I think they have to be more upfront with … more careful about promising results. They

> seem to be over promising. They make it sound like it's a fix-all. They are saying it will fix your self-esteem, your self-worth.

The second frequently mentioned form of misrepresentation was the undisclosed use of models who were not actual patients of the cosmetic surgeon. A number of participants shared that they felt this practice approximated deception.

> **Daria, 39, interior designer:** Well, if they use a model that isn't their patient without saying so. That's false advertising and it definitely crosses that [ethical] line.

> **Stephanie, 51, sales representative:** It's more inspiring to see a person who has actually gone through it. And I think it's deceptive when they don't let you know whether the model has had surgery or not.

As further confirmation, even one of the participants who creates marketing communication materials as a profession felt that this crossed an ethical line.

> **Cheryl:** I understand that sometimes you have to use models and not patients because you pay them and it's done. But I think the ad needs to say "not an actual patient." And if I see that, it's a signal to me that says they are being honest, because I understand why they have to use a model. But what I don't like is when someone uses an ad and tries to make you think it's a real patient. To me that's deceptive.

Participants also felt that an ethical line was crossed when youth were targeted in cosmetic surgery ads. Several of the women interviewed expressed concern about this trend:

> **Stephanie, 51, sales representative:** It's catching and it's too easy, particularly for kids. They don't get enough of a chance to work on their self-worth without someone letting them know how they can fix it all very easily. So I think it would be a problem if the ads were speaking directly to teenagers or in the magazines or TV shows they watch.

> **Paula, 40, nurse:** They are doing younger and younger people. I don't think 16 year olds need to have cosmetic surgery. And when they are targeting kids in the ads, that's not fair.

Physician Gender and Perceptions of Cosmetic Surgery Advertising

In an effort to better understand how consumers perceive male vs. female cosmetic surgeons and their advertising, the following question was asked:

RQ25: How do you view male vs. female cosmetic surgeons and do you perceive a difference in the way male vs. female cosmetic surgeons advertise?

Physician Sex Preference

Eight of the twelve women interviewed shared that they did not have a preference for male or female cosmetic surgeons, and nearly all of these women said that they considered qualifications, references and a caring attitude as more important than gender when selecting a cosmetic surgeon. For example:

> **Cheryl, 52, video production entrepreneur:** I have no preference for male or female cosmetic surgeons. For me it's more of a sense of whether they are qualified and do they communicate with me.

> **Daria, 39, interior designer:** I have no preference. I would rate more on ability and capability than gender.

> **Samantha, 36, title insurance escrow officer:** Gender doesn't matter to me. It's all about bedside manner. They should be caring about your goals and benefits, not letting you get enormous breasts. That would be so unrealistic and unhealthy.

Four women were adamant about their preference for a male surgeon and their reasons tended to reflect general sex role stereotypes. For some of these women this preference was based on instinct, rather than grounded in anything tangible. Interestingly, one of these women expressed slight embarrassment about this:

> **Margeaux, 51, sales manager:** I hate to say it, and it's terrible, but I would only go to a male cosmetic surgeon. I mean, there shouldn't be a difference, and there probably isn't, but that's what I would feel most comfortable with. I just think they are better. And I know that's bad to think. I'm kind of embarrassed to say it.

Others attributed the preference to the belief that male cosmetic surgeons are more rational and objective, which they felt enabled the physician to listen better.

> **Patrice, 49, nurse technician:** I'm a male physician person all day long. Primarily because I've had the experience of working with them. And I think that male physicians just hear better, they listen better, I think. Maybe they are just more objective while females add more to the conversation. I would go to a male before a female for everything. I went to a female for two consultations. And I love her, I think she is breathtakingly gorgeous herself, but I wanted a man. Because I think they are more objective.

Two of these women also shared that the differences they perceived in the objectivity and rationality of male versus female cosmetic surgeons also were reflected in the office environments.

> **Stephanie, 51, sales representative:** I can only go on my own personal experience and I felt like the female surgeon I interviewed avoided being completely direct and she had a bit more … she glossed over too many things. And the male surgeons, both of them, were very factually based and non-emotional. This is what you can expect. Here's the people to ask. But I was very inspired and excited when I went to her office. It was beautiful. It had all the amenities that would appeal to a woman. It smelled nice, it was beautiful, the colors … everything was gorgeous. So that drew me in. But the minute I talked to her, you could see through it. Fluff vs. substance. The female also verbally criticized male competitors and called them "boys club down the road", which revealed insecurity from my perspective.

> **Janet, 35, real estate agent:** And there were differences between the offices. Again, hindsight. The things I should have picked up on and was suckered into. When you walked into her office it was warm and spa-like. The lights weren't bright, the people were nice. The other office was a medical office. Very nice, mind you. Beautiful, as a matter of fact. But it was a medical office. Make no mistake. You were there to see a doctor. I didn't feel like I was on a spa day.

Although none of the women interviewed indicated a preference for female cosmetic surgeons, one participant (Diane) did acknowledge why some women might have that preference:

> **Diane, 49, philanthropist:** I actually might prefer a male because I think they tend to be more up front. But I think most woman would probably feel more

comfortable with a female, because they tend to be more understanding and caring.

Perceived Differences in Advertising

Most of the women interviewed recalled either seeing differences in ads for male versus female cosmetic surgeons or perceived that there would be such differences. Four areas emerged during analysis of the transcripts: 1) an emphasis on external physical attractiveness vs. internal satisfaction; 2) the use of gender as a competitive advantage, 3) the use of credentials in cosmetic surgery ads, and 4) the use of physician photos in cosmetic surgery ads.

The majority of participants felt that ads for male cosmetic surgeons placed more of an emphasis on physical and sexual attractiveness than did ads for female cosmetic surgeons, and that this attractiveness was defined from the perspective of the viewer, rather than the patient. Furthermore, they felt this approach was typically conveyed through the use of beautiful models. Conversely, participants believed that ads for female cosmetic surgeons tended to emphasize the internal satisfaction derived from surgery.

> **Samantha, 36, title insurance escrow officer:** I think male doctors use younger, glamorous women in their ads while woman [doctors] focus more on a healthy lifestyle and it being about you, not looking good for others. Male doctors portray it more in terms of being physically and sexually beautiful.

> **Margeaux, 51, sales manager:** Well, male doctors' ads would be more about what you look like and how others will look at you. Because that's how they look at women. They can't understand how we feel about it from our perspective like a female doctor can, so she might play that up. So I think it's an internal perspective for the female cosmetic surgeon in her ads with the guys going for more of a physical or sexual attractiveness thing.

Furthermore, most of the women interviewed shared that many female cosmetic surgeons played the so-called "gender card" when advertising, positioning themselves as having a competitive advantage due to their first-hand knowledge of the female body. For example:

> **Janet, 35, real estate agent:** Although doctors don't get their credentials because of gender, it's a huge marketing tool. You know, "I can better understand your needs as a woman because I'm a woman."
>
> **Stephanie:** So many ads for female cosmetic surgeons play up that they know your body and what to do because they are female."

One participant, however, felt that female cosmetic surgeons did not have a monopoly on claims of gender superiority.

> **Faith, 49, medical malpractice legal assistant:** Well, they both do the gender thing. You know, "I'm a woman and I know how you feel". Or, "I'm a guy and I'm a guy's guy and I know how a woman should look." They just do it differently.

There also was some indication that the use of gender as a positioning strategy by female cosmetic surgeons might actually result in a sort of backlash. Although the following excerpts were not reactions to cosmetic surgery advertising per se, they do provide insight into consumer reactions to such an approach:

> **Janet, 35, real estate agent:** Because in retrospect there appeared to be some things that she very much ad to prove about herself. I think she is going gangbusters because she has something to prove to everyone and in the meantime the patient suffers. I mean, as women, do we have something to prove? Occasionally. Depending on if you are highly driven and where you are in your life. And if you've been held back. But who knows? Do you have to take on a society or a group of doctors who are male dominated? She did a "They don't understand" and specifically pointed her finger at the other practice. She said, "I know you. This is not what you want. This is." And shame on me, I believed her. But part of it is we're trained to believe doctors.
>
> **Stephanie, 51, sales representative:** The female cosmetic surgeon I interviewed verbally criticized her male competitors and called them the "boys club down the road", which revealed insecurity, from my standpoint.

Participants also noted differences in the use of credentials as a point of differentiation. Several of the women interviewed felt that female cosmetic surgeons were at a disadvantage as compared to their male counterparts, echoing some of the responses to the query about physician gender preference. Furthermore, they felt that this shortcoming translated into a greater

propensity for female cosmetic surgeons to reference their credentials in advertisements. For example:

> **Stephanie, 51, sales representative:** Personally, I think women need to work harder to gain respect in general. So I think their ads would include more credentials than males, just to level the playing field.

> **Patrice**, **49, nurse technician:** It's so competitive and there are way more plastic surgeons who are males. I think females have a harder time. They have to try harder so they might try to convince you of their worth in the ads by giving more information about themselves and their qualifications.

As with claims of gender superiority, some of the women interviewed did not believe that this tactic was used exclusively by female cosmetic surgeons. One participant felt that ads for male cosmetic surgeons were more likely to include credentials, while ads for female cosmetic surgeons would focus on less rational characteristics.

> **Diane, 49, philanthropist:** I think the males would show more of their certification and experience. I think that female doctors might advertise more that way and show a caring and comfort, even spa-like, environment. That would be attractive to a lot of women.

Two of the participants, both of whom work in marketing communications, spoke of differences in the use of physician photos by male vs. female cosmetic surgeons. One of these women is the owner of a video production company and the other is a freelance copywriter whose client list includes a plastic surgeon. By their own admission, they look at cosmetic surgery advertisements from a different perspective than others, often employing a higher level of scrutiny as they compare and contrast message strategy and implementation. Although these women perceived few differences in cosmetic surgery ads based on physician gender, they both made an interesting observation about the use of physician photos.

> **Cheryl, 52, video production entrepreneur:** From what I've seen in ads, there's not a huge difference. But the visuals in ads for female cosmetic surgeons seem to be softer … more representational. And more ads for male cosmetic surgeons include their photo than for females.

> **Jennifer, 50, freelance copywriter:** I haven't noticed a difference in their advertising, except maybe the males use their own faces more in the ads. Maybe it's because we female patients don't hold males' faces/bodies as kind of a standard for the work they do, but we will for female cosmetic surgeons.

Type of Practice

Physicians practice cosmetic surgery within a variety of structures, including individual practices, group practices, being on-staff at hospitals, and even freelancing at investor-owned cosmetic surgery facilities. In an effort to better understand consumer perceptions of these types of practices and the advertising on behalf of these practices, the following question was asked:

R27: How do you view different types of cosmetic surgeon practices and do you perceive a difference in the way different practices advertise?

Every woman interviewed indicated that the type of practice was not a key point of differentiation when selecting a cosmetic surgeon. The decision to go with a certain surgeon was invariably predicated upon two things: the outcome of the consultation with the surgeon and strong references from former patients. Furthermore none of the participants recalled or anticipated differences in advertising for various types of practices, with the exception of the use of photos.

> **Margeaux, 51, sales manager:** You know, I don't think the type of practice makes a difference at all in what they choose to put in their ads. Except for those Centers where you don't know which doctor you'll get. Kind of similar to the places you go for lasik eye surgery. The ads for those centers obviously won't include photos of doctors or even their names. And that's one of the things that turns me off. You don't always know who you're getting and it's such an important factor. I mean, it's their reputation. You want to see their track record. But maybe it doesn't matter so much to some people for things like Botox. But even that for me … I would want to know who would do it. So I think those ads are things I wouldn't even pursue any further.

Table 5.1 provides a summation of key consumer insights obtained from this stage of the research. The next chapter summarizes the findings of both stages of the study, makes recommendations for future avenues of research, and discusses the limitations of the study.

Table 5.1. Key Consumer Insights

How Consumers Use Cosmetic Surgery Advertisements

- Participants use cosmetic surgery advertising primarily to become aware of three things: 1) which physicians practice in their market, 2) the respective credentials of those physicians, and 3) new cosmetic surgery procedures or techniques.
- Advertising is used early in the search for information process, often as a first step.
- Advertising plays a relatively minor role in the decision to have cosmetic surgery as compared to other information sources such as the Internet, consultations with cosmetic surgeons, interviews with former patients, and reality television programs.

Perceptions of Cosmetic Surgery Advertising Characteristics

- Participants find cosmetic surgery advertising to be more aggressive, stylish and glamorous than other forms of physician advertising.
- Participants find testimonials that include before and after photos to be be among the most persuasive types of advertising messages.
- Advertising messages help set expectations for the process of the surgery as well as the appearance outcome of the surgery.
- Participants would like advertisements using human models to disclose whether or not the model is an actual patgient. At the same time, they are realistic about the likelihood of their appearance outcome aligning with that of human models.
- Participants consider cosmetic surgery ads that ignore the impact of individual differences on physical surgery outcomes or that make life-changing promises to be unethical.

Perceptions of Risk Information in Cosmetic Surgery Advertisements

- Despite acknowledging concern about the risks associated with cosmetic surgery, participants did not recall, nor did they expect to see,, references to risks in cosmetic surgery advertisements.
- Inclusion of risk information within cosmetic surgery ads may or may not favorably impact perceptions of the physician's credibility.

Perceptions of Differences in Cosmetic Surgery Advertising by Male and Female Cosmetic Surgeons

- Participants believe ads for male cosmetic surgeons are more likely to emphasize physical and sexual attractiveness.
- Participants believe ads for female cosmetic surgeons are more likely to reference credentials in an effort to bridge a perceived credibility gap.
- Participants are somewhat suspect of female cosmetic surgeons who position their gender as a competitive advantage.

General Comments

- Participants often blurred the boundaries between advertising and editorial content.
- Participants are savvy consumers of cosmetic surgery advertisements.

CHAPTER SIX

SUMMARY OF FINDINGS, DISCUSSION AND FUTURE RESEARCH

The purpose of this study was to expand the current body of knowledge on cosmetic surgery advertising by providing an empirical description of the manifest content properties of cosmetic surgery advertisements, as well as exploring consumer interpretations of cosmetic surgery advertising. To accomplish this, a two-stage research project was conducted. Stage One consisted of a content analysis of cosmetic surgery advertisements placed within ten city magazines from 1985 to 2004, while Stage Two consisted of depth interviews with 12 women who either have had cosmetic surgery, or are planning to have cosmetic surgery within the next year. Data were collected to answer the 19 research questions posed in the first stage of the study, as well as the eight supplemental research questions posed in the second stage of the study.

This chapter discusses the findings from stage one of the study, the content analysis. It also integrates key themes that emerged from the in-depth interviews with consumers and outlines opportunities for future research. The chapter is organized thematically by sample and structural characteristics, message strategy characteristics, and executional message components of the advertisements (human model characteristics, risk information, inducements and physician characteristics).

Sample Characteristics and Physical Properties of Advertisements

Research Questions One through Three addressed the incidence, topic and general physical characteristics of the advertisements, as well as identifying any possible changes in these characteristics between the two ten-year periods (1985-1994 and 1995-2004).

The nearly three-fold increase in the number of advertisements appearing in the second decade as compared to the first decade is not surprising, given the 700 percent increase in the number of cosmetic surgery procedures performed by ASPS members from 1992 to 2004, as reported in Chapter Two. This growth pattern is similar to that of cosmetic surgery advertisements as expressed in Figure 4.1, providing partial support for observations that increased marketing activity is linked to the rise in cosmetic surgery procedures, perhaps underscored by increased competition among cosmetic surgeons.

Procedures Advertised

The percentage of cosmetic surgery advertisements that mention specific procedures has increased over time. This may be a result of more physicians moving away from placing advertisements that solely communicated practice information, as physician advertising in general became more common place post deregulation in 1982. In addition, the frequency with which certain cosmetic surgery procedures were featured in advertisements closely approximated the incidence of procedures performed for the first decade (see Table 6.1), where the five most advertised procedures during the first decade were also the five most performed procedures in 1994, and eight of the ten most advertised procedures were among the ten most performed procedures in 1994 (ASPS, 1994).[9] The picture is somewhat different for the second decade (see Table 6.2). While nine of the ten most advertised procedures are also among the ten most performed procedures, none of the five most advertised procedures also rank among the top five procedures performed.

[9] The ASPS only reports procedural statistics for two of the years that comprise the first decade: 1992 and 1994. Thus, the comparison is made using the 1994 cosmetic procedural statistics, as 1994 represents the ending year of the first decade of advertisements.

Interestingly, it appears that less invasive procedures such as Botox, soft tissue fillers, and chemical peels rank lower in advertising frequency than one might expect given their high incidence of occurrence. At the same time, more invasive procedures such as liposuction, breast augmentation, and eyelid surgery rank higher in advertising frequency than in actual occurrence. Perhaps this suggests that physicians perceive that more complex, expensive procedures require more promotion than do less invasive procedures. Alternatively, it could simply reflect a belief that promoting the ability to perform more complex signifies a competency with less invasive procedures. Future research could address this question by querying practitioners and their marketing service providers about the rationale for deciding which procedures to feature in advertisements.

Physical Properties

The study also revealed some interesting trends with regard to the physical properties of cosmetic surgery advertisements. Generally speaking, ads tended to be less than one-half page in size, black and white, to include photographs, and to be placed primarily as display ads within magazines or, increasingly, in special themed sections.

While the majority of ads were black and white overall, the use of color did increase over time. It is difficult to ascertain, however, whether the limited use of color reflects the capacity of the publication to handle color advertising, the higher cost typically associated with color, the creative resources used by the physician, or an intent to communicate a more serious tone. These determinations would require checking back issues of the publications to see whether color was present within the issues included in the sample, or asking physicians and/or their agencies about the rationale for such decisions.

Given the visual nature of cosmetic surgery outcomes, the high incidence of photography (67.7%) was not surprising. However, the fact that just over half the ads were between one-quarter and one-half page in size, and that the size of ads decreased over time in general, raises some questions. One might expect that cosmetic surgery advertisements would have become larger in size over time as the stigma of physician advertising receded and competition for consumers within the field of cosmetic surgery increased. In addition, the explicit aesthetic nature of the service being provided, reinforced by the fact that straightforward physical attractiveness appeals were the most common appeal, might likely prompt a move toward larger ad space. However, this appears not to be the case. Future research could examine ad size as compared to advertising rates to see if ad size appears to be a function of cost, with ads being smaller in city magazines with higher advertising rates.

Perhaps most interesting of the physical properties was ad placement trends. Over time a significantly higher percentage of ads (from 4.6% to 27.3%) congregated in special themed sections (e.g., health, beauty, top doctor) within the magazines. As noted earlier, this may reflect an increased emphasis on value added advertising packages. Future research could more specifically delineate the characteristics of these sections, including theme (e.g., health, beauty) and the presence and type of editorial coverage within such sections. It also would be interesting to examine these special themed sections from the perspectives of the publisher, the physician and the consumer. For example, are such themed sections part of a value-added package and if so, what comprises such packages? Are packages used to attract new advertisers or are they extended to all advertisers? With regard to physicians, how do they perceive such sections? Do they feel pressure to participate in order to avoid being perceived by consumers as conspicuously absent? Does message strategy change as a result of placement within a themed section

alongside other cosmetic surgeons? Are physicians relying on the magazine, their staff, or an advertising agency to create their ads? And, with regard to consumers, do such sections create a critical mass that more effectively captures their attention? Does this placement prompt more rigorous comparison of service providers? Does the presence or absence of related editorial content change how consumers interact with ads? Finally, does how the section is positioned (e.g., health vs. beauty) impact consumer perceptions of the advertisements?

Message Strategy Properties

Advertising Appeals

Research Question Four was asked to explore the types of advertising appeals used in cosmetic surgery advertising as an indicator of overall message strategy, as well as to identify any changes in the use of appeals between the two ten-year periods.

Interestingly, the more rational appeals, such as straightforward physical attractiveness (i.e., you will look better), assurance, and informational represented the three most frequent appeals overall and across both decades. Given the emphasis on the social, economic and psychological benefits of cosmetic surgery that are discussed extensively in the literature, one might expect that emotional appeals such as sexual, humor, self-determination, threat, psychological benefit and sociability might have been more frequently employed. This absence was echoed in the findings from stage two of the study. Interview participants did not reference any outcome expectation associated with cosmetic surgery advertising beyond that of improved physical appearance. Interestingly, several participants indicated that such "life changing" promises might cross an ethical line.

Perhaps these findings are an indication that, despite being freed in 1982 from the shackles of "practice information only" advertising, the majority of physicians remain cautious

about pushing their advertising strategies much beyond rational appeals that communicate physical appearance outcomes, information about procedures, or physician credentials. Alternatively, this might be a function of who is actually producing the advertisements. For example, physicians employing advertising agencies might have ads that push creative and design boundaries more so than their counterparts who rely on the magazine or staff members to produce their ads.

Sexual appeals were the most frequently used emotional appeal, present in 20 percent of the ads across the 20 year period. Using the typology of sexual appeals developed by Reichert and Lambiase (2003), this study found that more than three-fourths of ads using a sexual appeal implied that the model would be perceived as more sexually attractive as a result of cosmetic surgery, while more than half implied that the model would feel more sexy or sensual about him or herself. Sexual appeals implying that the model would be more likely to participate in sexual activity, or have greater enjoyment from such encounters, comprised just 12.9 percent of all ads using sexual appeals.

One point of interest, and opportunity for future research, rests in self determination appeals. Although present in less than 10 percent of the ads overall, there was an increase in the use of this appeal from the first to second decade. Such appeals explicitly emphasized consumers taking control of their destiny or rewarding themselves because they deserve it rather than doing it for someone else. The increase in prevalence of this appeal raises a classic debate about cosmetic surgery within the feminist literature. Is cosmetic surgery a resource for empowerment, as suggested by Davis (1995) and others? Or, as Morgan (1998) suggests, does cosmetic surgery represent an even more extreme example of women being duped by a male-dominated beauty system?

