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The Globalization of Cosmetic Surgery: Examining BRIC and Beyond

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Abstract:

What is driving the globalization of cosmetic surgery? Using BRIC (Brazil, Russia, India, China) countries as a model, this master's thesis systematically identifies and analyzes (1) the origins of cosmetic surgery in historical, regional, and country-specific terms, and (2) examples of how cosmetic surgery has become normalized. As a result, clear patterns emerge in regards to: embedded power structures related to racism and war; the results of Western interests rapidly opening countries' markets to high media and corporate influence—especially in the wake of political oppression and austerity; the exacerbation of pre-existing class, color, race, and gender prejudice by hyper-consumerism; the perception of the beauty industry and global beauty pageants as a gateway to the "modern" world's stage; and the practice of "Westernized" cosmetic surgery becoming synonymous with concepts of status, upward mobility, and a social transition to global citizenship. These overall patterns allowed for the subsequent analysis of a third key question: (3) Who ultimately benefits from mass-consumer cosmetic surgery? Following a comprehensive comparative analysis and a sustained theoretical framework concluding with a Foucauldian explanation of relationships of force, I argue that the globalization of cosmetic surgery is driven by pre-existing sociohistorical power structures that serve the status quo—benefitting exclusionary cultural, cosmetic, and corporate systems from the West (and those who run them), and thereby precluding authentic opportunities for individual enfranchisement via cosmetic surgery on a macro level. Furthermore, I argue that by constructing and labeling "modernity" in terms that benefit the status quo and reflect historical relationships of force, developed nations maintain hegemonic control in their own image; meaning that fast-developing countries must follow existing neoliberal consumer models if they want to enter the global stage—and look the part. Accordingly, the racist and bellicose discursive origins of cosmetic surgery are an inconvenient truth that "modern" cosmetic surgery culture seeks to ignore in order to self-perpetuate and evolve with the demands of capitalism. Recommendations for future study in this field include the industries of medical tourism, skin lightening products, and tissue harvesting, as well as an expanding market of cosmetic surgery for teens and children.

Key words:

Cosmetic surgery, the body, BRIC, plastic surgery, globalization, critical race studies

Table of Contents

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COSMETIC SURGERY AS A TOPIC OF STUDY

Although alterations of hair, skin color, diet, dress, and body accessories have always existed in order to reach the beauty ideals popularized by dominant groups, the increased precision, "invisibility," and permanence of cosmetic surgery has changed the nature, pressures, and results of physical transformation like never before in human history as the practice rapidly spreads across the globe. This paper specifically asks: What is driving the globalization of cosmetic surgery? In order to answer this research question, I must also address three auxiliary questions within the scope of this paper: (1) What are the *origins* of cosmetic surgery? (2) How does it become *normalized*? and (3) Who does it *benefit*? The early origins of this project are based primarily on a decade's worth of personal interest in the rise of consumer cosmetic surgeries, as well as my own informal theories and critical arguments derived mainly from the analysis of mainstream sources. However, the actual construction of this thesis topic relied on countless hours of academic research under the wise guidance of the University of San Francisco's global awareness-expanding, Master of Arts in International Studies (MAIS) program. Newly equipped with a deeper multidisciplinary understanding of globalization from the lens of my MAIS coursework but having no prior specific undergraduate or graduate experience in gender studies, I was pleasantly surprised to find at the onset of my research what I had hitherto not known existed: a rich selection of academic studies on cosmetic surgery examining the "tremendously complex and significant social trends concerning the body, gender, psyche, medical practice and ethics, globalization, aesthetic ideologies, and both communication and medical technologies" (Heyes and Jones 2009:2). Moreover, the subject appeared in media studies, race and ethnicity studies, psychological studies and carefully researched histories. At last, on these pages, I found gratifyingly similar arguments to my previously held views on the

growing phenomenon of "the culture of cosmetic surgery" and its broad effects (Blum 2003:49). Much of this research reaffirmed and deepened core concepts I had thought about in isolation, helping me to situate them in the field of existing academia and historical record for the purposes of this paper. What's more, I found that my specific topic regarding the rapid, globalized spread of cosmetic surgery in fast-developing countries had been oft alluded to but not yet systematically examined. Most importantly, my intention to approach the issue of globalized cosmetic surgery practices in individual countries through the lens of macro sociohistorical and economic power structures helped me to identify some of my own Western biases, as well as the associated limitations of some of the existing cosmetic surgery literature that lacked a broader, multidisciplinary scope.

For example, no study or discussion of cosmetic surgery practices would be complete without a thorough overview and analytical approach drawing from existing feminist literature. However, due to the international scope of this project, it was important to also question Western-originated discourse and theoretical frameworks as a potential extension of Western hegemony. For the same reasons, class and race/ethnicity analysis necessitated a critical eye and multiple voices in order to avoid the cycle of reifying generalized assumptions into bias-tinged and reductive "facts." Finally, I found it increasingly obvious that excluding, stereotyping, or automatically assigning a value to men's roles in cosmetic surgery culture was counterproductive to my goal of examining the globalization of cosmetic surgery in holistic, humanistic terms. Therefore, although there is a paucity of research specifically addressing average men's views and participation in cosmetic surgery, I do my best to approach growing global trends with the increasingly accepted view that a deeper understanding of cosmetic surgery culture is equally important for the collective futures of women, men, and children. This is, of course, also true for

transgendered individuals, who are somewhat outside the scope of this paper and require additional study as well.

Specifically, this paper will focus on the countries representing the highest total numbers of surgical and non-surgical cosmetic procedures after the top-ranked country, the United States (which, not coincidentally, has been the top producer and exporter of cosmetic surgeries and modern cosmetic surgery technology since World War I). According to the International Society of Aesthetic Plastic Surgery (ISAPS 2009, 2010)—known to offer the only available global empirical data—these countries are Brazil, China, and India (with Japan in a dead heat with India, sometimes surpassing its numbers of reported non-surgical procedures). Of course these happen to be countries with large populations, but they share other important similarities. They constitute nearly all of the so-called BRIC countries, which are in a stage of extremely rapid capitalist development and which Goldman Sachs has predicted will have combined economies that surpass the G6 (Germany, France, the UK, Italy, Spain, and Poland) by 2050 in terms of U.S. dollars (*Global Paper No. 99* 2003). Russia, the remaining member of the BRIC moniker, is traditionally among ISAPS' top 10 in terms of cosmetic procedures but was reported by Russian media in 2010 to be fifth among countries with the highest numbers of cosmetic surgeries (Firth 2010:n.p.). Therefore, Russia will be included in the analysis (and by extension, salient aspects of Central and Eastern European history), while key neighboring countries in East Asia, South America, and the Middle East will also be briefly examined in connection to cosmetic surgery. Finally, this paper would be remiss not to conclude by calling attention to several areas of the cosmetic surgery industry which warrant the kind of global-scale scrutiny that only a longer thesis or dissertation could provide. These areas include the industries of medical tourism, skin

lightening products, and tissue harvesting, as well as an expanding market of cosmetic surgery for teens and children.

This thesis presents a compilation, interpretation, and analysis of a variety of existing research within an overarching theoretical framework, the purpose of which is to provide a more systematic understanding of cosmetic surgery and its global expansion. As stated above, in order to explore what drives the globalization of cosmetic surgery, I address three key sub-questions regarding the origins, normalization, and perceived benefits of the practice in BRIC countries. For purposes of navigating the text, listed below are key causal factors and common patterns that will be discussed at length in relation to the first two questions:

(1) What are the origins of modern cosmetic surgery?	(2) How does cosmetic surgery become normalized in BRIC countries?
• Disease • Difference • War wounds • War economies • Relationships of force • Racist discourse • Eugenic movements • Cultural assimilation • Popularity of psychoanalysis • Commercialized medicine	• Embedded power structures related to racism and war • Western interests open countries' markets leading to high Western media/corporate influence • Transition from political oppression and austerity to booming capitalist economy • Pre-existing class/color/race/gender prejudice exacerbated by new hyper-consumerism • Lucrative beauty industry and pageants popularized, seen as gateways to "modern" world's stage • Narratives of "modern" female body/body practices as status symbol for the nation • Body modification as synonymous with upward mobility and social transition • Youth culture dominant and dominated by new goals to achieve modernity and opportunity via cosmetic surgery

Table 1.

The third question—who does cosmetic surgery benefit?—will be analyzed in terms of a theoretical argument developed during the course of the paper. By tracing the above patterns

throughout history and among contemporary populations of BRIC nations, a clearer picture of the driving global forces behind cosmetic surgery emerges. As will become apparent, the collective mass of individuals' personal body modification choices comes to affect all aspects of aesthetic plastic surgery culture. Race, gender, ethnicity, social status, and even the choice to remain non-surgical forge complicated and inextricable ties to both new and familiar spheres of identity politics and power structures.

THEORETICAL FRAMEWORK

The interdisciplinary nature of the study of cosmetic surgery allows for a multitude of theoretical directions, which appear in myriad publications examined over the course of this project. However, in order to make sense of these fragmented pieces of the puzzle, I have applied four key areas of theory to facilitate an understanding of the macro globalization of cosmetic surgery: (1) questions of ethnicity and whiteness as addressed by critical race theory; (2) concepts of gender as investigated by feminist and other criticisms; (3) theories addressing agency and "choice"; and (4) postmodern and Foucauldian analyses of power structures. These areas will be addressed first in order to provide a richer understanding of cosmetic surgery itself before proceeding to the main analysis of its macro globalization. Elements of all of these theoretical fields will reappear contextually during later examinations of BRIC countries and other important regional players. Furthermore, these theories summarize what is already known about cosmetic surgery as a social issue from empirical and critical studies.

What is "Ethnic" Plastic Surgery?

A plethora of theoretical issues surround the common use of the term "ethnic cosmetic [or plastic] surgery" by news and popular media to refer specifically to cosmetic surgery that

aims to “enhance someone's look without erasing ethnic identity” (Krall 2003:D1; Heyes 2009, appearing in Heyes and Jones 2009). In the United States, the term has generally received more media attention in relation to cosmetic surgery choices and rising trends for individuals of African, Asian, and Latino descent. In the field of academia, Kaw (1993) is known for having been one of the first to publish a prize-winning and widely referenced essay that ethnographically analyzed the motivations of 11 Bay Area Asian American women informants who had chosen to undergo either *blepharoplasty* (eyelid surgery) to create a double eyelid or *rhinoplasty* (nose surgery). Despite her informants’ statements that they were proud to be Asian American and “do not want to look white,” Kaw ultimately concluded that their decision to undergo cosmetic surgery rested on “an attempt to escape persisting racial prejudice that correlates their stereotyped genetic features…with negative behavioral characteristics” (i.e. appearing “sleepy” or “dull”) (1993:75):

> Through subtle and often unconscious manipulation of racial and gender ideologies, medicine, as a producer of norms, and the larger consumer society of which it is a part encourage Asian American women to mutilate their bodies to conform to an ethnocentric norm. (Kaw 1993:75)

Over 15 years later, Heyes (2009) notes the problems with this statement, which she argues continues to create a "double standard" that has been readily accepted into some Western feminists' readings of cosmetic surgery practices among minorities, referring to the statement by Davis (2003) that women of color are usually allowed less discursive space than white women to justify their cosmetic surgeries (appearing in Heyes and Jones 2009:192). Heyes challenges this characterization of women of color who seek cosmetic surgery to be "dupes of internalized racism" and critiques ethnographers' "countermanding of the self-interpretations" of minority women by asserting that feminist readings of cosmetic surgery should consider "a critical approach that reads all bodies as ethnically marked," understanding that white, Western people

are "also engaged in racial and ethnic projects of bodily conformity or appropriation" (*Ibid.* p. 193; also see Holliday and Elfving-Hwang 2012).

Heyes recognizes the history of ethnocentrism and assimilation that creates a backdrop for cosmetic surgery choices and mentions Zane's (1998) more culturally nuanced reading of Asian blepharoplasty, which also locates ethnocentrism as a significant force in its past and present practice. Significantly, though, in support of her argument (and article title) that "All Cosmetic Surgery is 'Ethnic'," Heyes emphasizes that many body parts outside of the face have historically been "racially indexed," including the breasts, buttocks, and a general fleshiness that is often surgically "corrected" on white bodies (Heyes and Jones 2009:201; also see Gilman 1999). Furthermore, Heyes (2009) notes that Northern Europeans' arguably "ethnic" penchant to seek anti-aging surgeries due to their thinner facial skin and higher susceptibility to sun damage "goes unremarked and untheorized," including the fact that other kinds of blepharoplasty are fairly common among older white women and men as a rejuvenation surgery (2009:201-202).

Heyes also channels Haiken (1997) in calling for investigations of "how cosmetic surgery enables white women to appropriate pieces of 'ethnic' physicality for their exoticism and eroticism [i.e. buttocks and lip augmentation], without risking the oppression that more marked bodies are vulnerable to" (Heyes and Jones 2009:203). For Heyes and a growing number of critics, cosmetic surgeries, especially rhinoplasty, often "aim to make already white people whiter" (especially in the case of Mediterranean and Middle Eastern noses) and try to match "norms that almost no white, Western people can actually live up to," which underscores the misguided nature of "project[ing] moral culpability for cosmetic surgery unequally onto people of color" (*Ibid.* pp. 203-204). Heyes concludes that "feminist analysis of ethnic cosmetic surgery

badly needs to learn the lessons of critical whiteness studies" because the social responsibility for cosmetic surgery is widely shared (as this paper will further examine) (*Ibid.* p. 203).

In reference to this discussion on a global scale and the question of whether "whiteness" effects international patterns and hubs of cosmetic surgery, Holliday and Elfving-Hwang (2012) argue that "two sets of studies emerge focused on differently gendered populations, with 'ethnic' cosmetic surgery studies including men (but not a gendered analysis) and 'feminist' cosmetic surgery studies excluding men (and a 'raced' analysis)" as each approach draws on particular surgeries while ignoring others (p. 65). Furthermore, Holliday and Elfving-Hwang (2012) warn against the tendency for "ethnic" cosmetic surgery analyses to "present minority ethnic populations as static, existing only in relation to a 'host' culture," while ignoring distinct national and regional cross-national contexts of cosmetic surgery culture—including expatriate community relationships (p. 65).

Without specifically referencing cosmetic surgery, Shome (2000) offers an overview of whiteness studies that relate to the above arguments, describing whiteness studies as situated in the recognition that "race scholarship usually tends to study the 'other' (the nonwhites) and in so doing leaves the 'norm' (whiteness) intact and free of any critical scrutiny" (p. 366). Thus, as Shome argues, the institutionalized and systemic nature of whiteness "is maintained and produced not by overt rhetorics of whiteness, but rather by its 'everydayness'"—an unquestioned normativity that makes "invisible the ways in which whites participate in, and derive protection from, a system whose rules and organizational relations work to their advantage" (2000:366). By asking questions about how whiteness functions as an organizing social principle in society and how it secures hegemonic normativity "disguised under facile values of individualism and meritocracy," critical race scholars in this field seek, ultimately, to challenge and make visible to

whites (and non-whites) the problematic nature of the accepted status quo (Shome 2000:367). According to Shome:

> These questions should make clear that whiteness is understood as a *process* constituted by an ensemble of social and material practices in which whites (and often non-whites for survival) are invested, by which they are socialized, and through which they are produced. Further, some of the recent strands in this literature also recognize that whiteness is contextual, and its complexities are best understood through an attention to its various geopolitical locations and their intersections with the interlocking axes of gender, class, sexuality, nation/ality, colonialism, and, today, the politics of transnationalism...Whiteness, then, is not a monolithic formation—it is constantly made and remade through its participation in other unequal social relations; it is a nuanced formation that secures its power in different ways through different sites—all of which nonetheless, secures its hegemony in a highly racialized global system. (2000:368)

In terms of the globalization of cosmetic surgery culture, this protean interpretation of whiteness as a subject of study becomes central to understanding why both white communities and people of color may not associate surgical enhancement practices with the process of "whiteness"; and, furthermore, why cosmetic surgery participants cannot neatly be dichotomized into oppressive or subjugated roles. Despite any possible gains made in awareness and pluralism since Shome's writing, according to this theoretical model (and even slightly at odds with some of the other authors' arguments above), millions of individuals around the world may be participating in bodily practices that are inextricably linked to the making and re-making of the "everydayness" of white norms—either in an active bid for "survival" or largely in step with the "invisible" reaches of hegemony. As both Davis and Bordo note in their chapters in Heyes and Jones' (2009) compilation, relativist positions must be careful not to decontextualize and depoliticize cosmetic surgery by presenting all changes in appearance as having the same cultural meaning or normative valence—and thus "*no* cultural meaning and *no* political valence" (Davis: p. 45). They assert that society has more often than not made clear that "not every body will do," and that "eyes are rarely made more 'oriental'-looking, any more than noses are made

to look more 'Jewish'" (or 'African', for that matter) (Bordo 1990:660, [1993] [2003] 2009:22; Davis 2009:45).

Cosmetic Surgery and Gender

Due to the fact that late twentieth and early twenty-first century cosmetic surgery patients have traditionally been overwhelmingly female, feminist scholars were among the first to discuss modern mainstream cosmetic surgery practices in academic literature. Their work to create an initial frame of analysis of (largely Western) cosmetic surgery practices has subsequently been characterized by differences of opinions among scholars in regards to concepts of women's agency, patriarchal gender relations, and "post-feminist" acceptance of the practice (Morgan 1991; Bordo [1993] 2003; Davis 2003; Holliday and Sanchez Taylor 2006:189). Both Sullivan (2001) and Woodstock (2001) write separately on the range of feminist response to cosmetic surgery: from those who characterize cosmetic surgery as a form of Foucauldian discipline and brutal manipulation of the female body for purposes of control (Chapkis 1986; Morgan 1991; Balsamo 1996; Bordo [1993] 2003), to those who recognize the patient-stated positive results in self-esteem as exercised through individual control of one's body (Davis 1995; Gillespie 1996). Morgan (1991) went so far as to propose strategic action to destabilize homogenized concepts of beauty by assigning new values to the "ugly" through the reappropriation of cosmetic surgery technology—purposefully reclaiming body forms considered deviant or undesired.

Blum (2003) writes that the bodies of women in postsurgical culture are all compromised regardless of whether they choose or refuse surgical interventions. Linking cosmetic surgery to identity and consumption, Blum sees beauty culture as concomitantly coercive and liberating for the individual. She emphasizes that the ongoing trend of concealing (or not commenting on) cosmetic surgery is paramount in constructing cultural trends, especially in regards to emulating

"celebrity culture" (2003:53). In contrast, Davis (1995, 2003) states that cosmetic surgery is increasingly presented as a neutral technology suited to altering personal preference, thus promoting an "equality" discourse (while minimizing the risks involved) and allowing patients to achieve their stated desire to be normal/ordinary. However, Blum (2003) joins Bordo ([1998] 2009) in situating cosmetic surgery as a quest for superlative appearance, where 'beauty' or 'perfection' is now 'ordinary,' and 'ordinary' has become 'ugly.' (Prominent feminist viewpoints on the associated issue of agency will be discussed in the following section.)

Critical analysis of cosmetic surgery also exists outside of feminist literature. For example, although Heyes believes that cultural historian Sander Gilman's analysis of gender structures lacks attention to available feminist literature, she credits him with leading "the view that the modern history of cosmetic surgery needs to be understood primarily as an intervention into racial psychology and ethnic belonging, rather than only as a form of gender normalization or beautification" (appearing in Heyes and Jones 2009:192). Gilman, who is cited widely in this paper, focuses on the early history of reconstructive and cosmetic surgery when most cosmetic surgery recipients were men. In Gilman's (1999) view, studies that stress "the invidious effect of the patriarchal institutions of medicine on women who have been made insecure about their bodies and who seek to 'cure' their 'unhappiness' through surgery" are much too reductive to explain the full origins of cosmetic surgery (p. 31). He writes further:

> Such a simple victim/perpetrator model does not come close to the complexity reflected in the history of aesthetic surgery in regard to gender. From its earliest moments, the claim of aesthetic surgery to creating mental "happiness" does not privilege any specific category, including gender. As many contemporary theorists following Judith Butler have been at pains to point out, gender is a socially constructed set of categories that are as much determined by as determinant of other social classifications. A history of aesthetic surgery solely from the perspective of gender would distort the role and definition of the patient as well as of the surgeon…In the final stage of this study "gender" plays an overt role, and yet, as we shall see, it is a concept of gender highly modified by the importance

> of racial science. Gender is a consistent presence in the history of aesthetic surgery, yet with constant shifts of meaning and nuances. (Gilman 1999:31)

Accordingly, recent studies have brought attention to the dearth of cosmetic surgery literature either inclusive of or focused on men, boys, and masculinity (with the exception of some feminist scholars such as Bordo (1993, 1999) who has written on representations of the male body and masculinity in the public and private spheres). For example, in his study of a population of Canadian men, Atkinson (2008) found that "men's preferences for and sensibilities about cosmetic surgery are contextualized within a perceived crisis of masculinity in Canada," and their understandings of acceptable body performance were impacted by "shifts in post-industrial work patterns, power relations between the genders, and ideologies of technological-scientific consumption" (p. 67).

Holliday and Elfving-Hwang (2012) challenge aspects of feminist literature, which they argue tends to place aesthetic surgery as primarily an entity of a misogynistic (beauty) culture affecting women and only an "exceptionally…small proportion of deviant (feminized) men" (p. 63). Noting that official statistics are almost impossible to produce due to the private and unregulated nature of elective aesthetic surgery markets (although ISAPS does estimate that over 20,000 risky penis enlargement surgeries were carried out world-wide by board-certified plastic surgeons in 2010 alone), Holliday and Elfving-Hwang (2012) argue that statistics on male clients and discussions of their motivations are often omitted or re-framed in various academic works:

> Men's procedures are still rarely mentioned in the cosmetic surgery literature, perhaps because 'official' statistics in the UK and US continue to hide men's treatments by excluding cosmetic dentistry and hair transplants. Figures on breast reductions – the second most popular surgery in the UK and US – are frequently assumed to apply only to women, despite Miller's (2005) claim that over 80 percent of these surgeries are actually performed on men. The few articles specifically on men's cosmetic surgeries position them as either part of the 'crisis of masculinity' (Atkinson, 2008) or the 'meterosexual' consumer-subject (Miller, 2005). Holliday and Cairnie (2007) have argued that while there is little evidence that masculinity precludes men from engaging in cosmetic surgery

> – since surgeries can provide significant body capital for men in the areas of both employment and relationships – some do offer more instrumental explanations than women; looking younger at work to remain competitive, for instance. (2012:64)

In their specific discussion of cosmetic surgery in South Korea, Holliday and Elfving-Hwang (2012) argue that Korean academics often use feminist and postcolonial approaches that have originated in the West to discuss cosmetic surgery practices in isolation from key national and local discourses, thus "demonstrat[ing] feminism's hegemony in accounts of aesthetic surgery and popular discourses which situate it as a 'woman's issue'" while also neglecting large numbers of South Korean men already engaging in the practice (p. 72). The authors argue that cosmetic surgery is a growing representation of how "consumer capitalism addresses [both] women and men as subjects, albeit subjects of consumerism" (p. 76). Additionally, Holliday and Cairnie (2007) write that a "central problem with feminist work has been the reluctance to acknowledge positive outcomes of surgery for the individual" (p. 75). As a result of Holliday and Cairnie's qualitative interviews drawn from a small pilot study of post-operative white men in the UK (aged 22 to 58 and varying in employment status, sexuality, and class background), the authors argued that existing feminist explanations linking aesthetic surgery to beauty, normalization, or pain were not indicative of the multiple factors they found at work in informants' decisions to consume aesthetic surgery, such as identity, work, relationships, and life events (2007:57). The British male participants most often linked their aesthetic (albeit sometimes borderline reconstructive) elective surgeries to "a logic of 'investment'"—which, as this paper will show, also becomes an important self-identifying theme in the narrative of cosmetic surgery patients in developing countries (p. 62):

> Even where respondents deployed the 'feminine' surgical narrative of psychic pain as [an] effect of flawed embodiment, tangible future benefits in terms of enhanced positions within specific fields were the acknowledged result. In some cases, this relation was *narrated* in highly strategic terms – surgery produces promotion at work, for instance. In

> others, the result was less tangible...improving relationships, for example. In fact, a multiplicity of reasons were given…since surgery is not an end in itself, but rather a technology that adds capital in a range of different fields such as careers, relationships or sexuality….The investments they make may be normative, but outcomes enable them to gain distinction [and] to distinguish themselves [from others]. (P.74)

Holliday and Cairnie also noted that "[i]dealized constructions of 'hegemonic masculinity' (Connell, 1995) and 'compulsory heterosexuality' (Rich, 1981) are embedded in the responses of the interviewees and deeply influenced their attitudes to appearance," while one informant indicated that he delayed his decision to undergo scar-revision surgery due to aesthetic surgery's reputation as a feminized practice that connotes homosexuality for male clients (2007:67). Arguing the evidence that men "also experience discipline, normalization and regulation of their bodies (Grogan, 1999; Kimmel, 1994) enforced through medical check-ups, exercise, grooming, dieting and so on (Featherstone, 1983; Turner, 1996)," Holliday and Cairnie noted that their male participants specifically associated aesthetic surgery with shifts in identity (2007:72); for example: feeling like a "new man" at the onset of a relationship with a younger partner, desiring to combat insecurities in order to have an increased rapport with women, or erasing/enhancing visual signs that the participant associated with his sexual self-identity (Holliday and Cairnie 2007:72).

Over the course of this paper, when a growing male population of cosmetic surgery participants is referenced, Holliday and Cairnie's pilot work with men in the UK serves as an important reminder that *both* genders suggest "multiple factors, including social mobility, access to and knowledge about available technologies, social class position, self-image, life events and economic capital, all play a role" in their quest for bodily modification (2007:71). In fact, academics from all (including dueling) disciplines have begun to comment on the sense that cosmetic surgery's current gender gap seems to be closing amidst growing ideas about the global

potential for individual transformation in the twenty-first century (Gilman 1999; Bordo [1998] 2009; Heyes and Jones 2009). Referencing a not-too-distant past where male cosmetic surgery patients were more highly pathologized in psychiatric circles than their female counterparts, Gilman concludes, "Men everywhere are no longer seen as psychopathic when they desire aesthetic surgery…[which] seems to be approaching a time when it is not gendered at all. The stigmatizing quality of the procedures seems to be diminishing" (1999:33).

Cosmetic Surgery and Agency: How is "Choice" Framed?

Kathy Davis's work examining women's motivations for cosmetic surgery has garnered much attention in feminist circles for some of her discussion of women's "agency" in the quest to achieve "normal" bodies, as well as her call for fellow feminist critics "to embrace our uneasiness" about cosmetic surgery in order to open up and explore what makes it both popular and problematic (Davis [2003], from Heyes and Jones 2009, ch.3:pp.35-37). Davis writes that her eschewal of early feminist themes to "just say no" underscores her resistance to paint women cosmetic surgery patients as "'cultural dope(s)'" whose decisions to undergo aesthetic procedures are "frivolous, mistaken, or manipulated" (*Ibid.* pp. 36, 42). Davis' focus on individual women's personal cosmetic surgery narratives, as well as the fact that her research was based primarily in the public healthcare system rather than among private consumers (some Western countries allow limited access to free cosmetic surgery procedures due to psychological pain or other indications), has been criticized by some academics as ignoring macro analyses of cosmetic surgery—and by others as helping to re-cast cosmetic surgery in a narrative of personal empowerment that effaces critical social causes and effects (Bordo [1997] [1998] 2009; Holliday and Cairnie 2007).

To clarify her point, Davis writes that her ethnographic informants' choices were often long weighed, ambivalent, and exercised in the understanding that cosmetic surgery was "not…a perfect solution, but…the only way they saw to alleviate [an abnormal amount of] suffering" (Davis [2003] 2009:36). Davis thus views cosmetic surgery for women as "a dilemma: disempowering and empowering, problem and solution all in one" (*Ibid.* p. 36). She further clarifies her position by stating that a woman's "decision to have cosmetic surgery is a choice, albeit a choice made under circumstances that are not of her own making" (1995:140). Davis goes on to say that her use of the term "agency" should not be conflated with "free choice," per se, but rather understood as a sociological concept referring to "the active participation of individuals in the constitution of social life," which is always situated in relations of power that provide "the conditions of enablement and constraint under which all social action takes place" (Davis [2003] 2009:39). She continues:

> The relationship between agency and structure has been the subject of one of the most long-standing and important debates within social science during the past century. What is at stake in the sociological use of agency is how to understand the ways that social action and social structures are mutually constitutive and sustaining without falling into the twin traps of methodological individualism on the one hand, and structural determinism, on the other. Agency is invariably linked to social structures and yet never entirely reducible to them. It is always multilayered, involving a complicated mix of intentionality, practical knowledge, and unconscious motives. (*Ibid.* P. 39)

Overall Davis writes that "listening to" and reporting the stories of cosmetic surgery participants does not mean that she "condones" the practice but rather that she seeks to "understand the circumstances which made it seem impossible for a women to live with her body as it is…[thus] imagining what might need to be changed so that she would not need to look to cosmetic surgery as a solution to her problem" (*Ibid.* p. 41). Furthermore, Davis claims to have followed Anthony Giddens' theoretical strategy in order to avoid taking the "comfortable" feminist position on cosmetic surgery by incorporating his analysis that "every competent actor

has a wide-ranging, but intimate and subtle, knowledge of the society of which he or she is a member" (Giddens 1976:73 quoted by Davis 2009:40).

Other analyses attempt to provide a middle ground in the sociological debate between structure and agency in terms of cosmetic surgery, such as Shilling's (1993) notion of the "body project," where the body is worked on but simultaneously does work, "presenting a theory of the body as simultaneously acting on and responding to social stimuli" (Holliday and Cairnie 2007:59). However, Shilling's references to market forces seem to compete with middling notions of individual agency, noting that "in a broader discourse wherein the body is seen as a site where identity is accomplished, often through acts of consumption...[t]he linkages between consumption as a normative endeavor and cosmetic surgery provide increased legitimacy for the latter" (1993:121).

Davis herself acknowledges that the "most sustained and well-argued critique" of her approach is that of feminist philosopher and social critic Susan Bordo, whose foremost disagreement hinges on Davis' use of the word "agency" (Davis 2009:37). While both authors acknowledge that they have few differences regarding the power and influence of cultural images and both recognize that ambiguity, contradiction, and multiple meanings exist in human motivations and choices, the debate between the two rests upon Bordo's focus on a macro Marxist/Foucauldian overview of constraints and opportunities, whereas Davis defends herself on a micro level as unwilling to dictate "unknown truths" from a "privileged position" in regards to "the bigger picture" of a culture in which she enjoys membership (Davis [1995] 2009:41). It should be reiterated, however, that Davis did publish later works offering macro criticism regarding growing "equality discourses" in cosmetic surgery that transform the practice into a "neutral" and commoditized "identity project," which frames "all individuals to be 'different' to

the same degree" and thus lowers the threshold to the plastic surgeon's office for everyone, "disguises difference," and depoliticizes surgeries for minorities, women and men (Davis [2003] 2009, ch. 3: p.44-46). Therefore, Davis (arguably in a double standard) sees later cosmetic surgery developments as ominously ignorant of "embodied difference" and fundamentally different from the kind of surgeries her former white female ethnographic subjects said they required for their personal welfare to appear "just like everyone else" (*Ibid.* p.43).

Bordo, who has written extensively on the subject of cosmetic surgery since the late 1980s, utilizes her chapter in Heyes and Jones' (2009) compilation of revised works to clarify some of her contrasting thoughts about choice and "agency," as well as discuss the growing personal and professional criticism she has faced over the last decade in tandem with the growing popularity of cosmetic surgery (wearily conceding that a blind acceptance of cosmetic surgery and its cultural costs has prevailed and will continue to do so). First, Bordo makes the point to separate the discursive strategies used to examine global power structures (in this case, feminist cultural criticism) from the everyday personal choices individuals make:

> [I]n my view, feminist cultural criticism is not a blueprint for the conduct of personal life…and does not empower or require individuals to "rise above" their culture…It does not tell us what to *do*…[but rather] [i]ts goal is edification and understanding, enhanced *consciousness* of the power, complexity, and systemic nature of culture, [and] the interconnected webs of its functioning. It's up to the reader to decide how, when, and where (or whether) to put this understanding to further use in the particular, complicated, and ever-changing context that is his or her life and no one else's. ([1990] 2009:23)

Although, as aforementioned, this paper aims to take a humanist, rather than specifically feminist, viewpoint, Bordo's explanation is very useful in describing the motives, methods, and implications of any macro cultural study and is a helpful framework for the tone of this project. Furthermore, Bordo makes a point to mention that men are increasingly feeling pressured to undergo cosmetic surgery "in order to compete with younger, fitter-looking men and women" in

the workplace and social arena (*Ibid*. p. 26). Bordo does not deny that human beings are continually making choices—but she departs from Davis by asserting that the choice for cosmetic surgery is not "first and foremost 'about' self-determination *or* self-deception" (*Ibid*. p. 24). For Bordo, Davis' use of the term "agency" in cosmetic surgery studies does not add "much beyond [the] rhetorical cheerleading" similarly used by mainstream talk shows and advertisements to lend credence to the cosmetic surgery consumer's defiant exclamation, "I did *it for me*" and me alone—when a more critically aware response is "[I did it] in order to feel better about myself in this culture that has made me feel inadequate as I am" (*Ibid*. p. 23). More importantly, Bordo believes that "the cheers of 'agency' create a diversionary din that drowns out [the constant cacophony] of consumer culture we live in and need to take responsibility for…[thus, masking the fact that] cosmetic surgery is more than an individual choice…[but also a] burgeoning industry and an increasingly normative cultural practice" (*Ibid*. p. 24). In terms of the globalization of cosmetic surgery, Bordo argues that although certain cosmetic practices (which will be examined in this paper) "may be highly understandable from the point of view of the individual's economic survival and advancement," by giving in to this requirement, individuals "participate in a process of racial normalization and…make it harder for others to refuse to participate. The more established the new norm, the higher the costs of resisting" (*Ibid*. p. 23).

On the other hand, Bordo notes that it is possible to recognize that normalizing cultural forms exist without accusing their participants of being "cultural dopes," stating that: "[p]eople know the routes to success in this culture—they are advertised widely enough—and they are not 'dopes' to pursue them. Often, given the racism, sexism, and ageism of the culture, their personal happiness and economic security may depend on it" (*Ibid*. p. 23). But, what Bordo laments is the

"complexly and densely institutionalized values and practices within a high level of physical modification" that first instructs individuals, en masse, to see themselves as defective, lacking and in need of correction—and then encourages them to re-frame this learned defectiveness into an "arena for the enactment of [supposed] creative agency" on the body (*Ibid*. p. 25). According to Bordo:

> This is the…essence of advertising and the fuel of consumer capitalism, which cannot allow equilibrium or stasis in human desire. Thus, we are…'empowered' only and always through fantasies of what we *could* be. This is not a plot; it's just the way the system works. Capitalism adores proliferation and excess; it abhors moderation." (*Ibid*. P. 27)

This argument serves as a crucial framework by which to examine "agency" in the globalization of cosmetic surgery—a system that relies heavily on the (sometimes forced) opening of free markets in developing countries. Furthermore, as Bordo notes, "perfection" is a much more ideal product to sell in a capitalist system (in comparison to Davis' theoretically perceived goal of 'ordinary') because "the bar of what we considered 'perfect' is constantly being raised—by cultural imagery, [technological pursuit] and by the surgeon's own recommendations" (*Ibid*. p. 26). As one surgeon admitted, "[p]lastic surgery sharpens your eyesight" for other flaws (*Ibid*. p. 27). And, even for those who forego cosmetic surgery, the proliferation of air-brushed digital images, surgically enhanced celebrities, and high-definition plasma television screens tend to do the same. Therefore, although "agency" from the macro cultural perspective may be out of our individual hands, Bordo notes that "[w]e are all culture makers as well as culture consumers, and if we wish to be considered 'agents' in our lives—and have it be more than just a titular honor—we need to take responsibility for that role" (*Ibid*. p. 27). Utilizing a consumer-sports analogy, she adds that:

> To act consciously and responsibly means understanding the culture we live in, even if it requires acknowledging that we are not always "in charge"….[T]he really dopey thing is living with the illusion that we are "in control," just because some commercial (or ad for

> surgery) tells us so. In the culture we live in [i.e. the U.S.], individuals are caught between two contradictory injunctions. On the one hand, an ideology of triumphant individualism and mind-over-matter heroism urges us to "Just Do It" and tries to convince us that we *can* "Just do it," whatever our sex, race, or circumstances. This is a mystification. We are not runners on a level field but one that is pocked with historical inequities that make it much harder for some folks to lace up their Nikes and speed to the finish line—until the lane in which they are running has been made less rocky and the hidden mines excavated and removed. (*Ibid*. P. 27)

The overall framework of this master's thesis will bring this analogy into vivid, global view, reflecting the argument that modern mainstream rationales, which compare cosmetic surgery enhancements to opportunities for full and fair social participation, "efface [much more than] the inequalities of privilege, money, and time that [still] prohibit [many] people from indulging in these practices" (Bordo 1999:656). As will be addressed later, popular perceptions of free "agency" in cosmetic surgery practices successfully efface not just this unequal access, but also the sense that the very origins of cosmetic surgery reinforce many of the inequalities it purports to correct.

Theories Relating to Power

Since the transfer of power and the associated question of who benefits from the globalization of cosmetic surgery is best left for discussion following the broad examination of the origins and normalization of BRIC countries' cosmetic surgery cultures, I will only briefly describe some theories that will be used in the final analysis of the overarching power structures examined in this thesis. As inferred by the previous section, discussions of free "agency" and "choice" are closely related to varying exercises of power and should therefore work as a framework throughout the course of the project to identify and question power structures described at the individual, national, regional, and global level. Ultimately, however, this paper aims to offer a macro theoretical interpretation more similar to the Foucauldian focus of Bordo,

which asserts that "power" is a terrain with hills and valleys, and is *not* (as Bordo says postmodern thinkers have oft misattributed to Foucault) "the *possession* of individuals or groups, [i.e.] something they 'have'" (Bordo 1990:665). Rather, Bordo (1990) describes French philosopher Michel Foucault's theoretical reconstruction of power in *Discipline and Punish* as a:

> dynamic of non-centralized forces, its dominant historical forms attaining their hegemony, not from magisterial design or decree, but through multiple "processes, of different origin and scattered location," regulating and normalizing the most intimate and minute elements of the construction of time, space, desire and embodiment. (P. 666, citing Foucault [1977] 1979:138)

However, Bordo asserts that Foucault's conception that power is "held" by no one "does not entail that it is equally held by *all*…[but] rather, people and groups are positioned differentially within it" (1990:666). Furthermore, she notes Foucault's insistence on "the *instability* of modern power relations," where resistance is perpetual and unpredictable and hegemony is precarious (1990:666). Bordo (1990) nevertheless cautions against the "notion of resistance as *jouissance*," conceptualized as "a creative and pleasurable eruption of cultural 'difference'" (p. 666). As will be examined later, some authors seek to frame the consumption of desirable cosmetic surgery practices as a form of resistance to systemic modern power structures. Rather, Bordo writes that:

> For Foucault, the metaphorical terrain of resistance is explicitly that of the "battle"; the "points of confrontation" may be "innumerable" and "instable," but they involve a serious and often deadly struggle of embodied (that is, historically situated and shaped) forces. (1990:667, citing Foucault [1977] 1979:26-27)

Using race as an example, Bordo argues that interpretations of "resistance" taken outside of the metaphorical battle terrain intended by Foucault tend to "efface…the arduous and frequently frustrated historical struggle that is required for the subordinate to articulate and assert the value of their 'differences' in the face of dominant meanings—meanings which often offer a pedagogy directed at the reinforcement of feelings of inferiority, marginality, [and] ugliness" (1990:666). In this sense, not all actions framed as "resistance" are effective in the struggle for

equality in an ever-shifting terrain of power relations. And, furthermore, ineffective discourses of resistance not only fail to contribute to the "struggle" but may do worse by detracting from it.

In terms of self-identity and power, Askegaard, Gertsen, and Langer (2002) join Davis (2009) in adopting Giddens' theoretical framework to guide their analysis of cosmetic surgery practices. However, beyond the acknowledgment that their informants' qualitative interview testimony indicated that cosmetic surgery had a generally positive impact on self-image, their work diverges from Davis' in key ways. In a bid to address what they note is a lack of sociologists addressing the macro level approach of cosmetic surgery, Askegaard et al. attempt to marry existing literature with postmodern approaches to the body and consumer research. While the authors do not deny the importance of a Foucauldian frame of reference, they seek to find theoretical fresh ground in terms of their view that feminist literature's attempts to produce more current macro-level analysis may have been stymied by dividing the complex problem of agency into two camps—focused either on oppressive power structures or the "choice" of new freedoms. Using Giddens' (1991) contributions to the study of self-identity in post/late modernity, Askegaard et al. (2002) discuss the "reflexivity" of cosmetic surgery, which is understood to be part of an individual's bidirectional construction of identity, in a time where nature has essentially "'come to an end,'…[and the fact] is known to the public at large." (Giddens 1991:221). Furthermore, Askegaaerd et al. expand upon Fromm's ([1947] 2003, 1976) concept of "marketing character" and Shilling's (1993) concept that the body is physical capital, which can be traded for economic/social capital. Utilizing this model, the authors focus less on the projections of underlying power structures and more on what they view as the role of social discourses in bodily reflexivity and self-imagery as expressed in the consumers' experience. In sum, within Askegaaerd et al.'s Giddens framework, selves are created/recreated in laborious

processes and self-identity has become a reflexive project that each individual must undertake individually and in interaction with others/institutions.

"Choice" is a key concept in late modernity, and the individual is expected to be seen as in charge of his or her life (which I would argue is very much a Western-centric construct). But this individualistic turn has also resulted in what Giddens (1991) calls "pure relationships" that must be mutually rewarding and chosen. This characterization imbues late-modern human relationships with little to no permanence. Thus, the situation of seemingly infinite choices and the resulting lack of permanence leads to more self-centered, narcissistic preoccupation, more emphasis on youth culture, and more anxiety that human relationships could be terminated at any time (an argument that Giddens relates to the rise in the mental health industry). Accordingly, this impermanence in relationships coupled with a technologically new impermanence of the body leads to an almost compulsive, ongoing (re)construction of identity.

The cosmetic surgery industry is a perfect fit for this late-modern dilemma—where in some ways you can control outward risk through augmenting bodily charm. But, in another sense of this model, the prison of no choices has been replaced by a prison of all choices (Askegaard et al. 2002). Furthermore, Askegaard et al. utilize Giddens' concept that although guilt (related to bad action) has been steadfast through the eras, (bodily) shame, in particular, is late-modern in the sense that it is related to insufficiency, and thus acts as the foil of narcissism. Although Askegaaerd et al.'s use of Giddens' model seems to be somewhat limited in scope by a Western-centric focus on issues more commonly experienced by individuals with comparatively high socioeconomic statuses in the throes of late capitalism (and thereby less representative of the comparative macro-level of this paper), I adapt aspects of this model in combination with a Foucauldian perspective to add to my analytical discussion.

Furthermore, although the majority of scholarly literature tends to associate any Foucauldian interpretation of cosmetic surgery as an extension of a feminist interpretation, the very discursive nature of Foucault's work welcomes interpretation by all disciplines and thus, in some ways, carries "tensions" with feminist studies (Bordo 1993). For example, Holliday and Elfving-Hwang (2012) argue that explicitly gendered interpretations of cosmetic surgery are "problematic from a Foucauldian perspective, which asserts that we are all—men and women alike—subjects not of ourselves, but of discourses," and adds that, "[n]either women nor men can stand outside language and culture and the power relations that produce our understandings of the world and our positions within it; men are just differently positioned within it (Grosz, 1994)" (p. 72). Accordingly, other critical race and feminist theorists such as Hill Collins (2000) have more closely focused on the intersectionality of different forms of oppressions, where "[i]ntersectional paradigms remind us that oppression cannot be reduced to one fundamental type, and that oppressions work together in producing injustice" (p. 18). Hill Collins' concept of a "matrix of domination" explores how intersecting oppressions, such as those based on race, class, gender, sexuality, and nation, are organized into reappearing domains of power that she categorizes respectively as: structural, disciplinary, hegemonic, and interpersonal—noting that the disciplinary domain of power is characterized by a Foucauldian reliance on bureaucratic hierarchies that have become "an increasingly prevalent feature of modern, transnational social organization…in capitalist and socialist countries alike" (2000:281).

Finally, Foucault's (1975-1976) series, *"Society Must Be Defended": lectures at the Collège de France*, offers unique pieces of theoretical insight (albeit, lacking any comprehensive theory due to the format), which address just such an intersectional analysis of many of the catalysts I will identify as driving the globalization of cosmetic surgery. Foucault's topics

include: the concept that societal power relations remain anchored in a relationship of force established through prior wars, which is then reinscribed on the bodies of individuals; the sense that capitalism applies primarily to bodies and what they do; and a critical take on the expansion of medical discourse. Furthermore, in these lectures, Foucault discusses the modern construction of race and racism, the origins of "racial" science, and the ways in which they relate to "the emergence of a form of state power that establishes the legitimacy of its relation to life and death on the basis of a new biological conception of race" (Mader 2011:98). As will be discussed at the end of this paper, this existential focus can be expanded to incorporate the notions of social visibility, citizenship, and acceptance that are closely linked to global cosmetic surgery practices.

