

# Beauty, health and risk in Brazilian plastic surgery

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*In this paper, I take up the theme of the volume by analyzing the dynamic and sometimes conflicting relationship between 'health' and 'beauty' in the practice of cosmetic surgery. Approaching Brazil as a case study, I show how cosmetic and medical rationales are merged within a broader field of 'aesthetic medicine' that manages female reproduction and sexuality. Beauty effectively becomes an integral dimension of health. But drawing on an analysis of the larger historical conditions that shape the use of medical technologies, I argue that a cosmetic logic can also conflict with the goal of health, and minimize perceptions of risks associated with surgical interventions.*

*[health, beauty, cosmetic surgery, health risks, Brazil]*

## Introduction

Much has been written about the medicalization of life. Anthropology and other fields have critiqued the process whereby diverse values and practices not previously thought of in terms of illness or health are brought into the purview of medical technology and expertise. Biomedicine, together with a psychiatry aspiring to science, have created a range of new disorders: from histrionic personality to social phobia (Horwitz 2002). Technology, experts, and drugs in many parts of the world play an expanding role in women's experiences of sexuality and pregnancy (Martin 1987). And the 'sick role' has become a means of resisting work regimes and participating in the redistributive politics of the welfare state. But what about cosmetic surgery – is this another case of medicalization? This question, though, begs another one. Performed on patients – or often *clients* – who are already healthy and seek aesthetic improvement, cosmetic procedures do not have an immediately obvious healing rationale. In fact, cosmetic surgery is so permeated by erotic fetishisms, racial hierarchies, medical marketing, and celebrity culture that we might ask in the first place whether this is a health practice?

There are obvious contradictions between the aesthetic aims of cosmetic surgery and its status as medicine. To legitimize their specialty, plastic surgeons in the late nineteenth century distanced themselves from early pioneers experimenting with beauty treatments. Plastic surgery simply *was* reconstructive surgery. But over the course of the twentieth century, cosmetic surgery gained institutional legitimacy, though it

remains a controversial practice for the larger public (Haiken 1997, Gilman 1999). Cosmetic surgery is always *elective* surgery. It is never necessary to save a patient's life, cure disease, or even improve her (physical) health. At the same time, cosmetic surgery, like any surgery, carries considerable risks: post-operative infections, adverse reactions to anaesthesia or substances inserted into the body, and damage to internal organs (e.g. puncture of the colon with a liposuction needle). In addition there are 'aesthetic risks', the real possibility that the operation will result in perceived new defects rather than an improvement of existing ones. Breast reductions or tummy tucks may leave so much scar tissue that the patient does not experience the net result as an improvement. The aesthetic rationale of cosmetic surgery clearly then can be at odds with the health of the patient.

Having made this observation, one might conclude that cosmetic surgery is simply not justified as a healing practice. But in fact it is not so simple. Surgeons argue that improved techniques yield better, more 'natural' results, and that recuperation times and risks of complications have diminished. But apart from whatever technical improvements have been achieved, the specialty raises questions about how to define health and healing. Most patients say they not only look better after procedures, but also *feel* better too. Are they then also healthier? Notions of health as well as beauty (and vanity) are not absolute, but culturally and historically variable (Edmonds 2008). So too are the boundaries between reconstructive and cosmetic procedures. Victorians saw correction of a cleft palate as cosmetic, not reconstructive, while orthodontic work is rarely (in the US at least) critiqued as a species of vanity (Haiken 1997). How much physical discomfort is necessary to classify a breast reduction in the reconstructive rather than cosmetic category? Is the social stigma or mental pain experienced by the ugly different in kind and quality from that suffered by those deformed by accidents or congenital defects?

This paper analyses relationships between beauty and health within the medical practice of cosmetic surgery. I show how plastic surgery has emerged as one technique in the broader field of 'aesthetic medicine' used to manage female sexual and reproductive health in a modernizing nation. Drawing on ethnographic fieldwork, I argue that cosmetic and healing rationales are merging within clinical practice. But while Brazilian surgeons and patients have envisioned a form of health that apparently reconciles beauty and health, tensions between these two aims continue to shape clinical practice and alter perceptions of risks.

## **Plástica and female health**

Global and national visions of Brazil often refer to the notion of a 'land of contrasts': a country schizophrenically split between wealthy and poor, Europe and Africa, past and present (or often future). The economy produces jet engines and sugar cane cut by hand with machetes. *Favelas*, shantytowns, nestle at the foot of high rise condominiums. And criminal gangs and the police have effectively privatized security ironically as the country emerges from a long period of military dictatorship into a stable elec-

toral democracy (Caldeira 2000).<sup>1</sup> A relatively recent addition to the list of symbols of Brazil's complex relationship to modernity is its exuberant embrace of plastic surgery.

