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Synthetic beauty: American women and cosmetic surgery

Anderson, Lenore Wright, Ph.D.

Rice University, 1989

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RICE UNIVERSITY

SYNTHETIC BEAUTY:
AMERICAN WOMEN AND COSMETIC SURGERY

by

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IN PARTIAL FULFILLMENT OF THE
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DOCTOR OF PHILOSOPHY

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ABSTRACT

Synthetic Beauty: American Women and Cosmetic Surgery

Lenore Wright Anderson

This dissertation constitutes an anthropological inquiry into the current American boom in facial and bodily cosmetic surgery. The exploration of this phenomenon utilizes the messages of the print media, the literature of the social and medical sciences, and the voices of women who tell their stories and interpret their experiences. The dissertation begins with a perspective on American society as a commercialized entity and also as a post-modern phenomenon. The commodification of American medicine is discussed as a related and yet distinct process. Chapter II provides an historical look at medical advertising in the United States and offers interpretive data on a collection of advertisements for cosmetic surgical procedures. Chapter III describes the conceptions of female beauty in the United States from the 1800s until 1989, and additionally supplies a feminist take on beauty and the viewpoints on female attractiveness held by cosmetic surgeons. Chapter IV overviews social science studies that discuss the importance of physical appearance, and psychological literature that establishes the nature of body-image over the life-cycle. This chapter also provides data on the interactions between plastic surgeons and their patients and discusses the potential psychiatric problems that might plague those who seek cosmetic surgery. Chapter V presents a discussion of the rhytidoplasty (facelift) and blepharoplasty (eyelift) operations, and outlines methods, side-effects, and complications. Additionally included are the stories and words of three women who have undergone these procedures and an analysis of the themes that recur and
seem pivotal to the process of having a facelift. Chapter VI discusses augmentation mammoplasty (breast enlargement) procedures and presents an overview of how the operation is done and the common side-effects and complications. Once again the stories and quotes of three women who have had this operation are provided, and the recurrent and relevant themes found in their discourse are analyzed. The final chapter provides a gloss on cosmetic surgery using the scaffolding of symbolism, ritual, and myth. The surgical rituals of facelift and breast augmentation as well as other American beauty rites are compared with feminine rituals in other cultures and the elements of pain and danger are discussed as common to many beauty rituals, across several cultures.
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PREFACE

The purpose of this work is an anthropological inquiry into the nature of the current American boom in cosmetic facial and bodily surgery, which has been documented by many sources. My exploration of this phenomenon will utilize the messages of the American media, the literature of the social sciences, and the voices of women from fieldwork and interpersonal interactions. My interest in this subject was initially stimulated by the recent significant increase in medical advertisements for plastic surgical procedures. As I collected these advertisements over time, however, and as I analyzed them for their explicit and implied messages, it became clear that the cosmetic surgery industry was burgeoning in response to many social, cultural, philosophical, and technological factors in addition to the boost it was receiving from a relaxation of the taboo on physician advertising. I became intrigued with the growing tendency for persons in the United States, especially women who undergo 85% of the procedures, to surgically alter their faces and bodies. Undeniably the advertising is exerting an effect, but is it creating the perceived need in the mind of the consumer or exacerbating an existing tendency towards narcissism? What is the nature of American society as it enters the decade preceding the year 2000: Has it progressed past the point that Marcuse described in the 60s to an end of total superficiality and commodification? What is the nature of the medical and surgical care delivery system within this society? How has the competitive, business ethos of contemporary American medicine influenced the fate of the patient, who is now termed "the consumer"? I have attempted to speak to these issues, and other theoretical social issues, in my first two chapters which deal with the characteristics of contemporary American society and
the nature of advertising within the United States: particularly that which
sells medical and surgical "products".

In chapter three I discuss beauty and its evolution in America since
the 19th century, since the quest for this highly valued attribute is one of
the principle forces that has determined the large increases in the numbers
of women who seek cosmetic surgery. I review, as part of this inquiry,
popular literature sources that help to document the standards of beauty
to which women have been held in the United States in the 1960s through
the late 1980s. In chapter four I consider the importance of physical
appearance in America and discuss some social and psychological data that
has been gathered on this topic. Additionally I cover the psychological
development of body-image and how this concept changes with maturity
and old age in America. This is especially relevant since subverting the
changes associated with aging is the most commonly identified reason that
women seek cosmetic surgery in America. I introduce, in this chapter,
information from the psychiatric literature which attempts to explain and
categorize persons who might seek cosmetic surgery. It is important to be
familiar with the opinions of psychiatrists, since they are widely regarded
as the final authorities on the inner needs that impel an individual to
change her exterior reality.

Chapter five introduces the consideration of rhytidoplasty or facelift,
and chapter six discusses augmentation mammoplasty or breast enlargement.
Each chapter explains the procedure medically and then introduces the
stories of three women who have chosen to undergo the operation under
discussion. The responses of the informants that I include are heavily
excerpted in the women's own words for two primary reasons. First, in
order that their stories, motives, and insights might be explored and shared with others. And second, in order that issues identified as important by these women, myself, or the literature might be introduced and explored. These pivotal issues will be covered partially through discussion with the subjects, and partially through the utilization of explanatory data from knowledgeable literature and professional sources. Examples of the type of issues that are dealt with, for example, are the question of ethics in the cosmetic surgeon's dealing with the patient, the topic of informed consent, and the problem of cancer screening accuracy in women who have undergone augmentation mammoplasty.

The final chapter attempts to bring anthropological closure to the subject via consideration of plastic surgical procedures as unconscious secular rituals within American society. I explore the similarities among some women's rituals found in ancient China, in current traditional societies, and in modern American society and come to some troubling conclusions. Finally I consider the symbolic nature of women's words about and actions involving their bodies and the meaning of the actual body parts themselves. It is my hope that a consideration of the semiotics of the female body will enable us to better understand the frenzied search for youth and perfection that we see around us. Perhaps, with understanding, societal and personal alternatives will be generated for women in America which will replace surgical bodywork as the "treatment of choice" for a plethora of non-medical maladies.
CHAPTER I: AMERICAN CULTURE IN THE LATE 1980s

The Frankfurt School

In order to mount a systematic study of such a complex and dynamic entity as late 1980s American society, it is necessary to utilize a model or a set of organizing principles. I will begin by invoking the work of some of the members of the Frankfurt Institute for Social Research -- the Frankfurt School. This association of left intellectuals came into existence in mid-1920s Germany and was composed of philosophers, literary critics, sociologists, psychologists, economists, and political scientists. Critical theory is the umbrella concept under which was united the wide spectrum of related yet differing viewpoints of the Institute's members. Critical theory is derived, according to Piccone, from the traditions of Kant's critical philosophy and Marx's critique of ideology (Arato and Gebhardt, 1985). Critique, in the Kantian sense, assumes a self-reflective, transcendental posture which was fused with the concepts of the limits of science, the importance of history, and a Marxian political thrust. The critical theorists sought to explain the "reproduction and transformation of society, the meaning of culture, and the relation between the individual, society, and nature (Held, 1980, p. 16). The critical theorists, especially Horkheimer, Adorno, Marcuse, and Habermas, according to Held, sought to re-examine orthodox Marxism in relation to contemporary events. In order to accomplish this they began with the philosophical foundation of Marxism (Kant and Hegel) and integrated Freudian theory in order to add human subjectivity, and Weberian sociology in order to factor in a perspective on rationalization and bureaucratization in contemporary society.
Marcuse and One-Dimensionality

I will begin my excursion into the complexity of contemporary American society with a look at some of the work of Herbert Marcuse, because, as Held states, he "was one of the few who sought to create a new a relation between theory and practice in the post-war years" (1980, p. 73). He was religiously read by the New Left intelligentsia in America in the 1960s and 1970s, and it was through his work that critical theory became known in the United States.

The work which made him famous, One Dimensional Man, is a political commentary, but more importantly, it is "a set of propositions about the actual and potential development of capitalist society" (Held, 1980, p. 387). In this well-known book Marcuse discusses the development of production and technology, the increasing regulation of free enterprise, the changing social structure where blue and white-collar populations are merged and the overwhelming influence of the possibility of nuclear war. I am particularly interested in his positions on technology and the blurring of class structures. Marcuse does not believe that technology (or progress) is neutral, and he states that it cannot be isolated from the use to which it will be put. He further postulates that the technological society is a system of domination. He states: "As a technological universe, advanced industrial society is a political universe, the latest stage in the realization of a specific historical project -- namely, the experience, transformation, and organization of nature as the mere stuff of domination" (1964, p. XVI). This statement seems particularly well-suited to the domain of modern biomedical technology; and even more specifically to the specialty of cosmetic and reconstructive (plastic) surgery. As
prosthetics and surgical techniques have evolved, especially over the last
decade, plastic surgeons have truly seemed to have found technologies for
the subjugation of nature. A person need no longer live with the face or
body dealt by the genetic code. Why should one? A surgical change is
only as far away and the nearest plastic surgery outpatient center -- and
the bank. But does the capability for surgical domination of physical
characteristics offer a person a choice, or force the individual into a
position of having to utilize these options because they exist? In other
words will people, and especially women, feel that if they are not
successful in work or in relationships, that they should utilize the
cosmetic surgical option? It is widely discussed (at least by plastic
surgeons) that plastic surgery can change a person psychologically: and if
this is true, should one not try it? I would submit that the plastic
surgical technology is only as "good" or "beneficial" as the use to which it
is put. And there is a great difference between reconstructing the face of
a injured or deformed person and the use of the same technology on the
face or body of a person who has a minor physical variation or some
changes associated with aging. Marcuse also discusses the influence that
mass communications has on intellectual freedom and the definition of
human needs. These needs, beyond the biological level, may been seen to
be socially and politically conditioned: and the creation of what Marcuse
calls "false needs" can be a measure of the repressive tendencies of a
given society and its components. Marcuse states that the satisfaction of
such needs might gratify the individual, but that this gratification might
make it difficult to "recognize the disease of the whole and grasp the
chances of curing the disease. The result then is euphoria in unhappiness"
(1964, p. 5). I would maintain that the "cosmetic surgical solution" is a perfect example of a false need: a manufactured solution that furthers the ends of the bio-medical establishment and the individual surgeons. It will remain to be explored, via fieldwork with persons who have had cosmetic surgery, whether or not their post-operative mood was euphoria or dejection and whether they feel the surgical procedure fulfilled the promise that they had envisioned. Marcuse himself states that in the end, the determination of what are "true" and "false" needs is an individual decision. He qualifies this position, however, with the counter-statement that we cannot take their answer as their own as long as they are "indoctrinated and manipulated (down to their very instincts)" (1964, p. 6).

Lest we over-estimate the power of the mass media, however, Marcuse reminds us that people are "preconditioned receptacles" long before any media exposure occurs. He expands this concept with his assertion that indeed a class structure still exists: and that the similar interests of the upper, middle, and lower classes indicate only that the preservation of the Establishment is an obligation that crosses class lines. In the case of cosmetic surgery, it is apparent that these procedures are currently being marketed to an identified middle-class market. It has been recognized for many years that wealthy, socially prominent women and media celebrities have had cosmetic surgery, and that it was very costly. I will attempt to demonstrate, through an analysis of medical advertisements and via my fieldwork, that cosmetic surgeons are making a clear marketing bid for the American middle-class. I believe, however, that the 1980s ideal of beauty and its value is widespread in American culture: crossing class, income, and ethnic boundaries. It is to the advantage of the medical beauty
establishment that the entire spectrum of American society accepts not only this ideal, but also the concept of elective cosmetic surgery, and connects it to biomedical technology in general. It is in the interest of male-dominated political and business systems that women continue to be predominately viewed as sex objects and that their faces and bodies be further commodified. And it benefits the hegemonic white Anglo-Saxon American institutions if those of other ethnic and cultural origins are forced to emulate -- even to their facial and bodily structure -- the dominant group. And yet, Marcuse reminds us of the "rational irrationality" of advanced industrial civilization. Indeed, the very surgical procedures which can make life possible for those with birth defects or traumatic injuries are marketed for trivial use. Clearly, most high-technology products have both beneficial and detrimental possibilities, but further, Marcuse questions the way in which our civilization "transforms the object world into an extension of man's mind and body" such that "people recognize themselves in their commodities" (1964, p. 9). And if it is possible to find one's soul in a Porsche or a diamond ring, how much easier it is to cathect the newly commodified (and overhauled) parts of one's own body. At least when objects outside of one's body were worshipped, the common scrambling to possess as much as one's neighbor was a force for the unification of society. When the quest is turned to a person's own body, however, one becomes introverted in the most extreme sense: lost in the adoration of self. I believe that this trend will eventually be able to demonstrate that to attempt to find oneself in things -- even if these "things" are aspects of one's own physical reality -- is to attempt the impossible. Marcuse reminds us that the "irresistible output of
the entertainment and information industries carry with them prescribed attitudes and habits, certain intellectual and emotional reactions which bind the consumers more or less pleasantly to the producers and, through the latter, to the whole" (1964, p. 12). We are manipulated into a state of false consciousness -- a one-dimensional pattern of thought and behavior-- which becomes a way of life and rejects alternate views on the nature of human existence. In spite of what would seem a resoundingly negative view on modern society, Marcuse does believe that the potential for mass social change exists. Revolutionary views may be shared by only a small minority, and yet this small group consistently articulates an alternative framework: the counterpoint to one-dimensionality. Held (1980) crystallizes Marcuse's position that it is the have-nots in advanced capitalism (minority races and the poor) and students and intellectuals who are catalytic agents for potential social transformation. To this list women must be added: a gender that outnumbers males in the United States and yet in many ways remains a disadvantaged group. We must find within our ranks the creativity and energy to oppose the one-dimensional reasoning that would encourage us to reduce ourselves to the sum total of what would be considered our "decorative value" in today's society.

The Culture Industry

Max Horkheimer and Theodor Adorno, also Frankfurt School theorists, coined the term culture industry (a synonym for mass culture) in their Dialectic of Enlightenment (Held, 1980). This term refers to the standardization of the cultural forms themselves and to the techniques of rationalized promotion and distribution. This culture industry produces for profitable mass consumption, and is thus integrated into capitalism. The
position of Horkheimer and Adorno was that mass distribution of art forms, such as symphonic music, undermined their potential value as uplifting experiences because they were often simplified and homogenized: blended into a product that could distract and entertain the masses and in fact manipulate their consciousness. As Held states, one can: “take flight and escape into the world of entertainment” (1980, p. 93). Although this escape can be therapeutic, it also fosters passivity and undermines the individual’s critical and activist tendencies: for Horkheimer and Adorno the products of mass culture “served to enhance political control and to cement mass audiences to the status quo” (Held, p. 88).

According to Horkheimer and Adorno (1973) the technology of the culture industry is “no more than the achievement of standardization and mass production” and “the need which might resist central control has already been suppressed by control of the individual consciousness” (p. 121). They discuss the different levels of cultural products, such as A and B films or stories in differently priced magazines as an attempt at “classifying, organizing and labeling consumers. Something is provided for all so that none may escape” (p. 123). Although the distinctions between products may be emphasized, in reality there are few differences in the actual products. The real distinguishing element is the varying amount of dollars laid out for each product. They discuss, at great length, the many areas into which the culture industry has reached, and what it has done to genuine art. They state that “art becomes a species of commodity ... marketable and interchangeable like an industrial product” (p. 158). (This position will be markedly similar to the one I will take on the commodification of the body, and of beauty). Additionally, they speak
about advertising, and its place in the commodification scheme. They point out that in important magazines in America, advertising can scarcely be distinguished from editorial picture and text: as advertising uses "so many factual photographs and details that [it represents] the ideal of information which the editorial part has only begun to try to achieve" (p. 163). They assert that the assembly-line character of the culture industry is well-suited to advertising. In point of fact, advertising and the culture industry "merge technically as well as economically" (p. 163). In both areas the same items are displayed in countless areas and the mechanical reproduction of the cultural product (or of a certain ideal of beauty, in the area of cosmetic surgery) comes to be the same as a propagandistic slogan. They state that both mass culture and advertising manipulate with catchy "skillful yet simple" refrains, with the objective being to "overpower the customer, who is conceived as absent-minded or resistant" (p. 163). Horkheimer and Adorno relate that freedom to choose a way of believing turns out to be a freedom to choose:

the model served up by the culture industry. The most intimate reactions of human beings have been so thoroughly reified that the idea of anything specific to themselves now persists only as an utterly abstract notion: personality scarcely signifies anything more than shining white teeth and freedom from body odor and emotions. The triumph of advertising in the culture industry is that consumers feel compelled to buy and use its products even though they see through them (p. 167).

I believe that this last statement is truly applicable to the response of American women to advertising for beauty products and cosmetic surgery: They recognize and ostensibly disregard the come-on, and yet, at some deeply socialized level, they know they must buy and use such services.

Another View: Popular Culture

Of course there is another position on the mass/popular culture
controversy, or it could not accurately be termed a debate. I will present another voice on mass culture by means of a review of part of the work of Herbert Gans. His book *Popular Culture and High Culture -- An Analysis and Evaluation of Taste* (1974) is a sociological study of popular culture and high culture in America, and defends popular culture as the aesthetic desire of many people and the idea of cultural democracy in general. He defines the mass cultural critique as an attack mounted by one societal element against another: the cultured versus the uncultured, the educated versus the uneducated. He states that the mass culture critique is "endemic to urban-industrial society" (p. 4) and has existed since the eighteenth century where it originated in the beginnings of popular literature, the fore-runner of our mass media. He points out that since the nineteenth century this critique has been preoccupied with American leisure pursuits: from alcohol and illicit sex to passive spectator sports and film and television viewing. During the affluent 1950s, the critique expanded its concern to mass consumption in general, while in the 1960s it settled mainly on television viewing. According to Gans, however, this critique has less to do with high and popular culture than with the societal position of intellectuals, who utilize this mechanism to increase a slipping power base. In the 1940s and 1950s the affluence and status of intellectuals was compromised and the critique became especially forceful. It declined during the 1960s with the flowering of the youth culture and the financial betterment of intellectuals under the Kennedy administration. It returned in the 1970s due to the academic depression which hit the universities where the majority of high culture practitioners are found. Gans states that another threat to the intellectuals comes from the revival
of egalitarian views in America and the fact that much of the impetus items from students, women, and blacks. Some intellectuals support this revival, while others oppose it as they see more equality as dangerous to high culture.

Gans defines high culture as "the art, music, literature, and other symbolic products that were (and are) preferred by the well-educated elite ... but also to the styles of thought and feelings of those who choose these products" (p. 10). Mass culture, a pejorative term, "refers to the symbolic products used by the uncultured majority" (p. 10). He suggests that the term "mass culture" be replaced by "popular culture." He further alleges that there are a number of popular cultures which, along with high culture, all may be defined as "taste cultures": serving to entertain, inform, and beautify daily existence, and consisting of values and the cultural forms which express them. Before further describing Gans' levels of taste culture, however, I would like to synopsize his points of departure from the critique of mass culture. The first two charges against popular culture that Gans speaks to concern the mass production of popular culture creations for a paying clientele and the negative effects of popular culture on high culture. These two areas are more directly related to artistic endeavors, although a similar charge of mass production of cosmetic surgical procedures done only for monetary profit might be levelled at certain high-volume surgeons. Gans' counter to the mass-production for profit charge is that this is also true of high culture, which does nothing to refute the charge against medical entrepreneurs who in spite of their medical training and supposedly humanistic outlook operate mainly for profit. The third and more serious charge against mass culture
that Gans addresses is the possibility of harmful effects on the people who use it. He states that there is no evidence that Americans exposed to popular culture are narcotized, escapist or unable to cope with reality. He says that "people pay less attention to the media and are less swayed by it than the critics "who are highly sensitive to verbal and other symbolic materials" (p. 33). Further, consumers use the media for diversion, would not think of applying its content to their own lives, and that the prime media effect is to reinforce already existing attitudes and behaviors, rather than create new ones. I agree with Gans on his last statement, particularly as this would apply to advertising campaigns for cosmetic surgery. I cannot agree with him, however, that only critics are sensitive to verbal or other symbolic content for his implication is that "regular people" just aren't very intelligent. I feel also, that scores of people do apply media content to their own lives. Gans states that people do not take media content at face value and use media materials to provide temporary respite from reality. He then states, in the next paragraph, that "unknown numbers of children and adults are unable to make the crucial distinction between the make-believe of popular culture and the reality of their own lives" and that "unknown numbers of children and adults are also taken in by the puffery and exaggeration of advertising and ought to be protected against it; but part of the attractiveness of the ads is that people want the offered goods and it is not at all certain that the ads themselves initiate the wants" (pp. 35-36). Gans refutes his own refutation in this statement and I agree with him that many people are confused and taken in by advertising campaigns: particularly those run by doctors, who are supposed to be protectors of humankind and who will
operate only when a patient has a genuine need. Gans' final statement in this area is to assert that studies of advertising effectiveness suggest that most people retain little of the ad content seen and that they frequently misinterpret the message. He adds that successful ads produce genuine increases in sales but "often these reflect the behavior of only a few hundred thousand people" (p. 36). I would assert that in the area of popular medical advertising that the repeated nature of the ads is as much an issue as the ad contents. People come to accept and then expect that cosmetic surgery is a reasonable and legitimate solution to their problems of self-concept and identity. And when one is speaking of surgical interventions, the behaviors of "a few hundred thousand people" are indeed significant. The last charge against mass or popular culture that Gans addresses is that it allegedly has negative effects on society: that the mass media "narcotizes" people and renders them more sensitive to persuasion. He quotes Marcuse's position that corporate technology results in a society where popular culture causes people to become complacent and then robs them of their freedom to oppose "an evil social system" (p. 44). Gans also quotes Ellul, a French conservative, who also sees modern technology as a villain. Gans states that although the State might take over the mass media for its own totalitarian goals, this might be done in wartime, even in democracies. He feels that the media have not impaired the family or other social groups. He points out that Marcuse advocates withdrawal of freedom of speech and assembly from "groups and movements which promote aggressive policies, armament, chauvinism, discrimination" (p. 48) and others, and that he is therefore reserving to himself the right to determine who is to be silenced and who should be allowed to speak.
He points out that Marcuse does speak in behalf of the politically oppressed, but also that he seems unwilling to accept any culture which is not revolutionary. I agree with Gans that all groups should have the right to advocate their position, but can Marcuse be wrong in his advocacy for those who are oppressed? A logical position that integrates both viewpoints in the area of advertising for surgical procedures would not disallow such advertisements but would require that they alert the potential patient to the fact that the procedures carry attendant risks.

Gans states that at one level the critique is:

a plea for an ideal way of life guided by the humanist dictates of high culture that emerged during the Enlightenment and by the standards of humanist thinkers who place a high value on personal autonomy, individual creativity and the rejection of group norms (p. 52).

Exactly. Why Gans then states that it is questionable that these standards should be applied on a society-wide basis is a puzzle, and also perplexing is his statement that the critique is also a plea for "the restoration of an elitist order by the creators of high culture" (p. 52) -- especially since he has been discussing Marcuse. I believe that part of the mass culture critique does seem a bit far-fetched and moralistic, particularly when the topic is the alleged harm that results when high culture is democratized. However when we move into the area of media exposure for medical and surgical procedures, the stakes are clearly and immediately higher.

I would like to return, at this point, to Gans' elaboration of a number of "taste cultures" and "taste publics" or "people who make similar choices for similar reasons" (p. 68). Gans states that different taste cultures and publics exist because of the varying aesthetic standards that exist in America, and he labels this concept "aesthetic pluralism" (p. 69).
I would submit that this is undoubtedly true for choices that people make about music and theatre and material culture, but that in the definition of human facial and bodily beauty in late 1980s America, particularly in the delineation of feminine beauty, that there seems to be a marked "one-dimensionality". I believe that persons from at least three, and probably more, of Gans' taste publics would give similar definitions of the constituents of female beauty and that these would be strongly influenced by current societal feelings on age, body weight, facial and bodily symmetry, and ethnicity. Therefore, I propose that the definition of feminine beauty in contemporary America will be common to several taste publics and will cross the lines of class and age, which Gans identifies as the two major sources of subcultural variation. (He discounts the current influence of ethnicity, religious affiliation, and regional orientation). Gans lists the five taste cultures as: 1. high culture, 2. upper-middle culture, 3. lower-middle culture, 4. low culture, and 5. quasi-folk low culture. He then forewarns us that these taste cultural descriptions leave out ethnic, regional and other variants, that the descriptions exaggerate the cohesion of the systems, and that some people often chose from more than one taste culture. He also states that he will not really deal with professional taste cultures which exist within many professions. It will not be of value in this work to exhaustively describe each of Gans' taste cultures, however I will introduce the descriptive elements about each that seem helpful in the study of those who seek cosmetic reconstruction. Gans states that high culture is dominated by creators and by users who occupy elite social positions. This culture serves a small public to whom exclusiveness is important and awards more status to creators than to performers. Upper-
middle culture is composed of the majority of the American upper-middle class: managers and executives and their wives. These people are well-educated, but are not as creator-oriented, although they do confer "star" status on some creators. This taste public is very interested in how "high society", and its leaders, work and live. They read *Time*, *Newsweek*, *Psychology Today*, *Harper's*, the *New Yorker*, *Playboy*, *Ms.* and *Vogue*. Gans states that this taste culture is the fastest-growing of all, having been influenced by a boom in college attendance. The lower-middle culture is the dominant one in America today, attracting lower-status professionals such as accountants, teachers, and lower white-collar workers. This culture is predominantly user-oriented, pays little attention to creators, and concentrates on performers. This group reads *Life*, *Look*, the *Saturday Evening Post*, *Cosmopolitan*, the *Reader's Digest*, and various women's magazines. Gans states that today this culture appears to be increasingly fragmented, with traditional, conventional, and progressive factions. This group may be changing as quickly as high culture, with no one able to predict what they will want or accept. Low culture is that of the older lower-middle class but mainly is composed of the skilled and semi-skilled factory and service workers and semi-skilled white collar workers. This culture has been decreasing, due to both longer school attendance and exposure to television and other lower-middle class media. In low culture, the performer is paramount and is given status as a star with whom vicarious contact is sought. This culture does not read much; they are served by tabloid daily and weekly publications typically found near the check-out counter in convenience stores. Additionally, this group has low purchasing power. The quasi-folk low culture is, according to
Gans, a simpler version of low culture that is virtually ignored by the mass media. Gans also mentions "youth", black, and ethnic cultures in his work. Potentially of most applicability to my inquiry are the latter two. Black culture became visible to whites in the second half of the 1960s and resulted from a larger, educated middle-class, relaxation of segregation, and civil rights and black power movements. Gans states that despite the growth and change in this group, black culture is still a partial culture due to the fact that in many areas of living blacks share white taste cultures, and their aesthetic standards, leisure activities, and consumption styles are very similar to whites of like socioeconomic level and age. Gans describes ethnic cultures as those maintained by immigrants, often for reasons of language, and that these are then discarded by second-generation group members. The immigrant taste cultures were mainly folk and quasi-folk low cultures, and as the immigrants became upwardly mobile they often adopted American higher taste cultures. Gans states that some Jewish taste culture was Americanized, but that many others such as Greek, Polish, and Italian have virtually disappeared except for a few traditional foods, songs, and dances, and some religious practices. He does allow, however, that some observers report a revival of ethnic cultures among some third and fourth generation immigrants, but he states that many community studies suggest that most contemporary "ethnics" live like other Americans of similar age and socioeconomic status. He does assert, however, that ethnic politics have become more visible.

Implications of Taste-Culture Data

Several interesting implications for my work on cosmetic surgery arise from Gans' descriptions of the five taste-cultures. First, that upper-
middle culture confers status on creators, as does the upper-class, and also that upper-middle culture is preoccupied with the lives of the upper-class. This should predict that both of these groups will be interested in finding society/celebrity surgeons if they contemplate cosmetic procedures. Since the upper-middle emulates the upper class, where plastic surgery has long been accepted -- if hidden -- it is predictable that they will seek out such procedures. It is also predictable that cosmetic surgical advertisements will be aimed at this large, fast-growing, educated, and well-heeled group. The dominant lower-middle culture is also being targeted by plastic surgeons who advertise time-payment and out-patient procedures. This group is interested in performers, as is the lower-class, and therefore the celebrity endorsement advertisement is particularly effective. I personally know or have heard of several nurses (who would by income and education fall into this group) who have had cosmetic surgery. Of course they may receive a professional discount from the surgeon and their hospitalization costs may be lower if they are cared for in the institution in which they work. I spoke with a kindergarten teacher who told me she would have an "eye job" as soon as her upper eyelids became a bit more baggy. To these patients the surgical, anesthesia, and hospital costs (unless the procedures can be called "functional" as in the case of some rhinoplasties and blepharoplasties and paid for by third parties) represent a significant portion of their income, yet they are willing to go ahead. I believe that plastic surgeons will continue to advertise to the upper-middle and increasingly to the lower-middle culture. The low culture group simply does not have the monetary power to interest the cosmetic surgeons -- at this point. I have noted that the publications in which I have found
advertisements for cosmetic surgery have been mainly upscale journals and magazines that would be read by the upper-middle public, and also intermediate publications read by the lower-middle group. This data also suggests that these two groups are heavily targeted by such advertising campaigns. Although it will not be the focus of my study to look into black and ethnic populations’ use of cosmetic surgery, I believe that Gans mentions some interesting factors about these groups. I feel that many black and ethnic women share the ideal of facial beauty which is predominantly defined by Caucasian features. I have collected no data to substantiate this, but I am aware socially that many Jewish and Italian girls have a "nose job" almost as a rite of passage during adolescence. I have also been told that many Iranian women have this procedure after immigrating to the United States (Personal Communication, Michael Fischer, Ph.D., 1987). I am not aware, at this point, of the numbers of black women who have rhinoplasties to achieve a more aquiline look, but I believe this would be done if finances permitted. It is quite common for Asian women to have a surgical procedure which changes their eye shape to the rounder, Western look. I think that these factors point strongly to the fact that there is a Western, Anglo-Saxon bias in the perception of feminine facial beauty that cannot be denied. If one needs further proof of this, he or she need only review the advertisements portraying ethnic women in American magazines. In almost every case these women have darker (but not too dark) skin, hair, and eyes, but their facial features are distinctly Anglo-Saxon.

Although Gans states that most taste cultures are not expressly political, his position is that cultural content expresses values that can
have political consequences. Therefore it is important to look at the way women and men are portrayed in medical advertisements in order to understand how the advertisers view society. If we take a Marcusian stance, as women, then these ads which depict us a sex and decorative objects, passively awaiting the surgeons knife, are not part of the solution and therefore part of the problem. We need to be aware of the implications of these ads because they are helping to keep us in a certain unfavorable position within society. Gans tells us that creators have more power than consumers because the consumer can only veto what the creator (the cosmetic surgeon) offers. We must be alert and exercise our veto power.

In evaluating his work, Gans states that the mass culture critics have "translated their own private evaluations into a public policy position which not only ignores other people's private evaluations but seeks to eliminate them altogether" (p. 21). He states that the critics demand that everyone embrace high culture and that this is not justified in a democratic society -- which seems a fair statement as far as it goes. He also states that the critics might be justified if they could prove that popular culture harmed either society or a significant number of people. In this area, especially where health procedures are involved, I would assert that a critique of medical advertising and practice is warranted. Overall, Gans offers some interesting and provocative points, especially in his descriptions of American taste cultures. I do not, however, find his refutations of the critical theorists convincing in such areas as the value and use of technology, the commodification of American culture, and the sins and excesses of the mass media in our society.
The Democratization of Beauty

Just as Gans extols the potential for the democratization of art, and the opportunity it affords to other than the advantaged members of society to enjoy the benefits of artistic creation, so too the voices of the beauty industry advocate the democratization of American beauty. The hawkers of beauty products and now the voices of medical merchandizing enjoin us to consider being beautiful as the right of every woman. Repetitive advertising messages batter down the ego-boundaries of many women until they accept -- at least subconsciously -- the idea that physical beauty is all-important and that cosmetic surgery is the avenue to this beauty and all its benefits. Held (1980) quotes Adorno on the culture industry as follows: "it impedes the development of autonomous, independent individuals who judge and decide consciously for themselves" (p. 106). We could easily utilize this description for the beauty industry or for cosmetic surgery in contemporary America. Those who escape into the world of cosmetic surgery dull their interest in developing other more lasting aspects of their "selves" and become living examples of our cultural premise that women will mainly function as decorative objects. As the culture industry can dull on destroy artistic style by offering homogenized, edited versions of the classics of music and art, so too the "beauty" industry attenuates beauty by making faces and bodies homogeneous and predictable. The individuality and uniqueness of human beauty will be sacrificed to the idols of absolute symmetry and Caucasian facies-reproduction. The standardization and homogenization of facial and bodily beauty is developed to its extreme with the technology open to plastic surgeons. Interestingly, the very imaging and measurement techniques that
make possible the astounding and gratifying craniofacial procedures for disfigured individuals can be employed to make possible the reduction of normal faces and bodies into such small units that asymmetries undetectable to the human eye are scanned, measured, and displayed—even holographically. Herein lies the ultimate rationalization for such procedures -- a mathematical variance in symmetry -- which paradoxically may constitute part of a given individual's unique physical appeal. Therefore we come full-circle, and provide the ultimate example of rational irrationality: a highly rationalized beauty that sacrifices the individuality of the subject. And undoubtedly more dangerous than this is the possibility that the person will look to her newly altered exterior as the answer to complex individual and social problems. I would contend that these procedures offer no solution -- merely temporary distraction -- and that the unresolved issues will "surface" again and again, until they are dealt with in a meaningful way.

Post-Modernism

In an effort to sharpen the focus on post-industrial, late-capitalist, consumer, media, information, electronic, high-technology society, I turn now to the work of Jameson (1984) who writes about contemporary society as a "post-modern" phenomenon. The post-modern movement, beginning in the late 1950s or early 1960s is associated with a waning of the one-hundred-year-old modern movement. This is a chaotic and heterogeneous period, characterized in the art world by the work of Warhol and other pop stylists and by the technique of photorealism. Post-modernism is characterized by "the effacement ... of the older (essentially high-modernist) frontier between high culture and so-called mass or commercial
culture" (p. 54). It becomes a kind of "aesthetic populism" a cultural filtering down of high cultural traditions toward the popular cultural domain and finally to the mass arena. In the area of sociological study, post-modernism is structurally quite similar to Daniel Bell’s "post-industrial society" which he specifies as having five dimensions: 1. the change from a goods producing to a service economy, 2. the domination by the professional and technical class, 3. the central importance of theoretical knowledge as a font of innovation and policy, 4. a future orientation involving the control of technology, and 5. in decision-making the birth of a new "intellectual technology” (1973, p. 14). In an effort to understand this complex age, it might be instructive to utilize information from the work of both Jameson and Bell in order to contrast the modern and post-modern periods. The modern period, extending from 1860 to 1960 was the stage of monopolistic, imperialist capitalism, in which production was at the forefront. Jameson has termed it the "age of anxiety" or the age of alienation: and although the individual was somewhat depressed, at least he or she had some unique personal style or a "distinctive individual brushstroke" (p. 64). The solutions to the anomie of the age seemed to have included a multi-dimensional approach, and they involved the entire person: a good example of this type of approach is psychoanalysis. This was a structuralist period, and was marked also by a concern for abstraction.

The post-modern period, beginning about 1960 and extending into the present, is the age of multinational capitalism. Although, of course, production goes on, Jameson contrasts it with reproduction: and often, even though photorealism or computer imaging or other techniques of
mechanical reproduction are employed, we are still searching for an object not existent in the real world. If the modern age was characterized by anxiety, the post-modern is known as a time of affectual flatness -- the age of no feeling. The subject is not alienated, but rather fragmented: and the solution to his schizophrenic state is a uni-dimensional, surface remedy. This is the age of larger-than-life cartoon portraits and computer personae (for example, Max Headroom), and now the age of cosmetic surgery. We currently have the potential to be transformed not only into our own photographic images, but into a computer image as well. In the modern era it seemed that the art forms and metaphysical solutions were discreet: Now we see a merging of genres and the reproduction of the face and body is both an art form and a solution (plastic surgery will "fix" you more rapidly than psychoanalysis, anyway). Jameson states that in this age of late or consumer capitalism, we find "the purest form of capital yet to have emerged, a prodigious expansion of capital into hitherto uncommodified areas" (1984, p. 78). Capital now penetrates and commodifies nature through "development" and the unconscious through the media and advertising: no part of the environment or person is safe. We have noted, for many years, the fetishization of or obsessive devotion to commodities -- things -- in American culture. Possession of certain objects became a marker of social and economic success and people came to define themselves through them. Now, in the late 1980s we see a fetishization of the human face and form. We devote ourselves to the service of our body and its appearance through cosmetics, diet, and exercise programs, and now through the expanded technology of cosmetic surgery. This is, truly, the age of the simulacrum, for "The image has
become the final form of commodity reification" (Jameson, 1984, p. 66). We seek, through cosmetic surgical reproduction, a self that will no longer be us.

The Reagan Era

Another commentary on many of the post-modern issues raised by Jameson is provided by Debra Silverman in her book Selling Culture (1986). Silverman, an historian, became interested in a series of shows at the Costume Institute of the New York Metropolitan Museum of Art that were organized by special museum consultant Diana Vreeland. These shows, on such topics as the costumes of the Ching Dynasty in China, Eighteenth-Century and "La Belle Epoque" feminine fashion in France, a retrospective on work of designer Yves Saint Laurent, and equestrian costume, are seen by Silverman as part of a broader movement of aristocratic invocation in 1980s American culture. The American aristocratic revival, however, has not been marked by increased interest in historical tradition or precedent, but has been instead a source of new images for consumer sales. Silverman laments the distortion of history that occurred in the Vreeland exhibits and parallels this with the era of Ronald Reagan and its dedication to "public relations, image-making and the obliteration of the past" (1986, p. xi).

In her preface, Silverman states that she believes that this "politics and culture of wish-fulfillment needs to be identified and criticized", but is aware, however, that the "evolution from reality to image is part of a long American tradition" (p. xi). She cites the shift in American society and personality beginning in the 1890s, from the values of production to the values of consumption, and quotes scholars who identify the emergence
of an "image saturated" consumer society in America as early as the turn of the century. Even at this earlier point in our past we Americans were shaking off the shackles of the Puritan ethic and embracing the consumer ethos of self-indulgence and personal pleasure. She paraphrases Lowenthal and others who documented, in the early 1920s, the national hero-worship of "idols of consumption" versus "idols of production" (p. xi). The idol of production was a driven, hard-working individual, admired for his achievements. The idol of consumption was a passive, lucky individual, admired for a pleasing appearance and for gratifying others: as many might characterize Ronald Reagan. Silverman quotes writers who identify the gap between image and reality in Reagan's politics and administration and connect this to the movement toward idols of consumption. Reagan was not only, however, deeply immersed in the modern consumer culture, but also was powerfully influenced in his thinking by his own movie roles. He was the perfect president for this period in American history: an ever-youthful, ever-cheerful media celebrity who was the personification of surface over substance, illusion over reality. Silverman connects this American love for illusion to the technological explosion and to the disillusionment that occurred following the destruction of the 1960s ideal and such heroes as the Kennedys and Martin Luther King. Silverman acknowledges the encroachment of fantasy into the area of politics, but is dismayed at its seepage into the world of the art museum. I will document the movement of fantasy and illusion as it overrides the individual: seeping in through cosmetics, enveloping one through fashion, and finally finding its ultimate expression in the surgical alteration of the face and body.
As Silverman moves through her discussion of the Diana Vreeland shows at the Metropolitan Museum and of the political, social, and merchandizing worlds that they brought together, several themes continually re-surface. These thematic elements echo and deepen the voices of the Frankfurt School, parallel the descriptions of the post-modern age, and form the organizing principles for my description of the cultural obsession with appearance and cosmetic solutions. The first theme is the importance of youth and the view on aging. Silverman speaks again and again of the perpetually young Reagans who seem never to change: two individuals who in spite of increasing years, project an image of ageless vitality. A second theme is the idea of illusion and fantasy that all of Vreeland's shows and much of the Reagan administration has exemplified. Two of Vreeland's favorite mottos speak eloquently to these ideas: "Never worry about facts, project an image to the public" and "Fake it, fake it" (p. 119). Another theme which flows naturally out of illusion is that of consumerism. Silverman wonders if the contemporary dedication to riches and what they will buy is but another example of what Thorstein Veblen termed conspicuous consumption: those visible displays of luxury that late nineteenth-century wealthy Americans were wont to display. Nancy Reagan and her show business and society friends have exemplified the true spirit of consumerism in America: don't wear the same outfit more than once and buy the most expensive and exclusive articles that can be found. A theme related to consumerism is the aspiration to and the reveling in wealth, status, and social position: the latter two allegedly things which money can't buy, but which are, in reality, always purchasable. Silverman speaks of the "Gospel of Wealth"
under Ronald Reagan which "worships material success and self-centered individualism and consigns the Social Gospel to the dustbin of 'dependency'" (p. 17). Many of Diana Vreeland's statements are perfect examples of this philosophy, such as: "Everything is power and money and how to use them both. We mustn't be afraid of snobbism and luxury" (p. 3).

Vreeland's catalogues from her various costume shows are replete with illusions to the "art of living well", the cult of "personal pleasures" and the "infusion of elegance and passionate aesthetics in all areas of daily life" (pp. 78, 80). Vreeland writes in her "Belle Epoque" catalogue that this period was one where "people had confidence in cash and when a stylish aristocracy helped to make the world a little more amusing and much less ugly" (p. 70). Vreeland evokes an upper-class image of herself in her autobiography D.V., and bombards the reader with the excesses of her personal and social life. Nancy Reagan is another such image, described by designer Adolfo as the "thoroughbred American look: elegant, affluent, a well-bred, chic American look ... It's elegant, it's not overbearing ... she has expensive taste, but it's an image of good taste" (Silverman, 1986, p. 137). Out of these high society and haute couture images come spin-offs that both illustrate and reinforce the fascination of the ideal of being wealthy and socially prominent. Silverman mentions the popularity of the television fantasy "Dynasty" and also another popular show "Lifestyles of the Rich and Famous", which tells "true" stories of well-do-do individuals. Another theme is that of beauty and the obsessive devotion to it which is the definition of narcissism. Beauty for the people who inhabit the fantasyland of high society, politics, show business and
high fashion is well-bred, elegant and linear, and yet opulent and expensive. This, of course, implies that nothing can be well-used, or comfortable. One must always be perfectly groomed and turned out in the latest fashion -- anything else would be gauche. A final theme, which emerges a bit less flamboyantly but is present throughout as an undercurrent is the idea that women's power lies not in character and intelligence, but in beauty and seduction. Silverman speaks of the "reassuring 1980s Reaganite fantasy: the influence of women on men through their appearance and seductive behavior" (p. 63). She also quotes Nancy Reagan who states: "A woman should look like a woman ... I'm tired of jeans and long hair" (p. 3). Many other examples of each of these themes might be offered, but I believe that this overview illustrates the ideas about society, beauty and personal worth that have contributed to the overwhelming importance of physical appearance as the marker of human value in contemporary American society.

The Commodification of Medicine

The recurrent themes present in American society which have concerned the Frankfurt School theorists, and perplexed and fascinated sociologists, are influencing the practice of American medicine. Medical practice in this country has clearly been evolving more toward the business than the humanitarian dimension for many years and there are several reasons for this shift. There are more physicians being trained than ever before. Dr. Arnold Relman, a Professor of Medicine at Harvard Medical School, and editor of the New England Journal of Medicine, relates that over the past 30 years, the number of medical schools in America has doubled, and so has the number of graduates (1987). By 1990,
according to the Graduate Medical Education National Advisory Committee, we will have 536,000 physicians in this country: 70,000 more than we need. By the year 2000, the number of physicians will be 643,000 and this will be 145,000 more than we need. Dr. Relman states: "This rapidly expanding population of physicians is already increasing the competitive pressure on practitioners to generate more income by using marginal or new unproven procedures, tests, and technology." (Bulger, 1987, p.205). This over-supply of physicians, which is most noticeable in metropolitan areas, coupled with the 1978 Supreme Court decision allowing professionals to advertise has created a class of doctors who view their practices as businesses and their patients as customers. These potential buyers of medical goods and services must be appealed to through competitive advertising campaigns and pandered to in office settings where they are able to buy whatever medical commodity they desire, even if they don't need it: the customer is always right. This turn of events causes concern to many who work in the health care field. Thomsama (1984) quotes Dr. Gene Stollerman, a past president of the Society for Clinical Research, who has said: "The emergence of a special advocacy for our patients as 'consumers' and the characterization of our activity as a 'product' are in themselves uncomfortable reminders of the increasingly industrial nature of medical practice" (p. 42). Thomsama elaborates on Stollerman's concern by postulating that professional altruism, or the wish to help another without serving one's own needs, is diminished in a consumer-product health care model. Economic factors enter the professional-patient relationship from both sides: the doctor must lure the patient via advertising and keep him or her with good service, and the patient, now like any potential buyer,
must beware. Compassion is eclipsed by merchandising, trust by consumerism. These ideas, clearly, do not mesh with the traditionally voiced aim of medicine: to heal. (Unless, of course, we are speaking about the physician’s healthy bank balance). Dr. Relman notes the trend toward commercialism in medicine and fears for the trust relationship between patient and doctor: "If we allow medicine to devolve into a commercial transaction, we will be stepping back into the 19th century. The consumer of medical services will then become a victim again of all sorts of purveyors of nostrums." ("Commercialization Said", 1988, p.5).

Ivan Illich warns us that the medical establishment has become "a major threat to health" and speaks of an iatrogenic epidemic (1976, p. 3) which he believes can only be stopped by the lay public. He believes that the medical monopoly over health care has grown because no checks exist, and that this control interferes with our liberty -- even over our own bodies. Society, it seems, has delegated to physicians the exclusive right to define what constitutes illness, who is sick, and how the patient should be treated. He states that health care has become a "sick-making enterprise" (p. 7) and defines three levels of iatrogenesis: clinical, social, and cultural. Clinical iatrogenesis includes the harm that can befall a patient as a consequence of a doctor's curative or exploitative efforts, and also that which results from the physician's attempts to protect himself against malpractice suits. Social iatrogenesis manufactures illness by encouraging people to seek out preventative, industrial, or environmental medicine. Cultural iatrogenesis results when the health care industry weakens or destroys the potential people have to deal with their own vulnerabilities and ills in a unique and self-determined way. Illich terms
this the "ultimate backlash of hygienic progress" that paralyzes potentially healthy responses to "suffering, impairment or death" (p. 34). Illich's objections appear exceptionally well-taken when applied to the current practices of cosmetic surgery. Clinical iatrogenesis can result when a patient has a complication associated with a surgical procedure that was, in most cases, solely elective and functionally unnecessary. Social iatrogenesis results from the advertising campaigns that encourage social acceptance of, and desire for, such frivolous and yet dangerous surgical procedures. Cultural iatrogenesis occurs when the symptom is treated by the surgeon, leaving the cause itself untreated, and depriving the patient of the necessity of coming to terms with his or her own imperfection or mortality.

I believe that Illich is correct in stating that iatrogenic medicine "breeds ever new categories of patients" (p. 43), especially within the specialty of cosmetic surgery, for these surgical entrepreneurs specialize in technologies which promise beauty and youth to the masses. In order to create an enthusiastic public upon whom to visit this technology, however, the surgeons must medicalize the aesthetic: the sphere of facial and bodily beauty. They legitimize their endeavors by coining Latin and Greek diagnostic nomenclature for facial or bodily asymmetry, imperfection, or aging, such as: "blepharochalasis, or sagging tissue over the eye; rhinokyphosis, or presence of an abnormal hump in the nose; macromastia or micromastia, or oversize or abnormal smallness of the breasts or mammae; liopexia, or accumulation of fat in the tissues", and others (Dorlands, 1974). These "diagnoses" confer disease status upon normal body variations and age-related changes. At the point where the surgeon
meets the public, however, in the media advertising campaign, the medical must then be aestheticized. Medical and surgical realities are referred to as "painless", "bloodless", "high-tech", "computer-assisted", "reshapings" and "alterations", as will be evidenced in the medical advertisements that are presented in Chapter II. The reality is that most of the surface conditions that these physicians treat are not medical at all, and yet the corrective techniques are distinctly medical and surgical with attendant risks. Physicians in general are trained to look for illness and plastic and cosmetic surgeons are trained to create facial and bodily perfection. If these two quests are joined we find that the cosmetic surgeon must create diseases of the state of physical perfection in order to justify his or her existence. Therefore "surface" maladies are created and made known to the public via advertising, as are the curative techniques. And so it happens that medicine becomes, in Thomasma's words, "an expression of culture" (1984, p. 34) but it is also adding to culture as it is utilized to reinforce nonmedical ideals. Medical advertising and treatment serves, in the case of cosmetic surgery, to encourage excessive and obsessive devotion to the body and its imperfections, which becomes further fetishized and commodified and endlessly reinforces the reductionistic view of the human being as a mere collection of parts with built in obsolescence.

It has been the purpose of this first chapter to present an overview of social and philosophical explanations for the changes in American culture and medicine that may help to clarify the increasing need people currently feel to surgically alter their physical appearances. We have heard Marcuse speak of the role of advertising in the creation of "false
needs." Horkheimer and Adorno speak also to the important role of advertising in the runaway commodification that is characteristic of the American society. It will be the task of the next chapter to explore the development and ethics of medical advertising in America, with an emphasis on advertising for cosmetic surgical services.
CHAPTER II: MEDICAL ADVERTISING AND COSMETIC SURGERY

In 1926 the venerable Philadelphia advertising agency of W.W. Ayer and Son made the following bold prophecy: "Historians of the future will not have to rely on the meager collections of museums, will not have to pore over obscure documents and ancient prints, to reconstruct a faithful picture of 1926. Day by day a picture of our time is recorded completely and vividly in the advertising in American newspapers and magazines. When all other sources of information on the life of today fail, the advertising would reproduce for future times, as it does for our own, the action, color, variety, dignity, and aspiration of the American Scene."