DEFINITION OF TERMS

Anthropometry: The study of human body measurements especially on a comparative basis.
Blepharoplasty: Plastic surgery on the eyelid especially to remove fatty or excess tissue.
Botox: Trademark for botulinum toxin type A...When locally injected, Botox blocks the release of the neurotransmitter acetylcholine, interfering with the ability of the muscle to contract. [When referenced by this paper] Botox is used for cosmetic purposes to treat facial wrinkles.
Breast augmentation: Surgery using implants or other methods to enlarge the breasts. Accordingly, breast reduction is surgery that removes breast tissue to make breasts smaller.
BRIC: An acronym for the economies of Brazil, Russia, India, and China combined. The general consensus is that the term was first prominently used in a Goldman Sachs report from 2003, which speculated that by 2050 these four economies would be wealthier than most of the current major economic powers.
Cosmetic or Aesthetic Plastic Surgery: Surgery that modifies or improves the appearance of a physical feature, irregularity, or defect [variations of the terms Cosmetic Surgery and Aesthetic Surgery will be used interchangeably throughout this paper]. Aesthetic plastic surgery is intended for the "enhancement" of appearance through surgical and medical techniques, and is specifically concerned with maintaining normal appearance, restoring it, or enhancing it beyond the average level toward some aesthetic ideal.
Cosmetic Surgery Culture: All things related to cosmetic surgery, a collective understanding of cosmetic surgery in the public sphere. As defined by Blum (2003:49) "a postbody culture inasmuch as the material body seems to lose all its pathetic vulnerability in the face of a host of medical/technological [and consumerist] advances meant to keep you perfect from the beginning to the end, indefinitely."
Eugenics: A science that deals with the improvement (as by control of human mating) of hereditary qualities of a race or breed.

G6: (Group of Six) An unofficial group of the interior ministers of the six European Union member states—Germany, France, United Kingdom, Italy, Spain, and Poland—with the largest populations and so with the majority of votes in the Council of the European Union.
GDP: An acronym for a nation's Gross Domestic Product— the gross national product excluding the value of net income earned abroad.
Globalization: The act or process of globalizing **:** the state of being globalized; *especially* **:** the development of an increasingly integrated global economy marked especially by free trade, free flow of capital, and the tapping of cheaper foreign labor markets.
Gynecomastia: Excessive development of the breast in the male.
Lipoplasty / liposuction: Surgical removal of local fat deposits (as in the thighs) especially for cosmetic purposes.
Miscegenation: A mixture of races; *especially* **:** marriage, cohabitation, or sexual intercourse between a white person and a member of another race.
Neoliberalism: A market-driven approach to economic and social policy based on neoclassical theories of economics that promote liberalizations, free trade and open markets, privatization, deregulation, and enhancing the role of the private sector in modern society.
Osteotomy: A surgical operation in which a bone is divided or a piece of bone is excised (as to correct a deformity). [When referenced by this paper] a procedure sawing off the leg bones and stretching the legs to allow the bones to grow longer.
Otolaryngologist: A physician who specializes in the diagnosis and treatment of diseases and injuries of the ears, nose, and throat. Also called: ENT specialist.
Otoplasty: Plastic surgery of the external ear.
Palpebral (fold of the eyelid): Of, relating to, or located on or near the eyelids.
Physiognomy: The art of discovering temperament and character from outward appearance.
Plastic Surgery: A branch of surgery concerned with the repair, restoration, or improvement of lost, injured, defective, or misshapen parts of the body chiefly by transfer of tissue.
Plastic Surgeon: A specialist in plastic surgery who may perform cosmetic and/or reconstructive plastic surgery.
Reconstructive Plastic Surgery: Surgery performed to correct functional impairments caused by burns; traumatic injuries, such as facial bone fractures and breaks; congenital abnormalities, such as cleft palates or cleft lips; developmental abnormalities; infection and disease; and cancer or tumors. It is usually performed to improve function, but it may be done to approximate a normal appearance.
Rhinoplasty: Plastic surgery on the nose usually for cosmetic purposes, called also *nose job.*
Rhytidectomy: Excision of skin for elimination of wrinkles or sagging skin, called also *face lift.*

THE UNITED STATES: MEDIA AND THE BIRTH OF COMMERCIAL MEDICINE

[U]nlike other medical professionals, cosmetic plastic surgeons must learn and perfect the art of sale. Because of the economics of cosmetic plastic surgery, the surgeon must also act as a marketing and economics professional, skilled in the art of procuring money from a consumer who does not require surgery but merely desires it…If the surgeons are not learning new medical skills they are…in seminars like "Web Marketing: What You Need to Know"…"How to Read People Like a Book"…or…"How to Rise above the Competition and Maximize Staff Utilization to Increase Surgery." (description of a national conference, Kuczynski 2006:157)

Since a plethora of existing cosmetic surgery studies focus solely on the United States or other Western countries, this paper will not duplicate prior work offering a comprehensive overview of Americans' deep-seated relationship with cosmetic surgery or the U.S.'s lengthy and influential role as an exporter of cosmetic surgery practices. Rather, select studies, theories, and historical context will be employed throughout to provide key insights and relevant support to BRIC country-specific trends and my overall theoretical discussion. In regards to comprehensive histories of cosmetic surgery, Sander Gilman (1999, 1998), Elizabeth Haiken (1997), and Deborah Sullivan (2001) have written extensively on the cultural, social, and corporate roots of the practice. With the exception of Gilman, these works are primarily focused on American experiences and social narratives, but they provide an important pool of historical data from which to draw for global analysis. Furthermore, Kuczynski (2006) and Blum (2003) contribute to a growing ethnographic and analytical narrative of the American cosmetic surgery industry and its most (globally) visible clients—those in the upper echelons of socioeconomic status who have become synonymous with the nip/tuck generation: so-called "beauty-junkies" of a non-determinable age and the prolific contributors to "star culture" in Hollywood and beyond (Kuczynski: p. 1; Blum: p. 147). The following section identifies and explores two primary prerequisites that allowed for the contagious visibility of surgical "beauty junky" norms: huge booms in cosmetic surgery advertising and the easy accessibility of digital media.

The Origins of Commercial Cosmetic Surgery in the United States

In her detailed account of the development of cosmetic surgery commercial medicine in the United States, Deborah Sullivan (2001) writes that a major turning point occurred in 1975 when professional societies like the American Society of Plastic and Reconstructive Surgeons (ASPRS) and the associated American Board of Plastic Surgery failed to stop a decision by the

U.S. Federal Trade Commission (FTC) applying antitrust law to the learned profession of medicine. This unilateral ruling, in step with the nation's burgeoning market liberalization at that time, challenged professional associations' attempts to restrict advertising and access to other legally qualified practitioners (Sullivan 2001). The decision eventually opened a floodgate for advertising that challenged the traditionally held professional ban against patient solicitation that ASPRS and other board-certified plastic surgeons had long used to protect their turf (and hard-earned reputation) from competing surgeons (*Ibid.*). Overall, Sullivan summarizes the changing structural dimensions of the political economy of medicine that led to cosmetic surgery's mass-consumer rise as:

> (1) the overall increase in the number of physicians, particularly surgical specialists; (2) the changing demand for some traditional surgical procedures; (3) the Federal Trade Commission (FTC) and [American Medical Association] AMA policies to promote "free trade" within the profession of medicine; (4) the breakdown of informal controls over cosmetic surgery, including restricted access to training, hospital privileges, and patients; and (5) the growth of managed care [i.e. the corporatization of health care delivery]. (2001:69)

Within five years of the FTC decision, marketing became the major priority of ASPRS, resulting in mixed feelings and controversy amongst members of a professional organization that had long been committed to acting as perceived gatekeepers for "legitimate" cosmetic surgeries and a trustworthy alternative to "quack" beauty doctors (Haiken 1997; Gilman 1999; Sullivan 2001:106). However, Sullivan notes that labels of quackery were sometimes unfairly used in campaigns against trained facial surgical specialists, like otolaryngologists, who presented a threat to a plastic surgeon's monopoly on the limited number of "legitimate" cosmetic surgery patients and their revenue. Therefore, as a result of this widening pool of competitive expertise and rising numbers of cosmetic surgeons (and since doctors were not willing to decrease their numbers), the only "answer" was to find some way to increase the population of cosmetic surgery patients and grow the market. "No longer could most practitioners cater only to the elite

who could afford to pay thousands of dollars in advance or the self-disciplined who saved the necessary money over time"; instead the rapid expansion of credit in the United States during the 1970s and '80s helped widen the net for consumers (Sullivan 2001:151). ASPRS launched the first physician-friendly financing program specifically for cosmetic surgery in 1989, which pays surgeons in advance (*Ibid*.). Meanwhile, other third-party investors and middlemen jumped at a new business model—even a used-car financing company re-emerged from bankruptcy in the late nineties to assert its right to "capitalize on America's vanity" (Sullivan 2001:152):

> Jayhawk [Acceptance]'s president argues that physicians who object to financing companies' role in democratizing cosmetic surgery are elitists in denial about their own entrepreneurial activity. He says, "[A] doctor who has made the decision to go into cosmetic surgery has decided to be a businessman" (qtd. in Barry 1998). (Sullivan 2001:153)

Indeed, this "democratization" has fast taken hold in the American consciousness, providing a multitude of entrepreneurs with an ever-expanding pool of consumers. Although true statistics are elusive due to growing, off-shore "medical tourism" sites (often in vacation locales) and other limits to this type of data collection, the American Society for Aesthetic Plastic Surgery (ASAPS) and the International Society of Aesthetic Plastic Surgery (ISAPS) have been collecting data samples from their members and colleagues for the past 15 years.

For example, according to ASAPS, there were over 9 million surgical and nonsurgical cosmetic procedures performed in 2011 (with a competing statistic from the American Society of Plastic Surgeons placing the total at 13.8 million). Invasive surgical procedures accounted for 18 percent of the total number of procedures but 63 percent of the total expenditures. Non-surgical, less expensive procedures have far surpassed surgical statistics with the introduction of Botox injections, facial fillers, and laser re-surfacing. Altogether, it is estimated that these procedures cost Americans over 10 billion dollars in 2011 (ASAPS:n.p.). In comparison to the first year data

was collected by ASAPS, 1997 saw just over 2 million procedures in the United States (approximately 86 percent female and 13 percent male patients, although as aforementioned men's surgeries are sometimes under-reported). In 2011, ASAPS reported that male patients had increased 121 percent from 1997 to consume over 800,000 cosmetic procedures (with the top surgery choice being *lipoplasty*)—but only comprising 9 percent of the total. American women were estimated to have increased consumption of procedures at a more rapid rate, 209 percent, and to have consumed 8.4 million procedures in 2011. This disparate increase since 1997 contradicts widely reported media that men's surgeries are becoming more common, thus re-emphasizing the general lack of reliability of cosmetic surgery statistics which can fluctuate from year to year—and according to economic climate. For example, Gilman (1999) reported figures that showed men accounting for 33 percent of U.S. facial plastic procedures as early as 1995 (p. 32). Furthermore, the majority of U.S. patients (46 percent) were in the 35 to 50 age range in 1997 and, today, that age range is still reported to lead in terms of total procedures. However, when taking into account non-surgical Botox treatment for wrinkles (up 3,920 percent since 1997), that could skew perception of the numbers. For example, other evidence shows that younger and younger patients are seeking surgical body modification (as well as Botox).

Thus, in less than two decades, according to ASAPS (2011), there has been an overall 197 percent increase in the total number of U.S. cosmetic procedures, with liposuction recently (and just barely) beating out breast augmentation as the nation's long-running most popular cosmetic surgery procedure. And although cosmetic surgery patients still account for a small segment of the total U.S. population, a study by the American Society of Plastic Surgeons (ASPS—not to be confused with ASAPS [American Society for Aesthetic Plastic Surgery]) published on LiveScience.com predicted that 17 percent of residents of the United States will be

getting cosmetic or body enhancement procedures by 2015—with more than 55 million cosmetic surgery procedures performed that year—averaging to nearly one procedure for every five Americans (including children), based on U.S. Census Bureau population projections (Britt 2008). Researchers based these predictions on ASPS National Clearinghouse of Plastic Surgery statistics from 1992 to 2005 according to the projected impact of economic and non-economic variables on industry growth. Of course, the study was conducted by the cosmetic surgery industry and is already four years old, but all current signs point to a future with more cosmetic surgery—not less.

Furthermore, although Caucasian patients were still estimated by ASAPS to account for nearly 80 percent of all documented U.S. procedures in 2011, cosmetic surgery among racial and ethnic minorities in the United States is reportedly on the rise. Accounting for approximately 21 percent of all cosmetic procedures in 2011 (up from about 15 percent of all procedures in 1997), ASAPS reports that 8 percent of total U.S. procedures were undergone by Hispanic Americans, 7 percent by African Americans, and 5 percent by Asian Americans (1 percent denoted "other"). To understand this in context of population, the U.S. Census Bureau reported estimates for 2011 that persons of Hispanic or Latino origin were 16.7 percent, Black persons 13.1 percent, and Asian persons 5 percent of the total population (Census Quick Facts 2012:n.p.). Lynch (2010) reported in Spanish-language news outlet *La Voz Bilingüe* that cosmetic surgery is a rising visible presence in Spanish media like Univision and Telemundo, reflecting a growing interest in cosmetic surgery among American Latinos—yet also emphasizing that "*mantener la identidad étnica es sagrada*" (to maintain one's ethnic identity is sacred) (p. 7). Bagalawis-Simes (2010) published ASPS data that estimated Asian Americans to have undergone over 743,000 cosmetic surgery procedures in 2009, with nose reshaping, eyelid surgery, and breast augmentation most

commonly requested. Mann (2010) also writes that, according to ASPS, over 900,000 African Americans underwent cosmetic surgery in 2008—a 145 percent increase since 2000. According to doctors interviewed by *Jet* magazine in 2007, "it'll only be a matter of time before patients of color dominate the industry," with growing numbers of African American patients resulting from a rise in practicing African American plastic surgeons, decreasing costs and healing times for surgery, and its increasing mainstream appeal (Moffett 2007:15-16). In addition to listing the most common surgeries for African Americans as nose reshaping, breast reduction, eyelid surgery, and liposuction, *Jet* has also reported on the growing popularity for buttocks shaping and fat re-distribution among women of color, as well as influential cosmetic surgeries among celebrities such as Tyra Banks, Tamar Braxton, and Naomi Campbell (Brown 2011; Turner 2011).

Additionally, Sturm-O'Brien, Brissett, and Brissett (2010) attribute fast-growing minority cosmetic surgery demographics to population growth within multicultural communities, improvements in social status, increasing disposable income, and a shift from the stigmatizing perception of surgery as a means of racial transformation—toward the view that cosmetic surgery can preserve a patient's racial and ethnic features. Mann (2010) writes that, despite the increasing normalization of cosmetic surgery from reality TV shows and other media, minority cosmetic surgery patients are often still hesitant to incur negative feedback from their family and community regarding the implications that such transformations hold for race and self-identity. However, according to African American psychologist Dr. Shane Perrault, this fear is apparently on its way out: "There was a time when we didn't do things because it felt like we were selling out. That mentality is gone and now we have a more glamorized, mainstream focus" (Mann 2010:1B). Similarly, ASAPS found in a 2011 survey they commissioned from a private research

firm (duly note the source), that 67 percent of white Americans and 72 percent of "non-white Americans" say they would not be embarrassed about having cosmetic surgery.

The above findings reflect a marked change from ASAPS "attitude" results in 1997, which found in a survey of 1000 American households that while 60 percent of white American respondents approved of cosmetic surgery, just 45 percent of non-white Americans approved of the practice. Moreover, results from 1997 showed that higher acceptance levels of cosmetic surgery corresponded with higher income levels (for example, 66 percent of those with incomes above $50,000 reported approval of cosmetic surgery, while only 40 percent of those with incomes under $15,000 approved). Not so any longer. In 2011, ASAPS reported data showing that 51 percent of all Americans regardless of income approve of cosmetic plastic surgery (a 3 percent increase from 2009). As reported in a *Newsweek Magazine* piece covering the trend of cosmetic surgery "gifts" during the holidays, as well as during the Great Recession:

> The economy may be a shambles this holiday season, but you wouldn't know it from looking at the cosmetic-surgery business. After a slight dip at the peak of the recession in 2008, the industry has rebounded in the last two years, even as most Americans were scrimping and saving on so much else. Between 2009 and 2010, Americans spent 3.8 percent less on food, 2 percent less on housing, 1.4 percent less on clothes, and 7 percent less on entertainment. At the same time, we spent 1.3 percent more on breast augmentation, 5.1 percent more on lipo, 8.1 percent more on eyelid surgery, and a whopping 24.4 percent more on butt lifts. (Dana 2011:13)

Even accounting for the small percentage of Americans with enough disposable income to casually pursue cosmetic surgery, Dana's *Newsweek* piece notes 2009 ASAPS data showing that "[n]early one third of cosmetic-surgery patients make less than $30,000 a year, and about 70 percent make less than $60,000…And those who can't afford it finance it" (Dana 2011:13). As far as motivations go, a general desire to look younger and gain a career boost in order "to stay in the game" are increasingly acknowledged (Dana 2011:14). And for those who already look "younger" and may only be at the start of their adult—let alone college—career? Once more,

there is a huge shift. In 1997, ASAPS reported that only 38 percent of 18- to 24-year-olds surveyed approved of cosmetic surgery (compared to approval ratings of about 60 percent for both male and female respondents on average). Now, ASAPS reports that out of all age groups, men and women between the ages of 18 and 24 are the most likely to consider plastic surgery for themselves now or in the future, and 69 percent say they approve of cosmetic surgery procedures (ASAPS 2011; Dana 2011). Illuminating the ever-widening scope of cosmetic surgery culture, a recent study by the Central YMCA found that one in four kids ages 11 to 16 has considered a procedure and, on the other end of the spectrum, cosmetic surgery for senior citizens has risen nearly 30 percent in the last five years (Dana 2011).

Since a rise in disposable income cannot sufficiently account for such an expansive popularity boost for cosmetic surgery among so many different demographics—including *kids* who have no income—most studies point to the decade's unprecedented boom in digital media consumption as the main culprit for American cosmetic surgery's normalization.

The Normalization of Cosmetic Surgery: Identity and Media

Many sociologists have used the United States as a template to understand what really motivates individuals to pursue cosmetic surgery. However, as with many other ethnographic studies, an American model of study will not apply uniformly to other global communities. Therefore, a brief overview will suffice. Through in-depth interviews, Schouten (1991) tracked the emergent themes of how cosmetic surgery procedures seemed to aid recipients in dealing with role transitions, sexual selves, romantic fantasies, control and efficacy, and identity play in regards to identity reconstruction and personal rites of passage. He focuses on the increasing malleability of the self and the generally accepted logic that more attractive bodies can facilitate social, economic, and romantic endeavors. Borrowing from Fromm's ([1947] 2003, 1976)

“marketing character,” he notes that cosmetic surgery makes it increasingly feasible to manage one’s life (or body) as a commodity in order to improve performance in key social roles. His research also noted that cosmetic surgery patients often speak of a single feature as "alien" or not belonging to their body, of which changing would make them more whole. Schouten theorizes that cosmetic surgery may serve as an act of symbolic self-completion during or following role transitions (including sexual roles and romantic fantasies) and individuals may seek aesthetic plastic surgery as a means of approaching positive or avoiding negative possible selves. Finally, he writes that “[t]he issue of control emerged in the form of two important subthemes: (1) plastic surgery as a perceived means of exercising control over one's body and one's destiny, and (2) personal efficacy as the ability to exercise such control” (Schouten 1991:418).

I mention Schouten’s study here in detail because other studies since have reported similar results. Some conceptual additions were: Gimlin’s (2000) idea that although cosmetic surgery allows women to reposition their bodies as “normal” (following Davis), at the same time, they “must work even harder to ‘reattach’ their identities to their new appearances” (p. 80). Her study's participants did this by invoking both essentialist notions of the self and corresponding notions of the body as accidental, inessential, or degenerated from a younger body that better represented who they truly were. Thorpe, Ahmed, and Steer (2004) note existing research that prospective patients with unrealistic plastic surgery expectations (i.e., a tool to improve marriage, get a better job, etc.) were more likely to have negative post-op feelings or even *lowered* self-esteem in contrast to the reported positive results of more “realistic” patients who just desired to improve their appearance. However, this particular study’s participants all reported being happy with their results. According to Thorpe et al., the master themes of the respondent's motives were: "embarking" (on new life chapters), looking age-appropriate (to how they felt), increased

"body integrity" and wanting "to look normal." A noted commonality was the sense that respondents constructed their experiences of their body image as if there *is* such a thing as an objectively normal body image. Thorpe et al. conclude by stating that "they (also) construct their beliefs from what could be argued are culturally created norms of body image" (p. 87).

Furthermore, several pieces of literature expand upon Schouten's themes about the malleable body as a capitalistic, socioeconomic exchange value. In Adams' (2009) content analysis regarding the divergent media framing of tattooing and cosmetic surgery (positive expression) versus body piercing (dangerous practice), he noted a common cycle of the media normalizing and sensationalizing body modification practices (such as cosmetic surgery) in alternation. Out of all three body modification practices—which at one point or another were deemed deviant, unnatural, self-mutilating, a sign of mental illness, and unattractive to the mainstream—cosmetic surgery exploded in numbers and assimilated into general culture much faster. Adams attributes this fact to the ways that media utilize gender stereotypes as a framing device to normalize and legitimize the practice. This overarching trend is indicative of the greater influence media and journalists have in selecting the public's exposure to, and evaluation of, ambivalent and controversial topics (Cho 2007), as well as how sub-cultural signs are converted into mass-produced objects with their original symbolic meanings diluted—which I would argue is reminiscent of Marxist commodity fetishism. Adams also references Shilling's (2003) argument that in a consumer-capitalist society, bodies represent a project to be worked at in achieving self-identity, which translates into "lifestyle" discourse. Additionally, aesthetic plastic surgery's almost seamless ability to fit the capitalist flow in myriad facets (advertising, self-betterment through buying, and surplus potential for new global markets) explains the lightning-fast way that current cosmetic surgery culture and discourse has become normalized.

Finally, a recent study by Markley Rountree and Davis (2011) used a dimensional qualitative research approach to understand motives for medically unnecessary plastic surgery and identified factors that influence consumers' decisions to undergo cosmetic surgery as including:

> [T]he desire to purchase and wear fashionable clothing (*behavior*); the assuaging of depression, low self-esteem, and general body-image dissatisfaction (*affect*); the lessening of psychic pain (*sensation*); the ability to envision oneself in a new and different way (*imagery*); the restoration of a nostalgic past life in addition to evaluating risk and making rational and informed decisions about value of body enhancement (*cognitive*); the ability to relate better to family, friends, and business associates, the wish to be liked or admired more, and the ability to be more competitive in the areas of sports and mating (*interpersonal relations*); the feeling that prior products or procedures did not work or go far enough to achieve the desired effect (*drugs*); and the desire to move toward the cultural idea of beauty (*sociocultural*). (P. 1039)

In the current age, most if not all of these motivating factors draw heavily from media and cultural influences and, accordingly, myriad sociological examinations of cosmetic surgery have relied on magazine and newspaper content analyses (Woodstock 2001; Jones 2004; Mindt 2005; Cho 2007; Kang and Langford 2008; Polonijo and Carpiano 2008; Hennink-Kaminski, Reid, and King 2010; Hennink-Kaminski and Reichert 2011). However, in terms of the continued globalization of cosmetic surgery, media traveling via the airwaves and Internet become a more forceful worldwide influence.

The Results: A Unique American Export

Despite cosmetic surgery print advertising, much of the American public and academic community still had scarce or sporadic exposure to growing cosmetic surgery technologies until a tipping point in the mid-2000s: the streaming of popular, primetime total-body plastic surgery makeover "reality" shows into Americans' living rooms. Television programs like ABC's "Extreme Makeover" and Fox Network's "The Swan" (both of which have since been canceled due to low viewership) initially represented a huge phenomenon, not to mention a new direction

for "reality" television that persists on a global scale. In the age of the cheap digital media export, with the potential for huge monetary returns, these shows (or a version of them) were exported to over 35 countries around the world.

The year 2004, which coincided with the peak of reality television makeover shows, featured a 44 percent increase in U.S. cosmetic procedures from the year before, totaling 11.9 million surgical and non-surgical procedures (Wegenstein and Ruck 2011). Much of the academic literature in response to this trend began to look at concepts such as the "surgeon's gaze" or the "cosmetic gaze," which Wegenstein and Ruck argue is a gaze already informed by the techniques, expectations, and strategies of bodily modification and a way of looking at bodies as awaiting an improvement. Conners (2007) writes about the ethics of plastic surgery TV portrayals, emphasizing both the influence of unknown TV program participants as well as individuals' known cosmetic surgery experiences from friends, family, or colleagues as factors determining interest in cosmetic surgery. Quoting a past president of the American Society for Aesthetic Plastic Surgery, Conners (2007) notes that even some industry professionals cite a "serious cause for concern" regarding media that promotes "unhealthy expectations about what plastic surgery can do for [show participants]" (p. 7).

In an empirical study, Nabi (2009) conducted two surveys of young adults in which cosmetic surgery makeover program viewing demonstrated a small positive association with a desire to undergo cosmetic surgical procedures. Both studies offered evidence that viewing cosmetic surgery makeover programs associates with interest in pursuing cosmetic enhancements, while the second study demonstrated that simple exposure may make these procedures cognitively accessible to young people such that they think of them as actions they might reasonably take. Another study by Leone and Bissel (2006) surveyed college-age men and

women to test for third-person perception regarding personal media influence. Their results showed that male and female respondents who reported higher exposure to reality TV makeover shows were more likely to endorse (and assume others were participating in) cosmetic surgery for American women in general, for other college women, and for themselves (if female).

In regards to the discursive production of plastic surgery representation on television, Tait (2007) argues that, "cosmetic surgery has become domesticated within increasingly globalised contexts" (p. 119). Tait's analysis across areas of feminist scholarship, the press, and cosmetic surgery television argues that "post-feminist" frames (celebration of physical transformation as the route to happiness and empowerment) have displaced "feminist frames" (risk, oppression, and cultural and discursive locations of suffering around the deviant body) for understanding cosmetic surgery. She concludes that this transformation of frames within a globalized visual context has enabled mass culture's surgical turn. In an attempt to empirically study women's agency, which they define as "[the] ability to make conscious choices and to act on them," Eriksen and Goering (2011) surveyed a population of Southern California women, showing results that indicated (p. 888):

> [C]osmetic surgery recipients were more likely to have friends who had undergone cosmetic surgery, endorsed more covert sexist beliefs, exhibited greater media usage, and had higher household incomes, than non-recipients. Recipients also evidenced lower ratings in global self-esteem than non-recipients. (P. 888)

Finally, among many of the themes that Heyes (2007) discusses in her critique of the "televisual makeover," including Foucauldian normalization and fairy tale tropes, one of the most powerful is her assertion that "cosmetic surgery makes promises about permanent and conclusively satisfying self-transformation that cannot be kept" (p. 18).

As this paper moves in succession to the BRIC countries producing the most cosmetic surgery procedures outside of the Unites States—starting with Brazil—it is important to keep in

mind whether and what kind of transformative promises are being made and what the consequences will be if they are not kept. In just one example: although Elliott (2011) writes extensively on the growing demand of cosmetic surgery consumers to specifically request copies of celebrity face and body parts (which have often been enhanced themselves), it is generally understood that the entertainment business has long been unique in the practice of hiring and firing based primarily on appearance. Tellingly, the vast majority of Hollywood insiders (informal estimates say 80 to 90 percent) undergo myriad cosmetic surgery procedures (RealSelf.com 2009:n.p.). Imagine if every career field operated by those standards. Fortunately, in the United States, we have federal laws on the books and enforced by a legal system that aims to prevent the average human resources executive from refusing to hire you based on protected characteristics like race, sex, age, and creed—characteristics that are associated with appearance. As we shall see moving forward, had the United States not already been a generally established democracy with a history of civil rights battles by the time that mass-consumer cosmetic surgery entered the scene, it might have been an entirely different story.

WHY BRIC MATTERS

In 2003, Goldman Sachs, one of the most prestigious investment banking institutions in the world, produced *Global Paper No 99*, "Dreaming With BRICs: The Path to 2050" (Wilson and Purushothaman 2003). The predictions outlined therein became known as the "BRIC" concept, which was highly publicized in the media and subsequent economic research for projecting that the economies of Brazil, Russia, India, and China were on course to become a much larger force in the world economy over the next 50 years. In the words of the report, and likely mirroring Western stalwarts' reactions: "The results are startling" (p. 2). Although news reports maintained that the U.S. would continue to remain on top as far as per-capita GDP and

among the top six largest economies (with Japan likely remaining there too), combined BRIC economies were projected to eclipse the G6 in less than 40 years. That means that although individuals in the BRICs are still likely to be poorer, on average, than those in the UK, France, Germany, and Italy (with the exception of Russia), BRIC economies are set to surpass and "offset the impact of greying populations and slower growth in the advanced economies" (p. 2). This chain of events has every opportunity to be the largest shift in global economic (and possibly cultural) dynamics since the Industrial Revolution. In India, for example, the massive boom in the number and wealth of India's billionaires since its economic liberalization in 1991 has invited comparisons to the United States' "Gilded Age" and the industrialist "robber barons" of the late nineteenth century (Dehejia 2012). As the *New York Times* recently reported:

> [In terms of billionaires' share of wealth] India is now on par with the United States and Mexico, where billionaires' wealth in both countries is about 10 percent of national income. Among the large emerging economies known as the BRICs,...India is more unequal than China (where the comparable statistic is below 5 percent) and amazingly even with Brazil (a little above 5 percent), historically a country noted for wide disparities in wealth and income...[Of the BRICs,] only Russia has a higher share of billionaires to national income (pushing 20 percent) – and that in a country famous for its oligarchs, latter-day robber barons who emerged during the heady days of former President Boris Yeltsin in the 1990s, when Russia held the dubious moniker of being the "Wild East." (Dehejia 2012: n.p.)

Not surprisingly, many news reports cite the need to curb public-private sector cronyism and corruption in fast-urbanizing BRIC countries, some of which are still home to many of the world's poorest and disenfranchised people outside of Sub-Saharan Africa (CIA World Factbook 2009). Accordingly, Goldman Sachs cautioned that each of the BRICs faces significant challenges in keeping its development on track, including ensuring the "Conditions for Growth": macroeconomic stability, institutional capacity, openness, and education, which must also be enhanced by growth determinants—such as higher schooling and life expectancy, lower fertility,

lower government consumption, better maintenance of the rule of law, lower inflation, and improvements in the terms of trade (p. 13). Yet, Goldman Sachs contends that these dramatic growth projections are wholly possible, given the even more spectacular achievements that Japan and South Korea gained in only a few decades: an eightfold increase of Japan's real GDP from 1955 to 1985; and a ninefold increase of Korea's GDP between 1970 and 2000, considered to be "miracle-economy" growth (p. 12).

One all-important prerequisite that Goldman Sachs omits in this recipe for explosive growth is the need for an expanding population of voracious consumers. And as many of these countries' residents emerge from relatively recent sociohistorical legacies of colonialism, dictatorship, communism, acute poverty, military occupation, and even slavery, the rapid transition to hyper-consumerism is wrought with difficult questions. One such difficult question lies in the origins of the cosmetic surgery culture that has boomed in tandem with the countries' economies—a culture that we will see is most often based on a history of disease, conflict, and intolerance. In terms of total numbers of procedures (albeit with few reliable statistics), the U.S., Brazil, China, India, and Japan lead in cosmetic surgeries (ISAPS 2010). Along with a robust and unregulated cosmetic surgery culture in Russia, these countries are likely to represent the future of cosmetic surgery. While several other countries have comparatively higher per-capita rates of cosmetic surgeries, like South Korea for example, BRIC countries represent an important global study in the ways that mass neoliberal consumerism becomes a force of embodiment. In many aspects, cosmetic surgery has become synonymous with the power of emerging "modernity" in each of these countries without being able to divorce the practice from the various conflicts and subjugations that characterize their not-so-distant pasts. Moreover, the United States' own national cosmetic surgery culture, one that has been exported around the

globe, is similarly complicit in practicing selective amnesia regarding its contradictory and less-than-pretty roots. Therefore, it is important to look at the patterns of the globalization of cosmetic surgery as a whole in order to understand and contextualize a phenomenon that shows no end in sight.

A Note on Global Statistics

As aforementioned, the basis of this paper follows 2009 and 2010 data from the International Society of Aesthetic Plastic Surgeons (ISAPS), representing 90 countries. The 2010 data lists the U.S. and Brazil leading in total numbers of documented surgical and non-surgical procedures, with China, India, and Japan following at about half the rate. It is estimated by ISAPS that up to 18.5 million total procedures occurred in 2010 on all continents, with Asia leading North America by over a million procedures (though other informal estimates project considerably higher numbers). Worldwide surgical trends mirror those of the U.S., with lipoplasty, breast augmentation, and blepharoplasty (eyelid surgery) in most demand. However, much of these formal statistics are merely rough guidelines. Statistics for aesthetic plastic surgery are not only relatively new but also notoriously spotty. This is especially true for the global statistics, which tend to be confusing and mercurial, varying by organization and year. ISAPS admittedly urges caution in comparing its own data to prior years, stating that confidence intervals change by procedure and country and that regression equations were used to fill holes in reporting. For example, ISAPS' 2010 global survey only includes a very limited population of *board-certified* plastic surgeons abroad—practitioners who are likely to be on the higher end of prestige and cost in countries that, more often than not, have no uniform regulation for elective procedures. In comparison, much of the American data from ASAPS, explored in the prior section, is surveyed from a population that includes board-certified plastic surgeons as well as

board-certified dermatologists and board-certified otolaryngologists (ears, nose, and throat specialists)—practitioners that have a storied American history of competing for aesthetic surgery markets. Even in the United States, prospective clients are not required by law to choose a board-certified plastic surgeon. In further light of a growing, statistic-skewing industry of medical tourism and varying per capita rates of aesthetic procedures per country, it is important to include a variety of qualitative sources in addition to any available quantitative data when analyzing geographic and cultural trends in this field.

BRAZIL: EMPIRE OF THE SCALPEL

[Leading plastic surgeon] Pitanguy has said that 'plastic surgery is not only for the rich. The poor have the right to be beautiful'....During the 1990s, the number of operations performed increased six-fold. In 2001, Brazil's largest news magazine Veja ran a story titled 'Brazil, empire of the scalpel,' which claimed that Brazil had displaced the United States as the world's 'champion' of cosmetic surgery (Brasil, império do bisturi 2001). As if to confirm the victory, a samba school honoured Pitanguy in a 1999 Carnival allegory, titled 'In the universe of beauty'. Brazil's leading surgeon led the procession from a perch on a float while hundreds danced to a samba song that celebrated his work. (Edmonds 2007: 364)

The Origins of the 'Democratization' of Cosmetic Surgery in Brazil

Brazil's cosmetic surgery culture is a field already studied at length by anthropologists Alexander Edmonds (2003; 2007; 2009; 2011) and Alvaro Jarrín (2010). Accordingly, Edmonds' quote above summarizes a great deal about what sets Brazil apart in comparison to other nations, including the sense that cosmetic surgery and beauty practices have moved beyond the discourse of individual agency to represent a democratic "right" that should be readily available to the public—rich and poor alike. In a country burdened by one of the highest rates of income disparity in the world (albeit having shown steady improvement over the last 15 years), a universal acceptance and nationalistic fervor regarding cosmetic surgery may seem

counterintuitive (The World Bank 2012). And while the man quoted above, Dr. Ivo Pitanguy—Brazil's current scion of plastic surgery and all-around national hero—helped build this "empire of the scalpel," many have wondered from afar whether or not some other rights for the poor should come first. As Brown (2012) writes in reaction to Edmonds' latest book, *Pretty Modern: Beauty, Sex, and Plastic Surgery in Brazil*:

> [Edmonds] takes seriously what many other analysts have dismissed as a trivial, narcissistic fashion fad and interprets the rise of cosmetic surgery and the beauty culture that it enables and incites as a significant indicator of the modernizing effects of late capitalism in Brazil, applicable as well to other nations on the margins of the modern world. A product of encounters between the globalizing forces of modernity and local Brazilian realities, beauty, he argues, has democratic appeal when, as in Brazil today, authoritarian structures are losing their legitimacy while opportunities for social mobility remain limited. Thus, a first world luxury appropriated by a needy population is claimed as a right when many other rights are denied. (P. 360)

Brown makes an astute point in noting that Brazil's long-standing, culturally embedded narrative of cosmetic surgery is an applicable model to other global communities and will continue to be an important future indicator as other nations' economies make their way from "the margins" to the "modern" world's stage. What better way to start, than by scrutinizing the effects of late capitalism in Brazil, which give a crucial glimpse into the emerging cosmetic surgery patterns that this paper will examine in regards to all the BRIC countries and a few of their neighbors.

For many a young woman in the United States, "Brazil" is synonymous with beauty regimens: the Brazilian Blow-Out to semi-permanently straighten curly hair; the Brazilian bikini wax to make hair barely there; and following in the steps of so many Brazilian supermodels known from the Victoria's Secret catwalk: the Brazilian-cut bikini to show off one's (hopefully ample) lower assets. And, though fewer American women might be familiar with this popular remedy: there is always the imported "Brazilian butt-lift" to help fill out those pesky bikini bottoms if need be. As reported by the *Associated Press*, Brazil performs more than 11.5 million

operations a year and is the world's second biggest consumer of cosmetic surgery after the United States, as well as a hot spot for medical tourism (Barchfield 2012). In fact, Brazil is one of the few nations from which American surgeons and patients actually import cosmetic surgery technology (Jarrín 2010). Usually, and almost universally, it is the other way around. And yet that doesn't mean that the United States hasn't played a role in the introduction and manifestation of the cosmetic surgery phenomenon in Brazil.

The octogenarian "philosopher of plastic surgery," Dr. Ivo Pitanguy completed his postgraduate studies in the United States and Europe, returning with the intent to train new generations of surgeons according to early Western foundations of the specialty (Edmonds 2009:466). In fact, Gilman (1999) contends that, due to his training with some of the pre-eminent European plastic surgeons in the world, "the line from Pitanguy's development of aesthetic surgery in Brazil, where he opened his first clinic in 1963, led in a straight line back to the beginning of [Western] aesthetic surgery at the turn of the [twentieth] century" (p. 215). Dr. Pitanguy's students—numbering over 500 and who have since trained multiple new generations of surgeons—studied the normalization of Brazilian cosmetic surgery through the dissemination of Pitanguy's personal intellectual and psychoanalytical take on the vocation, including the belief that "the goal of plastic surgery is...to harmonize the body with the spirit," and "establish an internal equilibrium" because "people have the right to their own divine image, like their own God" (Edmonds 2009:469, 470; Barchfield 2012).

It is important to note, however, that Pitanguy was writing in 1983, at a time when the popular psychoanalytic concept of the "inferiority complex" and, later, "low self-esteem" had already been used since the nineteenth century in the United States to grant long-sought legitimacy to "beauty doctors" who had been summarily marginalized as "quacks" in the early

medical community (Gilman 1999; Haiken 1997). Much like in the United States, Pitanguy's cerebral and humanistic framing of cosmetic surgery became dominant at a time when he was trying to near single-handedly pioneer a new medical field (and a lucrative one at that—he now lives on his own private island). Dr. Pitanguy became famous performing surgeries on eager legions of the rich and famous, who continue, along with the upper middle classes, to consume cosmetic surgery at record rates among high-profile private practices in Brazil. However, he also aimed to expand the "right" of beauty to all demographics. Pitanguy's early establishment of a well-known surgical wing at the Santa Casa de Misericordia hospital in Rio de Janeiro to provide reconstructive operations for burn victims and people with serious deformities blurred the line between "purely reconstructive" and "cosmetic" surgeries early on by providing discounted cosmetic procedures (Jarrín 2010). In most other established medical communities, the line between reconstructive and cosmetic plastic surgery is made clear through medical ethics rules and made even clearer by insurance carriers. Yet, Pitanguy's specific early emphasis on psychology helped to create a hybrid medicalization of cosmetic surgery that has since been institutionalized by the public and government sectors:

> Emphasizing the 'union' of reconstructive and cosmetic procedures, Pitanguy argues that both types of surgery essentially operate not on pathologies or defects, but on a suffering psyche. In this view, the plastic surgeon becomes 'a psychologist with a scalpel in his hand' – albeit, surgeons are quick to point out, a more effective one (Pitanguy 1976:125)…Pitanguy employs psychologists (including his daughter) to interview candidates and has even described the problem of establishing a 'differential diagnosis' for plastic surgery and psychotherapy (Pitanguy 1992:270). (Edmonds 2009: 466**)**

From this foundation, the public health system in Brazil has justified cosmetic surgery under the World Health Organization's definition outlining that health (as a human right) includes physical, social, and mental well-being, not simply the absence of illness. This allowed eventually for the re-defining of what are widely known in other countries as "elective" cosmetic

surgeries into procedures deemed "necessary" in serving a "social purpose" for the low-income (Edmonds 2009:471).

However, and as usual, there exists a larger benefit to the medical and corporate community that exceeds any actual noble "social purpose"—although many defend it as an exercise in symbiosis. According to Jarrín's (2010) dissertation:

> Pitanguy also laid the groundwork for blurring the distinction between reconstructive and aesthetic surgeries, particularly within his medical school, making it easier for surgeons, medical residents and patients to rebrand elective medical procedures as medically indispensable….This blurring between aesthetic and reconstructive designations allows medical schools to privilege procedures that generate profit in the private market….The Santa Casa da Misericórdia…has become one of the most highly respected plastic surgery schools in the world….This is not because the Pitanguy school is technologically more advanced or its educators more qualified; this is due to the simple fact that the Pitanguy school makes available the largest number of patients willing to undergo aesthetic procedures with medical residents….In other words, the transfer of knowledge from public hospitals to private practices is unique to Brazil, and the main reason for its global recognition….Making low-income patients available as experimental subjects is lauded as democratizing the consumption of beauty, thus portraying the expansion of plastic surgery as humanitarian, non-profitable work. (Pp. 115-116)

On the few days a year when people too poor to afford health insurance can apply for free or cut-rate cosmetic surgeries at certain public hospitals, the patients wait in lines that form outside and around hospitals where Edmonds' "middle-class informants would not set foot" (2009:469). Once their case has been approved, and after facing "labyrinthine bureaucracy, crumbling infrastructure, a lack of privacy, and sometimes rude service," patients often spend months or even years on the waitlist ahead of the actual surgery (Barchfield 2012; Edmonds 2009:469). By word of mouth, patients have become skilled at answering questions in the "correct" way for a surgeon to license their surgery for psychological reasons (and therefore public funding)—and sometimes it is an individual's first or second time ever in a hospital (Jarrín 2010:25). Although patients face long wait times and psychological questioning (where, reportedly, the magic word is *autoestima,* "self-esteem"), patients are rarely turned away (Edmonds 2007:366). Yet, often

during the process, low-income patients simply choose the procedure with the shortest waiting time when they arrive, settling for something other than the cosmetic procedure they desired by getting, for example, the nose job that was available (for teaching purposes) that day, rather than the new breasts they had hoped for (Edmonds 2009).

Moreover, some low-income patients seek out multiple operations "to take advantage of the anesthesia," or otherwise plan a long-term "therapeutic" series of procedures that build as the patient "begin[s] to like [herself] more" (*Ibid.:* p. 475). As one of Edmonds' (2009) ethnographic informants remarked, "You have patients who haven't been to the dentist. If I were poor I would take care of my teeth before having cosmetic surgery"—which strikes an eerie comparison to a low-income American contestant of "Extreme Makeover" who lacked basic health care and was afraid she would lose all her teeth unless she went on T.V. for a full cosmetic surgery transformation that included veneers (*Ibid.*: p. 481; Heyes and Jones 2009, citing Mayer 2005). Another informant of Edmonds', a Chief Surgeon in a public hospital, remarked somewhat nostalgically that during the era of Brazil's dictatorship:

> The hospital was for civil servants, it wasn't for the general people, *povo geral*. But now we attend all the people, *povo tudo mundo*. Before it was for people, gente, more elite, more fine, who didn't break windows, who didn't spit on the floor . . . It was middle class. Now everyone on the street comes, and we need more cleaning because the people really mess it up. (2009:481)

Even though now, after weathering the high-inflation years of the 1980s and neoliberal upheavals of the 1990s, the poor are allowed *inside* the hospitals, Brazil's "ailing two-tiered health system" is still not meeting much of the basic health care needs of low-income populations (Edmonds 2009:467). This begs the question of why the poor and low-income go through so much, including the medical risks involved, to receive elective surgery in lieu of basic health care rights. Furthermore, some have questioned why the majority of cosmetic surgery

patients in Brazil are women (although, of note, Brazil has enjoyed comparatively higher gender parity in male and female cosmetic surgeons than other nations). According to Edmonds (2009), 69 percent of cosmetic operations were performed on women in 2004, and the most popular surgeries are related to life cycle events like puberty, pregnancy, and menopause (p. 482). In fact, Brazil was a precocious developer in what is now known in the United States as the "Mommy Makeover," seeking to correct "minor 'deformities' linked to child bearing," and producing some of the highest rates of caesarian deliveries, tubal ligations, and "vaginal rejuvenation" surgeries in the world, a practice which Edmonds says may relate to an increasing cultural and "symbolic split between motherhood and sexuality" (*Ibid*: p. 483). Nonetheless, the interest in cosmetic surgery does span across genders.

Gilman (1999) writes that the number of Brazilian men undergoing aesthetic surgery increased by 80 percent in just one year (from 8,000 in 1994 to 15,000 in 1995). In another Latin American country, Argentina, "the number of men having procedures soared when President Carlos Menem publicly acknowledged his numerous hair implants, two face-lifts, an eyelid reduction, and teeth replacement" (Gilman 1999:32-33). Even Brazil's most recent former president, populist leader Luiz Inácio Lula da Silva, is widely known to have undergone an "extreme makeover" involving Botox and facial peeling to improve his "working-class" image among disapproving elites (Jarrín 2010:19-20). Moreover, the *Wall Street Journal* reported survey results from a financial-industry trade group indicating that as many as 70 percent of Brazilian women and 50 percent of men wanted plastic surgery as early as 2001 (p. A1). Swami et al. (2011) also found few significant sex differences in acceptance of cosmetic surgery among Brazilian adults in their empirical studies.