Since the 1980s, cosmetic surgery rates have risen dramatically in Brazil and other Latin American nations (Edmonds 2007a). During the 1990s, the number of operations performed increased six fold.<sup>2</sup> A news article in Brazil's largest news magazine *Veja* ran a story titled "Empire of the Scalpel," which claimed that Brazil had higher per capita rates of cosmetic surgery than richer European countries ("Brasil, Império do Bisturi" 2001). Cost cutting, the stabilization of inflation, and financing plans have made plastic surgery more accessible in the private sector. Patients can divide their bills into small monthly payments spaced over a period of a year or longer. With a reputation for quality surgeons, cheap prices, and pleasant beaches, Brazil has also become one of the world's top destinations for medical tourism. Cosmetic surgery is enjoying a boom in many parts of the world, from the US to Iran to China. It has also acquired heightened cultural visibility as a key symbol of a controversial plasticity of identity in Late Capitalism. But plastic surgery remains a consumer service in most of the world. Brazil though has taken the novel step of offering free operations within an under-funded public health system. Reconstructive procedures still have scheduling priority, but some patients also receive free cosmetic operations – such as breast implants, nose jobs, and liposuction – “within the limits of the long queues at public hospitals” (Edmonds 2007a).

Provision of cosmetic procedures within public hospitals is necessary in part, surgeons say, because the residents in surgery need “scientific training.” But surgeons also emphasize the healing function of cosmetic surgery. Dr. Ivo Pitanguy, a pioneering figure in the postwar growth of cosmetic surgery, insists that surgical incisions do not just alter the face, but “go beneath the skin, touching the psyche too” (Pitanguy 1983: 8). Plastic surgery becomes a form of healing that targets not an ugly or aging body but rather a suffering mind. As such, it can become a medical ‘necessity’, worthy of public funds. Potential conflicts between aesthetic and medical rationales have been partially resolved by this interpretation of cosmetic surgery's capacity to heal, as well as by a rather ingenious redefinition of health. But this vision of cosmetic surgery is not simply a justification for public funding found in the medical writings of a few plastic surgeons. Turning now to clinical practice and patients' experiences, I analyze how beauty is made into a form of health within clinical practice.

Cecilia grew up in the *periferia* of Rio, as the poorest suburbs are called. Her parents were migrants who fled drought and poverty in the interior of the Northeastern state of Ceará. As a teenager, her mother moved to Rio, where she married a migrant from the same region, Josefe. At age 15 she gave birth to Cecilia. Josefe has mostly African and Indian ancestry. But in Brazil's color terms, Cecilia's reddish hair, *cor de mel* (honey-colored) complexion, and pretty features leave no doubt that she is simply *branca* (white). Josefe learned enough English to pass the entrance exam to the Coast Guard, thereby escaping a life of menial labor. The couple still light candles at night to save money on electricity, but managed to send Cecilia to college, where she studied psychology. Soon after, Cecilia married and became a *dona da casa*, raising a family of three children.

When she was in her late 30s, Cecilia decided to have *plástica* – abdominal surgery and liposuction on the thighs and stomach (followed by an additional liposuction operation some years later). She explained how the operations were designed to “correct” the effects of her three cesarean births:

I did it on my belly, which had a very flaccid part due to the *cesareas*, the three cuts of the *cesareas* had dead tissue. And it bothered me a lot, because when I put on a bikini there was that little piece of skin hanging above the bikini, and so I decided to fix it. And the doctor he made a cut a little bigger than the caesarean scars, and took out that piece of meat that was really flaccid, without life, and then he sewed it up, and did the liposuction.

It feels odd – and often simply inaccurate – to use the blunt language of class to discuss the lives of those we know well. But to switch into a sociological mode, Cecilia inhabits a world where the middle class *moderno* blends with elements from the *povão*, the common people. She spends much of her time around two illiterate women, her mother and maid, and through charity work at a nursery, many other women excluded from key aspects of the middle class lifestyle that has become in the national imagination synonymous with full citizenship. In Portuguese she and her family might be called *emergente*, emerging, *into* middle class, and *away from* a more popular background. (The term has a less pejorative sound than ‘nouveaux riche’ in English, as it emphasizes escape from the poverty of the masses into the normality of middle class life.) This social passage is marked symbolically and materially by acquisition of key commodities and services. There are the usual class markers: real estate, car ownership, education. But some are particular to Brazil: e.g. a lavish debutant party for 15 year-old girls, or the more *moderno* alternative, a trip to Disneyland. Over the past three decades, a new addition has made it to the list, *plástica*, which, as *Veja* magazine put it, “has become integral to middle class aspirations” (“Os Exageros da Plástica,” 2002).

But *plástica* is also *not* just like any other consumer service. Cecilia may have chosen it because it has become part of a normal, middle class lifestyle. But her operations were also part of another social passage – through the female life cycle. When Cecilia was pregnant with her third child she had already begun to think about having *plástica*. She wanted to combine the birth, which like the others would be a cesarean, with a tubal ligation. But after her gynecologist told her that he couldn’t “fix her belly” during the birth since he was already “tying the tubes,” she decided to postpone the *plástica*. Cecilia associated *plástica* with other surgeries as a form of managing the maternal body. Abdominal surgery removed the ‘unaesthetic’ effect of the cesarean deliveries, and the both procedures corrected unwanted bodily changes due to pregnancy itself.