Roland Marchand, 1985, p. XV.

"Mirror, mirror on the wall, who's the most marketing conscious of all?"

Pediatric News, March 1987, p.79
Since 1977, when the Supreme Court ruled that attorneys have a constitutionally protected right to advertise, dentists, physicians, and other medical professionals have begun to place ads in newspapers, magazines, and also on radio and T.V. Medical advertising began slowly and conservatively, for although this practice was now legally allowed, the medical profession had long held the belief that advertising medical services was unethical. However, with each passing year medical advertising has increased in volume and sophistication: from self-conscious beginnings that included only name, location and specialty, to current examples that mine our most basic cultural and social values in order to expand the market for medical services. In the last two to three years I have noticed that in addition to advertisements for general medical services, there has been a substantial increase in the numbers of advertisements by plastic surgeons, dermatologists, and other physicians offering to perform cosmetic surgical procedures. These ads have often seemed sensationalistic, in poor taste, and have obviously targeted women. For about four years I have been collecting examples of medical advertising, particularly those ads that dealt with cosmetic procedures. I am interested in the beginnings, growth, and qualitative change in medial advertising and concomitantly in the new wave of advertising for cosmetic medical and surgical procedures. As a nurse and anthropologist, I am concerned with several themes that lie beneath the surface of these phenomena: social and cultural realities, ethical issues, legal and economic considerations, and feminist/humanist issues. This chapter will attempt to weave together these related themes in the following manner. First, a historical overview of the ethics of medical advertising will be presented. Second, the legal status of medical
advertising will be discussed. Third, a section on the effects of advertising in general and medical advertising in particular will be offered. Fourth, data from the literature will be presented which will provide some indication of the current opinions of physicians and consumers toward medical advertising. Fifth, a short overview of the specialty of plastic or cosmetic surgery will be offered. Sixth, a collection of medical advertisements will be presented, which will be followed by a rather detailed analysis of the symbolism and meaning present in the ads. Finally I will present my conclusions on: helpful and ethical medical advertising, the ethical objectionability of many advertisements for cosmetic procedures and the philosophy than spawns them, the "falling from grace" of the specialty of plastic surgery, and the responsibility that the print media must bear for the cosmetic surgery explosion.

**Historical Overview of Medical Advertising**

The First Code of Medical Ethics of the American Medical Association (AMA) articulated a clear position on physician advertising in 1847 under "Duties for the Support of Professional Character".

It is derogatory to the dignity of the profession, to resort to public advertisements or private cards or handbills, inviting the attention of individuals affected with particular diseases--publicly offering advice and medicine to the poor gratis, or promising radical cures; or to publish cases and operations in the daily prints or suffer such publications to be made;--to invite laymen to be present at operations,--to boast of cures and remedies,--to adduce certificates of skill and success, or to perform any other similar acts. These are the ordinary practices of empirics, and are highly reprehensible in a regular physician (Reiser, Dyck and Curran, 1977, p. 31).

In 1903 the AMA revised this code and in fact substituted the caption "Principles of Medical Ethics" for "Code of Medical Ethics" allowing broader discretion to the state and territorial medical societies.
This revised statement specifies the restrictions against advertising.

It is incompatible with honorable standing in the profession to resort to public advertisement or private cards inviting the attention of persons affected with particular diseases; to promise radical cures; to publish cases or operations in the daily prints, or to suffer such publications to be made; to invite laymen (other than relatives he may desire to be at hand) to be present at operations; to boast of cures and remedies; to adduce certificates of skill and success, or to employ any of the other methods of charlatans (Dyer, 1985, p. 77).

These two early statements by the AMA attest to the strong sanctions against such advertising. It was seen to impugn the dignity of the profession and to reduce medicine to the "ordinary practice of empirics" (Dyer, p. 77). (This quote refers to a school of medical practice which was based on experience only, without the aid of science or theory.) The 1903 statement relates such advertising practices to the "methods of charlatans" or quacks (Dyer, p. 77). Advertising of any sort was clearly incompatible with the practice of scientific, honorable medicine.

The 1912 revision of the AMA code reads as follows.

Solicitation of patients by circulars or advertisements, or by personal communications or interviews, not warranted by personal relations, is unprofessional. It is equally unprofessional to procure patients by indirection through solicitors or agents of any kind, or by indirect advertisement, or by furnishing or inspiring newspaper or magazine comments concerning cases in which the physician has been or is concerned. All other like self-adulations defy the traditions and lower the tone of any profession and so are intolerable. The most worthy and effective advertisement possible, ... is the establishment of a well-merited reputation for professional ability and fidelity. This cannot be forced, but must be the outcome of character and conduct (Dyer, p. 77).

This revision labels advertising practices previously outlined as "unprofessional". Bans on advertisement are further spelled out to include even indirect advertising or news media accounts that chronicle the work of the physician. The only acceptable method of advertising is by word-of-mouth: unsolicited accolades from admiring patients. A physician's
reputation was thus his advertising campaign as well as his reward.

By 1957, the AMA Principles of Medical Ethics stated simply: "He should not solicit patients" (Reiser, Dyck, and Curran, p. 39).

**Legal Challenges**

Recently however, the long accepted professional restriction against advertising in medicine has been challenged in the United States. Michael Young, an attorney for the Texas Medical Association, reviewed the legal challenges to the AMA's traditional stance on advertising in a 1983 article. In 1977 the United States Supreme Court discussed the topic of advertising by learned professionals in an Arizona case dealing with a challenge to a disciplinary ruling prohibiting advertising by lawyers. In *Bates v. State Bar of Arizona*, the Court ruled that attorneys have constitutionally protected rights to advertise fees for routine legal services in newspapers. Bloom and Stiff (1980) note, however, that three dissenting justices (the decision was 5-4) were concerned that people might go to a lawyer because of the low price being charged for a routine service and then find out that their needs were not routine and were much more expensive than they anticipated. In 1976 a Virginia statute prohibiting the advertising of prescription drug prices by pharmacists had also been disallowed. The Bates decision placed the subject of advertising by licensed professionals in a new light, but it left many questions unanswered. The Court did not speak to such issues as advertising in the broadcast media, "quality of service claims" (including testimonials), or in-person solicitation. The Court indicated that its attempt was to balance the First Amendment issue of the provision and receiving of information with the state's interest in protecting consumers of professional services.
In June of 1975, the US Supreme Court held in *Goldfarb v. Virginia State Bar* that the learned professions were subject to the Sherman Antitrust Act. In November of that year, the AMA began revising its ethical statements on several topics, including advertising, in order to reflect changes in medical practice, social values, and the law. Before the review was completed, however, the Federal Trade Commission (FTC) issued a complaint against the AMA in December of 1975. The complaint charged, among other issues, that the AMA restricted the ability of its members to advertise. In April of 1976 the AMA issued a comprehensive statement on advertising which sought to establish guidelines for honest versus deceptive advertising practices. This statement declared ethical the dissemination of fee schedules and other useful information which would assist patients in making an informed choice among physicians. In fact, the Supreme Court quoted the AMA statement in the Bates decision, and stated that professional associations should play a "special role" in "defining the boundary" between deceptive and non-deceptive advertising (Young, 1983, p. 80). In spite of these developments, the FTC pursued its complaint and entered a cease and desist order in the AMA case in May of 1982. This order prohibits the AMA from restricting some solicitation of patients and advertising of fees and services by physicians. Medical organizations are permitted to enforce:

reasonable ethical guidelines governing the conduct of members ... with respect to representations, including unsubstantiated representations that would be false or deceptive within the meaning of Section 5 of the Federal Trade Commission Act, or with respect to uninvited, in-person solicitation of actual or potential patients, who because of their particular circumstances, are vulnerable to undue influence (Young, p. 80).
The following statement is the AMA's current pronouncement on ethical advertising and publicity by physicians which is quoted by Young (pp. 80-81). Young reminds us that this statement is not directly binding on Texas physicians, but that it does serve as an "authoritative source of guidance for medical societies which are asked to decide whether particular conduct by a physician member is ethical or professional."

There are no restrictions on advertising by physicians except those that can be specifically justified to protect the public from deceptive practices. A physician may publicize himself as a physician through any commercial publicity or other form of public communication (including any newspaper, magazine, telephone directory, radio, television or other advertising) provided that the communication shall not be misleading because of the omission of necessary material information, shall not contain any false or misleading statements, or shall not otherwise operate to deceive.

The form of communication should be designed to communicate the information contained therein to the public in a direct, dignified, and readily comprehensive manner. Aggressive, high pressure advertising and publicity may create unjustified medical expectations. Any advertisement or publicity, regardless of format or content should be true and not misleading. The communication may include: (a) the educational background of the physician; (b) the basis on which fees are determined (including charges for specific services); (c) available credit or other methods of payment; and (d) other information about the physician which a reasonable person might regard as relevant in determining whether to seek the physician's services. Testimonials of patients, however, as to the physician's skills or the quality of his professional services should not be publicized. Statements relating to the quality of medical services are extremely difficult, if not impossible, to verify or measure by objective standards. Claims regarding experience, competence and the quality of the
physician's services may be made if they can be factually supported and if they do not imply that he has an exclusive and unique skill or remedy. A statement that a physician has cured or successfully treated a large number of cases involving a particular serious ailment may imply a certainty of result and create unjustified and misleading expectations in prospective patients.

Consistent with federal regulatory standards which apply to commercial advertising, a physician who is considering the placement of an advertisement or publicity release, whether in print, radio, or television, should determine in advance that his communication or message is explicitly and implicitly truthful and not misleading. These standards require the advertiser to have a reasonable basis for claims before they are used in advertising. The reasonable basis must be established by those facts known to the advertiser, and those which a reasonable, prudent advertiser should have discovered. As used herein, references to a "physician" apply also to information relating to the physician's group, partners or associates. Any communication or message within the scope of this opinion should include the name of at least one physician responsible for its content.

This statement allows physicians to use any form of print or broadcast media, but enjoins them not to deceive. I believe that the guidelines on the form of the communication are helpful, because they encourage "direct and dignified" messages, and discourage "aggressive, high pressure" advertising. These adjectives address some of the difficult issues having to do with propriety and taste in professional advertising. Following from this, the New York State Board of Regents, (Bloom and
Stiff, 1980) defined as "unprofessional conduct" advertising that is "false, fraudulent, deceptive, misleading, sensational or flamboyant". Additionally, these provisions label the following as unprofessional as well: "intimidation or undue pressure", testimonials, guarantees, discounts, and "claims of professional superiority which cannot be substantiated by the licensee" (p. 646).

Young states that the boundaries of legally permissible restraint by medical societies and states on physicians advertising will be delineated more clearly as individual cases are reviewed by the courts. Some issues have already generated debate, and Young presents some points covered in an article on MD advertising that appeared in the *Duke University Law Journal* by Canby and Gelhorn. First, in the area of deceptive advertising, that the public may be more "vulnerable to misstatements in physician advertising than in other forms...because of lack of sophistication with regard to medicine" (1980, p. 81). However, stringent standards requiring too much explanation are difficult to reconcile with the First Amendment. Additionally, any advertisement is capable of misleading someone, and protection of commercial speech is based on a balance between this risk and the right to possess information. Second, in the area of quality of services, it is argued that many descriptive statements, even those listing legitimate achievements of the physician, may seem "self-laudatory". And yet in many cases this information is precisely what the consumer wishes to know. Additionally, testimonials may involve a potential for deception, but are not intrinsically irrelevant. Canby and Gelhorn suggest that the consumer be allowed to judge the relevance of the testimonial to the service being advertised. Third, in the area of radio and TV advertising,
the authors state that "style will predominate over substance in television has raised the question of the need for additional protection for consumers" (p. 82). Again, the physician's voice and personal style may be irrelevant factors in choosing a doctor, yet the best approach may be to leave these matters to the discretion of the consumer. Fourth, in the area of time, place, and manner restrictions, Canby and Gelhorn state that the First Amendment considerations preclude "prohibitions based on professional traditions." In other words, even if the message is not dignified, the information must be delivered.

Effects of Advertising

The Voice of Technology

Ronald Berman states that: "Advertising is the voice of technology: because of that it represents the intention to affect life" (1981, p. 16). We know that technological development is a fact of life in Western cultures and advertising mediates between technology and the marketplace. And yet the idea that never-ending technological progress is beneficial is currently being challenged. Capra (1983) writes about our need for "a new paradigm - a new vision of reality" (p. 16): one that will represent a turning from the mechanistic conceptions of Descartes and Newton to a more ecological and holistic view. He links technology and progress out-of-control to ecologic ruin, inflation, nuclear threat, and individual and social disintegration. Other writers such as Jeremy Rifken (1985) and Larry Dossey (1982) would also agree with the heretical idea that "progress" can be "hazardous to your health". Rifken is best known for his opposition to genetic engineering and nuclear technology and Dossey decries the effect of the Cartesian world view on health care, where the
biological is separated from the "human". Just as there are now voices raised in opposition to unchecked technology, there are those who would oppose some of the utterances of "the voice of technology". Should advertising be allowed to expand unchecked as technology has? If one can adopt a detached and business-like view of the "marketplace" and not see it as being composed of human beings, then one is less likely to become alarmed at the contents of current advertising messages. The tendency will be to see advertising practices as solely concerned with profit and loss in dollars. Advertising becomes beneficial if the advertised product or service can be demonstrated to have increased its market-share after an advertising campaign. If, on the other hand, the advertising seems to have no effect on or to harm the salability of the product, then the sales pitch might be seen to be neutral to deleterious. If social considerations are factored in, however, one must also calculate a benefit/harm ratio for individual human members of the "marketplace" as well as for society. Profit and loss columns do not readily lend themselves to the inclusion of "incalculables" such as human physical and emotional well-being. For this reason social scientists have written prolifically about advertising - and they have most often been its severest critics. Gross (1977) reminds us that if ads gave only product information, that they would be of no use to the semanticist, the cultural critic, or the social scientist.

Galbraithian Theory and Supply-Creates-Demand

If we begin this discussion with advertising as the evangelist for technology it is appropriate that we first see it through the eyes of economist John Kenneth Galbraith whose theories have invalidated the classical idea of supply and demand. Many economists have held that the
free market responds to supply and demand, but Galbraith's view is that
demand is artificially induced in order to increase sales and profits. He
would see advertising's great fault to be the encouragement of unnecessary
production that wastes resources and that can negatively influence social
character. Those who agree with Galbraith have come to see advertising,
in addition, as the voice of capitalism. Advertising has been seen not only
to articulate but also to affirm capitalist ideology and to stand in
opposition to the conception of the Platonic rational state. It is also
linked inextricably to excess production and consumption, as it may create
the desires for the commodities it touts. Folland (1985) discusses the
application of Galbraithian theory to health care via the "supply creates
demand" hypothesis or the "availability effect" (p. 338). This theory
argues that health care providers have the power to create additional
demand for their services in times of competitive pressures. This power,
of course, might be wielded through the advertising of health care
services. Folland states, however, that there is evidence to suggest that
the supply-creates-demand effect may be relatively small, or perhaps
nonexistent. Pauly and Satterthwaite, for example, propose that prices
depend on the information that consumers have about physicians, and that
such information is more difficult to obtain when there are more
physicians, thus increases in provider/population ratios may sometimes lead
to higher prices. In the context of this model, advertising, as information,
would be expected to lead to lower prices. In related empirical work,
Pauly found evidence of only a small supply-creates-demand effect for
physician availability (these were ambulatory care MDs). He concluded
that "for the general population, the availability effect in ambulatory care
can be safely ignored" (p. 339). Two problems with this line of reasoning might be mentioned for the purposes of this paper. First, advertising is not uniformly viewed as "information" which has a beneficial overtone and effect. It can also be seen as "disinformation" or propaganda. Secondly, the "availability effect" for ambulatory care cannot easily be compared with that for plastic surgery. One is a service deemed necessary by perhaps a majority of persons in the United States. The second is a service that has been largely utilized by the wealthy elite in previous generations, although I believe that this is currently undergoing change in our society.

Folland also notes that increases in utilization, should they occur via advertising, do not necessarily result in lower welfare to the consumer. He observes that as long as the treatment has some positive effect, even if this appears small to the outside observer, it would be difficult to class the treatment as unnecessary from the patient's perspective. It is obvious that the truth of the first statement hinges on the service that is being increasingly used. If the service has harmful or dangerous effects, then "lower welfare" might indeed result. Secondly, the positive effects, whether physical or psychological, cannot be considered alone, but must be weighed against possibly harmful physical or psychological effects. Plastic surgeons often remark on the psychological improvements possible for patients after cosmetic surgery. The plastic surgeon with whom I spoke (personal communication, Dr. B., 1987) told me about patients he had seen whose entire affect changed subsequent to having perhaps a "small hump" removed from the nose. They would metamorphosize from shy, retiring individuals into extroverts: and he stated that this is a reason he believes
he should not necessarily tell a prospective patient whether or not he (the doctor) believes the procedure is "necessary". The problem with this position is, of course, that the doctor could cease to state any medical opinions to patients and his surgical services could become purchasable to any patient, for any reason.

Advertising As Information

Folland states in his article that there are two theoretical schools of thought on the subject of advertising. We have been discussing Galbraith and his ideas about supply-creates-demand, and this viewpoint would characterize advertising as attempting to change consumer tastes, which reduces price sensitivity, increases monopoly power and raises prices. Another school holds advertising to be information, which makes the consumer aware of alternatives. Having choices leads to more competition which lowers prices. Folland tells us that health care analysts who have addressed these issues have tended to favor the competition-enhancing view of advertising. Benham studied differences in the price of eyeglasses between areas where advertising was permitted and where it wasn't. He found that prices were much lower in areas where advertising was allowed. Cady noted that the presence of advertising restrictions raised the prescription drug price index by approximately four percent. Feldman and Begum found that when opticians and optometrists were not allowed to advertise, prices of eye examinations went up by five to ten percent. Comparable studies for physicians and hospitals have not been reported, however; and it is risky to assume that the prices of intangible health services will follow the trends noted for tangible goods such as eyeglasses and prescription drugs. Eye examinations, however, may be similar enough
to other standard primary care procedures to permit some cautious optimism. Problems with this line of reasoning surface immediately, however. First: Is the aim of advertising to impart information? Samm Sinclair Baker, an ad man with 30 years experience on Madison Avenue, wrote a book entitled: *The Permissible Lie - The Inside Truth About Advertising* (1968). His thesis might serve as a partial refutation of the idea that advertising is information (and of course this implies that the information is truthful). He states that:

First, the overwhelming aim of advertising is to make a profit; to serve the public becomes a secondary consideration. A lie that helps build profits is considered a permissible lie. Of course, the lie must not be so blatant that it results in eventual damage to the company's profits. Second, a substantial amount of advertising is based on the concept of the permissible lie. Third, this fakery, through saturation and repetition, undermines the attitudes and ethics of the adult, the child, and the family. (p. 5).

Baker quotes *Advertising Age* magazine as stating: "those holding ad competitions awards should make sales objectives and sales results the No. 1 criterion. After all, that's what the whole business of advertising is about." (p. 14). In order to increase sales almost anything goes: the hardest-selling campaign possible without perpetrating recognizable fraud. This attitude breeds the permissible lie -- the half-truth -- which Baker characterizes as "the worst half" (p. 14). In further discussion, he wonders if advertising is "fraudulent or just plain silly" and characterizes "silly" advertising as "flatulent puffery".

The subject of windiness in advertising is apparently a popular one: Ivan Preston has written an entire book on puffery in advertising (1975). In his book, Preston defines "puffing" as "advertising statements which are not illegal although they cannot be proven to be true" (p.X). The principal law by which most advertising is regulated in the United States
is Section 5 of the Federal Trade Commission Act, which states that "unfair or deceptive acts or practices ... are hereby declared unlawful" (p. 10). Puffery is seen by Preston to be not against this law, but to be a child of this law. He states that our government admits that sales puffs are false, but that it rules incorrectly that they are not deceptive. He holds that puffery affects purchasers' decision-making by "burdening" them with untrue beliefs, but that our regulators state that this is not the case except to the occasional "out-of-step" individual who "acts unreasonably and therefore deserves no protection" (p.4). Therefore, the law holds that reasonable people will automatically discount puffery and therefore will not be deceived by it. Preston feels that the law described is as much a piece of "baloney" (p.4) as the puffery itself: puffery deceives and the regulations making it legal are unjustified. Preston illuminates for us the lack of clarity in the legal definitions of the terms falsity and deception when applied to advertising claims. It would initially seem that what is false should be illegal and what is not false (therefore true) should be legal. But this is not the "Way" of the law. A more correct understanding is that what is deceptive is illegal and what is not deceptive is not illegal. Falsity and deception are not the same: what is deceptive is what is harmful to the consumer. Words and/or pictures used in advertising may be considered to be injurious and therefore deceptive according to the law even though they are not false. Therefore a false claim is not automatically illegal, and a true one is not automatically legal. The legal interpretation of these terms presents us with a problem, however: It is easier to detect falsity than to detect deception. Falsity is objective and can be detected when looking at nonhuman objects. Does
the product being sold match the advertising description? Deception, conversely, is subjective: a condition that must be ascertained by examining the beliefs of the consumer. Does the commercial message cause the consumer to believe that the product contains something it does not? If so, then even if the message is actually true, the subject has been deceived because he has acquired a false belief from its contents. This scenario describes the problem of puffery. As Preston tells us, the question is not whether puffery is false, which almost all of it is, but whether it is deceptive and illegal. The law states that puffery is not deceptive, Preston states that it is. The law further states that a person must be reasonably alert in examining the product he is purchasing and Preston quotes a 500 year old rule that holds that a person who purchases a horse and is told the horse has two eyes must check this fact out for himself, since it is so obvious. If the buyer doesn't count the horses' eyes, he is not acting "reasonably". This might seem to bode poorly for the buyer--especially if he can't count (or has no previous experience with horses) until we factor in another legal element. Preston tells us that the law decided "long ago" in cases where both buyer and seller bear some responsibility, the seller is not responsible (p.12). However, he then goes on to cite cases where improper (unreasonable, not alert) behavior on the part of the buyer "rendered inconsequential the proper behavior of the seller" (p.14). If the buyer flunks the "obvious falsity" test and doesn't count the eyes, let him beware. There are several facts, therefore, that must be kept in mind. Puffery is almost always false, and yet puffery is not necessarily deceptive (by law). Advertisers use puffery all the time, and they would not use it unless it were effective (i.e., customers are
purchasing the products). It seems that the buyer must protect himself in the marketplace: he must not only count the eyes but administer a vision test to the horse as well. He must expect the seller to use puffery and must become cynical about the "legalized lying" and "soft-core deception" (p.14) that are daily a part of his existence as a consumer. If puffery is part of advertisements for medical procedures, however, the consumer is at greater risk of injury. Most consumers are not as knowledgeable about medical products and services as they are about those used more often and it is therefore more difficult for them to be "reasonable" and make informed choices. Additionally, when a consumer makes a "wrong choice" involving a medical/surgical product or service, the stakes are much higher than when he or she is deciding between cleaning products or even high-priced items such as automobiles.

Advertising as "Capitalist Realism"

We have previously alluded to the link between capitalist thought and advertising in discussing the ideas of Galbraith. At this point I would like to discuss some of the ideas of Michael Schudson (1984) who sees advertising as "capitalist realism" (p.209). He agrees with the UNESCO MacBride Commission that advertising "tends to promote attitudes and lifestyles which extol acquisition and consumption at the expense of other values" (p.210). Advertising reflects and helps create a "common symbolic culture". Advertising may shape our values even if it does not change our buying habits. Advertising attempts to establish connections in people's minds between available products and services and certain social groups, occasions or overall feeling states. Advertising symbolically links a product to class aspirations, rituals that are important in our culture, and
"good" feelings such as happiness, peace and love. In this effort to connect rampant consumerism to our cultural aspirations and values, our shortcomings are reflected and intensified while our values are debased. Schudson compares capitalist realism to socialist realism: the term from which he derived it. "Socialist realism is official, state-sanctioned and state-governed art as practiced in the Soviet Union" (p.214). Soviet artists and writers must portray the spirit of socialism in a simplified, optimistic, pleasant way. Life pictured in this genre must be "life worth emulating" and should represent the positive value of social struggles. One can therefore see the parallels between what socialist realism is designed to do and what advertising in capitalist society intends to do. Schudson quotes the First Soviet Writer's Congress of 1934 which defined socialist realism as an art obliged to present a "correct historically concrete representation of reality in its revolutionary development" (p.215) and suggests that all we need to do to define advertising is to change the word "revolutionary" in the above quote to "capitalist". He suggests that American advertising and socialist realist art both simplify and typify. They do not picture reality as it is, but reality as it should be: life worth living. This means, of course, that reality in advertisements (and in Soviet art) will be a different entity than we know it to be in life. Advertising cannot be said to portray state sanctified or official reality in America, but it does articulate many of the operative values in our society. Schudson feels that as Soviet art idealizes the producer, American art idealizes the consumer. He states that advertisements point to the enviability of middle-class material comfort and that they "reproduce and even sometimes exaggerate long-standing social inequalities"
(p.220). He elaborates on this concept by noting the relative invisibility of Blacks in advertisements and the treatment of women as childlike and subordinate to men. He cites a study that examined five hundred magazine advertisements picturing couples taken from general circulation periodicals and women's and men's magazines. The couples were almost always shown as happy and as having fun, expressing affection or sexuality, or demonstrating devotion to each other. There were no old, sick or unattractive couples in the advertisements. This seemed to suggest that typification and idealization are dominant modes in advertising. This did not demonstrate couple-life as it really is, but rather portrayed social ideals and represented as normative "those relatively rare moments of specialness, bliss, or dreamlike satisfaction" (p.220). Schudson admits that these magical advertising moments portrayed are not in themselves "capitalist", except that the satisfactions evoked are private and do not include collective values. What is distinctly capitalist is that these values are employed to sell goods "invoked in the service of the marketplace" (p.221). Schudson also voices the belief that advertising leads people to certain beliefs. But he asks: "Do people put faith in the explicit claims of advertisements" and go out and buy the product, or do they have their attitudes and assumptions slowly changed to match the attitudes portrayed in the ads, whether they buy or not? As Schudson tells us, social critics have argued that the peril inherent in advertising is that it causes attitudinal changes of this larger type. He quotes Rorty who wrote of the religious power of advertising, stating that "advertising... becomes a body of doctrine". He also quotes Ann Douglas who characterizes advertising as the "only faith of a secularized consumer society" (p.225). Schudson
declares himself unconvincing by the advertising-is-religion metaphor, but states that advertising may be more powerful the less it is believed in. The fact that communications do not mean what they say may be the core of their power. Advertising may create attitudes even when it does not inspire belief: It succeeds in creating attitudes precisely because it does not ask for belief. Schudson parallels this with the "low-involvement learning" hypothesis that Krugman postulates as an effect of television advertising (p. 226). In such learning people are not "persuaded" to believe something -- and their attitudes (at least stated ones) may not change--but there is a "sleeper" effect. The viewers have the "structure of their perceptions" altered and when they are ready to make a purchase a real change occurs. In the purchasing situation the product is now seen in a different way: even though the consumer may have been able to verbalize no change in belief up to that point. People may take ads to be trivial or laughable or transparent, but what Krugman suggests is that these attitudes are exactly what enable the ad to be successful. If consumers believed in the power of advertisements they would deploy their "perceptual defenses" (p. 227) as they do in situations where they feel they are being influenced or persuaded on important matters. Schudson reminds us that it is part of our popular culture to regard advertisements as ridiculous: in fact we love to satirize our own advertising campaigns. We are unwary: even enjoying ourselves at the expense of the silly commercials, and they victimize as subliminally as we laugh. Schudson likens the belief or non-belief that people have in relation to advertising to that which they have about religion. Anthropologist Melford Spiro identified five levels at which people may "learn" an ideology: first, they
may simply learn it; second, they may learn about and understand it; third, they may actually believe the concept to be true; fourth, they may not only believe the concept but act on that belief; and fifth, they may internalize the belief so that it actually guides and instigates their actions. Most theories about advertising assume that the stages of belief are sequential: that you must pass through level 1, then level 2, then level 3. Krugman would argue that a person can reach level 4 (behavior influenced) without ever passing through level 3 (belief). If this, then, is possible, it argues persuasively that advertising must be considered a force to be reckoned with. Schudson seems to accept that this is the case. He does not seem to believe, with Galbraith, that advertising can create a belief. He quotes Clifford Geertz who says that art doesn’t create the material culture or function as a primary determinant of experience. The experience is there -- the art is a commentary on it. Advertising may not force people to believe in capitalist institutions or in consumer values, but when alternative statements of values are difficult to find in a culture, then capitalist realist art will have some power. Of course, one can find dissenting commentaries on American values, and Schudson is right that advertisements do not completely monopolize the symbolic marketplace. But, as he says, no other cultural form is as accessible to all groups in our society, even children and immigrants. And he postulates that only the imagery of professional sports exceeds advertising as a "source of visual and verbal cliches, aphorisms, and proverbs" (p.233). This is the potent cultural power of American advertising.

The Consumer: Puppet or Puppeteer?

It might seem, based on the previous discussion, that the consumer
has only a slim chance to save him or herself from the continual onslaught of direct and subliminal advertising thrusts. Is there hope for the beleaguered consumer: or is he or she a pawn in the hands of the aidmen? Baker (1968) would disagree that the consumer can be manipulated at will by the advertisers. He cites the commercial failures of several products, notably the Edsel, which didn't sell despite perfection in design, engineering, and sales pitch: the public simply didn't like it. He quotes a past president of AAAA (American Association of Advertising Agencies) who has said: "The consumer is in the driver's seat ...[He is] both rational and irrational ... shot full of foibles and idiosyncrasies, crotchety, hardboiled and given to inexplicable vagaries and whims ... as far from a puppet as one can get" (p.175). Baker reminds us no matter how much pressure advertising applies, no matter how silly or deceptive the campaign, people try a product and decide whether they like it or not. If the public decides against an item, then the advertiser and his product are out of business. This rationale, however, holds better for often-used, lower-priced products and services than it does for seldom-used, high-priced, and potentially risky medical and surgical services. Stephen Fox who also attributes less potency to the effects of advertising, has concluded that advertising gathered power early in the twentieth century and reached its peak of influence in the 1920s. Since then, he contends, despite its omnipresence and increase in volume, it has steadily lost influence over American life. Advertising has become more "mirror than mindbender, responding to American culture more than shaping it" (1984, p.272). Fox states that during the 60s this lessened influence was especially obvious: advertising could be seen to lag behind the course of
events, not to foreshadow and direct them. It is American society and culture that has changed and is changing, and with it, advertising. The advertising mirror merely reflects what is placed before it. Fox maintains further, that the volume and pervasiveness of advertising now works against its effectiveness. As advertisements proliferate, people attend to them less. According to one AAAA study, an average consumer was exposed to 1,600 ads a day: of these 80 were consciously noted and only 12 precipitated some reaction. Fox further states that most recent polls of public opinion about advertising have found neither approval nor disapproval -- merely indifference. Fox does not tell us, however, how the subjects were polled. Were they merely asked how they felt about these issues, or were some attempts made to appreciate attitudinal changes and/or actual consumption changes in the subjects? We are not told and yet previous discussion has suggested to us that what is verbalized by the subject may not tell the whole story. Fox further asserts that government and advertising industry regulations have limited advertising's freedom to lie, and that while advertising has grown less deceptive, the public has grown more skeptical and sophisticated. He cites a 1976 Gallup Poll where Americans rated the honesty and ethics in eleven fields and placed advertising executives last. Fox's position on the deceptiveness of advertising might be challenged by the previous discussion of falsity, deception and puffery. Additionally, the public may have truly grown more skeptical of advertising, or may be simply verbalizing what it believes and hopes to be true -- unaware of the continual, unrelenting erosion of former beliefs until it is too late. In order to refute the claim that advertising has the power to create and shape taste and behaviors, Fox
quotes advertising executives. He quotes Carl Ally, for example, who states: "Advertising doesn't manipulate society. Society manipulates advertising. Advertising responds to social trends. Agencies respond to advertisers. It's that simple" (p.329). It may be that simple for Mr. Ally, who has a vested interest in believing this statement and in being believed, but it is not so simple for individual consumers or society. Fox admits that the images in the advertising mirror do not reveal the best aspects of American life, but, he states: "Advertising must take human nature as it is found" (1984, p.329). Fox tells us that most of us would like to think that we act from admirable motives, but that in fact we are usually moved by selfish practical concerns. And: "Advertising inevitably tries to tap these stronger, darker strains" (p.330). Fox states that deTocqueville described American culture as "money-mad, hedonistic, superficial, rushing heedlessly down a railroad track called progress" (p.330) in the 1800s, long before the development of national advertising. He states that we miss the point if we blame advertising now for "these most basic tendencies in American history". We must not kill "the messenger instead of dealing with the bad news" (p.330). It is obvious that Fox is correct in stating that we must deal with society's ills and not simply blame advertising for them. It is apparent, as Gross states, that the "raw materials" for advertising are "our own drives and aspirations" (1977, p.52). Yet there are those who hold a more optimistic view of human nature than does Fox and who continue to attempt to act from other than a position of total selfishness. Perhaps we must deal with human and societal imperfections, but we must not give up and accept our individual and social "dark side" as the definition of humanity and society. We cannot
afford to "take human nature as it is found" (especially as it is found in advertisements). And we cannot allow the "messenger" to get off "Scot free".

**Physician and Consumer Opinion on Medical Advertising**

In order to serve as a kind of barometer of current opinion trends, this section will present the results of some attitudinal surveys administered to both physicians and consumers. In order to gauge the receptivity of consumers to advertising, Folland (1985) quotes a 1984 survey done by Kviz on 492 rural Illinois residents. Fifty two percent said that advertising would help them select a physician, although most expressed concern about false advertising. These results are similar to a national public opinion survey done by the AMA in 1982 which found that 62 percent of consumers felt advertising helped people to choose a doctor. Additionally, in this AMA sample, 64 percent felt it was ethical and proper for physicians to advertise, and 41 percent believed advertising would result in lower prices.

Young (1983) quotes a public opinion survey commissioned by the Texas Medical Association in 1982 which found that fifty three percent of patients thought that advertising by doctors in newspapers or on television would lower their credibility and professional standing. Seventy percent of the patients sampled stated that they would be less likely to go to a doctor who advertised on television or in newspapers. Some of the reasons these patients gave are as follows: "Good doctors don’t need to advertise", "I prefer a referral or a recommendation from a friend", and "It just seems unprofessional" (p. 79).
The editorial staff of *Legal Aspects of Medical Practice* conducted a random survey of 50 general and family practitioners chosen from the AMA Directory of Physicians in the United States that showed a change in the opinion of the doctors toward medical advertising from 1979 to 1980 ("Would You", 1980). In 1979 a poll taken by the magazine showed that 26 percent of the physicians favored the elimination of AMA guidelines that have discouraged M.D. advertising. By 1980 the poll showed that 34 percent felt these ethical restrictions should be eliminated. The 1979 and 1980 polls revealed that 14 percent of the physicians would advertise if the AMA restrictions were dropped. The 1980 poll also revealed that 26 percent of the doctors feel "more favorable toward advertising than they (did) five years ago" (p.36).

Folland (1985) quotes a 1978 survey of M.D.s and dentists in Denver, Kansas City, and Memphis, which found them generally averse to advertising. Most of them felt that advertising would not improve patient decision-making nor result in lower fees, and believed that advertising the quality and competence of a doctor would be very difficult. These attitudes appear to be changing, however. The AMA has followed physicians' opinion of fee advertising between 1978 and 1983 and survey data show that the percentage of physicians who support fee advertising in newspapers, radio, and television is growing steadily: from 8 percent in 1978 to 17 percent in 1983. It is interesting that younger physicians (less than 45 years old) are more favorable to such advertising by a ratio of two to one. Folland conjectures that the issue of advertising may be forced by the changing nature of the competition. Physicians have to compete with such recent trends as 24 hour emergency centers and
"mediglomerates", and are also dealing with projected M.D. surpluses.

Young, (1983) again quoting the 1982 survey sponsored by the Texas Medical Association, found that 87 percent of physicians sampled opposed advertising by physicians in newspapers or on radio and television. Further, 80 percent of those physician respondents agreed that advertising by doctors in newspapers and on television would lower their credibility and professional standing. If the advertising were limited to office hours and professional credentials only, however, 48 percent of the physicians stated that they would be more likely to support it.

A recent indicator of physician acceptance of advertising can be found in an article in American Medical News, (Lamberg, 1987) which describes the decision of the American Academy of Dermatology (AAD) to support a direct to consumer advertising campaign. The one year trial campaign will cost approximately $1.5 million, for which the 6,500 AAD members will be assessed $250 each. Stephen Webster, M.D., AAD spokesman on the campaign, made the following statement:

Many of us find advertising by individual physicians repugnant. But other medical organizations, as well as many hospitals and prescription drug manufacturers, are advertising today, and the climate is right. The AAD program will help patients make an informed decision about their own health care (p.9).

I have found several recent examples of statement by physicians, some of them plastic surgeons, which disapprove of and lament the current advertising campaigns by some M.D.s. A Newsweek article ("New Bodies," 1985) chronicles the story of an ad campaign run by Decatur Hospital, a small proprietary hospital in an Atlanta suburb, to promote its "You're Becoming" program of cosmetic surgery. "That's the last place anyone would go for plastic surgery," (p.69) snapped Dr. John Munna, an Atlanta
plastic surgeon and a former Chairman of the false and deceptive advertising committee of the plastic surgery society. The Decatur ads feature large pictures of beautiful young women in glamorous surroundings and expensive clothes. Dr. Munna concedes that they make no specifically false claims, but contends that they are "emotionally deceptive" because they are intended to create the impression that the prospective patient who has the advertised surgery will become like the lady in the picture (p.69).

Dr. Barry Uhr, a Dallas ophthalmologist, defines "modern medicine" as "commercial medicine", and states that the primary ingredient is advertising (1987, p.35). He speaks of M.D.s who advertise extensively as preying on and betraying the trust of patients, frequently selling them something they do not need. He feels that aggressive salesmanship by these doctors creates distrust which helps to foster distrust of physicians in general. He believes that ethical M.D.s must speak out against the "unscrupulous business-icians" who receive kickbacks for referring patients to colleagues, or who pressure patients to have tests or operations that they do not need (p.36).

Relman (1987) reviews some advertisements by a group of New York plastic surgeons who reassure the female public that their breasts can be beautiful and that what God didn't give to them, these surgeons can. He terms such advertising "crassly commercial" and contrasts it with informational advertising, which he finds to be consistent with "the spirit of medical professionalism" (p.206). Commercial medical advertising, which seeks to promote the demand for medical services, is not professional, according to Dr. Relman.
A final example that I will offer is the quote of Dr. Robert Singer, a California plastic surgeon, who finds advertising by individual physicians to be a compromise to his own public image. He says: "Are we physicians and surgeons or just in the beauty business; no different from the hair stylists and cosmetologists or operators of tanning salons and cellulite centers." (p.752).

It is apparent, therefore, that some physicians are concerned about the negative implications of medical advertising. Those who assume a moderate position on this issue generally endorse informational advertising, but not the more persuasive varieties. Some patients can be found who would support medical advertising, while others see this as injurious to a doctor's credibility. Many prospective patients continue to prefer a referral from a trusted doctor or the recommendation of a friend; neither of which, however, can be guaranteed to provide the person with the competent, ethical physician that they need.

An Overview of Cosmetic Surgery

Advertisements for cosmetic surgical procedures have been appearing with great regularity in Houston newspapers and magazines. They are also common on billboards and on television and radio but I will not deal with these areas in this chapter. To begin with, there are more ads because there are more physicians performing these procedures. Aronson (1983) states that:

Plastic surgery is the most lucrative surgical specialty in America, and not coincidentally the fastest growing. Young doctors, recent graduates of the Ponce de Leon School of thought, are flocking to the field, alighting on crow's feet in orchards of Granny Smiths (p.141).
Today, according to Morgan, there are almost 4,000 board-certified plastic surgeons in the United States: physicians who have completed 3 years of training in general surgery followed by 2 years of training in plastic surgery and success on the board examinations in plastic surgery. However, Morgan reminds us that any doctor can call him or herself a cosmetic surgeon: All that is needed is a medical degree and a state license to practice medicine. She is quick to point out that: "Cosmetic surgery is not a recognized medical specialty, and there is no medical board certification in it" (1988, p. XVI). However, as is probably obvious, Dr. Morgan is herself a plastic surgeon. She describes, as do many other sources, the turf wars that are now going on as physicians in several specialties attempt to convince the patient--often through advertising--that they should perform his or her cosmetic surgery. Doctors performing estetic surgery are general surgeons, obstetrician-gynecologists (OB-GYNs), otolaryngologists (ear, nose, and throat surgeons or head and neck surgeons), ophthalmologists, orthopedic surgeons, dermatologists, and oral surgeons. Board certified otolaryngologists feel that they are better qualified than plastic surgeons to do facial plastic surgery. Dr. E. Gaylon McCollough, M.D., former president of the American Academy of Facial Plastic and Reconstructive Surgery says:

In two years of training, plastic surgeons have to learn not only cosmetics on the face and body, but reconstructive surgery for burn, cancer, and accident victims. To become certified by the American Board of Otolaryngology, doctors must spend five years operating only on the face, head, and neck--mostly in plastics (Schmid, 1988, p.238).

Other specialists also feel better qualified than plastic surgeons due to their specialization in one body area. Ophthalmologists, for example, feel
that they are the eye surgeons, and are therefore, best qualified to do cosmetic eye procedures such as blepharoplasties. In order to be a member of the American Board of Cosmetic Surgery, the newest and most controversial esthetic surgery group, the applicant must first certify that he or she has been practicing primarily in the field of cosmetic surgery for at least five years and has performed at least 1000 cosmetic operations, or that he or she has completed an "approved" residency program and has done 250 to 500 cosmetic procedures. Once eligible for certification, the applicant must pass oral and written exams prepared by the American Board of Cosmetic Surgery. ("Qualifications for Membership"). This board, however, is not a member board of the American Board of Medical Specialties, and most medical schools do not consider cosmetic surgery a specialty in itself.

Donald Langsley, Executive Vice-President of the American Board of Medical Specialties, the American Medical Association recognized board that certifies different medical specialties, states: "The problem for the public is anyone can get together and form a board. You and I could form a board this afternoon." (Tatge, 1988, p.1-C). Therefore, some of the doctors may be board certified as cosmetic surgeons, but the consumers should inquire into the actual surgical training program of the individual. Plastic surgeon Sidney Eisenbaum states: "The problems come when some of these specialists are far afield from what their original training was. I question a gynecologist who is doing face lifts" (Tatge, 1988, p.1C). Of course, physician other than plastic surgeons who are performing plastic or cosmetic surgery complain that plastic surgeons are attempting to monopolize the field. Harrison Robbins, Vice-President of the American
Board of Cosmetic Surgery, states: "There may be surgeons who are less qualified to practice cosmetic surgery but they are not confined to any one (certification) group" (Tatge, 1988, p.10-C).

One check system that may have functioned as a partial safeguard for patients, however, is being circumvented by the large number of cosmetic surgical procedures being done on an out-patient basis (65% according to Tatge, 1988). In the past, hospitals had regulated doctors' practice patterns by limiting hospital admitting privileges. If a doctor couldn't admit his patient to a hospital, he couldn't operate. Given the current out-patient surgery trend, doctors don't need hospitals in order to operate, and can set their own individual standards in such areas as aseptic technique, and length of time the patient is monitored after surgery. Patients are often sent home the day the procedure is done, as this is the most economical course. The most affordable option, however, does not always translate into the best patient care. The deaths of two patients after liposuction by Houston OB/GYN Hugo Ramirez have been linked to poor surgical asepsis practiced in Dr. Ramirez' office surgical suite.

Current Practice

Figures on the numbers of cosmetic operations being done currently are difficult to pin down and vary greatly with the source consulted. The most recent news release from the American Society of Plastic and Reconstructive Society gives the following numbers of procedures for 1986: Abdominoplasty, ("tummy tuck") 32,300; blepharoplasty, (eye lift) 84,7000; breast augmentation, 93,500; rhinoplasty ("nose job") 82,200; rhytidectomy (facelift) 66,900; and suction-assisted lipectomy, (liposuction) 99,350. All of these procedures, plus the others listed which I do not reproduce here,
add up to 590,550 aesthetic surgery procedures done in 1986 by the numbers of the American Society of Plastic and Reconstructive Surgeons, Inc. These figures do not include operations done by "cosmetic" surgeons from all of the other specialties that have been previously mentioned. The total count of each of these procedures being performed by physicians of many specialties in the U.S. would be much higher, but these figures are unavailable.

According to St. Thomas (1987), more than 2 million people had plastic surgery in 1986, and this figure includes everything from removing moles to reconstructing faces. Hughes (1988) relates that three million Americans are currently having cosmetic surgery per year: three times as many as just five years ago. St. Thomas also states that plastic surgery is still largely the domain of women, who have 85 percent of the procedures done, but that increasing numbers of men are now seeking facelifts and hair transplants. Pesmen (1984) quotes a physician who documents the increasing numbers of men coming in for such procedures. Dr. Randall McNally, a Chicago plastic surgeon, states that ten years ago one in twenty of his patients was a man, but that now one in ten is a man.

If the reader doubts the growing national interest in plastic surgery, it should be noted that instruments used in this specialty can now be found in the medical sciences collection at the Smithsonian's National Museum of American History in Washington, D.C. St. Thomas quotes curator Barbara Melosh:

We're interested in plastic surgery because it tells us something about American culture and medicine. Aesthetic surgery, in particular, illustrates the expansion of medical intervention. When people turn to plastic surgeons to change their appearances, medicine becomes a tool for implementing cultural ideals of beauty (1987, p.5).
Examples of Physician Advertising

In the following section, I will present actual examples of physician advertising taken from newspapers and magazines during 1986 and 1987. The ads themselves will be presented, followed by a section of commentary on the form and content, both actual and symbolic, to be found in the advertisements.
FAMILY PRACTICE CENTER
PETER Kwan, M.D.

Health Care For Your Family
Complete Lab & X-ray Facilities

$10.00 OFF
INITIAL VISIT
(With This Ad - New Patients Only)
EXPIRES 4-15-87

2507 Williams Trace Blvd.
(Williams Trace Professional Bldg.)
SUGAR LAND, TX 77478
980-7090

FORT BEND ADVOCATE
Wednesday, March 11, 1987
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1c
Dr. Polinger wishes to announce additional office hours in the Stafford area.

IRIS S. POLINGER, Ph.D., M.D., P.A.
Diplomate of the American Board of Dermatology
DISEASES OF THE SKIN, HAIR AND NAILS
COSMETIC DERMATOLOGIC SURGERY, LASER SURGERY
LIPOSUCTION (FAT REMOVAL), SCLEROTHERAPY (LEG VEIN TREATMENT)

ADDITIONAL HOURS: WEDNESDAY & FRIDAY MORNING

TUESDAY: 8:30am - 12:00 & 2:00pm - 5:30pm
WEDNESDAY: 8:30am - 12:00
THURSDAY: 1:00pm - 5:30pm
FRIDAY: 9:00am - 12:00 & 2:00pm - 5:30pm

MAIN SOUTHWEST PROF. BLDG.
4915 S. Main, Ste. 104
Stafford, Texas 77477
TEL. (713) 491-9278
(491-WART)

SOUTHWEST STAR
February 4, 1987

Page 16, Section 7
Houston Chronicle
Sunday, March 1, 1987

LIPOSUCTION
Extraction of fat deposits on thighs, hips, buttocks, abdomen, face and neck.

- OFFICE PROCEDURE - EUROPEAN-TRAINED MEDICAL DOCTORS

DALLAS AESTHETIC MEDICAL GROUP
Houston (713) 668-8218
(Dallas) (214) 691-
FORT BEND DERMATOLOGY ASSOCIATES
MARTIN H. KAY, M.D.
(ADULT AND PEDIATRIC DERMATOLOGY
AND SKIN CANCER SURGERY)
Fort Bend Physicians Plaza, Sta. 106
FM 1092 At Hwy. 6, Missouri City
For Appointment Call
499-3987

HAIR
TRANSPLANTATION

Permanent
correction of baldness
with your own hair

Baylor Kurtis, M.D.
Dermatologic
Cosmetic Surgery

(713) 589-0180
12121 Richmond, Suite 325
Houston, Texas 77082

HOUSTON CITY MAGAZINE
February, 1987
Vol. 11, No. 2, Page 67
Gary L. Monroe, M.D.
General Practice

Dr. Monroe is pleased to announce the opening of his general medical practice at 4010 J Hwy. 6 South in the Highpoint Shopping Center.

"More than ever the public is in need of the General Practitioner to care for routine medical problems and to help him or her find the appropriate specialist when needed."

497-3515

Highpoint Shopping Center (West side of Hwy. 6, N. of Alief-Clodine) Se Habla Español

Monday, Wed., Thurs., Fri. - 9 AM - 6 PM
Tuesday 12 noon - 6 PM - Saturday 9 AM - 12 noon
Signs of BALDING?

The Proctor/MPB Clinic offers medical treatment of hair loss under physician supervision. We use Proxidil™, a potent new prescription combination of a hair growth stimulator with a synergistic hormone-blocking agent.

The growth stimulator makes your hair grow and become thicker, while the hormone-blocker helps to retard the balding process.

Proxidil™ is the product of eighteen years of skin and aging research by a well-known dermatology researcher.

For more information contact:

Proctor/MPB Clinic
Twelve Oaks Medical Tower
4126 Southwest Freeway
Suite 1616
Houston, Texas 77027

(713) 960-1616
PETER H. PROCTOR, M.D., Ph.D.