Regardless of gender trends, sex may be a major factor contributing to Brazilian cosmetic

surgery culture. As he alludes to in his coinage of the term, the "neoliberal libidinal economy," Edmonds contends that Brazil's national and evolving discourse of sexuality has collided with anxieties surrounding new markets—where "work and sex mingle with fantasies of social mobility, glamour, and modernity" (Edmonds 2007:366). Further explained:

> Plastic surgery does not only grow on the ground prepared, as it were, by the history of medical institutions aimed at female health, but also reflects a history of the body where attractiveness can be embraced as symbol of national identity and attribute of the people. Beauty is not only a key trope in representations of the mixed body politic, but can also be seen in popular culture as an equalizer in that its distribution does not follow class lines (Edmonds 2007a). In these circumstances, beauty practices reflect the mimetic desires that arise in the reciprocal gaze between different social strata. The people can be envisioned as mixed, sensual, and hot, whether incarnated in the traditional mulata dancer leading a samba parade, or by celebrities from 'the popular classes' who have become national sex icons. And some poorer patients in turn adapt the psychotherapeutic language and modern technologies of 'esthetic medicine' to work on the reproductive and sexual body. In the process, a practice of healing that ostensibly targets the lone, suffering ego thus reflects the erotic and class relationships of the larger body politic. (Edmonds 2009:483-484)

According to this analysis, many of the questions above can be explored by examining the roots of Brazil's "larger body politic" and the embedded socioeconomic power structures inextricably linked to its complicated history with race, miscegenation, and state-sponsored eugenics.

The Normalization of Brazil's Eugenics Movement and its Roots in Cosmetic Surgery

Thanks to Jarrín's (2010) exhaustive doctoral research, it becomes clearer that Dr. Ivo Pitanguy is not the only "Father of Plastic Surgery" in Brazil but one of several originators. These include (indirectly) French naturalist Jean-Baptiste Lamarck (1744-1829) for his early (albeit discredited) evolutionary theories that characteristics acquired during an organism's lifetime may be inherited by an organism's offspring, as well as a later offshoot of "Neo-Lamarckism" by Hermann Klaatsch who claimed that human races had evolved independent of each other. These are in addition to "important leaders of the [Brazilian] eugenic movement, like

Renato Kehl, [who] listed plastic surgery as one of the basic medical tools available in the fight against ugliness (Kehl 1923), and the…'father' of Brazilian plastic surgery, Rebello Neto, [who] defended the practice as a way to reduce dysgenic malformations" (Jarrín 2010:136). As a reminder, I provided earlier a common definition for eugenics as a "science" that deals with the improvement (as by control of human mating) of hereditary qualities of a race or breed. Jarrín argues that the eugenics movement is so deeply ingrained in Brazil's consciousness that the nation's popular sociologist-laureate Gilberto Freyre (1900-1987), considered a trailblazer in the nation's "racial democracy" movement to define Brazilian culture as a national asset through the hybridization of African, indigenous, and European elements, employed an "underlying neo-Lamarckian logic that pervades much of [his] work" and forms continuities with previous eugenic arguments (2010:146, 58).

Brazil's unique history made it particularly vulnerable to large-scale eugenics thinking due to its status as a large colony of indigenous people and more than three million African slaves under European Portuguese rule for nearly 300 years, as well as the fact that slavery continued upon the country's independence in 1822—only to be completely abolished in the comparatively late year of 1888 (Lyra and Eulálio 1977). Furthermore, a series of dictatorships and military rule preceded the Republic's democratization in the mid-1980s (Jarrín 2010). Jarrín writes that the period of the late 1800s, known as the "Old Republic," was marked by the desire of the country's ruling alliance of landowner oligarchies to join the global economy through rapid industrialization and urbanization. However, with the new constitution of 1891, little changed in regards to the social order of power, where 98 percent of the population was excluded from democratic participation and black and mixed-race populations (who made up 56 percent of the population in 1890) were reserved the lowest paying jobs due to state and private incentives

to increase the presence of (specifically) white immigrant workers (Jarrín 2010:39).

In fact, Brazil's so-called "racial dilemma" had been discussed among European academic circles for decades, utilizing racist discourse to paint the burgeoning nation as doomed to failure (*Ibid.*: p. 58):

> In 1874, the Count Arthur de Gobineau published a short essay titled *L'Emigratión au Brasil* [Emigration to Brazil], based on his experience as a French diplomat in Rio de Janeiro from 1859 to 1860. In this essay, he claimed that due to the extensive racial "miscegenation" [interracial relationships] occurring in Brazil, this entire society was destined to degeneration and would self-destroy in less than two hundred years. Gobineau described Brazilians as, "a completely mulatto population, polluted in the blood and the spirit, and frighteningly ugly" (Gobineau, quoted in Hofbauer 2006: 128). He argued that only by isolating its most "damaging" ethnic elements and encouraging European immigration, the destruction of Brazil could perhaps be avoided. Gobineau's claims sent shockwaves among the small white elite that controlled Brazil at the time. He had insulted their burgeoning sense of nationalism, and at the same time he seemed to confirm their worst fears that the non-white, extremely poor majority would overrun their authority and condemn the entire nation. In the next few decades, much of the intellectual production in Brazil seemed concerned with proving Gobineau wrong. In the early twentieth century, *miscegenação* [miscegenation] began to be consistently portrayed by the Brazilian intelligentsia not as a degenerative influence, but rather as a constructive force that would create a racially homogeneous country in the long run and render moot the problem of racial difference. (Jarrín 2010:34)

As Jarrín writes, this campaign by the governing elites to solve the "problem of racial difference" employed a neo-Lamarckian understanding of sanitation, race, and improvement of the population created by a scientific discourse of the correct "Brazilian" body, one that was dominated by the "whitening" of certain features, even when "brownness" (*morenidade)* came to be valued (2010:40,146). And despite heralding miscegenation as the solution of how to build a cohesive Brazilian nation, Jarrín (2010) argues that the Brazilian intelligentsia of the 1900s shared many racist assumptions with Gobineau and the European "science" that they admired. For example, Jarrín quotes an argument given by influential professor of public health and legal medicine Afrânio Peixoto in 1938:

> Gobineau predicted that 'children are dying in such high quantities that in the matter of a few, negligible years, there will be no more Brazilians'…Not only is the Brazilian population growing enormously…but racial mixture is also rapidly increasing. The white albumen is purifying the national molasses…Pure blacks do not exist anymore; mestizos disappear, either because they die prematurely due to somatic weaknesses, sensuality, nervousness and sensitivity to tuberculosis, or because they interbreed with whiter elements: thus the race whitens…In Brazil, the great race – that has assimilated and depurated the other two races, which are only undesirable due to their uncultured condition and ugliness – is the white race. Every day morbidity and mortality surrender to the sanitation of housing and of urban settings, in such a way that currently our mortality rate has a very dignified standing among the best in the world. (2010: 35)

Peixoto used a now familiar Brazilian cultural conflation between the undesirable "ugliness" of racial difference and the undesirable condition of poverty, which is repeated by informants of the ethnographic works of both Edmonds and Jarrín, and which relates to Edmonds' (2009) notion of "esthetic health." By creating cultural ideology that casually conflates the pursuit of health and survival with the pursuit of non-ugliness (i.e. beauty), Peixoto and others laid a foundation that is now clearly defined in modern Brazilian beauty culture (albeit absent any mention of race, which is now culturally taboo). Indeed, in his analysis of the significance of this faulty logic, Jarrín notes, "Sanitation complements the work of *miscegenação* by crafting the health conditions for the fittest to survive" (p. 35). Therefore, despite the intent of Peixoto's "counter" argument, Jarrín makes the grave assessment that Peixoto and Gobineau "both seem to agree on the *aesthetic* diagnosis of racialized bodies" (p. 36). Moreover, national Brazilian discourse continued to develop in juxtaposition to protecting 'healthy' urban bodies from the 'sick bodies' of rural migrant workers seeking work in the growing cities.

Anthropometry (spearheaded by Renato Kehl) became a widespread bureaucratic tool for "measuring" the health of the poor by study their physiognomic differences and "[t]he sanitation movement began to use anthropometry as a way to prove that hygienic measures could indeed alter the very dimensions of the human body," thus creating an improved working force for the

growing nation (Jarrín 2010:46). As a result, government-led mass sanitation efforts like mandatory vaccination campaigns initially met with strong popular resistance by these new anthropometric subjects, even resulting in a "Vaccine Revolt" in 1904 (*Ibid.*: p. 41). Furthermore, anthropometric studies among men enlisting for the army were used to try to solve what the Brazilian intelligentsia feared was a "crisis of virility," whereby problems of vice, illness, and social disorder were attributed to "a negative feminization of the population" and the "physical inferiority of Brazilian youth," stereotyped as the "poor, uncivilized, and lethargic rural worker" (*Ibid*: pp. 46-47). In the 1920s, writers like Mário Pinto Serva called for a new "race politics" that would take Brazil toward the "virilization" of modern civilization by molding "a still unformed ethnic mass, heterogeneous and plastic, which will assume the characters imprinted by the mental directors of its evolution" (Jarrín 2010: citing Flores 2007:185).

As Jarrín states, a "new intellectual class…was leading Brazilian modernization, declar[ing] themselves capable…of analyzing working bodies and declaring them fit or unfit" for the state of the nation (p. 48). Accordingly, miscegenation was considered necessary and positive to this intellectual class as long as it resulted in slightly whiter bodies, not the other way around:

> In other words, the Brazilian intelligentsia constructed a *medico-aesthetic visualization* of the body, whereby the subjects under scrutiny were read as aesthetically and eugenically superior according to their proximity to whiteness. Ugliness, on the other hand, was taken as a visible sign of dysgenic traits and racialized illnesses, like the "somatic weaknesses" Peixoto attributes to *mestizos* [those with mixed ancestry]. This particular way of visualizing racial difference allowed the Brazilian intelligentsia to equate their political project of improving the nation's population to the mission of improving the population's health as well. It also allowed intellectuals to portray themselves as the ones with the knowledge, will and leadership necessary to heal the nation. (Jarrín 2010:36)

Two such "healers" of the nation were Renato Kehl, the founder of the Eugenics Society of São Paulo in 1918, who believed the surgical removal of individuals' "malformation[s]" was "one valid technique among many for perfecting the Brazilian 'race'" as a whole, and Rebello Neto,

who quoted Kehl's writings in his efforts to establish plastic surgery as a legally accepted medical specialty in the 1930s (Jarrín 2010:101). According to Souza (2006), Kehl believed that ugliness simply meant the absence of health and that human beauty could be achieved as a eugenic ideal through proper hygienic and medical intervention (i.e. by encouraging only certain people to reproduce) (Jarrín 2010:101). Kehl wrote widely that this type of medical intervention should be "left to doctors" because "[n]ot everyone possesses the judgment necessary to make [the] evaluation" as to whether or not "he is in organic conditions to take on or restrain from" passing his "characteristics" to children (Jarrín 2010:49, quoting Kehl 1917). Yet Kehl did not just focus on preserving a future of "palatable" physical characteristics; he also showed "concern" for present characteristics. Quoted by surgeon Rebello Neto's writings, Kehl's popular book *The Cure of Ugliness* offers one of the earliest justifications of purely cosmetic surgical procedures in Brazilian scientific literature:

> A surgical intervention with the purpose of beautification is justifiable. In this way, one can frequently cheer up those sorrowful, downcast, discouraged and aged individuals due to perfectly removable malformations. In many cases plastic surgery restitutes to these same individuals new animation, new encouragement for life, which will thereafter be happier and full of charm (Jarrín 2010:51)

In this early text, the surgical body is seen as an extension of "life" and mental well-being, without addressing what dire social conditions might have made individuals "downcast" and "discouraged" in the first place. Summarily, Brazilian eugenicists believed that "[t]he 'positive' form of eugenics embraced by Neo-Lamarckism…represented a significantly different approach from that espoused by the 'negative' form of eugenics, popular at the time in Germany and the United States, that sought to [physically] prevent the reproduction of the 'unfit'" (Jarrín 2010:37). And while explicit forms of the eugenic movement declined with the end of World War II amidst revelations of its dangerous social effects and scientific illegitimacy, Jarrín (2010)

argues that Neo-Lamarckian ideals of improvement through beauty have far outlasted the movement by means of Brazil's modern cosmetic surgery culture. Thus, Jarrín's main dissertation arguments related to "affect" and "cosmetic citizenship" are framed by the concept that the "choice" to "personally define and improve oneself according to one's biology is a legacy of eugenics" (2010:27-28). As such, initial practices that sought to produce and "correct" the (too) racialized and gendered body by means of medical intervention adhered directly to the hegemonic aesthetic preferences of a traditional elite seeking to reinforce the existing social hierarchies they dominated.

Thus, it seems that Pitanguy had some help laying the foundation for Brazil's modern cosmetic surgery boom, which even he argued could be a result of "man's search for *eugenia* [eugenesis]" (Jarrín 2010:137, quoting Pitanguy 1993). Even so, when Pitanguy entered the Brazilian medical field after World War II, there was no surplus of Brazilian plastic surgeons and cosmetic surgery was portrayed as a rare luxury item strictly available to the upper class. His colleagues initially rebuffed his ideas to make plastic surgery a medical specialty available in public hospitals, accusing him of taking advantage of masses of poor people to use as "guinea pigs" in order to further his own career (Jarrín 2010). In what some may call an ingenious comparison, Pitanguy (born to a wealthy family) invoked his training with some of the most renowned reconstructive plastic surgeons in the United States and Europe like Gillies, McIndoe, and Iselin, who had built their careers reconstructing soldiers' horrific "visages of war" that had resulted from the unprecedented use of modern weaponry in both world wars (Gilman 1999:159; Jarrín 2010). However, Brazil had not really participated in World War II—so Pitanguy sought to convince his colleagues that the spiraling violence in Brazil's many shanty towns (*favelas*) was a war in itself:

> The experiences I had as I explored the alleyways of favelas, and during my stay in the United States, when I witnessed the return of mutilated soldiers with disfigured faces, made evident that suffering is the same in all latitudes and hemispheres…We live in an era of permanent trauma. Even if war creates a greater concentration of it, the day-to-day succession of urban violence creates just as many mutilations as war (Pitanguy 1998: 75). (Jarrín 2010:111)

Pitanguy's suggestion was not to begin ameliorating through social welfare programs the centuries of social inequality, fear of difference, and lack of resources that had resulted in millions of Afro-Brazilian and indigenous peoples living in crowded, squalid slums. Rather, as Jarrín (2010) writes, his intent was likely to invoke common social narratives in Brazil: that ugliness is a symbol of social disorder and the nation's social inequalities; and that plastic surgery (much like a form of sanitation) is capable of "suturing those inequalities [and] providing an invaluable service to the nation" (p. 112). Moreover, Jarrín notes that it is a continuation of fear of the other—rather than their acceptance—that drives this narrative: "By associating urban violence with war, Pitanguy tapped into the Brazilian imaginary about crime and disorder within the favelas and the fear that this violence might spill out into middle-class neighborhoods" (p. 111). Pitanguy even revived old arguments from criminology, noting that plastic surgery could correct congenital deformities that would, in turn, correct associated lapses in character.

During Brazil's fast-urbanization of the 1950s and 1960s, newspapers capitalized on lurid stories of dark-skinned and "ugly" criminals "descending from the [favela] hillsides to attack 'innocent' residents of wealthier areas" (Jarrín 2010:112). By citing "anthropological studies done on incarcerated criminals," Pitanguy framed the argument that plastic surgery could help reintegrate the poor and criminalized into society (*Ibid:* Pitanguy, quoted in Wolfenson 2005:62). Jarrín writes that "[t]he normalization of these patients through surgery was imagined as removing the racialized traits of their poverty," and thus, "absolving the upper-middle class from the economic and political forms of exclusion it perpetrated on the poor" (pp. 112-113).

Pitanguy's ideas gained ultimate acceptance when, in 1960, then-President Kubitschek granted the plastic surgeon funding to open his now-famous plastic surgery wing for the poor in the Santa Casa da Misericórdia philanthropic hospital—"doubling as a medical school" (Jarrín 2010: 112).

Who Benefits? Private-Public Medicine and the Social Outcomes of Cosmetic Surgery

As previously mentioned, the situation of medical schools in Brazil is unique—allowing surgeons unprecedented access to training and eventual private-sector benefits from a public government source. Although Jarrín writes in his definition of "cosmetic citizenship" that the working-class patients seeking free or low-cost plastic surgeries are "productive actors" who are "keenly aware" that they must be willing to become "bioavailable" subjects for the "advancement" of medical science, the fact that some of Edmonds' ethnographic informants were "functionally illiterate" leaves room for interpretation (Jarrín 2010:23-24; Edmonds 2009:477). Furthermore, in some respects, Jarrín's overarching arguments regarding working classes' agency in seeking "cosmetic citizenship" seem to contradict his lengthy analysis of the deeply embedded inequalities that helped create the medical specialty in the first place. In one example pointedly reminiscent of Jarrín's focus on the vestiges of Neo-Lamarckian and Brazilian eugenic discourse, the director of a residency program in aesthetic medicine told the anthropologist:

> No one is a guinea pig here. [We] provide for the wellbeing of the population, help with their self-esteem, and promote their inclusion in society… Appearance is one of the preponderant factors for individual success. Patients arrive with a lowly physiognomy, but leave with another perspective, exhibiting radical changes. (2010:153)

Of the many problematic issues raised above, one of the most important is the fact that "lowly physiognomies" have become a cash cow in Brazil. As described by Jarrín (2010), the

public monies set aside for "reconstructive" plastic surgery functions as "symbolic capital" that translates into more media recognition and professional prestige, increased funding, more medical students, and a higher number of private clients for surgeons (p. 24). Edmonds (2009) noted that surgeons from over 40 countries have trained in the country's plastic surgery residency programs, with one European resident advertising that during his third year of residency he had performed 96 surgeries, of which 90 percent were cosmetic: "There is nowhere else in the world, where I could have gotten that kind of experience in so short a time" (p. 474).

According to Jarrín's ethnographic account, most of the middle-to-upper classes in Brazil—including the politicians—believe that most, if not all, of the "humanitarian" plastic surgery carried out in public hospitals is used to treat congenital defects and burn victims (2010:24). However, as aspiring U.S. cosmetic surgeons quickly learned in post-World War II America, the relatively low rates of trauma and congenital defects do not make for big business (Sullivan 2001). The fact of the matter is, and for which Pitanguy actually advocated, many public hospitals currently draw an officially "murky" (and unofficially non-existent) distinction between reconstructive and cosmetic surgeries—referred to simply by low-income patients as surgical "repairs" (Jarrín 2010:24). Slightly complicating the matter is a government mandate stipulating that surgeries must be *officially* classified as reconstructive in order to be covered by Brazil's universal health care system (Jarrín 2010).

The majority of the costs of these dubiously legal surgeries are billed to the State, while surgeons subsequently enter the private market to profit from the innovations they developed in their residency or *pro bono* work (including inventions with dangerous potential side effects like the new permanent injectable *bioplastica*). As both Edmonds and Jarrín have noted, this practice raises significant ethical questions, especially since healthcare was "ambitiously defined as a

universal right in Brazil's liberal 1988 constitution, but per capita federal funding has markedly declined since then" (Edmonds 2009:475). Brazil's "universal" health care has been spotty, to say the least, and increasingly driven by "experimental regimes of self-tinkering …[driven by a combination of] market and state political rationalities" (Edmonds 2009:475). And in stark contrast to the droves of ritzy private clinics, much of the innovations in cosmetic surgery at the public level occur in "in messier conditions" [than the U.S.] without cutting-edge equipment and with "so many people to operate on" (*Ibid*: p. 475). Though foreign medical residents often state how impressed they are with the Brazilian "style" of doing more with less, Edmonds (2009) also discusses the ethical conundrum of foreign residents learning through a system of impoverished volunteers—and then bringing cosmetic surgery techniques and "philosophies" back home to another country where the conditions of their training would not have been legal. Furthermore, he notes that the rising number of young cosmetic surgeons is driving down prices, leading to a boom in cosmetic surgery "medical tourism" from foreign patients seeking lower rates for procedures and a vacation package that allows them to discreetly recuperate in a tropical locale (p. 475).

Just a few of the types of "reconstructive" surgeries that consume state health care funding include the official medically termed "correction of the 'negroid nose'" (*nariz negroide*), face lifts, and breast surgeries on minors (Jarrín 2010:149,151; Edmonds 2007, 2009). Alternatively, Jarrín writes that a "wider and non-European" nose is also described as a *nariz de pobre*, "a poor person's nose" (p. 3). This is remarkably unproblematized in a country where the existence of racism is firmly denied and the explicit topic of racial discrimination is considered taboo (Jarrín 2010). Despite this, Jarrín (2010) writes that the now fundamental Brazilian quality of *miscegenação* provides ample discursive space for everyday talk of racial and cultural

hybridity. Even one's color represents a relatively democratic and "fluid" "continuum" in Brazil, defying categories and status, while reportedly making official census data about racial demographics disputable (*Ibid*: p. 145). Jarrín quotes Robin Sheriff's (2001) argument that a form of polite "cultural censorship" exists across all classes, which encourages the absence of the topic of racism within Brazilian public discourse—leading Brazilians to focus solely on "class difference" as the main culprit of societal discrimination (2010:144). Therefore, to the average Brazilian, the use of charged terminology like surgical "correction of the negroid nose" speaks less of race than it does of the supposed ill result of *miscegenação*: having the "wrong" mix or the "wrong" part (Jarrín 2010:141; Holliday 2012). Moreover, plastic surgeons are:

> very careful to represent the surgery they perform not as a deracializing procedure, but as a subtle transformation that will hide its artifice and will bring "harmony" to the patient's features. In all cases, they insist, a patient's essential racial characteristics must be respected. At the same time, however, they are unclear about what represents a patient's essential racial characteristics, since everyone is imagined as racially mixed. On their personal website, for example, two plastic surgeons explain the role of *miscegenação* in producing the "Brazilian's nose." (Jarrín 2010:150)

Despite this supposed racial sensitivity, Jarrín argues that Brazilian figures of speech, such as "*traços finos* [fine features] to describe desirable 'European' facial features" and "*cabelo ruim* [bad hair] used to describe afro-textured hair," reinforce a national beauty standard "where European qualities are subtly enhanced, but not overpowered, by black and Indian influence" (2010:143,145). Moreover, though some surgeons have commented on the desire for white Brazilian women to receive implants to achieve the "buttocks and breasts of black women," while "European noses" are desired by everyone else, Jarrín's white, female upper-middle class ethnographic informants "tried consciously to distinguish their bodies from the body of the mulatta"—considered to be the excessive "export" body of the implanted, *siliconadas* in Carnaval parades (2010:140,72). Furthermore, much like Gilman's (1999) detailed historic

account of the early origins of Western rhinoplasty and the prolific nature of the "too"-racial or "too"-ethnic nose, generations upon generations of Brazilian families continue to "erase traces of…excessive ethnicity, which distances them from beauty" (Jarrín 2010:141). According to one of Jarrín's informants:

> The mixture of races in Brazil left a lot of people with the wrong nose or ["fan-shaped"] ear. That is why people do surgery, to look like those beautiful people that mixed less, like [models of European descent] Gisele Bundchen and Daniella Cicarelli. Sometimes whole families undergo nose surgery so that they do not have their father's nose. (2010:141)

Jarrín brings up the point that those with a primarily white background "are imagined as beautiful because they have predominant European ancestry, yet…still possess the hybridity essential for a genuine Brazilian identity" (p. 141). However, those with predominant African or Indian ancestry are "considered dysgenic and in need of further mixture or additional surgical intervention" (p. 141). Thus, the eugenic movement—taking many forms—maintains a continued, subtle (or not so subtle), and secure hold on much of the Brazilian popular imagination, not to mention its popular media (Machado-Borges 2008).

Magazines, film, and hugely popular telenovelas all reproduce the valued, visual feminine traits of "sensuality, tropicality and hybridity" associated with a "modern" Brazil and popularized by nationalist scholars like Gilberto Freyre, whose "erotico-aesthetics" of a new and thriving "'Luso-tropical' civilization" (one that has a powerful mixture of European and tropical qualities) captivated the Brazilian public (Edmonds 2009:473; Jarrín 2010:58). Edmonds (2009) notes that, in the process, "[f]emale beauty became a kind of national patrimony," partly following a colonial legacy of "eroticizing racial domination" (i.e. male slave owner and female slave) (p. 473). Accordingly, it is well known in Brazil that a mixture of African-European traits is highly valued in producing the prized Brazilian figure of a slender waist and large hips and

buttocks, while breast reduction surgeries soared due to the traditional preference for comparatively small breasts. Gilman (1999) attributes the phenomenon of "sweet sixteen" breast reduction birthday gifts for upper-middle-class Brazilian girls to a means of achieving a "healthy and erotic" cultural body, which does not look "too black" according to early, European racial physiognomic studies of the ethnically too-large and "pendulous" breast, which drove the earliest documented breast-reduction surgeries (p. 225). Gilman also compares this practice to rhinoplasty "gifts" for youth in the Jewish community during the 1950s and '60s up to the current day. Similarly, there is a growing current trend in the United States among some wealthy communities to give the "gift" of breast implants to daughters for high school graduation (Park 2008; Racco 2009).

One of Ivo Pitanguy's most famous contributions to Brazilian cosmetic surgery was his appropriation of the "inverted-T" lift and breast reduction, which left a prominent "T-shaped" scar that was seen as aesthetically normalized due to the popularity of the procedure (Edmonds 2011:300). In contrast, Gilman (1999) writes that Argentinean women had consumed nearly a million breast enlargement operations since 1970 (early even by American standards), stating that, at least at the time of publication, Argentina had the world's highest per-capita ratio of silicone implants. Indeed, with the increased global popularity of "voluptuous" Brazilian Victoria's Secret supermodel Gisele Bündchen (who is not considered incredibly busty by American standards), Brazilian breast implant sales soared in 2001, fast-becoming a "new national passion" and leading to silicone shortages (Karp 2001:A1). Moreover, breast implants, reduction, or both are recommended by some Brazilian surgeons for girls at the "ideal age" of 15 years (*Ibid.*:A1). According to the Brazilian Society of Plastic Surgery, 10 percent of the 300,000 Brazilian plastic-surgery patients in 1999 were teenagers (*Ibid.*:A1). Reflecting this growing

focus on teen cosmetic surgery, Miss Brazil 2001 reportedly had 23 cosmetic treatments before her 22nd birthday, normalizing very early on a model for surgically enhanced beauty competitions, which have spread throughout Latin American urban centers and beyond (Finley 2005).

The Miss Brazil competition's early role in setting pageant standards for cosmetically enhanced beauty may be due in large part to Brazil's eugenic movement. Brazil's first national beauty pageants took place in the 1920s (the first Miss America pageant was held in 1921), and Jarrín (2010) notes that the pageants were considered to be "an attestation of the physical qualities of a race [and] a testimony of eugenic fitness" in relation to other countries (p. 57, quoted in Besse 2005). Accordingly, the Brazilian intelligentsia discussed whether to choose the first "Miss Brasil" based on "strict anthropometric measurements" and/or based on a pool of white-only contestants (*Ibid*: p. 57). Ultimately, in an effort to make the pageant more inclusive, the contests were held at the city level, allowing for "Afro-Brazilian social clubs to crown their own queens" (*Ibid*: p. 57). In this way, Jarrín writes, "[f]emale beauty came to be seen as a nationalistic objective in which everyone could participate, and a signifier of the country's eugenic improvement" (2010:57).

Today, Brazilian media has utilized the pageant competition model in popular "reality" television shows such as "Beauty in the Favela," which in its first season sent model scouts to some of Brazil's poorest areas to "reveal…diamond[s] hidden" therein (Jarrín 2010:188). However, Jarrín notes that the scouts tended almost exclusively to favor girls with the "fine features" that "would be considered beautiful in the wealthy South Zones of Rio de Janeiro or São Paulo" (*Ibid.* p.188). Furthermore, beauty contests proliferate throughout the nation, generating pageants as varied as "black beauty" contests (bolstered by models of U.S. African-

American politics), “indigenous beauty contests” (a girl of indigenous descent in 2008 was the first to be accepted as a national contestant in Miss Brasil), “Miss Penitentiary” contests for “elevating the self-esteem” of female prisoners, and even the tongue-in-cheek “Concrete-Roof Girl,” an all-natural, working-class pageant that takes place in lingerie and eschews cosmetic surgery (Jarrín 2010:196-199).

But despite this somewhat light-hearted and pluralistic take on pageantry, both Jarrín and Edmonds ultimately assess the fact that Brazil’s cosmetic surgery and beauty culture navigates serious socio-economic terrain. Quoting Jean and John Comaroff (2000), Jarrín (2010) compares the uncertainty of Brazil's "millennial capitalism" to the global rise of "occult economies" that aim to "magically" produce value out of nothing—thereby "providing individuals reasons to hope in nearly hopeless situations" (p. 168). In Brazil, Jarrín argues, beauty is "one such form of magic...because it links hope to performances of femininity that are associated with upward mobility and citizenship" (*Ibid.* p. 168). In this view, the only guaranteed capital that low-income women possess are their bodies, "even if racism and sexism has historically excluded these women through those very same bodies" (*Ibid.* p. 169). However, as Jarrín writes, people of all classes in Brazil communicate their social standing through the body—with the general understanding that the *gente bonita* "beautiful people," a term interchangeable with the upper-middle class, are beautiful because they have money and the "ugly" are only unattractive because they are "poor" (2010:2):

> Since the body is considered to be infinitely malleable, a person who climbs the social ladder is expected to transform their body to conform to upper-middle class standards. My working-class interviewees would explain to me how the first thing a person does when they become successful is to straighten their hair and get a thinner nose through plastic surgery. As proof, they would show me examples of Brazilian celebrities “before” and “after” their fame, and remark: “They were not ugly, they were poor!” (P. 2)

Edmonds (2007) adds to the discussion of the "increasing fungibility and circulation of different forms of capital" by quoting Simmel (1907), who argues that money flows increasingly level traditional distinctions, drawing attention to the "relativistic character of existence" through generalized transactions (p. 376). Edmonds uses this example to describe how the bourgeoisie were able to convert capital into social position in the early stages of capitalism, while in late capitalism, the body itself has become an important unit of exchange "in the markets of production and reproduction, work and sex," thus weakening older forms of "moral restrictions" on the body, but also simultaneously inserting the body into the hazards of an expanding, capitalistic "beauty" market (pp. 376-377). In a similar vein to Shilling's (1993) concepts about "marketing character" and noting that a "growing importance of body capital incites fantasies of social ascent" (inferring the absence of real social mobility), Edmonds reveals in a later work that not all of his ethnographic informants utilized the Pintaguy-sanctioned psychological "diagnosis" of self-esteem to explain their surgeries (2007:377):

> Patients give quite diverse reasons for having surgery. Some mention job anxieties in Brazil's expanding service and informal economies, where appearance and youth often become a form of 'value' (Edmonds 2007a). Others describe their operations as simply *uma coisa da mulher*, 'a woman's thing', and either do not understand or simply scoff at the therapeutic rationale. Janaina, who had retired from a job as a 'mulata' (here a job description, not a racial term) in a traveling samba show, said 'Look, I'm going to do this surgery not because I'm bad in the head, but because I'm bad in the body. It's useless to think surgery will make you good in the head' (Edmonds 2009:477-478).

One may ask, however, whether it is actually "useful" for low-income peoples to invest in their bodies (rather than some other capital) or whether cosmetic surgeries only provide false extensions of hope in near "hopeless" socioeconomic conditions.

A look at the current state of Brazil's economy might shed some light. Although the jury is still out on how much Brazilian beauty culture actually serves the well-being of the working class, the benefits reaped by the beauty industry are quite clear. Armed with recent increases in

real income and better living conditions as a result of new government assistance programs and a growing global economy, working-class Brazilians have contributed their "explosive" new spending power to the nation's hygiene and beauty sector at high rates (Jarrín 2010:20-21). Brazil is now the third largest global consumer of beauty products in the world, after Japan and the U.S. (which have much larger economies), and the Brazilian beauty industry expanded by 11 percent even at the height of the 2009 global economic crisis (*Ibid.*). Even more surprising is recent data showing that working class families spend a share of their average monthly income on beauty products that is more than five times the share of total income spent by upper-middle class families (5 percent compared to less than 1 percent) (Jarrín 2010:21, quoting *Gazeta do Povo* 2009). A beauty regimen and a "good appearance" are considered essential ingredients for upward mobility (Jarrín 2010). This buying power has also resulted in working-class families being a major new target for marketing schemes and credit agencies (*Ibid.*).

Media outlets have silenced any social criticism of the cosmetic surgery boom with the argument that more *plástica* is merely a positive indicator of Brazil's economic health and a rise in the middle class (Edmonds 2007). But, as Edmonds (2007) argues, the growth in cosmetic surgery cannot be explained as a product of economic prosperity because "wealthier European countries have per capita cosmetic surgery rates only about a fifth of Brazil's...and the so-called 'democratization' of *plástica* occurred during a period of rising economic inequality [and 'savage capitalism'] in the 1980s and 1990s" (p. 365: citing Mello and Novais 1998). In alternate explanations, Edmonds (2007) states the case for "'sexual-aesthetic' motives" related to Brazilians' quest to pursue a "more perfect," eroticized body in the midst of changing social landscapes (i.e. rising divorce rates), as well as "conditions of scarcity [and] a hunger for modern consumer and technological wonders [that] produce medical and corporeal fetishism" (p. 375). In

short, Edmonds notes that women over forty with *plastica* increasingly find themselves in or near the playing field of women in their twenties, who, by now, are as likely to consume just as much cosmetic surgery (Brazilian rates of teenagers receiving cosmetic surgery had already reached 21 percent in 2004) (Edmonds 2007).

However, in terms of BRIC countries, the "modern" job economy may be one of the most important cosmetic surgery catalysts worthy of study (and it will be explored further in later sections). In Brazil, for example, Caldwell (2007) indicates that the all-important and aforementioned *boa aparência* "good appearance" is a term with racial undertones, having been used extensively in job advertisements to euphemize the preference of white applicants after such discriminatory prerequisites became illegal in 1951 (Jarrín 2010:89). Moreover, Jarrín writes:

> Only in 1995 was the phrase *boa aparência* also banned from appearing in job advertisements, an important victory by the black movement in Brazil, but unfortunately the cultural weight given to having the "right" appearance for white-collar jobs has not diminished. Today, magazines, websites and television programs continue to expound the importance of *boa aparência* in the job market, even if they circumvent the question of race, and claim that it consists of taking care of one's hygiene and having the right clothes and right attitude...for white-collar jobs – men are expected to cut their hair short and women are expected to straighten it if they have afrotextured hair. (2010:89-90)

A job consultant quoted in an online magazine describes *boa aparência* as being "always within a more common prototype: slim, light skinned, with *traços finos* [fine features]. People look not only for beautiful individuals, but for a standard type of beauty, that is not exotic or different" (*Ibid.* p. 90, citing *Bolsa de Mulher* 2005). Jarrín (2010) contends that, by creating and enforcing an index of physical characteristics that are suitable and unsuitable for well-paying jobs, social hierarchies are reinforced and cosmetic surgery becomes an economic necessity more than a physical vanity.

So, is anyone speaking out publicly about cosmetic surgery's blatant ties to inequality in

the nation, or at least against the existence of latent racism in the job market? It seems very few. Notably, Brazil's first black Supreme Court Justice appointed in 2003, Joaquim Barbosa, has recently made headlines not only for his recent landmark conviction of powerful white-collar politicians in the nation's biggest ever corruption trial, but also for choosing to publicly speak out about the nation's racial discrimination: "Nobody talks about it," he told *Reuters* in a recent interview, "I do the opposite. I make it public" (Boadle and Flor 2012). Yet for the many Afro-Brazilian and Indigenous-descended citizens who continue to lack a prestigious public forum, Jarrín (2010) notes that appearance is everything. As one of his unemployed informants lamented:

> People don't look at your clothes, they look at your body. Women run a risk [getting surgery], but if it is successful, as in most cases, it's worth it…Appearance is important to have credibility and from there on to gain trust. It doesn't matter if one is intelligent or one has a degree, immediately it is appearance that counts. Only after the exterior does the interior matter…Brazil is a developing country, and women work at home and outside of the home, in areas of risk, and this ages you...A person who makes a small salary, who doesn't eat well and has a bad marriage, is going to feel ugly. (P. 91)

The informant above makes an important reference to the highly complicated relationship between exterior and interior narratives in late modernity. Similar to Askegaard et al.'s use of Giddens' model, where human relationships (in this case, career contacts) are characterized by little to no permanence or depth, anxiety and outward risk seem increasingly controllable through the tangible augmentation of bodily charm. Yet unlike, the Western-centric theoretical model where the individual chooses to continually construct and re-construct identity in an array of endless consumer and lifestyle choices, the average low-income Brazilian consumer is forced to construct a *particular* identity in order to unlock a lifestyle where "choice" is even an option.

In sum, we have learned that the origins of Brazilian cosmetic surgery culture are deeply ensconced in its earlier nationalistic eugenic movement and that the practice was normalized

largely as a result of Pitanguy's comparisons of poverty to war wounds and cosmetic surgery to psychoanalytic therapy. We have seen how commercialized medicine and a hybrid public/private medical training model has fueled the nation's rise as an internationally renowned "empire of the scalpel" and how successful assimilation and class mobility continues to hinge on particular racial characteristics over a century after the end of colonialism and slavery. In terms of Shome's (2000) concept of the invisible everydayness of "whiteness," Brazil—a nation that prides itself as being collectively post-race due to miscegenation—has long effaced issues of race with the discourse of beauty. Narratives of the "modern" Brazilian female body and beauty regimen have become synonymous with the nation itself and known throughout the world. Furthermore, a narrow definition of beauty has become the visual definition of high socioeconomic status and the key to social mobility in a nation still burdened by some of the highest rates of income disparity in the world. Accordingly, Brazil represents a uniquely powerful starting point for the discussion of BRIC cosmetic surgery cultures due to the population's complex and intimate relationships with transformative beauty ideals and its deeply embedded "cultural consonance" of the body, in which embodied and emotional health outcomes become contingent upon individuals' perceived degree of success in achieving culturally-defined body norms (Dressler et al. 2012:331).

As far as the outstanding question of agency, Jarrín concedes beauty in modern Brazil to be a perception of social worth and recognition in which "everyone must stake a claim" (2010:16). Jarrín rejects the treatment of Brazilian working-class *plastica* as a static imitation of upper-middle class consumption and instead frames the practice as a somatic, political struggle, which can be used as a source of social instability to challenge historical inequalities (2010). For him, working class "actors" create political dimensions of beauty that complicate existing

hierarchies of "who deserves and who does not deserve to be recognized as a full citizen" through the "right of beauty" (p. 5). However, although Jarrín discusses the necessary "instability" noted in Foucauldian power structures, Bordo (1990) warns against a penchant for mis-framing the power of political struggle in terms of creative *jouissance*. Jarrín aims to qualify Foucault's theory that bodies are constructed discursively by emphasizing the "sensorial construction" of how individuals filter discourse, which Jarrín argues opens up political space for social change (p. 10). Yet, out of all the ways human beings can open up political space and demand citizenship, I would question whether the best way to go about it is for marginalized groups to "actively" embrace the corporate-consumer system once built to exclude them by allowing medical students to surgically alter their bodies in a throwback to racist-eugenic thinking. Jarrín also invokes Canclini's (1995) argument that consumers should not be understood as passive capitalist targets, but as "citizens-in-the-making who use products as powerful semiotic communications which politically and collectively affirm their place in the world" (2010:21). That school of thought stands in stark contrast to the aim of this paper, which seeks to question the existence of legitimate agency in a global system of embodied commoditization that seems to "reward" emerging "citizens" of the world with pre-packaged "modernity" in exchange for their role as consumers of pre-determined beauty ideals that cyclically reinforce existing hierarchies.

In closing, I am more aligned with Edmonds' (2009) view that, while the negative social origins and effects of cosmetic surgery culture surely exist, they have evolved to become "a touchstone for fears and aspirations surrounding modernity in the developing world," and thus scholars should resist the equally reductive binary analyses of either active self-empowerment or patriarchal oppression (p. 485). Edmonds (2007) adds that:

> [a]t a time when plastic surgery is growing in developing countries around the world, from Latin America to the Middle East and East Asia, the Brazilian case, I hope, will offer insights into how new configurations of medicine, therapy, and aesthetics are consumed in the peripheries of capitalism. (P. 366)

Conveniently, the statement above summarizes just exactly what my paper aims to do.

As stated at the outset, no academic work has yet sought to examine the globalization of cosmetic surgery from a macro view. By widening the geographic subject area to include the examination of multiple nations' cosmetic surgery cultures, I am able to better identify traceable, common patterns that indicate the hybrid scope of cosmetic surgery's global past and future. Brazil has shown how "peripheral regions can also be at the vanguard of medical 'innovation,' as patients and surgeons adapt a global medical practice to local conditions, creating new philosophies of health" (Edmonds 2009:484). However, the case of Brazil also raises grave ethical questions about the sociopolitical roots of cosmetic surgery and how it has come to be embedded and normalized in national and global discourse. As anthropologist Nancy Scheper-Hughes recently quipped in a review of Edmonds' (2010) book about low-income *plastica*: "'Only intellectuals like misery,' Edmonds... tells us through the voice of João Trinta, Carnival parade designer, 'the poor prefer luxury.' But misery wears many different guises" (2012:516).

CENTRAL EUROPE AND THE WEST: THE HUB OF INNOVATION

In Brazil, we see that the growing effects of cosmetic "modernity" are anachronistically dependent on embedded social structures related to early European pseudo-scientific eugenic movements. However, in order to contextualize and make clear the direct correlation between the two, it is necessary to revisit the history and social environment of the earliest pioneers of modern plastic surgery as we know it and the ways in which their own world views, political environments, and social statuses have indelibly marked the practice and future globalization of

cosmetic surgery. Furthermore, as this academic examination continues its journey across BRIC countries, Russia—as the stalwart of northern Eurasia—represents a connecting outlier, exhibiting both unique and parallel characteristics to cosmetic surgery cultures in East and South Asia as well as the West.

American cultural historian Dr. Sander Gilman provides a crucial window into the modern European "forefathers" of reconstructive and aesthetic plastic surgery. These were the men to whom young American surgeons flocked, seeking overseas plastic surgery training in the wake of World War I (Haiken 1997). As we will learn, many of these early European surgeons were in the margins, navigating the complicated political waters of pre-fascist Germany and a fast-transforming Europe as "colonials or Jews or people of mixed race or women" (Gilman 1999:158).

The Origins of Western Cosmetic Surgery

Modern-day historians have identified various writings detailing the practice of incisions and skin grafts to re-create lost noses in ancient India (900 B.C.E) and fifteenth century Italy, as well as to restore foreskin to circumcised penises among ancient Greeks and Romans, according to Roman physician Aulus Cornelius Celsus (25 B.C.E.-50 C.E.) (Gilman 1999; Haiken 1997). However, reconstructive "plastic" surgical technology was often lost and re-discovered throughout the centuries (*Ibid.*). Johann Friedrich Dieffenbach, the innovative German reconstructive surgeon considered one of the several "father(s) of plastic surgery," resurrected the Renaissance label "beauty surgery" in 1840s Berlin in order to contrast it negatively to the necessary practice of "real medical" reconstructive surgery (Gilman 1999:12). As Gilman notes, Dieffenbach's early and purposeful attempts to draw a clear line between the work of reconstructive surgeons alleviating debilitating deformities as compared to dangerous quacks

selling "beauty" to the average-looking person created an initial professional juxtaposition that was "seemingly arbitrary, but always meaningful" (1999:12). In fact, Dieffenbach's differentiation would have been welcome to many of his contemporaries like American surgeon Dr. John Peter Mettauer who lamented in late 1830s Virginia that he was "willing to hazard all that ignorance and presumption can possibly incur by any efforts which I might make in attempting to correct a natural deformity if the happiness and comfort of a fellow being could thereby be promoted even in an inconsiderable degree" (*Ibid.*: p. 44). Dr. Mettaurer's pioneering reconstructive work to correct devastating cleft palates and vesicovaginal fistulae (in child-bearing women) apparently exposed him "to the ridicule and sarcasm of short sighted if not invidious fatalism" from other American surgeons who lived strictly by the code that certain defects of the body were God's plan (*Ibid.*: p. 45). According to Gilman, many physicians of the time were influenced by seventeenth century English literary and cultural stalwart John Dryden, who wrote, "God did not make his Works for man to mend" (1999:45).

Save any spiritual commitment, this religious conservatism may have had more practical roots. For example, "elective" procedures were likely taboo in the 1800s because antisepsis and anesthesia were yet to be discovered and any patient (and surgeon) who chose surgical intervention was dangerously risking both infection and death (Gilman 1999; Haiken 1997). Furthermore, some of the most common deformities of the time had become synonymous with markers of disease, which allowed the "healthy" to identify and shun those they feared might be contagious. Syphilis had already ravaged European populations for centuries, leading not only to the complete loss of many noses but also to a congenital condition among the children of syphilis carriers to have collapsed bridges of the nose. Dieffenbauch rose to surgical fame exploring how to ameliorate this "saddle nose" by attempting to insert various materials into the bridge between

1829 and 1832. He helped originate a long tradition of trying to rebuild the nose with materials like rubber, celluloid, iron, copper, platinum, gold, ivory, and, later, paraffin wax, which were generally rejected by the body over time, causing scarring (Haiken 1997).

Even though, in the nineteenth century, a collapsed nasal bridge could indicate a range of diagnoses besides syphilis, including scrofula (tuberculosis), lupus, leprosy, or a tragic accident—the saddle nose fast became a powerfully stigmatized marker of illness, uncleanliness, and immorality (Haiken1997; Gilman 1999). Often viewed in "horror and loathing" by a public "apt to regard the deformity as a just punishment for [the patient's] sins," Dr. Dieffenbach's writings revealed his dismay: "As if all people with noses were always guiltless!" (Gilman 1999:51). For these reasons, and the need to get out and earn a living, many patients were willing to risk death for "an almost human nose" (*Ibid.*: p. 59). Six decades later, German surgeon James Adolf Israel would perform the first bone grafts to repair "the sunken, syphilitic nose" at the Jewish Hospital in Berlin, laying the groundwork for the kind of nose augmentation surgeries that are currently performed in East Asia to achieve a slightly more "Western" look. Moreover, like Dieffenbach, Gilman writes that Israel was "returning individuals to the category of the employable...mean[ing] that they were now visible members of the working class" (1999:57).

