

FACE WORK: CULTURAL, TECHNICAL, AND SURGICAL INTERVENTIONS
FOR FACIAL “DISFIGUREMENT”

By

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For Verba. It is doubtful that I would ever have been able to make peace with my face had I not met you. Of my blessed life, it is that moment of serendipity that I am most grateful for.

AND

For my mother. I am happy to have a face that so resembles her own.

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LIST OF ABBREVIATIONS

AJOB American Journal of Bioethics

DS Disability studies

FFS Facial feminization surgery

FT Face transplantation

IFGE International Foundation for Gender Education

MTF Male to female transsexual

CHAPTER I

ABOUT FACE: AN ETHNOGRAPHY OF FACIAL DIFFERENCE AND REPAIR

“The face is nothing but an instrument panel registering all the body mechanisms: digestion, sight, hearing, respiration, thought.”

Milan Kundera (1999: 40)

“The face is the most intimate, most individual characteristic of your body. It’s who you are.”

Linda Hogle quoted in Bowen (1999: 2)

Sociology of a Face

Facial difference circulates through our Western collective imagination. Stories of cutting-edge biotechnologies like face transplantation periodically make their way into major newspapers. Coverage of philanthropic mission work devoted to repairing the faces of “third world” children show up in magazine interviews with celebrities and in public relations promotion of good works accomplished by medical center teams. Plastic surgery television, featuring dramatic stories about reconstructive and cosmetic procedures, saturates the television schedule. Representations of faces and “facial disfigurement” circulate widely, and together these images inform our notions about what

it means to be facially variant.¹ Yet there is not one single or unitary notion about what disfigurement is. Those with facial differences are positioned as the monster, the cyborg, the recluse, the victim, the alien, and the non-human in varying accounts. While there are many stories and images of facial difference, particular stories capture our cultural imagination and these stories lend intelligibility to the meanings of facial difference.

In 1994, writer Lucy Grealy published a memoir, *Autobiography of a Face*, tracing her experience as a self-identified disfigured person. *Autobiography of a Face* chronicles Grealy's experiences with facial difference resulting from Ewing's sarcoma, a cancer of the bone and soft tissue. Grealy's cancer metastasized in her right jaw. The illness and subsequent surgeries resulted in a highly asymmetrical face. The book was celebrated upon its release, earning distinctions as a *New York Times* Notable Book and one of *USA Today's* Best Books of the Year. Reviews of *Autobiography of a Face* praise it not only as an exceptional work of non-fiction but also as an insightful account of the experience of facial difference. But because there is no one "real" story about facial disfigurement, I ask: What is the truth of disfigurement that circulates in and through *Autobiography of a Face*? What is it about this text that so captured critics and readers?

¹ The word "disfigurement" is a thoroughly problematic term. I use "disfigurement" not to reify social stigma of atypical faces, but rather to socially and semantically situate the faces about which I am talking. Rather than taking for granted the process of defining a face as disfigured, I analyze the construction of "disfigurement" as an operative category that shapes social meanings of and responses to atypical faces in various contexts.

I discuss the tensions implicit in use of the term more thoroughly in Chapter 2.

And more broadly, what is the cultural backdrop against which I analytically dissect various attempts to “fix” the face?

Autobiography of a Face explores one young woman’s experience of bodily suffering, but more specifically it chronicles her attempts to cope with facial disfigurement. At nine years old, Lucy Grealy was diagnosed. Following that moment, her life was irrevocably changed. As a child she began a series of treatments both to cure the cancer and to repair her face. *Autobiography of a Face* offers startling insight into the desire (and in moments, the compulsion) to “fix” or repair the human body. Like many others with faces defined as disfigured or non-normative, Grealy’s life could be reconstructed through her medical records. Countless surgeries changed Grealy’s face, and her life. Most dramatically, the use of “pedestals” temporarily restored the facial structure lost:

In the first operation, two parallel incisions would be made in my stomach. The strip of skin between these incisions would be lifted up and rolled into a sort of tube with both ends still attached to my stomach, resembling a kind of handle: this was the pedestal. The two incisions would be sewn together down its side, like a seam. Six weeks later, one end of the handle would be cut from my stomach and attached to my wrist, so that my hand would be sewn to my stomach for six weeks. Then the end of the tube that was still attached to my stomach would be severed and sewn to my face, so that now my hand would be attached to my face. Six weeks after that, my hand would be cut loose and the pedestal, or flap, as they called it, would be nestled completely into the gap created by my missing jaw. This would be only the first pedestal: the whole process would take several, plus additional operations to carve everything into a recognizable shape, over a period of about ten years altogether (154).

Ultimately, though, each surgery failed to offer any permanent fix. While Grealy’s pursuit of bodily transformation relies on the same kinds of concerted attention and constant cultivation employed for all kinds of aesthetic interventions, the significance of facial disfigurement imbues Lucy’s bodily repair with a particular weight.

Interspersed with descriptions of Lucy's interactions with the medical profession, we see Lucy as a child, adolescent, and later as a twenty-something writer. Lucy searches for some sense of normalcy either through the intervention that will repair her face or relationships that will lend her some sense of value. As a child, Lucy works in a horse barn. Of the experience, she writes,

The horses remained my one real source of relief. When I was in their presence, nothing else mattered. Animals were both the lives I took care of and the lives who took care of me. Horses neither disapproved nor approved of what I looked like. All that counted was how I treated them, how my actions weighted themselves in the world (152).

In her twenties, Lucy attends graduate school at the University of Iowa Writer's Workshop. There and in the writers' colonies that follow, Grealy desperately looks for the man who will have sex with her and who will remain with her in spite of her supposed ugliness. In adulthood, she is forced to look in the mirror after doctors who have promised technological miracles have given up and men intrigued by her tenacity and way with words have moved onto the next girl, one not so "different." The details change, but each of Grealy's stories centers on her insatiable search for love and normalcy.

The book is about Grealy's face, specifically, and about her "tragic" life, more generally, and throughout, *Autobiography of a Face* is about how one's life is predicated on one's face and its relationship to sense of self. She writes,

There was only one fact of me, my face, my ugliness. This singularity of meaning—I was my face, I was ugliness—though sometimes unbearable, also offered a possible point of escape. It became the launching pad from which to lift off, the one immediately recognizable place to point to when asked what was wrong with my life" (7).

Despite a promising few final pages, it is clear that Lucy's deep desire to be normal and valued are never to be satisfied as long as her facial difference remains.

Autobiography of a Face humanizes Lucy Grealy, and in the process facial disfigurement writ large. The book is a memoir, offering an intimate depiction of Grealy's experiences. Lucy speaks for herself. Her voice rises in stark contrast to the more common approach of talking *about* facial difference. Her voice makes her experiences real in a way that runs counter to most representations of facial difference. Be it the carnival barker who points to the sideshow performer with facial variance or the reconstructive surgeon who describes the techniques used on a face, disfigurement is talked about in ways that position people with faces defined as disfiguring as *objects*, as expressly *not human*. By contrast, Lucy describes what it feels like to look different and how that experience inspires obsession with normalizing interventions. Midway through her memoir, Grealy makes the startling admission, "For the first time I wished I were dead" (155). Grealy's account humanizes disfigurement, but unlike stories that offer an insider's perspective and, in the process, make the extraordinary a bit more mundane, *Autobiography of a Face* is startlingly bleak. Ultimately, Grealy suggests that disfigurement is worse than those with "normal" visages could ever imagine.

Perhaps the most compelling detail of Lucy Grealy's story is one that could not be chronicled in her memoir: Lucy Grealy is dead. The details of her death, most widely publicized in Ann Patchett's book *Truth and Beauty: A Friendship* (2004), are vague. Lucy was an admitted heroin (ab)user. Shortly before her death, she was committed to a psychiatric facility for clinical depression and suicidal ideation. On December 18, 2002, her body was found in a bathtub in a friend's New York studio apartment. Underlying

every account of Lucy's death is the story of her face, or so the story goes, as told in Patchett's acclaimed book. The drugs and depression may have facilitated her demise, but the story of Lucy's life and death is one about facial disfigurement. It was her face that killed her. But why is the explanation that Lucy's face killed her a believable and perhaps even appealing account of her death? The narrative that positions Lucy's disfigured face as the cause of her death rests on assumptions about what disfigurement means, the significance of the face in everyday life, and the supposed limits of living with facial difference. If facial disfigurement is unequivocally tragic (as it is in so many accounts) and if our faces are, in a very fundamental way, who we are to the world, then of course, life as a facially disfigured person is simply not possible.

Reviews of *Autobiography of a Face* reveal what critics found compelling about the text.² Over and over again, reviews celebrate three features of Grealy's story—the horror of facial variance, the cultural significance of appearance, and the overcoming of great suffering. In a *New York Times* book review, A.G. Mojtabai (1994) describes *Autobiography* as an “unblinking stare at an excruciatingly painful subject.” A *Mademoiselle* review refers to the “horror” of Grealy's disfigurement, while a *Mirabella* review references her “unbearable fate.” Reviews also suggest that Lucy's disfigurement gives her significant, expert insights about beauty and attractiveness. A *Seventeen* magazine review notes, “Grealy beat cancer, but this almost seemed inconsequential compared to the horrors of coping in a world that measures a woman's worth by her

² I cite reviews that are reprinted on the cover and in the front matter of the 1994 edition of the memoir. I provide citations for the reviews that are cited by critic's name in the bibliography.

looks.” And a *Ploughshares* review argues that “she makes a lyrical statement about the complex relationship between beauty and self-worth in our society.” While Grealy’s life as a person with facial difference is continually positioned as horrific, reviewers uniformly celebrate her story as an overcoming narrative or as “a powerful testament to the triumph of the human spirit,” as the *Detroit Free Press* described. A *Booklist* review notes, “She describes her heroic efforts to transform her misfortune into a source of revelations about the beauty and mystery of life...She saved her own life by telling herself stories to live by. Now she’ll change our lives by sharing them.” Ultimately, the story of Lucy Grealy’s life is compelling because it accesses tragedy. Both *Autobiography of a Face* and *Truth and Beauty* chronicle the life of a woman who searched for a technique that might refigure her face and thereby alleviate her suffering. Little wonder that the story of Grealy’s death focuses on her failure to find a satisfactory intervention.

Autobiography of a Face tells one story about the significance of disfigurement and our deep desire to repair the human face. In this dissertation, I tell a sociological story about the relationship between bodily stigma—specifically disfigured faces—and technical, surgical, and cultural repair of these faces. As Lucy Grealy’s life and the response to her memoir demonstrates, there is something socially and culturally significant about facial disfigurement. It is a physiological state and a morphological condition, but it is also a social status in the sense that it informs one’s position in society, in Grealy’s case her relative value as a human being. The power of a bodily state to determine a person’s status is not unique to disfigurement. Status is thoroughly informed by the body. Hierarchies of race and gender, physical mobility and

attractiveness are all structures of bodily status. Particular categories or social locations carry more social value; others carry less. In effect, humans are varyingly defined and devalued in accordance with our bodies. In this study, I explore the specificity of facial difference. I query the ways in which disfigurement not only confers low status but may in fact carry such significance that humans defined as disfigured are understood *as not altogether human*.

The specter of disfigurement saturates our collective imagination. It appears not only in *Autobiography of a Face* but throughout popular culture as a haunting reminder about the fragility of human bodies. Disfigurement looms not only as one possible trauma, but rather as a particularly dreadful and astoundingly horrific bodily threat (Kemp 2004). Because the face is understood to be hugely significant physiologically—as a mechanism for communication and as a means of eating, breathing, and seeing—facial disfigurement signifies a highly threatening bodily impairment. Facial disfigurement also threatens our fundamental notions of self and identity. The disfigured face compromises appearance and thus our most public selves precisely because it is so difficult to conceal our faces.³ In this way, disfigurement threatens our very way of being in the world. I argue that the specter of disfigurement together with the importance accrued to the physiological functions of the face infuse the material practice of face work such that the work of repairing the face is given particular social, political, and moral significance. *In short, I argue that face work is not simply a conglomeration of reconstructive techniques aimed at the human face but rather the work of making the*

³ Veiling offers one such means for concealing the face, but this, of course, is a culturally specific practice and one that is increasingly suspect in a post 9/11 world.

disfigured human. This thesis is simultaneously a cultural *and* material account of what makes repair of the face take on the import that it does, and with what consequences for individuals and society.

The Human Face as Sociological Object

The body is decreasingly an “absent presence” in sociology (Williams and Bendelow 1998). Instead, sociological theories of the body and empirical accounts of bodily experience have been on the rise for more than a decade. Yet for the most part, “the body” that appears in sociology often is a referent for embodiment writ large. Theories of the body, then, are ironically infused with “the nonfleshiness of social constructionism” (Rosengarten 2005). Following areas like disability studies and women’s and gender studies, sociologies of the body wrestle with how to theorize the body, as a material and social object. At its founding, disability studies (DS) rested on a distinction between disability and impairment (Wendell 2006). Disability was defined as a social, cultural, and political phenomenon. By contrast, impairment referred to a “natural,” and thus taken for granted, bodily state. This distinction mirrors the distinction in women’s and gender studies between sex and gender (Lorber 1993). Historically, sex was conceptualized as the “real” bodily material—genitals and chromosomes, hormones and gonads— in which gender was lodged. By contrast, gender was principally defined as the social and cultural meanings attached to sexed bodies. Because sex was conceived as bodily, it was a no “woman’s” land for feminist theorists. In bracketing impairment or sex, disability and women’s studies privileged metaphors of the body rather than bodily materiality. In the last decade, DS and feminist theory, in particular feminist

technoscience studies, have made claims that “the natural” is itself a cultural and political construction. Increasingly, then, it is both experiences and meanings of “the social” and “the natural” body that are subject to social theorizing.

While “the body” is increasingly taken up within sociology, accounts often begin with the “social” and move to the “bodily.” In other words, the body is made sense of via social processes and practices, but the material body and the relationships between materiality and social practice are rarely queried. As such, it seems curious to premise a sociological account on a particular body part, and yet this is precisely where my project begins. I open with questions about the physiological functions and the social meanings attributed to the face. In doing so, I suggest that there is a need both to theorize “the body” *and* to take the body apart analytically, to interrogate “embodiment” and specific body parts. Consider, for example, that aesthetic interventions are disproportionately aimed at features like breasts and noses and very rarely at elbows and bellybuttons. Understanding why demands not only a social account of medical technologies and aestheticization but also a cultural history of breasts, noses, elbows, and bellybuttons.

The face is a unique body part because it functions in a multitude of ways. The face facilitates vital bodily functions, most obviously eating and breathing, but it is hardly just a vital organ. The face is simultaneously a means of communication, a marker of identity and personhood, a signifier of social status, and a form of capital. Put another way, “Faces are the external manifestation of our persons (our souls?). They provide information about age, gender, ethnicity, and emotional states, and help to form the image that others have of us. Indeed, our face often provides the image that we have of

ourselves” (Robertson 2004: 32). In these ways, the face is through and through a sociological subject.

Beyond the functions that the face serves for sustaining life, the face also works as a mechanism for communication and as a facet of identity. In recent work entitled *Unmasking the Face* (2003), psychologists Paul Ekman and Wallace V. Friesen claim to have identified seven primary facial expressions: anger, disgust, fear, happiness, interest, sadness, and surprise. They argue that these are universal expressions, displayed by and recognizable to humans in every culture. Whether or not these facial features are biologically derived as Ekman and Friesen suggest, their research points to the pervasive ways in which the face is an instrument of communication.

In addition, the face is a basis for social identity. By the very fact that the face is so accessible as compared to most other parts of our bodies, it is central to our identity. Our faces are the primary points of reference for those we encounter. In this way, the face is a symbol which mediates subjectivity and public personhood. Put simply, as medical anthropologist Linda Hogle (1999:2) does, the face is “who you are.” In an interview on face transplantation for Salon.com, Hogle suggests that a transplant is complicated by that fact that “[y]ou're really transplanting more than the tissue itself. You're bringing someone else's identity and overlaying it on the recipient's body.” Sociology understands communication as a reality-generating endeavor and identities to be constituted through social interaction (Blumer 1969). As a mechanism for communication and as a central point of reference in social interaction, then, the face is a deeply compelling sociological object of inquiry.

For a discipline whose big questions often circulate around issues of social stratification, the face is a particularly salient point of inquiry towards understanding difference and inequality. The face works as a primary indicator of social status. While it is certainly true that looks can be deceiving—many of the inferences that we make based on another’s face may not be accurate—every face-to-face human interaction is premised on the “fact” that the face tells us something about one another. The face ostensibly betrays our age, our race and ethnicity, and our gender—as these are configured in social contexts. In this way, what the face tells others about who we are determines our status in social relations and systems of power. Its lines and colors and decorations and bone structure are all evidence upon which we actively construct some sense of the Other; thus, the face is a social technology through which people are labeled, differentiated, and potentially devalued.

Clearly the face is a powerful biosocial device, directly affecting what sociologists drawing on Max Weber (1978) deem “life chances.” From this perspective, the face, along with the entire body, might be construed as a kind of physical capital, a resource that is directly correlated with status. As sociologist Chris Shilling, drawing on Pierre Bourdieu, writes:

While our physicality has become a possessor of symbolically valued appearances, it is additionally implicated in the prosaic buying and selling of labour power and the accumulation of other forms of capital...Physical capital is most usually converted into economic capital (money, goods, and services), cultural capital (e.g. educational qualifications), and social capital (interpersonal networks that allow individuals to draw on the help/resources of others), and is key to the reproduction of social inequalities (Bourdieu, 1978, 1984, 1986) (Shilling 2005: 474).

If our bodies are forms of capital, the face is a key form of currency. Facial appearance is powerful. While attractiveness can translate into high status, so too can facial difference compromise one's value.

Disfigurement as Object of Sociological Inquiry

This dissertation offers an interrogation of interventions aimed at repairing facial disfigurement. It is an account of the social significance of facial variance—but what *is* facial disfigurement? In a real sense, there is no there, there. Disfigurement has no static intelligibility, no objective point of reference, no stable shared meaning. Yet it has a very definite, deeply felt social reality. As a target of intervention for various actors, facial disfigurement is an object of inquiry simultaneously in biomedicine and in the social sciences. Via attempts to “know” disfigurement, facial difference takes shape as a biomedical condition, as a technoscientific project, as a psychological trauma, and as a social problem. To define disfigurement, I first ask what constitutes disfigurement in fields that address the topic and shape intervention. Then, I explore the relatively limited life of disfigurement in sociology.

In the biomedical sciences, facial disfigurement operates almost exclusively as a condition in need of intervention. As such, the cause of facial difference is of primary importance in calculating how to proceed. Based on fieldwork conducted in a maxillofacial clinic,⁴ Michael Hughes (1998) offers a typology of the causes of disfigurement that captures the ways in which disfigurement is conceptualized in medical

⁴ A maxillofacial clinic describes a medical facility that specializes in treatment of the head, neck, face, and jaw.

contexts. For the purposes of intervention, facial difference is differentiated between those one is born with and those that result from illness or trauma. Congenital anomalies, or those conditions with which one is born, may result in facial difference. The most common example is cleft lip and palate,⁵ which can in most cases be surgically treated at birth. Facial reconstruction is also aimed at other congenital “diseases” like Down’s Syndrome to normalize appearance, though this kind of facial intervention is controversial (Frank 2004). Alongside his list of congenital facial anomalies, Hughes adds ethnic facial characteristics, noting that people who seek surgery for ethnic features often conceptualize the feature in question as an abnormality. Burns, accidents (automobile accidents, fights, etc.), cancer, and other illnesses can also result in facial disfigurement. Hughes’ research is in part a chronicle of the ways in which disfigurement takes shape in biomedical contexts, but like the surgeons that work in the clinic, Hughes takes these categories for granted. While the origin of disfigurement is crucial for elaborating techniques of repair, there is certainly more to disfigurement than its cause.

Psychological research on facial disfigurement focuses primarily on the emotional costs of having a disfigured face. The picture of disfigurement painted in psychological research is stark—both self-image and social encounters are profoundly and negatively impacted by facial differences (Callahan 2004; Kent 2000; Rumsey and Harcourt 2004). Wasserman and Allen (1985) find that children with cranio-facial anomalies are more

⁵ Cleft lip and palate describe a congenital condition resulting when either the lip or roof of the mouth do not fuse in utero. This results in a gap that is often treated with surgery at birth.

likely to be ignored by their parents, and Barden et al. (1989) demonstrate that facially variant children are less likely to be held, played with, and looked at by their mothers. Worse yet, Wald and Knutson (2000) suggest that children with facial difference experience more abuse than children with “normal” faces. Research indicates that life chances are affected into adulthood. For example, people with facial difference are significantly less likely to be hired even than those with other physical disabilities (Stevenage and McKay 1999).

In contrast with what one might assume, research demonstrates that the severity of disfigurement does not predict psychological adjustment (Landsdown et al. 1997). Rumsey and Harcourt (2004) write, “the extent to which a visible difference results in social disability involves a complex interplay of social and individual factors” (84). Psychologist and specialist on disfigurement Nichola Rumsey (2004) elaborates on this point:

Severe visible disfigurement does not condemn the affected person to the life of a social recluse. Powerful elements of adjustment include levels of self-esteem (and the extent to which esteem is derived from qualities other than outward appearance), a person’s disposition (in particular an optimistic outlook on life, the quality of a person’s support network, and the effectiveness of his/her social interaction skills (Rumsey and Harcourt 2004). Those who are most distressed by their appearance are more anxious and depressed, lack self-confidence, feel they cannot control social encounters, and do not believe they can use other techniques to compensate for their visible difference (22).

In this way the “trauma” of disfigurement cannot be nailed down conceptually or practically, making the project of facilitating coping particularly difficult. Psychological research conveys the *personal* trauma of disfigurement, but it does little to explain the *social* or *cultural* significance of facial disfigurement or the meaning of interventions designed to “fix” atypical faces. In a sense, psychological work explores facial

disfigurement in a vacuum, as if sociocultural context does not inform experiences of embodied trauma.

Facial disfigurement has taken shape as a sociological object in only a very limited way. Frances Cooke Macgregor, a social scientist who worked as a graduate student under Margaret Mead and as a photographer, began exploring facial disfigurement during World War II. Soon after the war, Macgregor met a surgeon, Dr. John Marquis Converse, who worked on the faces of disfigured soldiers. After this meeting, Macgregor began a psychological and sociological study of facial disfigurement using Converse's patients as data. Her research on facial disfigurement resulted in two texts: *Facial Deformities and Plastic Surgery: A Psychosocial Study* (1953) and *Transformation and Identity: The Face and Plastic Surgery* (1974). Her later text begins, "Facial disfigurement is one of man's gravest handicaps." (1974: xxiii). Her founding premise—like mine—is that the face is so central to human life that having an atypical face is a significant social problem and thus an important topic for critical, sociological inquiry. Macgregor's work is remarkable in that she offers a sociological perspective on that which had previously been understood simply as a psychological or physiological problem. But her claim that the experience of disfigurement is fundamentally determined by our cultural notions of what disfigurement signifies was only the beginning in terms of what sociology can offer towards understanding facial difference. Macgregor's *New York Times* obituary captured the essence of her work on facial difference:

As for those whose faces happen to deviate from the norm, there was and is, a special irony with which they must contend. Their problems have their roots in the inextricable relationship of the face to the person and its role in human relations. Moreover, it is a situation made even worse in a society whose frenetic efforts to look young and beautiful makes looking

different a social stigma—a stigma that has the potential for social and psychological death (New York Times 2002).

In the end, Macgregor demonstrated that there exists a complicated relationship between disfigurement and suffering and that dissolving it would require a radical cultural shift.

Each disciplinary attempt to know disfigurement wrestles with the suffering inextricably linked with disfigurement, though each makes very clear that suffering may not resemble what we imagine or that suffering need not be necessarily linked with disfigurement. The attempt to know disfigurement (as a biomedical condition, as a psychological trauma, or as a social problem) is always intertwined with the desire to alleviate the suffering linked with disfigurement. Underlying these accounts is a notion about how bad disfigurement is. Regardless of how one comes to be disfigured, facial difference is routinely positioned as a tragedy. Such rhetorical framing emphasizes the possibility of recovery. Within such a framework, the work of facial repair becomes a miraculous sort of task, one in which the afflicted and their “saviors” can triumph over what is taken for granted as a trauma.

By contrast, I rely on the emergent meanings of disfigurement that arise in each site I analyze. In this way, I do not employ an a priori definition of disfigurement that emphasizes, for example, the loss of facial function or a radical departure of facial appearance from some mythic norm. As a result, the faces that appear in this account look quite different from one another, and yet in each site I explore, the faces that circulate therein carry a shared meaning. For the purposes of this account then, disfigurement is less about what a particular face looks like and more about the meanings conferred onto particular faces. I suggest that the process of defining a face as disfigured

is one in which the humanity of a person is called into question. While I query the consequences of defining a face as disfigured, I take the definition that arises in each of the sites I investigate for granted. That is, I am less interested in pinning disfigurement down as a “real” thing than in asking what disfigurement signifies. What, for example, is disfigurement made to say about a person, and what does disfigurement cost or make possible in certain contexts?

A Brief Note on Facial Interventions

This is not a story about beauty. It is not an analysis of cosmetic culture. It is not an inquiry into the ever-expanding markets facilitating aesthetic body projects. But beauty culture—its tools and its effects—is implicated in the story of facial disfigurement. This *is* a story about normalization and technologies aimed at repairing the face. Technically and historically, reconstructive surgery and cosmetic surgery are kin. Contemporary technologies of cosmetic enhancement arise out of techniques developed in the service of reconstructive surgery (Haiken 2000, Sullivan 2004). While the techniques are similar, the project of reconstructive surgery is often differentiated from the aim of cosmetic surgery.

Specifically, the subject of reconstructive surgery is often characterized as “in (dire) need” of intervention. From this perspective, what makes cosmetic surgery distinct from reconstructive surgery is the ends, *not* the means. By contrast, cosmetic surgery is often distinguished as elective surgery, under the assumption that patients do not need surgery but rather want it. Most sociological and feminist accounts of cosmetic surgery take the ends of reconstructive surgery for granted (Blum 2003, Pitts-Taylor 2007). In

other words, these analyses rely on assumptions about what kinds of faces and bodies need intervention and that the need is self-evident.

Yet, doctors and patients alike may understand elective procedures as “needed,” and of course those with facial difference often “elect” to undergo reconstructive surgery. Clearly, the line between what constitutes reconstruction and what counts as cosmetic is not altogether clear, and this messiness is particularly telling. What distinguishes cosmetic surgery from reconstructive surgery is a taken for granted notion of which faces need intervention. When is it restoration? When is it optimization? When is it both? What are the stakes of claiming that something is restorative or optimizing? How is the project of healing related to the project of optimization?

In the gray area, then, there is the possibility of taking a face that might be deemed unattractive and defining it as disfigured. Given both the significance of the face and the specter of disfigurement, positioning particular faces as disfigured animates the imperative to repair. Thus while cosmetic and reconstructive surgery are technically similar, this project reveals the ways in which these distinctions are deployed with profoundly different consequences. This dissertation takes up sites of intervention, some of which might be alternatively characterized as sites of cosmetic and/or reconstructive surgery. I do not invest in this distinction and instead question the logic upon which this distinction rests.

Given the inordinate amount of scholarly attention paid to cosmetic surgery and beauty in the last several decades, it is interesting that ugliness is relatively unaccounted for. There are some exceptions. In Helen Deutsch and Felicity Nussbaum’s *“Defects”*: *Engendering the Modern Body* (2000), “ugliness as an aesthetic category” is taken up

along with other anomalous bodies. Their text interrogates the cultural work accomplished by monstrosity in the eighteenth century in the service of understanding modern notions of difference, particularly sexual difference. While the text inserts ugliness and disfigurement into the intellectual conversation, it is largely a historical account. There remains much to be said about how disfigurement operates in the contemporary socio-historical moment and how ugliness comes to carry particular consequences, specifically the push to repair, and for whom. By comparison, I situate notions of “ugly” and “disfigured” firmly in the context of 21st-century discourses and practices of *normalization*.

Sites of Facial Repair

I collectively refer to work aimed at repairing the face as “face work.” In Chapter Two, “Face Work: Normalizing Human Faces,” I locate the concept within a theoretical lineage, namely symbolic interactionism. My analysis looks at face work not as an interaction between a medical provider and a patient but as a social practice through which meanings about bodies emerge. Thus, I ask how is disfigurement produced in interaction? As I demonstrate, face work is a multifaceted, complex, and contradictory process wherein the face is technically repaired and what disfigurement means is negotiated. In this way, intervention happens both at the level of how bodies are materially managed/produced and at the level of how bodies are thought and talked about. As a *normalizing* technique, face work relies on the *ideological* links among aesthetics, disability, and technoscience. In other words, technological, cultural, and surgical interventions aimed at facial variance rely on meanings about the significance of

the human face and the costs of disfigurement, and the interventions elicit deep hope about the redemptive effects of science and medicine. The functional imperative in reconstructive surgery is most obviously repairing the human face, but the work accomplished by intervention is not entirely self evident. In her book *Future Face*, Sandra Kemp writes, “Facial surgeons have historically been associated with the restoration of physical appearance as opposed to surgery that saves lives” (2004: 73). Ultimately, I demonstrate the reverse, that repair of the face takes on profound weight, namely the restoration of a disfigured person’s humanity. Put more simply, to be human is to have a face, such that face work is ultimately the work of making the non-human human. In a very real way, face work which is often understood as “just” about appearance takes on the significance of life saving work in the sites in which it is accomplished.

Further, I argue that disfigurement is not simply responded to in sites of intervention. Instead, disfigurement is produced in the very sites constructed towards the eradication of facial variance. While biomedicine treats disfigurement as a bodily configuration that exists “out there,” the operations of biomedicine rely on the continual reproduction of “disfigurement” as a bodily crisis. The reality of “disfigurement” that is situated as the object of intervention cannot be understood outside of the technoculturalmedical sites that deal in aesthetic intervention. Thus even as I write a constructivist account of disfigurement, I do not situate intervention as an unequivocally avoidable response to facial variance. Ironically, perhaps, a critical cultural studies account of the fleshiness of bodies and materiality of the face requires wrestling with the possibilities and promises of technomedical intervention.

At the same time that I critique modes of intervention aimed at disfigurement, I recognize certain facts about face work. Repair of the human face literally saves lives. For example, children with cleft palates are often unable to adequately nurse without surgery to repair the oral gap. In addition, repair is often desired by those at whom the intervention is aimed. By analyzing interventions targeting the face, I do not mean to suggest that intervention is bad or that repair should not exist as a mode of coping; rather I critique face work in order to disentangle the multifaceted work accomplished under the guise of reconstructive surgery. In this way, my work follows Marsha Rosengarten's critique of the technomedical measurement of HIV. She writes, "How is it possible to query the object(s) of matter while contributing to materially necessary interventions? Is it possible to contribute to arresting the virus by not furthering its conceptual stability?" (2005: 72). Similarly, I ask how do we question, and thereby destabilize, a bodily matter while elaborating and understanding potential interventions aimed at reshaping the realities associated with that very bodily matter?

I investigate four sites where surgical and other interventions are employed to repair faces defined and presented as disfigured. While each of the four sites is engaged in the general project of surgical face work, each is distinct enough to provide a basis for generative comparison and rich sociological analysis. In each, the disfigurement varies both in kind and "severity," as well as in the cultural, social, and bioethical responses to the practices. While all four sites rely on surgery as the primary means for re-making disfigured faces, the technical sophistication of procedures used in each site differs as do the risks and consequences. Thus, each site offers a compelling data field in which I

explore constructions of disfigurement, meanings of “vital” and “non-vital,” and the (re)production of cultural definitions and meanings of “human.”

In Chapter Three, “Facing Off: Debating Face Transplantation and Constructing a Disfigurement Imaginary,” I examine an emerging biomedical technology that promises to be a revolutionary intervention for severe facial disfigurement. Face transplantation remains an experimental procedure in which a donor face is surgically removed and replanted on a recipient’s face. The procedure remains highly contested, with research doctors vying to complete a transplant, bioethicists predicting devastating consequences, and a public simultaneously dazzled and horrified by the technology. The debates surrounding face transplantation center on whether or not experimentation should occur. Ultimately, critics’ positions rest on how they conceptualize the significance of facial intervention. Some understand face transplantation as *non-vital* work, that is, work that may not be “lifesaving” per se but that improves the quality of life. Others understand face transplantation as a *vital*, or lifesaving, intervention. I use debates about face transplantation to interrogate the significance of facial disfigurement and to raise questions about how we might understand aesthetic interventions as lifesaving work, given that the side-effects (including death) are framed as acceptable risks for treating facial disfigurement. In addition, *I critically analyze how the work of technological innovation rests on the discursive negotiation of the meaning of facial disfigurement, in particular a disfigurement imaginary that positions disfigurement as a profoundly discrediting condition, one that potentially undermines one’s very humanity.* These ideas inform subsequent chapters in which I take up questions related to other types of face

work. Throughout this project, I continually ask how facial difference determines one's status as a human being.

In Chapter Four, “Not a Pretty Face: Facial Feminization in the Service of Unremarkability,” I explore another set of procedures aimed at “fixing” the face— facial feminization surgery (FFS). In the 1980s and 1990s, reconstructive and cosmetic surgeons developed a set of procedures collectively identified as facial feminization surgery. The procedures are marketed to male-to-female (MTF) transsexuals for the purposes of affecting a “feminine” appearing face. Facial feminization is accomplished through a variety of procedures including but not limited to a brow lift, a trachea shave, a jawline reduction, a chin reduction, and a face and neck lift at a cost of \$20,000 to \$40,000. I compare face work with the work of “fixing” other body parts, in this case genitals, to arrive at a theory about the particular social significance of the face. While faces subject to facial feminizing procedures are not immediately intelligible as “disfigured,” I demonstrate that what counts as disfigurement is contextual. I describe processes through which “the male-to-female transsexual face” is taken apart, both literally and figuratively, resulting in a theory of facial sex difference. Even as “the female face” is described and sought after, I argue that this is an ideal that it is ultimately unattainable through surgery. *I argue that technically repairing the face works to make the MTF face merely “less masculine” or, more precisely, unremarkable.*

In Chapter Five, “Making Faces: Extreme Makeovers and the ‘Reality’ of Disfigurement,” I take on another set of faces that are relatively unremarkable but that are displayed in a spectacular context, the world of reality television. In 2002, ABC pushed the boundaries of television by airing *Extreme Makeover*. In each of the fifty-five

episodes that aired over the course of three seasons, “real-life” people (most often women) moved to Hollywood to begin surgical, exercise, dietary, and other cosmetic regimens to prepare for their “big reveal.” Like the faces subject to facial feminization, the faces of *Extreme Makeover* candidates are not, prior to intervention, disfigured in a taken-for-granted sort of way but are continually framed as disfigured in the context of the television show. *I examine the narrative structure of the show and demonstrate that face work is often conflated with repair of other domains of human life, including economic, emotional, social, bodily, and intimate lives, and how appearance is positioned as the most important facet of our lives.* I then consider what is accomplished via an “extreme” makeover. I analyze what counts as a successful intervention and demonstrate that the erasure of disfigurement is the creation of a new face altogether, a face that does not resemble its former self. I ask what it means to desire the experience of non-recognition.

In Chapter Six, “Saving Face: The Mission of Face Work,” I consider the work of the international not-for-profit organization Operation Smile. First, I consider how “disfigured” children are pictured, talked about, and deployed. Specifically, I consider how children’s lives are described “before” intervention to understand what it means that crafting smiles is positioned as the “after” effect of the face work accomplished by the organization. I question what a smile is in order to understand why it is the most consistently relied upon imagery to describe Operation Smile’s work, and *I argue that the smile is deployed towards the ends of positioning surgery as possessing the capacity to transform miserable children into happy recipients and to grant them a facial expression that is understood as universally human.* Then, I consider the cultural work

accomplished by beautiful celebrity spokespersons, such as Jessica Simpson, on behalf of the organization. I argue that the juxtaposition of uncommon beauty and the grotesque body mobilizes hope and simultaneously reifies the very social context that makes facial difference the tragedy that it is. Based on this analysis, I conclude by questioning how Operation Smile figuratively “works” on disfigurement in ways that infuse disfigured faces with social meaning and positions donors in particular relationships with respect to facial difference. Specifically, I query how face work in the form of “missions” relies on colonialist notions of the relationships between the “first” and “third” worlds, between the global “haves” and the “have-nots.”

Throughout this dissertation, I suggest that dramatic social transformations of the last half-century must be taken into account in any contemporary analysis of facial disfigurement. In the previous half century, an American “makeover” culture has emerged and expanded exponentially. This transformation is detectable in the ever growing consumption of cosmetic surgery (Sullivan 2004) and other aesthetic services, popular culture like F/X’s *Nip/Tuck* and ABC’s *Extreme Makeover* centrally focused on cosmetic surgery, and prevalent discourses which increasingly make “body projects” into moral enterprises (Brumberg 1998). We are, in short, experiencing an “aestheticization of everyday life” (Turner 2001). Consequently, new ways of understanding and contending with disfigurement have emerged. These need to be interrogated to locate and assess meanings of disfigurement in this socio-historical moment.

Based on the four cases I analyze, I make several arguments about the meaning of attempts to repair faces defined as disfigured and implicitly about the significance of the face, and facial disfigurement. I show that interventions are embedded in systems of

logic. In order to justify interventions, facts must be employed in the service of diagnosing and making meaning out of those diagnoses. In this way, interventions cannot be taken for granted. Interventions rely on truth claims (Aronson 1984), and in order to make sense of these interventions we must query the truth claims upon which interventions rely. I argue that the fundamental truth claim upon which face work is based is that *disfigurement is inevitably a tragedy*, a threat to human existence. Thus, I show that the specter of disfigurement, specifically the idea that human life is not possible without a “normal” visage, lends itself to an imperative to repair. Repair is not a mode of coping, rather it is conceived of as an inevitable response; it is an assumed mode of being.

I conclude this thesis by asking what are the consequences of this particular arrangement, in which repair equals normalization? Instead of ending with a prescriptive or prohibitive conclusion about face work, I analyze and critique a different response to face work, namely the rejection by bioethicists and medical sociologists of technoscientific solutions to disfigurement. I consider the logic upon which calls for non-intervention rest and suggest that resisting medical intervention is an unsatisfactory response. But so, too, is the coercive imperative to repair. In part, I reject non-intervention as a solution because of the immense hope invested in face work, as illustrated in Lucy Grealy’s profoundly moving memoir. What does it mean that repairing the face is constructed as a lifesaving intervention? In a new century characterized by widespread aestheticization, what does the conflation of facial appearance and “life itself” mean? Finally, I step back and reframe the work accomplished in these sites as work aimed at making faces not only not disfigured, but

also “not ugly.” I make this distinction in order to connect the work accomplished in these specialized, expensive, labor-intensive, mediagenic sites with the aesthetic body projects accomplished by all of us in our everyday lives.

Epistemologies, Methodologies, and Reflections on the Writer’s Face

Epistemologies, Methodologies, and Methods

We bury strange things in landfills—syringes dripping insulin, toenail clippings, old credit cards, and sometimes, dead bodies. Of course, there are mundane things too—junk mail, orange peelings, cotton balls, and expired coupons. If we tried to separate our trash into clear categories, we would be hard-pressed to do so. Unlike the paper, plastic, metal, and glass of our recycling, our trash is hard to separate into easily distinguishable groupings—Are cotton balls paper? What if they are saturated with human blood? Then are cotton balls medical waste? Without a doubt, landfills are a mess. They are composed of a conglomeration of waste—human waste, food waste, chemical waste, paper waste, etc. And yet each item in a landfill tells us something about who we are (Alexander 1993; Rathje and Murphy 1992).

My thesis is an archeological project in the sense that I am attempting to make sense of messy, muddled, and disordered data. I draw on multiple, varied kinds of information to understand work aimed at repairing facial disfigurement. The landfill is an excavation nightmare, but taking each piece of garbage into account is incredibly revealing. Likewise, this project is empirically messy, but in the end, I produce an account that examines how facial repair operates as a biomedical technology, as a

meaning making intervention, as a cultural product, and as a discursive operation for the production of the category human. This work is based on four cases, and in my analysis of each I draw on multiple sources of data. While on its own, each piece demonstrates something about the significance of facial repair, taken together the data explored here allows for “thick analyses” (Fosket 2002:40).

I situate myself epistemologically in constructivist, postmodern, feminist perspectives and use various analytic perspectives including grounded theory and situational analysis in order to theorize disfigurement and repair. Likewise, I employ multiple methods—multi-sited ethnography, interviewing, content analysis—and rely on varying kinds of data—television shows, professional journals, websites, conferences, conversations, and consultations. I analyze my data—fieldnotes, interview transcripts, texts—using qualitative methods of data analysis (Clarke 2005). From one perspective, then, this dissertation bastardizes carefully conceived methods. From another perspective, this approach—perhaps best termed multi-sited ethnography (Marcus 1998; Rapp 1999)—employs methodologies as tools rather than as formalist procedures. As Foucault has suggested, ““All my books... are little tool boxes. If people want to open them, to use a particular sentence, a particular idea, a particular analysis like a screwdriver or a spanner... so much the better!”” (Foucault in Lindsay Prior 1997: 77). I intend this cobbling of method as a tribute rather than as a form of intellectual trespass.

Telling a critical story of face transplantation requires entering the sites in which face transplantation is taking shape. This means entering the medical-technological complex and becoming acquainted with the key figures working towards solidifying this technology in the making. For my chapter on face transplantation, I rely on fieldwork

conducted at weekly meetings of a U.S. based face transplant team, along with interviews with key team members to critically analyze how, in this case, the work of technological innovation rests on the discursive negotiations of the meanings of facial disfigurement. In addition, I employ content analysis of a 2004 issue of *The American Journal of Bioethics*, in which medical researchers, surgeons, bioethicists, and psychologists considered and debated the issue of face transplantation. Through content analysis of the *AJOB* exchange, I highlight the terms of contestation.

For my chapter on *Extreme Makeover*, analysis is based on observations collected while viewing 30 episodes chosen at random. In my fieldnotes, I chronicle the show as it unfolds for television viewers, emphasizing the narrative turns upon which each episode relies. In short, I trace the narrative arc embedded in each episode and query this pattern to interrogate what kind of storytelling the show accomplishes. Specifically, how does the series position disfigurement and cosmetic intervention?

Accessing facial feminization requires entering sub-cultural spaces. I base my analysis of facial feminization surgery on fieldnotes collected at seminars held during two of the largest transgender conferences in the world—Southern Comfort and the International Foundation for Gender Education Conference. At each conference, the four facial feminization surgeons currently practicing in the United States presented information sessions to potential facial feminization consumers. This allowed me to observe each surgeon in two different settings. In addition, I analyze the materials—pamphlets, journal articles, and promotional materials—distributed to attendees during these seminars.

My analysis of Operation Smile is based on content analysis of recent news coverage about the organization's work around the world. While news media works to convey "the facts," media also does the work of transmitting cultural hopes and fears about new technological, and in this case philanthropic, interventions. Using LexisNexis Academic, I gathered newspaper accounts from English international and national publications that discussed the work of Operation Smile starting in 2005 and throughout 2007. Based on analysis of 132 articles, I analyze the work of the organization. In addition, I consider how the organization represents its work on its website, particularly focusing on the deployment of celebrity spokespersons throughout the organization's own site.

Throughout the dissertation, I include artifacts from each site. In some cases, I reproduce excerpted text from written materials. Most often, I insert images of disfigurement or repair that circulate in each site. Cultural theorists including Walter Benjamin, Stuart Hall, and Barbara Maria Stafford theorize the postmodern era as an "empire of images" (Bordo 2003). This is a socio-historical moment in which the aesthetic is deployed in the service of cultural, political, and technoscientific work. As art historian Stafford contends in her analysis of the Enlightenment-era emergence of "visualization of knowledge," our ways of understanding the body are mediated through metaphor and imagery (1991). Understanding why we intervene in bodily difference in the ways we do demands comprehension of the images that circulate in the service of intervention. I reproduce, describe, and assess images of disfigurement and repair that feature prominently in each of the cases under review, and I examine the rhetorical work accomplished by such artifacts. Images are increasingly important to analyses of

medicine, science, and technology. Many scholars have argued that with the proliferation of imaging technologies like ultrasound and computerized tomography (CT) scan, visual images are central actors in the making of science (Aronowitz et al. 1996; Downey and Dumit 1997). Things, including images of faces, “talk” (Daston 2004). One central task of this project is to ask what images of disfigured faces and repair are saying, and to whom. Thus, the data upon which I base my argument includes not only the words transmitted in meetings and interviews and the prose of promotional materials, websites, and academic journals, but also the visual artifacts that constitute another means of knowing disfigurement. I include pictures of “disfigurement” not to capitalize on the spectacle, but rather to ask how knowledge about disfigurement is created and authority to intervene established through the deployment of images of disfigured faces.

I also insert brief pieces of experimental writing, along with stories about my own experiences in the sites I study. These are offered in an attempt to capture the affective experience of research. I outline the narrative structure of *Extreme Makeover* but to understand the work accomplished by the cultural medium, one must also think about the emotional responses elicited by watching the show. I describe the seminars in which facial feminization surgeons outline surgical techniques, but stories about conference attendees’ responses to my own appearance are useful for understanding the ways in which people are compelled to consume expensive and painful surgery. Storytelling and creative non-fiction are sometimes effective means for conveying ideas, and I do not hesitate to employ these genres here.

Research guided from postmodern perspectives, like my own, looks very different than that which might emerge from positivist, realist epistemologies. First and foremost,

I work from the assumption that all knowledge is partial or situated (Haraway 1988). In other words, all knowledge is shaped by a particular perspective and orientation to the world and by social location. No group will be able to tell the “Truth” about facial disfigurement. Rather, I use each site to create a story of repair that represents multiple standpoints (Hill-Collins 1990; Harding 1991; Hartsock 1983; Smith 1989). Particular standpoints may complement, contradict, or complicate other standpoints, but my intention is to create a story that highlights these tensions in the service of theory rather than a crafted narrative that glosses over differences in favor of a unified account.

It follows, then, that I understand my own project as a critical representation of facial repair as opposed to a definitive description of reconstructive interventions. While some sociologists might critique such a project for not attempting to create a generalizable social science account, work inspired by feminist and postmodern theories recognizes the “crisis of representation” or the problematics of constructing an account that claims authority (Rosaldo 1989). At the same time, I acknowledge the power a scholarly representation might have over other versions of the story. In the end, I position my own version as a complex, multi-layered, grounded theory about facial repair. Second, I emphasize both human agency and structural constraints. As a project with methodological ties to grounded theory, I am interested in human action and the ways in which actors shape their social locations. Situational analysis allows me to locate human action in broader situations (Clarke 2005). In this sense, I am attentive to the ways in which discursive formations, historical conventions, and institutional regulations influence human action.