- Hair Loss, Prevention and Treatment (Our new combination treatment often works when Minoxidil alone fails)
- Collagen Injections for Facial Lines and Scars
- Diseases and Surgery of Scalp and Face

Call today for an appointment
(713) 661-2321
Proctor/MPB Clinic
5401 Dashwood, 1d, Bellaire, Texas

HOUSTON CITY MAGAZINE
February, 1986
"Health Care" Section
Page 15

Be a picture of good health. It starts with your skin.

Sclerotherapy:
Removal of varicose and spider veins by simple injection

Laser Surgery:
Removal of birthmarks, keloids, tattoos and warts through bloodless surgery.

Hair Loss: Treatment of all forms in men and women.

Zyderm: Injectable collagen for wrinkles and scars.

General Dermatology and Dermatologic Surgery

(6 Dr. Esta Kronberg)
Board Certified

Good health starts with your skin

Esta Kronberg M.D.
Beechnut Professional Building, No. 228
7500 Beechnut at S.W. Freeway
Houston, Texas 77074
(713) 771-8941

FORT BEND ADVOCATE
October 1, 1986
Page 10
Hillcroft Medical Clinic Association

Announcing extended hours for your convenience.

Sharpstown Location
Mon. only 8 am - 8 pm
Tues. - Fri. 9 am - 5 pm
Sat. 9 am - 12

6630 De Moss 774-5861
(Sharpstown) *Walk-Ins Welcome

Stafford/Sugar Land Location
Mon. only 8 am - 5 pm
Tues. - Fri. 9 am - 5 pm
Sat. 9 am - 12

4913 S. Main 491-5290
(Stafford)

FORT BEND ADVOCATE
Wednesday, September 10, 1986
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m
SKINNER CLINIC

Multi-Specialty Adult Medical & Surgical Clinic
Complete Physical Examinations & Diagnostic Services

SPECIALTIES
General Surgery  Vascular Surgery
Urology  Cardiology
Pulmonary Disease  Internal Medicine
Obstetrics & Gynecology

DIAGNOSTIC SERVICES
Clinical Laboratory  Vascular Laboratory
Radiology  Physical Therapy
Diagnostic & Fetal Ultrasound  Pharmacy
Gastrointestinal Endoscopy  Outpatient Surgery
Bronchoscopy  Pulmonary Laboratory
2D Echocardiography  Cardiac Treadmill
Low Dose Xeromammography & Breast Ultrasound

DOWNTOWN
124 Dallas
San Antonio, Texas 78205
(512) 224-1771

NORHEAST
8601 Village Drive, Suite 226
San Antonio, Texas 78217
(512) 654-6364

TEXAS MONTHLY
January, 1987
Vol. 15, No. 1
Page 150
(Special Advertising Section)

In
80 Years of Accomplishment . . . And Still Leading.

Comprehensive medical and surgical services are performed by board-certified physicians in the areas of:

- Pediatric & Adult Otolaryngology-Head & Neck Surgery
- Facial Plastic & Reconstructive Surgery
- Otology & Audiology of the hearing impaired
  - Large hearing aid dispensary & repair services
  - Amplifying devices for telephones & TVs
- Allergy Services—Fully equipped to handle food & inhalant allergy test & treatment.

The trauma of allergy testing is minimized with RAST (Radio-Allergo-Sorbent-Testing) as it decreases discomfort.

E.A. Blackburn Jr., M.D., H.E. Medlock III, M.D., Tom F. Haskins, M.D., Bob E. Stout, M.D., Paul E. Brandly, M.D., G. Walter McReynolds, M.D., G. Gaye Clark, M.D., Stanford M. Shoss, M.D.,
& consultant Claude C. Cody III, M.D.

Houston Ear, Nose & Throat Clinic
Southwest: Memorial Professional Bldg. — 7777 Southwest Fwy. Ste 820
Downtown: MBank Bldg. — 910 Travis Ste 2418
Physician Available 24 Hours (713) 779-2211

HOUSTON HOME AND GARDEN
Vol. 13, No. 7
April, 1987
Special Advertising Section)
Page 7A

10
Belle Park Hospital 1986 Community Education Program for December

Making Stress Work For You - Part II

Happy Holidays: How To Make Them Happen

The holidays are often filled with unrealistic demands and expectations, when they should be a time of happiness and contentment. This program will help change your thinking to become accepting and fulfilled... and create a happy holiday season for you.

• Bob Hoke, M.D.

Thursday, December 4, 1986 • 7:30 p.m.-9:30 p.m.
Belle Park Hospital • 4427 Belle Park Drive
C.E.U.'s Available

Refreshments will be served and limited space for child care is available at no charge with a reservation. This program is offered at no charge as a community service of Belle Park Hospital.

For reservations and information, please call

933-6000 • Ext. 102

Belle Park Hospital

FORT BEND ADVOCATE
Wednesday, November 26, 1986
Page 11
I Can Visit The Woman's Hospital of Texas and Still Be Close to Home!

Every woman knows that The Woman's Hospital of Texas is one of the finest providers of women's health care in the nation. Now you can receive that top-quality care close to home. You can make an appointment to see a Woman's Hospital of Texas physician at The Woman's Place.

PHYSICIAN SPECIALTIES
- Obstetrics/Gynecology
- Cosmetic Plastic Surgery
- Ear, Nose, Throat
- Pediatrics
- Internal Medicine

Medical procedures requiring hospitalization will be performed by your Woman's Place physician at The Woman's Hospital of Texas.

The Woman's Place is only a few minutes away. Drop by today and pick up information concerning women's health topics.
OFFICE HOURS:
Monday-Friday 9 a.m.- 5 p.m.

Stanley Rogers, M.D.
Gynecology

John Ross, M.D.
Obstetrics/Gynecology

Guillermo Rowe, M.D.
Obstetrics/Gynecology

Marcelle Sulik, M.D.
Ear, Nose & Throat

Louise Terrill, M.D.
Internal Medicine

Peter Thompson, M.D.
Obstetrics/Gynecology

The Woman's Place
Sugar Land

In Affiliate of Women's Hospital of Texas

Sugar Creek National Bank Building
1 Sugar Creek Center Blvd., Suite 330
Houston, TX 77478
(713) 242-0767

FORT BEND ADVOCATE, Wednesday, September 17, 1986  1r
HAPPY NEW YEAR, HEALTHY NEW YOU
THE RESOLUTION TO KEEP FIT

First your boss took up jogging. Then your sister became a vegetarian. Finally, your best friend gave up ice cream in an effort to reduce fat in his diet. Everyone seems to have hopped on the fitness wagon. Everyone but you, that is. It seems that no matter how many fitful starts you’ve made, they have all ended in a return to your old habits. Somehow real change to a healthier lifestyle has so far eluded you. Is there hope in 1987 for the hesitant health fan? And can a healthy resolution help you succeed this year?

The answer is a resounding yes. Texas offers one of the widest arrays of preventive health care, early testing, wellness, and fitness programs in the country. Hospitals, clinics, health maintenance organizations, spas, sports medicine centers, insurance companies, and health clubs are all offering increasing numbers of new preventive care, wellness, and fitness programs to help you help yourself to better health this year.
COSMETIC SURGERY

If it seems to you that more people are having plastic surgery to improve their appearance, you're right. The reason is that cosmetic surgery has seen many recent improvements—the operating time has become shorter, facilities are more complete, and the anesthesiology is more finely tuned. There are now also computer imaging programs that can show the client in advance roughly how the changes may look. In short, plastic surgery has become safer. That has led to another trend in cosmetic surgery: patients are choosing to have several procedures done at once. It is not uncommon now to have a face lift and liposuction on other parts of the body in the same operation.

Large volume liposuction is a new approach. Dr. Howard Tobin of the Facial Plastic and Cosmetic Surgical Center in Abilene says that he has done liposuction to remove fatty deposits on large areas of the body, from the face to the knees, with great success. It is common for one of his liposuction patients to go down two or three sizes, although the weight remains stable. One of the newest procedures is fat injection. The surgeon takes the body fat removed during liposuction and replaces it in areas of the body that need to be augmented, for example in facial reconstruction.

TEXAS MONTHLY
January, 1987
Vol. 15, Issue 1
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From Special Advertising Section
"Happy New Year, Healthy New You"
HAPPY NEW YEAR, HEALTHY NEW YOU

I've circled the numbers corresponding to the companies from whom I'd like to receive more information. I understand my request will be forwarded to them without cost or obligation. This offer expires February 28, 1987.

1. The Aerobics Activity Center
2. Backs Unlimited
3. Belle Park Hospital
4. Blue Bell Creameries, Inc.
5. Blue Cross and Blue Shield of Texas, Inc.
6. Dallas Institute of Cosmetic Surgery
7. Dr Pepper
8. Facial Plastic & Cosmetic Surgical Center
9. Halina European Skin Care
10. The Institute for Aerobic Research
11. Kohler
12. Lake Austin Resort
13. Memorial City Medical Center
14. Dr. Peter H. Proctor
15. St. Joseph Hospital of Houston
16. St. Joseph Hospital Sports Medical Center
17. Skinner Clinic
18. Smoke Stoppers
19. Texas Children's Hospital
20. Timberlawn Psychiatric Hospital
   Plastic Surgery Program
   Houston Northwest Medical Center
22. "You're Becoming . . ."
   Plastic Surgery Program
   Garland Community Hospital

Name ____________________________ Title ____________________________
Company _______________________________________________________
Address _______________________________________________________
City ____________________________ State ___________ Zip ___________
POPULAR

Face Lift. A good rule of thumb is that a face lift usually makes a person look about five to ten years younger. Some surgeons contend that the younger the face at first lift, the more successful that procedure and later ones will be. Cost: About $2,500-$4,500.

Collagen Injections. Zyderm Collagen is an injection material that can help smooth age-related wrinkles. As a natural protein, it has relatively few side effects. The drawback is that its effect is not long-lasting; it requires yearly maintenance. Zyplast is for deeper injections, for creases above the mouth and on the forehead, for example. This is usually longer lasting and there are fewer allergic reactions than with Zyderm. Cost: about $250-$450 per treatment.

Chemical Peel. To remove crow's feet or acne scars, mild chemical acid gels are applied to produce a controlled burn. It results in redness and swelling, so the patient usually cannot return to work for about two weeks. Sun must be avoided for three months. The peel's effects last for ten years approximately. Cost: $1,200-$1,800.

Nose Lift (Rhinoplasty). Some people choose to have nose surgery because noses continue to grow over the years or because they have difficulty smelling or breathing. Cost: $1,800-$3,500.

Eyelid Lift. This is relatively painless, and it produces a more youthful look by reducing puffiness above the eyes and the bags below. Cost: $2,000-$3,000.

Liposuction. Body shape is enhanced by the removal of fat cells via this procedure. It can be performed on arms, thighs, buttocks, knees, hips, stomach, neck, jowls, and cheeks, and the fat will not grow back. Cost: About $750-$3,000.

Breast Augmentation or Reduction. Breast implants are one of the most popular procedures today, and reductions are also done more often than ever before. Cost: About $2,000-$3,500.

COSMETIC TRENDS

Among the many changes that have occurred in cosmetic surgery in recent years are two particularly interesting ones: More men are having procedures done, and now people are willing to talk about their operations. What was once a covert activity—a face lift or nose surgery—is now not only a popular cocktail-party topic but a status symbol as well. The stigma once attached to such “vanity operations” is definitely a thing of the past.

Dr. Russell Kridel, for example, sees about 40 percent males and 60 percent females. And his most popular procedure—the one he's most renowned for—is nose correction, both cosmetic and reconstructive.

Liposuction, the suction of body fat from
underneath the skin, is probably the hottest item in plastic surgery today, says Dr. Mark Gilliland. Men are interested in correcting sagging chins and abdomens and women usually seek help for the lower abdomen and hips and thighs. "Liposuction can make a big difference in the appropriately selected candidate," he says. "You can reduce body size and clothing size." Today, too, the application of liposuction has been greatly enlarged. "It used to be mainly for people under thirty-five with excellent skin tone and localized portions of fat," but, as Gilliland goes on to explain, now there are many acceptable candidates in less-than-ideal shape. An interesting offshoot of this kind of procedure is that many of these patients go on to lose weight far beyond the grams of fat that were removed from the body.

How far has plastic surgery come in recent years? Techniques are much safer, says Gilliland, and more predictable than ever before. "For example, a face lift is a muscle, fascia, and skin operation rather than merely the skin procedure it once was," he says.

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**COSMETIC SURGERY GUIDELINES**

- Make sure a surgeon is board-certified in his specialty. For the names of qualified physicians, call the American Society of Plastic and Reconstructive Surgeons, (312) 855-1618; the American Board of Cosmetic Surgeons, (213) 653-7700; or the American Academy of Facial Plastic and Reconstructive Surgery, (202) 542-4500 or 1-800-332-FACE.
- Check with friends who can tell you about good experiences with cosmetic surgery.
- Ask to see pre-op and post-op photographs.
- Choose a physician with whom you can communicate well. Good rapport is important.

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**FEAR OF BALDING** Several methods have emerged in recent years as successful surgical treatments for baldness, says plastic surgeon Dr. Russell Kridel. The plug technique is a redistribution method; scalp reduction entails removing bald scalp and stretching hair-bearing area to a more forward position; hair flap surgery is a rotation technique whereby a long section of hair-filled scalp along the side of the head is transferred to the receding hairline in front. As is often true with cosmetic surgery, patients express great satisfaction with their improved appearance.
RESOURCE GUIDE

- Dr. Edward Charlesworth, 9725 Lueded, 489-6395.
- Cosmetic Dental Associates, 7575 San Felipe #135, 783-2800.
- Dr. Angelica S. Frias, 7515 S. Main, Suite 510, 790-1255.
- Dr. Mark Gilliland, 7500 Beechnut #306, 770-9001.
- Houston Ear Nose & Throat Hospital Clinic, 7777 SW Freeway #820, 776-2211.
- Dr. Gordon Gibson, 10868 Beechnut, 879-4882.
- Dr. Albert Hergenroeder, 6621 Fannin, 794-6859.
- Dr. William Inzull, Jr., 6335 Fannin, 790-4232 or 790-4000.
- Dr. Reza Jafarnia, 8945 Long Point #102, 932-7074.
- Dr. William J. Kilah, 6621 Fannin, 791-3200.
- Dr. Guy Knolle, 4126 SW Freeway, #1700, 621-3800.
- Dr. Russell Kridel, 6410 Fannin, 635, 791-1375.
- Eddi Lee, D.D.S., 935 Gemini, 489-1236.
- Medical Center Del Oro, 8001 Greenbriar, 790-4100.
- Memorial City Medical Center, 920 Frostwood, 932-3000.
- Dr. Guy Newell, 1515 Holcombe Blvd., 792-3020.
- PACT, 2616 W. Loop South #500, 666-9811.
- Sam Houston Memorial Hospital, 1615 Hillendale, 468-4311.
- Spring Branch Memorial Hospital, 8850 Long Point, 467-6555.
- The Methodist Hospital, 6505 Fannin, 790-3311.
- Texas Children's Hospital, 6621 Fannin, 791-2031.
- Willowbrook Psychological Associates, 9725 Lueded, 489-6395.
- Dr. Craig Winkel, 6410 Fannin #345, 792-8844.

We're interested in what our readers think about Special Medical Sections. Please take time to answer some or all of the following questions and return to: Chris Johnson, H&G, P.O. Box 25386, Houston, TX 77256.

1. Do you find it helpful for physicians to advertise?
   - Strongly Agree; Agree; Neutral; Disagree; Strongly Disagree

2. Do you find it helpful for hospitals and clinics to advertise?
   - Strongly Agree; Agree; Neutral; Disagree; Strongly Disagree

3. Would you respond to either a physician's or a hospital's advertising?
   - Strongly Agree; Agree; Neutral; Disagree; Strongly Disagree

4. Is cost important when you select a physician?
   - Strongly Agree; Agree; Neutral; Disagree; Strongly Disagree

5. Is location important when you select a physician?
   - Strongly Agree; Agree; Neutral; Disagree; Strongly Disagree

6. Do you usually choose a hospital by physician referral or personal preference?
   - Strongly Agree; Agree; Neutral; Disagree; Strongly Disagree

SPECIAL ADVERTISING SECTION

HOUSTON HOME AND GARDEN
Vol. 13, No. 7
April, 1987
Special Advertising Section
Page 15A

1w
MACROMASTIA
is a
CURABLE DISEASE

MACROMASTIA (from the Greek: makros meaning large, mastos meaning breasts) is the condition of abnormally large breasts.

The over-development often affects teenagers, older women, and even men, with chest wall heaviness, shoulder and neck pain (sometimes leading to arthritis), clothing restrictions or personal hygiene problems. Furthermore, early breast cancer detection by physical examination and mammography may be exceedingly difficult. Besides the obvious physical hindrance, overly developed breasts might affect self esteem, or make a person appear overweight.

Fortunately, people with the disease need not unnecessarily endure the physical or personal difficulties associated with it. Breast reduction surgery offers the safety and comfort of not only looking better, but feeling better as well. Most health insurance plans cover the cost of the surgery.

For advice on the benefits of breast reduction surgery, seek the assistance of your family physician or consult a plastic surgeon Certified by the American Board of Plastic and Reconstructive Surgery.

HOUSTON HOME AND GARDEN
Vol. 13, No.7
April, 1987
Special Advertising Section
Page 15A

This information provided by

Texas Plastic Surgery
(713) 778-0001
A New Look, A New You

by Shawn Davis, B.A.

Plastic surgery, currently one of the fastest growing medical specialties, is not a panacea or an alternative for the proverbial "fountain of youth." However, plastic surgery can combat the advances or ravages of the aging process. While passing a mirror, one may not be looking into that "fountain of youth," but it is comforting to see that one has been able to improve one's appearance.

Why are more and more people turning to plastic surgery? First of all, it has become affordable for those other than the "rich and famous." Secondly, in today's world much emphasis is being placed on self-improvement. People of all ages are eager to exercise, adhere to sound nutritional practices, lose weight, stop smoking, attend continuing education classes, and work on one's self-esteem and self-image. It is possible that the 1979 federal ruling, which permits physicians to advertise, has had some influence in the growing popularity of plastic surgery. Some plastic surgeons have utilized advertising and media to sell their services. However, many Board Certified plastic surgeons are still reluctant to do blatant advertising.

An increasing number of women, and more and more men, are electing to have facelifts, double chin sculpts, nose jobs, eyelid sculpts, breast augmentation, breast reduction, suction lipectomies and tummy tucks to name a few.

Has plastic surgery become a fad? ... a passing fancy? Hardly! Not when one reads of the thousands of people with debilitating conditions who have been helped by reconstructive...
plastic surgery to live transformed and normal lives. These might have been underdeveloped faces, cleft lips and palates and mastectomies that have been corrected by the surgeon's skill and expertise. Even those opting for cosmetic surgery have been able to improve their self-esteem and image.

In a New York Magazine article, "Forever Young," author Patricia Morrisroe states, "It used to be that when people wanted to feel more confident, they'd go to a therapist or to EST, now they're going to plastic surgeons to buy new breasts and faces."

With modern technology, plastic surgery has become simpler with many procedures performed on an outpatient basis. There are, however, some steps or guidelines for those contemplating this type of surgery:

1. Find a Board Certified Surgeon. This is a surgeon with years of surgical training, followed by years of training and experiences in the plastic surgery specialty. He has gone through extensive testing by senior surgeons before attaining his board certification.

2. Check out physician costs and hospital costs as they do vary. Some procedures may be covered by insurance; others are not.

3. Select a physician with whom you have good rapport and can trust. If you do not feel comfortable with the physician, then seek another one.

In conclusion, cosmetic surgery is the aesthetic surgery which enables a person to attain a better self-image and to feel better about oneself. In contrast, reconstructive surgery can help a person who has had an illness, injury or birth defect to become more functional and also socially acceptable.

Plastic surgery, from the Greek "plastikos" meaning forming or molding, does just that ... gives form and molding to those who need it medically to live a healthier life, cosmetically to help people improve their image and self-esteem. The choice is yours!

For more information or a physician referral, call 44-WOMAN (713/449-6628), Monday through Friday, 8 am to 5 pm.

Chawn Davis, Director of Public Relations, has been involved in healthcare for over 10 years.

WOMENS HEALTH DIGEST
Vol. 1, No. 7
October 26, 1986

1z

The Woman's Hospital of Texas
The many facelifts of Marvin Zindler.
continued
2a
HOW TO CHOOSE A PLASTIC SURGEON.

Today, you no longer have to live with a face you hate. Or an unflattering figure. Modern plastic surgery can improve these and many other conditions.

If you're considering plastic surgery, you should make sure you select a doctor who is qualified as a specialist in plastic surgery.

Because of the level of expertise needed, a specialist in plastic surgery has completed five to seven years of supervised training. To be a board-certified plastic surgeon, the physician then is required to pass a series of stringent examinations.

However, the average consumer may not know that a doctor can legally claim to be a cosmetic surgeon without specialized training or board certification.

How can you tell?

Check his credentials thoroughly. Is he certified by the American Board of Plastic Surgery? Is he a member of the American Society of Plastic and Reconstructive Surgeons? Does he get good references from his patients? Is he listed in the Directory of Medical Specialists? Is he affiliated with an accredited hospital?

Make sure you check before you choose.

Sylvan Bartlett, M.D.
848 Central
Odessa, TX 79761

Call today for free information on plastic surgery or to make an appointment for consultation. You may call us collect at (915) 563-3110.
HOW TO PREVIEW THE RESULTS OF YOUR PLASTIC SURGERY.

Recently, high technology has come to the aid of plastic surgeons and their patients. The latest computer video equipment allows me to preview before surgery the type of changes that can be accomplished with cosmetic surgery.

Using computer video equipment I can discuss the changes desired with the patient as I sculpt away with the computer.

If you're considering plastic surgery, a consultation with a board-certified plastic and reconstructive surgeon is the first step you should take. You should be ready to discuss candidly your expectations about looking and feeling better after surgery. Then, after a thorough medical assessment, detailed information about the surgery, and an idea of the results through computer imaging, you will better be able to decide if plastic surgery is for you.

If you'd like to preview the results of plastic surgery or receive more information, call my staff at (915) 563-3110 to make an appointment. You may call collect.

Sylvan Bartlett, M.D.
848 Central
Odessa, TX 79761

Sylvan Bartlett, M.D., is a board-certified plastic and reconstructive surgeon and otolaryngologist. He is a member of the American Society of Plastic and Reconstructive Surgeons and the American Academy of Otolaryngology. Dr. Bartlett is a specialist in plastic and reconstructive surgery, including hand and micro-surgical surgery and otolaryngology as it applies directly to problems in plastic surgery.
Where would you go for cosmetic surgery?
The decision literally will reshape your life. It’s not an easy one. Naturally, you would search for great experience. The more your doctor is familiar with what you want to achieve, the more confidence you feel. **Do your homework.** Interview surgeons you are considering. Talk to them about their procedures and their results.
Ask about the entire experience. Some specialists in this field have created outpatient centers that are designed for the post-operative period as well. This combination can provide cost advantages along with a very comfortable environment for recuperation.

**A new facility in Abilene.** The Facial Plastic & Cosmetic Surgical Center in Abilene has been designed as a model for this new kind of outpatient care. *The Center* specializes in procedures for the face, nose, eye, neck, body and breast—including liposuction surgery, facial augmentation, treatment of wrinkles, and hair transplantation.

Luxurious private suites include bedroom, kitchenette, spa and the atmosphere of a vacation. Care is close by, should it be needed in the early postoperative period. American Airlines easily connects The Center to Houston, Dallas, Austin and San Antonio. Our two-engine pressurized aircraft is available for private transportation.

For further information, or a free book on cosmetic surgery, contact Candace Cason, Patient Coordinator. All inquiries are handled in confidence, and there is no charge for consultation.

Howard A. Tobin, M.D.
Certified American Board of Cosmetic Surgery
1000 Houston Falls, Abilene, Texas

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**TEXAS MONTHLY**
January, 1987
Vol. 15, Issue 1
Page 145
Special Advertising Section

2e
THE ROLE OF THE ORAL AND MAXILLOFACIAL SURGEON

Dental Implantology—Replacement for missing teeth to give effect of original teeth.

Facial/Reconstructive Jaw Surgery—Correction of abnormal jaw positions to provide stable alignment of teeth. May also be cosmetically enhancing.

Temporomandibular Joint Dysfunction—Popping and clicking of jaw joint that may cause headaches and discomfort in the jaw, teeth and ear.

Outpatient Oral Surgery & Anesthesia—Surgery performed in the office under sedation/general anesthesia, relieving patient of discomfort and apprehension.

Diplomate, American Board of Oral and Maxillofacial Surgery
Memorial City Medical Center • 909 Frestwood, Suite 262 • Houston, Texas 77024
Call for Subject Brochure and/or information
(713) 464-2833
WHY NOT BREATHE EASIER KNOWING THAT YOUR SPECIALIST IS A FACIAL PLASTIC SURGEON?

If you don't like the appearance of your nose, or if you can't breathe or smell well, why not take the time to correct a problem that's bothered you for years? See a Board-certified surgeon who has extensive experience with the complexities of the face. Facial plastic surgeons have years of postgraduate training and, in fact, perform most of the nasal surgery in the country.

Russell W. H. Kridel, M.D., F.A.C.S., specializes in nasal plastic surgery, both cosmetic and reconstructive. Widely published on the subject of facial plastic surgery, Dr. Kridel is highly proficient in the latest techniques of aesthetic and corrective facial surgery.

If you're considering nasal surgery or another facial procedure, call 791-1750 for a consultation with Dr. Kridel. So you can breathe easier.

Russell W. H. Kridel, M.D., F.A.C.S.
Facial Plastic Surgery Associates
In the Texas Medical Center
791-1750

HOUSTON HOME AND GARDEN
Vol. 13, No. 7
April 1987
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Page 4A

2g
Concerned about facial wrinkles, scars, and dilated blood vessels?
Modern dermatology offers numerous new treatments for these and other cosmetic problems.

MARTIN H. KAY, M.D., Ph. D.
Specializing in:
- Removal of scars, tattoos, unsightly moles,
- treatment of varicose and spider veins, wrinkles and hair loss.

Call For Appointment:
Fort Bend Physicians Plaza 499-3987
3807 Murphy Rd., Suite 206, Missouri City
A new outlook for your legs

Now there is a non-surgical, gentle medical procedure to eliminate unsightly varicose and spider veins.

Compression Sclerotherapy - the successful technique used in Europe for over 30 years is performed in the doctor's office and allows an uninterrupted lifestyle.

James W. Cromby, M.D.
The Houston Vein Center,
4600 West Loop West, Suite 201
(713) 944-2000

HOUSTON CHRONICLE
Wednesday, March 11, 1987
"Fashion - Lifestyle" Section
CHANGE YOUR BULGES TO ATTRACTIVE CURVES

LIPOSUCTION — Removal of fat, done with the latest equipment. Local anesthesia or general anesthesia can be used. Hips, tummy, thighs, buttocks, lower back, neck, knees, lipomas (fatty tumors), etc. can all be treated.

LASER SURGERY — Removal of skin growths including tattoos, warts, stretch marks, moles, birthmarks, ingrown toenails and fungus toenails, etc. Use of the laser can provide almost painless reshaping of the W.C. Fields type nose.

SCLEROTHERAPY — A method used to render varicose veins invisible. A must before bathing suit season.

ZYDERM COLLAGEN — Injections into wrinkles, acne scars and other types of scars to render them less visible.

COSMETIC SKIN SURGERY — Removal of skin cancers, moles, cysts, lipomas, etc.

— IN-HOUSE TREATMENTS —

IRIS S. POLINGER, Ph.D., M.D., F.A.A.D., P.A.
Diplomate of the American Board of Dermatology
Diseases of the Skin, Hair & Nails
Fellow of the American Academy of Dermatology
Member American Society of Liposuction Surgery

Tamef II Prof. Bldg.
6001 Tamef, Suite 204
Houston, TX 77477
Tel. (713) 968-7546
968-SKIN

Main Southwest Prof. Bldg.
4915 S. Main, Suite 109
Stafford, TX 77477
Tel. (713) 491-9278
491-WART

SOUTHWEST STAR
September 10, 1986

2j
NONSURGICAL TREATMENT FOR VARICOSE VEINS

Unsightly spider and varicose veins now treated nonsurgically by a simple office procedure. Call for an appointment with Dr. Cullen at Physicians' Clinic.

981-0005

HOUSTON CHRONICLE
October 16, 1986
"Lifestyle" Section

VARICOSE VEINS
CAN BE TREATED WITHOUT SURGERY
LARGE AND SMALL DISFIGURING BROKEN VEINS CAN BE ELIMINATED BY A SIMPLE OFFICE METHOD LONG ESTABLISHED IN EUROPE.
• NO HOSPITALIZATION OR ANAESTHESIA
• NORMAL ACTIVITIES CONTINUED, NO TIME LOSS
• COVERED BY MOST INSURANCE COMPANIES

JAMES W. CROMBY M.D.
HOUSTON VEIN CENTER
4600 POST OAK PLACE SUITE 211 HOUSTON, TEXAS (713) 622-0475

HOUSTON CHRONICLE
November 2, 1986
"Zest" Section
We feel blessed.

When Mom's eye developed a cataract, there were important decisions to be made. Our daughter helped us by finding the right people to take care of Mom. We didn't want her to miss a single moment life has yet to show. And we wanted to be certain our decisions made that possible.

See the difference in state-of-the-art surgical technique and the highest priority placed on patients' well-being.

KNOLLE & WRIGHT
OCULAR SURGERY CENTER
TWELVE OAKS TOWER
4126 SOUTHWEST FREEWAY
HOUSTON, TEXAS 77027

621-3900
Life Looks Better When You Do

Houston Northwest Medical Center has a program to help you make the changes you've been thinking about—a program called "You're Becoming."

"You're Becoming" is a total plastic and reconstructive surgery program that can help you make changes to reflect the beauty, confidence and health you wish to project to others.

If you've ever considered one of the procedures listed below, perhaps it's time to make a beautiful transition in your life by calling "You're Becoming."

Breast Proportioning
Ear Modification
Nose Improvement
Suction Liposcopy for
Face, Brow or
Neck Lift
localized body fat
Eyelid Surgery
And other corrective
Chin Reshaping
procedures...

The program's representative at Houston Northwest Medical Center is available to answer all your questions and offer assurance and guidance. And, once you've decided on the surgical procedure that is right for you, we will recommend a qualified surgeon from our medical staff.

We handle all the details—from scheduling the surgery to arranging for the comfort and safety of being cared for by an accredited, full service medical and surgical facility. All you need to do is think about making a change for the better.

"You're Becoming" offers both inpatient and outpatient services. This allows you the choice of recovering in the comfort of your own home or staying overnight in one of our suites.

All costs for hospital care are included in the price quoted. And we are pleased to announce that nine percent (9%) financing is now available for these hospital costs.

Call 713-580-0000 for an informational package and take your first step in the natural process of becoming your best. Because, life looks better when you do...

You're Becoming®
Houston Northwest Medical Center
710 FM 1960 West
Houston, Texas 77090
(713) 580-0000 Collect calls accepted

HOUSTON POST
October 12, 1986
2n
Life Looks Better When You Do

Houston Northwest Medical Center has a plastic surgery program that can help you make the changes you've been thinking about ... a program called "You're Becoming."

"You're Becoming" is a total plastic and reconstructive surgery program that can help you make changes to reflect the beauty, confidence and health you wish to project to others. Many people have already discovered the personal benefits of plastic surgery and consider "You're Becoming" a most rewarding chapter in their lives.

If you are considering one of the following procedures, "You're Becoming" might be just what you've been looking for:

- Breast Proportioning
- Nose Improvement
- Face, Brow or Neck Lift
- Eyelid Surgery
- Chin Reshaping
- Ear Modification
- Suction Liposuction for the reduction of localized body fat
- And other corrective procedures ... 

As an accredited, full-service medical surgical facility, Houston Northwest Medical Center has many years of experience in helping people like you. We will arrange your first surgical consultation and will handle all the details — from scheduling the surgery to arranging for the comfort and safety of being cared for by a major hospital.

All costs for hospital care are included in the price quoted. And we are pleased to announce that nine percent (9%) financing is now available for these hospital costs.

Call 1-713-580-0000 (collect calls accepted) for an informational package and take your first step in the natural process of becoming your best. Because, life looks better when you do ...
Life Looks Better When You Do

One of the nicest advantages of life today is that we have the ability to change what we want to make us look and feel better.

The "You're Becoming" plastic surgery program can help you gain the confidence, vitality and success you wish to project to others.

Two of Texas' full-service hospitals are offering the "You're Becoming" program to help you become your best.

If you have ever considered one of the following procedures, now is the time to make a positive move in your life with "You're Becoming."

- Hair Restructuring
- Nose Improvement
- Suction Liposuction
- Ear Modification
- Chin Reshaping
- Face Lift or the reduction of localized body fat
- Eyelid Surgery
- And other corrective procedures.

"You're Becoming" is a total plastic reconstructive and related procedure program designed to help you every step of the way. We'll handle all the details - all you need to think about is making a change for the better.

All costs for hospital care are included in the price quoted. And we are pleased to announce that nine percent (9%) financing is now available for these hospital costs.

Call us today and take your first step in the natural process of becoming your best, because life looks better when you do...

You're Becoming®

PLASTIC SURGERY FOR MEN

Garland Community Hospital
122 South International Rd.
Houston Northwest Medical Center
710 FM 1960 West
Houston, TX 77090
1-713-580-0000 (collect calls accepted)

TEXAS MONTHLY
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Special Advertising Section

2p
Through the looking glass ... into the world of cosmetic surgery, where your most flattering appearance awaits you. Let the Dallas Institute of Cosmetic Surgery help you achieve the image you want to reflect. Arrange for a confidential consultation today.

DALLAS INSTITUTE OF COSMETIC SURGERY 1-800-443-1793
6750 Hillcrest Plaza Drive, Suite 215, Dallas, Texas 75230

TEXAS MONTHLY
January, 1987
Vol. 15, Issue 1
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Special Advertising Section

2q
Have you been thinking about plastic surgery?

Looking your very best can give you an added measure of self confidence. Often your appearance can be improved with the help of plastic surgery.

Consultations for cosmetic plastic and reconstructive surgery are now available at The Woman's Place.

Surgery will be performed at The Woman's Hospital of Texas.

Charles W. Bailey, M.D.
Board Certified Plastic Surgeon

The Woman's Place
Sugar Creek National Bank Building
1 Sugar Creek Center Blvd., Suite 330
Sugar Land, TX 77478
(713) 242-0767

Office hours by appointment only.

FORT BEND ADVOCATE
October 29, 1986

2r
THE CREATION OF BEAUTY IS AN ART

Through the art of cosmetic surgery, you can now look more beautiful and radiant!
Dr. James Fowler specializes in cosmetic surgery of the Face, Eyes and Nose, as well as Breast Enhancement and Fat Removal through Lipo-suction. Dr. Fowler is known for his sensitivity and aesthetic ability to create beauty.

COSMETIC SURGERY CENTER OF NORTH DALLAS

James H. Fowler, M.D., F.A.C.S.
Board Certified
“For the Gift of Beauty”

Call now for a Consultation
(214) 931-1633
17330 Preston Road • Suite 216D
Dallas, Texas 75252
THE BODY BEAUTIFUL
How To Make the Most Of What You Have

Jerrold C. Gendler, M.D.
James A. McKeon, M.D.

3715 Prytania Street / Suite 402 / New Orleans, La. 70115 / (504) 895-2261,
9201 Sunset Boulevard / Suite 405 / Los Angeles, Ca. 90069 / (213) 276-3108

Convert Dumbo ears to pink shells flat against the head. Go for that new nose you've always wanted.

Trade in those puffs, bags and droops. Just a touch crepey? Tighten it up and throw out your turtlenecks.

Sagging jowls can be lifted. Get rid of flabby arms.

Too big, not enough? You can have it here.

The "rightlook" isn't always easy to achieve by diet, exercise or make-up alone. But now, certain flaws—the imperfect nose, the small bust, the stubborn bulges—don't have to be tolerated any longer thanks to the medical art of cosmetic surgery. Cosmetic surgery can "forgive" nature's transgressions, giving you the look and the life you always dreamed of... do it for you!

Patient Financing Available
10% APR Simple Interest
"I Can Visit The Woman's Hospital of Texas and Never Leave Sugar Land!"

Every woman knows that The Woman's Hospital of Texas is one of the finest providers of women's health care in the nation. Now you can receive that top-quality care in your neighborhood. You can make an appointment to see a Woman's Hospital of Texas physician at The Woman's Place.

PHYSICIAN SPECIALTIES:
• Obstetrics/Gynecology
• Cosmetic Plastic Surgery
• Ear, Nose, Throat
• Pediatrics
• Internal Medicine

Medical procedures requiring hospitalization will be performed by your Woman's Place physician at The Woman's Hospital of Texas. The Woman's Place is only a few minutes away. Drop by today and pick up information concerning women's health topics.

OFFICE HOURS:
Monday–Friday 9 a.m.–5 p.m.

The Woman's Place
An Affiliate of Woman's Hospital of Texas
Sugar Creek National Bank Bldg.
One Sugar Creek Center Blvd., Suite 330
Sugar Land, TX 77478
713/242-0767

Ask about our laboratory services.

BY APPOINTMENT ONLY:
Back-To-School Pediatric Exam $25
Includes Blood, Urinalysis and TB Test

FORT BEND ADVOCATE
September 17, 1986
Page 8
Finding the Meaning in Medical Advertising

It is my intent, in this section of the chapter, to analyze the form and content of the advertisements collected in some detail. I have attempted to roughly categorize them along several lines: format; overt or stated message; covert, subliminal, implied or symbolic message; artistic techniques and devices; and others. The reader will note, however, that often the categories overlap and the genres melt into one another. This is a function of advertising reality: several techniques are often used simultaneously in order to broaden market appeal. I will refer to the advertisements by figure number and often by the name of the advertiser as well. With one or two exceptions, the ads will be discussed sequentially.

Informational Medical Advertising

Figure 1a is an example of what Korcok terms "tombstone" advertising (Nov. 1, 1981). This type of ad contains "information about the physician which a reasonable person might regard as relevant in determining whether to use the physician's services" (p.1033). Figure 1b for the Hillcroft Medical Clinic is roughly similar, but it quotes a price. Figure 1c goes a step further in offering a coupon. Both price list and offering coupons are still unusual practices in medical advertising, although dental ads have contained both elements for some time. Additionally, figure 1c, Dr. Kwan's ad, tells the potential customer that health care for the entire family is offered and that lab and x-ray services are available. The Polinger ad (figure 1d) and that of the Dallas Aesthetic Medical Group (figure 1e), offer, in addition to information, explanations of liposuction and sclerotherapy. The Kay ad (figure 1f) outlines the particular
dermatological specialty of the doctor and the Curtis ad (1g) clarifies what is meant by hair transplantation. Figures 1d through 1g combine information and explanation, offering the consumer additional data in order to make an informed choice possible. They do not make value statements about the services offered.

Gentle Persuasion

With the Monroe ad (figure 1h) we begin to see informational/explanatory advertising combined with subtle persuasion. Dr. Monroe tells the consumer why he or she needs a general practitioner: "to care for routine medical problems" and to "find the appropriate specialist when needed".

The Proctor ads (figures 1i and 1j), attempt verbal persuasion by citing the physiological mechanism of action of the drug Proxidil and stating that it is "the product of the eighteen years of skin and aging research by a well-known dermatology researcher." Figure 1j compares the drug Minoxidil (now probably the predominant drug used to treat hair loss) with "our new combination treatment". Further, if we combine these two ads (which appeared in separate publications) we will realize that the "well known dermatology researcher" is Peter Proctor, M.D., Ph.D.

Photo Advertising

The use of photographs of the doctor appears to be increasing in medical advertising. The Polinger ad, (figure 1d), includes a photo of the doctor performing in a professional capacity, wearing a lab coat and using what appears to be a laser on the patient's hand. This image helps to associate the doctor with state-of-the-art technology and establishes her as a serious, skilled professional in the patient's mind. (Her concern for
the patient and the exacting precision of her work -- she's probably
removing a wart -- preclude a smile for the camera). Dr. Brian Tew
appears in figure 11 as he holds a small infant close to his body and
regards him "en face". This conveys that the doctor is a sensitive and
caring person who is skilled in the treatment of infants as well as the
rest of the family. The potential customer can also see that Dr. Tew is a
relatively young man and therefore recently trained. Figure 1k includes a
smiling full-face photograph of Dr. Kronberg, who appears to be a pleasant
young woman of "average" appearance and grooming. She is not glamorous
and has a rather "natural" coiffure and an unadorned neckline. In fact,
there is a certain dissonance between the image the doctor herself
presents and the quest for perfection that her ad conveys. The copy
exhorts the consumer to "be a picture of good health" and be rid of
"varicose and spider veins, birthmarks, keloids, tattoos, warts, wrinkles and
scars". The association of these common human skin lesions with lack of
"good health" is a powerful message to individuals caught up in the health
and fitness craze. Removal of these artifacts of living will make no one
healthier: in fact, such procedures will not produce an image of health but
an image of physical perfection which is rarely associated with life -- or
reality. But, then, in contemporary America we see the "real" and
"appearances" opposed continually. In few cases is the "real" also the
"ideal". And in those few instances in which a person's appearance does
approximate the cultural physical ideal, he or she often becomes a film
star or model and is enshrined for public scrutiny as an icon of popular
physical culture. For those regarding these "models for physical
perfection", the goal becomes a simulation of the ideal: and this facsimile
must often be created by the dermatologist or plastic surgeon. The reality created surgically, however, becomes a homogeneous synthetic reality: and the "plastic" surgeon holds the cookie-cutter.

Figure 1m presents a group photograph including all the doctors who are associated with the Hillcroft Medical Clinic Association. A group of ten conservatively dressed, smiling physicians regard us from the ad. They are not engaged in professional activities and no aura seems to emanate from the picture -- save that of middle-class dress and grooming. Why, then, does this ad, and others (see also figures 1q and 1r) utilize photographs of the doctors? Roland Marchand (1985) speaks of the "sincerity" of the photograph in advertising due to the fact that "people accepted it as showing the literal truth" (p.150). Americans accept the photograph of an attractive, well-dressed, smiling professional in lieu of references. We Americans are so hopelessly dependent on our visual perception of reality that we often judge character and/or accomplishment based on facial appearance. It has been shown, for example, that physically attractive children are often evaluated by teachers as more intelligent than their plainer contemporaries. A recent educational program televised in Houston dealing with child molestation repeatedly flashed photographs of the offenders on the screen and contrasted their appearances with the awful reality of their crimes. Apparently many parents and children had been deceived by the attractiveness, friendliness, and "normaley" of the appearances of these criminals: They didn't have the faces of child molesters! If one doubts that Americans have a sense that we can evaluate character based on facial appearance, one need only review some of the figures of speech we employ. For example, we hear it
said that: "I can read his face like a book" or "his face is an open book", and that "the eyes are the mirror of the soul". We allude to "saving face" as preserving one's honor and conversely if a person is "two-faced" he or she is hypocritical. We also prefer "face-to-face" meetings and speak of "face value". Hence the logic of photographs of the physicians in the advertisements: based on the belief that characterological "reading" is possible if we study a person's face. A naive assumption indeed in the context of ever-increasing plastic surgery.

Value by Association

Figures 1m, 1q and 1r present photographs of groups of associated physicians. Figures 1r, 1o and 1p list the names of the physicians or physicians who are associated with certain clinics or hospitals. Many physicians are not yet completely comfortable with the idea of advertising their services, and being part of a group advertisement does not seem quite as objectionable. Another motive for the physician in allowing his or her name to be linked with a clinic or hospital is that he or she becomes associated with a facility that has a good name in the community, such as the Women's Hospital of Texas, which many women feel to be a hospital setting where their needs are particularly well addressed.

The "Hidden Persuaders"

There are, additionally, cosmetic surgeons who wish to advertise, but who do not wish to bear the stigma of having done so. For these doctors, a good solution is to advertise in a "special advertising section" of an upscale magazine where this "special section" is made to look like an informational, "public service" offering. *Texas Monthly* magazine ran such a section (January, 1987) and called it: "Happy New Year, Healthy New
You", (figure 1s). This section is described as dealing with "preventive
health care, early testing, wellness and fitness" and contains
advertisements for aerobics centers, hospitals, skin care centers, plus three
cosmetic surgery centers and various plastic surgeons (see figure 1u).
Figure 1t, titled "Cosmetic Surgery" touts the recent improvements in
plastic surgical techniques and anesthesiology. It has become so safe, in
fact, that "patients are choosing to have several procedures done at once."
[This disturbing trend was first revealed to me by the secretary of Dr. B.
(1987, personal communication) who told me of the possibility of having a
"tummy tuck" at the same time that another abdominal surgery is done.
This way, the hospitalization costs and anesthesiology will be covered by
insurance for the other medical procedure. Additionally, the patient is
already anesthetized and doesn’t have to be "put to sleep" twice.] Dr.
Howard Tobin is quoted on "large volume liposuction" and states that it is
"common for his patients to go down two or three sizes, although the
weight remains stable." This short article is nothing more than an
advertisement for plastic surgery in general and Dr. Tobin in particular.

Houston Home and Garden magazine also ran such a "Special
Advertising Section" in April, 1987 (See figure 1v). Many doctors,
dentists, and hospitals advertised in this section (see figure 1w). This
figure also indicates that the editors of Houston Home and Garden are
unsure of the response of their readers to these "Special Medical
Sections": note the name change. Therefore they have asked the reader to
fill out a short questionnaire indicating opinions on physician and hospital
advertising and its effects on the consumer. Figure 1v is an article from
this section which briefly explains, and gives the cost of, various cosmetic
surgical procedures. The tone is overwhelmingly favorable toward all the procedures, although a few "drawbacks" are mentioned: such as redness, swelling, or necessity to avoid sun (rather difficult unless one ventures out only after dark). No real medical and/or surgical complications such as infection, bleeding, scarring and nerve damage are mentioned. The article tells us that many more men are having cosmetic procedures done now and that face-lifts and nose surgeries are no longer hidden, but are "cocktail party topics" and "status symbols". The "stigma" once attached to such "vanity operations" is a "thing of the past". Dr. Mark Gilliland is quoted as saying that liposuction is the "hottest item in plastic surgery today". The article includes "before and after" photographs of a woman who has had a "sagging chin" corrected by liposuction. Note that in the first photograph the woman is photographed in more revealing, probably natural light; is closer to the camera; wears no make up; has not had her hair styled; and does not smile. In the "after" photograph, her chin may be minimally tighter, but the other changes are more noticeable: she is farther from the camera, a flash attachment has been used, she wears make up and jewelry, her hair is styled, and she is smiling (which helps tighten the cheek and jaw muscles). This article advertises for plastic surgery in general and for Doctors Kridel and Guilliland in particular. See also figure 1x, which discusses "macromastia" (large breasts) as a "curable disease". One wonders how large the breasts must be in order to be considered "diseased". (We cannot escape at the other end of the spectrum, either, where we have the "disease" of "micromastia".) The disadvantages of large breasts to one's health and well-being are enumerated: shoulder and neck pain, hygiene difficulties, cancer risk,
lowered self-esteem, and the appearance of overweight. While some women do experience discomfort, and mammography for cancer detection may present more of a challenge, the major reason for having this procedure done is cosmetic. The information in this article was provided by "Texas Plastic Surgery" which sounds like an organization. When I called the number provided, however, I had reached the office of the aforementioned Dr. Guilliland.

Another informational/advertising article prepared for the Houston Chronicle by the Director of Public Relations for Women's Hospital of Texas is called: "A New Look, A New You" (figure 1y). Davis, the author, emphasizes the affordability of plastic surgery (a middle class appeal) and the link between cosmetic surgery and the self-improvement programs that are very popular in today's society. Davis also mentions that the "1979 federal ruling" which permits physician advertising "has had some influence in the growing popularity of plastic surgery". She mentions that some plastic surgeons have used "advertising and media to sell their services" but that "many Board Certified plastic surgeons are still reluctant to do blatant advertising". (Therefore she will speak for the "reluctant" surgeons.) She tells us that plastic surgery is no longer a fad, not when: "thousands of people with debilitating conditions have been helped by reconstructive plastic surgery to live transformed and normal lives". She relates that those opting for cosmetic surgery have been able to "improve their self-esteem and image". These statements link reconstructive surgery and cosmetic surgery in the reader's mind, giving cosmetic surgery a more worthwhile, socially useful aura. At the end of the article a number is given which the reader may call for more information or a physician
referral. When I called that number, the woman answering at "Women's Hospital Administration" wanted my name for the "doctor's records". When I did not want to leave my name, she at first refused to give me a doctor's name or more information. When I repeated my request, she put me on hold. When she eventually came back on the line, she gave me the name of the recommended plastic surgeon, Dr. B., and his telephone number. This is the physician that I went to see in order to gather information on the experience of seeing a plastic surgeon. He told me during my appointment that he thought some of the advertising for plastic surgery had "gotten like General Motors". He then stated that the ad in which his name appears is a hospital ad: "they just put my name in it." He seems to have conflicting feelings about these issues. In spite of his apparent desire to dissociate himself from the advertising, his name is featured alone in one advertisement, he is pictured with a group in another ad, and only his name is given out when a potential client calls the number listed by a local hospital for physician referrals.