But it wasn't just noses in the late 1800s that were being reconstructed through new medical technologies. American gynecologist Howard Atwood Kelly is not only credited with helping to found Johns Hopkins Hospital and establishing gynecology as a true specialty; in 1899 he also published a report of his first fat removal surgery on "a Jewess, Mrs. M., thirty-two years of age...with the complaint of 'excessive fat over the lower part of the abdomen,'" as well as a "'neuralgic headache'" (Gilman 1999:231, citing Kelly 1899:300). "Mrs. M." was reported to be nearly 300 pounds and had already undergone an early form of "pendulous" breast reduction

surgery with another Baltimore surgeon (*Ibid.*). In the end, the surgeons had removed a total of 40 pounds of flesh, leaving her without nipples or a belly button. As Gilman argues, it was no coincidence that "the body that began the history of the aesthetic surgery of the abdomen was a Jewish woman's body" (1999:231-232). One of the common visual stereotypes of the Jewish woman at the turn of the century was a heavy-set, large-breasted "primitive" female body (*Ibid.*: pp. 232-233). Moreover, Gilman notes that there was a "long German tradition of the ethnological understanding of the Jewish female body," underscored by writings such as those of Viennese archeologist Hugo Obermaier who used a journal entry to describe a "primitive" statue he discovered in 1908 as "a schematically degenerate figure...No face, only fat and feminine, prosperity, fertility, compare today's lazy/rotten [*faule*] Jewessses" (*Ibid.*: p. 232). Of course this virulent racist discourse was not limited to Germany or Jewish targets.

Largely popularized by Swiss "physiognomist" Johann Caspar Lavater (1741-1801), the practice of systematically attempting to assess a person's character or personality from his or her outer appearance fast "established the flattened nose as the icon of the black [person]" (*Ibid.*: p. 88). Lavater's ideas and the emerging "science of race" later spread throughout Europe and also held sway during unprecedented patterns of immigration to the United States from eastern and southern European countries, including Russia, Poland, and Italy, between 1890 and 1920. This ideology lent false "scientific" weight to the much publicized American physiognomy fad, which claimed that "small features indicated virtue and 'great delicacy of sentiment,' while large features indicated sensuality and slothfulness" (Haiken 1997:178). According to one tabulation from Haiken's research, between 1910 and 1914, American "general-interest magazines carried more articles on eugenics than on the topics of slums, tenements, and living conditions combined" (1997:179-180). In 1920, Knight Dunlap, one of the most prominent academic

figures in the establishment of the American discipline of psychology, published (early in his career) *Personal Beauty and Racial Betterment,* stating that "negative conditions," which deviated significantly from the "average" and thus precluded "beauty," were particularly visible in "negroid characters" because "[t]he type which is highest in value tends to approximate the European type, *wherever the European type becomes known*" and "[a]ll dark races prefer white skin" (Haiken 1997:181; emphasis mine).

Nearly two centuries earlier, Lavater's popular physiognomic texts had spread disturbing ideas from French and German intellectuals associating the "strong, fleshy" black body with lazy and slow temperaments, tropic environments and disease, as well as corporeal justifications for slavery (Gilman 1999:88*).* Furthermore, Lavater's characterization of Jews as a people with "short, black, curly hair" and "brown skin" is similar to nineteenth century Scottish anatomist Robert Knox's assertion of the "African character of the Jew" (*Ibid.:* p. 89). It became increasingly common in nineteenth century ethnology "studies" to spread the assumption that Jews shared a specifically close racial relationship with and had likely intermixed with black peoples.

Although accepted modern science now concludes that the earliest ancestors of *all* human beings originated from the continent of Africa and that any two humans are roughly 99.9 percent identical at the DNA sequence level, white Anglo-Saxon "racial anthropologists" of the 1880s certainly liked to pick and choose (National Coalition for Health Professional Education in Genetics 2012). They also saw the Irish "as derived directly from the big-eared Cro-Magnon man with a 'nose, oftener concave than straight' and with 'low intelligence,'" which led them to the foregone conclusion: "While Ireland is apparently its present centre, most of its lineaments are such as to lead us to think of Africa as its possible birthplace" (Gilman 1999:94). In order to

remedy the so-called primitive and dehumanizing marker of the Irish "pug nose," New York otolaryngologist (ear, nose, and throat doctor) John Orlando Roe sought in 1887 to help new immigrants by dispensing a new (intra- or endonasal) scar-less surgical "cure" for those wanting to "pass" as "Anglo-Saxons" (1999:91). However, Roe's fervor for noses went even further, leading him to divide the image of the nose into five categories, with each type of nose indicating qualities of character, following Samuel Wells' physiognomic theories of the time:

> The Roman [nose] indicates executiveness or strength; the Greek, refinement; the Jewish, commercialism or desire of gain; the Snub or Pug, weakness and lack of development; the Celestial [or turned-up nose], weakness, lack of development, and inquisitiveness. (Gilman 1999:93, quoting Roe n.d.:114)

According to texts, Roe saw himself as an "artist" and a "sculptor" who cured the kind of "mental distress" which can lead "after a time to a permanent distortion of the countenance" (*Ibid.*: p. 94). Moreover, Roe indicated that the "snub-nose" is "proof of a degeneracy of the human race" (*Ibid*: p. 93).

Gilman writes that during the United States' "Gilded Age" there was an "obsessive focus on racial 'passing'", where "[t]he Irish nose is the African nose is the Jewish nose," all considered nearly interchangeably deviant because they all represented difference (1999:161, 94). For Hans Friedrich Karl Günther, an influential German racial anthropologist/eugenicist during the Weimar Republic and, later, a member of the Nazi Party under the Third Reich, there was also a competition between the "black Jews" and the "white Jews," which he summarized as a conflict of the blunt noses against the long noses (Gilman 1999:91). Günther's anti-Semitic ravings also emphasized the "large, red ears" and "fleshy ear lobes" of Jewish males, called "Moritz ears" (in reference to a typical Jewish surname of the day), which Gilman has aptly accompanied with a much earlier 1888 illustration of individual "Jewish" body parts classified by number and with subtitles (*Ibid*: p. 126):

> *How We May Know Him*.: Fig. 1. Restless suspicious eyes.; Fig. 2. Curved nose and nostrils.; Fig. 3. Ill-shapen ears of great size like those of a bat.; Fig. 4. Thick lips and sharp rat's teeth; Fig. 5. Round knees; Fig. 6. Low brow; Fig. 7. Long clammy fingers; Fig. 8. Flat feet; Fig 9. Repulsive rear view [of the head, ears and neck]. (1999:128)

Meanwhile, amidst this social backdrop, Jakob Lewin Joseph, the son of a Rabbi, would become "Jacques" Joseph, one of the preeminent and most influential plastic surgeons in Berlin and the entire Western world. For purposes of perspective, the aforementioned eugenicist Günther was appointed the chair of racial theory at a major German university and was teaching in Berlin while Joseph was still practicing medicine there in his sixties (*Ibid*: p. 122). Gilman writes that Joseph "altered his too-Jewish name when he studied medicine in Berlin and Leipzig," and photos of him reveal conspicuous "dueling scars" on his face, which were important signs of masculine honor and acceptance into "conservative dueling fraternities" that were popular in the 1880s and a visible part of the German Christian mainstream (1999:122). After his medical training, Joseph took an apprenticeship with orthopedic surgeon Julius Wolff (who was also Jewish) but was dismissed in 1896 after undertaking an unauthorized procedure to correct the protruding ears of a young child. In 1890s Berlin (and in the tradition of Dieffenbach), Gilman notes that this type of operation was seen as "beauty" rather than "real" surgery (1999:125). However, and as witnessed above, undergoing surgery to correct "bat ears" (otoplasty) in 1890s Berlin would have also been a highly sensitive and racially charged decision. According to Jarrín (2010), and as stated in the previous section, "fan-shaped ears" or "Dumbo ears" are still associated with blackness and poverty in modern-day Brazil, and ear and nose surgeries are common "among upper-middle class families of Jewish and Arab descent that want to erase or attenuate 'ethnic' traces that might mark them as un-Brazilian" (p. 140). It is telling then that over a century ago Jacques Joseph was willing to risk his post in the beginning of his medical career to innovate such a procedure.

In fact, Joseph was able to start building a successful career and an extensive "patient population among the Jews in Central Europe" due to his innovations in primarily aesthetic surgeries (Gilman 1999:134). Just two years after his dismissal from Wolff, Joseph took on a patient whose prominent nose made him the target of stares and "ridiculing gestures" (*Ibid.*: p. 132). Joseph decided to perform his first reduction rhinoplasty, reporting on the innovative new procedure to the Berlin Medical Society in May of 1898. Furthermore, Joseph defended the scientific rationale for the procedure by touting the psychological effect on the patient, whose wife reported that he now wished "to attend and give parties" (*Ibid.*: p. 132). Yet, because this surgery had left tell-tale scars, Joseph became focused on achieving a scar-less and invisible nose reduction by operating through the nostrils (although Joseph is often credited with devising the first "intranasal" procedure, he acknowledged that American surgeon Roe originated it a decade prior) (Haiken 1997:306n5). Soon known as "*Nasen-Josef*" (nose-Joseph) or "Nosef," Jacques Joseph focused largely on those concerned about their "nostrility" as well as "hump noses" (Gilman 1999:133-134,177). His clientele "was heavily Jewish, and he regularly reduced 'Jewish noses' to so-called 'gentile contours,'" while "[m]any of his patients underwent the operation 'to conceal their origins'" (Gilman 1999:154). According to Gilman, Joseph justified the procedures in the medical community by calling upon the rationale of "the psychological damage done by the nose's shape," and "[t]his was one of the rationales cited by the other German-Jewish aesthetic surgeons of the period" (1999:154,155).

It is safe to argue, however, that the real source of this "psychological damage" was due to much greater forces of social exclusion, cultural derision, anti-Semitism, and fear—with the prominent nose being the easiest visual scapegoat. Haiken writes that the first groups of American practitioners to perform similar nose reductions in the late nineteenth century were

inspired by the work of Roe and Joseph and "already recognized that Jews and other ethnic Americans represented a large potential market" (1997:184). Southern and eastern European immigrants and their surgeons generally avoided the explicit subject of ethnicity, with patients asserting that they had no desire to deny their (often Jewish) religion or heritage, but merely hoped to blend in better and reap the benefits of being indistinguishably "American" (Haiken 1997:184*).* As noted by Haiken (1997) and Gilman (1999), some German and Mediterranean-American patients also sought nose (or later lip) reduction surgeries for fear that they might be mistaken as having undesirable ethnic "blood" (Haiken 1997:211).

This pattern of tandem German and American aesthetic surgical innovations continued with the first anti-aging procedures, often reportedly with the help of insistent female patients who had clear ideas about how to accomplish new surgeries. In 1901, according to his much later account, German surgeon and cultural historian Eugen Holländer completed the first *rhytidectomy* or "face lift" on a Polish aristocrat (Gilman 1999). The woman came in with a drawing to illustrate how she believed facial skin could be removed at the front of the ear and corners of the mouth in order to tighten the skin. Holländer did not initially want to undertake the procedure but said that he was compelled to do so through “feminine persuasion" (Gilman 1999: 310). In 1906, Erich Lexer undertook a similar procedure on an actress who had been taping her skin and securing it with rubber bands at the top of her skull, stretching out her skin, but also "provid[ing] a model for how a corrective procedure could be undertaken…[through] S-shaped incisions of skin at the temples, behind the ears and at the hair-line" (Gilman 1999:310). The rather notorious American surgeon Charles Conrad Miller wrote that he had already developed procedures to create dimples, alter lips, and remove “bag-like folds of eyelid skin” in 1906 (Haiken 1997; Gilman 1999:310). (Gilman actually asserts that Johann C.G. Fricke introduced

the modern term *blepharoplasty* as early as 1829.) And, in a morbid early precursor to Botox, Miller advocated for (though it is not clear he ever attempted) “subcutaneous dissection" of certain facial nerves and muscles to prevent the formation of "expression lines," to which he believed women were particularly prone (Haiken 1997:25). In 1912, Jacques Joseph himself developed a procedure to tighten sagging cheeks and, in the same year, a French woman became known throughout Paris for her discreet beauty surgeries (Gilman 1999; Sullivan 2001):

> In Paris, following the lead of Holländer and Lexer in listening to their patients, Suzanne Noël began to excise excess skin in order to tighten the face and remove wrinkles. She began [out of her home] in 1912 when an actress returned home from America (perhaps with a session with Miller in Chicago) and showed her the results of the procedures she had undergone there. The social stigma of such procedures in Paris was clear: "Women have their operations and do not talk about it," Noël wrote. (Gilman 1999:311)

In the U.S. a decade later, popular Jewish actress and Ziegfeld Follies star Fanny Brice shocked the American public by undergoing one of the first nationally publicized nose jobs in 1923, a time when the practice was still kept under wraps and most U.S. "beauty doctors" continued to be regarded with suspicion (Haiken 1997; Gilman 1999). (Ironically, Fanny Brice was portrayed in the 1968 film “Funny Girl” by Barbra Streisand, who won an Academy Award for the performance and is oft-referenced in cosmetic surgery studies for her refusal to alter her own “Jewish” nose). In 1920, New York surgeon Gustav Tieck reported that he had corrected the noses of over one thousand patients in the prior 12 years, yet had hesitated to previously report his work, wanting to make sure that it would be received on a "definite scientific basis" (Haiken 1997:35). By 1936, future founder of the American Board of Plastic Surgery, Dr. Vilray Blair, had finally ceased to oppose surgeries for “Jewish” noses stating that, "[c]hange in the shape of the pronounced Jewish nose may be sought for either social or business reasons" (*Ibid*: p. 184). A rare survey of one nasal plastic surgeon's documented patient population from the 1940s and

'50s showed that Americans of all socioeconomic statuses, including a surprising number of working class patients, discreetly sought rhinoplasty (Haiken 1997).

The normalized practice of rhinoplasty, spearheaded by Roe, Joseph, and others, continues unabated to this day among myriad Caucasian-American and more recently immigrated populations (including Latino, Middle Eastern, and Asian Pacific Americans) as well as multiple generations of Jewish communities—although one recent Jewish periodical notes a visible decline in Jewish teens' nose jobs as a "rite of passage" (Rubin 2012:n.p.). As cited prior in the U.S. section, although cosmetic surgery has long been a mainstay for black celebrities and has been on the rise among African American communities over the last two decades (starting with the nose), it is generally accepted that a combination of several factors delayed the onset of cosmetic surgery trends for black and mixed race individuals in the United States. These include the black community's early disapproval of possible race-related motives, a lack of cosmetic surgeons of color, and a higher risk for the (recently diminished) problem of raised keloid scarring (Chike-Obi, Cole, and Brissett 2009). Additionally, African Americans endured even more restrictive discrimination during the early and mid-twentieth century when cosmetic surgery was newly emerging, including U.S. laws enforcing racial segregation and legislation that made it illegal in many states to "pass for white" (Gilman 1999:113). As Gilman puts it, the first "correction" of the black nose is masked within the medical literature because "[n]o reputable surgeon in the United States wanted to be seen as facilitating crossing the color bar in the age of post-Reconstruction 'Jim Crow' and [anti]'miscegenation' laws" (*Ibid.*: p. 112).

This long legacy of Jacques Joseph's early surgical outcomes to re-shape and reduce noses was heavily inspired by Viennese anatomist and physiologist Ernst Wilhelm Brücke (1819-1892). Brücke, not inconsequentially, was also one of the favorite teachers of Sigmund

Freud, whose hugely popular ideas about psychoanalysis, along with Alfred Adler's "inferiority" complex, helped later to legitimize a new and broader generation of American cosmetic surgery in the 1920s and ‘30s (Haiken 1997; Gilman 1999). In 1891, Brücke published a handbook of the anatomical “beauty” of the body, presenting a normative body based on classic aesthetics from Michelangelo’s sculptures as well as classical Greek works believed to capture the “perfect” female breast and male torso (Gilman 1999:144). Around this time, European post-Enlightenment ideology saturated cultural discourse, and dimensions based on mathematical symmetry, balance, and proportion came to demarcate the beautiful and healthy “German” body (*Ibid.*: p. 144). According to my research, the commonly known "golden ratio" measurement schema (popularized through Leonardo da Vinci’s drawing “On the Divine Proportion”) continues to appear as academic justification for contemporary surgical intervention. Gilman (1999) also notes that early studies of the physiognomy of the "insane" as well as current "corrections" of ethnic difference continue to utilize clinical definitions of facial symmetry despite the fact that all adult faces are at least slightly asymmetrical.

Jacques Joseph was well aware of these numerical ideals and used the profile of his wife (who was not Jewish) to illustrate the perfect “Greco-roman profile with a 33 facial angle” based on its similarity to a drawing by Leonardo da Vinci (Gilman 1999:149). According to Gilman, Joseph's influential assertion that the cosmetic surgeon "must have something of an artist in him" may have stemmed from the desire to buck anti-Semitic stereotypes that reinforced a "double bind" for Jewish surgeons and patients who were stigmatized for their natural appearance, yet also accused of being "mired in the material world" if they sold or "purchased" mainstream ideals (Gilman 1999:148-149).

Despite these artistic associations, Joseph's 1904 summary paper on the reduction of the size of the nose betrays much more than an “asymmetrical” crisis of confidence among his male patients; it reveals an epidemic of normalized prejudice:

> The patients were embarrassed and self-conscious in their dealings with their fellow men, often shy and unsociable, and had the urgent desire to become free and unconstrained. Several complained of sensitive drawbacks in the exercise of their profession. As executives they could hardly enforce their authority; in their business connections (as salesman, for example), they often suffered material losses…The operative nasal reduction—this is my firm conviction—will also in the future restore the joy of living to many a wretched creature and, if his deformity has been hindering him in his career, it will allow him the full exercise of his aptitudes. (Gilman 1999:135)

According to Gilman's assessment, "the visibility of the Jew (often defined in the nineteenth century in terms of his mercantile ability) made it impossible for him to compete equally with the non-Jew in the economic world at the turn of the century" (1999:135). Likewise, Joseph asserts that these patients were “happy to move around unnoticed.” And yet, Gilman describes this "passing" not only as "vanishing into the visual norm" but enabling "the young Jewish male to become part of general society" and "function...more fully as a male" whose "masculinity was defined in economic terms" (1999:135).

It is this counterintuitive juxtaposition of having to *vanish* certain physical characteristics before meriting being *seen* and recognized by dominant society that marks a troubling and deep-seated existential dilemma in the roots of cosmetic surgery. Despite all of this, cosmetic surgery would not have offered any benefit to Jewish men trying to compete in the German economy had they been denied access altogether. Gilman writes that German legal restrictions on Jewish men were lifted in the late 1800s ("Jewish women were still bound by the limitations applied to women in late nineteenth century Europe"), and Jewish men had only recently been able, in Joseph's words, "to become free and unconstrained" (1999:135). The only caveat, according to Gilman, was that they appear "not too evidently Jewish" (1999:135):

> No law bound them (unlike African-American males in the United States at the same moment) from becoming officers, doctors, lawyers, or businessmen in the general society, but the powerful social stigma associated with the Jews continued in spite of civil emancipation. (Gilman 1999:135)

This state of affairs is significant given that Jewish surgeons like Jacques Joseph, Martin Gumpert, Ludwig Lévy-Lenz, and associated physician and sexuality scholar Magnus Hirschfeld (who was an early advocate for homosexual and transgender rights) were about to define a world-renowned field of plastic surgery in Germany's Weimar Republic. But first, World War I had to lend the specialty some global gravitas. Even though Joseph and his fellow aesthetic plastic surgeons in Europe and the United States had a growing clientele, they did not yet have full legitimacy or approval of their methods from the wider medical community and society at large. In fact, Gilman asserts that part of the reason they could practice at all had to do with the opportunities that cosmetic surgery had created on the margins of medicine. Joseph, equipped with no military training, was about to build an extraordinary surgical reputation in the "War to End All Wars" based on skills he had honed on the emerging *social* battlefield of Berlin:

> In treating those whose appearance denied them the honor of being accepted as equals in a society that promised them equality, and as full citizens of a modern state whose laws guaranteed their citizenship, the aesthetic surgeon also laid claim to his own status as an honorable practitioner of an honorable medical specialty. Such efforts are bound to be contested by the dominant culture at any time, but never more so than during periods of war and social upheaval. For German Jewish patients and physicians, the first half of the twentieth century would turn questions of “passing” into matters of life and death. (Gilman 1999: 155-156)

World War I and the Normalization of Reconstructive and Aesthetic Plastic Surgery

Surgeons like Jacques Joseph (for Germany and the Central Powers) and on the Allied side, New Zealander Sir Harold Delf Gillies, U.S. surgeon Vilray Papin Blair, and French surgeon Hippolyte Morestin "welcomed the opportunity to show the world how necessary and noble and redemptive their kind of medicine could be" (Gilman 1999:157). Both trench warfare

and new weapon technology were particularly cruel to the fragile bones of the face and jaw, allowing for innovative American oral surgeons like Harvard's Dr. Varaztad Kazanjian (of Armenian descent) to rise to prominence as well. As Gilman puts it, "[f]aces were literally blown away, jaws ripped off, skulls crushed, and soldiers with such wounds lived" (1999:159). Plaster casts of these unprecedentedly mutilated faces were exhibited at hospitals in Paris, Berlin, and London to show the public both the "visible results of war and empire" and the new ability of the surgeon to restore the faces to a "semblance of humanity" (*Ibid.*: p. 162,160).

Gillies, who was London-based and eventually knighted for his contributions to reconstructive surgery during World War I, had been heavily influenced by seeing Hippolyte Morestin work with skin grafts in Paris. He described Morestin, who was originally from the French-controlled Caribbean island Martinique, as "a strange and moody octoroon" with "dagger-like sharpness," while Gilman quotes a contemporary biographical account of Morestin's sensitivity about "his racial admixture [which] might have left him with a feeling of being a minority who perhaps could not enter into French society as he might have wished" (*Ibid.*: p. 158, 170). Gillies continued to contribute to the field of skin grafting by devising the "tubed pedicle" in 1917, which allowed surgeons to transfer skin in stages from one location to another while maintaining blood supply and ensuring the grafts would take (Haiken 1997:31). He also developed better means of anesthesia to replace the generally disliked use of ether and chloroform. Gillies' younger cousin Sir Archibald McIndoe would later follow in his footsteps, making a name for himself during World War II by devising creative ways to treat the faces and psyches of war-disfigured patients at the Victoria Hospital Centre for Plastic and Jaw Surgery in Sussex, which patients dubbed the now-famous "Guinea Pig Club" (Gilman 1999:162).

As noted previously by Jarrín (2010), Gillies and McIndoe trained Brazil's "Father of Plastic Surgery" Ivo Pitanguy. Yet, in post-World War I Europe, reconstructive and even aesthetic plastic surgeons could not fathom a future such as Brazil's, nor the need for vast new legions of plastic surgeons:

> Although French, British, and American surgeons worked together during the war, plastic surgery grew after the war only in the United States. Gillies was knighted, but while this increased plastic surgery's prestige throughout the British empire, it did not generate significant interest. At Sidcup [Queen Mary's Hospital], he trained "practically no one from Britain"; instead he trained the American surgeons who came over to study with him. Richard Battle, in 1936 a young British general surgeon considering specialization in plastic surgery, later recalled being told, "Really I do not think you have a chance, my boy. There are four plastic surgeons in the country and I can't think there will be room for more." In France, Leon Dufourmentel was remembered as the only surgeon practicing plastic surgery after the war. (Haiken 1997: 34)

Sensing an opportunity, American surgeons had a different vision. Gilman writes that, "[i]n the United States by the 1920s the very presence of reconstructed faces of veterans was used to claim a greater tolerance for aesthetic surgery" (1999:164). Legions of America's most celebrated plastic surgeons flocked to Berlin to study the newest techniques of aesthetic surgery with Jacques Joseph after the First World War, and for those who could not travel to Berlin, his 1931 definitive handbook of aesthetic surgery acted as a guide.

The future founder of the American Society of Plastic and Reconstructive Surgeons (ASPRS), born Jacob Maliniak in Warsaw, Poland, was a medical officer in the Russian Army during World War I. After working with both Hippolyte Morestin and Jacques Joseph after the war, he also took the name "Jacques" and moved to the United States. Jacques Maliniak formed the more inclusive ASPRS due to the fact that the existing American Association of Plastic Surgeons only allowed forty members with both dental and medical degrees (Haiken 1997). Yet, even after founding the ASPRS (which condemned beauty parlor surgery and deplored the sensationalization of plastic surgery as beautification), Maliniak's initial application to the

American Board of Plastic Surgery was mysteriously deferred over the summer of 1941 (*Ibid*.). Haiken (1997) explains the Board's "considerable reluctance" as likely resulting from "local prejudice" over his (assumed Jewish) heritage (p. 64).

By the beginning of World War II, the United States would claim about 60 (official) practicing plastic surgeons: "more than ten times as many in Britain, and almost twice as many as the rest of the world combined" (Haiken 1997:35). Peace-time American plastic surgeons aimed to hold on to this initial and tenuous grasp at legitimacy with two hands. Increasingly, American surgeons sought to organize exclusive associations and organizations to tout their specialty, setting their sights toward the civilian and psychotherapeutic practice of cosmetic surgery, while trying to protect their turf from both competing surgeons in legitimately related specialties as well as "unscrupulous charlatans" leaving countless "mutilations and disfigurements" in their wake (Haiken 1997:27). Many U.S. surgeons continued to protect their personal convictions not to dally with cosmetic surgeries they saw as unnecessary, while "board-certified" plastic surgeons' associations often outlawed or eschewed practitioners who brazenly publicized or solicited cosmetic surgery patients—unwilling to cheapen the medical legitimacy that they had worked so hard to build (Haiken 1997: Sullivan 2001).

For post-World War I Berlin, the environment was initially liberal. Jewish reconstructive surgeon Martin Gumpert was able to convince the City to approve a department of "social cosmetics" at the Institute for Dermatology at the University of Berlin with the crucial support of Suzanne Noël, who was by then a leading aesthetic surgeon in France and publisher of a 1926 study on the socio-psychological impact of the specialty (Gilman 1999). In her dissertation on Noël's life, Martin (2007) writes that Noël believed she helped women attain and retain independence in her role as a plastic surgeon and was highly influenced by the early feminist

movement in France, which focused on economic independence as one of women's most valuable assets and goals.

Furthering cosmetic surgery's ties to new progressivism in post-World War I Germany was the fact that "legally permitted" male transvestites were among Gumpert's German patients and, at Magnus Hirschfeld's associated Institute for Sexual Science, gynecologist Ludwig Lévy-Lenz was performing genitalia-altering surgeries on transgendered men in addition to the average rhinoplasty (Gilman 1999:172). According to Gilman, both Gumpert and Lévy-Lenz associated with ideas of psychological and corporeal mutability and "strongly believed in racial mixing as the solution to the 'Jewish problem'" (1999:174). More importantly, during this time Lévy-Lenz and his associates commented on the necessity of cosmetic surgery in the "modern" era. Writing in his 1928 work *Enlightened Woman,* Lévy-Lenz asserted that cosmetics are a sign of all high cultures, and with the negative impacts of the ever-increasing tempo and demands of modernity, aesthetic surgery was an acceptable form to preserve mental health as well as to restore the body:

> Thus I recommend to women who have a wrinkle or a dimple to have them operated upon; thus I also recommend nose and breast operations even when they have nothing to do with actual health. [Such blemishes] are a burden on the soul of the woman, even if they are only imagined. (Gilman 1999:176)

Within mere decades, it seems that the "masculinization of reconstructive surgery out of the cauldron of battle provided a new status for aesthetic surgery" that was quickly passed on to women clientele in Central Europe and the United States as a tell-tale symbol of post-war modernity (Gilman 1999:166). But given the fact that cosmetic surgery was a technology born out of disease, then prejudice, and then war—this "pretty" picture of modernity seemed rather bleak. Besides rhinoplasty and anti-aging procedures, the "New Woman" of the 1920s and '30s valued small or surgically reduced breasts that would allow for sport, fashion, and non-maternal eroticism (Gilman 1999:230). Although much of the modern technology to aesthetically reduce

breasts (by maintaining the nipple) had earlier been practiced on men with unwanted breasts (i.e. *gynecomastia*, a condition that still warrants hundreds of thousands of male breast reduction surgeries today), many women were taking heed of the kind of operations Lévy-Lenz freely recommended (Gilman 1999; ISAPS 2010). Gilman discusses the 1933 argument by Freidrich Pruss von Zglinicki (Lévy-Lenz's collaborator) in a popular journal that cosmetic surgery was now "normal":

> Zglinicki's argument is interesting because it defends the legitimacy of aesthetic surgery by connecting it to the rise of the modern and locating it in those cities associated with the emergence of the modern…he tied contemporary aesthetic surgery to the high status of Viennese medicine [in the world's opinion, and especially according to New York intelligentsia at the time]. He noted also that aesthetic surgery is "modern" because it is now most widely practiced in the United States [with New York joining Vienna as the central cites of modernism]. (1999:175)

This prescient argument is significant in an age of globalization, where "modernity" is located virtually anywhere there is television screen or a smart phone. Furthermore, in terms of twenty-first century sites of new "modernity," the picturesque cobblestone streets of Vienna have been traded in for the bustling throughways of Beijing and Mumbai. Yet, back in the fading days of the Weimar Republic, even this so-called modernity made way for cold barbarism. Jacques Joseph, who died of a heart attack in his home in 1934, never suffered the indignity of being forced to give up his private practice under the Third Reich. He also never stopped believing in the psychological power of rhinoplasty, writing in 1931 that "among patients of Semitic as well as of Aryan origin, a common desire is to be rid of their Semitic nasal shapes…in order to blend in appearance-wise with the remainder of the population….[T]he crucial fact is that these patients undoubtedly suffer emotionally; this realization leads inescapably to the conclusion that their emotional balance should be restored by means of surgery whenever possible" (Gilman 1999: 180-181).

The urgency in these words is palpable. One of his last recorded case descriptions occurred in 1933 shortly after Adolf Hitler was elected, revealing that Joseph was charitably operating on "Semitic" noses for "nothing" when the patient could not afford the procedure (*Ibid.*: p. 180). That same year, the Nazis closed Gumpert's social aesthetic surgery clinic, only to re-open it in 1938 for their own purposes. Gilman (1999) postulates that a 1936 law mandating the German state to "reconstruct" the potential soldier's body "against his will if necessary, as to extract from it its maximum fitness," implies forced cosmetic surgery (p. 179). Given records that Italian fascist dictator Benito Mussolini ordered all of his military officers over 40 to have their eyelids examined for possible correction of droopy eyelids, and Japan similarly ordered "vision enhancing" eyelid surgeries for thousands of their own soldiers, Gilman's hypothesis is sound (1999:179). Despite this focus on "fitness," Nazi Germany did not neglect "beauty" altogether. Hitler allowed beauty parlors to remain open during the course of the war in what he believed was an attempt to keep German women content (Gilman 1999). Furthermore, top party officials advocated for modern-looking women to fulfill a National Socialist female beauty ideal, which they believed would attract urban women to the party and benefit the German economy (Houy 2002). In fact, Gilman writes that the head of the Nazi Labor Front dedicated the Berlin "House of Beauty" to an audience of women in 1940 by describing the ideal Aryan woman and by comparing the beauty house to the war effort: "[P]arty affiliation and the army are the institutes of beauty for men…What benefits me and my people is beautiful; whatever makes me weak or ill is ugly" (1999:180).

In sum, we have learned that, after the model of treating disease, innovations in modern cosmetic surgery were explicitly based on the perception of inferior physical characteristics stemming from the illegitimate and incendiary "racial science" of the late 1800s as well as

associated social pressures to assimilate to the dominant Anglo-Saxon mainstream. Meanwhile, this Anglo-Saxon cultural influence was spreading around the globe via colonial and imperialist pursuits to "*wherever the European type bec[ame] known*"—often by force (Haiken 1997:181, quoting Knight Dunlap (1920); emphasis mine). Moreover, we saw the field of cosmetic surgery as opening sociopolitical professional space for surgeons often struggling to practice medicine in a system set up to exclude them; a situation that not only informed the spirit of their innovations but also the demographics of their early clientele. We learned that the "Gilded Age" harbored a new "obsession with racial passing," which situated minority populations in a position where survival often meant changing or erasing certain physical characteristics that marked them as the "other." Only then could many earn the chance to move around and upward in the job economy. Furthermore, we saw how technologically advanced global warfare changed what it meant to be able to "pass" as human after horrific injury and the ways in which aiding the war wounded lent much-desired mainstream credibility to a medical field that had existed on the margins and had been innovated by marginal figures. As American plastic surgeons sought ways to expand and commercialize their practice, cosmetic and reconstructive surgical technology, now associated by the masses as a product of modern war, soon became a legitimate and "normal" extension of everything "modern," including the increasingly visible post-war "modern woman."

A Foundation Firmly Placed: From "Curing" Disease to "Curing" Difference

When we look at the historic roots of cosmetic surgery described above, it is important to see these narratives as a frame for contemporary cosmetic surgery practices in both developed and developing countries, as well as cosmetic surgery's direct ties to both social and military conflict. When Gilman was writing at the turn of the twenty-first century, he maintained that "the stigma of marginalization continues to haunt the entire profession [of aesthetic surgery]"

(1999:171). Yet, this may be less true for countries newly entering the "world's stage" via globalization that are one step further removed from this early Western narrative of cosmetic surgery's stigma (skipping the "before" and seeing only the "after" photo, if you will). For example, parallels may be drawn to the fact that the current state of India has been described as entering its own "Gilded Age," while (as we will see) cosmetic surgery for Indian youth seems a mere afterthought in some wealthy urban centers, already surpassing norms in the United States (Dehejia 2012; Bhupta et al. 2007). In using BRIC countries as a template, we can examine what the world looks like when cosmetic surgery culture cuts ties with its long history of stigma. Furthermore, we can question whether or not it matters today if cosmetic surgery's colorful past fades amongst the white noise of globalized media and self-improvement narratives.

In hindsight, however, the answers seem more obvious. Less than a century after Dieffenbach and others attempted to assist the syphilitic "diseased" nose, the "ethnic" nose supplanted it as a marker of social disease worthy of surgical intervention. The *real* social disease is familiar: fear of difference, mistrust of immigrants, and exploitative measures to construct and reinforce the perceived "superiority" of a dominant racial or ethnic group. It is the technology that is new. Through subtle evolutions, medical technology aimed at curing the kind of physical disease that could affect anyone becomes conflated with a "cure" for the targeted "disease" of difference—imposed solely upon those deemed undesired and inferior. Rather than seeking early on to cure and eradicate the social seeds of racism and intolerance (which, understandably, many would dismiss as a quixotic venture), consumer society has allowed for cosmetic surgery to become a questionable and sometimes compulsory "tool" in the assertions of rights and opportunity. As seen in Brazil, however, the effectiveness of the bid for full and fair

citizenship by means of the body seems slow-going, if not static and distractive from the pursuit of more tangible victories in social justice.

RUSSIA: THE PERILS OF LAX REGULATION

Transcript from BBC Monitoring International Reports: "TV warns of risks as plastic surgery craze soars in Russia":

> **Presenter:** The number of private clinics offering services to make people look more beautiful is soaring. However, often the quest for beauty turns into struggle for life at state-run hospitals. It is extremely difficult to correct what has been done and it is equally hard to call non-professionals to account. Yelena Korobova reports.
>
> **Correspondent:** Yekaterina had decided to enlarge her breasts. In a clinic she applied to she had been advised to do so by using polyacrylamide gel. In three years the gel slipped down to her belly.
>
> **Yekaterina Ivanova, captioned**: The surgeon whom I turned to suggested that I should use this method of breast enlargement. He did not warn me about any possible risks.
>
> **Correspondent:** The doctor also did not say that the use of gel for such operations has been considered to be unhealthy for a long time and is practically banned. Glaring lies and mistakes of surgeons that are not qualified enough result in appalling consequences. (BBC text of report by Russia TV, February 3, 2006)

The Origins of Deregulation: Neoliberal Economic Policies and the End of the U.S.S.R

In the case of Russia's cosmetic surgery industry, the comparatively recent fall of the Soviet Union and the social restrictions it embodied has led to an atmosphere so lax that their de-regulated cosmetic surgery market seems to rival that of America's self-anointed "beauty doctors" of the early twentieth century. Although there is evidence that Russian surgeons contributed concomitantly to the early development of war-time plastic surgery innovations—for example, Odessa ophthalmic surgeon Vladimir Petrovich Filatov developed the "tubed pedicle" independently in 1916, a year before Gillies did—there seem to be few medical histories translated into English (Haiken 1997). Early titles like Suslov's (1966) "First Russian Handbook on Plastic Surgery", Mukhin's (1967) "Achievements of Soviet Plastic Surgery over the Past 50

Years," and Kabakov and Aleksandrov's (1977) "Landmarks in the Development of Plastic Surgery in the Soviet Union" indicate the existence of an early reconstructive surgery base in the U.S.S.R. There are also reports that the first limb lengthening surgery (now popular as a cosmetic procedure in East Asia) was originally developed in Russia five decades ago (wisegeek.com, n.d.). Furthermore, the fact that former Russian national, Jacques Maliniak, went on to work with famous European plastic surgeons after serving as a twice-decorated medical officer on the Balkan front and in Kiev speaks to the likelihood that other Russian nationals were exchanging plastic surgery ideas and training abroad after World War I (Haiken 1997).

Although Russia, along with the remaining BRIC countries to be studied, appears to have a relatively homogenous population in comparison to the United States' and Brazil's ethnic diversity, historically, the Russian Empire was home to the largest Jewish population in the world. Centuries of Russian history are characterized by complicated, alternating periods of both the cultural-political empowerment of Soviet Jews as well as their discriminatory persecution. For example, during the 1880s and 1890s when "racial science" and cosmetic surgery innovations were becoming popular in Central Europe and the United States, Jews were being expelled from major urban centers like Kiev and Moscow and suffering from systemic anti-Semitic legislation enforced by the state that controlled Jews' movement and access to education (Riasanovsky 2000). At the turn of the twentieth century, however, many Russian revolutionary party members and leaders were ethnically Jewish, leading to later Nazi propaganda that painted all Bolsheviks as Jewish (Gilman 1999). Hitler even commissioned a photographic study of Soviet Union Premier Joseph Stalin to analyze whether his earlobes were "ingrown and Jewish, or separate and Aryan" (Gilman 1999:130).

Although the unspeakable horror of the Holocaust and later mass emigration to countries like the United States and Israel have resulted in a decline of Jewish Russian nationals, Russia and the nations of the former Soviet Union continue to constitute one of the largest Jewish populations in Europe. However, in light of reports of the continued poor outcomes of basic rhinoplasty due to high rates of technical errors by contemporary Russian surgeons, it is unlikely that Russia's ethnic Jewish population nor many other Russian citizens participated in the volume of cosmetic nose surgery that characterized similar American and German patient populations over the last century (Vissarionov and Aleksanian 2010**).** (Israel, in comparison, has fast become one of the unofficial aesthetic surgery capitals of the Middle East, with an established practice of rhinoplasty for young Israelis as well as an intriguing spate of surgeries among young Israeli men before recruitment into the nation's compulsory military service (Gilman 1999)). According to *The Russia Journal*:

> The first cosmetic surgery clinic, now the Moscow Plastic Surgery and Cosmetology Institute, was established in the Soviet Union in the 1930s, but there have never been any uniform training programs, formal qualifications or exams. Russian medical schools have never offered plastic surgery as a specialization. As a result, plastic surgery training has been left largely up to the individual. Some surgeons learned their skills from talented self-taught pioneers, most of who [sic] originally specialized in vascular surgery. Some hand over their life savings to be trained in the West. And others believe their general medical and surgical training is sufficient. (1999: n.p, Issue 14)

Russia's lag is due largely to state regulations and restrictive flows of information during Communist rule and the Cold War, which (like China) limited physicians' access to "bourgeois" Western medical journals and training. In fact, before his death, Stalin infamously orchestrated the unrealized "Doctors' plot" in 1952 and 1953, which specifically targeted a group of doctors (more than half of whom were Jewish) to try to frame them for alleged attempts to kill Soviet officials (Ro'i 1995). Widely believed to have been a ploy to launch a massive party purge and an anti-Semitic provocation, the fact that Stalin specifically associated doctors with American-

sympathizing Jewish nationalists speaks to the continued marginalization of the medical profession in 1950s Russia (*Ibid.*). One Russian plastic surgeon who wrote to the Editor of *Plastic and Reconstructive Surgery* in 1993 had risked personal safety to request a handful of copies of foreign surgeons' articles by postcard over the years (and was still pleading for free copies of the publication to be furnished to the Russian medical community):

> [In 1955]…in all of boundless Russia only two libraries subscribed to the Journal: Moscow Central Medical Library and Leningrad (presently St. Petersburg) Scientific Library. To our great regret, no highly respected Soviet specialist surgeons could subscribe to *Plastic and Reconstructive Surgery* and other foreign journals because it was considered as an admiration for the West and was condemned as a dangerous thing in relation to the state. All such relations and links of soviet specialists with Western specialists were under the special supervision of KGB agents…[S]o-called enemies of the people were prosecuted and punished by imprisonment or exile. All of us were living under the wall of fear which was built by Lenin and was strengthened by Stalin. I think it will be difficult for you to imagine our state of fear, depression, and hopelessness…I want to believe that it was ruined finally in 1991, but I continue to doubt. Only now step by step are we beginning to realize the [medical] idiocy of our state—we are raising our heads—but again, an old burden of defenselessness weighs upon us. (Kruchinsky 1993: 1206)

Upon Boris Yeltsin's election in 1991 and the disintegration of the Soviet Union, Russia's economy began the neoliberal regimen of economic privatization and market liberalization as prescribed by the United States and International Monetary Fund (IMF), creating chaotic capitalistic and social upheaval that affected all sectors, including the profession of medicine. The clash of old and new systems of plastic surgery was painfully immediate. In 1990s Russia, according to Western news reports, women were still being routinely treated with radical mastectomies (which removed cancerous breasts, leaving large scars) rather than aesthetic breast reconstruction (Lasalandra 1992). One Salt Lake City, Utah, plastic surgeon and 14-year Russian émigré returned to his homeland in 1992 to find a once tightly restricted medical establishment summarily "out of control" (Nakoryakov 1992). Many Russian residents had lived

for years with untreated congenital and trauma-related facial deformities, which groups of U.S. surgeons ventured out to treat as charitable endeavors (*Associated Press* 1992; Redding 1995).

By 1997, *USA Today* reported that Russia was facing the negative results of unregulated cosmetic plastic surgery, which had fast attracted long lines for consultations at Moscow's Institute of Beauty that snaked "down the staircase and out the door" (Babakian 1997:3). A 1999 article published in *The Russia Journal* about the effects of the emerging cosmetic surgery market described how quickly the practice had been adopted over the decade, despite having formerly "had no place in Soviet medicine as it was viewed as a self-indulgent practice catering to the whims of the idle rich" (n.p., Issue 14). Referencing initial gains in dentistry and a fast preoccupation with so-called "Western" bodies, the article also refers to the plight that basic health care systems face in the shadow of new "domestic markets":

> The days of stainless steel teeth are over. Private dental clinics first opened in the early 1990s and now dental surgery is readily available to the hordes of New Russians eager for Hollywood smiles. But dental work is just the beginning. With the dozens of products and beauty magazines that have bombarded the market has come the impetus to "fix" everything. The wives and girlfriends of New Russians now want their whole bodies Westernized. But not as many wealthy Russians have turned to Western clinics as would have been expected. Going under the knife is never a pleasant experience, and the language barrier, fear of the unknown and general lack of information have kept Russians away. Instead, the thousands of potential patients are boosting the domestic market. Today, while the Russian health system barely limps along, cosmetic surgery is a thriving and immensely profitable business. (*The Russia Journal* 1999:n.p., Issue 14)

According to this piece, the hordes of "New Russians" who will symbolize the nation's entry onto the modern global stage will arrive accompanied by "wives and girlfriends" who have been "fixed" with new "Westernized" bodies.

This pattern will repeatedly appear as my examination continues to South and East Asia. In the case of the East, the neoliberal economic policies of the 1990s become akin to a mass "immigration" of new "citizens" of the world who, in the age of globalization, can actually remain where they are—just not as they are. Thus, true entry into the realm of Western-

dominated capitalism is not dissimilar to the 1890s immigrants' plight: if you want an *only slightly* more equal chance to compete, it seems better to look *slightly* more like the established visuals of the rich and powerful than your parents and grandparents. Moreover, as seen in Brazil, historically embedded relationships of power and conflict are fast conflated into standards of "beauty" and "ugliness." In addition, sheer media saturation eases the collective socio-psychological transition to accepting what "new" must look like, how much it costs to achieve, and why the investment is worthwhile. As will be explored in future sections, growing East Asian populations (as well as some Asian Americans) currently seem to prize subtle changes to the eyes, nose, breasts, and face shape to achieve a slightly more "modern" look. By contrast, in Russia, a country widely populated by people of Caucasian descent, requests for cosmetic surgery seem to border on the exaggerated (read: Pamela Anderson).

Normalization: 'Modernity' and the Media-Constructed 'Western' Body

Although the market has since expanded, *The Russia Journal* reported in the late 1990s that "[a]bout 10 percent to 15 percent of customers are show-business personalities or high-paid prostitutes seeking to improve their physical appearance, which they view as the main tool of their trade….[Seeking] nose jobs, liposuction, face-lifts, and silicone breast implants,…[t]hese patients usually come prepared with whole transformation agendas that will turn them into Barbie dolls or Marilyn Monroe look-a-likes" (1999:n.p.). The publication reported that the remaining clientele comprised well-to-do Russians seeking to fulfill "new lifestyles" with liposuction and/or facial rejuvenation (*Ibid.*). However, this imitation of Barbie and Marilyn Monroe (who, like many Hollywood stars, had cosmetic surgery at the beginning of her career) led to a spike in untrained cosmetic surgeons injecting the breasts of thousands of uninformed patients with unsanctioned cosmetic gel (*Ibid.*).

