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How Professionals Cooperate through Conflicts: Networks and Social Face in the Workplace

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Abstract

Conflicts are everyday sources of professional disagreement in the workplace. This article advances the study of professional conflicts by examining the symbolic interactionist processes through which professionals in South Korea cooperatively work through conflicts. Through ethnographic fieldwork conducted at a large hospital in Seoul in 2018, it is demonstrated that clinical professionals retain their poise and cooperate their way through conflicts by adhering to predetermined script-like "lines" of action that mandate the protection of a triadic conception of social face: their own social face, that of their colleagues, and that of their hospital. Locked in disagreement over the risk profile of procedures for clients, embattled clinicians and nurses reroute conversations about conflicts to stress a shared identity in a bid to prevent humiliation, maintain network reciprocity, and preserve social face – of their dissenting counterparts, themselves, and their hospital. Professionals exercise a discerning level of heterogeneity in their conflict avoidance to maintain harmonious relationships, foster a personal brand of trust with clientele, and ultimately safeguard professional unity in the hospital.

Keywords: conflict management, organizational workplaces, professions, social face, social networks, South Korea

Introduction

Diagnosis, Andrew Abbott (1988:135) classically asserts, is the fundamental process through which a profession establishes its body of expertise, distinguishes it from laypersons and competing professions, and comes to be socially constructed. Sociologists of professions have since demonstrated that distinctive expertise consists of a quality recognized in professional actors, gleaned from a combination of academic credentialing and situational work experience (Barley 1996; Collins and Evans 2007: 2; Eyal 2013; Halpern and Anspach 1993; Rose 1992: 356-7). Diagnosis is what affords expertise its distinctive quality by converting academic knowledge into expertise in the *workplace* of professionals amidst interactions with clients and co-workers (Abbott 1988:53; Freidson 1986; Liu 2018).

Situated within the scope of Abbott's (1988) ecological approach to professions, research has limned the many interprofessional conflicts that erupt on the grounds of diagnosis, on which hinges a profession's power and legitimacy (Freidson 1988; Malcolm and Scott 2011; Timmermans 2002). As Freidson (1994) argues, professionals fight to safeguard their monopoly over entry into a profession as well as the techniques and competencies for practice in order for their power to endure and their status to accrue. Liu stresses the dynamism with which professionals compete with clients, colleagues, and other actors involved in the social construction of expertise for control over diagnoses in the workplace (Liu 2013, 2018; Liu and Halliday 2009).

In the Anglo-American tradition of the sociology of professions, recent work has emphasized that conflicts among professionals are shaped by power dynamics in the workplace, demographic diversification, and increased specialization, distilled from studies on a variety of conflicts among medical workers (McNeil, Mitchell, and Parker 2013; Sexton and Orchard

2016), lawyers (Liu 2013; Sarat and Felstiner 1986, 1995), scientists and engineers (Latour 1987; Lipartito and Miranti 1998), corporate employees and businessmen (Flood 2001).

However, much of this work has been preoccupied with inter-professional conflicts that result in confrontation and without sufficient attention to the influence of cultural milieu of symbolic interactions that saturate a workplace. We know less about how professional conflicts within a workplace emerge, the forms they assume when it comes to diagnosis and what effects they have on professional unity, especially with respect to forms of conflict management that veer away from confrontation. It is important, as Abbott (1988) emphasizes, that disagreements or conflicts do not pass unresolved *within* a profession because they carry the potential to fracture the unity of the profession altogether, when intensely competitive diagnoses produce specializations and factions.

This paper adopts a processual approach (Abbott 2016) to investigate the symbolic interactions that lead to and defuse conflicts among cosmetic surgery professionals in Seoul, South Korea. For these professionals, the stakes of conflicts are high, given their clear effect on the physical health and safety of their clients. Additionally, cosmetic surgery professionals service clients from around the world in an age of globalization, evinced by the rise of medical tourism (Holliday and Elfving-Hwang 2012; Menon 2019), in a way that the most-studied professions like law do not.

Through in-depth ethnography at one of Seoul's top-performing cosmetic surgery hospitals in 2018, this article identifies sources of conflicts among cosmetic surgery professionals and relationally foregrounds how dissenting professionals express and manage their conflict through cooperation as a novel conflict management style. Using a Goffmanian interactional approach, this article theorizes that cooperation is mandated by script-like "lines" of

action that constitute bids at defending one's "face" and protecting that of her colleagues and their hospital. This strategy ultimately preserves professional unity in spite of dissent.

Theorizing Cooperation as Professional Conflict Management: A Goffmanian Approach

Conflicts are common in professional work, but two approaches to conflict management are typical of conflicts when they arise. The first is the outright rejection of one opinion in favour of another (Liu 2018). A board member dismissing a collaboration recommended by another member of the board is a good example. Broukhim et al (2018), in a recent survey study of workplace conflict among medical residents and students, describe this as a dominating or confrontational conflict style – or what Roscigno, Hodson, and Lopez (2009: 748) call "demeaning, abusive, derogatory, threatening, and violent interactions" and "passive ostracizing exclusions that create emotional injuries and a sense of injustice." Furthermore, only up to 25% of conflicts are avoided, with others evolving into direct confrontations or slander in peer circles and before attaining resolution roughly 30% of the time (Broukhim et al 2018; see also Almost et al 2010; Boateng and Adams 2016; Coombs 2003).

