

**Social Determinants of the Turnoutfor Reconstructive Surgery:**  
**A Field Study of Road Traffic Accident Victims in the Provinces of Algiers,**  
**Bouira, and Chlef**

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**Abstract:**

The present study was conducted with an aim to find out social determinants affecting the use of reconstructive surgery among the victims of road traffic accidents in Algeria and also to determine the effect of certain demographic variables such as gender and education level. Descriptive-analytical methodology was used for this study. Sixteen-item questionnaire was distributed among 62 road traffic accident victims undergoing treatments in Algiers, Bouira, and Chlef provinces in 2025. Descriptive and inferential statistical methods such as mean, standard deviation, frequency, percentage, independent-samples t-test, and one-way ANOVA were used for the data analysis only after ensuring that the assumptions associated with these statistical methods have been fulfilled. It was found out that social determinants had a considerable effect on the use of reconstructive surgery. More specifically, social stigma, lower social involvement, family support, and need to get socially accepted were found out to be the most influential determinants. Differences were found significant with respect to gender and education level.

**Keywords:** Reconstructive Surgery, Social determinants, Road traffic, Accidents, Physical deformities.

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## **Introduction:**

In recent decades, reconstructive surgery has experienced a number of significant advancements due to the development of the sciences and technology involved in medicine. Reconstructive surgery has turned into one of the major branches of medicine providing for the recovery of physiological functions and reconstruction of tissues and organs injured as a consequence of congenital deformities or accidents of different types. However, reconstructive surgery cannot be seen in terms of pure medicine anymore since it became tightly linked to a number of social, cultural and psychological aspects because the body is a key element in the social identity of a person and serves as the foundation of social interactions and integration in society.

Modern social transformations have also changed the connection between individuals and their bodies. Appearance has more and more turned into an integral element of the system of values that affects social status and social acceptability of an individual in the society to which he belongs.

In addition, the increase in the number of road traffic accidents and consequent injuries and physical deformities has increased the need for reconstructive surgery that aims at restoring the functionality of body parts as well as improving people's self-perception and social perception of themselves.

In this regard, the choice of reconstructive surgery cannot be seen as an exclusively personal one anymore. It becomes the product of the interplay of different social and demographic determinants that influence the perception of physical deformities and attitudes towards therapeutic procedures. Such variables as gender and education level, in combination with the impact of the social and cultural context, affect greatly the perception and attitudes toward reconstructive surgery.

In order to explain the issue under discussion, the current study employs several sociological approaches to the issue in question. Firstly, it makes use of Erving Goffman's approach to social stigma according to which physical deformities are considered to be attributes influencing an individual's social identity and, thus, making it necessary to seek ways of regaining social acceptance and social integration. In addition, the sociological point of view highlighting the importance of the influence of the values and norms created within the social groups to which individuals belong, which, in turn, shape their health-related and body-related choices.

Moreover, the study draws upon the structural-functionalist theory of "**Talcott**

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**Parsons**” according to which society designates specific social roles for men and women. In this theory, society demonstrates more lenience towards some minor physical defects or deformities of males as long as such defects do not affect their functionality and social role performance. On the contrary, females usually face higher standards of physical appearance. Moreover, the study utilizes theories by Pierre Bourdieu according to which the body represents social and symbolic capital that affects the social status of an individual in terms of the amount of cultural and social capital of the individual.

Despite the existence of many studies devoted to reconstructive surgery, all these studies were mostly concerned about the medical, religious and legal aspects of the process. Sociological researches concerning social determinants affecting the decision to conduct reconstructive surgery are rather scarce, notably in relation to Algeria.

In this situation, the relevance of the current research consists in considering the influence of social determinants, namely demographic factors and road traffic accidents on reconstructive surgery; in so doing, it attempts to offer a Sociological explanation of a process whose ramifications go far beyond the strictly medical aspect to include various intertwined social and cultural processes.

### **1. Problematic of the Study:**

Currently, reconstructive surgery is no longer limited to the medical procedure whose sole purpose is to restore the physiological capabilities of a body and correct deformations due to both congenital and acquired conditions. Reconstructive surgery has become a social process that has been influenced by various determinants associated with the social values of people, their cultural norms, and demographics. Thus, not only does the choice of reconstructive surgery depend on the need for treatment, but also on how people perceive their body, what are the existing social representation physical appearances, and on the nature of social relations in communities to which people belong.

In this regard, there are several variables that could affect individuals' choice of reconstructive surgery, such as gender and education, besides road traffic accidents, which are among the main factors of physical injuries and deformities. Moreover, variations in social and cultural capital of individuals may be an important factor behind differences in the perception and attitude towards reconstructive surgery. While reconstructive surgery has been a subject of interest for scholars, the existing body of literature has mainly examined its medical, religious, and legal aspects. However, sociological approach that looks at the

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impact of social determinants on individuals' choices and attitudes towards reconstructive surgery is rare, notably in Algeria. This calls for the need to examine the nature of these social determinants and the impact they have on the individuals' attitudes toward reconstructive surgery.