Another indirect method that focuses attention on the achievements of cosmetic surgery in general, as well as those of individual doctors, is the testimonial advertising that has been done by well-known personalities. Figure 2a depicts before and after photos of Houston T.V. personality Marvin Zindler and figure 2b shows Phyllis Diller. Both of these performers have been the recipient of the Franklin B. Ashley award: Diller in 1986 and Zindler for 1987. This award is given to a "non-medical, non-dental individual who has made outstanding contributions to the field of cosmetic surgery" (Hoffman, 1987, p.4F). Both performers' "contributions" have been to undergo multiple cosmetic procedures and
then talk about them publicly. Phyllis Diller, age 68, states: "I've done more for plastic or cosmetic surgery than Bayer has done for aspirin. I've taken it out of the dark ages and exposed it to light" (Shearer, 1986, p.7). What has been exposed to light, especially the operating room variety, is Diller's face and body. Since 1971 when she was 54, she has had two facelifts (a major and a mini), two nose-jobs, a tummy tuck, a breast reduction, three teeth bondings, a forehead and an under-eye lift, an eyeliner tattoo, cheek implants, and a chemical peel. No wonder the plastic surgeons love her. Dr. Richard Webster, the President of the American Academy of Cosmetic Surgery has addressed Diller as follows: "You, more than anyone alive today, made our specialty of cosmetic surgery one sought out, desirable and important" (Shearer, p.8). (This quote, of course, makes us wonder how those who are no longer alive came to be that way; but after a brief prayer that their ends were not iatrogenic, on to the topic at hand.) Diller, in turn, feels that plastic surgery has performed similar feats in her life, and says: "And after each surgery, I like myself better, and so do the men in my life. They're more interested in a pretty face than in my underlying character" (Shearer, p.8). This, in spite of the fact that Diller was educated at the Sherwood Music Conservatory in Chicago and Bluffton College in Ohio, has performed as a pianist with many symphonies, has acted in a dozen feature films, has appeared in every leading nightclub in the country, is the author of five books and writes most of her own comedy material, is the mother of five and the grandmother of three, and has been married twice. None of this was enough and 15 years ago, Diller put herself in the hands of Franklin L. Ashley, the well-known Los Angeles plastic surgeon. Since Ashley's
death in 1986, Diller has been ministered to by Drs. Michael Elam and Frederick Berkowitz of Newport Beach, California. She has also collaborated with them on making a videocassette tape, *Phyllis Diller Stars in Looking Better Through the Art of Cosmetic Surgery*. It is evident that Diller has helped to publicize cosmetic surgery worldwide, and has contributed to the notoriety of several surgeons.

Marvin Zindler, the Academy of Cosmetic Surgery's 1987 poster boy, is no more reticent on the benefits of plastic surgery than Diller: "Cosmetic surgery, man, is the biggest, most fantastic miracle of modern science. It changed my life. That's no bull". The eloquent Marvin expands on his position as follows: "Look, I once had a guy tell me I was too ugly for television! This business is about style, looks, the whole bit ... You think I'd still be on T.V. if I didn't have all this cosmetic surgery?" (Hoffman, 1987, p.4F). *All* is right. Marvin has had the following procedures done: two nose-jobs, multiple procedures on his chin including silicone injections and a cartilage implant, two facelifts, upper and lower eyelid procedures, collagen injections to remove wrinkles, and of course his teeth are capped. Poor Marvin begin his cosmetic reconstructive because he wasn't pretty enough for T.V., and he is doomed to continue because of the tyranny of time:

I knew it was time (in his 50s) for a facelift ... I knew it wouldn't be long before I got a note saying it was nice while it lasted, but you're getting a little too old. I know the facts of life about television. It's a very cosmetic world and anyone who tells you different is a liar (Hoffman, 1987, p.4F).

Marvin preaches the dogma of cosmetic surgery whenever he gets a chance. He relates that he spoke once to a group of communications
students and:

They had acne all over their faces and noses like Jimmy Durante. Some of the girls were the ugliest things I had ever seen. I told them, if you want to be in front of the camera, after you get your degree, I really recommend you see a cosmetic surgeon (Hoffman, 1987, p.4F).

In his final quote in the Hoffman article, Marvin established a parallel that must make the Fellows of the Academy of Cosmetic Surgery a little skittish: he compares the cosmetic procedures to embalming techniques. He says: "I use a certain makeup so I won't look like a damn sick man. I do exactly what an embalmer does. I make myself look better. That's what cosmetic surgery is all about", (1987, p.4F). It is tempting to suggest that Marvin's metaphor is not too far fetched. One wonders how many cosmetic surgery patients feel like the living dead: emotional zombies who present a facade ala Dorian Gray, while the interior goes to ruin.

These endorsements by celebrities, it can be seen, are utilized by the American Academy of Cosmetic Surgery as well as by the individual plastic surgeons mentioned, in order to publicize their specialty and market themselves. This is done in spite of the fact that the current pronouncement of the AMA on ethical advertising and publicity by physicians (Young, 1983, p.80-81) states:

Testimonials of patients, however, as to the physician's skills or the quality of his professional services should not be publicized. Statements relating to the quality of medical services are extremely difficult, if not impossible, to verify or measure by objective standards.

These articles and celebrity endorsements are examples of hype, not acceptable advertising by any definition emanating from the AMA. But the statements of media celebrities, unfortunately, carry great weight in our popular culture where large numbers of people attend to the voices of the
stars as if they were those of poets or philosophers. Knowing this, recognizing the shallowness of the public through personal introspection, the masters of cosmetic surgical hype invoke the hyperbole of Marvin Zindler, or the sad cynicism of Phyllis Diller. We are told that this is "a very cosmetic world", and that our "underlying character" is not important, and we listen -- in spite of ourselves.

More Public Service Announcements

Dr. Sylvan Bartlett, M.D. (figure 2c), is concerned that potential customers know "how to choose a plastic surgeon". We are told that we no longer need to live with a nose we hate, or wrinkles, or an "unflattering figure", but that we should "make sure" the doctor we choose is "qualified as a specialist in plastic surgery". He then explains the training and examinations that a board certified plastic surgeon must undergo. Dr. Bartlett's hidden agenda is to decrease the numbers of cosmetic surgical procedures done by other than board certified plastic surgeons. Other physicians with surgical training such as dermatologists, ear-nose and throat surgeons, OB/GYN specialists, and general surgeons, are "cutting into" his profits. In figure 2d, Dr. Bartlett tells us how the use of technology (specifically computer imaging) allows him to "discuss the changes desired with the patient as I sculpt away with the computer". Dr. Bartlett might be considered a chiseler in several senses of the word. He is also a thoroughly modern fellow, at home in the world of high-tech surgery. If only it were as simple to achieve symmetry in the human body as it is to eliminate lumps from a graphic depiction on a computer screen. It all seems so clean, so bloodless, so painless: a simulation of a simulation. One can only hope that Dr. Bartlett remembers to discuss the
potential complications with his patients. Computer images don't bleed, or swell, or get infections. Figure 2e asks the customer where he or she would go for cosmetic surgery and then exhorts the potential client to "do your homework", "search for great experience". The rest of the text in this ad details the new kind of "outpatient" facility that can provide "cost advantages" as well as a "very comfortable environment for recuperation". This "model" center provides "luxurious private suites" and the "atmosphere of a vacation". Lest the potential customer forget that he or she is going there for a surgical procedure, the ad does mention that "care is close by, should it be needed in the early post-operative period". Again, it's all so pleasant and civilized, one can easily forget that the procedures being discussed carry risks and very real complications.

Figures 2f and 2g attempt their sell in a somewhat different, but highly appealing, manner. These ads enable the prospective client to rationalize having the procedures performed on two counts: first, the conditions discussed are presented as causing real (as opposed to psychic) symptomatology; and second, because the patient's physical function is impaired, insurance reimbursement is usually possible. (This would corroborate Berman's position that often the consumer will not admit the genuine reason for the action, and the advertisement must enable him to rationalize his purchase.) Why not correct "abnormal jaw positions to provide stable alignment of teeth"? It "may also be cosmetically enhancing". And: "If you don't like the appearance of your nose, or if you can't breathe or smell well, why not take the time (as if this were the only variable) to correct a problem that's bothered you for years?" The fact is, if a patient's nasal septum can be demonstrated to be slightly
"deviated" it can be classed as a legitimate medical problem because it can be linked, however tenuously, to difficulties with breathing and olfaction. Of course, as the doctor will need to fracture the nose in order to realign the septum, he might as well remove a bit of cartilage and soft tissue and change the shape while he's at it. No one at the insurance company will ever know the difference.

Beginning with the ad for Martin Kay (figure 2h), the ads attempt more overt persuasion: utilizing language, photography, and other artistic devices. The Kay ad asks the reader if she is "concerned" about "facial wrinkles, scars, and dilated blood vessels". Clearly, one should be, and "modern dermatology" has "numerous new treatments" for these "cosmetic problems". Kay's ad, the Cromby ads (figures 2i and 2l), and the Cullen ad (figure 2k) use the words "unsightly" and "disfiguring" to describe leg varicosities and "spider veins" (visible capillary formations often occurring on the legs). These advertisements contribute to the prevailing belief that a woman's legs must be perfect and unmarred in order for her to be considered attractive.

It is worthwhile, as well, to consider the descriptive terms used to explain sclerotherapy and laser technology: "simple injection", "bloodless surgery", "modern dermatology", "non-surgical, gentle medical procedure", "allows an uninterrupted lifestyle", "almost painless reshaping" and "simple office procedure". These words impart an aura of painlessness and harmlessness to these procedures which is not completely congruent with the reality of multiple injections of saline into superficial capillaries and use of a laser. Such terms as "simple" and "almost painless" depend upon whether one is the doctor or the patient.
The reader should note that Dr. Polinger's ad (2j) reveals that she is a Ph.D. as well as an M.D. and is board certified dermatologist. Dr. Kay (2h) is an M.D./Ph.D. also. Both of these people are eminently well qualified on paper, but they find it necessary to combine useful information about themselves with aggressive, high-pressure sales techniques. I would suggest that this melding of legitimate professional credentials with frank propaganda has the potential to be especially misleading and dangerous.

Invocation of Dominant Symbols

Beeman relates that advertisers understand that in order to construct images that will attract consumer interest they must focus on "personal cultural, physical and emotional needs" and not merely information (1986, p.56). A widely-used technique in advertising is the attempt to connect the product or service with dominant cultural values. If we begin with the Knolle Wright ad, (figure 2m) we see a smiling elderly couple, standing close together and regarding each other with affection. Daylight from an unseen source illuminates their faces --or is it daylight? The copy tells us that the couple "feels blessed" so perhaps the light emanates from other than a natural source. Marchand states that advertising has usually declined the use of words with a liturgical connotation such as "bless", "pray", "revere", "worship", etc., and has conveyed the reverential attitude through illustrative effects. Apparently Doctors Knolle and Wright don't want to risk such subtlety. They wish to portray social ideals and convey familial love (the daughter is mentioned in the ad as having helped to find the "right people" to take care of "Mom"). Additionally they invoke the image of long-term commitment of husband and wife, and the idea of the
preciousness of life: "We didn't want her to miss a single moment life has yet to show". (Interestingly, since this is an ad for an ophthalmologist, life only "shows" us moments -- we don't experience them through any other sense.) Marchand quotes Laski who characterizes certain situations and events as "numinous" if they trigger "life-enhancing feelings" (1985, p.265). According to Laski this "numinous" realm includes religion, royalty, art, education, national glory, natural beauty, love and marriage, childbirth and childhood. Advertisers recognize that people long to experience moments of transcendent satisfaction and therefore attempt to link such experiences, through the medium of advertisement, to their product or service. One problem for the advertisers, according to Marchand, is that they must strategically identify their product with life-enhancing moments without "a blunt obtrusiveness that would destroy the quality of numinosity" (1985, p.265). In other words, the advertiser must not, if he or she is "respectable" beat the consumer over the head with both verbal and visual cliches. Doctors Knolle and Wright portray the elderly couple as "blessed" (both visually and in the ad copy) with long life, an enduring marriage, an appreciation of living, a loving daughter, and the intelligence to choose the Knolle-Wright Ocular Surgery Center. Apparently the overuse of the cliches is not an embarrassment for these two physicians who will no doubt be blessed by ever-enlarging revenues from cataract surgery as the population inexorably ages.

Although the Knolle-Wright ad is rather heavy-handed in the visual and verbal imagery invoked, it does combine motivating factors in a way that might be regarded as effective. Beeman summarizes the conclusions of Ann Keely, a market researcher, who has written that the most
effective factors that can be used to influence a potential consumer are "abstract, socially oriented, and ideational" and additionally those "that also deal with physical needs" (1986, p.57). In this advertisement a real physical problem, a cataract, which results in progressive loss of vision, is discussed as it influences a mother and a wife: a person of inestimable importance to husband and family. We are reminded of the transcendence of love, the value of life, and the brevity of human experience. But the wife/mother/ grandmother figure need not lose her vision and the precious moments left to her. These doctors combine "state-of-the-art surgical technique and the highest priority placed on patients' well-being". If doctors Knolle and Wright had deleted the "We feel blessed" copy and left it to the reader to ponder the source of illumination, they might have had a more credible advertisement. Marchand quotes an ad agency president who states: "A picture ... can say things that no advertiser could say in words and retain his self-respect" (1986, p.236).

In the Houston Northwest Medical Center ads (figures 2n, 2o, and 2p) beautiful, young people (in one a male has been added) remind the reader that: "Life looks better when you do". In figure 2n, the beautifully coiffed, jeweled, and gowned woman smiles at the reader across a table formally set with candles, flowers, and wine: clearly an upper-class illusion. In figure 2o, a beautiful young woman with a lovely figure gazes raptly through opened French doors. She is dressed in a pink satin negligee and is holding a single perfect pink rose, just plucked from the arrangement of roses and babies' breath in the expensive vase to the left. Again the ad conveys the image of prosperity, but also that of youth and beauty, tenderness and softness (a soft focus lens and artificial light have
been used), warmth, light, romance, and happiness. Interestingly, her
gown and the flowers are pink, suggesting traditional femininity in
American culture. In figure 2p a young man clad in tennis shorts looks
out an arched window on a city street. He is holding a drink and is
obviously not engaged in any working responsibilities. He is trim, his hair
is well-cut and he is of "average" masculine build. (An over-muscled
physique is not an upper-class image.) Again, an upper-class evocation:
Why isn't he working? Yet he is obviously somewhere other than home;
perhaps the setting is a health club? We see a demarcation of male and
female roles in these three ads in that the women haven't made it out of
the bedroom and the dining room whereas the male has at least gotten
himself downtown to the club to work out or play tennis. He is pictured
in a more active pose; at least he's having a drink while he looks out the
window. Note the stark angles in the window suggesting masculinity and
strength, versus the flowing lines of the woman's negligee and the skirted
table in the previous ad. The negligee-clad woman appears to be gazing
dreamily and passively at nothing, but perhaps she is watching her
children at play with their nanny. All of these examples are happy,
young, prosperous people. Clearly these ads can be interpreted to portray
what Michael Schudson has called "Capitalist Realism" (1984, p.214). The
portraits in these three advertising photographs dramatize the American
dream: youth, beauty, wealth, leisure, and in the male ad, a hint of
health-consciousness (depending upon what we imagine him to be drinking
-- Perrier perhaps?). Clearly though, this capitalist fantasy doesn't come
cheap. There has always been an elite market in Europe and the United
States for cosmetic surgery. Aronson, in his book _Hype_, (1983) presents a
list of plastic surgeons who "operate on" (my words) the rich and famous. Socialites such as Mrs. William Paley, Nan Kempner, the deceased "Sunny" vonBulow and the late Duchess of Windsor (who had so many facelifts she had begun to look "unreal", according to a famous plastic surgeon) have long indulged in cosmetic surgery. Another segment of the elite market is the group of celebrities enumerated by Aronson: Barbara Walters, (facelift) Johnny Carson, (eyelift) Betty Ford, (facelift) William Holden, (eyelift) Joel Grey, (nose reduction) Cher, (two breast lifts: that's twice on each breast) Sophia Loren, (facelift) Robert Goulet, (eyelift) Truman Capote, (facelift) and Phyllis Diller, (everything) to name a few. This "upper crust" market is well-established and little advertising is needed to keep it going; everything is word-of-mouth in these socially and monetarily rarified circles, anyway. But there is a relatively new market out there for cosmetic surgeons to tap: the mid- to upper-middle-class in America. The persons typified in the ads for plastic surgery are seemingly persons of wealth, but the advertisers do not target the wealthy. I believe that these ads are aimed at young to middle-aged upwardly mobile professionals: a group greatly concerned with appearances, anxious to appear even more prosperous than they already are, and possessing plenty of discretionary income. In "A New Look, A New You" an article written for Women's Hospital of Texas, the author states: "Why are more and more people turning to plastic surgery? First of all, it has become affordable for those other than the rich and famous." (See figure 1y). These ads would appeal, not to the masses, who wouldn't have the money, but to the middle-class individuals who seek methods to differentiate themselves from the lower-class. This is becoming increasingly difficult as the middle-class
expands in both directions. Unless one has "old" money or social connections, the only way to distinguish oneself socially is by appearance and possessions. Of course the outward signs must be the correct ones; it will not do to be marked as tasteless, vulgar, or too exotic. The look must combine well-bred attractiveness and covert sexuality. This large middle class group is sensitive to the call of conformity and integration voiced by these ads. These persons, according to Beeman, seek not social superiority, but rather social membership. They want to be card-carrying members of the upper-middle-class. Most do not attempt the near-impossible leap into "society" circles; it is enough that they and their friends have a "look" that makes it difficult to distinguish them visually from the very rich. Herein lies the democracy of appearance in America. Cosmetic surgery can make this "look" possible: When the consumer chooses the advertised product (or in this case service) she will assume the patrician image portrayed by the model.

The advertisements for the Dallas Institute of Cosmetic Surgery (figure 2q) and the Woman's Place (figure 2r) both feature women and their reflections in the looking glass. (See also figure 1y which is not an endorsement for an one plastic surgeon but rather plastic surgery in general.) In figure 2q the reader is invited into the world of cosmetic surgery, all she need do is enter "through the looking glass". The ad for "The Woman's Place" (figure 2r) shows a very attractive woman of indeterminate age regarding herself in a mirror as she touches her cheek. Marchand characterizes mirrors as "surrogates and symbols of those judgmental gazes of the world" (1985, p.175). The male observer might interpret the use of the mirror as underscoring the alleged "addiction" of
women to vain pursuits. The female reader, however, might be reminded of the fleeting nature of youth and our cultural aversion to aging—especially in women. The ad asks if the reader has been "thinking about plastic surgery?" This emphasizes the universal "need" for plastic surgery as the woman in the ad appears relatively young and has no discernible "defects". Still, she contemplates her image with grave concern. If she doesn't need cosmetic correction now, she soon will; there is no escape. Once she begins her journey through the looking glass, it is very difficult to turn back. The Dallas Institute of Plastic Surgery will help the reader to "achieve the image" she "wants to reflect". And in what would seem an apt parody, the woman in figure 2q has become a mirror. She no longer exists as a person, but only as a reflection: which has become reality. A beautiful example of illusion becoming reality is provided by Aronson, (1983) who states that famous models often visit the plastic surgeon carrying their portfolios, and ask the surgeon to make them look like their photographs.

Moving to figures 2s and 2t, we are confronted with advertisements that utilize sexuality more blatantly in order to engage our interest in cosmetic surgery. The ad for the Cosmetic Surgery Center of North Dallas combines upscale elements with sex appeal. Although the model is voluptuous, she is wearing a very expensive sequined evening gown and holds a harlequin mask, suitable for a costume ball. The ad features the theatrical use of light which dramatically illuminates the model's hair, her face, and her sequin-outlined bosom. The model herself combines two genres of female appeal: the upper-class beauty, and the tart. She evokes the upper-class ideal through the use of the following elements:
expensive gown and elaborately coiffed hair, slim hips, high cheekbones, aquiline nose, and an affect of moderate hauteur. But the tart emerges in the sensuous lips, the abundant bosom that defies the constraints of the bodice, the skin-tight fit of the gown, and the stance which accentuates every curve. And how does one go about becoming such a fascinating hybrid? Dr. James Fowler, M.D., "known for his sensitivity and aesthetic ability to create beauty" can accomplish this artistic endeavor for you. We are told that cosmetic surgery and the "creation of beauty" are both "arts". In order to receive the "gift of beauty" we are told to call Dr. Fowler for a consultation. Once again the godlike nature of the plastic surgeon emerges as he creates beauty where there was none and bestows his gifts upon lesser beings. The poor patient awaits him: a lump of warm clay awaiting his aesthetic shaping.

In the "Body Beautiful" ad (figure 2t) a "well-endowed" female, clad only in a swimsuit, gazes at the reader with sultry abandon. She appears to be no blend, like the previous model, but a pure example of the "oldest profession". We are told that we no longer need to tolerate our "flaws" such as "the imperfect nose, the small bust, or the stubborn bulge". Nature can be forgiven "her" mistakes by the plastic surgeon, who can, among other feats, convert "Dumbo ears" to pink shells, get rid of "puffs, bags, droops, sags, and flab" and create a "new nose" or a "delectable derriere". The ad educates one on "how to make the most of what you have" and yet it offers the reader a smorgasbord of "delectable" possibilities that, if chosen, will totally reconstruct the patient. What we see in these ads is a reflection of, as Marcuse states, our "culture that sublimates nature: ads full of naked women which convert love into
consumption" (Berman, 1981, p.26). Marcuse has seen the psychological consequences of advertising in an industrial economy; the emotional satisfactions provided are false. As one consumes and behaves in accordance with advertisements, he or she is degraded. Consumption has been noted to literally displace sexuality. Advertising is seen by Marcuse as the agency responsible for "controlled desublimation" (Berman, p.28): for the conversion of normal sexual desires into the compulsion to consume. Advertising can be seen to be not only vulgar and materialistic, but also "the mode by which the industrial society enforces its will. It allows the underlying unhappiness of our civilization to forget itself in the contemplation of plastic nudity" (Berman, 1981, p.28). All that must be done in order to establish the parallel harm possible through the routinized use of advertising for cosmetic surgery is to change one word in the final sentence of the previous quote: It allows the underlying unhappiness of our civilization to forget itself in the contemplation of plastic beauty. As we lose ourselves in this egocentric meditation we become one with our reflection and are trapped behind the looking glass: much as Narcissus was frozen in eternal contemplation of his beauty beside his shimmering image.

American Narcissism

The appeal to full-blown narcissism that is evident in these advertisements calls to mind the work of Christopher Lasch who offers, in *The Culture of Narcissism*, (1979) some insights into American culture which may help explain our need for cosmetic surgical interventions. Lasch proposes that narcissism is a central theme of American culture. He contends that following the political turmoil of the sixties, Americans retreated into purely personal preoccupations: hence the birth of the "me
generation". We cultivate, according to Hougan (Lasch, 1979, p.31) a "transcendental self-attention". Since society has no future it is expedient to live only for a moment, to fix our eyes on our own "private performance". What is important is the illusion, however fleeting, of "personal well-being, health, and psychic security" (p.33). Although the narcissist has occasional feelings of omnipotence, for the most part he or she depends upon others to shore up a flagging self-esteem. For the narcissist, according to Lasch, "the world is a mirror" (p.38). The trouble with this mirror, however, is that every gaze carries with it a risk. That risk is individual realization of non-perfection or worse, non-youth. Because the narcissist lives a life largely devoid of meaning, he or she feels the definition of self to be totally congruent with external appearance. Lacking meaningful interests or work, alienated from future generations, and having no religious base, the individual stares into the existential void. Perhaps this is why aging holds such a special terror for many contemporary Americans. Lasch states: "This irrational terror of old age and death is closely associated with the emergence of the narcissistic personality as the dominant type of personality structure in contemporary society" (p.356). This fear is so pervasive that men and women begin to fear growing old before they even arrive at middle age, and view the fortieth birthday as the beginning of the end. I believe that this fear causes individuals to cling to the illusion of youth, vitality, and beauty with a tenacity usually reserved for lifeboats. This fuels the guest for psychic and bodily self-improvement programs and lengthens the queue at the plastic surgeon's office.
Sexism and Myth

As we review these advertisements for plastic surgery we note that all of them, with one exception, depict female patients. These women are clothed in negligees, swimsuits, or evening dress. They are pictured in a home environment: bedroom or dining room. They are shown gazing into mirrors or looking passively out windows. In no instance are they pictured in professional dress or settings and they assume no active roles despite the fact that millions of women are in the work force. These images call to mind the leisure of wealth, but also reinforce stereotypical views of American womanhood. Except for changes in dress and hairstyle these advertisements might have been taken from 1950s publications. In The Feminine Mystique (1963) Betty Friedan indicts "those deceptively simple, clever, outrageous ads and commercials" as the perpetuators of the feminine mystique: "It is their millions which blanket the land with persuasive images, flattering the American housewife, diverting her guilt and disguising her growing sense of emptiness." She goes on to say:

Their unremitting harangue is hard to escape in this day of mass communications; they have seared the feminine mystique deep into every woman's mind, and into the minds of her husband, her children, her neighbors. They have made it part of the fabric of her everyday life, taunting her because she is not a better housewife, does not love her family enough, is growing old (p.228).

Perhaps these women pictured are afflicted with a sense of emptiness, and a fear of growing old, and these factors might help to account for their interest in cosmetic surgery. But why are they shown as homebound passive sex-objects? Is this a reflection of the 1980s backlash against the feminist movement? Is it merely to reinforce the female reader's identification with a wealthy, leisure-class mentality? Whatever the purpose that the advertiser had in mind, these images now flood the
marketplace and cannot help but reinforce the image of the American female as a vain, troubled creature, inactive except for her preoccupation with staying young, beautiful, and sexy.

Related to this theme is the interesting idea, as presented by Leymore, that advertising in modern societies is similar to myth in primitive groups. She states that myths exist to "resolve social contradictions, to reinforce accepted behavior, and to conserve traditions" (Berman, 1981, p.47). In this view, advertising would not be considered a force for social change, but rather a buttress for the existing social order. Advertising, like myth, according to Leymore, solves the four major problems of life: "One will belong rather than be excluded, one will have happiness rather than misery, good rather than evil, life rather than death" (Berman, 1981, p.47). In light of the window on American womanhood provided by the ads for plastic surgery, Leymore's hypothesis is supported. These ads depict traditional female roles and also invoke spring, light, youth, happiness, beauty, and the "good life". The imagery in these ads is polarized against winter, darkness, aging, sadness, ugliness, and the mundane working life. The plastic surgeon, armed with scalpel, laser, and suction catheter triumphs over ugliness, (or even "average-ness"), the winter of old age, and the darkness of death.

Conclusions

I have attempted in this chapter to chronicle the following topics: the development of medical advertising in the United States; the cultural, social, economic and ethical effects of advertising; the direction of physician and consumer opinion toward medical advertising; the development of the specialty of cosmetic surgery; and some of the
meanings to be found in a collection of medical advertisements, both
general and specifically designed to sell cosmetic surgery. At this point I
will present my conclusions: informed by my three perspectives as woman,
nurse, and anthropologist.

The Benefits and Culpabilities of Medical Advertising

To begin, I do not advocate, despite a growing personal opposition to
certain forms of medical advertising, a return to the days of blanket bans
on medical advertising. Advertising can and does serve a useful
informational function that should not be discounted. Physicians help
prospective clients as well as themselves when they alert the consumer to
the type and location of their practice, their qualifications, and some basic
pricing indices. As Baker states, informational advertising can provide a
"modest form of consumer protection" (1968, p.239) because people gain
knowledge of the availability of services and of the potential range in
physicians qualifications and prices. I believe this to be true, however,
only for informational medical advertising.

I do not support, however, medical advertising that seeks to persuade
in an unscrupulous manner, and many ads for cosmetic procedures seem to
fall into this category. I have several reasons for considering such
advertising unethical. First, I would contend that many advertisements
(such as I have provided in this text) by cosmetic surgeons and
dermatologists are unethical based on the AMA's current pronouncement on
ethical advertising. These ads are "deceptive", contain "false and
misleading statements", and in my judgement, "operate to deceive" (Young,
1983, p.80). Preston has made, I think, a good case for the persuasive and
deceptive potential of puffery: which might be termed hyperbole in poetry
or oration. Hyperbole is understood to be the conveyor of feelings and emotions in literature, but is taken as a statement of actual facts when it is a part of advertising. Following this line of reasoning, I would hold that much of the puffery found in cosmetic surgery advertisements is deceptive, but not legally so. Legal deception means not just that the buyer was fooled, but that the seller's message fooled him or her. We cannot prove that the puffery in cosmetic surgical advertisements has convinced the consumer; we can only surmise that in many cases this must be true. Another definition of deceptive according to Preston, however, is that which is harmful to the consumer. I believe by this standard some of the cosmetic surgery ads may be legally deceptive. If a patient is convinced to have plastic surgery by reason of advertising puffery or symbolic manipulation and he or she has a complication; this patient has definitely been harmed. For this reason I feel these ads must be more rigorously monitored than those for non-medical products and services. As more and more cosmetic surgery is done and more complications arise, I hope that physician advertisers will be required by law to indicate in their ads that the procedures can have serious complications. In the meantime, we must be cognizant of the subtle but significant influence that these repetitive messages can exert on us, and we must mount our defenses accordingly.

Further, these ads are not "direct (and) dignified", but rather are "aggressive, high pressure advertising"; and they definitely "create unjustified medical expectations" (Young, 1983, p. 81). According to the Rules of the New York State Board of Regents Relating to Definitions of Unprofessional Conduct (for all professions) these advertisements are
unprofessional as they are "false, fraudulent, deceptive, misleading,
sensational (and) flamboyant" (Bloom and Stiff, 1980, p. 646). These ads
mislead because they foster the quest for the unattainable: for physical
perfection. People view these ads which combine puffery with the text
about the marvels of laser and computer-assisted technology and they
believe that they can be physically renovated to some near-perfect state
with no risk at all. As Dyer states:

Advertising plays upon people’s unconscious wishes and fantasies:
sex, greed, the quest for power, status, perfection. The scientific
basis for advertising rests on the ability to identify and manipulate
such longings and fears. When we speak of 'the market' or 'market
forces' or 'demand', we are generally talking about human wants and
wishes (1985, p. 76).

And, as has been previously discussed, the imagery and symbolism present
in these ads seeks to connect physical "renovation" with emotional, social,
and spiritual renovation. If we have a rhinoplasty or a blepharoplasty or
breast implants, we will be beautiful, fulfilled (in more ways than one),
and socially secure (we are loved only for our appearances, anyway). Our
basic human wants go deeper than good looks and social position, however,
and these ads manipulate us into making unthinking, subliminal connections
between desires to be valued and loved and seeking plastic surgical
correction of our real and imagined physical flaws. Further, this process
of connecting our most deeply held beliefs to our narcissistic quests for
beauty and wealth debases whatever "enduring" values we have left to us.

Second, as I have previously mentioned, these objectionable ads have
an air of credibility and make no mention of the risk factors involved.
We need only to look at the wording of these ads to see that risks are
not only passively obscured by omission but actively denied by the use of
such euphemisms as: "out-patient" surgery, "local" anesthesia, "simple"
procedure, "painless" treatments, "lasers" versus knife or scalpel, "non-
surgical" treatment, "body sculpturing", "breast proportioning", "chin
reshaping", and a host of others. All of these terms imply a harmlessness,
an aestheticism, that is not congruent with the reality of incisions,
surgical excision of tissue, and sutures. In fact "aesthetic surgery" is the
new synonym for plastic or cosmetic surgery. Folland states that
"Increases in utilization, should they occur via advertising, do not
necessarily result in lower welfare to the consumer. Such increases could
be due to improved information on the usefulness and availability of
treatment" (p. 339). I would contend that these cosmetic procedures carry
many risks and that increasing the numbers of procedures being performed
could definitely compromise the consumer's welfare. Baker tells us that if
a product is bad, advertising will kill it. In this case, if the product is
bad, it may kill the patient. Henig (1985) identifies some of the possible
complications of facial cosmetic procedures: incisional bleeding and/or
infection, facial nerve damage, hair loss, skin necrosis and sloughing,
excess scarring (keloid formation), inability to close the eyes, and earlobe
misplacement. When liposuction is done, (and it is being done increasingly
by physicians other than plastic surgeons) the woman is at risk for
bleeding, soft-tissue edema, and infection. A tight surgical girdle must be
worn for several weeks postoperatively, and a surgeon (OB/GYN) quoted by
SoRelle (1986) stated that it can take as long as six months after surgery
for the swelling to subside. Patients must be closely monitored to
determine if they have hemorrhaged excessively during the procedure and
will require a transfusion. One commentary on the safety of liposuction is
the case of Dr. Hugo Ramirez, a Pasadena obstetrician-gynecologist, who
has been investigated by the Texas Board of Medical Examiners. His license was temporarily suspended by the Board related to two liposuction procedures he performed that have had tragic results: Patsy Howell, age 39, is dead, and Patricia Rogers, 31 years of age, eventually recovered after an overwhelming infection that almost killed her. Both patients contracted severe staphylococcal infections following surgery (SoRelle, 1987, April 2, April 8). A committee of the American Society of Plastic and Reconstructive Surgery, led by Dr. Simon Fredricks of Houston, conducted a five-year retrospective study of 100,000 liposuction cases (SoRelle, 1987, October). This committee documented 11 deaths and 9 serious illnesses resulting from liposuction procedures. Most of the deaths occurred from blood or fat emboli (clots) that impeded blood flow to vital organs. When breast augmentation and reduction procedures are done, the previously mentioned risks of bleeding, edema, infection, and scarring are present; in addition to problems with the prosthetic implant, loss of sensation in the nipple and/or breast, and decreased ability to breast-feed a child. All of these risky, expensive procedures (which are not eligible for third-party compensation) involve surgical invasion of a normal, healthy body. In light of these risks, the expense, and the fact that several sources state many women feel a facelift procedure only lasts 3 to 8 years, it is astounding that so many women are willing to undergo such procedures. The women must rely on the physician to provide her with a realistic assessment of her personal risks for each procedure. It is extremely difficult to determine if physicians are making patients aware of all the possible risk factors and complications so that they can make truly informed decisions on the safety and efficacy of cosmetic procedures.
When I spoke with Dr. B., he did not spontaneously initiate a discussion of the risk factors associated with blepharoplasty (the procedure I was ostensibly seeking) until I specifically asked him what could potentially go wrong. He then told me that complications were "rare" but that they included: cardiac arrest secondary to anesthesia (he uses "inovar": a combination narcotic analgesic and major tranquilizer, and local injections around the eyes), ectropion (where the eyelid turns outward after surgery, he's had 2 cases of this), bleeding, infection (he mentioned one case), and retinal artery spasm which causes blindness. When I asked him if he thought all plastic surgeons enumerated the potential risks for patients, he told me that a patient who came to him after being seen by an M.D. at Northwest Medical Center (the "You're Becoming" Program) told him that no risks or complications were explained to her. He further stated that he knows of cases where these doctors have told patients who have undergone augmentation mammoplasty that they can play tennis one week afterwards as long as they wear a brassiere. He said: "Maybe most of the time they can get away with it, but someone is going to get a hematoma (collection of blood under implant) or another problem." In the case of Patsy Howell, Ruth SoRelle quotes Howell's business associate who states: "She learned about it (liposuction) from a flier at the San Jacinto Mall. She called the doctor. It all sounded so simple like having your teeth cleaned. She was told there was nothing to it" (1987, April 2, p.16). If the physician does not make the patient aware of her risks in the office visits before surgery, her last chance to change her mind will be at the time that she signs the operative permit where the anesthesia and procedure risks are listed. At this point very few patients decide against
having the surgery. To be sure, it is in the doctor's best interest as well as the patient's for the doctor to be truthful: for a patient with a bad result might sue. *Hillman v. Funderburk* is one example case. The plaintiff was awarded damages because the surgeon did not obtain "informed consent" from her prior to the reduction mammoplasty, and she sustained malpositioned nipples and track mark scars secondary to the procedure ("Medicological Decisions", 1987). Another factor may mitigate against complete truthfulness, however: and this is the fact that the same physician who placed the high-pressure advertisement to draw the woman in is now asked to potentially dissuade her through a recitation of the risks involved. This is a clear conflict of interest and in this event ethics might be compromised in the service of cash-flow.

Third, although Galbraithian theory states that supply creates demand, and Lasch tells us that people are unaware of the "needs" for certain goods until the mass media force them to become aware, I believe that in the case of cosmetic procedures supply increases or intensifies demand but does not create it. It is more realistic to suggest that constant repetition of these messages reinforces an already existing popular consciousness that these procedures are commonly done, desirable, and even necessary in today's society. Schudson (1984, p.230) quotes Clifford Geertz who says that works of art do not "celebrate social structure or forward useful doctrine. They materialize a way of experiencing: bring a particular cast of mind into the world of objects, where men can look at it." Art is a commentary on already existing experience, and the public does not require this experience it already has but a statement of it, according to Geertz: "What it needs is an object rich enough to see it in; rich enough, even,
to, in seeing it, deepen it" (Schudson, 1984, p.230). What is the purpose of advertising if not to expand the desire for the product or service? These ads apply a bellows to the already existing flame of public vanity and fan it into a bonfire. Drummond (1986) mentions specifically the possibility that physician advertising could lead consumers to think they need health care when they do not. This is particularly likely if the health service is elective as is the case with cosmetic procedures. Henig (1985) documents that many women in their thirties are currently asking for facelifts. This fits easily into the previously discussed narcissistic trend in our culture. Dr. B. told me that the youngest patient on whom he has done a facelift was a "38 or 39 year old lady" on whom he operated when he was newly out of training. He stated that she had obtained two other medical opinions, and both physicians said they would perform the procedure. He related that the woman told him that she was going to have it done whether he did it or not, but that she wanted him to do it. Dr. B. therefore, did the procedure, and stated: "It really changed her a lot; she looked a lot better" (1987, personal communication). Drummond contends that high-technology medicine institutionalizes hypochondria by bombarding individuals with amplified physiological feedback. He states that machines do not help us interpret the information that they provide and that it is "quickly and profitably translated into grounds for intervention" (1986, p.18). I would contend that constant advertising causes individuals to fixate on their physical imperfections, and this fixation translates into cosmetic procedures performed, and profit for the physician.
Fourth, these advertisements are unethical because they are sexist, with women as their main target. The overwhelming majority of ad photographs picture young, beautiful, idle, women. We have already established that women undergo by far the majority of cosmetic surgical procedures. I would contend that the definition of self by external standards is even more problematic for women than for men in our contemporary society. Their work as homemakers and mothers has been devalued, and yet they are frequently prevented by a male-dominated society from making a meaningful contribution in the work force. Appearance, therefore becomes all-important: for this is the way to catch or hold onto a man, the way to ensure the love of one's children, the way to promote an illusion of success and happiness. For these reasons women are especially vulnerable to the vicissitudes of fashion, the lure of cosmetics, and the beckoning of the surgeon's knife (or laser).

The Culpability of Cosmetic Surgeons - A Specialty of Merchandisers?

Some evidence suggests that while reactions to advertising are becoming more favorable, many physicians are not in favor of advertising that departs from the realm of "informational". Kocock states that: "there have been charges--aimed mostly at some plastic and cosmetic surgeons in Southern California--of advertising abuses" (1981, p. 1028). Leonard Rubin, the director of a plastic surgery residency program in New York, contends that "plastic surgery is entering the era of merchandising" (1982, p. 117). Rubin states that every plastic surgical society has codes on ethics and advertising that each doctor must accept as a condition for membership. Violations, therefore, are breaches of contract and cause for dismissal. The reason that these societies do not act against these abuses,
according to Rubin, is because the FTC directive on advertising is in conflict with professional society codes. Dr. Rubin summarizes his viewpoint as follows.

The vast majority of plastic surgeons are hard-working, highly trained doctors who desire their competence to be the basis of attracting patients. They feel advertising is a bad method for the public to judge a surgeon's capabilities. They want no association with those doctors who advertise, employ public reactions agents, or give 'lectures' to the laity in department stores. They do not care to rub shoulders with those individuals who put monetary success before the work ethic competence success. They feel those who advertise or employ PR men, even if they hold high academic positions, have breached the code contracts and should be asked to leave our societies. Let them form their own groups, where reputations are brought by gold and money is worshipped (1982, p. 117).

Dr. Rubin concludes his editorial, however, with a story that seems to refute his characterization of "the vast majority of plastic surgeons". Faced with what he calls the "advertising dilemma" and feeling "impotent", he offered to address the membership of the Regional Society in New York (I assume his is speaking of the Regional Plastic Surgery Society) and propose that the offenders resign. The only condition he made was that he be followed by at least two seconding speeches by other members of the advertising committee. Months passed, but no one came forth, despite the committee's agreement in principle. He ends with this statement: "Is it possible that the once lofty specialty of plastic surgery will become a specialty of merchandisers?" (1982, p. 118).

Judging from the advertisements that I have read, listened to, and watched over the last two years, I would have to answer Dr. Rubin in the affirmative. As previously stated, I do not advocate a return to the days of blanket bans on physician advertising. Consumers have a constitutionally protected right to information about medical practice that
will enable them to make informed choices. Although physicians cannot be totally devoid of business acumen if they hope to support themselves in private practice, neither, I would contend, can they be lacking a sense of commitment to their patients and to society. Havighurst (1978) quotes the Massachusetts Medical Society code of 1920 which provided that: "A spirit of competition considered honorable in purely business transactions cannot exist among physicians without diminishing their usefulness and lowering the dignity and standing of the profession" (p. 45). And yet the AMA Judicial Council said, in 1976, that: "Freedom of choice of physician and free competition are prerequisites of optimal medical care" (Havighurst, 1978, p. 45). I believe that it is possible to combine the sentiments of these two quotes and advocate the use of informational advertising which will assist the consumer—not assault him. It is my hope that professional medical societies and professional standards review organizations (not to mention medical malpractice insurance carriers and consumers) will bring some pressure to bear on the physician-merchandisers whose advertising campaigns—and motives—seem suspect. Is it possible that some plastic and cosmetic surgeons will be slower to operate than the advertisements would indicate? Is it a vain hope that some benevolent medical paternalists might gently reinterpret reality for a prospective candidate for cosmetic surgery, thereby obviating the "need" for the procedure? (Dr. B. did try to dissuade me from having a blepharoplasty at the time that I saw him. I had told him that I had just turned 40 and felt that the lines around my eyes were worsening. He said that I was a "young 40" and looked 35, and that if I were his sister he would try to dissuade me. He also stated that he felt that I should wait until 2 to 3 months after my 40th birthday and
then reconsider the procedure, so that the two events would be more separate. He did, however, state that I was a "candidate" for the surgery because of some laxity of tissue under my eyebrows. When I left, he told me to think it over and come back for a second discussion if I wished: He would not charge me another consultation fee. He told his secretary to list my diagnosis as blepharochalasis (which is a relaxation of the skin of the eyelids due to atrophy of intracellular tissue). Therefore, although he temporarily discouraged my quest for surgery, he left me with the notion that I had a "medical" condition that would eventually need correction. If one listens to Dr. William H. Canada, M.D., of Houston, however, it can be seen that everyone is a candidate. "In cosmetic surgery, perfection is a necessity. It is an attempt to surpass the normal." The cosmetic surgeon is "performing surgery not to remove pathology, not to mend a defect, but to make that part of the body beautiful" (p. 146).

As I have analyzed and critiqued the advertisements for cosmetic surgery, it has become impossible not to critique the procedures themselves and the practitioners who perform them. Clearly, there would be no advertisements without the surgeons who perform the procedures. These doctors have enshrined the philosophy of narcissism and the profit motive at new heights: such that they are unable to function as physician and counselor. One wonders how many potential patients will be dissuaded by these doctors when this action would essentially nullify an expensive advertising campaign. A related concern, also relevant to this conflict of interest, is that the complication risks of these procedures may not be fully explained -- or not explained at all. Further, these practitioners reinforce narcissism (and our societal and personal neuroses) through the
medicalization of aging, imperfection or asymmetry ("unattractiveness"), and fat deposition. When these conditions are medicalized, they then merit aggressive treatment, or preferably, surgical excision. Excision of wrinkles, bumps, bags, and sags, unfortunately, does not confer health, success, or contentment on the patient. Cosmetic surgical solutions are often short-lived, costly simulacra and frequently put a healthy individual at risk. And what will become of the individual who has exhausted the available options for cosmetic improvement and still remains "imperfect" or continues to age? Having none of the consolations of an earlier era that had faith in God and in posterity, the narcissist is doomed to cynical despair. Why must these physicians, sworn to the Oath of Hippocrates, be the purveyors of our flawed social status quo? If society is the doctor's identified patient, we have a case for malpractice. For by fostering in the Durkheimian collective consciousness or the Jungian "collective unconscious" the superficiality of narcissism, these physicians do, in fact, great harm.

The Culpability of the Media

Although I will not discuss this idea in depth, I feel I must mention the fact that television programming and magazine and newspaper coverage has greatly expanded the interest in plastic surgery. As Dr. B., put it: "People find the topic interesting and entertaining" (Personal Communication, 1987). I have found several relevant magazine and newspaper features, including the following. Houston Home and Garden magazine (1987, April) had a special advertising section that heavily sampled cosmetic topics, as did Texas Monthly magazine (1987, January). Susan Waldron wrote a feature article for Houston City Magazine (1986,
February) entitled: "Mirror, Mirror on the Wall -- Undergoing Outpatient Elective Surgery". In it she presents the case of a 35-year-old Houston woman who had a blepharoplasty and suction-assisted lipectomy. The "before" photographs feature natural light, poor posture, and absence of makeup as opposed to the "after" photographs utilizing flash photography, more flattering camera angles, and more attractive makeup and hair style. The article tells us that the procedures are becoming "cost effective" and that we can be: "In for surgery in the morning and home, propped up in bed, in time for 'Dynasty'" (p.10). Haley, the patient, states that she woke up one morning and realized her "Penthouse" figure was gone. "My tummy was no longer flat, and my thighs were supporting saddle bags" (p.12). She goes on about the "miracles" that plastic surgeons can perform and her desperation due to the fact that dieting, exercise, and body wraps hadn't worked. Waldron sounds totally impressed with the outpatient accommodations and the reasonable cost, but does comment on the extensive bruising "from belly button to knees" (p.15). This is the only side-effect mentioned in the entire article, although one doctor is quoted as saying that this "discoloration" will remain for six to eight weeks and the "discomfort" can be controlled with medication. Another physician mentions that this procedure is not the answer to obesity, but no mention is made of the risks of bleeding and infection by any of the three plastic surgeons interviewed. The names and affiliations of the three plastic surgeons are printed, as is the number of the American Society of Plastic and Reconstructive Surgery, so that readers will know how to find a well-trained plastic surgeon in their area. The overall tone of this article is extremely favorable to cosmetic surgery, and glosses over potential
problems or doesn't mention them at all.

The August 1986 edition of Harper's Bazaar has the caption "over 40 and terrific" on the cover. Included in the topics covered is an article entitled "Does Your Face Need a Lift" which presents a "self evaluation chart" devised by Dr. John Grossman, a Denver plastic surgeon. This chart presents the potential patient with tips on the tell-tale signs of aging for each separate part of the face, followed by the name of the plastic surgical procedure that is the "potential treatment" (1986, p.155). This article intensifies the aversion to the "stigmata of aging" (Kotler, 1983, p.524) and heightens public awareness of each subtle change possible as one ages. The article states that many women have "rejuvenating procedures" for the first time in their mid-40s, but "those who begin early (in their late 30s) can have an unlimited number of additional treatments" (p.155). A "good" facelift is quoted as lasting from three to five years, and a blepharoplasty seven to ten years. The text does present a list of "noncandidates": patients with uncontrolled hypertension, diabetes, or bleeding disorders, and individuals who take aspirin for rheumatoid arthritis. Additionally, it is mentioned that many doctors will not perform facelifts on smokers due to increased vascular problems. Further, the editors state that the patient must have his or her "mental attitude in shape. Plastic surgery can enhance an already sound self-image, but don't think it will solve deep-seated problems" (1986, p.155). Fine, but who is going to decide the "shape" of the person's mental attitude? How unrealistic can a patient's expectations be before a plastic surgeon will refuse to operate, especially since many of these physicians believe that the procedures will rejuvenate mental attitudes? This Bazaar article
presents a case-study of Christine, a 53-year-old corporate lawyer who has had multiple cosmetic procedures (p.155). She had her "eyes done" at 38, followed 4 years later by a facelift, plus cheekbone implants and an earlobe shortening. After another four years she had a partial facelift and alteration of the tip of her nose. The patient is planning on having another lift in several months accompanied by a "chemical peel to erase the tiny lines around (the) mouth." To her, these lines are: "profound evidence of aging, and I find them unsightly." She further states: "When you look older, you're treated differently, and then you're apt to limit your activities to what people expect of you." She goes on to say:

I'm not sure my experience with plastic surgery is like other peoples'. For me, even a total face lift is a relatively minor operation. I'm aware of the risks, but I don't consider it like other kinds of surgery, which deeply invade the body. As a result I don't spend much time worrying about the outcome. ("Does Your Face", 1986, pp.155,211)

The Editors do offer some rebuttal to Christine's unrealistic (and common) view of plastic surgery.

Like Christine, the majority of plastic surgery patients are pleased, if not enthusiastic, with their new looks and are willing to undergo repeat procedures. However ... her postoperative reaction is not considered typical. Surgeons caution that pain, discoloration, bruising, scarring and depression are all likely side effects, even when the patient is well-informed, realistic, and highly motivated. ("Does Your Face", 1986 p.211)

They further state that "no cosmetic surgery is superficial or without the risk of either complications or an unwanted result." They mention that depression can result because the results are "barely perceptible" or because more noticeable changes can be "emotionally unsettling", or because other life changes fail to materialize after the surgery. The patient must also avoid direct sunlight for several months while healing takes place. These comments do help to balance out Christine's
enthusiastic testimony, but the Editors never mention the serious risks of infection, nerve damage, vision loss or anesthesia reactions.