The second is hybridity, when organizational actors incorporate the values of a competing logic into their own practice (De Laat 2015; Noordegraaf 2011). Managers faced with a change of leadership often mediate between different organizational logics (Adams 2020). Sociologists of professions, for instance, have sourced professional conflicts in Anglo-American workplaces to factors such as tensions between specialists with variant professional identities (Malcolm and Scott 2011; Oh 2014), differences in professional values (e.g. work-life balance, commitment, etc.) by demographic factors like age and gender (Lewin and Reeves 2011; Noordegraaf 2016), the appreciation for and experiences of discrimination among people of

colour and minorities (Boateng and Adams 2016; Sullivan and Mittman 2011), and status differences in hierarchies within the workplace (Broukhim et al 2018).

However, this literature neglects an important way through which conflict can be defused – by working through it. I theorize a new type of that conflict management style that assumes the form of conflict avoidance in connection to cooperation, whereby interactions are moderated by and conceptualized as refractions of social face. Resonant with Goffman's (1963) sociological theorization of dramaturgy, social face consists of the image one presents of oneself to others and the desire to appear as competent and respectful. But more than managing impressions of the desired self during social interactions in Goffman's theorization (Goffman 1963: 109, 114), social face foregrounds both an actor's awareness of their own social face as well as that of others within social relations (see also Kirschbaum 2012; Ting-Toomey and Oetzel 2001). According to Goffman, people in social situations like conflict are immediately cast into expectations of acting out a line, "a pattern of verbal and nonverbal acts by which he expresses his view of the situation and through this his evaluation of the participants, especially himself" (1967a: 7).

Acting out a line is an involuntary exercise, for Goffman, because of the social embeddedness that characterizes all interactional settings – that even if one does not voluntarily adopt a stance, others will assume that (s)he has. These expectations comprise the "situational properties" or standards of conduct that interlocutors take cues from to adjust their behaviors in service of face (Goffman, 1967b: 259).

Put differently, it is the structure of one's interactions (the professional values that one conveys through her performance) that matters most in preserving social face. After all, one's social face is what Goffman calls "on loan" from society – actors are given face from society

contingent on the expectation that they will behave according to established norms and rules, through which, incidentally, they are taught to constrain themselves (Goffman, 1967b: 9).

Given that face is a condition, not an objective, of interaction that is manifested in the observation of lines, I theorize that the social embeddedness of clinical workplaces motivates professionals to respond to conflict with cooperative, rather than confrontational, responses. This embeddedness distinguishes itself from other professional workplaces because of the multiplicity of identities present. Conflicts are played out in the co-presence of clients, third parties to whom not only clinical professionals are obligated to serve, but also their representative clinical institution. Indeed, clinical professionals thus "come to *share* a face, so that in the presence of third parties an improper act on the part of one member becomes a source of acute embarrassment to the other members" (Goffman, 1967b: 42, italics added).

Thus, social face for clinical professionals is *triadic*: the stakes are raised for them, whose social face is not only "on loan" to them individually, but to their institution as well. The "line" that clinical professionals are incentivized to abide by is, therefore, to repress immediate emotional reactions to events as a matter of respecting one's own face, that of their colleagues, and by extension, that of their institution (Goffman, 1967b: 10-11). Correspondingly, I theorize the interactive form of this cooperative response to professional conflict as (a) the rerouting of conversations about conflicts to (b) stress a shared objective or identity, in so doing preserving the social face of themselves, their counterparts, and by extension, their organization itself. Goffman (1967a) describes this face-work as a way of counteracting incidents or events that threaten face. In rerouting conversations to stress a common objective, then, professionals effectively perform a kind of "poise" through which they suppress embarrassment and that which colleagues might feel because of their embarrassment (p.2) to *both* "defensively" save their own

face as well as "protectively" save others' face (p.3). Indeed, the motivations for and functions of face-work (or behaving in line with "cooperation") encompass both defensive and protective modalities, since professionals' social face is bound up in that of their colleagues and their clients due to the co-presence of all three in the same space.

In this respect, there was no status difference between nurses and clinicians (who, in this study's clinics, act as front-end consultants and liaisons for clients). More importantly, the triadic character of social face made it so these professionals' social face was tied to the institution, a higher level of abstraction, rather than individual positional status differences. Goffman (1967b: 28) acknowledges as much in his remarks that corrective face-work, or cooperating according to "lines" in face of conflict, is agnostic to positional differences, for even the high class are required by such "lines" to treat their lessers as equals or risk losing social face all the same.

In preserving harmonious relationships with their dissenting counterparts, professionals bolster trust with their clientele by improving their own social face by cultivating a reputation as a harmonious individual, an individual quality conducive to positive evaluations of reputation (Au, 2021), at the same time they avoid deeper fractures within the organization that would brood instability (Kalleberg, 2009).

