Evaluating Cosmetic Surgery in Britain and the US

I referred earlier to Davis’ (1995) claim that national healthcare systems both determine who has access to cosmetic surgery and foster particular ways of thinking and talking about this controversial practice. I also noted that despite her assertion, Davis fails to fully examine how the Dutch health system of the 1980s and 1990s shaped her respondents’ accounts of their own aesthetic procedures. That is, by funding cosmetic surgery only in cases of extreme emotional distress and/or physical deformity, Dutch healthcare encouraged narratives emphasizing such conditions. Furthermore, given the apparent consistency of Davis’ findings, there seems little reason to suspect that her respondents were being deceptive when they explained their need for cosmetic surgery in these ways. In fact, it is more likely that their explanations reflected culturally available understandings of when cosmetic surgery is justifiable and when it is not – understandings which were concretized within the guidelines of the Dutch healthcare system and enacted through its eligibility criteria. I am not suggesting that accounts which frame cosmetic surgery as a response to unbearable physical or psychological suffering are unique to the Netherlands, but instead that they are more likely to be readily available in societies where healthcare is publicly funded and decisions about the allocation of medical resources are based on assessments of relative need.

Edmonds’ (2007a, 2009) research on Brazilian plasticá supports my general argument about the relevance of healthcare systems in women’s accounts of cosmetic surgery. As Edmonds describes, Brazil’s 1988 Constitution included the ambitious claim that healthcare is
‘the right of every individual and a duty of the state guaranteed by social and economic policies’ to provide ‘equal access to services’ that ‘promote, protect and recover health’ (Edmonds, 2009: 156 n2). Despite such universalistic ideals, the economic downturn in Brazil since the 1990s has resulted in a marked reduction in public health funding as well as rising social inequalities. Nonetheless, Brazil’s already sizeable cosmetic surgery industry of the 1990s has continued to grow, largely because it provides a training ground for young surgeons from around the world. These newly qualified (and relatively inexpensive) specialists come to Brazil to hone their skills, thereby making it possible for the nation to provide free or discounted aesthetic procedures to much of its poor, for whom plástica is justified as ‘a species of healing’, a means of achieving health ‘by being happy’ and, ultimately, a social right (Edmonds, 2009: 157).

Furthermore, Edmonds (2009) points out that the growth of cosmetic surgery in Brazil has accompanied the increasing medicalization of female sexuality and reproduction, through which caesarean sections (and, in some cases, tubal ligations and other forms of sterilization) have come to be viewed as not only the more convenient, pain-free and safer option, but also a marker of modernization. Demand for medical care that is perceived as ‘progress’ is, in turn, magnified by the deep inequities of the Brazilian healthcare system, in which only wealthier women have access to private obstetric services, thus leading to their higher rates of caesarean births (Edmonds, 2007a, 2007b). Given these circumstances, surgical interventions such as caesarean sections have become a symbol of social privilege, and poorer women respond to its denial by employing a range of informal but powerful tactics intended to coerce their doctors to perform the operation (Béhague et al., 2002).

While Edmonds (2009: 161) rightly notes that caesarean section, tubal ligation and aesthetic surgery are ‘very different procedures’, he argues that they are linked in Brazilian culture through the association both of female beauty with reproduction/sexuality and of surgical intervention with class position and aspiration. In the context of a publicly funded healthcare system that promises but cannot deliver universal access, poor women who pursue cosmetic surgery frequently conceptualize it as compensation for their otherwise limited means of social mobility, and so narrate their desire for it in terms of an unacceptable appearance, as well as the emotional suffering and