This work is conceived as a volley to both sociology and disability studies to seriously take up the experience of disfigurement, a bodily experience and social status that is surprisingly overlooked in social theory. And yet, inquiries into facial disfigurement reveal much about who we are, what we fear, and how we recover—and even about who “we” may be. Disfigurement is also a significant sociological topic of inquiry for altogether different reasons. Interrogating appearance is critically important because beauty and ugliness determine status in fundamental ways. It is a wonder that a discipline premised on accounting for difference and devaluation does little work towards understanding how appearance matters. Sociologists analyze the practices aimed towards producing beauty (most obviously cosmetic surgery) and theorize these as deeply gendered practices, but do not query ugliness. We acknowledge that research indicates that those who are more attractive fare better in the world, but we have not developed lines of inquiry directed at dismantling aesthetic structures of inequality. This is a project about what people look like, but it is not sociological fluff. It is a first attempt to account for how appearance, specifically ugliness, matters in critical ways.

Self Reflections

How I position myself in relation to my research is inspired by feminist and queer theory along with disability studies, interdisciplinary fields that emerge from remarkably similar epistemological locations. In each field, difference and devaluation relative to gender, sexuality, or the body is redefined, reformulated, and recovered. All are politically motivated intellectual projects. These are critical theories of the world, knowledge bases aimed at social practice. Put more simply, the point is not simply to

understand but to transform. In addition, these areas of inquiry have traditionally celebrated self definition and, by extension, theorizing from the female, queer, or disabled subject position. As a consequence, writing what we are not remains a suspect practice.

And so there is no way around the question of my own face. I am not disfigured in many senses of the word. My own face is what most would call unremarkable. It is, for the most part, seen and unnoticed by others. I have been called ugly more than once. But this insult has been hurled at me most often in instances in which I refused to conform to the expectations of a stranger or a girlfriend or a mother. It is the word that has been used against me when I stopped to help a woman whose boyfriend accosted her on her way onto campus, screaming and shaking her. It is the word used by a drunk lover on our way home from nights that started good and ended badly. It is the word that my mother desperately regrets using when as a teenager I would leave the house dressed provocatively, unconventionally. Leaving aside the question of why ugliness works as the ultimate insult, I *can* claim to know and understand what it means to be temporarily devastated by another's insistence that what I look like is not good enough or unattractive and even repulsive. And I can claim to know what it means to hear those words and to take them in, to have the experience of seeing one's self inexorably determined by the worst things you have ever heard about yourself. I think that most of us know the feeling of momentarily glancing in the mirror only to be disgusted with our own reflection. But as Margo Jefferson in a *New York Times* review of Lucy Grealy's *Autobiography of a Face* writes, "Suffering is exact. Each kind has its own weight and measure. Fearing you are ugly is not the same as knowing you are."

Despite my own tenuous relationship with ugliness, I cannot and do not make claims about “knowing” disfigurement in any profoundly personal way. And yet, I dare to speak of it. I am a cautious though not timid speaker, and so I make claims on knowing disfigurement in some very real ways. I know disfigurement as a cultural specter in the ways that we all do. Many claim that they have never seen someone who is disfigured. This is doubtful. But whether or not we encounter disfigurement in the mundane acts of everyday life, we certainly encounter disfigurement in popular culture, in spaces of religion and spirituality, in literature, in visual art, and in science. We are, as of this writing, at war for the fifth year, with some 27,000 injured veterans. We encounter disfigurement, and I would argue, routinely produce disfigurement as part of our war work.

I know disfigurement as a work object. In her account of fetal surgery, sociologist Monica Casper (1998) describes the work object as “any material entity around which people make meaning and organize their work practices” (19). Through this project, disfigurement has taken shape for me as a work object of biomedical intervention. When I speak about disfigurement as an object of repair, I speak as some kind of authority. I have empirically investigated the ways in which disfigurement takes shape in surgical wards, in philanthropic literature, in bioethics debates, and in popular culture, and I claim to know something about the ways disfigurement is imbued with significance in sites that aim to fix faces defined as different.

And yet I know disfigurement also as a politically tricky subject. How we speak of disfigurement is constitutive of the ways we think about, respond to, manage, and represent disfigurement, and so I am cautious about how I speak of disfigurement in this

work. Disability studies has done much to demonstrate how tropes about disability infuse discursive formations and social practices (Longmore 1997). One common response when speaking of bodily difference has been to resist the trope of tragedy that so often surrounds disability. This has been a critical move towards recovering the lives of people with disability from a monolithic story of suffering and the imperative to overcome. But then *what of suffering?* Though politically problematic to acknowledge, can we not agree that there is real suffering that is experienced and attributable to our bodies?

I do not mean to suggest that disfigurement and suffering are the same thing. Essentializing narratives of disability imagine that there is nothing to disability outside of suffering, and this is certainly an inadequate account. But there is also a phenomenological account of disability that acknowledges that suffering is experienced by all of us as a condition of embodiment, and yet that this suffering is not wholly constitutive of our human experience. There is then the possibility of speaking of the suffering that comes with disfigurement without producing a totalizing narrative of disfigurement. If we are to acknowledge suffering, which we must do if we seek to capture and represent a broad range of human experience, we must deploy narratives of suffering in the service of political and social change rather than cultural stagnation. Stories of suffering must be told, but they must not be told in order to confirm that what we are already doing and how we are already thinking is all that can be done and thought. If we speak of suffering, let us come to know how suffering itself and stories of suffering activate particular patterns of response, relationships, and thought, and let us ask if these patterns alleviate or reify suffering. Talk about suffering that is couched in terms of pity is never in the service of those suffering but rather in the service of voicing the feeling, be

it guilt or pleasure, in the experience of pitying another. Let us speak of suffering in the service of alleviating suffering. There is no pity here.

CHAPTER II

FACE WORK: NORMALIZING HUMAN FACES

“Face, of course, is a metaphor. But it is a very powerful metaphor.”

Thomas Holtgraves (1992: 156)

Representations of Disfigurement/Images of Face Work

1. Beside an MSNBC news feature entitled “Face Transplant Woman Battled Tissue Rejection” announcing the “success” of the world’s first face transplant, a single photograph was featured:



Figure 1. Surgeons at Work on Face Transplant

The photograph of surgeons at work, as opposed to a “face transplant woman” as the title suggests, was accompanied by the

following caption: "French surgeons performed a partial face transplant operation on a 38-year old woman at Amiens hospital, northern France on Dec. 2."⁶

2. From a story entitled "Jessica Simpson in Kenya" featured on the Operation Smile website:

"Operation Smile has been honored to have Jessica Simpson serve as its International Youth Ambassador since 2003 when her good friend and hairstylist, Ken Pavés introduced her to the organization. Helping to spread awareness for the organization, Ms. Simpson has performed at Operation Smile's Los Angeles Gala in 2003 and gave a benefit concert as part of NBC's reality hit, "The Apprentice," in front of a packed house at the Trump Taj Mahal in Atlantic City... During the Kenya medical mission, Ms. Simpson witnessed the medical volunteers' skills first-hand by donning scrubs and joining Operation Smile co-founder, Dr. Bill Magee and the surgical team in the operating room. Simpson also formed a special bond with one child, 1-1/2-year-old Boke whose father had sold one of his six cows, his only source of income, for money to travel 12 hours in the hopes of receiving surgery for his little girl. Simpson saw Boke through her evaluation and surgery - she comforted Boke as she was put under anesthesia, and then delivered her back to her father after her recovery."⁷

3. From *Vanilla Sky*

⁶ <<http://www.msnbc.msn.com/id/10906232/>>

⁷ <http://www.operationsmile.org/aboutus/spokespeople/jessica_simpson/>

David (Tom Cruise) meets with a team of doctors to discuss options for coping with his facial scarring following a car accident.)

Dr. Pomeranz: We're not cowboys. We can't just wing it...And there are things that we'll continue to investigate. However, there are so many others who've not had the aesthetic benefit of plastic surgery as you have.

David: This isn't about vanity, Dr. Pomeranz. This isn't about vanity. This is about functioning in the world. It's my job to be out there functioning. I've got the money. I'll pay any amount. Just invent something. Just play jazz. You say you're the best face man in New York. Fucking prove it..

Dr. Pomeranz: Nobody here takes your feelings for granted. We did prepare something for you based on the preliminary examination.

David: Tell me. Bring it on.

Dr. Pomeranz: It's sometimes useful in the early stages of rejection. It's a facial prosthetic. It was two weeks in the making..

David: A facial prosthetic.

Dr. Pomeranz: The aesthetic replacement does work—emotionally and actually...It's a helpful unit.

David: Good. Because for a minute there, I thought we were talking about a fucking mask!

Other Doctor: It's only a mask if you treat it that way.

The preceding are stories about facial disfigurement.

Simultaneously, these are stories about surgeons and celebrities, each working, in their own way, in the service of *repairing* the human face. The resolution in stories about the "tragedy" of facial difference is almost always facilitated by a cadre of devoted face workers. In this historical socio-technical moment, in the early years of the twenty-first century, can we tell a story of disfigurement without [a story] privileging repair?

Recovering Face Work

One of the few places in sociology where the face has been explored theoretically is the work of symbolic interactionist Erving Goffman. My project is, in part, a contemporary reexamination and rearticulation of Goffman's theoretical work. I consider

the relationship between bodily stigma and repair by taking up Goffman's concept of face-work and his astute analysis of stigma as a social project. Goffman approaches face-work as a technique of interaction focused on saving metaphorical face, specifically the version of self projected in social encounters. I expand the notion of face work to consider the social, cultural, and technical interventions aimed at saving material, that is, corporeal, faces.⁸ While Goffman elaborates the significance of stigma in the context of social interaction and the interpersonal strategies employed to restore one's social self, I examine technological, surgical, and cultural responses to bodily stigma, specifically disfigurement, in a range of contexts to understand how the imperative to repair relies upon the ongoing construction of stigma. In this way, I complicate notions of repair as simply the recovery from a stigma, and instead, I examine and reveal the contradictory social processes implicit in technical projects of recovery.

Symbolic interactionism understands social interaction as processes of meaning making and negotiation in which our sociality, in essence our very humanity, is constituted (Mead 1934; Blumer 1969). Goffman's "On Face-Work: An Analysis of Ritual Elements in Social Interaction" first appeared in 1955 in *Psychiatry: Journal for the Study of Interpersonal Processes*, and the piece marked Goffman's initial foray into mundane facets of social interaction. Its reprint in Goffman's *Interaction Ritual* (1967) introduced to sociology the study of face-to-face interaction. In Goffman's social theory,

⁸ Goffman uses a hyphen when discussing face-work. In innovating the concept, I omit the hyphen. When the term appears hyphenated, I am making reference to Goffman's ideas. When the word appears unhyphenated, I am extending the concept towards my own theoretical ends.

the face circulates as a metaphor for self-image, as a possible marker of stigma, and as a central component of human interaction. Goffman's concepts of face and face-work are analytical devices that capture how practices of everyday social life are constitutive of lived realities.

Goffman's notion of face follows a theoretical lineage well established in symbolic interactionism wherein sociality is conceptualized through metaphors of the body generally and reflection more specifically. Most importantly, Charles Cooley's (1902) theory of the "looking glass self" established a framework for thinking about the relationship between the self, and by implication the body, and others. For Cooley, the looking glass self describes a process wherein individuals constitute a sense of self through other's responses, opinions, and feedback. It is a process that relies on reflection, through which a sense of self emerges in relation to community. In this way, individuals incorporate a sense of self thoroughly determined through others via social interaction. Goffman's theory of face-work is an extension of this very premise, and provides a more elaborated way of thinking about how self and society are formed in concert.

Face is understood as "an image of self delineated in terms of approved social attributes" (1967: 5). In other words, symbolic face is the projection of the self as it is deployed in social interaction. For Goffman, face is not inherent to an individual. It emerges through collaboration in the sense that others respond to and, in the process, affirm the face of others. Face is "on loan to him [sic] from society" (10). The threat of "losing face" demands ongoing attempts to "save face." Face-work describes "the actions taken by a person to make whatever he is doing consistent with face" (12). It is the social action aimed towards maintaining face. For Goffman, social actors engage in

reciprocal face-work to affirm both one's own face *and* others' faces. In this way, the maintenance of a social situation relies on "tacit cooperation" aimed at preserving the self-image and the face of others in a social interaction.

Through face-work, humans continually constitute self-image and social identities. In this way, "maintenance of face is *a condition of interaction*, not its objective" (*my emphasis*, 12). Face-work is strategic. Maintaining face relies on processes of avoidance, defensive measures (avoiding topics and activities) and protective maneuvers (employing discretion and deception), along with corrective processes (fixing threats to face). Face-work involves calculation and social cunning, but it is not (necessarily) manipulative work (Manning 1992). For Goffman, mundane social interaction is a deliberative ritual and practice not in the service of personal gain, but rather in the service of the interaction itself. Without face-work, social interaction falls apart.

While Goffman's work on stigma and dramaturgy retains sociological currency, Goffman's concepts of face and face-work are all but forgotten in sociology. In several sociological surveys of Goffman's theoretical contributions, face and face-work are surprisingly absent (Burns 1991, Smith 1999, West 1996). Contemporarily, Goffman's concepts of face and face-work are taken up in linguistics, specifically in politeness theory. Brown and Levinson's classic work on politeness (1987) relies on both Goffman and Durkheim, but specifically on Goffman's concepts of face and face-work. While Goffman's notion of face is a distinctly social concept, Brown and Levinson's focus on Face Threatening Acts (FTAs) puts a distinctly individualistic twist on the concept. Rather than emphasizing face-work as an ongoing practice central to the creation of

social reality, they understand face-work as a strategy deployed by *individuals* in the service of politeness.

In a recent re-examination of Goffman's contribution to linguistics, Francesca Bargiela-Chiappini (2003) argues that Brown and Levinson dilute Goffman's concepts. Rather than dispensing with face and face-work, Bargiela-Chiappini offers a sustained discussion of face and face-work and argues that the concepts demonstrate the "fundamental role" of politeness in creating social order (1453). In the spirit of Bargiela-Chiappini's recovery of Goffman, other linguists and communication researchers continue to engage Goffman's work (Heisler et al. 2003, Merkin 2006a, 2006b). Scholars have also employed face and face-work to examine such varied phenomena as divination (Wyllie 1970), pornography (MacCannell 1989), presidential billboards (Kusa 2005), and health care professionals' management of risk (Myers 2003). These extensions of Goffman's analysis of face and face-work tend to frame face-work as simply a communicative process rather than a fundamental reality-generating practice. For example, Holtgraves (1992) elaborates a "face management theory of language" to account for how linguistic communication facilitates the projection of identity and impression management, and cross-cultural (mis)communication.

Most contemporary examinations of face-work approach communication as a disembodied practice. While Goffman relies on the "face" as a metaphorical concept and a symbol, I argue that face-work is also a deeply embodied process enacted through expression and articulation. Not coincidentally, Goffman uses the word *face*, as opposed to any other part of the human body, to connote the public self. Social interaction relies on the human face. The face functions as a mechanism of communication. Articulation

of language is made possible by facial structures, most obviously the mouth, and eyes, brows, and cheeks to facilitate non-verbal communication. In addition, faces distinguish one person from another. Recognition is made possible largely by the human face which we think of like a fingerprint—each might resemble another, but no two are *exactly* the same. It is the face, thus, that acts as a referent in symbolic interactionism for the display and conveyance of public self-image.

My work moves beyond Goffman's analysis by challenging the idea that "the person's face clearly is something that is not lodged in or on his body, but rather something that is diffusely located in the flow of events in the encounter," in other words in the interaction order (Goffman 1967: 7). While Goffman's work does not explicitly engage face-work as an embodied process, face-work is made possible by a human body in a social encounter.⁹ The face is not merely a rhetorical device; rather, the material face plays a central role in interaction rituals. Even Goffman makes passing reference to the role of the body: "One objective in dealing with these data is to describe the natural units of interaction built up from them, beginning with the littlest—for example, the fleeting facial move an individual can make in the game of expressing his alignment to what is happening" (1). My work frames the symbolic processes elaborated in Goffman's interactionism as simultaneously a material social process forged through the negotiation of a human body and language.

The face work identified, described, and analyzed in this account of facial surgery is a variation on the face-work that operates in Goffman's theory of interaction ritual. At

⁹ Others have explored the sociology of the body implicit in Goffman's work (Gardner and Gronfein 2006, Waskul and Vannini 2006).

their core, both “face-work” and face work are attempts to explain processes through which public selves are constructed. Goffman is interested in the creation and maintenance of “face,” a metaphorical representation of identity, whereas I am interested in technical interventions aimed at deciphering, diagnosing, transforming, and creating human faces. In both cases, what is at stake is the social self or, in other words, one’s status as a human being, a legitimate member of the collective. In this way, the objective of face work is always the construction of a self and the subsequent reality afforded to those designated appropriate social beings, human beings. My articulation of face work directly follows Goffman’s examination of face-work in multiple other ways. Both accounts understand the process as a collaborative venture, as a ritual, as a process of generation and recovery.

First, face-work is a collaborative process that involves multiple social actors who together are invested in the maintenance of face. In the social interactions Goffman describes, social actors engage in face-work to create and maintain their respective faces. This is ongoing work in social interaction, but face work is also an implicit process in social interaction without which a shared reality breaks down. Goffman argues that face is a condition for interaction; thus, everyone embedded in an interaction is invested in each other’s face. Social interaction is a collective undertaking, but the face work that operates in my account, specifically the repair of the human face, is a cooperative endeavor, as well. Multiple social actors (human and non-human) including surgeons, patients, popular culture, technologically generated images, bioethicists, plastic polymers, news media, anti-rejection medication, and cultural narratives about the face come together to infuse face work with meaning, in short making repair of the face carry

symbolically the particular significance that it does. Thus, the project of face work is accomplished literally and symbolically in collaboration. Neither the surgeon with her technical skill nor the patient with his desire for a different appearance accomplishes face work in isolation. Face work only becomes what it is in the give and take among social actors.

*Second, Goffman, drawing on Durkheim, understands face-work as an interaction ritual.*¹⁰ Goffman understands the self as a sacred entity forged through social interaction. Given what is at stake in interaction, ritualistic respect is required in order to maintain social order and to forge a collective consciousness (Trevino 2003). Face work aimed towards repairing the human face is imbued with the sacred. Because the face is imagined as so essential to making us who we are and to facilitating everyday life, the repair of the human face is approached as sacred work. In several sites, the work is described as a “mission,” a designation that relies on religious overtones. But it is not simply that the language used to characterize face work relies on invocations of revered imagery. Ritual is ultimately oriented towards solidification of the social order. Face work aimed at repairing the face is ultimately aimed towards restoring humans to “basic working order” (Spelman 2002). This process of repair is not simply about giving those with facial variance a new face and a new life, but rather about facilitating social solidarity. Because facial difference animates social anxiety about the body, repairing facial difference is a project accomplished on behalf of all of society towards the goal of solidifying social order.

¹⁰ For Durkheim (1965), ritual refers to the sets of practices imbued with sacred meaning that societies engage in towards the creation of solidarity.

Third, Goffman's discussion of face-work describes the strategies through which one maintains social interaction. Avoidance practices aimed at stabilizing social interaction are productive processes that generate social order. Corrective processes or attempts to “save face” in response to what threatens to destroy the face are practices of repair wherein the social interaction is recovered. In large part, face-work accomplishes the work of generating a shared reality for interaction participants *and* repairing the interaction order in response to potential threats. Similarly, the material face work I describe is aimed towards generating a certain reality. In particular, face work produces human bodies that correspond to shared notions about what faces should look like and how they should act. In this normalizing process, face work affirms what constitutes a “real” (i.e., normal) human face and what visages are not acceptable faces. The material face work practiced in the spaces within which this project unfolds is deployed, then, as a technique of recovery and repair. Face work aims to transform a “disfigured” face into an unremarkable—read: acceptable—appearance. In this way, face work is accomplished in the service of normalization.

Goffman's face-work is obviously an intrinsically social process, one that all human interaction relies upon. It is a communicative practice in which face (the positively valued facets of the social self) is negotiated and maintained. By contrast, the face work that circulates in this account is a material and symbolic practice in which the human face is negotiated through diagnosis, intervention, and representation. What is at stake in both Goffman's face-work and my own articulation of face work is the social self. In short, both are processes through which human beings come into (re)formation. I use the term “face work” not simply to describe the technical intervention accomplished

in each of the four sites I analyze, but rather to capture the larger project of human face repair. I interrogate face work as technical work, cultural work, and social work that crafts a new visage, infuses this work with meaning, and, in the process, constructs a notion of what it means to be human.

Retrieving Stigma

Whereas Goffman's discussion of face-work is relatively neglected in sociology, stigma, another Goffmanian invention, is continually taken up, most often in the sociology of deviance. In a 2001 *Annual Review of Sociology* essay "Conceptualizing Stigma," Bruce G. Link and Jo C. Phelan write,

The stigma concept is applied to literally scores of circumstances ranging from urinary incontinence (Sheldon & Caldwell 1994) to exotic dancing (Lewis 1998) to leprosy (Opala & Boillot 1996), cancer (Fife & Wright 2000), and mental illness (Angermeyer & Matschinger 1994, Corrigan & Penn 1999, Phelan et al 2000). It is used to explain some of the social vagaries of being unemployed (Walsgrove 1987), to show how welfare stigma can lead to the perpetuation of welfare use (Page 1984), and to provide an understanding of situations faced by wheelchair users (Cahill & Eggleston 1995), stepparents (Coleman et al 1996), debtors (Davis 1998), and mothers who are lesbian (Causey & Duran-Aydintug 1997).

Stigma retains theoretical utility even outside sociology, most notably in disability studies, an emerging interdisciplinary field that interrogates how social contexts determine what disability means and how these meanings determine the shapes human lives take. Through cultural analysis and social critique, disability studies interrogates how stigma translates into discreditation, devaluation, and marginalization, in short, dehumanization.

In Goffman's approximation (1963), a stigma is "an attribute that is deeply discrediting within a particular social interaction." Stigmas may take one of three forms.

“Blemishes of individual character” are those attributes like personality characteristics and personal faults that result in stigmatization. “Tribal stigma” describes those stigmas related to group membership including race, nationality, and religion. “Abominations of the body” are those stigmas related to the physical body. A stigma is not simply an undesirable attribute, but one with significant consequences in everyday life. Goffman writes, “By definition, of course, we believe *the person with a stigma is not quite human*. On this assumption we exercise varieties of discrimination, through which we effectively, if often unthinkingly, reduce his life chances...” (*my emphasis*, 5). Through social interaction, stigma is negotiated and made real, in some cases resulting in the discrediting of one’s very humanity and thus membership in the collective.

Goffman dissects social interaction to understand how the stigmatized person manages social situations and how others, who Goffman terms “normals,” respond to stigma. According to Goffman, the stigmatized constantly anticipate and react to what normals think about and how normals respond to stigma, employing self-isolation, avoidance, depression, hostility, and defensiveness to navigate social interaction. While Goffman describes normals’ awkwardness in the face of stigma, the theoretical emphasis is on how the *stigmatized* manage social interactions. What remains less clear is how “normals” respond to ever-present stigma. Specifically, how do so-called normals cope with “abominations of the body,” visible markers of difference that abound in everyday life? If social reality is the result of collaborative interaction, what realities do normals make possible for those with facial difference? And most importantly for this project, how is face work deployed in the service of managing stigma?

Within Goffman's theoretical project, while face-work is a concept used to describe the workings of the interaction order, stigma is a concept that captures the relative value of human characteristics and behaviors. These concepts remain distinct in Goffman's own work, but they are interrelated concepts. For Goffman, face-work is often aimed towards recovering a potential threat to face. Stigma is one potential source of threat. Thus, one way of approaching face work is to consider it as *a technique of social interaction, a material practice that serves as a mechanism for coping with bodily stigma*. As a practice, face work relies on processes of transformation. The threat to face is neutralized; the contentious social interaction is reordered. Appearance is transformed; facial difference is made unremarkable. But what is threat to face or stigma transformed to? The face work in my account is not simply a mechanism of transformation, but rather principally a technique of normalization.

Face Work as Normalization

With modernity, abnormality emerges. Lennard Davis (1995) situates the emergence of the word "normal" around 1840 and its modern usage in 1855. New modes of production and governance demanded a new way of classifying, managing, and controlling modern citizens. Thus, a new point of reference emerged in addition to the "ideal." Aided by modern statistics, specifically Adolphe Quetelet's normal curve, human characteristics were measured and plotted as never before, and in turn, the "average man" [sic] is born. In effect, the mean becomes the point of reference by which human variation is judged (Ravard and Stiker 2001). Modernity bears witness to new ways for relating to the human body such that the body, as opposed to the mind or the

spirit, comes to differentiate human beings from one another. The normal body, a fictive collection of averages, becomes the reference point for constructing subjectivity and national identities. The aggregate is born.

But normalcy itself is shifting category, historically constituted and determined largely through ideological investments. In his first volume of *The History of Sexuality*, Michel Foucault (1990) argues that modern nation states survey, regulate, and control entire populations through the production and disciplining of human bodies. Central to Foucault's understanding of the operations of the state is biopower. Via biopower, "an explosion of numerous and diverse techniques for achieving the subjugations of bodies and the control of populations," regulation emerges (140). Biopower is a disciplinary power deployed by experts, often medical professionals, in an institutional, often clinical, encounter. As a technology of power, biopower relies on systems of categorization organized around the distinction between the normal and the abnormal. As Deborah Lupton writes,

The central strategies of disciplinary power are observation, examination, measurement and the comparison of individuals against an established norm, bringing them into a field of visibility. It is exercised not primarily through direct coercion or violence (although it must be emphasized that these strategies are still used from time to time), but rather through persuading its subjects that *certain ways of behaving and thinking are appropriate* for them (*my emphasis*, Lupton 1997: 99).

In short, the "average" works as the point of reference for intervention and the subsequent control of human bodies. In this way, techniques of biopower incite normalization. The process becomes one of intervening for the sake of making modern persons as much like the mythic norm, and in the process as much like one another, as is possible.

Foucault's fascination with the regulation of human bodies through notions of normalcy was largely shaped by the work of Georges Canguilhem (1991). In *The Normal and the Pathological*, Canguilhem queries what constitutes normalcy and how the normal and the pathological operate through medicine and science. For Canguilhem, the pathological is given meaning through some notion of normalcy. Put another way, the normal has no intrinsic meaning separate and apart from the context in which it emerges. In other words, normalcy does not correspond to any static or predetermined way of being. Although normalcy may have a sort of taken for grantedness, it is constructed, negotiated, and manufactured through social practice, specifically operations of science and medicine. At the same time normalcy is deployed in taken for granted albeit coercive ways.

Through "micro-systems of social regulation" facilitated by the medical gaze, the body is socially constructed and discursively produced within the bounds of normalcy. Pathology is regulated. For example, medicine becomes not simply the work of saving and prolonging life but also intervention accomplished in the service of normalization (Foucault 1999). As Deborah Lupton drawing on Nicholas Rose writes,

Medicine and health have become central to the notion of the 'normal' person because, in part, medicine: 'has come to link the ethical question of how we should behave to the scientific question of who we truly are and what our nature is as human beings, as life forms in a living system, as simultaneously unique individuals and constituents of a population' (Rose 1994: 67-8) (1997: 100).

Normalization facilitated through medical intervention depends upon notions about what constitutes an acceptable and recognizable human being. Face work, I argue, is the work of inscribing or cultivating these bodily norms.

The narrative surrounding face work is about making the grotesque unremarkable, the abject less abhorrent, and the pathological more normal. Unlike cosmetic surgery that aims (often unsuccessfully) to make the average body extraordinary and beautiful, face work is a technique of normalization aimed to transform aberration into something ordinary. In this way, face work is centrally about minimizing human aesthetic variation, and it is also about making that which borders on the non-human, human. But what distinguishes a human body from a non-human body (Haraway 1990)? Particular bodily norms become reified as facts about what constitutes a human body. To carry the distinction of human, a body must be sexed and raced (though how sex and race might be identified or understood varies according to context). Embodiment also depends on face. In ways akin to, or perhaps even more central than sex, the face is “a principle of intelligibility for human beings, which is to say that no human being can be taken to be human, can be recognized as human unless that human being is fully and coherently” faced (Butler 1992: 352).¹¹ Without a face (or with a face unlike what we imagine a normal face to be), the body is ambiguously human.

Just as the experience of encountering a dead body devastates our notion that bodies are alive, disfigurement calls into question what human embodiment entails. In the case of disfigurement, an embodied state incontrovertibly outside of the “symbolic order” (Kristeva 1982), *something* is needed to cope with the trauma of encountering or experiencing it (or the possibility of it). As I show in this project, abjection in the form of facial disfigurement is recovered through various techniques of face work. In this way,

¹¹ Here I use a quotation from Butler. While she is speaking of sex in the original, I excerpt the quotation and extend her original meaning to speak about the human face.

face work is the material process of making a face more visually approximate a “normal” face. It is accomplished in the service of restoring humanity to those designated facially abnormal. As a material practice, face work repairs the human face, but as a meaningful practice, face work—as a technique of normalization—restores the symbolic order.

Face work accomplished in the service of normalization is not simply about making the subject intelligible. Normalization of the face is intrinsically a *social* project. Disability, in this case facial variance, takes shape as a departure from the bodily norm. These differences threaten national identity, specifically our cultural assumption about what bodies should populate our imagined community and American ideologies surrounding neo-liberal economic production. As Rosemarie Garland Thomson (1997) has written, “The disabled figure calls into question such concepts as will, ability, progress, responsibility, and free agency, notions around which people in a liberal society organize their identities” (47). In the American mode of life, disability is something to be compensated for because it connotes a loss of productivity, and thus of value and worth. Thus, face work in the service of normalization is a project invested in manufacturing and enabling productive American citizens.

Characterizing interventions on the face as normalizing practices emphasizes the social investment in the intervention. By claiming that face work is accomplished in the service of normalization, I focus on the biopolitical dimensions of face work in order to highlight its coercive operations. Patients understand their bodies and employ interventions in the context of the clinic, but not simply in response to the dictates of medical expertise. Biopower is enacted through social interaction, not forced on a relatively less powerful, unknowledgeable public. For Foucault, power is relational, and

often the body is produced and regulated by the self. Together, expert power and subjective experience identify and employ interventions that determine the directions embodied life will take. While face work might be deployed in response to an individual's professed desire for transformation, the intervention is always in the service of social norms, and in a broader sense, social and even national and global interests. In this way, there is a coercive dimension to face work.

As Foucault surmised, normalization is deployed in the production of docile bodies receptive to state interests and cultural hegemonies. Face work may simultaneously fulfill individual desires for a more unremarkable face, but because face work is premised on normalization, it is typically oriented towards disciplining bodies. In most cases, intervention aimed at faces defined as disfigured can only effect a rough approximation of an unremarkable face. Often, disfigurement remains perceptible, but because the human face is a normative facet of human experience, bodies are compelled to intervene, to attempt normalcy (Clark and Myser 1996). There is, in short, an imperative to "fix" abnormal bodies in accordance with notions of normalcy.

Technological possibility mixed with cultural norms about what constitutes a normal human being make a "fix it" reaction almost unavoidable. According to bioethicist Arthur Frank (2004), the imperative to normalize is facilitated by new technologies such that "The possibility of fixing renders inescapable the question of whether or not to fix" (18). Body projects are often facilitated by individual choice through capitalist modes of consumption, but normalizing interventions partially stand outside of this logic. Techniques of normalization, from surgery deployed on infant's anomalous genitals to cranio-facial surgery aimed at mending a cleft palate, are deployed

towards making patients (more) human. In this way, techniques of normalization like face work are not simply biomedical products consumers can purchase but interventions aimed at making patients human and subsequently obligatory. As Frank notes in reference to surgery on intersex infants, people are “acceptable *only if* their anomaly is fixed” (24). The choice to intervene is not made outside of social constraints. The difference between elective body projects and techniques of normalization is that life is not made better, but rather in the logic of normalization, life is made *possible*.

Even in critiques of the tendency towards normalization in the context of biomedicalization (Clarke et al. 2003), normalization techniques aimed at the face are taken for granted value whereas techniques like limb lengthening and intersex surgery are interrogated more critically. Frank writes of the Hastings Center project “Surgically Shaping Children,” which examined the ethics of interventions aimed at anomalously sexed, facially variant, and short stature children:

[T]his critique of surgical normalization is difficult to apply to the craniofacial surgeries that our project group saw. Our seeing again took place through the conventional medical rhetoric of before-and-after slides, and these slides like the word *deformity*, depend on normative visual convention, and those conventions need to be contested. Yet it would challenge most observers to see these pictures and not feel the appropriateness of this language of deformity. Faced with such faces, it is difficult not to affirm the value of surgery as at least an improvement in what are readily (perhaps too readily) perceived as life impairing conditions...*The public visibility of the face and the symbolic importance that links faces to character*—exemplified by the aphorism attributed to Lincoln that after a certain age a person is responsible for his or her own face—*make facial deformity a problem of a different magnitude, and that difference commands our respect (my emphasis, 25)*.

Frank contests the term “deformity” as a self-evident category and suggests that ways of looking and diagnosing, and corresponding ways of intervening, must be critically assessed. At the same time, Frank suggests that, even in the context of a Hastings Center

bioethics working group interrogating the ethics of intervention, intervention to affect facial difference is essentialized. Rather than critically examining the complex project of intervention, face work is reduced to “fixing” a face in need of repair. In other words, the imperative to fix the face is made self-evident and thereby intervention on the face is imagined as outside of critical, ethical analysis.

The normalization of facial variance is almost always understood as a form of necessary repair, a sort of work that relies on the assumption that things defined as broken invariably need fixing. There is something about facial “disfigurement” that makes normalization so taken for granted. Rosemarie Garland Thomson (2005) writes,

[A]pppearance tends to be the most socially excluding aspect of disability. Bodies whose looks or comportment depart from social expectation—ones categorized as visually abnormal—are targets for profound discrimination. Bodily forms deemed to be ugly, deformed, fat, grotesque, ambiguous, disproportionate, or marked by scarring or so-called birthmarks constitute what can be called appearance impairments that qualify as severe social disabilities. Perhaps the most virulent form of body disciplining in the modern world is the surgical normalization of bodies that deviate from configurations dictated by the dominant order (my emphasis, 1579).

The “fact” that the face *is* deformed leads to the fact that the face *needs* repair. Face work conflates a technique of normalization with a technology of repair. Because face work is a form of repair, the face is treated as intrinsically flawed and in need of intervention. In effect, repair obscures the coercive dimensions of bodily intervention in favor of a narrative that frames face work as a necessary and unavoidable mode of bodily intervention. It is precisely this narrative that my project seeks to disrupt.

Face Work as Repair

Humans are a kind of “repairing animal.” Not only do we invest resources in repairing our material possessions like cars and houses, we repair ourselves through doctors, therapists, and priests. According to Elizabeth V. Spelman (2002), “Repair is the creative destruction of brokenness” (134). The work of repair is simultaneously the work of rehabilitation, restoration, and redemption. But what and how we repair, along with the urgency that infuses the work of repair, reveals something about our cultural values. What do we believe needs to be repaired, as opposed to disregarded, and what are our reasons for fixing? What values are implicit in arguments about why we need to repair the face? What lessons about economics, citizenship, family, love, sex, community, and humanity are embedded in arguments to repair the face? Identifying what logics inform face work—the repair of the human face—reveals what the face, and by implication disfigurement, means.

Spelman distinguishes between two forms of repair work. *Bricolage* innovatively pieces together both material and non-material remnants to repair an object. The car is rebuilt with salvaged parts and mechanical know-how. Junkyard finds and the work of multiple mechanics restore it to working order. It does not matter *how* it got fixed as much as *that* it got fixed. In contrast, *invisible mending* aims to fix an object so that it appears to never have been repaired. For example, art restoration and tailoring attempt to mend art works or garments in such a way as to conceal decay and damage. Face work, I will show, involves both bricolage and invisible mending. Face work aims to erase disfigurement and in the process make a “grotesque” face unremarkable, but the technological limits of surgery along with the complexity of the facial structure mean that

face work more often resembles a kind of bricolage in which techniques are cobbled together to make for the best possible outcome. In most cases, people defined as disfigured undergo numerous surgeries. The hope is that a more desirable visage will emerge. In this way, the realities of erasing facial difference fall short of the fantasy of face work, as shown in Chapter 1 through the story of Lucy Grealley.

Repairing humans is often accomplished under the guise of returning people to “basic working order” (Spelman 2002). In this way, repair work is presented as necessary and unavoidable. It is *needed* not simply desired. Bodily interventions couched in terms of repair are distinct from body projects framed as self-improvement. In the latter case, intervention is accomplished in the service of enhancement. Botox injections diminish the appearance of fine lines and, according to some, consequently improve one’s appearance. Few would argue that this is a *vital* intervention. In contrast, repair work is understood as indispensable. Surgery aimed at a cleft palate is understood as obligatory, an intervention needed to assure basic bodily functions like eating. As Spelman writes,

Repair is not about the new. It is by definition about the survival of the old. Repair appears to be not about making progress but about halting decay, about sustaining something after it has degenerated from its ideal state. Inventive as repair can be, it is not about creating original objects or even about keeping existing objects from breaking (that is maintenance), but about responding to the damage they have endured and finding a way to continue their existence in the aftermath of such damage (137).

In the context of face work, images of disrepair abound, most often represented through the “before” image. “Before” images almost always appear in conjunction with “after” images, displaying the transformation possible through face work. But “before” pictures display the face in its original “disfigured” state, and these images exist in a state

of suspended ruin as referential images. These faces are displayed to mobilize support and investment in face work in particular ways. They are objects that incite fascination and horror, and therein support for work aimed at resolving what is displayed as being in ruins. By featuring before pictures of disrepair, sites of face work position intervention as vital work, work that facilitates humanization and in the process restores the symbolic order. Spelman writes,

To repair is to acknowledge and respond to the fracturability of the world in which we live in a very particular way—not by simply throwing our hands up in despair at the damage, or otherwise accepting without question that there is no possibility of or point in trying to put the pieces back together, but by employing skills of mind, hand, and heart to recapture an earlier moment in the history of an object or a relationship in order to allow it to keep existing (6).

Face work becomes both necessary and critically important as the work of restoring human status.

Modernist tendencies towards progress (both social betterment and individual self-improvement) coupled with an ethic of neoliberal medicine that makes consumption of medical intervention possible, result in a social context in which repair is the most accessible mode of relating to bodily difference. Repair circulates throughout this analysis of face work. The work accomplished in each of the four sites I describe is discursively constructed as a form of repair. I investigate how face work is the enactment of normalization, and thus is laden with social norms about what constitutes a normal human, but is also framed as repair, a mode of work understood as neutral and impartial. I embed this project in disability studies, sociology of medicine, health, and illness, and sociology of the body, three theoretical locations from which to ask questions about appearance, disability, and repair.

Disability Studies

Disability studies is an emergent, interdisciplinary field of inquiry. What demarcates disability studies from other academic explorations of disability is the ways in which the field defines and understands disability. Specifically, disability studies approaches disability as a socially situated, culturally mediated bodily experience (Barnes 1998; Davis 1997; Shakespeare 1998). It rejects essentialist, biological understandings of disability in favor of definitions that illustrate how the body is disabled via social means and understandings. Disability studies works from the assumptions that bodies carry different meanings depending on their social location and that disabled bodies are hindered by social environments. From this perspective, the body is not intrinsically disabled, rather social environments and cultural attitudes are disabling. This approach to disability rejects medical and religious models, which are critiqued for narrowly focusing on the “problem” of disability by treating the individual.

As a field of academic inquiry, disability studies has interrogated disability by asking questions about how disability is culturally represented, discursively and institutionally constructed, and politically determined. As a site of political struggle, disability studies attempts to articulate a viable and transformative disability politic, and as such engages with disability rights activists (Linton 2006). Disability studies offers a theoretically nuanced account of bodily difference and devaluation *and* a framework for thinking about responses to challenge that devaluation. Like other intellectual projects that take shape on the margins of the academy, disability studies requires a critical praxis, a thought project aimed towards emancipation (Thomson 1994, 2002).

Bodily difference includes a wide range of experiences, and disability studies seems appropriately situated to think through multiple kinds of bodily experiences. And yet, disfigurement is conspicuously missing from disability studies. Disability studies often focuses on societal and institutional responses to functional impairment—the inability of a body to function in the ways we expect bodies to function. It is not always obvious to many how a disfigured face creates functional impairments. Particular disabilities and images (especially the wheelchair) have worked as heuristic devices in disability studies to signal questions of mobility and function (Gerschick 1998). The nature of the images routinely invoked rarely includes references to disfigurement. So while disability studies leaves itself open to analyses of disease, disfigurement, *and* other kinds of bodily difference, it is not always clear where these experiences fit within the rubric of disability studies. Where, for example, in an academic field of inquiry that values self determination is space made for the theorizing of cognitive disabilities as they are experienced? It makes political and theoretical sense to create a field of interdisciplinary studies around bodily difference and bodily oppression, but given that the core concept “disability” fundamentally situates “ability” at the center of discussion, bodily differences such as disfigurement get pushed to the margins.

Disability studies has identified the ways in which disabilities compromise citizenship. In the U.S., what it means to be an American relies on notions of self-reliance and determination. Yet disabilities sometimes impact people’s ability to function in particular ways—to economically provide for one’s self, to care for one’s own body, to reproduce other self-sufficient American citizens. In this sense, disability does not conform to what it means to be American. Independence is an American value imbued

with moral significance. Independence is bound up with function. And for disabled people whose function seems limited in particular architectural, educational, legal, and cultural contexts, stigmatization and devaluation seems an almost taken for granted American response. When we recoil from “disfigurement,” a disability that is primarily aesthetically compromising, what is the logic that we use to defend that stigmatization? What American value is compromised when someone is perceived to be ugly, unsightly, or deformed?

One area of disability studies has focused on bodies that are visually different. Rather than employing the language of disability, this work on “extraordinary bodies” explores our cultural fascination and stigmatization of “freaks” and “monsters” (Braidotti 1996; Thomson 1996). As Rosemarie Garland Thomson has argued, extraordinary bodies help us to define what it means to have a “normal” body and how significant bodily difference is. Academic analyses of “freak shows” have highlighted how public display of non-normative bodies defines relationships between freaks and norms as simultaneously characterized by fear and fascination (Hawkins 1996; Miles 2004). While freak shows are rather “politically incorrect,” bodily difference remains a subject of intense scrutiny via talk shows, exposés of surgical procedures, and tabloid photojournalism. *And* congenital conditions, diseases, and “accidents” (especially in an age of militarization and technologization) mean that disfigurement will continue to define human experience.

My project uses ideas from disability studies to explicate facial disfigurement. I pose two questions that speak to theoretical issues in disability studies. First, what is the cultural significance of facial disfigurement? Disability studies locates bodies within

cultural and institutional locations, allowing for analysis of the societal significance of disfigured bodies. By analyzing face work, I account for social responses to facial variance. As disability studies demonstrates, the experience and meaning of disability is always informed by the social response to particular bodies. By focusing on responses to disability, mine is a critical project that refuses to locate the “problem” of disfigurement at the level of individual experience. Second, how is appearance disabling? By asking this question, I introduce a theory about how aesthetics, in addition to functional impairments, matter in significant ways. I demonstrate how the opposite of disability is not always ability but rather unremarkability, or a way of being that goes unnoticed in everyday life.

Sociology of Medicine, Health, and Illness

Medical sociology problematizes essentialist and biological notions of the body by framing many diseases and disorders as social problems. By locating the body and medical professions in socio-historical-cultural contexts, medical sociology opens up topics often perceived as natural or scientific to sociological analysis and critique. By framing disease and disability as social problems, medical sociologists dislocate the experience of the body and knowledges about the body from scientific narratives in order to articulate how knowledge and experience are always mediated through history, politics, and economics. In doing so, medical sociology destabilizes the practice and profession of medicine in order to think about how professional power defines bodily experiences and what better ways of coping with disease and disorders of the body might look like (Conrad 2005).

With the concept of medicalization, sociologists began to understand how various human experiences may be defined through medical practices—diagnostic categories, assessment techniques, and treatment modalities (Zola 1972). We now understand medicalization as a defining transformation of the twentieth century. In fact, unveiling processes of medicalization has become routine to sociologists. Much of the work of medical sociology in the last twenty-five years has focused on how a variety of human conditions (alcoholism, homosexuality, hyperactivity, etc.) became subject to medical expertise (Conrad and Schneider 1992). Yet, the last twenty years have been characterized by such dramatic technical, informational, and organizational shifts that some theorists argue we need to reconsider how we understand medicalization (Bowker and Star 1999; Clarke et al. 2003). Clarke et al. argue that we are currently experiencing *biomedicalization*—“the increasingly technoscientific, complex, multi-sited, multi-directional processes of medicalization” (162). Most importantly, biomedicalization signifies a shift from *controlling* nature to *transforming* nature (Clarke 1995).

While Clarke et al. identify five related processes of biomedicalization, two of these are particularly pertinent to my own research. First, biomedicine transforms the body and the patient through the “technoscientization of biomedicine.” Biomedicine is increasingly dominated by technoscience through computerization, geneticization, and technology design. Whereas antibiotics destroy (control) microorganisms, new biomedical technologies like genetic engineering manipulate (transform) genes. In this context, radically new technologies emerge that rework the very terms of medicine. Rather than extending life, new biotechnologies take the human body to the extreme. Technoscience allows for technologies that intervene in new physiological processes

through radically invasive means. Second, new bodies and identities are created via biomedicalization. While one-size-fits-all medical treatments persist, we are currently experiencing an explosion of customized technologies that seek to transform bodies in unique ways. These technologies rest on the understanding of the human body as flexible (Martin 1995). New biotechnologies “focus on assessing, shifting, reshaping, reconstituting, and ultimately transforming bodies for varying purposes, including achieving new identities” (Clarke et al. 2003: 181).

This project follows the logic of the sociology of medicine by framing facial disfigurement as a social problem. From this perspective, technologies of face work (face transplantation, facial feminization, and reconstructive surgery) are not simply surgical techniques or technological artifacts; rather, they are apparatuses with complex histories and social lives. These practices permeate our imaginings about what science is and what contemporary medicine can do. Rather than understanding these as good or bad technologies, I begin with the premise that we are embedded in a society currently undergoing unprecedented biomedicalization. As such, my project engages technologies as tools that shape how we see and relate to bodies, especially disfigured bodies. Medical technologies are simultaneously miraculous *and* problematic. Part of this project involves articulating how face work is both of these things simultaneously.

This project focuses on two questions of interest to medical sociology. First, how do we conceptualize medical treatments as vital *or* non-vital, as life saving *or* life enhancing? As Clarke et al. (2003) acknowledge, what “big science” looks like has changed. Whereas innovations like the artificial heart, the iron lung, and immune isolation chambers were primarily oriented towards extending life, I argue that face work

is geared towards revolutionizing a patient's quality of life. In this way new technological innovations, like face transplantation, reorganize medical practice by concentrating resources in projects aimed towards "non-vital" ends. In contemporary culture wherein the "makeover" has reached epidemic proportions, medical technologies aimed at transformation must be explored further in order to make sense of the ways in which medicine is used to make postmodern bodies (Haraway 1991).

