Title: Can Medicine Be Aesthetic? : Disentangling Beauty and Health in Elective Surgeries
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This is the author’s post-print. Please cite the final version of the article, available at http://dx.doi.org/10.1111/maq.12025.
This article analyzes tensions between aesthetics and health in medicine. The blurring of distinctions between reconstructive and cosmetic procedures, and the linking of plastic surgery with other medical treatments, have added to the legitimacy of an emerging “aesthetic medicine.” As cosmetic surgeries become linked to other medical procedures with perceived greater medical necessity, health and aesthetics become entangled. One consequence is that medical needs are magnified while perceptions of the risks of surgery are minimized. Drawing on ethnographic work on plastic surgery, as well as other studies of obstetrics and cosmetic surgery, I illustrate this entanglement of health and aesthetics within the field of women’s reproductive health care in Brazil. I argue that while it would be difficult to wholly disentangle aesthetics and health, analysis of how risk–benefit calculations are made in clinical practice offers a useful critical strategy for illuminating ethical problems posed by aesthetic medicine.

In 1973, a French, Belgian, and Italian dermatologist met on a Mediterranean cruise ship while traveling on holiday. The three friends little suspected that a few days of chatting would give birth to what they termed a “restless and revolutionary Aesthetic Medicine.” This little history is recounted by the Brazilian Society for Aesthetic Medicine, one of several such organizations that are staking out a new field of medicine with ambitious aims, from “chemically remodeling the body’s silhouette” (SBME 2011) to “prevention and treatment of all types of aesthetic pathology” (SEME 2011). This field incorporates diverse specialties and has already spawned new hybrids such as “aesthetic gynecology” and “aesthetic endocrinology” (Gruber et al. 2002).

As its name implies, aesthetic medicine aims at nothing less than fusing health and beauty. Taking this logic to its extreme, beautification becomes a means of healing, and conversely, ugliness a form of disease. The eerily utopian or dystopian language aside, the very notion of an “aesthetic medicine” raises basic questions about the legitimate uses of medical technology. Do treatments with an “aesthetic indication” conflict with the Hippocratic imperative to do no harm? Or do they instead simply recognize the importance of appearance for health?

In this article, I examine medical border zones where aesthetics and health become entangled. Initially derided by plastic surgeons seeking legitimacy in the early 20th century, cosmetic procedures gained new acceptance in the post–World War II period (Haiken 1997). Cosmetic surgery seems to be an anomalous medical practice in that it makes aesthetic improvement the exclusive aim of surgery, even to the point of justifying health risks in an otherwise healthy patient. Yet aesthetic aims are becoming salient in a wider range of clinical contexts. Cosmetic surgery is often combined with a growing number of medical procedures that harm beauty and sexuality. Plastic surgery can “correct” flaccidity or scars resulting from a
Cesarean (C-)section, or remove flaccid skin and improve appearance after bariatric (weight loss) surgery. Bariatric surgery and C-section are very different procedures, but they both have medical indications—albeit sometimes controversial ones—of promoting physical health. These procedures can thus lend greater legitimacy to cosmetic procedures as they become linked in management regimes with blurred health and enhancement rationales. This entanglement of health and beauty, I argue, has major health implications because it makes the risks of elective procedures more medically acceptable.

The field that calls itself “aesthetic medicine” is for now mostly marketing hype and perhaps a dream, a medical vision of the future. But although it remains a fringe area of consumer medicine, aesthetics is making inroads into more established domains of medical practice. I focus in particular on women’s reproductive health care in Brazil. Drawing on my own ethnographic fieldwork on plastic surgery in Brazil, as well as other studies of obstetrics-gynecology (OB-GYN) and plastic surgery, I believe that there is an emerging sexual aesthetics of women’s reproductive health. In Brazil, cosmetic surgeries are positioned as a kind of postpartum correction and clinically linked to other surgeries, such as C-sections. Sexual and aesthetic concerns become blurred with health concerns within OB-GYN and a wider popular culture that views reproduction as a threat to women’s aesthetic integrity and psychological well-being.

I also examine ethical and health implications of aesthetic medicine. The notion of an aesthetic medicine presents a conundrum for critical studies of medicalization. On one hand, it is potentially dangerous because it can amplify medical need and justify risky procedures. On the other hand, the rising acceptance of aesthetics in medicine simply reflects social recognition of the importance of appearance for well-being. Plastic surgeons might reasonably claim that “history is on their side” in that society increasingly accepts the use of medical technology to achieve aesthetic aims. Moreover, a growing number of surgeries and pharmaceuticals (such as antiretrovirals and antidepressants) result in damage to sexuality and appearance. Such sexual and aesthetic iatrogenic damage can be corrected with additional medical treatments, such as liposuction, which themselves have health risks. It is thus difficult to fully disentangle health and aesthetics in medicine.

One response to this conundrum, I argue, is a critical focus on problems in calculating risk–benefit ratios. Aesthetic treatments present a special difficulty for weighing benefits against the health risks posed by any surgery. Can aesthetic or psychological gains be balanced against the potential harm to physical health? Any difficulties in measuring risks and benefits cast doubt on the ethics of performing a particular procedure. There are indeed problems in how physicians evaluate aesthetic need, risk, and benefit. Aggregate risks are often minimized within clusters of operations that have both medical and aesthetic indications.

