Cosmetic Surgery in Two Healthcare Contexts

This chapter examines the history of plastic surgery in Britain and the US, with a particular focus on the factors that have contributed to the significantly higher prevalence of aesthetic operations in the US (ISAPS, 2010). Davis (1995) has argued that the organization of healthcare in any country both determines who has access to cosmetic surgery and shapes the discourses employed in expressing the practice’s controversial elements. Based on Davis’ claims, a comparative analysis of cosmetic surgery in Britain and the US requires attention to their very different healthcare systems. At the same time, the field of plastic surgery cannot be explained solely as a product of its medical context. As Haiken (1997: 18) notes, cosmetic surgery is a ‘cultural practice’ as well as a medical one; its analysis should therefore consider the ‘cultural, as well as medical’ setting.

Haiken’s (1997) claim is accurate up to a point – the meanings of cosmetic surgery are informed by a range of issues that are not explicitly medical, including social divisions of age, gender, ‘race’ and class, consumption practices, media imagery and constructions of ‘beauty’. A similar point can be made, however, about the ‘medical context’; rather than being reducible to, say, technological developments or ‘pure science’, the medical is also cultural. Any nation’s healthcare system is the product of a particular set of historical circumstances, social structures and shared values; the specific manifestations of these in Britain and the US – in each country’s ‘racial’/ethnic mix and relations, popular culture, welfare system and military history – have also shaped practices of and attitudes towards cosmetic surgery.
in both settings. The following discussion focuses primarily on the period between 1915 and 2005.¹

When contemporary plastic surgery emerged in the US and UK, it did so in two very different healthcare systems and, by implication, in the context of different approaches to medical practice. Much has been written on the history of American cosmetic surgery (e.g., Gilman, 1998; Haiken, 1997; Kuczynski, 2006; Pitts-Taylor, 2007; Sullivan, 2001). Yet, the roots of many modern aesthetic procedures actually lie in reconstructive techniques developed in Britain during the First and Second World Wars. In fact, the first plastic surgical unit ever was established in January 1916 at the Cambridge Military Hospital in Aldershot, England, under the direction of Harold Delf Gillies. Born in New Zealand in 1882 and trained as an otolaryngologist at St. Bartholomew’s Hospital, London, Gillies went to France in 1915 as a general surgeon with the army. While there, Gillies saw the vast numbers of mutilating facial wounds that occurred during trench warfare and for which no specialized medical care was then available (Matthews, 1979; Tempest, 1987). With teams of dental surgeons, anaesthesiologists and nurses, Gillies soon began developing techniques for repairing such injuries (Matthews, 1979: 69).

By 1917, the volume of work at Aldershot had increased so dramatically that the unit was overwhelmed. As a result, the treatment of most maxillofacial wounds was transferred to a new, larger unit at Queen’s Hospital in Sidcup, Kent, which was devoted exclusively to plastic surgery (Barsky, 1978). Between the unit’s opening and early 1921, over 11,000 operations were performed there on nearly 9000 patients (Battle, 1978). Given such volume, the work being carried out at Sidcup attracted national and international attention from laypersons and medical professionals alike. Numerous surgeons interested in reconstructive procedures travelled to Sidcup from France, the US and the British Commonwealth to work with Gillies (Matthews, 1979). Among them was the American Vilray P. Blair, who would later organize four hospitals and three training centres in the US, all devoted to the treatment of plastic surgery cases (Haiken, 1997). Other American surgeons who were trained by Gillies include Ferris Smith, John Staige Davis, George Dorrance, Gustave Aufricht, Varaztad Kazanjian, Ralph Millard, Joseph Eastman Sheehan and Maxwell Maltz (Tempest, 1987). These doctors were to