Cecilia’s experience is somewhat typical at least for an urban, middle class woman. She is not a ‘scalpel slave’ – not compulsively interested in surgery and not particularly *vaidosa*, vain. She also did not deliberate much about the decision to have abdominal surgery and liposuction. Her operations seemed a natural response – one of course made possible by modern medicine – to a physical defect caused by the event

of pregnancy. What I explore next is what social forces have made plastic surgery a 'normal' part of female reproduction and sexuality.

It would be difficult to underestimate the gendered aspect of plastic surgery. It is true that men are the fastest growing demographic group of patients. The male percentage of the total number of cosmetic surgery patients grew from five percent in 1994 to almost 30 percent six years later ("Reino das Formas Perfeitas," 2000). Nevertheless, in 2004, 69 percent of operations were performed on women in Brazil (SBCP 2005).<sup>3</sup> *Plástica* is also complexly intertwined with female nature/culture. Operations can be linked to key milestones in the social and biological lifecourse. For example, mothers give their daughters operations on the breasts or nose as a coming of age present. *Plástica* in this case also links mother and daughter in a rite of womanhood, as the elder relative has herself often had cosmetic surgery. A divorce or separation can also trigger a desire for *plástica*, or else menopause can be an occasion for 'body contouring.' But it is women's reproductive and sexual lives that are most often 'managed' through *plástica*.

Cecilia blamed pregnancy for a weight gain while a cesarean delivery created "dead tissue" that needed to be removed. But in some cases, women already plan future cosmetic surgery *before* having children. In part, they fear that breast surgery will make breast feeding impossible, but they also worry that pregnancy will simply "ruin," *estraga*, the body (requiring the *plástica* to be redone). As a woman in her early 20s put it, "I want to put in silicone. But first I want to have kids. I'll wait, after the law of gravity acts, and everything falls, then I'll do it."<sup>4</sup> Many patients also see pregnancy as a cause of *inestecismos*, 'unaesthetics,' in the abdominal area. Breast surgeries are the most common type of cosmetic procedure in Brazil, but abdominal operations are a close second (not counting liposuction as it can be performed on many areas of the body) (SBCP 2005). Patients similarly blamed pregnancy and breast feeding for thickened waists, caesarean scars and stretch marks, localized fat, and bellies, breasts, and buttocks that were *caído* (fallen) and *murcha* (shriveled). Such comments reflect a striking rejection of the 'marks' of motherhood. At the same time, motherhood itself remains a highly valued condition for most women. I return below to the question of how such conflicts reflect an older patriarchal sexual culture as well as new sexual subjectivities arising in medical and consumer culture.

Patients and surgeons see *plástica* as a powerful technique that corrects such defects. As a popular lay manual puts it, "During pregnancy the breasts grow, and then eventually become smaller than their initial size, losing their projection. This is one of the routine motivations of patients in search of a *plástica*" (Ribeiro and Aboudib 1997: 125). Other procedures remove flaccid skin and localized fat in the abdomen or minimize scars from cesarean deliveries or other "female" surgeries. Finally, some patients have recourse to *plástica na intimidade*, or genital cosmetic surgery. Both patients and surgeons then view several (but not all) operations as a kind of 'post-partum correction', even if they followed the patient's last pregnancy by three decades or more.

## Beauty as health

To understand how Cecilia's cosmetic surgery became essentially a kind of health practice I discuss how *plástica* is linked to a larger field called *medicina estética*, aesthetic medicine, or *estética feminina*, feminine aesthetics, that manages reproductive, sexual, and mental health (see Edmonds 2009). This experimental field combines several specialties, including ObGyn, dermatology, geriatrics, nutrition, psychotherapy, and plastic surgery, as well as the broad range of pseudo-medical cosmetic services.<sup>5</sup> What is most remarkable about *medicina estética* is its ability to forge links between diverse medical and non-medical specialties and effectively merge notions of health and beauty.

In some cases, a medical specialist – a GP, gynecologist, or even psychotherapist – might make a friendly suggestion or informal referral. Lídia related how she had gone to her gynecologist after giving birth to her first child: “I asked him in the consultation about my belly. And he said that I could exercise, but that my belly would never go away with exercise, that I could only get rid of it with plastic surgery, and that’s when I began to think about it.” At first Lídia hesitated, but then decided to see a plastic surgeon. “He gave me a lot of support. He said, You are really young ... no way. You have to have a surgery. If your husband can’t pay for your breast [surgery], I’ll do it for free, because it’s absurd, a young woman of your age having to look like that.”

*Plástica* is linked to other specialties not just through referrals but in a ‘discursive field’ – if that term can adequately refer to the lavishly illustrated materials of news media and medical marketing. For example, a national magazine article on *estética feminina* lists smaller liposuction needles that minimize bleeding and “more modern” texturized breast implant materials next to improved procedures for diagnosing breast cancer and osteoporosis. The tone of such marketing and medical publications – evoking notions of progress, hygiene, and development – almost recalls positivism (a philosophy which, like a few other nineteenth century intellectual vogues, survives in parts of Latin America). Medical techniques such as plastic surgery and the whole range of pseudo-medical cosmetic services can thus be understood in relation to the larger mystique surrounding ideas of progress and modern technology (Larvie 1997).