Future research could explore the content of cosmetic surgery advertising appeals within the framework of this literature base, and perhaps expand the scope to include interviews with physicians whose marketing strategies contain such appeals and with consumers to assess their interpretations of these appeals.

Executional Components Content Properties

The following sections discuss executional components that flow from the overall message strategy/appeal, including human model characteristics, risk information, inducements and physician characteristics.

Human Model Characteristics

Research Questions Five and Six were asked to determine the incidence, demographic characteristics and treatment of human models portrayed in cosmetic surgery advertisements, as well as to identify any possible changes in these characteristics between the two ten-year periods.

Demographics. The presence and demographic profiles of human models within the ads proved unsurprising. The high incidence (75%) of human models over the 20 year period echoes the results of Sullivan's (2001) examination of ads from the early and late 1990s. Advertisers appear to recognize that an illustration or photograph of a human being is a direct and effective way to communicate a desirable physical outcome. In addition, the slight, but significant decrease in model presence between the two decades potentially could be related to the simultaneous increase in the percentage of ads featuring physicians and the rise in special themed top doctor sections, perhaps reflecting a shift in the marketing strategies of both the magazines and physicians. Such ads typically focus on the physician and do not include photos of human models.

With regard to sex, the overwhelming majority these of ads featured one or more female model (94%) as compared to male models (12.7%), and this did not change significantly across the two decades. This distribution approximates patient gender statistics reported by the ASPS and reported in Chapter 2 of this study. The race of human models in advertisements also is consistent with the patient race breakdowns reported by the ASPS. While it appears that the minority racial representations in cosmetic surgery advertisements lag slightly behind actual instances of minority cosmetic surgery patients, this could be a function of the difficulty coders had in assigning a racial category to one or more model in nearly one-third of the ads the included human models. Race traditionally has been a difficult variable to code, particularly for Hispanic models.

The demographic profiles of these human models provide potential insight into the target market strategies of city magazines, as well as cosmetic surgeons. The preponderance of white and/or female models may reflect a strategic intent by physicians to maintain and solidify the current patient base. It may also reflect a well-founded media planning strategy of placing ads that contain models similar to the demographic composition of the readers of city magazines. One of the key tenets of social comparison theory (Festinger, 1954) is that humans are motivated to compare themselves to similar others. At the same time, the ASPS appears to recognize that it may be short-sighted to ignore other minority populations. In 2006 the organization introduced a new "News in Spanish" section on its website, likely signaling a desire to tap the growing Hispanic market in the United States.

Human Model Portrayals. The portrayal of human models in cosmetic surgery advertisements also raises potential ethical concerns. The core issue is whether these advertisements use images of models "that falsely and deceptively create unjustified expectations

of favorable results", an action forbidden in the ASPS code of ethics. This study examined two ways in which this might occur through the use of human models: 1) does the ad identify whether or not the model is an actual patient and 2) does the ad use before and after photos of patients and to what extent are photographic elements held constant between the two photos.

Arguably, creating the impression that a physically attractive person pictured in an advertisement is an actual recipient of cosmetic surgery when s/he actually is not a patient could be considered as false or deceptive, potentially contributing to an unjustified expectation of results. Although only a very small percentage of ads explicitly identified the model as an actual patient (7.3%), this does not necessarily indicate that only 7.3 percent of the models *actually were* cosmetic surgery patients, as actual patients may have been used in the ads without being identified as such. For example, it is conceivable that ads that featured a before and after photo of a human model may in fact have portrayed an actual patient without denoting so in the copy. However, even when one includes such ads in the analysis, the percentage of ads considered as identifying the model as an "actual patient" only increases to 15 percent, still representing a minority of the advertisements overall.

The findings of stage two of the study provide additional insight into this issue. Several of the women interviewed felt that not revealing whether the human model portrayed in the ad was an actual patient or not was a deceptive practice and crossed an ethical line. At the same time, many of these same women celebrated their ability to set realistic physical appearance outcome expectations for cosmetic surgery even when encountering ads that featured beautiful human models. Perhaps there is merit in attempting to persuade ASPS members to make such disclosures in their advertisements, if only to provide the appearance of propriety, if indeed most

consumers are savvy enough to negotiate their own expectations for cosmetic surgery appearance outcomes.

As discussed in Chapter Two, there is concern that the use of before and after photos also may contribute to unjustified expectations of favorable results to the extent that photographic elements other than part of the body/face affected by surgery (e.g., lighting, pose, makeup, hairstyle) are not held constant. In essence, such outcome photos may reflect favorable characteristics beyond just the results of the surgery.

The results of this study suggest that the use of this tactic within ads placed in city magazines is rather limited, as less than one-fifth of the ads included before/after photographs of models. Furthermore, this study found that the majority of ads that did use before/after photographs tended to hold constant other photographic elements. For example, more than three-quarters of the ads held pose and lighting constant, over half held makeup and hairstyle constant, and nearly one-half held clothing constant.

Two alternative explanations might account for the low incidence of before/after photographs in ads placed in city magazines. First, as mentioned in Chapter Two, some publishers have moved to ban the use of before and after photos in cosmetic surgery, though largely out of concern for tastefulness rather than ethic concerns (Sullivan, 2001). A subsequent analysis of the presence of such ads by market revealed that all magazines featured before and after photographs at some time during the 20-year period. While there were no such ads placed in *D Magazine* from 1998 to 2004, in *Los Angeles Magazine from* 1989 to 2004, or in *Phoenix Magazine* from 1997 to 2004, it is unknown whether these absences reflect official advertising policy, it is doubtful that publisher bans could account solely for the relatively low percentage of ads utilizing this technique. A second explanation may be self-monitoring by cosmetic

surgeons. Yavas & Riecken (2001) acknowledge that physicians and dentists consider the use of patient testimonials to be among the least ethical marketing tactics. Perhaps this belief dissuades cosmetic surgeons from utilizing before/after photos, one specific form of patient testimonials.

Interestingly, most of the interview participants reported high exposure to, and interest in, such photographs. In fact, many of the women indicated that they believed advertisements featuring before and after photos and actual patient profiles were among the most compelling and persuasive messages about cosmetic surgery. This disconnect between the reported high levels of exposure and actual incidence of before/after photos in city magazine ads suggests that ads placed in other media channels may be utilizing before and after photos more frequently than are ads placed in city magazines. For example, participants reported using the Internet to research both doctors and procedures, and many of the physician and professional organization web sites include before and after photos are part of patient testimonials. In addition, it could also reflect the difficulty consumers have in parsing out marketing communications from editorial coverage, as experienced during Stage Two of this study. Television programs and print articles about cosmetic surgery frequently employ before and after comparisons, which increases overall exposure to this tactic in general.

Future research could examine in greater depth the attitudes of both physicians and consumers towards the use of such techniques and their perceived credibility. This would perhaps provide insight as to how cosmetic surgeons and their marketing services providers might avoid violating the spirit of the ASPS code of ethics.

Risk Information

Research Question Seven was asked to assess the extent to which risk information was present in cosmetic surgery advertisements, and whether there were any changes over time. Just

8.5 percent of all ads over the 20 year period included some reference to the risks associated with cosmetic surgery and there was no discernable change between decades in the overall presence of risk information. This finding echoes that of Sullivan (2001), who also reported a low incidence of risk information in her comparison of ads from the early and late 1990s, and may provide a partial explanation for the inability of interview participants to recall the presence of risk information in advertising.

The risk information that was conveyed in the ads tended to focus on the tangible, direct physical results associated with surgery (e.g., downtime/recovery period, pain, swelling, bruising, scarring, and bleeding) and there was no significant change over time in the incidence of risk information type, other than a near doubling of references to recovery period. This increase may be related to the introduction of new, less invasive techniques that have shortened recovery periods, allowing physicians to position a shorter recovery period as an advantage rather than a disadvantage.

Interestingly, the second most prevalent type of risk was that of not selecting the "right" doctor. Nearly one-fourth of the ads that contained risk information also contained this warning, and a subsequent analysis revealed that 51.3 percent (n=20) of the 39 ads warning about physician selection also referenced that the advertiser was a board certified plastic surgeon[10]. Admittedly, the number of cases is small. However, it is interesting to note given the well-documented literature about the quest by the ASPS and its members to establish their superiority in performing cosmetic surgery procedures over other types of physicians. This strategy may have paid off. Many of the women interviewed felt that the extent to which their expectations of cosmetic surgery would be met was a function of selecting the "right physician".

[10] The design of the coding sheet makes it impossible to determine whether the balance of ads containing warnings about physician selection were placed by board certified plastic surgeons who did not disclose their certification credentials in the ad, or whether the ads were placed by other types of physicians.

As discussed in Chapter Two, cosmetic surgery is a different animal than other types of surgery for several reasons, all of which contribute to the need for cosmetic surgeons to more aggressively market their services than do other types of physicians. Perhaps the only other medically related product or service category that relies as heavily on advertising is the pharmaceutical industry. However, direct to consumer (DTC) prescription drug advertising is required by law to convey risk information, while cosmetic surgery advertising is not, in part because of differing regulatory influences.

While the Federal Trade Commission (FTC) typically has regulatory jurisdiction over consumer advertising, the Food and Drug Administration (FDA) has the primary responsibility for regulating DTC prescription drug advertising. The FDA has enacted a number of requirements for such advertising beyond the Federal Trade Commission's mandate that advertisements be truthful, non-deceptive and fair. Also media organizations present yet another, less formalized regulatory influence. Both the FDA and FTC seek assistance from the media in screening for deceptive advertisements.

Conversely, cosmetic surgery advertising by physicians is under the formal authority of the FTC, although the FDA does have some jurisdiction over the advertising of devices or drugs used by physicians in conjunction with cosmetic surgery. As a result, the only legal requirements are that such advertising is truthful, non-deceptive and fair. At the same time, physician advertising also is guided by self-regulation. In an effort to distinguish medicine as a profession rather than a trade, the AMA has published a code of ethics for all physicians that includes advertising guidelines. Furthermore, the ethical codes for medical associations such as the American Board of Plastic Surgeons and the American Society for Plastic Surgeons contain even more detailed advertising guidelines in recognition of fact that cosmetic surgery practices

are consumer oriented and heavily promoted by advertising. Such medical associations, however, can only suggest to members that they adhere to such guidelines. As with DTC prescription drug advertising, media organizations provide another layer of influence by screening for deceptive advertisements or, in the case of many city magazines, instituting policies that prohibit certain tactics such as before and after photographs.

While the fact that cosmetic surgery advertising currently is free from the federal regulatory influence that requires risk disclosure in DTC prescription drug advertising provides a partial explanation for the low incidence of risk information, it does not render the issue mute. There may be merit in requiring or recommending that cosmetic surgeons disclose risk information in advertising. Interestingly, the interviews revealed that although the risks associated with cosmetic surgery were a salient topic in general, participants did not expect cosmetic surgery advertisements to include risk information. Furthermore, participants had mixed reactions about whether the inclusion of such information would result in a favorable predisposition toward the physician.

Future research could identify more discrete content properties of risk information. For example, are the references to risk indirect (e.g., causing *less* bruising, swelling and discomfort) or direct (e.g., some patients may experience bruising, swelling and discomfort). Further delineation of the physical properties of risk information, such as type size and placement, might also prove interesting, as well as whether ads are designed to inform about doctors, procedures, or both. Future studies could also look at women who considered, but did not decide to have, cosmetic surgery and the role that risk information played in that decision.

Inducements

Research Question Eight was asked to gage the prevalence and type of inducements that cosmetic surgery magazine advertisements employ in an effort to motivate consumers along the path toward purchase. The fact that nearly half of the ads included some form of inducement, and that the presence of inducements overall decreased over time, is best interpreted by looking at a breakdown by inducement type.

The use of three of the four inducement types decreased over time: 1) opportunities to receive additional information, 2) references to financing options and 3) indications of accepting credit cards. Furthermore, opportunities to receive additional information accounted for the majority of the decline. This decrease perhaps can be explained by several factors.

First, it is conceivable that consumer knowledge of cosmetic surgery procedures was higher during the second decade as a result of an increase in editorial coverage and reality television programs. Furthermore, as the number of cosmetic surgery patients rose, this potentially created more opportunities for consumers to engage in interpersonal discussions with others who have had cosmetic surgery. As noted in Chapter Five, interview participants frequently identified such conversations as a key source of information about cosmetic surgery.

Secondly, the Internet also likely contributed to the decline in informational inducements during the second decade. Although just 6.1 percent of the ads from decade two (n=86) explicitly directed consumers to go to physicians, manufacturers or professional organization (e.g., ASPS) websites to ask questions or request print and electronic information, it is likely that consumers seek out additional information online even without such direction.[11] Additional

[11] This study did not include invitations to visit websites as an informational inducement, given the definition of an inducement as a formal, intentional mechanism for relationship marketing. Physicians are able to personally identify, track, and arrange for follow-up interaction with consumers who request that DVDs, videos, or brochures. Visitors to websites can only be identified or tracked if they make such requests online or elect to provide contact

support for this position was found in stage two of this study, as nearly all of the women interviewed cited the Internet as a primary information resource about both cosmetic surgery procedures and surgeons.

The decrease in references to both financing options and the acceptance of credit cards was surprising, as recent consumer research shows that disposable income remains a significant barrier to having cosmetic surgery (Mintel, 2005). The relatively small percentage of ads that included such references may reflect a desire by physicians to avoid having their advertisements look too much like ads for other products and services, or may actually reflect the absence of financing and payment options.

This potential concern, however, is contradicted by the increase in the use of monetary incentives over time, a finding consistent with that of Sullivan (2001), who noted an increase in the use of discounts and other financial incentives in cosmetic surgery advertisements from the early to late 1990s. Monetary incentives represent perhaps the most controversial form of inducement. Miller, Brody and Chung (2001) discuss how such tactics put the physician in the role of a salesman and Yavas & Riecken (2001, 1983) note that doctors and dentists believe that the use of special price offers and discounts are among the least ethical messages physicians can employ to attract more business. Such inducements may be seen as even more controversial to the extent that they are time-sensitive or bundle several procedures together into a package deal, thus pressuring consumers to make quick decisions or to contemplate a procedure they previously had not considered. Admittedly, one would expect to see fewer time sensitive offers in magazines due to the longer shelf life of the publications.

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information. Thus, an ad directing a consumer to email a physician, manufacturer or professional organization to receive additional information was considered to be an inducement , while an invitation to visit a website was not.

This finding raises some interesting questions. Are cosmetic surgeons, through the use of inducements, in fact creating demand rather than responding to it? At issue is whether such advertisements undermine the sacred divide between the medical profession and other commodities or trades. Future research could extend the body of knowledge about how both physicians and consumers perceive the use of such inducements by cosmetic surgeons as compared to physicians with other types of practices. Do the distinct nuances of cosmetic surgery practices (i.e., the elective nature of the practice, the absence of insurance coverage, and the high level of competition in the field) warrant, if not explain, the use of such tactics? How are these offers perceived by consumers and how do these perceptions align with the ASPS code of ethics? How does the use of inducements relate to overall trust in cosmetic surgeons?

Physician Characteristics

How physicians themselves are represented within cosmetic surgery advertisements is perhaps one of the most interesting questions, particularly amidst the contextual factors of an increasingly competitive environment, recent concerns about misleading statements or claims about physician qualifications, as well as the historically negative perceptions of physician advertising in general, and the use of certain tactics in particular.

Demographics. The demographic characteristics of cosmetic surgeons represented in the ads revealed few surprises, as male physicians were featured more frequently than female physicians and medical doctors more frequently than osteopathic doctors in the overwhelming majority of advertisements. This is in line with AMA statistics about the gender of physicians board certified in dermatology, general surgery, ophthalmology, otolaryngology, and plastic surgery, the five areas of specialty that perform the majority of cosmetic procedures in the United States. While the percentage of these physicians who are females has doubled from 8

percent in 1989 to 16.9% in 2004, women still represent a minority of physicians practicing in this area (see Figure 6.1).

Despite the fact that physician race could not be assessed for the majority of the ads, advertisements featuring white physicians occurred more often than for any other race. This breakdown closely approximates physician statistics provided by the AMA, which began to report this information in 1996 (see Figure 6-2). In 1996, 59.6 percent of physicians practicing in dermatology, general surgery, ophthalmology, otolaryngology and plastic surgery were white. Just 10.7 percent reported their race as black, Hispanic, Asian or other and 29.7 percent of physicians did not report their race. By 2004 there was a slight increase in the percentage of physicians reporting their race as other than white (13.8%), but white physicians comprised the majority of practitioners (54.2 percent).

Practice Type & Named Physicians. There are some potential indications that the stigma of physician advertising is decreasing over time. This study showed a decline over time in the percentage of ads that featured an Institute/Center where physician(s) were not named and a corresponding increase in both ads for individual practices and group practices where physician(s) were named. Similarly, there was an increase over time in the percentage of advertisements that named a physician, regardless of practice type. Furthermore, the percentage of advertisements that included a physician photo also increased. Collectively, these shifts may suggest a greater comfort level for cosmetic surgeons in being personally identified with their advertisements. The willingness of cosmetic surgeons to be featured in "top doctor" sections of the city magazines in the second decade may give further credence to this trend.

Physician Credentials. A common approached used when advertising in a highly competitive environment is to emphasize certain competitive advantages or attributes of the

product or service. In the case of physician advertising, credentials such as board certification, membership in professional organizations, and other types of professional qualifications can serve as key attributes or competitive advantages. Accordingly, it is not surprising that the percentage of advertisements that included such references increased significantly over time. Admittedly, however, the increase in references to professional affiliations also may reflect an increase in the overall number of professional organizations related to the field. Sullivan (2001) charts the expansion of professional organizations related to the field.

The merit of including physician credentials in advertising is evident in the responses of interview participants. Interview participants indicated that physician credentials were a key piece of information they actively sought out in cosmetic surgery advertising, and that they paid particular attention to the type of board certification.

The trends in board certification references also are interesting. References to board certification in plastic and reconstructive surgery occurred most frequently and actually increased over time, as did ads referencing board certification in dermatology and ophthalmology. This is not surprising, as dermatologists and ophthalmologists, along with general surgeons and otolaryngologists, have been the most assertive in expanding their practices to include cosmetic procedures (Sullivan, 2001). At the same time, however, ads referencing board certification in general surgery actually decreased over time, and ads referencing board certification in otolaryngology occurred less than 20 times across the entire 20-year period.[12]

Amidst increasing competition, the ASPS has sought to establish its members, who are all board certified plastic surgeons, as the physicians most qualified to conduct cosmetic surgery.

[12] Sullivan (2001) discusses the awkwardness of the word "otolaryngology" and the fact that it may put off consumers. Accordingly, it is conceivable that in an effort to appear more user-friendly, ads for otolaryngologists may simply reference "board certification" in ads. There is no way to determine this, however, from advertising content alone.

The overwhelming preference of interview participants to use board certified plastic surgeons perhaps provides some indication that these efforts have been successful. Over the past several years, the ASPS and others have tried to get Congress and State level regulatory boards to begin to legislate the use of claims such as board certification, particularly for physicians who are not certified by the American Board of Medical Specialties, but by some other body.[13] This pressure may account for the decrease in references to board certification in "cosmetic surgery" and "facial plastic surgery", which are not ABMS board certified specialties, as well as the decrease in generic references to board certification, as those physicians who are ABMS board certified become more specific about their certifying board and area of specialty.

According to the results, nearly one-third of the ads made a claim of superiority other than board certification. Such claims include physician gender (i.e., a female cosmetic surgeon knows the female body best), or being the first/only to perform a procedure. Subsequent research could examine these various types of claims, including board certification, more specifically vis a vis the current legal research on false claims in cosmetic surgery advertising.

Comparative Questions Regarding Advertising Sources

This study also addressed a series of comparative questions to gain insight into the advertising approaches taken by content sources – the cosmetic surgeons. Specifically, this study asked whether there were differences in the message strategies (i.e., appeals) employed by male versus females physicians, as well as potential differences in the use of credentials, physician photos, and the inclusion of risk information or inducements. These areas also were examined to address potential differences by type of physician practice.

[13] The American Board of Medical Specialties is a non-profit organization that represents 24 medical specialty boards which establish and maintain high standards for physician certification and the delivery of safe, quality medical care by certified specialists.

Advertisement Characteristics by Physician Sex

Appeals. Stage one of this study revealed that a greater percentage of ads featuring female cosmetic surgeons utilized assurance and informational appeals, while a greater percentage of ads featuring male surgeons utilized straightforward physical attractiveness and humor appeals. This may signify a perceived need by female physicians and/or their marketing services providers to focus more on message strategies that build credibility or, alternatively, that female cosmetic surgeons have different perceptions about what patients are looking for than do their male counterparts

Ads placed by male physicians, on the other hand, were more likely to emphasize physical appearance than were ads placed by females. This may reflect a lesser perceived need to build credibility for male physicians than for females. The greater percentage of ads using humor that were placed by male as compared to female physicians also may signify male physicians' perceived freedom to embrace other message strategies given the credibility they are conferred due to their gender.

The findings from stage two of the study provide additional support for some of these observations. Many of the women interviewed discussed how ads for male cosmetic surgeons placed more emphasis on external physical attractiveness, often conveyed through the use of beautiful models. Their assertions that ads for female physicians tended to emphasize internal satisfaction and improved self-esteem, however, was not echoed in the content analysis.