In comparison, the risks of (less expensive) breast injections were already widely understood by the rest of the world: New York and Viennese physicians experimented with injecting paraffin wax into breasts in the early 1900s, Japanese and American surgeons tried injecting breasts with liquid silicone in the 1950s, and the inevitable result was the melting, migrating, hardening, and scraping out of materials from many a breast, including the appearance of associated cancers and gangrene that required breast removal (Haiken 1997; Gilman 1999; Sullivan 2001). Moreover, the United States had already gone through the Dow-Corning silicone breast implant scandal in the early 1990s that led the U.S. FDA to restrict even coated silicone gel-filled breast implants, which was re-lived recently over Europe's mass ban and recommended removal of hundreds of thousands of sub-standard silicone Poly Implant Prothèse (PIP) breast implants, as well as some male chest, buttock, and testicle implants (Haiken 1997; Jones 2012). Thus, the injection of loose gel into breasts by Russian surgeons at the dawn of the twenty-first century is hugely symptomatic of a perilously unregulated cosmetic surgery market. (However, it should be noted that black-market "pumping parties"—the practice of injecting foreign gels into the buttocks, hips, and chest—continue even in the United States among marginalized and poor communities, including low-income women of color, sex workers, and transgendered men. One man even recently died from a blood clot after his penis was pumped with illegal silicone (*CBS News* online 2012).)

Even though plastic surgery was just recently recognized as a formal medical specialty in Russia, it is still relatively legal for doctors with minimal plastic surgery training to operate. Accordingly, it is no wonder that cosmetic surgery was early on associated with fraud, crime, and the Russian underworld. Common gossip in the early 1990s speculated that many private cosmetic surgery clinics operated as fronts for the dealings of the Russian mob (although

surgeons apparently told the press that Russian mafia prefer to get higher-quality appearance-changing surgeries abroad) (*The Russia Journal* 1999). In 2005, a spate of news media reported that one of Russia's most famous plastic surgeons was stabbed to death on his doorstep by a man for hire, while an unrelated story described the Russian government's offer to pay for the plastic surgery and relocation of anyone with information leading to the kill or capture of a Chechen guerilla leader (*Associated Press,* Ingram 2005; *Agence France-Presse* 2005; *The Independent* (London) 2005). Furthermore, cosmetic surgery patients were fast becoming younger with a 2010 report by RT.com noting that a 21-year-old woman had undergone a facelift procedure. In 2004, *The Independent* reported that the doctors implicated in the widely publicized "Sleeping Beauty" trial had been sentenced to six months' probation and two-year practicing bans after their liposuction procedure put a 23-year-old former beauty queen in a coma (Osborn 2004:n.p.).

Fearing similarly lax sentences for doctors accused of malpractice (or none at all), many unhappy Russian patients do not press charges. Stories about plastic surgery deaths, botched surgeries, and false advertising by surgeons are far too common in Russia, with RT.com reporting that in comparison to nearly 10 years of training undergone by prestigious plastic surgeons in the United States, any Russian surgeon can now get a license for cosmetic surgery after completing a month-long course (Firth 2010). Furthermore, the news channel quotes lawyer Dmitry Aivazyan's assertion that:

> There are no clear controls or sanctions. Doctors avoid punishment in a large number of cases. One reason is that medical documentation submitted to the judge or the investigation officers are often falsified. Also, patients will often sign consent forms without thinking of the risks. Unfortunately, such circumstances make it hard to ensure an objective trial. (*Ibid.*)

One cosmetic surgery blog noted that profit-driven Russian plastic surgery clinics proffer simplified consent forms that de-emphasize the risks of the surgery, citing Moscow City Bureau of Forensic Medical Examination statistics that up to 10 percent of civil cases against health care

institutions resulted from unsuccessful plastic surgery (beautysurgeries.blogspot.com/2010/07). However, a Russia TV report translated by the BBC explained that few Russians' cases even make it to court, with some not willing to make their cosmetic surgery attempts public and many others overwhelmed by the client's responsibility to compile enough evidence against the doctor, "such as contracts, medical records, [and] photographs before and after the operation" (February 3, 2006). Any trial can take up to years in court and the process hinges on a medical examination conducted by a secondary surgeon that must conclude medical error took place (*BBC,* quoting *Russia TV* 2006). Unfortunately, this is a Catch 22 in the Russian medical field, where it is taboo to publicly criticize fellow colleagues (*Ibid.*). Moreover, even though it is reported that "[b]lack lists of doctors-saboteurs do exist in the medical inner circle," the Russian Federal Supervisory Service for Health and Social Development only has the right to issue medical licenses—not the right to revoke them, which may only occur through court verdict (*Ibid.*). Even if the court is successful and a medical license is revoked, the organization or individual has the right to apply for it again. As a result, Russian Medical Academy members note that their main clientele are individuals desperate to correct prior botched surgeries from doctors who should not be practicing (*Ibid.*).

Who Does an Unregulated Cosmetic Surgery Market Benefit?

It is difficult to understand why, after two decades, the Russian government has not done more to regulate the industry, but it is possible that the private embarrassment of botched surgeries and a lack of political solidarity among many of the Russian women experiencing them have prevented mobilization around the issue. Despite all of these many problems, there are at least some happy customers. One ambiguously-aged Russian "socialite" with exaggerated breasts and lips (after undergoing over seven surgeries to her face and body) commented to *RT*

News, “I make money with this look; when people call me crazy, I answer that in my house in Florence I don’t care what they think.” Even Russian President Vladimir Putin, who was recently (and controversially) re-elected to the nation’s top post, sparked rumors that he is no stranger to cosmetic surgery by sporting an unlined face on his 60th birthday. Russian feminist punk band and performance artist group Pussy Riot, who have gained international attention for their controversial anti-Putin activism, recently released a song that mocks his alleged use of cosmetic surgery for political means (*Associated Press*, "A guide to..." 2012). Besides information about the unregulated nature of Russian cosmetic surgery, there seems to be little documented cultural criticism available in English. And beyond disapproving media reports regarding a Ukrainian woman who uses large breast implants, a reduced waist, and makeup illusions to resemble a human Barbie doll and a Russian pet owner’s decision to buy her cat cosmetic eye surgery for competitive cat shows, it is unclear at the time of writing whether Russian civil society, academic, or religious groups have voiced any collective opposition to the increasing social visibility of cosmetic surgery.

While RT.com concedes that there is still no official data on service providers or numbers and types of procedures, the Russian Plastic, Reconstructive, and Aesthetic Surgeons' Society confirms that Moscow alone is home to hundreds of cosmetic surgeons and clinics. Moreover in 2010, RT.com reported statistics from an unnamed source that placed Russia at fifth amongst countries with the highest level of plastic surgery operations (Firth 2010). Although, and as aforementioned, all global cosmetic surgery statistics are fairly unreliable, this statistic would make good sense in the BRIC model. Whereas the most reliably cited 2010 statistics from ISAPS (and some much less reliable Internet postings) show countries like Italy, Greece, and France with large spikes in numbers of procedures over the last two years and Russia falling out of the

top 10, that shift makes little sense in terms of the current European economic climate, as well as my fairly recent personal experiences in major urban centers of those countries. (It should also be noted that Mexico often appears high on the list of ISAPS total cosmetic procedures, which is not surprising due to its proximity to the United States and its long-held participation in the medical tourism industry.)

In sum, Russia is an intriguing example of the dynamic and ever-evolving motivations for cosmetic surgery in a rapidly globalizing world. This is especially true due to its singular status as having close ties (and proximity) to the cultural, ideological, and physical characteristics of the birth place of modern cosmetic surgery in Central Europe, but a comparatively delayed entry into cosmetic surgery culture due to its divergent political past. As will be studied at length in the example of China, public reaction to perceived new liberties after Russia's sociopolitical history of repressive Communist and authoritarian rule may be a key factor in the speedy popular acceptance of embodied displays of "modern" capital. While the Unites States established a cosmetic surgery culture over the course of a century, Russia's seems to follow in a flood of newfound bodily freedoms—albeit ones that suffer for lack of bureaucratic uniformity and accountability. Despite this bold new "right" to achieve upward mobility and invest social capital into the body through surgical intervention, patients and surgeons lack any democratic guarantees to ensure that their decisions will result in clear benefits rather than harm.

Medical Commercialization 2.0

Russia's example makes even clearer the type of global "citizenship" that is supported when the freedom of markets is valued over the freedom from undue risk. And yet, as explored earlier in the theoretical debate around agency, the prevailing logic that cosmetic surgery is a "choice" with associated risks is still an integral part of the practice's social narrative. As

Sullivan (2001) notes, "patients have long trusted the ancient Hippocratic oath [i.e. "do no harm"] to protect them"—an ideology that has been challenged by the ever-expanding grasp of cosmetic surgery and market culture, where patients who can pay high prices for more experienced plastic surgeons generally assume they are at less risk. However, even this assumption is tested by the fact that many cosmetic procedures have a relatively short shelf life, and any long-term side effects from "cutting-edge" cosmetic technology are always, at least initially, unknown.

Furthermore, Sullivan's analysis shows us that Russia's problems don't seem so foreign when it comes to examining nations with even long-developed cosmetic surgery industries. Even the contemporary "medical-industrial complex" of the United States continues to lack sufficient regulation (Sullivan 2001:203). According to her analysis of a Pulitzer Prize-nominated 1998 investigative series by Schulte and Bergal in Florida's *Sun-Sentinel* newspaper, 810 malpractice insurance claims were filed and at least 39 cosmetic surgery-related deaths occurred in Florida between 1986 and the first quarter of 1999 (Sullivan 2001). In a state that was only surpassed by California (and approached by New York) in terms of cosmetic surgeries at the turn of the twenty-first century, patients of all ages (including a three-year-old with a large birthmark) died from complications like anesthesia overdoses, blood clots in the lungs, fecal peritonitis, cardiac arrest, and emergencies occurring in office facilities that lacked life-saving equipment and round-the-clock aftercare (*Ibid.*). Insurance companies judged about 40 percent of the claims to involve serious permanent damage, including burns, infections and disfigurement—doling out $38.2 million in compensation (*Ibid.*).

Sullivan (2001) notes that these injuries and deaths illustrate three crucial problems that still define the modern American cosmetic surgery industry. First is the deregulation of

marketing. The need for competing surgeons to make substantial promotional investments and churn out enough cases to meet their advertising budget and professional association dues often involves misleading advertising and the up-sell of multiple procedures that keep patients under anesthesia for dangerously long periods of time. Second is the lack of state regulation of surgery in private office facilities. As of 2001, no state (with the exception of New Jersey) required physicians operating outside of hospitals to report deaths and serious complications, while California was the only state that required surgical offices to be accredited or even inspected. The third problem according to Sullivan is the lax oversight of individual physicians' practices by their own licensure boards. Most states have very few barriers to office-based surgical practices, and practitioners with little-to-no supervised experience and no formal training in plastic techniques (or even surgery) can take up cosmetic surgery. Even so, in the case of Florida, more than 80 percent of Florida's physicians with multiple medical malpractice claims for deaths and serious injuries were board-certified in plastic surgery (Sullivan 2001). Furthermore, a 2010 study reported in *Health* magazine found that nearly 40 percent of liposuction practitioners in Southern California were not trained as plastic surgeons (Patel Shepelavy 2011).

From the macro viewpoint, Sullivan (2001) sees both the patients and physicians as victims of two larger "villains": appearance discrimination and the commercialization of medicine (pp. 201-202). Likewise, those are two major variables that this paper examines in the globalization of cosmetic surgery. Furthermore, the point at which commercialization enters a nation's (established or unestablished) medical system becomes a key factor in the future of public access and health outcomes for low-income groups. As will later be discussed in terms of recommendations for the further study of medical tourism and as explored in the case of Brazil,

commercial medicine is appearing virtually overnight in places that have yet to build functioning public health systems for basic preventative care. The idea that "modern" commercialized medicine will have a trickle-down effect—creating opportunities for millions of marginalized people to access quality medical care where none existed before—is counterintuitive. More likely is the scenario where crucial public health funding is siphoned into private channels for more lucrative research and cosmetic innovations.

In the case of Russia and India, the globalization of commercialized medicine has even led to a reported rise in "stem cell tourism," where a lack of effective regulation and the promise of miracle treatments with few proven results have raised concerns about the harm and exploitation of desperate patients with serious and disabling medical conditions (Cohen and Cohen 2010). In Moscow, dozens of clinics and beauty salons are utilizing legal loopholes to inject clients with "stem cell" serums (although the contents are anyone's guess) (*Associated Press*, "Stem-Cell Craze..." 2005). Hundreds of patients are rushing to Russian facilities that claim to offer expensive embryonic stem-cell therapy for a range of diseases as well as "cosmetic therapy" for wrinkles, cellulite, stretch marks, skin rejuvenation, and treatment to "stop the process of ageing" (*Ibid.;* Parfitt 2005:1220).

Since the clinics' actions are technically illegal and they don't have the proper scientific equipment to cultivate and isolate stem cells, scientists say that non-autologous donor injections "may be anything from a fetal tissue extract to skin cells...[or] animal stem cells" (*Associated Press* 2005:n.p.). Besides the fact that future side effects are not known and Russian scientists fear illegal actions will detract from their sanctioned stem-cell research, the most controversial and disturbing aspect of the market is its common use of material from aborted human fetuses. In 2005, Professor Vladimir Smirnov headed a prominent group of scientists lobbying the Russian

parliament to introduce a law prohibiting the clinical use of stem cells from embryos and aborted fetuses. He told *The Lancet* medical journal that there existed a criminal trade in fetuses where impoverished Russian and Ukrainian women were being "paid about $200 to have a caesarean at about 15 weeks and the fetus is then passed on to a clinic" through the black market (Parfitt 2005:1220). Furthermore, *The Lancet* relayed the investigative work of well-known NTV news reporter Andrei Loshak who discovered that inquiries to a Moscow-based "stem cells hotline" were directed to a *state-run* obstetrics center, whose immunology department director told Loshak that the center only worked with embryos obtained from "voluntary...social abortions" (Parfitt 2005:1220). The article does not mention whether women terminating their pregnancies were informed. Although "donated" human tissue and circumcised infants' penis foreskins are also known to appear in some cosmetic facial fillers distributed in the United States (which will be briefly discussed in a later section), these examples only hit the tip of the iceberg amidst the dark and murky ethical questions lurking at the depths of today's commercialized medicine. And, while the Russian Ministry of Health was in the process of assembling an expert council in 2005 to investigate the country’s unregulated stem-cell treatment trade at private clinics and beauty salons, it is unclear at the time of writing whether there has been any progress. It is certainly not encouraging that state-run medical facilities seemed to be operating within the same legal loopholes they aimed to repair.

Like Russia, India has also moved into the arena of commercialized medicine and has in fact become a major global hub of stem-cell and medical tourism, including "commercial surrogacy" through organized "baby factories" that allow wealthy foreign couples to utilize the wombs of impoverished Indian women for a fee (*The Independent* online 2012). Moreover, India

is also home to a booming beauty industry and a bustling domestic cosmetic surgery market that is transforming the milieu of urban centers nearly as much as the nation's growing wealth.

INDIA: ANOTHER OPEN MARKET

DREAM CUSTOMERS. The beauty pageants are yet another manifestation of the liberalizing forces at large since India opened its economy 10 years ago. The proliferation of cable television and foreign films has made Indians more open to international images of health and beauty just when Western cosmetics had become widely available…Analysts estimate that India's beauty market is worth $1.5 billion and growing 20% a year—twice as fast as in the U.S. and Europe. Unilever PLC subsidiary Hindustan Lever Ltd. is launching 50 new beauty products each year. "The Indian woman no longer compares herself to other Indians," says Lever's new-ventures chief Dalip Sehgal. "She uses the international concept of beauty." (*Business Week* 2000:68)

Once again, as we continue to South Asia in the BRIC journey of cosmetic surgery culture, it is important to keep in mind the historic roots and racist discourse of early cosmetic surgery. As this paper argues, it becomes difficult to divorce the modern technology from its ideological source, especially when clear, larger patterns of power structures emerge.

The Origins of Indian Plastic Surgery: Teaching the West

In 1794, an anonymous article in London's *Gentleman's Magazine* detailed the "curious" story of a Parsi "bullock-driver" named Cowasjee working for the British who was punished by the amputation of his nose and hand after being captured by Tipu Sultan, Fath Ali Nawab, of Mysore who had been fighting British occupation (Gilman 1999:75-77). When Cowasjee was released a year later, he went to a member of the brick maker caste to replace his nose with a skin flap graft from his forehead. In fact, the use of skin grafts had been discussed in detail in the Sanskrit writings of Sasruta (or Sushruta) from 900 to 800 B.C.E, as well as in the classic traditional Indian medicine of Ayurveda (Gilman 1999).

According to Gilman (1999), Western surgeons eager to have a response to the still continuing ravages of syphilis reacted swiftly to the news of the 1794 case in India by adopting the discovery from the East and characterizing it in several key ways: First, they noted that such a punishment was a sign of the type of primitive "Oriental practice" that required the presence of British moral authority. Second, the British press rationalized that only "barbaric" practices could account for the necessary innovation of such surgical technology, which explained Europe's late arrival to it. And third, the story allowed for a long-sought-after public relations boost for reconstructed noses (and the practitioners reconstructing them): transforming the noses from a marker of sexually transmitted disease to that of a heroic battle injury.

However, the British in 1794 were ignorant to the fact that similar types of nose construction by graft had *already* been found in the Orient and re-appropriated into European culture as early as the 1500s before becoming lost once again to history (Gilman 1999). In 1597, one of the forefathers of plastic and aesthetic surgery, Gaspare Tagliacozzi of Bologna, documented for the first time in modern history the means of replacing a missing nose (resulting from trauma or syphilis) by the use of pedicle (attached) flap skin grafts from either the forehead, cheek, or in the case of his illustrated book *De curtorum chirugia,* the arm (Gilman, 1999; Haiken, 1997; Sullivan, 2001). The procedure—painful, dangerous (due to potential sepsis), and tedious (the patient's arm was connected by skin flap to his head for as long as 14 days)—was not novel to Renaissance Italy. Rather, the sought-after "trade secret" for European men and women desperate to lessen the social stigma of disease was kept quiet through generations (Gilman 1999:67). According to historians, the Sicilian Branca family rebuilt noses in the fifteenth century. And Henrich von Pfalzpaint, a knight of the Teutonic Order, described performing similar procedures as early as 1460, which he had learned from a "foreigner," and

which had allowed him to "earn very much money" (Gilman 1999:67). For reasons unknown, although Gilman and others hypothesize disapproval from the Church, the technology disappeared from Western surgery just over a century and a half later.

This time around, however, British colonials were determined to retain the technology and use it to their advantage. It wasn't long until British doctors were re-importing the Indian technology back to their colonial subjects following the establishment of the Raj (Gilman 1999). In cases where surgery was not affordable or feasible, the British imported surplus light-colored nose prostheses to the darker-skinned Indians, at a price. Noting this long history of plastic surgery in India, Gilman (1999) comments on its current status in the emerging, industrialized state, free of British rule since 1947:

> In contemporary India the fashion of aesthetic surgery is part of the globalization of medicine. As elsewhere, the surgeon's anxiety about being seen as a vanity surgeon predominates, even (or perhaps especially) in a culture in which the "nose job" has had its longest uninterrupted history. (P. 83)

Over a decade after Gilman's writings, the globalization of aesthetic surgery has indeed taken hold in contemporary India. However, few Indian surgeons today are reporting qualms regarding the nation's booming beauty industry.

The Normalization of Cosmetic Surgery in India

According to 2010 data from the International Society of Aesthetic Plastic Surgeons, India, with its population of over 1.2 billion, generally comes in at about fourth or fifth among the top five countries in terms of the total number of surgical and non-surgical aesthetic procedures (split about equally and comprising over 1.1 million *reported* procedures) (ISAPS p. 3). The most popular surgical procedures performed there are lipoplasty (liposuction), rhinoplasty, breast augmentation, and, according to some surgeons, otoplasty (surgery on the ears) as a result of heavy ear ornamentation among women (Thomas 2011). While India

experiences the fundamental changes that accompany being one of the fastest-growing major economies and a target of increased foreign investment, its media publications continue to buzz with news of the latest cosmetic surgery trends. Many note that the quest for personal alteration has quickly followed the speedy transformation of urban centers and the accumulation of new wealth among middle and upper classes.

According to a 2011 *Business Today* interview with 41-year-old Vijay Raghavan, "When I underwent liposuction, it was new to south India. Now, I have a lot of friends who have got things done and they talk about it. With more disposable incomes, changes in technology, and better after-care, the attitude (towards cosmetic surgery) has changed and their numbers have increased" (p. 129). In the same article, the President of the Indian Association of Aesthetic Plastic Surgeons, Dr. K. Ramachandran, notes, "There has been a threefold increase in cosmetic procedures compared to five years ago." Another hospital administrator added, "The numbers are pretty much like those in the West" (p. 129). Indeed, according to ethnic newspaper *India-West*, Indian American plastic surgeons in Northern California and Los Angeles had their hands full in 2010 answering demands from affluent Indian American women to achieve "the cutely-up-turned proboscis of Freida Pinto," star of the Oscar-winning film "Slumdog Millionaire" (Sohrabji 2010:A20). Moreover, the resident "king of noses" for A-list Hollywood stars happens to be Calcutta-born Beverly Hills plastic surgeon and "Dr. 90210" star, Raj Kanodia (Minihan 2009:J1). However, most Indian publications agree that the days are over when cosmetic plastic surgery was confined to the very rich and Bollywood movie stars. According to *Business Today*, the cosmetic market in India is estimated to surpass $1 billion by 2014, and Dr. Aniruddha Bose states that "[t]he increase in the number of trained plastic surgeons is taking cosmetic surgery to the masses" (Chaturvedi 2011:130).

So, what exactly are the "masses" doing with their newfound consumer clout? The consensus is body sculpting, nose jobs, and hair transplants for bridal parties and for those who would like to improve their marriage prospects (Chaturvedi 2011); facelifts for ageing members of the workforce; and nose reduction, "especially [for] Northerners, who tend to have larger noses than their Southern siblings" (Sohrabji, 2010:A20). There has also been an explosion of expensive salons and "face gyms" offering facial exercises and anti-ageing skin treatments (Mehta 2005), as well as inexpensive Botox injections for all ages and skin-lightening creams galore (Parameswaran and Cardoza 2009).

These consumer trends do not exist in a vacuum but have evolved with the help of several key shifts that Indian authors elucidate with differing shades of acceptance (no pun intended). For example, in addition to a boom in the skin-lightening market, multiple authors mention the pivotal (and some claim, corporate-strategic) role that several high-profile international beauty pageant wins played in embarking India on a new wave of aesthetic consumerism. As one *Business Week* article described it:

> Blame it on the beauty queens. Ever since India's loveliest began bringing home international crowns five years ago, the nation's beauty business has never looked so--well--attractive. Not so long ago, Indian women were limited to two brands of lipstick and cold cream. Now, thanks to market liberalization, they have plenty of choice--be it hair mousse, foot cream, or sparkly nail polish. And, inspired by the likes of Lara Dutta, crowned Miss Universe 2000 in May, they are spending with abandon…The stampede to the cosmetics counter is only part of it: In their newfound obsession with looking hip and trim, Indian women are also rushing to join fitness centers. Even cosmetic surgery is experiencing a boom. Indian girls increasingly see Dutta and other beauty queens as role models: You can't buy advertising like that. (Kripalani 2000:68)

Well, maybe you can. While staying within the bounds of this paper and without going into too much background regarding the different histories and social implications of beauty pageants, there are two different American-made pageant tracks: Miss USA and Miss America. Miss USA was created in the 1950s by a bathing suit company (Catalina) that had formerly sponsored Miss

America after a winner declined to wear her Catalina bathing suit on stage for modesty purposes (Anand 2006). In contrast to the Miss America scholarship pageant (which is a domestic-only, non-profit, volunteer-based organization requiring contestants to perform a talent, have an issue "platform," and compete for scholarship funding), Miss USA feeds into Miss Universe. The Miss USA-Miss Universe track has never required any specific talent besides "beauty," involves cash prizes, and is a corporate enterprise (Banet-Weiser 1995). The Miss Universe organization (including the Miss Universe, Miss USA, and Miss Teen USA pageants) has been co-owned by real estate tycoon Donald Trump since 1996. Similarly, Miss World is a separate, for-profit company based in London.

Banet-Weiser (1995) argues that the for-profit pageants Miss Universe and Miss World, and specifically Miss India, Miss South Africa, and Miss Lebanon, "have been far too narrowly focused on the organizing structure of Western Imperialism" (p. 298). She notes that "[c]ritiques [of the pageants] have frequently depicted the events as global showcases for American products and [regard] the women who participate in these events as being constructed according to American norms and standards" (1995:298). Banet-Weiser goes on to describe India's reaction to its 1994 Miss World-Miss Universe double win as a means of "securing a place within what Benedict Anderson calls an 'imagined community' for any nation or national identity, [and signifying] efficient and successful management on an international stage…as a particular kind of moral community" (p. 301).

Citing Liisa Malkki (1994), Banet-Weiser also compares the pageants to the anthropologist's description of the Disneyland ride "It's a Small World": "Interesting…for what it tells us not only about the erasure of inequality, but about the domestication, neutralizing, and stage-managing of difference among people" (p. 303). Although critical of the artifice

surrounding this means of situating India in the "family of nations," Banet-Weiser does not deny that the double pageant win held sway among the Indian public and international media circles:

> A [1994] Los Angeles Times article detailing the success of the two women led with this query: "If China boasts the world's fleetest female swimmers, France the most select of vintages and Ukraine the greatest pole vaulter, where do the world's most comely women come from? From India, of course. It's as official as these kinds of things ever get. This year, anyway....Some [citizens of India] felt as jubilant as if the country had received an armful of Nobel Prizes or Olympic medals. The unexpected honors paid to two young Indian women were also debated for what they signaled about India—its international image, the place of women in its society and its attitudes toward sex. 'It's a victory for the nation. The Indian subcontinent has come into the limelight,' said a happy Deepa Bhatia, an executive in the advertising section of Femina, a woman's magazine." (1995:304)

A decade later, in a piece written for *Little India*, Anand (2006) reminisces about the shorter, "plump" and curvy Bollywood actresses of the 1980s and early 1990s. Referencing the global pageant double-win in 1994 by taller, light-skinned (and light eyed) Sushmita Sen and Aishwarya Rai (who are both rumored to have since undergone cosmetic surgical procedures), Anand draws a connection to the convenient timing of the win with the "opening" of India's economy, stating that, "[a] demand had to be created for Indian consumers to buy their products and Suzanne Sommers wasn't going to cut it" (p. 33). She adds, "What worked in the West is now at play in India" (p. 33). In his review of globalized beauty marketing patterns from 1945 through 1980, Geoffrey Jones (2008) also references the use of international beauty pageants as "a proxy" for corporate interests, noting:

> There were 20 Caucasians and 6 pale-skinned Latin Americans among the winners of Miss World. Apart from a pale-skinned Miss Egypt in 1954, Miss India in 1966 was the first "darker skinned" winner and Miss Grenada (1970) the first of visible African descent. The Miss Universe winners included 14 Caucasians and 7 pale-skinned Latin Americans. There was a Japanese winner in 1959, a Thai in 1965, and a Trinidadian of African descent in 1977. A "Miss Universe standard of beauty" involving face, figure, proportions, and posture was diffused into national beauty contests, as has been shown in the case of Thailand. The sponsorship of US cosmetics companies co-opted women of every nationality into their international marketing. (P. 144)

In the midst of international marketing schemes and a new flood of product "choices" for Indian beauty consumers, Anand closes her article with the lament: “Indian women are being exhorted to live up to Western beauty standards in a fool's paradise. It's not that people don't have a right to create a name for themselves in these arenas, but they should do it by being themselves and not by masquerading to some false standard” (p. 33).

The Results of Cosmetic Surgery Culture: Social Critique or Social Networking?

In a piece entitled “The Colonized Mind,” Balaji (2009) deliberates: “[B]eauty products such as hair straighteners and skin lightening cream have reinforced the notion that whiteness is an ideal to be striven for. As we continue to idolize fairness, I'm reminded of postcolonial thinker Frantz Fanon's (1968) commentary on the tragic state of the colonized mind: 'we seek to shed ourselves of our native skin and occupy the skin of our colonizers, even as they continue to mock us and see us as their subjects'” (p. 58 [direct quote unverified]). In the aptly named "Cultural Politics of Fair/Light/White Beauty in India," Parameswaran and Cardoza (2009) examine the intersections of gender, nation, beauty, and skin color as represented by Indian magazine and television advertisements for fairness (skin lightening) cosmetic products. Currently, laser sessions for "unwanted pigmentation" are also a popular choice (Mehta 2005:M6).

According to Parameswaran and Cardoza (2009), although “colorist” bias against darker skin existed even in pre-colonial India, “[t]he expansion in the skin-lightening sector in India over the past decade has followed in the wake of accelerated state-sponsored economic reform, that is, the central government's decision to dismantle socialist state policies that had hindered private or ‘free’ enterprise, and hence inaugurate the creation of a robust global capitalist consumer economy” (p. 216). A key mandate of these stark economic changes centered on encouraging domestic and multinational companies to produce and market “lifestyle” products,

like skin-lightening creams for example, to the burgeoning Indian middle class (Parameswaran and Cardoza 2009).

In the same vein, the authors are careful to note that "discourses of race/class/ethnic/caste mobility embedded in popular representations of 'fair' beauty" are non-linear and "do not *necessarily* imply" Indians' desire to alter ethnic identities for the sake of a white racial other (2009:217) (emphasis in original). Moreover, they note that there are divergent historical theories explaining "colorism" in South Asia, including the existing caste system, ancient influxes of foreigners, and the fact that desired "fairness" is actually a range of colors depending on India's diverse population (p. 225). However, it is also important to consider the implication that even the widespread use of the word "fairness" in regards to these products mirrors an English-language synonym for "beauty," as well as the fact that colonial conquest is the primary reason that Indians and Indian media utilize this kind of English vernacular at all. It seems that with the help of profit-seeking multinational corporations, the vast Indian population continues to consider the meanings of "fairness" and "beauty" interchangeable.

Parameswaran and Cardoza's (2009) lengthy analysis of Indian advertising argues that audiences are persuaded to register discourses of beauty "as part of a larger system of overlapping statements—global mobility/local authenticity, tradition/modernity, and nationalism/cosmopolitanism—about particular geographies, namely 'modernizing' India and its closer alliances with the west" (p. 218). They also quote Chowdhury and Halarnkar (1998:58): "The Indian obsession with fair skin is often painfully obvious. Now, the train of the globalising middle class, far from leaving our color consciousness, is only hitching its carriages of old prejudices and attitudes to new engines" (2009:219). Citing a dearth of academic research on the slew of skin-whitening practices that have hit Asia, Africa, and the Middle East, Parameswaran

and Cardoza further explore the social (and economic) currency that light skin carries *within* the social boundaries of postcolonial India. According to their analysis, which they support through myriad related studies (of the African American community, for example), having even slightly lighter skin in ethnically uniform communities of color operates "as a form of social capital in a non-White community…[by] challeng[ing] dominant Euro-American myths of a homogenous 'brown' South Asian population" (2009:221). Parameswaran and Cardoza (2009) argue that this, in turn, creates new hierarchies of power and inequality within the communities of color themselves—a process that Mamdani (2001) has associated with the colonial practice of divide and rule that relegated different sections of the population into "subject races" according to constructed and arbitrary markers like skin tone.

Whatever the origins and the symptoms, colorism seems to be omnipresent in Indian society. From the story lines of children's comic books, to casting calls for entertainers and blatant skin color preferences listed in matrimonial (arranged marriage) Web sites, "fair" or "wheatish" skin is much preferred to "dusky" or dark skin (pp. 229-230). Some marriage ads on commercial Web sites even include apologetic disclaimers from parents stating that their daughter is not of fair complexion: "NEGATIVE POINTS....Of course she is not very dark, but with no amount of extrapolation she can be called as fair" (Parameswaran and Cardoza 2009:230, quoted in Adams and Ghose 2003:431). Apparently, this stigma is good for business:

> According to Sachdeva (2001), the fairness cream market had been expanding at the average rate of 25 percent per annum since the early nineties, faster than the overall cosmetic market growth of 15 percent per annum. In 2002, fairness creams constituted 70 percent of the total sales for Avon, a recent multinational player in the fairness market in India (Prasad, 2002). The primary consumers of skin-lightening products are young girls and women in the age group 15 to 30 years old, and the industry has spread its tentacles far and wide to target consumers across a wide spectrum of socioeconomic categories. (Parameswaran and Cardoza 2009:235)

In addition, a *New York Times* piece cited by the authors reported on a Euromonitor

International research firm finding that up to 65 percent of Indian women use a skin-lightening product in their daily routine, "so manufacturers say they ignore [the products] at their peril. The $318 million market for skin care has grown by 42.7 percent since 2001" (*Ibid.* p. 262 citing Timmons 2007). Although multinational companies like Revlon, Clinique, Elizabeth Arden, L'Oreal, Vichy, Nivea, Avon, and Ponds started to enter the market in the early 1990s, Indian companies have recently secured the largest share of the "fairness market," with Hindustan Lever Limited (HLL, Indian subsidiary of Unilever) holding a 70 percent share alone (Parameswaran and Cardoza 2009:235-236). Hindustan Lever's none too subtly named *Fair & Lovely* facial cream has led the market for the past three decades, exporting the brand to 38 countries in Asia and Africa. In response to growing criticism of its expansion, the brand linked up to a philanthropic wing of the company in 2002 to "empower" Indian women to "change their destinies" through education and career training (*Ibid.* p. 237). In a more direct response to public criticism of *Fair & Lovely*, a Unilever corporate representative in India argued from the standpoint of cultural relativism, stating that critics of the skin lightening products had a "very western way of looking at the world" (*Ibid.* p. 262, quoted in Timmons 2007). Similarly, when questioned about the Garnier brand skin-lightening cream market in South Asia, a corporate executive for L'Oreal India suggested that Indian women's pursuit of light-skinned beauty was "deeply rooted" and had little to do with imperialism or European colonialism (*Ibid.* p. 262).

Slogans such as *Fairever* cream's, "There is nothing that cannot be changed," and Revlon's *Touch & Glow* tagline, "Discover the confidence that fairness brings," do not mince words (*Ibid.* p. 244). Parameswaran and Cardoza's (2009) study reveals that popular advertising techniques such as these include the use of pharmaceutical jargon, themes of traditional Indian feminine domesticity, and the supposed gains that being fair-skinned will produce in the pursuit

of successful courtship and marriage. The authors do note, however, that some headway has been made by collective activists to criticize colorism and sexism in Indian media, resulting in a few instances of corporations puling their ads. Meanwhile, they are pleased to report that dark-skinned Indian women tend to occupy more positive cultural space in independent and international films.

Yet, fairness and beauty pressures in India are no longer exclusively geared toward women. *News India-Times* reported in 2008 that a new product, "Fair and Handsome," and others like it were growing in sales at a rate of nearly 150 percent in emerging markets for lower-middle-class men looking for social mobility: “The creams often cost about $1, or half a day's wages for many Indians. Despite the expense, the creams might as well be liquid gold for some young men, who believe pale skin will lead to well-paid jobs and wealthier mates” (Wax 2008:3). As reported by the publication:

> Vinod Kumar, 18, a dark-skinned cigarette salesman, said he buys Fair and Handsome every month. "I want to be rich and fair like my film hero," he said. "To be pale would make me be so smart." Some companies have started to produce tiny packages of the cream so that poorer Indians who can't afford an entire tube can still strive toward lighter skin. "It's something we have internalized, and it's propagated by everyone since we still have this colonial hang-up that white is better, white is wealth, white is someone rich enough to never toil in the sun," said Nikki Duggal, a New Delhi-based graphic artist who created T-shirts that say "Dark and Lovely" and "Fair and Ugly" -- which in many ways mirror the "Black Is Beautiful" T-shirts that became a symbol of empowerment in the United States. "It's so prevalent in India that fair equates to more success in life. There is a very sad message that if you are dark, you are doomed." (Wax 2008:3)

And for Indian men in the mid-to-high socioeconomic range, cosmetic surgery is also on the rise at a number estimated by some surgeons to be at least 40 percent of procedures. According to *India Today*, doctors are not surprised, even stating that male patients have begun to outnumber women for a number of procedures: “There is a perceptible change in the male attitude towards reinventing their body image through cosmetic surgery. And it’s a made-to-order macho image,”

said Dr. Ramesh Kumar Sharma (Datta et al. 2007:46).

In addition to crossing gender and socioeconomic barriers, increasingly the enthusiasm for aesthetic procedures is surpassing age barriers. According to a recent *Times of India-Allahabad* online article:

> Kiran, a mother of a 17-year-old girl is nowadays busy counselling her about the surgery she has to go [sic] in couple of months. The operation that young Niharika wants to undergo would make her nose look better. A growing number of people, even mothers belonging to middle and even lower middle class, are opting for such surgeries for their daughter to look better…."Some want it for job requirement [sic] like modelling or marketing while others want their daughters to look pretty for getting married." (April 21, 2012: n.p.)

One plastic surgeon who was interviewed added, "I believe cinema and TV are playing a leading role in it. Since celebrities act as a role model for lot of these youngsters, they get influenced a lot" (*Ibid.*). Another *India Today* article voiced serious concern over the rising trend of teenage cosmetic surgery in chic urban areas: "No Kidding; From manicures to hair styling, laser surgery and even breast implants, today's adolescents, encouraged by parents, are obsessed with looking good. That is a dangerous trend, making them adults long before their time" (Bhupta et al. 2007:50). According to the piece, over 20 percent of clients in India's urban cosmetic surgery and beauty clinics are between 12 and 16 years old, with many looking to snag careers in entertainment or modeling, often with the support of their parents. Never-before-seen businesses catering to kid-focused spas, high fashion, and grooming have some Indian experts worried about fueling a generation of "emotionally vulnerable" narcissists, according to one child psychologist (*Ibid.* p. 50). Apparently, both the worries and the business plans may have merit: 475 million Indian children are under 20 years of age, with the majority of them being younger than 15 years old (Bhupta et al.).

The *India Today* article also made a point of publishing a sidebar that lists the descriptions and possible side effects of popular cosmetic surgeries for Indian teens, including

pectoral implants (for boys), rhinoplasty, breast implants, liposuction, and laser skin lightening (Bhupta et al.). The authors commented that:

> [B]e it to please the boyfriend or win the next beauty pageant, these kids are not willing to wait for time and tide. If hormones are playing truant, they deal with it by undergoing the laser treatment for hair, and if their face is not perfectly shaped, they align it by using Botox. If girls are not the perfect 34B by the time they are 15, they seek solace in implants. If the nose is not perfectly rounded, they get a rhinoplasty done. (Bhupta et al. 2007:50).

Quotes from Indian plastic surgeons reveal that parents are often either willing "catalysts" or "helpless bystanders" in their child's surgeries (*Ibid.* p. 50). Some parents (often "more malleable" mothers) accompany their minor children to the clinic, replete with a photo of the child's favorite film star (*Ibid*. p. 50). Some parents even request liposuction for minors to combat their being overweight. Defending such practices is Dr. Vijay Panjabi, president of the Indian Medical Association in Maharashtra, who asserts, "In a democracy, it is the patient's choice to look good and highlight their features. If we have consent of parents in [the] case of minors and the doctor is confident of the surgery, it is absolutely ethical to operate" (Bhupta et al. 2007:50).

In sum, we see the discourse of "democracy" and "choice" actively informing cosmetic culture among Indians with newfound disposable income, as well as those who continue to make just two dollars a day. Furthermore, evidence shows that India's huge population and growing middle class have been explicitly targeted by multi-national corporations in the cosmetic industry since the opening of their consumer market in the early 1990s and likely beforehand. We learned that India's entry into the world economy happened in tandem with global corporate pageant wins, boosting national pride in the prestige of Indian beauty and womanhood while simultaneously boosting domestic cosmetics sales. However, some Indians decry what they see as a continued manifestation of India's colonial oppression in the image of its beauty market and

the characteristics considered emblematic of, and necessary for, social mobility. Moreover, although it was discovered that ancient Indian traditional medicine and its innovation with skin grafts may have formed the entire foundation of the origins of reconstructive surgery as we know it today, had it not been for appropriations by Western and Central Europe, that technology may have remained un-commercialized. In the age of India's globalization, pre-existing class, color, and gender prejudices are reportedly exacerbated by a burgeoning hyper-consumerism. As a result, body modification has become synonymous with upward mobility and social transition, while a vast emerging youth culture among the upper and middle classes is increasingly dominated by the goal to achieve opportunity and success through cosmetic surgery.

Parameswaran and Cardoza (2009) cite a number of studies that indirectly support Shome's (2000) understanding of the remaking of "whiteness" through its participation in other unequal social relations. Quoting Zacharias (2003:398), the authors note that a flood of signs of "whiteness, whitened bodies, and hybrid foreign bodies" seductively promise "infinite possibilities of transformation and mobility to the socially ascending postcolonial viewer" by means of consumer empowerment (p. 229). This complicated question of whether the promise of social transformation, mobility, and global enfranchisement can be fulfilled through consumer empowerment—and similarly through cosmetic surgery—continues to rear its head among BRIC nations. For some, political struggle and social justice are not meant to be purchased and promised from above, but rather, still exist in the spaces in between and outside the reaches of hegemonic imperialism. According to Said (1993), “In our time, direct colonialism has largely ended; imperialism, as we shall see, lingers where it has always been, in a kind of general cultural sphere as well as in specific political, ideological, economic, and social practices” (p. 9). Thus, the question of who cosmetic surgery culture benefits on a macro level will also hinge

upon whether it is the kind of specific practice that perpetuates the cultural sphere of a lingering imperialism.

Although India is not alone in South Asia among countries coming to grips with cosmetic surgery and medical tourism—surprisingly Pakistan was recently listed by *The North Africa Post* as one of "the current giants in the field of medical tourism" (2012:online)—our journey heads eastward to China. It should be quickly noted, however, that neighbors across the Arabian Sea such as Iran, Saudi Arabia, and Lebanon are experiencing the mass normalization of procedures like rhinoplasty, which have become a common standard of appearance despite Muslim restrictions on dress and certain modifications of the body; by some accounts Tehran is the nose-job capital of the world, with Ayatollah Khomeini having provided his religious blessing to rhinoplasty in the 1980s (NPR 2001; Spolar 2006; Young 2006; Davis 2008; Salehi 2010; *NYDaily News* via AP 2009; Neild 2010; *Inside Islam* 2011).

Moving onward, China's cosmetic surgery culture shares some important characteristics with India's, including the fact that its skin-lightening product market was estimated to be worth over $1.3 billion in 2002, including innovations where skin is purportedly lightened via an expensive off-market intravenous **(**IV) drip (Parameswaran and Cardoza 2009, citing Miré 2005; Wen 2011). However, the Chinese use and history of cosmetic surgery has many unique aspects, especially in terms of its complicated relationship with a competitive job market.

CHINA: COSMETIC SURGERY AND THE JOB MARKET

> *[One hundred] years ago, meirong (activities related to beautification or beauty service) belonged to the upper class. Now it has developed into a huge industrial army. The industry has contributed significantly to our social life and economic development, including bringing beauty to us. I hope that the beauty industry will lead fashion, bring a better life and build a new image of [China's] beauty industry by following the nation's orientation in building a xiaokang society and improving people's living standard.* (Wen 2011: 266, citing Xu 2007: prologue)

The above quote came from the Deputy Director of the General Administration of Press and Publication of China, Liu Binjie, during the October 2004 economic forum of China's International Beauty Week in Beijing. And according to Wen Hua's (2011) dissertation on cosmetic surgery in Post-Mao China, it is a statement laden with meaningful implications of "the new ideology" and "pragmatic redefinition" of a Chinese Communist Party (CCP) dedicated to what Latham (2002:231) calls the "rhetoric of transition" (Wen 2011:267,263). Wen elaborates:

> [T]he party-state has also used the concept of *xiaokang* (relatively well-off, comparatively comfortable, or comparative prosperity) to form its development strategy and to legitimize its vision for the future of China. The current usage of *xiaokang* invokes earlier Chinese ideas in support of the CCP's Marxism. In ancient Chinese thought, a *xiaokang* society was the predecessor to the *daton* (great unity), a utopian vision of the world in which everyone and everything is at peace. By invoking *xiaokang*, Chinese leaders intend to legitimate the current inequality associated with the capitalist market. (2011:265-266)

To understand just how counterintuitive a statement like this from a Chinese party leader would have been only a few decades ago, it is important to examine the sociohistorical context of China's past and current relationships to global "beauty" markets.

During the 2004 International Beauty Week Forum, four Chinese economists released the first ever *Annual Report of China's Beauty Economy*, which found that the sales volume of China's beauty industry had increased more than 200 times in just two decades—from 200 million yuan ($24 million USD) in 1982 to 52 billion yuan ($6.2 billion USD) in 2003 (Wen 2011:267; Yang 2011). Experts and industry insiders argued that a booming beauty industry, employing mostly low-income women in a one-to-one service ratio, could constitute "a potential solution to the country's unemployment problem," which resulted partly from gendered layoffs during the late 1990s' breakdown of the state's life-time job allocation system (Wen 2011:citing *Xinhua News Agency* 2005a:n.p.; Yang 2011). By 2005, studies suggested that the burgeoning

beauty industry already employed more than 16 million Chinese, with more than $2.4 billion USD spent each year on roughly a million cosmetic surgery procedures (Wen 2011: 268-269). Moreover, 2009 and 2010 data from ISAPS found that China ranked third, after the U.S. and Brazil, in total number of surgical and non-surgical cosmetic procedures, comprising more than 3.4 million reported cases (*Women of China* 2012). Despite this present outlook, Liu Binjie's earlier quoted reference to "a huge industrial army" and "building a *xiaokang* society" are more reminiscent of the booming beauty economy's dissonant relationship with China's not-so-distant past.

Closed and Opened Doors: The Long Origins of Globalization

For thousands of years, Chinese traditional medicine stressed the philosophical importance of an intact body and did not allow for incisions to operate on ailing patients or the dissection of cadavers (Haiken 1997; Gilman 1999; Wen 2009; Wen 2011). As a result of the Qing Dynasty's insularity, the influence of Western medicine was largely blocked until the arrival of Christian missionaries during the "Opium Wars" (or "Anglo-Chinese Wars") in the mid-1800s, which were fought largely due to the British Empire's unsavory trade practices and its attempts to infiltrate Chinese markets (Kong 2000). Although villagers rebuffed the missionaries' initial introduction of Western medical practices "as a kind of sorcery and a dismemberment of live bodies," savvier Chinese elites also played a role in stoking fears as a means of keeping foreign missionaries away (Wen 2011:70).