This article focuses on peer groups as a site where these moral codes of the institutional culture interlock with those of the Korean networking culture to inform this conflict management strategy. In South Korea, social relations are embedded in *yonggo*, a networking culture that stresses a moral obligation to serve ties, to the extent that personal network reputation depends on their ability to do so (Au, 2022; Bian and Ikeda 2018). Peer groups thus comprise a significant social space where statuses are judged and, more importantly, where the networking culture's emphasis on reciprocity is enacted – to the effect of reinforcing the institutional code of

conflict avoidance. A large body of social psychological research has similarly corroborated this impulse for collectivism in South Korean networks and its manifestation in the workplace, where respect is conveyed through direct expressions and accommodations for others' objectives and ideas, and professionals tend to avoid conflict (Peng and Tjosvold 2011: 1032; Ohbuchi and Atsumi 2010). Thus, to fail to behave according to a cooperative "line" is to humiliate oneself, her colleagues, and her institution – and through it, to accentuate humiliation of oneself. The interactional settings of the clinic as a socially embedded workplace thus motivate members to respect the cooperative "line" of a situation and the social face of others.

A good illustration of the social psychological hold that such codes have over decisions in Korean *yonggo* is with gift exchange. Actors continue to give in social exchanges even in conditions of breakage (when an alter fails to reciprocate) because they "feel their reputation… depends on how well they appear to an alter as an active and present supporter of [the alter] and the emotional wellbeing of their relationship" (Au 2021: 1903; see also Bian 2018: 18; Bian 2019).

Indeed, social face motivates action not just through values, but through "lines" because the latter are effectively social scripts. Social scripts exert powerful influences on action because they provide a logic or roadmap for action, more than just a motivation (Kaufman, 2004: 340; Swidler (2001:86–87; Vaisey 2008: 605). As Goffman (1967a: 2) notes, "all acts involving others are modified, prescriptively or proscriptively, by considerations of face." Considerations of social face (gains and losses) are what provide the rewards and sanctions through which "lines" are monitored and enforced in social situations like professional conflicts (DiMaggio 1997: 265; Swidler 2001: 202).

The Case: Cosmetic Surgery in South Korea

This article uses the case of clients interested in non-surgical cosmetic procedures, such as Botox, fillers, and other forms of injections, in South Korea's cosmetic surgery scene. South Korea is home to one of the fastest rates of cosmetic surgery consumption worldwide, making it an ideal context to examine the concomitant expansion of professional activity within the sector (Au 2022; Holliday et al 2017).

In the context of cosmetic surgery, individuals who participate in extensive surgery and those who were clientele of this hospital were elites, recognized as those with vast economic resources, even if not cultural or political capital (Khan 2012; Mears 2015). However, not all clients and even staff are elites, with some being middle-class or below, especially with the increasing affordability of procedures as the industry massifies in the nation (Leem, 2016a). Non-surgical procedures like injections in particular are more affordable, have minimal to no recovery time, and are even commonly advertised by clinics as a convenient, "same-day" procedure – one that a client can obtain on their lunch break and return to work unfazed. Reporting on clients of non-surgical cosmetic procedures thus offers better visibility into the interactions and conflict management styles that govern professional service provision at large, encompassing, yet moving beyond elites.

The data for this study comes from a larger project on the Korean cosmetic surgery market. This study reports on a six-month period in 2018, during which time I conducted participant observation at a large hospital for cosmetic surgery in Seoul, South Korea, whose clinics are among the world's most prominent. The Korean city remains one of the most popular global destinations for medical tourists and the nation exhibits one of the fastest and highest

growth rates in the number of surgeries purchased worldwide (International Society of Aesthetic Plastic Surgery 2020).

Clinics in Seoul thus constitute an apposite fieldsite for understanding the sprawling dynamics of professional conflict management as well as tapping into variegated sources of conflict and interaction in their service of a diversity of consumer biographies. Though these clinics may offer procedures for health benefits, they are overshadowed by aesthetic ones. Like typical privatized medicine, these clinics do not receive referrals from outpatient doctors, and neither do they enjoy inclusion in typical health insurance programs.

The hospital I visited was located in a multi-floor building in Gangnam, the most affluent district of Seoul. In the already-large building of about twenty floors that it was housed, the hospital occupied over half, a tribute to its success even as far as clinics go in Seoul. By comparison, the overwhelming majority of such cosmetic surgery clinics in even Seoul consisted of one or two floors at most, serving as private practices of individual surgeons who became entrepreneurs.

Each floor of the hospital had a different group of surgeons, nurses, and clinicians for a specialty. One floor was for skincare, for instance, a second for eye surgeries, a third for procedures related to bone structures of the skull, a fourth for breast augmentation, and so on. Again, by comparison, other clinics in Seoul often do not have such specialties even as far as cosmetic surgery goes, often offering injection services and at most, one or two bodily areas that fall under their sole surgeon's expertise.

My participant observation consisted of observing interactions between clinical professionals that included clinicians, service-providers, as well as interested consumers. Service-providers like nurses are responsible for administering procedures to consumers.

Clinicians are effectively beauty consultants who act as the frontstage salespeople for the clinic. They liaise with consumers about any concerns and interests and are often their first and most consistent point of contact throughout their journey at the clinic. Procedures often consist of a consumer entering the clinic by appointment and sitting down with a clinician, where they will speak about their goals, the surgical procedures that the clinic can provide in service of these goals, as well as payment methods and follow-up scheduling.