Physician Credentials. Further support for credibility positioning by female cosmetic surgeons is present in the incidence of physician credentials. A higher percentage of ads for female physicians employed references to board certification and memberships in professional organizations than did ads for male physicians. The use of such credentials flows naturally from

the adoption of an assurance or informational appeal, leading one to expect such a linkage. Furthermore, interview participants expressed a belief that ads for female cosmetic surgeons would be more likely to emphasize credentials in an effort to level the playing field and compete more effectively with male cosmetic surgeons.

Physician Photos. This study showed that a higher percentage of ads for female physicians included a physician photo than did ads for male physicians. Anecdotally, it appeared to the researcher that female cosmetic surgeons were more attractive than male cosmetic surgeons. This may suggest that perhaps female physicians perceive their own physical attractiveness as enhancing their credibility with consumers. Or it could reflect that female physicians are on average younger, and therefore more youthful in appearance, given their more recent entry into the medical field. Conversely, several of the interview participants remarked that ads for male cosmetic surgeons were more likely to contain physician photos. One of these women opined that female patients didn't perceive a male physician's face or body as an indication of work quality, but that they did for female cosmetic surgeons.

Risk Information. Risk information was included in a higher percentage of ads for male physicians than for female physicians. Perhaps this reflects a belief by physicians and their marketing service providers that it is safer for males to include such information, and that consumers might read greater severity or susceptibility into any risk information present in ads for female cosmetic surgeons. In essence, the inherent perceived superior credibility of male physicians may cause consumers to keep such risk information in perspective, while consumers might perceive greater severity or susceptibility to cosmetic surgery risks when the physician advertised is a female.

Inducements. While the use of inducements was high for both male and female physicians, a greater percentage of ads for males employed these tactics, perhaps signaling a greater perceived freedom by male physicians to employ mainstream consumer marketing tactics typically less common within medical marketing.

In summary, while the theme of building credibility appears rather constant, it is not clear whether this is unique to female cosmetic surgeons, or is something experienced by female physicians in general. Indeed, it may be the case for any professional female advertising in a field dominated by males. Future research could examine this further.

Advertising Characteristics by Practice Type

While the rank order of appeals was the same for all four practice types (physical attractiveness, assurance, informational, sexual), there was a significant difference between practice type in the prevalence of each of the four appeals. Not surprisingly, ads for Institutes/Centers were the least likely to use assurance or informational appeals. Ads for Institutes/Centers most likely need to rely on other message strategies less grounded in the credibility and credentials of physicians. This may be one explanation for the higher incidence of physical attractiveness and sexual appeals as compared with the other types of practices. In keeping with this position, advertisements for Institutes/Centers were also the least likely to include references to all three categories of physician credentials, as well as claims of superiority.

Ads for Institutes/Centers were also the least likely to include risk information, while hospitals were most likely to do so. Perhaps this reflects an inability to offset risk concerns with physician credentials on behalf of Institutes/Centers. Conversely, hospitals may be more accustomed to disclosing risk information, even in their advertisements.

Finally, a smaller percentage of advertisements for hospitals and Institutes/Centers contained inducements as compared to individual practitioners and group practices. Perhaps individual practitioners and group practices are more nimble and flexible in their ability to establish and adhere to the logistics and compensation changes potentially required by such inducements. They may also have more control over promotional activities than hospitals or Institutes/Centers, whose adoption of such practices may impact a greater number of physicians on a less consistent basis.

At the same time, none of the women interviewed as part of this study indicated that practice type had a bearing on their decision about who to select as a provider, perhaps suggesting limited relevance for this area of inquiry.

Theoretical Observations and Implications

This research is situated within the Sarwer et al. (1998) model of the relationship between body image and cosmetic surgery. As stated in Chapter 2, Sarwer and others have identified the interaction of the mass media and cultural ideals about appearance as a key sociocultural influence on the decision to have cosmetic surgery. At the same time, they call for additional research to help illuminate this influence. An underpinning of this study was the idea that social comparison theory might constitute a first step toward explaining the process by which the mass media influence societal standards for physical appearance, ultimately affecting body image and the decision to have cosmetic surgery.

The focus of this research was not to build a model of how the mass media in general, and cosmetic surgery advertising specifically, impact the decision to have cosmetic surgery. Rather, the objective was to provide initial insight into the content dimensions of cosmetic surgery advertisements as well as consumer interpretations and use of such advertisements.

Accordingly, the findings of this study are discussed in relation to both theoretical frameworks and suggestions are made for future research that potentially can contribute to model building or an extension of social comparison theory.

Support for the Sarwer Model

First, the findings from stage two of the study provide support for including media as an important sociocultural influence in the Sarwer et al. (1998) model. All of the women interviewed made reference to editorial coverage and television programs about cosmetic surgery, in addition to discussing cosmetic surgery advertising. Furthermore, while advertising played a more limited role in the decision to have cosmetic surgery, many of these women credited reality television programs in particular with educating them on the vast number of procedures available and preparing them to interview potential physicians. These comments suggest that the future models should include a variety of mass media categories, including advertising, reality television programs and editorial coverage.

Social Comparison Theory, Idealized Images and Dissatisfaction

According to the Sarwer et al. (1998) model, the decision to have cosmetic surgery is predicated upon one's body image valence (whether or not physical appearance is important to that person) and one's degree of satisfaction with one's body image. A decision to have cosmetic surgery typically occurs when a person has a positive body image valence and is dissatisfied with their body image. Although the model acknowledges that some people with a positive body image valence *and* who are satisfied with their body image may still decide to have cosmetic surgery, dissatisfaction appears to be a key triggering event. Enter social comparison theory.

Succinctly stated, social comparison theory is about exposure to idealized images that raise comparison standards, potentially yielding post-comparison dissatisfaction, lowered self-esteem and engagement in various behaviors. Most of the research on social comparison theory focuses on exposure to idealized images of beauty and the resulting dissatisfaction with appearance that can affect body image, self esteem and lead to engagement in a variety of body investment behaviors. This literature also singles out advertising messages in particular, given their propensity to include highly attractive models.

While most social comparison research has focused on idealized images of physical attractiveness, some studies have extended idealized images to include financial success (e.g., Gulas and McKeage, 2000). In keeping with social comparison theory, the results of this study suggest that a variety of idealized images are present in cosmetic surgery advertisements, and that these images both are recognized as such by consumers, and also aspired to.

The results from stage one of the study reveal that the majority of advertisements examined emphasize physical attractiveness in that three-fourths of the ads contained a human model and more than half of the ads included a straightforward physical attractiveness appeal. Although the study did not capture the coders' assessments of the relative attractiveness of these models, it is conceivable that advertisers included attractive persons in the ads or, at a minimum, a before and after comparison of a patient whose physical appearance was much improved post surgery.

The literature suggests that cosmetic surgery is considered a conduit to psychological health and social and economic success, in addition to enhanced physical appearance. As discussed in Chapter 4, the content analysis revealed that in addition to physical attractiveness, cosmetic surgery ads also included sexual (20.0%), self-determination (8.4%), psychological

health (5.3%) and sociability (1.4%) appeals. Thus, a significant percentage of advertisements promoted idealized images of physical appearance or lifestyle, implying that they are attainable by virtue of undergoing cosmetic surgery.

Further support for the merit of using social comparison theory to illuminate the process by which the mass media and cosmetic surgery advertisements influence the decision to have cosmetic surgery is found in stage two of the study. The majority of the women interviewed acknowledged seeing or hearing advertisements that portray the perfect life, the perfect face, and the perfect body. Furthermore, they did acknowledge comparing themselves to those images. At the same time, however, they expressed an understanding that the images in cosmetic surgery advertisements (and in other forms of mass communication) were not fully attainable by the average person. This was also reflected in comments about cosmetic surgery being positioned in ads as "life changing" as compared to ads for other types of surgeons.

While social comparison theory may prove useful in explaining how exposure to idealized images of beauty in the mass media *in general* contribute to the decision to have cosmetic surgery, it may not be the most appropriate theoretical frame to illuminate the role cosmetic surgery advertising specifically plays. Cosmetic surgery advertisements add another dimension to the social comparison equation, in that they inform persons who previously may have been dissatisfied with their appearance (due in part to exposure to idealized images of beauty in the mass media) that a relatively safe and effective treatment exists. In other words, a form of efficacy is built into the message itself and that message has a specific, persuasive intent. Conversely, virtually all of the studies using social comparison theory to date have focused on the indirect and unintentional impact of the mass media.

While future research could extend social comparison theory to incorporate this efficacy component and explore whether it has a differential impact on body image, self esteem and a variety of body investment behaviors beyond cosmetic surgery, the theory of planned behavior (Ajzen, 1985) may prove a more useful theoretical frame to employ. The theory of planned behavior provides another model of how individuals might weigh risk and benefit information when contemplating cosmetic surgery and takes into consideration attitudes about having cosmetic surgery, subjective norms about cosmetic surgery, and perceived behavioral control, akin to Bandura's (1982) concept of self-efficacy. In summary, it appears that it would be prudent also to explore the contribution that the theory of planned behavior could make in illuminating the Sarwer model.

Practical Implications

The findings from this research raise several issues for practitioners and their marketing service providers to consider when developing the marketing communication plans for cosmetic surgery practices. The findings also provide potential insight for the broader medical community concerned with the challenges raised by consumer-oriented, entrepreneurial cosmetic surgery practices.

Generally speaking, the results from stage one indicate a strong, steady climb in the volume of cosmetic surgery advertisements placed within city magazines, confirming an increasingly competitive marketing landscape. In addition, this also could reflect greater acceptance of this type of advertising by physicians. Such an environment will require practitioners to be strategic, even aggressive on the business front while still maintaining the ethicality of their profession. The following observations provide more detail.

First, although its overall role is limited in the decision to have cosmetic surgery, advertising is a key information source about who practices cosmetic surgery and what types of procedures are performed. As acknowledged in Chapter 5, this suggests the need for a continuous advertising presence to reach newly emerging prospects. Furthermore, practitioners may want to consider directing consumers to their Web sites by providing URLs or employing some other type of online response mechanism. Results from the content analysis suggest that this practice is already well underway, as the percentage of advertisements examined that contained physician website URLs increased from 7.1 percent in 1996 to 85.3 percent in 2004. Finally, the findings from stage two of this research identify specific types of information practitioners should consider including in, or hyper linking to, their websites, including details about procedures, physician credentials, areas of specialty, references from prior patients, and testimonials, including before and after photos.

Secondly, credentials are of utmost importance -- particularly board certification. The results from stage two of the study suggest that consumers consider board certification to be the most important credential and qualifying point for consideration of a physician. Furthermore, participants indicated a strong preference for board certification in plastic surgery. Physicians who are board certified in plastic surgery or by any of the other ABMS recognized areas of specialty potentially could gain a competitive advantage by including specific board certification credentials in their advertisements.

Results from stage one of the study suggest that the value of this credential seems to be recognized, as over half of the ads examined included references to board certification and the percentage of ads including such information increased over time. In particular, the study noted

an increase over time in references to board certification in plastic surgery, as well as a decrease in generic references to board certification.

Third, the results from stage two suggest that consumers value testimonials, including before and after photos. At the same time, less than one-fifth of the ads in the content analysis included such information. Practitioners may want to give additional thought to using this approach in advertisements to the extent that such tactics are permitted in media vehicles and that the approach does not bring about the derision of the broader medical community.

Fourth, while risk information currently is virtually non-existent within advertisements, practitioners may want to consider including information about the potential risks or complications associated with cosmetic surgery, as well as the chance of less than fully satisfying outcomes. Furthermore, physician web sites may be a better place for this information. The positioning of cosmetic surgery as an effortless, guaranteed, life-changing 'Cinderella-like' transformation is a concern voiced by scholars and addressed in both the ABPS and the ASPS codes of ethics. Furthermore, participants in stage two of the project raised this issue in the form of both outcome and process expectations established by advertising but not realized in actual experience. Admittedly, disclosing such information either could serve to establish credibility with consumers or it could backfire and scare off potential candidates who would have experienced positive outcomes. A less drastic approach might be to exhibit more restraint when communicating outcome expectations. For example, physicians could avoid including references to "life changing" results, alluding to any type of outcome guarantee, or disclosing when a human model featured in an advertisement is not an actual patient.

This study also makes a potential contribution to the medical organizations concerned with the respectability of the profession, namely the American Medical Association, the

American Board of Plastic Surgery, and the American Society of Plastic Surgeons. While the current AMA Code of Ethics (2001) only restricts advertising that is false or misleading, it advises physicians that certain types of communication have a significant potential for deception and should receive special attention, including the use of testimonials, claims of superiority, and implied certainty of result. And, as noted in Chapter 2, the American Board of Plastic Surgeons and the American Society of Plastic Surgeons have gone even further in their prohibitions of certain advertising practices.

This study examined the incidence of five potential areas of concern: 1) the use of before and after photos which employ different lighting, poses or photographic techniques to misrepresent the results achieved by the individual; 2) the use of human models without disclosing whether they are actual patients, implying an intention to create false or unjustified expectations of favorable results; 3) the use of appeals that play on layperson's fears, anxieties or emotional vulnerabilities; 4) claims of superiority by physicians; and 5) the presence/absence of risk information, which may serve to minimize the magnitude and possible risks of surgery.

The results of this study suggest that, for the most part, cosmetic surgery advertisements are responsibly portraying before and after photos and avoiding exploiting fears, anxieties or other emotional vulnerabilities. However, it also raises some questions about how advertisements are conforming to the respective codes of ethics with regard to claims of physician superiority, creating unjustified expectations through the use of models, and minimizing the magnitude and risks of surgery. As stated earlier, nearly one-third of the advertisements examined included a claim of superiority other than board certification, and this percentage increase over time. A mere 8.7 percent of the advertisements included any reference

to risk information. And although a human model was present in three-quarters of the advertisements examined, just 7.3 percent of those ads identified the model as an actual patient.

That being said, the majority of the women interviewed expressed having a certain savvy or literacy about advertising and its tendency to emphasize the perfect and positive. This may suggest that the end result, and perhaps also the intent, of the respective codes of ethics is to protect the image of the profession, thus distinguishing it from other businesses and trades, as opposed to protecting consumers, who may or may not need to be protected.

Regardless, the results of the study may help illuminate areas where the ABPS and ASPS codes of ethics have potentially influenced advertising efforts as well as areas where cosmetic surgeons could do a better job of conforming to the codes.

Limitations of the Study

As with all studies, this research project has a number of limitations. The limitations for the first stage of the study revolve around the sample. This project examined just one specific media class through which cosmetic surgery advertisements are disseminated – city magazines. In addition, the sampling frame focused on metropolitan areas with the highest buying power. It is conceivable that the content properties of cosmetic surgery advertisements from small markets would differ from those assessed in this study. Furthermore, the study employed a systematic random sample rather than a census of ads from 1985 to 2004. Finally, the findings from the second stage of the study are not projectable. However, they are still useful in suggesting additional venues for future research.

Post Script and Future Directions

The topic of cosmetic surgery is seemingly ubiquitous today, thriving amidst a culture that reveres appearance. At the same time, relatively few studies have examined the relationship

between the mass media and the decision to have cosmetic surgery. And, there is a paucity of research specifically about cosmetic surgery advertising.

Accordingly, this study serves as a first step in better understanding the role that cosmetic surgery plays as a sociocultural influence on the decision to have cosmetic surgery. More specifically, its contributions include a comprehensive view of message characteristics over a twenty-year period and initial consumer insights about how consumers use and interpret cosmetic surgery advertising.

The importance of this study is further underscored against the backdrop of concern about the commercialization of medicine. Cosmetic surgeons navigate their practices through somewhat turbulent waters. On the one hand, the elective nature of their services combined with competition from other practitioners all but necessitates smart, aggressive marketing. On the other hand, what is an acceptable business practice for selling other types of products and services may not necessarily be appropriate for medical treatment, potentially compromising the integrity of the medical profession.

The medical profession has a long tradition of concern about physician advertising stemming largely from concern about the vulnerability of patients vis a vis an imbalance of power and knowledge between physicians and patients. As noted by Miller, Brody and Chung (2000), informational advertising that alerts individuals to unattended medical needs and appropriate treatments is in keeping with the standards of a profession while advertising that stimulates demand for elective procedures has the potential to compromise this professional integrity. This intent need not be explicit – the mere willingness of a physician to conduct a procedure may be construed by the patient as a form of legitimation. The AMA's general ban on

false and misleading advertising and the more detailed ABPS and ASPS codes of ethics are intended to mitigate such threats.

At the same time, one must not forget about the agency of the consumer. Cosmetic surgery, when performed by a licensed practitioner, is a legal service. Furthermore, advertising constitutes an important mechanism for consumers to obtain information about cosmetic surgery, as it falls outside the realm of standard physician referrals for medically necessary procedures. Thus, truthful advertising is a legitimate means to link consumers with cosmetic surgeons. Stage two of this study underscores the important, though limited, role that advertising plays in this process. It also reveals a degree of savvy that consumers have when interpreting advertising messages – even when placed by physicians, traditionally a highly credible source.

Despite the fact that cosmetic surgery is both prevalent and controversial, few studies have systematically examined the content of advertising messages about cosmetic surgery or how consumers use that information. This study has begun to fill that gap and will inform subsequent research.

Immediate next steps include extending the study to include physicians and their marketing service providers to better understand the underlying strategies behind cosmetic surgery advertisements, rather than attempting to infer such strategies from the content. Furthermore, the nature of the relationship between the marketing services provider and the physician will be explored to understand what role the parties play in message strategy development. For example, might the agency and physician have different opinions about interpreting the codes of ethics?

Second, this research has suggested several content areas that may not conform to the respective codes of ethics of the AMA, ABPS and ASPS. Consumers can be presented with a

sample of advertisements that reflect those content areas and asked to assess, from their perspective, whether the advertisements align with the codes of ethics. This would be, in part, a replication of the Spilson et al. (2001) study of consumer perceptions of Yellow Pages advertisements.

Finally, future research will be undertaken to delineate more specifically the types of claims made by physicians in cosmetic surgery advertisements and the extent to which they pose a challenge to state laws as well as the professional codes of ethics. These findings may prove helpful to policy makers interested in protecting consumers, as well as to physicians and their agencies as they make judgments about their marketing messages.

Table 6.1. Procedures Performed vs. Advertising Presence: 1985-1994

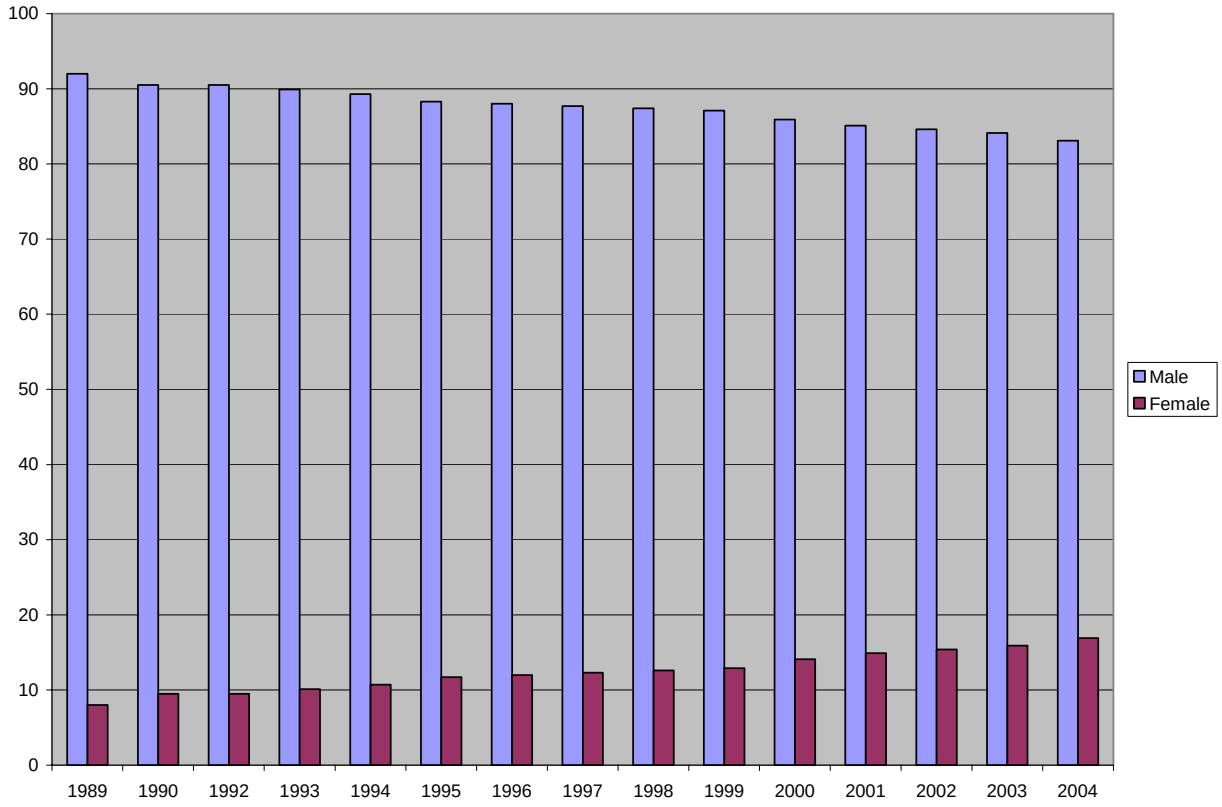
Procedure	Procedures Performed Rank (1994)	Percentage of Ads Rank (1985-1994)
Liposuction	1	1
Eyelid Surgery	2	5
Breast Augmentation	3	2
Nose Surgery	4	4
Facelift	5	3
Chemical Peel	6	8
Breast Implant Removal[1]	7	n/a
Collagen Injections	8	7
Retin-A Treatment[2]	9	n/a
Tummy Tuck	10	9

Source: 1994 Cosmetic Surgery Trends as reported by the ASPS (ASPS Member data only).
[1] Ads mentioning breast implant removals occurred less than ten times over the 20-year period.
[2] Retin-A is considered to be a skin care treatment. No ads over the 20-year period made specific mention of this type of treatment.