Yet biomedicine oriented towards these ends is contested. Critics question the role biomedicine should play in crafting lifestyles and identities (Frank 2004). In light of these concerns, I ask how human experiences of disfigurement are altered through face work. The assumption underlying face work is that interventions benefit patients by transforming the patient's lived experience and identity. The logic is: via face work, a disfigured face is made into a new, aesthetically "normal" face, and in the process a patient's identity shifts from a highly stigmatized identity to a normalized (if not quite normal) identity. By analyzing the social work accomplished through technologies of face work, I complicate the understanding that intervention necessarily leads to progress.

Sociology of the Body

Historically within sociology, the human body occupies an "absent presence" (Shilling 2003, 17). The body is implicated in the big sociological questions—How is human life organized via work, intimate relations, politics? How do humans cope with constraint? What are the possibilities for agency and resistance?—and yet the body has only recently been explored as a distinct topic of sociological analysis (Turner 1996, Shilling 2007, Waskul and Vannini 2006). As a modern(ist) discipline, sociology tends

to conceptualize human action as a disembodied set of practices emerging from human thought. In solidifying a disciplinary identity distinct from biology and psychology, sociology distanced itself from accounts which granted the human body explanatory power. This intellectual move against biological determinism led to a disembodied sociology. Instead, sociology focused on how human thought and ideas, language, and behavior facilitated social world-making, but the ways in which the body facilitated, disrupted, and influenced these human processes were largely ignored. As an emerging substantive area, the sociology of the body understands bodies and embodiment not simply as factors that shape human experience, but rather as theoretically significant subjects of inquiry in their own right. From this perspective, the body is understood as not only impacted by but also *constitutive of* complex social arrangements.

Sociology of the body is centrally interested in questions about the experience of embodiment and how these experiences are embedded in social contexts. Increasingly, analyses of the body focus on bodies that differ from the accepted (and enforced) norm (for example, female, queer, disabled, young, and old bodies) and the ways the specific histories of these bodies are determined through culture, technology, and politics. This focus on devalued bodies is facilitated by postmodern bodily metaphors that emphasize flexibility, hybridity, fragmentation, fluidity, difference, and ambiguity. Haraway's cyborg, Kristeva's (1982) abject body, Martin's (1995) flexible body, Braidotti's (1996) monstrous bodies, Shildrick's (1997) leaky bodies, and Shabot's (2006) grotesque body are direct, feminist responses to a Cartesian model that emphasizes mind-body dualism or an Enlightenment biological elaboration that approaches the body as a uniform, intelligible object. Postmodern figurations are attempts not only to describe embodiment

as it is experienced in the twenty-first century but also to imagine a place from which to articulate and enact a body politics. For the disfigured body, postmodern conceptualizations of the body, particularly Sara Cohen Shabot's (2006) "grotesque body," that center difference are useful for thinking about the nature of disfigurement and for understanding attempts to normalize facial difference.

Shabot posits a "grotesque body" as a subversive alternative to Haraway's cyborg (1990). The cyborg is a postmodern metaphor deployed as a direct challenge to dualisms premised throughout Western thought, most notably between humans and machines. The cyborg is an optimistic metaphor, a heuristic device intended to aid feminists in theorizing the twenty-first century. Haraway writes,

Cyborg imagery can suggest a way out of the maze of dualisms in which we have explained our bodies and our tools to ourselves. This is a dream not of a common language, but of a powerful infidel heteroglossia. It is an imagination of a feminist speaking in tongues to strike fear into the circuits of the super-savers of the new right. It means both building and destroying machines, identities, categories, relationships, spaces, stories (39).

Based on an analysis of science fiction, Shabot argues instead that cyborg imagery is problematic because even as it operates to break down distinctions between humans and technologies, the hypersexualization of cyborg bodies reinforces traditional notions of gender and sexuality. But perhaps even more importantly, in practice the cyborg metaphor, perhaps inadvertently, abandons the material body. As Shabot writes, "The [cyborg] is never a meaty body" (226). In effect, the nitty-gritty of an organic body is overcome in cyborg narratives in favor of a techno-fantasy. Without fleshiness, a politics centered on bodily experience, particularly bodily suffering, is not possible.

While I contend that Haraway does not imagine her cyborg politics as entirely imitative of science fiction, and thus not limited by pop culture failings, Shabot's argument is insightful to the degree that it insists on a metaphor of the body that dispenses with hyper-ness in favor of an everyday mediocre-ness that centers meatiness or materiality in bodily accounts. The disavowal of the organic body might work as a means of coping with anxiety related to the vulnerability of the human body, but the body is a fact of human life that cannot be dreamt away with cyborgs or any other fictive kin. For Shabot, then, body metaphors of the twenty-first century must center fleshiness, while retaining a postmodern sensitivity to messiness. Drawing on Mikhail Bakhtin (1941), Shabot premises the grotesque body as simultaneously fleshy and boundary-less. Like the cyborg, the grotesque body exemplifies hybridity.

Grotesque bodies are hybrid bodies: mixtures of animals, objects, plants, and human beings. Hence, the grotesque has been recognized as a concept evoking monstrosity, irrational confusion, absurdity, and a deformed heterogeneity...The grotesque subject, provided with such embodied and open subjectivity and constituting a *radical deviation from the norm*—mainly by way of exceeding it (Russo, 1994, p. 10)—is *unrepresentable* or *unknowable* by way of any normal system of knowledge or representation...They are not clean, closed, well-defined, clear-cut, beautiful bodies striving for symmetry and order. Rather, the grotesque body is a body that defies clear definitions and borders and that occupies the middle ground between life and death, between subject and object, between one and many (229).

The grotesque body is a particularly apt metaphor for understanding disfigurement. As a “radical deviation from the norm,” facial variance calls into question the distinction between what is human and what is non-human, and as a result, disfigured faces routinely evoke anxiety and revulsion.

Yet while the grotesque body is an analytically useful metaphor, it is rhetorically problematic. Postmodern figurations are formulated as means for describing human

bodies writ large. The word grotesque, while provocative in postmodern parlance, carries with it a burden of meanings. My work is about “disfigured” faces and as such characterizing these faces as “grotesque” is linguistically and morally problematic. In doing so, I do not intend to reproduce the intense stigmatization of facial variant people. Rather, I use the metaphor to highlight the profound ways in which bodies characterized by difference challenge modern notions of intelligible subjectivity.

Sociology of the body has come to focus on the specificity of bodily experience—the male body, the black body, the disabled body, the child’s body, the aging body—as a way of undermining universalizing essentialist narratives about the “nature” of the body (Evans and Lee 2002). The body is given meaning in terms of a number of distinctions, including but not limited to gender, race, sexuality, ability, nationality, age, religion, and ethnicity. In this way, postmodern accounts of the body make an attempt to analyze the messiness of the body, its reality as shaped by categories that are made real in social contexts. While messiness abounds in sociological accounts of the body, fleshiness does not. That is, sociology interrogates body experience as it is mediated by a multitude of social factors but offers little towards making sense of the ways the material body is experienced.

I argue that social categories matter, but so, too, do physiological factors. While the ways the material body determines human experience are always imbued with social meanings, these are not entirely reducible to social explanations. Disfigurement matters in the ways that it does because of socially constituted notions of aesthetics, but it also matters because different facial configurations can affect the ways people love, see, eat, speak, and smell. In this way, “disfigurement” is socially constructed, but it is also

materially significant. By focusing on the face, a body part, I begin with the fleshy body, but I do not take it for granted. I neither reduce the significance of disfigurement to social arrangements nor do I fetishize biological determinism by locating explanatory power in the body itself. Instead, I aim to produce of fleshy account of social relations that simultaneously takes material experience, physiological functioning, relations of power, and social meanings into account.

As contemporary accounts of the body repeatedly demonstrate, bodily difference is almost never construed simply as a variation of human possibility. Even relative to the few bodily characteristics like hair and eye color that are relatively acceptable in their variability, there are ideals. Gray hair does not carry an equivalent meaning to brown hair. In response, multitudes of social practices are aimed at containing difference, which is often conceptualized in terms of stigma. Bodily difference almost always elicits great anxiety and immense mobilization of resources aimed at refiguring and resituating it (Shildrick 2002). The variant body is defined as abject and subject to normalizing techniques that aim to restore a “clean and proper body (Kristeva 1982). Difference is normalized again and again. From genital surgery for intersexed infants to cosmetic surgery that erases ethnic facial characteristics defined as undesirable, medicine routinely works as an agent of social control, a technological handmaiden to social norms (Kaw 1998; Kessler 1998).

I locate my own work within a sociology of biotechnological interventions aimed at normalizing the body, and specifically the human face. Biotechnologies shape embodied experience, and in doing so, they help to determine our bodily future. Often interventions promise a new body of sorts—a younger body, a stronger body, a more

mobile body, a prettier body. But it is not simply the desire for beauty that undergirds the imperative to intervene in bodily aesthetics; it is also the haunting specter of ugliness. I analyze interventions aimed at transforming disfigured bodies into unremarkable ones, those sociotechnical practices designed to repair a “grotesque” face so that it becomes a mundane face. In pursuing this research, I rely on sociology of the body to ask how work on the body is organized not only around progress but also around sufficiency or unremarkability. I demonstrate that the goal is sometimes not to have a better or more perfect body, but rather a “good enough” body, one that will ensure membership in the human collective.

CHAPTER III

FACING OFF: DEBATING FACE TRANSPLANT AND CONSTRUCTING A DISFIGUREMENT IMAGINARY¹²

“Science and society would be all the poorer if scientists lacked the ‘courage to fail’, but these risks [of face transplantation] indicate that we presently need more caution than courage.”

Richard Huxtable and Julie Woody (2004: 513)

“An ethical face transplantation that would eventually lead to a failure will be remembered as an honorable attempt (as were all the other first organ transplantations). An unethical face transplantation that would eventually lead to a technical success will be looked at as a “trick” made by mercenaries of science.”

Francois Petit et al. (2004: 15)

¹² My use of the term “face off” in the title of this chapter is not a reference to the popular film of the same name. I use this term to emphasize the ways in which debates infuse face transplantation with meaning.

A Face Transplant Story in Images



Figure 2. Face/Off Movie Poster

The film starring John Travolta and Nicolas Cage tells a story in which face transplantation figures in a plot centered on diverting terrorists.¹³



Figure 3. Rat with Transplanted Face

Images of white rats with the faces of black rats were published in *Transplantation Proceedings* to illustrate the results of animal models for face transplantation.

¹³ From < <http://en.wikipedia.org/wiki/Face/Off>>



Figure 4. Magazine Cover Announcing the World's First Face Transplant

This cover of *Paris Match* announces the first face transplant and shows surgeons at work on the recipients face.¹⁴

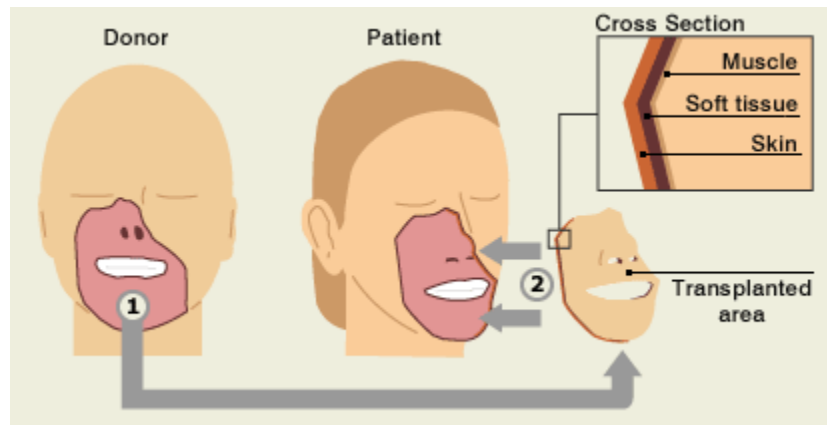


Figure 5. Face Transplant Technical Diagram

This graphic published on the BBC's website graphically represents what tissue was transferred in first partial face transplant.¹⁵

¹⁴ From <<http://www.lifesite.net/ldn/2005/dec/05120907.html>>

¹⁵ From

<http://news.bbc.co.uk/cbbcnews/hi/newsid_4680000/newsid_4686000/4686058.stm>



Figure 6. If You Had to Have a Face Transplant, Whose Famous Face Would You Want?

A *People* magazine backpage feature asked celebrities to identify the face they would most like to receive via face transplantation.¹⁶



Figure 7. Third Face Transplant Recipient Post-Surgery

This photograph was released to publicize the world's third partial face transplant.¹⁷

¹⁶ From *People* magazine

¹⁷ <<http://www.newscientist.com/article/dn9010.html>>

These pictures position face transplantation as a plot device, as a scientific experiment, as a news story, as a surgical technique, as a topic for celebrity speculation, and as an intervention that restored a man's face. In other sites, it carries the meaning of life saving work.

Spectacles of Innovation

On November 27, 2005, a team of French surgeons led by Jean-Michel Dubernard and Bernard Devauchelle performed the world's first partial face transplant in Amiens, France. Simply put, face transplantation or FT is an experimental procedure in which a face is surgically removed from a donor and replanted on a recipient's head for the treatment of "several facial disfigurement," the kind of disfigurement that results from both congenital conditions and trauma. News accounts alleged that the recipient's lips, chin, and nose were chewed off by her own dog's efforts to rouse her after a suicide attempt (Bernard and Smith 2006). Some accounts claimed that the brain-dead donor had also attempted suicide. Initial stories announcing the transplant were followed with reports that the recipient's results were so good that she had regained enough facial functioning to resume smoking. This news was met with derision from other surgeons, suggesting that the French team's choice of patient was less than ideal (Osterweil 2006).¹⁸

This larger than life story of trauma and repair was followed by a similarly outlandish story. In April 14, 2006, reports confirmed that a Chinese surgical team

¹⁸This French surgical team had previously transplanted a hand and forearm to a New Zealand man who had lost his own in a chainsaw accident while serving time in prison.

working at Xijing Hospital completed the world's second partial face transplant (Macartney 2006). This time the recipient had been attacked by a black bear two years prior, leaving open wounds and visible pink flesh in the place of a recognizable face. Press releases following the surgery displayed a man's face, albeit swollen and stitched, but for all intents and purposes intact.

The third face transplant was again completed in France by different surgeons, but unlike the two premiere patients, the third recipient had not experienced an animal encounter resulting in facial trauma. Instead, the experimental procedure was used as a last-ditch intervention to treat neurofibromatosis, a condition that causes the growth of tumors on the face. This is the same condition Joseph Merrick, irreverently termed "The Elephant Man," is thought to have experienced. The story of a man with a congenital condition is certainly less dramatic than the stories of "animals on the attack," but spectacular in its own right given the rarity and severity of the condition.

In the United States, clinical researchers affiliated with various medical institutions have expressed interest in FT, though as of this writing, no American team has actually completed a procedure. A team at The University of Louisville has conducted extensive research to establish the technical, immunological, and ethical protocols necessary to completing the procedure. Much of their research established the groundwork that allowed the French and Chinese transplants to occur. Other American researchers have announced plans to complete a face transplant. Most notably, Marie Siemionow from the Cleveland Clinic declared in 2005 (even before the first face transplant in France) to Katie Couric on NBC's *The Today Show* that she was in the process of identifying her first patient. Following Siemionow's appearance, periodic

media outlets have “announced” the Cleveland Clinic’s intention to complete the first American transplant (Glaister 2005). There is no evidence to suggest that any American team will actually complete a face transplant in the near future. Yet, the declaration that an American transplant is impending has intensified the media circus surrounding FT in the United States.

It is not simply the details of the recent transplants or the innovative and emerging science of FT that make it so spectacular; fantastic images pervade pop culture accounts of FT, too. Some stories rely on fantasies fed by celebrity culture. In these stories, the hook is that FT makes realizing celebrity-like faces possible. “Have you ever wished that you had the good looks of Halle Berry or Ashton Kutcher or the hottest student in school?” (McLaughlin 2003). On the final page of a 2005 issue of *People* magazine, Hollywood actresses were asked to identify another starlet whose face they would most want transplanted onto their own. These stories of FT couch the technology in a culture of glamour and consumption. In these accounts, FT is treated as the newest, most innovative, albeit still “in development” intervention that promises to make the body beautiful. While “experts” repeatedly deny that FT will ever be available as a cosmetic procedure, the story persists.¹⁹ Other media accounts make reference to science fiction themes of wonderment or futuristic horror. Several recent newspaper articles reference

¹⁹ This is a common theme in popular media coverage about experimental surgery. Stories question what the routinization of cutting edge technologies and practices, might look like in the future, while experts insist that these are specialized, and thus not intended for wide-spread use. Monica Casper (1998) explores this trend in her work on fetal surgery.

the Hollywood action thriller *Face/Off* in which a main character receives a face transplant in order to thwart a terrorist attack and a 2005 episode of *Nip/Tuck* in which a botched face transplant results in rejection of the new face that is then removed (Hanlon 2005; La Ferla and Singer 2005). These are sensationalized media accounts that continually rely on “what ifs” to simultaneously glamorize the technology and to titillate the public.

At the same time, FT has been celebrated as scientifically noteworthy. Dr. L. Scott Levin, chief of plastic and reconstructive surgery at Duke University Medical Center, has described the procedure as “the single most important area of reconstructive research” (Mason 2005). Yet it is unclear what the future holds for FT. Experimentation may morph into a viable treatment option offered as standard of care, or FT may vanish from the scene entirely due to failure or ethical issues. Or, it may be operational in limited circumstances but remain a contested “experimental” procedure. FT is positioned strategically by proponents as a revolutionary intervention and by critics as too risky, and as such its ultimate trajectory is unknown—and thus deeply interesting analytically. The story relies on hope but cannot help but simultaneously provoke anxiety.

I began this chapter with a series of images, each representing a piece of the FT story. There are endless images to choose from, and so the work of (re)presenting FT is tricky. There are multiple stories that could be told—the story of an emerging technology, the story of hope for cure, the story of media (mis)representation, the story of public understandings of science in the making, the story of Dr. John Barker and Isabelle Dinoire. I tell none of these stories in their entirety. Partially, I represent FT as a product of popular culture, a technology of entertainment. Partially, I represent FT as a

technique, forged through scientific knowledge and clinical practice. Partially, I represent FT as an experience, a biotechnical intervention into real lives saturated with trauma, suffering, and hope. Partially, I represent FT as a subject of public inquiry and deliberation. Taken together, I use these images to convey the complex life of a technology and to point to the ways in which even an intervention as embryonic and uncommon as FT saturates social life. What is it about FT that has captured our (both expert and lay) imaginations?

This chapter focuses on a technology in the making. I attempt to make sense of the medical and scientific midway that surrounds the technology in order to understand its significance both as a technological innovation that raises unique bioethical concerns and as an intervention imbued with the promise of erasing facial disfigurement (Miles 2004). As I write, the story of FT continues to unfold. As such, I analyze a key moment of contemporary deliberation surrounding FT. In a 2004 issue of *The American Journal of Bioethics*, experts—including medical researchers, surgeons, bioethicists, and psychologists—considered the advent of FT. Through content analysis of the *AJOB* exchange, I highlight the terms of contestation. While critics raised numerous bioethical concerns, the debate was dominated by questions about whether the physiological, psychological, and social risks associated with transplantation were worth the benefits accorded to future recipients. Put more simply and more dramatically, *is a new face worth the risk of death?* I demonstrate that each position is structured by varying claims about risk, conceptions of what constitutes a “vital” intervention, and articulations of the relationship between disfigurement and the possibilities of a life “worth living.”

Underlying these claims is the assumption that the face is a different kind of work object than any other bodily part.

I then turn my focus from broad debates about FT to the specific work of one face transplant team. Drawing on ethnographic research and interviews with key members of a U.S. based research team, I critically analyze how, in this case, the work of technological innovation rests on the discursive negotiation of the meanings of facial disfigurement. Over the course of several years, the team invested significant resources in working through the scientific (surgical and immunological) barriers to FT via laboratory experimentation on animals and human cadavers. While their research made human experimentation conducted by other transplant teams possible, the team has yet to complete a clinical transplant in a human patient. Instead, the team has created an ongoing research agenda examining the ethical, social, and psychological implications of FT. I demonstrate that, rather than clinical experimentation, *the* central work of the team became the rhetorical work of conveying the significance of facial disfigurement. In a very real way, the Louisville team helped to create a disfigurement imaginary that positioned disfigurement as a quality of life affecting condition but rather as deadly and as a threat to one's very humanity. Ultimately, I demonstrate that this disfigurement imaginary calls into question what constitutes "vital" and "non-vital" intervention in clinical terms. I argue that how FT is positioned relative to these technical and moral distinctions does much towards imagining what facial disfigurement and medicine mean in this socio-historical moment.

A Social Anatomy of Face Transplantation

FT is simultaneously a scientific practice and a cultural object. I approach FT from the perspective of science and technology studies, conceptualizing this emergent practice as a “socio-technical ensemble” in order to emphasize the ways in which culture and science inform one another (Bijker 1995). Constructivist approaches to science and technology do more than illustrate unidirectional relationships between “society” and “science.” Rather, science studies “trace[s] the way[s] in which social interests, values, history, actions, institutions, networks, and so on shape, influence, structure, cause, explain, inform, characterize, or co-constitute the content of science and technology” (Hess 1997: 82). Science studies simultaneously interrogates the production of technoscience from the inside (laboratories, scientific texts, surgery wards, etc.) and situates technoscience in social and cultural contexts in order to understand the cultural activities of science, the symbolic and political practices at play, *and* the technical goings-on. Scientists are embedded in “construction machineries” and “cultures of fact” (Cetina 1996). From this perspective, the construction of science is a literary process and a representational craft that employs local materials, means, and resources.

FT builds upon knowledge and skills from numerous scientific specialties including transplantation surgery, immunology, reconstructive surgery, and psychology. The technical history of FT begins with reconstructive techniques, or perhaps rather dissatisfaction with reconstructive techniques. For the faces subject to an extreme intervention like FT, reconstructive techniques like free tissue transfer, which involves the relocation of tissue from one site on a patient’s body to another for the purposes of repair, are notoriously ineffective. Not only do these techniques require surgeries

throughout the course of a lifetime, sometimes numbering into the hundreds, but the end results of reconstructive techniques rarely erase facial difference altogether.

Technically, FT is most akin to facial replantation in which a person's own facial tissue is reattached after trauma. The first case of facial replantation took place in India. After a nine year old girl's face and scalp were torn off after a grass cutting machine caught one of her braids, her family packed the tissue on ice and traveled to the nearest hospital. After ten hours of microsurgery, the girl's face was reattached. The case made reconstructive surgery history, and opened up the possibility for the transplantation of one face from a donor to a recipient (Thomas et al. 1998). While replantation offers better results than other reconstructive techniques, it is only available in cases in which a facial tissue remains in good condition. Thus, many kinds of trauma and other congenital differences are not treatable through replantation.

In addition, FT shares a technical and social history with hand transplantation. In 1998, a French team also led by Jean-Michel Dubernard completed the world's first hand transplant, though credit for the world's first "successful" hand transplant belong to a research team at the University of Louisville. In the French case, the transplanted tissue was eventually removed after the patient stopped following his immunosuppression regimen. Many understand hand transplantation and FT as analogous procedures. Both types of transplant are composite tissue allotransplants involving a number of tissues including muscle, nerves, blood vessels, arteries, veins, and skin (Baylis 2004). Referencing the success of hand transplantation has become a key strategy in arguing that surgeons have established the technical skills to begin transplanting human faces (Wiggins et al. 2004). But critics contend that the results of hand transplantation do not

necessarily support the continuation of experimentation with composite tissue allotransplantation (Caplan 2004). Critics acknowledge that “a face may be like a hand from the perspective of a surgeon interested in the technical problem of repair,” but there are “morally significant differences” (Baylis 2004: 30). As Baylis argues, that idea that the hand is just like a face only works as a technical analogy because in the event of rejection or failure, the stakes are significantly different. A hand can be replaced with a prosthesis. A face cannot.²⁰ Analogizing face and hand transplantation highlights the technical similarities of the body matter, but the juxtaposition also points to the divergent meanings and significance accrued to each body part.

The move in reconstructive techniques towards transplantation is made possible by transplant medicine, an innovative field of health care research with a history shaped by ethical debate. Because FT involves the transplant of a donor organ from a dead body onto a living recipient, FT relies on the work of immunology. Like all kinds of transplantation, FT requires that recipients begin a life-long regimen of immunosuppressive drugs in order to prevent rejection of the transplanted tissue. Debates about FT largely hinge on this fact—immunosuppressive drugs are toxic.²¹ FT

²⁰ There are some kinds of facial prosthetic devices. They function by helping patients aesthetically but sometimes make facial function like eating or drinking more difficult.

²¹ Just how toxic these drugs are is highly contested. While some critics of FT understand the use of these drugs as a death sentence, others including the University of Louisville team argue that the risk is grossly overstated since most information about the drugs is based on research with people suffering from serious illnesses like kidney failure. In essence, the team contests that the drugs, themselves, are toxic but rather that

relies on the technologies of transplant medicine but it also activates ongoing conversations within the field of transplantation specifically, and medicine, more broadly. Transplant medicine has pushed the bounds of medical intervention by continually making possible the seemingly impossible (Fox and Swazey 1974). With the advent of heart transplantation as a technological possibility, bioethicists, medical professionals, and lay publics were forced to reconsider what constitutes “life.” Thus within the specialty, there is a well entrenched history of debate around unprecedented bioethical questions. FT calls into question how we balance the benefits of intervention, in this case a new face, with physiological, psychological, and social risks, most notably chronic illness, death, identity crisis, and public contempt and distrust.

Face Debates: The Contested Risks and Benefits of Face Transplantation

AJOB: A Site of Deliberation

In 2004, *The American Journal of Bioethics*, touted on its website as the most widely read bioethics journal in the world, featured a series focused on the ethics of FT. The commentary, which was published before any attempt by any surgical team to complete a face transplant, was structured as a forum in which to consider the issue *prior to* clinical experimentation. According to the journal’s website, “The mission of The American Journal of Bioethics and bioethics.net [*AJOB*’s complementary website] is to provide the clinical, legal, academic, scientific, religious and broad community-at-large

the drugs in combination with a pre-existing condition give the indication of serious side effects.

with a rapid but comprehensive debate of issues in bioethics” (American Journal of Bioethics 2004). The debate (like others that unfold on the pages of *AJOB*) was spurred by a Target Article, a piece that focused on a single biomedical issue, in this case written by the face transplant team at the University of Louisville. The article, “On the Ethics of Facial Transplantation Research” argued that the ethical criteria developed for innovative transplant surgery had been satisfied and that it was time to pursue clinical experimentation.²² An Open Commentary, a series of pieces written by scholars in

²² Wiggins et al. (2004) rely on Francis Moore’s four criteria to argue that they are ethically well positioned to begin clinical experimentation. Moore, himself a transplant surgeon, developed these criteria to aid in the innovation of transplant medicine. First, Moore encourages surgeons to consider the scientific background of innovation. Wiggins et al. argue that solid organ and hand transplants provide information about procedures and immunosuppressive drugs. They argue that have reached equipoise wherein the uncertainty posed by the innovation can only be resolved by proceeding and that the potential benefits are balanced with the risks. Second, Moore considers the skill and experience of team “field strength.” The team at the University of Louisville is comprised by specialists including reconstructive surgeons, head and neck surgeons, transplant surgeons, immunologists, psychologists, psychiatrists, ethicists, IRB members, and organ procurers, and thus they argue that they are primely situated to conduct a face transplant. Third, Moore queries the ethical climate of the institution. The team argues that the motivation of the institution is not self-aggrandizement but rather for benefit of patients. Fourth, Moore encourages open display and public and professional discussion and evaluation. In an attempt to initiate discussion, the Louisville team hosted the first

response to the Target Article, followed. The entire debate consisted of fifteen articles.²³ Interestingly, the second response entitled “A Surgeons’ Perspective on the Ethics of Face Transplantation” was co-authored by the French surgeons who, within a year after publication, completed the world’s first partial face transplant. The result is, as the

International Symposium on Composite Tissue Allotransplantation in November of 1997 and in May of 2000 the 2nd International Symposium on Composite Tissue Allotransplantation to share and discuss the initial hand transplantation results. In addition, the team participated in public discussion concerning face transplants at the Dana Center of London Science Museum. Yet, even how the Louisville team employed the work of Moore was criticized in the *AJOB* issue. Agich and Siemionow (2004) respond, “Although Moore’s reading of the ethical obligation to develop innovative treatments for desperately ill patients strongly supports innovations like facial transplantation, nowhere does he explicitly argue that ‘open display and public and professional discussion’ is an ethical requirement for performing an innovative surgical procedure (Wiggins et al. 2004). Is this commitment to publicity simply a misreading of Moore or does it reflect deeper program commitments that deserve ethical scrutiny?” (25).

²³ The analysis that follows is based on the debate contained in *AJOB*. Because references to work that appears elsewhere is sometimes cited by critics, a number of references to previously published research appear in my account. These works are not subject to my analysis per se, but how they are employed by critics in articulating a position in the *AJOB* accounts shapes my understandings of the debates.

website describes it, “a conversation” about pressing bioethical issues.²⁴ And yet the *hope* of actually performing a transplant infused the debate. As Chambers (2004) writes, “They [Wiggins et al.] view the publication of their essay in *AJOB* as an important illocutionary speech act that will permit them to begin performing the surgery” (21).

The *AJOB* commentaries represent a unique moment in the development of a technological innovation. While research including animal trials, testing of anti-rejection medication, and cadaver experimentation were successfully completed, experimentation on human subjects did not commence as is often the case in biomedical research. In lieu of human experimentation, the University of Louisville face transplant team initiated a conversation with transplant surgeons, bioethicists, philosophers, immunologists, and psychologists to debate “the issues,” a strategy that Arthur Caplan described as “prophylactic ethics” (2004: 18). Institutional constraints, specifically university leaders’ refusal to support the team’s work, prevented human experimentation, but the team’s own

²⁴ *AJOB* attempts to structure the writing and review process in accords with this spirit of conversation. As the website describes, “*AJOB* does not leave the reader in the passive mode of reading. Unique JournalX technology lets the peer commentators respond to each other and to the Target article during their writing process. Then bioethics.net opens the conversation with additional Open Peer Commentary articles and online Letters to the Editor. Live conversations fill out the discussion of each Target Article. With the American Journal of Bioethics, Taylor & Francis Group and Penn have implemented a publishing system that is truly worthy of bioethics, a way in which scholarship about bioethics can reach the widest and most intellectually broad audience, magnifying the rigor, intimacy and interdisciplinary value of the discipline.”

insistence on deliberating social and ethical concerns spurred a series of publications (from 2004 to 2008) aimed at coming to some resolution about the “problems” of FT. The Wiggins et al. Target Article came at a particularly contentious moment. In 2003, a Working Party of the Royal College of Surgeons of England, an independent body of surgeons, refused to endorse experimental FT, arguing that the requirements it outlined for ethical practice had yet to be met (RCS Working Party 2003).

As a key site of ethical deliberation, *The American Journal of Bioethics* issue can be analyzed as a cultural space wherein questions and critiques about FT are articulated and the terms of contestation are highlighted. Here, I use the *AJOB* special issue on FT as a source of data about the making of a new technology. I identify and analyze the contours of the debate surrounding FT in order to illustrate the ways in which the face, more specifically the *disfigured* face, operates across various accounts to shape possible futures for this new technology. In identifying the salient questions circulating throughout the *AJOB* debates, I position the journal issue as an object of sociological analysis. Specifically, I focus on two seemingly self-evident questions: First, what are the *risks* associated with FT? Second, what are the *benefits* associated with FT?

In enumerating the risks and benefits of FT—or what is at stake—the *AJOB* issue provided a forum in which interested stakeholders interrogated the various and contested meanings of the procedure, specifically the technical and moral significance of repairing the face. I argue that FT was cast simultaneously as a vital *and* as a non-vital intervention, a risky *and* a relatively safe intervention. Specifically, proponents characterized FT as “non-vital” given that it is not “life saving” in the traditional sense of the term, but went onto to argue that the consequences of disfigurement are so severe that

fixing disfigurement is more akin to life saving work than life enhancing work. Given that disfigurement took on such weight, the risks of FT (including the risk of death) were positioned as a reasonable threat to gain the benefits of facial repair. Ultimately, then, debates about the risks and benefits of FT both contain within them notions of facial disfigurement as a form of suffering and reveal the individual and collective risks people are willing to endure to repair it.

Most central to the *AJOB* debates were estimates of/claims about physiological risks associated with FT, specifically the rate of rejection of foreign tissue and the side effects of immunosuppression. In addition, psychological risk, most often operationalized in terms of “identity crisis,” circulated as an ever-present threat. Critics also debated social risks associated with FT and the institutional protocols necessary for ethical experimentation. Against this litany of risks, proponents relied on a shared taken for grantedness that FT promises to assist patients to recover (from) disfigurement in ways that greatly exceed other modes of intervention.

Physiological Risks

Transplantation carries bodily risks. On this everyone agreed, but among the *AJOB* pieces, there were considerable discrepancies about what these risks entailed. Specifically, the rate of rejection emerged as the most contentious issue. In the world of transplant medicine, rejection is a specter to be prevented, feared, and managed. In a sense, transplantation medicine is as much about warding off threats of organ rejection as it is about transferring organs. Sociologically, claims about physiological risk and graft rejection are notable in part because they vary so widely both in numerical estimates and

in their conceptualization of the significance of “rejection.” Huxtable and Woodley (2004) argue that the face is one of the most antigenic tissues in the body. They, along with Strong (2004) estimate that, at best, one in five faces would be rejected within the first three years following surgery. Maschke and Trump (2004) cite the Royal College of Surgeons (2003) report estimating that ten percent of grafts will be rejected in the first year and that 30-50 percent of patients will experience graft loss function within the first 2-5 years, but they concede that estimates about rejection vary widely. Yet in the Target Article, Wiggins et al. (2004) argue that FT is no more risky than other reconstructive techniques which use a patient’s own tissue. The Louisville team claims that complications related to tissue donation are fewer than critics imagine since the tissue comes from a donor as opposed to the patient (as is the case when tissue is harvested from another location on the body). They buttress this claim with the fact that in the case of FT, patients experience one major surgical procedure as opposed to traditional means of reconstruction, which often require multiple, in some cases upwards of one hundred, surgeries.

While claims about the “actual” risks of rejection vary across accounts, the meanings critics attribute to rejection differ as well. Strong (2004) argues that because FT potentially involves transplantation of vascularized skin, subcutaneous fat, muscles, facial nerves, and bony facial structures, graft loss would result in major facial wounds. Yet proponents argue that graft rejection would “merely” return the recipient to a state of disfigurement similar to the disfigurement preceding the intervention (Agich and Siemionow 2004)—so disfigurement is specifically NOT a risk because it would simply replicate the original state prior to surgery. The implication is that rejection of the new

face is certainly a risk, but not one that should prevent face transplants from occurring. Because these journal debates occurred *before* clinical trials, estimates of the rates of rejection operate in place of empirically derived risks calculated post-experimentation. These various estimates are the basis upon which contributors oppose or support FT. Yet in all accounts, rejection operates as a significant risk, and one that must be thoroughly minimized through immunosuppression.

Immunosuppression or anti-rejection medication carries significant health risks, including infection and end-organ toxicity leading to diabetes and malignancies that can result in death. While contributors agree that there are risks associated with immunosuppression, the significance of the risks varies. While transplantation medicine provides a theoretical framework for thinking about how these drugs work on the human body, the particulars of FT make the work of identifying the risks of immunosuppression an exercise in estimation rather than an empirically grounded project. The specificity of transplantation matters. Recipients of organs like kidneys are critically ill at the time of transplantation. By contrast, FT recipients are what is often referred to in clinical contexts as “grossly disfigured” but not critically ill. How critics approach FT as similar or different than other kinds of transplantation impacts the ways in which they conceptualize the risks of immunosuppression. The only empirical evidence upon which to estimate risk is research conducted in relation to hand transplantation which explored complications related to tacrolimus and mycophenolate mofetil/prednisone combination therapy, the drugs the Louisville team argues would most likely be used for FT. How researchers made sense of this data, particularly the fact that information was based on cases of life saving transplants, varies.

On one side, critics argue that undoubtedly a face transplant would increase recipient's quality of life but that immunosuppression would threaten life itself. The patient may, in fact, be accepting a shorter life in favor of a better life (Petit et al. 2004). Yet the Louisville team argues that risks associated with immunosuppression are far less significant for face transplant recipients than for other transplant recipients. They claim that recipients of FT will be less compromised than recipients of other kinds of transplantation because they have not experienced chronic disease (Wiggins et al. 2004). Debates about the risks are sociologically significant for two reasons. First, these debates demonstrate how facts are subject to deliberation and contestation, an insight established throughout science and technology studies. Second, and more importantly, the *AJOB* commentary illustrates that how risk is construed deeply affects the direction of medical innovation and the terms upon which ethical debate rests. In other words, a technology comes into formation depending on how risks are construed and represented in ethical debate, and at the same time the contours of bioethics shift as new ways of thinking about risk emerge.

Taken together, debates about the physiological risks of surgery, rates of rejection, and effects of immunosuppression deeply structured how FT is positioned as a risky or safe medical intervention. In some accounts, FT is imagined as an incredibly threatening intervention, specifically a life threatening practice. Others treat these concerns as overblown. Yet all sides ultimately wrestle with the following question: Is disfigurement a condition in which compromised health (or even death) is an acceptable risk to be incurred to improve appearance? Clearly, the answer to this question extends far beyond physiological factors.

Psychological Risks

While transplantation always involves a multitude of risks, critics suggest that the transplantation of a human face seems to elicit unique concerns about psychological risks.²⁵ Thus the physical risks of FT are outlined in conjunction with psychological risks. If the question that informs concerns about physical risks centers on the loss or rejection of the graft (and subsequent disfigurement) alongside the risks of immunosuppression, then the concerns that dominate debates about psychological risks center on the loss of identity and mental stability. In the *AJOB* exchange, then, FT is positioned as a technology with incredible power not only to reconstruct the face but also to undermine the very parameters of the self.

The Louisville team argues in the lead article that potential psychological risks of FT are akin to those faced by solid-organ transplant recipients including:

“a desperation that creates unrealistic hopes, fears that his or her body will reject the transplant, guilt feelings about the death of the donor, difficulty conforming to the treatment regimen and its side-effects, and a sense of personal responsibility for the success of the procedure (Zdichavsky et al. 1999)” (5).

Psychologist Nicola Rumsey (2004), who specializes in disfigurement and is a contributing member of the Working Party of the Royal College of Surgeons in England,

²⁵ The work of Margaret Lock (2001), Lesley A. Sharp (2006), Linda Hogle (1999) demonstrates that psychological risk has long been positioned as a risk of transplant surgery. *AJOB* contributors suggest that the face elicits *unique* psychological risks. In this way, critics imply again that something about work on the face is different than work on other parts of the body.

concurr that the psychological risks of FT are similar to other kinds of transplantation.

She notes:

“These include fears relating to the viability of the transplanted organ or limb, fear of the aftermath of rejection, the burden of adhering to complex postoperative medical and behavioral regimes and associated fears of personal responsibility for the success or failure of the transplant, coping with the side effects of immunosuppression, the difficulties of integrating the transplant into an existing body image, and identity, and emotional responses, including gratitude and guilt, in relation to the donor and family” (22).

Yet Rumsey also understands the psychological risks of FT to be unique because of the particular significance of the face and the psychological effects of facial disfigurement and wonders about the psychological costs recipients would endure while waiting for a facial tissue donation—would life be put on hold in the meantime? Others reject claims that the psychological risks are as serious as many claim, arguing that even in cases with terrible outcomes, the patient would be back to where she or he started and not worse off. For example,

“The psychological consequences of graft rejection would undoubtedly be significant, but the significance relates to the fact that the patient would return to a situation of disfigurement that preceded the facial transplantation. The graft failure would return the patient to a state of disfigurement similar to the pre-transplant disfigurement” (Agich and Seimenow 2004: 26).

In particular, contributors debate how a *new* face might transform a recipient's identity, the assumption being that the repair promised by FT would be beneficial but fundamentally life altering. As Wiggins et al. (2004) claim,

“What is unique to facial transplantation, however, is that facial appearance is intimately and profoundly associated with one's sense of personal and social identity” (5).

Proponents and critics alike express concern about psychological risks, but they disagree about the degree to which FT might alter a recipient's identity. Huxtable and Woodley (2004) seem to downplay the effects of a new face, arguing that *all* transplants complicate a patient's identity. Others, in contrast, imply that FT could lead to an identity crisis (Baylis 2004, Strong 2004).

Social Risks

In addition to the physiological and psychological risks of FT, several contributors address the “social risks” of FT, including risks to potential recipients' social support networks and risks to society writ large. In his response, Strong (2004) raises questions about how a new appearance might affect a recipient's social networks.

Several critics focus on how the patient's family will respond to the new face (Agich and Siemionow 2004, Wiggins et al. 2004). Other concerns include the burden of caring for someone who has received a face transplant (Rumsey 2004) and impacts on the family of donation procedures.

Concerns about how FT might impact society's views of science mostly focus on how media (mis)representations shape public understanding. Some critics worry that the

media can not be trusted to “accurately” represent the story of FT and that sensationalism might result in a demand for cosmetic (i.e., clearly “nonvital”) face transplants (Rumsey 2004, Wiggins et al. 2004). Petit et al. (2004: 15) warn that “care should be taken to not frighten or repulse the population” given that this is a “Frankenstein story.” They add that “FT is *not* a weapon of mass distraction” and as such should not be used towards entertainment purposes, fearing that these kinds of stories will exacerbate the organ shortage. Huxtable and Woodley (2004) posit that the public may reject the procedure based on the “YUK! factor” or on grounds that it meddles with “nature.” Other teams worry about what transplantation conveys about the quality of life with facial disfigurement. These critics worry about sending the message that a good quality of life is not possible without radical intervention (Rumsey 2004, Wiggins et al. 2004).

Beyond the work of identifying risks, critics inquire about the institutional and ethical protocols for FT. In particular, concerns about patient selection, patient and donor confidentiality, and donation procedures circulate throughout the *AJOB* issue. Most commentators agree that the premiere patients need to be psychologically stable and understand the risks of the procedure. In other words, ironically, those who have adjusted to their disfigurement would make the best patients (Huxtable and Woodley 2004; Wiggins et al. 2004). This leads to a Catch-22 wherein those who might actually most want the procedure have been defined by scientific and ethical communities as poor patients (Powell 2006). Critics like Butler et al. (2004) demand that a team develop a thorough protocol for psychological assessment of potential patients. In the Target Article, the Louisville team outlines a protocol to obtain informed consent and to institute ethical experimentation, suggesting that candidates be assisted by a patient advocate, but

they argue that scientific reporting might compromise their ability to assure patient and donor confidentiality. Because they intend to use unaltered photographs in scientific contexts, the Louisville team acknowledges that a patient's identity could be discovered. The Louisville team rejects standard ethical protocol in an additional way, proposing that patients will not be able to withdraw after they begin treatment (Wiggins et al. 2004). (This distinguishes face transplant trials from other clinical trials which are often premised on the patient's ability to withdraw at their discretion.) Critics argue that it will be virtually impossible to ensure the confidentiality of patients and donors, but that researchers should attempt to guarantee patient and donor anonymity at all costs (Agich and Siemionow 2004; Miles 2004; Rumsey 2004). In the case of biomedical innovations such as FT, there seems to be a tension between preserving patients' anonymity and publicizing medical successes. The concerns about confidentiality point to a much larger question—how do researchers preserve ethical standards, specifically confidentiality, while publicly exposing and celebrating biomedical innovation?

Critics pose multiple concerns about donation procedures, questioning the feasibility of face donation given American rituals surrounding death. Given the prevalence of open caskets, how will a donor's "body integrity" be preserved and/or restored (Petit et al. 2004) and how will families contend with the fact that their deceased loved ones have been disfigured in death (Caplan 2004, Rumsey 2004, Strong 2004)? How will families "say goodbye" when they are left with a faceless corpse (Agich and Siemionow 2004)? Others argue that the question of donation must be seriously considered since the face signifies a continuation of the deceased in a way that a kidney, for example, does not. Because loved ones tend to think about and remember the

deceased in terms of their faces, it is important to consider whether the family will, in the case of donation, believe that their loved one is living on (Robertson 2004). And if so, what are the consequences?

Benefits?

Central to the task of assessing the risks and the benefits of FT is the designation of FT as a “non-vital” procedure, but given the significance some critics accrue to work aimed at recovering disfigurement, the designation of FT as “non-vital” (and thus implicitly “life enhancing”) seems precisely at stake in the debates. The Wiggins team begins with the assertion that FT is a “non-vital” intervention:

“With the relatively recent advent of human hand transplantation, however, ethical reflection has shifted to the need to weigh the risks the patient assumes for the sake of receiving a donated organ that, unlike a heart or liver, is not necessary for his or her survival” (2004: 1).

According to the Louisville team, rather than “life,” the aims of FT include

“a person’s self-image, social acceptability, and sense of normalcy as he or she subjectively experiences them” (1).

The team continues by emphasizing how FT is different from other kinds of transplantation precisely because it is life enhancing rather than life saving:

“While using transplanted tissues to reconstruct facial deformities would significantly improve a patient’s quality of life, in most cases these procedures would not be life-saving in the strict sense of the word. This situation stands in

contrast to life-saving treatments, like heart and liver transplants, in which the risk/benefit ratio is more readily conceptualized” (Wiggins 2004: 3).

But what does life saving in “the strict sense of the word” mean? In what ways does face transplant stand in sharp contrast to heart and liver transplants? Is FT inherently different from these “life-saving treatments” or, rather, is FT conceptualized differently? And most importantly, what are the consequences to patients, to innovation, to the biotechnomedical complex, to lay publics of conceptualizing FT as altogether different from life saving interventions? Conversely, *how does a life risking intervention require reconfiguring the object of intervention—disfigurement— as life threatening?* In other words, how does disfigurement take shape as a life threatening condition in sites aimed at fixing the face? While the Louisville team relies on traditional characterizations of FT as “non-vital,” the nature of the intervention calls into question the very terms of the debate. Throughout the *AJOB* debates, critics infer what the stakes of facial disfigurement are and subsequently what constitutes a vital and non-vital intervention.

At the most basic level, the *AJOB* operated as a forum for risk-benefit assessment. Much of the commentary was devoted to identifying, contesting, and questioning the physiological, psychological, social, and institutional risks associated with FT. And yet, in the context of procedural deliberation about risks, the benefit of FT was taken for granted. That is, proponents and even many critics resoundingly agree that the technology would benefit patients in ways that exceed traditional techniques, despite the risks articulated above.

Butler and his colleagues (2004) ask “To what benefit?” but rather simplistically answer,

“[T]he desired outcome for this type of surgery clearly [would] be improvement in the facial function and appearance and not normality” (16).