Methods

I conducted ethnography for six months at the hospital in Seoul, South Korea. I visited the hospital once a week during this period, and spent several hours each visit observing their operations. There, I attended initial consultations between clinicians and interested consumers, as well as non-surgical procedures that interested consumers received from nurses. I also conducted "go-along" interviews (2003) by following clients to their treatment rooms and recording observations of their interactions along the way.

I was a passive observer during consultations and procedures, only recording what was said by clients and professionals during these situations. I recorded my fieldnotes on the design of the clinical spaces as well as the dialogue between professionals and clients using my phone only after each session had concluded. I became slightly more active as an observer when professionals were alone, not working or in the presence of consumers, during which time I asked questions about their feelings on parts of their craft and their colleagues or clients. I was never an active participant, such as to assist clients arrange a session or to conduct tasks for professionals.

Verbal consent was obtained prior to any observation of a consultation, in order to prevent any discomfort from a signed form and to minimize the impact on operations. A signed form, by contrast, may have produced feelings of social awkwardness from the formality associated with written documents in the local culture. An information form was still provided to clients before participation, and their rights were discussed prior to observation. Ethical approval was obtained from the ethical review board of my university at the time, a large, R1 university in North America.

I analyzed my field notes by using thematic network analysis, akin to the cross-comparative coding scheme in grounded theory (Charmaz, 2006), which unearthed the organizing themes and principles behind the structured interactions observed (Attride-Stirling, 2001). As "a form of pattern recognition within the data, where emerging themes become the categories of analysis" (Fereday and Muir-Cochrane 2006), my thematic network analysis consisted of coding initial themes about interactions, strategies, meanings, attitudes, and conditions, after which commonalities were coded within these initial themes and leveraged to theorize overarching narratives about the way professionals ideated and operationalized the concept of face vis-à-vis conflict.

Cooperating through Conflict: Cases from the Clinic

I spent a considerable amount of time on the hospital floor for skincare, as it had the largest quantity of clients on average. The floor had a luxurious front desk where clients were greeted, a waiting room, one consultation office, and several procedure rooms. It was common for just one procedure room to be left open, with the others closed, on days with less client traffic. The floor would typically receive twenty to fifty clients in a day. The floor was helmed

by one senior clinician, Jeanne, supported by one to three nurses who would carry out the procedure, depending on the day.

Conflicts were common and captured in the case of Jeffrey, a 25-year-old man. Upon first entering the floor, he was greeted by a row of uniformed young women behind the front desk, who bowed and smiled to welcome him. Learning he had an appointment, one of the front staff gestured to the waiting area glowing in a bath of warm light. Dimmed yellow light rained down on the entire hospital from bulbs carefully hidden out of sight along the periphery of the walls, as one might expect of a therapist's office.

It was but five minutes till the same staff walked over to Jeffrey and guided him to another room around the corner and out of sight from the waiting area. There, he sat down in a small office with Jeanne. I later learned from Jeanne that no one else typically sat in on these consultations at their hospital, not for confidentiality purposes since many other clinics had multiple staff present with the client during consultations, but to impress upon the client an ambience of personal affect.

In their initial discussion, Jeanne learned that Jeffrey was interested in improving his skin. Jeanne thus remarked of their hospital's procedures:

> "We use patented technologies, such as sonification. It will use ultrasound technologies to infuse vitamins directly into your skin. It will be a permanent, long-lasting treatment. The effects will stay for a long time, unlike topical treatments, because it penetrates into the deepest layers of your skin and improves your skin's *health*, not just appearance.
>
> Jeffrey: Hmm… I want Botox, since I got it before. I also want Ultherapy. I also got it before, and I liked it. I then took Accutane, so I could not do Ultherapy after.

Jeanne: We have Ultherapy here! We can definitely provide that. It would be good for your skin. You don't have to worry about Accutane. It was a while ago that you took it. We are the right place to help you with your skin."

Jeffrey was keen on improving his skin health, but expressed some ambivalence about the methods with which to achieve it. Ultherapy was a type of heat treatment that proposed to reverse the appearance of aging skin. Despite his eagerness to obtain it, Jeffrey later revealed that he had held back for a couple of years because of Accutane, which was a powerful anti-acne drug that worked by shrinking the body's oil glands to stalwart the production of acne, but sensitized the body to heat and made the skin easier to burn. Though he had discontinued the drug, the sensitivity effects were likely to linger for months after.

Their consultation thus agreed upon Botox that day. Jeanne stood and guided Jeffrey out of her office down the hall to the nurse's office for his injections. Bracketing the walls were framed photos of past consumers that Jeanne waved to and beamed, noting the hospital's decorated history of helping clients to satisfaction. After a winding path down a row of photos and offices, they entered a clinical room that looked like a dentist's patient room: an inclined patient chair, an elevated tray at the ready to receive tools, a counter with equipment, needles, and procedure materials – and a clinical professional, smiling.

Jeanne waved to Esther, then to Jeffrey, "this is Jeffrey. He's here for a v-shape Botox injection that will help his skin as well."

Esther pointed at the angle of his chin and jawline. "Oh! You already have a v-shape face!"

Jeanne laughed, "Yes. He is good looking! Now he will be even *more* good looking."

Esther nodded, "Yes, he will have more of a v-shape. Like the pop stars."

After Jeanne left, Jeffrey climbed into the procedure chair and Esther busied herself at the counter, combing her fingers through a row of boxed Botox vials in the cupboard.