In the area of reproductive health, the Brazilian state retreated from a pro-natalist position in the 1970s and made cheap medical forms of contraception widely available within the public health system (Mello and Novais 1998). The expansion of health care thus helped to institutionalize and secularize medical reproductive practices. State involvement in the area of family planning perhaps reduced the ‘psychological costs’ of fertility control for Catholics (Martine 1996). And doctors, sexologists and psychologists disseminated a rational, scientific understanding of sex (Parker 1991: 87). The dual processes of modernization and the medicalization of reproduction contributed to a spectacular decline in Brazil’s fertility rate, from six children per woman in 1960 to below 2.5 in the mid-1990s (Martine 1996). The point is that the movement of sex and reproduction *away* from a religious and folk idiom and *into* a medical and consumer one has been fast and recent in Brazil. This political economy of reproductive and sexual health has created conditions particularly receptive to aesthetic medicine.

Within an expanding health care system, technological management of female health became normalized as a middle class practice, but could also be perceived as a medical good in conditions of scarcity. Brazil has high rates not only of cosmetic surgery but also operations such as tubal ligations and cesarean sections. The national sterilization rate for women in union in 1996 was 37 percent, accounting for half of all contraceptive use in Brazil (Caetano and Potter 2004). Cesareans accounted for 36 percent of all deliveries in the 1990s, but can reach 60 percent or more in hospitals that have a policy to perform a cesarean unless the mother requests otherwise (Hopkins 2000). According to the WHO, rates above 10 to 15 percent indicate the operation is being used for “non-clinical reasons.” A ‘culture’ of cesareans and sterilizations began with the expansion of the public health system in the 1970s and, like *plástica*, has rapidly spread across social classes.

High rates of surgical intervention in female reproduction point to the presence of a market logic and class aspirations in medical practices. Female sterilization operations can be distributed as a form of political patronage (Scheper-Hughes 1992: 337). Sterilizations also feed cesarean rates as the two procedures are piggy-backed in the public health system (just as *plástica* is similarly linked to other operations to reduce costs). Some women and ObGyns also see cesareans – like tubal ligations – as desirable in themselves: modern, convenient, pain-free, and even safer (Downie 2000). The naturalization of particular technologies as tools of reproductive and sexual freedom can mask the class and gender inequalities underlying medicine. Limited access to ‘elective’ cesareans, tubal ligations, and cosmetic surgery reinforces a notion of these as modern, medical goods (Béhague 2002). And abortion (which remains illegal), played a key role in the decline of Brazil’s fertility rates, though medical abortions are only available to wealthier women (Martine 1996).

The rise of new medical regimes of female health perhaps also reflects cultural elaborations of femininity. While aesthetic ideals are certainly variable (up to a point), so too are notions of vanity. Vanity is part of a larger array of moral concepts that are necessary in any society to define ideals of the good life. But judgments of vanity are also inseparable from European religious conflicts, colonialism, and sexual politics. Their social use can mark the inferiority of women, feminized men, and others not conforming to particular Anglo-Germanic notions of self-mastery (Lichtenstein 1987). In Brazil, vanity or *vaidade* has different semantic and moral connotations than it does in Northern European societies. When I began fieldwork I generally avoided the word, assuming that it would be insulting. But in everyday speech, *vaidosa* often has a neutral or even positive connotation of self-care that aims to preserve or enhance femininity, and perhaps even health. One woman said, for example, “I consider myself vain, but I would like to be more vain. To take better care of myself.” To express a negative judgment of someone else, people often resorted to the phrase “an excess of vanity,” as vanity in itself was not necessarily excessive.

The moral field surrounding beauty work has implications for perceptions of health. The relative acceptance of ‘vanity’ implies a greater acceptance of beauty work, including even extreme practices such as plastic surgery. Patients face relatively little social sanction, and may even acquire prestige from having operations. Certainly *plástica*

is discussed very openly. Techniques of aesthetic medicine were often assimilated to the category of hygiene rather than cosmetics. Some patients see fat and loose skin as abject material, both self and not-self, and implicitly dirty. After having a face lift a patient could say, "I felt cleaner, as if I had shaved." Or others compare a plástica procedure with a session at a beauty parlor, implying both activities are a species of personal grooming.<sup>6</sup> Such a view minimizes health risks, but also suggests a routine aspect to medical intervention. It assimilates cosmetic work to practices of self-care necessary for normal social functioning. Hygienic self-care and grooming only rarely invite disapproval. In fact, practices that remove unsightly hair, cysts, warts or other growths are perceived as a basic social duty, oriented towards normal self-presentation. Such practices often fall within a broad category of health, and in fact neglect of them can signal a state of physical or mental *ill* health. As aesthetic medicine becomes a part of such 'normal' hygiene or self-care, it also becomes more compatible with health.