Therefore, the current study attempts to answer the following research question:

**-To what degree is there variability in the use of reconstructive surgery among victims of road traffic accidents who suffer from deformities of various body parts based on their demographic characteristics, notably gender and education, in view of social determinants?**

## **2. Hypothesis**

The hypothesis that will be tested through the research question above is:

**-There is variability in patients' choices of undergoing reconstructive surgery based on their demographic characteristics, specifically gender and education.**

## **3. Significance of the Study**

The significance of the present study may be concluded as follows:

- The contribution to the scientific and knowledge base regarding the necessity of reconstructive surgery in general. This study may be viewed as a scholarly attempt to reveal the urgent therapeutic and preventive reasons for reconstructive surgical interventions, as well as the social reasons for patients' demand for reconstructive surgery. In a small way, it may help to advance knowledge and cast light upon the nature of the subject.
- Attracting the attention of academic, medical, and social centres to the significance of further research in this field in order to reach sound scientific conclusions that can reveal patients' motivations in relation to reconstructive surgical interventions.

## **4. Objectives of the Study**

- The primary objective of our study is as follows:
  - ✓ To identify the determinants that influence the utilization of reconstructive surgery by Algerian patients who have experienced road traffic injury.
- To attain this primary objective, there are several specific objectives, such as:
  - ✓ To reveal the types of reconstructive surgical procedures and their purposes.

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- ✓ To identify the social motives for the utilization of reconstructive surgery by Algerian patients.
- ✓ To determine whether there is a link between demographic characteristics (such as gender and educational level) and the utilization of reconstructive surgery.

## **5. Conceptual Definitions**

### **5.1- Reconstructive Surgery**

Saleh Al-Fawzan describes reconstructive surgery as “a surgical medical procedure whose objective is to enhance the appearance or function of the apparent human body parts” (Al-Fawzan, Saleh bin Fawzan (2008), p. 48).

Al-Shanqeeti describes reconstructive surgery as “a surgical procedure whose objective is to treat and correct deformities, acquired because of various incidents like road traffic accidents, burns, etc., or due to congenital anomalies.”

Thus, reconstructive surgery may be defined as a surgical procedure whose objective is to restore a particular body part to its normal function or natural appearance, aiming at correcting abnormal body parts due to congenital anomalies, pathological conditions, or acquired anomalies due to various incidents. Reconstructive surgery includes the restoration of blood supply to the limbs to prevent amputation, also referred to as microsurgery. Therefore, it mainly focuses on functional restoration rather than aesthetic improvement; however, aesthetic improvement can be considered a secondary outcome of reconstructive surgery.

### **➤ Operational Definition of Reconstructive Surgery**

Reconstructive surgery can be defined as a medical procedure intended to treat, rehabilitate, and relieve physical and psychological burden. The indications for reconstructive surgeries can be considered under two motives:

- **Essential Indication:** A set of motives that intend to correct a defect, deformity, damage, or deficiency where a certain procedure is required to save life or avoid serious harm.
- **Need-based Indication:** A set of motives that intend to correct a deformity or defect that causes physical or psychological damage but does not reach a level of necessity.

### **5.2- Social Motivations**

Social motivations are viewed as a source of stimulating motivation that produces activity and interest in a framework of reciprocal interaction. They exist in a network of people who are engaged in various social processes that include

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adaptation, cooperation, integration, conflict, social status, goals, perceptions, beliefs, and orientations. Social processes that are related to people as individuals in interaction with others in society are considered to affect human behaviour. They are generated in interaction and vary in nature and purpose. (Al-Azzawi, Mohammed Abdelwahab (2012), p.12).

➤ **Operational Definition of Social Motivations:**

Social motivations of patients who are in need of reconstructive surgeries are measured in this study using the following indicators:

- The need to correct birth defects in order to build better social relations.
- Inability to fulfil social roles.
- Social stigma.
- Social participation level.
- Influence of peer groups (friends who have had reconstructive surgeries).
- Family and societal pressures as major determinants in making a decision to have reconstructive surgeries.

**5.3- Definition of Demographic Factors**

Demographic factors are defined by Chouki Kacimi as “population size, distribution, composition, and the changes affecting them—that is, the number of individuals, their spatial and temporal distribution, and their structure in terms of age, gender, marital status, and other factors, as well as changes such as birth rates, mortality, and migration” (Kacimi, Chawki (2015), p. 3).