One advantage of a critical focus on risk–benefit calculations is that it frames discussion in ethical language that is familiar to physicians, health authorities, and the wider public. It also acknowledges that aesthetic aims have already become a legitimate part of clinical practice. Critics of medicalization have exposed the marketing strategies and wider social processes that extend medical institutions into the domain of beauty, yet cosmetic treatments may nonetheless have therapeutic efficacy for some patients. Analysis of the risks posed by clusters of surgeries allows for a more fine-tuned critical approach that can be applied to particular clinical settings, while avoiding the problem of attempting to normatively define “health” or a legitimate medical intervention. My aim is to develop a critical strategy for analyzing how aesthetic medicine is becoming legitimated in the growing number of contexts where beauty and health are entangled.
Research Methods and Design

I conducted fieldwork in Brazil for approximately two years intermittently between 1999 and 2007, primarily in Rio de Janeiro. Research consisted of participant-observation fieldwork and semi-structured interviews with plastic surgeons and patients, hospital ethnography, and fieldwork at media production facilities. Important research sites were public hospitals with plastic surgery residency programs that offer both cosmetic and reconstructive operations for free to poorer patients. I was thus able to include in this study patients from a wide range of class and racial backgrounds. I also interviewed a diverse group of surgeons, including chief plastic surgeons in public hospitals, senior surgeons with flourishing private practices, and younger residents-in-surgery. I have given a fuller ethnographic account of this research elsewhere (Edmonds 2007, 2009, 2010), including analysis of the social aspirations of working-class patients, the racial logics employed in clinical practice, and the construction of female beauty as a major trope in Brazilian national identity. In this article, I put this fieldwork in comparative perspective, drawing on ethnographic studies of OB-GYN, other scholarship on cosmetic surgery, bariatric surgery, and hormonal therapy, and analysis of medical discourse and marketing.

Making Beauty Healthy: Legitimation Work in Plastic Surgery

Diane Naugler (2009) points out that feminist critiques of plastic surgery have ignored operations that inhabit a gray zone between reconstructive and cosmetic surgery. She says that the “overwhelming focus of feminist criticism on cosmetic procedures such as breast augmentation has left the cultural understanding of the cosmetic/reconstructive divide unchallenged” (2009:227). Breast reduction, she points out, is an example of a procedure that straddles this divide. While it has functional rationales like alleviating a patient’s back pain, it also “potentially ‘improves’ her approximation of the narrow norms of aesthetic femininity” (228). Rather than draw a line between reconstructive and aesthetic surgeries, it is important to look at the medical and social forces that create—and often blur—this distinction.

Historically, the boundaries between reconstructive and cosmetic rationales in plastic surgery have shifted. In the late 19th century, even procedures such as correction of a cleft palate, now widely perceived as reconstructive, were considered cosmetic (Gilman 1998). Much has changed since then. While controversies still surround cosmetic surgery, it is approved by government health agencies in many nations. Some countries have even offered a limited number of free cosmetic procedures in public health systems, including the Netherlands (Davis 1995), the United Kingdom (Gimlin 2007), and Brazil (Edmonds 2010). The change in the medical legitimacy of cosmetic surgery is not limited to the West. In China, plastic surgery came under ideological attack for a “bourgeois” concern with form during the cultural revolution, but since the 1980s cosmetic operations have gained rapid acceptance (Brownell 2005).

Doubts about the legitimacy of cosmetic surgery were resolved partly by the discovery that it could perform psychological healing. The “inferiority complex” —a psychoanalytic concept popularized in the United States in the 1920s—lent credibility to the idea that appearance has profound effects on mental health (Haiken 1997). Significantly, some of the boldest arguments for the psychological benefits of cosmetic surgery have been made in Brazil, a country where demand has been particularly robust over the past two decades. Brazilian plastic surgeons have forcefully argued that both cosmetic and reconstructive procedures heal a
suffering psyche (Edmonds 2010). Such reasoning, though not entirely new, has accompanied a more radical development of offering free cosmetic surgery in Brazilian public hospitals. Though the public health system did not officially authorize cosmetic surgeries, surgeons have been able to offer them in public hospitals, partly as a means to provide “scientific training” to residents. Some surgeons working in public hospitals have also provided justifications of cosmetic surgery that emphasize its psychological health benefits. For example, Dr. Claudio, chief plastic surgeon in a public hospital, told me: “We were able to show that plástica has psychological effects for the poor as well as the rich of course” (Edmonds 2010).

Dr. Claudio’s reasoning can be seen as a kind of legitimation work in that it provides a health rationale for cosmetic surgery. The notion that cosmetic surgery patients have a medical need for their operations may have more traction in countries where some form of cosmetic surgery is available in a public health system. In a comparative study of the United Kingdom and the United States, Debra Gimlin (2007) analyzed legitimation work in the accounts patients give of their cosmetic operations. She found that in the United Kingdom women tended to justify surgery by invoking notions of “need” based on physical or psychological suffering. In contrast, American patients spoke more of their own efforts and financial sacrifices, a form of justification that has more legitimacy, she argues, in a market-based health care system. Gimlin concludes that accounts of cosmetic surgery that emphasize the patient’s need are more “readily available in countries where healthcare is publicly funded” (2007:45).

In Brazil, as in the United Kingdom, some patients also spoke of their need for cosmetic surgery. During the many hours spent in waiting rooms of public hospitals with reconstructive surgery patients, some of whom have congenital deformities or rare diseases, a few candidates for cosmetic procedures began to question their decision to undergo surgery. However, few ultimately desisted from pursuing the operation, claiming that defects caused psychological suffering, or simply affirming—echoing the words of surgeons—that they had a “right” to surgery. Such justifications for cosmetic surgery testify to a lingering pressure to justify, that is, an uncertainty about the nature of medical need. But while the presence of cosmetic surgery in public hospitals may create a need to justify the use of scarce resources for aesthetic aims, it can itself also become de facto a form of justification. Why else would public money be used for cosmetic surgery if it were not a legitimate form of medical healing?

