Original Article

Types of trust experienced in a risky medical operation (A case among cosmetic surgeries in Isfahan)

Mehdi Zhianpour, Vahid Ghasemi, Mahmood Keyvanara¹

Department of Social Sciences, School of Humanities, University of Isfahan, ¹Social Determinates of Health Research Center, Isfahan University of Medical Sciences, Isfahan, Iran

ABSTRACT

Background: In all areas of life including health, choices have widely increased and concerns over getting hold of further choices have made trust a necessary element. This study, taking into consideration the interconnection of three concepts of trust, risk, and body, aims at describing and interpreting different types of trust experienced in a risky medical operation (cosmetic surgery). **Materials and Methods:** To achieve the given purpose, within interpretative paradigm and employing qualitative method, in-depth phenomenological interviews were conducted with 26 people who volunteered to have a cosmetic surgery. Participants, who have been selected through purposive sampling techniques, were fully aware of their participation in the study and were insured that the data would be confidential and would be used only for the purpose of the study. Data were gathered within a one-year period of the study, from February 20, 2012 to February 20, 2013. Results of three-phase interviews were validated against participatory feedback and researchers' triangulation and were further analyzed by means of seven-stage Colaizzi method. **Findings:** Consequently, five main themes, namely, vicarious trust, trust within the reach, institutionalized trust, criterion trust, and wrapped trust were extracted. **Conclusion:** Apart from existing differences among these five themes (e.g. degree of the subjectivity and objectivity in the patient), they can be regarded comparable in terms of being single-sided (from the patient's side).In other words, in all experiences, participants, having considered "the necessity of gaining trust" as a presupposition, have made a unilateral effort in creating the aforementioned phenomenon.

Key words: Cosmetic surgery, risk, trust

Address for correspondence: Prof. Mahmood Keyvanara,
Social Determinates of Health Research Center,
Isfahan University of Medical Sciences, Hezar Jirib Street, Isfahan,
73461 - 81746, Iran.
E-mail: keyvanara@mng.mui.ac.ir

This article may be cited as: Zhianpour M, Ghasemi V, Keyvanara M. Types of trust experienced in a risky medical operation (A case among cosmetic surgeries in Isfahan). J Edu Health Promot 2015;4:25.

INTRODUCTION

The world in which we live has been under the influence of an extensive territory of goal-oriented human efforts. We are moving from destiny-based societies toward the societies where evolution is made by human factors.[1]Dealing with this ever-changing world requires a kind of trust in the people who make more contributions to the formation of social life. Although the idea of trust is a century-long thought process,[2] almost over the past decade, it has gained a significant position within the sociological ideas.[1]

Moreover, there is such a strong relationship between trust and risk that Luhmann defines trust as "the solution to the

specific risk-related problems."[1] A risk which, in its most general term, means being subject to a particular danger or hazard has undergone a lot of changes in meaning and function,[3] in a way that it has become more inclusive and has been used under different conditions.[4] At the conceptual level, risk has been distinguished from danger and hazard; at the phenomenon level, also, risks of contemporary world are claimed to be effects and consequences of human actions and decisions.[5] In other words, risks are constructed adventures;[6] while danger is a harm, which is suffered from outside.[7] Explaining the contemporary world, the sociologists of risk refer to the concepts such as reflexivity, insecurity and uncertainty, individualization and reflective biography and consider different arenas of life as a constructed and not assigned affair.[8]

Such evolutions have totally influenced the functions of the social sciences, in general, and sociology, in particular. Accordingly, riskology has been considered as the essential element and the pioneer of the sociological modern reformation.[9] Meanwhile, the medicine and health, as one of the most important fields of research in sociology, is closely related to risk.[10] The importance of the study of risks within the field of body and health is due to the fact that body and beauty are now prone to manipulation and personal motivation more than ever and discourse of beauty has been replaced by discourse of attractiveness.[11] This means that attractiveness in appearance, thanks to the change in view of beauty and advances in the field of cosmetic surgery, has imparted an acquired aspect to beauty.