Table 6.2. Procedures Performed vs. Advertising Presence: 1995-2004

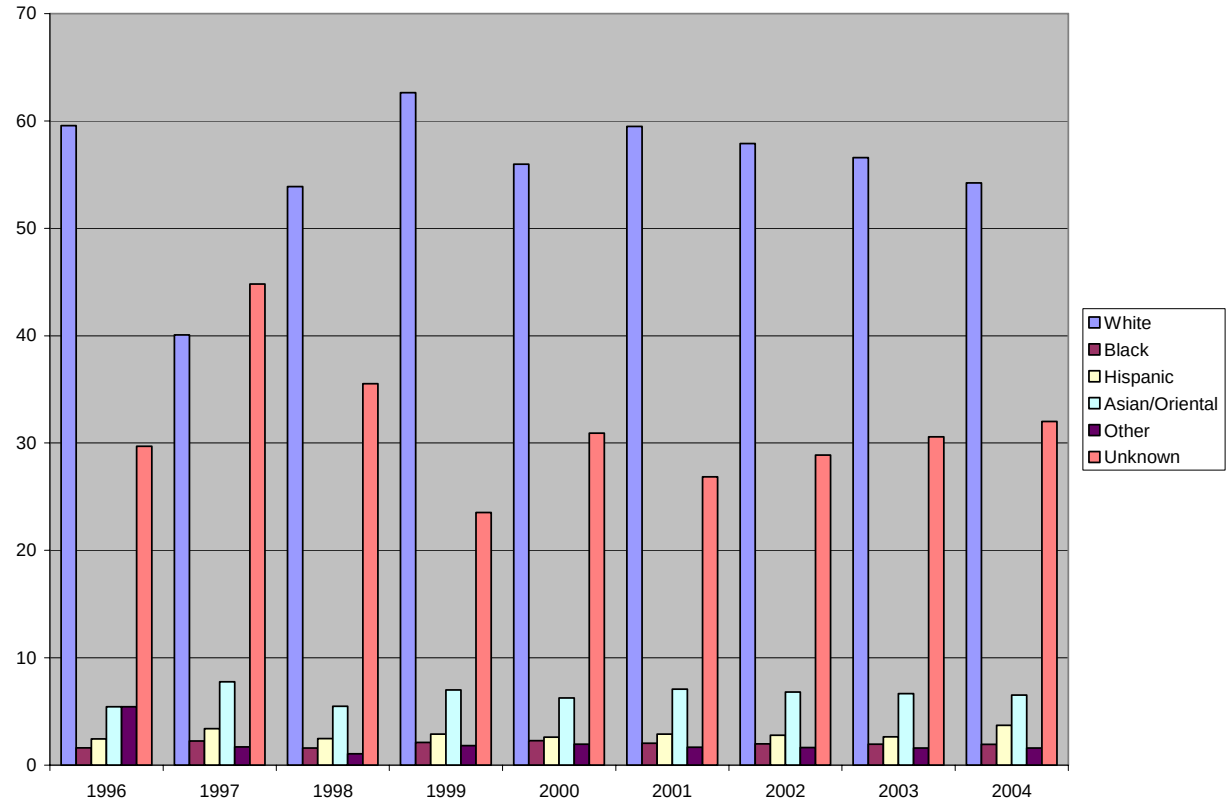
Procedure	Procedures Performed Rank (2004)	Percentage of Ads Rank (1995-2004)
Botox	1	6
Soft Tissue Fillers[1]	2	7
Chemical Peel	3	12
Laser hair removal	4	9
Sclerotherapy	5	10
Liposuction	6	1
Nose reshaping	7	8
Breast augmentation	8	3
Eyelid surgery	9	2
Laser skin resurfacing	10	5

Source: 2004 Cosmetic Surgery Trends as reported by ASPS Member Surgeons certified by the ABMS as well as other physicians certified by the ABMS-recognized boards.
[1] All procedures for soft tissue fillers as reported by the ASPS were combined.



Source: American Medical Association: Physician Characteristics and Distribution in the U.S.

Figure 6.1. Gender Breakdown for Physicians Board Certified in Dermatology, General Surgery, Ophthalmology, Otolaryngology and Plastic Surgery (1989-2004)



Source: American Medical Association: Physician Characteristics and Distribution in the U.S.

Figure 6.2. Race Breakdown for Physicians Board Certified in Dermatology, General Surgery, Ophthalmology, Otolaryngology and Plastic Surgery (1996-2004)

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LIST OF APPENDICES

Appendix A

City Magazine Readership Statistics and Cosmetic Surgery Patient Profiles

City magazines were selected as the sampling frame for the study based in part on the following similarities between readership and the demographic profiles of cosmetic surgery patients as reported by the ASPS:

- Female skew
- Older age skew
- Higher than average median household income

Aggregated national demographic profiles for city magazine readership and cosmetic surgery patients are outlined below:

	City % Regional Magazine Subscriber Base[1]	Cosmetic Surgery Patients[2]
Female	64.4%	88%
Average Age	51	n/a
% 35-64	78%	75%
Median Household Income	$117,000	

[1] *Source: City & Regional Magazine Association (2005): A Profile of the National CRMA Audience (http:www.citymag.org).*
[2] *Source: ASPS 2005 Age Distribution Statistics (http:www.plastic.org/public_education)*

Audience profiles for specific magazines used in this study are outlined below:

Magazine	Gender Profile	Age Profile	Median HH Income
Atlanta Magazine	67.6% female	63.4% 25-54	$193,900 (average)
Boston Magazine	51% female	Median age: 46	$188,000
Chicago Magazine	56% female	63% 25-54	$192,100
D Magazine	71.4% female	Median age: 52	$227,000 (average)
Hour Detroit	60% female	Average age: 46	$125,000
Los Angeles Magazine	54% female	Median age: 51	$139,300
New York Magazine	52% female	Median age: 52	$146,818
Philadelphia Magazine	60.4% female	Average age: 44	$193,500 (average)
Phoenix Magazine	56% female	Average age: 46	$131,369 (average)
Washingtonian	64.8% female	Average age: 52.7	$185,800 (average)

Source: 2006 Advertising Rate Cards

Appendix B

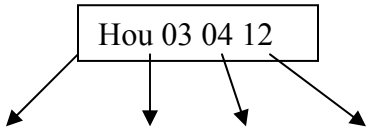
Coder Training Manual

Coder Training Manual – Final Version for Coders

IDENTIFICATION OF AD

Data for each market includes the following:

- One .pdf file for ***each*** individual, unique ad.
  Ad ID # can be broken down as follows:



Market	Year	Month	Ad number within issue
(hou)	(2003)	(April)	(12^{th} ad in that issue).

PHYSICAL CHARACTERISTICS OF AD (Q 2-5)

A. Ad Production – Visual cues

Combination: Example of black and white photography, black type and color logo. Also known as "spot color".

B. Ad Type - Visual and verbal cues

Display: Ads that appear within the magazine that are typically 1/8 of a page or more in size and are NOT part of special advertising section.

Classified: Ads that appear in a designated "Classified" section and are located at the back of an issue. These ads are typically less than 1/8 of a page in size and may or may not include artwork or photos.

Display ad in Special Ad Section w/o Editorial: Display ads that are placed with in a designated "Special Advertising Section" of the magazine. There is typically, though not always, a banner that runs along the head or foot of the page designating the section and the pages will include a reference to "special advertising section" or "advertising section". For example, a "Looking Good" section featuring only ads.

Display Ad in Special Ad Section w/ Editorial: Same as above, but the ads are dispersed within the section around editorial articles related to health, beauty or cosmetic surgery."

Advertorial About Procedure: Display ads that look like an article about a procedure but are actually a paid advertisement. These ads are copy intensive and will be labeled "advertisement" on the header or footer of the ad.

Advertorial About Physician/Dentist: Display ads that look like an editorial profile about a doctor, dentist or practice but are actually paid advertisements. These ads often feature a photo of the practitioner, are copy intensive and will be labeled "advertisement" on the header or footer of the ad. Like a doctor/dentist profile.

Practice/Location Announcement: The focus of these ads is to convey information about the opening, reopening or relocation of a practice.

Hint: Look at header or footer of ad to see if it designates "Advertisement" or a theme banner. Then, check to see whether or not page includes related editorial with a byline.

C. **Ad Size – Visual cues**

D. **Ad Illustration – Visual cues**

Photos: Select this if the ad includes photos that may or may not include some retouching. Ask yourself whether the image *started* as a photograph.

Artwork: Select this if the ad includes images that are hand drawn illustrations or computer generated illustrations. Do NOT include logos in your assessment.

Combination: Select this option if the ad includes images that contain portions that appear to originate from a photograph, as well as portions that have been hand drawn or computer generated. For example, see the Houston Invisalign ad that features a mouth. The teeth originate from a photo, but the lips are computer generated.

None/All Copy:

VISUAL CHARACTERISTICS OF AD (Q 6-7)

A. Indoor Setting – Visual and verbal cues

Photo Studio: Many of the photos of doctors and models have been taken by photographers in a studio. This option is **bolded** to help you locate it more quickly. Use this if there is a solid background (white or color).

Can't Determine: Select this if the person is clearly inside somewhere, but you can't tell what the place is. For example, the background may be blurred or it may simply not have enough information for you to determine the exact setting.

No Indoor Setting: Be sure to mark this if the setting is an outdoor one. It is also in **bold** for easy identification.

B. Outdoor Setting – Visual and verbal cues

Exterior of doctor/dentist/hospital/surgical facility - select this if the outside of a building is represented.

Can't Determine: Select this if the person is clearly outside somewhere but you can't tell where. For example, the background may be blurred (as in the Houston ad with the female business

person on the cell phone) or it may simply not have enough information for you to determine the exact outdoor setting.

No Indoor Setting: Be sure to mark this if the setting is an outdoor one. It is also in **bold** for easy identification.

CHARACTERISTICS OF MODELS (Q 8-14)

A. Human Model (Depiction) Present? – Visual cues

A human model is defined as any depiction of a **non-physician/dentist or employee** human that is represented in an ad. A photo can be a representation of a human, as can an illustration. This also includes **body parts** – the entire model may not be featured in the ad. In addition, if the same person appears more than once in an ad, count that person as only one model.

If you check "YES", there is a sub-question that asks you to designate whether the human depiction takes place in a **photograph** (including those that appear to be retouched) or an illustration/artwork.

Tip: You can skip over all the questions in this section if the only human portrayed in the ad is the dentist/physician/staff member – information about them will be collected in the next section.

B. Sex – Visual cues

C. Race – Visual cues

This study adopts the race categories as used by the U.S. Census.

White: Includes American, and those of western and eastern European ancestry.

Black:

American Indian/Alaska Native: people having origins in any of the original peoples of North and South America.

Asian: people have origins in any of the original peoples of the Far East, Southeast Asia or the Indian subcontinent. It includes: Chinese, Filipino, Korean, Japanese, Vietnamese, Indian (from India), Burmese, Thai, Pakistani.

Hispanic: of Mexican, Cuban or Puerto Rican origins

Native Hawaiian/Pacific Islander: people having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.

Multi-racial: people whose ancestors are not of a single race.

D. Type of Pose – Visual Cues

Categories are meant to be mutually exclusive. Coding should be done using a hierarchical approach if more than one human model is present. Select a coding category based on the model who has the most body square footage showing. For example, if only one model appears from the waist up and the other two models appear from the neck up, code the pose as "waist up".

Face Only: face shown without neck

Head/Neck/Shoulder: Model shown from the neck up or shoulders up.

Waist Up: model shown from waist to head (rib cage area upward)

Torso: model shown trunk to neck – no head.

¾ Body: model shown from head to thigh or shoulders to feet.

Full Body: model shown from head to calf or toe.

Buttock: model's backside shown from just below buttocks to waist

Leg: model's leg is shown, either in entirety or portion (e.g., calf or thigh or all)

Mouth: model's mouth is shown, can include jaw, but not entire face.

Stomach: model's abdomen is focus of the photo, without face or below the knees.

Other specific body part: Select if only one body part is shown (e.g., arm, nose, chin, breast) and write in the body part.

E. Type of Clothing Attire/Degree of Nudity – Visual cues

Categories are meant to be mutually exclusive. Coding should be done using a hierarchical approach if more than one human model is present. Select a coding category based on the model who has the least amount of clothing – if only one of the three models in an ad is nude, code attire as "nude".

Demure: Select this option if model is in everyday attire, including walking shorts and tennis outfits, but excluding mini skirts or evening gowns that expose cleavage.

Suggestive: Select this option if model is wearing a miniskirt, short shorts, muscle shirt, full-length lingerie (unless see-through) or other dress/shirt that exposes cleavage or chests, and "hiked" skirts that expose thighs. Ask yourself whether the curves of the breast are visible to count as "cleavage".

Partially clad: Select this option if some part of the body that is typically clothed is exposed while another part of the body is clothed. For example, wearing a bathing suit, under garments and ¾ length or shorter lingerie. Also "close ups" where the shoulders of the models are bare.

Nudity: Select this option if the body, or part of the body that is depicted, is completely unclothed. For example, unclothed models, silhouettes, models wearing translucent under garments and lingerie, models clothed in nothing except a towel, and "medium shots" where the model is depicted with no clothing, except perhaps a towel draped over his/her shoulders.

Can't determine: Select this option if you can't tell whether or not they are wearing clothes. Examples include a waist up shot with a shirtless male (you can't tell whether or not he has trunks, pant, swimsuit or underwear on, or whether he is naked. Or, body parts such as arms, legs, etc, where you can't tell if the rest of the body is clothed. An exception, however, would be a breast, since that body part is typically covered.

F. Before/After Shots – Visual and verbal cues

Technique where a picture of a model is shown before and after a procedure has been undertaken. In some cases the photos are clearly labeled "before" and "after" and in other cases there is no copy support, but it is presumed that the first photo is the "before" photo and the second photo is the "after" photo.

In its purest form, the only variance between the "before" and "after" photo would be the results of the procedure. However, many times the "after" photo differs from the "before" photo in many ways, including:

Comparable lighting:
Comparable hairstyle:
Comparable makeup:
Comparable pose/distance from camera:
Comparable clothing:

G. Actual Patient – Verbal Cues

Does the ad specify in writing that the model portrayed actually underwent the procedure? Some ads simply use a beautiful model to portray beauty in general, rather than featuring an actual patient. Select "yes" if there is an explicit written statement such as "actual patient" or "Sue, 54, after facelift".

CHARACTERISTICS OF PHYSICIANS/DENTISTS (Q 15-26)

A. Nature of Practice – Visual and Verbal Cues

Individual Practitioner: the doctor or dentist has his/her own, individual practice. No other doctors or dentists are listed in the ad. Note that this does not include staff or personnel (e.g. registered esthetician) associated with the practice.

Group of Practitioners: two or more doctors or dentists work together in a group practice. The copy and/or photos will list/show more than one doctor/dentist. Again, this does not include staff or personnel associated with the practice.

Hospital with Doctors: Some ads will feature a division of a hospital dedicated to cosmetic surgery. The emphasis will be on the hospital and doctors may or may not be mentioned. Select this option if the emphasis is on a hospital (must have the word "hospital") and specific physician(s) are named. Then continue with balance of questions in this section about the doctors name.

Hospital w/o Doctors: Select this option if the ad emphasizes a hospital (must have the word "hospital") and no specific doctors are named. Then skip ahead to Q28.

Institute/Center/Non-Hospital Surgical Facility: Some ads feature a center/institute, but no specific doctors/dentists are named. This includes centers/institutes with dedicated, permanent physicians/dentists, as well as centers/institutes with rotating medical and dental practitioners. Then skip ahead to Q28.

B. Physician/Dentist Identified by Name – Verbal Cues

C. Photo of Physician/Dentist – Visual Cues

D. Sex of Physician/Dentist – Visual and Verbal Cues

If using verbal cues without a photo, watch out for gender neutral names like "Leslie", "Pat", "Jamie". Tip: if there is body copy, it may reference a "he" or a "she", providing additional evidence for sex.

E. Race of Physician/Dentist – Visual and Verbal Cues

Use same categories/definitions as above for models

F. Type of doctor/dentist – Verbal Cue

Physicians will fall into one of two categories:

M.D. – medical doctor who is certified by the American Board of Medical Specialties

D.O. – medical doctor who is certified by the American Osteopathic Association

G. Stated Area of Specialty – Verbal Cue

This question is intended to capture how the doctor/dentist advertises or positions his/her practice, rather than capturing any type of specific board certification. For example, a physician board certified in General Surgery may advertise that s/he has a cosmetic surgery practice. Similarly, a physician board certified in dermatology may advertise that s/he has a facial plastic surgery practice, although s/he is not board certified in plastic surgery. The key here is to examine how the doctor/dentist defines their practice, typically in the body copy or in the name of the practice. If this information is not available in the copy or name of the practice, rely on board certification information as a last resort (if it is mentioned).

H. Board Certification in a Specialty – Verbal cue

The American Board of Medical Specialties have designated 24 areas of official board certified specialties. This section is intended to capture whether the ads explicitly reference that a physician is board certified by the ABMC in an area. There are five ABMS/AOA board certified specialties relevant to the field of cosmetic surgery, and both D.O. and M.D.s can become certified in these areas:

Plastic surgery:
General surgery:
Dermatology
Ophthalmology
Otolaryngology
Board Certified/General – select this if ads reference generic board certification but not specialty area.
Board Certified/Other: select this if there is a reference to board certification other than the five listed above or attributed to something other than the American Board or ABMS.

I. Professional Affiliations

This section is intended to capture the types of professional organizations to which physicians and dentists belong -- membership. Organizations will be listed in full text or by abbreviation. 28a. Lists those relevant to physicians and 28b. references those relevant to dentists. Note: These are professional organizations, not organizations founded by manufacturers (e.g., Botox).

J. Other Professional Qualifications

This section is intended to capture other ways in which physicians and dentists try to establish credibility.

Number of Years of experience/general – general references not related to a specific procedure. For example, "practicing medicine for more than 15 years".

Number of Years of experience in specific procedure – must include reference to specific procedure. For example, "5 years performing liposuction".

Medical/Dental school affiliation – reference to where they received their M.D., D.O. or D.D.S.

Masters or Undergraduate school affiliation – reference to where they received their masters or undergraduate degree.

Number of procedures performed – explicit quantitative reference to number of procedures (e.g. more than 100 facelifts performed).

Continuing Education: this information will appear either as text in the body copy (e.g., 8 years of continuing education) or as a credential behind their name (e.g., FAGD, MAGD or FACS).

Academic Affiliation: references to the doctor/dentist serving as a professor, trainer of a procedure or instructor.

K. Claim of Superiority to other Practitioners – Verbal Cue

This section is intended to capture direct or indirect claims of superiority made **by physicians/dentists** about their practice or competency in relation to another practice (named or unnamed). These do NOT include:

- a claim of board certification (originates from third party)
- a reference to being named "top doctor/dentist" by some other entity
- a reference to appearing in other media

Examples include: #1/Best doctor in town; first to offer a certain procedure; best educated; more procedures performed than any other.

L. Top Doctor/Dentist Award – Verbal and visual cue

Many city magazines coordinate a contest each year in which medical/dental peers, readers, or consumers select top area doctors/dentists. The results are typically published in the magazine and often the winners promote the fact that they have been named a "top doctor/dentist" in their advertisements.

VERBAL CHARACTERISTICS (Q 27-36)

In Headlines, subheads and copy blocks

A. Facility & Safety Accreditation

Answer YES to this if the copy includes an explicit statement about where the procedure will take place (e.g., all procedures performed in the privacy of our offices). Do not infer this information – it must be absolute in the copy.

Hospital:

Professional Surgical Facility: This can be a surgical suite talked about as separate from the doctor's office, or a general reference to "facility".

Doctor's Office: Copy will specifically say that procedures are performed within the doctor's office.

While hospitals are regulated by the government and must meet certain safety standards, this is not mandatory for non-hospital surgical facilities. However, many surgical facilities seek safety accreditation, particularly if procedures require anesthesia or are complicated enough to require a certain nurse/staff to patient ratio. Is there any type of reference to accreditation?

B. Media References/Cross Promotion (Q 32&33)

Cosmetic surgery, cosmetic dentistry and makeovers have become a popular topic in print and electronic media. This section is intended to capture the extent to which ads are making references to such programming/editorial content. This can occur on two levels:

- General -- references to information presented in a program/article (e.g., Dr. Smith performs weekend facelifts, a procedure featured on 20/20).
- Specific -- references to a program/article in which the advertiser was an actual guest or author (e.g., "Dr. Brown, as seen on Oprah" or "Dr. Green, author of …..".

C. Language

D. What is Advertised?

There are four basic categories:

- Services (cosmetic surgery, cosmetic dentistry, spa)
  Services are procedures provided by physicians and dentists (see tables for details)
  Ads for services can reflect a general area or specific procedures. This reference can occur directly in the body copy or headline, or be part of the name of a practice.

  An example of a general category is an ad to "improve your smile". Nowhere in the body copy does the ad mention a specific procedure that will contribute to improving one's smile, nor does the copy mention the word "cosmetic dentistry". The only reference occurs in the logo for the practice – The Aesthetic Dentistry Center. Here you would select "Aesthetic Dentistry (no specific procedure).