Such a cultural elaboration of femininity, together with Brazil's health care institutions, is helping to make elective surgery a normal part of reproductive and sexual health. Former experience with surgery can make it seem easier to undergo more. As Cecilia said, "I liked it. The hospital was good, hygienic, it was simple, superficial, only seven days." There is thus a kind of self-perpetuating logic of surgery whereby an initial intervention sets in motion a chain of operations. Cecilia said that her abdominal surgery was not "*really* plastic surgery, it was a repair of the three cesareans, mainly the first two, which were on top of each other – this isn't good." In other words, her first two births were too closely spaced (doctors recommend three years between cesarean deliveries to allow the body to fully recover) causing damage to her body, and requiring plastic surgery as a 'repair.' On the other hand, she could also not have a natural birth after having had a cesarean only a year earlier because it would "risk tearing things inside." The first cesarean birth was thus linked in varying degrees of necessity to *six* subsequent operations: two more cesarean births, the last one combined with tubal ligation; abdominal surgery to correct flaccidity resulting from the cesareans; and two liposuction operations.

### **Beauty vs health**

I have so far analyzed how cosmetic surgery is being normalized as part of a larger management regime of female reproduction and sexuality. But here one might point out that aesthetic medicine is hardly unique in claiming a fundamental link between health and beauty. Beauty may be (even for biological reasons) an index of health in many societies. Sociobiologists argue that sexually attractive traits in females are signs of fertility (such as low waist to hip ratios, or the young, 'nulliparous' body – one that has not yet given birth). For males, attractive features such as a large jaw are biologically expensive adornments that signal an underlying state of health. And for both sexes, traits such as symmetry, smooth skin, and lustrous hair signal to potential mates a healthy, parasite-free, reproductively fit organism (Etcoff 2000). Anthropologists and others have critiqued this account for ignoring the ideological and histori-



cal dimension of beauty (Lancaster 2003). Humans are also biocultural beings, and whatever evolutionary mechanisms of sexual selection that work in us are shaped by symbolic processes. And certainly, sometimes cultural elaborations of beauty seem to go 'against nature.' In China, the erotically fetishized, crushed foot was not a *signal* of health, but rather a complex, multivalent *symbol* in linked cosmologies of power, sex, and nature (Ping 2000). And the European consumptive, cheeks burning with fever, had a beauty that emanated from her proximity to the netherworld of death, rather than her reproductive potential. But even those taking a constructionist approach have also noted that a fundamental relationship between health and beauty can be part of cultural common sense. The beautiful body in Fiji, for example, symbolizes not a disciplined individual capable of exercising self-control, but rather social relationships necessary for it to be healthy – both physically fit, and socially nurtured (Becker 1995).

Health thus is perhaps always a labile notion, shifting in relation to larger social organization and conflict. Medical anthropologists have long argued that many societies define health in ways that concern not just the individual organism but also larger social and cosmological patterns (Van der Geest 1985). The notion of 'social death' – where isolation from the group leads to the death of the individual – is the most dramatic illustration of how health is measured by the strength of social connections. To cite a less exotic example, researchers argue that 'social capital' – the ability of individuals to draw on social networks – helps maintain health (Edmonson 2003). Seen from a cross-cultural and historical perspective, plastic surgery is perhaps not such a unique practice of body modification. Like many others it brings notions of health and beauty into a particular relationship in accordance with the structures and symbols of a local reality.

But this relativist perspective leaves me unsettled. Plastic surgery cannot simply be viewed as a local practice, but is rather part of a global system of medical technology, capital, and media. As such, its spread must be related to the historical conditions that shape judgments of beauty as societies undergo the wrenching transformations of capitalist development (Edmonds 2008). Female youth may be universally seen as sexually attractive, but the psychosocial significance of beauty for women is also informed by changes in patriarchy. For much of its history, Brazil had a system of formal 'patriarchalism' where fathers and husbands, and later a paternalistic state, had extraordinary control over family life (Besse 1996). The beauty industry's rapid expansion has been accompanied by the decline of many formal and legal aspects of this system as women are interpellated as autonomous beings by global markets, medical technologies, and liberal laws. But yet older forms of inequality also resurface in beauty culture. A traditional form of patriarchal morality with roots in the slave plantation symbolically divided sexuality and reproduction between women in different social and racial categories, a tradition that is reflected perhaps in views of a 'split' between the maternal and erotic body (Young 1990, Goldstein 2003). Patients' forceful rejection of the marks of motherhood, which in some cases seemed to even border on disgust, suggest the persistence of such traditions. But demand for cosmetic practices is perhaps also linked to new sexual subjectivities that emphasize the possibility and necessity of regulating the aesthetic body, as well as rights to sexual autonomy for longer periods of the life cycle (Castells 1997). Plastic surgery can in

these conditions be perceived as a powerful, modern technology that helps manage contradictions between the aesthetic-sexual and mothering requirements of normative femininity. It reflects both a definition of sexuality as a domain of the modern self, as well as the dangers of self-commodification as attractiveness become a form of capital within diverse 'markets' of the service economy, sexual relationships, and marriage (Edmonds 2007a).