The use of cosmetic surgery suggests that the beauty is more a social-cultural notion than a natural and god-given phenomenon. Advances in the field of medicine have also contributed to the emergence of the idea that body can be a function of medical technologies.[12] Accordingly, notions of "uncertainty of body" and risk taking make sense.[13] A glance at the previous research shows that these studies have mainly been conducted by the quantitative method in which the cosmetic surgery and the body management were considered as dependent variables. In these studies, attempt has been made to measure the effect of variables such as age, gender, education, marriage, socioeconomic status, the status of different resources (economic, social, cultural), social-normative pressure, consumerism, and media consumption on the domain of body. What makes the present study different from others is that it aims to reconstruct the experience of the cosmetic surgery as a risky enterprise under a qualitative approach and describe and interpret different forms of the confidence experienced by those who apply for this surgery.

MATERIALS AND METHODS

Participants and research design

The present study has been conducted within the interpretive paradigm, employing phenomenological method, which is of the qualitative design.[14] This method, which is applied with the purpose of description, understanding and interpretation of the meanings in human's living experiences, is very creative and flexible and does not follow a particular or preplanned procedure.[15,16]

In phenomenological studies, purposive sampling or criterion-based sampling is used.[17] Samples are those who directly experience the given phenomenon. This experience, which is called "*lived experience*," is in contrast to "*second-hand experience*." In this study, mixed purposive sampling technique was applied. That is to say, based on extreme case sampling, snowball or chain sampling and opportunistic sampling were simultaneously used.

According to extreme case sampling, namely, looking for outstanding and not necessarily very unusual cases from the phenomenon under investigation, it was tried to select the ones who met the characteristics including experience of the surgery, wide and extensive communication with different physicians, ability in stating the experience exactly and in details and being in a context of those who had the experience of the surgery in their relatives, and to include all groups with different demographic information in the sample and to examine, as much as possible, all aspects of the individual cases. Then participants were asked to introduce the ones with the same characteristics in order to have the similar interview.

Also, with regard to the requirements of the study and emerging the new themes and concepts in analysis of data, participants in accordance with the given requirements were selected. Totally, 26 participants were sampled among those who had the cosmetic surgery in Isfahan. The above said characteristics have been indicated in Table 1. It should be mentioned that, medical information was not of importance

Table 1: The variation among participants in terms of the gender, age, level of education, marital status, and type of the surgery

	Maximum	Minimum	Mean
Age	44	21	27.6
Number of the surgeries	4	0 (giving up)	1.5
The time passed after the surgery	72 months	1 month	6 months
Level of education			
Diploma	10		
Associate degree	2		
Bachelor degree	10		
Master's degree	4		
Marital status			
The first marriage	2		
The second marriage after divorce	2		
Divorces	2		
Single	20		
Gender			
Female	16		
Male	10		

in this study and solely the demographic information was collected. In accordance with the criterion of data saturation, sampling procedure continued until the researcher found out that, with regard to the content and the notions being created, no further new or appropriate piece of information was elicited.[18]

Data collection procedure
The research data was collected in an extensive phenomenological interview as developed by Dolbear and Schuman.[19,20] In this three-phase set, the first interview forms the context of the participants' experiences. The second interview allows the participants to reconstruct the details of their experiences within the context in which the experiences have occurred. And the third interview encourages the participants to contemplate over the meaning, which is attributed to their experiences.[20] Data were gathered within the one-year period of the study, from February 20, 2012 to February 20, 2013. The interviews were conducted without any interval and lasted about 45–60 minutes.

The participants' taking part in the research was based on their informed consent and guarantees of confidentiality and anonymity of data. Indeed, participants were taken under consideration in clinics and offices of cosmetic surgeries in Isfahan. Next, in order to have their consent for cooperation in the study, in an informal and friendly environment, aims and methodology of the study were implicitly discussed with them. After initial consent, they were asked to give their final approval or disapproval for taking part in the interview in the following phone call. The interviews were recorded by two interviewers using a checklist of all the factors to be asked, guided by all the body movements, facial expressions, diction, and emotions. In the first 15–20 minutes of the interview, participants' life histories were discussed. In this phase, participants were invited to talk about their personal experiences regarding cosmetic surgeries as much as possible. In the next 20–30 minutes, the focus was on the concrete details of the lived experience of the participants with regard to the risks of cosmetic surgeries and how to trust to this process. In the last 20–30 minutes, they were asked to share their conception of risk and trust, based on their sense from their experiences. All the conversations were tape recorded and then, were transcribed word by word. Before transcribing the interviews, researchers listened to each conversation several times so that a better understanding was achieved of the data.