➤ **Operational Definition of Demographic Factors:**

In the study, demographic factors were defined as:

- Patient gender
- Educational level

**5.4- Road Traffic Accident**

According to the World Health Organization, a road traffic accident is defined as “an unintentional event resulting in visible injury” (Khairallah El-Sayed Mohamed & Al-Kinani Abdel-Moneim (1996), p. 17).

➤ **Operational Definition of Road Traffic Accidents:**

The definition of a road traffic accident was based on any accident taking place along the road involving one or more vehicles, a vehicle and an object, rollover of a vehicle, resulting in fatalities, bodily injuries, and physical deformities, with the victims involved unintentionally and without prior intent.

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## **6. Methodological Procedures and Research Method**

### **6.1- Study Scope**

#### **a) Spatial Scope:**

The field study was carried out in the following regions: the province of Bouira, Algiers, and Chlef.

#### **b) Human Scope:**

This refers to the number of participants in the field study. The sample was administered to patients who had acquired injuries from road traffic accidents. The sample was administered to the following number of patients: **33** patients from rural regions; **29** patients from urban regions. Patients were sampled purposively. They were sampled according to key variables such as gender and education.

#### **c) Temporal Scope:**

The study was carried out starting from the half of **April 2025**, and all the questionnaires were administered by the end of **May 2025**. On average, five patients were interviewed every day.

### **6.2- Methodology of the Research:**

The descriptive-analytical method was used because of its suitability to the nature of the study and its objectives. This method was achieved through the use of the Likert scale, which is defined as a summated rating scale (**Okasha Mahmoud Fathi & Zaki Mohamed Shafiq, pp. 132-133**).

This method is based on giving degrees of agreement or disagreement to each statement in the scale, as follows for a three-point Likert scale:

- Agree: 3 points
- Neutral: 2 points
- Disagree: 1 point

The participants, or patients, were asked to indicate their responses by marking the option that best represents their opinion for each statement in the scale (**Landshere, Gilbert (1992), p. 201**).

### **6.3- Study Sample and Sampling Method:**

The study sample included 62 patients who were victims of road traffic accidents. The sample was selected through a purposive sampling method, which was represented as follows:

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**Table (01): Distribution of study participants according to gender.**

| Gender | Frequency | Percentage |
|--------|-----------|------------|
| Male   | 37        | 59.68%     |
| Female | 25        | 40.32%     |
| Total  | 62        | 100%       |

**Source:** Prepared by the researchers based on SPSS outputs.

As presented in Table (01), male patients account for 59.68% of patients undergoing reconstructive surgery, whereas females account for 40.32%.

**Table (02): Distribution of Study Participants by Educational Level**

| Educational Level | Frequency | Percentage |
|-------------------|-----------|------------|
| Primary           | 8         | 12.9%      |
| Middle School     | 11        | 17.8%      |
| Secondary         | 19        | 30.6%      |
| University        | 24        | 38.7%      |
| Total             | 62        | 100%       |

**Source:** Prepared by the researchers based on SPSS outputs.

Distribution of respondents according to their educational levels: 38.7% have a university educational level compared to 12.9% who have a primary educational level. Meanwhile, 30.6% have a secondary educational level, and 17.8% have a middle school educational level.

#### **6.4- Data Processing and Statistical Methods Used:**

To attain the objectives of the study and analyse the gathered data, Microsoft Excel was used for coding, checking, and validating the accuracy of the data entered. After that, the data were processed and analysed by applying the following statistical tools:

##### **a) Descriptive Statistics:**

-Frequencies and percentages to describe the study population according to their personal characteristics.

-Arithmetic mean to calculate the average rating given by respondents for each statement, as well as the average for each dimension.

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-Standard deviations to check for the variability of respondents' ratings for each statement of the questionnaire.

-Three-Point Likert Scale, where responses were defined as follows: agree = 3; neutral = 2; disagree = 1. This will be used to check for the degree of agreement among respondents regarding each statement, as well as to check for the strength or weakness of each statement.

### **b) Inferential Statistics:**

By using the following methods:

- Pearson's correlation coefficient: this method is used for checking for a linear relationship between observed data, as well as the strength and direction of the relationship between the variables.
- One-way Analysis of Variance (ANOVA): it is used for checking for differences in mean values between groups and within groups for different study variables.
- Independent samples t-test: it is used for checking for differences in mean values for different study variables.
- Cronbach's Alpha and Spearman formula.
- Interpretation of the respondents' answers was done through the comparison between the weighted mean for each item in the questionnaire and the theoretical mean of the three-point Likert scale in an attempt to identify the attitude tendency of the respondents towards the item. The theoretical mean was set at 2.00, which is the result of the division of the sum of the values for the weight of each response option (1, 2, and 3) by the number of response options.

Hence, when the weighted mean is greater than the theoretical mean (2.00), it implies that there is a high level of agreement of the respondents to the content of the item, while a weighted mean less than 2.00 implies a low level of agreement or disagreement. A weighted mean of 2.00 means a neutral response.