A more even-handed presentation found in a popular women's magazine is from the April, 1987 edition of *Better Homes and Gardens*. The tone of the article, although not unfavorable toward plastic surgery, is also not overwhelmingly enthusiastic. The author quotes Dr. Mark Gorney, a plastic surgeon, who states that ads create a "carnival spirit". And Gallo, the author, states: "If you choose a surgeon because of an ad, you may regret it later" (p.94). We are also told that before and after pictures can be misleading because of differences in weight, bone structure, and skin color. The article discusses rhytidectomy, liposuction, blepharoplasty, rhinoplasty, abdominoplasty, and breast procedures, and enumerates complications possible with each procedure. In addition to other factors, the article mentions possible nerve damage secondary to facelifts, the significant scars present after abdominoplasties, and the rather common (perhaps one in three) complication of hard breasts due to scar tissue formation around implants. Gallo mentions that the popularity of liposuction has prompted unqualified physicians to attempt it, and that serious side-effects such as infection, muscle and nerve damage, significant blood and fluid loss, and even death can occur when it is improperly performed. Gallo does not, however, mention anesthesia risks.

Other, less favorable, articles are beginning to appear in the popular press and magazines, although these are greatly outnumbered by those in favor of cosmetic surgery. One example is an article by Bardach (1988) which explores "The Dark Side of Cosmetic Surgery." In it, the author discusses the horrifying consequences for patients who have had silicone
injected into their faces and bodies. Bardach also discusses the hazards of breast implants and details the costs and risks associated with hair-replacement surgery, facelifts, "nose jobs", breast augmentation, "tummy tucks", and liposuction. Ann Scheiner (1986) has written an article about her own facelift which cautions readers. Kaplan (1988) outlines, in her article, the controversial nature of liquid silicone injections, and also discusses the hazards of "premature" plastic surgery. A final article, found in Self magazine, is entitled "Breast Frenzy", and Alderson, (1988) the author, exposes some of the controversy surrounding breast augmentation procedures. Alderson introduces testimony by a plastic surgeon, and others, that breast implants are probably being overdone, and discusses the social factors which may be driving this trend. He relates some of the problems that can plague the implant patient, and also raises the question of mammogram difficulties for women with breast implants. At the end of the article, Alderson reiterates the question asked by plastic surgeon Robert Goldwyn: "What would future archeologists think if they found these implants in our tombs? What would they think we were doing?" (1988, p.89).

It can be seen that the popular press has presented accounts of cosmetic surgery that have often been overly enthusiastic and optimistic, and that have disregarded complications. The use of testimonials and before and after photos has been, and is, especially misleading to the public. I feel that this coverage can be as effective in increasing the desire for cosmetic surgery as physician advertisements are -- perhaps even more so. What we need at this point in the cosmetic surgery explosion are more articles like those of Bardach, Alderson, Scheiner, and
Kaplan, so that potential "consumers" of this surgical beauty service will consider the serious nature and potential complications of these most extreme beauty treatments before they decide to undergo these procedures.

This chapter has attempted to weave together the themes of advertising, medical advertising, and cosmetic surgery, in order to deepen understanding of the processes that occur when a sub-specialty within the medical field becomes truly commodified and "patients" become "consumers." Chapter III will attempt to interpret the concept of feminine beauty as it is understood in America, in an effort to appreciate the quest for attractiveness that women are compelled to undertake, and in order to anticipate what it is that they will come to expect from cosmetic surgery.
CHAPTER III: FEMININE BEAUTY IN AMERICA

Definitions and Conceptualizations

Webster (1986) defines beauty as "the quality or aggregate of qualities in a person or thing that gives pleasure to the senses or pleasurably exalts the mind or spirit: loveliness" (p. 76). The very non-specificity of this definition foreshadows the difficulties inherent in capturing the idea of beauty on paper. I will attempt nonetheless, to isolate and interpret the factors which seem to constitute a definition of facial and bodily beauty for American women because the pursuit of these qualities is a major contributing factor in the decision to undergo cosmetic surgery. The fact that the majority of persons who seek such procedures are female underscores the relatively greater importance and necessity of beauty for women. This state of affairs has a long history in the United States. Banner (1983) relates the nineteenth-century American view that women were responsible for spiritual and religious mores, higher cultural values, and also the creation and preservation of beauty. She quotes an 1852 issue of Godley's Lady's Book which states:

It is a woman's business to be beautiful. Beauty of some kind is so much the attribute of the sex, that a woman can hardly be said to feel herself a woman who has not, at one time of her life, at all events, felt herself to be fair (p. 10).

The word beauty is derived from two Latin roots: bellus, meaning pretty, and bonus, meaning good. Banner notes that the term was first used only to describe women and children and establishes that the Romans believed that men and women possessed entirely different virtues: ambition, for example was characteristic of men and beauty of women. The medieval code of chivalry was centered around the veneration of women and their beauty as a symbol of love, truth, and peace. Renaissance artists and
poets continued this traditional view of women as morally superior and as spiritual guides to a union with God. The idea that women were, by nature, more beautiful than men originated, according to Banner, with eighteenth-century painter William Hogarth, who argued that a curved line was naturally more beautiful than a straight one. Banner also quotes philosopher Edmund Burke who agreed with Hogarth and added the qualities of smallness, smoothness, and delicacy as indices of beauty: qualities that he found best represented in females. Banner goes on to demonstrate that not only philosophers but also fashion designers and other "experts" on physical beauty continually referred to Hogarth's curved line of beauty and quotes Ralph Waldo Emerson: "beauty reaches its perfection in the human form" and "its height in women" (1983, p. 11). Nineteenth-century poets, novelists, and philosophers were fixated on female beauty and often characterized women as closer to nature due to their recurrent physiological cycles and alleged intuitive powers. And yet, to male authors, woman was anomalous and perplexing. She was the personification of beauty, love, and spirituality as virgin and mother, but she was also a sexual temptress: the daughter of Eve. Banner demonstrates the late nineteenth-century appearance of woman as seductress in Western art and explains that such personifications paved the way for another definition of female beauty: one concerned with sensuality and the surface lures of face and body for men. It is this theme that is linked most closely with idea of beauty as an avenue to power for women: a way in which they might tie themselves to influential men and thereby better their lot. Lakoff and Scherr (1984) also speak to the fact that beauty is closely tied to power, but they state "the power of beauty is the
power of the weak" (p. 20). However flawed and illusory this path to
car

power and influence, however, it was and has continued to be, for many
women, considerably better than nothing.

Lakoff and Scherr (1984) attempt in their book to determine the
"reality" of beauty and state that there is a "general physical configuration
that, in a particular time at a particular place, has the potential to be
beautiful" (p. 28). They cite regular, though not too regular features and,
presently, the importance of beautiful hair and slim figure to the ideal of
t feminine beauty. Given these attributes, almost any women might be able,
with a bit of work, to approximate beauty. In their chapter on how
artistic or aesthetic philosophers have represented female beauty, Lakoff
and Scherr mention some of the following characteristics: "symmetry,
proportion, predictability and regularity" (1984, p. 57). The nose must fit
the face but it cannot be too large, or hooked, nor be too small and snub.
The mouth must not be too large nor too small; but these authors comment
on the obvious fact that the use of the word "too" illustrates the
subjectivity of this endeavor. The figure cannot be terribly obese, nor
painfully thin, nor must any part of it be out of proportion. And yet,
despite these ground rules for beauty, many examples of beautiful women
can be cited who defy the standards of symmetry, expectedness, and
harmony quoted by Lakoff and Scherr.

The authors go on to discuss the myths and the reality of the
problem of beauty. They first advance the myth that there has been held
to be such a thing as the most beautiful women in the world: a standard
that would be more or less universal, such as Helen of Troy. They then
present the counter myth that beauty is fashion, is determined by those in
power, and is therefore unpredictable and not based on any kind of universal aesthetic. This argument is particularly relevant when we look at beauty cross-culturally and consider the beautifying rituals that seem disfiguring to our Western eyes. Lakoff and Scherr believe that the reality line should probably be drawn somewhere in the middle, but perhaps closer to the counter myth. They cite as an example the fact that an American Caucasian can, with training, come to accept some Asian or black women as beautiful in beauty pageants, but that usually these "exotic" contestants will be found to more closely approximate the Caucasian ideal than that of their own race. Therefore, beauty is probably not instantly and "instinctively" recognized, but learned over time. However, certain classical standards of beauty, as exemplified in Greek sculpture or by the Mona Lisa, still have the power to move us, suggesting that beauty is still understood as a complex of features that set us apart from the animals: "flowing hair, full lips, sculptured nose" (Lakoff and Scherr, 1984, p. 30). These authors feel that these characteristics occur time after time, in culture after culture, as exemplifications of the feminine ideal of beauty. They also state that another unchanging norm is the idea of some recognizable proportion or symmetry for various parts of the female figure, even though the actual proportions can very markedly from period to period. A second myth-counter myth duality that Lakoff and Scherr outline is the idea of beauty as good for us versus the notion that beauty is evil and destructive. This comparison pits the innocence and virtue of beauty against the allure that can propel men, via their sexual impulses, to their doom. A third duality examines the personal happiness or unhappiness of the beautiful woman. Does great beauty bring
misery to its possessor? It is possible, of course, to list famous beauties, such as Marilyn Monroe, who have been "blessed" with every American cultural parameter of beauty, and who appear to be unhappy. Lakoff and Scherr posit that one can't link beauty with happiness or unhappiness, as there are several possible responses to beauty on the part of the woman herself. She may become less insecure than the rest of us and demonstrate great graciousness and generosity, or she may lack a sense of the struggles of others and evidence no compassion. Even worse, since she has had everything come to her via her beauty, she may never develop any other aspects of her personality and may become a decorative empty shell. But unlike a shell that can remain lovely for generations, the face and body of a beautiful woman inevitably ages and changes leaving only the intellect, character, and spirit of its possessor in the final analysis. A fourth myth-counter myth is that beauty is tied either to stupidity or braininess. Most of us are aware of the "dumb blond" stereotype that exists in American culture based on the blond bombshell movie star with the high twittery voice and the inability to think her way out of a brown paper bag. The other side of this dichotomy is not really well developed in our culture; Lakoff and Scherr cite Jill St. John and Jayne Mansfield who have been represented as having beauty, sex-appeal, and genius I.Q.s. This illusion, however, is not prominently held in American society, and in fact its converse -- that smart woman are invariably ugly -- has been the prevailing belief. This belief is currently being disproved as more women are finding success in the male world and many of them are very attractive. It is allegedly no longer in style for a woman to camouflage her intelligence in order to become less threatening to men, and yet I
believe that many women still continue the charade in order to preserve their relationships. The final dichotomy that I will mention is that between beauty as powerful and beauty as powerless. The myth is that beauty is powerful in that its possessor can sometimes use it to influence others, specifically men, to do her bidding. The counter myth is that the power of feminine beauty winds up being no power at all, for it must be exercised through another. When one's beauty fades, therefore, she has lost all influence. The reality in this case is closer to the counter myth. Although a beautiful woman can get things done, this power depends on manipulation and as such is suspect and capable of creating great resentment in others. I think that Lakoff and Scherr's myth-counter myth structure illustrates the complexity of our thoughts and feelings about beauty, as they claim. This method of conceptualizing beauty also foreshadows the difficulties and pain that arise from the obsessive search for, and cultivation of, physical beauty.

An Historical Look at Female Beauty

Lois Banner provides an intriguing historical view of female beauty in her book *American Beauty* (1983). I will provide a brief synopsis of some of her data covering the nineteenth and early twentieth centuries and then will cover the mid to late twentieth century from a more varied perspective.

Banner begins her characterization of early nineteenth-century female beauty with a depiction of the "steel engraving lady": a title which described both a lithographic process and the sense of moral rectitude that emanates from these portraits. This ideal was not voluptuous, but was, rather, "sylphlike", "ultra-attenuated", "etherealized", "fragile", "frail", and
"slight", with a "wax-doll prettiness". The steel engraving lady had an 
"oval or heart-shaped" face, her chin was "soft and retreating", and her 
mouth was "tiny", "beestung", or "a rosebud". Her body was "short and 
slight, rounded and curved". She possessed a small waist that came 
between a "rounded bosom and bell-shaped lower torso". Her feet were 
"tiny and delicate", her hands were "small, her fingers tapering". Her 
complexion was "white, with a blush of pink in her cheeks" (1983, pp. 45-
46). This ideal of beauty, according to Banner, was not new, but had first 
emerged in the late Middle Ages as part of the cult of chivalry. In 
succeeding eras, such as the sixteenth and seventeenth centuries, the 
"earthy, voluptuous type" of female beauty made its appearance and artists 
such as Rembrandt and Rubens painted "full, weighty, solid, beings" (1983, 
p. 46). By the eighteenth century, however, the ideal of feminine frailty 
was again in vogue, although a preference for greater height and weight in 
women become more prominent during the French Revolution and the 
Napoleonic Era. By the 1830s the steel-engraving look was solidly 
entrenched in America where women dieted compulsively and corseted 
themselves so tightly that headaches and fainting spells resulted. In this 
era medical advice books represented women as drained by their feminine 
physiology and childbirth, and as possessed of a delicate digestive system 
that could absorb only small amounts of light food. Woman was the 
weaker sex, but was characterized by a refined spirituality. Facial 
features, in order to reflect this, had to be small and delicate, for if they 
were large they indicated "sensuality and slothfulness" (1983, p. 50). Other 
factors which influenced this look were the desires of the young woman to 
resemble the heroines of early nineteenth-century fiction and the
prevalence of tuberculosis or consumption during this era. Victims of consumption became more beautiful, according to the prevailing norms, as they grew more frail and their skin assumed a translucent quality. Banner states that the steel-engraving ideal of beauty was an "embodiment of the restrictive, middle-class Victorian view of woman's role" (1983, p. 53). In the rapidly changing industrialized society women represented innocence, spirituality, and domestic values, and this view of womanhood represents "an analogue of the "feminine mystique" of modern times" (1983, p. 53). Banner adds two other salient characteristics of this beauty ideal: youth, which underscored purity, romanticism, and also the infantilization of woman; and aristocratic features, such as small hands and feet, slim waists, and small noses and mouths, which exemplified the American drive for "gentility" and high status.

By the 1860s in America, the steel-engraving ideal was being challenged by other prototypes. One was the natural woman touted by advocates of physical exercise and described by Elizabeth Cady Stanton as having a "large waist and strong arms"; another look was the "voluptuous woman" who had a large bosom and hips and was in general a woman of greater weight. This model of female beauty had been seen earlier in English visitors to the United States, in German immigrants, and also in actresses and prostitutes. In the period following the Civil War, physicians began to propose that it was healthier to be fat, and women began to pad bosoms and hips. Plump women were thought to be good-natured and cheerful, and voluptuousness was equated with sensuality. The artist Bouguereau painted fleshy nudes during this period, and actresses such as Eugenia Doche in the 1850s and Adah Isaacs Menken in the 1860s
exemplified the voluptuous ideal. Changes in fashion during this period heralded the decline of Victorianism as dress styles were modified into a body-revealing mode which included a bustle in the rear by the late 1860s. At the same time cosmetics became widely used and enamelling became popular: a process that involved coating the face and neck with an arsenic or lead-based enamel. Banner relates that the corseted, high-heeled, and heavily made-up fashionable woman of the late 1860s was dubbed a "Dolly Varden" after the flirtatious, working-class heroine of Dickens’ Barnaby Rudge (1983, p. 119).

By the 1890s, the physical fitness movement in America had led to a widespread interest in the human form and the natural woman became the newest beauty ideal. The natural woman was brought to life through the illustrations of Charles Dana Gibson whose "Gibson girl" dominated standards of beauty in America between 1895 and World War I. This new model was tall and statuesque with thick, dark hair upswept in the pompadour style. Her figure was much thinner than that of the voluptuous woman, but she retained the large bosom and hips of the preceding model. She usually was drawn with a small mouth and snub nose, although Gibson sometimes lengthened the nose to a "longer Roman style" (Banner, 1983, p. 154). Banner relates that the popularity of the Gibson girl look was partly related to the fact that Gibson often drew her in satiric situations as well as the fact that this cultural model could be seen to represent a variety of styles. Feminists of the time apparently saw her as a prototype of the "new woman": for the blouses and skirts she wore seemed to herald dress reform and the illustrations often showed her playing sports which seemed to validate the claims of the physical exercise proponents. Banner quotes
a description of the Gibson girl as "braver, stronger, more healthful and skillful and able and free, more human in all ways" (1983, p. 156). Yet this newest feminine model was only partly a reform figure, for she was rarely depicted as a college or working woman. Interestingly, according to Banner, many analysts described the Gibson girl as a "representative of the aristocracy with which Gibson was personally associated" (1983, p. 158) as she was often pictured at elite gatherings such as balls, the opera, or horse shows. Gibson's focus on society women undoubtedly played an important part in the popularity of his drawings because the lives of the wealthy held tremendous fascination for the American public of the 1890s. Gibson's images, however, did not evoke the highest aristocracy in America, but rather young women of the elite who were rebelling somewhat against the rigid standards of society: who wanted some freedom in personal style. Gibson was providing a model of a new woman who wanted "to excel in some individual attainment" (Banner, 1983, p. 165).

Additionally, as Banner suggests,

Behind the genesis of the Gibson girl lay a general American fascination with young women. Since the days of Cooper, Hawthorne and Poe, American writers had used young women as symbols of the American character, as representing the conflicts between purity and sensuality, between traditional society and the future (1983, p.166).

Significantly, the women that were seen as the personifications of innocence and beauty in the raw, industrialized world of the nineteenth-century were artistically represented as young. The Gibson girl can be seen to have represented emerging new realities for women, and yet she was often a fantasy figure that combined beauty, youth, and aristocracy. As Banner explains to us, she was not, nor was she meant to be, a radical figure: for if she had been she could not have attained such enormous
The Gibson girl look began to be superseded in the 1910s by a "small, boyish model of beauty exemplified by Mary Pickford and Clara Bow" (Banner, 1983, p. 5). In the 1920s the "flapper" became the model of physical appearance and exhibited such characteristics as shorter skirts and discarded corsets, bound breasts, small face and lips, and constant movement. Clara Bow defined the 1920s look as characterized by "vivacity and fearlessness and a basic indifference to men" (Banner, 1983, p. 279). At times the flapper was portrayed as a stick figure with comic overtones. Banner describes the 1920s as possessing an almost adolescent quality: as Americans were first exposed to consumer goods and as advertising began in earnest to celebrate and reaffirm spiralling consumption. By the 1920s the American beauty industry was developing rapidly and such factors as fashion, cosmetics, beauty contests, and modelling became important. Banner affirms that since the 1920s the quest for beauty has involved "artificial means, whether cosmetics, hair curling, or even plastic surgery" (1983, p. 274).

The 1930s, however, was a time of economic downturn in the United States, and Americans seemed to favor a more sedate and mature model for behavior and appearance. In 1929 hemlines descended and bosoms and waists reappeared. Women were portrayed in the media and on the movie screen by stars such as Crawford and Garbo as glamorous yet assertive: typically shoulder-padded, buxom, and self-reliant. Besides movie stars, sportswomen provided a new image for American women to emulate in the 30s. Many of these women promoted more functional, comfortable clothing, which fit the new athletic vogue of beauty: complete with tan.
The 1950s was the era of the "feminine mystique": Betty Friedan's term for a view of women that consigned them to the domain of home and family and emphasized their sexual nature. Banner notes that two models of physical appearance were combined in the 1950s: the voluptuous and the childlike. Some examples of movie stars from this period who exhibited this duality were Sandra Dee, Annette Funicello, Debbie Reynolds, Doris Day, and the most important model of childlike sensuality, Marilyn Monroe. Lakoff and Scherr also speak of the importance of "cuteness" in the 1950s and the "harmless" nature of these sex symbols (1984, p. 90). Grace Kelly and Audrey Hepburn provided cool, restrained, "ladylike" images of beauty during this period, but theirs was not the prevalent model of feminine attractiveness. The 50s look was large-bosomed and small-waisted, and was often padded or corseted to achieve this aim. Longer full or tight skirts and three-inch high heels with pointed toes were worn. Banner states that fashion in the 1950s "reflected the combination of social repression and sexual exploitation that characterized American attitudes toward women" (1983, p. 285) and likens the 50s dress code to that of the Victorian era. Banner relates also that women athletes seemed to have faded from public view: to be replaced by cheerleaders and pompon girls who were chosen solely for their physical appearance.

The 1960s mark the beginning of what has been termed the post-modern period in American society, and in this decade a new ideal of beauty was born. Vogue magazine called the new movement a "Youthquake" in 1965 (Lakoff and Scherr, 1984, p. 96) which would overturn the "constraints and structured looks of the 1950s". As those who participated and those who watched from the sidelines will remember, the 60s was a
time of rebellion, idealism, and freedom in behavior and dress. Radical chic had everything to do with politics, fashion, and beauty. The youth of the 60s seemed almost uniformly united against what had been the prevalent cultural values of the 1950s in America, and free sex, drugs, Eastern religions, and natural foods became commonplace. Many young women eschewed makeup and adopted short gamin hairstyles or the long straight look. Banner (1983) relates that for the first time in America ethnic beauty was not only celebrated but was offered as a cultural model. Most of us remember the "Black is Beautiful" slogan and the origin (in the U.S.) of the Afro hair style which became popular for Caucasian women by the end of the 1960s. Although rigid standardization of beauty seemed cast aside, however, the 1960s did manufacture blueprints for feminine attractiveness, as has every other period. Lakoff and Scherr (1984) tell us that some favorite Vogue magazine stars were models, such as: Jean Shrimpton, Twiggy, and Lauren Hutton; or "personalities" who became models: such as Verushka, Penelope Tree, and Marisa Berenson. The 1960s overemphasized youth, institutionalized thinness, and inaugurated the bizarre and the androgynous as legitimate "looks". Above all, everything was youth: youth and freedom and nontraditionality. Eileen Ford, who heads the well-known modeling agency in New York, and certainly has a finger on the pulse of American beauty, calls the 60s "freaky" in retrospect ("Modeling the 80s", 1981, p. 82).

According to Eileen Ford, again, the 1970s look became "slovenly" ("Modeling the 80s", 1981, p.82). Those in powerful places in the beauty and modeling industries had economic reasons for concern during this decade, for the natural look and the feminist movement both gathered
great momentum during this period. The feminist beauty ideal emphasized naturalness and pride in being a woman, a celebration of ethnic diversity, and, not least, that beauty emanated from within. Barbara Streisand was presented as beautiful and sex symbol enough to co-star with Robert Redford -- despite a prominent nose which she refused to alter. Some feminists took to bra-burning and eschewing all makeup and hairstyling, while others covertly applied beauty aids. Feminists were, and are, rather conflicted on this topic, as I will discuss later.

Super-star models were still cultural blueprints for beauty, but the models now had an "American" look: less makeup, casual hairstyles, a healthy glow, and perhaps some minor physical flaw which made them all the more approachable. Lauren Hutton is a good example of this genre of American beauty: she has a gap between her front teeth and describes her nose as banana-like (Lakoff and Scherr, 1984). Cheryl Tiegs is another example of the tall, blond, athletic, California-girl beauty who became a modelling super-star, followed by Farrah Fawcett, who Vogue magazine termed "the sex goddess of the seventies" (Lakoff and Scherr, 1984, p. 105). Farrah became a phenomenal success with her trademark mane of tousled blond hair and her impossibly wide smile. We knew, of course, that these models wore makeup and spent hours on their hair, but they told us otherwise. Lakoff and Scherr (1984) quote Phil Donahue who states that Farrah spent an hour in her dressing room with her hairstylist and makeup man before an appearance on his show, only to emerge and say to the audience, "My hair? Oh, I just sort of toss it around up there, and that's how it comes out" (p. 105). Farrah was featured in August, 1987 on the cover of Harper's Bazaar magazine and still has her untamed
mane of blond hair. We learn in the article that she is "40 and loving it" (p. 124). We are told that she still takes a "casual approach to beauty and fashion" and she says: "Tousling my hair is about as much styling as I can stand" (p. 124). She does say that she likes to wear more makeup, now, and that "my usual mascara and lip gloss routine doesn't feel complete anymore" (p. 125). We doubt, of course, that this was ever Farrah's makeup routine. She is featured on a two page spread, her nude body partially covered by a multicolored drape, looking tousled, toothy, and sexy. She says:

Years of regular exercise have paid off. I can still fit into the same pair of jeans I wore in college. My hips and thighs are even thinner than they were before I had my baby. Basically, I feel I don't have to worry anymore. I love my body (Farrah, 40 and", 1987, p. 126).

Farrah personified beauty in the 1970s when she was represented as "natural", even though she wore as much makeup as any 60s model. She moves well into the 80s where the bodily fitness craze has become a national obsession. Her statement, additionally, is a wonderful comment on 80s narcissism.

The beauty hallmarks of the 80s are not only a highly toned body, and consequently strength, but also seductiveness and youth. Eileen Ford sees progress now toward a "strong, classic look" ("Modeling the 80s", 1981, p.82). Elaborating on this image of strength is a quote from Dr. Norman Pastorek, a New York facial plastic surgeon who says women tell him: "I don't want to look sweet, when I'm toe-to-toe with those guys on the stock exchange. I don't want to look ineffective and vulnerable." Therefore Pastorek has begun constructing noses that are "slightly assertive, longer and straighter, closer to handsome" (Adler and Raine, 1985, p.67). These same authors quote a Minnesota plastic surgeon, Dr.
William Carter, who states: "The executive woman is in. The Debbie Reynolds look with the cute turned up nose is out the window" (p. 67). The other advantage of a straight nose, apparently, (apart from its toe-to-toe assertiveness value) is that it doesn't look like a nose-job. Dr. Thomas Krizek, Chairman of plastic surgery at the University of Chicago Medical Center says: "The scooped-out nose, which used to be very popular, just doesn't occur in nature very often, and that bothers people today". (Adler and Raine, 1985, p.67) Naturalness is the expected outcome in cosmetic surgery today: people, says Dr. Pastorek, want to look "better, but normal." In eyes the trend is away from the "starved, ascetic, haute-couture, awe-struck look" and more toward a more natural athletic look that is partly achieved by leaving more fat in the eyelids. In facelifts the "rocket-sled look" of the 1950s is also out: people want a softer, more natural result (p. 67). Adler and Raine document contradictory trends that seem to be operating in the area of ethnic beauty, however. They quote Dr. Blair Rogers of New York who says "a Mediterranean, Italian, Greek, near-Eastern look is coming in. A lot of young patients today don't want to lose their ethnicity" (p. 67). And yet, plastic surgeons in San Francisco are reported to do a "brisk business" creating the upper eyelid fold for Orientals: a simple procedure that Adler and Raine report can be obtained at sidewalk eyelid booths in Asian cities. Surgeons also report that increasing numbers of black patients are asking for noses that look Caucasian. What we seem to have described here is a look of assertive, yet natural beauty. And if one is ethnic, a toned-down version of the look of the ancestors. This is very much in
keeping with the Madison Avenue idea of ethnicity that smiles at us from liquor and cigarette ads.

In another article Eileen Ford further defines the 80s look: "a firm body, healthy hair and skin, and a look of serene determination in the eyes. Today, health is beauty. You can't have one without the other" ("The New Ideal," 1982, p. 77). Kaplan (1988) states: "Today an 80s fitness ideal, not a youth quest, is behind many women's desire for cosmetic change" (p. 205). Zoltan Rendessy, the owner of Zoli modeling agency feels that "well-scrubbed class" is the look of the 80s: "clean and healthy", he intones ("Modeling the 80s", 1981, p. 83). Perhaps this is a defense against the onslaughts of the 80s scourges: herpes, and now AIDS. Whatever the reasons, antiseptic is in: along with elements of physical strength. Time magazine quotes Gail Eisen, 40, a producer at CBS News in New York and co-author of The Pilates Method of Physical and Mental Conditioning:

Just being thin isn't pretty anymore. Now beauty is the vibrancy of someone who's got blood rushing through her body from exercise. To be beautiful you have to be healthy. And to be healthy you have to exercise ("The New Ideal", 1982, p. 74).

Whether getting in shape is about immortality, health, or mere narcissism, American women are doing it. We do aerobics and jazzercise along with Hollywood stars like Jane Fonda and Victoria Principal, who have marketed video exercise tapes. Muscles may have become a status symbol for some, but a more mainstream ideal would probably be a fit-but-sexy look: necessitating some curves and cleavage among the bulging muscle groups. Joanne Kaufman states in Mademoiselle (1987): "No doubt about it, calendar-girl bodies are back" (p. 70) and then mentions the full figures of 80s stars Kim Basinger and Madonna and additionally that even the
mannequins in department-store windows seem to have expanded their fiberglass in the areas of breasts and hips. Kaufman quotes New York plastic surgeon Dr. Steven Herman who says that "the full-breasted European look is definitely in" and that he has performed breast augmentation surgery "on many dozens of models in New York City" (p. 70). Dr. Herman believes that these models are paying him $5,000 to $6,000 more for an improved self-image than out of a belief that increased breast size will mean more bookings. Eileen Ford is quoted and disapproves of this trend: "Surgery would be very ill-advised", she says. "The real problem is once you put that stuff in, you can't take it out" (p. 70). In an article entitled "Beauty and the Breast" (Vogue, 1986) Holly Brubach discusses the fact that breasts seem to be back, and that they are getting larger. She contrasts the small-breasted models of the 1960s and the "liberated" 1970s with models and movie stars of the 1980s who are quite well-endowed: Christie Brinkley, Jerry Hall, Kim Basinger, Jessica Lange, and Jamie Lee Curtis. Eileen Ford is quoted yet again, this time to announce that breast implants are "epidemic" at her agency and that in the past six months ten of her models had their breasts enlarged without her encouragement. Brubach states: "Breasts hold out the promise of nourishment, comfort and salvation" and that they are also a "sign of fecundity, an open invitation to men to come and sow their seed". She suggests that "the bigger the breasts, apparently, the louder and clearer their message" (1986, p. 205). Interestingly, Brubach polled the men she knows and they all asserted that size meant nothing: that small breasts were fully as erotic as large ones. She then spoke with some women who were amply endowed who told her that men had admitted to them that big
breasts are, in fact, what men really want. Brubach quotes designer Norma Kamali who states: "When I'm thinking about fashion I think of perky little firm breasts that can go braless and not bounce or hang, and then I talk to men and realize that they like big tits" (1986, p. 206). Brubach states that there is more emphasis on breasts by women and men both in America than in Europe where sex appeal seems to be based more "on the harmony of the whole than on the impact of the parts" (1986, p. 244). It seems that American women are, in the 80s, very self-conscious about their breasts, whether large or small. Brubach suggests that breasts, a paramount symbol of motherhood, have been rediscovered at a time when a lot of 70s feminists decided to climb down from the corporate ladder and reproduce. This suggestion parallels Banner's feeling that the resurgent conservatism of the 1980s may succeed in "re-creating domesticity as the dominant ideal for women" (1983, p. 291). This conservatism may be responsible for the renewed popularity of large bosoms, and the current rise in hemlines, although some of the other data on "assertive" noses appears to contradict this idea. Perhaps this underscores the fact that women continue to want it all: success in the market-place (buoyed by a quest for non-cutesy beauty and strength) as well as success in relationships with men (marked by a preference for large breasts and short skirts). It remains to be documented whether women in America are going to continue the nearly impossible quest for career, husband, and children, or whether she will settle for one, or perhaps two out of three. We may witness a rebirth of the feminine mystique as women drop out to stay home with children, only to discover that Betty Fredan was right after all.
A Feminist Perspective on Beauty

The concept of personal beauty is not a topic with which feminists have wanted to bother; it has been the feminist position that women need to move beyond physical appearance in order to be self-actualized and to be able to compete on equal footing with men. I personally remember discussions with other women in the late 1960s and the early 1970s about makeup and hair coloring and shaving one's legs: those of us who elected to continue some of our previous (culturally conditioned) beauty behaviors were seen by some women as not seriously committed to women's issues.

I also remember conversations with men, many of whom stated they just couldn't find women attractive if they didn't shave their legs or underarms or wear a bit of makeup and style their hair. Of course the men were culturally conditioned as well, and it is very difficult to disregard the personal hygiene and beauty routines that one has observed and practiced for an entire lifetime. My own decision was to continue to use whatever beauty aids I wanted and to continue to work as well for women's rights, but I always wondered if at some level I had "sold out". I guess I considered myself a flawed feminist because I knew I cared about how I looked. When I read Lakoff and Scherr's introduction to their book *Face Value* (1984) I felt a personal draw -- perhaps a vindication -- for they were talking about this very issue: the fact that every woman wants to be beautiful, or at least attractive. We tell ourselves that looks don't matter: that being concerned with appearance only intensifies the stereotype of vain, ego-centric, frivolous womanhood. We say these things to ourselves and to other women, but as Lakoff and Scherr state, this is a defense mechanism. These authors state that they had thought that the
diversity in the way women now physically adorn themselves, from completely *au naturelle* to stage makeup and cosmetic surgery, proved that there was no "universal feminine terror, no widespread neurosis" (1984, p. 16). Then they began to talk among their friends, acquaintances, and students about doing a book on beauty and women begged to be interviewed. These were serious, intellectual women: women who considered themselves feminists, as did the two authors. Not even the most intellectually gifted and serious women, apparently, had come to terms with their looks. Lakoff and Scherr decided, they say, to write their book for themselves as much as for their readers: in the hope that they could understand and make sense of the confusion and lessen the pain.

Lakoff and Scherr asked many women, ranging in age from their twenties to their fifties, how they felt about several issues: their own looks, beauty and its genesis, aging, and what they liked and disliked about themselves. They begin their synopsis of the responses of these women by stating that one thing that all women said without exception, including those who identified themselves with the women's movement, was that beauty was important to them. Many felt that concern about beauty was detrimental to feminism, however, because it still has the power to divide women. In the responses of some of the 50 undergraduate students who answered a questionnaire, the definition of beauty took on transcendental qualities dealing with "radiance of the soul, concern for others, vibrancy, or intelligence" (1984, p. 141). Other undergraduates emphasized physical and mental health and fitness. Lakoff and Scherr see these themes as uniting prevalent spiritual values of the 60s with
widespread fitness and self-care movements in the 70s. These responses defined beauty in the abstract sense. When, however, the subjects were asked to evaluate their own looks, even those who had called themselves attractive had serious concerns. They almost unanimously felt the need to lose weight: even those who looked to the authors to be not at all overweight. Another interesting topic that was dealt with was the use of cosmetics. Most of the women interviewed considered themselves feminists and had argued that beauty is found in health, intelligence, and being fit. The overwhelming majority of the women, however, used many cosmetic products. The subjects seemed to differentiate cosmetics that enhanced appearance, such as perfume, eyeliner, and colorless nail polish, from those that actually changed appearance, such as hair dye, lipstick, and mascara. Almost none of the younger women wore foundation, which they seemed to regard as a "mask" that had been affected by the older generation. Lakoff and Scherr also asked whether the subjects enjoyed certain traditional women's beauty activities, such as wearing cosmetics, getting their hair cut and styled, going shopping, and dressing up. A large majority stated that they enjoyed one or more of these activities: Some did them all. The authors note that these young women were all socialized during the 1960s and early 1970s when the feminist consciousness was at its peak. They did not, however, view these beauty rituals as detrimental to feminism, as had an older generation of feminists who argued that cosmetics reinforced superficiality, passivity, and dependence on male approval. Some beauty activities were viewed as excessive and to be avoided: such as dyeing the hair, primping for long periods, or being obsessed with fashion. It was, to them, a matter of degree: if keeping up physical appearance occupied too
much of a person’s time and energy this was narcissism, while if one did only enough to indicate a feeling of self-esteem, this was healthy.

There is not a large body of data in the literature outlining a feminist perspective on cosmetic surgery. As I have previously mentioned, I consider myself a feminist, even though I use makeup. I do, however, identify a qualitative and quantitative difference between mainstream female beauty routines in America and undergoing cosmetic surgery. These are, of course, related issues, but the difference is one of degree. Using creams and potions is very different from submitting to anesthesia and scalpel and the possible sequelae. I have never felt that one of my facial features was disharmonious enough to necessitate surgical intervention. At 42, I am not very much concerned about the changes aging has wrought, although I am conscious that I look older than I did a decade ago. I do not know, of course, how I will feel at 52. I can recall, when I was single and much younger, wishing I had more of a bustline: and even wondering about breast implants. I was stopped, however, by the thought of anesthesia, surgery, and complications, and because I knew I would want to breast-feed any children I would eventually have. I was, therefore, not dissuaded by the feminist perspective of noncompliance with a hegemonic paternalistic culture, but rather by fear of medical complications. I believe that many feminists oppose and have opposed breast augmentation on the former as well as the latter grounds. One feminist article giving evidence of this is entitled "Beauty and the Breast—A 60% Complication Rate for an Operation You Don’t Need" (Nashner and White, 1977). In it the authors discuss and document the complications of breast enlargement via silicone injections (now, seemingly discarded as a
useful technique) and implant procedures: infection, deformity, hardening, scarring, and emotional difficulties.

A friend of mine, aged 45 and a feminist, told me that she very much disliked the changes in her face that are associated with aging, and that she would have a facelift if she could afford it. Mary-Lou Weisman has written a very entertaining essay, originally published in the *Hers* column of the *New York Times*, which chronicles the feminist ambivalence about the facelift procedure (1986). She begins by stating that an "over-forty feminist contemplates a facelift with the same ambivalence with which an environmentalist with bugs in his garden eyes a can of DDT" (p. 10). She elaborates that she is ashamed of herself for spending time and energy scrutinizing her sagging jawline, but not ashamed enough to stop obsessing. She wonders if the facelift is truly a feminist issue and suspects that many men probably contemplate the procedure out of not only vanity but also based on an assumption, perhaps accurate, that the competition for jobs favors the young. She feels that a facelift is more a woman's issue in the sense that few women leave their husbands for a younger man, but that they are the ones who *are* left and who subsequently undergo this operation to enable them to venture forth and find another man. Weisman speaks of the rationalizations that she employs to justify a facelift, such as appearing "neater", when indeed she admits to wanting to look younger. In the end she concedes that the facelift is "a frivolous issue, but a potent metaphor [for the way in which we] face up to ourselves, and concludes that "one must fight for one's self; even though the reward for waging that battle is ... the cold consolation of integrity" (p. 13). She ends with the statement that this is the reason
that she hasn't sought a facelift -- "so far".

Another view is provided by a recent article in *Ms.* magazine by Ann Scheiner (1986) who outlines her experience in having a facelift. *Ms.* Scheiner is a writer, has been a frequent contributor to *Ms.* magazine, and has been described by her husband as: "a feminist ... a card-carrying NOW member". She states:

I always thought that having a facelift was the most frivolous indulgence -- until I decided to do it. For the last year, I hadn't been able to stand looking in the mirror. The face I saw seemed tired, wrinkled, and years older than I felt (1986, p. 58).

*Ms.* Scheiner knew women who had had less than a perfect surgical result: she mentions one whose eyes were now "too staring" and another who "lost her marvelous quirkiness" but she ran into another friend her age who looked "more vibrant and beautiful" (p. 58) than when she had last seen her seven years previously, and it was from this friend that she obtained the name of the plastic surgeon who eventually performed her surgery. She mentions that she rationalized the procedure as just another kind of beauty treatment and conceptualized cosmetic surgery as "just a more radical facial" (p. 58) although at least one friend reminded her that this facial would involve having her face cut open. Her husband said: "To me, you're beautiful. I love your face the way it is. And I don't want you to have any pain" (p. 58). Her son was non-committal, but her daughter, a new mother and a feminist, was against it. *Ms.* Scheiner had her facelift and experienced what would be considered "normal" postoperative sequelae of pain, swelling, bruising, and numbness. On her sixteenth postoperative day, however, she awakened with such pronounced light-sensitivity that she couldn't fully open her eyes. When she visited the surgeon to consult with him on this problem and on her rather
extensive scab formation, he told her she was "fine" and that she should continue her icepacks and eye drops. By the fourth week postoperatively her eyes were still light-sensitive, she needed to wear dark glasses all day, and her husband reported that her eyes didn't close completely when she was asleep. Into the fifth week she experienced "quick bursts of searing pain in the left eye" (p. 83) and made an emergency appointment with the plastic surgeon to be told that everything was healing normally and to be shown her "before" pictures in answer to her complaints. The ophthalmologist she consulted was less sanguine. He said:

Corneal abrasion. Your lids were stretched too tight. Your eyes don't entirely close and have dried out. I see many of these after cosmetic surgery. I ask my patients if the results were really worth months of red eyes and pain and concern (1986, p. 83).

By her sixth postoperative week, Ms. Scheiner was able to work again.

The following comments constitute her "tally" of the circumstances:


Ms. Scheiner relates that she considered publishing this article anonymously but "then I realized that I wouldn't be facing the truth about myself, as I didn't when I chose to have a facelift. I decided it was important to admit in my own name how far I've had to travel to accept the natural process of my aging" (1986, p. 83). I believe that Ms. Weisman's article and Ms. Scheiner's experience illustrate well the ambiguous nature of the feminist position on beauty and aging. We are all concerned about how we look but we feel that this culturally determined
value lessens us somehow, as serious individuals, and so we deny that appearance and evidence of aging are relevant factors in our lives. They are factors, nonetheless: a point that has been underscored for me (as it was for Lakoff and Scherr) by the fact that I have encountered tremendous interest among women with whom I speak on the topic of beauty, and more specifically, on the topic of cosmetic surgery. Friends, work associates, and neighbors have introduced the topic often, have introduced me to others as someone who is working in this area, and have even asked to read drafts of my text! The individuals who are interested are women who are not employed outside the home and have not finished college, as well as individuals with Ph.D.s, M.D.s, and executive positions in business. It is my impression that concern about physical appearance and aging is probably a universal phenomenon among women in America: one we cannot avoid totally because we have all been socialized in the United States. I believe, however, that greater (sometimes debilitating) and lesser (perhaps tolerable) degrees of concern may be mediated by other factors such as support structures, meaningful work or interests, and belief and value structures that both comfort us now and offer us hope for the future.

**Beauty In The Eye of the Surgeon**

It is into the hands of the cosmetic surgeons that we commend our faces, our bodies, and our lives, therefore it is necessary to understand something of the way in which they view us. They are, of course, part of the larger American culture, but they are also products of both their medical training and of their specialization in cosmetic and reconstructive surgery. As Americans these doctors share, in varying shades, our
collective obsession with youth and beauty. As physicians they have been socialized into a medical subculture that over-values the identification and eradication of "disease" and under-values the maintenance of health. As cosmetic surgeons they take on a worldview that encompasses both surgery ("When in doubt, cut it out") and the American beauty culture which institutionalizes the belief that no American woman ever looks good enough. In order to legitimize cosmetic surgery, diagnostic categories have been created to confer disease status upon wrinkles, sagging skin or eyelids, small or large breasts, fat deposits anywhere in the body, small chins, and almost any other variation in the human body that is not consistent with perfection or youth.

I have found many examples of plastic surgeons' opinions on beauty and their ideas on the appropriate timing for cosmetic surgery in popular magazine pieces, newspaper articles, and books written about plastic surgery. In the summary section of his book Beauty Surgery, William H. Canada, M.D., says the following:

In cosmetic surgery, perfection is a necessity. It is an attempt to surpass the normal. When a plastic surgeon accepts a patient for a cosmetic operation, he is undertaking one of the most responsible tasks in surgery. He is performing surgery not to remove pathology, not to mend a defect, but to make that part of the body more beautiful (p. 146).

In other words, there is no one who is not a candidate for cosmetic surgery.

To expand a bit on this theme, consider the yearly list of individuals labeled by doctors Joel Friedman and Andrew Breiman as "bogus beauties" (1988). These two cosmetic surgeons have provided the following assessment on 10 women considered to be beautiful even though they fail to meet "clinical and classical" standards. Actress-model Lauren Hutton
has a "space in her teeth" and "her face is too long". Actress Susan Lucci
has an "asymmetrical face" and her "jaw is off-center". Game show
hostess Vanna White has too much gum showing when she smiles and Gary
Hart's friend Donna Rice has a chin that is "too long". Actress Daryl
Hannah has a "protruding chin" while Tom Cruise's wife Mimi Rogers has
an "asymmetrical face". Jackie Onassis has a "convex face" and model
Jerry Hall's face is "too long". Farrah Fawcett has "difficulty bringing her
lips together" while super-model Paulina has a "convex face" (p. 3).
Initially it might be comforting that even these women, famous for their
beauty, are "imperfect": until one realizes that these assessments only
intensify our obsession with beauty and perfection and cause us to line up
at the plastic surgeon's door.

Dolan, in an article in the Wall Street Journal (1987) begins with the
quote of a San Francisco surgeon as he performs suction lipectomy on a
female patient's leg: "I'm going to take out this fat pad" to create "a far
more idealized, beautiful view". Dolan describes how the surgeon inserts
the liposuction cannula and "vigorously pulls it back and forth" and then
asks the anesthesiologist: "How's that contour look?" The other man,
evaluating the now reduced thigh, states: "That will look nice in a bikini"
(p. 1). This, of course, tells us that "fat pads" are definitely not
considered beautiful. We don't know, however, how large these "fat pads"
were. Dolan also quotes Dr. Carson Lewis, a plastic surgeon in LaJolla,
California, who says: "We can literally be like a sculptor of the human
body. It boggles the mind" (p. 1). In San Francisco, dermatologist Alan
Gaynor and two colleagues run what they term a "one-stop shop" (this is
beginning to sound ominously close to the ads for fender repair, but we
women seem not to mind the General Motors imagery that is continually applied to us: the most common being the "too many miles" image. A prospective patient can get almost any type of cosmetic surgery at Dr. Gaynor's Garage: permanent eye liner or an acid face peel to remove wrinkles are two examples given. Gaynor himself performs the liposuction procedures and describes his work as humanitarian and life-changing for patients. "Can you imagine the trauma these women have shopping?" he asks (Dolan, 1987, p. 2). I, for one, cannot believe that we are to take this comment seriously. He has liposuctioned his wife's stomach and neck, and his 11-year-old daughter has already inquired about the procedures. He will probably open the first pediatric liposuction clinic in America. Dr. Franklin Rose, a Houston plastic surgeon, is quoted in an article in *Houston Health and Fitness* magazine which tells the story of a top model who has recently had breast augmentation surgery. He states:

One needs only to look at the cover of *Cosmopolitan* and similar publications to note that the fuller breast appearance is highly sought. This is true not only among fashion models and actresses that are very figure-conscious, but also for women from all walks of life ("Update on Plastic," 1988, p. 31).

Dr. Rose subtly voices and reinforces the late 1980s breast obsession and encourages all women to seek such procedures. Dolan states that 85% of cosmetic surgery patients are still female, and quotes Dr. Richard Burton Aronsohn, past president of the American Academy of Cosmetic Surgery, to explain one of the reasons. "Most men want to get involved with a women based on her looks. It's rather tragic and shallow, but that's how most men are", states Aronsohn. He says working on patients is "like playing Pygmalion or God" (p. 2). This is a male god speaking, so we assume he knows whereof he speaks. But even if we must accept some
measure of this drivel as an approximation of truth, are we to act on this
information and employ cosmetic surgery and liposuction as the preferred
methods to increase our attractiveness? Have we exhausted all other
available options?

In their professional journals and books, plastic and reconstructive
surgeons have attempted a more rigorous determination of what constitutes
beauty. Krugman discusses the techniques that should be utilized to insure
the success of the rhinoplasty procedure, stressing that "It would be a
mistake to search for an ideal set of proportions or angles and to attempt
to accommodate every nose to meet that norm, although such has been
done in the past by both artists and surgeons" (1981, p. 56). An
experienced surgeon, he feels, should be able to devise a treatment plan
based on careful observation of the interrelationships in the nose and face,
and high-quality photography is essential. Krugman discusses how
photographic analysis is carried out using vertical and horizontal lines
drawn using facial landmarks. In general, according to Krugman, the
average Caucasian nasal tip should be about the same width as the inner-
canthal distance (the space between the eyes). The ideal width of the
nose is 70 percent of its normal length, and the normal nasal length is
one-third of the facial height. Several other parameters are listed which
define the nasolabial angle, the angle of projection on profile, and which
establish the preferred sizes for various parts of the nose, such as the
nostrils. Krugman emphasizes at the end of the article that the angles
and relationships listed "vary with age, race, and sex, and are meant

Seghers, Longacre, and DeStefano (1964) discuss the golden proportion
(also called the golden section or golden mean) as the standard by which human facial and bodily beauty might be measured. Lendvai (1966, p. 175) defines the golden section as:

division of a distance in such a way that the proportion of the full distance to the larger part should correspond geometrically to the proportion of the larger to the smaller part ... when full distance constitutes the unit, the value of the larger section amounts to 0.618 and that of the smaller section of 0.382.

Huntley relates that the ancient Greek geometers, the Pythagoreans, worked with the golden ratio, and that "the problem of finding the golden section of a straight line is solved in Euclid II, 11" (1970, p. 25). Greek architects and sculptors utilized the golden ratio in their work and the dimensions of the Parthenon bear witness to the importance of the golden rectangle in Greek architecture. Both Huntley (1970) and Ghyka (1977) speak of the importance of the golden rectangle to art and of the work of a famous German psychologist, Gustav Fechner. In 1876, according to Ghyka, Fechner found that this "golden rectangle, for which the ratio between the longer and the shorter side is 1.618", was the most aesthetically pleasing rectangle to a majority of observers (1977, p. 10). Ghyka goes on to relate that the golden section plays an important part in the proportions of the human form. It can be demonstrated, for example, that in a well-built human body the ratio of the total height to the vertical height of the navel is always 1.618 or a near approximation. Ghyka also notes: "Amongst Miss Veronica Lake's measurements given in an American magazine, I notice 34" for the chest contour, and 21" for the waist ... having as (a) ratio 1.619". Of additional interest is the fact that:

in the average or ideal face we find also the Ф ratio between the height of the face (up to the roots of the hair) and the vertical distance 'line of eye-brows -- lower tip of chin', and between the
vertical distance 'lower part of the nose -- lower tip of chin' and the distance 'meeting line of the lips -- lower tip of the chin' (Ghyka, 1977, p. 98).