Data analysis
Seven-stage Colaizzi method of data analysis was used for analyzing the data and extracting different descriptive, interpretive, and explanatory codes.[21,22] Since the participants' reflection as a persistent process in data analysis contributes to the higher reliability in the qualitative research, according to the Colaizzi method, the researcher gave the interview transcription to the participants and asked them to examine the findings and control their conformity with their own experiences.[16,23] Furthermore, since devoting enough time for

collecting the data enhances the profundity, hence, actuality of the data, in addition to the application of the intense three-phase interviewing technique and devoting enough time for each phase of the interview, the research data were collected in a 9-month period being supported by a group of skillful colleagues who had expertise in using qualitative method.

RESULTS

The risky enterprises somehow require a kind of triumph over fears and gaining trust. In fact, for making a decision and burdening the risk associated with that decision, the cases need to overcome the negative experiences (here means fear and stress) and gain some positive experiences (trust). The major trusting procedure here occurs between the doctor and the patient and is considered a bilateral act; gaining trust on the part of the patient and drawing trust on the part of the doctor. Below, different types of the participants' experienced trust have been classified.

Vicarious trust
In this type of trust, little energy is used and the participants do not have accurate information about the surgery; Expressions such as "maybe," "I don't know," and the words that show their uncertainty have been frequently used in their speech and they only visit one special doctor (the doctor that is the target in vicarious trust). These few short visits are limited to: "*I said: Yes, I want to have a surgery. s/he said: Such and such a thing*" or "*S/he asked: What do you want to do? And I didn't want a special thing from him/her.*"

In other words, not only does this person have little preplanned ideas about his/her wants but also s/he acts passively in his/her visits to the doctor and get subdued by the doctor's ideas.

This passivity is expressed as follows:
"*I said: First of all, treat my Nasal Polyp; then, s/he examined my nose and said: Your left septum is deviated. It should be corrected.*" I said: "Okay!" then, s/she said: "Don't you want to change your nose shape?" S/he told me that the men's nose should be long, should not be humpbacked or hooked, or in any special shape; I mean, it is possible to give it a special shape, if you want, but after a while, you will regret your decision. On the other hand, as you get older, maybe you cannot cope with it." S/he told me such things.*"

Since these participants, as those who passively put their trust on others, do not make any effort to pass trusting procedure, and limit themselves to the friends' experiences and their trust on doctor, no changes occur in their decision upon different experiences with the doctor. The sub-codes of the vicarious trust, therefore, can be as follows: "*Inaccurate data*," "*gaining trust by using the least amount of energy*," "*the first hand and the unique experience with the doctor.*"

Criterion trust
In the criterion trust, the person who builds the trust, having considered a criterion or criteria, put the trust on a doctor

who is the surgeon of those who have those criteria instead of putting trust directly on the person or the object of the trust. This criterion can be the treatment process, the shape and form of the nose, the type of the relationship, etc. Describing his/her experiences, one of the participants states:

"As to my brother who was also one of my encouragers in this case, some of his friends had had surgery; then, he said that one of his friends had had surgery and he was satisfied by his surgery and his doctor was such and such a person and the check-up procedure is in this manner."

The persons with the criterion trust are polarizing the doctors largely based on the concerned criterion and making a dichotomy of good and bad like this:

"Before I became determined, among the addresses I had of the cosmetic surgeons, one of them was a doctor who was also in Isfahan. It is always said that s/he performs awful surgeries and a few friends of mine who had undergone surgery with him/her looks really bad. But, when he introduced the doctor, my brother and specially those who had already visited him… I talked with them; I felt that the fear of {under whose care you are going to be} is going away."

Accordingly, in this group of the participants, trusting the doctor is partly due to the mistrust in the doctor who is located at the bad pole of the dichotomy. Upon the appearance of such a dichotomy, most of the participants become determined quickly and use the least amount of energy for data collection and trust building processes. Based on the participants' experiences, the sub-codes of the criterion trust are: *"Relatively accurate information," "gaining trust through using a lot of energy,"* and *"little polarized experience with doctors (limited to the extensions of good and bad dichotomy)."*

Wrapped trust

In this type of trust, the required trust for the surgery will be wrapped and presented to the doctor after a long, careful, and empirical endeavor. This type of trust is in a way that the doctor:

"At first told me: Don't have a high expectation of your nose! But, since I believed in his work, I said: No! I'm sure it will get well. I waited for 2 years to see how my friend's nose looks after the surgery."