Jeffrey asked, “So, what makes you guys unique?

Esther: Ah, we are different because we look to Los Angeles, we all over the world for the latest treatments and technologies and integrate them. We make sure we are cutting-edge in the industry with a lot of the best technologies. Our patents give us exclusivity too. It prepares us to treat a lot of clients from different backgrounds with different needs. We are different because our protocols are safer and with better results. We have different options for treatment plans and cater it around your specific needs. We are very transparent about what we do. All the photos we can share we have done so on our Instagram account. You can go ahead and look right now.”

Esther promised personal customization in the experience of cosmetic surgery, tempered with consideration for safety, superior results, and transparency. This customization was watched over by her professional gaze that was caring as much as it was vigilant, with her finger on the pulse of every innovation in the space and a fervent desire to integrate it into clinical services for her clients. Their conversation rolled on as Esther swept through a drawer of individually packaged needles, then homing in with surgical precision on one, lifted it out and inspected its size.

It was here that Jeffrey raised again his interest in Ultherapy, an option that Jeanne previously encouraged. As Jeffrey explained to Esther his medical history with Accutane, juxtaposed against his desire for the youthful aesthetics that Ultherapy promised, he said as he did in his consultation: “I got Ultherapy before, so I really want to do it again. Maybe next time?”

Esther walked around to face Jeffrey and set the vial down on the tray beside his chair. With solemn eyes and a grimace, she remarked,

> "I don't recommend it at all. Your skin has been compromised after taking Accutane. It has stripped away your skin's natural barrier, a moisture barrier, leaving it exposed and vulnerable. Ultherapy uses a lot of heat, and will be too harsh for your skin as it is now."

Eyes widening, Jeffrey nodded and stammered, "Jeanne said it is okay, and I should get it."

Esther pursed her lips and narrowed her eyes in a sympathetic look, but pressed on,

> "Well… I *won't let you* get Ultherapy. Not for the next eight months, anyway. To be safe, I – *we* – personally recommend something like close to a year before we do anything drastic like Ultherapy, things to do with heat, laser. We can get rid of your acne scars and go ahead with needle treatments, like the *Infini* laser, but we need to replenish your skin's moisture first. We have to prepare you for that too, so… in the meantime, I recommend for you our Hollywood facial and Hollywood facial express. It will help with pigmentation."

In denying Jeffrey the Ultherapy procedure he wanted, Esther expressed a kind of care that also presented a point of conflict with Jeanne. Jeanne recommended a battery of procedures that included Ultherapy under the premise of helping Jeffrey attain his aesthetic goals. However, Esther broke from Jeanne's recommendation, evoking a rift in professional opinion within the same clinical space.

Yet, the way she did so was carefully nuanced to preserve the "line" that had been established by Jeanne as well as her social face. Esther acknowledged Jeanne's opinion so as to prevent humiliation by outright dissenting from her (Goffman 1967b: 10). The way Esther made

her own disagreements known was by recognizing the same problem that Jeanne had identified, but rerouting the discussion to an alternative procedure.

In so doing, Esther evoked the protective function of the "line" for her social face, but also that of her colleague, for she did not say that the advice that Jeanne gave (to prescribe a procedure) was poor, but that it needed a redirection (to a different procedure) – namely, to their Hollywood facial package, which was a series of facials using a mix of vitamins and natural supplements. Differences in opinion were reframed in Esther's domain of expertise with her note that her advice to Jeffrey was the most updated that "we" had to offer as representatives of the same hospital.

Where Jeanne appeared to base her decisions on the managerialist or market-logic driven by short-term profits and costs (Olakivi and Niska 2017), Esther expressed a professionalism logic that sought first and foremost the wellbeing of her clients in pursuit of the long-term sustainability of the hospital (Andersson and Liff 2018).

In follow-up interviews with Esther, she confirmed her disagreements,

> "I do not think Jeanne chose the right procedure to recommend the customer, but I cannot say this in front of the customer. The customer himself is also not right for wanting that procedure, but it is easier to correct the customer than it is to correct a colleague. I see the customer once, but I see my colleague everyday. We represent the same hospital. It would be like slapping the entire hospital and myself in the face if I disagreed openly!"

Esther thus repressed the embarrassment and immediate emotional reaction she felt as a result of her colleague's decision to protect her face, her colleague's face, and that of their institution (Goffman 1967b: 42), the three of which were enjoined because the conflict was played out in the presence of a third party (the client). It was thus predetermined that Esther was expected to

collaborate her way through the conflict by respecting the cooperative "line" that was initiated by Jeanne, namely, her initial decision about a course of action.

Esther ideated and sought to preserve the social face of her counterpart, Jeanne, and reframed their disconnection in professional opinions to a connection to the same organization driven by the same mission – to help Jeffrey. Simultaneously, the professional rift that Esther drew from Jeanne was an opportunity for the former to reframe the incident as a demonstration of her professional integrity, her self-face, in a bid to improve trust with her client. Her rejection of Ultherapy was personalized and moralized – that she personally would *not* let Jeffrey get Ultherapy – as a mother might say of her child.