Nevertheless, by 1908, the Union Medical College in Peking was founded as "a joint effort of the British and American missionary societies," and the Rockefeller Foundation's 1921 Peking Union Medical College (PUMC) eventually played a major role in developing Chinese plastic surgeons (*Ibid.* p. 70). Quoting Frank Ninkovich (1984:799), Wen writes that "[t]he

Rockefeller Foundation's attempt over the course of forty years to channel China's modernization in a liberal direction epitomizes the marriage of national interest and private policymaking" (2011:71). As Yang Nianqun (2006:2) put it years later, "When the first Western scalpel cut a Chinese body, it was an 'event of modernity'" (Wen 2011:72). Wen elaborates on Yang's (2006) argument that this moment serves a metaphorical purpose for the Chinese body politic by stating:

> As the sick body is a metaphor of the weak nation, healing the sick body through Western anatomical medicine gradually became a metaphor of building a strong nation in terms of Western science and technology. (2011:72)

Ironically, despite this notion that expanded Western medical practices signified a rise in national strength, Western-style surgeries soon became indispensable largely due to China's divisive civil conflicts and regional wars. This was especially true for reconstructive plastic surgery technology, which became essential in response to the use of modern weapons during continuous conflict among Chinese warlords between the Kuomintang and Communist Party and between China and Japan during the second Sino-Japanese war. From the 1920s to the 1940s, the government even sponsored groups of Chinese surgeons to study reconstructive plastic surgery in the United States (Wen 2011).

However, the Chinese soon found themselves in even closer proximity to Japanese practitioners who had already been developing Western-style surgical expertise for many decades. As early as the 1930s, according to surgeon Zang Disheng, "[w]ith the invasion of Japan and other imperialist countries, some Japanese surgeons opened business in Shanghai…[and] gained fame by performing cosmetic surgery on a batch of Chinese actresses" (Wen 2011:77). Although the "[t]raditional images of female beauty in Chinese literature and paintings always showed long, thin almond-shaped eyes with single-fold eyelids," flawless fair

skin, "an oval, melon-seed-shaped face," and “small breasts, as a sign of elegance, modesty and good manners," surgeons in large cities were soon performing rhinoplasty, blepharoplasty, cheek dimple creation, and breast surgeries (Wen 2011:78,76,338; Guterl and Hastings 2003). Whereas China enjoyed a diverse range and long history of renowned imperial beauties, varying from the historical ideals of two women, "buxom Huan and slinky Yan" (Wen 2011:279), according to Charles Darwin's studies, traditional beauty standards were showcased in stark contrast "with the eye of the red-haired barbarians," adding in *The Descent of Man* (1871):

> It is well known, as Huc repeatedly remarks, that the Chinese of the interior think Europeans hideous with their white skins and prominent noses. The nose is far from being too prominent, according to our ideas, in the natives of Ceylon; yet Chinese in the seventh century, accustomed to the flat features of the Mongol races were surprised at the prominent noses of the Cingalese; and Thsang described them as having "the beak of a bird, with the body of a man." (As cited in Gilman 1999:101)

Thus, it is a common reaction for the Chinese and others of East Asian descent, including academics, to resist what they say is a reductive and biased label produced and disseminated by Western media: the idea that a boom in eyelid, face, and nose procedures mainly serves to "Westernize" Asian features (Wen 2011; Davies and Han 2011). While taking this local perspective into account, it is also important to examine the strength of their arguments.

For example, Wen (2011) repeatedly emphasizes her reluctance and that of her ethnographic informants to connect the actual physical nature of popular surgical trends to Western European racial discourse, focusing instead on the "cultural hegemony" of Western fashion and media popularity or the general belief that certain facial features are associated with modernity and beauty (p. 339). In fact, Wen’s sample population of Chinese women interviewed from 2006 to 2007 who had opted for cosmetic surgery often expressed offense and incredulity in response to suggestions that such surgeries resulted in more white or Western-looking features (2011:314-315). Moreover, in regards to possible causes for the popularity of surgeries creating a

fold in the eyelid, many have long countered that about half of East Asia's population is already born with double eyelids (Haiken 1997; Wen 2011). A typical response in Wen's fieldwork is described below:

> "Double eyelids make my eyes bigger and more beautiful." When I then asked why big eyes are considered beautiful, some of them stared at me in puzzlement. As one informant said, "It's universal! Big eyes are always considered beautiful. It is kind of a benchmark of whether a woman is pretty or not. Aren't big eyes beautiful?" (P. 278)

Wen nevertheless generally struggles to find a convincing social impetus in 1930s China for the pursuit of double eyelids and bigger breasts apart from Western influence. Although she quotes opaque passages about greater women's equality during the period after the Xinhai Revolution, the cessation of foot binding, and the emergence of nude models in fine art schools around that time, their connection to cosmetic surgery falls somewhat flat (2011). Her revelation that Chinese women had wrapped their breasts tightly to make them smaller and more attractive for centuries wholly conflicts with the sudden introduction of faulty attempts to augment breasts and noses with paraffin wax injections and ivory implants—techniques that produced immediate desired results with alarming rates of disastrous bodily rejection, scarring, and infection later. She writes, "Even in the late Qing China and the early Republican period, Chinese women struggled over whether they should stop wrapping their breasts tightly" (Wen 2011:78).

A more persuasive argument accounting for these dramatic sociocultural changes stems from Wen's focus on Shanghai's 1920s and '30s reputation as the "Paris of Asia." In the biggest, bustling, cosmopolitan, and commercial city in China, "increasing contact with the West stimulated the development of mass media, the Hollywood film industry and department stores," which were flooded with Western fashions, undergarments, cosmetics, photos of Hollywood starlets, as well as pervasive images and ideologies of Western women's "modern lifestyles" (2011:80). Shanghai "calendar posters" also emerged in the 1920s through 1940s as a form of

advertising that featured beautiful Chinese women (sometimes wearing Western clothing and engaged in outdoor activities) aimed at selling foreign products like cigarettes, Western medicine, and cosmetics. As will be explored further in reference to Japan, Vietnam, and Korea, American servicemen also had a role in making Western body ideals a lucrative aspect of informal economies such as bars and brothels. Xu and Feiner (2007) likewise support a similar argument:

> When Western ‘‘barbarians’’ invaded China in the middle of the nineteenth century, traditional notions of Chinese…national identity were undermined by the barbarians’ greater power and technological superiority. At the same time, ‘‘their women’’ (white women now visible, but taboo) began to displace traditional Chinese beauties as objects of desire. This shift can be seen most clearly in Colonial Shanghai, China’s cultural capital in the first half of the twentieth century. Here, émigré Russian cabaret dancers and prostitutes were more popular (and expensive) than Chinese women (Andrew Field 1999). During this period, Chinese pictorials attracted readers with photos of Western beauties. And even while Chinese prostitutes continued to receive rankings and appraisals from their customers in local tabloids (Han Bangqing 1894/1930; Gail Hershatter 1999), Western-style beauty pageants gradually came into vogue. By 1946, the Miss Shanghai competition was a full-blown imitation of the Western form. (Pp. 312-313)

However, this Western influx of people, commerce, trade, and pageantry, as well as training and travel between American and Chinese surgeons, ground to a halt in 1949 with the establishment of the People’s Republic of China under Chairman Mao Tsetung (or Mao Zedong). During the Cultural Revolution in the 1960s and 1970s, the quest for beauty was regarded as a symptom of decadent Western bourgeois culture antithetical to the Marxist-socialist ideas underpinning his government, and thus cosmetic surgery, makeup, and even gendered clothing were also forbidden (Gilman 1999; Yang 2011; Wen 2011; *Women of China* 2012; see also Brownell 1995). During this period, plastic surgery as a specialty was demolished by the state and only a few reconstructive surgery departments maintained operations for trauma wounds and burns (Wen 2011).

Moreover, (and not dissimilar to Stalin's aforementioned "Doctors' plot") many prominent reconstructive plastic surgeons and medical doctors were targeted as subversive academics in the 1957 Anti-Rightist movement against critics of Communist party rule (Wen 2011). Elderly surgeons recalled later in news interviews that only "art workers," such as famous actresses and actors, could receive cosmetic surgical procedures—and only with strict permission from Beijing's City Culture Bureau (*Ibid.* p. 91). State propaganda exemplified a model of "iron women" and "comrade sisters" with androgynous photos of short-haired, muscular-looking women welding and driving tractors (Wen 2011:88,46). Quoting Chen T.M. (2003), "In Mao's China, dress and body discourses constituted fundamental components of a political-aesthetic ideal in which proletarian subjectivity became aestheticized" (Wen 2011:89). Yang (2011) also notes that Maoism's eschewal of femininity and gender differences between men and women served to maximize the use of female labor for nation building.

After the 1976 collapse of the "Gang of Four" and the end of the Cultural Revolution, a widespread policy of modernization and economic reform swept the country based largely on the development of science and technology infrastructure, which resuscitated plastic surgery (Wen 2011:91-92). In 1979, prominent surgeons re-opened the Plastic Surgery Hospital at PUMC in Beijing, and although most plastic surgery procedures were strictly reconstructive at first, cosmetic surgery rates consistently increased. In one plastic surgery hospital in Beijing, for example, operations increased by 118 percent from 1991 to 2004, with the number of reconstructive surgeries increasing by 33.9 percent and the number of cosmetic surgeries increasing by a whopping 336 percent (Wen 2011:94). The first congress of the Chinese Society of Plastic Surgery was held in May of 1982 (*Ibid.*: p. 93). And although cosmetic surgery made some headway in the 1990s, it still "existed on the fringes of society" and was largely kept secret

from others (*Women of China* 2012:n.p.). In 2010, by contrast, the value of China's plastic surgery market had reached 300 billion yuan ($48 billion USD), with the industry employing more than 20 million people. Today, "[t]he beauty economy has become the fourth largest consumption hot spot following housing, vehicles, and tourism" (*Women of China* 2012:n.p.).

In a related vein, Wen (2011) cites numerous studies that examine how social norms and attitudes toward "embodied pleasures," sexuality, love, and marriage have been changing rapidly in the market orientation of post-Mao China, including a resurgence of prostitution and concubinesque relationships that put renewed public emphasis on erotic bodies and gendered power dynamics (pp. 49-51; see also Farquhar 2002; Yang 2011). According to Yang (2011), the Post-Mao Communist Party must now move in the polar opposite direction of policy to impose a biopolitical strategy that "naturalizes and even essentializes biological differences between men and women in order to meet the demands of labor reduction for a market economy" (p. 355). Citing Wang (1998), Yang writes:

> The focus on the body is part of China's shift in governing from Mao's emphasis on the public and politics to the post-Mao emphasis on the individual and the body as a way to prove to the capitalist world that China has overcome the ideological excesses of Maoist socialism in order to stake out a position in the global market...Indeed, in the post-1989 context, the rise of consumerist culture is not merely an economic event but also a political event, because the penetration of such culture into people's daily lives is carrying out the task of reproducing hegemonic ideology. (2011:339)

In other words, the Chinese government has worked hard to dispel the once ubiquitous image of its gray, unisex Mao suit (Wen 2011). Beauty industry growth and the "choice" to submit to surgical and non-surgical aesthetic regimens are supposed to signal that "China is becoming an affluent and tolerant open society" (Wen 2011:370). Accordingly, Chinese women, recalling the aesthetic constraints placed upon their mothers or grandmothers, have begun to embrace this newfound "freedom" with open arms but with varying results:

> On the one hand, I found cheerful stories describing women who have undergone cosmetic surgery as being finally bold and creative enough to take control of their bodies in the quest to become beautiful—an act which they could not imagine during the Mao era. On the other hand, I found miserable stories reporting that a huge number of women had been disfigured and some even killed from cosmetic surgery. It has been extensively reported that at least 200,000 people have been disfigured from cosmetic surgery in the last decade in China. (Wen 2011:3 citing Weaver 2003; see also Gilman 1999; Guterl and Hastings 2003; *Economist* 2004; Magnier 2004)

Despite being legally prohibited from performing any invasive surgical or medical procedures to repair or reshape the body, a 2006 investigation by the Beijing Municipal Health Bureau found that out of 66 "daily beauty service providers" (i.e. salons or spas) in eight districts and counties, more than 70 percent provided medical aesthetic procedures (Wen 2011:98). For example, the report found that nearly 20 percent of the daily beauty centers provided breast augmentation and liposuction surgeries (*Ibid.*). In addition to the dangers associated with a fast-emerging, unregulated cosmetic surgery industry populated by as many amateur opportunists as there are trained doctors (a familiar story even for the United States at the turn of the twentieth century and contemporary Russia), scholars note that there has been a clear trend toward the "commoditization" of women's bodies in China in recent years (Wen 2011:46; see also Brownell 1995; Yang 2011). Tellingly, by the end of 2011, mainland China had 34,000 or more cosmetic surgery institutions, including beauty salons, clinics, comprehensive plastic surgery departments, and hospitals (*Women of China* 2012).

The Normalization of Cosmetic Surgery: China on the Global Stage

In China, as in India, some scholars have focused on the multi-faceted effects of the introduction of corporate-sponsored international beauty pageants—a practice that has the distinguishing characteristic in China of suddenly shifting from a state-banned to a state-sponsored activity in 2003 (Xu and Feiner 2007; Wen 2011; Yang 2011). When China for the first time hosted the final round of the Miss World pageant in 2003, it came as a surprise to

many. Traditionally, beauty pageants in China were considered to be "spiritual pollution"—elitist, tasteless, and demeaning to women—although Xu and Feiner argue that in pre-modern China, "beautiful women were ranked through public activities enjoyed by both the educated elite and the peasantry" (The *Economist* 2004:55; Xu and Feiner 2007:312). As of 2002, the "Miss China" pageant was still an "underground competition" and had even been raided by Chinese police half way through for not having an official permit (Wen 2011).

However, after two decades of Deng Xiaoping's liberalizations, the Chinese government officially endorsed Wu Wei, the first ever ''Miss China,'' to appear at a Miss Universe pageant in early 2003. As Xu and Feiner note, "the pageant was beamed live to 1.3 billion Chinese, making the audience for the 2003 Miss Universe broadcast the largest in history, so the potential for commercial exploitation could not have been more obvious" (2007:314). Simultaneously, city government officials from the resort town of Sanya were working hard to convince the Miss World corporation to allow them to host. Still recovering from having to move the 2002 pageant in the eleventh hour from Nigeria to London after Nigerian Muslim leaders' opposition to the contest's values spurred social unrest, pageant executives overcame their reluctance after Sanya agreed to pay a $4.8 million "permission fee" and complete $31 million in city renovations. Government officials also assured organizers that the 2003 Miss World pageant would be free of controversy (Wen 2011).

At a press conference referencing the culminating event, Sanya Mayor Chen Ci proclaimed, "It is a milestone in the development of Chinese culture….We did spend quite a lot of money, but the consequence will be huge. It will have a positive influence on the city's future" (Wen 2011:272 citing *People's Daily* 2003b). The pageant's television audience was estimated at two billion, prompting the BBC to comment that "with the Olympics in five years'

time, China hopes to gain not only financial rewards from investment and tourism but also the kind of kudos and camaraderie it craves as an accepted, fully-fledged member of the world community" (Wen 2011:273 citing Luard 2003). Indeed, with Sanya's GDP up 13 percent the following year (*The Pakistan Times* 2004), China hosted at least six more major international beauty pageants in 2004, including Miss World, Miss Asia, Miss Tourism World, Miss Tourism International, and Miss Intercontinental (Wen 2011:273). Xu and Feiner (2007) argue that these beauty pageants bolster China's neoliberal policies by promoting consumerism, reinforcing and symbolizing commoditization, diverting attention to the personal, and undermining political protest of the ravages of economic reforms. Calling such efforts "beauty diplomacy," Liang (2007) adds, "[the fact that] [b]eauty pageants are a stage for politicking should come as a surprise to no one. For Miss World in particular, the idea of exploiting the competition as a conduit for political brinkmanship is all too familiar" (cited by Wen 2011:274).

Ironically, after hosting four more rounds of the Miss World pageant, Miss China finally secured the Miss World crown just six months before the Beijing Olympics, the timing of which raised a few eyebrows in the press. As reported by the Chinese periodical *Women of China* (2007), when asked why she should win the 2007 competition, Miss World contestant Zhang Zilin answered, "There are 1.3 billion people behind me….If I win I want to become a link between the Olympic Games and the Miss World Organization" (Wen 2011:275). The timing of Zhang Zilin's win was not the only surprise. With a height reported from varying sources as somewhere between 5'9" and 6'1", fair-skinned Zhang stands over 7 to 10 inches taller than the average Chinese woman (IMDb.com 2012).

These types of atypical height and appearance standards did not go unnoticed as a new wave of informal beauty competitions swept through China. For example, Xu and Feiner (2007)

report that most Chinese beauty pageants have a minimum height requirement of 5'9". Even the most recent news reports show that pageant contestants are often held to rigid and bizarre numerical standards, such as one pageant's requirement that candidates' nipples be "spaced at least 20 centimeters (7.8 inches) apart" and "the space between candidates' pupils should be 46 percent of the distance between their pupil and their ear" (*New York Daily News* 2012:n.p.). Furthermore, Wen documented similar standards sanctioned by the Chinese state during the selection process for the Beijing Olympics hostess committee, where 337 women were chosen from thousands based on eye length ("3/10 of the face"), distance between eyebrows and eyes ("1/10 of the face"), width of the mouth ("should equal distance between the pupils"), and the length of the chin ("1/6 of the face length") (2011:343 citing Guo et al. 2008:A02). Those chosen also went through a "beauty boot camp" where they were "trained to smile in a perfect way exposing six to eight teeth" (Wen 2011:343).

Not surprisingly, this degree of exacting discrimination has encouraged many to fulfill pageant expectations via the surgeon's knife. In one case, when it is was revealed that an 18-year-old Miss Intercontinental contestant and aspiring model had undergone $13,000 worth of cosmetic surgery to her face, she was disqualified from the pageant. In response, the contest's sponsor, Beijing Culture, created a new type of pageant in 2004, which was heralded by international press as the first of its kind. The *Los Angeles Times* reported:

> Welcome to the brave new China, which is making history with what it claims is the world's first Miss Plastic Surgery contest. "Naturals," with their God-given, pain-free looks, have no place here. This stage belongs to those who have suffered for their beauty and now live beyond the cutting edge. All nationalities are welcome, but contestants must show a doctor's certificate at the door. (Magnier 2004:A1)

With only $1,200 in prize money (a fraction of what their surgery may have cost), the real pay-off for contestants—and the cosmetic surgery industry—is publicity. The pageant was televised

and the inaugural winner was promised a role in a planned Chinese TV drama "in which every actor or actress boasts man-made charms" (*Ibid.*: p. A1). Another arguable contributor to the "artificial beauty" pageant was a now-famous 24-year-old freelance writer named Hao Lulu, whose chance meeting in 2003 with the marketing manager of a flagging cosmetic surgery clinic allowed her to upgrade her already above-average looks with $50,000 worth of head-to-toe plastic surgery, free of charge (Wen 2011). By agreeing to be the Evercare clinic's spokeswoman for a year, going public with the announcement, and allowing international news channels to document the six-month process, Hao brought Chinese cosmetic surgery to a new level of visibility and public debate (Wen 2011).

As a result of the publicity stunt, Evercare has since opened several new locations, Ms. Hao has written two books and is a TV personality, and marketers have generated countless copycat campaigns recruiting "Image Ambassadors" for cosmetic surgery clinics hoping to achieve similar results (Wen 2011:115). After Hao went public, the *Economist* (2004:55) even reported that a "Beijing hospital offered 'guinea pigs' the chance to win seven free operations to become the first 'artificially handsome man'." When Hao was asked whom she would ultimately like to look like, *Newsweek* gave the account, "'I'm not trying to look like anyone, just like myself,' she says, lighting up a cigarette, her plastic deadpan betraying no irony" (Guterl and Hastings 2003:48). According to Wen's (2011) dissertation, where Hao Lulu served as one of her key informants, an Evercare ad featuring Hao sported a caption that read: "Evercare, making women a beautiful dream coming true" and "let ordinary women become beautiful, and let beautiful women become perfect" (p. 113). In justifying her own surgery, Hao employs the notion of harmony, "a core value of traditional Chinese philosophy, to balance the dichotomy

between inner character and outward appearance, and natural beauty and artificial beauty," which Hao believes "are the same and they should be recognized as such" (Wen 2011:134,135).

Hao's sentiments mirrored those of many other informants in Wen's ethnography, whose self-proclaimed reasons for cosmetic surgery centered around "the self-fulfillment narrative": "doing it for oneself," "the right of choice," "individual freedoms," and efforts "to increase confidence" (2011:141-143). As seen in other sections of this paper, these tropes are nearly identical to studies exploring Western women's cosmetic surgery motivations. However, as the 2004 *Economist* article "Saving Face" put it (albeit largely in the oversimplified, dichotomized, and assumptive rhetoric that irks at least some Asian academics), outsiders looking in allege variations between East and West:

> But there is a difference. Most western women (aspiring actresses apart) make use of beauty products or undergo plastic surgery primarily to boost their self-esteem. In China, by contrast, an enhanced appearance—often to add an eyelid crease and build up the nose—is primarily viewed as a ticket to higher earnings. Surgery is a commercial investment, often funded with a loan. (P. 55)

Indeed, Wen later states that many Chinese women opt for cosmetic surgery for "very practical reasons, such as finding a better job or spouse, securing a marriage, solidifying social status, or fitting into urban life" (motivations that—although arguably more frank or transparent—are ironically supposed to be red-flagged as psychologically unhealthy and "unrealistic" by doctors when witnessed in Western cosmetic surgery patients) (2011:263; see also Thorpe et al. 2004). According to Wen, "During my fieldwork, I constantly heard women justifying cosmetic surgery as a 'scientific' method to improve their physical appearance….The rationality of undergoing it is legitimated by the narrative of science," as well as facilities' constant sales-boosting emphasis on the "sophisticated" methods and "technical efficiency" involved in cosmetic surgery (2011:124). As seen in the cases of Brazil and India, the

commoditization of one's body is more than an aesthetic or emotional decision; it is an economic one that one hopes will result in increased social mobility. However, a problem remains for Chinese college graduates amidst rampant unemployment stemming from the breakdown in socialist work structures: cosmetic surgery becomes less a choice than a mandate already built in to the neoliberal policies guiding an expanding workforce:

> I was naïve to believe that if I study hard, I will get a good job. So when pretty girls in my class were busy hanging out with boys, I stayed in the library to read more. But when we were about to graduate, pretty girls and boys could get employed more easily than me. It's so unfair! I was so frustrated! To get an opportunity to show my ability, I first need a pretty picture in my resume. [China lacks everything but people!] A college graduation certificate cannot guarantee me a job. I need an edge to stand out! (Ethnography informant Chen Jiang, Wen 2011:163)

Unfortunately, Chen Jiang's experience is not an isolated one, nor an exaggeration. As reported by Zhou and Li (2005), a survey by China Central Television in Beijing, Shanghai, and Chongqing found that more than 40 percent of those undergoing surgery are college students and 30 percent are in high school (Wen 2011:162). Even prior to having cosmetic surgery it is common for young girls throughout East Asia (and even the U.S.) to glue or tape their eyelids with niche products like "eyelid tape" (Heyes and Jones 2009:190, fig. 11.1). One nurse from a prominent hospital told Wen, "Every day, we receive about two dozen girl students asking for cosmetic surgery, which accounts for about half of all our patients" (2011:162).

Another survey conducted in Nanjing reported that 85 percent of girls had their parents' prior approval for cosmetic surgery. Facial surgeries like double eyelid, jawbone and cheekbone shaving, and rhinoplasty were the most common (Wen 2011:162,163). Contrary to nearly all other contemporary rhinoplasty trends around the world, surgeries in East Asia are done to "build up" a slightly higher or larger bridge and the price of a nose job depends on what kind of material is used to fill the bridge (Wen 2011:162). Often a bone shaving from another area of the

patient is used. Furthermore, the most desired and expensive materials for building up noses are imported from abroad, while some other fillers may include the use of harvested cadaver tissue (Wen 2011:250). Multiple publications describe patients who feel that their lives have been changed in a positive way by having their "too flat" nose raised even just a few millimeters (Gilman 1999; Guterl and Hastings 2003).

The Result: Embodied Capital

As one of Wen's informants described it, "[b]eing good-looking is capital" in an employment system suffering the continued aftershocks of China's transition from its life-time job allocation system to a "bilateral selection or mutual selection" process in the late 1980s and then the "personal responsibility for job search" process in the mid-1990s (2011:164,166). Coupled with the policy of *kuozhao* in 1999, which aggressively recruited more students to China's higher education institutions (largely in order to stimulate sluggish domestic consumption and relieve unemployment after the 1997 Asian economic crisis), students have found themselves at crowded, competitive job fairs (Wen 2011).

Chinese economists predicted that growth would catch up with resulting waves of prospective graduates in the coming years. However, the continued over-flooded job market has resulted in "crazes" for graduate studies, extra degrees, studying abroad, and cosmetic surgery, with parents also bowing to the pressure. Wen (2011) even cites evidence that rates of youth cosmetic surgery and rates of university graduates' unemployment have risen at roughly the same rate, although international news sources report that China has no reliable way of even calculating its unemployment rate and global economists dismiss their official numbers (Chase 2012). More disturbing from a human rights perspective is the unusual side effect that has surfaced: Human resources managers now have more leverage to choose applicants almost solely

based on their physical attributes. After losing a job to an under-performing but taller schoolmate who had recently had surgery, one 22-year-old job applicant got a nose job and planned to trim her jawbone to make her face smaller, adding that companies often ask applicants to include their weight and height in their resume (Wen 2011:171).

Additionally, Wen chronicled her experience at an overcrowded job fair, noting that job postings were listed as "male priority" (technical/managerial) or "female priority" (face-to-face service sector) (2011:173). In some advertisements specifying gender, a woman's appearance and height requirements were specified, with applicants needing to be "above-average looking" or "good-looking," with "an elegant manner" and a "height over 1.65 meters" or 5'4" (p. 173). Wen writes that although ads for male applicants seldom spelled out appearance prerequisites, it was usual to have a height requirement, with a normal minimum of 1.75 meters (5'7"). Restrictive age conditions, such as "under thirty years old," were common on job descriptions for both sexes (p. 178). More specifically, a 2003 study of newspaper recruitment ads found that, among other inequalities, 88.3 percent of positions open to women had an age limitation requiring applicants to be under 30 (Wen 2011:175-176). Moreover, the HR managers that Wen interviewed, one male and one female, candidly defended these hiring biases as perfectly "natural" (2011:175).

It is therefore no surprise that highly dangerous and medieval-looking leg lengthening procedures (*osteotomy*, which entails sawing the leg bones and stretching the legs to allow the bones to grow) were by some accounts only temporarily banned by China's Ministry of Health in 2006 (Wen 2011). As described by Kahn (2004), a 35-year-old woman lost a government legal affairs position after scoring high on the entrance exam and being one of 80 finalists out of a pool of 600. It was revealed that during her second physical checkup she was disqualified for

being two centimeters shorter than the required height (as cited by Wen 2011). In another example cited by Wen, a civil servant recruitment ad posted by the Hunan government in 2004 even listed "a pair of symmetrical breasts" as an application criterion, a requirement that was only dropped after public outcry (2011:181).

According to *Women of China* (2012), the month of November is peak season for senior college students' cosmetic surgeries because they need to be fully recovered before the job-hunting season begins in April and May. The online article also cites data estimating that "college students have become the second largest group of cosmetic surgery customers in China…with about 60 percent under[going] cosmetic procedures to enhance their job prospects" (2012:n.p.). One vocational high school came under fire in December of 2007 when it was reported to have organized a "field trip" for 30 of its final-year students to a cosmetic surgery hospital for a consultation (Wen 2011:179). The school also required the students to record their weight every two days.

Thus, Wen's and several other sources' descriptions of persistent and even worsening "occupational gender segregation" and employment discrimination in nearly every category of Chinese society has a connection to the opening of China's economy and a symbiotic relationship with the booming cosmetic surgery industry (Cai and Wu 2006:37 cited by Wen 2011:176). While the beauty economy is designed to employ older women left behind in the wake of state employment reform, in a Catch 22, the services they render to make women and men appear younger are often the only viable option for job-seekers of a certain age—thus contributing to the same cycle of discrimination that marginalizes them in the first place.

As long as standards of living are generally on the rise, some Chinese seem to be resigned to the fact that both the young and the old are being discriminated against on every level

of the job market. According to a 2007 study conducted by the China University of Political Science and Law that surveyed over 3,400 participants in 10 cities, 86 percent of respondents reported that discrimination exists in China's employment market, including civil service and government jobs, yet only half (51 percent) labeled it "serious" (Wen 2011:180). These results suggest that employment discrimination has become a normalized fact of life for many Chinese who regard it as part of a status quo that is out of their hands. It is also possible that certain forms of China's popular media have distorted the view of American workplaces. For example, in his best-selling book *Meili liandan zhang dami* translated as *Beautiful Faces Grow Rice*, Lu Junqing (who is even cited seriously by some academics) "invents a 'typical' American company, 'Yamaxun' (loosely translated as Amazon), in which female employees are divided into ten levels based on their looks" (Xu and Feiner 2007:318). Lu also presents the highly questionable estimate that "every dollar spent on beauty pageants generates four additional dollars of income" (2004:28 cited by Xu and feiner 2007).

Xu and Feiner note that "this book is a bestseller at least, in part, because it makes the attainment of Western beauty the key to a woman's economic success. Most Chinese readers, however, do not know that women in the US workplace earn less than men, on average, and many factors other than looks play roles in career advancement" (2007:319). In any case, it just so happens that the author, Lu Junqing, was head of one of China's largest PR agencies, which franchises beauty pageants and trains contestants. Other motivations for China's rising cosmetic surgery rates include the fact that the practice is seen as a boon in bolstering prospects within China's traditional marriage system, as well as a mainstay for sex workers and women arriving to the city from rural areas. Moreover, just like in the United States, models in glossy lifestyle magazines, manipulated digital images, and rumored celebrity plastic surgery fuel demand (Wen

2011). However, the use of secret cosmetic surgery for marriage purposes can be fraught with complications in China, with the *Los Angeles Times* reporting in 2004:

> In a case reported this spring in the newspaper Heilongjiang, businessman Jian Feng married a woman from Qingdao without realizing she'd had a [$100,000] surgical overhaul. When an "amazingly ugly" child arrived in 2003, Jian accused his wife of infidelity, then divorced her, obtaining a $120,000 settlement for misrepresentation. (P. A1)

Lindridge and Wang (2008) contribute another motivational aspect for cosmetic surgery in regards to the traditional Chinese emphasis on protecting or boosting one's familial reputation. The authors interviewed adolescent women ages 15 to 25 who were living and working in Shanghai in order to examine how strict hierarchical social systems and traditional Confucian notions of collective inter-dependence affected a desire for surgeries, especially in regards to the all-important family unit. Citing Yeung and Tung (1996), the authors argue that a loss of face brings shame to the individual as well as to their family members: "Therefore, any decision to undertake plastic surgery in China, from a Confucian perspective, would not be seen as an individual decision…[but rather] for face reasons" (Lindridge and Wang 2008:499).

For Lindridge and Wang, "face" represents a positive social value and is affected primarily by media, economic, and family influences. (As a side note, Hee Song [2003] reported similar findings among her Asian American respondents, who she said based cosmetic surgery choices on western hegemony, class, and as a rite of passage.) Although Lindridge and Wang's (2008) study participants all commented that they had experienced happy and loving childhoods, many remarked on familial tales of woe, especially their mothers' stories of poverty and lost opportunities from earlier eras. As the authors note: "Mothers appeared to exert a strong influence over our participants, in a manner that was not evident in relationships with their fathers. Whilst the father may have approved or supported plastic surgery, it was always the

mother who appeared to exert a powerful control over our participants, often manipulating, cajoling or pressuring our participants to undertake plastic surgery" (2008:501,502). For example:

> My mother is a crazy fan of many western stars, such as Madonna and Catherine Zeta Jones. She thinks that pointed nose [sic] is very beautiful. Therefore, she went to hospital to undertake plastic surgery to change her flat nose into pointier one [sic]. The surgery was very successful. She advised me to undertake plastic surgery to change my nose. I took her advice.… I will try my best to improve myself, both inside and outside, to become a very excellent person. I cannot let my parents lose face in front of others. I must render [my parents] back for their efforts. (P. 502)

Although Lindridge and Wang's informants all expressed pride and happiness as a result of their surgeries, they noted that "the concept of face was also one that was carefully manipulated and manufactured….Public admissions of plastic surgery were carefully told, removing any admissions of pain, imperfections, complications, or future health implications within the wider consumption process" (2008:505). Offering possible reasons for this "self-denial," the authors suggest that the approval the women received from wider society and the new opportunities they believed would result constituted a greater pleasure, which they did not want to mar by discussions of pain (p. 505).

All the participants justified their operations "through a need to compete and succeed in a modernizing China, along with the need to fulfill their parent's wishes" and were "unable to acknowledge the physical pain" resulting from their recovery—not even one interviewee who had been bed-ridden for six months due to a leg-breaking procedure (p. 505). The mothers' participation was deemed:

> "[J]ust another investment in their daughter, in a similar symbolic manner that paying for their education was….Western perceptions of the invasive nature of plastic surgery in reconstructing a physical appearance and the ethical/moral implications of this within a daughter-mother context were not an issue. Instead all our participants felt they were enhancing their own and their family's face in wider Chinese society" (Lindridge and Wang 2008:505).

Separate interviews by Wen (2011) confirm this general outlook, although one particular mother admitted some reluctance:

> She asked for [the surgery]. I have been aware that she wasn't satisfied with her looks. She complained that she did not get good genes from me and her father. If it were 20 years ago, in my generation, I would ask my daughter to keep the original appearance she was born with. But society is so competitive. The competition for jobs and every kind of resource is so fierce [Especially, it's more brutal for girls as they have less opportunity than boys]. She is a smart and adorable girl who studied so hard….If a crease in her eyelid could make her more happy and competitive, why not?....Although I keep telling my daughter that the most important thing about a person is her good temperament and ability…If other parents already put investment in their daughter's appearance, I need to do something for my daughter as well. (Pp. 159-160)

Meanwhile, a *Women of China* (2012) subheading notes that, increasingly, it's "Not Just the Women." According to the periodical, although Chinese men only account for about 10 percent of the proportion of procedures, their numbers have quickly doubled due to growing interest in chin and nose surgeries among men in client-facing occupations. Wen (2011) cites a study that found that 44.8 percent of male respondents surveyed wanted a straighter and more "masculine-shaped" nose, while over 32 percent would consider double eyelid surgery (p. 283). *Women of China* adds:

> The male plastic surgery craze can also be traced to the rise of celebrity culture and male beauty culture subverting more traditional gender norms. The new culture has generated all kinds of popular men's beauty contests, male skin care lines and professional beauty institutions. Regardless if the overall aim is improved job prospects or simply a better physical appearance, men are definitely growing more concerned about their appearance. (online, 2012:n.p.)

And despite Wen's and others' focus on Western media as primarily responsible for the promulgation of the concept of the globalized "Westernization" of features, *Women of China* does not shy away from discussing a direct link. Under the subheading "Adopting a Western Aesthetic," the article opines: "Different human races have different facial features and standards

of beauty. However, the trends in Chinese cosmetic surgery show a clear tendency to favor the large eyes, high noses and clear-cut chins of the Western beauty ideal" (online, 2012:n.p.).

Similar to Heyes' (2009) arguments regarding "ethnic" cosmetic surgery labels as a double standard, Wen counters, "What I saw from the Western media and what I heard from my interviewees form a sharp contradiction. It is understandable that my interviewees are uncomfortable with the argument...after all, no one likes the idea that one attempts to conceal or deny one's own ethnic heritage. In this sense, while some women might have accepted Caucasian features as standards of beauty, it is also necessary to listen to voices of many women who deny that they seek to look more Western" (2011:315).

While agreeing wholeheartedly with Wen's adherence to impartiality and a desire to take her informants' statements seriously, this section on China must also function as a critical interpretation of the macro forces of power relations at work. In one instance, Wen (2011) argues for her readers to see the modern "symbolic meaning behind double eyelids and big eyes rather than the features [themselves]" in the interview response below (p. 316):

> Well, it's kind of a Western look. Small eyes with a single fold make people look soft, but big eyes with double eyelids make people look spirited. I definitely like big eyes. Western women always have such big and expressive blue eyes. Their eyes can talk! Just looking at their eyes, you can feel how confident they are! I wish I could have that kind of attitude. Well, I think that is a kind of *yangqi*, a sense of being independent and modern. (Wen 2011:315)

However, anyone who has ever read Toni Morrison's ([1970] 1993) novel, *The Bluest Eye*, cannot help but pause over the racial connotations implicit in the hyperbolic generalization above.

Chinese women insisting that they only want to get rid of the "sleepy look" (p. 318), that the convenience for makeup application is better (p. 319), or that the cut "can't be too wide," 'high," or "open" because then it "would make my eyes too Western [and] obviously 'artificial,'"

(p. 321) betray a subtle sense of complicit opacity to the heavier implications of this practice (Wen 2011). Wen also suggests, as have some Western ethnographic studies, that cosmetic surgery has a parallel to ancient "rites of passage," sometimes serving as "a kind of ritual which marks people stepping from one position in their lives to another" (2011:322). As one informant put it before she moved internationally, "a beautiful look is always a good 'passport' for a woman, no matter in the East or the West. Everybody loves beautiful women" (p. 321). This analysis begs the question: To what symbolic location does this practice—driven initially by populations in conflict and then by globalized capitalism, and which masks genetic features that, left untouched, traditionally denote one's membership in an ethnic group—signify passage? And, at what cost?

Wen (2011) and Xu and Feiner (2007) state that Western media have appropriated a "quintessential Oriental [female] face" that serves "Mulan" and "Madame Butterfly" fantasies more than the Chinese public—which finds such a "slanted," "small-eyed" visage old-fashioned and unattractive (Wen:327). I would add that, while this image may very well be another systemic form of Western racism, might it also be considered "quintessential" and "stereotypical" because it is, at its heart, a pre-surgical face? Brownell (1995) argues that a reverse-appropriation is at work when it comes to cosmetic surgery, stating that blepharoplasty has been subtly appropriated as part of the nationalist project in China and thus exemplifies how a transnational practice can be transformed by and imbued with local meanings: "Chinese cosmetic surgeons claim technical superiority to their Western counterparts and…Chinese claim double eyelids as an essential feature of Chinese ideas of beauty rather than imitating the West" (paraphrased by Wen 2011:41-42).

Yet, I argue that the specific method of reverse-appropriation or the unconscious "subtlety" of the process does not change the ethical implications of its larger sociocultural results. Wen asks that her readers channel Johansson (1998:59) by paying more attention to “hybridity, Creolization and local resignification of global beauty ideals,” with Wen (2011) adding that "[s]urgical body alteration such as double eyelid surgery…are cultural behaviors which should be interpreted in the settings where they are found" (pp. 339, 331). However, I argue that due to globalization, we no longer have that luxury. As revealed in this comprehensive overview of China, although a culture-specific hybridity and re-signification of Chinese cosmetic surgery certainly exists—it cannot exist outside of embedded sociohistorical power structures born out of conflict, relationships of force, and racist discourse.

As I will explore in the next section, China’s proximity to formerly Western-occupied countries like Japan, Vietnam, and especially Korea (not to mention China's occupation by Japan) have led some to attribute cosmetic surgery to an oversimplified source: Many pinpoint the “Korean Wave” of popular culture for leading China toward its cosmetic-surgery boom. Therefore, it is important to examine Japan and Korea's cosmetic surgery roots in order to see the whole story and to exhibit support for my above argument regarding the inextricable discursive ties shared by cosmetic surgery cultures in East Asia, and throughout BRIC countries. In line with my argument regarding these macro relationships of force, Wen (2011) summarizes her final argument with a metaphor to the Chinese state:

> The body, especially the surgically altered female body, becomes something reflecting the perplexing and uncertain nature of the society. To put it differently, Chinese women’s anxiety about body images, longings for beautiful appearance and better lives, and decisions to undergo cosmetic surgery, are deeply entangled within China’s larger economic reform and changing social structure” (P. 361).

For Wen, and to some extent Yang (2011), rather than the pure pursuit of beauty, surgical body alteration indicates a pragmatic choice: One can control their body, and cosmetic surgery gets the job done…in the sense that it quite literally "gets the job." This "choice" is fueled by a contemporary sense of instability and uncertainty that is linked to China's rapid technological and social changes (Wen 2011:364). However, as discussed earlier in relation to the theoretical framework, this paper recognizes that "choice" on the micro level is understood to be distinct from "agency" on the macro level. Brownell (1995:22) adds to this parallel by noting that, "Since the devastating encounters with Western powers in the last century, Chinese nationalism has been very closely linked with the body, so that the act of individuals strengthening their bodies was linked to the salvation of the nation" (as cited by Wen 2011:45). Furthermore, these authors state that they are not naïve to the fact that this in turn only serves to strengthen the Chinese government's relationships with profit-driven multinational industries by promoting the "kind of individualism and lifestyles typical of a market economy" (Yang 2011:342) and acting as a kind of "social palliative" that maintains the status quo (Wen 2011:269). Wen (2011) even compares the state role, in Foucauldian terms, to a "new form of surveillance and control of the body through consumption" (p. 265).

Indeed, Xu and Feiner (2007) take an unequivocal and less relativist stance than Wen (2011), which is more in the tradition of the whiteness studies earlier described by Shome (2000):

> One may argue that changes in the concepts of beauty are natural, normal, and not culturally specific, and that the changes we are describing in China are merely reflections of the recurring vicissitudes of fashion. While it is one thing to change one's make-up, weight, and clothing to fit current trends, it is something else entirely to pursue an appearance antithetical to one's own ethnicity….These changes in the Chinese concept of beauty have far-reaching consequences, including the admiration and imitation of whiteness, contempt for one's own cultural and ethnic heritage, and discrimination against those who look ''native.'' A reserved, calm, and indigenous aesthetic has been

> devalued in favor of a foreign, outgoing, aggressive, athletic aesthetic. [T]he internalization of Western norms of beauty…[t]ogether [with] celebrations of Anglo-European aesthetics (i.e., Occidentalism: ‘‘the West is better than the rest’’) further promote the internalization of the logic of imitation. (2007:317)

Others have also begun to question China's cosmetic surgery practices from a critical perspective. Lindridge and Wang (2008) argue that the perception of the body as a positive metaphor for a changing Chinese society is problematic. Noting that their study's young female participants expressed feeling isolated or harboring depressive fears about their potential failure to succeed in a modernizing China, the authors cite the propensity for modernization to induce widespread crises of identity, dissociative identity disorder, anxiety, and depression (p. 504). The All-China Women's Federation (ACWF), the main organization of state feminism, submitted an (apparently unsuccessful) 2005 government proposal to prevent state sponsorship of beauty contests and to set a minimum age for cosmetic surgery.

However, Yang (2011) argues that the ACWF has ambivalent and inconsistent views toward the development of the beauty economy, often assuming a double voice by compromising with the central government and counting beauty industry insiders among its own ranks (p. 344). Finally, Zhou Xiaozheng, a sociologist from Renmin University, has publicly invoked older, traditional party values by making the claim that "beauty contests and cosmetic surgery…[are] invisibly but violently increasing the gap between the rich and the poor, and enlarging social conflicts" (Wen 2011:136).

In sum, in the post-Mao era after a lengthy process of globalization and new access to capitalist markets, although the state appears to retreat from the personal sphere allowing for a market economy to "triumph" in favor of new freedoms, Wen (2011) and others caution that Communist ideology is still very much immersed in people's daily life (p. 276). According to Wen's work, the state channels the shape and direction of market trends and the limits of

accepted freedoms. In this way, it forms a mutual negotiation between markets and state that counteracts the embodied freedoms and civil liberties newly promised to the individual via increased capital. In a sense, both the Chinese state and its cosmetic surgery patients are securing the perceived immediate benefits first and asking questions later.

At the same time, both entities seem to assert that they can cherry-pick the specific meanings behind the transitions. For example, "[b]y developing many new terms and concepts of Marxist theory," such as "'building socialism with Chinese characteristics'....to legitimize the new [capitalistic] economic system, the CCP maintains that Marxism has not been abandoned ideologically" in favor of bourgeois capitalism (Wen 2011:262). Similarly, by appropriating cosmetic surgery as a banal and economically necessary Chinese beauty regimen, participants legitimize the idea that the widespread alteration of Chinese faces does nothing to affect or relegate their ethnic and cultural legacy (Wen 2011:261-262). However, one might say that both narratives attempt to marry concepts that are rather mutually exclusive—relying on a little ideological smoke and mirrors to maintain the argument of authenticity.

Another crucial similarity between the two is that the Chinese government's narrative directly benefits its own uninterrupted grasp on state control, whereas the average cosmetic surgery recipient's narrative *also* benefits the state's uninterrupted ability to allow the violation of basic human rights in its employment sector (and by extension, other sectors). As a result of cosmetic surgery origins related to war wounds, war economies, and relationships of force, as well as the normalization of cosmetic surgery during China's transition from political austerity to a booming capitalist economy, pre-existing class and gender prejudices are exacerbated. In the absence of government action, and in the reign of free markets, the only solution that has been offered to help Chinese citizens combat this prejudice is one that feeds right back into existing

systems of inequality: the cycle of commercialized cosmetic surgery. This leads, once more, to the question of whether the individual cosmetic surgery patient is actually being served in the long term, or at all.

In the meantime, however, Wen (2011) notes that surgical trends themselves are now "customizing to fit Chinese faces" by abandoning the comparatively exaggerated "European-style [extra wide] double eyelid, very high noses and very plump lips," which have been replaced by the same types of invasive surgeries using different methods that supposedly "play up, instead of distort Asian beauty" in a more subtle way (p. 340). Furthermore, the editor of the popular publication *China Beauty* has made several "call[s] for beauty standards featuring Chinese characteristics to resist the hegemony of Western beauty standards," even by publishing a book in 2005 called *Standard Beautiful Women in China*. Included in the preface is an interesting piece of advice: "An open-minded Chinese should hold two aesthetic standards: one comes from our traditional cultural heritage and another from Western standards of beauty. Economic globalization requires us to know ourselves as much as others" (Wen 2011:341 citing Zhang X.M. 2005:Preface 5).