Of course, the required ingredients for this type of trust are picked up from the specialized showcase of the doctor in a way that the participants, explaining the reasons for putting trust on the doctor, refer to doctor's professional competencies outweighing over the financial benefits, the doctor's fame in doing natural and specialized surgeries, and the use of certain techniques such as the application of smaller tampons or local anesthesia. In this type of the trust, participants, while presenting their wrapped trust to their selected doctor; do not necessarily observe all the doctor's prescriptions, stating that they have a comprehensive knowledge of the cosmetic surgeries:

"I knew all of these points completely, for example, my own research, my own information about the nose surgery was much

more than [stated in a higher tone of voice and with more stress] *what others are saying."*

Sometimes they also modify these prescriptions claiming that: *"I was saying: No, what doctor is saying works only for himself."*

According to the above mentioned experiences, the wrapped trust can be described as constructed upon the following sub-codes: *"Accurate and detailed information," "gaining trust by using the maximum amount of energy," "person's utmost capacity," "making definite decisions,"* and *"selecting the doctor as a case study."*

Trust within reach

In this type of trust, participants have chosen their options within a predetermined framework or structural limitations and referred to the only possible case within reach. This framework may be an organizational option like this:

"My father works for the oil company! For this, we went there (the oil company); they recommended…"

Another major limitation for these persons is the time limit. One of the participants, stating: "I didn't go after visiting a doctor", acknowledges his/her lack of sense of selection and effort to choose his/her treating physician:

"I was in such a hurry that I didn't go after finding a doctor! I went to the office of this doctor; they said: He is good. Give me a time to visit him right now."

Another participant says about the selection of the doctor:

"I made haste in that case. I'm telling you I wanted to travel to Germany; then, I traveled to Germany right away, [laughter] *… to show it to my sister!* [Laughter]."*

Another experienced limitation is the family limitations:

"I was telling to my husband that I want to have a surgery. My husband said: Well, find a doctor! If s/he would be in Shahinshahr, we'll visit him/her. I rarely commuted to Isfahan; honestly, because I had to take care of my children."

According to the results, the sub-codes of the trust within reach can be described as follows: *"Being satisfied with the available information," "gaining trust by using little energy," "structural limitations," "making haste in decision making,"* and *"limitations in selecting the doctor."*

Trust in specialized role (institutionalized)

In this type of the trust, the participants show their emphasis on the specialized role of the doctor and their awareness of such a role and describe their first visit to the doctor, saying: *"That doctor is a cosmetic super-specialist"* or *"I went to his office. He said: 'Well, what is your problem? Because he is a cosmetic and Nose Prosthesis super-specialist, I said: 'I want to have a nose surgery.'*

It is where their trust arises. One of the participants, pointing out that s/he had been very careful in selecting the doctor and

trusting him/her, asks: "*first of all, what is his/her specialty?*"to explain different sides of this evaluation. Believing in the distinction between the specialties, s/he claims:
"*The cosmetic surgeries are, now, performed by ENT specialists with a lower fee. It is not their specialty; just as we see there were some patients who died in such surgeries.*"

Most of the people who experience this type of the trust, consider the experience of the surgery as a simple experience to overcome, and this simplification is carried out by the reliance on the doctor's specialty. In fact, surgery, as a rerun experience of the doctors, is conceptualized as a simple and nonthreatening procedure. One of the participants says:
"*Specially my daddy! He saw the whole issue as a very simple matter: {honey, take it easy! You just go! They are all super-specialists; they know their work!} There were so many people who told me. They all told me that the doctors knew their work. And honestly, they all told the truth in the case of this surgery. Doctors perform such a surgery about a dozen times a day. The day I had surgery, six surgeries were performed at the same time. Six surgeries were performed by the same doctor as mine. Well! This issue made me calm; s/he knows his/her work!…. He is similar to me!….Some of the works are within my specialty and I can perform them with my eyes shut. So, I shouldn't feel fear. This is within his specialty. I'm not the first person. It has been for several years that such a thing has happened to him; with about thousands of individuals! Only in this way, I got myself together.*"