  If, however, reference is made anywhere in the ad to one or more specific procedures, circle "NO" for the general references, "YES" for specific procedure, followed by "YES" for the specific procedure(s) mentioned.

- Devices: Physicians/dentists may apply certain devices to clients as part of their services offering. Such devices are implanted/affixed by a medical/dental professional and not by clients themselves. Examples include breast implants, braces. In some cases these devices are advertised using a brand name.

- Products: some physicians/dentists may advertise that they sell products that clients can use at home on their own. Examples include skin creams, at-home tooth bleaching kits.

Cosmetic/plastic surgery procedures:

Procedure	Description
Botox	
Breast Augmentation	Surgical Implants
Breast Lift	Raise and reshape for limited duration of time
Buttock Lift	Raise and reshape for limited duration of time
Cellulite Treatment	

Chemical Peel	Chemical solution that removes outer layers of facial skin
Chin Surgery	Reshapes chin by enhancement with implant or reduction surgery on the bone
Dermabrasion (also dermaplaning)	Refinish the skin's top layers through controlled surgical scraping to give skin a smoother appearance
Ear Surgery	Set prominent ears back closer to the head or reduce large ears.
Eyelid Surgery (blepharoplasty)	Remove fat and excess skin and muscle from the upper and lower eyelids, correcting drooping upper lids and puffy bags below your eyes that make you look old/tired and may interfere with your vision.
Facelift	Remove excess fat, tighten underlying muscles, and redrape face and neck skin.
Facial/Cheek Implants	Improve and enhance facial structure, giving balance to your face and features so that you feel better about the way you look. Strengthen jawline or bring the chin/cheekbones into balance with the face.
Forehead/Brow Lift	Removal of muscles and tissues that cause furrowing or drooping
IPL (Fotofacial, Epilight, PhotoDerm)	High intensity pulses of broadband light
Laser Skin Resurfacing	Remove areas of damaged or wrinkled skin, layer by layer. The procedure is most commonly used to minimize the appearance of fine lines, especially around the mouth and the eyes.
Laser Hair Removal	
Laser Treatment of Leg Veins/Sclerotherapy	Veins are injected with a sclerosing solution, which causes them to collapse and fade from view.
Liplosuction/Lipoplasty	Sculpt the body by removing unwanted fat from specific areas, including the abdomen, hips, buttocks, thighs, knees, upper arms, chin, cheeks and neck. Including liposculpture, tumescent procedure, and UAL (ultrasound liposculpture).
Male Breast Reduction	
Microdermabrasion	a skin-freshening technique that helps repair facial skin that takes a beating from the sun and the effects of aging.
Nose Shaping/Rhinoplasty	
Permanent Makeup	Including eyeliner
Soft Tissue Fillers	Soft-tissue fillers, most commonly injectable collagen or fat, can help fill in these lines and creases, temporarily restoring a smoother, more youthful-looking appearance.
Thermage	Radio frequency treatment
Thigh Lift	Raise and lift
Tummy Tuck (Adominoplasty)	Remove excess skin and fat from the middle and lower abdomen and to tighten the muscles of the abdominal wall. The procedure can dramatically reduce the appearance of a protruding abdomen.
Upper Arm Lift	Remove loose skin and excess fat deposits in the upper arm

E. Overall Outcome – Visual and verbal cues.

Ads may suggest an overall state that may be achieved as a result of the procedure(s). To determine, look at the copy and visuals of the ad. Do NOT refer to mere lists of procedures that you think fall into one category or the other. Instead, look at references in the body copy or what the headline/visuals are trying to communicate.

The outcome may be physical (looking good) or affective (feeling good) in nature. Typically that outcome may be classified as one of two things:

- Restorative – returning you to a prior physical/affective state (e.g., turning back the clock; repairing damage)

- Transformative – helping you to look/feel better than ever before (e.g. create something)

Answer Both if there is an explicit reference to both outside of a mere procedure name or listing (e.g., Liposculpture to create curves or to return you to your prior form).

Answer Can't Determine if there is not enough information provided, or if the ad is an announcement.

F. Call to Action

Space limitations often preclude advertisers from communicating everything they want to say, particularly with complex products/services such as cosmetic surgery. Often an ad will suggest the next step(s) that the audience can take to get more information and move them closer to making a decision.

This section is intended to capture explicit requests or invitations for the audience to do something. Mere presence of a response mechanism (e.g., phone number, address, URL) does **NOT** count as a "call to action".

G. Response Mechanism

This section is intended to capture the mere presence of information that will assist the audience in responding. For example, an address/location, phone number, or URL.

H. Attributes/Benefits

This section is intended to capture the presence of explicit, verbal information cues about product/service attributes and benefits that are present in the ads. These cues are presented from the perspective of the ***consumer*** and can be thought of as executional components that flow from the overall communication strategy. These items are **manifest** content and are absolutely mentioned in the copy. These cues are not to be confused with the overall appeal (Q 41).

Affordability: Cosmetic procedures have become less expensive and providers have found ways to make financing available or establish installment plans so clients don't have to pay all the fees up front. Examples of references to affordability could include "available to all, not just the rich and famous" or could be even more direct, "safe, affordable". Do NOT include the presence of a discount or other special offer here. Does the ad specifically refer to the affordability of the product/service?

Confidentiality/Secrecy: Although cosmetic surgery and cosmetic dentistry have become more commonplace, many patients may be concerned about confidentiality. This could include keeping their name private, having a procedure done in a location more private than a hospital, or even within a reference to length of the recovery period/return to work so that others won't notice any short term side effects. Does the ad make any explicit references to confidentiality, privacy or secrecy?

Disclaimer about duration of effect: Some procedures wear off over time (e.g., breast lifts, facelifts, tooth whitening) or involve devices that will need to be maintained or replaced (e.g., breast implants). Does the ad provide such a disclaimer?

Ease of Recovery: Cosmetic procedures are often portrayed in the media as simple, quick and involving little downtime – even when undergoing several procedures simultaneously. Examples include: "a new body overnight", "instantly", "no/little down time". Does the ad portray the procedure as easy to recover from?

Foreign Language Skills: Physicians/dentists and their staff may be able to speak languages other than English. This may be tied to a desire to provide a high level of customer service, or as a result of

a practice that targets certain ethnic groups. Does the ad explicitly reference the ability of the physician/dentist or staff to speak a language other than English?

Guarantee of satisfaction/success: Does the ad specifically state that the procedure/product will be successful and/or that the customer will be satisfied?
New: Throughout the years new procedures, products, devices and equipment are introduced. Does the ad refer to the procedure/product/device/equipment as being "new"?

Healthy: Physical or mental health are often considered to be a desired outcome of cosmetic surgery or dentistry procedures. Does the ad make an explicit reference to the procedure or outcome being "healthy"?

Helpful, Qualified Personnel: This attribute is salient to service industries, including medical and dental services. Does the ad make an explicit reference to positive customer service characteristics of the staff (not the doctor/dentist)?

Hospital Affiliation: A specific, named hospital must be present and the name must include "hospital". Many cosmetic surgery procedures are performed in a hospital. Does the ad include the name of a specific hospital where the procedures are performed or with which the physician is affiliated?

Innovation: Some procedures/products/devices/equipment are hailed as being more than just new, but rather as a significant improvement over came before. For example, you will see terms such as "revolutionary", "break-through" or "innovative". Does the ad make such a reference?

Painless: Cosmetic procedures also are portrayed as painless or without side effects. Does the ad explicitly convey painlessness or lack of discomfort?

Physical Attractiveness – Slimming: Does the ad specifically reference becoming more physically attractive as a result of a slimming procedure (for example, liposuction)?

Physical Attractiveness – Other than slimming: Does the ad specifically reference becoming more physically attractive in a manner NOT related to slimming down? For example, "smart and beautiful", "a new look".

Reference to Minority Patients: Cosmetic surgeons or dentists may want to target specific minority or ethnic groups or establish that they have experience working with members of certain background that may have specific physical characteristics. Does the ad include a reference to working with certain ethnic groups/races (e.g., Asians, Blacks, Hispanics)?

Reference to Achieving Perfection: Cosmetic surgery/dentistry may make physical perfection possible, however one defines "perfection". Does the ad use the word "perfect" or "perfection?"

Reference to "Makeover": Makeovers have become a popular topic in the media and the most involved makeovers typically include cosmetic surgery/dentistry. Examples could include stating a doctor is a "makeover expert", reference to a procedure being featured on the television program "Extreme Makeover", or a caption under a model's photo that says "after her dental makeover". Is the word "makeover" present anywhere in the ad?

Scientific Claims: References to things like "scientifically advanced", "advanced technology", "state of the art". Distinct from Innovation.

Video or Computer Imaging: Many physicians provide such imaging as part of their consult or services to help clients visualize what they will look like. Does the ad state that such imaging is available?

Safety: Over the years there have been concerns about the safety of certain types of procedures and products (e.g., breast implants) or the facilities in which those procedures are performed. Does the ad use the word "safe" or "safety" with regard to procedures/products or facilities?

I. Fee Information

The vast majority of procedures are elective and not covered by insurance, so patients must pay out of pocket. As a result, if physicians and dentists advertise the actual cost of a procedure, they may do so in terms of total cost or break that cost down into a lesser amount based on a payment schedule (e.g., by month or by year). This section is intended to capture if and how fees are advertised, as well as any financing options presented.

Total Price – Total cost of procedure is given (e.g., $4,500 for liposuction)

Cost per week -- Cost is divided into weekly amounts so as to appear more affordable than the total lump sum (e.g., "You can look like this for only $50 per week)

Cost per month: Same as above, only given in monthly amounts (e.g., "Llook like this for $100/mth)

Credit Cards Accepted (with or without credit card logos)

Financing – Provided by doctor/clinic

Financing – Provided by mentioned third party company

Financing Available – no mention of source (e.g., "financing available")

J. Sales Promotion Tactics

The elective nature of such procedures makes them more amenable to fee structures and sales promotion tactics that are used for other consumer products. This section is intended to capture the use of such tactics.

Discount – Quantified: Select this category if a discount is mentioned and a specific dollar amount (e.g., $100 off) or percentage discount (e.g., 10% off) is given.

Discount – Not Quantified: Select this category if there is a general reference to a discount (e.g., "ask about special discounts" or "discounts available").

Time Sensitive/Seasonal Promotion: Select this category if the ad includes a specific expiration date for an offer, or a general reference to "limited time only", or if the ad focuses on a special season (summer special; holiday special).

Multi-procedure discount/package rate: Some ads reference a special package rate if a client has more than one procedure, or purchases a pre-packaged menu of procedures (e.g., $3,995 for liposuction in three areas).

RISK INFORMATION (Q 37)

Cosmetic surgery is often portrayed as an easy, painless and side effect-free experience. This isn't always true. This section is intended to capture the presence of risk information that is conveyed in cosmetic surgery/dentistry ads, as well as the presentation of that information in relation to other information in the ad.

This information can be direct (e.g., you may experience some swelling and slight pain for the first few days) or indirect (e.g., Now is the perfect time to have your leg veins taken care of since you don't wear hosiery in the summertime – implying that there will be some visible proof of the procedure and hosiery can help cover up the temporary side effects).

It may be expressed positively (e.g., virtually no risk of swelling, significantly reduced downtime, minimal bruising) or negatively (e.g., swelling may occur, two week recovery period).

A. Type of Risk Information

General reference to "risks" but no specifics – includes "side effects"

Adverse reaction to anesthesia

Allergic reaction

Bleeding

Bruising

Caution about risks involved in choosing wrong doctor – e.g., licensed

Discomfort/pain

Dimpling/puckering

Infection

Recovery period/downtime – Include here only if it is portrayed as a risk instead of a benefit. If the emphasis is on no to low downtime, it should be marked in the "attributes/benefits" section. References may be direct (recovery period of one week) or more indirect (plan to take a week off from work; have this procedure over the long weekend for extra time before returning to work).

Swelling

Quantified probability estimates: Does the ad give numeric odds ratios or percentage information about the likelihood of experiencing any of the above? (E.g., "1 in 20 patients experience …" or 1% of patients experience")

Qualitative probability estimates: Does the ad provide qualitative references to the likelihood of experiencing any of the above? (e.g., "most patients", "all patients", "seldom do patients", "few patients" "rare")

B. Type Size of Risk information
What is the type size of risk information in relation to body copy?

OVERALL APPEAL (Q38)

Derived from: Visuals and major headline only!

Advertising appeals are the method used to draw the attention of consumers and/or to influence their feelings toward the product, service or cause. There are hundreds of different appeals that can be used as the foundation for advertising messages. Generally advertising appeals are broken into two categories: rational appeals and emotional appeals.

An appeal is a strategic statement and this section is intended to capture the overall communication strategy of the ad (what is the ad trying to do?), as opposed to capturing explicit, executional components that flow from the strategy (e.g., attributes/benefits).

Here I am looking for the ***overall impression*** generated by the visuals and major headline, as opposed to a specific verbal component of the ad. The appeal is presented from the strategic perspective of the advertiser.

Rational appeals, also known as informational appeals, target the customer's need for the product or service and highlight the features or a product or service and/or the benefits for owning or using it. Rational appeals tend to be informative and are used to convince consumers that the advertiser's product or service has attributes or gives a benefit that satisfies their needs.

Emotional appeals are the consumer's psychological or social needs for purchasing a certain product or service.

Start by asking yourself if the ad suggests that you will be more physically attractive (e.g., beautiful, good looking, etc.). Most ads will start here. Ads they are more about building the credentials of the physician or dentist may or may not also contain a physical attractiveness appeal. Then branch out from there to ask what else is going on and is there evidence to support it based on the headline and visuals ALONE! Go for an overall impression and not actual verbal statements, but do not dive too deep.

Assurance in physician/dentist or procedure: The visuals and major headline of an ad may be intended to give the audience a sense of confidence in having a procedure, or in that physician/dentist being the one to perform the procedure. Ads will emphasize credibility of the surgeon or safety of the procedure. For example, an ad with a photo of a dentist in his lab coat with the headline "Educated, Experienced Dental Care". Similarly, an ad by a dermatologist with the headline "Facts About FotoFacial".

Anti-Aging: The visuals and major headline will focus on going from old to young, turning back the clock, defying mother nature.

Economic Benefit: Some ads suggest that you will achieve career success and financial security as a result of having cosmetic surgery. For example, "he wouldn't have gotten the job with his old smile".

Health: Some ads go beyond the outward appearance and convey that cosmetic surgery and physical attractiveness leads to a healthier life.

Humor: Visuals and major headline may use humor through a play on words, puns, use of incongruous visuals (e.g., using a wrinkled bull dog or elephant skin in lieu of a human) or nonsensical statements.

Informational: Visuals and major headline will provide basic information such as location, hours of operation and a list of services provided, rather like a business card or an announcement of a practice opening. There is no effort to persuade you to see the doctor or to have a procedure. Just information.

Psychological Benefit: Visuals and major headline may move beyond outward appearance to convey impact on self-esteem and self-confidence. For example, "feel better about yourself". Do not infer that something such as good posture implies self-esteem.

Self-Determination/Control: Visuals and major headline convey a sense of doing it for yourself because you can, or taking control of your life. For example, "Change your life". Note that this is from the perspective of the consumer taking control, not from the perspective of the service provider. For example, "We Change Lives" would NOT count as self-determination on behalf of the consumer, but rather what the service provider accomplishes.

Straightforward Physical Attractiveness – Other than slimming: Visuals and major headline emphasize outward appearance (e.g. "look beautiful", "Spring into a New You"). Often this will be the default selection, given the product category.

Social Benefit: Visuals and major headline convey that you will have more friends, more dates and be more popular if you have the procedure. Note that dating could count as both a social benefit and perhaps also a sexual appeal IF nudity is used to attract attention and/or there is an implicit promise of a sexual outcome or benefit associated with the date.

Threat Appeal: The overall impression is that you will suffer in some way if you don't have the procedure.

Weight Loss/Slimming: The overall impression is that you will be thinner as a result of the procedure – a specific form of physical attractiveness. For example, "remove inches", "drop clothing size".

Sexual Appeal:
Advertisers often blend sex with their brands to gain attention or to market products and services by touting sex-related outcomes. Sex Appeals are defined as sex-related promises or benefits. Sex is used as a central message element to convince people to buy the brand/service. Sexual content involves stimuli within the ad that people interpret as sexual. Overt message elements often include:

- physically attractive models whose alluring bodies are partially revealed by provocative apparel
- double entendre, innuendo and suggestive meaning requires viewers to complete the intended reference.

If you answer YES to sexual appeal, please designate what **type of appeal**. Remember that sexual appeals either implicitly or explicitly offer the promise of sexual outcomes that can be expected as a result of undergoing cosmetic surgery or cosmetic dentistry procedures. These are NOT mutually exclusive – one ad may offer more than one appeal.

- **Sexual attractiveness** of the consumer undergoing the procedure
    - These appeals imply that the model would be perceived as being sexually attractive because of using the product/service. Example: "A body that gets the looks" copy line.

- **Sexual behavior** –
    - These appeals imply that the model would be more likely to participate in sexual activity after using the product and/or have more enjoyment from encounters.

- **Sex esteem** (feelings of being very sexy or sensual)
    - These appeals emphasize internalized sensual feelings for the ad's model alone – that s/he will feel very sexy or sensual as a result of using the product/service

- **Decorative --** sexual ads with no discernable benefit – sexual info merely to draw attention and not part of ad's message to consumers.

Appendix C

Coding Sheet

Date:_____Coder Initials: AS CS EB ER M SH SK LH **AD ID# _____**

1. Magazine: ___1) Atlanta Magazine ___ 2) Boston Magazine ___3) Chicago Magazine ____4) D Magazine
___ 5) Detroit Monthly ___6) HOUR Detroit ___7) Los Angeles Magazine ___8) New York Magazine
___ 9) Philadelphia Magazine ___10) Phoenix Magazine ___11) Washingtonian Magazine

PHYSICAL CHARACTERISTICS OF AD:

2. Ad Production: ____ 1) color ____ 2) black & white ____ 3) combination ____ 4) can't determine

3. Ad Type: ___ 1) display ___2) classified ___3) special ad section w/ editorial
____4) special ad section w/o editorial ___5) advertorial about procedure
____6) advertorial about physician/dentist ____7) practice/location announcement

4. Ad Size: ___1) less than ¼ page ___ 2) ¼ page ___3) > 1/4 page but < ½ page ___4) ½ pag
___5) > ½ page but < ¾ page ____ 6) ¾ page ____7) > ¾ but < 1 page ___8) full page
___9) > one page but < two pages ___10) two pages ____11) >2 pages

5. Ad Illustrations: ___ 1) photos ___ 2) artwork (non-logo/photo) ___ 3) combination artwork/photos
___ 4) none/all copy

VISUAL CHARACTERISTICS OF AD:

6. Indoor Setting (may be more than one): ___1) photo studio ___2)doctor office ___3) dentist office
___4) workplace ___5) bar/tavern ___6) restaurant/diner ___7) kitchen/dining room of house
___8) living room/den of house ___9) bedroom of house ___10) sporting event ___11) theater
___12) other indoor setting: _____ ___13) can't determine indoor setting
___14) **no indoor setting**

7. **Outdoor Setting (may be more than one): ___1) exterior of office/hospital/facility** ___2) yard ___3) park
___4) beach/lake/river/ocean ___5) pool ___6) parking lot ___7) farm/ranch ___8) urban/city street
___9) small town street ___10) sports event ___11) other outdoor setting: _____
___12) can't determine outdoor setting ___13) **no outdoor setting**

CHARACTERISTICS OF MODELS IN ADS:

8. Human Model Present: (including body parts) ___1) yes ___ 2) no **(SKIP TO 15)**
9a. **IF YES:** ___1) photo depiction of human model
___2) illustration/artwork depiction of human model

9. Sex of Human Models:

Number of male models	0	1	2	3	4	5	6	7 +
Number of female models	0	1	2	3	4	5	6	7 +
Number whose sex can't be determined	0	1	2	3	4	5	6	7 +

10. Race of Human Models:

Number of white, non-hispanic models	0	1	2	3	4	5	6	7 +
Number of black, non-Hispanic models	0	1	2	3	4	5	6	7 +
Number of Asian models	0	1	2	3	4	5	6	7 +
Number of Hispanic models	0	1	2	3	4	5	6	7 +
Number of multi-racial models	0	1	2	3	4	5	6	7 +
Number of models of other ethnic group	0	1	2	3	4	5	6	7 +
Number of models whose race can't be determined	0	1	2	3	4	5	6	7 +

11. Type of Pose (hierarchical coding):
___1) face only ___2) head/neck/shoulder ___3) waist up ___4) torso (without head) ___5) ¾ body shot (shoulder/foot; head/thigh) ___6) full body (head to toe) ___ 7) buttock ___8) leg ___9) mouth ___10) other specific body part: _____
___11) stomach

12. Type of Clothing/Attire (hierarchical coding):
___1) demure (typical attire) ___2) seductive (short/hiked skirt; exposed cleavage) ____3) partial nudity ___4) nudity ____5) can't determine (e.g., non-breast body part, shirtless male from waist up).