Even in the private sector, where cosmetic surgery has become more widely available due to greater access to consumer credit, both surgeons and patients often position cosmetic surgery in ways that reinforce its legitimacy by blurring distinctions between reparadora (reconstructive) and estética (aesthetic) operations. Plastic surgeons still use the distinction to classify degrees of medical need, but they also question or collapse it in different ways. For example, some surgeons classify operations as reparadora on an insurance form so that a patient can be reimbursed by health insurance (Gonçalves 2001). While this is considered fraud, I found that surgeons also use more subtle tactics. In his private clinic one surgeon spoke of “repairing” and “reconstructing” a patient’s self-esteem, implying an affinity between reparadora and estética. Moreover, surgeons argued for the “union” of reconstructive and aesthetic procedures on the grounds that both are guided by aesthetics and a concern for psychological suffering. As Dr. Claudio put it: “There is great difficulty in knowing what is reparadora and what is estética” (Edmonds 2010:Part 1).

The boundary between reconstructive and cosmetic rationales is more blurred with particular operations, such as breast reduction. Naugler (2009) argues that although the operation produces “normative aesthetic results” (230), it is usually seen to have primarily a functional, not cosmetic, rationale. The substantial scars it leaves are seen as “proof” of need. In Brazil,
however, the same procedure can have primarily an aesthetic rationale in a popular culture that fetishizes smaller breasts. Rosa, a working-class patient, said that at 36, she was “of a certain age,” and thought it was a good time to correct problems she attributed to motherhood:

I detest large breasts; I think they’re horrible. I was talking about this the other day in a bar, and even men don’t like big breasts; they are something more to do with a celebrity. Deus me livre [God help me], to walk around with a thing of that size! I like a small breast, it’s bonitinha [cute], inside a bikini, inside anything.

Other patients mentioned multiple reasons for having breast reduction, such as alleviating back pain, improving body shape, or expanding clothing options. It is thus often unclear where a functional rationale leaves off and an aesthetic one begins.

Some indeterminacy between aesthetic and functional rationales for surgery is perhaps inevitable. Critics of biological reductionism have argued that organic causes of pain subtly interact with mental and social processes (Kleinman and Becker 1998). The psychological suffering caused by a perceived defect may not be entirely distinct to the patient from physical pain and discomfort. Yet, the blurring of health and aesthetic rationales for medical interventions also has troubling implications. Treatments that have a physical health rationale are generally considered to have greater medical necessity, and hence justify greater risk, than do treatments with an aesthetic rationale. For instance, brain surgery with a 30% mortality rate could be perfectly legitimate as a cure for a life-threatening disease but would be clearly unethical in cosmetic liposuction. A physical health rationale thus has the potential to add medical necessity to an aesthetic rationale, thereby complicating the difficult balancing of risks and benefits necessary for ethical clinical practice.

The Entanglement of Health and Aesthetics in Weight Loss Management

The blurring of boundaries between aesthetic and health rationales occurs not just within the specialty of plastic surgery, but also within management regimes in which plastic surgery is combined with other treatments that have more established medical indications. I discuss two examples of such a management regime: (1) weight loss management through combined bariatric surgery and cosmetic surgery; and (2) women’s reproductive health care. Before taking up the more complicated case of reproductive health care, I begin with a brief discussion of bariatric surgery (weight loss surgery) because it clearly illustrates how aesthetics and health become entangled in clusters of procedures. I briefly move from Brazil to North America, where bariatric surgery is more prevalent and has been more studied.

Bariatric surgery includes a variety of procedures that achieve weight loss by reducing the size of the stomach or resecting the small intestine. Though highly controversial, the surgery is considered to have a medical indication of reducing risks of obesity-related disease. In the United States, the surgery is covered by some insurance plans, but not others, and co-payments are high (Salant and Santry 2006). It also carries a high risk of serious complications.

While the medical indication for bariatric surgery stresses reducing health risks, marketing of the surgery often highlights dramatic improvements to well-being, appearance, and sexuality (Salant and Santry 2006). Rationales for this risky procedure thus reflect both concerns about physical health as well as complex aspirations for “makeover,” which Meredith Jones (2008) claims is an important idiom of self-work in consumer culture. Although bariatric surgery
is not itself considered aesthetic, it is, however, often followed by additional procedures to improve appearance: from arm and thigh lifts to liposuction, buttocks implants, “corset trunkplasty,” and panniculectomy (which removes hanging folds of skin) (CGBS 2011). Cosmetic surgeries can thus acquire more medical legitimacy as they become clinically linked to bariatric surgery, which has a medical indication of promoting physical health.

The blurring of functional, health, and aesthetic concerns in surgical weight loss management raises difficult questions about calculating the risks of combined procedures. Should health risks of liposuction be included in the initial risk–benefit calculation of a bariatric surgery? Does the health rationale for bariatric surgery have the effect of legitimating an aesthetic rationale for a group of surgeries that together have a high compounded risk of complications? These questions are important because they affect the perceived medical legitimacy of bariatric surgery and associated aesthetic surgeries.

Though demand for it is growing, bariatric surgery remains a controversial procedure and is usually classified as consumer medicine. I discuss now, however, how beauty and health are also becoming entangled within a much more established and routine management regime: women’s reproductive health care.

Plástica as Postpartum Correction

Women’s reproductive health care is focused primarily on physical health. Not wanting to “ruin a perfectly good set of genitals” —even though voiced in this way by a medical doctor—is not a “good” or medically accepted reason for a C-section (Braun 2009:135). Whereas plastic surgery is more or less legitimately concerned with aesthetics, this is hardly the case with OB-GYN. Because aesthetic concerns are controversial, they may be difficult to measure in quantitative studies. Some qualitative studies, however—especially those including observation of obstetrical practice—depict the emergence of a sexual aesthetics of women’s reproductive health. I focus on Brazil, where a concern with aesthetics has become particularly explicit in clinical practice.