### **C) The criteria of interpretation of the findings used in the current research were the following:**

- Weighted mean < 2.00: Low level of agreement (disagreement).
- Weighted mean = 2.00: Neutral/moderate response.
- Weighted mean > 2.00: High level of agreement (agreement).

The assumptions associated with the use of parametric tests for statistical inference were first considered before the inferential statistical tests were performed.

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**First**, the assumption of independence of the observation was addressed by considering each participant as an independent unit of analysis. Independent observation is achieved if data are collected from individual participants without repeated responses or interaction between participants while collecting the data.

**Second**, the assumption of homogeneity of variance was tested using Levene's test. A p-value above 0.05 means that the variances are homogeneous in the different comparison groups, thus fulfilling this assumption and providing justification for the use of parametric statistics.

**Third**, the normality of total scale scores was tested using the Shapiro-Wilk test. A p-value greater than 0.05 shows that the data is normally distributed, thereby allowing the use of parametric statistical techniques.

The output of the Levene's test was found to be  $F = 0.81$  with  $Sig = 0.372$ . Similarly, the test statistic of the Shapiro-Wilk test was found to be 0.978 with  $Sig = 0.183$ .

In this way, since the values of significance derived from the two tests were more than 0.05, the necessary assumptions for carrying out parametric statistical tests were fulfilled in the current study.

### **6.5- Data Collection Tool:**

A questionnaire method is used as a data collection tool from a sample of patients who are going through reconstructive surgery. It is appropriate for the purpose, methodology, and effectiveness of addressing the research questions.

### **6.6- Questionnaire Development:**

After perusing the relevant literature and previous research, and in consideration of the study's data, research questions, and objectives, the research tool or questionnaire was constructed. It had three parts, as indicated below, and the process followed to ensure the study's validity and reliability:

**-First Part:** this includes a defining introduction, which indicates the study's objectives, the type of data and information needed from the participants, and the confidentiality of the information provided, undertaking to use it only for scientific purposes.

**-Second Part:** it contains the personal characteristics of the participants, which are: (gender, educational level, and place of residence).

**-Third Part:** this consists of 16 statements concerning the axis of social determinants.

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### **6.7-Validity of the Tool:**

For the verification of the validity of the tool, two methods were applied. The first method is face's validity, which entails presenting the tool to a panel of experts in the field. The second method is internal consistency, which is premised on the calculation of the correlation coefficient between each individual item of the tool, and at large. For the verification of the validity of the tool, the following steps were undertaken:

**-Face Validity:** after developing the questionnaire in its primary form, it was sent to a panel of experts in the field with the objective of:

- Ensuring the appropriateness and relevance of the content, as well as appropriateness for measuring the variables of the study.
- Checking for the clarity, logical arrangement, and correct wording of the questions, as well as the absence of redundancy.

After making the necessary corrections according to the feedback of the experts, a final version of the questionnaire was developed, including 16 questions for the social determinants' axis.

**-Internal Consistency:** In the measurement literature, the term reliability is used to refer to the consistency of the measuring instrument in measuring the construct it is designed to measure.

Internal consistency was verified by finding the correlation coefficient between each dimension and the total score of the measuring tool, which is one of the standard ways to verify the internal consistency and reliability of the measuring tool.

**Table (03): Correlation Coefficient of each item with the total Score of the axis to which it belongs (Social Determinants Axis).**

| Statement No. | Statement                                                                                                                   | Correlation Coefficient |
|---------------|-----------------------------------------------------------------------------------------------------------------------------|-------------------------|
| 1             | I am unable to perform activities of daily living (e.g., dressing, eating, transport) in a normal manner                    | 0.504                   |
| 2             | I have confidence that surgery will improve my functional status and quality of life                                        | 0.516                   |
| 3             | My current disability makes surgery the most appropriate option for restoring my ability to work and maintaining employment | 0.567                   |
| 4             | I have been influenced by the opinions of friends who have undergone similar surgical procedures                            | 0.651                   |

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|    |                                                                                                                                                      |       |
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| 5  | I feel that my current condition limits my social participation                                                                                      | 0.532 |
| 6  | I desire to improve my physical appearance or functional ability for social interaction                                                              | 0.551 |
| 7  | Perceiving that society views you negatively due to your injury or deformity                                                                         | 0.557 |
| 8  | Exposure to bullying due to visible deformities (e.g., post-traumatic facial deformities)                                                            | 0.672 |
| 9  | Members of society tend to overemphasize physical perfection, perceiving deformities, particularly visible ones, as defects that should be concealed | 0.643 |
| 10 | I avoid attending social occasions such as celebrations                                                                                              | 0.574 |
| 11 | I avoid social interaction due to perceived lack of acceptance                                                                                       | 0.534 |
| 12 | The body as a medium of social communication and a marker of social status                                                                           | 0.714 |
| 13 | The desire for acceptance and belonging through changing appearance                                                                                  | 0.531 |
| 14 | Family support and encouragement to undergo reconstructive surgery                                                                                   | 0.503 |
| 15 | I get annoyed because of others' remarks about my appearance due to deformities                                                                      | 0.453 |
| 16 | I am willing to undergo reconstructive surgery regardless of cost, provided it conceals deformities or restores normal function                      | 0.57  |