With this final and (to some) arguably agreeable commitment to "open-mindedness" in the face of globalization, this paper moves forward in examining both the similar and unique characteristics of neighboring East Asian countries which share influences and histories related to war and occupation by the United States. Accordingly, it is important to question why "knowing oneself" amidst the marriage of "two aesthetic standards" should necessitate invasive and permanent cosmetic surgeries—and what it means to "know others" when they have arrived on your shores for battle.

EAST ASIA: THE VESTIGES OF OCCUPATION—PAST, PRESENT, AND FUTURE

In early 1954, [Miami surgeon D. Ralph Millard] was stationed in Korea. In response to requests to change oriental eyes to occidental eyes, he began to research the process and found that little had been published [in English], so he devised an original solution and in 1955 published a report of his work in Plastic and Reconstructive Surgery. Millard was surprised and offended when a "communist magazine" picked up the story and "devoted a two-page spread…stating that 'Herr' Millard had taken it upon himself to improve, by westernizing, the races of the population of the entire Orient." He commented, "By neglecting to mention that this surgery had been carried out at the request of the patients, facts and motives were twisted out of all proportion." Millard's indignation may have been due in part to the fact that Asian surgeons were also performing such surgery. When he traveled through Asia, he found that different techniques prevailed in different places, but already in Seoul, Hong Kong, Tokyo, and the Philippines, surgeons were daily westernizing hundreds of Asian eyes. (Haiken 1997:201)

When it comes to understanding China's cosmetic surgery culture and its relationship to the West, it is impossible to glean a sense of the deeper meaning behind it without also looking to the intersecting histories and implications of East Asia as a whole. Furthermore, since Japan and India are virtually tied in numbers in terms of ISAPS-estimated procedures, and South Korea is leading the world in per-capita cosmetic surgery, their individual analysis (in addition to the BRIC countries) is warranted.

Japan: The Origins of Cosmetic Surgery in East Asia

A slew of quick historical summaries of Japanese cosmetic surgery give glossy descriptions of how the country "opened its doors" (Sergile and Obata 1997:662) or "open[ed] her ports" (Nakamura, Mulliken, and Belfer 2000:283) to the rest of the world in the 1850s after over 250 years of national isolation. Suddenly, "the Japanese were astonished at the civilization of these foreigners," and "[f]or the next 50 years, the modernization of Japan became Westernization, supported by the strong admiration of the Japanese for things Western" (Shirakabe et al. 1985:224). Notably, these are not the accounts of Japanese historians but rather of medical doctors writing for three separate English language aesthetic and reconstructive

plastic surgery publications. According to Columbia University's East Asian Curriculum Project, things were much more complicated.

The Japanese Edo Period (1603-1868) was widely characterized as a period of stability, peace, strict isolationism, and social mandates (including the banning of Christianity), as well as an increase in the popular enjoyment of arts and culture. This era started to come to a close upon the arrival of U.S. Commodore Matthew Perry and his naval squadron to Edo Bay in 1853. Using "gunboat diplomacy," he presented a letter from President Millard Fillmore demanding trading rights, bunkering stations, and protection for shipwrecked American sailors. Commodore Perry made clear that the Japanese had an option between war and one of the "Unequal Treaties," which the Japanese knew to have been imposed on China following the First Opium War of 1838-42. Begrudgingly yielding to the Americans' superior military strength, the Japanese signed the Treaty of Kanagawa in 1854, which led to wider concessions of Japanese supply bases for U.S., French, and English navies under the 1858 "Treaties of Amity and Commerce." Once again, U.S. Consul Townsend Harris made Japan's options quite clear by pointing to the bellicose imperialism that France and Great Britain had been practicing against China at that time (during the Second Opium War). He suggested that, should the country not accept the United States' treaty alternative, the European stalwarts might not hesitate to expand their military horizons to Japan.

Despite violence against foreigners in port cities and a rare Imperial order in 1863 to "Expel the Barbarians," the Japanese military shogunate was ultimately weakened, leading to the subsequent Meiji Restoration in 1868 and a rise in more Western influence. In some ways, this was typified by Japan's successful 1890s transformation into a Western-style, modern military power and its subsequent conquest of China, its defeat of Russia over rights to Manchuria and

Korea, and its later annexation of Korea as a colony. In an ironic twist, Korea's long-time refusal to comply with Western demands to open its shores after over 500 years of (largely) independent rule was finally undone by the new imperialism of its (albeit historically contentious) Japanese neighbor. Moreover, Korea's subjugation was signed into law by the kind of "unequal treaty" that Japan had itself bitterly resisted just two decades before. The U.S. and Europe soon followed on Japan's heels to "open" trade with Korea at the turn of the twentieth century. Korea remained a Japanese colony during both World Wars until 1945 when the U.S. military entered and divided the area in two halves along the 38th parallel under a shared "trusteeship" with the Soviet Union, eventually leading to the Korean War from 1950 to 1953 and an influx of hundreds of thousands of American troops.

These historical, economic, and military power dynamics are important to keep in mind when examining long-term cultural exchanges and the social-psychological remnants of foreign occupation. They may also be helpful in interpreting the unbridled optimism that the aforementioned Japanese plastic surgeons describe as a "strong admiration…for things Western" in the American cosmetic surgery periodical quoted above. Much like what had occurred in China, Japanese traditional medicine was supplanted by the adoption of Western surgical innovations under the Meiji Restoration of 1868 and the "opening" up of Japan. As Gilman (1999) describes it: "Unable to open the body, traditional [Japanese] medicine was relegated to second-class status with the Medical Act of 1874, which demanded that all new physicians be trained in Western medicine and surgery" (p. 103).

According to Gilman's history, the ability to surgically open up the body became a symbol of "privileged status" in the medical community, stating that, "[i]ndeed, as traditional, nonsurgical medicine was transformed into a subordinate form of Western medicine in Meiji

Japan, surgery of the eyelid and nose became commonplace signs of the advantages of Western clinical practice" (1999:103,101-102). Some who argue against direct Western influence on the proliferation of aesthetic eye surgeries in Japan (and throughout East Asia) point to the fact that Japanese physician M. Mikamo first published evidence of his performing reconstructive and aesthetic eyelid surgeries as early as 1896. However, in light of the timeline described above, Mikamo would have already experienced over 20 years of Western medicine's influence and Western surgical techniques would already have been an emerging sign of status among physicians in Japan. Furthermore, although no direct connection has been established, Gilman (1999) briefly notes that "Johann C.G. Fricke introduced the 'modern' term *blepharoplasty* [eyelid surgery] in 1829" (p. 310). Therefore, it is important to keep in mind both Mikamo's stated and perhaps unstated motives for developing and publicizing the procedure.

Despite offering only reductive and disconcertingly simplistic discussion regarding the sociohistorical significance of Mikamo's contributions, Sergile and Obata (1997) are the first to publish an English translation of Mikamo's original article in *Plastic Reconstructive Surgery*. Their full translation opens up a host of questions and potential criticism for Mikamo's surgical legacy. For example, according to their translation, Mikamo writes in his "Plastic Operation of the Eyelid (*Chugai-Ijishimpo),*" published on September 20, 1896:

> There is a condition of the eyes which has been closely observed by our painters and writers, but has long been overlooked by physicians and even the very intelligent and careful people of the Western world. It is a partial defect of the muscle fibers that end on the skin of the upper eyelids. The young women who have this condition do not have double folded eyelids, [or] "double eyelids," which writers and painters have regarded as an indicator of beauty. Instead they have single folded eyelids, making their facial expression monotonous and impassive. The disease, probably a small defect of the muscle fibers that elevate the eyelids, can also cause narrowed vision. As far as I know there does not appear to be any report or review about this problem. Therefore, I will first report the common features of several hundred cases that I have observed over the past two years. (P. 663)

In this telling introduction to the "problem," Mikamo informs his readers that he has singlehandedly discovered a "disease" among "young women"— but not men nor the elderly?— which has somehow gone unnoticed by the Japanese populace for many thousands of years.

It is important to clarify that there was and still is no documented, legitimate science to support Mikamo's statements regarding muscle fiber defects contributing to, or narrowed vision resulting from, single eyelids. In fact, it becomes increasingly clear to a reader of Sergile and Obata's (1997) reported translation that Mikamo seems to have procured data on the basis of his own limited geographic area and his personal aesthetic opinions toward young women. Furthermore, there is a plethora of historical evidence in opposition to his statement about "writers and painters," which instead affirms that traditional Japanese portraiture "emphasized the 'straight eyes and nose, flat, single eyelids and receding chin'" (Gilman 1999:100-101). As Nakamura et al. (2000) mention, these traditional features of ideal beauty expressed "the Buddhist idea of harmony and universality" (p. 283).

Even Sergile and Obata (1997) quote an American scholar of Japan, Alice M. Bacon, who wrote in the early 1900s that "to the Japanese, the ideal female face is long and narrow…the eyes should be long and narrow, slanting upward at the outer corners; and the eyebrows should not be outlined at all, either by the brow, the cheek, or by the nose," adding that "the untraveled Japanese seldom admires" what they consider to be the "fierce grotesqueness" of deep-set blue eyes and a high-bridged nose (pp. 665-666). Additionally, Gilman writes that prominent Japanese physician-anthropologists, such as Yoshikiyo Koganei (1858-1944), often showed outright bias against the "long noses and round eyes" of the ethnic Ainu minority in Japan, considered at the time to be "primitive" and not representative of a "real" Japanese face (1999:101). In fact, the Ainu are considered by scientists and anthropologists to be descended

from the earlier Jōmon-jin people who were indigenous to the area and shared many physical characteristics with Caucasians. In order to avoid continued discrimination, Ainu often sought to intermarry with Japanese, resulting in "features that had virtually vanished through intermarriage by the late nineteenth century" (Gilman 1999:101).

These facts appear in sharp contrast to Mikamo's "investigation" into the "defect" of "single-folded eyelids," where he found that "single eyelids [were] much more common than we expected" (Sergile and Obata 1997:663). Though Mikamo's specific location in Japan (as well as his full name) seem to have been lost to history, it is possible that he lived in a rather genetically homogenous area where double eyelids were more common. Whereas it is now widely accepted that about 50 percent of all East Asians, including the Japanese, lack any distinct palpebral fold and can thus be described as having "single eyelids," (Haiken 1997; Gilman 1999; Nishioka 1999), in 1896 Mikamo put this number at a surprisingly low "17 to 18 percent" (p. 663). Furthermore, Mikamo does not hesitate to jump to a hugely problematic conclusion: "Judging from these results," he writes, "we should consider double eyelids as the physiologic normal appearance" (Sergile and Obata 1997:663).

After establishing this dubious standard, Mikamo adds that he had gotten the idea for double eyelid plastic surgery from an ophthalmology book detailing the results of operations for entropion, a medical condition in which the eyelid folds uncomfortably inward, "Dr. Komoto stated in his book… [that after surgery] his patients had clear double eyelid[s] and looked more attractive" (*Ibid.*:p. 663). In his paper, Mikamo also details the process of his procedure, noting that positive results were affected by the proper timing of the removal of silk sutures that formed an eyelid fold, which did not resemble a scar. He notes that, "I have performed this operation on more than 10 young ladies who had bilateral and unilateral single eyelids. All the patients were

very satisfied with the results" (*Ibid.*:p. 664). Mikamo does not note, however, why his patients are almost exclusively teenage girls. Moreover, most of the patients he describes required surgeries that, today, would not be deemed elective for aesthetic reasons but rather reconstructive or due to medical necessity (for example, corrections after chronic eye infections that had created problems with the lid and vision, as well as those who had been born with one single eyelid and one double or "shallow" eyelid) (p. 664). Therefore, it may be possible (or lost in translation) that he uses "single eyelid" terminology interchangeably with indications of already existing medical "disease" or complications of the eye. Also possible, is a scenario where Mikamo medicalized, imposed, and proliferated an invented "disease" upon others, which merely reflected his own personal aesthetic (and, dare I say, amorous?) desires. To understand what I infer, see the following—rather bizarre—conclusion that Mikamo offers readers as reflected in Sergile and Obata's (1997) published translation:

> The double eyelid operation leaves no major scars, and a physician can control the results after mastering the procedure. The result of the operation is natural looking double eyelids. I hope that you try this procedure and let the beautiful young ladies become much more attractive. Appearance is by all means one of their greatest concerns. With the most delightful smiles and new double eyelids, your patients will surely give you the gratitude and true words of love that are usually so hard to get from the young ladies. (P. 664)

Whatever his motives, Mikamo's short paper in 1896 has had extraordinarily far-reaching effects. After failing to find more medical reports on aesthetic eyelid surgeries until the late 1920s, Sergile and Obata (1997) suggest that Mikamo's work may have been initially shunned by "a still overwhelmingly traditional Japan" (as if the acceptance of elective cosmetic surgery signifies modernity) (p. 662). However, more than 20 papers on the methods of double-eyelid operations were published in Japan in the decades after Mikamo according to Shirakabe et al. (1985), who suggest that language barriers prevented Japanese surgeons from reporting outside

of the country. Shirakabe et al. write that "[i]n the next 60 years, many surgeons followed Mikamo with similar attempts to westernize the eyes of Japanese women," and referring to his first reported patient with a unilateral single-fold, "We admire Mikamo's courageous attempt to satisfy this woman's desire" (p. 224). In fact, the casual reading of Mikamo's early innovation is often interpreted as a reaction to Western influence (if not explicitly to achieve a wider, Caucasian-looking eye). For example, Sergile and Obata (1997) praise:

> Mikamo's keen insight into Japanese women's new concerns with physical attractiveness…as Western influence led to social changes in Japan that took some women's roles in society from housewives to workers in schools, hospitals, and factories. Women's changing status in society challenged the importance of traditional feminine virtues of submissiveness and obedience to husband, family and society. As the individual gained importance, Japanese women's concerns with physical appearance grew, creating an environment amenable to the Western practice of aesthetic surgery. (P. 662)

The authors go on to say that "[w]ith rudimentary statistical data and scientific method, Mikamo defined a Japanese norm for attractive eyes and then offered a surgical means to arrive at that norm…intend[ing] to enhance female attractiveness within the limits of normal Japanese characteristics" (p. 662). The fact that the primary author, American doctor Suzanne Sergile, MD, is writing from her industry's standpoint is a poor excuse for her and Obata's general lack of critical analysis in response to Mikamo's writing. Given that Mikamo's little-described process of single-handedly "defin(ing) a Japanese norm for attractive eyes" was ostensibly not a "rudimentary" scientific method but rather a *non-existent* one, Sergile and Obata's matter-of-fact reference to "normal Japanese characteristics" seems academically irresponsible. Furthermore, the authors seem to project an ahistorical Western lens on turn-of-the-century Japanese women that provides more of a self-serving rhetoric to engage a '90s American audience, rather than any hard evidence that nineteenth century Japanese women were suddenly "freed" by Western influence to care about their looks. This is an argument made only more offensive by the racial

undertones Sergile and Obata employ while describing what they deem problematic in eighteenth century Japanese moralist Ekken Kaibara's text *Onna Daigaku* (translated as "Greater Learning for Women"): "Kaibara wrote, 'more precious in a woman is a virtuous heart than a face of beauty.' The ideal face as the physical manifestation of these inner virtues had a monotonous, flat appearance with limited expression created in part by broad single eyelids without depth and minimal to no appreciable scleral aperture" (p. 665). Clearly, over a century later and as a result of a highly questionable text, Mikamo's influence has been internalized by medical communities near and far, allowing them to recycle and circulate their own questionable "medical" observations.

Yet, beyond Mikamo's legacy, what likely had an even stronger and more rapid effect on the growth of cosmetic surgery rates in Japan (and subsequently China and Korea) can be characterized by three key catalysts: natural disaster, wars, and new media technologies (Shirakabe et al. 1985; Sergile and Obata 1997; Nakamura et al. 2000). The first catalyst occurred with the 1923 Kantō earthquake, fires, and tsunami, which devastated Tokyo, the port city of Yokohama, and the entire region, requiring their complete reconstruction and allowing Tokyo to re-emerge as a cosmopolitan hub with modern travel infrastructure. An influx of foreigners and foreign investment brought with it enormous Western influence, including American films (*Ibid*.). Much like the Japanese and foreign influence seen in 1930s occupied Shanghai, China (in the previous section), Tokyo was the first reported Asian city to adopt, cultivate, and spread the practice of cosmetic surgery. In eerie parallel with the young cosmopolitan city itself, Japanese women began to "rebuild" themselves with the changing times. As Shirakabe et al. (1985) write for the *Annals of Plastic Surgery* regarding the cultural changes leading to the evolution of double-eyelid surgeries, "the modernization of Japan became

Westernization…No matter how well they copied Western civilization, however, it was impossible for Japanese people to have the same facial features and figures as Westerners. Because of these differences, the Japanese felt they looked ridiculous in Western clothes" (p. 224).

As described earlier, one of the most vital Western-originating concepts that Japan increasingly sought to achieve was a vast military-industrial complex that would eventually afford them tremendous influence throughout East Asia. Reportedly, cosmetic surgery was even employed on Japanese servicemen to achieve racially charged standards of fitness for duty:

> The American surgeon Henry Junius Schireson wrote in the late 1930s that "the effect of this [shape of the eyelid] is not only esthetically unpleasant; it is also a definite impediment to good vision. That is why the Japanese are reputedly such poor marksmen, why this highly intelligent race has so high a percentage of airplane crashes. Japanese women were the first to seek correction of this defect, for esthetic reasons. Today in military Japan the functional objective is the moving motive and thousands of Japanese men are having the correction made…It is estimated that more than twenty thousand persons…have recently undergone this operation." (As cited in Gilman 1999:102)

Meanwhile, many of these Japanese soldiers would have had an increasing presence in certain areas of China and in colonized Korea. Although the so-called "Westernization" of Japan largely subsided during World War II (including eyelid operations), cosmetic surgery began a large resurgence following the end of the war and American occupation of Japan (Shirakabe et al. 1985; Haiken 1997; Gilman 1999; Nakamura et al. 2000). According to Haiken (1997), "surgery to westernize Asian eyes became increasingly popular, first in Asia and then in the United States. With the American occupation of Japan and the conflict in Korea, American films, magazines and soldiers familiarized Asians with Western models of beauty, and the surgeons began to explore what they called 'revision' of the 'Oriental eye'" (p. 200).

During this time, Japanese physicians published several new techniques that far surpassed Mikamo's modest surgical methods by actually excising tissue from the eyelid and orbicular

muscle to create a structurally deeper lid and a "deep-set eye," the latter of which had to be abandoned two decades later when aging patients had developed a "sunken" appearance (Shirakabe et al. 1985:234-235; Sergile and Obata 1997). By then, however, it wasn't just eyelids. Reversing traditional beauty ideals valuing "modest," small or flat breasts (as would China a few decades later), Japanese surgeons in the 1940s began to conceive of procedures that would fulfill "the [recently modern] Western notion of the larger breast as a sign of the erotic" (Gilman 1999:103). And although it was American industry (in the form of Corning Glass Works and Dow Chemical's formation of Dow Corning Corporation) that developed the war-effort "wonder product" of silicone to lubricate engines, by many accounts, it was the Japanese who first brought liquid silicone out of war machines and into humans:

> Accounts differ as to when, and by whom, liquid silicone was first used to enlarge small breasts, but all locate it around World War II and most locate it in Japan (according to one report, Japanese surgeons first used silicone to plump out legs withered by polio). The widespread publicity later accorded the Japanese *sakurai* formula, invented in 1954, supports the attribution of this technique to Japanese physicians, although several other accounts place the invention earlier. According to the *New York Times*, Japanese cosmetologists pioneered the use of silicone to enlarge the breasts of Japanese prostitutes during the war, after such solutions as goats' milk and paraffin were found wanting. (Haiken 1997:246)

In fact, Gilman (1999:103) writes that "Akiyama actually produced a silicone breast prosthesis as early as 1949," yet liquid silicone breast injections often had highly devastating results, as many American women learned throughout the 1960s while the practice moved West.

As described by Haiken (1997) below, though American plastic surgeons sometimes questioned the safety of these early Japanese methods (having already discovered the grave mistake of paraffin wax injections in the early 1900s), they "voiced no misgiving about the goals" (p. 202). And, having already accumulated nearly a century's worth of experience diagnosing normally occurring human features as physical defects in need of (lucrative) surgical

"corrections," American cosmetic surgeons were apt to (re)define average Japanese features as a condition of genetic underdevelopment:

> In 1963, surgeon George V. Webster noted that "the urge to Westernization of the Japanese people has created a demand for cosmetic improvement of the essentially small breasted Japanese women, and the excessively flat nose and heavily padded Oriental eyelids....Correction of hypogenetic defects, such as small breasts and flat nose by the use of implant materials has led to the employment of a great variety of foreign bodies, some of which are unquestionably poorly tolerated by the human host. A reversion to the injection of paraffin-containing materials is especially to be condemned." (P. 202)

Therefore, Shirakabe et al.'s (1985) buoyant statement (mirroring Sergile and Obata's) that post-war Japanese women were increasingly "liberated from traditional habits" to participate in social activities outside the home must also be contextualized within the broader power structures of war and occupation and the political nature that cosmetic surgery embodied for women and men living in a rapidly changing and hugely traumatized society (p. 230). As Gilman (1999) poignantly addresses in his footnotes:

> The meaning ascribed to the reconstructed face and its association with the "West" in modern Japan is also colored by the experience of the atomic bomb and the Hiroshima maidens. If the desire to "look American" through aesthetic surgery captured Japanese (and then Vietnamese) society from the 1950s to the 1970s, then it was paralleled in both cultures by the meaning of the scars of war and their reconstructive amelioration. In 1955 twenty-five women who had survived the dropping of the atom bombs at Hiroshima and Nagasaki were invited by a private goodwill group to receive cosmetic surgery at Mt. Sinai Hospital in New York. They became known in the United States as the "Hiroshima maidens."….Their images were widely circulated in periodicals such as *Life* magazine, and their scarred faces (and the desire of American medicine to recuperate them) became part of a shared American and Japanese understanding of the scarred face….The "curative" power of the surgery was experienced more by the Americans who saw the correction of war wounds in the civilian population as a form of moral correction….In Japan…the psychological wounds were never healed. (Pp. 353:53)

Note the choice by the United States to exclusively invite a handful of "maidens" to their shores to receive goodwill surgery supposedly to address the unthinkable wounds of the atomic bomb, which were obviously experienced by men, women, and children, alike. After the First World War, Western soldiers' "visages of war" and extensive reconstructive facial surgeries had

been put on display to be a cautionary symbol of grotesque anti-war propaganda (Gilman 1999:159). Yet, for post-colonial, post-World War II, and post-Cold War countries of the global East, the use of this symbolic, diplomatic body seems to have shifted. Whether in a conscious or sub-conscious attempt to exclude and make docile the foreign male bodies that represented recent war enemies and political resistance—or possibly in an effort to present a "nicer," "non-threatening" alternative to engage a nation's pride and approval whilst re-opening its all-important consumer markets—this period seems to begin a new type of Western politico-corporate affirmation of formerly unwelcome states through the process of placing token examples of foreign female beauty on mass public display.

Simultaneously, new technology allowed for an unprecedented media influx of white Western bodies displayed by visual markets in the global East and South. As witnessed in previous sections, both China's and India's entry onto the so-called global stage is marked by the revision of the "modern" female body often augmented through cosmetic surgery and/or embodying unreachable/unlikely standards that approximate Western physical stereotypes rather than national ones. These new, "modern" bodies are presented in an almost diplomatic manner, supposedly embodying novel powers and state freedoms. At the same time, however, these nascent bodies carry an invisible but heavy cargo: the ills of hyper-consumerism, the social costs of neoliberalism, and the tensions of balancing both new and old societal pressures.

Japan offers one of the original and quintessential examples of this process in the story of Kojima Akiko, the first Asian Miss Universe, and one of the first women of color to win the competition (two Latin American titleholders preceded her). According to Bardsley's (2008) comprehensive analysis of the event, "At the height of its popularity, the Miss Universe Pageant, much like the Olympics, championed uniqueness through national costume events and peace

through friendly competition. The pageant also promoted the belief that all its girls embodied a modern kind of femininity, one emancipated into a liberal swimsuit feminism of global beauty and upward mobility" (p. 375). According to Bardsley's account, the 1959 Long Beach, California, pageant was a commercial venture that conspicuously involved the United States military and local government (by means of the use of tall, young, and overwhelmingly white servicemen as the official escorts of contestants) during the midst of the Cold War in an attempt to display the "modern" ideals of a "Pax Americana" (2008:376,380). Moreover, (and similar to India and China) some in Japan and the United States could not help but question the unusual timing of a win for Miss Japan that virtually coincided with the controversial renewal of a U.S.-Japan Security Treaty:

> Understanding the politics surrounding Japan's Miss Universe – the girl and her body as representing her nation – takes us to the contest itself and media attention to this spectacle of American diplomacy and showmanship. For Japanese viewing this international competition, the controversies building over the potential ratification of the US-Japan Security Treaty and the status of Japan's future alliance with the US were never far from view. Those opposed to the treaty hoped Japan could achieve a more equal footing with the US and ''maintain a neutral stance with regard to U.S. hegemony in East Asia'' (Igarashi, 2000, p. 134). Yet there was also the bloom of Japan's steadily improving economy, the benefit of its subordinate relation to the US. Ambivalence over this relationship proved to be an important subtext to Japanese readings of their Miss Universe. (P. 379)

Bardsley (2008) goes on to quote Shibusawa (2006:3), who argues that "fears of communism motivated postwar American policymakers to 'make Japan a model of capitalism in Asia'" coupled with a necessary transformation of Japan in the American imagination from its status of WWII enemy to U.S. ally "through a sympathetic focus on Japanese women and children in various projects such as those to support orphans and women disfigured by the atomic bomb (Hiroshima Maidens) as well as by popular novels and films such as Sayonara" (p. 383). Japan's ambivalence and discomfort in becoming "America's Geisha Ally," a term marked

by lost dominance and themes of emasculation, is embodied in the mixed reactions and controversy that followed Miss Japan's win. Some saw the win as a boon for Japan, remarking on its proof of "the general goodwill of the Americans toward the Japanese" (Bardsley 2008:384). And, while Kojima Akiko's confident international media tour was also seen by many as a happy symbol of progressive Japanese women who were quickly adapting to new occupational, economic, and social opportunities accorded them by the country's post-war Constitution, her unusually long legs, curvy figure, and towering height (by Japanese standards) complicated and politicized the global reception of her Japanese identity (Bardsley 2008).

With a reported height of five feet, seven inches, Kojima was considered oddly tall according to Japanese beauty standards, and her height was attributed to spurious factors in the press, including self-professed American contributions to nutrition in Tokyo: "Well, what do you think got them sprouting so high and filling out that way – our lessons in diet, less rice, more milk and other body-building foods" (Douthit 1959A-3 as cited by Bardsley 2008:384). Others pointed to the apparently bone-stretching effects of Japanese women's liberation:

> The emancipated young women have confidence in themselves and are free to express their joys and sorrows whereas before they were taught to hide their feelings. Such spiritual liberation must have helped women to hold their heads high and thus grow taller and more attractive....Not only Miss Kojima but many postwar Japanese girls have caught up with their Western sisters in poise, stature and appearance. Young girls of today are lively and attractive compared with the expressionless girls of prewar days. (Tsugi 1959:4 as cited in Bardsley 2008:384)

Notably, Tsugi's emphasis above on the "expressionless" Asian female face in direct comparison to the appearance of their "Western sisters" is a discursive tactic commonly deployed to frame and justify the need for double eyelid cosmetic surgeries, as discussed in previous sections of this paper. In Kojima's case, however, other parts of her body came under scrutiny. Upon her return to Japan, Kojima was forced to "vehemently deny" reports by a Japanese surgeon published in

the *Sankei shinbun* newspaper that he had injected her breasts with silicone earlier in the summer "to create her 37-inch bustline" (Bardsley 2008:386). This claim "no doubt recalled painful memories of the sexual politics of the occupation," when early post-war Japanese sex workers sought the dangerous procedure to attract American customers (Bardsley 2008:387; see also Haiken 1997).

Following this theme of a new lack of modesty and the commoditization of the pageant-winner's body, "one secretary commented, 'It just goes to show what we've been saying for a long time: Japan exports only the highest quality goods now.' More cynically, another said: 'Miss Japan looked more like a Western girl than an Oriental. She was tall, unlike a Japanese. Maybe that's why she won'" (Bardsley 2008:384 citing Douthit 1959:A-3). Others quoted by the media reflected a global exclusion of (and widely commented-upon malaise among) post-war Japanese men reacting to widespread social changes and Western hegemony: "'Why the devil can't the outside world leave us alone to enjoy Japanese beauty? I guess the Japanese male will have to add six inches to his height if he intends to hold his own against the new Japanese female'" (*Ibid.*:p. 384). While others, still, asserted traditional Japanese ideas that "if a woman was obsessed with glamour it was seen as detracting from her efforts to achieve inner beauty and role fulfillment" and that one gets "tired of beauty after 3 days" (Nakamura et al. 2000:287). Similarly, in reaction to the win, "Ultra-conservative Prime Minister Kishi…was quoted as saying, 'We are all happy that Miss Kojima won the contest. Not only is she physically beautiful but also she has beauty of the soul and beauty of the mind. Japanese always seek the ideal of beauty of the soul'" (Bardsley 2008:385).

In addition to political questions about the diplomatic convenience of a Japanese Miss Universe win, Western corporate interests fed into rumors in the Japanese media that the contest

had been fixed. Although Miss Universe sponsor and cosmetics giant Max Factor Company strongly denied influencing the results of the pageant, smaller Japanese cosmetics companies chafed at the announcement that Kojima would be the exclusive one-year representative of Max Factor's new cosmetics launch, signifying its expansion into Asia and marked by its recently founded Japanese office. Bardsley's (2008) description of a Japanese newspaper's front-page publication of a satirical cartoon lambasting Max Factor is also interesting in its depiction of some of the last vestiges of Japanese efforts to other the original "grotesqueness" of the high-bridged Western nose:

> The caption reads, 'Exclusive rights of American firm – Hands off!' The comic depicts Miss Universe, in her crown and royal cape, riding on the back of a big, long-nosed ''American sponsor,'' while the little Japanese businessmen of Japan's cosmetic industry are literally being kicked about by the American sponsor. (P. 387)

Nevertheless, throughout the following decades of the 1960s and '70s, female Japanese television personalities began to take on a cartoonish look themselves—some becoming almost unrecognizable as not being distinctly Japanese, Caucasian, nor even Asian for that matter. Photos included in Shirakabe et al.'s (1985) examination of the cultural evolution of Japanese aesthetic surgery show women with procedures that are now considered risky, due to too much excision of tissue, or anachronistic, resulting in a tragicomically wide-eyed look (so much so that many early patients, including some to this day, have trouble completely closing their eyes).

As has become apparent, in just one century—from Western medicine, to Western war machines, beauty queens, and media storms—Japan's traditional beauty ideals had radically transformed. Offering telling evidence of the explosion in cosmetic surgery, Haiken (1997) writes:

> By the early 1960s, Tokyo, with 108 clinics serving two hundred thousand women each year, was the destination of choice for Asian women who wanted plastic surgery. Dr. Fumio Umezawa, director of Tokyo's Jujin Hospial of Cosmetic Surgery, told the *New*

> *York Times* that he often operated on as many as forty patients each day and that the hospital's one-day record for all cases was 1,380 operations, performed on a wide range of Asian women who shared "a general desire to look like Elizabeth Taylor." At Jujin in 1957, the double-eyelid operation cost $8.33. By 1965 the cost had increased substantially to about $56, but Umezawa believed it was still underpriced. Suggesting that Americans had succeeded in exporting not just the practice of cosmetic surgery but the philosophical basis for it as well, Umezawa explained, "When women are confident of themselves they look prettier. To beautify women by measures endorsed by science also benefits men and therefore society itself." (P. 203)

Here we see the continuation of a common repeating pattern throughout this paper: cosmetic surgery's origins in war and conflict, its commercial normalization, and the gendering of the practice to assist its successful commercialization in the tradition of Western economic and pseudo-scientific models. This increasing visibility of purely cosmetic surgery in Japan soon resulted in a distinction between reconstructive plastic surgery and the separate Japanese specialty of aesthetic surgery, which was legally established in 1978 (Nakamura et al. 2000). More recently, cosmetic surgeons and their clients have lauded the rejection of exaggerated "Westernizing" cosmetic surgeries without addressing the fact that today's more "ethnically sensitive" surgeries (Lim 2003) continue in the same sociohistoric legacy:

> We have come to the realization that [due to the cultural and social changes which came with the tides of Westernization] it is time for us to go back to Mikamo's original idea and intention for the double-eyelid operation and to create eye shapes tailored to individual patients. Therefore, any operation, when used properly, should accentuate the inherent benefits of each eye type while moderating any negative features. Furthermore proper caution must be exercised in regard to the influence of cultural fads and fashions (Shirakabe et al 1985:240)

Furthermore, in the 1990s and early 2000s, as aesthetic surgeries climbed, Japanese academics began to examine the contributing factors and psychological motivations of the patients, often revealing data or research questions that reflected possible cultural biases. For example, Nakamura et al. (2000) discuss the high demand for cosmetic surgery, especially among young women, to achieve "[t]he new paragon [of] Caucasian-like facial features, the

round eyes with a tarsal crease and strong nasal dorsum," but their specific research focuses on a cross-cultural comparison of an increasing number of Japanese and American men choosing to undergo cosmetic surgery (p. 283). As referenced previously in terms of gender studies relating to cosmetic surgery, while Nakamura et al.'s efforts are significant in the sense that too few academics choose to examine male cosmetic surgery motivations, their overly broad conclusions "detail(ing) the [well known] psychological problems specific to male patients seeking aesthetic surgery" reductively characterize male patients as psychologically deviant without assigning an equally critical standard to female patients' motivations (2000:284). Moreover, although they astutely attribute Japanese male clients' cosmetic surgery requests to the influence of shifts in cultural norms and expectations, they display cultural, gendered, and discriminatory bias against male cosmetic surgery patients in their assertions that "American plastic surgeons underscore their concern that males seeking cosmetic changes are likely to have underlying psychological problems" and that American research had found that "the non-homosexual male patient seeking rhinoplasty may be more confused emotionally and intellectually about his gender identity and consequently uncertain about his perception of his nose" (2000:284).

Ishigooka et al. (1998) argued that the results of their sociological study on Japanese cosmetic surgery patient demographics "[were] noteworthy [because] such a considerable number of patients with mental disorders or with poor social adjustment had sought cosmetic surgery. Distinct gender differences were found: male subjects were characterized to have a greater number of mental disorders" (p. 283). The tone of this Japanese research is significant not only because American historians have shown that emerging pop psychology memes in the 1920s regarding the importance of self-esteem and the inferiority complex were explicitly used by the cosmetic surgery community in attempts to legitimize the long-marginalized practice, but

also due to the fact that even up until the 1970s most prospective U.S. cosmetic surgery patients, male and female alike, were suspected of having some psychological aberration that necessitated an "unnecessary" surgery (Grimes 1972; Haiken 1997; Gilman 1999).

In this case, however, Western hegemony seems to have already normalized Japanese women's quest for cosmetic surgery, while the token Japanese man is excluded and marginalized as medically and socially deviant for pursuing identical surgeries (p. 285). While, to some extent, Nakamura et al. acknowledge that a level of bias is present and that the new pressures of Western influence, globalization, and economic competition affect Japanese men as well, the authors' overall and one-sided message is to develop surgical-psychiatric collaboration that addresses a growing population of male cosmetic surgery patients. Increasing rates of cosmetic surgery among Japanese men does not escape Gilman (1999) either, who mentions in his footnotes a rise in costly cosmetic surgery among teenage boys, which he attributes to "the masculine drive for 'happiness' through the Western aesthetic alteration of the *too*-Japanese body" (p. 354:59).

Meanwhile, late 1990s Japan saw a surge in young female students pursuing eye, nose, and face surgeries at the end of the school year, which, as was the case in China, usually signified a graduation gift from parents. As the former Japanese Chair of the International Cosmetic Surgery Association cosmetic commented in 1997:

> It was just amazing to see this many young girls at my clinic all of a sudden. I felt there was something funny going on around mid-March, so I asked my assistant to go through the files. The number…by the end of the month had tripled compared with the previous year…And what surprised me even more was the fact that they were the graduates of those prestigious top-ranking junior-high schools. They weren't girls dreaming of becoming a TV star or a magazine model. They were serious, innocent-looking girls with their mothers. (Gilman 1999:105)

As one 15-year-old Japanese girl stated, "It's like piercing your ears. Everyone is doing it now. I cannot understand why some people make a big fuss out of it" (*Ibid.*:p. 105). With the advent of

the Internet, this type of matter-of-fact pervasiveness has become increasingly normalized.

Torigoe's (2008) important work on the role that both "whiteness" and "racial 'Otherness'" ideologies play in Japanese online cosmetic surgery advertisements underscores why critical analysis of this phenomenon is in fact necessary (p. 1). Outlining five rhetorical strategies that are utilized to reconstruct and sustain Japanese racial ideologies in the advertisements, Torigoe writes that "standardization" sets white females as the standard of beauty, "fragmentation" cuts images of women in parts or emphasizes certain body parts, "sexualization" focuses on a model's feminine body, "distancing" rhetorically creates symbolic and psychological distance between models in the ads and audiences, and "fixation" on repetitious images imposes stereotypical gender and racial images on the models in the ads (p. 1). She analyzes the normativity, invisibility, and "everydayness" of whiteness as a form of power fueling these rhetorical strategies, drawing upon theorists like Shome (2000) and Gabriel (1998). Although Torigoe found that, overall, the whiteness of models appearing in cosmetic surgery ads was valued, she stressed that the white models were also "othered" as distinctly non-Japanese (2008:4).

For example, among the 40 cosmetic surgery clinics' Websites that Torigoe analyzed, only four sites exclusively used Japanese models, reflecting a popular Japanese practice since the 1970s to use foreign (often white) models or actors in media advertisements (pp. 5, 7-8). Out of the 269 advertisement images studied, only 27 used Japanese models, and of those models, most tended to "have double-eyelids, big eyes, high noses, fair skin (some may be due to [skin] lightening), light colored hair, and long legs," adding that "[i]t is important to note that the process of portraying white females as ideal beauty in these ads [is] nothing new or noble; rather it is naturalized and unquestioned" (2008:15-16). However, in the process of "othering," most

white models were pictured as nude or nearly nude and less likely to look directly into the camera, whereas Japanese models were pictured as fully clothed and looking directly into the camera to reduce the "distance" felt by a visual audience (Torigoe 2008:18-22). Torigoe hypothesizes that this divide emphasizes a Western beauty ideal, while still relegating it to a less threatening "outsider" status and rewarding Japanese women's national hierarchy and modest, "moral goodness" (pp. 20, 18).

Accordingly, Shome's (2000) multi-faceted definition of whiteness as a complex and contextual "*process*" is reflected as much by Torigoe's contemporary findings in Japan's cosmetic surgery culture as it was in the first sentence of Mikamo's historic published report (p. 368). The "unquestioned" narrative of cosmetic surgery described by Torigoe here is characteristic of the longer sociohistoric process of Japan's globalization and the commercialization of its cosmetic surgery industry. While I have shown that East Asia's cosmetic surgery past is firmly rooted in Japan, its presence is currently known in numerous neighboring countries.

Vietnam: A Similar Pattern of Normalization

As seen through nearly identical patterns in China, Japan's early and influential relationship with cosmetic surgery is significant to the entire East Asia region. Moreover, American military occupation later in Korea and Vietnam followed the same patterns—heightened, in the case of Korea, by the fact that it was also a Japanese colony for over three decades. For example, once again, American GIs carried with them to Vietnam not only guns and napalm but also internalized standards of beauty along with highly influential *Playboy* magazines (Haiken 1997). And while most Vietnamese had not been previously wealthy enough to travel to cosmopolitan Tokyo for cosmetic surgery, "as the war progressed, surgery came to them" (*Ibid.*:p. 204).

Once again, the perceived necessity of cosmetic surgery became intertwined with gendered and racial discourse and dreams of social mobility:

> "Vietnamese girls have beautiful, classic faces, but remove their clothing, and they look like boys with long hair," one surgeon told *Time* magazine in 1966. Surgeons Pham Huu Luong and Pham Ba Vien offered a similar explanation for the marked increase in plastic surgery since the American buildup in 1965. "A bargirl's capacity to earn is based on her ability to attract American males," Dr. Luong told the journalist. "Many desire operations to make themselves more beautiful to them. Others just prefer larger noses and breasts. Some are giving into the fad of the time"….Vietnamese surgeon Vu Ban also cited the American buildup. "The bargirls said the GIs preferred them with rounded eyes and big breasts and hips….It became part of their livelihood. Then they found it helped them get jobs and American husbands," Dr. Ban told the *New York Times* in 1973. (Haiken 1997:204)

And once again, dangerous injection practices that had been abandoned elsewhere made a resurgence: "They're just pumping silicone everywhere," one Vietnamese physician complained (*Ibid.*:p. 204). Right on cue, the widely touted "positive" psychological effects for women were borrowed from the United States to justify "exciting" new surgical frontiers for Vietnamese surgeons seeking to remove newly identified ethnic "defects":

> In a 1973 *New York Times* article, Dr. Ban claimed to have given thirty-four-year-old Tham Thuy Hang, South Vietnam's top film star, new eyes, nose, breasts, hips, thighs, and even fingers: "She even had dimples put in her cheeks and a cleft in her chin. You might say she was an entirely different woman." Like other plastic surgeons, Ban believed his surgical skill offered more than just "superficial beauty." "By removing a woman's complexes we give her confidence and transform her psychology," he asserted. "It's a lot of fun. And it's an art form in itself." Dr, Ban particularly prided himself on his ability to remove "natural Asian defects" in an hour. (Haiken 1997:204)

As a result of this excess, post-war Vietnam temporarily sought to reclaim its distinct ethnic features not by ceasing cosmetic surgery altogether (although Gilman [1999] reports that aesthetic surgery nearly vanished in Saigon after 1975), but by drafting "a detailed physiognomic study determin[ing] the relative facial dimensions of the Vietnamese so as to provide an adequate, non-Westernizing model for the relationship among features, including the form and shape of the eyes, for aesthetic surgeons" (Gilman 1999:105). Similar to Japan, however, the

practice of cosmetic surgery in contemporary urban areas of Vietnam soon re-emerged as sufficiently normalized—even accepting growing numbers of men into the field of patients:

> Today in Ho Chi Minh City [formerly Saigon] there are a dozen mini-clinics, sometimes masquerading as barber shops and staffed by lay surgeons. Their patrons are most often men. Clinic owners say that the most popular operations are for the nose, the chin, the eyes, and the buttocks. One man even asked surgeons to bulk up his chest, which he believed would make him more attractive to women. (Gilman 1999:106)

Yet, nothing in Vietnam comes close to the kind of universal acceptance that cosmetic surgery has enjoyed in South Korea, a small country that boasts the highest per capita rate of cosmetic surgery than any other nation (Davies and Han 2011, quoting ISAPS 2009).

South Korea: Outlier or the Future of Globalized Cosmetic Surgery?

A 2009 survey by market-research firm Trend Monitor suggested that at least one in five women in Seoul had gone under the knife (*Economist* 2012). Similarly, in 2006 a visual studies publication offered an unverifiable yet telling statistic: "In the United States only 3 percent of the general public have undergone cosmetic surgery, while the rate in Korea is 13 percent" (King 2006:25). Highlighting a 1994 change in legal policy that allowed the South Korean advertising industry to use non-Korean models and celebrities to sell their wares, the article ignores a vast array of historical context that also contributes to South Korean cosmetic surgery rates. However, it does pinpoint the early 1990s timing of Western ethnic and mainstream media's re-directed focus on what it considered to be a "new" and surprising phenomenon in East Asia.

Both the *Wall Street Journal* and The *Los Angeles Times* reported in 1993 on emerging changes in Korea's ever-growing cosmetic surgery industry, noting the importance that South Korean women and, increasingly, men were placing on cosmetic surgery's valued role in job advancement, "self-esteem," and the desire to "go Anglo" as the economy boomed (Glain 1993:A1). Describing the popular procedures of widening eyes, implanting nose bridges,

enlarging breasts, liposuction, and shaving cheekbones, the Western news publications interviewed cosmetic surgeons, patients, lay people, and academics. Significantly, these articles also voiced the kind of public cultural opposition that is harder to find in reports today. Noting Koreans' "love-hate relationship with Western culture that manifests itself in paradoxical ways," *The Wall Street Journal* writes:

> For conservatives in this devoutly Confucian society, the trend is upsetting. They doubt Confucius, who antedated cosmetic surgery by more than 2,000 years, could have reconciled his philosophy of filial devotion and ascetic naturalism with breast enlargements and liposuction. "This is an example of students confused between Western and traditional Eastern values," says Cho Sung Nam, professor of sociology at Ewha Women's University here in Seoul. "They think Westernization is more advanced and sophisticated, but we should preserve our own values of beauty and ideology." (Glain 1993:A1)

The *LA Times* likewise quoted both a South Korean professor's retort, "What's wrong with a flat nose? Why do we all need an extra fold in our eyelids?", and a mother of two who asked, "What's next? Will parents start changing their baby's face?" (Lim 1993:28). Even the plotline of a 1990s popular Korean soap opera revolved around solving the mystery of why an "extremely handsome" couple ends up with a "very ugly" child (hint: DNA is [so far] surgery-proof) (*Ibid.*:p. 28). These articles describe a window of time since lost—portraying a transitioning Korea where surgeries were still kept somewhat secret from friends and disapproving family, and a government-launched austerity program attempting to reign in excess actually discouraged Koreans from getting cosmetic surgery.

By 1997, however, a Korean-American journalist writing for L.A.'s English-language *Korea Times* noted that regardless of the fact that "all the [Korean] girls are stick thin and beautiful with porcelain-like skin," due to large swaths of girls becoming nearly identical through cosmetic surgery, mothers-in-law were requiring prospective daughters-in-law to provide high school photos for verification of their natural looks (Kim 1997:20). By 1999, San

Francisco's *Asianweek* gave the estimate that 40 percent of Korean women were undergoing double-eyelid surgery, a practice that, along with breast implants, had swiftly gained popularity in Asian-American communities as well (Nishioka 1999:14D). In 2001, the American ethnic news outlet *Korea Times* published several articles about the cosmetic surgery "craze" that had become an "everyday affair" among young Korean women and men, "with TV show emcees asking female entertainers without hesitation if they had surgery" (Park 2001:15).