In a similarly reductionistic tone, Robertson (2004) writes,

“Face transplants are electric because they are aimed not at treating end-stage organ disease, but at improving the patient’s quality of life in a central aspect of personal identity. In this case the improvement appears to be so crucial to the patient’s well-being that the risks and costs of life-time immunosuppression seem justified” (32).

In this way, the technology is made to speak for itself; that is, its benefit is considered to be self-evident. Despite the multitude of risks identified in the debates, there is a shared assumption that biomedical innovation is intrinsically beneficial.

Only the Louisville team specifically outlined the functional, aesthetic, psychological *and* social benefits of FT:

“When, as in most cases, the original tissues are not available, autologous tissue and/or prosthetic materials are used to reconstruct large tissue defects of the face. In these situations, complications caused by prosthetic materials (e.g., infection or rejection) are common, donor site morbidity (at the location from which the autologous tissues are taken) is almost, always present, and multiple “revision” operations and prolonged rehabilitation are usually required. Moreover, functional and aesthetic recovery is usually poor, and the resulting deformity almost always leads to major psychosocial morbidity. The latter in turn often prompts these patients to retire to a secluded environment, becoming social recluses (Lefebvre and Barclay 1982; MacGregor 1990). A possible solution to

the above scenario is to reconstruct these severe facial deformities with identical tissues transplanted from brain-dead human donors (Composite Tissue Allotransplantation), as is done in solid organ transplantation (2).”

In this fragment, the benefits of FT are outlined but not elaborated in any great detail, a criticism noted by Goering (2004) in her response to the team’s article. In fact, the benefits are articulated in reference to the effects of other kinds of interventions aimed at facial disfigurement. By juxtaposing FT with traditional reconstructive techniques, it is positioned not only as a mode of repair for the face but also as an alternative to the additional disfiguring and social isolating effects of other medical interventions. In this account, the primary benefit of FT is that it is *not* reconstruction.

In the most specific references to the benefits, authors point to functions of the human face, writing that the face is the source of vocal communication and a means for non-verbal communication and that FT could restore blinking and improve oral continence (Huxtable and Woodley 2004; Wiggins et al. 2004). In a very real way, then, the debate about risks versus benefits leaves open the question about what precisely the benefits of FT are. In effect, FT is taken for granted as a promising intervention, albeit a risky one.²⁶

Ultimately then, infusing the *AJOB* debates are two spectacular images of FT—that of severe disfigurement erased and that of incomprehensible consequences—both

²⁶ FT is undeniably a revolutionary procedure. As the results of the few experimental transplants reveal, the results are dramatically better than can be effected by traditional reconstructive methods.

written on the face. Caplan describes the risks as “staggering” and in the most critical analysis that appeared in the issue, he writes,

“It is not certain that the transplant will result in a functioning or even partially functional face. The drugs required to maintain a transplanted face are powerful, noxious, and potentially life-threatening. If the procedure should result in acute rejection, then the subject may die with the entire graft sloughing off his or her head. Even if that grim prospect does not occur, chronic rejection problems may be such that the recipient is exposed to doses of immunosuppression that lead to cancer, kidney failure, and other major problems. And this presumes the subject is compliant with the postsurgical regimen, a state that some patients find very difficult to achieve post-transplantation. Not only are the prospects of physiological complications and functional failures very real, but the first face transplant recipient will face enormous psychosocial challenges as well. Their ability to retain their privacy will almost certainly be nonexistent” (18-19).”

In contrast, FT proponents Agich and Siemionow (2004) claim:

“Arthur Caplan has been widely quoted as saying, ‘What will you do if a face transplant fails?..I understand a disfigured face may be terrible to live with. But if a transplant should be rejected you’re basically dying. That’s a serious, high-stakes issue’ (Allen 2003). This is clearly an overstatement , one that Caplan would not likely claim in a published article...We think that the inordinate suffering of patients with severe disfigurements should be recentered in the public ethical discussion (26).

In a sense, Agich and Seimenow's response to Caplan disregards his concerns and instead positions FT as a crucial technology for alleviating suffering. E. Haavi Morreim (2004) goes much further, narrating the story of encountering a disfigured taxi driver,

“This is not the story of someone who would qualify for a face transplant. But it hints at the enormous difficulties facing people whose appearance is abnormal. What outsiders might categorize in dry academic terms as ‘quality of life’ is for some of these people a very real assault on their personhood and their membership in society. Their problems will not be remedied by urging people to be more tolerant. Neither can we downgrade the idea of transplant because facial abnormalities are not life threatening. As autonomous adults we routinely do, and must be free to, undergo substantial risks to improve our quality of life and act on the many other values we hold dear. If general anesthesia is an ethically permissible risk for a cosmetic face lift, then so, surely, can significant medical risks be acceptable in hope of a significantly greater gain for those who are grievously disfigured” (28).

In contrast with Caplan, the latter two accounts forefront the risks in order to position FT as particularly incredible. Each argues that disfigurement is so imbued with suffering that the procedure may be worth it, *in spite of and because of* the significant risks. It is by centering “inordinate suffering” and “enormous difficulties” in the description of what life with disfigurement entails that makes the risks associated with FT justifiable.

Benefits of FT are not only taken for granted in the *AJOB* debates, but they are taken for granted in a very particular kind of way. Proponents acknowledge that, technically, FT is not life saving. Morreim characterizes facial disfigurement as “not life

threatening.” He along with other contributors who mention the benefits concede that ultimately FT is an intervention aimed at improving “quality of life.” Yet their accounts imply that what FT accomplishes is different than what other life improving interventions achieve. Morriem compares FT with a cosmetic facelift and concludes that FT is infinitely more beneficial. Thus, while critics employ traditional notions of vital and non-vital to characterize FT as technically “non-vital,” they also suggest that FT is different than other interventions that are “life enhancing.” Proponents argue that FT alters “central aspects” of a patient’s life, yields “crucial improvements,” and ameliorates the “assault on their personhood and membership in society” caused by disfigurement. These are benefits that are different from the benefits offered by interventions like “life saving” transplantations *and* by “life enhancing” technologies like face lifts.

FT is simultaneously differentiated from “vital” interventions but positioned as more significant than “non-vital” interventions. Thus, some of the cultural work accomplished by the *AJOB* commentaries is simply imagining the present and future possibilities of FT. On the pages, it took shape not simply as a technological artifact but as an actor in the story.²⁷ Across these varied accounts, FT takes shape as a risky practice but as one with incredible potential to alleviate human suffering. Specifically, it

²⁷ It is no surprise to scholars of science and technology that artifacts work as actors. In fact, actor network theory is based on this idea. In Latour’s (1987) explication of the “roles” technologies play in the making of science, he pays careful attention to the ways in which non-humans are produced by humans and subsequently shape human action. The case of face transplantation demonstrates how non-humans are also imbued with personalities that shape the making of science and technology.

emerges as something with the potential to make life worth living, to give patients a place in society, to alleviate deep suffering. In this way, FT is positioned as a “life saving” practice, albeit life saving in a new sense of the term.

Ultimately, positions are founded on particular notions about the significance of the human face. Part of what explains the variance among where critics stand in relation to FT is how each conceptualizes what the face means. For example, if the face is reduced to appearance (and appearance is conceptualized as non-essential), then it is not reasonable to incur the risks of immunosuppression to repair it. If on the other hand, the face is, as contributor Robertson (2004: 32) wrote, “the external manifestation of our persons (our souls?)” then the “reasonable” risks might very well include threats to life. In other words, if the face is vital to human life then FT can more easily carry the designation as a vital intervention. On the other hand, if the face is extraneous to human life then it remains different from “life saving” organ transplants.

We Submit that the Time is (Not) Now

The debate over risks and benefits of FT demonstrates much more than the cost-benefit analysis so endemic to the modern biomedical complex. The debate did not end in a position, made possible through calculation and weighing of the risks and benefits. This is not particularly unusual. Bioethics debates often take the form of sustained conversation that result in no clear answer about how innovation should proceed. Yet, the specific terms through which the debate unfolds reveal a working set of assumptions about how interventions are organized, when they are deemed necessary, and how risk and human experience are understood and structured into medical practice.

Contributors' conclusions about the future of FT widely vary, with some calling for immediate experimentation, others expressing reservations, and still others rejecting the technology altogether. As would be expected, the University of Louisville team endorse immediate experimentation with a relatively simple declaration:

“There arrives a point in time when the procedure should simply be done. We submit that that time is now” (2004: 11).

Petit and his colleagues were the closest in agreement with the Target Article writing,

“[O]ur position is that FT could now be performed. The switch from “could” to “should” depends on the ethical conditions surrounding the procedure” (2004: 15).

Many others did not agree. Butler and colleagues (2004) ultimately endorse the procedure but call for caution before experimentation:

“There are a large number of ethical issues that require consideration, and it is imperative that this occur *before* any face transplants are carried out” (*my emphasis*, 17).

In a more scathing critique, Arthur Caplan contends that the Louisville team had not satisfied the ethical standards of experimentation:

“Any experiment should not only be the subject of moral reflection and deliberation prior to its initiation, but also must be able to successfully engage the concerns and objections raised as part of that process. Has this standard been met in the case of FT? I do not think so” (2004:18).

The implication embedded in both Butler et al. and Caplan's responses is that the *AJOB* debates have not sufficiently resolved ethical concerns but that FT is potentially an ethically viable intervention.

By contrast, others conclude by contesting the very idea of FT. Nichola Rumsey writes,

"The Louisville team feel [sic] that the time is right to undertake face transplants. The headline benefits of a normal appearance and fully functioning facial communication are certainly seductive, however, the message in the small print is much less clear-cut...[S]urgical solutions rarely provide miracle cures for complex psychological issues" (2004: 24).

Sara Goering (2004) echoes Rumsey's critique, writing,

"But are their faces truly the source of their suffering? Our faces are intimately tied to our identities, and accepting oneself requires coming to terms with one's face...Suffering can be addressed in multiple ways, and we should be careful about offering services that frame the problem as primarily an individual deficit. Such a focus may exacerbate our tendency to misidentify sources of suffering" (38).

In this way, Rumsey and Goering reject FT altogether as a response to facial disfigurement and seem to eschew medical intervention, opting instead for intense psychological treatment and a radical restructuring of aesthetics.

While the questions that circulate throughout the debates are often positioned as empirical questions by critics, I argue that the work of posing and debating these points

represents a crucial step towards infusing FT with meaning and significance. One contributor, taking note of this tension, writes,

“The question posed in this commentary is not whether the research team got its facts right or jumped through the ethical hoops gracefully, but a deeper one about the production and use of ‘objective’ empirical data associated with composite tissue allotransplantation (CTA) and the assessment of their ethical relevance to the determination of whether this experimental procedure should proceed” (Ankeny and Kerridge 2004: 36).

As a technology in the making, the *AJOB* debate is characterized by uncertainty and fantasy, and ultimately, the debate raises more questions than it answers. Critics and opponents alike argue that several scientific and ethical questions need to be resolved before clinical experimentation,²⁸ but these answers are available *only through* experimental practice, and even then “facts” are not self-evident. “Facts” themselves must be given meaning and significance. The debates, in and of themselves, actually do very little to establish the “truth” of FT with which science can proceed, but they act as a forum wherein ideas, fears, and hopes about this technology are articulated and, subsequently, disseminated.

Ultimately, the question that guides the debate as a whole centers on whether or not FT, even in its most ethical form, should be attempted at all (though several contributors frame their positions in technologically deterministic terms—how *should* FT

²⁸ Proponents of immediate clinical trials argue that uncertainties about the innovation can only be resolved by attempting the procedure. Critics argue that because we do not have answers to critical questions clinical trials should not be attempted.

proceed?) . Subsequently, critics wrestle with one central question—do the benefits of FT outweigh the risks? In particular, does a future with a face transplant (as opposed to a face repaired through traditional reconstructive techniques) justify the risks associated with immunosuppressive drugs? This question activates an engaged and highly divisive set of responses that attempted to work through the significance of deploying a risk-laden technique in the service of what has historically been understood as life enhancing, rather than life saving, intervention. In essence, this question about risks versus benefits animates concerns about technology, questions about what constitutes life, and worries about human suffering. The debates about the risks of FT contain arguments about life itself, particularly what constitutes life saving work

And yet, the debate opened up big bioethical questions that remain obscured in the talk about specifics of FT. In the final response in the issue, “Medical Ethicists, Human Curiosities, and the New Media Midway,” Steven H. Miles analyzes the debate that precedes and offers a perspective about the work accomplished via the deliberation relative to the field of bioethics. Miles characterizes the *AJOB* debate on FT as a “medical docu-soap” a form of what Dovey (2000) calls edutainment. He argues that a contract governs the public work of bioethicists. According to Miles, bioethics is not “allowed to reflect publicly on why particular subjects or framings of the issues have been chosen” (41). And yet the framings of a subject have very real effects. How disfigurement is framed seems to be evolving and how it is framed will do much towards determining the future of FT. In an era when life is hardly a stable or unambiguous designation (consider that organ donors’ hearts continue to beat until the organ is harvested), it is not entirely self-evident what it means to characterize FT as a non-vital

procedure. What is clear is that the *AJOB* debates contains within it the first echoes of a radical reappraisal of disfigurement, specifically as a “life threatening” condition.

It should be no surprise that no consensus emerges in the *AJOB* debates. No protocols are formulated. No timelines are produced. No funding is attained. No institutional partnerships are formed. If the debate is conceptualized as a key moment in making FT come into its own as an emerging technique, it is arguably a failure. In a very real way, nothing that has transpired relative to FT can be firmly sited as a direct result of the *AJOB* commentary. But in another sense, the debates are and continue to be incredibly momentous. The debates open a Pandora’s box that promises to be increasingly salient as technologies that improve the quality of life while simultaneously threatening life emerge. The question of whether to intervene or not requires some interrogation about the circumstances in which life is, in short, not worth living and some claims making about whether or not medicine can make such a determination.

The Disfigurement Imaginary

As science studies scholars routinely find, the work of innovating technologies is more mundane than spectacular “science news” coverage suggests. Oftentimes, the development of medical practices occurs within the university, and as such, the emphasis on respectability, protocol, and institutional politics abound. In the case of FT, and in most innovative procedures, what appears to be revolutionary science is built on a foundation of mundane scientific tinkering (animal experimentation, immunology studies), intellectual labor (scientific theorizing, articulation of ethics arguments), and political maneuvering (grant writing, Institutional Review Board submission). In this

way, the everyday reality of the work of a face transplant team is perhaps surprisingly ordinary to those unfamiliar with the inner workings of medical innovation.

The face transplant team I studied met at a 7 AM Monday morning meeting, each week for almost three years. The meetings were held in a commonplace conference room in an ordinary building with an unremarkable name—Med Center One. At the meetings I observed, those who attended varied, but four key members of the face transplant team emerged. The team was led by a leading plastic surgery researcher whose career had been spent innovating techniques including hand transplantation.²⁹ In addition, a philosophy professor served as the team’s bioethicist, while a sociologist and a psychologist offered insights about the social psychological facets of FT. While the team was also comprised of medical students along with additional clinicians and researchers, these four comprised the hub around which the team’s work was organized and carried out.

While the topic of the meetings might be spectacular, the meetings were routinized and commonplace. From the time I first attended a meeting in May 2006 until the team disbanded in July 2007, the work of the team was almost entirely focused on disseminating results of the team’s research, particularly those based on what the team called the LIFT survey and articulating an ethical approach to FT. The face transplant team’s relationship with their institution, specifically hospital administration, is critically important for understanding the work of the team. Although the team had established the

²⁹ I use pseudonyms in place of team members’ names to protect anonymity and to emphasize that this account is not about the particular characters that occupy the case but rather about the discursive structures deployed within the site.

scientific understandings and technical skills needed to complete a transplant, the institution had rejected requests from the team to serve as a site for human experimentation. There was to be no face transplant at the team's home institution nor were any team members to participate in any transplant anywhere else in the world. In a strange way then, the team's immediate goal was not to complete a face transplant, rather the central task was rhetorical—professional and lay publics needing convincing that FT could and, in fact, should proceed. The work of the team took two related forms: collectively developing arguments based on the team's research and collaboratively completing the mundane tasks of scholarly research, specifically writing articles for publication in peer-reviewed journals. The meetings of the FT team were similar, then, to other sites of academic collaboration:

As is typical, the director opens up his notebook, a bound journal, to review his notes on the manuscripts in process. One by one he goes through the team's writing projects. The team will talk details. Who is writing what? Where are they sending it? Who is its intended audience? Can the stats be made more intelligible? But in the midst of these details, the team discusses why the team is writing the pieces they are writing. What purpose does each serve? The goal is clear—the team is establishing ethical arguments and extending knowledge for the purpose of facilitating FT (fieldnotes April 16, 2007).

At any one time, the team worked on multiple articles. Several were aimed at putting medical specialties in conversation with one another. For example, the team submitted an overview of FT to a general plastic surgery journal with the aim of introducing the

immunological information to professionals with the technical skills to complete face transplants. Other pieces focus on the ethical questions raised by FT.

Much of the team's writing examined the psycho-social consequences of FT. The most crucial piece of research completed by the team was a survey, known within the group as the LIFT questionnaire. The survey, largely developed by the psychologist who worked on the team, was aimed at empirically demonstrating the risks individuals were willing to incur in order to receive a face transplant. From the perspective of the team, critics' claims hinged on the assumption that the risks of FT were too great relative to the benefits. To combat this claim, the team decided to interrogate this operating assumption empirically, specifically by asking respondents a series of questions indicating the level of risk they would assume in order to receive a face transplant to repair facial disfigurement. The head of the team describes the results of that research:

“Over the years, we've had over 300 people fill that [the LIFT survey] out. And that population that has filled it out are people who are missing their hand, i.e., somebody that could benefit from a hand transplant; people that are missing their larynx, i.e., somebody that could benefit from a larynx transplant; facially disfigured, i.e., somebody that could benefit from a face transplant; kidney transplant recipients, i.e., somebody that lived with the risks of immunosuppression. Also we had controls that are healthy individuals who do not have direct experience with either with the risks or the benefits and plastic surgeons and transplant surgeons... In a nutshell, what came out of all that research over the years is that regardless of who you ask everybody (and these are people without larynx, hands, with disfigured faces, on immunosuppression),

everyone would risk absolutely the most to get a face transplant than any other procedure. Even the kidney transplant recipients would risk more to get a face transplant than the kidney that they already have and they are on immunosuppression... If I came to you and said that you needed a heart transplant otherwise you would die, but that you would have to take very toxic drugs for the rest of your life to ensure that the heart does not reject. You would probably tell me that yes, you would take those drugs to get a heart because the alternative is death. There, there is no debate about the risks vs. benefits. Whereas in hand or face transplantation, you can live a healthy life without a hand or with a disfigured face and so we as physicians are exposing you to the toxicity of immunosuppressive drugs and in exchange for that we're not saving your life we're just improving the quality of your life. That is the crux of all of our research, i.e., analyzing what risks people would be willing to expose themselves to for the benefits of one of these non-lifesaving procedures. That is what the LIFT questionnaire addresses exactly ... We try not to inject our opinion but the opinion of 300 respondents to our questionnaires and these are people with direct experience with the benefits and the risks of immunosuppression. These are not our opinions. These are the opinions of people with real life experiences.”

Several claims are made using the LIFT research. First, those with direct experience of the risks of immunosuppression agree that a face transplant is worth the side effects of the drug regimen. This is tantamount to arguing that the benefits outweigh the risks. By interpreting the results in light of respondents’ “real life experiences,” the LIFT survey is given weight because it captures a kind of authority that critics, with presumably no real

life experience, do not have. Second and related, those already negotiating chronic illness and disability understand facial disfigurement as somehow worse than other kinds of bodily suffering. Getting a new face is positioned as more important than many other kinds of interventions, including kidney transplantation which has saved the lives of some LIFT respondents. The rhetorical force of the LIFT survey centers on the assumption that those with personal experience can say. What they say is that any risk is reasonable for the benefit of a new face in cases of severe disfigurement.

The head of the team clearly characterizes FT as non-vital, remarking that FT “just” improves quality of life, but the LIFT survey results suggest that the work accomplished by FT is anything but “just” another intervention. By conveying that any risk is justifiable for the sake of facial recovery, the LIFT survey positions disfigurement as particularly threatening. The construction of disfigurement as a very particular kind of bodily impairment is a significant, albeit unintended, component of the work accomplished by the face transplant team.

In this way, the team’s work is twofold. Empirical research gives FT shape as a medical intervention, a bioethical object, and a social issue. At the same time, research relies on and works to actively infuse facial disfigurement with meaning. While constructing “disfigurement” is not an explicit aim of the team, their work implicitly relies on notions about how facial disfigurement shapes human life. In interviewing the four key team members, relationships between disfigurement, human suffering, and the hope of intervention are continually discursively negotiated. Consider the following excerpt from an interview with the team’s director:

“The hand and the face are very unique parts of our anatomy...As you sit here and talk to me and as I respond to you, you are using your hands to express yourself to me...Not only do we use them for doing our daily activities, but we also use them for expressing ourselves. That is uniquely human. If you talk to the hand transplant recipients, and you ask them years after they’ve had their transplanted hands: what is the most important part of getting a hand transplant? All of them, the first thing they say are things that are more related to being a human being... ‘Now I can wear a wedding ring.’ That’s something that doesn’t have a lot of function. It’s symbolic. ‘Now I can walk downtown holding my daughter’s hands.’...There are very emotional human aspects of having a hand...With the face, it’s the same but times ten. Our faces, we use to communicate to the world around us, it is a window through which people see our emotions. The perfect example of that is to sit across from someone with severe facial disfigurement. It’s not only that the person with the disfigurement feels uncomfortable but you, we, as human beings it is very difficult to sit across from someone who is severely facially disfigured... we feel uncomfortable. We don’t know where to look. We feel uneasy. All of that emotion comes from the fact that we as human beings can’t live without our faces. We take cues of communication from looking at people’s faces. When that is robbed from somebody because of facial disfigurement, it only underlies how important the face is to making us human. We’re social animals, without interacting with other human beings our quality of life is severely lessened. To be able to give somebody back normal human features is just a tremendous thing. One of the things that when we talk to people

we were considering for face transplantation... we ask them [is] what would you like to get out of getting a face transplant? It's funny because the answer that I've heard many times—I just want to be able to walk into a room and have nobody notice me. What does that mean? The face is so central to them that when they walk into a room and everybody just changes because they see this horrible facial disfigurement. All these people want is to be not noticed. To just have a healthy looking face. The face is just a tremendous part of us as human beings. I would even venture to say with all the debate about risks versus benefits and that it's not life saving. I would say it *is* life saving...not just quality of life improving."

In the preceding excerpt, the face is characterized as a crucial bodily part, a fundamental element of humanity. Face transplantation is described as such a "tremendous" development in reconstructive surgery that its ends are not simply life improving but rather "life saving." Each of these claims are informed by an idea that circulates throughout the interview, namely that facial disfigurement is "horrible." More specifically, if taken to their logical ends, the notions of the importance of the face and the significance of face transplantation rely on conceptualizing facial disfigurement as deadly and as a threat to one's humanity.

Other interviews echo these sentiments. When asked to respond to critics who suggest that efforts to develop FT should be redirected towards changing society's view of facial disfigurement, the team's bioethicist explains:

"The argument goes like this: people who are facially disfigured suffer a lot of discrimination, but the problem is with the discriminators. The problem is not with the facially disfigured...It's the general public who discriminates that needs

to do something about themselves...That's true...but suppose with face transplantation people could get a normal face and live better lives....There's certain people we could really help out from doing this, but we're not going to do it. We're going to wait twenty years, thirty years, forty years till society changes its opinion... In the meantime these people are going to live out their miserable life, behind closed doors, behind curtains, and they're going to die, but that's okay cause we're preparing for a better future in which people don't discriminate...That's using facially disfigured people as a means to an ends in a way you shouldn't do...We told ourselves anytime we get up to talk in public we will say, 'The best solution here is for the public to change it's attitude towards facially disfigured people...but in the meantime there's people who really suffer because they don't have a normal appearance and we think if you have the means to help these people you should use it. It's a medical benefit that we shouldn't withhold while we wait for society to change...' Politically it's very desirable, but it's unethical.”

This is a carefully crafted response, one that considers the possibility of social change while at the same time affirming the promise of FT. It is also a highly empathetic reaction. Ultimately, he supports FT because he imagines that it will alleviate profound suffering. Specifically, the bioethicist argues that waiting for social change while technologies are available to impact the present moment is an “unethical” response. Even though he imagines social change as a politically preferable response, he characterizes such a response as unethical because it allows for the unnecessary continuation of suffering. At the same time, embedded in his response are notions about what suffering

FT targets. Social isolation and, more startling, the specter of death haunt this explanation.

Death also appears in the narrative of another team member who describes how he became compelled to work on the face transplant team.

“A psychologist named Frances Cooke Macgregor...writing about disfigurement. She had a concept called ‘social death.’ She got me to thinking about how we’ve come up with different definitions of age. Age just doesn’t mean chronological years anymore. Now we have an emotional age, a maturation age, a middle age. I started thinking similarly along the lines of death. We can have different kinds of death. We have the death that everybody grieves. We also have brain death. Why can’t we have social death?...The stigma facing these folks, perhaps, is the strongest that still exists. It seems to be universal...It is the most damaging social disability that still exists...Reconstructive surgery does not bring them back to life. Face transplantation can do that.”

This account explicitly positions facial disfigurement as like death and FT as a kind of life saving intervention. The team psychologist, in an effort to characterize the importance of FT, analogizes disfigurement to cancer,

“The face is a primary organ of communication... Clearly, it doesn’t entail the same level emergency or immediacy as medication to cause someone to recover from an ongoing stroke or heart attack, nor is it a cure for cancer. But facial disfigurements are a form of social cancer given that it’s constantly intruding in your social relationships.”

Though this explanation somehow positions disfigurement as not as “immediate” as other bodily conditions, it nonetheless relies on a link between disfigurement and death. Taken together, the interviews with team members capture a shared way of thinking, and by extension, talking about facial disfigurement.

Sociologically, it is crucial to ask how ways of thinking shape response or intervention. Sociologist Chrys Ingraham (1994), drawing on Louis Althusser (1971), employs the concept of “imaginary” to highlight the ways in which ideas about heterosexuality structure gendered relations. For Althusser the concept of imaginary provides a way for understanding how ideology translates into social practice and obscures political and economic interests. For Ingraham, an imaginary is a way of thinking about reality that masks material conditions. She describes the heterosexual imaginary as “that way of thinking which conceals the operation of heterosexuality in structuring gender and closes off any critical analysis of heterosexuality as an organizing institution” (203-204). I position ways of thinking and talking about facial difference as a disfigurement imaginary. In doing so, I mean to highlight the ways in which how we think about facial disfigurement obscures the assumptions underlying responses to disfigurement and closes off critique of those responses.

First and foremost, the disfigurement imaginary presumes the tragedy of facial differences. Employing the disfigurement imaginary positions the experience of disfigurement as *inherently horrific*. In doing so, it reduces the experience of disfigurement to one of suffering. Second, the disfigurement imaginary naturalizes a “fix it” response. The disfigurement imaginary understands repair as a necessary and unavoidable response to facial difference. Disfigurement is positioned as an emergency

necessitating intervention. In this way, the disfigurement imaginary animates the imperative to repair and infuses the work object with meaning.

Third, the disfigurement imaginary is a way of thinking about faces but also about the work aimed at “fixing” faces. In other words, the disfigurement imaginary fundamentally understands facial difference *in relation* to face work. Finally, the imaginary positions recovery around the most mundane of outcomes—unremarkability. If facial difference is so horrific, then it is significantly beneficial to take on just a normal face, one that goes unnoticed in a room. In fact, producing a mundane outcome actually carries connotations as life saving work. Such a framing of face work is only possible when facial disfigurement is conceptualized as intrinsically horrifying, profoundly abject, and even deadly.

By positioning ways of thinking about disfigurement as an “imaginary,” I do not mean to suggest that the meanings accrued to disfigurement are not real. To the contrary, as W.I. Thomas and Dorothy Thomas (1928) suggest, “If men define situations as real they are real in their consequences” (572). While the disfigurement imaginary is a social fiction, it perpetuates a particular social reality. Faces are made intelligible as objects of intervention based on the meanings attributed to them. Thus, characterizing ways of thinking about facial variance as a disfigurement imaginary puts into sharp relief the ways in which ideological formations shape material practices and bioethics deliberation. Only by questioning the ways that disfigurement is thought about and talked about can interventions be critically analyzed.

As a social practice, face work simultaneously relies on and reinforces the disfigurement imaginary. As the mundane work of one FT team demonstrates,

intervention, especially one that is controversial because of the risks it entails, requires that disfigurement be positioned in a particular way. The disfigurement imaginary serves those ends, and thus it works ideologically to support the position that FT should proceed. Given that FT remains a technology in the making and that much of the work of the team is rhetorical in nature, the work of the team is not only giving voice to the disfigurement imaginary, which certainly persists in various arenas of social life, but also reifying the imaginary by continually relying on it in their work. It works to position disfigurement as deadly, and in the process calls into question the stakes of the intervention, implicitly reframing work on disfigurement as a vital intervention.

Bioethics in the Making: Disfigurement as “Deadly”

FT relies on boundary work of sorts (Gieryn 1983). In this instance, what is at stake is not a boundary between science and non-science but rather a distinction between the kinds of scientific work accomplished by FT. The boundary work currently unfolding around FT centers on distinctions between vital intervention as “life saving” work and non-vital intervention as “life enhancing” work. FT is clearly not a life saving or vital intervention in the sense that it does not ward off actual death, at least what is traditionally thought of as cessation of life. Yet as a way of thinking that undergirds FT, the disfigurement imaginary situates face work as life saving work, warding off what might be termed social death. Boundary work has high stakes. Characterizing the work of FT as “life saving” work relies on a particular notion of disfigurement and carries consequences for the project of bioethics.

Sociologically, it is important to ask what constitutes an “ethical” practice? When should an intervention be used? How should a new technology be employed? What limitations should be placed upon innovations? These are questions about the everyday practice of medicine, and while these conversations take up the nitty gritty of medicine, these questions depend on “metaethics”—the theoretical frameworks that infuse a particular knowledge and praxis claim (Shildrick 2005). Constitutive of the metaethics that determine ethical medical practice are conceptualizations of human life and notions about progress. Of course, “life,” “death,” and “progress” infuse debates about medical intervention, but what life and death and progress mean varies, changing in response to new technologies that interfere with how we have traditionally understood what constitutes life or death.

In the practice of articulating pragmatic ethical positions, bioethics often fails to name the metaethics operating in the process of staking an ethical claim. Yet metaethics saturates each and every claim about a particular innovation. In debates about FT, the question about whether or not the procedure is ethical persists. Bioethics stakes positions along a continuum characterized by unqualified support for progressing or unequivocal rejection of the technology. Not surprisingly, most critics, if not all, lie somewhere in the middle, supporting FT if (and only if) certain conditions are met and under specified limitations. These debates about whether to do or not to do a face transplant fundamentally ignore the metaethics operating and saturating bioethicists claims about the technology. As Shildrick argues, bioethics arising from liberal humanism organizes knowledge claims according to binary oppositions that rely on unequivocal boundaries between self and other, mind and body, subject and object, health and disease, and life

and death. It is this last binary that operates throughout debates about FT. Arguments over the ethics of FT rely on varied notions about what constitutes life, and they call into question how we want to conceptualize “life itself.” While heart transplantation elicited a real need for conversation about what constitutes death, FT demands a reevaluation of what counts as life. Can one “live” with a disfigured face or not?

The central task of bioethics is one of claims making (Aronsen 1984). As the *AJOB* debates reveal, the truth is not self-evident. A future for FT will take shape in accordance with those claims that come to be counted as true. It is a rhetorical practice, wherein arguments are made to defend a particular position. The “strategic claims making processes” that comprise the work of bioethics have significant consequences. Each position imagines a different future for medical intervention. Each set of claims relies on implicit definitions of life and death. Specifically, it begs the question: are we to take social death as seriously as biological death? The history of bioethics reveals that while terms like life and death are contested in response to debates about specific interventions, how life and death come to be understood extend far beyond the reaches of the particular technology at stake.

There is another story of transplantation that dominated our collective imaginings. The emergence of heart transplantation elicited public fascination. The procedure not only signified a technological feat but also required a redefinition of life and death. Consider that in the last thirty years, death has been radically reappraised such that new interventions are made possible but concomitant with that transformation is a much less visible though equally massive development. How we encounter those most dear to us has changed. Some of us can now easily conceive of the mother/partner/friend whose

heartbeat and respiration is made possible with technological support as, in fact, *not* living, as dead, and more specifically as a possible organ donor. How will situating disfigurement as a form of death and framing interventions which traditionally have been life enhancing as life saving infuse other domains of life? How will this radical reappraisal of vitality determine our bodily futures?

FT troubles how we conceptualize life saving and life enhancing work. If disfigurement is merely unfortunate or even tragic, it is not ethically justifiable to pursue FT, given its myriad risks. But if disfigurement is life threatening as the disfigurement imaginary presumes that it is, then FT promises to be a revolutionary mode of repair, a tremendous innovation in reconstructive surgery. FT captures our imaginations because it seems so radical, unfathomable, too risky. And yet when we hear the story of a French woman awaking from a suicide attempt, a drug overdose to find that her own dog in a desperate attempt to rouse her chewed off a third of her face, the question arises what kind of life can possibly follow?³⁰

In a moment in which being beautiful means so much, having an abject face takes on particular weight. The debates about FT and the meaning attributed to the work therein are situated within this socio-historical moment, and these debates reveal that we are undergoing a dramatic social transformation. Whereas interventions on bodily appearance used to be understood as life improving work, for particular bodily

³⁰ This is an incredibly problematic position to hold. To assume that no life follows disfigurement is to shut down the productive and imaginative ways in which people make lives after bodily injury. I reference this collective imagining not as a justifiable one but merely as a common one.

configurations, in this case facial disfigurement, work on the aesthetic is understood as life saving. Disfigurement equals death. As we watch the face transplant story unfold, the question arises— what might this conflation of appearance and life, disfigurement and death mean for us all.

CHAPTER IV

NOT A PRETTY GIRL: FACIAL FEMINIZATION IN THE SERVICE OF UNREMARKABILITY

"Helping transsexual women to look like women, a healthy mind is a healthy soul. *The first step to feeling like a human being, FFS is a very big part in that process.* Looking feminine, appearing as a female, is of course extremely important to you. *First impressions are often made based just on your face. That which is first seen in an initial contact is what frequently defines you.* It establishes not only just who you are but frequently what you are as well. As a transgender individual, perhaps nothing is more important to you than appearing sexually as you feel emotionally. Facial feminizing surgery can help bring these two together."

Excerpt from "Feminization of the Transsexual"
a pamphlet distributed by Dr. Douglas K. Ousterhout

Facial Feminization Defined

In the fall of 2007, ABC announced that upcoming episodes of its hit show *DirtySexyMoney* would feature a new guest star. Candis Cayne, a transgender³¹

³¹ I use the word transgender to make reference to a range of non-normative gender identities. Put another way, transgender describes gender identities that challenge hegemonic understandings of the relationships between bodies (specifically sex characteristics) and gender identity. Transgender and related terms I use throughout this chapter to describe the identities of those that appear here are emergent and contested terms. The meaning of these words depends on the context, and much debate ensues

performer whose work had been limited to drag venues (albeit at some of the most well regarded clubs) and independent films like *Wigstock* and *To Wong Foo Thanks for Everything Julie Newmar*, would play the role of William Baldwin's transgendered girlfriend. The casting was celebrated in gay media outlets, such as the *Advocate*, because it marked the first time a real transgendered person had been cast to play a transgendered character (Herman 2007). The decision also alerted outlets like the *Los Angeles Times* and *The Boston Globe* who publicized the move as a momentous shift in attitudes about transgenderism (Catlin 2007; Weiss 2007).

In media coverage, next to brief articles about Cayne's role on the show were photographs featuring her stunning face. As Baldwin remarks in a *People* magazine feature about Cayne, "She's an absolute showstopper" (133). While Cayne admitted to the press that she had undergone cosmetic facial surgery, she resisted offering a detailed account of her physical transformation. In the same *People* feature, Cayne remarks, "Like every girl, we don't talk about our surgeries." Candis Cayne's face appears not altogether unlike that of A-list pin-ups turned B-list actresses Carmen Electra and Pamela Anderson, both of whom are admitted cosmetic surgery consumers. Her lips have the fullness typically effected through injectables like collagen. Her bone structure is impeccably sharp. Her face is widest across her cheekbones and narrows into a perfectly pointed chin. Her cheeks are full, perhaps through the use of implants or fat injections.

about what is meant by each term. Language usage is further complicated by issues related to self-identification. People use different words to talk about similar identities. These tensions make the act of description which I attempt inherently problematic. I employ these terms cautiously and invite criticism about the language usage herein.

Undoubtedly, network television audiences are titillated by the thought of Cayne's surgically crafted vulva, but Cayne's more visible face certainly contributes to her widespread appeal. Just as genital reassignment surgery for transsexuals relies on techniques used in other forms of genital surgery, specifically reconstructive surgery aimed at intersexed bodies, face work aimed at transsexual³² faces relies on common plastic surgery techniques. Yet in the case of surgery aimed at transgendering the face and body, the goal of surgery is somewhat different than that aimed at cosmetic surgery consumers or intersexuals. Work on Cayne's face is not simply about creating a beautiful visage; rather it is, first and foremost, about making Cayne's face appear reliably female.

In the 1980s and 1990s, a Northern California plastic surgeon with extensive experience in reconstructive surgical techniques developed a collection of procedures identified as facial feminization surgery (FFS). These procedures are marketed to male-to-female (MTF) transsexuals for the purposes of changing facial appearance. In the United States, facial feminization surgery is currently marketed and practiced as "facial feminization surgery" by four surgeons.³³ While FFS consumers may desire a pretty face, what distinguishes facial feminization from cosmetic surgery, more generally, is that work is expressly aimed at making the face more feminine, rather than simply more attractive—although some accounts of what constitutes beauty suggest that the most

³² I use the word transsexual to specifically describe those who pursue medical technologies (surgery, hormones, cosmetic surgery, etc.) to craft gendered bodies.

³³ Other surgeons practice techniques akin to facial feminization surgery, but the four I discuss in this chapter treat facial feminization as a distinct and intelligible set of practices.

feminine faces are often perceived as the prettiest (Etcoff 1999). Facial feminization is accomplished through a variety of procedures including but not limited to a brow lift, a trachea shave, a jawline reduction, a chin reduction, and a face and neck lift. While surgeons are often vague about how much feminization costs, patients' websites report that FFS can cost between \$20,000 and \$40,000.

Other cosmetic surgeons may offer transwomen³⁴ patients a variety of procedures that have the effect of feminizing the face, yet facial feminization is intelligible as a distinct set of surgical techniques aimed at refiguring the masculine face. Like other forms of reconstructive surgery, the results of facial feminization require intensive surgery often lasting hours, sometimes as many as ten. Because procedures are aimed at radically altering multiple facial features, patient's faces (and skulls) undergo serious surgical manipulation. For example, jawline and chin reduction may require actually breaking or severing the bones of the face with a surgical drill. Facial bones are then re-secured with screws, wires, and bone pastes. Brow shave or forehead recontouring involves removing a section of the skull, reshaping it with a device that resembles a dremel drill,³⁵ and reattaching it to the skull. To reduce the distance between the hairline and the eyebrows, a cut is made along the hairline, a section of skin is removed, and the scalp is pulled forward, bringing the hairline down lower on the forehead. Swelling, bruising, and scarring are common. Some patients experience changes in the face's range of motion, reducing the facility with which one moves one's jaw, for example. Others report a loss in facial sensation, typically a sort of numbness that leaves a face unable to

³⁴ I use the term transwomen to describe male-to-female transsexuals.

³⁵ A dremel is a high speed rotary tool used for grinding, drilling, and sanding.

perceive human touch or the searing burn of a curling iron. Like all forms of surgery, infection and death loom as potential side effects. And of course, the resulting face may not resemble what one had desired.

Facial feminization is an invasive, expensive, dubiously successful intervention. And yet it remains a highly sought after technology of transgendering for transwomen. By contrast, female-to-male transsexuals achieve masculinization of the face through hormone therapy, thus there is no such comparable set of surgical practices termed facial masculinization surgery. In this chapter, I interrogate facial feminization as a mode of face work for two reasons. First, I position facial feminization as an example of a site in which the specter of disfigurement is employed to incite immediate repair. In other words, defining the face as disfigured becomes an important precursor to positioning FFS as needed. While faces subject to facial feminizing procedures are not obviously intelligible as “disfigured,” I demonstrate that what counts as disfigurement is contextual. I show that facial feminization is routinely framed as a kind of reconstructive enterprise. Second, focusing on the significance of the face in the process of transitioning from male-to-female puts into sharp relief the significance of gendered facial appearance in everyday life.

I begin by situating my analysis in scholarly and professional work on genital reassignment surgery. I query the focus of surgery aimed at the genitals and compare face work aimed at transwomen with the work of “fixing” genitals. I aim to arrive at a theory about the particular significance of the face during the process of transitioning genders. Specifically, I demonstrate that in sites of facial feminization, transwomen’s faces are defined as disfigured and facial feminization itself is positioned as a method of

reconstructive surgery. In this way, face work employed in the process of transitioning is not simply a mode of “doing gender” but rather a technology of repair. Using ethnography conducted at seminars featuring facial feminization surgeons and content analysis of surgeons’ promotional materials, I demonstrate that the ways in which transwomen’s faces are positioned as disfigured is informed by a theory of facial sex difference. I describe the processes through which “the male-to-female transsexual face” is taken apart, both figuratively and literally.

Surgeons emphasize the differences between “the female face” and the “the male face” through continual references to images, particularly illustrations of human skulls. Emphasizing difference brings into formation a way of seeing the face that inspires the literal taking apart of the skull through feminization surgery. In this way, the processes through which facial sex difference is articulated act as a diagnostic strategy. Yet even as “the female face” is described and sought after, I argue that this is an ideal that is unattainable through surgery. This leads me to pose the following question: If feminization surgery is not successful at crafting the ideal female face, what kind of face does facial feminization produce? More broadly, what is the corporeal objective of such face work? I show that the face work accomplished by facial feminization surgeons is aimed at eradicating “masculine” facial features in the service of crafting an unremarkable face, a face that goes unnoticed in public, a face that facilitates passing. I conclude by querying the difference between creating a “female” face and crafting an unremarkable face.

Much of the data upon which this chapter is based comes from fieldnotes taken through my attendance at conferences featuring seminars on facial feminization.

Transgender conferences, including Southern Comfort and the International Foundation for Gender Education (IFGE), are unique quasi-public spaces. Overwhelmingly, most of the people who attend and many of the people who present seminars self-identify as transgendered. In this way, conferences offer attendees opportunities to network with others with shared interests and concerns and to access specialized information.

Transgender conferences feature seminars that address a wide range of topics including politics, spirituality, mental health, and activism, but a significant number of featured speakers address topics related to body modifications made possible by and forged through medical technologies. Not surprisingly, seminars on hormone therapy and genital reassignment surgery appear throughout conference schedules. In addition, each of the primary U.S.-based facial feminization surgeons appears at transgender conferences to discuss and market facial feminization.³⁶ Seminars are opportunities for potential patients to meet and consult with surgeons, to learn more about facial feminization techniques, and to view the faces of other transwomen who have undergone facial feminization. Thus, seminars are simultaneously information sessions, commercial advertisements, and public spectacles.

³⁶ Each of the surgeons I observed are male. This should not necessarily be surprising given that men disproportionately pursue plastic surgery specialties, but it does make for interesting, and sometimes concerning, gendered dynamics between surgeons and transwomen patients. Specifically, male facial feminization surgeons often offer their personal opinions about appearance, and sometimes interactions between surgeon and patients take on flirtatious overtones. In the context of medical care, these patterns should be thoroughly interrogated.

Passing From the Neck Up: Faces Versus Genitals

In her groundbreaking work on transsexuality, Marjorie Garber (1997) asks, “[D]oes a transsexual change subjects? Or just bodies—or body parts?” (105). While Garber is primarily interested in the category crisis marked by transsexualism, scholars who have taken up her work have ignored the complicated question of shifting subjectivity and the subsequent crisis around gender this shift signifies. Instead, questions about transgenering have come to focus inordinately more narrowly upon body parts, specifically the transformation of genitals through genital reassignment surgery (GRS). In Sander L. Gilman’s *Making the Body Beautiful* (1999), “transsexual surgery” is reduced to surgery aimed at the genitals (and breasts in his discussion of FTM transsexuals). Given that much of Gilman’s book is focused on aesthetic surgery targeting the face, it is curious that there is no examination of facial feminization surgery. Janice Raymond’s (1979) scathing account of transgenderism, *The Transsexual Empire: The Making of the She-Male*, positions sex reassignment surgery as *the* crucial act, and from her perspective the most fetishized by transwomen during the act of transitioning. Similarly, social scientific research often queries the “success” of transitioning, focusing on genital surgery as the crux of change (Peterson and Dickey 1995; Ines et al. 2006).

In the aforementioned texts, there are occasional references to the bodily effects of hormone usage and even dress or fashion, but relatively little attention to other technologies of transgenering. And there *are* other technologies employed in the process of cultivating a transsexual body. Recent arrests for “murder by silicone” have

led to a growing awareness of the black market silicone industry (Luscombe 2003).³⁷ At what the media have deemed “pumping parties,” industrial grade silicone is injected subcutaneously, often to affect breasts and hips and to contour the face. Because the silicone is injected directly under the skin and not contained in any protective casing (as is the case with silicone breast implants), migrating silicone can result in a number of fatal conditions including pulmonary embolism, which results from free floating silicone entering the bloodstream and pooling in the lungs (Martinez-Jimenez et al. 2006). The very risk of subcutaneous silicone injections begs the question: what are the benefits of such a technology? Put simply, silicone injections are a cheap means for affecting a feminized appearance overall. Precisely because it is in such a highly risky intervention, the use of silicone by transwomen puts into sharp relief the significance of body modification aimed not solely at genitals but at the entire body, and the face, in particular. What is it about a softer jaw line, rounder cheeks, and fuller lips that inspires consumption of a potential deadly material?

The overwhelming scholarly preoccupation with genitals is curious for many reasons. First, not all transsexuals choose to undergo genital reassignment surgery. Given myriad transgender identifications, inscribing one’s identity on the body may not necessitate “bottom surgery.” In fact, some people choose to “do transgender” in a range of ways, employing particular technologies and resisting others. Some transwomen may forgo genital surgery in an attempt to retain access to particular sexual practices.

³⁷ Silicone is a cheap means of cosmetic intervention, but given the serious medical complications associated with its use, it has not been approved by the FDA for medical use.

Financial constraints may also mean that one must prioritize medical interventions, and for some, genital surgery is deemed less crucial or desired in comparison with other costly interventions. Second, positing genitals, a facet of the human body most often hidden in everyday life, as the locus of transgender identity is peculiar. Social identity is less determined by actual genitals and more determined by what we assume is true about other's genitals. In the course of everyday life, people do not typically have access to firsthand knowledge about another's genitals, as Kessler and McKenna note (1978). We might think that we know about another's genitals, but in most cases, we have very little evidence upon which to base assumptions.