**Source:** Prepared by the researchers based on the output of the SPSS.

**\* Pearson's correlation coefficient, where the values are expected to be positive:** as shown in Table (03), it is clearly evident that all the correlation coefficients, which are the values of the statement-total correlation, are positive and statistically significant at 0.05 level. These values range from 0.453 to 0.714. This implies that all statements are internally consistent and valid in measuring the constructs they are supposed to measure.

#### **-Reliability of the Tool:**

To validate the reliability of the tool, Cronbach's Alpha was employed. The table below shows the reliability coefficients obtained.

**Table (04): Reliability Coefficients of the Study Tool for the Social Determinants Axis**

| Axis                | Number of Statements | Cronbach's Alpha Coefficient* |
|---------------------|----------------------|-------------------------------|
| Social Determinants | 16                   | 0.879                         |
| Overall Instrument  | 16                   | 0.879                         |

**Source:** Prepared by the researchers based on SPSS outputs.

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As shown in Table (04), the values of the Cronbach's Alpha coefficients' reliability are high and above the standard value of 0.70. The values of the coefficients were between 0.765 and 0.812, while the general value of the reliability coefficient of the questionnaire was 0.887. This indicates the appropriateness of the tool, which in turn confirms the credibility of adopting the tool in the present study.

## 7. Results Analysis and Discussion

**Table (05) shows the measurement of the social determinants influencing the turnout for reconstructive surgery among road traffic accident victims**

| No. | Statements                                                                                                                                           | Agree<br>(n, %) |        | Neutral<br>(n, %) |       | Disagree<br>(n, %) |       | Mean | Std.<br>Deviation | Sample's<br>Orientation |
|-----|------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|--------|-------------------|-------|--------------------|-------|------|-------------------|-------------------------|
|     |                                                                                                                                                      | No.             | %      | No.               | %     | No.                | %     |      |                   |                         |
| 1   | I am unable to perform activities of daily living (e.g., dressing, eating, transport) in a normal manner                                             | 44              | 70.97% | 4                 | 6,45  | 14                 | 22,58 | 2.48 | 0.84              | Agree                   |
| 2   | I have confidence that surgery will improve my functional status and quality of life                                                                 | 38              | 61.29% | 8                 | 12,90 | 20                 | 32,26 | 2.43 | 0.94              | Agree                   |
| 3   | My current disability makes surgery the most appropriate option for restoring my ability to work and maintaining employment                          | 28              | 45.16% | 9                 | 14,52 | 25                 | 40,32 | 2.05 | 0.93              | Agree                   |
| 4   | I have been influenced by the opinions of friends who have undergone similar surgical procedures                                                     | 45              | 72.58% | 7                 | 11,29 | 10                 | 16,13 | 2.42 | 1.98              | Agree                   |
| 5   | I feel that my current condition limits my social participation                                                                                      | 49              | 79.03% | 4                 | 6,45  | 9                  | 14,52 | 2.64 | 0.73              |                         |
| 6   | I desire to improve my physical appearance or functional ability for social interaction                                                              | 48              | 77.42% | 3                 | 4,84  | 11                 | 17,74 | 2.60 | 0.78              | Agree                   |
| 7   | Perceiving that society views you negatively due to your injury or deformity                                                                         | 50              | 80.65% | 5                 | 8,06  | 12                 | 19,35 | 2.77 | 0.62              | Agree                   |
| 8   | Exposure to bullying due to visible deformities (e.g., post-traumatic facial deformities)                                                            | 53              | 85.48% | 3                 | 4,48  | 6                  | 9,68  | 2.76 | 0.62              | Agree                   |
| 9   | Members of society tend to overemphasize physical perfection, perceiving deformities, particularly visible ones, as defects that should be concealed | 49              | 79.03% | 6                 | 9,68  | 7                  | 11,29 | 2.68 | 0.67              | Agree                   |
| 10  | I avoid attending social occasions such as celebrations                                                                                              | 47              | 75.81% | 5                 | 8,06  | 10                 | 16,13 | 2.60 | 0.76              | Agree                   |