In Brazil cosmetic surgery is often seen as a tool for the management of female reproduction. While conducting fieldwork, I was struck by how often patients and doctors discussed operations in relation to pregnancy and breast feeding. Patients blamed these events for “localized fat” or breasts that were caído (fallen) or murcha (shriveled). They viewed many cosmetic operations—such as abdominoplasty, breast surgery, and liposuction—as a kind of postpartum correction (Edmonds 2010).² Physicians also promoted the notion that motherhood often causes major aesthetic and psychological harm to women. One senior surgeon, for example, sought to reassure a working-class patient seeking a breast reduction that “it’s a good breast for a woman who’s already given birth.”

Such views are not confined to medical discussion among professionals but are disseminated by Brazilian media. There has been much public fascination with “plástica” —as plastic surgery is often termed—and the country’s rise to international prominence in the field. News media, talk shows, telenovelas, and blogs as well as beauty magazines and books have brought a range of medical information (and misinformation) to consumers, including the notion that plastic surgery is a legitimate means to manage the maternal body.

Institutional ties between OB-GYN and plastic surgery in Brazil also reinforce an aesthetic approach to managing reproduction. Some ob-gyns referred mothers to a plastic surgeon for postpartum corrections. Plastic surgeons not only “correct” perceived defects linked to birth but also scars or abdominal flaccidity resulting from a C-section. Plastic surgery is
perhaps further associated with the medical management of motherhood when it is combined with tubal ligation—a procedure that, like C-section, occurs at high rates in Brazil (Caetano and Potter 2004).

Not all cosmetic surgeries are related to birth or breast feeding. Some operations are indicated to “correct” ethnic traits not associated with the reproductive body. But even women who have not yet had children often planned surgeries in relation to an imagined reproductive future, for example, delaying breast surgery until after breast feeding so as not to “ruin” the operation. Thus, both plastic surgeons and their patients saw a wide range of bodily surgeries as a means of “managing” the reproductive and sexual body over the life course.

A sexual aesthetics of reproductive health is, however, not confined to cosmetic surgery but is sometimes present in two of the most commonly performed surgical procedures in Brazil: C-section and episiotomy. In the following two sections of the article, I draw on studies of obstetrical practice in Brazil to analyze how these routine operations are linked to a larger aesthetic management regime.

Sexual Aesthetics in OB-GYN

Brazil has a notoriously interventionist approach to women’s reproductive health care and high rates of C-section, episiotomy, and sterilization. C-section rates, for example, are among the highest in the world, at nearly 44% nationwide and 77% in private hospitals (Rebelo et al. 2010). Compare this with the World Health Organization recommendation that Cesareans account for around 15% of total births (Carranza 1994:110). There has been heated controversy about the causes of this high rate, including debate about whether so-called elective C-sections really are “elective,” that is, resulting from women’s choice as opposed to factors such as physician convenience. Some Brazilian obstetricians have blamed a “culture of Cesareans” for high rates of the procedure, claiming they are under pressure to perform what parturients view as a more “modern” mode of delivery (McCallum 2005). De Mello e Souza (1994) argues, though, that talk of “culture” in this context shifts responsibility away from physicians and onto women. Kristine Hopkins found that a majority of first-time mothers did not express a preference for C-section (though a higher proportion of second-time mothers did) (2000:739).

Other studies, though, stress that women exercise considerable agency in acquiring C-sections in Brazil. For one, demand for tubal ligation can create demand for C-sections in public hospitals (since the former can be provided free to the patient during the course of a C-section) (Caetano and Potter 2004). Some women view vaginal birth in public hospital as an inferior or even abusive medical treatment, Dominique Béhague (2002) argues. The public health system does not typically provide epidural analgesia for women in labor (Hopkins 2000:727), while oxytocin is frequently administered to induce contractions—a combination that can increase pain (Béhague 2002:485). Cecilia McCallum (2005) also found that some mothers are subjected to paternalistic, rude, and negligent care while giving birth in public hospitals. Some women strive to be classified “at risk” during antenatal care to gain access to a C-section (Sanabria 2011:108), and women attended in public hospitals use tactics like “making a scandal” during labor to force a doctor to perform a C-section (Béhague 2002). Moreover, the high rate of C-sections in the private sector reinforces a perception among poorer women that C-sections are a better standard of care (Béhague et al. 2002).

The reasons for high rates of “elective” C-sections then are complex, including physician and hospital incentives, class dynamics, and women’s agency in negotiating obstacles to good
care. In addition to this complex mix, another factor has been discussed: a sexual and aesthetic rationale of avoiding vaginal and perineal trauma from birth (Barrett et al. 2005:306). This rationale has been promoted (Safarinejad et al. 2009) — and more often disputed — in the international medical literature. Meta-studies have concluded that any sexual benefits only concern dyspareunia in the early postnatal period and that there is no evidence for advocating C-sections to protect women’s sexual function (Barret et al. 2005). Yet perceptions of C-section as a valid means to avoid vaginal trauma persist in medical and popular discourse in some regions, including in Brazil. Maria Carranza (1994:113–114) points to a “popular belief” in Brazil that a Cesarean birth is not only the most secure birth method for the baby but is “also capable of preserving the vaginal and perineal anatomy of the woman, while a vaginal birth would produce distensions making sexual relations more difficult.”

This belief, however, is also held by some physicians. Emilia Sanabria (2011:107) found that Brazilian gynecologists described natural birth as “violent and aggressive” or as a “spectacle of aesthetic misery.” Similarly, McCallum quotes a professor of obstetrics in Bahia who claimed: “More and more, the vulva and the vagina are becoming the organs of sexuality and not of parturition. She [the parturient] doesn’t want to touch them, mess them up” (2005:226). McCallum argues that the “sexually adapted, attractive and active female body—the proper condition of modern Brazilian women—is represented by untouched and aesthetically pleasing genitalia.”