Perhaps academic attention to the genitals at the cost of sustained examination of other bodily sites of transformation simply mirrors preoccupation with genital surgery in the oft-referenced Harry Benjamin International Gender Dysphoria Association (2001) (HBIGDA) Standards of Care.³⁸ The Standards of Care are clinical guidelines

³⁸ Harry Benjamin was a sexologist who pioneered treatment of transsexualism beginning around 1950. Through his work, Benjamin made contemporary modes of transitioning possible by encouraging the use of hormones and surgery. His work forms the basis used by most professionals who “treat” transgenderism. The Harry Benjamin Standards of Care have undergone five revisions and updates since they were first released in 1979. The Standards are often employed as a protocol, meaning that many surgeons will not provide surgery to patients who have not satisfied the suggested route prescribed in the document. Oftentimes, surgeons require that patients receive “permission” from their therapists before receiving surgery. The organization has recently changed its name to The World Professional Association for Transgender Health (WPATH).

specifically aimed at helping professionals who work with patients diagnosed with “gender identity disorders” to develop treatment protocols. Implicit in the standards is that patients will undergo the process of transitioning with the assistance of medical technologies. This assumption is reflected in the outline of the Standards of Care. The initial sections of the document focus on diagnosis, followed by a discussion of therapeutic treatment of patients. Subsequent sections discuss technologies of transitioning, with an emphasis on “triadic therapy” involving counseling, hormone treatment, and genital surgery. The Standards are structured as a general model of treatment that is comprised of a series of steps—psychological counseling proceeds hormone treatment which proceeds genital surgery. In this way, the Harry Benjamin Standards of Care position the renovation of genitals as the pivotal and ultimate step in embodying one’s self. In this way, changing the genitals operates as a litmus test for determining if a transition has been completed.

Feminization of the face appears briefly in the 2001 revision of the Harry Benjamin Standards of Care. A section entitled “Other Surgery for the Male-to-Female Patient” reads: “Other surgeries that may be performed to assist feminization include reduction thyroid chondroplasty, suction-assisted lipoplasty of the face, rhinoplasty, facial bone reduction, face-lift, and blepharoplasty” (21).³⁹ This is the only mention of facial procedures in the document. There is something curious about the fact that the standards intended to guide treatment aimed at transitioning largely ignore technologies aimed at the face. While scholarly, professional, and popular interest in transsexualism has disproportionately focused on surgery aimed at the genitals, face work is a crucial

³⁹ Each of these procedures is used in feminizing the face.

part of transitioning for many, and in terms of navigating everyday social life, the appearance of the face is arguably more significant.

In a June 16, 2006 letter published on her widely accessed and cited website www.tsroadmap.com, transgender activist Andrea James encouraged HBGDA to reconsider its position on facial feminization surgery in future revisions of the Standards of Care.⁴⁰ James argues that facial feminization is “medically necessary for male-to-female transitioners.” Based on her own experience, James argues that “Vocal and facial cues are far more likely to be factors in how others respond to a trans woman and are in my opinion the key to being accepted more easily in one’s target gender. These cues affect everything from one’s personal and professional relationships to one’s ability to move through the world safely.” In essence, James argues that contrary to the assumption embedded in the Harry Benjamin Standards of Care, feminizing the face disproportionately facilitates transitioning. By the very fact that the face is so visually accessible, according to James, it is much more crucial to passing, or to navigating everyday life unencumbered by threats to one’s privacy or safety. It is with such concerns in mind that James encourages both medical practitioners and transwomen to refocus attention to “passing from the neck up.”

⁴⁰ Tsroadmap.com is an internet resource providing information on all things related to transitioning from male-to-female. James cites her annual traffic at around 4 million visitors per year.

The Transwoman's Face as Disfigured

But how are interventions aimed at “passing from the neck up” a kind of face work? How does facial feminization constitute a case through which we can understand repair aimed at disfigured faces? The faces subject to facial feminization are not immediately intelligible as disfigured faces, yet within sites of facial feminization, the faces of male-to-female transsexuals are positioned as untenable, and thus the face is in *need* of repair. Certainly, impetus of repair implicitly mobilizes the specter of disfigurement, but explicit references to disfigurement appear frequently in subtle and not so subtle ways.

Faces that might commonly be referred to as ugly are discursively constituted as disfigured via brief, but revealing, references. In one facial feminization seminar, a surgeon pointed to a photograph of a seemingly unremarkable face, remarking,

“You can see her forehead deformity.”⁴¹

Words like deformity mark the face not simply as masculine but rather as fundamentally disfigured. In another seminar, a doctor explained why somebody might choose facial feminization:

“This is the same thing as if you were in a car wreck and you want to look like who you really are.”

The male-to-female transsexual face is equated here with an injury or a trauma, and thus in need of repair. From this perspective, facial feminization is hardly elective surgery but

⁴¹ The text that appears throughout as data has been excerpted from fieldnotes taken while attending Southern Comfort and IFGE.

is rather positioned as unequivocally necessary—especially by those who stand to benefit commercially.

Perhaps even more revealing is a strategy used by one surgeon, Dr. Peterson⁴² who is often referenced as the founder and developer of modern facial feminization techniques. The first time I attended a seminar presented by this surgeon, I watched as his assistant connected his laptop to a projector. As the doctor and his assistant readied themselves for the lecture, images flashed on a large screen that appeared at the front of the hotel meeting room. When I saw the photographs, I was sure that his assistant had opened the wrong PowerPoint file. What filled the screen were images of children with a range of cranio-facial anomalies. These images seemed shockingly out of place. Why begin a lecture on facial feminization with the faces of facially variant children?

Fieldnotes from a second seminar presented by the same surgeon reveal why it made precise sense from the perspective of the surgeon to begin with such images:

Dr. Peterson tells the audience that he spent 20 years running a center focused on the repair of cranio-facial anomalies. He's worked on hard cases, "horrible" facial anomalies. He flips through slides of people with a variety of congenital facial differences. One has a cleft palate. One has an unusual skull shape. It is not spherical. The surgeon refers to the photograph as an example of "clover leaf skull." One picture of a baby illustrates asymmetrical facial features. The eyes and the nose appear randomly placed as if in a Picasso painting. One has eyes

⁴² I use pseudonyms when quoting from my fieldnotes. This attempt at anonymity is a move to emphasize that the story is not about the personalities in this site but rather the narratives that operate.

that upon profile extend dramatically beyond a recessed eye cavity, resulting in look of extreme surprise. You can see the shape of the entire eyeball, and they look as though they may fall out of the skull. Next to each is an “after” picture that shows the face post-surgery. Each face looks remarkably different, more “normal.” Dr. Peterson remarks, “Those three patients show what I do to feminization patients.”

Without a doubt, the images convey technical skill and surgical “successes,” but this introduction accomplishes much more than that. By beginning the presentation with images of children with craniofacial anomalies, the audience is immediately engaged with representations of disfigurement. While looking at these pictures, the audience was solemn. The pictures appear within a cultural lineage in which photographs of disabled children are to be witnessed as evidence of the tragedy of congenital difference. By claiming that “those three patients show what I do to feminization patients” the faces of the transwomen in the audience are positioned as somehow just like the faces of the disfigured children—in need of repair. In addition, such a claim characterizes facial feminization as somehow akin to reconstructive surgery, as opposed to elective cosmetic intervention.

Other surgeons offer a narrative about their own careers that firmly locates their facial feminization practices within a trajectory of reconstructive surgery.

A pamphlet distributed by an East Coast surgeon, Dr. Thomas describes his educational history and professional affiliations:

Advanced training was obtained with fellowship in Facial Plastic and Reconstructive Surgery, and Microsurgery through Harvard Medical School. He

currently devotes his practice to facial plastic surgery and head and neck cancer reconstruction. The busiest component of his practice is Facial Feminization Surgery (FFS).

Another, Dr. Adams, emphasizes similar career ties in a handout distributed to potential patients entitled “Head of Plastic Surgery of Nation’s Oldest & Busiest Military Hospital Relocated to Chicago.” The feature describes the techniques innovated by the surgeon while serving as the chief of the Plastic Surgery Department at Naval Medical Center, Portsmouth, VA. Plastic surgery departments located at military hospitals often function to innovate reconstructive techniques that address disfigurement resulting from war injuries. Thus, work as a plastic surgeon in the military locates one’s professional history within the domain of reconstructive surgery. I am not arguing that it is unique for cosmetic surgeons to have training in reconstructive techniques; rather, I am interested in the ways in which surgeons use that training to communicate something about the work they do as facial feminization surgeons. By positioning facial feminization as a logical extension of training accomplished towards the ends of reconstructive surgery, surgeons both produce and rely on associations between disfigurement and the male-to-female transsexual face.

It is not simply that facial feminization and reconstructive surgery are discussed as technical equivalents and that transwomen’s faces are characterized as disfigured faces. More significantly, facial feminization surgeons invoke meanings attached to reconstructive surgery to accomplish the work they do to feminize the face. Just as face transplantation is taken up as “life saving work,” facial feminization is described as life changing work—both for surgeons and patients. Dr. Nelson, a surgeon whose practice is

divided between facial feminization and genital reassignment surgery begins a presentation by explaining to the audience what makes a surgeon trained to “fix” facial “abnormalities” decide to start one of the country’s pre-eminent centers for transgender related surgery:

“What deformed people remember is what they looked like before.” He continues, by telling the audience that his patients are happy to be in the hospital. His patients are happy to see him.

In contrast to presumably unhappy “deformed” patients, this doctor suggests that the work of facial feminization is about making patients happy. Rather than being preoccupied with their pre-surgical visage, the surgeon suggests that transwomen embrace their interventions, and that this gives a particular significance to his work. Dr. Adams goes further. He replies when asked by an audience member, “Why do you do this?”:

“I came out of the Navy with a great set of tools...As a plastic surgeon, it is rare that I can make a difference. I have profoundly affected their [transwomen patients] life so that they can go in society and live their lives. We all know how cruel society can be.”

This surgeon frames facial feminization as life changing work, as a form of repair that allows people to “live their lives.” The focus is on changing the individual rather than the society that presumably makes living life difficult for transwomen. This echoes the sentiment expressed in other sites of reconstructive surgery and other sites of face work that appear in this account, namely face transplantation and Operation Smile.

By introducing facial feminization as an extension of reconstructive surgery, FFS is unequivocally positioned as a kind of repair for disfigurement. Facial feminization surgeons “fix” disfiguring conditions. This is body modification aimed at specific ends, but facial feminization is weighted differently than other gendered bodily practices like hair styling or make-up application. Candace West and Don H. Zimmerman (1987) approach gender as a “routine, methodical, and recurring accomplishment” (126). In other words, gender is an iterative process, enacted through dress and style, voice and gesture, along with roles and statuses. In short, “doing gender” is the way in which gender comes to be seen as a salient and recognizable social category. To be sure, facial feminization is a way of “doing gender.” It is a way that the transwomen effect femininity, but it is unlike other aesthetic means of feminizing. Make-up, for example, is used to give the face a feminine, and thus a more socially valued, appearance. By contrast, FFS is positioned as a mode of repair, not simply a means of “looking better.” As a technique for fixing something defined as flawed, in this case disfigured, FFS is understood as necessary. It is not simply gender that gets constructed through facial feminization but rather a bodily stigma that becomes managed.

The stigma, in this case the masculine face, is a product of gendered expectations. To a large degree, a masculine appearing face can be defined as disfigured for the transwomen because of the stringency of gender. There are two, and only two, socially intelligible gender categories. As Judith Lorber (1993) writes,

[I]n Western societies, we see two discrete sexes and two distinguished genders because our society is built on two classes of people, ‘women’ and ‘men.’ Once the gender category is given, the attributes of the person are also gendered: Whatever a ‘woman’ is has to be “female”; whatever a “man” is has to be ‘male’ (567).

Transwomen, by the very nature of transitioning, already challenge the social prescription that one is born sexed and that one's gender follows from one's sex assignment at birth. Facial feminization is an enactment of gender—both a means of “doing gender” and a means of thoroughly and resolutely succumbing to a discrete notion of femininity. Because gender is conceptualized as a discrete category, “doing gender” is compelling but it is also constraining. In other words, “doing gender” (and doing it in particular ways) is compulsory, unless one is willing to accept the costs of resisting. In this way, facial feminization and other techniques of transitioning from one gender status are not simply elective in the sense that they are desired. Rather, modes of gendering like facial feminization get chosen partially because gender difference must be contained. Facial feminization works, thus, as a technique of normalizing gender variance.

As opposed to elective or optional interventions, techniques of normalization are directed towards avoiding consequences related to an undesirable or unsustainable social status. Gender can be the grounds upon which normalization proceeds. As West and Zimmerman note, doing gender is required:

[D]oing gender is unavoidable. It is unavoidable because of the social consequences of sex-category membership: the allocation of power and resources not only in the domestic, economic, and political domains but also in the broad arena of interpersonal relationships (145).

In other words, social life depends upon doing gender, and not simply any gender as West and Zimmerman seem to suggest, but rather socially acceptable modes of gender. Judith Lorber further outlines the consequences related to rejecting or living outside of normative gendered statuses. “Political power, control of scarce resources, and, if necessary, violence uphold the gendered social order in the face of resistance and

rebellion” (578). As Lorber asserts, there are consequences for challenges to the gendered social order.

For transwomen, masculine facial appearance is a direct challenge to sexual dimorphism, to the cultural dominant model upon which gender relies. The narrative that positions the masculine face as a disfigured face maps gender and normalization onto one another. The masculine face is not simply unattractive; rather, it is untenable. Put simply, because gender is a heavily enforced normative category, facial feminization serves as a technique of normalization. What a surgeon does to facial feminization patients is to give them faces that make it possible to lead a “normal” life. But what precisely is disfiguring about the male-to-female transsexual face? To answer this question, I turn my analysis to the theory of facial sex difference that circulates in sites of facial feminization.

Sexing the Face

Feminist accounts of cosmetic surgery have pointed to the ways in which cosmetic surgery consumption is gendered. Not only are women more prone than men to pursue particular interventions, but what men and women hope to accomplish via intervention is largely determined by social conventions about men’s and women’s bodies (Blum 2003 Pitts-Taylor 2007, Sullivan 2004). As Diana Dull and Candace West (2002) argue,

This [gender] is the mechanism that allows them to see the pursuit of elective cosmetic surgery as “normal” and “natural” for a woman, but not for a man. The accountability of persons to particular sex categories provides for their seeing women as “objectively” needing repair and men as “hardly ever” requiring it (137).

In this way, cosmetic surgery is both an effect of gendered relations and a means of doing gender. Cosmetic surgery consumers employ surgery as a means for more closely approximating gendered cultural ideals. Women purchase faces that might be described as beautiful or, perhaps, sexy. Men consume interventions that result in a good-looking, though certainly still masculine, face. Yet not all women who get cosmetic surgery change their bodies in precisely the same ways. There are a range of possibilities, a multitude of means for aesthetic enhancement that one can choose towards more desirably doing one's respective gender. For example, a woman may choose any number of surgically constructed noses—the ski slope, the upturned, or the perfectly angular. The desired outcome is gendered, but it is gendered in a very generic sort of way.

I argue that facial feminization is different. It, too, is a method of surgically inscribing gender onto the body, but facial feminization takes up gender as its very object of intervention (and invention). Facial feminization is not a technology simply employed in the process of doing gender. Rather, facial feminization is about surgically constructing gender itself. It is *not*, as is the case in cosmetic surgery, directed towards helping women achieve a prettier face. Rather, it is the surgery that inscribes a face that is perceived as female at all. To this end, facial feminization relies on extant, essentialized notions about what distinguishes a male face from a female face.

In a 2007 issue of *Clinical Plastic Surgery*, in an article entitled “Transgender Feminization of the Facial Skeleton,” general plastic surgeons were introduced to the idea of facial feminization by a group of Dutch surgeons (Becking et al.2007). The article begins by defining transsexualism and describing multiple modalities employed in the treatment of gender identity disorder, specifically genital reassignment surgery and

hormone therapy. Yet, the authors contend that these are crucial though insufficient means of addressing gender identity disorder: “For passing in public as a member of the opposite gender, facial features are of utmost importance for the transsexual individual” (558). Beyond suggesting that the face should be conceived as a critical site of intervention, the surgeons propose the following:

There is a need for more objective standardization of the differences in the facial features of the two sexes, to facilitate surgical treatment planning and more objectively assess the outcome of the facial surgery on psychosocial functioning and appearance, not only from the perspective of those treating, but also from the patient’s own point of view (563-564).

By calling for “objective standardization,” Becking et al. argue that rigorous scientific research aimed at *discovering* facial sex differences would help in elaborating a basis for surgical practice and a standard by which to judge success. Although there has been a limited amount of the kind of research they propose, there are already circulating “theories” of sex differences in facial appearance.

In a pamphlet distributed by Douglas K. Ousterhout, the American surgeon often credited with developing facial feminization surgery, entitled “Feminization of the Transsexual” and targeted to prospective consumers, techniques of facial feminization are described in detail. However, the pamphlet is not simply a list of surgical procedures often accomplished in the process of feminization.⁴³ Rather the pamphlet offers a theory

⁴³ The degree to which it makes sense to emphasize the importance of a single pamphlet must be contextualized. First and foremost, Dr. Ousterhout is often attributed with articulating facial feminization methods. His work appears to be the first account published in a peer-reviewed medical journal (1987). Secondly given the fact that there are so few doctors from which to choose, there are relatively few sources of information

of facial sex difference and a subsequent account of why facial feminization works. In the introductory section, the pamphlet reads:

“There are basic differences between a male and a female skull, differences long appreciated by anthropologists studying skulls but also by artists as well. Females have a more pointed chin, tapered mandible, and less nasal prominence than males. These areas must be modified from those more massive areas on the male... You must change the underlying structures to affect a real change. Changing the shape of the skull will markedly assist in changing one from distinctly male to female....REMEMBER: TO APPROXIMATELY FEMINIZE THE FACE, THE SKULL MUST BE APPROPRIATELY REDUCED TO FEMININE SIZE AND PROPORTIONS.”

Ousterhout’s theory is comprised of two central claims. First, Ousterhout asserts that anthropological evidence suggests that on average, the skulls of men and women differ in both shape and size. His pamphlet follows a well established pattern of employing scientific research in the service of identifying sex differences through cranial measurements, hormones, and skeleton size and shape (Gould 1981; Oudshoorn 1994; Shciebinger 1986). In this way, Ousterhout offers an objective, “scientific” explanation

through which potential patients can understand what constitutes facial feminization.

While I do not have the data to definitely determine the meanings patients attribute to the sources of information, there is evidence to suggest that Ousterhout’s pamphlet is widely read and discussed by potential patients in that it is routinely mentioned on websites on which transwomen chronicle their experiences transitioning and discuss possible interventions.

that accounts for why face work is important to transitioning from male to female. This theory of facial sex difference also posits that changing the skull through surgery will alter the appearance of the face, specifically the gendered effect of the facial structure. In effect, Ousterhout's account of facial feminization works to position face work as a crucially important intervention for male-to-female transsexuals, at the same time that it advances essential, naturalized accounts of sex/gender differences.

The pamphlet continues by elaborating the differences between male facial features and female facial features, including the brow, forehead, hairline, chin, mandible (jaw), cheeks, lips, neck, and nose. First, the differences between male and female features are identified. A single image (reproduced below) appears in the pamphlet. It is a basic graphic used to visually represent dissimilarities between the "male" and "female" face.

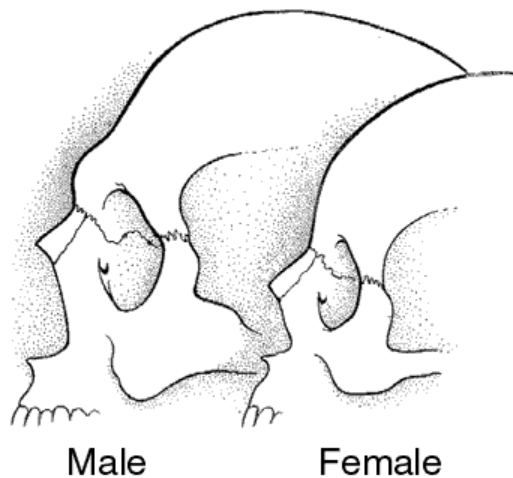


Figure 8. Graphic Used to Illustrate Sex Difference in Skulls by Facial Feminization Surgeon

The pamphlet is a guide for potential patients that identifies the disparity between the two skulls. The image is a reference point that patients can continually consult to confirm the claims made in the text that follows.

Throughout the pamphlet, facial sex differences are identified and surgical techniques for addressing these differences are described and prescribed. In regards to the forehead, the pamphlet emphasizes the “prominence” of male bone structure:

“As the male forehead is so different than the female forehead this may be one of the most important areas to modify. Males have brow bossing with a flat area between the right and left areas of bossing while females have a completely convex skull in all planes and markedly less prominence.”

To deal with the masculine forehead, bone contouring is used to reduce the bossing (or ridge) that appears across the forehead. The distance between the hairline and the browline also becomes salient:

“In physical anthropology studies, it has been shown that men have a longer distance from the brows to the hairline than do women...A long forehead is generally acceptable for the male but not for the female.”

The pamphlet suggests that this distance be shortened by way of scalp advancement and in some cases a brow lift. The chin also works as a crucial mark of gender:

“The chin varies markedly between the male and the female. The male chin is generally wide and vertically high while the female chin tends to be more pointed, narrow, and vertically shorter...Thus the chin is an extremely important area in gender recognition.”

To address this “important” feature, Ousterhout suggests a sliding genioplasty, which involves the cutting and removing of sections of bone to reduce the “squareness” associated with male chins.

As the preceding excerpts indicate, “Feminization of the Transsexual” follows a particular pattern. In it, each facial feature is dissected for sex differences, and those differences are described in detail, further reproducing understanding of such differences. These descriptions of facial sex difference are followed by brief descriptions of surgical techniques aimed at repairing, specifically re-gendering, faces. The underlying theory of facial sex difference articulated in Ousterhout’s pamphlet structures facial feminization seminars, as well.

As social interactions that inspire face work, facial feminization seminars function to position facial feminization and male-to-female transsexual faces in particular ways. Specifically, seminars work to forward the theory of facial sex difference that undergirds the imperative to repair transwomen’s faces. One seminar offered at Southern Comfort 2006 is described in the conference program in the following way:

“Dr. Ousterhout will discuss his philosophy about facial feminization based on anatomical differences between male and female skulls. There will be discussions also about tissue differences between the male and female face. Examples will be shown of these differences via a slide show of long-term results of patients before and after surgery. Dr. Ousterhout will also be holding clinic after his lecture for those who desire a consultation.”

And in fact, seminars very much correspond with this description. The following excerpt from fieldnotes taken during Southern Comfort 2006 describes the format of the seminar.

Then, the doctor suggests that “anthropological differences” matter, that “anthropologists can tell the difference between male and female”...On his PowerPoint presentation he clicks to a graphic of two different skulls and two

different faces (one male and one female). He then begins to point out the differences between the two skulls, demonstrating how each feature of the face varies between men and women... “There are basic differences between the male and the female skull.” The angle of the mandible is different. The bossing is different. The nose angle is different. The vertical height of the mouth is different. In most of his procedures, the surgeon removes skin to minimize the distance between the hairline and the brows...For cheeks, he suggests cheek implants which come in different sizes, but he says that not everyone needs them. “The cheeks are not male or female.” He also suggests upper lip shortening. The doctor argues that this is necessary because men only show lower teeth when they smile and women show upper teeth... Females, he argues, have a tapered face, and males have a square face. He suggests a sliding genioplasty and a lateral mandibular reduction to eliminate squareness.

This theory about facial sex difference serves as the working framework for approaching facial feminization.

Other surgeons, however, take issue with some of Dr. Ousterhout’s contentions. For example, each surgeon puts a varying degree of emphasis on the importance of soft tissue work relative to bone work. But every surgeon relies on similar strategies in his seminars. Each reviews images of male and female faces to emphasize facial differences and describes how facial feminization will affect appearance. An almost identical strategy is used by Dr. Adams:

To illustrate how much bone work is needed to appear female, the doctor posts two pictures side by side on the screen. A male skull and a female skull. He

begins to point out male and female facial characteristics. “When you look at your female counterparts, I’m not trying to be rude, but there are differences.”

Dr. Adams points a number of facial features--the temporal ridge, facial hollowing, the cheeks, the eyebrows—and points out the differences between the male skull and the female skull. “Soft tissue is the magic.”... “Procedures on the upper face are the most feminizing...The forehead is the most critical thing.”

In this seminar, images of skulls are projected side by side for the audience to see. One by one, each facial feature is examined and in each case, differences are highlighted. A presentation by Dr. Nelson is virtually indistinguishable:

To understand how Dr. Nelson approaches FFS, he posts pictures of men and women in order to identify the differences between male and female faces on the PowerPoint screen.

The same occurs in presentations by Dr. Thomas:

The surgeon poses the following question to the audience: “What is it about the face that allows the distinguishing of gender?” He compares slides of men and women’s skulls and argues “the thing that’s really making the difference—the bone. The skin is just the skin” Dr. Thomas goes through parts of the face one by one and describes what is needed to make the face appear more feminine. Using a laser pointer, the surgeon riffs on each face that fills the screen, identifying what features appear too masculine. He tells the audience that he feminizes the face through neck surgery (tracheal shave), forehead remodeling (osteotomy and ostectomy), feminization of the jaw (width reduction), and feminization of the nose.

In every seminar, then, surgeons use images to demonstrate and to foster notions of facial sex difference. Selective images are invoked as “proof” that the male face is demonstrably different from the female face. In this way, facial feminization surgeons take a reductionistic approach. Single images of a male skull and a female skull are positioned to represent sex and gender *writ large*. In this way, surgeons rely on a theory of sexual dimorphism that presumes real, measurable difference between men and women and downplays variability in appearance among the categories of men and women. This strategy works to reify the differences between facial appearance in men and women, and thus to reproduce sex/gender differences. Instead of using images as representations or examples of male and female faces, they are used as *evidence about* general patterns, which then inform surgical practice and patients’ notions both about what is “wrong” with their pre-surgical face and what a new face might look like.

In the talk of FFS surgeons, “the female face” is deciphered, dismantled, and identified in the service of identifying the truth about what constitutes a feminine face. In the process, a surgical standard is constructed by way of fetishizing facets of femininity, in this case feminine facial features, and positioning these features as constitutive, as opposed to indicative, of femininity. “The female face” becomes the symbolic standard against which a patient’s real face is compared. Facial features that do not correspond are subject to intervention. Those features that do not evoke the female face are deemed masculine. In this way, masculinity becomes an empty signifier, a repository for all features not defined as female. This stands in sharp contrast to a long history wherein female bodies have been conceptualized simply as not male.

While surgeons publicly dissect the images and point to differences in almost every facial feature, in the process male and female faces are positioned not simply as dissimilar from one another on average but rather drastically divergent and *thoroughly* problematic for transwomen. Dr. Thomas articulates the degree of difference in this way:

“It’s not just bone work and pull some skin, you need a global change.”

By “global,” the doctor seems to suggest that facial feminization is a surgical overhaul. This radical change is not simply desired, that is elective, but rather for the transwoman, it is “needed.” Dr. Adams similarly suggests that the change needed is drastic:

“In order to look female you must change your skeletal appearance. To do less is absolutely wrong. Less is not more.”

To accomplish the objective of facial feminization, that is looking appropriately female, requires not only *some* surgical intervention, but rather, as the previous excerpt suggests, a drastic reworking of the skeleton. By emphasizing how invasive facial feminization needs to be, surgeons imply that the male face is untenable. It is in short, a problem, as Dr. Peterson doctor suggests in a seminar:

He turns to pictures of “real” men and says that the pictures illustrate a “female face on males.” Dr. Peterson says is “not a problem.” Then he shows a picture of a “male face on a female” and says, “but a male face on a female really is [a problem].”

What makes traces of masculinity so unsustainable is not altogether clear in the surgeons’ discourse, but the diagnosis is simple enough: if one wishes to live as a woman, then one’s face cannot appear masculine. It is unnatural. It follows then that facial

feminization would be aimed at producing a feminine face, but interestingly FFS surgeons concede that they cannot actually create a female face.

The Making of an Unremarkable Face

Even as surgeons identify differences *between* male and female faces, they recognize variability in facial appearance *among* “real” women, or as one surgeon puts it, transwomen’s “biological counterparts.” In this way, surgeons acknowledge that, in reality, there are a range of faces that may appear female. Thus, they contradict their own assertions about sex/gender. Comments by Dr. Adams surgeon reveal this concession:

“Everyone else uses a cookie cutter approach but we all know there is a wide range of feminine.”

In accusing other surgeons of using a “cookie cutter approach,” Dr. Adams suggests that facial feminization needs to be customized to each individual patient. According to his logic, if there are a wide range of female faces, there must also be a wide range of approaches to feminization. Dr. Thomas concludes his discussion of the “significant differences between male and female skulls” with the following claim:

“There are ranges. However for someone who is transitioning you want to change everything you can with surgery to appear feminine.”

Even as Dr. Thomas relies on a theory of facial sex difference, he acknowledges that facial appearance varies for “biological” women. At the same time, he seems to caution transwomen that a limited number of procedures will not sufficiently feminize the face. This moment certainly echoes other surgeons who suggest that the change needed is “global” or in other words all-encompassing. But if there is such a range in female facial

appearance, as these surgeons suggest, it is not altogether clear why feminization is necessary or what FFS literally inscribes on the face.

Ultimately then, because there is a range of female faces, successful surgery is not facial feminization per se, or the crafting of a female face. Instead, facial feminization aims to erase those features defined as masculine. Dr. Peterson suggests as much to patients:

“I cannot explain completely and exactly why but in my experience the transsexual needs to eliminate every remnant of facial masculinity as possible in order to pass.”

In a sense, then, facial feminization is a misnomer. Rather than feminizing the face, facial feminization is more directly aimed at expunging masculinity—the defect— rather than inscribing femininity.

I suggest that facial feminization surgeons are engaged in a precarious enterprise. Surgery can never perfectly create “the female face” deciphered by theories of facial sex difference, both because the standard is an ideal type and because the results of surgery are never fully knowable or predictable prior to surgery. As Dr. Nelson notes,

“You can only go so far. That’s just the way the anatomy is.”

Yet at the same time, distinguishing between the male and the female face is an indispensable element in inspiring intervention. Thus, facial feminization relies both on deploying a theory of facial sex differences *and* conceding that there are range of faces that read as female.

Such strategic claims seem contradictory at first glance. In the process of deciphering facial sex difference, male and female faces are conceptualized as radically

divergent from one another but also as simultaneously coherent and homogenous within each category. This contradiction begs the question: why do surgeons rely on discourses seemingly in tension with one another? Put simply, the theory of facial sex difference animates the imperative to repair by locating transwomen's faces as unacceptable, disfigured, and outside the norm. Elaborating the differences between male and female faces undergirds the need for surgery by continually deploying a notion of "the female face" that positions the faces of male-to-female transsexuals as untenable. At the same time, recognizing the variability among female faces opens up the standards by which surgery might be deemed successful.

FFS surgeons must walk a fine line between acknowledging variability among female faces to insure that surgery is assessed positively, but they cannot risk suggesting that any face is acceptable since such a suggestion would undermine the very theory upon which their practice rests. In other words, surgeons must acknowledge the limits of facial feminization, while ensuring potential patients that it holds much promise. But what is that promise?

There is a story in my experiences conducting this fieldwork that stands out. It is a story that I told over and over again as a way of talking about the trickiness of ethnography, the complications of positionality, the deception that may be unintended but is always already part of the work of the social scientist:

I am sitting in the hotel lobby. I am working on my laptop, trying to clean up a crappy draft of my *Extreme Makeover* chapter. It's already late to my ethics dissertation writing group. But I'm cutting and pasting hoping that moving one paragraph will make the rest of the thing fall into place. It's not so much that I'm

lost in my argument. There is no argument. I notice someone slightly behind me. She is not just over my shoulder. She is on top of me. Standing too close. “You were in Dr. Adams’ presentation this morning,” she tells me. “You shouldn’t spend the money girl. You look okay. You don’t need it.” Later a friend will tell me that the same thing has happened to her at Southern Comfort. A stranger has commented that she doesn’t need the surgery, that she looks okay. I try to think of another context in which strangers can begin a conversation by telling you their personal opinion about what you look like. Generally, offering personal judgments about another’s body is agreed to be an egregious invasion of privacy. Not here. In between opportunities to “consult” with surgeons who will tell you what exactly is wrong with your face, strangers will offer their two cents. “You shouldn’t spend the money, girl. You look okay. You don’t need it.” What is okay? And what do those that get facial feminization need?

The woman who approached me did not say that I looked good, pretty, or remarkable; rather, she indicated that I looked “okay,” that is, acceptable. But why not good or pretty, and why did the fact that I looked merely “okay” to her mean that I did not “need” the surgery? She did not use these specific words—“you look pretty”—because this was not the point, nor is it usually the point. Whether I looked attractive was another issue altogether. The point is that I looked okay. We all could pursue surgery to have fuller cheeks, tapered chins, and shorter foreheads in order to be “prettier”. But in the context of a facial feminization seminar where gender is undone and redone, the relevant question was: do we *need* facial feminization? But what is it, exactly, that facial feminization patients need?

Surgeons commonly conclude seminars by demonstrating how successful facial feminization can be. Often this is done with the use of before and after pictures—just as in the other sites I discuss in this dissertation. These photographs work to convey how (successfully) facial feminization can alter appearance. Undoubtedly, patients look different post-surgery. In this way, before and after pictures are a testament to the fact that facial feminization can transform one’s face. Yet many of the after pictures capture faces that are not exactly beautiful; most transwomen are not Candis Cayne. Nor are they ugly. They just simply are.

In addition to pictures, some surgeons regale the audience with success stories to demonstrate what facial feminization can accomplish in the context of a life. In the last few minutes of his IFGE seminar, Dr. Adams talked fast, giving one example after another of how facial feminization can benefit patients:

Dr. Adams begins: A transwoman post-facial feminization walks into a Chicago GLBT bar. A patron says, “Miss did you know you were in a GLBT bar.” The transwoman replies, “No but I think I’ll stay.” Here’s another— A trans lawyer gets on a train from New York to Philadelphia for this conference. She sits next to a fellow passenger. He asks the lawyer, “Where are you headed?” She replies that she is headed to Philadelphia. He tells the lawyer that he too is headed to Philadelphia to give a presentation at a transgender conference. The lawyer replies, “That’s nice.” The train arrives and the two depart the station. Over the course of the conference, the lawyer runs into the passenger from the train. When he sees her, his face drops. He looks at her and tells her, “I didn’t know.” Dr. Adams tells us that he often gets in touch with patients when he travels. One

drove two hours to have breakfast with him in Vancouver. Another met him on a family vacation in Disney World. He tells us, “It’s amazing how many boys she had at the table with her.” Another met him on the beach in Hawaii. It was “full of hot bikini bodies,” and she walked the beach “turning heads.” Another has “30 boyfriends” in Vegas. An audible gasp rises from the audience.

These stories of success hinge on one effect of feminization—that “no one will know.” In the process, these stories position anonymity as the promise of facial feminization. Dr. Adams’ final story of the woman with “30 boyfriends” suggests that facial feminization can produce attractiveness, but it is the promise of passing that gives these stories such rhetorical force. Other surgeons use passing as the ultimate ends of facial feminization surgery. As Dr. Peterson blatantly says,

“Our basic objective is for you to pass. You want to look, appear, and act female. Without doing anything else—putting on make-up, fixing your hair— I want you to be that female.”

This surgeon suggests that after facial feminization, no other methods of aesthetic enhancement—make-up or hair—will be needed to be taken for granted as female. Again, the promise is not that one will be beautiful, but rather that one will look like “just another female.” Dr. Thomas promises “excellent” results:

“We have the ability to get excellent results. There is nothing to suggest that these are transwomen.”

By “excellent,” though, Dr. Thomas does not mean to suggest that patients will be beautiful. Rather success is achieved by eradicating that which “suggests” transgenderism, the traces of masculine. “Excellent results” is code for “no one can tell.”

In this way, passing is posited as the net benefit of facial feminization. In rare cases, beauty might be a side-effect, but passing is the stated aim.

The idea that cosmetic intervention facilitates a kind of passing is not new. Sander Gilman's (1999) work on cosmetic surgery employed by Jews in post-war Germany frames his claim that all forms of contemporary cosmetic surgery constitute a form of passing. For example, face lifts allow women to "pass" as younger. Following Gilman, Kathy Davis (2003) in a piece entitled "Surgical Passing: Or Why Michael Jackson's Nose Makes 'Us' Uneasy" frames cosmetic surgery on "ethnic" facial features as both modes of assimilation and means of upward mobility, and she questions the politics of surgery that enable "passing." Additionally, Eugenia Kaw's (1998) work on surgery aimed at Asian facial features queries the tensions of passing. For these scholars, passing refers to the taking on of another identity both as a means of distancing one's self from stigma and acquiring privilege accrued to another identity status (Ginsberg 1996). In the case of cosmetic surgery aimed at racialized facial features, changing the face is a way of approximating dominant (usually white) group's aesthetic standards. This surgery may or may not actually culminate in identification with or acceptance by the dominant racial group, but it typically transfigures stigmatized bodily characteristics into something more socially desirable.

What constitutes passing in the case of MTF transsexuals is being taken for granted as a woman. Passing in this way is different from passing as another race. Whereas racial passing is almost exclusively understood in terms of a racial minority assuming the identity of the racially dominant group, in the case of transwomen, passing involves taking on a *devalued* status, that of female. The passing sought after through

facial feminization is also different from that which Gilman and Davis describe, in that the stakes of “passing” as female for the transwomen are significantly greater than the stakes of “passing” as thirty-five for the approaching-fifty cosmetic surgery crowd or, perhaps even, “passing” as white. As the recent murders of Gwen Araujo, Sanesha Stewart and many other victims demonstrate, the stakes of being “read” as transgendered as opposed to passing are, quite literally, those of life and death.⁴⁴

As these cases demonstrate, the burden of passing lies not in being perceived as female as much as it lies on *not* being perceived as male. It is crucial then that one’s face (and body) not suggest masculinity. In doing gender, one must do gender in corporeally appropriate ways. Pursuing facial feminization with the aim of passing is, in essence, a method for going unnoticed, for achieving a taken for grantedness. It is the technical work of eradicating those features that might give one away. Practically, then, facial feminization produces less masculine faces.

In sum, “the female face” works as the point of reference for surgical intervention. Of course, there is no such thing as “the female face.” It is a constructed

⁴⁴ I cite these names because both cases received relatively large amounts of publicity, especially in gay media outlets, but these murders are in no ways unique. In 2002, Gwen Araujo, a 17 year old transwomen, who was brutally beaten with a frying pan and barbell before being strangled by four men when they discovered that she was transgendered. In February of 2008, Sanesha Stewart was stabbed to death in the Bronx by a john after he “discovered” that she was transgendered. While stories of violence inflicted upon transwomen abounds, it is difficult to locate statistics because “gender identity” is not currently a protected class under federal hate crime legislation.

conglomeration of measurements, which depends on averages (via references to skulls) in its making. It is an ideal type, in the Weberian sense, an analytic comprised via reference to particular characteristics that does not correspond to any individual case. Given that one of the primary goals of facial feminization is passing, it should hardly matter that intervention fails to literally inscribe the conceptual ideal onto the face. For the purposes of passing, a less masculine face might very well be sufficient.

Premising an intervention against any ideal can only be successful in limited ways. In all sites of face work aimed at disfigurement, normalcy operates as a point of reference and an unattainable ideal. In the case of FFS, the standard is a gendered norm, “the female face.” Yet norms, because they are ideal types, are tricky points of reference. At what point would one be *definitely* normal? As the case of facial feminization makes evident, the logic that undergirds intervention positions a standard, in this case “the female face,” as the reference point around which surgeons organize practices of face work and patients understand them. Yet the female face is a conceptual ideal, as opposed to an empirical point of reference; thus, facial feminization can never literally produce the female face. Like the female face, normality is a conceptual ideal that can never be surgically produced. When does one achieve normalcy? Normalcy is elusive, and as such, the technical work of repairing the face might be understood not at producing the ideal, but rather at minimizing the abnormal. If it is impossible to inscribe these ideals onto the face, what then is technically accomplished through face work? If the face cannot approximate the female face, what can it exact?

The female face and normalcy might well be elusive, but passing is not. Interventions can and do facilitate passing because passing only requires being taken for

granted in specific social settings. Unlike normalcy, one can approximate how successfully one passes based on the ease of social interactions. In this way, passing is tangible in a way that ideals like normalcy and “the female face” never are. Passing is gauged successful to the degree that one is taken for granted. The case of facial feminization puts into sharp relief how taken for grantedness is desired, sought after, and crafted.

Facial feminization specifically, and face work more broadly, takes unremarkability as its end point. The desire for beauty, on the contrary, is the desire to appear exceptional, remarkable, fantastic. There is something besides beauty to be attained via face work. By contrast, the desire for unremarkability is the desire to go unnoticed, to blend in, to pass. As a mode of normalization, face work aims to recover a face defined as disfigured. In practical terms, it crafts a face deemed ugly for a woman less ugly, less masculine. In this line of work, there is little to suggest that beauty is even hoped for by potential patients or ever promised by face workers. There is something that exists between or perhaps outside of beauty and ugliness. To desire unremarkability is at the most basic level the desire to live outside of the stigma of ugliness and the extraordinariness of beauty. If one cannot embody the ideal of normalcy, one can at least hope to live outside of stigma. Unremarkability is equally, if not more, compelling than the desire for beauty. This desire for unremarkability is an often unstated but critical impetus for the face work I describe throughout this dissertation. It is, I argue, the corporeal objective of face work. To query unremarkability as an aesthetic puts into sharp relief how the desire to be “not ugly” structures bodily interventions, both mundane and extraordinary.

Candis Cayne's casting in a network television drama carries the significance that it does because her story is so exceptional. She has established careers as a performer both within the subcultural scene of drag performance and on mainstream or "normal" television. Her story of transition is striking for its lack of dramatic twists. Her family supports her. She is currently engaged to a New York deejay with whom she regularly appears in public, and she is stepmother to his daughter from a previous relationship. Her personal life is, in short, unremarkable but also typically feminine. Her face, on the other hand, is exceptional. Whatever face work she has undergone has accomplished something rare—a face that approximates beauty, at least of the sort so desired by conventional men's magazine subscribers. By contrast, for others who employ face work to transition, the face will not approximate the looks of the celebrity glamazon. It may look like just another face, and yet this unremarkability is so often precisely the point.

CHAPTER V

MAKING FACES: EXTREME MAKEOVERS AND THE “REALITY” OF FACE WORK

“If you had to describe the American mythos in one single word, “reinvention” really would not be a bad choice. One could argue that from the time of the Pilgrims’ arriving at Plymouth Rock, a lot of at least the European settlement story of America has been about reinvention, leaving the Old World for the New. It’s American culture as the annihilation of history, of the past... In a very real sort of way, the history of the United States is one big fat makeover show.”

Robert Thompson (2003: B4)

Extreme Face Work

1. First Name Middle Name Last Name
26. Why do you feel you should be chosen to receive the Extreme Makeover?"
27. If you are selected to receive the "Extreme Makeover," list everything you would like to have altered?
28. What areas or parts of your body are you most unhappy with? Have you always felt that way? If not, what event changed your image of yourself?
29. In what ways has your physical appearance affected your life?
30. If you were to receive "The Extreme Makeover" in what ways would your life be altered?
31. Tell us about your relationship with your parents?
32. Tell us about your relationship with your siblings?
33. Tell us about your relationship with your mate/significant other?
34. Tells us about your relationship with your friends?
37. Have You Ever Been Treated For Any Serious Physical or Mental Illnesses Within The Last Five (5) Years? (Circle One) Yes No
39. Have you ever been treated for Depression? In your opinion, what triggered your depression?
42. Have You Ever Been Diagnosed With Alcoholism Or Any Other Drug-Related Addiction?
43. Do you have any sexually transmitted diseases? If so, please describe:
45. In A Brief Statement, Tell Us Why We Should Choose You, Over Anyone Else, To Receive The "Extreme Makeover"?
46. Besides altering your appearance, what is your biggest dream?

The videotape must meet the following restrictions:

1. Tell us who you are and why you deserve the Extreme Makeover. Explain how your looks have affected your life and how they continue to affect you.
3. Make sure you shoot a 30-second close up of your face and profile with NO MAKE-UP...**We need to be able to see what problems you have.**

Excerpt from "Extreme Makeover" Application
(ABC Television Network 2006)

Cars, dogs, presidential contenders, and nation states are all getting "extreme makeovers" (Baker 2007, Hinchcliffe 2007, Marcus 2007, Stanley 2007). In the five years since ABC aired its controversial reality show, "extreme makeover" has entered the American vernacular. Extreme makeovers are the order of the day. While makeovers are not new, *extreme* makeovers seem to be. To qualify makeovers as "extreme" points to their presumed greatness and their magnificence, but extreme also reeks of excess and severity and risk. The aforementioned news accounts of "extreme makeovers" approach the subject with awe and derision. They gloat about the technological, cultural, and financial achievements that make extreme makeovers possible, while chastising the desire for such makeovers as overindulgent and the experts whose work produces extreme makeovers as overambitious. "Extreme makeovers" seem to ignite concerns about consumption, technology, desire, industriousness, and human possibility. The stories told about extreme makeovers are moralistic tales that convey a profound fear of going too far *and* an intense desire for seeing how far we can go.

In 2002, ABC first aired *Extreme Makeover*, an innovative and controversial reality television show.⁴⁵ In each of the fifty-five episodes that aired over the course of

⁴⁵ Reality television is a genre of television that purports to chronicle unscripted situations as they are experienced by ordinary people, though celebrities increasingly

three seasons on ABC and in subsequent syndication on the Style Network, “real-life” people (most often women) moved to Hollywood to begin surgical, exercise, dietary, and other cosmetic regimes to prepare for their “big reveal.”⁴⁶ This moment serves as the climax of the show in which participants along with their friends and family see candidates for the first time post-makeover. Under the supervision of the “extreme team” (comprised of cosmetic surgeons, dermatologists, cosmetic dentists, eye surgeons, hair restoration specialists, physical trainers, stylists, make-up artists, and hair stylists), participants’ appearances were radically altered--in many cases making them unrecognizable to family, friends, and themselves.

While the format of episodes changed slightly over the three seasons, the basic structure of the show remained consistent, indeed formulaic. In fact, while participants vary from episode to episode, each episode follows the *same* narrative structure.⁴⁷

participate in programs modeled on similar premises. Later in this chapter, I describe and query reality television in more detail.

⁴⁶ Emily M. Boyd (2007) analyses the first season of Extreme Makeover in order to understand the production of identity via reality television. She provides descriptive statistics about participants from the first season. Of the thirty-three makeover candidates featured, twenty-two are women. Thirty were white.