This defies the conventional "customer-is-always-right" mentality that dominates other professional services (Grandey, Dickter, & Sin, 2004; Sciulli, 2005). As Esther put it, correcting clients was a feasible task that could even be leveraged as an opportunity to build rapport with them – but correcting colleagues in front of customers was forbidden by the "lines" that she was beholden to so long as she was in the situation (Goffman 1967a).

Such cooperation would come to preserve and bolster social face for Esther, Jeanne, and the hospital well once more in a subsequent conflict over Rebecca, a 30-year-old woman. Rebecca entered the hospital and, like Jeffrey, first sat down in a consultation with Jeanne.

In their initial discussion about Rebecca's goals, she noted to Jeanne that she wanted Botox and fillers. Fillers are a type of injection of a dissolvable gel meant to plump up areas that lose their natural fat over time, such as eye circles or smile lines. Though both are considered common procedures in cosmetic surgery, Rebecca raised a point of inquiry about fillers:

> "Will fillers make the procedure permanent? I heard that fillers don't actually fully dissolve over time.

Jeanne: Well, permanent is good! Because that way, your skin will build up collagen and a protective fibrous capsule around the foreign material and you will have that bump [in your skin] forever. It will look good! Especially in your case… I highly recommend fillers. You can definitely get facials and massages still.

Rebecca: So… it will kind of be permanent? Is that good?

Jeanne: Some does stay, and that is positive — you do not need to get more over time. Anyway, we have a specialist and you will feel her techniques, you will… feel how they are different and unique."

Despite being aware of differences in professional opinions and logics, Jeanne sought to preserve Esther's social face, lauding the prowess of her technique and professionalism. As Jeanne remarked in follow-up interviews after the client left, "even though we have our differences in opinion, I cannot break from her [opinion] entirely. There are moments where I have my pride, but I have to swallow it. We all have to compromise to make. If we don't, we would lose the customers – and that would be the worst loss in face of all."

"Swallowing" her pride and repressing her emotions to prevent embarrassment to herself, her colleague, and her hospital, Jeanne emphasized compromise as a theme in her account, just as in Esther's. Jeanne felt accountability to preserve Esther's face and the "line" that she had set, the same way that Esther previously felt toward Jeanne. Face, in their accounts, was not merely about their selves, but interwoven and contingent upon the face of their colleagues and their hospital. The presence of a third party (the client) introduced another incentive for cooperation by raising the stakes – the potential loss of a customer, as Jeanne put it, would constitute the worst damage to social face.

This is because, as Goffman (1967b: 41) explains in his account of cooperation, individuals are evaluated on the basis of their teamwork. The expression of respect and reciprocity enshrined in the Korean networking culture of *yonggo* and enacted in peer groups further enforced professionals' expectations of their own and their colleague's behaviours. Protecting their colleague's face effectively became a way to protect their own face. With this in mind, they repressed their emotional reactions, abided by predetermined "lines" of action, and subsumed differences of opinions into commonalities based on their common organizational membership and objectives. As consumers and Esther would later remark, this was effective in preserving morale and kept consumers feeling safe and assured in coming back to the hospital, and Esther motivated to continue working at the hospital.

Thus, it was important to foster harmonious relationships within the hospital on multiple levels. Preserving harmonious relationships was a benefit to the hospital itself, improving its brand as a place of innovation, service, and repute, all of which latently depended on the ability of its members to keep rank with one another. We would not trust the integrity of a restaurant, after all, if the waiter disparaged every item on the menu.

Rebecca eventually decided on Botox, but was ambivalent about fillers. She received the opportunity to discuss it again with Esther, who was waiting in the procedure room. The concern about social face in the conventions with which Esther addressed professional conflict with fellow professionals within her own hospital surfaced in how she addressed it with professionals outside. Esther retrieved a thin marker and dotted lines on Rebecca's face, who leaned back on the procedure chair. As she did, Esther remarked, "other clinics will not do this for you, walk through every step of the process…" Esther drew dots around the corners of Rebecca's jaw, "and the masseters where I will inject are only here."

Rebecca pointed up her cheeks, equidistant from her cheekbones and jaw. “What about here? I found that my masseters are developing up here, closer to my cheeks. A doctor I had before at this other clinic did it for me there before.”

Esther grimaced, “Ah, the people who give you Botox higher than that, injecting near cheek, are targeting a different muscle – the zygoma muscle. The people who do that know nothing about Botox actually! If we target that muscle, it will affect your lips and will cause you to smile poorly.”

Faced with a rift in professional opinion about the location of the Botox procedure with someone *outside* the hospital, Esther was quick to dismiss the opinion altogether. Gone was the delicate consideration for other-face that she had shown to Jeanne, and in its place was an outright assault on the very integrity of the other doctor’s professional capabilities.

Esther then went on to describe her own procedure known as “micro-Botox” prior to administering it.

“My style of Botox is when we inject smaller doses of Botox into the surface-level skin, creating small papules under the skin that help pull your skin together. It is aimed around the jawline and cheek areas. It makes your skin tighter and shrinks your pores and fine wrinkles very well. Botox will shrink your masseter muscles, but… it may cause your skin to sag as a result of the shrunk muscle. So, micro-Botox will pull it up…”

Rebecca: I see.

Esther: It is all the rage these days. Look at BTS, every one of them gets micro-Botox. Everyone looks at them and is ‘wow’ed by their v-shape, but this is actually the work of micro-Botox! People care so much about beauty in Korea. People care a

little *too* much though. My clients just love micro-Botox. They do it for their whole face and come right back for it after a few months.