Beauty practices reflect not just tensions in gender ideologies in a modernizing nation, but also an historical tradition of viewing beauty in relation to a national body politic. The female body was a key symbol in the ongoing elaboration of racial and culture mixture (*mestiçagem*) as crucial to modern Brazilian identity (Freyre 1986, Edmonds 2007b). Under the sway of European 'scientific racism', elites in the late nineteenth and early twentieth centuries worried that 'miscegenation' resulted in moral degeneration and ill health for the national population. As nationalist scholars, artists, and politicians challenged this form of racial thought, racial mixture became a positive emblem of a popular culture infused with traits such as sensuality, 'tropicality', and interracial sociality. It also was seen as producing a physically attractive population with a distinct sexual culture. Female beauty became a kind of national patrimony, a view that partly reflects a tradition of eroticizing racial domination, though it also embraced by men and women in contemporary popular culture (Goldstein 2003).

Plastic surgery specifically references this tradition. Surgeons praise the beautiful effects of racial mixture on the female body, echoing older nationalist celebrations of 'miscegenation'. And ads promote techniques to achieve a 'Brazilian *bunda*' ('bottom'), or use samba song lyrics to advertise the slender, 'pestle waist' as a national ideal. Earlier I suggested that health is in part a measure of the strength of an individual's connection to the collectivity. If this is true, then perhaps it makes sense that Brazil – a nation that sometimes represents itself as 'a country of pretty people' – should view beauty practices as health practices. Some plastic surgery patients simply want to belong, and belonging to some kind of group may be important for health, broadly conceived at least. But the 'aesthetic nationalism' underlying some visions of Brazilian modernity also has implications for the perception of health risks associated with beauty practices.

In Brazil's popular culture, ample female hips, buttocks, and thighs have been the aesthetic ideal, while relatively smaller breasts were admired (Kulick 1998). A resident of a shantytown built on a steep hill could joke that she didn't need to take out an expensive gym membership, because simply ascending the long road home was enough to *engrosar as pernas*, 'thicken the legs.' (This ideal though also co-exists with a dislike of fat 'in the wrong places', as well as desires for overall slenderness among many women.) Such a traditional ideal, which some view as a valued contribution of Afro-Brazilian culture to national identity, is partly reflected in medical procedures (Hanchard 1999). For example, among the most popular operations are breast procedures that reduce the breast and have a purely cosmetic logic (in North America breast reductions more often have at least a partly 'functional' rationale of reducing back pain or discomfort.) The nationalist dimension of this aesthetic ideal was illustrated by the challenges posed to it by a more recent '*moda*' or fashion for silicone breast enlargement, ostensibly provoked by a number of Brazilian celebrities

who displayed their surgically altered bodies during the 1999 Carnival parades. In the United States, implants provoked an ongoing debate about their safety and led to the largest class action lawsuit in US history against the silicone manufacturer Dow Corning. In Brazil, the silicone implants raised different issues as the national media debated whether they threatened 'national identity' and represented 'cultural imperialism.' An historical tradition of viewing female beauty as national patrimony diverted discussion of health issues involved in cosmetic procedures in another direction.

Brazil's particular vision of the body politic is – like many group symbols – also *mythic*: not false, but a story that is collectively told, a pattern of forgetting and remembering, which affirms some aspects of social reality, and neglects others (Edmonds 2007b). National identity is, of course, only one kind of belonging that vies with many others. Mixture may be a key symbol in national identity, but color hierarchies are also part of everyday life. Among the procedures classified as cosmetic that are available in private clinics and public hospitals is one termed 'correction of the Negroid nose.' Also marketed in plastic surgery publications directly to consumers, its aesthetic aim is to *afinar*, refine or thin, the nose. This form of rhinoplasty can be chosen precisely because it is *not* seen to correct racial features, but simply 'beautify.' But once more, we are led to the uneasy relationship between health and beauty. This 'diagnosis' makes a racial trait into a pathology (it also, of course, makes the racial trait, as there is no biological meaning to this notion). Brazil's particular folk taxonomies of color perhaps enables such an operation to be chosen as aesthetic improvement (Edmonds 2007b). But once this cultural common sense passes into the clinic, it takes on a new medical reality as it is clinically diagnosed and visualized.

I began this essay asking whether cosmetic surgery is a health practice. As it becomes integrated with management regimes of female reproduction and sexuality, patients often tend to see it as an important or sometimes 'necessary' technique for maintaining health. But one consequence of this process is that tensions between health and beauty are obscured, and the risks of surgery minimized or masked. The level of acceptable risk in an 'elective' surgery such as a cosmetic procedure is much lower than in other surgeries that may be life saving. In fact, as mentioned earlier, from one perspective cosmetic procedures can never be justified as health practices since all surgery carries risks to the physical organism as well as mental happiness (e.g. crises of identity can occur after a facelift). It's possible this point of view judges too quickly what 'health' is. Both kinds of surgery can reduce stigma suffered by the ugly, which itself can affect health – if we accept a broader view of health as depending on links between physical, social and mental well-being. But however difficult it may be to evaluate 'true health', plastic surgery has a special kind of cost-benefit ratio that can be difficult to calculate. How much aesthetic 'improvement' will offset the scars left by a procedure – generally viewed as an unaesthetic, albeit unavoidable, result of surgery? How much of a boost to *auto-estima*, self-esteem, and hence to health, is necessary to make the risk of surgery acceptable? Cosmetic surgery also requires an investment of time and resources that itself can disrupt the social relationships of the patient. Often kin are supportive of the patient, but some oppose the decision. Husbands can become jealous, assuming the patient is trying to attract attention,

or see it as a waste of resources. Other kin oppose surgery because they are afraid of risks. Thus if health also depends on the relationship between the patient and a larger social world, plastic surgery can also threaten health in this sense as well.