|                                                                                                                                                                                           |                                                                         |                                                  |                        |
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|                                        |                                                                                                                                     |    |        |   |       |   |       |             |             |              |
|----------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|----|--------|---|-------|---|-------|-------------|-------------|--------------|
| 11                                     | I avoid social interaction due to perceived lack of acceptance                                                                      | 51 | 82.26% | 7 | 11,29 | 4 | 6,45  | 2.76        | 0.56        | Agree        |
| 12                                     | The body as a medium of social communication and a marker of social status.                                                         | 52 | 83.87% | 3 | 4,84  | 7 | 11,29 | 2.73        | 0.66        | Agree        |
| 13                                     | The desire for acceptance and belonging through changing appearance.                                                                | 50 | 80.65% | 4 | 6,45  | 8 | 12,90 | 2.68        | 0.70        | Agree        |
| 14                                     | Family support and encouragement to take-up of reconstructive surgery.                                                              | 49 | 79.03% | 6 | 9,68  | 7 | 11,29 | 2.68        | 0.67        | Agree        |
| 15                                     | I get annoyed because of others' remarks about my appearance due to deformities.                                                    | 52 | 83.87% | 4 | 6,45  | 6 | 9,68  | 2.74        | 0.63        | Agree        |
| 16                                     | I am willing to take-up of reconstructive surgery regardless of cost, provided it conceals deformities or restores normal function. | 50 | 80.65% | 3 | 4,48  | 9 | 14,52 | 2.66        | 0.72        | Agree        |
| <b>Overall Mean Score for the Axis</b> |                                                                                                                                     |    |        |   |       |   |       | <b>2.61</b> | <b>0.80</b> | <b>Agree</b> |

**Source:** Prepared by the researchers based on SPSS outputs.

Based on the data interpretation, it is obvious according the data presented in Table (05) that the mean scores of all the statements were greater than the hypothetical mean of (2), which indicates that the participants' responses were all positive.

- The highest level of agreement among the respondents was observed on Statement (07), which stated: ***“Perceiving that society views you negatively due to your injury or deformity”***, with a mean score of 2.77 and standard deviation of 0.62, indicating a relative importance of 95%. This finding highlights the central role of perceived negative societal attitudes in motivating patients to seek reconstructive surgery, as follows:

-The second level of agreement among the respondents was observed on Statement (08) and (11), which had a mean score of 2.76 and standard deviation of 0.62 and 0.56, respectively, with a relative importance of 95%. These statements stated:

\* Exposure to bullying due to visible deformities (e.g., post-traumatic facial deformities);

\* I avoid social interaction due to perceived lack of acceptance.

|                                                                                                                                                                                           |                                                                         |                                                  |                        |
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- In the third rank, Statement (15): I get annoyed because of others' remarks about my appearance due to deformities – had a mean of 2.74 with a standard deviation of 0.63 and a relative importance of 91%.
- In the fourth rank, Statement (12) – the body as a medium of social communication and a marker of social status – had a mean of 2.73 with a standard deviation of 0.66 and a relative importance of 91%.
- In the fifth rank, Statements (09), (13), and (14) each recorded a mean score of 2.68, with standard deviations of 0.67, 0.70, and 0.67, respectively, and a relative weight of 89%.

\* Statement (09) states: “members of society tend to overemphasize physical perfection, perceiving deformities, particularly visible ones, as defects that should be concealed.”

\* Statement (13) states: “the desire for acceptance and belonging through changing appearance.”

\* Statement (14) states: “family support and encouragement to take-up of reconstructive surgery,” stresses the importance of the immediate social environment.

- In the sixth rank, Statement (16), which states ***“I am willing to take-up of reconstructive surgery regardless of cost, provided it conceals deformities or restores normal function”***, recorded a mean score of 2.66 and a standard deviation of 0.72, with a relative weight of 87%.
- In the seventh rank, Statement (05), ***“I feel that my current condition limits my social participation”***, yielded a mean score of 2.64 and a standard deviation of 0.73.
- In the eighth rank, both Statements (06) and (10) recorded identical mean scores of 2.60, with standard deviations of 0.78 and 0.76, respectively, and a relative weight of 87%. These items pertain to the ***“I desire to improve my physical appearance or functional ability for social interaction”***, and ***“I avoid attending social occasions such as celebrations”***.
- In the ninth rank, Statement (01), ***“I am unable to perform activities of daily living (e.g., dressing, eating, transport) in a normal manner”***, recorded a mean score of 2.48 and a standard deviation of 0.84, with a relative weight of 85%, indicating a moderate yet notable functional limitation.

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- In the tenth rank, Statement (02), ***“I have confidence that surgery will improve my functional status and quality of life”***, achieved a mean score of 2.43 and a standard deviation of 0.94, with a relative weight of 84%.
- In the eleventh rank, Statement (04), ***“I have been influenced by the opinions of friends who have undergone similar surgical procedures”***, recorded a mean score of 2.42 and a notably higher standard deviation of 1.98, with a relative weight of 83%.
- Finally, in the twelfth rank, Statement (03), ***“My current disability makes surgery the most appropriate option for restoring my ability to work and maintaining employment”***, recorded the lowest mean score of 2.05 and a standard deviation of 0.93, with a relative importance of 80%.