13. Before/After Photo: ___1) present ___2) not present

14a. FOR BEFORE/AFTER PHOTOS ONLY:	YES	NO	Can't Determine
Both pictures used comparable lighting	1	2	3
Model in both pictures has comparable hairstyle	1	2	3
Model in both pictures has comparable makeup	1	2	3
Model in both pictures has similar pose/distance	1	2	3
Model in both pictures has similar clothing	1	2	3

14. Model identified in writing as actual patient? ___1) yes ___2) no

PHYSICIAN CHARACTERISTICS:

15. Nature of Practice: ____ 1) Individual Practitioner ___ 2) Group of Practitioners
___3) Hospital w/ doctor(s) names ____4) Hospital w/o doctors **SKIP to #21**
___5) Institute/Center/Non-Hospital Surgical Facility (no doctors) **SKIP TO #21**
____6) Other: _____

16. Number of physician(s) mentioned by name: 0 1 2 3 4 5 6 7 +

17. Photo of physician(s)? ___1) yes ___ 2) no
18a. IF YES, Number of physician(s): 0 1 2 3 4 5 6 7 +

18. Sex of Physician(s):

Number of male physicians/dentists	0	1	2	3	4	5	6	7 +
Number of female physicians/dentists	0	1	2	3	4	5	6	7 +
Number whose sex can't be determined	0	1	2	3	4	5	6	7 +

19. Race of physician(s):

Number of white, non-Hispanic physicians	0	1	2	3	4	5	6	7 +
Number of black, non-Hispanic physicians	0	1	2	3	4	5	6	7 +
Number of Asian physicians	0	1	2	3	4	5	6	7 +
Number of Hispanic physicians	0	1	2	3	4	5	6	7 +
Number of multi-racial physicians	0	1	2	3	4	5	6	7+
Number of physicians of other ethnic group	0	1	2	3	4	5	6	7 +
Number whose race can't be determined	0	1	2	3	4	5	6	7 +

20. Type of Doctor/Dentist: ___1) M.D. ___ 2) D.O. ___3) can't determine ___ 4) both

21. Stated Area of Specialty: ____1) aesthetic plastic surgery ___2) cosmetic surgery
___3) cosmetic and reconstructive surgery ___4) dermatology ___5) facial cosmetic surgery
___6) facial plastic surgery ___7) general surgery ___8) ophthalmology
___9) otolaryngology ___10) plastic surgery ___11) plastic and reconstructive surgery
___12) other: _____ ___**13) none mentioned**

22. Reference to board certification in specialty area?: ___1) yes ___2) no

22A. IF YES:

____ 1) Dermatology
____2) General Sugery
____3) Ophthalmology
____4) Otolaryngology/ENT
_____5) Plastic Surgery
_____6) "board certified" but not specific
_____7) Other: _____

23. Reference to Professional Affiliations? ___1) yes ___2) no **(SKIP TO #24)**

23a. IF YES:	YES	NO
Academy of Cosmetic Surgery (ACS)	1	2
American Academy of Dermatology (AAD)	1	2
American Academy of Facial Plastic & Reconstructive Surgery	1	2
American Society of Aesthetic Plastic Surgeons	1	2
American Society of Plastic Surgery (ASPS)	1	2
Lipoplasty Society of North America	1	2
State level professional organization (e.g., Texas Academy of Plastic Surgery)	1	2
City level professional organization (e.g., Houston Academy of Plastic Surgery)	1	2
Other: _____	1	2

24. Reference to Other Professional Qualifications? ___1) yes ___ 2) no **(SKIP TO #25)**

IF YES, what kind? (can be more than one)	YES	NO
Number Years of experience/general	1	2
Number Years experience/specific procedure	1	2
Medical School affiliation	1	2
Undergraduate or masters school affiliation	1	2
Number of procedures performed	1	2
Continuing education (e.g., FACS)	1	2
Academic affiliation (professor, trainer, instructor, academic journal)	1	2
Chief of Staff at hospital	1	2
Other: _____	1	2

25. Is there a claim about superiority to other practitioners (other than board certification)?
___1) yes __2) no

26. Is there a reference to a "Top/Super Doctor" Award? ___1) yes ___2) no

VERBAL CHARACTERISTICS OF AD: (in headlines, subheads and copy blocks)

27. Does the ad explicitly state where the procedure will take place? ___1) yes ___2) no
____3) can't determine

28a. If YES, what type of facility?__1) hospital __2) professional surgical facility
__3) doctor office ___ 4) Other: _____

28b. If YES, does ad mention facility safety accreditation? ___1) yes ___2) no
___3) can't determine

28. Does the ad refer to information presented in other media (print/electonic)? ___1) yes ___2) no

29. Does the ad reference guest appearance, authorship, or other program participation by physician in other media (print/electronic)? ___1) yes ___ 2) no

30. Does the ad include copy in a language other than English? __1) yes ___2) no

34a. If YES, what language? ___1) Spanish ___2) French ___3) Other: _____ ___4) can't determine

31. Which of the following is advertised? (can be more than one)

___1) Cosmetic Surgery (no specific procedure)
___2) Facial Cosmetic Surgery (no specific procedure)
___3) Plastic Surgery (no specific procedure)
___4) Facial Plastic Surgery (no specific procedure)
___5) Specific cosmetic/plastic surgery procedure(s)

If YES, type of procedure:

	YES	NO		YES	NO
Botox	1	2	laser skin resurfacing	1	2
breast augmentation (implants)	1	2	laser hair removal	1	2
breast lift	1	2	laser treatment of leg veins	1	2
buttock lift	1	2	liposuction (liposculpt, tumescent)	1	2
cellulite treatment	1	2	microdermabrasion	1	2
chemical peel	1	2	nose reshaping (rhinoplasty)	1	2
chin surgery (implant or reduction)	1	2	permanent makeup/eyeliner	1	2
dermabrasion	1	2	soft tissue filler (Radiance, collagen, Restylane, fat, hylaform)	1	2
ear surgery (otoplasty)	1	2			
eyelid surgery (blepharoplasty)	1	2	thermage	1	2
facelift	1	2	tummy tuck (adominoplasty)	1	2
facial/cheek implants	1	2	thigh lift	1	2
forehead/brow lift	1	2	upper arm lift	1	2
IPL/Fotofacial	1	2	Female breast reduction	1	2
male breast reduction	1	2	Other: _____	1	2

___6) Branded breast implants?
If YES, brand advertised: _____

___ 7) Branded product? (used at home; e.g., skin care products)
If YES, type of product: _____
If YES, brand of product: _____
___ 8) Spa services?

32. Is there a call to action? ___1) yes ___2) no

34b. IF YES, what type? (can be more than one)

	YES	NO		YES	NO
Call physician/dentist/practice for info	1	2	Visit website of professional assn	1	2
Call professional assn for info (ASPS)	1	2	Schedule consultation	1	2
Call professional assn for referral (ASPS)	1	2	Request video	1	2
Email physician/dentist for info	1	2	Request informational brochure	1	2
Email professional association for info	1	2	Attend seminar	1	2
Email professional association for referral	1	2	Schedule appointment	1	2
Visit website of physician/dentist	1	2	Other: _____	1	2

33. Is there a response mechanism(s) is/are included in the ad? ___1) yes ___2) no

33b. IF YES, what type? (can be more than one)

	YES	NO		YES	NO
Local phone number of physician	1	2	Website URL for physician/dentist/practice	1	2
Toll free# for physician	1	2	Website URL for professional association	1	2
Toll free# for professional assn	1	2	Email address	1	2
Address/Location	1	2	Other: _____	1	2

34. Product/Service Attributes/Benefits (can be more than one)	YES	NO
Affordability (e.g., "available to all, not just the rich and famous")	1	2
Confidentiality/secrecy	1	2
Disclaimer re: duration of effect (re-touch needed, # years)	1	2
Ease of Recovery (e.g., no/little downtime; overnight)	1	2
First/only to offer procedure	1	2
Foreign language skills	1	2
"Guarantee" of satisfaction/success	1	2
"Healthy" , "healthier" or any derivative of the word	1	2
Helpful, qualified personnel	1	2
Hospital affiliation	1	2
Innovation (e.g., "break-through", "revolutionary")	1	2
Natural (using the actual work "natural")	1	2
Painless/no discomfort	1	2
Physical attractiveness – slimming	1	2
Physical attractiveness – other than slimming	1	2
Reference to minority patients	1	2
Reference to "perfection" or "perfect"	1	2
Reference to "makeover"	1	2
Scientific claims (advanced technology, state of the art)	1	2
Video/Computer Imaging	1	2
"Safety" or "safe"	1	2

35. Is Fee Information present? ___1) yes ___2) no

IF YES, what kind? (can be more than one)	YES	NO
Total Price	1	2
Cost per week	1	2
Cost per month	1	2
Credit Cards Accepted	1	2
Financing by doctor/clinic	1	2
Financing by third party company	1	2
Financing general – source not mentioned	1	2
Reference to Insurance Coverage	1	2

36. Are Sales Promotion Tactics present? ___1) yes ___2) no

IF YES, what kind? (can be more than one)	YES	NO
Discount – quantified in percentage or dollar amount	1	2
Discount – not quantified	1	2
Time-sensitive/seasonal promotion	1	2
Multi-procedure discount/package rate	1	2
Other: _____	1	2

RISK INFORMATION IN AD

37. Presence of risk information: ___1) yes ___ 2) no (**SKIP TO Q38)**

37a. IF YES, Type of Risk Information Provided (can be more than one)

	YES	NO
General reference to "risks" but no specifics	1	2
Adverse reaction to anesthesia	1	2
Allergic reaction	1	2
Bleeding	1	2
Bruising	1	2
Caution about choosing right doctor (e.g., licensed)	1	2
Discomfort/pain	1	2
Dimpling, puckering	1	2
Infection	1	2
Recovery period/downtime	1	2
Scarring	1	2
Swelling	1	2
Quantified probability estimates (e.g., 1/3 or 33%)	1	2
Qualitative probability estimates (e.g., most, all, rare)	1	2
Other: _____	1	2

37b. Type Size of risk information is: ___1) smaller than body copy ___2) same as body copy ___3) larger than body copy

____4) other: _____

OVERALL APPEAL IN AD (Visuals and major headline ONLY!)

38. What type(s) of appeal(s) (May be more than one)

	YES	NO
Assurance in physician/dentist or procedure	1	2
Defy age (e.g. "reverse the clock", "beat mother nature")	1	2
Economic benefit (e.g., career success, employment)	1	2
Health (e.g., physical attractiveness leads to healthy life)	1	2
Humor (incl. puns/play on words)	1	2
Information – straightforward about procedure	1	2
Psychological benefit (e.g., self-esteem, self-confidence)	1	2
Self-determination/control (e.g., all limitations are self-imposed)	1	2
Straightforward physical attractiveness - not slimming(beautiful)	1	2
Weight loss/slimming as physical attractiveness (remove inches)	1	2
Social benefit (e.g., friendship, popularity, dates)	1	2
Threat appeal (e.g., you will suffer if you don't have this done)	1	2
Sexual appeal	1	2
Affordability	1	2
Other: _____	1	2

38a. IF "YES" for sexual appeal, what type of appeal? (May be more than one, EXCEPT for 4)

___1) Sexual attractiveness (e.g., others will look at you more)
___2) Sexual behavior (e.g., likely that you'll have more sex/better sex)
___3) Sex Esteem (e.g., you'll feel better about yourself sexually)
___4) Decorative (only to attract reader's attention – no implied sexual promise or benefit).

Appendix D

Recruitment Script for Colleagues/Friends

I am working on my dissertation, which is about cosmetic surgery advertising. As part of the study I am interested in speaking with women who have had cosmetic surgery, or who are thinking about having cosmetic surgery in the next year or two, about the information sources they relied upon as they thought about having cosmetic surgery. I'm specifically I interested in women between the ages of 35 and 55 who come from middle to upper-middle class households.

> I realize that this is a personal, private topic, so please don't share any names with me right now, but do you know anyone who meets these criteria?
>
> Would you be willing to touch base with them and ask if they would be interested in learning more about the study and perhaps consider letting me interview them for 30 to 40 minutes?
>
> If they are interested, please give me their name and phone number or email address and I will contact them about speaking with me.

Recruitment Script for Prospective Participants

Thank you so much letting me get in touch with you about my research. As XXXXX may have told you, I'm a doctoral student at the University of Georgia and I am working on my dissertation, which is about cosmetic surgery advertising. I am interested in finding out about the role that advertising plays in the decision about whether to have cosmetic surgery.

> Now, just to confirm, are you thinking about having cosmetic surgery or have you had it already? Great.
>
> I will be speaking with about 20 women like you over the next two months about their decision-making process and how they used advertising as an information source during that process. Do you recall ever hearing, seeing or reading an ad for cosmetic surgery? Great.

What I would like to do now is answer any questions you might have about the project. If you decide to participate, it would involve a 30 to 45 minute face to face interview so I could ask you some questions. I would like to tape record the interview and then have it transcribed. I want to keep your identity private, so that your name is in no way linked to your responses, so if you participate I will assign you a pseudonym – in other words, a fake name – and I would use that in my manuscript. I understand how important confidentiality is.

Do you have any questions for me about the project?

Does this sound like something you'd be willing to participate in?

IF YES:

I would like to set up a time and place for the interview, and send you a consent form to review and sign. If you have any questions, feel free to call me. You can bring the form with you when we meet. What might be a good place, date and time for us to meet?

Where should I send the consent form for you to review – a mailing address or by email?

Great. I will get that out today. And where can I reach you a few days ahead of our meeting to confirm?

IF NO:

I understand. And I do appreciate your taking the time to at least hear about the project. Thank you.

Appendix E

INTERVIEW PROTOCOL "A"

Women Who Have Had Cosmetic Surgery

Briefing

>Thank you for agreeing to talk with me about information sources and your decision to have cosmetic surgery. This interview should take between 30 and 45 minutes. I have your signed consent form here. As I mentioned on the phone/in my email, my dissertation is about cosmetic surgery and one part of the study involves speaking with women about information sources they relied upon as they contemplated having cosmetic surgery. I really appreciate your willingness to talk with me about this. I am going to tape record the interview so I can go back and examine the responses in more detail. However, as I indicated in the consent form, I will give you a pseudonym so that in no way will your identity be linked to your responses or mentioned in the study itself.

Grand Tour Question(s)

>You mentioned to me that you have had cosmetic surgery. Could you tell me what kind of procedures you've had and when you had them?

>Are you thinking of having any more cosmetic surgery done?

>Now, can you recall when you first encountered information about cosmetic surgery in the mass media? What were the sources of that information?

If participant does not raise mediated messages in their response, prompts:

>What about television programs, or fashion magazines?

>What about advertisements? What can you tell me about those sources of information about cosmetic surgery?

Thematic Apperception Test

Now I'd like to show you a few drawings and ask you some questions.

[Drawing 1]

>This is a woman sitting on a coach reading a cosmetic surgery ad in [Atlanta Magazine].

>What do you suppose she is thinking after reading the ad?

>Is there anything else she is thinking?

>How do you think she feels?

[Drawing 2]

>Now the woman is sitting on the coach with her best friend and reading a cosmetic surgery in [Atlanta Magazine]?

>What do you suppose the woman is thinking after reading the ad?

>Is there anything else she is thinking?

>How do you the woman is feeling?

>What do you think the friend sitting next to her is thinking?

>How do you think her friend feels?

[Drawing 3]

>Now the woman is sitting on the coach with her significant other and reading a cosmetic surgery ad in [Atlanta Magazine].

>What do you suppose the woman is thinking after reading the ad?

>Is there anything else she is thinking?

>How do you think the woman is feeling?

>What do you think the man is thinking?

>How do you think he is feeling?

Now I'd like to ask you some questions specifically about cosmetic surgery ads.

Questions about use of ads

>How much attention do you pay to cosmetic surgery ads in general?

>How much attention do you pay to cosmetic surgery ads in [name of city magazine]?

>At what stage of your decision-making process did you use advertisements?

>Did you pay more attention to cosmetic surgery ads *before* or *after* you made the decision to have cosmetic surgery?

>What role(s) did advertising play?

>Provide information about the procedure?

>Provide information about doctors/who to go to?

>Provide price information?

>Provide facility information?

>Provide risk information?

>How important was advertising relative to other sources of information in your decision to have cosmetic surgery?

Questions about confirmation or disconfirmation of expectations

>Now I'd like for you to think about the results of your surgery in relation to the information presented in the ads. Were your expectations met?

>How so?

>How not?

>If you were going to have cosmetic surgery again, how would you use the information in advertisements?

>Would you use ads the same or differently?

>Doctors who perform surgery other than cosmetic surgery also advertise. Do you think there is a difference in how cosmetic surgeons advertise their services?

Catch-All Question

>Is there anything else you'd like to share about advertising and your decision to have cosmetic surgery?

Debriefing

This has been very helpful. I have no further questions. Do you have anything more you'd like to bring up, or ask about before we finish the interview?

INTERVIEW PROTOCOL "B"

Women Who Are Contemplating Having Cosmetic Surgery

Briefing

>Thank you for agreeing to talk with me about information sources you are using as you think about whether to have cosmetic surgery. This interview should take between 30 and 45 minutes. I have your signed consent form here. As I mentioned on the phone/in my email, my dissertation is about cosmetic surgery and one part of the study involves speaking with women about information sources they rely upon as they contemplate having cosmetic surgery. I really appreciate your willingness to talk with me about this. I am going to tape record the interview so I can go back and examine the responses in more detail. However, as I indicated in the consent form, I will give you a pseudonym so that in no way will your identity be linked to your responses or mentioned in the study itself.

Grand Tour Question(s)

>You mentioned to me that you are thinking about having cosmetic surgery in the next year or two. Could you tell me what procedures you are thinking about having done?

>Now, can you recall when you first encountered information about cosmetic surgery in the mass media? What were the sources of that information?

If participant does not raise mediated messages in their response, prompts:

>What about television programs, or fashion magazines?

>What about advertisements? What can you tell me about those sources of information about cosmetic surgery?

Thematic Apperception Test

Now I'd like to show you a few drawings and ask you some questions.

[Drawing 1]

>This is a woman sitting on a coach reading a cosmetic surgery ad in [Atlanta Magazine].

>What do you suppose she is thinking after reading the ad?

>Is there anything else she is thinking?

>How do you think she feels?

[Drawing 2]

>Now the woman is sitting on the coach with her best friend and reading a cosmetic surgery in [Atlanta Magazine]?

>What do you suppose the woman is thinking after reading the ad?

>Is there anything else she is thinking?

>How do you the woman is feeling?

>What do you think the friend sitting next to her is thinking?

>How do you think her friend feels?

[Drawing 3]

>Now the woman is sitting on the coach with her significant other and reading a cosmetic surgery ad in [Atlanta Magazine].

>What do you suppose the woman is thinking after reading the ad?

>Is there anything else she is thinking?

>How do you think the woman is feeling?

>What do you think the man is thinking?

>How do you think he is feeling?

Now I'd like to ask you some questions specifically about cosmetic surgery ads.

Questions about use of ads

>How much attention do you pay to cosmetic surgery ads in general?

>How much attention do you pay to cosmetic surgery ads in [name of city magazine]?

>What role is advertising playing in your decision about whether to have cosmetic surgery?

>Providing information about the procedure?

>Providing information about doctors/who to go to?

>Providing price information?

>Providing facility information?

>Providing risk information?

>How important is advertising relative to other sources of information as you decide whether or not to have cosmetic surgery?

Questions about confirmation or disconfirmation of expectations

Now, I'd like you to think about information presented in cosmetic surgery ads. Do you think your surgery as presented in the ads will meet your expectations?

>Why do you think that?

>Doctors who perform surgery other than cosmetic surgery also advertise. Do you think there is a difference in how cosmetic surgeons advertise their services?

Catch-All Question

>Is there anything else you'd like to share about advertising and your decision about whether or not to have cosmetic surgery?

Debriefing

This has been very helpful. I have no further questions. Do you have anything more you'd like to bring up, or ask about before we finish the interview?

Appendix F

In-Depth Interview Participant Profiles

JANET

Janet is a 35 year-old real estate agent from Michigan. She is married and has two children. Janet had augmentation in 2004 and a breast lift in 2006 and is not planning on having any additional surgeries in the near future. Janet's situation is unique, in that she originally wanted to have a breast lift but was talked into breast augmentation by her first cosmetic surgeon, who was female. The results of the surgery were problematic and Janet sought out another cosmetic surgeon who corrected these problems and gave her the breast lift she wanted from the start. Janet feels that her first surgeon pushed her to have something she was not intending to have, and wished she had stood her ground.

Janet has seen advertisements for cosmetic surgery in national magazines and on television. She doesn't feel that she pays much attention to such ads currently, since she is not planning on having additional surgery in the near term, but recalls using advertisements in the past to get information about doctors in the area.

SAMANTHA

Samantha is a 36-year-old title insurance escrow officer from Michigan. She is divorced and the mother of two children. Samantha has not had any cosmetic surgery to date, but is planning to have a tummy tuck and butt lift within the next year.

Samantha has seen advertisements for cosmetic surgery in national magazines and in city magazines, and occasionally on television. She feels that she pays some attention to cosmetic surgery ads in general, but a lot of attention to those that mention tummy tucks or liposuction. Samantha said that she uses the ads to get information about which physicians do which

procedures and where they are located, but relies on the Internet to get information about the procedure itself. She visits WebMD and the ASPS website rather than a website for a specific physician.

RENEE

Renee is a 39-year-old dietician from Michigan. She is single, but in a committed relationship and has a one-year old child. Renee had rhinoplasty in 1994 and breast augmentation in 2005, both by board certified plastic surgeons. This past year she had microdermabrasion and a chemical peel from her dermatologist. She plans to have laser resurfacing and permanent hair removal within the next year. Renee considers herself to be very analytical and savvy about medical issues, due to her occupation.

Renee has seen ads for cosmetic surgery in the newspaper, the city magazine, and on television. In addition, she picked up brochures from booths at a Women's Expo trade show and has received direct mailings about cosmetic surgery from her dermatologist. Renee said that she pays quite a bit of attention to cosmetic surgery ads. She uses print ads to determine which physicians to research further, and then looks them up on the Internet, and asks people at the hospital about the providers' reputations. Renee says that the information on the Internet played the greatest role in her selection of a plastic surgeon for her breast augmentation and a dermatologist for the microdermabrasion and chemical peel.