Perceptions of the health risks of cosmetic surgery are shaped by several aspects of clinical interactions and the larger social meanings of beauty and medicine. In public hospitals, consultations can be very short, and some patients – grateful for the ‘opportunity’ for surgery, humbled by the charity of the doctor, or ashamed of their ignorance of medical procedure – refrain from asking questions about complications or recuperation. A few patients were not aware that a facelift would leave a scar. As we saw, some patients assimilate cosmetic procedures to the category of routine grooming, not surgery. “Plástica is only skin,” one patient said, i.e. a superficial intervention. Others see surgeries as more or less ‘necessary’ interventions on the reproductive body, and thus implicitly raise the level of acceptable risk to that associated with other procedures, such as a cesarean delivery, hysterectomy, or mastectomy.

News media and private sector marketing also shape perceptions of risks, and hence of plastic surgery as a health practice. Especially younger or less successful surgeons compete for patients in a crowded market. They thus have an incentive to minimize risk (especially given the fact that patients are less willing and able to successfully pursue malpractice suits in Brazil, relative to the US, surgeons say).<sup>7</sup> Medical publications – glossily monthlies sold in newsstands – are filled with stories on technological ‘progress’ and profiles of celebrity patients. I asked the editor of one such publication, titled *Plástica & Beleza* (Plástica & Beauty), whether it communicated information about medical risks. I was surprised at his concise response. “No. But there was a doctor in Mato Grosso who wasn’t a plastic surgeon and did various surgeries. But it was the only proven case of medical error that really caused a controversy.” He then added, “There really isn’t much risk because Brazilian plastic surgery if it’s not the best is the second best in the world ... we lose only to the Americans, né?” A central feature of such publications is the ‘before and after’ image which portrays the miraculous transformations of patients. Given the ubiquity of this medical photography, I was surprised to learn that officially the specialty views its use as unethical because it conveys false expectations to the patient. Such forms of marketing though subtly alter the way patients view the cost-benefit ratio of surgery: the greater the benefit they perceive, the more risk they may be willing to undergo.

Surgeons acknowledge there are always risks in surgical procedures but tended to emphasize the safety of cosmetic operations – provided they are performed by a doctor with adequate training. A Chief Plastic Surgeon at one public hospital said that despite often aging equipment and crumbling infrastructure the rate of serious complications was “low”: “Over the past three years, doing about 1,200 plastic surgery operations per year, there has been only one complication. Five percent of patients complain. Of these half choose to re-operate. Look there are risks, but at least in hospitals there is a life support system – most private clinics don’t have these.” He is right at least that public hospitals have life support systems, while many private clinics do not, and so risks in the private sector may indeed be greater. In part this is due to the fact that competition among surgeons has led to aggressive cost cutting. A São Paulo clinic

advertised a liposuction operation for only 600 reais, but with only local anesthesia, performed in the doctor's office. For 2,500 reais, the patient would receive general anesthesia and be interned in a hospital ("Beleza à Prestação," 1998). In August 2001, the death of a patient from a liposuction operation prompted an investigation into the availability of life support systems in plastic surgery clinics ("Clínicas de Cirurgia Plástica Não Tem UTI," 2001). The study found that many clinics are not properly equipped in the event of a medical emergency, such as a severe allergic reaction. In fact, most of the deaths due to cosmetic surgery result from liposuction performed outside a hospital, leading one magazine to warn its readers against playing "Russian Roulette" with plástica ("Beleza à Prestação," 1998). Cost cutting to attract patients is a problem that public hospitals to some extent avoid since they can count on steady demand for their free services.

Whatever the risks of surgery, the growth of plástica has also been accompanied by a rise in malpractice cases, even if they remain difficult to win. The Association for the Victims of Medical Error reported that 30 percent of medical complaints in 1996 were against plastic surgeons ("O Preço da Vaidade," 1996). And according to the Federal Council of Medicine in 2001 plastic surgery became the medical specialty with the most malpractice suits ("Os Exageros da Plástica," 2002). Cases of horrific complications or deaths are occasionally reported in the national media. For example, two patients – one described as a "maid" and the other the wife of a well-known soccer player – died undergoing liposuction in a clinic in a small town in the interior of São Paulo ("O Preço da Vaidade," 1996). The rise in cases of medical error stems in part from the large number of doctors performing plástica who have not completed residencies in the specialty, estimated at 1,500. In order to join the Brazilian Society of Plastic Surgery, doctors must complete three years residency in general surgery, an additional two years in plastic surgery, and then pass an exam administered by the society. But of the 130 doctors who took the exam in 2000, only one half passed. There is no legal mechanism to prevent doctors who are not certified as plastic surgeons from performing procedures ("Os Exageros da plástica," 2002). (I was told by a surgeon that in Brazil's vast, under-populated interior, specialization is a luxury and doctors must be allowed to perform any medical procedure.)<sup>8</sup> One consequence of this minimization of risk is that when complications do occur, patients often blame themselves – an attitude encouraged or produced by surgeons.<sup>9</sup> After suffering several complications after having breast enhancement, one patient said, "Plástica is a lottery ... Because of the first operation I had to do others, and others and others. They cut the nerves. It was an elaborate and sad road. It started 30 years ago. I was one of the rare ones who failed with plástica."