The Genitals as Aesthetic “Object” in the Medical Management of Female Reproductive Health

While the notion of “aesthetically pleasing genitalia” may not have official medical status in routine obstetrical practice, it is more explicit with female genital cosmetic surgeries (FGCS). There has been a rise in demand for this group of surgeries since the late 1990s in different regions, including Brazil (Braun 2005; Sanabria 2011). As with other cosmetic surgery, blurred functional (reducing physical discomfort), psychological (healing low self-esteem), aesthetic (improving genital appearance) and sexual (enhancing pleasure) rationales have been used to justify FGCS as a medical practice (Braun 2009; Tiefer 2008). Vaginoplasty, for example, has been marketed as a means to become “multiply orgasmic” (Braun 2005:413). Medical and marketing discourses have also stressed that sexual functioning is influenced by a new psychological notion of a (good) “genital self-image.”

Beauty, sexuality, and mental health are represented as integral to overall well-being in this cosmetic surgery, as in others. The benefits of FGCS, though, have been sharply disputed by mainstream OB-GYNs.

In Brazil, rationales for FGCS also sometimes refer to childbirth. “Intimate plástica” is advertised as a tool to “correct” “vaginal widening” following normal birth, which “reduces vaginal orgasm” (Cirurgia íntima feminina 2006). This reasoning, in ways similar to discourses surrounding C-sections, promotes a view of childbirth as a process that puts women at sexual and aesthetic risk. In Brazil, FGCS is also institutionally linked to the larger management of reproductive health. Drawing on her ethnographic work on OB-GYN in Bahia, Sanabria (2011:109) shows that corrective plástica vaginal (vaginal plastic surgery) following birth is common in public hospitals among women who, in the words of a gynecologist, “have to give birth vaginally” (emphasis in original). She argues that “plástica vaginal offered to low-income women functions as a kind of proxy for the C-sections that are so common among middle- and upper-class women” (2011:109). Rationales for elective C-sections thus echo a cultural
construction of the vagina as vulnerable to trauma and as potentially “aesthetically pleasing” (McCallum 2005:226).

A view of childbirth as posing aesthetic and sexual risk to women that can be medically managed is also sometimes present in the practice of routine episiotomy. Episiotomy is a surgical incision made in the perineal muscle during delivery. Its primary medical indication is to ease a difficult vaginal birth. In some regions, episiotomy is, however, performed at very high rates, provoking debate about the benefits and harm of the routine use of the procedure. In the 20th century, the rising use of the procedure was part of a larger medicalization of childbirth that included growth in rates of C-sections and forceps delivery (Cleary-Goldman and Robinson 2003). Justifications for routine episiotomy include the claim that it is an improved mode of delivery because it “protects” the parturient from sexual and physical damage. Medical discourse also suggests that routine episiotomy offers an implicit “aesthetic benefit,” for example, in wording that claims that it replaces the “ragged tear” of normal vaginal birth with the “clean cut” of a surgical incision (Cleary-Goldman and Robinson 2003:4).

The ostensible benefits of episiotomy have been disputed by medical studies of routine episiotomy (Hartmann et al. 2005:2147), as well as feminist critiques that argue the procedure is often performed for physician convenience (Wajcman 1991). It has even been described as a “paradigmatic example” of a potentially harmful intervention introduced into clinical practice “without scientific evidence” (Belizán and Carroli 1998:1389). Today routine episiotomy is widespread in many regions, though rates vary widely, from a low of just under 10% in Sweden to over 90% in parts of Latin America (Graham et al. 2005:220).

In Brazil, high rates of episiotomy—as well as routine C-sections—are due, Diniz and Chacham (2004) argue, partly to harmful cultural and medical constructions of female sexuality. Analyzing the links between “the cut above” (C-section) and the “cut below” (episiotomy), they argue that physicians promote a view of the vagina as “passive,” in line with norms for appropriate female sexual behavior, and underestimate its ability to distend and contract after birth. Moreover, some Brazilian physicians believe episiotomy is beneficial because it is often accompanied by the ponto do marido, the extra “husband’s stitch,” intended to make the vagina smaller. Diniz and Chacham argue that the surgical intervention—like C-section—is thus justified by physicians as an improvement over unassisted birth.

Ironically, they claim moreover, the routinization of episiotomy itself contributes to greater demand for C-section—which becomes a means to avoid the damage caused by assisted vaginal delivery. In Brazil, surgeons of any specialty often “do their first stitch” performing an episiotomy, sometimes leading to complications (Diniz and Chacham 2004:104). Faced with routinized instrumental delivery and episiotomy, some women see vaginal birth as a form of “sexual victimisation” and describe it with rape imagery (106). Thus, accurate perceptions of the risks of assisted vaginal delivery may contribute to a perception of C-sections as an enhanced mode of delivery.

C-sections and episiotomy both officially have health rationales, while cosmetic surgery has an aesthetic rationale. However, when these operations are situated within a larger management regime of female reproduction and sexuality, distinctions between health and aesthetics, and between healing and enhancement, become blurred. Medical and cultural constructions of birth as posing sexual and aesthetic harm that should be prevented or corrected underlie these diverse surgeries, in some clinical contexts at least. And while a view of the female genitals as an aesthetic “object” is explicit in cosmetic surgery, it is implicit in some obstetrical practices. Moreover, high rates of surgical intervention reinforce patient perceptions
that cosmetic surgery has a legitimate “reconstructive” aim, because it corrects scars or problems caused by other, medically legitimate surgeries or by motherhood itself.