⁴⁷ In later episodes, the “mini extreme makeover” was introduced. The “mini” quality of these makeovers is striking given the “extreme” quality of most of the other makeovers captured by the program. In these very short segments, which usually comprise no more than five minutes of an episode, candidates are restyled using non-surgical techniques like wardrobe makeovers, haircuts and coloring, and teeth whitening. These segments

Brenda Weber (2005) argues that *Extreme Makeover* follows a “strict formula” that reflects a “deep structure” embedded in the program that allows viewers to anticipate what is coming in each successive episode. In this way, the meaning making accomplished by *Extreme Makeover* is continually established in each episode. The show opens by describing participants’ backgrounds. We meet candidates in their hometown and get a glimpse of their “real lives.” Most importantly, we are told a story that conveys to the audience why this particular candidate needs an extreme makeover—in other words, what problems will be fixed by the intervention. Then, on camera, candidates are “surprised” by the announcement that they are leaving for Hollywood. Once in Los Angeles, participants meet with the Extreme Team. During these meetings, candidates identify which bodily features they most desperately want to change and members of the Extreme Team describe what kinds of interventions can “fix” the problem areas. Within days, participants are admitted for surgery, and each episode offers a brief glimpse into what cosmetic surgery entails. Post-surgery, we encounter participants who are experiencing physical pain and often homesickness. Once candidates have healed, they meet with personal trainers and/or stylists for the final touches. Afterward, candidates ride (sometimes in a limousine) to their “big reveal” where family and friends will see their new looks for the first time. Without exception, family, friends, and candidates are elated when they see post-makeover candidates. Interviews with spouses, parents and children who universally express amazement are interjected with images of the big reveal celebration. Finally, “before” and “after”

mirror other television makeovers like those featured on *Queer Eye for the Straight Guy*, *Oprah*, or the *Today* show.

pictures fill the television screen. The announcer outlines each procedure that comprises each participant's extreme makeover. Participants' entire bodies are remade over the course of their stay, but significantly, procedures overwhelmingly focus on participants' faces.

In October 2006, ABC aired the first episode of the fourth season of *Extreme Makeover*, but no additional episodes aired during the fall season due to low ratings. In June 2007, the network announced that *Extreme Makeover* was officially canceled and that three pre-recorded episodes would air in summer 2007 to fill a summer time line-up, according to a network press release (ABC Television Network 2007). While *Extreme Makeover* aired on a major network for only three seasons, it irrevocably changed American discourse about and, by extension, American's relationships to cosmetic interventions.

The broadcast of *Extreme Makeover* animated public debates about cosmetic surgery, television, and America's never-ending pursuit of self improvement. Reviews of *Extreme Makeover* revealed both an infatuation with and contempt for transformations that push the boundaries of the possible (Elber 2002, Petrozzello 2002).⁴⁸ According to

⁴⁸ What shows like *Extreme Makeover* do is offer participants the resources to challenge the stability of materiality, to subvert the limits of embodiment. While Americans seemed obsessed with self improvement, public response to changing bodies elicits policing. Historically, bodily variance was understood in supernatural terms; one's moral standing, one's virtuousness, one's elect status is made manifest in one's body (Daston and Park 1998). Disabilities and chronic illness, disfiguring conditions and bodily trauma are indicative of moral failings and thus, in a sense, deserved. There is a lingering

reviews, the results were astonishing, but most agreed that they had exceeded the limits of how cosmetic interventions should be deployed. In a scathing review, *New York Times* television critic Caryn James (2002) wrote,

As a reality show it's a flop, with bad casting and the tackiness of a cheap syndicated series...As a cultural barometer, though, *Extreme Makeover* is fascinating. It displays both the voyeuristic excess of reality shows and the cultural ideal of creating a purely artificial personality (everyone goes to Hollywood)...We all fantasize about changing something, but these Frankenstein dreams seem spooky...television is shifting our idea of what cosmetic revisions seem normal.

When ABC added the show to its regular line-up, even the Academy of Cosmetic Surgery condemned the show, releasing a statement objecting to the glamorization of radical cosmetic interventions featured as entertainment (Oldenburg 2003). These critiques rested on the fact that while participants' wanted to improve their appearance, they were not disfigured. The disgust with *Extreme Makeover* relied on a shared sensibility that cosmetic interventions for unremarkable faces should be kept to a

collective sensibility that our bodies are objects that are expressive of our moral transgressions and our admirable asceticism. The discourse around body weight which posits obesity as the result of a lack of willpower clearly relies on such moralism (Bordo 1993). We deserve the bodies we have, and makeovers interfere in what seems natural and fair. Interestingly, the public response to *Extreme Makeover: Home Edition* is strikingly opposite, suggesting that offering someone the opportunity to improve their class status is much more acceptable.

minimum, the assumption being that only in the case of “real” disfigurement would it be appropriate to try to effect such radical, transformative results.⁴⁹

And yet, participants on *Extreme Makeover*, prior to intervention, are described using words often reserved for the faces of those who have experienced facial trauma and congenital difference: Freak. Deformed. Defective. Damaged. Monster. Witch. Cursed. Nightmare. Abnormal. Disfigured.⁵⁰ While most participants are not exceptionally good-looking (based on Western notions about what constitutes attractiveness), neither are they extraordinarily unattractive. These are faces that would go unnoticed on the street as opposed to faces that would elicit public staring indicative of the public’s discomfort with facial difference. Yet the faces of participants are routinely depicted through narration and participant’s own voices as grossly disfigured. What does it mean for *Extreme Makeover*, a site of popular discourse and imagery, to position itself as a mode of face work, as a *technocultural response* to disfigurement (and a legitimate, necessary response at that)?

In this chapter, I locate *Extreme Makeover* in a long standing history of producing distinctly American bodies devoted to self-improvement through makeovers. Through

⁴⁹ In the Summer of 2007, a British television network announced that they were looking for “disfigured” persons to participate in a show in which they would receive cosmetic intervention (Templeton 2007). The announcement was met with public outrage, but the response seemed to be directed towards the idea that *broadcasting* such an event was uncouth. The idea of intervening in disfigurement with radical means seemed to generally be accepted.

⁵⁰ Examples of such language can be identified in almost every episode analyzed.

content analysis of 30 episodes of *Extreme Makeover* (2002-2007), I examine the narrative embedded in each episode, analyzing these as discourses on bodies, disfigurement, and normalcy. Rather than approaching *Extreme Makeover* as a site of celebrity look-alike production, I argue that *Extreme Makeover* posits aesthetic intervention as a response to traumas in participants' intimate, economic, bodily, social, and emotional lives. In this way, the "cosmetic" work accomplished on *Extreme Makeover* is akin to other modes of face work in that it is technical work aimed at the face but invested with significant promise. I ask what cultural work is accomplished by framing cosmetic intervention as a solution to whatever problem ails, particularly problems whose resolution cannot, in fact, be achieved exclusively by changing bodily appearance.

Next, I focus on an unexpected moment but one that routinely occurs when participants see themselves for the first time following the completion of the makeover. Following social theorists that employ schizophrenia as a metaphor for understanding postmodernity, I analyze how participants' responses mirror the symptoms of depersonalization disorder, a kind of dissociative disorder characterized by a disruption in self-perception. In some cases, depersonalization is accompanied by the inability to recognize one's own transformed reflection in the mirror. I conclude by asking what it means to frame consumption of aesthetic interventions as a global solution for the problems of modern life, to cultivate a facial appearance that aims to be unrecognizable, and to position initially unremarkable faces as disfigured.

The (American) Makeover

Makeovers are quintessentially American, with their emphasis on self-improvement and diligence. They rely, moreover, on thoroughly American values. From Ben Franklin's *Poor Richard's Almanac* to JFK's calls for volunteerism, Americans have been encouraged to embody, oftentimes quite literally, innovation and industriousness (Crawley 2006). Not surprisingly, makeover culture, both of the self-help and aesthetic variety, appears to be on the rise. According to numbers released by the American Society for Aesthetic Plastic Surgery, cosmetic surgery rates began rising during the same period in which sales of self-help books increased (McGee 2005). Sociologically, two critical questions are: why makeovers, and why now?

Makeovers involve two central figures. They center on an entity (most often a person but sometimes a house or a business or a relationship) that is transformed in the process of the makeover. The object of transformation is a work object (of sorts), a "material entity around which people make meaning and organize their work practices" (Casper 1998: 19). The second key figure is the expert who possesses the skills and know-how to transform the person or room or relationship into something else. Experts or transformers rely on tools. Both material apparatuses like scalpels, hammers, and television network finances and knowledge including physiology, architectural design, and therapeutic insight aid the process of transformation. Each makeover requires the "right tools for the job" (Clarke and Fujimura 1992).

But why are Americans increasingly obsessed with transformation? Sociologist Micki McGee in her analysis of self-help culture argues that this is an era of "new insecurity" (Wallulis 1998). Lifelong careers are the exception rather than the rule.

American work life is now characterized by stagnant wages and erratic employment opportunities. Family life is more unpredictable than in previous periods. With divorce as a very real option, marriage no longer lasts until death, and flexibility around socially acceptable family configurations means that what intimate life looks like over the course of a lifetime has become increasingly difficult to predict. In addition, social welfare programs that promised a safety net in the case of hard times have been severely cut. These changes are not necessarily indicative of grim times, as conservative social commentators suggest. To the contrary, divorce and job flexibility make it possible for many to pursue more desirable lives. Setting aside the question of whether these are positive or negative social transformations, what is the effect of living in a time characterized by flexibility, insecurity, and unpredictability? McGee understands the consumption of self-help literature as a social imperative in this new world. Self-help, indeed makeover culture, provides an avenue for making one's self increasingly desirable in both economic and intimate spheres that are constantly changing. In short, a makeover is one way of securing desired outcomes—a job we want, a partner we like, or a sense of psychological or financial stability.

While self-help involves a variety of projects centered on the self (yet often, ironically, in relation to others), makeovers commonly focus on appearance. Makeovers promise endless choice and the fantasy of transformation. Often, these *aesthetic* makeovers are not about getting what we want, at least directly. Rather, aesthetic intervention is also about ridding ourselves of what we do *not* want—acne, cellulite, wrinkles, jowls, “defects,” markers of ethnicity, and other undesirable features.

Individuals, seemingly ineffective in changing society, make a decision to change themselves. In makeover and plastic surgery narratives, choice

typically involves discarding the past, be it an old sofa or, as in the case of cosmetic procedures, an 'old' face. This shedding of personal history expresses the self through the body (Corvino 2004: 56).

In fact, the cosmetic surgery industry, a key transformer in aesthetic makeovers, understands its work as largely aimed towards the resolution of psychological pain. According to Corvino, patients understand their pre-surgical body as an abject body. Cosmetic surgery then acts as a means for keeping abjection, those parts of ourselves that we do embrace as constituting our subjectivity and identity, under control. Through cosmetic surgery, patients attempt to rid themselves of abjection in favor of identification with clean and proper bodies (Kristeva 1982).

And of course, self improvement through work on the body is a highly gendered enterprise. The burden of body maintenance and improvement compels women in ways that are different from men. Women are embedded in longer histories of intense body surveillance facilitated through the consumption of cosmetic products and services (Bartky 2003). Even as men are increasingly subject to a new aesthetic which increasingly positions men's bodies as subject to appearance interventions, women's lives are changing (Bordo 2000). The "second shift" has expanded (Hochschild and Machung 2003). Not only are women maintaining busy work and family lives, but rather the expectations for how women will manage the time bind with style and grace mean that success is largely determined by how coiffed one appears at work, how quickly the baby weight is lost, and how well one maintains a youthful aesthetic.

But just like becoming a "highly effective" person (as Steven R. Covey's 1989 extraordinarily popular bestseller puts it) is often in the service of becoming a more efficient and thus successful worker, aesthetic interventions are often about ridding the

body of what is unwanted in the service of others' desires. For example, erasing the signs of aging might be accomplished by eradicating fine lines and age spots, but this is often done in the service of remaining a competitive force in the labor market or an attractive mate in the dating pool. In short, aesthetic makeovers do not simply change the object of transformation from one state to another. As a mode of resolving abjection, the makeover is a process of repair in which the patient fixes a, perhaps related, but entirely distinct problem through cosmetic intervention. It is in this way that *Extreme Makeover* operates as a form of face work.

Making Over *Real Lives*

In the last ten years, reality television has saturated the television line-up. Upon the airing of the first reality shows like *The Real World* and *Survivor*, critics remarked that within a few seasons Americans would be sick of watching themselves on TV (Huff 2006). They were wrong. As of the Spring 2007 television season, NBC's *The Apprentice* is in its 6th season, CBS's *Survivor* is in its 14th season, and MTV's *The Real World* was in its 18th season. In 2003 and 2004 the Primetime Emmy Awards, arguably a reliable barometer of television culture/industry, responded to the surge of reality programming with two new awards for the genre—Outstanding Reality Program and Outstanding Reality-Competition Program.⁵¹

⁵¹ CBS's *The Amazing Race* has won the Reality-Competition Award every year since 2003. Makeover shows have won in the Reality Category as well. ABC's *Extreme Makeover: Home Edition* was the 2005 and 2006 winner, and Bravo's *Queer Eye for the Straight Guy* was the 2004 winner.

Reality television is a medium that blurs the very terms used to distinguish genre. Reality television is simultaneously fact, fiction, education, and entertainment (Homes and Jermyn 2004). While reality television relies on the continual negotiation of the very terms used to distinguish one genre from another, reality television has come to employ two identifiable and predictable characteristics, chronicle and competition, in order to construct an intelligible narrative. First, reality television chronicles the life of the cast as it unfolds in environments engineered by television producers. For example, shows like *The Real World* and *Big Brother* capture participants' lives over the course of a pre-determined period of time as they live in a made-for-television mansion. The thrill comes in watching cast members respond to factors that are introduced throughout the time they occupy *The Real World* or *Big Brother* House. Reality television participants not only live their lives on camera, they also compete for prizes. On *The Apprentice*, contestants compete for a job in Donald Trump's empire. Some shows rely more heavily on documenting events than on competition and vice versa, but almost all reality shows employ both strategies in order to capture television audiences. For example, ex-Victoria's Secret supermodel Tyra Bank's massive television hit, *America's Next Top Model*, captures gangly, bitchy, teenage hopefuls as they pose their way through a variety of highly crafted photo shoots that "mimic" those experienced by "real" models. The girls also participate in bizarre challenges that purportedly work to pedagogically cultivate America's next top model (Lane and Giles, forthcoming). As a formula, chronicling "reality" and capturing "competition" have made for successful television.

In the world of reality television, makeover television is, arguably, an emerging sub-genre in and of itself. Not only *Extreme Makeover* but also television shows like

MTV's *I Want a Famous Face*, TLC's *What Not to Wear*, Fox's *The Swan*, Bravo's *Queer Eye for the Straight Guy*, Style's *Style Her Famous*, and E!'s *Dr. 90210* have created a pop culture landscape exclusively devoted to cultivating new appearances effected through aesthetic interventions. Reality television has established a reputation for enacting the unthinkable and the crass (think: Fox's *Who Wants to Marry a Millionaire* and its denigrated spin-off *Who Wants to Marry a Midget*), and makeover television pushes the boundaries too. *Extreme Makeover* stands apart from most other makeover shows. As opposed to other makeover shows which rely primarily on non-surgical interventions, it routinely employs *numerous* surgical interventions aimed at making participants *unrecognizable* to themselves, friends and family, and presumably the television audience.⁵²

What makes reality shows like *Extreme Makeover* different from cable shows of the 1990s that focused on cosmetic surgery is that *Extreme Makeover* is about the meaning making miracle facilitated through transformation whereas cable shows often

⁵² While FOX's *The Swan* is similar to *Extreme Makeover* in the sense that both pushed the boundaries for what makeovers had previously attempted on TV, *Extreme Makeover* stands apart from *The Swan* for several reasons. *The Swan* aired for two seasons on FOX. *Extreme Makeover* lasted for three seasons and part of a fourth. In addition, on syndication on the Style network *Extreme Makeover* continues to reach audiences in a way that *The Swan* does not. In addition, *The Swan*'s gimmicky concept included forcing participants to participate in a beauty pageant post-makeover. Because *Extreme Makeover* purported simply to chronicle the process of transformation, it garnered a degree of respectability not afforded to *The Swan*.

demonstrated the technological miracle made possible by surgical techniques. In other words, cable plastic surgery shows displayed emerging techniques to convey the miraculous effects afforded by modern science. By contrast, makeover shows deploy science in the service of displaying the miracle of self improvement. In each case, television featuring cosmetic surgery makes surgery increasingly accessible culturally, even if it remains materially inaccessible. Viewers become acquainted not only with the “facts”—the procedures, the doctors, the bodily risks, the financial costs— but also with particular meanings of cosmetic surgery (Tait 2007). Yet, makeover television discursively situates the audience within particular logics about cosmetic surgery—what such intervention means and what it makes possible. Importantly, the television watching public is consuming the idea of cosmetic surgery as it is produced on reality television. Thirteen million viewers tuned in to the December 11, 2002 premier of *Extreme Makeover* (Huff 2006).

Melissa Crawley (2006) argues that via plastic surgery television, people witness the “medicalization of real people’s everyday lives.” But it is not simply that people consume medicalization in the form of television entertainment, the medicalization of the audience’s everyday life is also intensified. *Extreme Makeover* is a show particularly conscious of its audience. Experts who guide the makeovers of participants routinely address the audience directly. These moves invite the viewer to intervene in her or his own appearance using the techniques modeled on *Extreme Makeover*. This is a pedagogical move. Viewers are not simply voyeurs; rather, television viewers themselves are objects of intervention. As a cultural object with pedagogical force,

Extreme Makeover instructs the audience about how to view, assess, categorize, and manipulate appearance. In this way, reality television is not *just* entertainment.

Rather, *Extreme Makeover* instructs the audience about how to look at and attribute meanings to candidates' appearance. In an episode featuring Deshante, a middle-aged, black woman born with cleft palate, the announcer tells us that although we may think Deshante is unremarkable, she is, in fact, *not*. "From a distance seemingly normal, but closer you see it—the deformity that has cursed her life—cleft palate." Despite appearing "seemingly normal" to the untrained eyes of the television audience, Deshante needs intervention. The announcer urges us to look closer, to reconsider what we initially see, and to redefine Deshante's unremarkable face as a face marred by a "deformity." *Extreme Makeover* plays the role of aesthetic arbitrator deciding who needs intervention. It does not matter that Deshante seems normal at a glance. *Extreme Makeover* urges the audience to look closer, to see the deformity.

Early attempts to define "reality TV" positioned "real life" and the participation of "real people" as central criteria towards determining if the genre truly captured "reality." Critics have denigrated reality television as a genre that purports to chronicle reality, but instead fashions a plastic (read: fake) reality characterized by a producerly aesthetic. The question of whether reality television is real or not seems beside the point, rather it matters only that the program makes the "discursive, visual and technological claim to be 'the real'" (Holmes and Jermyn 2004: 5). While *Extreme Makeover* is mediated (and thereby "fake"), in the sense that it relies on a cadre of experts to enact the transformation, it purports to intervene in candidates' "real" lives. In this way, *Extreme*

Makeover shapes viewers sense of what is real, both what is possible and what is in need of repair.

Each of the one-hour episodes follows the same narrative arc. *Extreme Makeover* chronicles the experience of undergoing radical cosmetic intervention, but the show also engages in storytelling. The audience meets the candidates. Images of the participant's hometown and of the candidate at work and home are juxtaposed with shots of the candidate in a range of settings—at the rodeo, in a dance class, at their college graduation party. Intermittently, the camera often captures the candidate as they stand in front of a generic bathroom mirror staring at their own reflection. Audio clips from interviews with the candidate, their family, and friends, play over the images so that the audience hears about their lives. The announcer interjects to connect the disparate images and audio so that a logical narrative emerges, one that emphasizes why each person *needs* an extreme makeover. Then, we watch as they are transformed.

Repair Via Extreme Makeover

I imagine the producers sitting behind the camera asking:
"When did you first notice that you are ugly?"
"How much would you say that you hate yourself?"
"You're life must be very hard. Right?"
"Have you ever felt that your motherfatherhusbandboyfriend hated you because you are ugly?"
"Do you ever want to die?"
She cries and says that she wants to stop. Can't everyone see why she needs the makeover?
"If you want the surgery, you will have to talk. You will have to tell us your story, your very sad story."

The opening credits roll. Images of patients and doctors fill the screen as non-descript instrumental music plays. One image comes after another, but for a second, each image freezes, and one by one we are introduced to members of the "extreme team."

Doctors' specialties are spelled out next to their pictures. Each member of the extreme team has a different expertise. Throughout, audio clips are interspersed. These feature the voices of the experts, and their words foreshadow the transformation that is about to occur. "Wow! You look fantastic!" "I'm here to introduce you to a rock star." "Mission Accomplished!" Precisely, what mission is it that *Extreme Makeover* accomplishes, or claims to accomplish?⁵³

Not everyone is a candidate for *Extreme Makeover*. To participate, one must prove that she is sufficiently in need of cosmetic intervention. Given that the show is about making over participants' visual appearance, it seems logical that the primary selection criterion would be an applicants' looks. Using this standard, the "ugliest" would be the neediest. But the narrative structure of each episode centers on explaining *why* a particular recipient, whatever their looks, *needs* and *deserves* an extreme makeover—and quite often, the quality or severity of one's facial or corporeal problems is not the main criteria determining their ultimate success as a candidate. My question is not whether or not these explanations reveal the "real" motivations of the production staff; rather, I am interested in the cultural work accomplished by these narratives.⁵⁴

⁵³ A more extensive discussion of the connotations of the word "mission" appears in the chapter based on my analysis of the work of Operation Smile.

⁵⁴ Excerpts from the application participants used to apply for the show appear at the beginning of this chapter. Besides eliciting basic information (age, occupation, race, and gender), multiple questions ask applicants to explain why they need a makeover. They are asked to describe what parts of their face and body they most dislike, how their

In each episode, a story is constructed that explains the need for radical intervention. Rather than introducing us to an extreme makeover candidate and letting a picture of the candidate, in essence the person's appearance, speak for itself, a narrative is constructed wherein candidates, their families, and their friends describe in detail the candidate's problems. This "cataloguing of inadequacies" (Deery 2006:166) posits the makeover as a solution to a myriad of problems, most of which will not be directly affected by aesthetic intervention. Candidates do identify facets of their appearance that they would like to change, but the thrust of the story emphasizes emotional, intimate, social, bodily, and financial difficulties.⁵⁵ The narrative positions the makeover as not simply a response to a candidate's appearance, but rather as the sole means of repairing the candidate's disfigured life.

Emotional Repair

Art is a fifty-five year old seemingly average American guy—medium build, brown hair, male pattern baldness. In short, he looks like millions of middle aged men. Within minutes of meeting him, we find out that Art lost his wife five year ago and is intensely depressed. According to the *Extreme Makeover* announcer, in that time Art has appearance has affected their life. Applicants are even asked to imagine what life would be like post-makeover.

⁵⁵ For the sake of brevity, I am providing exemplary examples of each kind of narrative deployed in *Extreme Makeover*. In the episodes I have analyzed, there are multiple cases of each narrative I have identified, and each candidate's story fits within the framework I am positing.

been “asleep in every sense of the word...Art needs to chart a change of course.” The announcer’s words are dubbed onto images of a sullen Art pacing along the edge of a lake. In Art’s case, emotional trauma is the basis for repair. Art’s salvation comes through an extreme makeover. In Hollywood, Art meets with a cadre of surgeons, dentists, optometrists, and stylists that help craft a new visual aesthetic. At the end of the episode, Art concludes, “I’d lost the winning edge and now it’s back.” Even Art’s reflection post-makeover suggests that while he does look different than he did at the beginning of the episode, the success of the makeover lies in its ability to restore Art’s mental health.

In another episode as candidate Amy describes her life and the way she feels about herself, she begins to cry. The announcer suggests, “Beneath the pock marks on this woman’s face, deeper scars.” She is intensely insecure. “Pretty is not what Amy sees when she looks in the mirror.” She points to gaps in her teeth, her nose, and her complexion. She tells us that as a child she was made fun of. She used to scrape her face with steel wool to make her acne go away. Her acne scars remind her of the humiliation she endured. The announcer tells us that there are very few pictures of Amy growing up. “When I was a teenager my mother never told me I was pretty...I hated how I looked.” Understandably, she never accepts a compliment. “I can’t dwell on it. I have a life to live...But it’s always there. It’s always in the back of your mind.” After a series of procedures including a nose job, brow lift, and laser resurfacing, Amy declares, “For the first time in my life I feel like I have a beautiful smile...It really is a dream come true.” Her makeover has done more than change the look of her face. The announcer concludes, “Amy’s *life* has turned around.”

Social Repair

Regina is a recently divorced, middle aged mother of two. Like many women in her circumstances, she appears to have little time to devote to her appearance. She wears her hair tied back. Her wire rimmed glasses are not particularly stylish. If she wears any make-up, it is not visible. Although she does not seem to invest much in her appearance, she wants a makeover. Regina explains that before her children were born, she prayed that her kids would not look like her. She tells her children, "I don't want you guys to go through the hurt that I went through. People constantly talking about you all of the time." In short, it is social exclusion that has led her to so desperately want a makeover. After a regime of cosmetic surgery, Regina remarks, "I am the swan on the lake. I'm going to strut my stuff." Instead of being the outsider, Regina anticipates a post-makeover life at/as the center of the party.

Ray Croc spent ten year on death row, but DNA evidence exonerated him from a murder conviction. Dubbed the "snaggletooth killer," Ray was convicted of murdering a bartender based on a bite mark found on the dead woman's body. His crooked, mangled teeth resembled the bite mark. The announcer asks, "Was his only crime bad looks?" Ray concludes that "My crooked, irregular teeth and my haggard looks, I think that led to the outcome of me being sentenced to death." Being judged based on appearance is what led to his imprisonment. Now he works as an inspirational speaker encouraging others to look beyond appearance. In Hollywood the announcer tells us, "The extreme team decriminalizes Ray's outlaw looks." In addition to dental implants and a custom toupee, Ray receives a brow lift, upper and lower eye lift, liposuction, nose job, and laser resurfacing. "Our whole goal is to give you a more innocent look," plastic surgeon Dr.

Griffin tells Ray. The makeover works as a way of erasing the social stigma of Ray's criminal past, and indeed his very criminality. And the team claims to succeed. The announcer declares, "Prison took ten years from Ray. *Extreme Makeover* gives ten years back."

Financial/Economic Repair

In another episode we meet brother and sister pair Bill and Kim. Both want an extreme makeover. Both cite their inability to function in public as the prime reason why they need aesthetic intervention. For Bill, an extreme makeover promises to fix problems he has had while working as a manager at Home Depot. "Bill's shyness has held him back at work," the announcer tells us. Bill elaborates, "I deal with a lot of people. It's hard when I have to directly face them...I feel like they're looking at my big lips. I feel like they're looking at my big forehead, and feel a lot of insecurities because of it, so I had to step down as a manager." One of *Extreme Makeover's* star surgeons Dr. Fisher agrees that Bill needs cosmetic intervention, but not because he is ugly. In a consult before his surgery, Bill explains to Dr. Fisher, "A lot of people tell me I look angry." Dr. Fisher replies, "You have really heavy bones that make you look very intense." To deal with Bill's "intense" bones, Dr. Fisher suggests a collection of cosmetic procedures including a nose job, liposuction on his chin, an eyelift, and a sculpted brow sanded down in surgery. In *Extreme Makeover* terms, new bones promise to make for new job opportunities.

Another episode begins by promising the audience a look at a dramatic, new procedure. The announcer declares, "New weapons target the world's most rampant

disease.” What’s the disease? Acne. Tammy’s face is red and inflamed. She lives “her life in a darkened room” working as a telemarketer. She admits that although she wants to be a professional dancer, she works a job where no one can see her so that “They [coworkers] don’t have to see me or be judging me for my appearance...I can just let my inside out.” After a series of facial procedures including a brow lift, nose job, upper eyelid lift, and dermatological treatments, Tammy exclaims, “When I look in the mirror it’s definitely not the same person from eight weeks ago. I have more confidence. I don’t have to hide anything.” No more hiding means that Tammy is primed for the work she has always wanted to do.

Intimate Repair

Unlike many *Extreme Makeover* candidates, Aimee is *not* looking for a partner. She is married to a man who tells producers in an interview preceding Aimee’s extreme makeover that he loves her heart and soul, not her looks. Presumably, not many would love Aimee for her looks. Upon seeing Aimee, her surgeon Dr. Moellekan admits, “Aimee is the most difficult case of my entire professional career.” Her mother, echoing Dr. Moellekan, seems to imply that even she thinks Aimee is ugly. “I know she’s a beautiful person, but I’m her mother.” But Aimee’s ugliness doesn’t matter in and of itself. Aimee’s appearance matters because as her story seems to suggest, it influences her relationship with her husband. He tells the camera that she has trouble being completely naked, suggesting that their sexual relationship is troubled. “She’s always saying that she doesn’t like herself.” And yet after a three month stay in Hollywood and

some fifteen cosmetic procedures, Aimee declares, “I’m ready to...walk out with confidence,” presumably into the bedroom with naked self assuredness.

Pam is a respiratory therapist, a real “girl next door” with sandy blond hair and non-descript facial features. She wants a makeover for herself but also for her boyfriend. Even though they have lived together for three years, he has not popped the question, and she wants to get married. Maybe a makeover will give him the incentive he needs? In Hollywood, she gets her ears pinned back, an upper and lower eyelid lift, a nose job, dental work, and Botox and collagen treatments, along with a slew of body work, but even two weeks after surgery she is still extremely swollen. Her recovery proceeds slowly, but in the end, it is all worth it. At her big reveal, Pam’s boyfriend who is waiting to see her drops to one knee and proposes. More than the makeover, she seems excited about the idea of her upcoming marriage. It is what she always wanted.

Bodily Repair

We meet Sara, shirtless, sitting on her bed. She speaks into her home video camera, attempting to convince the producers why she needs a makeover. Her left arm covers her right breast. A large scar marks her chest where a breast used to be. Sara is a “victim of breast cancer.” Sara has “aged ten years” during her treatment, and she has also developed a deep sense of fear. “When I found out I had cancer, I was devastated because you think you’re going to die.” Sara receives a number of interventions including a face lift, laser skin treatments, and breast implants. Her final stop on her day of styling is to buy a bra. She is whole again.

“By all appearances Rachel Myer from Colorado is a normal, lovely young woman...but appearances like beauty itself can be deceiving,” the announcer tells the audience. Rachel looks “normal,” but Rachel needs a makeover because she has alopecia, an autoimmune disease that results in hair loss. “Rachel is headed to Beverly Hills to be beautiful, *to be normal*.” In Hollywood, Rachel meets with the extreme team and undergoes a variety of procedures including a brow lift, facial fat injections, tattooed eyebrows, and laser skin treatments. But Rachel most desires a wig that would allow her to go swimming and to “not worry if there was a wind storm.” But a custom wig accomplishes more than diminishing Rachel’s anxiety. According to the narration, “We’re [the extreme team] going to give back what nature stole.” At her reveal, Rachel concludes, “I feel like a person with a real head of hair.” In a sense, the makeover has conquered the disease and repaired Rachel’s life.

Extreme Face Work as Repair Work

Other plastic surgery television offers the promise of a makeover based on the logic that a participant has earned a reward. For example, a participant’s life of meaningful work earns them the reward of plastic surgery (Crawley 2006). But *Extreme Makeover* participants are often offered surgery not as a reward, but as a form of compensation for suffering.⁵⁶ Reality is the problem—living among people who may judge you—and television offers the solution. How does cosmetic intervention help a candidate’s given problem? How does a new face make for better sex? How does a nose

⁵⁶ The only exceptions are two “Battle of the Bulge” episodes in which three participants must lose weight in order to earn their makeovers.

job help a spouse grieve the loss of his wife? How does laser resurfacing absolve the humiliation of childhood torment? How does cosmetic surgery resolve the experience of breast cancer? How does cosmetic surgery help someone get a better job?

By framing the cosmetic facial intervention accomplished on *Extreme Makeover* as repair, *Extreme Makeover* imagines itself not simply as a television show about cosmetic surgery, but rather as an opportunity for much needed repair. While this transformation is about appearance, *Extreme Makeover* makes constant reference to repair work and in the process consistently constructs the project of cosmetic intervention. In essence, as the program transforms the visages of makeover candidates, it simultaneously transforms the notion of what cosmetic intervention can accomplish. In a therapeutic culture, cosmetic surgery becomes another tool in the repertoire of tools to save the troubled psyche, a self help device used to resolve life problems. The intense narrative work invested in explaining *why* candidates need surgery centers on facets of the candidate's lives that are not working. Being ugly is *not* a sufficient reason for receiving an extreme makeover. Rather, recipients' facial appearance is made over in the service of transforming, or more specifically, repairing their lives. Because makeovers are projects of repair, they are so often prefaced by a story of defeat or destruction. *Extreme Makeover* stories outline the financial, emotional, intimate, bodily, and social problems experienced by candidates. In any sociological framing, these would be seen as social problems. Yet the makeover works as a superficial repair mechanism: cosmetic solutions for a social dilemma. I argue that the work of repair must be interrogated, because it is laden with assumptions about what needs fixing and what being fixed entails (Spelman 2003).

Cultural critic Brenda Weber argues that *Extreme Makeover* engages in the work of “eradicate[ing] embodied anxieties” (1). In a sense, cosmetic surgery has always framed its work on appearance as an intervention in the service of psychological wellness. Only after doctors convincingly argued that changing a patient’s outer appearance profoundly impacted a patient’s wellbeing did cosmetic surgery emerge as a respectable medical specialty (Sullivan 2001). In essence, cosmetic surgery, as we know it, imagines itself as a sort of practiced psychiatry. Instead of psychopharmaceuticals, cosmetic surgeons use scalpels. Instead of conversation about a patient’s emotional state, cosmetic surgeons talk with patients about what needs changing while viewing “before” pictures (as if these pictures speak for themselves). What is interesting about *Extreme Makeover* is that the show understands surgery as a means for effecting not only psychological wellbeing, but also improving other facets of human life including the financial, social, intimate, emotional, and bodily. The story goes that one’s very life is made over. In conflating a changed appearance with a changed life, life itself is reduced to appearance. The aesthetic is triumphant as a register of living.

The degree to which aesthetic makeovers can work in the service of self-improvement or repair, writ large, is a question. While appearance undoubtedly shapes of all areas of social life, is it likely that cosmetic intervention can work to repair in the ways the industry and patients believe that it can? I contend that the very pain patients hope to resolve through surgery consumption may be reproduced because in effect, the cosmetic surgery industry relies on that very pain for its survival and expansion (Corvino 2004). While the potential for aesthetic makeovers to transform, and in effect repair, the

subject's life are limited, in popular culture aesthetic transformation facilitated by makeovers are continually purported as the solution for whatever ails.

An *Extreme Makeover*

I am looking at before and after pictures. Before *and* after pictures side by side do look amazing. Staring and comparing, I see what the surgeons mean. Softening her jaw line does make her look, well, "softer." I wonder if, like her, I can get cheek implants. Would they help? Facial definition is key, even if it is effected by pockets of polymers or shaving sections of skull. Biotechnofantasies make it possible to craft faces that maintain almost *no* resemblance to their former shape. Before and after pictures juxtaposed make for shock and awe. But a before *or* after picture taken by itself captures *just another face*. One that I would look past if it was not filling up my television screen.

Extreme makeovers take place in Hollywood, America's center of fantasy production, and employ the services of many self-professed celebrity surgeons and style-makers. It is a biotech Cinderella story, except rather than becoming a princess, candidates are primed for becoming celebrities or, more precisely, looking like celebrities. In fact, *Extreme Makeover* explicitly positions itself as a proverbial fairy godmother: through the magic of television (and the resources available to primetime shows) producers turn beasts into beauties.

Cultural critics of *Extreme Makeover* take for granted that producing celebrity look-alikes is exactly what is accomplished (Deery 2006, Weber 2006). Weber argues

that “*Extreme Makeover* offers viewers the promise of the exceptional (coded as high-glamour beauty) built on an economy of sameness” (1). For Weber, the sameness inscribed on the bodies of makeover recipients is significantly shaped by celebrity culture. But if *Extreme Makeover* offers the promise of celebrity exceptionalism, as I agree that it does, viewers might be sorely disappointed. Promising celebrities is not the same as producing celebrities.

While *Extreme Makeover* discursively constructs celebrity look-alikes, its cosmetic interventions fall far short of producing the exceptionalism of celebrity aesthetics. While the techniques of intervention are undeniably extreme, the results are radical, though not in the ways many imagine. The pageantry of the show obscures the fact that while many candidates look different at the end of the makeover, they are still relatively unremarkable vis-à-vis somebody famous like Angelina Jolie or Johnny Depp.

Undoubtedly, candidates are more stylized. Most go from wearing little or no make-up to a full face of professionally applied cosmetics. Most arrive at the *Extreme Makeover* mansion in jeans and sweatshirts and leave in designer suits and gowns. And surgery has erased (or at least diminished) facial characteristics conventionally defined as unattractive. A scar that remains after multiple surgeries to repair a cleft palate is lightened. A brow ridge is reduced. A nose is broken and set at a straight angle. Acne is lasered away. Participants look *very* different at the end of the process compared to how they looked in the beginning, but they do not look like celebrities. Consider the following images reproduced from the *Extreme Makeover* website:



Figure 9. Tammy “Before” and “After”



Figure 10. Anthony “Before” and “After”

Undoubtedly, the after photographs are slick—faces are well lit, make-up is expertly applied, candidates are smartly posed. These photographs are professional headshots. But looking closely, they resemble head shots of character actors as opposed to movie stars. Think William H. Macy as opposed to George Clooney.

Periodically, episodes include updates. We meet candidates post-makeover who have returned to their “real” lives. Not surprisingly, these candidates look significantly different than they appear at their big reveals and in their post-makeover glamour shots.

High maintenance hairdos have been traded for pony-tails. Despite all of the surgical intervention, without the extreme team, candidates appear rather unremarkable. In short, participants appear entirely unlike celebrities whose aesthetic is built around chronic exceptionalism. And yet, even in updates, the story, as told by the announcer, remains one of glamorous transformation—the housewife turned starlit ingénue.

“I look like a movie star.”

“From the girl next door to the girl of her dreams.”

“From snaggletooth to a draw dropping dazzling beauty.”

“Bill looks like a movie star.”

“A nightmare transforms into a dream.”

Understanding *Extreme Makeover* as a site of cosmetic intervention that culminates in the production of celebrity look-alikes relies on a fantasy of cosmetic surgery that ignores the ordinariness of post-makeover candidates' faces.

While the techniques of intervention are undeniably extreme, the results are radical though not in the ways many imagine. Setting aside instances in which consumers purchase cosmetic procedures for the purposes of inscribing classical art works onto their bodies as in the case of French performance artist Orlan or embodying animals as in the case of Seattle's CatMan Dennis Avner, there are few examples of cosmetic intervention going further than what occurs on *Extreme Makeover*. The level of intervention most candidates experience is excessive, or at the very least extraordinary. In each episode following a candidate's big reveal, before and after images of the candidates wearing only their underwear are projected onto the television screen. The announcer narrates as the images are turned revealing a side profile with a newly

achieved ski slope nose or a strong jaw line enhanced by a chin implant. As the image shifts the announcer offers a comprehensive list of the procedures undergone. Often, candidates have experienced ten cosmetic procedures. Sometimes, they have undergone almost twenty. Their entire bodies are explored, outlined, marked, magnified, cut, and conquered. But if candidates are not made into celebrities, what do candidates look like at the end of the show? Rather than extraordinary, the results are mundane. Rather than celebrities, candidates appear like different versions of everyman and everywoman.

What becomes clear is that Extreme Makeover is less about producing the exceptional and instead settles for the creation of an unremarkable face. This is precisely what distinguishes face work aimed at disfigurement from cosmetic surgery aimed at attractiveness. Candidates are made over into a radically different version of themselves, albeit an unremarkable version. The investment in a different version of what remains an unremarkable face is curious.

Extreme Dissociation

The patient sits dressed in a robe, surrounded by experts poking and prodding at her face. Then at once, they stop. The experts step back and assess the patient. Slowly, her chair is turned around so that she comes face to face with her own image. Any moment she will see herself for the first time. The first time in a very long time. For a micro-second, they hold their breath. We hold our breath. She holds her breath. Slowly, her eyes open. Her jaw slacks. Her eyes widen. She sees herself for the first time in a very long time, but we cannot see her. Through the awkwardly positioned wide-angled television camera, we cannot see the mirror or her reflection in it. We watch the woman

watching herself (herself?) in the mirror. She looks in the mirror but does not recognize the image reflected back. Who is that in the mirror? Surely, I think, we are about to witness a psychic break, an existential crisis. Surely, this is the beginning of a science fiction nightmare, one in which the self will slowly, but perceptibly, begin to unravel. Her facial muscles begin to tighten, and slowly she begins to smile. At once she is laughing crying saying, "Oh my god. Oh my god. Who is *that* in the mirror?" Smiling and laughing—who is that in the mirror? (Did you ever wave into the funhouse mirror trying to confirm which reflection staring back belonged to you? How did it feel to look in the mirror, to not recognize your own reflection?)

Depersonalization : A frightening and/or disturbing experience of not being within one's own body or of being in immediate danger of vanishing/separating from reality – often described as the sensation of living inside a dream. Although cognitive functioning remains intact, the sufferers feel disconnected from their sense of self and often interpret it "as if I am losing my mind."

"My own face in a mirror seems foreign, like I have never really seen it before this moment..."

From DPSelfHelp.Com (a website for those "suffering" depersonalization disorder)

In episodes from the last two seasons of *Extreme Makeover*, there are two climactic moments of makeover magic. Just prior to the "big reveal" and following all surgical, dermatological, optical, and dental procedures, Sam Sabora, *Extreme Makeover*'s resident stylist, accompanies participants to a Hollywood hair salon where candidates' hair is remade via hair cuts, hair extensions, hair coloring, custom toupees,

and texturization procedures.⁵⁷ Some participants undergo eyebrow re-shaping and coloring. Men receive old-time barber shop shaves. Finally, Hollywood make-up artists apply the final touches to women's faces⁵⁸, shading the face in such a way as to complement the surgical transformation. Sam and the salon workers surround makeover participants who sit like obedient work objects in salon chairs wearing generic drapes to protect their clothing from cut hair and color drips. Together the team turns the recipient around to face a mirror.

While the show is constructed around the promise of a big reveal, this much smaller reveal is a significant dénouement of the show. While participants have seen facets of their transformation throughout the process, this is the moment when participants see the finished product, their new faces transformed through surgery and enhanced through styling for the first time. Camera angles allow the television audience access to view the back of the participants' heads, as opposed to the participants' reflections in the mirror. In effect, the audience cannot see their faces. Rather, we watch participants from behind and listen to each see him or her self for the first time. While the big reveal centers on the audience's surprise at seeing participants post-makeover for

⁵⁷ The description I offer here does not occur in the first episodes of *Extreme Makeover*. These episodes only captured patients' surgery, and candidates' styling is done off camera. And yet, patients still express sentiments that could be described using the language of depersonalization.

⁵⁸ Make-up is not applied to male candidates on camera, though it is likely that even male candidates sport make-up on their big television reveal.

the first time, this moment relies on the shock that candidate's experience when seeing him or her self for the first time.

While the big reveal is continually referenced as *the* climax of the television show, the moment in the salon when the participant sees and responds to their new look for the first time represents a momentous narrative turn. When participants see themselves for the first time, many have an uncannily similar response. Respondents do *not* immediately revel in their newfound appearance. Initially, they do not remark that they are so happy to be so beautiful. They do not admire themselves in the mirror. Instead, they stare at their reflection and repeat that they do not recognize the face staring back at them.⁵⁹

“Is that me? Is that really me?”

“When I look in the mirror it's definitely not the same person from eight weeks ago...I could just look at myself all night and say there's no way.”

“It doesn't even look like me.”

“Is that me? Is that me?”

“Who is that? I cannot believe it. That's me!”

“I could just look at myself all night and say there's no way.”

“This is not me...This is so different...I love it!”

“That's not me. She's beautiful. I can't breathe. I can't believe that.”

“It's like a different person staring back at me.”

⁵⁹ This is the moment in which most candidates who remark that they do not recognize themselves make such comments. Occasionally, these sorts of comments are voiced over images of the candidate riding in a limousine to their big reveal or in a final interview.

What is especially interesting about this moment in *Extreme Makeover* is that participants seem to delight in not recognizing themselves. It seems as if not identifying one's reflection in the mirror is indicative of a good change. In short, this narrative turn relies on the celebration of depersonalization, not simply a changed appearance but a shift in identity.

References to mental illnesses, particularly schizophrenia, pervade social theory as an evocative point of reference through which a postmodern theory of the self is articulated. In clinical contexts, schizophrenia refers to a collection of disorders characterized by disordered thinking and speech, hallucinations and delusions, withdrawal of emotional expression, and compromised motor ability (Jenkins and Barrett 2004). Social theorists who have taken up schizophrenia to theorize postmodern subjectivity bracket the clinical construct "schizophrenia" in favor of a metaphorical schizophrenia. And yet the clinical construct schizophrenia does not exist apart from the culture in which schizophrenia is identified and diagnosed. Cultural anthropological accounts of schizophrenia note that onset, symptom formation, personal experience, and social response all vary according to the cultural context in which schizophrenia is produced and experienced. In short, the clinical construct "schizophrenia" is a product of the culture in which it emerges. It is "an instance of transgression situated at the margins of culture, at the very edge of meaningful experience" (Jenkins and Barrett 2004: 5). It may be at the margins, but it remains within the bounds of culture, informing other facets of experience.

For Deleuze and Guattari (1983), schizophrenia is a heuristic device used to theorize postmodern subjectivity against modernist rationality.⁶⁰ Similarly, for Frederic Jameson (1984), schizophrenic sensibility is a product of late capitalism, specifically the consumption of postmodern culture. To approach postmodern sensibilities using metaphors of mental illness is not to diminish the very real experience of schizophrenia and other experiences characterized as mental illness. The schizophrenia that circulates in postmodernist accounts crudely approximates the schizophrenia determined in the medical clinic. In this way, postmodernists who employ metaphors of schizophrenia do not claim that the subjects in their theoretical narratives would necessarily be clinically diagnosed as schizophrenic (though some surely would). While schizophrenia as a metaphor does not exactly work to explain the kind of sensibility depicted by *Extreme Makeover*, the general affect described by schizo theory and a detour through clinical accounts of depersonalization are useful for understanding what appears to be at first glance a curious narrative turn.

⁶⁰ Keith Doubt's (1996) sociological exploration of Deleuze and Guattari (1983) and other postmodern theorists conflates the clinical object schizophrenia and the theoretical object schizophrenia. Doubt is right to point out that playing with schizophrenia obscures the suffering experienced by those diagnosed with schizophrenia. Yet even as Doubt understands the schizophrenia that circulates in these accounts as a heuristic device, he approaches these accounts as constructing an etiological account of schizophrenia. It is obviously problematic to make the claim that schizophrenia, the clinical object, is an ideal model for constructing relations between the self and society, but it is Doubt who makes this claim on behalf of Deleuze, Guattari, and Foucault.