## Conclusion

Plastic surgery is an anomalous practice within modern medicine, a highly invasive procedure that provides no (physical) health benefits. Yet, clearly there is no shortage of examples of 'tribal' body modification that pose serious health risks. It is perhaps a

basic human impulse to modify – or improve – the human form, and the natural body that is the elusive target of some western countercultural movements is itself a social construction. If the healthy body is the body that is free from gender and national ideologies then it may be a frustratingly elusive one to cultivate.

But I have argued that plastic surgery also creates a new relationship between beauty and health. As the very phrase ‘aesthetic medicine’ suggests, cosmetic aims are integrated within medical practices, in the process redefining notions of health. Institutional links with other medical specialties help make a visit to a plastic surgeon seem a necessary part of the female passage through the lifecycle. The political economy of reproduction can make high tech medical interventions appear as prestige goods that signify the normality of middle class. Cultural notions of vanity and femininity contribute to a view of cosmetic surgery as a hygienic or self-care practice. Cosmetic and healing rationales have become subtly blurred making beauty appear as an integral dimension of health.

Despite this apparently peaceful co-existence between the goals of healing and cosmetics, conflicts between them persist. As the complex processes that shape beauty and medical culture enter into clinical practice, the therapeutic rationale for cosmetic surgery runs into difficulties. Class aspirations shape demand for medical procedures. Plastic surgery is often seen as a treatment for ‘female health,’ raising questions about how gender ideologies are reproduced in the medico-cosmetic culture of a modernizing nation. And while surgeons bracket the question of beauty to focus on mental suffering, the larger processes that define aesthetic ideals – from nationalist discourses on mixture to global media – also shape clinical practice.

The ugly, the deformed, and those with an appearance viewed as anomalous have in diverse societies been subject to myriad forms of stigma and, undoubtedly, mental suffering. Conversely, the healthy body – whether as a symbol of biological or social thriving – has often been viewed as beautiful. But the medical and psychotherapeutic culture developing around fields such as aesthetic medicine subtly reverses this equation, making beauty itself a form of health. In doing so, the health risks of ‘elective’ cesareans, post-partum body contouring, and other practices are minimized as these procedures become absorbed into the medical management of female health.

## Notes

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## Notes

- 1 I invoke such symbols to characterize dominant images of Brazil. Its historical trajectory towards modernity is more complex, and beyond my scope here.
- 2 A survey of 3,200 women in ten countries found that 54 percent of Brazilians (compared to 30 percent of Americans) had “considered having cosmetic surgery,” the highest of the countries surveyed and more than double the average (Etcoff et al. 2004).
- 3 While senior surgeons are typically male, the residents in plastic surgery residency programs had a more balanced gender ratio, reflecting the fact that students in Brazilian medical schools are now about half female.
- 4 Patients often see breast feeding as the cause of a “fallen” breast. But curiously some patients also blame a breast defect on the decision *not* to breast feed. Flávia, who didn’t breast feed her only child out of fear of her breasts “falling” said she needed a lift because her breasts didn’t return to their original shape after pregnancy.
- 5 Though *medicina estética* does not refer exclusively to medical practices related to *female* health, I use it to indicate *plástica*’s links to other medical specialties with a concern with aesthetics.
- 6 It is perhaps not coincidental that not only medical interventions in female health, but also more intensive kinds of cosmetic or grooming work have become normalized for women, such as the so-called ‘Brazilian’ full body wax.
- 7 This is one factor creating a ‘favorable environment’ for the plastic surgeons in Brazil, a resident told me. Patients who *do* attempt to file malpractice suits, however, face many obstacles. In one case, the doctor simply left Brazil and began practicing in another clinic in Italy.
- 8 Another factor contributing to a rise in medical error is the growing popularity of liposuction. In 1999, more than half of all *plásticas* were accompanied by liposuction (“Brasileiras Queriam Esculpir Bumbum,” 1999). Unlike a facelift or nose job, it is an operation that is “apparently easy,” Dr. Pitanguy argued, and thus more likely to “fall into the hands of those without training” (“Entrevista: Ivo Pitanguy, 2001). Gynecologists or general practitioners may thus be tempted by the apparent ease of the procedure – and the lucrative market for it – despite not having proper training to perform the operation.
- 9 A newspaper reported on the case of a woman who suffered complications arising from an operation to correct “flaccid breasts”: “nipples pointing in opposite directions, fleshy protuberances in the sides of her ribs, and deep scars on the bust and stomach.” After she complained, the director of the clinic commented, “I greatly doubt [there was an error], because this is a clinic of Zona Sul quality.” The anesthesiologist added, “As to the scars, they are inherent to the patient” (“Cirurgia Entorta Busto e Separa Casal,” 1986).

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