Ghyka compared these measurements or "harmonically analyzed" the face of a famous sportswoman, Helen Wills, and the profile of Isabella d'Este, the subject of a well-known painting, superimposing upon them the golden rectangle and illustrating the aforementioned relationships among facial landmarks. Seghers, Longacre, and DeStefano (1964) reproduce the facial harmonic analysis of Miss Wills in their article, and relate the importance of the use of the golden rectangle when undertaking the reconstruction of a deformed face. These surgeons cast a wax replica of the deformed face, and determined the amount of bone to be resected on one side and to be replaced on the other by means of an harmonic analysis. They show a mold of the reconstructed face at the conclusion of their work and note the closeness of the proportions of the reconstructed face to the golden proportion as determined by harmonic analysis. They illustrate, in this manner, that the reconstruction of a deformed human face is "not a free and improvised art, based on feelings or impressions; on the contrary, it is an art strictly tied to and developed from the laws of geometry" (1964, p. 386).

Moving much further along in this attempt to quantify facial normality and beauty is a book by Leslie G. Farkas and Ian R. Munro (1987) which is an ambitious, highly technical study of face and head measurements according to sex, ethnic origin, and age. These authors have attempted to replace the neo-classical canons of facial proportions as formulated by Greek sculpture and Renaissance artists (and based on the golden mean) with measurements providing exact relationships among
various areas of the face and head in order to facilitate the planning of craniofacial surgery. Anthropometric measurements and aesthetic relationships among various parts of the face are reported to be helpful in planning reconstructive and cosmetic procedures, as these factors make possible the more precise identification of asymmetries. Interestingly, in the discussion section of the chapter contributed by Whitaker on "Facial Proportions in Aesthetic Surgery" we are told that the neo-classical canons of facial proportionality, used by some surgeons, are only "partly realistic" and that the "most objective source for determination of the proportions is the facial indices developed from anthropometric findings in a healthy normal population". Whitaker states, however: "Judgement about the relationships of the measurements is still usually visual and dependent on the subjective taste of the surgeon" (1987, pp. 111-112). Therefore, in the end, the possession of minute indices for the determination of facial reconstruction gives way to the subjectivity of the surgeon. At the final moment, when measurements have been utilized to the greatest extent possible, beauty is back "in the eye of the beholder" and the patient is returned to the hands of the human being conditioned by American culture and medicine.

I have attempted, in this chapter, to provide an historical view of feminine beauty in America, to introduce a limited feminist discourse on beauty, and to offer a glimpse of the perspective on womanly beauty held in the plastic surgical community. The chapter to follow will outline some issues around the purported psychological and social effects of physical appearance and will also introduce some data from the American
psychiatric literature on body image, aging, and on the psychiatric personality disorders that seem most relevant to obsession with one's appearance.
CHAPTER IV: SOCIAL, PSYCHOLOGICAL, AND PSYCHIATRIC DETERMINANTS IN THE QUEST FOR BEAUTY

The Psychological and Social Effects of Physical Appearance

Berscheid (1980) relates that only recently have social scientists begun to investigate the social and psychological effects of physical appearance. There now exists a large body of literature, only a small part of which will be addressed here, that speaks to the effects of different levels of attractiveness. Berscheid feels that the reason this research thrust is relatively new in the social sciences is because many persons, including many psychological and psychiatric investigators, have been uncomfortable with the fact that:

physical appearance, and particularly whether others find it pleasing or displeasing, should make an important difference in a person's life -- from such intimate matters as the quality of their sex life, and who (or if) they marry, to such formal but far-reaching matters as their educational and career opportunities (1980, p. 6).

Berscheid states that in our culture people agree more often than disagree on the level of attractiveness of a given person. There are two studies that seem to corroborate this belief. British psychologist A. H. Lilffe (1960) conducted a study in which a major London newspaper published twelve photographs of female faces taken under uniform conditions. The girls were aged twenty to twenty-five and were selected to represent various facial types. The range of beauty was purposely kept narrow, as very beautiful and very homely girls were eliminated. Almost 4,300 Britons responded to the request to rank the twelve faces in terms of prettiness. The responses were correlated according to age, sex, and occupation of the respondent. The positive correlations were high enough in this study to suggest that a common basis for judging feminine beauty did exist, and that it was shared by men and women of all ages, from most occupations,
and from all sections of England. An American sociologist, J. R. Udry (1965) replicated this study in the United States, publishing the same twelve photographs in a national Sunday supplement. An estimated 101,000 ballots were received and 6,162 responses were finally analyzed after randomization and elimination of incorrectly marked ballots. The three top ranking photographs in the American sample were exactly the same as the top three in the British sample. There were some differences in placement of three of the other photographs. In the American sample age was more important than occupation in influencing beauty preferences, while this was just the opposite in England. In Britain there were some minor regional differences in preferences, while in the U.S. region made no difference. In neither country were differences by sex noticeable. In general, American beauty preferences were more uniform than those of the British. Udry interprets this result as follows:

I would hazard the explanation that this is because feminine beauty has become such an important focus of American culture, and consensus is so reinforced by the mass media that opinion has become highly standardized in all social groups (1965, p. 337).

Berscheid feels that the data on uniform ideas on feminine beauty challenges the "happy notion" that there is someone out there for everyone, someone who will find any given individual "beautiful" or "handsome". She also states that if a high level of agreement exists on who is attractive, and if a person is influenced by people's perceptions, then appearance is going to make an important difference in a person's life. Beauty, therefore, will definitely be more than skin deep.
Adams, a social scientist who has studied interactions between elementary school teachers and their pupils, states:

Teachers are swayed in their individual expectations of children's classroom performance by a child's physical appearance. ... Teachers appear prone to give attractive children more information, better evaluations, more opportunity to perform and more support for their educational endeavors (1980, p. 26).

Berscheid (1980) quotes a study by Clifford and Walster that asked 400 fifth grade teachers to look at a student's report card and give their professional evaluations of the student's I.Q., his parents' attitudes toward school, the pupil's social status with his peers, and their estimate of the student's future potential. All of the teachers received the same report card, which gave extensive information on the student: grades in every subject and information in the areas of "healthful living," "personal development," and "work habits and attitudes." To each identical report card was attached the one differing element: a photograph of the student, which was one of six "attractive" or six "unattractive" girls or boys. Clifford and Walster report that the more attractive the child, whether male or female, and whether the evaluating teacher was male or female, the higher the assumed I.Q. and educational potential, and the better the assumed social relationships and parental interest.

Adams (1980) discusses the fact that researchers disagree on when little children begin to employ a facial attractiveness stereotype in their own social impressions. A study by Adams and Crane is quoted which determined that preschool children are capable of identifying an attractive child or adult, but that this did not influence their social play preferences. In another study evaluating peer relations Adams quotes studies by Lerner and Lerner and Korn that suggest that chubby children "experience a more
distant interpersonal environment when interacting with peers" (1980, p. 31).

Dion, Berscheid, and Walster (1972) designed a study to investigate whether physically attractive males and females were assumed to possess more desirable personality characteristics and to lead more successful lives than unattractive persons. Their results suggest that "a physical attractiveness stereotype exists and that its content is perfectly compatible with the 'What is beautiful is good' thesis" (p. 289). Berscheid and Walster (1974) report a study by Kopera, Maier, and Johnson that indicates a high level of agreement among male and female college student judges on the attractiveness of Caucasian female college seniors who are rated from photographs. Berscheid and Walster state that other studies show lower reliabilities when subjects are rated in the flesh rather than via photographs, but that the reliabilities are still "respectably high" (1974, p.182), although exact values are not given. These authors also quote a study by Cross and Cross who examined the effect of age, sex, and race on the evaluation of female beauty. Judges were black and white, female and male, and in four age categories: 7 years, 12 years, 17 years, and adult. Evaluations were made of facial photographs of females and males, blacks and whites, of three age levels: second graders, high school seniors, and adults. Females rated all but adult male faces higher than did males; blacks gave higher ratings than did whites, white males comparatively downrated females and white females downrated males; female faces were found more attractive than male; and white faces were judged more attractive than black ones. It is interesting that Cross and
Cross report:

The most popular face in the sample was chosen as best of its group by 6 of 207 judges but there was no face that was never chosen, and even the least popular face was picked as best of its group by four subjects (Berscheid and Walster, 1974, p. 183).

Therefore, although people appear to exhibit noticeable agreement in what they find attractive in the appearance of others, this study would appear to shore up the romantic hope that anyone can be found beautiful by someone. I also think it is significant that ratings of attractiveness of individuals in person show decreased inter-rater reliability. Other factors also influence assessment of a person's beauty, such as whether or not the raters actually knew the subjects being evaluated. In Cavior's study (Berscheid and Walster, 1980) there was greater agreement among non-knowers than knowers of those being rated and knowers tended to use the "handsome" and "pretty" categories significantly more, and the "ugly" categories significantly less", than did the non-knowers (p. 184). Therefore in this study knowing the subject appeared to increase his or her attractiveness. Berscheid and Walster (1980) also quote the study by Walster that demonstrates, however, that a person's attractiveness may be downgraded if his political position is not similar to the judge's. These factors witness the complexity of the physical evaluation of known individuals in "real-life" situations and illustrate why the impression of the attractiveness of a given individual "in-the-flesh" is not a phenomenon well suited to testing and measurement.

Snyder, Berscheid, and Tanke (1977) conducted a study meant to evaluate the influence that stereotypes of physical appearance might exert on interaction between college-aged males and females. Male subjects were given biographical information and a snapshot of a woman and then
were paired up to interact by telephone with a woman they believed to be pictured in the photograph and described by the biographical data. The snapshots of college women had been previously rated as attractive or unattractive by other college men, but the snapshots did not correspond with the person to whom the subjects were talking. The male students who received an attractive snapshot on the biographical folder seemed to form a more favorable impression of their partners than did those whose folder had a snapshot of an unattractive girl. The men who thought they were talking to attractive women expected them to be more sociable, poised, humorous, and socially adept; and the men with the presumed unattractive partners conceived them to be unsociable, awkward, serious, and socially inept. The experimenters then had other judges (again college students) evaluate the taped conversations and found that the beliefs of the men seemed to start a chain of events that influenced the women with whom they were paired to interact. The authors report:

Those who were thought by their perceivers to be physically attractive appeared to the observer judges to manifest greater confidence, greater animation, greater enjoyment of the conversation, and greater liking for their partners than those women who interacted with men who perceived them as physically unattractive (p. 662).

This study suggests that erroneously held beliefs about the appearance of an unknown person can influence the behaviors of that person. It appeared that women were reacting to the cues given them by the men over the telephone and they were able to sense a warmth and interest or a lack of these attributes and to respond in kind. This study might be seen to simulate a situation where social responses to a person determine that person's responses and feelings, thus underscoring the importance of how others react to us. Perhaps stereotypes can create their own social
reality, especially in a dating and therefore appearance-centered context.

Many other studies dealing with the social and psychological effects of physical appearance are available, but are not reviewed in this paper in the interest of brevity. Many of them suggest, some more convincingly than others, the importance of appearance in late twentieth-century America. Perhaps this is due, as Berscheid suggests, to our increased "one-time or few-time interactions with other people" (1980, p. 19) owing to increased geographic mobility and large concentrations of people in urban areas. Perhaps faces do serve more now as mobile billboards employed by their owners as metaphors for all manner of non-physical attributes. While I do not deny that it is important to "put one's best face forward", I feel that in daily life experience all the variables can't be controlled as well as they appear to be in psychological experiments. In "real" life one is not presented with still photographs of a person's face and asked to evaluate beauty. People react to face and body, age and race, language and context, intelligence and manner -- and the list goes on. I believe that the majority of us fall in the average range on the beauty continuum and with the aid of culturally appropriate grooming can improve our lot significantly. One can, therefore, function quite well socially: perhaps not reaping the rewards of great beauty, but feeling neither maligned nor the object of discrimination. Those with a definite physical disability or a feature that is culturally defined as unattractive or ugly are the far end of the beauty curve, as are the true beauties. For these relatively few individuals, social and psychological reality might indeed be an initial or first-impression advantage for the beautiful or a disadvantage for those culturally judged as ugly.
Body-Image and the Life Cycle

Just as there are psychological, sociological, and cultural discourses on human beauty, and specifically on feminine beauty, there exists as well, a voluminous psychiatric discourse on the interrelationships among facial and bodily form and diagnosed psychiatric health or disease. I believe that a logical place to begin what will be of necessity an abbreviated look at this data, is an overview of the concept of body-image, which has been defined by Schilder (1950) as: "the picture of our own body which we form in our mind ... the way in which the body appears to ourselves. The body scheme is the tri-dimensional image everybody has about himself. We may call it 'body-image'" (p. 11). Schilder goes on to discuss the development of body-image and states that two factors, pain and motor control over our limbs, play a most important part: sensation, therefore is integral to the building of a sense of body-image. He further elaborates that the development of body-scheme "probably runs to a great extent parallel with the sensory motor development" (p. 105). Sensation and motor experience, however, do not act alone to enable the individual to form his own body-image, also involved are:

- pain, dysesthesia, erogenic zones, the actions of our hand on the body, the actions of others towards our body, the interest of others concerning our body, and the itching provoked by the functions of our body (which) are therefore important factors in the final structuralization of the body-image (p. 127).

We are told, then, that physiological experiences and our own perceptions of our bodies are pivotal, but also that the interest that others shown in our bodies may be equally important. As Schilder states:

They may show their interest by actions or merely by words and attitudes. But what persons around us do with their own bodies is also of enormous importance. Here is the first hint that body-image is built up by social contacts (p. 137).
Therefore our "inner history is also the history of our relations to other human beings" (p. 138). Schilder goes on to describe body-image as "never isolated and ... on principle social" (p. 241). We cannot escape the evaluations of others and these responses become part of what we integrate about ourselves:

Our own beauty or ugliness will not only figure in the image we get about ourselves, but will also figure in the image others build up about us which will be take back again into ourselves. The body-image is the result of social life. Beauty and ugliness are social phenomena of utmost importance (p. 267).

Watson and Johnson (1958) speak of the development of body-image in similar terms, emphasizing both the neurophysiologic components of the infant's gradual building of a postural model of his body and also the importance of the interaction between the infant and its mother. Early on, the mother's attitude toward the baby and its body is conveyed via her ways of touching it, nursing it, and holding it. Later on the mother's approval or disapproval of the infant's body or physical features is conveyed in words as well as nonverbally. "The infant and young child senses and imitates the parental attitudes. The child's valuation or devaluation of his own body reflects the value ascribed to it by those who take care of him" (1958, p. 86). Watson and Johnson state that the "memory picture of the properly aligned and complete, intact body is relatively fixed or stable" (p. 86) and cite the occurrence of the phantom limb phenomenon, the illusion of a nonexistent extremity following amputation, as the most conspicuous example of the stability of the body-image. Nevertheless, they also cite the tendency for the perception of the phantom limb to gradually fade, demonstrating the possibility for modification and revision of the body-image. These authors present case
studies of children with traumatic deformities that illustrate that a young child's attitude toward him or herself and toward a physical defect reflect the attitudes perceived in adults. When significant adults support and accept the child and his altered or deformed part, he or she is able to experience and verbalize mourning for the part and also the concomitant anger felt. The child will be able to more quickly modify his or her body-image to the new structure and will suffer less or no depression or loss of self-esteem. When, however, the child has learned non-recognition of his physical body as it actually is, whether normal or disfigured, he will not be able to form a body-image that is realistic to his bodily form.

As a child grows older and moves beyond the social configuration of the nuclear and extended family to become part of the society of other children, he or she is exposed to the responses of other children and adults who are not relatives. The previously cited response studies of young children to each other and of teachers to children have identified the influences of physical appearance -- especially if a child falls at one or the other end of the bell curve for appearance. Goin and Goin (1981) cite the work of Mahler and her co-workers who have studied the processes of separation and individuation in toddlers. They found that two factors are responsible for successful separation and individuation in toddlerhood: 1) the child's strong trust that the mother will not desert him, and 2) responses of interest and warmth from other children and adults with whom he interacts. Goin and Goin state that for these reasons it is imperative that congenital or acquired deformities be corrected as early as possible so that rejection and cruelty during these formative years will not hamper healthy emotional growth in the child.
Adolescence is a time when body-image concerns become greatly intensified due to the person's increased consciousness of his or her own rapidly changing physical features, to the inflated emphasis placed on physical traits by peers, and to increasing identification with culturally determined physical standards (Schonfeld, 1963, May). Schonfeld identifies four interrelated components that determine the structure of the body-image on both conscious and unconscious levels: 1) the actual, subjective perception of the body, related to both appearance and function, 2) the internalized psychological factors arising from the individual's personal and emotional experiences as well as body-concept distortions expressed as somatic delusions, 3) sociological factors such as how parents and society react to the person and his or her interpretation of these reactions, and 4) the ideal body-image formulated by the person's attitudes toward the body due to his or her experiences, perceptions, comparisons, and identifications with others' bodies. Schonfeld explains that the growth process during adolescence tends to be asymmetrical and may intensify the instability that is usual in adolescence, leading to anxiety, self-consciousness, and feelings of inadequacy. He cites Greenacre's work identifying height, strength and muscular development, length of penis, presence of testes, and hirsutism as paramount factors in adolescent boys' concept of self. Girls identified menarche, size of breasts, and hip development as pivotal to female identity formation. Schonfeld states that many adolescents are somewhat overwhelmed for short periods by the effects of the maturing process, such that some degree of body-image disturbance results. If an adolescent has lacked stability during childhood due to disturbance of parent-child relationship, long illness, or adjustment
problems, he or she may fail to develop a healthy frame of reference for
the self-concept. When such an individual is called upon to integrate the
changes in body structure that are part of pubescence, he or she may
experience greater anxiety and difficulty than those who are better
adjusted. Schonfeld states that adolescents with a "variety of personality
disorders manifested their psychopathology through distortions of body-
concept" (p. 849). He reiterates the importance of social reinforcement on
the self-concept of the adolescent stating that the "attitude of the parents
or parent substitutes imparts an indelible impression on the child's concept
of himself, his body, and its functions" (p. 850). Children who are
accepted by their families tend to neither over-evaluate or under-evaluate
their bodies, but if a child feels his body fails to conform to the
expectations of those around him, he or she will frequently develop self-
deprecatory feelings. Adolescents are extraordinarily sensitive to self-
image concerns since these factors are in a state of flux. The issue of
approval or disapproval by others assumes critical importance and deviancy
from peer-held norms may place the individual at a social disadvantage.
The individual's response to his own maturational progress or physical
appearance is often largely a reflection of the social reaction he
encounters. He may accept, at this point in life, the value that the group
places on him. If the adolescent has an actual physical handicap, he or
she may in actuality be a subject of discrimination. Schonfeld states that
advertising, mass media, and hero worship of athletes (and I would add
rock stars and models) have contributed to glorifying the ideal body and
degrading the deviant. Adolescents also internalize attitudes toward their
bodies as a consequence of their: "perceptions, comparisons, and
identifications with the bodies of other persons, both real and fantasized, creating a concept of the ideal body" (p. 851). Schonfeld states that the adolescent requires repeated reassurance, interest, and help so that he may: "understand the vast difference between being abnormal and not being average. He must learn to cope with reality factors in his disturbed body-image. If a defect can be modified, it should be done" (p. 852). Goin and Goin (1981) deal with adolescence in their chapter on life-cycle and body-image. They also speak of the body as the source of special emotional stresses at this time, and mention, since their book is dealing with psychological effects of plastic surgery, that some of these adolescent body-image concerns are of "practical importance to plastic surgeons" (p. 77). The authors mention Benedek's study of adolescent girls' intense reaction to breast development and the "disturbed feelings which accompany breast development that is perceived as excessive or inadequate" (p. 78). They mention their own study of reduction mammoplasty patients who "frequently reported that their breasts were abnormally large at 10 or 11" (p. 78) and that this made peer relations with both males and females difficult. They cite Edgerton and McClary's study of augmentation mammoplasty patients which identified that all of the women reported feelings of inadequacy about their small breasts since puberty. Knorr and his co-workers are quoted who found in interviews with adolescents requesting breast enlargement that their primary motivation was related to concerns about their ability to become involved in relationships with men. Goin and Goin also identify the nose as a feature which changes significantly during puberty and which may cause the adolescent to be teased or ridiculed, and may lead to real or perceived
rejection by peers. They again quote Knorr who found that adolescent rhinoplasty patients were often motivated to seek this procedure due to difficulties "in interpersonal relations which they related to their nasal deformities" (p. 79). Goin and Goin state "for the surgeon, one of the bright spots of adolescence is the ease with which adolescents incorporate surgically produced changes into their body-images." They quote a plastic surgeon colleague who says, "You can make any change you want because they don't know who the hell they are anyway". They end with this statement:

Well-conceived and competently performed operations during adolescence can be most rewarding. The adolescent patient not only is able to accept the physical change easily, but the feedback loop of improved appearance, peer approval and increased self-esteem, provides one of the most important ingredients for his sense of security (p. 79).

I believe that the key phrase in this last statement is "well-conceived" which might translate to "genuinely necessary". All of the writers on adolescence have emphasized the normal nature of body-image concerns and even distortions during this period. It would seem reasonable and prudent, despite the "ease" with which adolescents adapt to "surgically produced change" in body-image, to defer plastic surgical procedures on minimal to moderate physical variations of normal until a time when greater psychological and social stability has been reached.

Goin and Goin (1981) define "young adulthood" as that part of the life cycle extending from the end of adolescence to the age of 45: a terminology that greatly pleases this writer who might in other such chronologies be termed "middle-aged". These authors feel that while longevity steadily increases, the stages of the life cycle expand and contract at different rates: they offer as one example the rather well
known phenomenon of the 29-year-old graduate student. They state that although John O'Hara in a novel about New York in the late 1920s characterized middle-aged as 30 to 50 years old and felt that between 40 and 50 a person might "expect to reap the benefits of ... ability and experience" that in 1980 many extensively trained professionals, such as plastic surgeons (their example, not mine) are just getting their practices "off the ground" (p. 80). Erikson characterizes young adulthood as the time when the person is struggling to attain intimacy and departs from his or her parents' home to find a job, a mate, and establish a new home and family. Goin and Goin state that an attractive physical appearance is desirable during this phase, just as it is throughout the life cycle, but that:

Deficiencies or inadequacies in appearance do not ordinarily result in the kind of cataclysmic emotional devastation that can occur during adolescence. In fact, in most but not all parts of this great Republic, obsession with one's own beauty or with the 'beautiful people' is usually regarded as immature, adolescent behavior. In young adulthood the body-image is relatively stable and less likely to be affected by feedback from others who, moreover, as a result of their own maturity, are less likely to make negative comments about physical imperfections. The mature have learned to live harmoniously together, raise a family, confront the sticky realities of life and enjoy its fleeting pleasures (p. 80).

For these reasons, the authors feel it is especially important to ask young adult patients requesting plastic surgery how long they have been dissatisfied with the body part in question. If this sense of dissatisfaction is not reported by the patient to have begun in adolescence, then the physician must strongly consider the possibility that such patients are "blaming one of life's disappointments on a physical defect and hoping unrealistically that an operation will resolve some difficulty that is intrinsic to life itself or due to character or personality defects rather
than to physical ones" (p. 80). The authors feel, however, that there are many "practical" reasons, such as monetary problems, or hesitancy to bring the topic up with one's parents, which cause the person to put the surgery off until adulthood, even though the patient has been unhappy with some aspect of physical appearance for many years. Therefore these physicians believe that the age at which the operation is requested is not as important as the age at which the unhappiness with the body part began. Goin and Goin group "injuries and bodily deformities" acquired during young adulthood such as:

- scars, baggy eyelids, mastectomies, sagging abdomens and ... facial aging changes [as conditions that will], ... of course, be attended by psychological traumas, and, in some cases, significant body-image disturbances ... These recently acquired deformities will ... add more stress and anxiety to the struggles to achieve intimacy and enduring relationships at home and at work which characterize this stage of the life cycle (p. 81).

Why, I wonder, do these doctors classify "scars and mastectomies" in the same category with "baggy eyelids", "sagging abdomens", and "facial aging changes" and classify all of the above as "deformities"? Why must they medicalize the aging process? Are we to view any person with any changes associated with aging as "deformed"? Goin and Goin state that baggy eyelids and abdomens and aging faces will "add more stress and anxiety to the struggle to achieve intimacy and enduring relationships" during the "young adulthood" period. If this is true, why is it so? These changes don't occur in early adulthood, but begin in the forties: a period during which many women currently seek cosmetic surgery. As will be repeatedly discussed, the genuine reason for wanting the cosmetic surgery must be established pre-operatively. Are these people doing this "for themselves" (considered a legitimate reason in the plastic surgery
literature) or from an extrinsic motivation, i.e., job or man? Dr. Lois Davitz conducted a study in which she asked 300 men, ages 18 to 65, single, married, and divorced, to complete checklists describing their ideal woman (1985). She found that men in their 20s were "without exception" looking for physically appealing women. Thirty-year-olds did not give up on beauty as a criterion, but were more realistic: they also wanted intelligence, sensitivity, and potential to earn money. Sexual attractiveness dropped in importance on these men's lists. The 40-year-old man, however, does an about-face from his 30-year-old counterpart, and again places beauty and sex appeal at the top of his list. He may begin to find fault with his wife's appearance, or more subtly, begin to admire younger women, and his wife may come to view herself as less than attractive. It is incumbent upon cosmetic surgeons to ask about the relationships of their female patients in order to determine for whom the procedure is really being done. The problem with intimacy may not be the woman's at all, but that of her mate -- and he may not be satisfied after her surgical procedure is completed. In a case such as this, the woman may well be devastated afterwards, when her husband or lover seeks his "intimacy" elsewhere.

Midlife, according to Goin and Goin (1981) encompasses the span of years between 45 and 65 and contains stresses that resemble those of adolescence in that they cluster around physiological and sociocultural changes. They characterize these changes as "less dramatic" than those of adolescence, and less erratic, but proceeding "slowly, steadily, relentlessly, and the progress is downward" (p. 81). These authors discuss menopause and state that women are forced, at this time of life, "to make some sort
of adjustment to annoying, sometimes nearly incapacitating episodes of physical and emotional irritability". They state that psychological responses to the end of fertility vary widely, from a sense of liberation to "the irrevocable end of cherished hopes" for those who have not had children but have wanted them. They add that: "The inescapable realization that there will never be children or grandchildren can deprive such women of the flimsy sense of immortality that progeny often bestow and intensify fears about death and dying" (p. 81). Well, Goin and Goin are not totally optimistic about the lot of women, are they? Either we are deluded in our old age with a "flimsy sense of immortality" having had children, or we are devastated by the fact that we will never have any and are overcome with death fears. It certainly sounds like we can't win. Men don't fare much better, as they are said to have to cope with "new sociocultural stresses" and a "variety of anatomical and physiological changes, including declining vigor, thickening, sagging bodies, and enlarging prostates" (p. 81). The doctors state that the most common elective plastic surgical procedures during midlife are facelifts, blepharoplasties, chemical peels or dermabrasions, post-mastectomy breast reconstructions, and reduction mammoplasties. The first three are clearly linked to aging and loss of skin elasticity. These "restorative" procedures, according to Goin and Goin, are very important to those who want them, but are not sought mainly to alter bodily appearance. They feel that physical appearance is:

closely linked with -- but definitely subordinate to -- pre-occupations with strength, durability, and vitality of their bodies and the awareness that these are diminishing. Despite all optimistic and 'positive' thinking, life does not begin at forty. On the contrary, forty marks the beginning of the decade during which death becomes a reality, [and] the finiteness of life is truly appreciated .... Baggy
eyelids, sagging jowls, and the inevitable middle-age spread are constantly present reminders of the passage of time (p. 82).

Good grief, this is grim! With an outlook like this one is certain to need cosmetic surgery. We all know that gravity and the passage to time are literally dragging us down, but should we just lay down (either on or off of the operating table) and give up? Goin and Goin quote others who have written about the psychology of midlife and identify several potential causes of anxiety and unhappiness: fears of physical and financial dependence and failing health, children leaving the home, boredom, the necessity of caring for aging parents, and illness and death of spouse, parents and friends. The middle-aged person must adapt positively in many areas if he or she is to respond to the Eriksonian challenges of midlife with "generativity" as opposed to "stagnation". Goin and Goin present some case studies of facelift patients which illustrate, for them, the difference between remaining creative and becoming stagnant. One attractive woman in her fifties was an executive in a government agency. In her pre-operative psychiatric interview she stated her reason for wanting a facelift was to look "refreshed" and a little younger. She related that she now had to compete not only with men, but also with a lot of young, good-looking, and very aggressive women. Following her operation she felt she did appear "refreshed" and younger. She described a significant increase in self-confidence, and discussed her volunteering for committees that she felt would help her to get an advancement that she wanted. This patient, according to Goin and Goin, exemplifies the drive toward "generativity" and away from "stagnation". Another patient, the same age as the first, had different motivations. She was also very attractive and was a senior flight attendant for a major airline. Pre-
operatively she expressed a desire to "look better". She had been widowed for 3 years, was well-off financially, and was enjoying the single life and sexual involvement with several men. According to the doctors, her "objective" facelift result was excellent and everyone thought she look wonderful, but she wasn't really happy. She said:

I don't feel any different. I exercise every day of my life to stay fit and trim and I'm sick of it ... I suppose I thought I was going to feel younger -- I don't know -- be younger, I guess. But I don't. I'm just the same old clunker with a little body work and a new paint job.

According to doctors Goin and Goin this patient was:

not trying to make the most of what she was, to build on her past life experiences and accumulated wisdom. Instead, she was attempting rather pitifully to recapture her long-lost youth. She had 'stagnated' long before her facelift and, inevitably, the operation did nothing to move her toward 'generativity' (p. 84).

The doctors Goin reveal that she was one of the two (of 50) patients in their study who became depressed after the operation and still felt a sense of despair at the 6 month (and last) follow-up visit. This case points out, I think, that even with "enlightened" pre-operative screening (Dr. Marsha Goin is a psychiatrist and Dr. John Goin is the plastic surgeon) patients will be chosen who have unrealistic expectations and who consequently become depressed. One cannot ignore the first patient's stated conviction that her facelift had helped her greatly, but it is significant that she had a stimulating job that she obviously enjoyed, and future goals that would involve further personal growth. Goin and Goin state that their case histories demonstrate that the various anxieties of midlife, especially concerns about death and dying and fears of dependence related to finances and failing health, are "inextricably interwoven with the expressed surface motivations for elective plastic surgical procedures" (p. 85). The
person during midlife is constantly reminded of the passage of time due to
the changing external appearance of the body and various inner signals of
deterioration. These authors emphasize that the procedures under
discussion are "restorative", in terms of external appearance, but that they
do not affect the aging process in general. Goin and Goin state:

It has been our experience that operations which turn back the
(external) clock can often be quite helpful in coping with the stresses
of midlife. Sometimes, these operations undoubtedly can provide the
stimulus to move an individual from a position of 'stagnation' to a
fuller, more rewarding life of 'generativity' (p.85).

Even "unrealistic, magical motivations" of which a patient is unaware,
although they may result in failure to make a "positive adaptation", are
unlikely to decrease a person's pleasure with the surgical results or to do
psychological damage (p. 85). The position of these authors is, therefore,
that facelifts are often psychologically therapeutic, give the person an
added boost toward the dimension of "generativity", and cause no psychic
damage. I cannot be entirely sure what is meant by failing to make a
"positive adaptation", but if this might mean depression or inability to
function psychologically, then it would seem that "psychological damage"
has resulted. Additionally, in this section, the authors provide no data on
intra-operative or post-operative complications, which might result in
physical as well as psychological damage.

While Goin and Goin (1981) chronicle "midlife" as an endless battle
against the psychological and physical trauma inflicted by aging -- a
commentary on their medical training and the view of aging as a disease
process -- other researchers and authors view this period a bit differently.
Sheehy (1981) speaks of "women and the comeback decade" and states that
the women who go "off the charts in happiness are middle-aged, just past
menopause" (p. 279). They are friends with, but not responsible for, grown children; feeling a firm sense of their own identity, perhaps for the first time; less bored; less lonely; and more in charge of inner and outer needs. Sheehy states, however, that most of the women between 46 and 55 who were surveyed in her study did seem to be passing through a "danger zone". She feels that just as men are premature in sentencing themselves to sexual inadequacy, women are "brutally premature in disqualifying themselves as attractive to men, simply because they are no longer young" (p. 280). Sheehy also speaks of parental illness or death and menopause as new and trying factors for women at this age. It seems to Sheehy, however, that a very great influence on the way in which "one maneuvers into middle age is one's sense of accomplishment". She lists this as the:

number-one long-range goal for women between 46 and 55--although 'accomplishment' seldom ever appeared among the sought-after values of these same women at an earlier age. Few middle-aged women of today were prepared, professionally or emotionally, for the reality that paid employment becomes central to the self-esteem of the middle years (p. 280).

As the mothering role changes, many women who Sheehy speaks of as "deferred achievers" look back toward the work place and may face a difficult re-entry that necessitates starting over at entry-level jobs. Nevertheless, the majority of them seem to rally. They are able to disengage from the mothering role and reanimate their assertiveness and goal-direction. Many move from re-entry jobs into more responsible positions. Sheehy writes:

Despite the danger zone, a mobilization usually begins in the late forties that registers with rising exhilaration as women move into their fifties. They drop happyface masks. They break the seal of repressed anger. They overcome habits of trying to be perfect and of needing to make everyone love them. ... This period could be
called ... the Comeback Decade -- a declaration for life, an intentional reanimation (pp. 282-283).

Another note of optimism is injected, at least for those women in midlife who desire to keep up or initiate relationships with men, by the work of Davitz (1985) who describes the typical 50-year-old male in her study as "serene, both about himself and in describing the woman of his dreams" and as looking for "a companion, a friend, someone who won't let me down, a person who cares about me". Davitz reports that the terms like great body or sexy rarely came up in the surveys done on this age group and the men picked adjectives like "kind", "sociable", "relaxed", "poised", and "warm". One man said: "My wife is as beautiful as the day I married her. She's probably changed, but I don't see it" (p. 148). Therefore midlife can be conceptualized as a time when some males may prefer younger or more glamorous women because of their own tenuous sexual self-image but his is not true for all midlife men. Women, however, are often ready to move up the self-actualization scale and find new satisfactions and increased self-esteem. A key to the achievement of happiness and success for midlife women would seem to be finding a meaningful job or career where she is paid for her services and can make a difference.

Goin and Goin (1981) define old age as 65 and beyond and list the inevitable characteristics to include: fading memory, failing health, death of friends, families becoming less available, and financial worries. They remind us, however, that even though these conditions exist for some older people, that others are:
and jumping into the beds of lovers one-third their ages. Chronology is not as important as physiology. That is why it is unsurprising to receive requests from the elderly for aesthetic operations (p. 85).

Of course elderly women are very much less likely to be engaging in activities from this list (except the Disneyland excursions) and yet they are the elderly who request the surgical procedures. Dr. Goin the plastic surgeon provides case-study examples of two older women, one 63 and another 69, who were embarrassed about their wish to have breast reconstruction operations. The 63-year-old woman was keeping her operation a secret because she feared that "people would think I'm perverted having a breast operation at my age". The 69-year-old said she felt "so foolish to be so excited about it at my age" (p. 86). Both comments demonstrate a probably widespread feeling among (and about) the elderly: that they simply shouldn't care about their bodies any more. Dr. Goin speaks of a 79-year-old woman who wrote "69" in the age section of his pre-operative patient information sheet, out of what he suspected was a fear that her age would not only be a medical contraindication, but a sociological one as well. He also describes the fourth face-lift that he recently performed on an 85-year-old woman who is Chairman of the Board of a corporation and has outlived two previous plastic surgeons. He doesn't mention the outcome of her surgery, and so we presume -- and hope -- that it was successful. Dr. Goin states that it is a misconception that elderly people sit around worrying about death and quotes a study done by Swenson (p. 86) in which 210 elderly people were interviewed on their attitudes toward dying. Swenson found that only 10% feared death and that most used the coping mechanism of denial to adapt to aging bodies and the inevitable end. One can only hope that the elderly seeking
cosmetic surgery are helped to understand and not deny the surgical and anesthesia risks for people in their age group so that they don't end up like Queen Mother Frederika of Greece who expired as her eyes were being lifted (Aronson, 1983).

In her book *Pathfinders* (1981) Gail Sheehy went in search of individuals who had, in varying endeavors, made a success of life and exhibited a high level of "well-being". She found many such persons and explores how they became "pathfinders". In this endeavor, she of necessity collected data on and interviewed many older persons and states that in spite of the impressions received from many social scientists, old age is not necessarily a time of "depression, poor health, rejection by children, creeping impoverishment, loneliness, and loss" (p. 287). She points out that only 5 percent of all Americans over 65 are in institutions; two-thirds live in their own paid-for homes. About 95 percent remain relatively independent in their own communities, and about 80 percent have children nearby and see them weekly. Sheehy feels that one source of the misinformation about older people and their lives might be due to the ages of the researchers. It is difficult, she contends, for people early in midlife to properly interpret the experiences of people well into middle or advanced age; she states that she could not. She characterizes aging as a "commutable sentence" and states that there is no fixed number at which we change from "middle-aged" to "old". And yet, many of us are able to make little distinction between the decade of the sixties and that of the seventies, and the eighties or beyond is unthinkable. An important decision to make, according to Sheehy and others she quotes, is how long an individual wants to live. If a person feels that he or she would enjoy
life, even in old age, and could continue to make a contribution, then health issues such as diet, exercise, and stress reduction become important in middle-age -- with a probable increase in life-span. Sheehy quotes a study conducted by the Institute of Human Development at the University of California, Berkely, that identified four combinations of personality and way of life that seemed to be most consistent with high personal satisfaction in the sixties and seventies. Dominant women who had heavy involvement beyond family in clubs, church, and politics, constituted one group. They were often in leadership roles in their organizations and consequently did not miss their previous employment. These women did not look to their families for their primary gratification, had "distant" marriages, and yet were in the best shape physically and mentally. Married men involved with larger social issues had the greatest level of satisfaction among men in this age group. Like the dominant woman they had little emotional involvement with their wives or grown children. They had noticed little change in their health since their forties. A third group exhibiting high well-being was composed of divorced or widowed women who were still heavily involved in their careers. These women also had children, and were seeing at least one of them more frequently now than they did in their forties. Interestingly, the zest for life was much higher among these still-working women than among the widows who did not work and who reported that they had withdrawn from many of their interests since their husbands had died. The last high-satisfaction group was made up of retired male blue-collar "hobbyists" who had invested large amounts of time and money in their interests. They often had workshops away from home to which they went everyday. All in all, the single
common ingredient in all four high-satisfaction groups was independence: all of these people had prepared themselves before retirement with interests and commitments that would structure their time and keep up their involvement with life.

Sheehy quotes George Burns, who contributed a piece of his personal philosophy on aging: "The nicest thing about getting to be old is that you don't have to worry about it anymore" (1981, p. 321). One is now freed to use his or her energy to explore the mind, remember personal and collective history, and contemplate the meaning of existence. And many quite old people have considerable energy: Sheehy maintains that today's healthy 70-year-old is equivalent to yesterday's 60-year-old. People in their seventies and eighties who remain in relatively good health have higher self-esteem than young people under 25, and also feel more independent. Clearly, not all of use will remain exceptionally vigorous into our eighties, but many of us will be this fortunate. Sheehy quotes Malcolm Cowley, who in his book The View From 80 states that attaining this venerable age is like a "belated bar mitzvah": a celebration of a new beginning. She reports the common statement made by people of advanced years whom she interviewed that there was considerable discrepancy between the way they looked or what their bodies allowed, and the way they felt inside. Sheehy lists several famous individuals who continued to perform amazing work in their eighties: Goethe, Michelangelo, Claude Monet, Alice Roosevelt Longworth, and others. She interviews Roger Baldwin, the founder of the American Civil Liberties Union, who, at the age of 94 still spoke before five hundred people -- with no microphone--on the occasion of the 1978 ACLU Convocation on Free Speech. The
interview is a fascinating exchange punctuated by the observations of a man born in 1884 who has lived and experienced the multiple shock waves of nearly a century of social evolution -- and clearly he has missed nothing. He responds as follows to being asked how it feels to be 94:

I never thought longevity itself was worth much. I think that what you do with life, the way you enjoy it, is more important than how long you live. ... I feel just the same as when I was in my twenties (1981, p. 331).

When asked what secret he would pass on to young people, he said:

Enjoy more things. Grow, Develop. Most of them get into a specialty, a rut of doing one thing well, and they don't live fully. Music, art, nature, reading, drama -- all these things should have attention. Cover it all, as much as you can (p. 332).

Clearly, this interaction with Mr. Baldwin is an uplifting experience. Read in its entirety it leaves one with the feeling that advanced old-age, if it is the culmination of a vital, committed life, and hence retains part of that vitality and commitment, is not all bad after all. Of course Baldwin had led a privileged life: one that had enabled him (along with the luck of the genes) to enjoy a healthy and economically independent old age. He has the means and the energy left to allow him to continue to participate in causes that interest him. Lasch (1979) is not convinced that Sheehy's method of presenting the reader with models of "pathfinder" older and elderly persons is the answer to our fear of aging, for if we deviate from the normative model of these successful people, we are left with a feeling that we have failed. He states that Sheehy does not question the social realities that cause many old people to view old age as a disaster. He decries the fact that she seems to view early retirement as desirable as long as the person has adequate income and something to keep busy. He feels that the process of planning for retirement can be a "recipe not for
growth but for planned obsolescence" (1979, p. 362). In the midst of an already disconnected society, people are being urged to start over with new lives and interests lest they degenerate into bored senility. Obviously, those who can free themselves from the exigencies of everyday life in order to pursue plans for retirement are members of a privileged group. DeBeauvoir (1972) also reminds us that the age at which a person begins to "decline"; "has always depended upon the class to which a man belongs" (p. 541). (Of course, this would be equally true of women.) She speaks of the laboring man whose body and health are used up during his productive years, leaving no reserves for the enjoyment of much during old age except living one day to the next. Sheehy's sketch of aging individuals; therefore, although skillfully and humanely crafted, is nonetheless skewed toward the optimistic by virtue of her sample.

**Further Reflections on Body-Image and Aging**

It would seem that there is no agreement on the meaning of aging after reviewing the contributions of these authors and yet the dread of the physical decline of old age has been a thread that has run throughout history according to Simone deBeauvoir. She writes about the Egyptians who hoped to rejuvenate an old man by feeding him "fresh glands taken from young animals" (1972, p. 92). The early Greeks seemed to find physical decay the ultimate horror and had many fountains of youth. Greek legend tells the story of Tithonus, whose wife Aurora asked the gods to make him immortal, but forgot to ask them to give him eternal youth as well. He aged, but never died: becoming more and more withered and dried until the gods took pity on him and changed him into a cicada. This demonstrates that for the ancient Greeks, physical decay was a fate
worse than death. De Beauvoir states that old age was associated with wisdom in Homer, but that it was also spoken of as "the accursed threshold of old age" (1972, p. 99). Indeed the Greeks seem quite ambivalent about old age: viewing it as possessing elements of honor and sacredness, but also of wantonness. Plato and Aristotle both wrote about old age, but came to different conclusions. Plato felt truth dwelled in man's immortal soul, disdained the body, and felt the elders must rule and the young obey. Aristotle felt that the diseases that affect the body affect the individual as a totality, and that the body must remain intact for old age to be happy. He viewed the aged as having piled up mistakes, instead of wisdom, and he favored removing the elderly from power. In these historical societies old age was spoken of almost exclusively in male terms, as most of them were patriarchal, but when old women were described, it was with particular vehemence. De Beauvoir quotes some examples of this from the Latin poets: an old woman described by Horace has "black teeth", "furrows" in an "ancient forehead", "breasts ... as flaccid as the dugs of a mare" (p. 122). Lucian, in the second century, addresses an elderly woman in this epigram: "You may dye your locks, but you can never dye your years; you may never make the wrinkles vanish from your cheeks ... Never will white lead or vermilion turn Hecuba into Helen" (deBeauvoir, 1972, p. 112). Although old men are most often made sport of, when old women are reviled it is with particular vehemence, for the contribution of woman is usually conceptualized in terms of her potential as an erotic object. When she ceases to be of value in this context she becomes: "a monstrum that excites revulsion and even dread. Just as we see in certain primitive nations, she takes on a supernatural
character when she falls outside the human state: she is a witch, a
dangerously powerful sorceress" (1972, p. 123).

De Beauvoir speaks at great length, also, about old age in present
day Western society and of the injustice and abuse that the old must
tolerate. She discusses the fact that age takes most of us by surprise,
and that within each of us is the Other, or the person one is to the
outsider, and this Other is old. We grow old so gradually, day by day,
that we become used to the changes. But from time to time we may catch
sight of ourselves and wonder, as my mother repeated to me, "Who is that
old lady? Is that me?" (Personal Communication, Janice Norris, 1988).
De Beauvoir seems particularly pessimistic in her evaluation of what it
means to be an aging woman. She states:

I have never come across one single woman, either in life or in
books, who has looked upon her own old age cheerfully. In the same
way no one even speaks of a 'beautiful old woman': the most one
might say would be 'a charming old woman'. Some 'handsome old
men' may be admired, but the male is not a quarry; neither bloom,
gentleness nor grace are required of him, but rather the strength and
intelligence of the conquering subject: white hair and wrinkles are
not in conflict with this manly ideal (1972, p. 297).

In The Second Sex, de Beauvoir asserts that in reality it is only man
who grows old gradually: that the femininity of woman is suddenly
snatched from her when she is still relatively young and yet now no
longer erotically attractive or fertile. "With no future", de Beauvoir
states, "she still has about one half of her adult life to live" (1974, p.
640). She further describes the aging process in women in frighteningly
negative discourse as "the eventual mutilation" and "the horror of growing
old". She speaks of the woman's anxiety as she helplessly observes the
degeneration of her physical body:

She puts up a battle. But hair-dye, skin treatments, plastic surgery, will never do more than prolong her dying youth. Perhaps she can at least deceive her mirror. But when the first hints come of the fated and irreversible process which is to destroy the whole edifice build up during puberty, she feels the fatal touch of death itself (1974, p. 641).

De Beauvoir goes on to describe the "pathetic urgency" with which a women attempts to turn back the clock by having another child or finding one more lover, or attempting to dress as a younger woman might. She describes the depersonalization process that my mother addresses when she is startled by her appearance in the mirror as an "old lady" although she feels no different inside. De Beauvoir writes of the older woman battling systematically to preserve her physical beauty, especially if she has few other resources, and describes scenarios where she takes -- and even pays -- younger lovers, or turns to a female lover. We are told, finally, that when the woman eventually consents to growing old, her situation changes:

Up to that time she was still a young woman, intent on struggling against a misfortune that was mysteriously disfiguring and deforming her; now she becomes a different being, unsexed but complete: an old woman (1974, p. 649).

At this point woman may be freed from the bondages of dieting, fashion, husband, and the opinions of others: and yet as de Beauvoir describes this new freedom one is left with the image of an unhappy misanthrope who has disconnected herself from even the people who have been meaningful in her life. She finds no satisfaction in a relationship with her husband, nor any justification for her existence in her children or younger associates and friends. The narrative becomes ever bleaker as de Beauvoir chronicles the uselessness of the aged middle-class woman who has grappled with the problem of killing time all her life. She speaks of
masking the "horrible illness" with "fancywork", social calls, and in America, with club activities that "are in themselves their own reason for existence" (1974, p. 659). Occasionally, we are told, a woman may become genuinely committed to a cause and become truly effective, at which point she no longer merely occupies her time. This eventuality, according to de Beauvoir, is quite rare. The author describes the old woman as becoming serene at the very end of her life: "when she has given up the battle, when the approach of death frees her from all concern for the future" (1974, p. 662). And yet, de Beauvoir does not really describe serenity for she speaks of the old woman as "sane and mistrustful" with a "pungent cynicism" and a negative wisdom manifested in "opposition, indictment and denial; it is sterile" (1974, pp. 663).

Susan Sontag (1973) is also convinced that aging is a trial and indeed equates advanced age to a shipwreck. She further concurs with de Beauvoir in believing that growing older is infinitely more problematic for women than it is for men. Although males may be periodically dispirited about aging, particularly if they haven't reached a predetermined career-point by a certain age; Sontag feels they rarely panic about aging as women frequently seem to. She identifies a "double standard" (1973, p. 210) in that men are permitted to age -- without penalty -- in several areas that women are not. Men are encouraged to develop their intelligence and highly rationalized marketplace competencies and these parameters actually sharpen with age and experience. Women, on the other hand, are not expected to develop past the point of intellectual dilettante, and are often barred from highly-paid and exciting careers. Their particular wisdom, often considered to be intuitive in nature, is not thought to increase with
age. This double standard about aging appears most clearly, however, in the "humiliating process of gradual sexual disqualification" (1973, p. 210) that women must endure. We are considered maximally eligible at some point on a short continuum between our late teens and mid-twenties, and rapidly approaching the "old maid" category if we are not married by our mid-twenties. We may have considerable difficulty finding a mate in our thirties, forties, or fifties, and if we do so we must choose someone our own age or older, for it is unseemly to find a younger man. Our male counterparts, on the other hand, are considered eligible and marriageable from the teen years through senescence: and they may choose women of any age as partners without fear of being harshly judged by society. (Although we do have a cultural label of "dirty old man" it is applied with a certain indulgent jocularity as opposed to the insulting and little used term "dirty old woman".)

Sontag notes that there is cultural variation in the age at which women are judged physically undesirable and that it comes earlier in Spain, Portugal and Latin America than it does in the United States and later in France, where women between thirty-five and forty-five have an allegedly institutionalized position as sexual initiators for young boys. Aging also varies with social class, and Sontag finds, as does de Beauvoir and many others, that the poor look older sooner than do the rich. Sontag comments, however, on the more pronounced age-related anxiety among middle-class and rich women in America than among the working class. Less affluent women in this country can't afford to battle aging as do the materially advantaged, who ironically have had more sheltered lives and better diets and still feel the sting of aging more keenly than their poorer
sisters. This points out to Sontag that: "Aging is much more a social judgement than a biological eventuality" (1973, p. 210).