On the other hand, the overall mean score for the axis was found to be 2.61. The standard deviation was 0.80, and the relative importance was 86.69%. This is because the overall mean score falls within the third category of the Likert scale, which ranges from 2.35 to 3.00. This range corresponds to the response category labelled “Agree”. This implies that there is an agreement of 86.69% among the sample members regarding the fact that the main motivation for the turnout for reconstructive surgery is the social motivation.

This is supported by the views of Edward Suchman, who believes that social networks to which the patient belongs have an impact on the health-seeking behaviour. In other words, the patient perceives his/her health through the opinions of the people. In the context of deformity caused by road accidents, negative remarks and bullying lead to the reproduction of bodily stigma in the daily interactions, which is reflected in self-image and self-esteem.

**“Erving Goffman”** also points out that stigmatized individuals with physical stigma develop impression management techniques to reduce the effects of stigma and gain social acceptability (Goffman, Erving (1963), p. 50). Thus, the turnout for reconstructive surgery may be viewed as a way to remove physical stigma and reconstruct social identity.

Moreover, Anthony Giddens states that ***“the body is not merely something that we possess; nor is it a merely tangible stuff, existing ‘beyond’ society. Rather, our bodies are significantly influenced by our social experience, and by the values and standards of the social groups to which we belong”***. From this, we can deduce the following:

- Social determinants are regarded as a major motivation for reconstructive surgery

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among individuals with deformities caused by road traffic accidents.

However, the following question arises: **Does this utilization differ according to personal characteristics such as gender and educational level?**

### **7.1- Differences by Gender:**

The measurement process indicated that the calculated value of  $t$  (-7.067) was greater than the tabulated value of  $t$  (1.671) at a degree of freedom of 60 and a significance level of 0.05. This shows the presence of statistically significant differences between males and females regarding the turnout for reconstructive surgery in relation to social determinants. Moreover, during the calculation of Cohen's effect size, it was evident that the value of Cohen's effect size was 1.830, showing the presence of a large effect size regarding the social determinants based on gender, specifically females regarding the turnout for reconstructive surgery.

Thus, it could be mentioned here that social determinants regarding the turnout for reconstructive surgery are different based on the gender of the patient. This can be understood through cultural constructs in which femininity and beauty are related to physical appearance, making women more sensitive to deformity and physical damage. Therefore, it is not only a medical necessity but also a social necessity, as the female body is an integral part of one's identity and acceptance in society. Contrary to the female body, the perception of the male body is more related to functionality than aesthetic qualities. This is also evident in the study of Erving Goffman, which stated that society perceives scars and deformities as markers that create a spoiled identity. Furthermore, women are more exposed to societal scrutiny, which leads to an increase in stigmatization because of the centrality of physical appearance in the construction of femininity (Goffman, 1963, p. 437).

Additionally, there are the roles that place pressure on females to ensure that they have a socially acceptable image that represents care and attention to physical appearance. On the other hand, there is more leeway for men to have minor physical defects or deformities, provided they do not affect the performance of functions, as argued by (Parsons, Talcoltt (1951), p. 437).

It is therefore safe to conclude that females will have a greater propensity to seek reconstructive surgery, which is therapeutic and preventive in nature, owing to the influence of the social determinants.

### **7.2. Differences by Educational Level**

Based on the results of the measurement, the calculated F-value (12.879) concerning the social determinants axis with the variable of educational level is greater than the tabulated F-value (2.764) with degrees of freedom (3, 58) and a significance level of 0.05. This confirms the existence of a statistically significant

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relationship between social determinants and the turnout for reconstructive surgery. In other words, the turnout for reconstructive surgery varies depending on the educational level of individuals with deformities resulting from road traffic accidents.

To determine the differences between the patients with regards to the educational level variable through the social determinants' axis, the Scheffé post hoc test was applied to compare the different categories.