In this type of the trust, the participants' trust in doctor is to the extent that they do not state anything as to existing dichotomies such as private/public hospitals, snub/sharp nasal septum, open/closed surgery, using suture/burning the surgical site, and do not challenge and question the doctor for his decision about the selection of one of these alternatives:
"*Just as, I told him: {Doctor, I put all the things under your care. I don't tell you dome this one or that one.*"

Based on what is said, the institutionalized trust can be described as constructed based on the following sub-codes: "*The quantitative and general information,*" "*gaining trust by using a relatively large amount of energy,*" "*total self-submission to the doctor's specialty,*" "*simplification of the surgery,*" and "*selection of the doctor pending on the specialty.*"

DISCUSSION AND CONCLUSION

The present study was to describe, understand and interpret different types of the experienced trust in one risky medical

enterprise. In other words, based on the participants' experience, the effort of the cases to have surgery is a kind of risky enterprise. For the cases under study, making decision for the surgery (or putting their decisions for the surgery into effect) is not easy. The cases are faced with the propelling and encouraging factors (justifications) on the one hand, and the dissuading factors (doubts), on the other.

The conflict between justifications and doubts, change the decision making process for the surgery into a challenging experience. In this challenge, the phenomenon of trust and its different types gain significance based on the participants' experiences. As the results of the present study indicate, five types of trust were experienced by the participants. The construct of these five types of the trust has been based on the common sub-codes that have had different levels. For example, different types of the trust can be scaled on a spectrum based on the amount of energy used or the amount of information. Figure 1 shows this spectrum.

To sum up, what seems to be common among all the forms of the trust is that the trust is an event, which has occurred as a result of the diligent endeavor of the cases (participants) against that there is no remarkable act on the part of the doctors for building or drawing this trust. If, in terms of the participants' degree of subjectivity, vicarious trust can be placed at the bottom and the wrapped trust can be placed at the top, in all the experiences, participants, having considered "the necessity of gaining trust" as a presupposition, have made a unilateral effort to create this phenomenon. To be more exact, the doctors, having presented a showcase of the premade frameworks for drawing trust, have dealt with all the patients in a same manner and according to a unilateral premade plan, and have made no effort to give some special meaning to each dual relationship and cases, here as patients, are left alone in interpreting these premade frameworks of drawing trust (e.g. reference to the specialty, offering the catalogue of the work sample, the effect of the doctor's office as the meeting place).

Based on the Habermas' classification of the instrumental and communicative rationality, it can be said that none of the participants have reached the level of communicative rationality. To be more exact, this choice has not been changed by those who trust into a relationship between those who trust and those who are trusted. Meanwhile, doctors do not make any effort to create such a relationship and it seems that they do not even feel the need to do
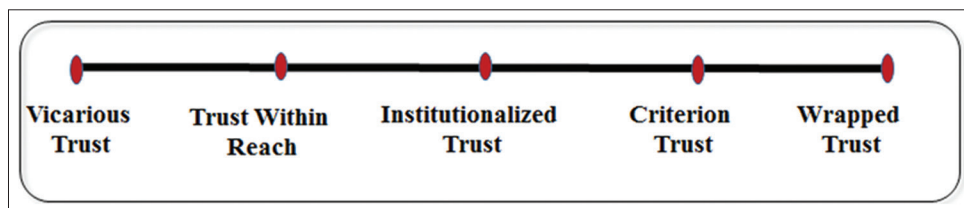

Figure 1: The spectrum for different types of the experienced trust based on the common sub-codes

that. They, as the specialists, in one unequal relationship, do not feel the need to exchange information with the public and they make no distinction between the optional and compulsory surgeries. While, according to the communicative rationality expected by the participants, in each new visit, based on the existing exigencies on the part of the patient (e.g. age, gender, type of the concerns, fears, and the previous experiences of the patient), a new doctor–patient relationship must be made and reconstructed.