Rebecca: I didn't know you could do it for the whole face.

Esther: Yeah! You can do it for your forehead, for your cheeks, for your whole face, because it's just skin-level – not as deep as the muscle-level.

Rebecca: Wow, I didn't know you could shrink pores and tighten skin with just micro-Botox! Can it help with my eyes? Do you recommend I get fillers for my eye circles?

Esther: I do not recommend you get fillers actually… for your concerns about the eyes, as a micro-Botox specialist, I recommend you get micro-Botox – it is 100% safe. It goes away. This gives you sense of security. It will target up here, closer to the areas around the eyes around your socket and will *pull* your skin up so we do not inject something semi-permanent into the risky area… I do not recommend you get fillers around the eyes for eye bags, because that area has so many blood vessels… injecting something synthetic there can cause blindness. This only happens for one every ten or hundred thousand people or something, but just once is enough. I cannot say anything [in critique] because we offer this practice here. But I am saying this to you, because I know you're interested and I can say it is not worth it — safety is my number one priority. Our main concern."

From people "caring too much" about beauty to denying the need for fillers, a recommendation set forth originally again by Jeanne, Esther broke once more from consensus in the cosmetic surgery industry at large.

Esther's departure on these fronts was rare for a market with a consumer culture so saturated with an insatiable desire for procedures concomitant with the rise of global celebrity culture (Elliott 2011). The perpetual evolution of beauty ideals that sustains the cosmetic surgery market's growth is typically fuelled by the voluntary participation of clinical professionals who actualize cultural ideals, bringing bodily design into the realm of technological possibility with their expertise (Leem 2016b). Theirs is a managerial drive for short-term profit, as witnessed earlier with Jeanne.

But this drive for profit is not a totalizing force, not enough to overcome the micro-level drive to preserve face (both one's own and that of her colleague's) in the immediacy of the workplace. Esther's conflict with Jeanne's recommendation for fillers was done with careful attention to their shared organizational identity, group membership, and most importantly, their social face as professionals in the same hospital. Rather than casting doubt on Jeanne's diagnosis that would cause her to lose face, Esther stressed that all she offered was an *alternative* procedure suggestion, micro-Botox, and rerouted the narrative to their shared professional commitment to client safety and satisfaction, preserving face while guiding the client away from perceived risks. Not only did this ensure that her face as a professional and her hospital's face as an institution were protected in front of the client, but it ensured that her face as a colleague was protected in the eyes of her colleague Jeanne (Goffman 1967a), preserving both the "lines" laid down by Jeanne and the norms of reciprocity that live large in peer groups of *yonggo*.

Indeed, Esther's professional pull toward client safety had its limits, outmatched by her loyalty to the hospital and cooperation with the "line" that was set out. The hospital had already decided to offer fillers and other colleagues were already in agreement with offering them. As such, Esther resigned herself to administering fillers and restricted her comments because the

hospital recognized their legitimacy and worth, even if it did so on the grounds of profit rather than health. Her face-work was protective as much as defensive. She was protective of the hospital's face, and by extension, defensively protecting her own.

Attempting to mediate this tension, Esther leveraged the conflict itself to encourage trust from the client and align herself with the hospital in "*our* main concern" with safety, a discursive practice that attempted to convey that her dismissal of fillers was not a smear on the hospital's integrity and that they were equally concerned about safety, albeit implied to be to different extents.

Fillers served as a particularly contentious area of conflict between clinicians and service providers like Esther for reasons the latter had stated. Though clinicians were eager to encourage clients to purchase the procedure in many of my observations, I found the nurses themselves were reluctant to match their enthusiasm or support the procedure unless clients themselves had already decided they wanted it. The nurses observed that their risk was too great for certain areas of the body and without sufficient evidence of the reverse to justify their injection, most of all in sensitive areas such as near the eyes.

The conflict about fillers resurfaced with renewed strength in the case of Aera, a 24-year-old woman. On the day of her visit, Jeanne was absent, but another senior clinician was there to take her place from another floor, a woman named Chaewon. In her initial consultation with Chaewon, Aera expressed interest in Botox and fillers, just as Rebecca had. Chaewon smiled and expressed with enthusiasm, "we have a filler specialist in this hospital, a nurse here. You will love her."

Aera was taken to the procedure room, where she was greeted by Hannah, another nurse on the floor who had just about as much experience as Esther. When it came time for the Botox,

Hannah pressed a cloth-covered pack of ice on the injection site, followed by a gauze to soak up any blood. “Can you please hold this gauze for me?”

Aera complied.

Hannah retreated to the counter to dispose of the needle. “You know, you’re very good with pain. Women are usually very good. They never complain about the pain. They just hold it in. ‘No pain, no beauty,’ is what they think, right?”

Aera had gone further than Rebecca and already purchased fillers to inject into her laugh lines, though conveyed a similar uncertainty about their aftereffects and sought advice from Hannah in this regard. Once more, the issue of the fillers’ ability to completely dissolve out of the body was called into question.