In clinical contexts, depersonalization is a diagnostic category used to label patients experiencing feelings of “unreality,” particularly the feeling that one’s body does not belong to one’s self (Simeon and Abugel 2006). It along with dissociative fugue, dissociative identity disorder (also known as multiple personality disorder), and dissociative amnesia comprise what are characterized as dissociative disorders (American Psychiatric Association DSM-IV-TR 2000). This cluster of diagnoses is characterized by disruption in consciousness, memory, identity, and/or perception. I am not claiming that *Extreme Makeover* produces depersonalization as it is understood in diagnostic accounts. Rather, like social theorists Deleuze, Guattari, and Jameson, I use depersonalization as a metaphor for framing the events that unfold on *Extreme Makeover*. I use depersonalization to understand the momentary disruption in perception that is cultivated and fetishized on *Extreme Makeover*.

Deleuze and Guattari celebrate the schizo—the radical annihilation of an intelligible self and the glamour of dissociation. “The schizophrenic process, which is not an illness, not a ‘breakdown’ but a ‘breakthrough,’ however distressing and adventurous: breaking through the wall or the limit separating us from desiring production, causing the flows of desire to circulate” (1983: 362). I am reluctant to approach the depersonalization of *Extreme Makeover* as a celebratory moment. Rather I am interested in questioning what it means that depersonalization is des in the context of *Extreme Makeover*. Setting aside the ethical debates about whether or not schizophrenia (the metaphor or the diagnosis) should be romanticized in social theory (or if mental illness or disability should be metaphorized), dissociation is conceptualized as a sort of “breakthrough” on the television show.

In Keith Doubt's (1996) sociological interrogation of schizophrenia, he argues, using George Hebert Mead's (1934) framework for understanding the development of the self, that schizophrenia may result in limited reflexivity or, in other words, the inability to rely on one's perception of oneself. Symbolic interactionism understands the development of the self as an intrinsically social process that relies on a productive relationship between what Mead identifies as the "I" and the "me." For Mead, the ability to reflexively respond to one's own behavior by taking into account what he terms the generalized other is essential to the development of a self and to social interaction. In symbolic interactionism, there is no intelligible self without self reflexivity. In comparison, Deleuze and Guattari approach postmodern subjectivity leaving open the possibility of compromised self reflexivity (a radical divorce between the "I" and the "me" in Meadian terms). In other words, they argue that part and parcel to postmodern selfhood are moments of dissociation. This dissociation is not the breakdown of the self but rather a characteristic of postmodern selfhood. In short, postmodernism leaves open (and perhaps encourages) the possibility of breakdown/breakthrough. Similarly, depersonalization is not the destruction of the self, but rather a process through which the self is continually refashioned.

In the case of *Extreme Makeover*, depersonalization is staged in the presence of experts whose labor is invested in effecting a more desirable appearance. Together they surround the participant who is turned around to face a mirror. The makeover recipient does not recognize the reflection of his or her face in the mirror. Embodiment, the subjective experience of living in and through a body, is characterized by fluidity and malleability, but malleability implies a shifting, evolving bodily subject. *Extreme*

Makeover recipients do not seem to understand or approach their transformed bodies as new manifestations of their pre-surgical body. Rather they seem to understand the post-surgical body as an altogether different body, and in some cases, a new identity and as a result a different human being altogether. In this way, the climax of *Extreme Makeover* relies on a moment of (non)recognition. What cultural work does this moment accomplish? What does it mean to look in a mirror and not recognize one's self? What does such a moment convey to the audience? Not recognizing oneself is the test of a successful makeover. A good makeover is a dramatic makeover, and in the context of makeover culture, the most dramatic outcome that one can hope for is for one's family and friends not to recognize the makeover candidate. This response is standard. Families and friends who attend a candidate's "big reveal" display the same reaction in *every* episode. They revel in their non-recognition. What does it mean to desire an aesthetic that is unrecognizable? What does it mean that we do not want to recognize our faces?

Writing about *Extreme Makeover*, Brenda Weber (2005) argues that pre-makeover anxiety is expressed by participants as a dissociation of subjectivity from embodied experience. This anxiety is resolved via surgery, after which candidates "claim a unity of identity and body, a sense that she has finally become herself" (1). Weber's analysis of *Extreme Makeover* is that the process offers candidates a classical (read: integrated and intelligible) subjectivity. While candidates certainly express a sense of "becoming who they really are," Weber ignores how this sense of self is forged through depersonalization. It is not simply that the makeover offers candidates a means for resolving a divided self. Rather, the makeover is investing in a moment of productive dissociation. It is the moment of depersonalization that produces a sense that the

makeover is sufficiently dramatic and thereby a success. The new face is not simply the manifestation of a buried self that is obscured by ugliness and hidden underneath disfigurement. Rather, this is a much more postmodern, diffractive, and complex process. A new face, one that appears so different as to be unrecognizable, becomes a moment so desired that depersonalization becomes fetishized. A successful transformation is hardly a transformation at all but rather a radical reformation wherein a new face is crafted.

Much has been made of the way in which cosmetic surgery is an avenue for becoming one's "true self" (Crawley 2006). In this logic, cosmetic surgery is imagined as a tool for unearthing the authentic self that always already existed but was only obscured by an imperfect appearance and a corresponding lack of self esteem. Certainly, this logic operates on *Extreme Makeover*. Toward the end of their makeovers, participants often remark that they have recovered their "real" selves. In a comment reminiscent of other participants' post-makeover reflections, Pam concludes, "I'm the person I've always wanted to be on the outside and that's completed me and made me whole." I argue that the makeover is not only a recovery project but simultaneously a project of (re)invention wherein something *altogether new* is created. In displacing the old self, an entirely new future is imagined, courtesy of cosmetic intervention. What is created? What is the future that cosmetic intervention promises? *Extreme Makeover* promises a complete displacement of the previous self, an erasure of history, a dissolution of old traumas. In short, it situates a radically de-historicized self, in literal terms an unrecognizable face, as the ideal outcome.

Extreme Conclusions

Cultivating Consumption

Extreme Makeover makes a cultural narrative available that encourages projects of self-improvement forged through consumption towards the end of improving appearance. The rhetoric goes that everything else will fall into place post-makeover. All self improvement narratives rely on some notion of the consumer as at least inadequate and sometimes profoundly deficient. Financial guides assume that the reader does not know enough about economics. Dating books assume that the reader does not grasp how successful social interactions should proceed. What makes *Extreme Makeover* unique is that it approaches the participants as aesthetically inadequate, but rather than positing that appearance interventions will make the participant more attractive, the show goes much further. In fact, the show posits that an entire disfigured life is made over as an effect of the alteration of appearance. Survey data suggests that those with a more desirable appearance (based on conventions about what is attractive) fare better in life than those with less desirable visages (Langlois et al. 2000). Appearance matters, but does it matter in the way that *Extreme Makeover* claims that it does?

Extreme Makeover ends a makeover declaring, “Mission Accomplished!” as if radical *self*-transformation happens via aesthetic intervention. Whether this happens or not is an empirical question, but undoubtedly this is what both experts and makeover participants claim at the end. As these shows continually frame psychological wellbeing, bodily health, along with work, family, and intimate life as fundamentally dependent on one’s appearance, these shows help to propagate “endless insufficiency” (McGee 2005).

Extreme Makeover predicates all other projects of self-improvement on a desirable aesthetic. If every facet of our lives depends on our appearance, it is *the* most important facet of our selves and one worth investing incredible resources into repairing.

Self-determination through transformation assumes that “the individual comes before society so any societal change is effected from the inside out” and that the “self is at the centre of the world” (Palmer 2004: 185). Focusing on aesthetics forgoes any kind of structural analysis that locates the causes of participants’ problems in a socio-historical-cultural context. Subsequently, individualized intervention (i.e. face work) is favored rather than broader social change, and this model for transformation is readily available for incorporation into the audience’s lives, particularly because it is so compatible with contemporary American consumerist culture and the rise of the aesthetic register. Transformation happens through consumption (Deery 2006; Weber 2005). Makeovers require purchasing clothes, beauty products, aesthetic services, and cosmetic surgery. Insofar as life transformation is forged through aesthetic intervention *and* popular culture, individual enhancement cannot help but solidify and exacerbate an aesthetic glamour culture that depends on and expands consumption (Weber 2005). *Extreme Makeover* provides viewers with language to identify bodily flaws and information about expensive interventions, in effect broadening the ever-expanding market of appearance related industries.

Exploiting Vulnerability

Reality television has been hailed as a profoundly democratic medium—for the people, by the people, and about the people (Andrejevic 2003). Oftentimes, the audience

shapes the outcome (through voting) and/or dialogues with participants (through blogs and online chat sessions). Audience members are given the opportunity to apply to participate in upcoming seasons. In this democracy, though, participation is only possible in exchange for exposure and vulnerability. As Andrejevic argues, participants do the “work of being watched.” Reality television relies on “a form of production wherein consumers are invited to sell access to their personal lives in a way not dissimilar to that in which they sell their labor power” (6). Reality television production seems democratic in the sense anyone can do the work of being watched. Typically, shows do not demand that participants have any special skill, and participants are not excluded based on educational attainment or background. But in the case of *Extreme Makeover*, participation relies not on a particular status (i.e. citizenship) but on a very sad story (i.e. vulnerability). In this confessional culture/democracy, one trades vulnerability for the chance at a better life.

Cultural critic Jon Dovey (2000) describes television that features behind the scenes images of plastic surgery as “trauma TV.” Like other plastic surgery shows, *Extreme Makeover* is trauma television in the sense that it documents the bodily trauma of surgery, but if we think about trauma as a bodily or psychic injury often inflicted from an external source that compromises wellbeing, *Extreme Makeover* is through and through trauma TV. It captures the trauma of the makeover, relies on stories of trauma, and arguably produces a trauma all of its own by positioning depersonalization as the definitive test of success. The entire experience, not simply the surgery, could be understood as traumatic. Participants often struggle alone with the effects of profound isolation and the pain of cosmetic interventions. The narrative constructed and deployed

on *Extreme Makeover* capitalizes on participant's trauma (death of a spouse, a miscarriage of justice, profound social isolation, memories of school yard bullying) by offering intervention in exchange for a detailed sensational account. Progress is measured by continually invoking participants' traumatic life stories: "A lifetime of heartache mended and healed." The desired outcome is, ironically, traumatic. *Extreme Makeover* is devoted to disrupting participants' identities. The show forces a radical reappraisal of self by attempting to reshape participants' appearances so that they are unrecognizable to themselves and to their families and friends.

Producing Disfigurement

And what of disfigurement? *Extreme Makeover* participants are constructed through image and narrative as disfigured, but there is no escaping that most participants look (in their before *and* after pictures) like unremarkable people. No doubt, "before" pictures resemble photographs of persons many would refer to as dowdy, unkempt, or even ugly, and "after" pictures feature faces that more closely conform to dominant notions of attractiveness. But there is no self-evident facial difference that firmly situates the face work accomplished on *Extreme Makeover* as a kind of reconstructive surgery. Nevertheless, participants are firmly located within narratives about disfigurement through claims that candidates experience profound suffering and compromised lives due to their appearance. The story is strikingly familiar to studies of people clinically defined as "grossly disfigured." In both cases, the face is understood and experienced as profoundly disabling.

But what is the difference between a face marred by crooked teeth, wrinkled skin, or a nose with a bulbous tip and a face distorted through fire that displays the signs of third-degree burns? In the world of *Extreme Makeover*, there is no difference. The bodies subjected to extreme makeovers are disfigured discursively in the hyperreality of twenty-first century reality television culture. What is the effect of framing bodies as disfigured that range in their relative ugliness but that are, for all intents and purposes, normal? This is a site engaged in the production of disfigurement—faces that in many context would be thought about as normal are redefined as disfigured—and indeed actually disfigured through intervention. Not coincidentally, the imperative to repair emerges in the same place and time as a site fully invested with the tools to intervene. This is a site devoted to repair, to face work, but also to the creation of its very work objects. In this way, *Extreme Makeover* is unavoidably and simultaneously invested in repairing and producing “disfigurement” and expanding notions of disfigurement.

In trying to account for the success of makeover television, Robert Thompson writes that “in a very real sort of way, the history of the United States is one big fat makeover show” (2003: B4). In a very real sort of way, the *future* of the United States may be fashioned through makeover shows. Extreme makeovers are a culturally accessible model for the formation of the self, but a self that is continually remade through consumption and dissociation. Who are these selves that we are fashioning? What does it mean that unremarkable bodies can become defined using tropes of disfigurement? What are the consequences of positioning facial appearance as a threat to life and positioning face work as a means for alleviating that with which we struggle?

CHAPTER 6

SAVING FACE: THE MISSION OF FACE WORK

“Changing Lives One Smile at a Time.”

“Together, we create smiles, change lives, heal humanity.”

Operation Smile Slogans

Mission Defined

2. b. A body of persons sent out by a religious organization to evangelize abroad; the enterprise or expedition on which they are sent. Also (esp. in *pl.*): the organized effort involved in preparing, equipping, and maintaining such bodies; freq. in *foreign missions*.

7. a. The sending of representatives to a foreign country, esp. for the purpose of conducting negotiations, establishing political or commercial relations, watching over certain interests, etc.; a body of persons thus sent.

9. a. A task which a person is designed or destined to do; a duty or function imposed on or assumed by a person; a person's vocation or work in life, a strongly felt aim or ambition in life.

9. b. *on a mission*: determined to achieve a goal, complete a task, fulfill an obligation, etc.

From the Oxford English Dictionary

A Portrait of Operation Smile

The specter of global health crises periodically emerges in everyday American life. News stories about “AIDS in Africa” appear on evening broadcasts and front pages. GAP t-shirts and iPods, tagged with Bono’s RED label, are bought and sold with

promises that a portion goes towards fighting AIDS/HIV, tuberculosis, and malaria.⁶¹ Travel warnings circulate, promising an impending Avian flu pandemic. In a socio-historical moment increasingly characterized and conceived of in “global” or transnational terms, relationships between nations and populations are forged through technoscience, specifically through biomedical interventions. Not surprisingly, cadres of international, medical philanthropic organizations, examples of which include Doctors Without Borders, the ONE Campaign, and Mercy Corps, have emerged to cure, fix, and treat bodies around the globe. These organizations rely on the traffic of treatment from the United States to places defined as “in need.”

⁶¹ Product RED is a brand deployed by companies like the Gap, Converse, American Express, Apple, Motorola, and Microsoft to denote products that are part of the RED campaign. A portion of the sales from RED products supports the Global Fund initiative. Founded in 2002 by Irish rock band U2’s lead singer Bono, the RED campaign is aimed at fighting AIDS, malaria, and tuberculosis in parts of the world where rates of infection are increasing. RED products are differentiated from most of the products sold by each participating company with a logo that identifies which products are affiliated with the RED campaign. As the Manifesto published on the official website of the campaign indicates, the hope is to use consumption towards philanthropic ends. “As first world consumers, we have tremendous power. What we collectively choose to buy, or not buy, can change the course of life and history on this planet...All you have to do is upgrade your choice” (Product Red 2007). In this way, the campaign markets the idea that social change is easy. This chapter describes a similar sort of marketing strategy deployed by Operation Smile.

Without a doubt, many of these global health crises have incited panic because of the threat of massive fatalities. In some cases, warnings predict the impending death of entire generations. For example, the World Health Organization reports that AIDS/HIV is the *leading* cause of death among adults in Africa (World Health Organization 2006). But death is not the only global health emergency. In fact, the specter of disfigurement motivates international efforts to repair the face. These efforts are spearheaded by medical philanthropic organizations, the two biggest of which are Operation Smile and Smile Train. Interestingly and ironically, repair of the face is understood as a critical intervention at the precise moment in which children in the places Operation Smile operates die of HIV/AIDS, malaria, and malnourishment. In this chapter, I focus on the work of Operation Smile in order to interrogate the social and cultural work accomplished by charitable efforts geared toward the face.

The story of Operation Smile recounted on its website and in many popular news media accounts about the organization begins in 1982 in the Philippines. During a trip with other medical volunteers, Dr. William P. Magee, a plastic surgeon, and his wife Kathleen Magee, a nurse and clinical social worker, encountered “hundreds” of children “ravaged by deformities.” Most were turned away. The story is told that after encountering such overwhelming need, the Magees founded Operation Smile. Through what the organization terms “medical missions,” free reconstructive surgery is provided to “indigent” children to repair facial anomalies, mostly cleft lips and palates (Operation Smile 2007a).

Since 1982, the organization has conducted “missions” in 25 countries.⁶² Over 100,000 children have received reconstructive surgery through the efforts of Operation Smile. According to the 2006 Annual Report, the operating budget expenses (i.e. programming, fundraising, administrative costs) hovered around \$41 million. During the same time period, the organization accumulated \$42 million in revenue mostly through donations and grants. The value of donated medical services hovered around \$16 million dollars. During this year, Operation Smile “changed the lives” of 9,334 children through medical intervention. Perhaps, in response to the ongoing U.S. military presence in Iraq, the organization focused efforts on providing treatment to Iraqi children. In 2006, 245 Iraqi children received free reconstructive surgery through the organization. In addition to providing surgical procedures, the organization devoted efforts toward increasing public awareness of its work by placing ads in the *Financial Times* and *National Geographic* (Operation Smile 2007b). That these are the two titles in which ads appeared is telling. The *Financial Times* is an international business paper, the British equivalent of the *Wall Street Journal*, a paper with an economically privileged readership, a prime audience to target for financial contributions. By contrast, *National Geographic* is a journal devoted to educating readers about global cultures, but especially those regions largely unaccessed by most travelers. The publication overwhelmingly features the

⁶²Missions have taken place in Bolivia, Brazil, Cambodia, China, Colombia, Ecuador, Egypt, Ethiopia, Gaza Strip/West Bank, Honduras, India, Jordan, Kenya, Mexico, Morocco, Nicaragua, Panama, Paraguay, Peru, Philippines, Russia, Thailand, Venezuela, and Vietnam.

Global South, and this is, perhaps, not coincidental since most of Operation Smile's efforts are focused on the "third world."

In addition to providing surgery, Operation Smile spearheads fundraising efforts, provides physician training and referrals, and educates American families with children born with facial anomalies. Operation Smile also sponsors student-led organizations that build awareness about Operation Smile's efforts in local communities and on high school and college campuses. According to its website, 450 student organizations exist. Participating college students are invited to volunteer on medical missions as Patient Imaging Technicians.

This chapter describes how the work of Operation Smile is represented through image and infused with meaning both on its website and in news media about the organization. First, I consider how "disfigured" children are pictured, talked about, and deployed "before" intervention. I ask why "creating smiles" is positioned as the "after" effect of face work. I show that the imagery of a smile is deployed in the service of positioning surgery as an intervention that transforms miserable children into happy recipients and grants them what is understood as a universal facial expression. Then, I consider the cultural work accomplished by Operation Smile celebrity spokespersons. I argue that the juxtaposition of uncommon beauty and the grotesque body mobilizes hope and simultaneously reifies the very social context that makes facial difference the tragedy that it is. I conclude by querying what it means to characterize face work as a "mission," and I speculate about the consequences of such a framing.

Creating Smiles, Changing Lives

The Operation Smile homepage is a busy website. It is cluttered with an abbreviated organization mission, links to news and events, and portals to video footage documenting B-list celebrity Roma Downey's participation on an Operation Smile mission. The page offers a hodgepodge of possibilities—visitors can donate, volunteer, or, simply, learn more. Of all that appears on the homepage, the circulating “before” and “after” photographs of children, along with the accompanying text, constitute the central focus of the Operation Smile homepage. A slideshow of such photos fills a larger space on the page than any other single feature, and because it continually circulates images and text, the feature is particularly captivating. Like the other sites that display images of “disfigurement,” it also relies on voyeuristic appeal. Children with cleft palate and lip are pictured, and because web surfers view these images on a computer screen, there is a way in which staring is made possible and almost invited.

The rotating images and accompanying text reveal much about Operation Smile, particularly how it constructs and deploys particular meanings of work on faces of “third world” children. Because this final site in my dissertation, wherein face work occurs is a not-for-profit international organization, the work is unique in particular ways. Like the other sites described in this analysis, Operation Smile engages in technical work aimed at normalizing facial difference, but to complete this work it relies on donations and volunteer labor, and thus is also intensely invested in mobilizing public support for its missions. The homepage feature culminates in a request for donations and in this way, the face work accomplished by Operation Smile is not simply conducted by the medical staff that volunteers for “missions.” Rather, because the face work relies so much on

public investments, financial contributors and volunteers, too, become implicated in the organization's work. In this way, the face work accomplished by Operation Smile is technically carried out by a relatively small number of volunteers but symbolically carried out in the name of those invested in the project. It begs to be asked: what is the work of Operation Smile? I demonstrate that the organization markets its work as the manufacture of smiles and that a simple smile takes on a great significance given how children are described and thought about prior to intervention. In other words, children are depicted using "before" images but also through "before" narratives. I describe these narratives prior to analyzing the significance a smile carries in this context.

In the fall of 2007, the Operation Smile homepage featured a rotation of captivating images. "Before" pictures of six children—five year old Venezuelan boy Arnoldo, three year old Chinese girl Min Zhu Lei, thirteen year old Kenyan boy Brigid, five month old Nicaraguan baby boy Guillermo, and nine year old Vietnamese boy Thanh—circulated sequentially so that each visitor randomly encountered a child's face and story. Each "before" picture is a perfectly framed head shot, featuring the face of a child with a cleft palate or lip. The tightly framed photographs are situated at the very top of the homepage, and so they fill the computer screens of most anyone visiting the Operation Smile website. The photographs invite viewers to stare at each child's disfigured face, while the text that alternates below each before photograph incites empathy:

"Every night before I go to bed, I pray for a miracle. Will it ever come?"

"My village is afraid of me. My papa hides me away. My mama cries.
Happiness?"

“Fear. Shame. Sadness. Will there ever be a day when I do not have these feelings?”

“They call me ‘Sut’ [which means split lip in Vietnamese]. Will there ever be a day they call me by my name?”

“They point. They stare. They call me names when will it stop?”

“Will I ever feel like smiling with the sun shining brightly on my face?”

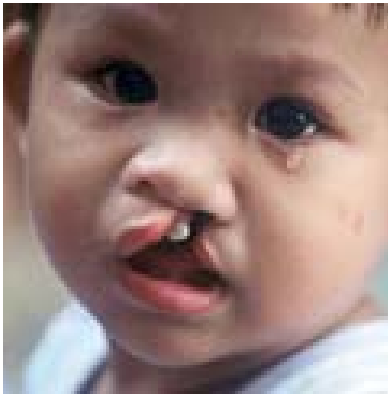


Figure 11. Thanh Ngan “Before” and “After”⁶³

As these questions are positioned next to each child’s “before” picture, they are posed to the viewer as if spoken by the very child whose face appears in the photograph. It is not clear whether these are actual words spoken by the children, though at best they are a translation since it is unlikely that each child speaks English. A moment later, the word “someday” flashes next to each photo. Then, an “after” picture appears. These pictures are not altogether unlike the “before” pictures. They are tightly framed headshots too, but as opposed to the “before” pictures which feature dejected (in some cases crying) children all with cleft lips and/or palates, the “after” pictures capture

⁶³ Images from <<http://www.operationsmile.org/testimonials/ngan/>>

smiling, beaming faces that contain only traces of facial difference. Below each “after” picture, the following text appears: “With your donation, you can make someday today.”

What is this slideshow, presented to all who visit the Operation Smile homepage, trying to tell us? At the most basic level, the slideshow plays on the trope of pity to encourage visitors to “get involved,” to type in their Visa number (Longmore 1997). In this way, the slideshow is a marketing tool that strategically positions image and text towards the ends of soliciting empathy, financial contributions, and perhaps future volunteers. While marketing is aimed at calculated ends, in this case donations, it simultaneously relies on and articulates meanings of disfigurement and of face work. In other words, the slide show also alludes to *what* work will be accomplished by that \$25, \$50, \$500 donation and what this work means. With a donation to Operation Smile, a child will receive reconstructive surgery. If the “after” pictures are the visual representation of what Operation Smile gives to children, as I argue, then the photographs suggest that surgery does not simply “fix” the face but rather results in a smiling face. But what does a smiling face connote? Operation Smile deploys smiles to position the work of repairing the face as a project that restores both happiness and humanness. That the face work conducted by Operation Smile can produce these ends is striking, given how facially variant children are described in news coverage about the organization.

Over and over again, the costs of facial disfigurement are enumerated and the resulting image is quite stark. At the most basic level, stories about the work of the organization establish one idea consistently—that children “suffer” from “defects,” “deformities,” and “abnormalities.” This suffering takes multiple forms. News accounts often offer details about how children’s lives— their physical and psychological health,

their relationships with other children and with their families, and their status as normal and thus their future—are affected by their faces. By describing in detail how children suffer because of facial difference, what the work of Operation Smile accomplishes is put into sharp relief. Telling “before” narratives is crucial to making sense of “after” narratives.

In news accounts, physiological effects of craniofacial anomalies are referenced, making the “suffering” of children intelligible through the use of details and descriptions. The face can be, as the following news account suggests, a “huge handicap,” specifically producing difficulties speaking, eating, and hearing. Images of children display visual difference and descriptions of children emphasize physical impairment. In this way, the children are characterized as not only disfigured but also impaired. As an *Africa News* articles puts it:

“Facial deformities are not only a physical defect but can be a huge handicap from an emotional level... ‘These children can’t speak clearly. They can’t even eat properly because the food goes flying so they have very low self-esteem’” (Argus 2007).

Another account echoes these ideas:

“Inability to feed well eventually leads to malnutrition and then ear and chest infections. Also, speech defects later occur as the child grows up and there are also other problems such as poor mental development, social maladjustment among others...These kids with cleft palate can get fluid into their middle ear which can result in hearing loss” (Champion 2006).

News media describe the physical consequences of facial variance in order to give readers a sense of what the “costs” of disfigurement are. The insistence that children are both visually atypical and physically impaired works to characterize the children as disfigured and disabled and thus “in need.”

Interestingly, both accounts make connections between the physical costs of disfigurement and the emotional or psychological experiences of children. In the first story, images of food flying from the lips of a child are used to describe both the physiological effects of cleft lips and palates, but also the presumed humiliation accompanied by such effects. In the second, difficulties with speech are linked with “social maladjustment.” Both accounts make plausible connections between the physical and the emotional wellbeing of children, namely that the physical impairment results in emotional distress.

News accounts capitalize on children’s difficulties with social interaction. In describing a child’s experience interacting at school with other children, *The Irish Times* (2007) writes,

“The condition can cause children to be shunned.”

Another article quotes a girl, who says,

“‘I want to look pretty...I want to go back to school and get an education,’ said Sounya, who had dropped out of school because of taunts by other children”

(Halloran 2006).

Disfigurement is positioned as yielding difficulties both in social encounters with peers and in the children’s own families. As *Africa News* (2007) claims,

“Even some parents do not want to be associated with their [the children’s] deformed faces.”

More than schoolyard taunting, parents’ rejection of their children puts children’s lives especially at risk. Because abject poverty characterizes the places Operation Smile works, food, medical care, and water are virtually inaccessible, thus children’s caregivers are critically important for their survival. Stories like this intimate that intervention to fix the “deformity” is a child’s only hope if he or she is actually to survive, much less be “happy.”

Another article draws on an interview with an Operation Smile worker that repeatedly makes reference to the children’s inability to be “normal”:

“‘These children are unable to have a normal life. They can’t breath, eat or speak properly, are often not admitted in schools, and are ridiculed. Our aim is to restore normal life to these children,’ said Mr. Racel Wawn, development director, Operation Smile India” (Bolpur 2006)

While Wawn begins by identifying the physiological effects of cleft lip and palate, he quickly emphasizes that it is not simply physiological functioning that is at stake but rather the overall normalcy of the children toward which Operation Smile directs its efforts.

Most dramatically, descriptions of the children’s lives pre-surgery continually call the future into question. In some cases, stories suggest that children with cranio-facial anomalies have, at best, an uncertain future. One article describes a child who

“cannot blow out the [birthday] candles”(Business World 2007).

This reference points to the functional effects of cleft lip and palate but also plays on the uncertainty of maturation. If she cannot blow out the candles, did she have a birthday at all? In another account, a mother is described as

“not certain what the future held for her child” (Africa News 2007).

Perhaps this is the case, given the outcomes described in other stories. An *Irish Times* article offers the following:

“Without surgery, these children in the developing world don’t stand a hope. They are never part of the school going population. Many are hidden at home, and in some countries, they will be placed in institutions” (The Irish Times 2007).

In this account, children’s futures are determined by several factors—the unlikelihood of attending school, the certainty of social isolation, and the chances of institutionalization. Each of these probable futures is absolutely “hopeless.” Other stories conjure images of impending despair through the use of particular words. Consider the following references:

“plight of afflicted children” (Business World 2007)

“the faces of children who would otherwise have faced a bleak and very lonely future” (Condren 2007)

By characterizing the future of children with cleft lips and palates using language like “plight,” “bleak,” and “very lonely,” Operation Smile interventions become material work aimed at the face, but also the work of creating a future and a radically different kind of life.

According to news accounts, children’s lives are impacted by disfigurement in tangible ways—they are mistreated by their families, they are alienated at school, they

experience physiological effects. In short, children upon whom Operation Smile intervenes are described as uniformly unhappy, just as the “before” pictures of children on the organization’s own website often show patients crying. Stories about Operation Smile infuse repair forged through facial reconstruction with meaning by describing what children’s lives are like pre-intervention and by focusing on specific effects of disfigurement.

While descriptions of disfigurement locate children in desperate and hopeless circumstances, face work is positioned as the work of giving children the ability to smile. Considering how children are described “before” surgery, the restoration of happiness “after” surgery is quite remarkable. Images on the Operation Smile website prominently feature smiling faces, but in press coverage about the organization and in self-promotion and fundraising materials, the smile also figures prominently. Most obviously, the word “smile” figures in the organization’s name, and perhaps not coincidentally in the name of another organization, Smile Train, which touts itself as the “the world’s leading cleft charity.”⁶⁴ The name of the organization, thus, is quite revealing relative to its goal.

Consider too other instances of the term “operation.” The word “operation” as it has been used in the last fifteen years by the U.S. government in cases of military incursions, including Operation Desert Storm and Operation Iraqi Freedom, signifies an action aimed at a particular purpose. In the first case, the goal of the operation was, in basic terms, to storm the desert. A new presidential cabinet known for euphemistic language maneuvers termed the second military expedition in a way that positioned mass death and destruction in the service of “freeing” Iraqi citizens. The terming of a medical

⁶⁴ From <<http://www.smiletrain.org>>

charitable organization, Operation Smile, undoubtedly capitalizes on militaristic imagery. Like excursions to the Middle East, the work of the organization is characterized as calculated, organized, and directed towards a very specific goal. The name Operation Smile suggests that crafting smiles is the most central target of the enterprise.

Undoubtedly, the reference to smiles makes for a catchy tag, one that is more easily remembered than a more descriptive alternative, perhaps Operation Craniofacial Anomaly Repair. And of course, much of the work of the philanthropic organization is aimed at lodging itself in the hearts and minds of potential volunteers and donors. But references to smiles abound. It is not simply the repair of facial difference but specifically the production of “the smile” that animates the organization’s work. But what is a smile, really?

As Natalie Miller, Southern Africa Operation Smile regional director, quoted in a *Sunday Times* article acknowledges,

“Together we are changing the lives of children one smile at a time” (Doke 2007). The reconstructive techniques employed by Operation Smile produce a change in appearance that could be described in terms of repair or the return of facial function. Instead, it is the smile that is continually evoked as *the* product of an Operation Smile intervention. At the same time that the smile is used as the principal “after” effect of surgery, the smile works as a shorthand, a taken for granted point of reference. Rather than describing in detail how intervention affects the lives of children, accounts make reference to the smile as if everyone understands what crafting a smile signifies. As one *Africa News* account demonstrates, the product of intervention is described simply as a smile, without a real examination of what that means:

“But when they come here they know the stigma will go and they will go back home with a smile, said the nurse” (Africa News 2007).

Of course, children will return home with a changed appearance and restored facial function, but the smile serves as the primary way of referencing the change that has occurred. The previous excerpt does make reference to the fact that stigma is averted by intervention. In this way, children leave a marker of difference behind, but they also return home “with a smile.”

In fact, the smile is positioned as something one can possess. It is, as one account describes:

“the best gift you can give a child” (Franco-Diyco 2006).

In this way, smiles are characterized as “gifts” which are “brought” or bestowed onto recipients, as the following excerpts indicate:

“One campaign has literally brought smiles to faces of children” (Birnbaum 2005).

“Operation Smile South Africa, whose mission is to give ‘the gift of a smile’” (Argus 2007)

In these accounts, the work of Operation Smile is positioned as a kind of transaction, in which a valued good, a smile, is given to children in need. Setting aside the kind of relationship such claims rely on for the present moment, it is striking to consider a facial expression, a mode of communication as an intelligible object capable of being transferred from one to another. The smile is described as an “after” effect and more specifically as a “gift,” but what kind of gift is it?

The meaning of a gift is not intrinsically discernible but rather determined by context. Just as the gift of flowers can function as a sign of love, sympathy, or apology, the gift of a smile carries an ambiguous meaning in and of itself. The smile could be a gift of restored facial function or a gift of a new appearance, and certainly reconstructive surgery produces both of these effects, but news accounts suggest that the smile is a gift that symbolizes a particular kind of future. In other words, giving the gift of a smile is a way of talking about giving children the possibility for a happy life. The future is continually invoked in these accounts, as the following demonstrates:

“The correction of deformities makes a world of difference for these children. It helps build self-confidence. It not just creates smiles, it also paves the way for a brighter future” (Business World 2007).

Another story quotes a volunteer for an Operation Smile Kenya mission, who describes how a relatively small amount of money can create a smile that remains for the rest of a child’s life.

““Most of these children are only Sh15,000 from that precious smile that they will live with for the rest of their lives”” (Africa 2007).

References to the smile as a gift position the smile as a gift that is so great precisely because it embodies a kind of durability. Once facial structure is restored in such a way as to facilitate smiling, presumably a child will *always* be able to smile. In this way, the effect of the smile extends beyond the present moment and shapes the future lives of the children upon whom Operation Smile works.

The smile is also used to reference what volunteers get from participating or contributing to Operation Smile. Specifically, the smiles of children are often described in relation to how they make volunteers feel.

“The danger of challenging political and religious barriers is more than compensated by the smiles that eventually grace the faces of thousands of poor children every year—children who have been stopped from attending school, who have been locked away, ostracized by their communities and, often, by their own families... but it’s the smiles that keep him [a volunteer] going back...the smiles are worth more than a million bucks” (Condren 2007).

In this account, the smile acts as proof that the work of Operation Smile has been successful. In particular, the smiles of children serve as a “pay-off” for Operation Smile volunteers, evidence that their investment has been worthwhile. What makes the smile such a gratifying outcome is that it operates as a way of talking about something much larger than a simple smile and much more weighted than facial function. Given the narrative that functions to describe the effect of Operation Smile intervention, volunteers have given children the gift of hope, the gift of a brighter future, and indeed what greater gift can one give a child?

When used in these ways, the smile is deployed as evidence that the organization is accomplishing something significant. Interestingly, the smile is made to speak for itself. How a smile changes the lives of children is never explicitly articulated. Rather the claim is simply that it does. This claim relies on a shared global sense of understanding about what a smile means. To understand what work the organization claims to be doing by crafting smiles, the smile itself must be unpacked a bit. I focus on

two features of the smile—its association with happiness and its status as a universal facial feature—to theorize what smiling signifies.

In everyday life, a smile bespeaks happiness. A smile is typically taken as a clear indicator of contentment and even joy. Facial expression researchers would be quick to point out that a smile can be indicative of many emotions in addition to happiness. As psychologist James A. Russell writes,

[W]hereas a smile in the context of just having received a gift might be interpreted as a sign of pleasure, a smile in the context of just having spilled soup might be interpreted as a sign of embarrassment, and a smile in the context of greeting an adversary might be interpreted as an act of politeness (1994: 123).

As opposed to this more nuanced account of what a smile means, Operation Smile undoubtedly relies on common associations and everyday meanings. In the context of medical philanthropic marketing, “giving the gift of a smile” is akin to “bringing joy to the world.” The charitable aim is obviously material. It is an intervention on the physical body, surgery aimed at children’s actual faces. Yet the intervention may be facial reconstruction, it is positioned as more than a material intervention. By claiming that the children operated on can now smile, Operation Smile and the media outlets that cover their work suggest that happiness is a direct result of face work. The claim is that the material intervention produces an emotional, or affective, outcome.

By so centrally focusing on the smile, the aim of the organization is characterized as equal parts material and non-material. One consequence of such a claim is to infuse face work practiced by the organization as particularly spectacular. Given that children are routinely described in tandem with suffering, the shift to happiness is quite striking, almost miraculous. At the same time, happiness itself is an indefinable outcome. What

precisely is happiness? How do we know if someone is happy? While answering these questions is, arguably, impossible, there is a shared sense that everyone desires happiness and that to be happy is one of the best results one can hope for in life. Producing happiness then is no small thing. It is both a highly valued outcome and one that is ineffable. By claiming to produce something that is so beyond definition, the work of Operation Smile takes on an aura of wonder. Surely, this facilitates financial contributions but so too does it reposition the “disfigured” face as an object in need of miraculous intervention.

To claim to create smiles is also significant because smiling is often thought of as something that is universally human. Those who study facial expressions claim that virtually everyone everywhere smiles (Ekman 1992). It is cliché, but confirmed in the scholarly literature, that a smile is one of the rare universals. The idea is that anyone could encounter anyone from anywhere and that each would understand (at least in a general sense) what a smile suggests about the other. The fact that the smile is one of the rare features of human life that continues to be thought of in universal terms makes Operation Smile’s deployment of the smile particularly compelling. Because the smile is conceptualized as a *universal* expression, being able to smile becomes indicative of one’s essential humanity. By restoring a smile, Operation Smile gives children access to an attribute that is understood as universally human. Of course, the claim to give the gift of a smile presumes that children did not have the ability to smile prior to intervention. In this way, the granting of a smile signifies the transformation of a child’s status. “Before” intervention, children are lacking a universal feature of humanity. “After” intervention,

children possess this universally human trait. Like other forms of face work, the intervention is imbued with human making potential.

Positioning the work of the organization as crafting smiles infuses it with social and moral significance. First, children whose lives are characterized as profoundly lacking in significant relationships and burdened by emotional and physiological consequences, are ostensibly made happy by Operation Smile. This transformation from crying and hopeless to joyfilled and hopeful is dramatic and helps to qualify work aimed at repairing the face as incredibly important. In this way, deploying smiles is a critical move towards demonstrating the kind of transformation afforded by intervention. At the same time, by restoring a smile, as opposed to any other facial expression, the face work accomplished by Operation Smile becomes infused with humanizing potential.

Producing a universal expression, a smile, takes on the weight of restoring one's humanity. Because the smile carries such meanings, invoking the smile, that universal icon, makes the following conclusions about the work of Operation Smile possible:

“The results are great, now he has a chance of a normal life...When they [volunteers] come back, they invariably say they could not believe the difference they were able to make. We give people an opportunity to dramatically change a child's life. The power of that is phenomenal” (The Irish Times 2007).

As this excerpt indicates, normalcy constitutes on the work of the organization, and face work is imagined as “dramatic,” “phenomenal,” larger than life.

By focusing on what children are like “before” and then describing the “after” effects in spectacular terms, the face work accomplished by Operation Smile is positioned as a shift from a life characterized by absolute dejection to one of effortless

joy, a transformation from non-human to universally human. These are remarkable changes. By continually visually and rhetorically picturing children in these ways “before” and “after” surgery, Operation Smile’s work becomes a radical mode of social repair wherein the work objects, in this case children’s faces, are dramatically remade and in the process new ways of being and experiencing the world are made possible.

Yet, it is unclear what kind of repair is actually accomplished by the organization and what kind of repair is marketed by the organization. Certainly, the organization understands its work as life changing, as the organization implies with their slogan “Changing lives one smile at a time.” The tangible, material repair forged through reconstructive surgery is undoubtedly a goal, but it is not simply the face that is repaired but rather life itself. Yet as the descriptions of children’s lives “before” intervention suggest, structural conditions, namely poverty, largely determine the quality of their lives. The radical making over effected by Operation Smile is forged through individualistic response, specifically surgery. It is certain that this matters for the children, but it remains doubtful that the future promised by Operation Smile can be facilitated simply through surgery since future is largely determined by economic structures, political arrangements, and cultural contexts. Both news accounts and materials produced by the organization intimate that despair is turned to hope, that out of horrible circumstances life is made possible. This is certainly a narrative that works as an effective marketing tool. The question remains to what degree what is marketed reflects what face work actually accomplishes for the children subject to intervention.

Celebrities at Work

While smiles are the primary symbol deployed by Operation Smile, celebrity spokespersons are also used in the service of the organization's work. Philanthropic causes and charity events have long employed entertainment to engage audience members with the aim of eliciting financial contributions. The annual Jerry Lewis Labor Day Muscular Dystrophy Telethon relies on the (declining) name recognition afforded by Jerry Lewis' participation, and on performances by other B-list celebrities. U2's Bono seems to spend more time promoting his brand RED than recording pop music. Oprah's Angel Network relies on donations largely garnered through exhortations by Oprah herself to contribute to the fund. In this way, celebrities accomplish the work of inspiring donations or philanthropic consumption aimed at alleviating social ills (Talley and Casper, forthcoming). Celebrities have also often been mobilized by philanthropic organizations. For example, UNICEF relies on a cadre of celebrity Goodwill Ambassadors including David Beckham and Susan Sarandon, while the UN has received attention for its work through the promotion efforts of Angelina Jolie. In short, finding a celebrity who is not involved in some philanthropic or charitable cause is next to impossible. It seems that the work of being famous requires good works.

But whether celebrities are engaged in entertainment or philanthropy at any given moment, their role is based upon their exceptional ability to produce an *emotional* experience in their audience. In a sense, then, the charitable work of celebrities is startlingly similar to their work as entertainers. And sometimes it is not altogether clear where the philanthropy begins and the entertainment ends. More likely, celebrity work

on philanthropic causes deploys a kind of entertainment, a genre that engages audiences if not to act then at least to observe.

While I remain interested in the cultural work accomplished by the recent explosion of celebrity sponsored philanthropy, I am particularly interested in the work of celebrities in relation to the issue of facial difference. Operation Smile is not unique in its use of celebrities as spokespersons. But what makes the use of celebrities curious is the particular focus of the organization. Celebrity culture is inextricably intertwined with beauty culture. The work of being a celebrity is, to a large degree, the work of being attractive. Operation Smile is focused on repairing faces deemed ugly, and even grotesque. One can hardly imagine a charity focused on alleviating world poverty, with Robin Leach leading a tour of “Lifestyles of the Starving and Destitute” complete with televised images featuring slums described in detail in Leach’s immediately recognizable brogue. No doubt such a move would be deemed bizarre, and even offensive to potential donors and volunteers. I argue that the participation of celebrities in the work of Operation Smile is similarly curious, and potentially problematic. Inciting beautiful celebrities to join the cause of repairing “ugliness” seems at least curious, if not grossly insensitive. I ask what particular work is accomplished by celebrities, and I show the consequences of deploying celebrities in the service of “third world” facial repair.

No doubt the most famous Operation Smile celebrity spokesperson is Jessica Simpson. The blonde pop-star’s fame skyrocketed after asking her then-husband ex-boy band member Nick Lachey if the meat in the Chicken of the Sea can was tuna or chicken in an episode of their MTV reality show *The Newlyweds*. Simpson makes reference to her work with Operation Smile in many appearances and interviews. Curiously, the pop

star, who is infamous for her less than average intelligence (or perhaps merely the appearance of being less than competent), was invited to meet with Congress in March 2006. According to press releases appearing on the Operation Smile website, Simpson in her role as the Operation Smile International Youth Ambassador talked with senators, representatives, and congressional staffers to promote the work of the organization. Accompanying the press release is a photograph of Simpson, as usual surrounded by flashing cameras, but atypically dressed in a smart but rather conservative black suit, with her golden locks pulled into a tight bun. Operation Smile's logo hangs from a poster plastered to the front of Simpson's podium. In attendance with Simpson is Operation Smile's founder and CEO Dr. Bill Magee, who is quoted in the same press release describing Simpson's visit to Capital Hill:

“Now more than ever, it is crucial that the United States support private sector programs that exhibit the truly compassionate nature of its foreign policy objectives. Working closely with humanitarian organizations like Operation Smile, which have developed a proven track record of cross border friendships and trust, should be one important feature of a broader strategy to secure peace in the 21st Century” (Operation Smile 2006).

Here the work of the organization is framed not simply as reconstructive surgery, but rather the development of international friendships and, even more important, world peace. Operation Smile Ambassador Jessica Simpson facilitates this work. Her role as celebrity is marshaled not only in eliciting support from Congress but also in facilitating international relations with people who will presumably know who she is. But Simpson's work with the organization has extended beyond the celebrity bread and butter of

promotion. Simpson has participated in the hands-on work of the organization as support staff on a medical mission, and as such, she has acquired a sort of expertise that she also strategically deploys.

For example, in 2005, Simpson participated on an Operation Smile mission to Kenya, during which 280 children were assessed. Of the experience, Simpson reported, “My experience in Kenya with Operation Smile was incredible. To witness the truly miraculous transformations in the lives of so many desperate needy children was both powerful and personally rewarding.”

By directly participating in a mission, Simpson acquired the authority to speak about the work. The work of celebrities in this site—through participation on missions, fundraising, and publicly speaking about the organization—infuses the face work accomplished by Operation Smile with a kind of cache or cultural legitimacy. Their purpose is unique from the work accomplished by medical volunteers, fundraisers, or student organizers. Celebrities both draw attention to the work of the organization and glamorize work in the global bio-trenches.

The work of celebrities is described not only on the organization’s own site but also in news media accounts about Operation Smile. As the following excerpt indicates, the work of celebrities on behalf of the organization seems to be newsworthy:

“‘When people come to charity events and they see a celebrity, they want to know why the celebrity is there,’ she says. ‘They become interested and want to learn more about the charity and support the cause.’ That can have a serious effect on donor figures and much-needed promotion in the media. Jessica Simpson’s role as international youth ambassador with Operation Smile, which provides

corrective surgery to underprivileged children with facial deformities, has generated \$5.2 million in television coverage, according to the organization.

Operation Smile founder and CEO Bill Magee says Simpson's involvement has focused the world spotlight on the group" (Hellard 2007).

In this account, "Simpson's involvement" brings name recognition and corresponding global attention to the work of the organization. While this certainly speaks to the power of celebrity in this socio-historical moment, it also demonstrates a way in which organizations aware of the interests stirred by a celebrity can use celebrity culture towards their own ends.