**Table (08): Results of the Scheffé Test**

|                               |               |
|-------------------------------|---------------|
| <b>Groups (1, 2)</b>          | <b>1.820</b>  |
| <b>Groups (1, 3)</b>          | <b>15.391</b> |
| <b>Groups (1, 4)</b>          | <b>29.117</b> |
| <b>Groups (2, 3)</b>          | <b>7.341</b>  |
| <b>Groups (2, 4)</b>          | <b>18.735</b> |
| <b>Groups (3, 4)</b>          | <b>3.202</b>  |
| <b>Scheffé Critical Value</b> | <b>8.291</b>  |

**Source:** Prepared by the researchers based on SPSS outputs.

The results shown in Table (08) revealed that there were statistically significant differences between Groups (1) and (3), Groups (1) and (4), and Groups (2) and (4). This reflects differences between patients with primary education and those with secondary education in favour of the latter group; between patients with primary education and those with university education in favour of the university group; and between patients with intermediate education and those with university education in favour of the latter. The calculated Scheffé values for these group comparisons were 15.391, 29.117, and 18.735, respectively, all of which are greater than the tabulated Scheffé critical value of 8.291. However, no statistically significant differences were found between Groups (1) and (2), Groups (2) and (3), and Groups (3) and (4), as the calculated Scheffé values for these comparisons were 1.820, 7.341, and 3.202, respectively, all of which are less than the critical value of 8.291 at a significance level of 0.05.

These findings clearly demonstrate that patients with higher levels of education have a higher tendency to take-up of reconstructive surgery within the framework of social determinants. This may be explained by the fact that, for patients with higher levels of education, the personal choice to take-up of

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reconstructive surgery is based on personal empowerment, rational choice, and health awareness. This group has the ability to better grasp the medical and social aspects of reconstructive surgery, and they have a higher tendency to be receptive to modern medical advancements. On the contrary, patients with lower levels of education have their personal choices based on economic, social, and traditional factors.

From the perspective of Bourdieu, it could be argued that education forms one of the important types of cultural capital, helping individuals develop a better understanding of the various options in modern medicine, as well as assessing the associated risks and benefits of these options. Additionally, in modern society, it is feasible to consider the body as one of the types of physical capital, helping individuals develop improvements in social status as well as symbolic status. This perspective would explain why better-educated people tend to be more inclined to invest in their bodies by seeking healthcare services, and reconstructive surgical interventions in particular (Bourdieu, Pierre (1984), p. 57).

Therefore, it is possible to consider the relationship between educational level and the turnout for reconstructive surgery as a direct one: the higher the educational level, the greater the awareness of the importance of these procedures in order to enhance not just the functioning of the body but the quality of life as well.

### **-Conclusion:**

In this study, the social determinants that affect the adoption of reconstructive surgery have been examined together with the relation between the social and demographic factors of individuals, their level of awareness, and attitudes towards reconstructive surgeries. It was found out that the process of undergoing reconstructive surgeries cannot be solely explained from the standpoint of medical necessity and aesthetic value. Instead, there are various social, cultural, economic, and educational determinants that contribute to individuals' attitudes and willingness to undertake reconstructive surgeries to different extents.

Consequently, it was shown that there is a positive correlation between the level of education and the desire to undergo reconstructive surgery among the participants of the study. Those participants who had higher levels of education were more cognizant of the significance of reconstructive surgery and its role in restoring bodily functions and improving overall quality of life.

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The scientific contribution of the current study is the enrichment of the Arab literature on reconstructive surgery from the sociological point of view. This field still lacks several studies despite the abundant research works on the medical and surgical aspects of reconstructive surgery. Moreover, the study stresses the significance of employing a multi-disciplinary approach combining the health sciences and the social sciences to gain a complete understanding about the determinants of health behaviours and health treatments choices.

Based on the results of the research from a practical standpoint, it becomes necessary to reinforce measures that relate to increasing the awareness of patients about their conditions through health and social means, improve the quality of the information delivered to them, and consider the psychological and social aspects of reconstructive surgeries while dealing with patients. These steps would make possible well-informed treatment choices, taking into account realistic evaluation of the possible advantages and disadvantages of the surgeries in question.

### **- Practical Ssuggestions:**

**In light of the current findings, we would like to put forward the following practical suggestions:**

- 1) Adopting wide-ranging multimedia-based awareness programs on reconstructive surgery among various social groups.
- 2) Including psychological and social assessments in the pre-operative evaluation process of the patients receiving reconstructive surgical procedures.
- 3) Improving communication between physicians and patients by providing accurate and reliable information regarding the indications and complications of reconstructive surgeries.
- 4) Promoting patient-centred care among healthcare institutions in that takes into account the social and cultural privacy of the patients.
- 5) Concerning future research prospects, it is imperative that more extensive research be conducted using larger samples of participants to improve the external validity and generalizability of the results.

Moreover, future research will benefit significantly from longitudinal research designs, which will enable researchers to track changes in patients' attitudes, perceptions, and decision-making before and after reconstructive surgery. In addition, future research will have to broaden its scope by investigating the impact

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of other psychosocial factors such as the impact of social media exposure and family support, as well as conducting cross-cultural comparisons to explore the impact of social and cultural differences on people's decision to have reconstructive surgery.

Despite the importance of the present findings, it is essential to take into account certain limitations associated with the methodology of this research when interpreting them. In particular, these findings are limited by the nature of the sample used and by the nature of the research design itself.

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