In less than a decade, Korean survey statistics had gone from the finding that 35.1 percent of high school and college students reported desiring cosmetic surgery (Glain 1993:A1) to 2001 data showing that "nearly 80 percent of women in their 20s said they are willing to undergo surgery if they could be prettier and can afford to pay it, despite the risk of expenses and possible ill effects" (Park 2001:15). A separate survey of over 5,000 Koreans under the age of 18 showed that 75 percent would take the chance to improve their looks through cosmetic surgery (Sohn 2001:16). According to the *Korea Times*, more than 5.7 million procedures had taken place in 2000, up nearly 25 percent from 1999 (Park 2001:15). Cosmetic surgery clinic numbers were "mushrooming in Seoul" to the extent that the wife of one cosmetic surgeon "asked her spouse to buy a money-counting machine" to handle the sheer volume of currency coming home (*Ibid*.:p. 15). And forget government-sponsored austerity measures; when the global financial crisis recently hit Korea's cosmetic surgery industry, "the government sought to protect this important source of GDP by temporarily allowing its citizens to claim tax credit for the cost of cosmetic surgery" (Holliday and Elfving-Hwang 2012: 61 quoting Digital Chosun Ilbo 2007).

While official aesthetic surgery statistics (in every country) are notoriously unreliable due to the use of private clinics, medical tourism, and poor regulation, surveys from 2008 stated that 30 percent of South Korean women between the ages of 20 and 50 underwent some form of

cosmetic surgery procedure in that year alone (Holliday and Elfving-Hwang 2012). In 2010, moreover, the Korean Association for Plastic Surgeons estimated that about 15 percent of men had undergone a cosmetic surgery procedure (*Ibid.*:p. 59). A more recent survey conducted by a Korean employment Website found that 44 percent of male college students were contemplating some form of aesthetic surgery (*Ibid.*:p. 59). Holliday and Elfving-Hwang also discuss the current popularity of young Korean men seeking the *kkonminam* look: bone-shaving for a "softer" (non-militarized) face, yet a still muscular (and often implanted) body, popularized by Japanese boy bands and *manga* cartoons, while older men prefer "noble cosmetics," like facial implants (2012:60-61,73-74).

Not surprisingly, given the skyrocketing rates of cosmetic surgery, complaints to the Korea Consumer Protection Board are also on the rise, fueled by a lack of regulation among amateur practitioners. Nevertheless, in 2001, despite some muted concerns among cosmetic surgery professionals that "compulsive plastic surgery" was occurring at higher and higher rates in Seoul, no actions were considered to curb cosmetic surgery rates in minors:

> Students…even form private savings clubs, called "kye," aimed at assisting each other with various types of plastic surgery that cost enormous sums of money. Up to 70 percent of people undergoing plastic surgery are high school students, a recent poll showed. Parents' consent over their children's zeal for enhanced beauty has combined to make the nation a paradise of cosmetic surgery for teenagers. "We exchange information on cosmetic surgery clinics when we get together," said Mrs. Kim whose daughter is an 11th grader. "Double-eye lid surgery is so simple. I will let my daughter undergo surgery come this winter vacation. She has been begging me to pay for that because she thinks all of her friends with that kind of surgery look better," she added. (Sohn 2001:16)

The *Korea Times* reported, however, that not all of the surgeries were "so simple," nor did first-time patients fully understand the physical pain and risks involved—adding that a Korean 12th grade girl died in 2001 after falling into a coma as a result of a botched chin-bone shaving surgery (Sohn 2001:16). Despite disturbing news like this, many Koreans (like the Chinese in

prior sections) argue that cosmetic surgery has become necessary due to the belief that it is equally if not more important than a university degree in the competitive job market:

> "It is natural that people groom themselves for beauty. The problem is that our society places more value on appearance and school background than people's ability or job skills," said Park Jae-heon, a Korean-language teacher at Osan Middle School in Seoul.… The media and parents should educate children not to rely on their appearance but to cultivate their inner qualities and strengths." (Sohn 2001:16)

Despite this admonition, in a similar pattern to other East Asian countries, young female students have to make "reservations" months in advance in order to secure a coveted spot in the O.R. once school lets out (Park 2001:15).

Moreover, as in all of the BRIC countries, beauty pageants have played a major role in the normalization of the practice. Supported by corporate and government interests, many pageant winners go on to land coveted acting roles, inspiring viewers to purchase identical cosmetic surgeries that may lead to similar upward social mobility:

> More than 20,000 beauty queen wannabes put their similarly looking face and body to the test in over 200 beauty pageant events across the nation every year. According to a news article, they spend 5 - 10 million won ($5,000 - $10,000) to compete in local beauty contests and more than 30 million won ($30,000) for national ones. They do all this to pose on the catwalk to show off their thick-powdered faces and voluptuous bodies, tuned to "Western" beauty standards. Local governments have been offering financial aid to beauty contests aimed at promoting the regions' famous products. (Sohn 2001:16)

Despite these less-than-attractive descriptions, one *Korea Times* article finishes with the shallow yet familiar, "Why not?" media trope, given the potential for personal social and economic rewards and adding the tellingly Western, individualistic question, "Haven't personal liberty, a rise in wealth, democracy, and confidence building all augmented personal happiness?" (Sohn 2001:16). However, another *Korea Times* author tentatively asks some tougher questions: "Although it may be a useless worry, what will it be like if the beauties with similar and standardized looks…flood the streets?" and "[What about] the birth of babies that do not

resemble their mothers?" (Park 2001:15). One 22-year-old Korean-American student experienced this conundrum firsthand when she decided to spend a year in Seoul to seek her cultural "identity." She was instead dismayed to find that, because she had not had cosmetic surgery, she felt like she was "abnormal" and "a freak!" (Lee 2010:5). Despite having had to navigate the common stereotypes of Koreans in the United States throughout her life, she soon described entering a no man's land between two cultures:

> [M]y identity was crashing even more than before. Now I had an eating disorder! I don't know why, but I felt ugly and unaccepted by Korean society. I felt like I had to become Korean in Korea, whatever that means. I no longer looked Korean. (Lee 2010:5)

In academic circles, Korea represents an unusual model of study, as well as a potential template for the future of cosmetic surgery trends in some fast-developing countries, such as BRIC countries housing huge populations. In fact, Korean surgeons' techniques are now highly sought-after throughout East Asia, since they are considered more skilled, sophisticated, and less expensive than surgeries in China and Japan (*Tantao News* video report 2010; Davies and Han 2011; Kim 2012). Accordingly, China has become Korean cosmetic surgery's "largest export market," with over 50 Korean-owned clinics operating in Beijing and Shanghai by 2005 and Chinese-owned clinics flying in Korean surgeons for the weekend (Davies and Han 2011:146). Korea itself has become a destination not only for foreign patients but also for Chinese surgeons seeking to train and add the lucrative "Korean" label to their product, a practice which has irked Chinese state-owned hospitals (*Ibid.*).

In addition to their argument that Asian societies are increasingly marked by an almost fanatic adherence to digital technology which may relate to fanaticism for cosmetic surgery, Davies and Han (2011) attribute this regional phenomenon to the "Korean wave" or "Hallyu" resulting from the widespread popularity of Korean media culture throughout East Asia, which

has garnered enormous revenue for the country since the 1990s (p. 146). This regional boom in Korean film, TV, music—and the surgically altered celebrities who populate them—has also evolved with the help of news reports that publicize cosmetic surgery. Kim's (2010) unpublished conference papers on the normalization of cosmetic surgery in Korean and U.S. news outlets, found through a comparative content analysis that Korean newspapers were more likely than those in the United States to suggest cosmetic surgery as an effective means to achieve beauty and offered more "positive information on expected outcomes" (Kim 2010:23).

According to *Tantao News* (2010), however, some in the Korean psychological community have voiced concerns over the increasing superficiality of Korean culture, where external qualities have become an unprecedented priority without considering the social consequences. For example, Kim (2010) quotes a study by Jung and Forbes (2006) revealing that Korean women showed the greatest body dissatisfaction even though their average BMI (body mass index) was found to be the lowest among sampled countries. Moreover, Seoul-based psychiatrist Dr. Jinseng Park states his belief that Western influence after the Korean War is one of the reasons for the cosmetic surgery boom (Australianetwork.com news video 2011). Quoting Lee's (2004:617) characterization of the "homogenizing toxin of Westernization," Kim (2010) found that Korean newspapers were more likely to explicitly depict Western facial features as ideal, while U.S. newspapers were more likely to idealize youthful appearance (p. 11).

As previously mentioned, some academic sources have questioned or criticized the common tendency of Western media and academia (but, as I have shown, also of Korean-American and Korean-originating sources) to focus on Western cultural hegemony as the primary or sole contributing factor to Korea's high rates of cosmetic surgery (Davies and Han 2011). For example, Holliday and Elfving-Hwang (2012) bring up several key points in relation

to Korea that support my general theoretical direction, including the argument that existing literature on cosmetic surgery, which primarily draws from feminist and post-colonial discourse, excludes important international, gendered, and sociohistorical components by reductively "presenting cosmetic surgery as pertinent only to female and non-western bodies found lacking by patriarchal and racist/imperialist economies" (p. 58). Holliday and Elfving-Hwang assert that this critical focus on Western cultural hegemony, often originating from the Western academic canon, easily misses important cultural influences specific to the country in question: in this case Korea's national identity discourses and its traditional beliefs and practices, such as physiognomy.

While I agree with the authors' aim to re-frame cosmetic surgery into a broader gendered analysis (rather than the typically more narrow framework) in order to allow proper space for the discussion of men's varied roles in cosmetic surgery culture, my own studies regarding both country-specific sociohistorical national discourse, as well as Western racist/imperialist economic catalysts, have tended to show that within decades, the latter can handily transform the former. Therefore, though I do not discount the continued and significant influence of country-specific national discourse on its own beauty culture, we must also acknowledge the origins of massive shifts in that discourse, which are shown by this paper to be systematically born out of racist/imperialist histories and then nurtured to full-blown maturity by post-war economies and neoliberal capitalism.

I agree with Holliday and Elfving-Hwang's (2012) argument that multiple considerations of the meanings and practices of aesthetic surgery frequently intersect and occasionally contradict one another, representing:

> [A] process of negotiation between multiple discourses concerning national identity, globalized and regionalized standards of beauty, official and non-official religion,

> traditional beliefs and practices (in some instances historically imported from some other place), as well as the symbolic practices of coming of age, caring for the self, marking social status and seeking success. (P. 59)

My own comparative analysis, however, has shown that these globalized standards of beauty follow nearly identical regional patterns based on clear, historically based power structures of force, which have become inextricably embedded in national identities and discourses over time. The authors make the point that foregrounding cosmetic surgery as a culturally imperialist practice is a key weakness in existing literature. While I concur that some scholarly analyses present assumptions as facts without referencing the historical record, any dismissal of cultural imperialism begs a crucial question addressed by my comparative research: How can one separate cultural imperialism from cosmetic surgery practices, when Western medicine itself was brought to East Asian countries largely through forced trade, military conquests, and (undesired) religious missionaries? It is not possible to separate the two.

Nonetheless, Holliday and Elfving-Hwang (2012) do make important points about how specific Korean discourse has influenced an unprecedented per capita proliferation of cosmetic surgery practices. The authors cite a wide range of regional academics such as Taeyon Kim (2003:106–7), who argues that Neo-Confucian ethics continue to inform rigid gender scripts that create a "culture of conformity," where beauty becomes a new "requirement of decorum" for Korean women (and, separately, where the unity of the whole community is more important than the individuality of the one), as well as Park Sang Un's (2007) discussion of national origin myths that lend themselves to painful self-sacrifice to achieve the ideals of Western "Eurasian" beauty (cited by Holliday and Elfving-Hwang 2012:67).

The authors also quote Woo (2004:60), who highlights the "voluntary and empowering" pleasure- and status-seeking aspects of these surgeries for contemporary Korean society that also

produce surgery "addicts" and a helpless acceptance of the logic of technological capital to correct Korean bodies that have been "branded as inferior and flawed [in comparison to the images of white women]... through mass media...forums such as Miss Universe competitions and Hollywood movies" (*Ibid.*:p. 67). However, Holliday and Elfving-Hwang present these authors' analyses as remaining "rooted narrowly in patriarchal and western systems of beauty and neoliberalism" (2012:67), adding that:

> In grounding their arguments only in patriarchies – be they Neo-Confucian, western or technological – all these writers fail to adequately explain not only men's cosmetic surgeries, but all Korean cosmetic surgeries, since gender is clearly not the only cultural mechanism at work here. (P. 67)

Holliday and Elfving-Hwang go on to make key references to Korea's colonial period under Japan, including a post-World War II "nationalistic discourse mobilized by the West as a way of rejecting Japan as the self-declared bearer of civilization," (2012:69) citing writings from Na Se-jin in 1964 that state:

> The Korean is of medium to tall height, among many races of the world. The neck is thin and long, and because of the superior development of the Korean's body and muscular structure, the posture is straight and erect. The calf is long, and since every part of the body's measurements are very even, the Korean resembles the wellproportioned [sic] stature of the Europeans and Americans [rather than the Japanese]. (Pai 2000:260 as cited in Holliday and Elfving-Hwang 2012:69)

Although the authors successfully present the "western body" as "mobilized in defiance of Japanese standards of beauty" in the form of "anti-colonial discourse," they fail to consider the possibility that cosmetic surgery was likely initially brought to Korea by Japanese surgeons who had already been citing the influences of cosmetic "Westernization" for nearly a century. Moreover, while the authors briefly mention the series of dictatorships and rapid industrialization that precipitated competing discourses for "authentic Koreanness" following the Korean War and the country's division in 1953, they say nothing about the effects of U.S. occupation, not to

mention the large number of mixed race "G.I. babies" that were put up for adoption or the numerous "war brides" who subsequently traveled to the United States (Williams 1994:12, citing Kim 1977; Holliday and Elfving-Hwang 2012:69).

All in all, Holliday and Elfving-Hwang (2012) contribute to the cosmetic surgery literature by emphasizing the importance of discussing the existence of indigenous, traditional, and re-emerging forms of divination and physiognomy that may characterize Korean cosmetic surgery, such as the widespread belief "that one can 'read' a person's character by looking at their face," necessitating the correction of the culturally "'inauspicious face'" and the perceived importance of having the "right [Korean] face" for first impressions, marriage, and employment (pp. 70, 72). Indeed, they note that "physiognomy is often used to evaluate candidates where qualifications and experience are equal, [whereby] an employee with 'friendly' (*insang'i choun*) facial features will always be preferred, given the importance of social bonding in the workplace" (p. 73).

This emphasis on "neo-Confucian" physiognomy appears in popular media as well, with one news interviewee remarking: "Just as the Asian moral standard is rigid and clearly defined, so too are standards of beauty....If you're lucky enough to be born naturally beautiful, okay. But it's not that naturalness per se is a good thing. When plastic surgery comes along, it means that things can be done about this" (Werb 2005:76). Similarly, another news source noted: "Koreans see plastic surgery, and becoming prettier, as a challenge....Koreans have less respect for inherited beauty. They see beauty not as something to be envied, but something to be attained" (Kim 2012:n.p.).

One of Holliday and Elfving-Hwang's (2012) less persuasive arguments focuses on the fact that changing Korean face shapes and eyes may be a way of rejecting "the maternal body" as

a way of "expressing sexual (and marriage) self-determination and occupation of the public sphere" (for example round eyes for women were traditionally and pejoratively associated with "lasciviousness") (p. 72). However, I see this latter argument as contradictory to their overarching call to question "feminism's hegemon[ic]" readings of cosmetic surgery as a whole. Moreover, the authors do not give any evidence to support their argument from Korean feminist groups, which they say offer "practically the only opposition to cosmetic surgery in Korea," albeit limited in practice "to prosecuting cosmetic surgery clinics for illegal advertising in women's magazines" (*Ibid.*:p. 62).

In sum, Holliday and Elfving-Hwang (2012) conclude their article by suggesting that:

> [M]any instances of apparent westernization can be related to a strong sense of indigenous identity. The existing literature has a tendency to reify globally mediatized bodies as western, but the globalized body is already 'mixed' and bears little resemblance to actual women in either the West or the East. Rather, the 'western' body links to idealized (and, of course, exceptional) characteristics in many countries...Claiming Korean women want to look western denies the constructed nature of western beauty and that western beauty has been valued because it entered Korea fitting *preexisting* notions of class and status. Such claims position western cultural borrowings as appropriation and non-western ones as colonization while ignoring the fact that all modern nations actively appropriate, reject, hybridize or acquiesce in elements of transcultural influences that circulate through the globalized media, cheap travel and migrations. (Pp. 74-75)

Of course, this final argument about Korea could apply to every country and region examined in this paper, and it is one that has merit. However, the phrase the authors use that jumps off the page in relation to my argument is the assertion that "all modern nations" actively participate in the appropriation of transcultural influences—because this simple phrase falsely implies that these "modern nations" exist on a level playing field in the globalized world. Furthermore, there is no mention of the constructed nature of what a "modern" nation and its people look like and why. Holliday and Elfving-Hwang certainly do not present cosmetic surgery motivations in an "all-or-nothing" sense. Nor do I. However, this paper does attempt to reveal through a

systematic, comparative analysis that sociohistorical power structures have acted as catalysts in constructing and labeling "modernity" in terms that benefit pre-existing cultural, cosmetic, and corporate systems in the West, which then provide neoliberal models for fast-developing countries to follow if they want to enter the global stage—and look the part.

During the process, cosmetic surgery did not exist in a vacuum, suddenly appearing in the 1990s as a hybrid expression of international media and indigenous cultural memes. Rather, this paper has shown that cosmetic surgery is one of the earliest, embodied symbols of the unequal balances of power among nations often *forced* open to compete in a quickly modernizing, globalized economy. And although I agree with the assertion that, today, few Western women can approximate the idealized global body, what Holliday and Elfving-Hwang (2012) do not address is the fact that, at the early onset of globalization, mass images of "normal" white women helped define that very ideal.

Moreover, the reasons these mass images were so easily produced and proliferated throughout the global East and South had to do with the power, wealth, and technology accumulated by the West—often at the expense and exploitation of the rest of the world. If scholars avoid the (admittedly uncomfortable) historic evidence that racist and bellicose discourse infused colonial ambitions, nationalist eugenics movements, immigrant assimilation and, yes, the innovation and spread of cosmetic surgery, it only serves to further legitimize "modern" discourses of cosmetic surgery as a positive lifestyle choice producing self-esteem, upward mobility, and social opportunity. This paper argues that the discursive origins of cosmetic surgery are an inconvenient truth that "modern" purveyors of cosmetic surgery culture seek to ignore in order to self-perpetuate and evolve with the demands of capitalism.

As time marches on, will cosmopolitan cities begin to look more like Seoul, South Korea,

where cosmetic surgery and skin treatment clinics are now commonplace in urban shopping malls, constantly inviting "walk-in" customers? (Holliday and Elfving-Hwang 2012:59). Will the public get "sick of the similar looks on the street [allowing] women with natural Korean eyes and round faces [to] suddenly look better?" (Park 2001:15). Or, as BRIC countries' booming economies and staggering populations surpass the West, will standards finally change? One Korean surgeon interviewed by *The Wall Street Journal* examined the possibility:

> "Everything is centered on Western culture now," he says. "But if we become the dominant culture, the Asian look will be favored." So will the next generation of plastic surgeons be "Orientalizing" white people in Manhattan and Beverly Hills? Dr. Kim thinks a moment. "I don't know of a procedure to make Western eyes look Asian," he says, "but I'm sure it's possible." (Glain 1993:A1)

Will there soon come a time when future cultures look back in bemused wonderment about why so many generations spent so much time and money to achieve bizarre standards of homogenized beauty? Or, will they just pity a generation who hadn't yet marketed mass technologies in "designer" pre-natal gene therapy (Masci 2001:425). As I move on to discuss these trends and predictions from a theoretical standpoint, the question of lost time, money, and attention as the result of an increasing preoccupation with cosmetic surgery offers a provocative angle of analysis. While aesthetic surgery continues its global proliferation, more than 2.5 billion women, men, and children continue to live on less than two dollars a day (UN Works 2012). Given such vast inequalities, what does it mean if global ideals and media visualizations of the coveted benchmarks of economic success continue to look more and more like something "perfected," "ageless," and achieved only by means of the scalpel? How might this affect priorities, "agency," and freedom in our shared global future? Who, in the end, is mass-consumer cosmetic surgery benefitting?

DISCUSSION

After utilizing the BRIC model to identify and analyze the origins of cosmetic surgery and to provide examples of how cosmetic surgery has become normalized in various nations throughout the world, the final piece of the puzzle to understand what drives the globalization of cosmetic surgery hinges upon the question of motivation and reward. My intention of questioning who benefits from a globalized cosmetic surgery culture is not to detract from individuals' experiences on a micro level, but rather to illustrate that the macro force of this phenomenon must, and will, have macro consequences—likely continuing *ad infinitum* (albeit with slight variations in cultural hybridity) to construct and reconstruct the same patterns and power structures upon which it was founded. In a sense, that is the very nature of cosmetic surgery technology itself. And as we now recognize, cosmetic surgery technology was founded on the basis of combating disease, war wounds, and human difference in the tradition of conflict, racist discourse, eugenic movements, war economies, and neoliberal commercialization.

Therefore, I argue that (barring reconstructive procedures) most modern cosmetic surgery technology is not far removed from its intolerant ideological roots and therefore continues to serve a pre-determined standard of appearance that reinforces and perpetuates both historical and existing myths of superiority. Furthermore, global financial markets (built upon the same superiority myths) fuel and capitalize on an infinite demand for products and services that claim to help new global consumers approach this pre-determined standard. Thus, BRIC and other countries' cosmetic surgery cultures continue to simultaneously elevate both the free market and the sociocultural status of those whom the market has historically served best: namely, the same "superior" groups that are perceived to fit the pre-determined standard of appearance in the first place. It is this cyclical concession to the old status quo (conveniently packaged as "the modern")

which undermines any long-term collective benefits that cosmetic surgery practices seem to offer at first glance: such as greater parity, opportunity, or more enfranchised national and global citizenship. Although individuals certainly may experience the benefits of their cosmetic surgery practices on a personal, micro level—amidst this global backdrop—macro analysis must call into question the idea that cosmetic surgery culture is fundamentally based on individual agency, self-improvement, and self-investment.

Ultimately, then, in the ironic guise of transformation, the globalization of cosmetic surgery benefits the status quo of power—*not* (as some have theorized) the type of instability of power roles that can create enough discursive space for fundamental social change. From the Foucauldian perspective described by Bordo (1990), this does not mean that modern cosmetic surgery is used currently as a conspiratorial relic of the past, "held" by one dominant group as a way of duping another into corporeal subjugation (p. 666). Instead, like all discourse, cosmetic surgery power structures comprise "a dynamic of non-centralized forces" which have attained hegemony through myriad "processes, of different origin and scattered location" (Bordo 1990:666, citing Foucault [1977] 1979:138). Meanwhile, in this paper, we have examined power relations of widely varying origins and scattered locations and have seen them converge into consistent patterns informing the globalization of cosmetic surgery.

One common pattern overall is the sense that cosmetic surgery culture (combined with neoliberal commercialism) effaces potential rallying points of power for historically underrepresented groups by further de-centralizing *collective* opportunities for "struggle" and displacing them with the *individual's* postmodern "project" of the body (Bordo 1990:667; Giddens 1991; Shilling 1993). For example, rather than create a million-strong force of job-seekers to demand that the Chinese government end discriminatory hiring practices based on

appearance and instead focus on providing enough jobs for an expanding workforce, bright and talented college graduates undergo cosmetic surgeries that they believe will make them more competitive on an individual level. According to many ethnographic informants quoted throughout the paper, cosmetic surgery is often considered the only option for success. Without it, one is left behind, unable to participate in modernity. Tellingly, this option of surgery much better serves a Chinese state long adept at enforcing the status quo by squelching public protest and calls for reform. In the process, Chinese cosmetic surgery patients seem only to be solidifying, not ameliorating, a continued system of employment prejudice historically exercised against ethnically diverse populations—and this surprisingly occurs in a country that is largely ethnically homogenous. Why should that be?

I have theorized that current neoliberal economic policies and the opening of new capitalist markets have become akin to a mass "immigration" of new "citizens" of the world who, in the age of globalization, can actually remain where they are—just not as they are. In a regressive sense, entry into the realm of Western-dominated capitalism seems to require one to assimilate into a sudden and new demographic *within* the homeland of one's ancestors. Not dissimilar to the 1890s immigrants' plight, if you are to have any hope to compete on a more level playing field, you must define modernity and your modern identity in the pre-packaged global image of "success"—which may or may not resemble your parents, grandparents, or future children for that matter. When examined as a whole, this so-called empowerment is short-lived, thwarted by genetics, and in danger of preemptively placing the unborn into a disadvantaged position—one that can only later be mitigated through similar surgical interventions that, in turn, perpetuate the market.

The only entity in this power dynamic that is *not* forced or encouraged to change is the system itself, which continues to profit ideologically and financially through the reinforcement of centuries-old "Western" values of superiority disguised to all as the "normal." As in Shome's (2000) theories about whiteness, the underlying system benefits in the long term as a result of its "everydayness," and those who usually benefit from an unchanged sociopolitical system will likewise continue to do so, a fact that often goes unrecognized. At the level of the individual, it is difficult to question the discourse of identity, agency, and the possibility of self-construction in late modernity—("I did it for me")—possibly because the body is considered one of the last vestiges of permanence among fleeting images, capital, time, and relationships (Askegaaerd et al. 2002; Giddens 1991). People need to believe that they are, at the least, in control of their body and its degree of malleability. Furthermore, no one wants to sacrifice a perceived opportunity for self-betterment today, in spite of the fact that their actions may make it harder for others like them to participate tomorrow. Of course, there are always individuals who will defy these pressures but who may also increasingly be put at a disadvantage while the bar raises higher (Bordo 2009). Furthermore, there are those who will avoid "correction" by happening to be born with the "right" kind of "modern" physical characteristics (which were pre-determined by "racial science" centuries ago). But, that too is in flux; in late modernity, there is always room for "improvement."

While Askegaard et al. (2002) discuss cosmetic surgery's "reflexivity" at the micro level (i.e. the individual's reflexive construction of identity), Bordo addresses the self-reflexive and self-constitutive nature of cosmetic surgery as a discourse:

> That we are surrounded by homogenizing and normalizing images...whose content is far from arbitrary, but instead suffused with the dominance of gendered, racial, class, and other cultural iconography [is painfully] obvious...Yet contemporary understandings of [cosmetic surgery and beauty culture] not only construct the situation very differently,

> but in terms that preempt precisely such a critique of cultural imagery. Moreover, they reproduce, on the level of discourse and interpretation, the same conditions which postmodern bodies enact on the level of cultural practice: a construction of life as plastic possibility and weightless choice, undetermined by history, social location, or even individual biography. (1990:657)

Contemporary cosmetic surgery discourse has preemptively and conveniently reclaimed a generic space untouched by history, location, and stigma and thus has constructed the kind of sociohistorical clean slate that is attractive for mass consumption and which many of its patients seek to accomplish in their own lives: a fresh start. By challenging this discursive facade and situating cosmetic surgery back in its rightful place in global history, its original power dynamics are exposed.

In the end though, cosmetic surgery discourse feeds off of any kind of exposure, as there is little motivation to curb a flood of attractive normalizing images whose appeal lies as much in the pleasure of seeing 'beauty' as in the pleasure of 'learning' and appropriating what has already been culturally defined as beautiful. Furthermore, cosmetic surgery discourse is supported by existing organizational structures. Hill Collins (2000) notes in her analysis of Foucault ([1977] 1979) that bureaucracy is an increasingly powerful tool of social organization, managing intersectional power relations based on race, class, gender, sexual orientation, and nation. As observed in disparate examples of cosmetic surgery medical systems, we see in Brazil and Russia that both overly-efficient and inefficient bureaucracies are equally good at masking the effects of intersecting forces of power as well as contributing to the dilution of personal choice (i.e. the availability of cosmetic surgery in lieu of quality health care for Brazil's low-income patients versus the Russian state's complicity in the continuation of a dangerously unregulated cosmetic surgery field). These bureaucratic structures in the field of commercialized cosmetic surgery contribute to the effacement and dispersal of potential group struggles that *could* make

demands for government accountability but do not, thus serving the status quo by reinforcing political inaction.

Furthermore, and as affirmed by this project, war, conquest, and conflict have played a vital role in each turning point of the development and sustenance of globalized cosmetic surgery practices. Michel Foucault's lectures to the Collège de France (1975-1976) are an intricate web of complicated texts that have sometimes confused scholars but are noted for their historical examination of the model of war as a grid for analyzing politics and understanding power. In the absence of any comprehensive theory due to the format of the endeavor, Foucault's lectures offer unique but disparate pieces of theoretical insight regarding race, racism, the body, war, and power.

In my research, I was consistently surprised by how often academic discussions of cosmetic surgery in countries like Japan and Korea glossed over information regarding American occupation, or neglected to mention that the initial "opening" of trade and Western influence in places like China and India occurred by force. The very traumatic context and confrontation of war seemed to embed an early, more threatening, notion of the "West" and its enforced "unequal treaties," which I understood as likely intimately related to the understanding and acceptance of "Western" culture, even in much later generations. Even though time had moved forward and wounds had healed, I suspected that war not only informed the historical construction and technology of reconstructive and cosmetic surgery practices but also played an unseen role in contemporary cosmetic surgery motivations. In a step by step re-construction of a working definition of power, Foucault makes the point that "politics is the continuation of war by other means," which, according to him, would imply:

> First, that power relations, as they function in a society like ours, are essentially anchored in a certain relationship of force that was established in and through war at a given

> historical moment that can be historically specified. And while it is true that political power puts an end to war and established or attempts to establish the reign of peace in civil society, it certainly does not do so in order to suspend the effects of power or to neutralize the disequilibrium, revealed by the last battle of the war. ([1976] 2003:15)

While I argue that most forms of cosmetic surgery belong to a system that perpetuates and benefits the status quo which is based fundamentally on forms of inequality, it also follows that, as a product of war, cosmetic surgery would remain "anchored" in the relationship of force upon which it was established. One could thus argue that certain cosmetic surgery practices among a populace remain entrenched in their power relationships to hegemonic forces. By their very nature, hegemonic forces can certainly establish a "reign of peace in civil society" and the conditions for success, but hegemony does not work to undo its own power or "neutralize" imbalances on its own. Instead, hegemony exists in the stable acceptance of the status quo, which is only upended through the instability of resistance (Bordo 1990). Foucault goes on to assert:

> According to this hypothesis, the role of political power is perpetually to use a sort of silent war to reinscribe that relationship of force, and to reinscribe it in institutions, economic inequalities, language, and even the bodies of individuals.…We are always writing the history of the same war, even when we are writing the history of peace and its institutions. (P.16)

This characterization of political power as the perpetual vestiges of a prior war continuously, systematically, and silently "reinscribed" into the everydayness of life—and onto one's body—lends itself to the notion of a perpetual re-writing of the divergent roles of war in global discourse and the process of globalization. Similarly, this continuous circulation of power may manifest itself, as Said (1993) writes, "in a kind of general cultural sphere as well as in specific political, ideological, economic, and social practices" (p. 9). In the discursive sense, the evidence of this paper suggests that cosmetic surgery culture is, in fact, one of the ideological, economic, and social practices that reinscribes prior and perpetual relationships of force onto the body.

On the other hand, Foucault does not assert a helpless lack of choice or a preordained victimhood for bodies inevitably marked by relationships of force. In fact he offers as a "methodological precaution" *not* to "regard power as a phenomenon of mass and homogeneous domination—the domination of one individual over others, of one group over others or of one class over others" (Foucault 1976:29). Likewise, I do not aim to argue that the macro effects of cosmetic surgery are directly *imposed* upon populations or that these populations are *dominated* directly by them—only that cosmetic surgery does not *benefit* participants as much as it benefits the status quo of inequality and prejudice. Specifically, and as discussed by Bordo (1990), Foucault notes that:

> unless we are looking at it from a great height and from a great distance, power is not something that is divided between those who have it and hold it exclusively, and those who do not have it and are subject to it. Power must, I think, be analyzed as something that circulates, or rather as something that functions only when it is part of a chain. It is never localized here or there, it is never in the hands of some, and it is never appropriated in the way that wealth or a commodity can be appropriated. Power functions. Power is exercised through networks, and individuals do not simply circulate in those networks; they are in a position to both submit to and exercise this power. They are never the inert or consenting targets of power; they are always its relays. In other words, power passes through individuals. It is not applied to them. (Foucault [1976] 2003:29)

Although Foucault does not reference "agency" specifically, his assertion that individuals are in a position to exercise power and be conduits of power seems to relate to individuals' ability to engage in resistance and create instability within and among hegemonic forces (Bordo 1990). In these lectures, however, Foucault states that his goal is not to analyze power at the individual level "of intentions or decisions" but rather to study power externally, "at the places where it implants itself and produces its real effects" (p. 28):

> In other words, rather than asking ourselves what the sovereign looks like from on high, we should be trying to discover how multiple bodies, forces, energies, matters, desires, thoughts, and so on are gradually, progressively, actually and materially constituted as subjects, or as the subject. ([1976] 2003:28)

Accordingly, one area that Foucault mentions as a space of increasing confrontation between what he calls "the mechanics of discipline and the principle of right," where there is an increasing incompatibility between "disciplinary normalizations" and "sovereignty" is "the expansion of medicine....[and] the general medicalization of behavior, modes of conduct, discourses, desires, and so on" ([1976] 2003:39). These arguments seem to relate to contemporary discussions regarding the medicalization of the body and the increasing pathologies of constructed defect in cosmetic surgery practices, as well as the associated theoretical tensions regarding notions of agency versus structure in cosmetic surgery studies. As discussed earlier in relation to regulatory practices and commercialized medicine (specifically in terms of the U.S. and Russia), Sullivan (2001) writes that this expansion of medicine is inextricably linked to free markets. Foucault, for his part, writes that techniques of power can be understood by concentrating on "the economic profit or political utility that can be derived from them" ([1976] 2003:33).

In regards then to cosmetic surgery culture among the United States and BRIC countries, techniques of power related to the cosmetic surgery market link directly back to the multinational beauty companies, financing middle men, professional marketing consultants, medical tourism businesses, aesthetic plastic surgeon professional societies, plastic surgeons, and sometimes the nation-states themselves, all of which profit at a much higher rate than their average patient/client/consumer. The mere process of monetary exchange in the business of elective body modification represents its own system of power networks.

Finally, Foucault's connection of modern race and racism to the emergence of life sciences and biology in the nineteenth century provide key insights into a major theme discussed in this paper, namely a catalog of spurious claims from "racial anthropologists" in the 1800s that

set the stage for the emergence of cosmetic surgery as a form of cultural assimilation (Foucault [1976] 2003; Gilman 1999; Mader 2011). According to Mader (2011), "Foucault proposes that the advent of the modern discursive orientation to the notion of life both permits and requires new forms of race and racism as well as new justifications for the exercise of state power" (p. 98). Specifically Foucault writes:

> What in fact is racism? It is primarily a way of introducing a break into the domain of life that is under power's control: the break between what must live and what must die. The appearance within the biological continuum of the human race of races, the distinction among races, the hierarchy of races, the fact that certain races are described as good and that others, in contrast, are described as inferior: all this is a way of fragmenting the field of the biological that power controls. It is a way of separating out the groups that exist within a population. It is, in short, a way of establishing a biological-type caesura within a population that appears to be a biological domain. This will allow power to treat the population as a mixture of races, or to be more accurate, to treat the species, to subdivide the species it controls, into the subspecies known, precisely, as races. That is the first function of racism: to fragment...([1976] 2003:254-255)

As clarified by Mader (2011), Foucault's allusion to killing can also refer to repression "done by exclusion" (p. 106). Accordingly, as seen in this investigation of BRIC and beyond, relationships of force between racial "science" and the origins of cosmetic surgery portray intersecting dynamics of exclusion, marginality, and dehumanization. Although Foucault frames his analysis in terms of the new forms of state or "juridical" power that resulted from ideologically constituted biological conceptions of human difference, it is clear that throughout Europe, the United States, and in the throes of colonial conquest, harmful "biological-racist discourses of degeneracy" precluded—in multiple sociocultural dynamics—the visibility, acceptance, and citizenship of countless minority and immigrant populations trying to survive and succeed (Foucault [1976] 2003:61). Therefore, the discursive elements of both racism and global warfare form a dark backdrop to myriad forms of cosmetic surgery practices that continue to this day. As Foucault ([1976] 2003) notes, through exclusion and segregation, the discourse of

race struggle functions, "ultimately, as a way of normalizing society" (p. 61). As this paper has demonstrated, the discourse of exclusion has also played a key role in the normalization and globalization of cosmetic surgery practices.

CONCLUSIONS AND RECOMMENDATIONS FOR FUTURE STUDY

During this global journey across history and several continents, we sought to answer the question: What is driving the globalization of cosmetic surgery? Using BRIC countries as a model, this paper systematically identified and analyzed (1) the origins of cosmetic surgery in historical, regional, and country-specific terms, and (2) examples of how cosmetic surgery has become normalized. As a result, clear patterns emerged in regards to: embedded power structures related to racism and war; the results of Western interests rapidly opening countries' markets to high media and corporate influence, especially in the wake of political oppression and austerity; the exacerbation of pre-existing class, color, race, and gender prejudice by hyper-consumerism; the perception of the beauty industry and global beauty pageants as a gateway to the "modern" world's stage; and the practice of "Westernized" cosmetic surgery becoming synonymous with concepts of status, upward mobility, and a social transition to global citizenship.

These overall patterns allowed for the subsequent analysis of a third and all-important question—one that forms the foundation of any global catalyst—who ultimately benefits from all of this? I have argued through a systematic, comparative analysis that the globalization of cosmetic surgery is driven by pre-existing sociohistorical power structures that serve the status quo—benefitting exclusionary cultural, cosmetic, and corporate systems from the West (and those who run them), and thereby precluding authentic opportunities for individual enfranchisement via cosmetic surgery on a macro level.

Furthermore, by constructing and labeling "modernity" in terms that benefit the status quo and reflect historical relationships of force, developed nations maintain hegemonic control in their own image; whereby, fast-developing countries must follow existing neoliberal consumer models if they want to enter the global stage—and look the part. Thus, BRIC and other countries' cosmetic surgery cultures continue to simultaneously elevate both the free market and the sociocultural status of those whom the market has historically served best. It is this cyclical concession to the old status quo (conveniently packaged as "the modern") that undermines any long-term collective benefits that cosmetic surgery practices seem to offer at first glance—such as greater parity, opportunity, or more enfranchised national and global citizenship. Accordingly, this paper has shown that cosmetic surgery is one of the earliest embodied symbols of the unequal balances of power among nations and their people, situated among old relationships of force as they compete in a new globalized economy.

Finally, by avoiding the historical evidence that racist and bellicose discourse have infused the innovation and spread of cosmetic surgery practices, it only serves to legitimize current narratives of cosmetic surgery as a lifestyle promoting self-esteem, acceptance, upward mobility, and social gain. While these cosmetic surgery benefits may appear attainable on the individual level, more often it happens that group struggle for these goals and tangible social progress become sidelined in favor of the flashy but ephemeral victories of individuals' purchased charms. Thus divided, new generations of individuals may find it harder to participate in society as they are. In this manner, the discursive origins of cosmetic surgery are an inconvenient truth that "modern" cosmetic surgery culture seeks to ignore in order to self-perpetuate and expand with the demands of capitalism. And, although it is likely that the ugly,

discriminatory roots of the surgical quest for global beauty will continue to conveniently fade from public view, it is my hope that this paper will be a small blemish on its polished facade.

Limitations and Recommendations

One limitation of this project was the fact that I could not use more country-originating or citizen-written critiques and explorations of cosmetic surgery practices due to language barriers. However, most historical and ethnographic texts utilized throughout have been translated directly from in-country sources or firsthand accounts. An extension of this project could also involve an original empirical or ethnographic study of some kind. Naturally, studies of cosmetic surgery in other countries and regions should be explored at length. BRIC was a specific sample, albeit one that exhibited a broad and pluralistic scope. Another limitation or possibility for future study would be to incorporate comparisons of countries that have lower levels of cosmetic surgery rates while still offering certain cosmetic surgeries free or subsidized through government health programs. For example, an examination of slower rates of consumer adoption in some Scandinavian countries might explore how the popularity and "need" for cosmetic surgery is related to the consumerist element of commercial medicine. Finally, there are four related areas that should be explored on a macro level in regards to the themes discussed in this paper: the industries of medical tourism, tissue harvesting, skin lightening, and the growth of cosmetic surgery among minors.

Much has been written to date about the $3 billion global medical tourism market, especially in regards to the already stalwart markets of India, Brazil and Latin America, Thailand, and the Philippines (Filipino Reporter 2011; Bell et al. 2011; Sengupta 2011). Foreign tourists choose among a multitude of travel agency and on-line medical-vacation packages to exotic locales where they have the added benefit of built-in recovery time, lower costs, and more

discretion. South Korea, another major medical tourism hub in East Asia, even advertises special cosmetic surgery recovery hotels equipped with shuttles to and from the clinics (Kim 2012). Increasingly, surprising regions are eager to join in this lucrative venture, which attracts foreign funding and fuels large economies yet often further limits actual residents' access to affordable public healthcare and sometimes results in dangerous outcomes for foreign patients arriving home with complications (ISAPS 2010; Sengupta 2011). According to a regional news source, North Africa has become the newest cosmetic surgery tourism hub with Tunisia, Egypt, and Morocco inviting medical tourists for cosmetic surgery at low costs in places recently rocked by social unrest due to disparity and disenfranchisement (*The North Africa Post* 2012). This industry as a whole raises a multitude of sociological questions and should be explored in a multi-country, multi-regional comparative analysis.

Similar to some of the issues discussed regarding illegal stem cell black markets cropping up in Russia and India, recent investigative reports have uncovered grisly evidence of how "donated" tissue (many who agree to be an organ donor are automatically also assigned to be a tissue donor unbeknownst to them) is harvested from bodies and used for medical, dental, and cosmetic surgery products. There has been evidence of sordid, semi-legal practices among profiting companies as well as revelations that an illegal trade of human tissue is traveling across borders (Houston Chronicle 2005; Ethicsworld.org 2006; Willson et al. 2012). There is no regulation of this tissue industry and no way to track what is done with loved ones' remains, how they are treated and transferred, who profits from them, or, furthermore, if you will unknowingly end up with cadaver tissue in your surgical beauty regimen. More academic attention should be given to this billion-dollar industry and its cultural ethics.

As discussed at length in the India section, Parameswaran and Cardoza (2009) give a comprehensive overview of the skin-lightening market, which has ballooned in recent years in the regions of Asia, Africa, and the Middle East:

> In 2005 alone, 62 new skin-whitening products were introduced in the Asia-Pacific region, thus consolidating "a trend that has seen an average of 56 new products introduced annually over the past four years" (Fuller, 2006, p. A3). A *New York Times* report with an image of a Hong Kong subway advertisement for skin-lightening treatments notes the aggressive marketing of visions of "pale beauty" in Asia where supermarkets and pharmacies distribute "vast selections" of creams…In Hong Kong, Malaysia, the Philippines, South Korea, and Taiwan, four of every ten women use a whitening cream, a survey by Synovate a market research company found. The skin-whitening craze is not just for the face. It includes creams that whiten darker patches of skin in armpits and "'pink nipple' lotions that bleach away brown pigment" (Fuller, 2006, p. 3). Cheaply priced creams and bleaches that promise to brighten and tighten skin are the "rage in many African countries" where women are beginning to report serious dermatological and medical problems — hives, rashes, bumps, scaly skin, ringing in the ears, and nausea — after prolonged use of these products (Baxter, 2000; Jenkins, 2001; Simmons, 2000). (P.219)

The authors also quote analysis by Mire' (2005) that examines a lesser-known but growing market for high-end skin-whitening creams to treat age spots among older white women in North America and Europe (p. 220). Furthermore, Chisholm (2002) and others have written about the sociocultural status that bleached skin holds in certain communities in Ghana and West Africa, as well as the devastating health effects caused by mercury and other unregulated ingredients found in these products. A systematic macro analysis of the capitalistic structure (i.e. who and which companies are benefitting from this market) should follow (de Souza 2008).

With books by plastic surgeon authors coming out such as, *The Safe and Sane Guide to Teenage Plastic Surgery* (which vouches for surgeries to combat bullying, but also for cosmetic vaginal surgeries for girls “if there is a real issue” 2010:5) and *My Beautiful Mommy* to help children understand through pictures their mother’s “mommy makeover” surgical overhaul, this field is badly in need of scrutiny (Bliss-Holtz 2009; “The Safe and Sane…” 2010; Abate 2010).

As witnessed during the course of this paper, some other developing countries are even farther ahead of the United States in their normalized acceptance of cosmetic surgery for teens and children as a purported attempt to combat bullying but also merely for the sake of appearance, with rhinoplasty, liposuction, and breast implants occurring at younger ages. The results of 2007 statistics for the United States show numbers that are likely to have doubled by now: "The American Society of Plastic Surgeons [reported] 38,886 nose reshaping procedures…performed on thirteen- to nineteen-year-olds, and 10,505 breast augmentations performed among eighteen- and nineteen-year-olds (a 15 percent increase from 2006)" (Park 2008:8).

Although some studies have begun to examine the motivations and possible psychological effects this phenomenon may have on young children (Sarwer, Infield, and Crerand 2009) and a few studies have questioned the broad scope of authority that parents currently have to request surgeries for their children (one example was Asian blepharoplasty performed on a newly adopted child) (Gilbert 2009; Ouellette 2010), others have questioned whether it may be necessary to look into universal legal frameworks to regulate the practice of cosmetic surgery on minors (McHale 2012). Overall, the academic community should take note. The upward trend of cosmetic surgery among children and teens in the United States and abroad is a harbinger of things to come in the future of globalized cosmetic surgery practices.

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