DARIA

Daria is a 39-year old interior designer. She is married with step children in their 30s, but has no children of her own. Daria had permanent makeup applied to her lips in 2000 and had a breast reduction in 2004. She is planning on having surgery for varicose veins this year and liposuction or a tummy tuck once she loses some weight.

Daria recalls seeing ads for cosmetic surgery in the newspaper and city magazine, as well as brochures at Women's Expos. She says that she pays a lot of attention to cosmetic surgery ads to see who is out there and what they are doing, but that ultimately word of mouth will determine who she goes to for her next surgeries. She acknowledged that ads might become more important to her if she moved to a new area where she was not as strongly networked.

PAULA

Paula is a 41-year-old nurse from Michigan. She is single and does not have any children. Paula had an upper arm lift and abdominoplasty in 2004 and plans to have liposuction on her chin, back and legs this year, all from a board certified plastic surgeon. Paula's story is unique, in that her reason for having cosmetic surgery was to remove excess skin and fat cells after losing 179 pounds. Paula says that her medical background causes her to more carefully research physicians and their facilities than might others.

Paula recalls encountering cosmetic surgery ads on the radio, newspaper and in city magazines. Paula believes that she pays more attention to cosmetic surgery ads now than she did before she had her first surgery, a decision prompted by the need to remove excess skin so that she could fit into clothing better. Now she is intrigued with the wide variety of procedures available. She has used ad most to find out who the providers are, where they are located, how long they have been in practice, where they went to medical school and residency, and whether they are board certified. After finding out about a doctor through an ad, she visits the doctor's websites to get more information, which she will use to narrow her search and eventually make consultation appointments.

PATRICE

Patrice is a 48-year-old nursing technician from Michigan. She is married and has five children. She had a breast reduction in 1991 and an eyelift in 2004, both by a board-certified plastic surgeon. She also plans to have a tummy tuck as soon as she loses 40 pounds. Patrice has worked at the hospital for 22 years and has used her position to gain as much information as she can about procedures and providers.

Patrice has seen advertisements for cosmetic surgery on television has used the Internet to research cosmetic surgery providers and procedures. She says she pays a lot of attention to ads and focuses most on the procedures that are advertised, and whether the advertising physician is board certified and a specialist in that area.

DIANE

Diane is 49-year-old philanthropist from Georgia. She is married and has two daughters. Diane had breast augmentation and eyelid surgery in 2005 and plans to have laser resurfacing within the next year. Diane's story is unique, in that one implant ruptured the day before our interview. There was a pinhole in the implant and it had to be replaced.

Diane recalls seeing most ads for cosmetic surgery in New Beauty magazine, newspapers, and a few ads on radio and television. Diane shared that she uses New Beauty to source potential physicians and to learn what procedures are out there. She also used the Internet to get additional information about physicians and procedures, visiting physician websites and the ASPS website. She is happy with her plastic surgeon and probably will use ads in the future to learn about procedures, rather than other practitioners.

FAITH

Faith is a 49-year-old legal assistant for a medical malpractice firm. She is married and has one child. Faith had breast reconstruction on one breast after a mastectomy in 2001. She is scheduled for a breast lift on the other breast toward to "even things out" at the end of 2006 and also is considering having liposuction at the same time. Faith says she does extensive research on physician credentials due to her occupation.

Faith recalls being exposed to cosmetic surgery advertisements in magazines, newspapers, on the radio and on television. She says that she pays quite a bit of attention to cosmetic surgery ads now because she needs to select a new plastic surgeon because she lives too far away from the one who did her reconstructive work. I particular, she looks for information about new procedures or technologies, as well as to identify potential surgeons. Faith also researches physicians extensively on the Internet, including the ASPS web site, physician websites and legal sites that disclose pending litigation.

JENNIFER

Jennifer is a 50-year-old freelance copywriter from Georgia. She is married and has four children. Jennifer had an upper and lower eyelid lift in 1996 and Botox in 2005. She is planning on having additional Botox injections this year. Her story is unique, in that she lives next door to a plastic surgeon and is also has a cosmetic surgeon as a client.

Jennifer recalls seeing ads for cosmetic surgery in Atlanta Magazine and Points North magazine and uses the Internet to research procedures and physicians. She acknowledges that this causes her to look at cosmetic surgery advertisements differently than most people, since she is analyzing what the competition is saying and offering. However, Jennifer insists that she would still pay a lot of attention to ads even if she were not writing copy for a cosmetic surgeon.

MARGEAUX

Margeaux is a 51-year-old sales manager from Michigan. She is married and has one teenage daughter. Margeaux had breast augmentation in 1996 and liposuction in 1998. She is planning on having eyelid surgery and a neck lift in the next year and is aggressively interviewing physicians in several cities.

Margeaux does not recall seeing many ads prior to her first two surgeries, but recalls seeing ads in newspapers, city magazines, on radio and television, and in brochures since then. She also uses the Internet to research physicians in other cities, since she wants to have the surgery done in a large, metropolitan market. She says that she pays a lot of attention to cosmetic surgery ads and uses them to keep current on what the new procedures are and to know which doctors are doing which procedures. However, she feels that advertising is less important than the information she gets online, from people who have been prior patients, and from the consultation with the physician.

STEPHANIE

Stephanie is a 51-year-old sales representative from Michigan. She is married and the mother of two grown children. Stephanie had a breast lift in 1994 and a tummy tuck in 2004. Although she does not plan on having any additional procedures within the next year, she would eventually like to have an eyelid lift and brow lift.

Stephanie does not recall seeing cosmetic surgery advertisements prior to her breasts lift, but does recall seeing ads since then on billboards, in magazines, on radio and television, in direct mail and brochures at Women's Expo trade shows. She also has attended informational seminars hosted by physicians. In addition, Stephanie uses the Internet to Google information about new procedures. When she was selecting a surgeon for the tummy tuck she made a list of

doctors from ads, then looked them up on the ASPS website and then linked to the physician websites.

CHERYL

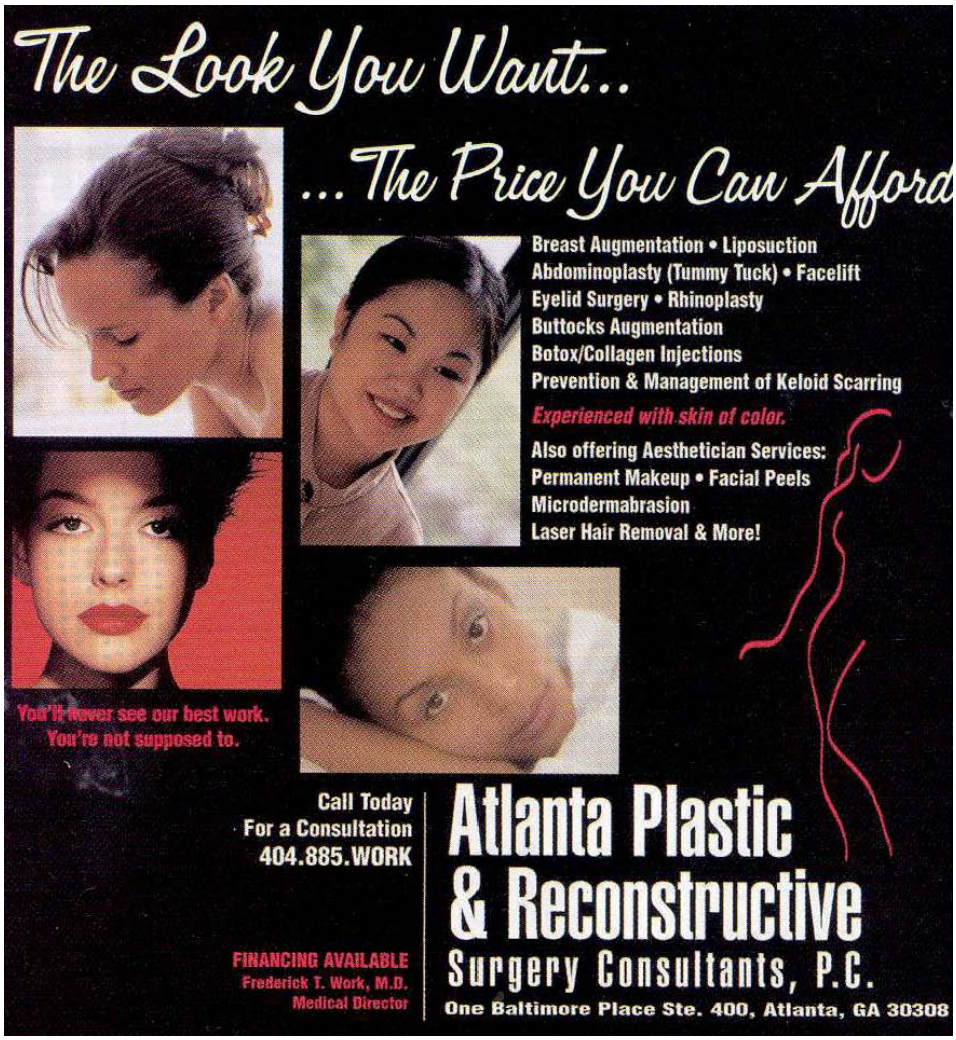
Cheryl is a 52-year-old owner of a video production company in Michigan. She is single with no children. Cheryl had an eyelift in 1999, laser skin resurfacing in 2003, and has been receiving Botox injections every six months since 2003, and plans to continuing do so. She is also planning on having tumescent liposuction within the next year.

Cheryl recalls seeing ads for cosmetic surgery in national women's magazines, city magazines, on television and radio and in the form of POP displays in her dermatologist's office. She says she is mildly interested in cosmetic surgery ads in general, but pays more attention during those times in her life where she is not feeling good about herself or when she is actively seeking out info for a specific procedure that she wants to have. Cheryl uses the ads to obtain baseline info about procedures and to source physician credentials that she later fact checks. She also uses the Internet, seeking information on WebMD and the ASPS website seeks out information on the Internet.