As to this issue, it should be said that one of the major concerns of the participants is that there is no room for the conversation in which they can convey their demands and preferences, while, doctors, having referred to their technical-specialized competence, do not acknowledge the general knowledge of the participants and the conversation atmosphere is not created. This is while the presupposition for the communicative rationality is the extrapolation of knowledge and the possibility for establishing the relationship and expressing the ideas about the field under discussion. This finding is supported by a few similar studies within the same area in Iran – in the world of medicine. In a study titled: "the cultural plays of the death and dying," utilizing the field theory, the researchers investigated the cultural patterns of the death and dying within people who live with cancer.[24] In one part of the results of the study, it has been pointed out that the patient finds the opportunity for talking with the specialists and advisers more effective than the any other treatment and medicine.[24]

Doctor, however, focuses his attention on the clinical signs, body and the injured member and do not set a time to talk with the patient.[24] Meanwhile, for patients, talking with a doctor who is well informed of their disease is very important. The most important consequences of lack of conversation with therapists is that the patient is changed into a solitary, defenseless, unaware, and submissive person; the right for selection and making decision in the crisis is reduced; and patient experiences a kind of mental breakdown.[24] According to the results of this study, further research should focus on doctors' offices as a meeting place for cases and the role of such a meeting in stimulating, encouraging, and facilitating the process of making decision or giving up, as well. More studies can describe and interpret the mechanism used by doctors to impress others and the process of negotiation with patients. It is worth mentioning that this study was based on the conceptual framework of Giddens and Beck in which cultural differences among societies are not of importance.

REFERENCES

1. Sztompka P. Trust: A sociological theory. Cambridge: University Press; 2003.
2. Silver A. "Trust" in social and political theory. In: Suttles GD, Zald MN, editors. The challenge of social control, norwood, mass. New York: Ablex Publishers; 1985.
3. Gabe J, Bury M, Elston MA. Key concepts in medical sociology. London: Sage Publication; 2004.
4. Lupton, D. Risk (key ideas). London: Routledge Publisher; 2005.
5. Tavasoli GH, Dadhir A. The knowledge-policy relations in a risky society: A sociological reflection on the development of the risky administrative societies in the current era. Iran SocJ1388; 10:22-42.
6. Giddens A. The consequences of modernity. Cambridge: Polity Press; 1990.
7. Harrison PR. Niklas Luhmann and the theory of social systems. In: Abazari Y, Translator. The Arghanoon Quarterly Journal, 17 (original work published in 1995). 2000: 19-50.
8. Lupton D. Fear and the reflective modernization. In: Rafat Jah M, Translator. The Arghanoon Quarterly Journal, 18, (original work published in 1999). 2001: 293-316.
9. Beck U, Giddens A, Lash S. Reflexive modernization. Cambridge: Polity Press; 1994.
10. Synnott A. Tomb, temple, machine and self: the social construction of the body. Br J Sociol 1992; 43: 79-110.
11. Wilkinson I. Risk, vulnerability and everyday Life. London: Routledge; 2001.
12. Giddens A. The modernity and the distinction: Society and the personal identity in the new era. In: Movafaghian N, Trans. 4th ed. Tehran: Ney Publication; 1385. (Original work published in 1991).
13. Williams SJ. Modern medicine and the "uncertain body": From corporeality to hyperreality? Soc Sci Med 1997; 45:1041-9.
14. Iman M. Paradigmatic basis of the qualitative and quantitative research methods in humanities. Ghom, Iran: Research Institute of Hawzah and University; 1388.
15. Bloor M, Wood F. Keywords in qualitative methods: A vocabulary of research concepts. London: Sage Publication; 2006.
16. Mohammadpour A. The anti-method: The logic and the plan in qualitative methodology. Tehran: The Sociologists Publication; 1389.
17. Mohammadpour A. The anti-method: The steps and the practical procedure in the qualitative methodology. Tehran: The Sociologists Publication; 1390.
18. Given LM. The sage encyclopedia of qualitative research methods. London: Sage Publication; 2008.
19. Schuman D. Policy analysis, education, and everyday life: An empirical reevaluation of higher education in America. Lexington, Mass: D. C. Heath; 1982.
20. Seidman I. Interviewing as qualitative research. London: Teachers College Press; 2005.
21. Collizzi P. Psychological research as the phenomenologist views it. In: Valls RS, King M, editors, Existential phenomenological alternatives for psychology. New York: Oxford University Press; 1978. p. 48-71.
22. Knafl KA, Webster DC. Managing and Analyzing Qualitative Data: A Description of Tasks, Techniques and Materials. West J Nurs Res1988; 10:195-218.
23. Flick U. An Introduction to qualitative research. In: Jalili H, Trans. Tehran: Ney Publication; (original work published in 1998); 2009.
24. Ghane'ei Rad M, Karimi M. The cultural plays of the death and dying. Q JCult Stud Commun1385; 2:51-73.