It is not clear how prevalent such aesthetic and sexual rationales for medical treatments are in the field of reproductive health. Measuring their prevalence, in any event, would be difficult precisely because such rationales are entangled with health ones. Many factors underlie high rates of obstetrical interventions, and uncertainty surrounds the degree of agency the patient has in acquiring or refusing them. Many of the concerns with beauty and sexuality I discuss emerged in the course of ethnographic fieldwork rather than in medical studies (perhaps because survey respondents are likely to give “good” responses, i.e., ones that stress legitimate health concerns). Nor is obstetrics a monolithic field in Brazil. A broad social movement, including many doctors, have critiqued high rates of C-sections and advocated a “rehumanization” of childbirth (McCallum 2005). But even if sexual aesthetics were only a minor factor in high rates of C-sections and episiotomy, it is a major development in health care due to the sheer prevalence of these procedures, which are among the most common women’s surgeries in the world (Graham et al. 2005).

A Critical Conundrum

The institutional embedding of cosmetic surgery within reproductive health has serious health implications. It can reinforce the legitimacy of cosmetic surgery as a necessary health intervention, represent the maternal body as suffering from “aesthetic pathology,” and advance a larger medicalization of female reproduction. Yet, as I noted in the introduction, the shifting boundary between health and aesthetic rationales for medical treatments raises a critical conundrum.

Critical studies of medicalization and “biomedicalization” have identified different processes underlying the growth of elective procedures, such as the profit motive in medicine, the creation of new disorders and nosologies, and the transformation of aging processes into deficiency diseases (Clarke et al. 2010). For example, cosmetic surgery and FGCS pathologize minor deviations from norms (Morgan 1991). Risky bariatric surgeries are justified by a medicalized notion of obesity (Salant and Santry 2005). Hormonal therapies construct menopause (Greer 1991; Klein and Dumble 1994)—or male “andropause” (Marshall 2009)—as a degenerative disease rather than a normal stage of life. Emphasizing the constructed nature of the diagnoses used to justify such elective treatments, these studies have tended to debunk the health claims made in their name.

This approach sheds light on the discursive and institutional forces at play in the expansion of medicine. One risk is that it can imply that new medical needs and benefits are “false” since they depend on invented disorders, dubious healing rationales, and constructed pathologies, et cetera. While there is certainly reason to doubt the benefits claimed for aesthetic medicine, it should not be assumed a priori that it does not or cannot “work” (i.e., have therapeutic effects). To dismiss the possibility that sexual experience is affected by interventions affecting the endocrine system, anatomy, or neurochemistry paradoxically reproduces the mind body dualism that some critics argue underlies the spread of medicalization (Bordo 1993).

Moreover, some elective treatments have gained legitimacy due to greater recognition of unacceptable damage that surgery or pharmaceuticals cause to appearance and sexuality. Psychotropic pharmaceuticals can result in sexual anhedonia or weight gain. Antiretrovirals can cause lipodystrophy—an “unaesthetic” redistribution of body fat. Mastectomy can negatively
affect body image and sexual experience. These unwanted effects of medically legitimate treatments are a kind of sexual and aesthetic iatrogenic damage. There is arguably a growing number of surgeries and drugs (e.g., SSRI antidepressants) that cause such damage. There are also new treatments, or increasing use of older treatments, that aim to correct such damage, such as plastic surgery, hormonal therapy, and erectile dysfunction drugs. When a medical treatment that is perceived as legitimate itself causes sexual or aesthetic damage, it becomes more legitimate to correct such damage. Medical advances as well as expanded aspirations for well-being in a sense bring sexual aesthetics into the domain of legitimate medicine.

There is thus no stable yardstick of health against which health claims of elective procedures can be readily measured. Notions of health are plastic and revised by people’s interactions with medical institutions (Edmonds and van der Geest 2009). Brazilian plastic surgeons seem to echo this point in advocating for the healing powers of their specialty. For example, while explaining to me his decision to authorize cosmetic surgeries in a public hospital, Dr. Claudio cited the WHO’s well-known definition of health as a “state of physical, social, and mental well-being, not simply the absence of illness.” This reasoning essentially positions plastic surgery on the side of a “progressive” recognition of the contributions of social and psychological determinants to health. To critique cosmetic surgery, then, according to Dr. Claudio, one must also critique the WHO and accept a possibly outmoded, certainly narrower, definition of health as “absence of disease.”

Calculating Risks and Benefits within a Field of Surgical Possibilities

One response to this problem that may be useful for critically analyzing the health implications of aesthetic medicine is to focus on the risk–benefit question with which I began this article: What risks are justified with cosmetic surgeries? Risk–benefit calculations lie at the “heart of all medical practice” (Pochin 1982:183) and are an essential part of evidence-based medicine (Fitzgerald 2007). To do no harm in giving any medical treatment, physicians must balance risks against potential gains to health. If benefits are unknown, risks cannot be justified. If risks are unknown, benefits—no matter how important—are generally not ethically justifiable.

But there are special difficulties in calculating both the risks and benefits of aesthetic surgeries. For one, such surgeries have not only a potential aesthetic benefit, but also an aesthetic risk. A question I heard often from plastic surgeons in Brazil’s busy residency programs is: “Does the surgery compensate the scar?” In other words, do the aesthetic benefits of surgery outweigh the unaesthetic effect of scarring? Making this call requires clinical judgment. A senior surgeon, Dr. Martins, who was critical of the provision of cosmetic procedures in public hospitals, told me,

A scar, no matter how small, you’re going to have the rest of your life. . . . You have to trade costs and benefits (troca custa benefícios). You have a 20 year old who wants to raise her breasts. This doesn’t compensate the scar. Or you have a really flat-chested youth with sexual and emotional problems—in this case implants justify the scar. . . . Surgeons who don’t pay careful attention to this are going to cut anywhere.

Dr. Martins told me another story of a patient who came to him for a breast-lift and face-lift. He did the face-lift but refused to do the breast-lift because the scar wouldn’t be sufficiently “compensated” by an aesthetic improvement. Surgeons who are unwilling to do such a risk—
benefit calculation are going to “cut anywhere,” that is, do medically unjustified surgeries that can harm the patient.