Appendix G

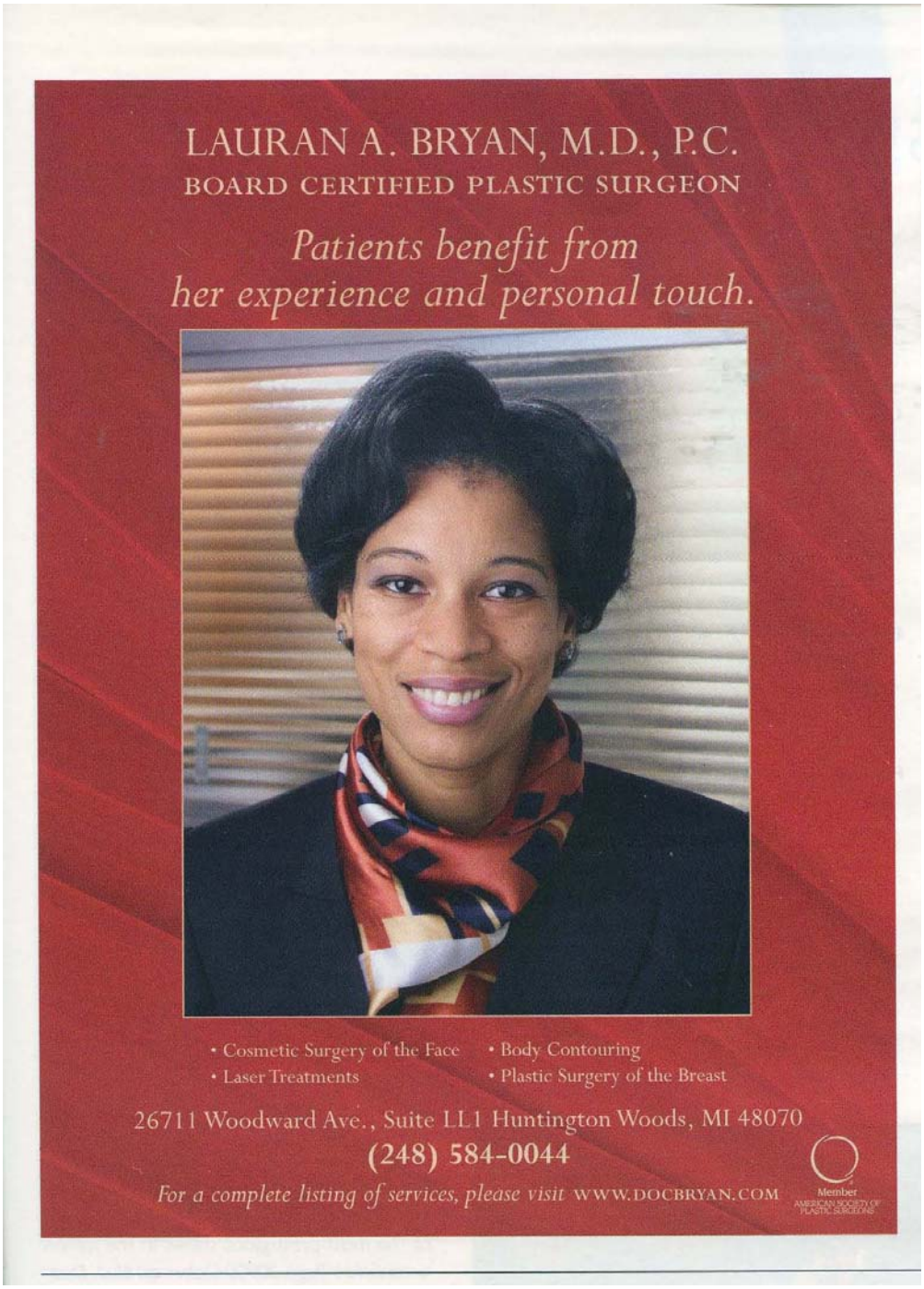
Examples of Advertising Appeals

Affordability Appeal

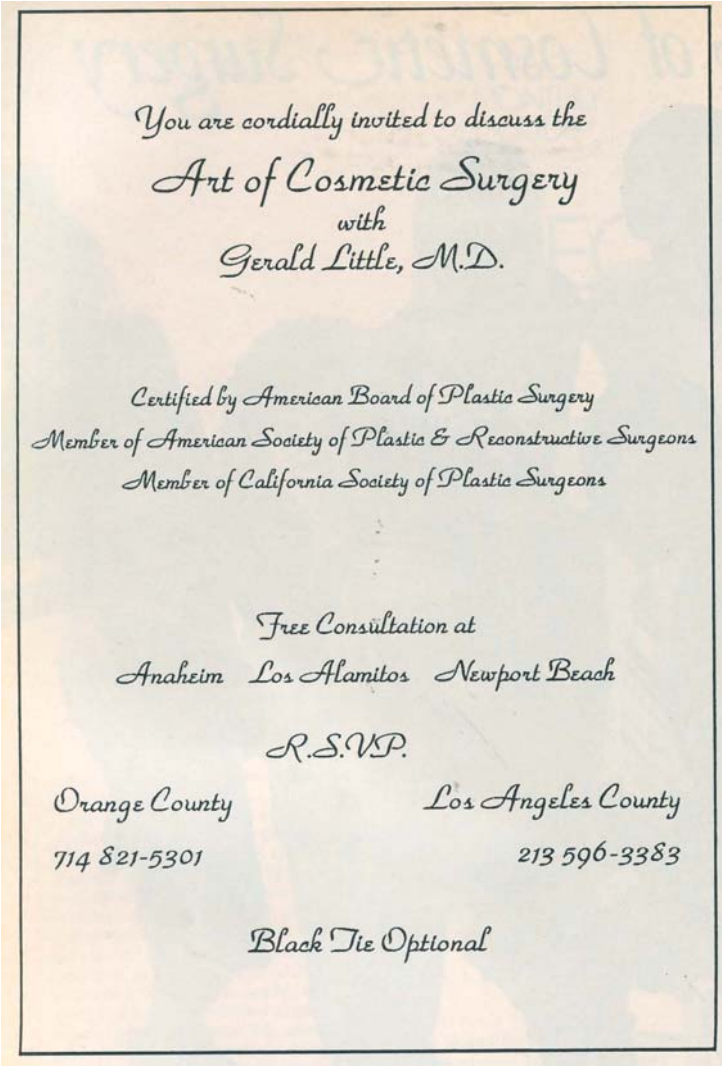


Anti-Aging Appeal

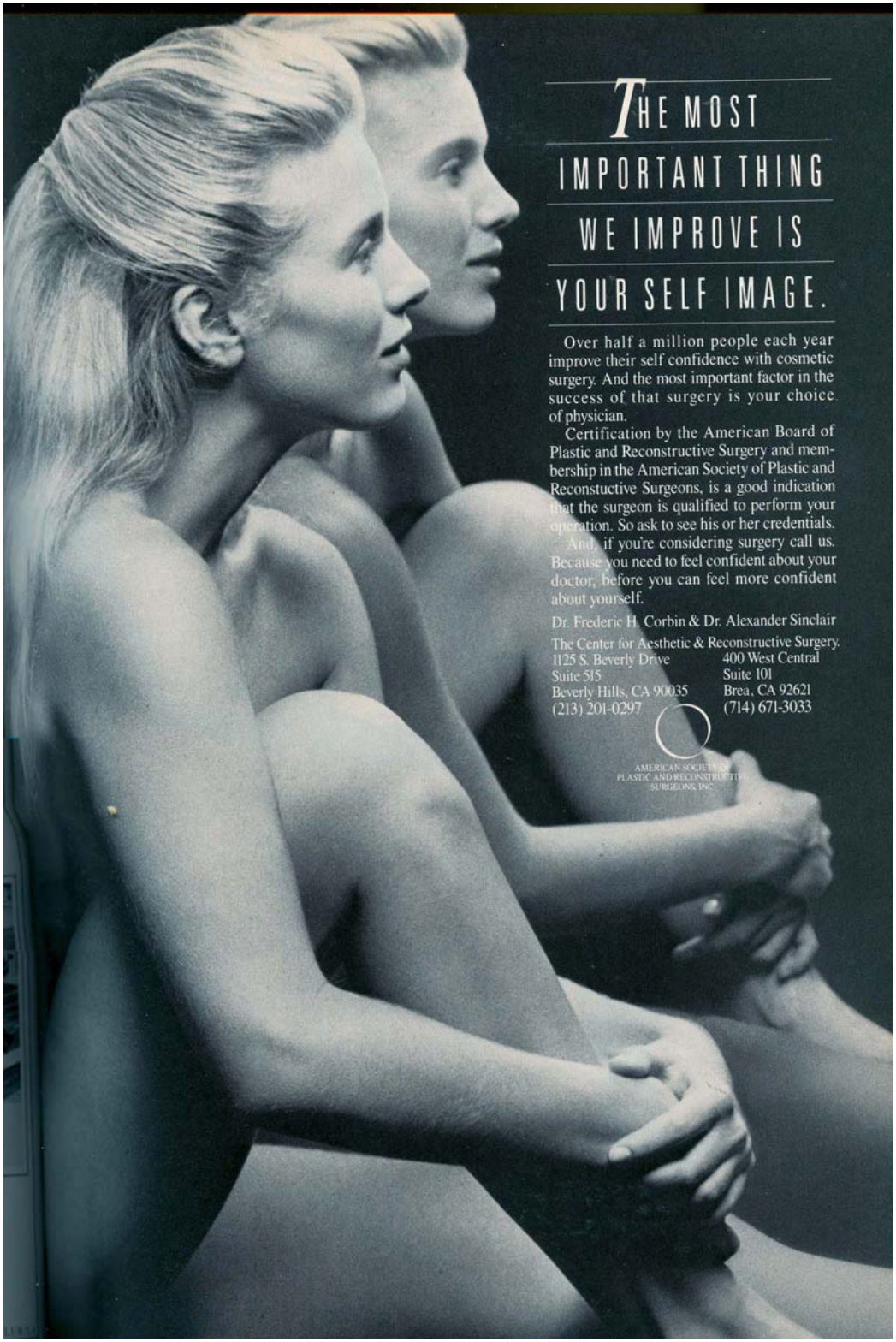
Assurance Appeal



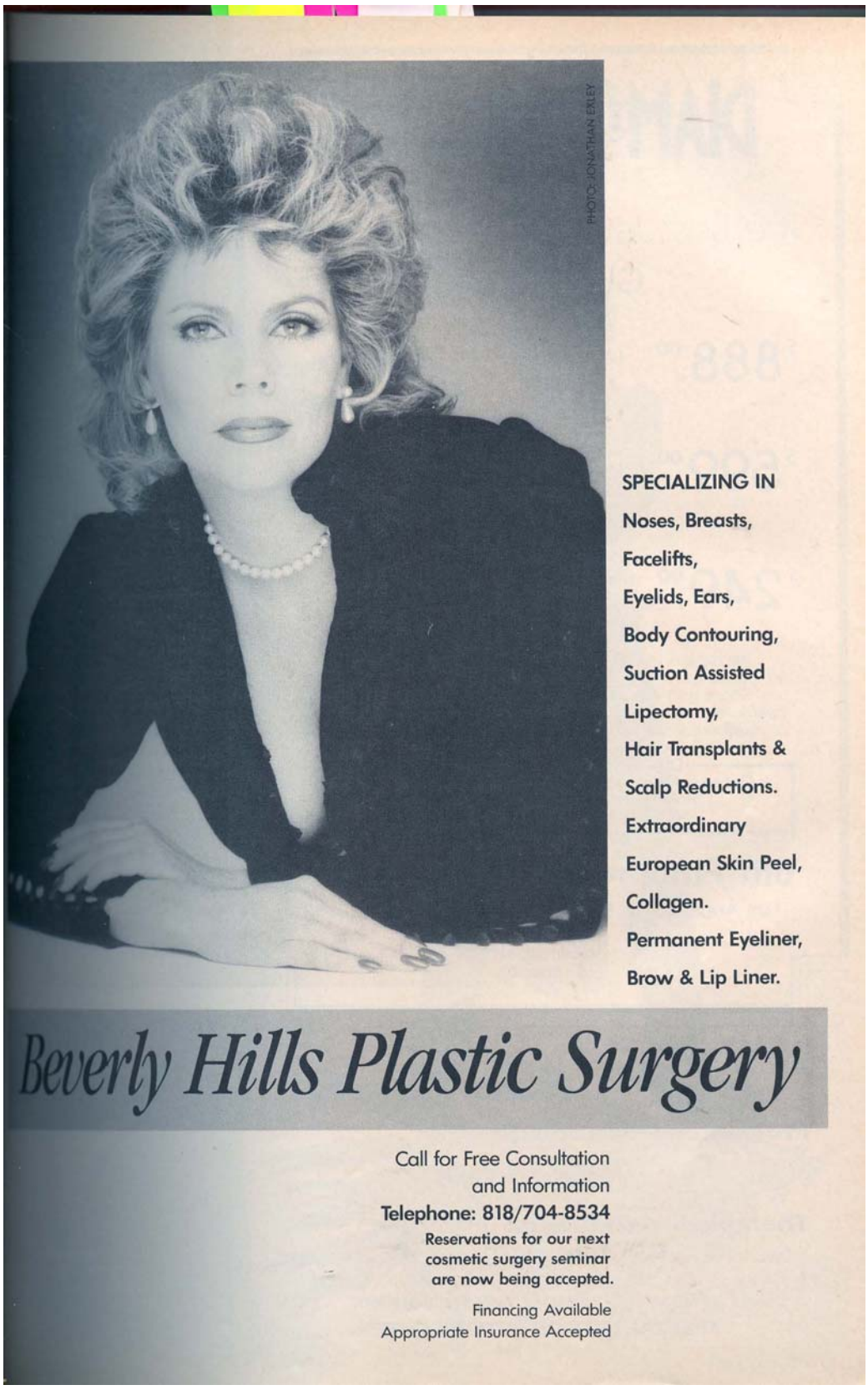
Informational Appeal



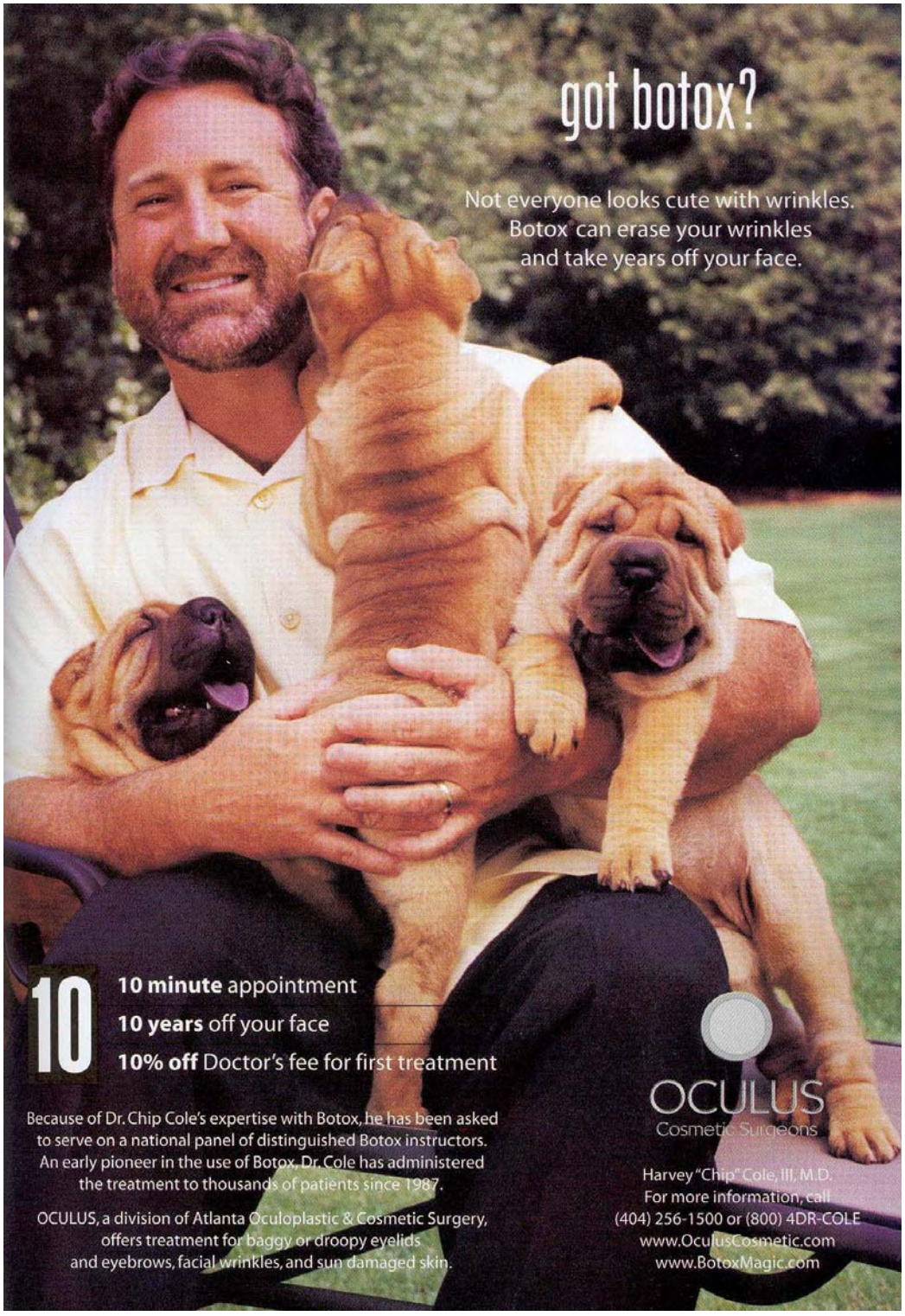
Psychological Benefit Appeal

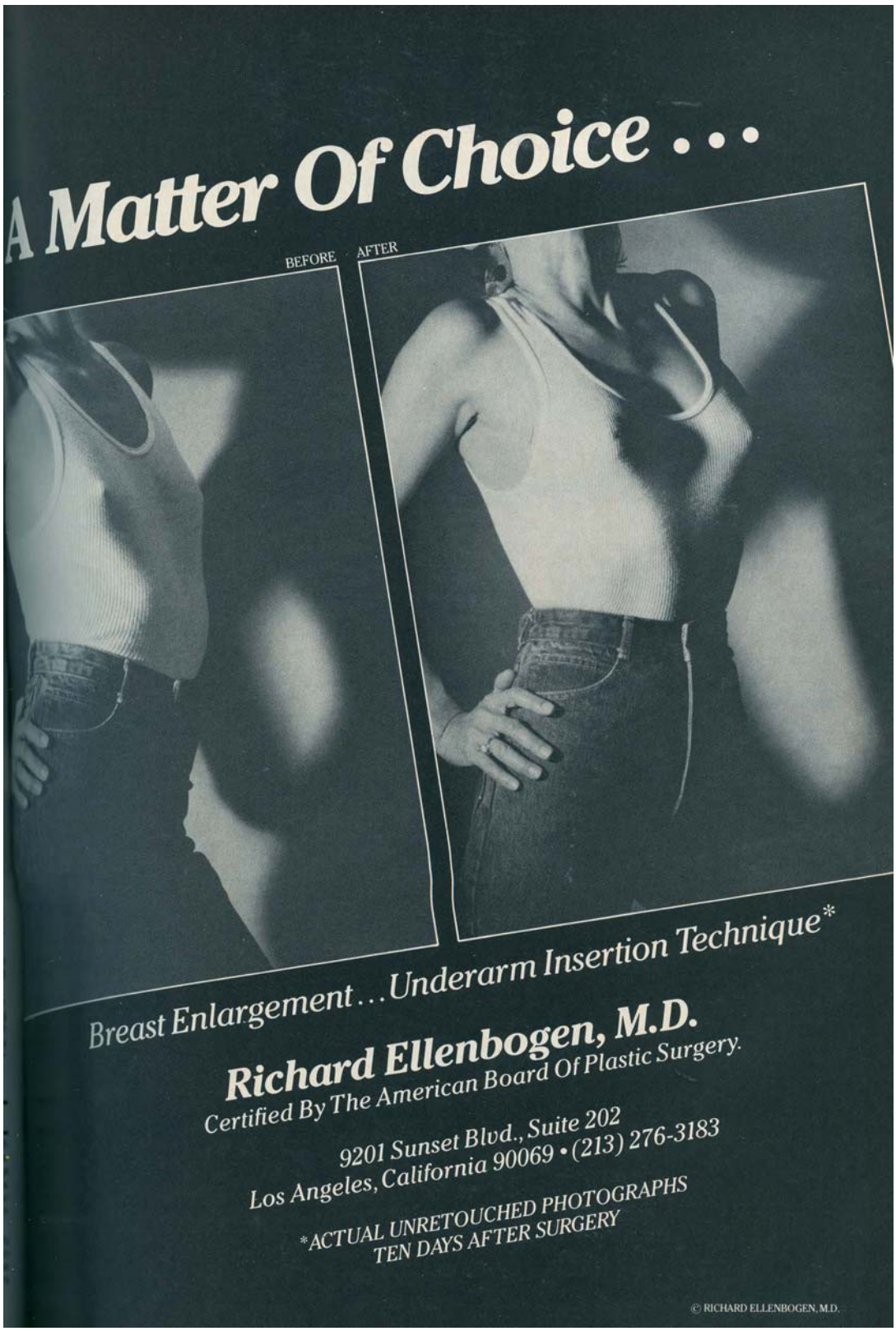


Physical Attractiveness Appeal



Humor Appeal




A Matter Of Choice . . .
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AFTER
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Certified By The American Board Of Plastic Surgery.
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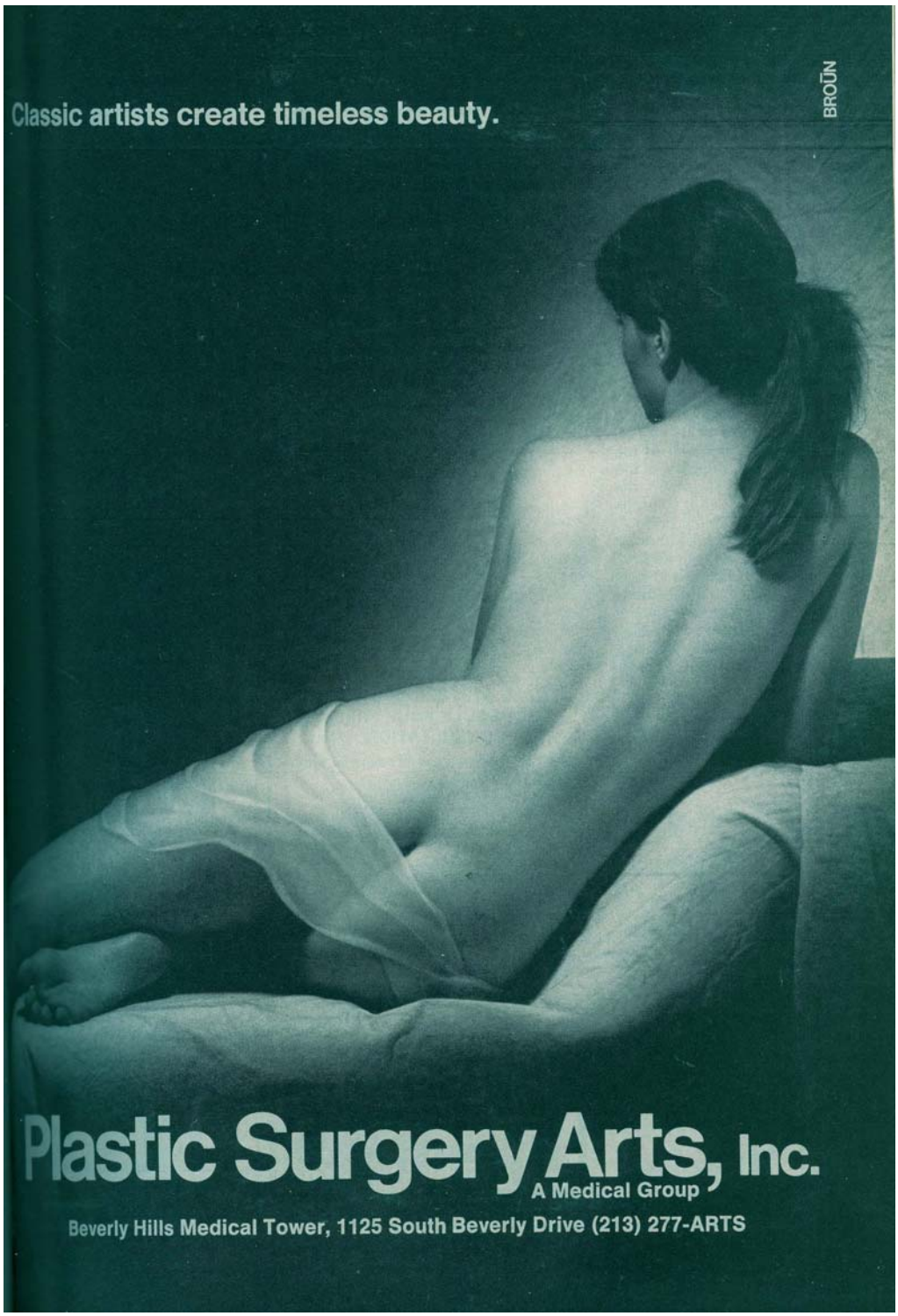
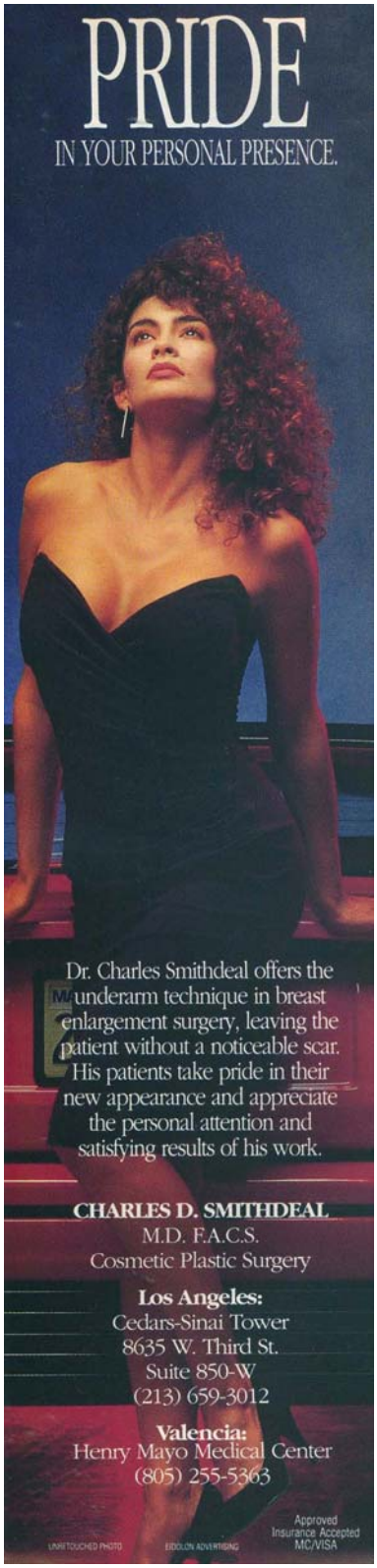
*ACTUAL UNRETOUCHED PHOTOGRAPHS
TEN DAYS AFTER SURGERY
© RICHARD ELLENBOGEN, M.D.

Sexual Attractiveness Appeal

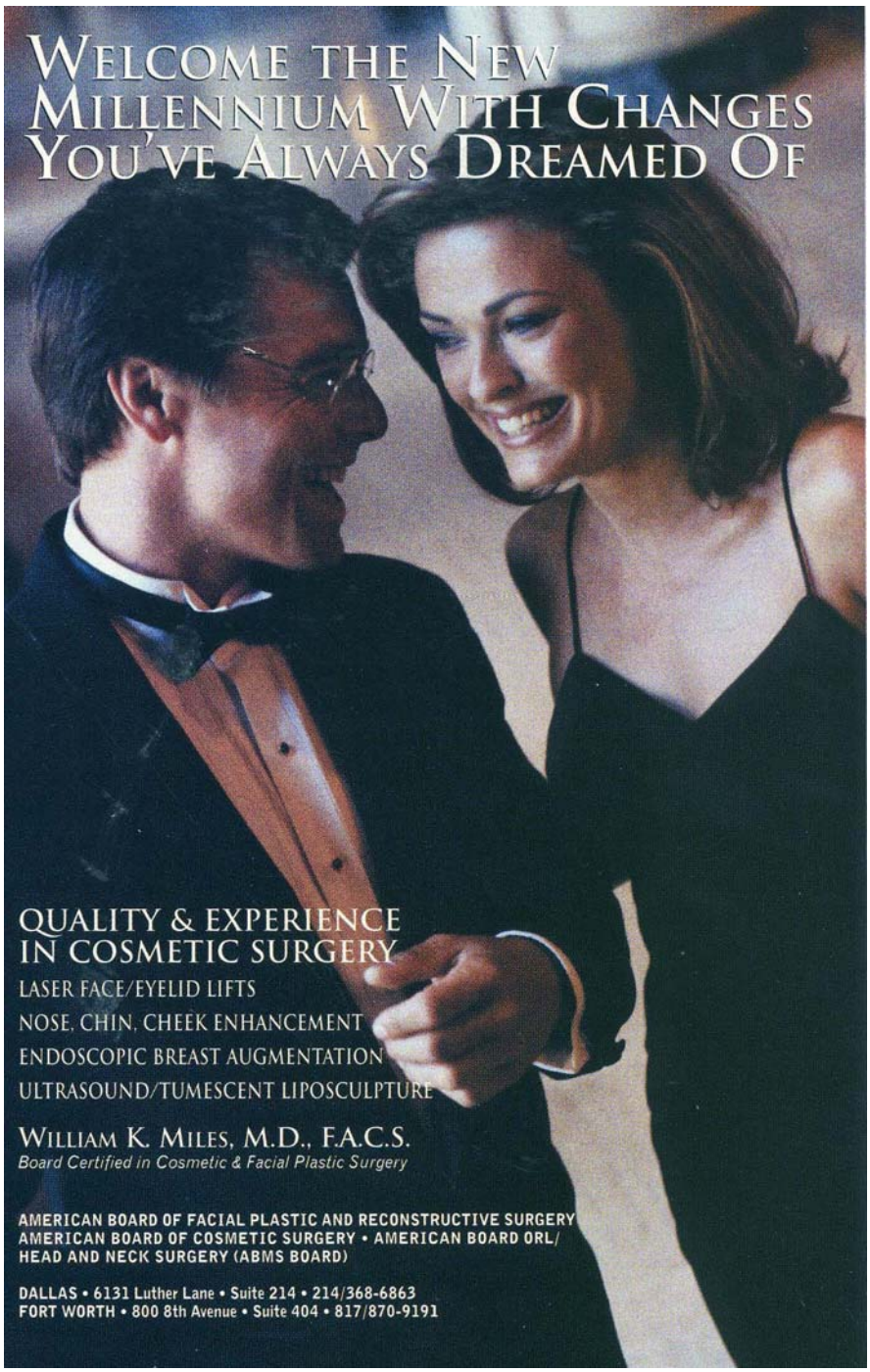


Sex Esteem Appeal



Sexual Behavior Appeal

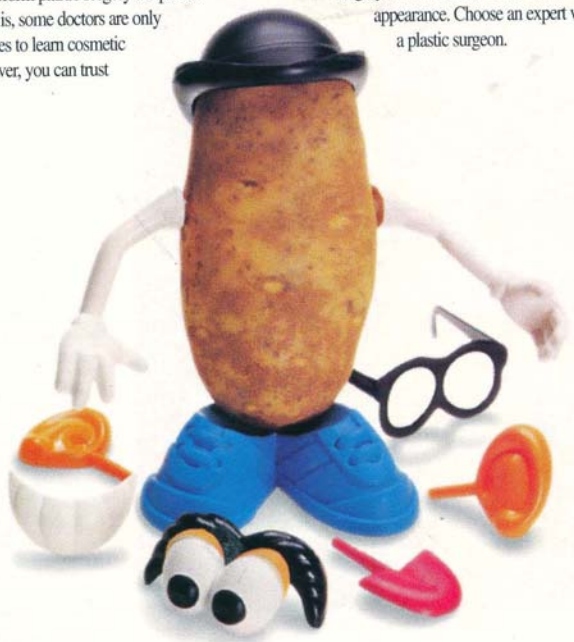
Sociability Appeal



Threat Appeal

Not Everyone Who Does Plastic Surgery Is A Plastic Surgeon.

As a kid, it was fun to make faces. But surgery certainly isn't child's play. It might even surprise you to know that not all doctors who perform plastic surgery are plastic surgeons. The fact is, some doctors are only taking quick courses to learn cosmetic procedures. However, you can trust doctors certified by the American Board of Plastic Surgery. They have gone through years of extensive training in plastic surgery of the face and body. So, don't toy with your appearance. Choose an expert who's fully trained as a plastic surgeon.



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