Aera asked,

> “I’m getting fillers for my laugh lines, but this is just my second time getting fillers. I’m still not too familiar with them. I heard they do not really dissolve or something? Like you need to inject an additional kind of acid to fully dissolve them.
>
> Hannah: Ah, yes… if you get fillers for anywhere, know that the other risk for fillers is that they never go away. 20 to 30 percent always remains. It is permanent… so it builds up, and as you keep getting fillers over time and it keeps building up, it may protrude unnaturally from your face, wherever it is.”

Visibly concerned, Aera then asked if filler injections were the right choice for her laugh lines. Hannah shifted her tone to one of assurance, remarking that,

> “We have different styles of injection for clients. Some people get addicted to getting fillers and Botox. I know that. But I assure you that you will not get addicted, because we are experts in beauty. We know what is beautiful and what is not. We will stop you from

> getting too much. This treatment in particular will also not let you get addicted because it is very targeted."

When the conflict had already gone past the point of return, such as when Aera had already committed to a non-refundable purchase of fillers, Hannah responded with the same cooperative impulse but with a softer tone. Evident was her attempt to enact protective face-work (Goffman 1967a), to preserve the face of her colleagues and hospital for suggesting the procedure by downplaying the risks. She did not emphasize the dangers as much as Esther did with Rebecca, for the decision had already been made. Rather, Hannah made her references to the risks with brevity and far less hysteria, and stressed instead her ability to help Aera navigate her aesthetic journey moving forward.

Hannah converged here with Esther in positioning the conflict as a conveyance of a unique kind of care: that she would protect Aera from the dangers of risky procedures, even if they came from herself. That whatever impulses Aera expressed toward her choice of procedure, they would be filtered through Hannah's professional – and caring – gaze. This was also a performance of the broader code of reciprocity instilled in *yonggo*, which extended not only to fellow professionals but to clients. This reflects the particularistic quality of trust that defines many interactions in Korean (peer group) networks. Trust, essentially, is performed through gestures of goodwill and exchanges of gifts and favours to convince the recipient that the giver is doing things within their best interests (Au, 2021).

Also like Esther, Hannah aligned her personal brand of concern for Aera's "natural" appearance and wellbeing with that of the hospital. Even if the hospital was complicit in pushing procedures with dubitable outcomes like fillers, nurses like Esther and Hannah hesitated to critique the organization or its clinicians and instead framed their concerns about risk and safety

as a commitment they shared with the hospital. Asserting this unity was a boon for their social face as affable people capable of maintaining harmonious relationships, a status that subsequently lent legitimacy to their admonitions against risky procedures to clients, ensuring that their clients saw them and their hospital in the best light possible, while preserving morale and face for all actors at the hospital.

Conclusion

This article contributes to the literatures on which it draws by articulating a general theory of conflict management. Indeed, though this article is based on fieldwork on clinicians, the theory of professional conflict offered may be generalizable to other professions where professionals interact with one another in the co-presence of clients, their multiple identities interacting in ways that enact the same triadic conception of face identified in the present study.

Conflicts between professionals raise issues of dislocation and disunity in the social structure of the workplace (Abbott 1988). As exemplified in my fieldwork in a large cosmetic surgery hospital, conflicts and the quandary they pose were unrelated to the issue of jurisdictional control or professional agency (Liu 2018), such as nurses fearing the concession of their professional autonomy or jurisdiction, and instead concerned the relational reputation that is the social face of each actor involved.

As such, in contradistinction to confrontational conflict management styles documented in cases of workplace conflicts in professions like lawyers and engineers (Adams 2020; Allan, Faulconbridge, and Thomas 2019), hospital professionals responded by working through the conflict. They abided by script-like cooperative “lines” of action by discursively reframing the conflict itself as a demonstration of their personal and affective care for clients, as well as

aligning this brand of care with the overarching objectives of clinicians with whom they dissent and the hospital itself. Irrespective of the source of the conflict, such as when clinicians initiated recommendations to clients later deemed risky by nurses or vice versa, dissenting professionals strove to protect the face of their counterpart, and in so doing, defensively protect their own face as well as the reputation of the hospital itself.

Implicit in the nuanced layering of cooperation documented in this article is a dynamic theory of social change and action in organizations and invigoration of the significance of cultural influences in shaping the architecture of this theory. Cooperation was enacted by professionals within the same hospital, but quickly turned to confrontation and challenge when concerning professionals across clinical organizations, even without having met.

On the contentious issues of proper Botox administration and fillers, nurses were highly vocal in challenging professionals in other clinics, vocal in their admonitions of risk toward clients who were ambivalent, but much more recessive in their dissent and even cooperative when clients had already acceded to risky recommendations put forward by clinicians.

The heterogeneity inherent in these variegated modalities of conflict management suggests that professionals are highly discerning in their conflict management and that social face plays an understated role in determining the elasticity of organizations, wherein employee dissatisfaction owing to conflicts is not likely to become a barrier to change or unity, but remains to be seen whether it offers sufficient checks and balances for ascertaining the quality of innovative ventures.

Future research may extend the findings of the present study through examining the intersection of social attributes in the social construction of the clinical profession. Many of the clients and staff, for instance, were women who were not all elite, which may be grounds for

further examination of class. Studies of other clinics may find different compositions of men and women among professional staff and, by extension, find gendered schemas at work with respect to the provision and selection of a procedure, which is beyond the scope of this study.

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