To balance risks and benefits, it is thus important for surgeons to be able to reliably estimate a patient’s aesthetic need as well as the aesthetic improvement they can expect from surgery. However, assessing both of these qualities is plagued by a number of difficulties. Kathy Davis (1995) points out that a Dutch experiment offering cosmetic surgeries in a public health system floundered precisely because it attempted to triage patients on the basis of their aesthetic need. Doing so led to a failed search for “objective” definitions of aesthetic defects (such as a difference in clothing sizes between top and bottom) and ultimately the exclusion of cosmetic procedures from state-funded health care.

Many Brazilian surgeons stress that their real therapeutic object is not an aesthetic defect but rather the patient’s body image—and the pain that it causes her. In practice, however, surgeons do use aesthetic ideals—as they define them—to make risk–benefit calculations. They must be able to evaluate, for example, whether the health risks and scars of a particular surgery will be justified by aesthetic improvement, as we saw in Dr. Martins’s refusal to perform a breast reduction. Such judgments involve an aesthetic assessment of the patient’s body. In one consultation in a public hospital, a candidate for silicone implants removed her T-shirt while her surgeon exclaimed, “They’re bonita (pretty),” and tried to dissuade her from surgery. There is thus a highly gendered dynamic to this medical gaze on female beauty (for more discussion see, e.g., Bordo 1993; Edmonds 2010; Jones and Heyes 2009; Morgan 1991). Surgeons not only try to discourage patients who are “already pretty” but also suggest additional operations that will give the best aesthetic results, in their eyes.

Although plastic surgeons’ concern with beauty is hardly surprising, clinical aesthetic judgments do raise ethical questions about the medical status of cosmetic surgery. For one, Brazilian surgeons themselves stress that beauty ideals are historically and ethnically variable. Out of this flux they must stabilize an ideal against which to measure need. Yet surgeons often perceive different defects than patients do. In one consultation, a surgeon assumed a patient wanted a breast augmentation, when in fact she wanted a reduction. While interacting with surgeons, some patients learned to see new defects, such as small asymmetries in the face. Undergoing this therapeutic practice can thus create new medical “needs” that make it difficult to assess benefits. Moreover, aesthetic norms and ideals are rapidly changing in Brazil. The coexistence of differing aesthetic ideals casts doubt on the ability of surgeons to make meaningful medical judgments of need.

Surgeons might respond that they are merely responding to demand, or as a lay manual put it, “following the desires” of the patient (Ribeiro and Aboudib 1997:105). But such desires are influenced by the diverse fetishisms of Brazil’s sophisticated mass media and a racialized sexual culture with roots in colonial society (Goldstein 2003). “Following desires” can thus lead surgeons far from the medical definitions of need and benefit important for ethical decision-making and into a mercurial sexual imaginary.

There are problems not only in calculating the benefits but also the health risks of aesthetic procedures. In Brazil doctors and patients often minimize the risks of cosmetic surgery—including infection, complications from anesthesia, and psychological trauma. Some patients in public hospitals—where consultations are often peremptory—were unaware their surgery would leave a scar. Another senior surgeon complained of patients who had no “understanding that this is a serious medical practice.” The fact that a highly trained medical
professional is performing the operation on a patient who is, by definition, already healthy, may also minimize perceptions of risk.

There is also a potential for risks to be minimized when cosmetic surgeries are associated with other surgeries that are considered to have a more established medical indication. In Brazil, as we’ve seen, both surgeons and patients often perceive cosmetic surgery as a routine aspect of reproductive health care in a medical culture with high rates of surgeries with disputed indications. Some women saw cosmetic surgery as a necessary “correction” of damage sustained during a C-section, or often multiple C-sections. Other patients viewed cosmetic surgery as a “compensation,” or gift to the self, for medical and psychological suffering caused by other surgeries, such as a hysterectomy (see Edmonds 2010:Part III).

It is thus important, when analyzing the risks and benefits for an elective procedure, to view it not in isolation but rather as part of a larger field of surgical possibility. I use this term to situate a single elective procedure within a larger cluster of possible treatments, which have overlapping clinical, cultural, or economic rationales. Seeing how a particular procedure is associated with probabilities of additional treatments is important for calculating overall risk. A more accurate assessment of risk would consider risks not only of single procedures but also of iatrogenic damage from associated pharmaceutical or surgical treatments.

Studies of obstetrical practice have found that one intervention, such as induction, can result in a “cascade of interventions” leading to surgery (Béhague 2002:500). The point is also relevant to cosmetic surgery, when it is combined simultaneously or sequentially with other operations. In Brazil, many patients have multiple surgeries, plan a series of future surgeries, or combine two procedures to “take advantage of the anesthesia.” For example, a liposuction can be performed simultaneously with a tubal ligation or with other cosmetic surgeries that have mingling functional, psychological, and aesthetic rationales. This combinatory logic can reduce perceptions of the risk of multiple surgeries.

Medical ethicists have noted that risk–benefit calculations in evidence-based medicine systemically overestimate benefits and underestimate the aggregate risks of multiple interventions. This is because clinical trials tend to “tally only the adverse outcome of an individual intervention,” whereas benefits are dependent on previous interventions (Fitzgerald 2007:971). Fitzgerald argues that risks of multiple interventions are more than the compounded risk of individual interventions: The “complex structure of medical practice becomes more than a sum of its parts” (971). The point is all the more true for aesthetic treatments, because benefits to well-being are harder to balance against risks to health.

A critical analysis of risk–benefit calculations can thus help to refocus attention on the ethics of performing elective treatments. Difficulties in calculating risk–benefit ratios raise questions about the medical legitimacy of aesthetic treatments. If benefits are unclear, then it becomes unclear what risks are justified. If risks are unclear, then it becomes uncertain whether they can be justified by benefits. And if need is a malleable notion dependent on the medical assessment of beauty and psychological suffering, it becomes difficult to weigh the risks and benefits of elective procedures.