Sontag comments on the extent to which the self-esteem of women is dependent on the flattery of men and notes that in American society sexual attractiveness (and consequently the ever-necessary compliments) is specifically identified with youth. Men may regret growing older, but women feel vulnerable and shamed as they age. A woman, according to Sontag, does not simply possess a face, as does a man, but rather she is identified with her face, upon which she paints "a revised, corrected portrait of herself. Her face is an emblem, an icon, a flag" (1973, p. 221). The woman whose face is marked by the normal changes of aging is not seen, as is a man, to possess character and maturity, but rather is seen to be marred and disfigured. Sontag remarks that only one standard of female beauty is accepted: the girl, whereas for men two standards exist: the boy, and the man. The beauty of boy and girl possesses similar qualities of smoothness, roundedness, softness: the look of the young. The woman, however, is forever held to this fragile ideal of beauty while the man can look forward to an evolution into the second standard of beauty that allows some roughness and heaviness and a body that may be more heavy-set. Sontag states:

This is not to say there are no beautiful older women. But the standard of beauty in a woman of any age is how far she retains, or how she manages to simulate the appearance of youth. ... Society allows no place in our imagination for a beautiful old woman who does look like an old woman (1973, p.221).

She further elaborates that our society as a whole, including the majority of woman in it, view the aged female as repulsively ugly. We are
reminded that:

Taste is not free, and its judgments are never merely 'natural'. Rules of taste enforce structures of power. The revulsion against aging in women is the cutting edge of a whole set of oppressive structures (often masked as gallantries) that keep women in their place (1973, p. 222).

Men support the double standard of aging because this reinforces their masculine initiative to choose in courtship, while women must wait to be chosen. This system of calculated inequality could not exist, however, if it were not tacitly accepted by women. As Sontag says: "Women reinforce it powerfully with their complacency, with their anguish, with their lies" (1973, p. 223). Sontag labels denying her age as the "model corruption in a woman's life" (p. 223) which contributes to her undervaluation as a human being. We have other options if we listen to Sontag: we can opt to be not merely nice, but wise; to be not merely helpful, but competent; to be not merely graceful, but strong; and to be actually ambitious for ourselves. We should allow our faces to show the lives we have lived; we should tell the truth.

Unfortunately, it is difficult to follow Sontag's advice when, as Aronson says: "a woman with gray hair and wrinkles is perceived as being old, while a man with gray hair and smile lines is perceived as being powerful and sexy" (1983, p. 142). It may be true that we are protected by law from discrimination based on age, but women do have to compete in the job market. If one has a high skill-level occupation, physical appearance and aging factors may be less relevant. If a woman works as a secretary, or receptionist, or in sales, however, she must present an attractive and youthful face and figure to keep her job. If a person works in an extremely high-visibility occupation, such as in the
entertainment field, beauty and youth may be everything. Cher, an American actress and singer quoted on getting older, said: "It stinks.... Also, it stinks in this business big time. Men get character. But not women. They say, 'Get me a younger Cher'" (Parks, 1987, p. 4). The unfortunate component here, is that many women feel that they must react to aging as if they were actresses or models. Often those most at risk seem to be people who have not in the past developed all the possible aspects of their "selves". If one is truly multi-dimensional, perhaps the perceived lessening in the physical attractiveness component due to age is less devastating.

Christopher Lasch (1979) states that old age "holds a special terror for people today" (p. 351), and speaks of the two approaches to this problem: not to lengthen life but to improve its quality, and to deal with old age as a medical problem. This second approach, of course, is what cosmetic surgery for aging people is all about. The surgeon removes part of the ravages of time, and the patient attempts to deny the reality of aging and mortality a bit longer. This approach fits well with the currently popular idea that physicians will ultimately gain total control over the genes controlling aging such that growing old will be a "curable disease". As Illich states:

Old age has been medicalized at precisely the historical moment when it has become a more common occurrence for demographic reasons; 28 percent of the American medical budget is spent on 10 percent of the population who are over sixty-five (1976, p. 82).

These figures, which have increased since 1976, underscore the fact that as the American population ages into the twenty-first century, more and more resources will be applied to the "problem" of aging. We can hope that the greater part of these dollars will be channeled to enable older
people to function relatively comfortably toward the end of their lives and not to enable them, through ever more innovative cosmetic surgery, to become "caricatures of themselves" (de Beauvoir, 1972, p. 540). Although this phrase is de Beauvoir's, she intends it to refer not only to physical appearance, but to several aspects of the individual's former (younger) life to which he or she clings: often resulting in a cruel parody of a successful and happy previous existence. De Beauvoir tells us that there is only one answer to prevent this unhappy outcome, and that is:

- to go on pursuing ends that give our existence a meaning -- a devotion to individuals, to groups or to causes, social, political, intellectual or creative work. In spite of the moralists' opinion to the contrary, in old age we should wish still to have passions strong enough to prevent us turning in upon ourselves (1973, p. 540).

Cultivation of energizing passions and an outer-directedness may well be our salvation against what Lasch (1979) terms the "irrational terror of old age and death" associated with "the emergence of the narcissistic personality as the dominant type of personality structure in contemporary society" (p. 356). Without an inner life and a commitment to beliefs and people outside the self, an individual may be unable to resist the often irresistible pull of narcissism.

**Psychiatry and Cosmetic Surgery**

**The Problem of Patient Screening.**

In chapter one of their book *Changing the Body* (1981) Doctors John and Marsha Goin tell the story of the 1977 murder of a prominent Madrid plastic surgeon and his two nurses by a disgruntled, and obviously unstable, former patient. The surgeon, Dr. Jesús Vasquez Añón, had performed a rhinoplasty on the patient, a 45-year-old male, in 1976 and had performed a revision procedure to correct a left nasal deviation and
breathing problems 9 months after the original procedure. Dr. Añón saw the patient on the third and seventh postoperative days following the second procedure and recorded the result as "satisfactory". On at least one occasion following the second operation the patient "insisted" on being examined by the doctor, but apparently the doctor's nurses "protected" him from this bothersome patient who was not allowed to see the doctor. His staff was unable to protect Dr. Añón after March 14, 1977, however, because on that day this patient shot and killed the surgeon and his nurses after being admitted to speak with the doctor. Dr. Añón was a physician who was reported to be seriously concerned about the multiple psychological problems of many patients who consulted him for aesthetic procedures and was quoted as saying that the majority of persons who requested an aesthetic surgical operation needed a psychiatrist rather than an aesthetic surgeon. In spite of these factors, however, Dr. Añón operated on the patient in question: a 45-year-old bachelor and fairly affluent landowner, who lived a rather reclusive existence with few friends, and often socialized with prostitutes. He stated that he had never married because of his rather large nose. The patient's family history revealed a sister with two mentally retarded children, a cousin who murdered his girlfriend and then committed suicide, two other cousins who murdered a neighbor and a wife respectively, and an uncle who attacked a business rival with a gun. Dr. Añón identified the patient's psychological problems before the first and second operations and yet he operated on the patient, and failed to request psychiatric evaluation for him. The point of this story, of course, is its illustration of the potentially tragic circumstances that can result when cosmetic surgery is performed on an
unstable patient. In this patient's case the warning signs were multiple. He was male, and there is quite a bit of evidence to suggest that male cosmetic surgery patients have more psychological difficulties than an equivalent female group. The patient was requesting a change in an obvious and what psychiatrists would consider a "psychologically loaded" feature, the nose, which had been present with no change for the patient's entire life to that date. It is significant that he sought the operation rather late in life. Additionally, the patient seemed to have unrealistic expectations about the expected outcome of the procedure; there is evidence to suggest that he may have told Dr. Añón that there was a woman he loved who had agreed to marry him if the appearance of his nose was improved. His familial psychiatric history was one that psychiatrists would consider extremely risky. Dr. Añón should have recognized these factors, according to Doctors John and Marsha Goin, and should not have consented to perform surgery on this patient. Admittedly, the majority of cosmetic surgical scenarios will not result in such a tragic aftermath. The risks are genuine, however, and should not be downplayed for surgeon or patient. In the majority of physical or psychological "problem" cases however, the risk is overwhelmingly that of the patient. The large risk faced by the physician is that he or she may be -- and frequently is -- sued. The patient, of course, faces multiple risks: death, infection, hemorrhage, nerve and tissue damage, an unfavorable aesthetic result, excessive time lost in recuperation, and potential for interpersonal and psychological problems of several varieties.

How, then, do plastic surgeons decide whether or not to "accept" a given patient for cosmetic surgery? And what are the issues involved in
the exclusion of patients? I will present the preoperative screening
criteria utilized by three plastic surgeons in order to identify the factors
that physicians in this specialty regard as important determinants of
patient selection.

Dr. Mark Gorney (1978) makes the following statement:

Just like an iceberg, significant dangers in a patient's true motivation
for aesthetic surgery may be hidden. ... Thus careful patient selection
is the single most important method of avoiding postoperative
problems, including those related to malpractice (p. 1).

Gorney identifies the following categories or patient types as
"associated with an excessively high frequency of subsequent trouble"
(1981, p. 1). First, there are those patients who exhibit great concern
about minimal deformities. Second are those persons who expect surgery
to enable them to make friends and become socially successful. Third are
those patients who have unrealistic expectations as to the degree of
improvement possible. Fourth are those whom Gorney classes as
"demanding" and who arrive with sketches, pictures, or other engineering
specifications. A fifth category is comprised of those labeled "indecisive":
persons without clear objectives who may ask the doctor if they should
have the procedure done. Sixth are the VIP patients, who attempt to
impress the surgeon with their social or professional status: Gorney states
they are "difficult to satisfy" (p. 5) often need extensive ego-bolstering,
and frequently forget their financial obligations. A seventh category is
made up of those individuals who insist upon unqualified secrecy. He feels
that these patients often have a problem with guilt and that the absolute
secrecy is difficult to guarantee in any case. An eighth group is
comprised of immature persons: often young and possessing "excessively
romantic and unrealistic expectations of the psychologic effects of their
cosmetic improvement" (p. 5). Postoperatively they may be shocked and behave irrationally. Gorney's last group is made up of persons whose families are not in agreement with the surgical procedure to be performed. He states that he often refuses to operate on those whose families are opposed. Dr. Courtiss, who edited the book in which Gorney's chapter appears, adds his perspective at the end of the chapter and advises that the surgeon beware of patients who exhibit "selective deafness" prior to surgery, repeatedly asking the same questions, and those who require multiple interviews. Courtiss emphasizes also that a surgeon avoids malpractice suits by developing "strong positive relationships with his patients" (Gorney, 1978, p. 12) and that "problem patients should be seen more, not less". Courtiss also advocates prepayment of fees for aesthetic surgery and states this should be a "universal policy" as a "swollen, tender or ecchymotic" patient may be "aggravated" or "threatened" by postoperative billing (p. 13). Unstated here, of course, is the obvious: the "swollen, tender or ecchymotic" patient may decide not to pay her bill.

Robert Goldwyn, M.D. (1984) also mentions that plastic surgeons should exercise care in operating on patients with minimal deformity and great concern, those who are indecisive and vague about what they want done, those who are socially "important", and those who are "rude or pushy". He lengthens the list of patient characteristics that should raise plastic surgeons' " antennae as well as (their) threshold for operating" (p. 5). Persons who write excessively long letters to arrange initial consultations reveal their "obsessive and perhaps neurotic nature" and should be approached with caution. Also problematic are the following: persons giving false histories; those who won't conform to the surgeon's
usual regimen, such as preoperative photographs; those who have "doctor-shopped" and have come after seeing four or five other M.D.s; those who seek and undergo multiple operations; those who desire an operation in order to please someone else; those who appear visibly depressed or paranoid; those in psychotherapy who have not allowed the surgeon to speak with their therapist; an older male patient who seeks a rhinoplasty "in order to resolve sexual inadequacy" (1984, p. 5); or the patient whom the doctor dislikes. Goldwyn states that in speaking to many plastic surgeons who have had dissatisfied patients, he has found that either they or members of their staff had been uncomfortable about operating on these persons. Goldwyn urges the surgeon to trust his and/or his staff's intuition in cases where this phenomenon occurs.

It is apparent that the plastic surgeons do not, in general, affix psychiatric diagnoses to their patients, but rather that they place them in undesirable groups based on the functional difficulty the surgeons have experienced with similar patients in the past. Psychiatrists demonstrate a different orientation to patients seeking cosmetic surgery, which will be explored next.

**Historical Interaction between Psychiatry and Plastic Surgery**

In a review article on the links between plastic surgery and psychological factors, Kalick (1978) relates that the first articles published on this topic, 50 years ago, tended to assume a linear relationship between physical defect and psychological illness: the disfigured individual was truly sick. This led to enthusiastic support of cosmetic surgery until it was noted that some patients reacted badly even with satisfactory aesthetic results from the procedures. As Freudian theory came to
dominate American psychological thinking, researchers began to focus on
the symbolic meanings of actions and events. Karl Menninger, in the
1930s, became interested in what he called "polysurgical addiction" and
wrote about a patient who had undergone 28 operations by the age of 21
(Gifford, 1984, p. 25). Menninger analyzed patients in whom the need for
surgery was a manifestation of masochistic tendencies (a wish for
punishment or castration) or longings for a symbolic penis or fetus.
Kalick relates that Menninger proposed two hypothetical explanations for
the seeming addiction of some patients to surgery: many patients may
want to be "protected" by the powerful, "father-figure" who is the
surgeon; and surgery, as a perceived danger, may be undertaken to delay
other dangers: such as a difficult life situation that the operation may
forestall (p. 245). When the patient recovers from the procedure and finds
the troublesome life events still ongoing, he or she may scheme to obtain
another operation. Much has been written about the symbolic meanings of
plastic surgery on specific body parts. The nose, for instance, has often
been invested with phallic meanings in the writings of psychiatrists, and
women's breasts have been suggested to symbolize several qualities: from
maternal devotion to carnal lust.

Kalick asserts that if a defect mentioned by a patient only seems to
be his or her source of distress, that there is a good possibility that the
patient will be dissatisfied with the surgery regardless of the result. He
postulates that such patients might become "addicted" and seek one
cosmetic procedure after another, never feeling satisfied with the results.

Kalick (1978) mentions the 1950 work of Hile and Silver, who
suggested that the percentage of normal, well-adjusted persons among
plastic surgery patients is small, but even emotionally troubled persons can benefit from plastic surgery as long as they haven't derived too much secondary gain from their real or imagined defect. He also mentions a 1961 study by Edgerton, Jacobson, and Meyer in which 98 patients with minimal deformity were evaluated by psychiatrists and 70% were assigned a psychiatric diagnosis. In view of this data, Kalick asks why this might be so: do disturbed persons become easily upset about their appearance, or did their physical defect and the resulting social response of others lead to their disturbed state? Linn and Goldman's 1949 work is quoted, which argued that even minor physical flaws can represent a source of considerable anxiety to some persons. These persons are said to be seriously depleted emotionally by this problem, and seek cosmetic surgery to free up the energy and normalize their lives. Reich's 1969 work is mentioned, which, based on interview data from 750 patients, concluded that a person's acceptance of his appearance or body-image depends on the attitudes of those around him and on a comparison of his body with those of other people throughout his life. Kalick states that this implies that successful surgical correction can enhance the body-image of persons with personality problems and even "borderline psychotics, provided their concern is over a real, correctable flaw" (p. 246). He quotes Reich who states: "Psychotherapy is unlikely to be successful as an alternative to surgery where a correctable deformity exists and when the patient's expectations are realistic, irrespective of psychiatric diagnosis" (pp. 246-247). The problem with this line of reasoning is in the definition of a "real, correctable flaw" and "realistic expectations": both of these entities are nebulous and highly variable depending on the viewpoint of
the individual -- and what he or she stands to gain. The "real, correctable flaw" might be seen very differently by the patient, the spouse or parent, the family doctor, and the plastic surgeon. "Realistic expectations" can be easily voiced now that prospective patients have read so much in the media about what they are supposed to expect from a procedure.

Kalick mentions that the previously quoted study by Edgerton, in which 70% of the patients were assigned psychiatric diagnoses, reported a 96% favorable psychological outcome at six months, despite the fact that only 30% of these patients were well-adjusted. Gifford (1984) states that: "A vast majority of cosmetic patients also obtain satisfying, long-term results, although nearly all seek operations on the basis of neurotic or unrealistic motivations" (p. 39). This seems quite strange; why should it be so? Gifford postulates the following reasons. First, cosmetic patients are seeking the "restoration of an ideal state" and the operation is experienced, "symbolically and often literally as an augmentation" (p. 40). Second, since the conditions leading to cosmetic surgery and the procedures themselves do not confer illness status, the patient has a reduced potential for secondary gain. He states that they usually think of themselves as "ugly or defective rather than sick, a state equated with being morally bad or incapable of inspiring love" (p. 40). Third, narcissistic women may experience the operation as a "restitution of previous losses" and as such a reinforcement of existing defenses (p. 40). Finally, cosmetic surgery, since it is external and visible and often performed under local anesthesia, does not excite fantasies of terrifying unknown mutilations as other surgery can. Gifford's explanations for the
high incidence of patient-perceived success are all psychoanalytic as opposed to Kalick's more practical explanation: he proposes that cosmetic surgery, since it improves a person's appearance, gives her greater social value and enhances peer success. Kalick states, however, that we do not know the social importance of gradations of physical attractiveness--within the normal range. This, I feel, is an important point. Are these gradations even relevant? Is it not more probable that persons with a significant appearance deficit can be helped more by such a radical solution as surgery than those whose results are unable to be detected even by persons who knew the patients well before? And as the number of cosmetic procedures increases daily, are all of these persons in possession of a "genuine defect"? I would propose that inevitably plastic surgeons will find persons with "objective deformity" in short supply and that they will be manipulating normal acceptable physical features; merely making them different, not better.

Gifford (1984) states that there are only a "few" failures in terms of perceived results, and that these are highly "malignant": describing the "chronically dissatisfied insatiable cosmetic patient" as a borderline personality with no close attachments, sexual and vocational inadequacies, and a tendency to blame personal failures elsewhere (p. 46). When the body and its various parts is the identified "cause" of the problems, the surgical procedure will effect no miracle and the patient will blame the surgeon and pursue redo after redo. He states that although more men are now seeking cosmetic surgery, they are still fewer in number and demonstrate "more severe pathology of all types than do women" (p. 41). He cites the 1967 work by Knorr where 28 of 28 "insatiable" cosmetic
surgery patients were males with low self esteem, long-standing personal, sexual and work relationships, and inability to state clearly what they desired from the cosmetic procedure. Gifford feels it is a "rare" woman patient who develops delusional preoccupations with a damaged body part as do these men. As the numbers of patients, both male and female, increase, I do not think that such persons will be "few" or "rare". The following data offer some contemporary psychiatric evidence that such "malignant" cases are on the increase.

Current Psychiatric Opinions

In order to gain a better understanding of how these issues might be viewed by a psychiatrist currently practicing in Houston, I spoke with Dr. Richard Pesikoff, M.D. (Personal Communication, 1988, Feb. 21). He suggested to me that the diagnostic category in which to look, in order to understand most of those individuals seeking cosmetic surgery, would be the section on "personality disorders" in the Diagnostic and Statistical Manual of Mental Disorders, (American Psychiatric Association, 1980). This volume, referred to as the DMS III, is the current listing of revamped and restated psychiatric diagnoses, and defines mental illness by symptom complexes or by their effect on a person's functioning. Dr. Pesikoff stated that the personality disorders lack the criteria for true psychotic disorders, and added that he felt four of the disorders, the histrionic, the borderline, the dependent, and the narcissistic would be most likely to afflict those persons who seek cosmetic surgery.

It must be understood, then, that I am not covering every diagnostic possibility: I will only attempt to discuss the disorders that might affect more or less functional persons seeking these procedures. More seriously
disturbed individuals might be diagnosed as having schizophrenic disorders, paranoid disorders, affective disorders, anxiety disorders, or any of several others. The reader is referred to Goin's text (1981, pp. 39-60) for an overview of all of the psychiatric diagnostic categories from the *DSM III* that Dr. Goin suggests might be necessary for a more complete understanding of the disorders most probable in this group of patients. Each of these personality disorders is defined by certain behavioral characteristics which must be documented over time as part of the person's usual behavior, well or ill, and lead to "significant impairment of social or occupational functioning or subjective distress" (Goin, 1981, p. 54). I will include brief descriptions of each of these four disorders as discussed by Goin (1981), and Pesikoff (Personal Communication, 1988).

Histrionic patients are overly reactive or dramatic and manifest an intense need to draw attention to themselves. They have disturbances, also, in their interpersonal relationships and demonstrate shallowness, egocentrism and lack of consideration for others, vanity and demanding behaviors, dependent reassurance seeking, and manipulative suicidal threats or attempts. Borderline patients are diagnosed as such if they demonstrate at least five of the following behaviors: impulsivity or unpredictability that is often self-damaging such as spending, sex, overeating, substance abuse, shop lifting or gambling; unstable and intense interpersonal relationships; inappropriate or uncontrolled anger, identity disturbance in areas such as self-image, gender identity, long-term goals, friendship patterns, or others; affective instability, which is typically short-lived; intense distress on being alone; physically self-damaging acts; and chronic feelings of emptiness or boredom. Dependent personality disorder patients
are unable to function independently and may passively allow others to assume responsibility for major areas of their life, such as allowing a spouse to dictate job choice. Dependent individuals subordinate their own needs to those of the dominant person such that no self-reliance is possible. These people are extremely lacking in self-confidence, and may view themselves as stupid or inept. Dr. Pesikoff stated that dependent personality disorder patients are highly sensitive to rejection, and will go to great lengths to avoid this eventuality. Narcissistic personality disorder, also a common diagnosis, is heavily represented among the aesthetic surgery patient population according to Goin (1981). Among the characteristics manifested by these patients are: grandiose sense of self-importance, preoccupation with fantasies of success, power, brilliance, or beauty; exhibitionism and need for constant attention and admiration; cool or intensely angry response to indifference, criticism or defeat; and at least two of the following interpersonal relationship problems: expectation of special favors without willingness to give back in kind, exploitation of others, relationships that vacillate between over idealization and devaluation, and lack of empathy. Dr. Pesikoff added that persons in this diagnostic category are extremely superficial: investing in most issues at only a surface level. Additionally, during our discussion, Pesikoff classified those who would seek cosmetic surgery as three types. The first type he termed "those who really need it" and mentioned persons with congenital malformations or traumatic deformities. The second group he labeled "swing people", identified as those who are "sociologically swayed" by what is happening in America and in the media: for instance our preoccupation with youth. He stated that these individuals are "not
terribly pathologic. The third group, which he identified as 'seriously disturbed or pathologic' are persons who are overly concerned and invested in appearance, and whose 'whole existence rides on the procedure'. An individual of this type would fit rather well into the narcissistic personality disorder category. Pesikoff stated that these patients may attempt to have every procedure that comes along, resulting in multiple revisions.

Indeed, evidence that some patients are seeking multiple and repetitive procedures is mounting. Conant, Gordon, and Donovan write about "scalpel slaves": "perpetual plastic surgery patients [who] go from facelift to facelift in search of physical perfection" (1988, p. 58). Doctors quoted in this article identify an increasing number of persons in affluent urban areas who seek procedure after procedure. Most of these people are women in their late 30s and 40s who go from doctor to doctor seeking multiple operations, waiting only a few months in-between. Dr. George Sanders, a plastic surgeon in Encino, California, describes this quest as follows:

It's almost like an addiction. They experience a temporary high, but there's a certain sense of lacking that they try to fulfill with yet another procedure.

What distinguishes the junkie from the more desirable patient is that (junkies) are looking for a profound change in their social life and answers to problems they haven't found through more conventional means (Conant, Gordon, and Donovan, 1988, p. 58).

The authors of this article identify women in their forties as "particularly vulnerable" to the lure of plastic surgery. Many of the "scalpel slaves" are older women who have recently been divorced or widowed and who must find employment or venture back into the dating game. Others suffer from the empty-nest syndrome. Dr. Susan Chobanian,
a Beverly Hills cosmetic surgeon, calls these "re-entry women" who "get insecure about their appearance and show up every six months to get nips and tucks" (Conant, Gordon, and Donovan, 1988, p. 58). Chobanian’s patients who are in show business return most frequently: "Women feel compelled to have surgery to look their best. Their self-scrutiny becomes microscopic. They start complaining about bumps the average person doesn’t see" (p. 59). Doctors identify plastic surgery junkies as similar in many ways to the anorexic or bulimic. Some of these patients have, in fact, had eating disorders in their teenage years, and now are trying again to alter their body-image. Dr. Richard Ellenbogen, a Los Angeles plastic surgeon says the following: "It's a body-image disorder. (Junkies) don't know what they really look like. When they run out of operations they start having themselves redone" (Conant, Gordon, and Donovan, 1988, p. 59). Doctors Nancy Andreasen and Janusz Bardach would corroborate this definition and identify a symptom, or perhaps syndrome, which they term "dysmorphophobia" in an article in the *American Journal of Psychiatry* (1977). This term refers to a "subjective feeling of ugliness in a person of normal appearance" (p. 763). These doctors state that the examining physician would be unable to predict the nature of the subjectively experienced "deformity". The patients are usually in their late teens or early twenties. A few may actually have very minor "defects", but the concern of the individual is disproportionate to the degree of the problem. The doctors relate that when these patients are questioned about the nature of the change that can be effected surgically, they have "quite unrealistic and magical expectations about the extent to which their appearance can be beautified" (p. 673). And yet, according to the authors,
these patients "rarely expect the surgery to make any significant change in their lifestyle" (p. 674). The onset of dysmorphophobia usually occurs during adolescence and is described as a "pathological response to the various dramatic physical and physiological changes of this period" (p. 674). (Considering the emphasis on beauty in American culture and the fact that adolescents have rapidly changing and unpredictable bodies, I have difficulty with their label of pathology here. I would suggest that some degree of "dysmorphophobia" is rather normal in contemporary American teenagers.) The authors go on to describe the patient as brooding about the defect for several years before consulting a physician, although he or she may have read about cosmetic surgery extensively in popular magazines. They describe the patient as a shy person, with few or no close friends, few dates, and limited sexual experience. The patients are markedly self-conscious, feeling that people are staring at them, and are perfectionists in all areas of their lives. The authors suggest that these patients have many traits characteristic of a personality disorder, but that no single pattern predominates. They exhibit normal affect and thought content. Andreasen and Bardach state that the appropriate treatment for this condition is psychiatric rather than surgical. These patients, however, characteristically resist psychiatric referral and treatment, and will go from surgeon to surgeon until they find one willing to operate. The authors further describe the patients as follows:

Patients who do find a surgeon to correct their original 'deformity' will often then find a new 'defect' which needs correction; they may eventually become synthetic creations of artificial noses, breasts, ears, and hips. Since their real 'defect' is emotional rather than physical, they are rarely fully satisfied with the physical modifications obtained (1977, p. 674).
Conant, Gordon, and Donovan (1988) assert that scalpel slaves will tend to undergo operations in groups: an abdominoplasty ("tummy tuck") followed by mastopexy (breast lift) is a common combination. Even though the procedures may yield only tiny results, the patients are inordinately grateful, showering the surgeons with gifts. Listen to the quote of Dr. Ellenbogen, the plastic surgeon quoted earlier: "So you know (after receiving the gifts) that they're going to hit you up again in a year to have something else done. They think they look great, but they really look like a cartoon" (Conant, Gordon, and Donovan, 1988, p. 59). I wonder, as I relate his words, why Dr. Ellenbogen doesn't refuse to operate further on some of these unhappy patients, instead of "consenting" (for a hefty fee) to perform further cosmetic procedures and then describing his creations as "cartoons".

Conant, Gordon, and Donovan state that persons who hop from doctor to doctor seeking multiple procedures run a much higher risk for complications. If turned down by reputable surgeons for a third or fourth facelift, they will seek out any doctor who will do what they want. Dr. Chobanian discusses the case of a 33-year-old woman who requested a facelift. This patient was already badly disfigured from previous operations: she had extensive scarring from a forehead-lift and from eyelid surgery. When Dr. Chobanian advised against the lift, as had other surgeons, the woman went to Mexico to get it done. The problem is, that once damage is done, it isn't easy to repair. Extensive scarring can result for some patients, as well as an artificial look punctuated by tilted noses, absent foreheads, and skin stretched thin. Further, surgeons of good reputation may hesitate to attempt to fix a poor result for fear of getting
themselves entangled in a malpractice suit. Dr. George Sanders, a plastic surgeon in Encino, California, states that he tries to weed out patients who have had multiple previous procedures, all done by different doctors, but that many of these patients are skillful at lying about their medical histories. In addition to lying, they become adept at providing the "appropriate" answers to preoperative screening questions. Conant and his co-authors provide testimony from at least one plastic surgeon, Dr. Fritz Barton, Professor and Chairman of the Division of Plastic Surgery at the University of Texas Southwestern Medical School at Dallas, that patients who seek repeated unnecessary cosmetic surgery are rare. His quote is a similar rationalization to many I have now encountered. Even though they are repeating the procedures this fact: "doesn't mean people are abusing cosmetic surgery. Because someone's life-style is different than yours or mine doesn't mean their choices are inappropriate" (Conant, Gordon, and Donovan, 1988, p. 59). These choices, unfortunately, may only be seen as inappropriate by the patient when he or she has a complication or begins to look like a caricature of a former self. Repeated procedures for reasons that are suspect will only be seen as inappropriate by ethical plastic surgeons who can divorce themselves from total pursuit of wealth long enough to dissuade at least a few unhappy patients.

This discussion, then, has provided testimony from psychiatrists about which psychic maladies might affect those who would seek cosmetic surgery. It has also explored the idea that there will almost certainly be persons who will repeatedly seek such surgical interventions, and that these persons are suffering from a body-image distortion that results, according to Dr. Pesikoff, when the sense of "not being OK" is transferred
to one's "outer coating" (Personal Communication, 1988). How, then, can plastic/cosmetic surgeons avoid "problem patients"?

Dr. Marsha Goin, a psychiatrist previously quoted, states: "Troublesome patients are usually troubled people" (1978, p. 17). Goin identifies, however, no preoperative test that will identify potentially "troublesome" patients: only emphasizing the usefulness of the surgeon's "common sense" and "clinical judgement" (p. 17) and the importance of taking time during the preoperative consultation to allow the patient to speak freely. In another source (Goin and Goin, 1981) she identifies the following information that the surgeon should know after the first interview:

(1) how long the patient has been dissatisfied with the relevant body part; (2) why he is requesting the operation at this particular time; (3) his motivations for surgery; (4) his expectations as to what effects a successful operation will have on him and his life; (5) whether the patient is now in a life crisis of some sort; (6) how the patient's family and friends feel about the proposed operation and what degree of support (if any) can be expected from them (p. 12).

These, then, are the psychological screening questions that Goin suggests cosmetic surgeons ask prospective patients. This would take time, and of course presupposes that some individuals will not be suitable candidates. We can only hope that some plastic and cosmetic surgeons take the necessary time and actually decide against operating on individuals at physical or psychological risk.

Narcissism: Individual and Collective

In order to extend the inquiry about the presence or absence of pathology a bit wider than the psyche of the individual, it may be helpful to discuss the concept of narcissism in other than a purely psychiatric context. In order to accomplish this, I will draw first upon the work and
writings of Dr. Heinz Kohut, a psychiatrist and psychoanalyst and the father of self psychology: the antidote for pathologic narcissism. Secondly, I will discuss narcissism as it is interpreted by social critic Christopher Lasch.

Dr. Kohut is the well-spring of a new brand of analytic theory, which he terms self psychology. Although trained as a Freudian analyst, he has chosen to bypass the Oedipus complex with its twin themes of sex and aggression as the principle conflict for the developing child, and to concentrate instead on the narcissistic conflicts and their healthy or unhealthy resolutions. Susan Quinn, who interviewed Kohut for an article, (1980), relates his hypothesis that changes in family relationships and in the fabric of society itself may be producing a patient group in which the narcissistic disorders predominate. She reports that there is a growing impression within the psychoanalytic community that this change is taking place and identifies the fact that the most frequent psychoanalytic diagnosis, was hysteria in the early 1900s, followed by clinical neurosis in more recent decades. Supplanting neurosis, narcissism has assumed the position as the "paradigmatic" complaint of today, according to Arnold H. Modell, who trains analysts at the Boston Psychoanalytic Institute (Quinn, 1980, p. 123). A narcissistic character disorder results when a child fails to receive, and therefore cannot internalize, parental love: the basis for the individual's sense of self-esteem. Without this internal sense of worth and value, individuals are doomed to spend the rest of their lives seeking the affirmation of others, and never receiving enough. The modern household, with one to two parents, according to Kohut, tends to provide a child with too little input, which can result in feelings of isolation.
Kohut writes:

If the grandiosity of the narcissistic self, however, has been insufficiently modified because traumatic onslaughts on the child's self esteem have driven the grandiose fantasies into repression, then the adult ego will tend to vacillate between an irrational overestimation of the self and feelings of inferiority and will react with narcissistic mortification to the thwarting of its ambitions (1985, pp. 105–106).

Failures in parental empathy are the ammunition for this assault on the child's self-esteem, which is buffeted by inappropriate parental responses to the inner state or needs of the child. The child becomes, in adulthood, a narcissist: a discontented, superficial individual, a charming user of people, an insatiable glutton for recognition and praise.

Moving beyond contemporary family dynamics to larger social trends, Quinn quotes analyst John E. Mack who identifies a "great sense of insecurity that grows out of the breakdown of local structures. Nobody is safe from terrorism, the bomb. There's a feeling of rootlessness" (1980, p. 123). Christopher Lasch (1979) has stated that self-absorption is the hallmark of contemporary American society: that narcissism is "one of the central themes of American culture" (p. 61). Lasch attributes the blame for the narcissistic personality disorder of the individual sufferer to the society at large: "Every society reproduces its culture -- its norms, its underlying assumptions, its modes of organizing experience -- in the individual, in the form of personality" (p. 76). Personality and its disorders, therefore, are very likely the results of culture "writ small". American cultural indifference to the past and the future, according to Lasch, reveals its bankruptcy. The current watchword is therapy, not religion. As a society we do not seek salvation, nor the restoration of a golden age, but rather the illusion, however brief, of physical and psychic
well-being. We have turned from psychoanalysis to 3 day seminars in est or relaxation therapy or behavior modification. We move finally to the suite of the cosmetic surgeon: the most rapid (and dangerous) psychic therapy of all. This seems the solution especially as we age; I have previously quoted Lasch's belief that the American narcissistic personality is truly terrified of old age and death. Men and women begin to actively fear growing old before they arrive at middle age, and the fear of death is intensified in a society that eschews religion and rejects posterity. The aging narcissist seeks one diet or exercise regimen or plastic surgical procedure after another while the interior dimension remains undeveloped. And yet Lasch tells us that creative, useful work which presents the individual with "unsolved intellectual and aesthetic problems" thereby mobilizing narcissism in pursuit of activities outside the self, is our best hope of salvation (Kohut, 1985, p. 48). Kohut writes that we must overcome narcissism through humor, creativity, empathy, and wisdom: for it is by these four mechanisms that pathological self-absorption can be transformed.

**Fieldwork and Interpretation**

The remaining chapters of this dissertation will be focused on my fieldwork experience with five women whom I have used as informants. The resulting interviews, which were more often conversations, were arranged with women who were introduced to me by friends and colleagues. All of the women agreed to have our conversations taped as we talked about their lives and the cosmetic surgery they had undergone. I used no pre-drafted questions, but I would introduce certain key topics if they did not emerge naturally in the dialogue. I was interested in the
women's beauty ideal, and how it was shaped: this included reflection on
the physical appearance and beauty routines of their mothers or other
significant females in their lives. I wanted to understand how each woman
saw herself physically, both before and after the operations. I was
interested in how they came to want the operations, and the influences of
advertising, media coverage, peer pressure, family expectations, and love
interests on their choices. I asked them to tell me how they chose their
doctor, to describe interactions with him or her and other doctors, and to
narrate the events of the actual surgical procedures and their aftermaths.
Within this framework there was a great deal of latitude, which may not
be totally reflected in the somewhat edited conversations. We talked
about topics that were pivotal to beauty and plastic surgery and about
subjects that were only tangentially related or that were unrelated to
these issues. I present a great deal of the informants' own dialogue and
in addition, I preserve my tapes as the archives of the actual
conversations, which could be shared, if necessary, with some editing to
obscure names and places.

In order to introduce some elements of reflexivity, reciprocity, and
fairness, I gave the women some information about myself. I explained my
age (42), my origins (St. Louis, Missouri), and that I am married. I
volunteered that my husband is a physician who does research and that I
have three children: two boys, nine and seven, and a girl, five. I told
them about my background in nursing, and my experience as a nursing
educator. I explained that I was interested in the health care issues that
affect women and children, in American society and in other cultural
groups. I linked my interest in cosmetic surgery to the fact that it was
increasing at a rapid rate, was primarily being done on women, and that it was a hybrid issue, involving women's appearance and also possibly their health. I did not want to overstate my position or influence their responses, but I did not attempt to maintain a position of neutrality on all issues. If I had mixed or negative feelings about a topic under discussion and it was appropriate for me to state these feelings, or if the woman asked me, then I told her how I felt. I did not, and do not, want any of these women to read this work and be shocked at my position on these issues. I found it impossible to shed my nursing persona and the informants and I discussed some current or past complications of their procedures in this light. In keeping with my nursing identity I felt it necessary to introduce the topic of mammograms for cancer screening with each woman who had had augmentation done, so that I could share my concern that she have a more careful examination (with perhaps more X-ray views) and a more exacting interpretation of the results. This was the only message that I wished to give to the women, at least the only one of which I was conscious. I have included information from the psychiatric and psychological literature in the cases of both facelift and breast augmentation, but it is not my intention to diagnose my informants. Rather, I present the conclusions from this literature, which are often conflicting, as additional descriptive information and the discussed patients as additional informants. These informants, however, are somewhat distanced and muted by the "scientific" style of writing in the articles. I have introduced other voices as well: women (patients) and physicians who speak in magazine articles, books, and television broadcast transcripts. In this way I hope to increase the depth and scope of this work, for while
they are not "live" informants, their words represent further perspectives on the controversial issues under discussion. As I read and thought about the woman's words, I became aware that the cosmetic surgical procedures were, in reality, much more extensive versions of their normal beauty rituals. I became interested in exploring the ritual nature of the medical and/or surgical encounter with a physician in America, and how this compares with the visit to the shaman or ritual expert in more traditional cultures. As I explored some women's rituals the elements of pain and possible danger seemed striking to me, as was the parallel occurrence of these elements in American beauty ritual, both surgical and non-surgical, both past and present. The exploration of the symbolic nature of the breast and the face, is a most relevant inquiry in my work, and I am fortunate to be able to utilize the work of persons as skilled in the art of semiotics as Victor Turner and Sherri Ortner. Using the magnification lenses of these experts and keeping my ear to the ground of the American vernacular, perhaps I have exposed some of the symbolic shadings that color our perceptions of these body parts. A look at dominant symbols within American culture, however, would not be complete without some thoughts on the contemporary myths that help drive our complex society, and I have included this as well. I have found the technique of using symbolic and ritual analysis to be a helpful one since the ritual process I am describing is so close to and so much a part of my own life as an American woman. In this case the methodologies of anthropology have enabled me to de-familiarize the commonplace and to understand the roots of my own feelings about feminine beauty as well as to approach an understanding of the other women with whom I have interacted.
CHAPTER V: A CHANGE OF FACE

A Western Conception: from *Cosmopolitan* magazine

She was the reigning beauty of the hour ... I will not try to describe her looks because I would ... be driven to cliches like 'ethereal', 'heavenly', or 'devine'(sic). ... She was then in her early thirties and at the very peak of her near perfection. She had just divorced a very rich husband. ... After this first meeting my paragon of beauty went abroad and married a handsome foreigner. ... It was ten years before I met her again. ... She was still very beautiful. ... Soon after she returned to Europe where she married her third husband, who was neither as rich as her first nor as handsome as her second. ... As time went by I lost track of her. Somewhere along the grapevine I heard that, disillusioned with love and life, she had become a recluse. And then a few years ago in Paris, on a chance walk in the gardens of the Tuileries, I encountered her. She was sitting alone on a bench. ... I recognized her at once despite what the years had done to her. ... A ruin, yes, but a lovely ruin, like the Acropolis by moonlight. We talked for a bit, and I invited her to a dinner I was giving. She shivered and shook her head. 'I never go anywhere anymore', she said. 'I can't bear to show this battered old face in public. I can't even bear to look at it anymore in my own mirror'.


A third-world conception: from *Nisa -- The life and Words of a Kung Woman.*

Me, I'm an older woman. But I still have strength. I still have interest in sex.

There are many men who still want me and don't refuse me because I am old. They come to where I sit and talk to me about it. But I refuse them. I tell them that I am old and don't want lovers. They ask, 'Why? What's wrong? Other older women have lovers.'

Another day I'll be interested again. Another day I'll think about men. Then I'll put on some powder and string some beads to wear. I'll wear the beads and powder and I'll be beautiful again.

It is the intersection of many important cultural themes that impels me to interact with and write about the women who elect to undergo facelifts. Few would deny the primacy of the face in a culture that overvalues the seen and seems unaware of the unseen. For it is to the face of another that we speak and react: It is to the face that we look, primarily, for the "connection" that we seek with another. I believe that a cultural dictum exists in mainstream American society that requires us to look at and read the face of another perhaps more closely than we listen to and interpret the words spoken. I have written earlier of the plethora of American figures of speech utilizing the imagery of the face. I have also alluded to the fact that Americans seem naively to believe that one can judge another simply by evaluating his or her facial features. All of these factors, it would seem, testify to the importance of the face in American culture. Additionally, one cannot invent many legitimate cultural excuses for hiding the face in America: We wear no veils, and sunglasses are usually reserved for outside wear, (except perhaps for Stevie Wonder and Ray Charles). What is left for the rest of us is rather constant presentation of self "at face value": and we seem to agree that "what you see is what you get". I have already discussed the importance of attractiveness in American culture, and this all-important personal billboard, the face, must therefore be attractive. When the problem of aging is factored in, the situation becomes yet more complex. Many authors have suggested that aging seems to be associated with fear and dread in contemporary American culture, but most especially for women. A woman in today's society is easily rendered insecure about appearance as she is induced to compare herself at every turn with female physical
perfection as it appears in multitudinous advertisements and commercials. If her appearance has been singularly important to her self-concept, then she stands in peril of increased insecurity about her looks as she grows older. For these reasons, in order to understand how society has shaped the experience of many women such that cosmetic surgery to subvert facial changes associated with aging seems the only comfortable course, I have chosen to talk with three women who have had facelifts, and to consider their reality in the form in which they wish to share it.

**Rhytidoplasty or Facelift**

Before beginning this exploration into the experience of facial cosmetic surgery from the patient's perspective, however, I would like to explain, in a rather simplified manner, since this is not a technical paper on operative procedures, how a facelift or rhytidoplasty is accomplished, and also how an eyelift or blepharoplasty is done. These explanations will be excerpted from Morgan's (1988) book, with commentary by me.

For the facelift procedure the patient is usually sedated using intravenous medication and locally anesthetized with injections to the operative sites. When the facial skin is numb, the surgeon makes an incision beginning above the ear, in the temporal hairline, extending down in front of the ear, curving behind the ear, and finally curving up to an end point at the hairline. Next the facial skin will be freed from the underlying tissues and the doctor will remove fat deposits from beneath the skin in the neck using liposuction or scalpel. Following this the deep tissue layers in the face and the platysma muscle in the neck will be "undermined" or undercut so that the tissue and muscle can be pulled up and back and stitched in place above and behind the ears. After the
deeper tissues have been stitched in place, the surgeon will pull the outer layer of skin up and back, trim off the excess, and stitch the edges in place above and behind the ear. Sometimes, if there is a collection of fat or excess skin ("turkey-wattle" as it is sometimes termed) at the front of the neck, the surgeon will make an incision under the chin and cut or suction out fat and shorten the neck muscle. During the procedure, the surgeon will use an electrical cautery to seal off small blood vessels, as the face and scalp are very vascular areas. Surgical drains may be inserted into the incisions at the sides of the face, in order to prevent a hematoma, or accumulation of blood, and a pressure dressing will be placed around the face and neck when the procedure is finished. Facelift procedures take between three and five hours, depending on bleeding and what is done. The patient will be markedly edematous or swollen for one week and moderately swollen for another two weeks. She will note facial and neck tightness for as long as six weeks. The facial, neck and chest bruising may last up to twenty-one days postoperatively. The trauma of surgery may cause hair thinning at the temples that can be noticeable. It may take six months for the hair to grow back in. The patient will have sutures or stitches in front of the ears and under the chin, and stitches, staples or both, in the incisions behind the ears. The front sutures are removed about five days post-operatively, while the sutures or staples behind the ears must remain until seven to fourteen days after the operation. The scar in front of the ear is usually located in a natural crease and may not be readily apparent. The scar behind the ear is often the one that presents problems. It may be red and rather lumpy for months, and if the patient is slow to heal the scar may widen to 1/2 inch.
Side effects and complications are many and varied after a facelift. Firm, lumpy scars may persist behind the ear or in the back hairline for three to twelve months, or longer. The face and neck will be numb for about six weeks, but sometimes numb patches may remain on or close to the ear for a year. Occasionally, feeling will not return to a numb area. As mentioned earlier, hair in the temple area may thin markedly, and may not return in full thickness for a year. Facial skin may be dry and feel firm or tough to the patient for six months. Ridges or cords of swelling in the neck and lower face may persist for six months. The sideburn area of hair in front of the ears will be narrower after surgery and closer to the ear. The scar under the chin may indent slightly, creating a depression that may be visible on profile, and might need surgical correction. If the upper face is pulled tight, the eyes may have an almond shape for up to a year, until all swelling is gone. Even well-healed scars may often be visible as a thin white or pink line in people with ruddy, sallow, or tanned skin. And, as mentioned earlier, the scars behind the ears may widen or move lower, becoming visible from certain angles or with some hairstyles.

Dr. Elizabeth Morgan, the plastic surgeon who has written a new book on cosmetic procedures (1988) says: "These side effects are the reason that facelift recovery takes emotional stamina. Most people nevertheless find that these annoying side effects are a small price to pay for the results" (p. 178).

They are a "small price to pay" if they go away. The complications that can follow facelift, however, can be more severe or prolonged than the side effects, or can be permanent. For example, as Dr. Morgan herself discusses, if the nerve that controls movement of the lower lip is bruised
or badly injured, the lower lip on that side will not move with the other side when the person smiles. She states: "The nerve virtually always recovers, but it can take two years for lip motion to return". Two years: by then approaching the time (3-5 years) when another facelift is "necessary". Perhaps normal lip movement one year out of three is adequate -- a "small price to pay" -- if you will. Please note, however, that Dr. Morgan states the nerve "virtually always" recovers. There are patients for whom lower lip movement has not returned. Dr. Morgan mentions that the surgeon is also concerned about "major bleeding and poor healing" (p. 178) and states that both could require additional operative procedures: to drain the blood and stop bleeding or to repair a section of skin if a large area (an inch or more) would not heal. She says that the nerve injury might require reoperation if the muscles of the face did not move properly and seemed not to be recovering. In talking about these complications Dr. Morgan says:

All of these occur rarely, unpredictable, and unavoidably. Although it seems evident that bleeding or poor healing might be uncontrollable, most people think that nerve damage would obviously be the surgeon's fault -- but not necessarily so. ... These serious major complications are intimidating if you are considering surgery, but that is true if you look into the rare, potential problems of doing anything at all (1988, p. 178-179).

Yes, Dr. Morgan, people choke regularly while eating steak and are hit by cars while crossing streets, but we must eat and move about. We do not require facelifts in order to survive. I know that many people could be found to debate my last statement, and I feel and understand our need in this culture to remain youthful, but I will suggest a considered resistance to the cultural standard that demands major surgery with these potential outcomes.
To introject another voice, here are the comments of Dr. Michael Sachs, the Director of the Division of Facial Plastic and Reconstructive Surgery at New York Eye and Ear Infirmary and New York Medical College Affiliated Hospitals:

About one out of 100 facelifts ends in partial or total paralysis around the eyes, mid-face or lower lip, depending on whether certain key nerves that control facial expression -- frowning, blinking and smiling -- are irritated, scarred, bruised or cut. Because the coronal lift (this is the forehead lift) cuts even closer to the facial nerves, it increases this risk. Fortunately, about 80 percent of these cases are only temporary, healing spontaneously in three to six months ("Second Thoughts", 1985, p. 118).

Until recently, according to Dr. Sachs, surgeons were able only partially to restore movement to paralyzed facial muscles. Patients couldn't chew or smile without blinking simultaneously and their facial expressions were unnatural. Now Dr. Sachs has devised a nerve-connecting procedure that restores independent movement and "near normal" animation to the upper and lower face. Perhaps, therefore, if a person's face is partly paralyzed after a facelift, it will come back, and if it doesn't, perhaps it can be corrected -- almost. Dr. Sachs mentions another hazard of facelift: the removal of too much skin, which leads to flaring nostrils and a tight look around the mouth and nose. Sometimes, when this occurs, the skin peels away around the incision at the ear due to a lack of blood supply. Dr. Steven Genender, a Los Angeles plastic and reconstructive surgeon, explains that the skin can begin to blister behind the ear, where it is farthest from the blood vessels. It eventually scabs and then sloughs off, leaving the patient with an open area that may gradually scar over, or which will require a skin graft.