What is striking about these accounts is not simply the way the work of celebrities makes for "news" but also how their charitable work is positioned alongside signifiers of their celebrity status. In a *Daily News* article, a scandal revolving around gift bags packed with high end merchandise is referenced:

"Is Jessica Simpson the Queen of Swag or—as her flack insists—Our Lady of Largess? After the perky pop tart was caught with an amazing haul of freebies during last week's MTV Video Music Awards—tens of thousands of dollars worth of jewelry, clothes, high-tech electronic gadgets and a \$50,000 Chrysler convertible—Simpson's damage control guru, Rob Shuter, vowed that she'll donate her VMA gift bag to Operation Smile" (Grove 2006).

Simpson's public relations consultant spins the story, and Simpson's questionable behavior towards charitable ends by publicizing her donation to the organization.

Stories about celebrities consistently make reference to that which distinguishes celebrity life from the everyday. Specifically, celebrities' exceptional appearances and

their access to glamour and luxury culture are described and capitalized on. In the following article entitled “Mariah Is Just Smiles Better,” Mariah Carey’s participation at a fundraiser is noted via reference to her spectacular smile:

“Here’s sexy singer Mariah Carey flashing her gnashers for Operation Smile...She looked stunning at the New York charity bash for kids with facial deformities” (Daily Star 2006).

The irony that Carey already has a great smile and that the organization works in the service of children, some of whom are not physiologically able to smile, goes unnoticed. Even brief asides rely on celebrity culture to describe the work of the organization:

“Actress Roma Downey attends an unveiling party at the Lladro boutique in Beverly Hills” (Los Angeles Times 2006).

Lladro is a Spanish company that produces high end porcelain. The event Downey attended marked the launch of the Utopia Collection, from which a portion of sales benefited Operation Smile. Prices of the small figurines that represent such concepts as love and friendship range in price from \$250 to \$1000 on the collectibles market. The associations among Operation Smile, Roma Downey, and Lladro porcelain work to lend meanings to each. Operation Smile acquires some cultural cache from its association with celebrities and luxury goods, and at the same time Roma Downey and Lladro porcelain become affiliated with good works.

Stories of celebrities’ charitable involvements often capitalize on how the celebrity, as opposed to children, has benefited from their participation. In a *Daily Star* account, Simpson’s curvaceous body, no doubt a quality that lends her an air of Hollywood glamour, is briefly described. This reference to a celebrity signifier is

followed by a quotation from Simpson, which hinges on how her charitable work makes her feel, namely humbled:

“But caring Jessica has to cover up her curves for a special mission-meeting high ranking US politicians. ‘I was part of her work for charity Operation Smile which helps disfigured youngsters to get facial surgery...To entertain is what I know naturally. But to go into Congress and talk on behalf of a charity is incredibly humbling’” (Partasides 2006).

Another story chronicles Simpson’s various roles as a celebrity—entertainer and product endorser are named:

“The 25-year-old blond singer/reality star/Pizza Hut spokeswoman is the International Youth Ambassador for Operation Smile, a nonprofit medical charity that repairs facial deformities for Third-World children. Of all the good works needed in this world, how did Simpson pick this project? Her hairdresser’s nephew had a cleft palate...Our star is smaller in person (aren’t they all?) and dressed like a proper lobbyist—black pantsuit, pearl earrings, hair tucked conservatively in a loose bun...She talks about observing the surgery of a little girl on a trip to Africa last fall. ‘It was a very spiritual moment,’ she says, ‘and made me realize the purpose of life is to go through it smiling.’ She calls plastic surgeon Bill Magee, founder of the charity, an ‘angel.’ Rep. Trent Franks (R-Ariz.), who has had 10 operations for his cleft palate, says, ‘Maybe God sends people like Jessica to the earth to make everyone smile.’ Magee says it’s time to stop ‘paying lip service’ and give some sorely needed funding to the cause. He

calls it a ‘serious day’ and Simpson a ‘serious woman’” (Argetsinger and Roberts 2006).

She describes her experience as a “spiritual moment” which she claims worked to reveal the purpose of her life. In a sense, then, the story of her philanthropy is about her. No wonder that the story quickly moves towards an insistence that Simpson is a “serious woman.” In this way, celebrities’ involvement with Operation Smile lends them credibility. Clearly, celebrities benefit from their participation with philanthropic causes like Operation Smile. But what are the consequences of mobilizing celebrities towards the ends of alleviating disfigurement?

The unique status of celebrities, and I would argue their aesthetic, infuses the work accomplished by celebrities on behalf of Operation Smile. Celebrities’ bodies have long been pictured next to bodies of the sick. Princess Diana’s work in AIDS wards in the initial years of the HIV/AIDS crisis typifies the charitable work of high-profile celebrities. In photo-ops documenting celebrities’ hospital visits, the presumably healthy and vibrant body of the celebrity is positioned next to the ill and dying patient. The contrast puts into sharp relief both what it means to be healthy and conversely what it means to be sick. Likewise, the juxtaposition of the celebrity face (which is to a large degree their claim to fame) with the faces of children with craniofacial anomalies confers a particular significance to the disfigured face. Specifically, the celebrities’ own face is proof positive that the face can make or break a life. Because it is no secret that the celebrity would likely not be famous if he or she looked otherwise, they are walking reminders of the intense importance of appearance. The very faces of celebrities serve as evidence of how important the face is. If the celebrity face makes success possible, then

positioning it next to a disfigured face suggests that facial difference threatens one's access to a life worth living. Thus, celebrities are living proof that "Changing Lives One Smile at a Time" is not only possible, but that in fact a smile is necessary for a changed, and presumably better, life—even for impoverished "third world" children.

As aestheticization increasingly characterizes everyday life, celebrities are integral to this process. Through endorsements of products associated with improving appearance and constant information provided by the stream of celebrity news coverage, we are well acquainted with, and encouraged to undergo, the work required to look like a celebrity. At the same time, tolerance for bodily flaws has undoubtedly declined. Whether consumer culture created these needs or simply responded to our ever-increasing preoccupation with all bodily flaws, Americans are engaged in more "body projects" than ever (Brumberg 1998). Things deemed natural, attributed to aging, or simply ignored twenty years ago are now subject to an array of interventions. As feminists scholars interrogating men and women's relationships with our bodies have well demonstrated, celebrities are key figures in the making of beauty culture (Bordo 1993). Celebrities' bodies are images available for modeling, like human clay. These bodies are reference points for what the body might become; they are central figures in making attractiveness take on the significance that it does in American life. Thus, one consequence of the juxtaposition of celebrities with the faces subject to intervention is that emulation may be mobilized. Because the celebrity's body is already overdetermined, a referent that so many hope to approximate, it works as a standard or an ideal point of reference. Children will not necessarily and, in fact, probably will not leave surgery beautiful or glamorous. The face work practiced by Operation Smile is not

aimed at inscribing the celebrity aesthetic, yet the philanthropic work of the organization continually relies upon beauty culture.

If ideas about what constitutes an acceptable body and how bodies might be made better have changed in conjunction with the rise of celebrity glamour culture, celebrity involvement in philanthropic work aimed at appearance implicitly positions disfigurement far outside of acceptability. Celebrities like Jessica Simpson, Roma Downey, and Billy Bush, then, work towards opposite ends. As Operation Smile spokespersons, they raise awareness and mobilize support for the reconstructive surgery used to normalize faces. Simultaneously, as extraordinarily attractive celebrities, they intensify beauty culture. The celebrities' looks signify what they do because they are embedded in a cult of appearance, a hierarchy of aesthetic, a systematic privileging of attractiveness. And much of their look is made possible by the products and services offered and capitalized on by glamour culture. Their look is expensive, highly desired, and requires ongoing maintenance. In this way, the look of a celebrity is a rare commodity, and one that cannot be attained by the children subject to Operation Smile interventions. In short, celebrities are a key part of the cultural landscape that makes disfigurement the tragedy it is often thought to be. In a socio-historical moment where beauty has never been more important, the costs of being ugly have never been so great. We must ask: What can the celebrity do for disfigurement, when so much of her or his work is always already invested in the stigmatization of ugliness?

The “Mission” of Operation Smile

Operation Smile deploys the word “mission” to describe its technical work. Designating the travel as a “mission” infuses the work with particular connotations, often religious, for a mission relies on certain kinds of relationships. As the epigraph to this chapter reveals, the word mission describes travel wherein “missionaries,” representatives, or evangelists are sent from one place to another place, a “foreign” place, a place occupied by the Other. By characterizing its work as a mission, Operation Smile’s face work is framed as purposeful but also as work that relies on traffic between “haves” and “have-nots.” The smile is a “gift” in the context of a mission only because Operation Smile volunteers, specifically those from privileged “first world” countries, possess the resources, technical know-how, and presumably generosity to bestow the offering. It is a relationship forged through and reliant upon differential power dynamics—global economic, political, and cultural forces.

If we do not take the terming of Operation Smile’s work as a “mission” for granted, what is revealed? What does a critical sociology of missions tell us?

Sociologist, Robert L. Montgomery (1999) describes the area of study in this way:

[T]he sociology of missions may be defined as a comprehensive sociological study of the spread or diffusion of religions...What makes sociology of missions distinct from other sociological studies of religions or religious growth is its focus on the crossing of socio-cultural borders by religions. In short, the sociology of missions is simply the sociological study of religions and ideologies in their diffusing activities, not simply through migration, but primarily as they have spread across sociocultural boundaries by propagation or dissemination (2).

In defining a “sociology of missions,” Montgomery provides a framework for knowing a mission when we see one. Ultimately, a mission is constituted by three factors. First, a mission is aimed at the diffusion of religion, but also, as Montgomery notes, at the

circulation of ideologies. Second, the dissemination of religion and ideology takes place across “socio-cultural borders,” including but not limited to geopolitical borders. Finally, “propagation,” as opposed to passive diffusion, is the means for transmitting religion and ideology.

Operation Smile’s work qualifies as a mission in each of these ways. Most obviously, the organization’s work takes place across geographic and cultural borders. Operation Smile engages in biomedical work that unfolds across the borders of the “developed” and “developing” worlds, between the global North and the global South, between “America” and the “rest of the world.” These are relations between places but these places are simultaneously characterized by varying degrees of privilege. In this way, a distinction between where the work takes place and where the people that conduct this work come from structures the relationships among the recipients that occupy this site. In addition, the organization’s work mimics a religious mission in that the activities are directly organized around a central task, namely the eradication of congenital facial anomalies.

Perhaps most crucially, Operation Smile disseminates an ideological formation. Specifically, the organization conceptualizes facial disfigurement in particular ways and requires recipients to subscribe to this worldview. Operation Smile is a “troubled person industry,” which understands its work as generosity to people in need (Gusfield 1989). In an examination of programs related to deafness, Harlan Lane (1997) argues that a troubled person industry, like those organizations dominated by hearing professionals who “provide services” to the Deaf, “seeks total conformity of the client to the underlying construction of deafness as disability” (158). Operation Smile demands the

same sort of conformity to expectations about what disfigurement means. It relies on a subjectivity saturated with suffering, an identity determined by the horror of facial difference. As opposed to the work of organizations that are premised on a disability rights model that calls into question the trauma or suffering of disability, Operation Smile continually characterizes the children's lives as intrinsically tragic, and participants subscribe to this notion. Take as evidence the kinds of comments recipients and their parents make to news media about life "before" intervention.

Operation Smile medical missions resemble traditional religious missions in basic ways, though the following questions remain: to what degree do Operation Smile missions *function* like traditional missions, and what might be the consequences of structuring medical interventions on the mission model? In his book *Mission in Today's World*, theologian and missionary Donal Dorr (2000) identifies five functions of contemporary missions. Missions facilitate dialogue, evangelization, inculturation, struggle for liberation, and reconciliation. Rather than speculating about if the organization does or does not enable these practices, I want to briefly describe what each of these functions might look like in the mundane activities of medical missions in order to raise questions about the possible consequences of Operation Smile's work.

For Dorr, the notion of dialogue is intended to interrupt the notion that missions are simply about "doing" for others and are, additionally, about listening and sharing. In the context of a medical mission, such conversation might take place via a consultation or in the downtime of recovery. Dorr translates evangelization into "bringing the good news." For Operation Smile volunteers, bringing good news might be constituted through describing the hope and promise offered by technological intervention,

specifically, and the Global North, more broadly. Relatedly, inculturation involves the processes through which a culture embodies the good news. By surgically shaping children's faces, it seems as if Operation Smile quite literally facilitates inculturation. Dorr emphasizes three levels at which liberation must occur—economic, political, and cultural-religious. Certainly by offering free medical intervention, Operation Smile “liberates” recipients from the limits of poverty. Finally, reconciliation involves a move towards forgiveness and understanding. It is the work of acknowledging that a relationship has been forged through inequality, and perhaps violence.

But Operation Smile is not the Catholic Church. It does not deal in holy water, blessed beads, and devotional candles. Operation Smile deals in surgery, anesthesia, and radical shifts in subjectivity and status. The Christian missionary project has long been criticized as ventures that propagate colonialism (Neill 1966). Conversion sometimes comes at the costs of destroying local culture, perpetuating relative powerlessness in global economic structures, and rampant geopolitical Othering. It remains a question to what degree the mundane work of Operation Smile medical missions produces similar outcomes.

In particular, it is unclear what the consequences of liberation or reconciliation forged through a medical mission might be. Is liberation constituted through self reliance, or is liberation conceptualized as being freed from one's present circumstances? In the case of the latter, what circumstances do missionaries hope the liberated will embody? If the unspoken assumption is that those liberated through missions will be empowered to be more like their missionaries, Operation Smile may facilitate “a liberation” that is in effect a solidification of the economic, political, and cultural

relations between the Global North and the Global South. In thinking through the consequences of the reconciliation, it seems important to distinguish reconciliation from reparation. While reconciliation relies on naming inequality, it is ultimately forged when that injustice is let go. By contrast, reparations involve the sustained acknowledgement of victimization and relative powerlessness through compensation. Reparation remembers who did what to whom. Medical missions offered in response to global inequality and/or the related guilt of privileged “first-worlders” may forge a sense of reconciliation that is accompanied with a kind of forgetting that perpetuates the structural inequalities at play.

If the missions of Operation Smile function in the ways contemporary religious missions do, the consequences of this work are critically important to understand if intervention is to unfold in responsible and ethical ways. Understanding the consequences of mission work requires thinking through the mission from all sides. At the most basic level, the mission requires someone “going” on a mission and someone “receiving” a mission. To be sure, “receiving” a medical intervention on behalf of a mission situates one in a relatively powerless position, but there are consequences too for those that go on missions and for the societies that missionaries come from.

While I intend to further explore these ideas through ethnographic research conducted during an Operation Smile mission, I offer a preliminary analysis here. Missions are directed at social problems in such a way as to minimize the complexity of the issue. A mission is bounded. There is a beginning and an end, a task to be completed, and a plan for completing it. Simplification of social problems is not unique in charitable ventures, but there are consequences. Missions provide missionaries with

the pleasure of “helping.” In this way, the mission directly benefits the missionary, but the satisfaction derived by the missionary is often concealed by a narrative that overwhelmingly focuses on how “good works” benefit the needy. The mission of Operation Smile is enticing not only because it is described as so meaningful, but also because it seems so easy.

The “Quick Facts” feature on the Operation Smile website seems to suggest that the “fix” for facial difference is so simple relative to other health issues:

“For \$240 Operation Smile can change a child's life by giving the gift of a surgery...In a little as 45 minutes, one cleft lip surgery can change a child's life forever” (Operation Smile 2007a).

While repair of the face is seemingly suspect at the precise moment in which children in the places Operation Smile operates are dying of structural inequities, facial intervention is positioned both as critical and as more simple. It is described as life-changing, but at relatively little cost and little time. Children are helped, but they are helped without any radical restructuring of economic relationships, as would need to happen, for example, to provide drugs to children in the world suffering from HIV/AIDS. Children’s lives are changed, and at the same time no political alliances must be dissolved or erected, as is needed, for example, to make Iraqi children safe from U.S. sponsored bombings. Children are given the gift of a future, but not by reassessing policy which keeps U.S. borders closed to those seeking entry for education or asylum. If charity is desired but not at any real costs to those positioned as gift givers, then the work of Operation Smile is a perfect mission, at least for the missionaries. The consequences for recipients have yet to be determined.

Disfigurement operates in a particular way throughout the work of Operation Smile to infuse repair with social and moral significance. The disfigured faces of children subject to Operation Smile interventions are described using stigmatized terms. Disfigurement operates as an unambiguously tragic, perhaps the most catastrophic state of human existence, and the face is positioned as exceptionally significant, making intervention on human visages crucial. Yet in the site of Operation Smile, the faces are those of children around the globe. In this site, repair happens across borders, such that intervention is more like a form of charity than a procedure purchased by a medical consumer or a technological innovation which positions the patient as a collaborator of sorts in the making of a new intervention. The faces upon which Operation Smile operates are resolutely Other. But like the other sites included in this account, fixing the face takes on a much more significant weight than simply improving appearance. It may be a 45-minute, \$250 operation, but it—like so many other interventions aimed at children in the developing world—is imbued with the discursive force of “life changing” and human making work.

CHAPTER 7

AT FACE VALUE

“Ugly people are just beautiful people with horrible facial deformities.”

bathroom graffiti in The Villager, a dive bar in Nashville, TN

The Flesh Becomes Human

This is a story of repair, an analytic exercise towards understanding how we cope with trauma superimposed onto and embedded within one of the most precious parts of our physical selves, our faces. We are at a cultural crossroads, professing to our children and our students and ourselves that the inside is more important than the outside, and yet simultaneously we consume services and products that promise to make our outsides better, like addicts desperate for one perfect high. If our faces, as we have seen, are imbued with our very being—our identities, our histories, our truths—what does the repair of faces come to signify? What desires and hopes infuse the work of repairing the human face?

In Catholic lore/creed, the moment in which the Father, deep male consciousness, lifts a communion wafer (water, flour, and salt) into the air circulating above the altar, bread becomes body. The story of the Last Supper is recounted and the words of Jesus Christ are repeated, “Take this all of you and eat it, this is my body.” And in that moment, as an altar boy rings a tiny bell, a miracle occurs. Transubstantiation is not only a ritual; it is a technology in which wheat becomes flesh, and the mundane becomes

sacred. As a lapsed Catholic, thirteen years of parochial schooling in the making, I remember the desire saturating that moment. Miracles are hot. They are dramatic and earth shaking, and true for those who believe. A miracle can be defined as making that which is impossible real. We know we have witnessed a miracle when we can reach out and touch the ineffable.

Face work is the work of transubstantiation. It is the work of making that which is not configured as human, human. What is more sacred in this world? If we seek to understand why—why anyone spends tens of thousands of dollars to make the face perceptibly more feminine, why death in exchange for a face is, in fact, ethically justifiable, why celebrities become mobilized around the “tragedy” of cleft palate, why some trade public humiliation on television for the chance to be less ugly—we need only to consider our desire for technologically mediated self-improvement. Who has not held out hope for the slightest intervention—a haircut, a moisturizer, or even a facelift? How much more so, then, for the techno-intervention that holds the potential to humanize? For those defined as disfigured, face work animates the hope that life can be better and elicits desire for future embodiment, new subjectivities. Face work, like transubstantiation, is a miracle of sorts. But it may not be the only mode of humanizing the facially disfigured in the 21st century.

Throughout this thesis, I have argued that face work is so much more than reconstructive surgery aimed at repairing faces defined as disfigured. The work of fixing the face is always the work of humanizing the abject, those defined as so close to the margins. At each site I studied, the work of fixing the face is imbued with particular kinds of social and moral significance. In the case of face transplantation, a recipient’s

disfigured face is replaced with an altogether new face, and this is positioned as “life saving work.” In the case of facial feminization, a face that bespeaks masculinity is surgically revised to signal unremarkability, and the new face makes passing and consequentially a public life as female possible. In the case of *Extreme Makeover*, a face that compromises romance or work is remade, premising a life worth living on a particular kind of surgically altered visage. In the case of Operation Smile, congenital facial anomalies are amended, restoring facial function and a smile, which comes to signify a future. To be human is to have a face, an intelligible face, and so ultimately face work is about repairing and normalizing faces in the service of restoring humanness. It is the cultural and material work of making the non-human human. But what are the consequences of this particular arrangement? If we do not take repair of disfigurement at face value and instead try to understand the work it accomplishes not simply corporeally but culturally, as I have done here, what are we left with?

In this final chapter, I turn to critique, a project distinct from criticism. As Margrit Shildrick (2005) argues,

Critique is not destructive per se. Its purpose is to expose the shortcoming, the unreflective assumptions, the hidden contradictions and elisions of hitherto unchallenged structures; *to bring them into question but not to make them unusable...* The point is that things could always be otherwise, and that the answers we give ourselves—often the basis for far-reaching actions—must never be allowed to settle, to take on the timeless mantle of absolute truth or moral right or universality. (*my emphasis*, 9).

This is the mode of critique that I have employed throughout this account. My intent has not been to demonize the skilled surgeon or mock the hopeful patient. Rather, my hope and strategy is to deploy questions with the end of demonstrating that things could be otherwise, more specifically better. Procedures that improve the quality of life could be

distributed more democratically. Cultural assumptions that incite painful, expensive, and risky repair might be dismantled, opening up the possibility for “choosing” intervention in a less coercive context. Our ways of seeing and categorizing humans as abled and disabled, ugly and beautiful, “okay” and “in need” might be interrogated to reveal that *who* people are is to a large degree constituted by *how* we think about who people are. I ask and answer questions with the hope of producing all of these effects. I do not ask questions with the intention of dismissing the interventions I have interrogated in the preceding pages. This, unfortunately, has been the perhaps unintended consequence of some social critiques of medicine, science, and technology. Denunciation has too often masqueraded as questioning. Put another way, as bioethicist Arthur Frank (2004) does, the critical intervention I pose is less about offering guidelines for practice and more about “open[ing] up the discourses in which people—both professionals and potential patients—are able to think about how their actions affect themselves and their communities” (19).

Before offering my own critique, I want to counter a common refrain that appears in response to normalizing interventions: the call to not intervene, to reject medical practice, to instead focus on social change. As a sociologist, I want to query this response as a quick fix or a lazy logic that has come to dominate some bioethics assessments and social critiques of science and medicine. What, I ask, are the costs of rejecting intervention in favor of social change? At the same time, I do not want to suggest that things need be as they are or that suffering is inevitable.

In addition, I consider here several consequences of deploying face work in the service of humanizing. I question the work of facial repair in relation to bodily trauma,

and I ask what happens to our bodily histories when work is directed towards repairing or “returning” the body to a mythical past, a body pre-trauma, a body unmarked. I conclude by thinking about the animating effects of unremarkability, and I argue that, rather than beauty, so many of us simply desire to be taken for granted as human.

How does a conclusion about the political and ethical ramifications of face work simultaneously take into account the coercion embedded in the imperative to repair, the immense hope contained in the possibility of face work, and a social climate so hostile to facial difference? I understand the task of the medical sociologist, the disability studies scholar, and the writer of the body to complicate the understanding of intervention as unambiguously optimistic *and* to hold intact the suffering of bodily difference without reifying variance as necessarily tragic. The point, then, is not to conclude by identifying which interventions are ethical or politically preferable under certain conditions. Rather my aim is to comprehend the politics of biomedical intervention in relation to suffering and hope.

The Politics of Non-Intervention, The Promise of Social Change

With the rise of institutionalized, professionalized bioethics, the necessity, feasibility, and ethics of biomedical interventions of all kinds have been interrogated and contested (Franklin and Roberts 2006, Stock 2002). Concerns that particular medical interventions are unethical, coercive, exploitative, or otherwise unsatisfactory have given way to skepticism about biomedical intervention more broadly. These critiques routinely take social context into account, revealing the ways in which social norms, institutionalized power, and corporate structures feed the imperative to intervene. Take,

for example, the case of infant male circumcision (Aggleton 2007). Because, as critics suggest, circumcision serves no purpose other than to surgically inscribe social norms about genital appearance, intervention is characterized as unethical. From this perspective, a more reasoned and ethically justifiable response is to challenge social dictates to circumcise male infants rather than intervening medically. This is a critical challenge, not only to medical practice but to society writ large. It is a position made possible by employing a particular logic; critics question the motivations for intervention and conclude that intervention should be avoided in favor of interrogating and reworking social norms.

In the last two decades, it has become almost theoretically cliché to interrogate bodily intervention and conclude that social institutions and discursive structures inspire intervention and thus intervention should cease. Sometimes explicitly but often implicitly, critics argue that social change is more favorable to biomedical intervention (Kessler 1998, Sullivan 2004). In a sense, then, the ethical tensions and anxiety surrounding science and technology are dealt with by concluding that intervention should be avoided. This is ultimately, I contend, a technophobic response. Because medical intervention lives in society, there is no intervention outside of social embeddedness. In addition, criticisms sometimes premise non-intervention on the vulnerability of those subject to intervention. While vulnerability is certainly important to consider in assessing the ethics of medical practice, it is oftentimes precisely the intervention at stake that aims to address the very vulnerability critics point to. These facts make calls for non-intervention particularly curious and unwieldy. At the same time, rejecting intervention in favor of widespread social change reads as euphoric.

An impasse has emerged between the knowledge and practice of medicine and the critiques articulated by scholars due to opposing commitments (Rosengarten 2005). One group relies on a stable notion of the real, and the other is invested in deconstructing the possibility of an existing matter. Accounts of medical science have very often created a division between critical scholars and medical practitioners. What kinds of medical practice and what kinds of intellectual accounts would emerge out of a generous collaboration? Drawing on Haraway (1991), Rosengarten articulates a compromised constructivist position. The body does not simply come into being through social practice. Rather, the body takes form at the “intersection of bodies, knowledges, treatments and associated tests, and social practices” (86). Is there a politics of intervention that simultaneously holds what an intervention might promise and queries the context in which interventions are deemed necessary in the first place?

Critique of medical practice is part of the intellectual project both in the sociology of health and medicine and in bioethics. At the same time, each discipline is aimed at different ends. Bioethics is charged with articulating normative positions (DeVries and Subedi 1998, Kuhse and Singer 2006). Interventions and the ways in which these are deployed are designated as either ethical or unethical, albeit through a range of perspectives and orientations. In essence, for bioethicists the question is: under what conditions could or should an intervention be used? By contrast, sociology is relentlessly non-normative. Sociologists of health and medicine typically engage in mapping exercises that display the embeddedness of an intervention and thus the problematics of normative judgments. For sociologists the question is: at what costs to individuals and to society do medical practices proceed? In both disciplines, dissatisfaction with medical

practice sometimes results in conclusions that celebrate the promise of social change. I want to think about the limits of such a response.

The case of face transplantation is particularly useful for illustrating how calls for non-intervention in favor of social change operate in response to face work. In the *AJOB* accounts, some contributors employ technophobic logic when trying to come to grips with the question of whether or not to pursue face transplantation. I query these logics and raise three questions of significance to intellectual projects aimed at critiquing and assessing medial practice. First, does understanding why interventions work in the ways that they do necessarily make an intervention ethically untenable? Second, if not precisely because of the experience of suffering, upon what basis do we intervene? And third, how is the call for social change itself a practice that relies on and reproduces differential power dynamics and continued suffering?

Several *AJOB* responses argue that the cultural desire for attractiveness is so compelling that the work of repairing the face is always infused with socially derived expectations. Several critics go so far as to claim that the desire for face transplantation is constituted in conjunction with socio-cultural dynamics that stigmatize disfigurement. Thus, in this framing, there is no possibility for ethical face transplantation. As Huxtable and Woodley (2004) write,

“The patient might be influenced or even coerced by our beauty-fixated society and as such there may be less invasive and certainly less risky means of improving both society’s and disfigured individuals’ reactions to facial disfigurement” (507).

In this critique, rather than surgery, the solution proffered is a complete social overhaul. It is not the face that needs fixing, rather it is “the society” that deems the face abject that needs fixing. Such “solutions” are common. Sociologists have long dismissed individualized solutions in favor of social change, but we rarely outline the processes by which social change will be effected. Thus, it is not altogether clear how such work would be accomplished.

Other responses conclude similarly that intervention should be avoided, but by way of a varied logic. Some accounts suggest that the suffering experienced by those with facial difference makes potential recipients too vulnerable for face transplantation. In these accounts, suffering becomes the grounds upon which repair is withheld, and potential patients are imagined as psychologically fragile, desperately hopeful, potentially unreliable, and unfoundedly optimistic. Consider an excerpt that appears in Butler et al.’s (2004) response:

“This process [recipient selection] would involve identifying those patients who would have functional benefit and who also had realistic expectations of the procedure. The patient would have to be determined and resolute in adhering to the prolonged rehabilitation and the need for chronic immunosuppression. The patient must be robust enough to cope with these challenges and the psychological effects involved” (16).

Their insistence that potential patients be “realistic,” “determined,” and “robust” suggests that some patients are not realistic, not determined, and not robust. These are presumably “bad patients,” but what makes them bad is not their “condition” per se, but rather their desire for repair. The response continues,

“Ironically, it may be that people who have well-developed coping strategies and good social skills cope well with disfigurement, while those who find life generally more challenging, also cope poorly with disfigurement. The concern for us as clinicians proposing this complex procedure is that this group might also cope poorly with face transplantation; thus, *the very group who might benefit most are those who are least likely to cope with the procedure*, particularly if the results fall short of their expectations” (*my emphasis*, 17).

It is ironic, indeed, that suffering is simultaneously the grounds upon which critics base arguments *for and against* face transplantation.

These responses are not only technophobic. They also employ tautological reasoning—because potential patients are “disfigured,” they are not able to consent to the surgery. By implication, the surgery is unethical because candidates are disfigured. Not only is this a logically untenable position, it works to situate potential consumers of medical technologies as always already inadequate for assessing those technologies.

Strong’s (2004) contribution demonstrates such logic:

“Potential recipients are likely to be psychologically vulnerable because of their disfigurement. Affective factors may compromise their ability to weigh risks and benefits autonomously and to have realistic expectations about the success of the transplant” (13).

In essence, Strong argues that because potential patients might want the procedure too much, they are incapable of providing informed consent. Psychologist Nicola Rumsey employs a similar logic arguing,

“These [those most distressed about their disfigurement] are the people most likely to seek a face transplant, yet they are also the more psychologically vulnerable and less well equipped to deal with the rigors of complex surgery, uncertain outcomes, and demanding postoperative treatment regimens” (23).

Desire for technology becomes the criteria upon which to deny the technology, and recipients’ ability to consent is questioned in light of the suffering they may be experiencing. If the experience of disfigurement becomes the grounds upon which to deny technologies aimed at repairing the face, it is unclear then what the “solution” to disfigurement is. Additionally, given that in the United States so much medical intervention is located within consumer structures, why, in the case of face transplantation, is desire for consumption indefensible?

The impetus to *not* intervene demands as much critical attention as the compulsion to intervene. Upon what grounds is intervention resisted? Who gets to say that a desired intervention should not be made available? Why isn’t suffering precisely the grounds upon which informed consent can be given? What might bioethics understand about face transplantation if it were read through suffering rather than outside of it? In a health care system characterized by a free market model of supply and demand, why does a patient’s desire for face transplantation preclude him or her from being an “ideal candidate”? In what cases are long and difficult solutions, namely social change, reasonable and ethical alternatives to biotechnological interventions? These are questions not posed often enough, but they are the questions that to be asked of self-reflexive, feminist, and/or critical accounts of science and technology. If theory has

fallen into a rut, dominated by predictable logics, then these questions are important for exposing the assumptions that undergird “critical” accounts.

Importantly, calls for non-intervention vary according to context. Some interventions, like those practiced by Operation Smile, are taken for granted in ways that “extreme makeovers” are not. Some bodies seem to be positioned as “really” defective and thus “in need,” while other forms of intervention are taken up as “elective” and thus not necessary. To be sure, repair of cleft lip and palate may facilitate physiological functioning, but functioning itself is not the linchpin upon which claims for non-intervention rest. As I demonstrated, critics encourage non-intervention in the case of face transplantation, even as those faces are surely most “in need” of intervention relative to functioning. In this case, innovation seems to animate fear that results in a rejection of biomedical intervention.

Another factor seems to inspire non-intervention. The children upon whom Operation Smile operates are innocent by the very fact of their youth, and they are poor and disenfranchised relative to global operations of politics and economics. They are, by most standards, deserving. By comparison, the faces that circulate in the narrative of *Extreme Makeover* belong to those whose very participation is premised on their inability to cope. While their faces do not look altogether different from those of the audience, extreme makeover candidates are presented as desperate, inappropriately so. Facial feminization is aimed at male-to-female transsexuals, a group who remain the object of widespread cultural mockery and, in some cases, loathing. Face transplantation is aimed at repairing “severe disfigurement,” cases in which public personhood is significantly

compromised because of appearance. The common story is that potential recipients are repulsive to the general public.

How is it that the children of Operation Smile unequivocally deserve intervention and the “psychopathological,” the transsexual, and the severely disfigured do not? It is not simply that functionality works to justify some forms of normalization and invalidate others; rather, there is a way in which the most devalued, the most stigmatized, the most inhuman get positioned as not deserving. The call for non-intervention rests on such an assumption. It rests on valuing social change, ostensibly change aimed at the already human, more than the change an intervention might produce in a single life. When change is aimed at a life that is fundamentally devalued, it can be easily dismissed in favor of a kind of progress that extends the suffering potentially alleviated by medical intervention. In some cases, a single life is deemed to matter, and in other cases, it is not. The ways in which the call for non-intervention rests on privileging some lives at real costs to others must be named and critiqued. This is not a logic upon which theoretical projects can continue to operate if bioethics and/or the sociology of health and medicine are at all interested at understanding in the service of alleviating suffering.

In the case of bioethics, these questions matter for articulating a normative stance; and in the case of sociology of health and medicine, these questions matter in mapping the consequences of particular interventions. There are consequences, too, of suggesting social change as the solution to what ails us. And at the same time, however, I do not dismiss social change out of hand. Perhaps more than anything else, this project reveals the ways in which living with facial difference is untenable not because of something intrinsic to the face but rather something endemic to society. The solution clearly

involves restructuring how “we” look at bodies and assign these bodies differential value, redefining what constitutes the “grotesque” body, and interrogating how people are expected to navigate bodily difference. Radical social change is needed, but it is deep social revision that may be long and hard in the making.

What shall be done in the meantime? What of Isabelle Dinoire who has a life made possible by the transplant that gave her back a face? What of the woman who approached me at IFGE claiming that her life was infinitely better after facial feminization surgery? What of Thanh Ngan whose crying face occupies the Operation Smile homepage? What of *Extreme Makeover*'s Ray Croc, the “snaggle tooth killer,” who is trying to start a new life after spending years on death row? It is the either/or that is so problematic. It is the call for ceasing intervention in favor of social change that is so problematic. Dismissing intervention brackets the possibility of improving lives *now*. It is true that improving life via face work carries consequences, but I remain hesitant to reject this possibility altogether when the social change needed may not come in Dinoire, Ngan, or Croc's lifetimes.

The Imperative to Erase

In the case of facial trauma, as in the case of an animal attack or a car accident, face work relies on a notion of the face as it existed before the trauma. Face work becomes a way to return the face to its pre-trauma state or some close proximity. But in the case of congenital anomalies, what is the reference point for face work? What face is it that interventions for cleft palate return the face to since there was no face pre-existing the atypical? This is one way in which face work aimed at faces congenitally marked by

features defined as undesirable is unique. While the language of such surgical intervention may be characterized by notions of repair, rehabilitation, reconstruction, and restoration, face work is a generative or productive intervention. Whether in the case of trauma or congenital difference, face work creates a face that does not pre-exist medical intervention.

No face pre-exists the medical intervention that shapes it. There is no surgery that returns the face to its prior state—the younger, the slimmer, the unburned, the unmauled. And yet, face work (along with other cosmetic interventions) is couched in these very terms. Face work is sold, consumed, understood, researched, and enacted as if this is precisely what it does—that it “recovers” the face. Instead, as I have shown here, face work is a kind of surgical, technical, and cultural erasure, in which experience is erased in favor of the face that does not bespeak aging or, perhaps more importantly, trauma and fetal development. If the face is so important to us for all the reasons that we know it is, then face work accomplishes the incredible by erasing the parts of our history and experience that make themselves known by bearing witness on our bodies. The narrative and practice of recovery and repair obscures the replacement central to face work. There is a difference between making something more functional or more pleasing and transforming that thing into something different. The difference between these aims is striking when the something being repaired *or* replaced is the human face.

That which marks our bodies speaks of something true, something undeniable and inescapable. Sighted people see these marks. What would people know about us if they knew something about our trauma or embryological path? Bodily marks call for storytelling, an answer to the ubiquitous question, “What happened to you?” And

storytelling is revealing. In the case of fetal development, congenital anomalies reveal that we were born imperfect, that our lives are characterized by difference. Our bodies have always been marked. Yet, to have never been considered normal is very different than to have been normal and to become abnormal. As Arthur Frank writes, “Scars do hit us like a brick, as they connect immediate persons to imagined forms of suffering and thus render that suffering tangible” (Frank 2004: 28). The trauma on our bodies tells the story of where we have been and what we have encountered. Erasing these embodied stories obscures part of what makes us who we are. In this way, the desire for face work embodies the desire for erasure.

Biotechnological interventions like face work rely on and mobilize hope. They promise that, through bodily interventions, life can be better. Techniques of intervention mobilize hope, but often the access to a better future is conceived of as solely accessible through particular interventions. Thus, choosing an intervention, hoping for repair, is always already embedded in coercive discursive structures which rely on the imperative to repair. Face work becomes not simply one mode of coping, but the presumed mode of negotiating bodily difference.

Positioning interventions as humanizing is potentially insidious for this very reason. If a technology or a practice possesses the power to make one human, is there a way of opting out? If humanity hangs in the balance, how does normalization rely on coercion? If normalization is deployed as a necessary intervention, then the assumption remains that there is no other way to live. As Clarke et al. (2005) argue, biomedicalization is facilitating radical reappraisals of what constitutes life. These transformations are not simply raising questions to be answered; rather, the work of

humanizing is something that is increasingly part of the work forged through medical practice and technologies. Face work calls into question how we conceptualize life and death. What is at stake is *not* our heartbeat, our respiration, our nourishment. In this case, what is at stake is the face, which depending on one's perspective might be *just* a face, or it might be everything. It might be what makes humanness possible.

But is face work the only means of imbuing humanness? In 2002, the National Portrait Gallery in London debuted a series of portraits by artist Mark Gilbert. The paintings captured disfigured faces “before,” “after,” and “during” interventions aimed at normalizing these faces. According to the website of Saving Faces, a United Kingdom organization that commissioned the works, those painted by Gilbert reported that the experience of being painted was “cathartic” (The Facial Surgery Research Foundation 2007). It was the experience of being captured precisely because of, rather than in spite of, disfigurement that elicited such an emotional, and presumably healing, response. Could the experience of being treated as a valued aesthetic object because of one's face, and all its difference, work as a mode of repair?

On the New York University sponsored Literature, Arts, and Medicine blog, artist Laura Ferguson writes in an article entitled “Towards a New Aesthetics of the Body,”

As an artist, I understand that fixing, healing, transforming an abnormal body into a more normal one, is what gives doctors satisfaction, a sense of accomplishment - that it is their form of creative expression. But the result is that there is no alternative paradigm offered to patients, no acknowledgment that an unusual body might be okay the way it is – that there doesn't have to be a ‘fix.’ I realize that the idea of deformity having its own beauty, without the need of fixing or altering, is a radical one. But I believe in an alternative vision of aesthetics in medicine, one that gives more value to process, to empathetic connection, than to fixing or curing. Art is a good place to look for an alternative aesthetic: a place where the less-than-perfect body can be shown to have its own kind of beauty, grace, sensuality, originality” (Ferguson 2007).

Ferguson's work captures the beauty of her own body. It is a body marked and devalued, in particular contexts, by scoliosis.⁶⁵ Ferguson does not seem to suggest that "fixing" be dismissed altogether, but she does call for a new "aesthetics in medicine," one that leaves open the possibility of alternative beauties. Imagine a body desired for its originality, for the ways in which life and biology have made themselves visible on the body. Imagine a face longed for because it embodies a vision of the self in all its trauma and suffering.

Making Not Ugly

So much intellectual inquiry has focused on the work invested in making the body beautiful, but what of making the body *not ugly*? The work of making the body not ugly is aimed at both grotesque bodies and bodies already unremarkable. It is not simply the disfigured face, but rather all of our faces that are subject to attempts at erasing ugliness. The work of making not ugly stands in sharp contrast to making the body beautiful. Rather than inscribing the most desirable attributes onto the body, as is so clearly the case in cosmetic surgery, the work of making the body not ugly attempts to erase those features of ourselves that situate us precariously close to the abnormal. It is not simply being beautiful that pervades our everyday aesthetic practices. Many are unambiguously aimed at erasing ugliness. For example, eyebrows that grow together meeting over the bridge of our noses are plucked, waxed, and lasered in an attempt to avoid a uni-brow. Concealer and pressed powder and bronzer together do more than define faces into more

⁶⁵ Scoliosis describes the condition wherein the spine displays curvature from side to side.

beautiful structures. These are tools for hiding pores, obscuring lines, evening skin tone. Imperfect teeth are whitened, with bleach and flashes of light, sometimes in attempts to make a beautiful smile, but just as often in attempts to reduce yellowing or graying, so that flaws are less noticeable. Hair is cut and colored, straightened and relaxed not purely in an attempt to be beautifully tressed but also in an attempt to make our hair less ugly—less frizzy, less gray, less blah—than it would “naturally” be. Sometimes better is not more beautiful. Sometimes better is less ugly.

In erasing the abject, we inscribe unremarkability. Like the *Extreme Makeover* participants who desire the moment of unrecognition—the moment at which the reflection in the mirror is unrecognizable—in our attempts at unremarkability we desire to disappear, to become more like the taken for granted, to erase that which threatens to mark us as different. The collective fantasy is that our bodies might be made beautiful, which is ultimately a desire that would mark us as separate and unique. In our continual attempts to identify what beauty is, we routinely find that much that is beautiful is a sharp departure, an aesthetic outlier from the average. To be beautiful is to be different and unusual. And yet while we may hold onto the fantasy, the dream and wonder about what it might be like to be so beautiful, so distinct, we fiercely hold onto another fantasy, though this one so often goes unnamed. It is the fantasy that we will be good enough, and that those facets of our appearance which make us different and thus dangerously close to the margins might be erased. As opposed to a fantasy about standing out, this is a fantasy about blending in, about embodying an aesthetic so unremarkable that no one notices us at all. What does it mean that we so desperately desire to be unremarkable, to, in a word, disappear?

Beauty and ugliness exist, then, in an uneasy tension. Of course, each informs the other. In the same way that black denotes the presence of all color and white the absence, beauty and ugliness stand in sharp contrast to one another and yet entirely depend on the other for their respective significance. Beauty and ugliness are contextual. We know beauty when we see it, partially because we have some looming sense of what is ugly. But there is much to be learned by analytically separating out attempts towards producing beauty and techniques aimed towards obfuscating ugliness. Our desire to be beautiful is a desire infused with cultural discourses and practices related to youth, ablebodiness, gender, race, and class, and this desire is continually forged through commercial culture, through material and experiential consumption. Yet this desire is also informed by notions of uniqueness and rarity. Most of us know that there is only so much that we can do.

In contrast, the work of making the body not ugly is a never-ending project. It is a Sisyphean task. The stone will not stay atop the mountain. Aging, bodily trauma, and aesthetic fashions are not fixed, and thus the work of not being ugly is an ongoing and impossible project. We may be finished for today, but tomorrow is another day complete with another set of problems—new freckles, fine lines, solar damage, car wrecks, standards of bodily care. The specter of disfigurement, specifically, and ugliness, more generally, is so overwhelming because it is always there, threatening to affect our bodies with every passing day, with every risk encountered. Relative then to our everyday lives, the feat of being not ugly looms large, and the ways in which the specter of ugliness inspires consumption (including consumer debt), self loathing, and postmodern

sensibilities must be queried in the same way that the fantasy of beauty has been dismantled.

The question of ugliness matters for us all, but it particularly matters for those with bodies unambiguously ugly as defined by our collective norms of bodily appearance. We know that we are not all equally beautiful, but we are also not all equally unremarkable. We all wrestle with ugliness, but as this inquiry into the work of repairing the face demonstrates, this struggle is disproportionately stacked against those with facial difference. The stakes are much higher. The possibilities for unremarkability are much lower, and thus the specter of ugliness not only looms for those with facial difference but it infuses everyday life. In assessing these technologies, these mechanisms of face work, these interventions aimed at repair, it is essential to recall that interventions are simultaneously coercive, compelling, and desired.

Rather than dismissing face transplantation as a technology too risky for potential recipients while too advantageous for those who continue to innovate it, rather than criticizing Operation Smile for investing in appearance rather than sustenance, rather than exposing *Extreme Makeover* as a circus in which participants are the clowns, rather than focusing on the violence inflicted on the faces of male to female transsexuals undergoing facial feminization, I empathetically ask: what forces make choosing these interventions compelling, what structures make appearance so essential, what pleasure and hope is there to be had in repair? It is these questions that help us understand why face work means what it does and what consequences emerge out of processes aimed at fixing the face. I am left with rage that only some choices seem possible in the 21st century, despair that some lives are defined as lives not worth living, fascination about what we have

made technologically possible, and compassion for those of us desiring by whatever means possible to be fully human.

Coda

At the end of this narrative, I am reluctant to conclude by endorsing or demonizing face work, or even by offering a framework that differentiates between the ethical and necessary moments of intervention and the unethical and gratuitous. I conclude acutely aware of how intervention varies according to context—that the specificities of the faces involved matter and that procedures technically identical carry different meanings for patients, practitioners, and societies depending on the particulars. I end with some sense that the desire to be unremarkable is profound, and despite what I know are problematic means towards this end, I am reluctant to definitively reject what so many hope for. And mostly, I finish this story with a sense that despite the ways in which embodiment is socially mediated and thus shaped by forces not unique to any particular individual, bodily experience varies to such a degree that attempts to communicate across experience inevitably fail.

If there are any facts of life, they are that all humans breathe, consume, and excrete, though even these functions are mediated socially and technologically. Language, geo-political locations, familial context, and personal narrative vary, but *all* humans are embodied. This is universally true, but even in the face of the only universal, there is no there there. Even the universal experience of breathing varies dramatically. Some breathe with the aid of ventilators. Some breathe through transplanted lungs. Others breathe air saturated with pollens. Some are allergic, and others are not. Bodily

experience varies so dramatically that it is certain that even those bodily experiences shared by all humans are experienced differently. This is the paradox of bodily experience and the source of tension that makes a politics of bodily intervention so complicated. The fact is the only thing common to all humans is that we inhabit a body, and yet bodily experience differs profoundly between human creatures. Culture, ability, aesthetics, and trauma imprint the common body, marking and making each one in ways entirely different from the other. Utterly common, yet incomprehensibly different.

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