Conclusion

In this article, I argue that aesthetic aims and concerns are more prevalent in medicine than is commonly assumed and not confined to cosmetic surgery. Cosmetic surgery often forms part of a larger cluster of treatments that have differing degrees of medical necessity and a complex
blend of aesthetic and health rationales. I analyze in detail the emergence of sexual aesthetics in the field of women’s reproductive health care. Referral practices, media representations, and constructions of female sexuality and childbirth contribute to a view that aesthetic management of reproduction is a legitimate medical goal in some clinical settings. One disturbing result is that medical needs are magnified while perceptions of surgical risk are minimized.

I hope that this analysis will stimulate more work on the changing status of aesthetics in other realms of medicine as well—a topic that has been rarely researched. One important example is hormonal therapy. Some surgeons are offering bioidentical hormones as part of an “integrated” anti-aging therapy (Kinney 1998:392). A North American plastic surgeon reports that hormonal therapies offer diverse aesthetic and sexual benefits, such as better skin tone, loss of visceral fat, and higher libido, as well as improved health indicators such as lower cholesterol (Garcia 2007:212). While plastic surgeons are expanding into endocrinology, endocrinologists are adding aesthetic treatments to their practice. A group of Austrian physicians are promoting a subfield called “aesthetic endocrinology,” which uses topical and oral hormones to improve “the aesthetic well-being of women” (Gruber et al. 2002:431). They discuss how androstanolone changes “body silhouette,” estradiol enhances skin collagen, and androgens reduce abdominal fat (Gruber et al. 2002). Such medical developments are important to study because they potentially mask the risks of hormonal supplementation as aesthetics and health become entangled.

What are the ethical and health implications of the emergence of such new hybrid medical fields? While it would not be possible to completely disentangle aesthetics and health, I have argued that an analysis of risk–benefit calculations offers one critical tool for drawing attention to the potential harm of aesthetic medicine. Balancing risks and benefits—which is necessary for ethical medical practice—is particularly difficult with clusters of procedures where health and aesthetics are blurred.

Such a focus on risks and benefits might not initially appeal to critics of medicalization because it seems confined to a narrower, clinical perspective. Thus, at first glance, it may seem to ignore the larger social, political, and economic forces that undergird medicalization. Yet it presents a few advantages. For one, it may be an effective way of engaging clinicians and other health professionals because it is expressed in the professionally familiar language of medical ethics, as opposed to social science analysis of medicalization and biopolitics. It is also relevant to health authorities who take into account risks and benefits in approving medically implanted devices, such as silicone prostheses.8

Secondly, analysis of risk–benefit calculations is a useful critical strategy due to the rising legitimacy of aesthetic aims in medicine. Many surgeries and drugs create iatrogenic damage to sexuality, appearance, and body image. The anthropological argument that there is no ahistorical notion of material need could also be applied to “medical need” (Sahlins 1974). Notions of medical need are expanding to reflect aspirations for more diffuse qualities such as well-being, self-esteem, sexual realization, and even happiness. Focusing on risks and benefits of particular procedures (and series of procedures), rather than dismissing all aesthetic aims in medicine, is important due to the malleable quality of the notion of “health.”

Finally, investigating risk–benefit calculations can shed light on how social constructions of the body enter into medical decision making. I argue that assumptions about female sexuality and reproduction—which often become more clear in ethnographic research—underlie clinical judgments of “aesthetic need” and “aesthetic benefit.” An anthropological approach can thus contribute to a critical discussion of aesthetic medicine by showing how forces outside the clinic
shape the balancing of risks and benefits. Such an approach expands the narrower focus of medical ethics by showing that risk–benefit calculations are not, as one ethicist has argued (Sokol 2008:514), made primarily on the basis of medical facts; rather, medical facts are also made by social perceptions of risk, benefit, and need.

Notes

Acknowledgments. I’m grateful to Princeton University and the Social Science Research Council for funding this research.

1 While some fully public hospitals offer cosmetic surgery for free, one Rio hospital, Santa Casa hospital, receives a mix of charity and state funding, and charges cosmetic surgery patients a heavily discounted fee. Pedagogical techniques, hospital procedures, and patient demographics at Santa Casa are similar to those at fully public hospitals, so I include the clinic here in my discussion of public hospitals (Edmonds 2010:Part I).

2 Patient attitudes toward motherhood, appearance, and sexuality were complex and often reflected considerable ambivalence. For discussion of patient views of plastic surgery within the context of changing family structure, gender ideology, and sexual culture in Brazil, see Edmonds 2010:Part III.

3 For example, a study of female English obstetricians found that among those who said they would choose a C-section for themselves, 80% mentioned as a motive “fear of perineal damage from vaginal delivery” (Al-Mufti et al. 1996:544).

4 Health researchers have also tried to develop and “validate” a genital self-image scale for women, claiming that a low score indicates vulnerability to sexual dysfunction (Herbenick and Reece 2010).

5 The American College of Obstetricians and Gynecologists stated that genital surgeries are not “medically-indicated” and there is “no scientific evidence regarding their benefits” (ACOG 2007).

6 In Brazil, not just episiotomy but also forceps are used routinely for primiparae to speed up labor, though forceps delivery carries a much higher risk of perineal injury and sexual problems (Diniz and Chacham 2004).

7 A new preference for larger breasts in popular culture beginning in the early 2000s was blamed on the breast augmentation surgeries of Brazilian celebrities.

8 For example, the FDA in the United States requires that medically implanted devices be not just “reasonably safe,” but also “reasonably effective,” with effectiveness defined as measurable improvements to well-being and body image (FDA 2011). Studies (Zuckerman 2010) that dispute breast implants’ “effectiveness” thus open a space for questioning the regulatory approach to cosmetic procedures.

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