An upper and lower eyelid lift, termed an upper lid blepharoplasty
and lower lid blepharoplasty, may be done together, or singly. I will paraphrase Dr. Morgan’s book (1988) again in order to explain these operations. Both lid procedures are now most often done on an outpatient basis in a doctor’s office operating room or in an outpatient surgery center. The patient is sedated, and local anesthetic is used to numb the eye area. The surgical procedure on each lid generally takes from 1 to 1 1/2 hours, unless the patient has a greater bleeding tendency, in which case the procedures can be prolonged, as all bleeding around the eye must be stopped. To do the upper lid, the surgeon makes an incision in the area of the lid crease and removes the excess skin and any stretched muscle fibers. Next, the muscle will be lifted and some of the fat underneath -- not all of it or the eye may seem sunken afterwards -- will be resected or cut away. The patient may feel stinging or brief sharp pain as the fat is resected. The physician will check to see if all bleeding has been stopped, and then will sew the incision closed with small silk or nylon sutures. To do the lower lid, the incision is made just under the lashes and only a small amount of skin is removed. When the resected skin has been lifted off some of the excess fat which lies below the skin is cut away. Once the fat is removed, excess muscle and skin are cut away also. The incision is then closed, and the surgeon will begin the procedure(s) on the opposite eye, often giving the patient extra sedation first. When both eyes have been finished, cold packs are placed on the eyes to lessen bruising. The patient rests in the surgical center for at least one hour after surgery, or until alert, and then may be taken home. The patient will probably experience aching in the operated lids, beginning about one hour after surgery. The lids will be swollen and sore for five
to seven days. Bruising is variable, reported to last seven days or up to thirty days, depending on the patient (and also the skill of the physician, of course). The eyes will be sensitive to factors such as light and wind for fourteen to thirty days. Patients' eyes may tear excessively after the procedures for two weeks or so, or they may now produce too few tears and feel dry. Dr. Morgan assesses upper and lower lid blepharoplasties as rather easy surgeries to undergo since she feels most persons have a fast recovery and can see improvement right away. She lists a not-surprising number of side-effects and complications, however, for such "easy" surgeries. First, the skin of the lids will be numb for many weeks, often six or more. Also, the eyelid scars will feel stiff for at least six weeks. Swelling at the inner corner of the eye may take six weeks or longer to disappear. The patient's scars may be slightly asymmetrical: one may be slightly lower than the other. Dr. Sachs ("Second Thoughts", 1985) relates that if too much skin is removed from the lower lid, causing it to pull away from the eyeball, the eye will not close. This can cause serious eye problems if not corrected by a second surgery. One disturbing complication may be red, swollen, or visible scars that "usually" fade within three months. Morgan states that "bleeding, poor healing and infection are extraordinarily rare" (1988, p. 193). The eye may produce fewer tears, resulting in irritated and dry eyes after blepharoplasty. This effect may last days, months, or in "a few" cases "may make eye lubricants necessary, indefinitely" (p. 193). In other words, the patients' eyes will never produce tears normally again. In five to ten percent of cases, the scar does not lie completely flat and "minor" correction can be done in the doctor's office. In one percent of cases "poor healing" makes more
extensive surgery necessary (p. 173). Listen however, to the doctor's last quote:

There is a rare possibility after any eye surgery or treatment that bleeding will irritate your nerve of vision and cause permanent damage to your vision. Anything that could affect our vision sounds alarming. To put it in perspective: it is much more hazardous to cross a street or drive a car than to have eye surgery (1988, p. 193).

To put the above quote in another perspective, translate "damage to vision" to blindness. And, as previously discussed, there is a different level of need associated with crossing streets and driving than with having cosmetic eyelid surgery. Perhaps in this latter case, with the exception of those whose actual vision is hindered by overhanging tissues, any risk of blindness or visual damage is too great.

The Informants

Marie, Sybil, and Marlene are real women, not composites put together artfully to reflect reality as I see it. Their statements and their examples created delight and dismay, generated hope and disappointment, much as my own did, and do. Therefore I found no ready answers to the dilemma of beauty for women in America: in fact even the relevant questions are cast and recast, cycled and recycled, as I attempt to impose order on the conversational data between me and each of them. As I listen to my tapes, and read my transcripts I note both their contradictions and their affirmations of shared beliefs. Oftentimes they could have answered each other far better than I answer them: I wish I had tried less to do so. I will introduce them initially through the presentation of mini life-histories so the reader can better appreciate the complexity and meaning in the conversational data that will be used. After the life-histories have been presented, I will begin my common sense
analysis of the themes that occurred and recurred in my conversations with the women. I will excerpt and use exact quotes from our conversations and sometimes from other sources in order to illustrate the apparent meanings of the issues involved and perhaps, through reflection, those which are less apparent. I will not present transcriptions of the long interviews in their entirety in the interests of space, although these are available, as are the original tapes, for those who would be interested.

Marie

I was introduced to Marie through a mutual friend, and was told of her wealth and privileged life-style. I found myself preparing a bit more carefully for this than for my other interviews: choosing clothes that would be a notch above my often very casual attire. Marie's home is lovely: situated on 2 1/2 wooded acres in an area of prime real estate. Her private secretary opened the door and welcomed me into an elegant interior filled with antiques, oriental rugs and well-placed memorabilia. As I waited for Marie, I had coffee and looked out onto a landscaped terrace appointed with statues, columns, and a pool. Marie returned from her hair appointment thirty minutes later. She is a very pretty woman of sixty years: tall and slender, possessing a fine-boned elegance. She is wearing pink slacks and blouse, a light blue sweater and sneakers and no jewelry. Her make-up is unobtrusive and well-applied, finished off with blue eyeshadow. She has rather bright red hair, artfully coiffed, upswept on top. Marie has a patrician look, and would blend easily into the coterie of ladies that has surrounded Nancy Reagan. Marie is friendly but reserved and speaks in a quiet cultured voice.
Marie was raised in a mid-sized southeastern university town, where her father owned "the corner drugstore" and her mother, a university graduate, worked as a teacher and eventually a school principal to "help support the family". Marie's maternal grandfather had owned a tobacco warehouse, but "lost everything in the depression". She was born in 1927, the last of four children and describes her childhood as very happy. After graduation from high school, she attended a well-known university in the southeast and then moved to the east to work at a large retail store, where she met her first husband. She and her husband lived in the east for twenty-five years and had four sons, who are presently 36, 34, 32, and 30 years old. Marie told me few details of her married life with her first husband: She did mention that he was very successful. At some point after being married to her first husband for 25 years, Marie "fell in love with the guy next door". This man also had a wife and children, but both he and Marie left their marriages to be together. She offered few details and said, "You don't want to hear about that". Marie and her second husband, who was the C.E.O. of one large corporation and then a second, moved to a large southwestern city and quickly fit into the upper-level social scene. Marie lived with her second husband for 15 hears before he died, at 70, in 1985. She had contemplated a facelift for several years before she actually had it, but her second husband "didn't approve, he thought people ought to grow old gracefully". A few months after her husband died of a heart attack, Marie had a full facelift and had her eyes done. She did not have a brow lift, but did have liposuction done under her chin. She states she is glad she had her surgery, and feels the only persons who wouldn't be happy afterwards would be those who "had a big
problem afterward". Marie has a very full social life. She goes out with
several men, all of whom are older than she, stating that "sex doesn't
mean that much anymore". She has a group of older single people she
goes out with a lot as well. The day I talked to Marie she was going that
evening to a black-tie benefit "for education". "They needed a body", she
said. She's invited to a lot of similar functions and says: "I always go
when I'm invited and I meet someone interesting to talk to. I always have
a wonderful time. Life doesn't owe me anything. I've had it all. I've
had a very full life."

Sybil

Sybil is a very good-looking woman of 50. She is rather tall and
slender, with proportions that would be considered a good figure. She has
shoulder-length, artificially colored red hair worn in a sophisticated
tousled style. She wears light facial makeup, which is also carefully done.
She is dressed in form-fitting jeans, sneakers, and a shirt which is tied in
a knot in front: allowing 2 to 3 inches of a trim midriff to show. Sybil
prepared me in advance for her rather marked interest in physical
appearance. When I phoned her to set up our meeting, one day was not
convenient for her as she needed to get a haircut and had broken a nail
and needed to get it fixed. Sybil has a very expensive manicure, popular
now among well-turned-out women whose hands are used for limited
activities: false, but genuine-looking nails are bonded to the person's own
nails and then grow out with the real nail. She said: "What would you
expect from someone who has a facelift?" Three months before our
conversation, Sybil had a facelift, a brow lift, and liposuction under her
chin. She was very willing to discuss her operations, her motivations, and
her feelings. When I arrived, she invited me into her apartment which was attractive and cluttered, filled with rather good furniture and expensive objects. She was friendly, unassuming, and open. She liked to joke and laugh: I liked her, I was comfortable. We agreed to walk down to a local restaurant and have lunch while we talked. Before we began taping, on our walk to the restaurant, Sybil told me about her earlier life. She was raised in the Jewish faith by parents who were "ardent Zionists" and who contributed money to Israel. Her grandparents had been European immigrants to the United States. Sybil's maternal uncle later moved to Israel. Her parents were the editors of a weekly Jewish newspaper in the mid-sized southern city where she was raised. Her 76-year-old father continues to edit the paper. She describes her mother as "very beautiful, gorgeous" and relates a quote she remembers hearing often as she grew up: "Oh, your mother is so beautiful: You don't look anything like her." She adds that her mother was also extremely articulate and intelligent. Sybil was raised in a conservative Jewish milieu, but married a man who was Orthodox. She said that her own parents "had a chip on their shoulder about the holocaust", but that this event had colored and "ruined" her husband's entire life. She said the event was all that was talked about, especially at the synagogue "they want you to remember". Her husband was very intelligent, a C.P.A. who "couldn't handle success: the more success he got, the more depressed he got". He didn't know how to "enjoy life", either, and Sybil became depressed herself. When her husband became "withdrawn" she sought therapy in her 20s. One of her psychiatrists was "great ... he made me accept myself like I was and like myself". She states he also made her
start to realize that she had "outgrown" her husband. Sybil worked as a model in her 20s, and stated that "all she thought about" was her appearance and the latest outfit. She describes herself as "very superficial". During this period she also had two children: a son who is 25 and works for a professional sports team in this city, and a daughter, 27, who works as a dental hygienist in the southern city where Sybil was raised and spent her married life. When Sybil was 37, and realized that she was going to seek a divorce, she pursued and finished a college degree in psychology and management. She was divorced, and eight years later moved to a very large, southwestern city. She is currently working as the benefits manager for a bank. She states that she has had "many new lives", and that now, at 50, she has "fewer problems than I've ever had anytime in my life". She belongs to several organizations: a scrabble club, a business volunteers for the arts group, and is on the advisory board of the Cancer Society. She has a boyfriend, Richard, who is 52, in what sounds like precarious health, and who doesn't want to participate in all the varied activities that Sybil enjoys. Consequently she goes out to dinner by herself sometimes, and has travelled alone to Jamaica and England. Sybil is very outgoing and animated. I was sure, and told her this, that she met and interacted with people easily. She agreed, and offered anecdotes about such experiences. Sybil seemed an upbeat person who was determined to enjoy life.

Marlene

A professional colleague of mine suggested that I interview Marlene, a nurse who has had several cosmetic surgical procedures. When I called her to arrange our session, she was quite friendly and we talked for
several minutes. During the course of our phone conversation Marlene gave me some preliminary information about herself and her family. Two observations that she made seem especially significant when taken in the context of the topic we were discussing. Marlene told me that she felt the first five minutes of most face-to-face conversations are useless, because one is visually evaluating the other person, noting such factors as their mismatched outfit, tacky hairstyle, or other personal details. She also mentioned that, in spite of her cosmetic work, that she supposed she didn't look "all that great" now, perhaps not any prettier or any uglier. I felt I was being put on notice that I would be visually scrutinized on our first meeting, and simultaneously cautioned not to expect Marlene to be very attractive, despite her plastic surgery.

I met Marlene at the hospital where she works as the coordinator of an out-patient surgery and diagnostic unit. It was late afternoon and most of the patients had been discharged, allowing Marlene some free time to talk to me. She was waiting at the nurses' station that faces the elevator as I emerged with my notes and tape recorder. She smiled broadly and introduced herself and some nurses at the desk. She made us coffee and we sat in a small conference room to talk.

Marlene is, as she describes herself, "a tall girl", who appears to be of average weight. She is wearing a maroon surgical scrub top and pants, with a white lab coat over them. She has a friendly, open face, her features and expression combining to produce what might be termed a pleasant visage: perhaps not quite pretty. If I had not already known Marlene's age, which is 44, it would have been difficult to guess; I feel she appears to be in the early to mid-40s range. She has medium-length,
dark-brown hair, worn in a casual but styled coif. Her makeup is minimal: very light blush, pale eyeshadow, and lipstick. As we began our conversation, Marlene told me of her family and life. She was born into an "ethnic German" family. Her parents were immigrants and spoke German, and they lived in a large northeastern city in the United States. Marlene has one sister, ten years older than she, to whom she was never close. She had what she termed a "very good relationship" with her father, who has died. She did not describe her relationship with her mother as we began, but over two hours later, when I was no longer taping, she stated that she had never done anything well enough to please her mother, and described many negative comments her mother had made and continues to make. Now, she said, she lets her mother's comments "roll off". Marlene went to a diploma school of nursing, graduated, married young, and had three children in quick succession. Her twin daughters are now twenty and her younger girl is sixteen. Marlene worked part-time as a nurse during her marriage, so that she wouldn't have to put her children in day-care every day. She divorced her husband when her children were eight and twelve and went back to work full-time. Her priorities have been raising her children and developing her nursing career. She described herself as "Mom: a mothering female -- who consequently chose nursing". Her mother who is now 78 years old and blind, lives in a nursing home during the week, and with Marlene and the girls on the weekend. Marlene has not remarried, but has dated off and on. Currently she is dating a man who is eight years younger. She has worked in and around surgical recovery rooms and in out-patient surgical areas for years, and has gotten to know several cosmetic surgeons, some
of whom she has worked with quite closely. In 1975 she underwent a nasal airway reconstruction (for breathing problems) and a cosmetic rhinoplasty (a "nose job"). She paid for this work as a private patient. In 1978 she had a bilateral breast augmentation, done by a plastic surgeon she knew well. She paid him for the procedure ($2,000) but states he gave her the implants. In 1985 she had a browlift and an upper facelift, a lower blepharoplasty, and a "tuck" in the platysma neck muscle. These procedures were done, at no charge, by a cosmetic surgeon (his specialty is E.N.T., ear, nose and throat) with whom Marlene had worked for eighteen months. She has been happy, overall, with the outcome of all of her cosmetic procedures, but does not think she will ever have any other such operations. She described herself at this point as: "totally happy with myself and my life".

**Analysis and Interpretations**

**Three Decades Represented**

Marlene, Sybil, and Marie represent three distinct decades within the life-cycle of American women: the 40s, 50s, and 60s. They also represent variation in ethnicity, religion, personal philosophy, educational level, and socioeconomic status with its attendant life-style. Marlene had her facial surgery at 41, at what used to be an "early" facelift age. This is no longer the case, however, as more and more women in their thirties are seeking this surgery. Some surgeons suggest that the younger the face at first lift, the more successful that procedure and later ones will be. Here it is folks, prophylactic cosmetic surgery: None of us need ever age! The following quote is from Dr. Gary Fenno, who describes cosmetic surgeons in this article as "real people taking care of real people" ("A Guide", 1988,
p. 32). Dr. Fenno intones: "Facial rejuvenation surgery is very rewarding if presented realistically. ... There's no certain age. We see a number of people in their 30s" (p. 33). Of course he "sees" them -- the problem is, he operates on them as well! Listen to Dr. Larry Wolf, another cosmetic surgeon. "People today want to fix it before its broken -- they believe in routine maintenance every 50,000 miles" ("The Face", 1988, p. 36). Dr. Wolf adds: "You'll probably get better results if you have a facelift early" (p. 38). Sandra Stallings, the wife of Dr. James Stallings, a cosmetic surgeon, describes to Oprah Winfrey why she had her facelift.

Winfrey: And so you had a facelift at 35. Were you sagging?

Mrs. Stallings: No, I wasn't sagging, but I didn't want to all of a sudden wake up and sag. My mother had a facelift when she was 60 years old. She waited that long to do it and when she -- she got a beautiful, magnificent result, but it was so obvious. I don't want to ever be obvious, and I still don't. And I intend to continue to do this as often as I think I need it. I want people to just think I'm like Bob said, that I always look relaxed and look like I've just come off of a nice vacation. I wanted to stop the aging process before it really started ("Plastic Surgery", 1988, p. 6).

One can see where this is leading -- but where will it stop? Even now, it seems that if one surgeon rejects a patient for reasons of youth or lack of a recognizable defect, another one will gladly operate on the patient. As I have previously related, Dr. B., to whom I spoke, described doing a facelift on a 38-year-old woman who didn't really need it yet, but who was going to have it done no matter what he said (and by another surgeon if he didn't do it). If this is a general trend, then there is no point in posturing about pre-surgical consultations and acceptance of patients. Virtually anyone can request any surgery and get it done.
Psychiatrists have been interested in, and have studied, the personalities and reactions of facelift patients. A study done by Webb and others at Johns Hopkins in the early 60s (Goin and Goin, 1981) noted that younger patients (those under 40) had had or were having greater personal adjustment difficulties — whatever this means — and reported greater family disruption during childhood than did the older patients. Webb reported that the patients in the 29- to 39-year-old age-group were quite insecure, and if married, were very dependent on their husbands. They are described as relating to their children on a childish level and relating to their own parents with a mixture of hostility and dependence. Webb and his associates term the age-group from 40 to 50 as the worker group, because of their deep commitment to their work and to those with whom they worked. This group reportedly showed the greatest anxiety about aging. Sybil had her facelift at 50 and Marie at about 58. Both of them would fall, chronologically into Webb's grief group, which is defined as a group of over-50 persons of which 90% had lost an important person within five years of the facelift. Marie, of course, is a relatively recent widow, but Sybil is not: She would fit, if we used these categories, far more easily into the worker group with Marlene. According to Webb, in contrast to the younger, dependent, patients, the older persons were quite independent, viewing the acceptance of help from others as weakness. The average facelift patient in this sample was a 48-year-old married Caucasian Protestant woman belonging to the upper-middle-class. She was described as socially poised, as having high aspirations and yet as having "superficial" interpersonal relationships. Fifty-seven percent of these women were employed. Marlene has stated that, in her experience, there
seems to be no "typical" facelift patient in 1989, and that a large number seem to be divorced (or perhaps widowed) women who are re-entering the job market and the singles' scene. None of the women to whom I spoke fit the older profile. It should be noted that 70% of the 72 patients in Webb's study were assigned psychiatric diagnoses, although the diagnoses tended to be less serious in nature, such as: depression, unstable personality and passive dependent personality. In contrast to this study, studies of facelift patients done by Goin and Goin in 1976 and 1980 (Goin and Goin, 1981, p. 149) demonstrated to these psychiatrists that their patients "as a group were reasonably normal". About half were described as having high personal expectations, being perfectionistic, and as having difficulty admitting mistakes. They relate two predominant personality patterns. One group was composed of energetic, assertive, and aggressive persons, who tended to show poor judgement in sexual and social situations. The other group appeared to be extroverted, but maintained "a certain superficiality in their personal relationships" (p. 150). The average patient in this study of fifty patients was 56, and 90% were employed or retired. Seventy-five percent financed the operation themselves. Fifty-four percent were married, 24% divorced and 18% widowed. Goin and Goin report the following, in their assessment of patient motivation: "Beneath the facile and easily accepted motivation so readily volunteered by patients are deeply subterranean motivations, often magical in nature, which are never revealed to the surgeon" (p. 51).

Twelve of the twenty patients who were interviewed extensively pre and postoperatively revealed different answers for having wanted the operation postoperatively than they had given beforehand. Goin and Goin
feel that some of the motivations were purposely hidden, but that more frequently the patients only became aware of their "real" motives when their hopes failed to be realized. One group who preoperatively expressed pragmatic desires to look less tired, or get rid of sagging skin, actually either hoped for a greater involvement with younger people or for the actual feeling (rather than the look) of being younger. Another hidden motivation was that the operation would reawaken their husband's interests and improve their marriages. Two women hoped to get better jobs: either via improved appearance itself, or resulting from the increase in self-confidence. The authors state, however, that even those who were disappointed that the operation failed to produce the magical changes were no less happy with the outcome of the surgery. Sixty percent of their patients described their results, on a questionnaire, as "excellent", 38% checked "good", and 2% placed a minus sign after good rather than checking "fair" or "other". It should be noted that these patients made their assessments within the first six months postoperatively: a time period when "minor" complications may still be present, but also a time when, as Marie discussed, the postoperative edema plumps out and often obscures the fine wrinkling in a patient's face and neck. In the earlier Webb study, 85% of the patients reported an "improved sense of well-being", while in the Goin and Goin study about 50% were judged by psychiatrists to have shown "definite psychological improvement" (p. 156). In this later study, also, 54% were reported to have given evidence of psychological disturbance at some time during the postoperative period, either of a transient or continuing nature. Goin and Goin make the following summary statement on the nature of facelift patients' difficulties:
The key to understanding facelift patients is the recognition that they are, for the most part, in those middle years which are so fraught with crises. Situational stresses are common, and inexorable bodily changes threaten the self-concept. Along with these stresses comes a change in the patient's perception of time. The future is no longer limitless, and the 'deserts of vast eternity' are in view (p. 161).

These doctors further characterize facelift patients in general as being rigid in attitude and unable to easily accept help. Their self-esteem tends to be low, and they are lonely people with high expectations of themselves. They state that it is "essential" to understand that many facelift patients are overtly or covertly depressed at the time the operation is requested. I offer this data as a partial -- and tenuous-- explanation of some of the possible factors and motivations that might have been relevant in the cases of the three women with whom I spoke. I cannot speak to her psychiatric profile, but the most recent loss was for Marie, who certainly might still be feeling grief: exacerbated by the recent death of her brother. Marlene and Sybil, both divorced and in the work force, stress different factors in their motivation. Marlene says that she needs to look young in her job, and she also has a boyfriend who is eight years younger. Sybil states that she did it for herself, that she is not competing with younger persons, and that after thirty, age is more or less relative. Many persons in the work force, however, would agree with Marlene that looking young -- or at least not looking old -- is important for them. Since women in our society may have more difficulty in finding work and since staying "young-looking" is deemed part of "woman's work", it is logical that women, especially, will seek cosmetic surgery as "job insurance". I could cite many, many examples from the media to support this belief. One is taken from yet another recent newspaper editorial on
plastic surgery (Myler, 1989) in which cosmetic surgeons are interviewed.

The following statement is Dr. Russell Kridel's.

People want plastic surgery to project a better image. This may help them. It doesn't take the place of a skill or knowledge. But if somebody has bags under their eyes and looks tired all the time, he may be passed over for a guy who looks younger and more energetic, though he may be the same age (p. 4D).

Dr. Kridel's quote is interesting for several reasons. First, he assumes a moderate position and states that image doesn't substitute for skill or knowledge. I believe, however, that many persons feel an improved appearance will "flesh out" a marginal skill level and make them competitive with very competent persons of less personal beauty. Second, and more damaging, is Kridel's assertion that a person can be passed over even by a person of the same age. Now we are in competition not only with the younger generation, but with our age-mates as well. Anyone becomes a potential rival: based not on knowledge, but on physical appearance alone. It is not possible for me to evaluate these women using the many parameters outlined by the psychiatrists -- perhaps only the women themselves can do so. Other factors, such as their feelings about their appearance and about aging, will be further elucidated through examining the dialogue of the women. These ladies certainly seemed to me, "reasonably normal" in the doctor's parlance; I hope that I seemed so to them!

Another informed source, Rita Freedman, Ph.D., a psychologist who has written a book (1986) on the quest for beauty, makes the following statement: "Would a mentally healthy person endure that much pain, invest that much money, suffer that much trauma for a temporary reprieve from a few wrinkles? She probably would" (p. 214).
Freedman believes that facelift patients are viewed less critically today because cosmetic surgery is now regarded as a "valid psychotherapeutic tool", accepted as an "augmentation rather than a mutilation", and seen as a chance to "take authorship of one's own appearance". She elaborates further on this theme (p. 214).

The facelift is being sought by many psychologically healthy females who take an active problem-solving approach to life: by career women who decide they need it for personal survival; and by single women who feel they need it for social survival.

Women who seek a surgical solution to the double standard of aging may be making a healthier response than those who withdraw into a depressive state.

Freedman identifies the enormous pressure on women to preserve their youthful faces, and explains that a woman's decision to have cosmetic surgery must be viewed in the cultural context in which an unfair standard is applied only to women. It is undeniable that the pressure is there and that unfair standards exist. We must realize, however, that these are temporizing solutions -- and very expensive and risky ones in terms of cash assets and potential complications. Marie speaks to this "active, problem-solving approach" when she states: "There's something about American people who just want to do things better, and improve all the time, which I think is OK. I think that's good."

Marie identifies our American Protestant work ethic: here pressed into service to promote the pursuit of beauty as woman's special vocation. All of the beliefs about hard work and diligence can be applied to the quest for youth and attractiveness. Zsa Zsa Gabor is quoted as saying, "There are no ugly women, just lazy ones" (Freedman, 1986, p. 64) and the achievement of women in this area is not a threat to men, which makes it
acceptable. We can profligately expend energy and resources to better our appearance and our only points of conflict will be with other women: who should be our allies in the denial of the double standard. It sounds so seductive to us, though; Marie is right! Shouldn’t we make ourselves as attractive (and young) as we can, through any available means? And doesn’t this fit in nicely with the American idea, previously mentioned, that beauty can be purchased: an equal opportunity commodity? This is a democracy: nothing is rationed, no standing in lines for beauty. Of course the availability is mediated, in the case of cosmetic surgery, by personal resources. (In this way we have just about the only parallel that cosmetic surgery has to other forms of health care in the United States.) Fee-for-service cosmetic surgery is very expensive, this in spite of new "package deals" and out-patient surgery. Marie, who didn’t need to give it a thought before writing out a check for $10,000 says: "It's too much: It's a lot, it is a lot. And it's too bad: Let's put that way, because there are a lot of people who really need it, you know, who can't afford to have it done."

Sybil states that the payment on the $8,000 loan she took out is more than her townhouse payment, and mentions fleetingly that she hopes it was worth it. Marlene had her operation done, at no charge, by a doctor she knew. Third party payment (insurance) will not pay for cosmetic procedures, as previously mentioned, unless the patient has an associated functional problem: examples might be breathing problems due to a deviated nasal septum or vision problems associated with overhanging eyelid tissue. Unfortunately, the practice of attempting to dupe the insurance adjuster is widespread, contributing to the soaring rates for
personal health coverage. I have mentioned my experience in having the plastic surgeon's receptionist suggest it to me. Sybil also had such an experience, which she relates in her dialogue, and she is quite angry at the suggestion since she works in benefits management. She states that this idea "burned [her] up", that she would "never do that". She emphasizes that the plastic surgeon knew that she, in fact, had no visual problem, but suggested it anyway. If many cosmetic surgeons' dreams come true, perhaps insurance companies will reconsider paying for cosmetic procedures: then we will all subsidize those who seek the surgical solution to "imperfection" and aging.

Representations of Physical Appearance

Although Sybil, Marlene and Marie had varied backgrounds, represented three different age decades, and had different current lives, they were all similarly and remarkably attuned to the nuances of their own -- and presumably others' -- physical appearance and changes associated with aging. Only Sybil seemed to have been presented with a blueprint for beauty within her own home, describing a mother who was "gorgeous": and who later had a facelift. Marlene's mother was an uncomplicated -- if critical -- ethnic German woman who used Pond's cold cream and has few wrinkles today at 78. Marie "worried" about the wrinkles in her mother's face, thinking they impaired her look of prettiness and health, and describes her own skin as like her mother's. Other obvious factors that may have conditioned these persons to be sensitive to small physical details could be modeling in Sybil's case, working in the area where cosmetic surgery was done in Marlene's case, and being in the company of very wealthy peers who were having their faces lifted in Marie's case.
Sybil speaks of scrutinizing herself many times a day using a mirror she kept in her desk. Freedman (1986) describes women who are "focused on the smallest details of appearance", who "constantly turn to their mirrors for a fix of self-reflection" as "image addicts or mirror junkies" (p. 31). These women are pictured as looking into rearview mirrors at red lights and using compact mirrors at restaurants. Judging from experience as a woman and observation of other women, this "condition" is widespread indeed: Perhaps an epidemiologist would term it an epidemic. Sybil is merely more honest than some: revealing her own need to check and see if she looks acceptable, or pleasing, or whatever it is that we are checking for. Freedman identifies the corollary that if we examine ourselves mercilessly, we must also turn the microscope on others— noting their every flaw and asset -- comparing ourselves to them. I remember how surprised I was when Marlene admitted spending the first few minutes with a new woman studying her physical appearance. I know who uncomfortable I was with this honesty: even though I admit to finding the faces of others fascinating myself. How closely do women examine each other? Freedman quotes Alta as follows:

And here we are again folks, a table of women, seven of us, and the first thing I do to assess my coworkers ... is look around at all of you to see who is prettier than I. ... my lover used to say how I was prettier than the other women in my women's liberation group and I would feel better while feeling worse ... it drives me crazy and actually prevents me from enjoying social situations ... I got so that I could count on being the second prettiest woman in any given situation! ... I would always be able to find one woman who was prettier and usually not more than one ... even on buses, even in classes, doctors' offices, restaurants (1986, p. 32).

Is this representative -- or even fair? Freedman quotes one of her
patients, a beautiful 42-year-old woman obsessed with her looks.

I feel so sick -- crippled by those horrible thoughts. I just dread one customer who comes to the office. If she stands near me, even for a minute, I begin to sweat and tremble. I can't even think about her without feeling awful. It can happen anywhere. Some women will come along who I know is better looking and she kind of erases me, cancels me out. Next to her, no one even sees me. If I'm not the best, I'm just nothing. These thoughts have been tormenting me for years, but now it's getting even worse because I see myself shriveling up with age, just like my mother. Every morning when I put on my makeup, I see her face staring up at me. I find a new wrinkle and wonder how many more years I have. It's ridiculous, wanting to be the prettiest one forever, although I used to be, really I was a 10, now ... maybe just a 5 (pp. 32-33).

This woman, who Dr. Freedman describes as "stunning" recently had her eyelids done and her face peeled. She says the following: "I'll go back for more as often as I can. It's the one thing that keeps me sane, knowing that surgery can preserve whatever good looks are left" (p. 33).

Where do we go from here? Perhaps back to a consideration of the elements of beauty as described by my informants. Perhaps they can further detail the blueprint for female attractiveness that is superimposed on all of us -- without our knowledge. Marie describes such factors as "nice face structure", "beautiful skin", "pretty hair" and "nice shape" as components of beauty. Sybil lists "beautiful skin", "good grooming and cleanliness", "big eyes", "straight nose" and "pretty white teeth" as "features you're supposed to have". Neither of them, however, initiated their discussion of beauty in a woman with these pragmatic points. Marie began by saying, "Well, first of all, it [beauty] has to be coming from inside". She met Gold Meier while in Israel and describes "something coming from her that just made her the most attractive -- beautiful person". Sybil states unequivocally, "It's an old cliché, but it [beauty] comes from within". She describes her meditation instructor, who "has a
big nose, and not really pretty features" as "gorgeous" and "radiant". She has, however, duly noted the big nose in spite of -- or in the middle of? --the radiance. She further elaborates that "Beauty is in the eye of the beholder". Marlene asserts that "Each person develops a different kind of beauty as they go from one phase of their life to another".

An audience member on the Oprah Winfrey show ("Plastic Surgery", 1988, p. 14) relates that she almost died after having a chemical peel of her face. She woke up two weeks later, she states, on life support systems in Intensive Care. She had a $50,000 hospital bill, and two months later is still not completely well. Here is her interchange with Oprah.

Audience Member: We seem to be into fast food restaurants and fast bodies. The imagery is great, I suppose, if you're into all that. But my point is what we are going to do -- you know, I'm finding after my experience that beauty has got to be within. I have a terrific mother -- who rides bikes and is involved and she's beautiful. Oprah and I are not size 4's and we're beautiful, right?

Oprah: Yeah, we are.

Audience Member: Come on, now.

Oprah: You know, really, I agree with you, I certainly do.

Audience Member: I mean, you're beautiful and it has to be within.

Dr. Stallings (cosmetic surgeon): I agree.

Oprah: This comes from a woman, though, who was getting a cosmetic peel, though.
Audience Member: That's right and I was really gung ho in the beginning and I think when I hit that wall almost called death, it made me really prioritize my life.

This woman embraces the clichés now that cosmetic surgery has helped her achieve a near-death experience. She may have almost convinced herself: Now she is probably not going to seek additional cosmetic surgery. Oprah, as many of us know, was not certain she was "beautiful" as evidenced by her subsequent 75 pound weight loss. Perhaps I should not be surprised at the use of clichés and "easy" answers that are evidenced here. We have an unreasoning love, in America, for pithy one-liners that seem to sum up a complex reality. The reality, and its complexity, however, are conveniently smoke-screened by our words. There are some sentiments that are so exquisitely "good to think" to us, that we find them good to say: again and again and again. We say them quietly to ourselves, where they pass for a prayer, and more loudly, to each other, where they masquerade as the truth. Could truth be the converse of our clichés in the case of beauty? Perhaps the reader will remember the earlier quoted words of my witty favorite aunt, who admonished me, in my work, not to be naive or corny enough to suggest that beauty comes from within. You were right, Aunt Mill. In America, physical beauty seems a country mile from that which emanates from within: and the eyes of the beholders are unkind indeed.

Since my subjects intone the predictable and the cliché in their definitions of beauty, it might be more profitable to look at the actual words they use to describe themselves and the changes that they note with aging. Marlene describes herself rather mercilessly, "never perceiving
[herself] as pretty", but as "overweight", "small-busted", having "large hips" and a "pear-shaped figure". She had a "very long, Grecian nose with a hump in it". She describes herself, at 41, as having "continuous furrows" in her brow and "little window shades" over her eyes which also exhibit "dark circles". She had "extra folds" under her eyes and a "tired look" all of the time. After the rhinoplasty she states her features were "softened". Currently, three years after her facial procedures, Marlene sees the "jowl line" returning already and describes how, when she leans forward, her "face falls forward". She states now, however, that she is "real comfortable with the way [she] looks", and she wishes that she could "keep this look ... for a long time". This however, is contradicted by her statement that she "doesn't mind" her "face changing anymore".

Sybil describes the "laugh lines" she had before her facelift, and that when she was tired, at the end of the day, these made her look "awful". When she was tired, she said, she had "creases down to there". She describes her face "sagging" and "all this stuff under my chin". She was "tired-looking" and there was an "overlap" at her cheeks: an area she further describes as "all that flab": which she states she noticed and no one else did. After listing these signs of aging which she describes as "awful", Sybil relates: "There's nothing wrong with being old as long as you don't look like an old bag". She further describes an "old bag" as: "all shrivelled up" and "shuffling around in big black shoes, with white hair in buns".

Marie, despite her refinement, merges with the mainstream in her descriptive terms for her own aging face. She had a "double-chin", her face was "loose", had "lost its elasticity" and was "saggy". She had "extra
folds" above her eyes, and "puffiness" or "little sacks" under them. She always "hated" her "scrawny neck" and still does. She had been happy with the rest of her face when she was younger, however. She feels that men age better than women do, and that maturity adds to male attractiveness but not to that of women.

It is striking that the imagery used by these three women to describe facial aging changes includes many terms for vessels, emptied of their contents, and therefore deflated. There are bags, sacks, and pouches, which sag, hang, wrinkle, fold, and wither. Are these images metaphors for the emptiness the women feel when evaluating their lives and in contemplating the future? Interestingly, Sybil mentions an "old bag": one of these aging "symptoms" which has been enlarged to personify an old woman. When she describes this term, she uses the term "shrivelled". Another prominent set of images are those associated with redundancy: double-chin, looseness, lost elasticity, overlaps. As women watch themselves age, and note signs such as these, are they reminded of the superfluous nature of the contributions they now make to life? Another common descriptor is "tired-looking" and indeed dark-circled, hooded eyes suggest fatigue and/or limited worldview. Are these women growing "tired" of a world where they must demonstrate a "young" outlook: where experience and accumulated wisdom count for little or nothing? The metaphors associated with facial aging are almost universally negative ones, with the possible exception of Sybil's "laugh lines": one light note in a morass of unhappy adjectives.

Of course these women, and others, don't manufacture their self-descriptions de novo, but reflect them back from the society in which they
must try to function. Dr. William Canada, a Houston plastic surgeon, makes the following statement about growing, and looking, older.

The furrowed brow, the wrinkled cheek, and the sagging jowl have no place in modern America, where the smooth firm flesh of youth has become a cultural totem. In this affluent society with its emphasis on youth, few grow old gracefully (pp. 93, 94).

Cosmetic surgeons, as I have noted previously in this paper, help to substantiate the need for their services by portraying the signs of aging and various human asymmetries in the most negative light possible and also by coining new terminology for such conditions. Dr. Canada's prose is liberally seasoned with such terms as "turkey wattle" (p. 101), "bird chin" (p. 103), and others, and posits a close connection between facial characteristics and mental abilities.

The extremely receding chin causes grave social problems. It may be a definite business drawback because of the general attitude that a receding chin means an ineffectual, timid personality. The condition is often called the "Andy Gump" chin. The receding chin in a woman not only spoils her looks but may cause severe inferiority feelings. The deformity gives the afflicted person a look of being dull-witted (p. 104).

Dr. Russell Kridel, an often-quoted Houston cosmetic surgeon elaborates on this theme (Myler, 1989). "There are aesthetic proportions of the face. ... People who look professional don't stick out. ... Part of plastic surgery is making people feel more comfortable in their group" (p. 4D). Myler (1989) also quotes Michael Kemper, the 40 year old director of Sakowitz Beauty Centers in Houston, who has himself had five plastic surgeries. "We're judged on sight. If you look tired, you don't look capable" (p. 4D). Or, as Dr. Canada relates in the final summary of his book:

Man lives surrounded by powerful stimuli, which when added to his daily problems, soon leave their marks on his face. And while he is attaining his life's goal, the struggle to do so has left the wrinkles of premature aging which can make his work difficult and even impair his emotional life. He soon realizes that the living of the fully productive
life in every field is incompatible with a prematurely wrinkled old face (p. 146).

Since Dr. Canada speaks and exhibits before and after photos only of female patients in his chapter on facelifts, we can be reasonably sure that his use of the word "man" and the pronoun "he" in the above quote is the paternalistic rhetorical. My point here is to demonstrate, with only a few of the many quotes possible, that women's descriptions of attitudes toward themselves are reinforced and worsened by the viewpoints of those with whom they interact in society and those to whom they go for a "cure" for the "diseases" of asymmetry and aging. These quotes point out that getting older is often regarded, in America, as a business and social impediment. Marlene admits that she wants her surgery to help her in her job, while Sybil does not, but many persons list business success as a reason for seeking facelifts and other cosmetic surgery. Marlene has, in addition, a boyfriend who is much younger than she, and is disturbed by the difference in their ages. Sybil protests that there is nothing wrong with being old as long as one can be "glamorous", but qualifies this position elsewhere when she states: "I don't want to age! I don't like it; I think it's very sad!" She talks about getting a very painful bursitis in her shoulder and that this physical difficulty was a "shock". "And I just can't stand having that! You know -- I'm not old! It's just amazing to me that that happens to you -- you get old". She states that she doesn't think the facelift made her look any younger, but that the operation "made [her] accept being fifty easier". Sybil was the most verbal about the topic of aging in general and utilized cultural clichés having to do with a person's only being as old as he or she appears and acts, and about being "young in spirit". She reflects, in these statements, our marked
cultural intolerance of aging and our wish to obscure this fact with band-aid statements. In reality, most of us say to ourselves, along with Sybil, "You know, I'm not old", staving off the inevitable with this mantra for yet a little longer.

**Shoppers for Beauty**

"You are a shopper. 95% of these patients now are shoppers. They're shopping for the right doctor that they get along with, the right price." Marlene made this statement about the doctor selection process, and both Marie and Sybil visited several doctors before choosing one to do the operations. Marie related that doctors vary in the amount that they tell patients and that her "main concern was getting the right doctor". In the end she chose a well-known, high-priced plastic surgeon who is on the faculty of a local medical school. She had heard of his meticulous techniques and his tendency not to make patients' faces "too tight". Her only regret, in spite of having some permanent numbness anterior to her ears, is that she didn't talk with him more beforehand about his techniques for eliminating crow's feet. Sybil is quite scathing in her description of Dr. F., whose stomach preceded him into the room, and who informed her, unbelievably, that her "wax [was] melting". She feels he was unethical in his description of other doctors she mentioned having seen, his point being to dissuade her from going to another doctor in this area. She also mentions Dr. E's lack of ethics in suggesting that she try to collect for her eyelift from the insurance company. Sybil does not mention any unethical behavior on the part of Dr. K., but relates what he told her on the day of her surgery. "Now this won't last real long; you'll have to keep having more facelifts. This won't last but a few years. If
you want to look like Dinah Shore, you'll have to have them every few years." I asked Marlene, who had worked with several cosmetic surgeons, whether she thought it was common for these doctors to suggest additional procedures to patients who come to them seeking only one cosmetic change. She stated, "Of course they do." In her mind, this is due to the fact that these doctors can "visualize more than you visualize", and not because they wish to generate any more revenue. She explains that Dr. F. will take the patient "as far along as [she] wants to go". He sends her to a dentist so she can "smile a lot" and not reveal "ugly-looking teeth". Why should the patient "just change [her] nose or [her] chin and still wear frumpy grandma clothes and clodhopper shoes"? She emphasizes that one should "go the whole nine yards": that changing only one aspect of the person's face is rather a waste of time and will yield less than optimal results. The real issue, however, is patient satisfaction as it becomes linked to the doctor's image. If the patient isn't happy, she will not recommend the physician and might even do damage to his reputation. Marlene has swallowed the party-line, as evidenced by her description of the cosmetic surgeon as the "guide to the beautiful look that you're trying to attain": The beauty hype, in general is thick with journey, voyage, and travel images. This quote makes one wonder if Marlene should consider a second career writing advertising copy. In discussing less-than-optimal results, Marlene states that sometimes it's not the doctor's fault that a person has poor "healing qualities" or that "a bone starts shifting in the nose". She discusses her friend who had her nose done three times by Dr. F. in order to get a good result because of poor bone or cartilage healing, or due to allergic reactions to the suture he uses. Dr. F's technique is
never implicated. Marlene mentions that he is the "type of doctor" that will go back "at his cost" until the patient is satisfied. Marlene seems to negate the other "costs" to the patient besides cash: such as surgical and anesthesia risks, pain, and recuperation time. As we talk about other complications we discuss the area behind the ear as a prime location for post-facelift skin slough if the skin has been pulled too tight. Marlene, however, begins again to find ways for the cosmetic surgeon to elude responsibility. There is "so much neck movement", she says, and describes how the patient is told to hold the head "a certain way [and] keep your nose slightly tipped up". I have visions of the difficulty of this assignment, and when I ask the length of time it might last, she says "over a period of time -- maybe several weeks". And, she continues "certain people -- I guess they don't follow the physician's advice and they're not compliant". A time-honored way, within medicine, to blame the victim has been to label the person as "non-compliant": or someone who doesn't follow medical advice. This "non-compliance" can, at times, assume the status of a psychiatric diagnosis, and the offending patient is often thought then to "deserve" any complications that ensue. Marlene excuses even those surgeons who do facelifts that are too extreme. "Some doctors are just very into pulling you tight 'cause they want you to feel like you have a good result."

I would like to compare, at this point, Marlene's and Sybil's ideas about the ethics of cosmetic surgeons with the ideas of others on this topic. The notion of a physician suggesting alternative or additional cosmetic procedures to a patient is troubling despite Marlene's protest that the "surgeon knows best" and that its done for the patient's "own good".
Marlene states that this is commonly done, and my conversations with patients would corroborate this. A colleague of mine relates that a plastic surgeon that she knew suggested a chin implant to her, and this was part of a social conversation, not during an office visit. Marie reveals, in her conversation, that her plastic surgeon suggested a chin implant to her at the time her facelift was done. Marie rejected this procedure, however, unlike many patients who are unable to refuse the suggestions of the medical "expert". Marie states that she has a "slight hump" in her nose, but that her doctor didn't mention that. As I was interviewing Susan, a subject whose words will appear later in this work, another woman joined our conversation. This woman was about to undergo an operation on her nasal sinuses necessitated by frequent infections. The surgeon who was to perform the operation asked her if she would allow him to repair the exterior of her "Karl Malden" nose at the same time he did the sinus repair. She had been startled by this suggestion, not previously feeling the need for a cosmetic rhinoplasty (surgery to change exterior of nose). She left his office and was unable to put his suggestion out of her mind. She became extremely self-conscious about her nose, describing how she would put her hand up to her nose when she was stopped in traffic so that other motorists wouldn't see her profile. This woman subsequently decided to have both operations done concurrently.

In their book (1981) the Goins describe what they term the "Pygmalian effect": caused by a surgeon's desire "to produce the best possible postoperative photograph rather than the happiest possible patient" (p. 115). Dr. Goin the plastic surgeon gamely discusses an elderly woman who came to him for a facelift, which he did in addition to a chin implant,
which he had suggested to the patient. After six months of silent unhappiness, the distraught patient returned and asked him to remove the implant, which was done. Dr. Goin suggests that whenever a doctor directly recommends an aesthetic operation that the patient has not requested, that he should stop and "question his own motives" in addition to determining whether "the condition that the operation is intended to correct is something that bothers the patient". Dr. Goin however, doesn't want to alienate his colleagues entirely with his notes of caution, and therefore ends his discussion with this quote.

We don't mean to imply that the surgeon, with his greater experience and objectivity, should not let patients know that certain obvious deformities can be corrected. The Pygmalion Effect is at work only when he fails to recognize that what he perceives as deformities may be perceived as neutral or even attractive features by the patient (p. 115).

It should be obvious, of course, that questioning patients about another facial feature in order to determine their feelings about it will immediately alert them that the cosmetic surgeon, the "expert", views this feature (or features) as less than optimal. Persons possessed of low self-esteem or those overly willing to invest in the advice of experts will often be hypersensitive to such comments. Dr. Thomas Rees, a prominent New York plastic surgeon, makes this statement in his book (1987).

Despite the fact that a receding chin is a most common facial characteristic, it is amazing how many people never mention this anatomical imperfection when visiting a plastic surgeon to discuss a nose operation or a facelift. Even less frequently are they aware that this problem can be corrected with a procedure that can be performed at the same time as the rhinoplasty [nose operation] or facelift. In fact, about fifteen percent of the people who can be helped by nasal plastic surgery are also good candidates for chin augmentation.

As I said, many people seeking other types of facial surgery are not aware that their chin is out of balance with the rest of the face until it's pointed out to them or until they see medical photographs of their profile that graphically demonstrate it (p. 72).
Webster (Webster and Smith, 1985) states that "One sign of aging rarely exists in isolation, although it may be the only finding noted by the patient at that time". He points out to the patient that the consultation fee includes a comprehensive analysis of the face, and that after "diagnosis and discussion" it will be up to the patient to decide if "treatment" is desired only for the original complaint, or for others as well. He mentions that "combining procedures" when this seems safe, "may save the patient appreciable amounts of time away from work and social activities, as well as large sums of money in charges for surgery, hospitalization, and anesthesia" (p. 28). Of course, the patient would also save her time and money if she elected not to have the "other treatments". Other physicians' comments tend to support Dr. Webster's thesis. Dr. Harold Smith states: "I do, however, point out the other problems, such as recessive chin, submental fat, and that a single procedure may be quite out of place in view of some of the other facial defects" (p. 28). Dr. Joseph Walike takes photographs of the patient during the initial consultation and has the patient return to view these at a second appointment. "It is easy at that time to mention other defects or aspects of the patient's face that may need correction for a maximum result, but of which he or she may be totally unaware" (p. 37). Dr. George Brennan emphasizes that he "owes" patients a thorough facial evaluation and that he embraces the concept of "total facial improvement". He likens his assessment of the face to the internist's assessment of the body, and notes that it would be "absurd" for a patient to limit his or her internist to examining just the lower right abdominal quadrant (pp. 37-38). Dr. John Hilger likens working on just one specific area of the face to "slipcovering a chair over the arms and
the back, leaving the seat and the fringe untouched" (p. 38). Dr. Mark Rafaty seems to disagree, and says, "In an occasional situation the patient may not want a complete facial analysis by me." (One is almost reassured, but read on). He states that he will discuss the requested operation in detail, will perform it, hopefully satisfactorily, and then: "those patients will be 'mine' and I can suggest other procedures (if they haven't requested them already) without the fear of offending them or their referring doctors" (p. 38). Dr. Webster sums up by saying the following:

> With few exceptions, most surgeons agreed that problems other than the ones the patient complained of are brought up in the consultation. ...
>
> Obviously, it must be made clear to the patient that one is not trying to 'sell' him or her on having a long list of procedures performed (p. 39).

Webster goes on to describe that intelligent patient choices depend on his explaining all the "problems", how they relate to each other, and what the appropriate "procedures" to correct them would be. He states: "If my attempts to be a 'good doctor' are misconstrued by an occasional or rare patient, as attempts to load him or her up with unwanted work, so be it" (p. 39). Better this, he states, than a patient who finds out later that her results would have been better had she had another procedure concurrently.

Webster furthers this discussion by asking nine cosmetic surgeons to relate how they would justify, in a consultation with a prospective facelift patient, bringing up defects not caused by aging. Only one, Dr. Jafek, said he would restrict his comments to the patient's stated complaints.

I don't bring up all defects, except as they contribute to the chief complaint. I think that it is unfair to patients to confront them with all of these defects, as I perceive them. Beauty is in the eye of the beholder, as are 'defects'. The patient may be perfectly happy with a 'humpy' nose, if it's like that of other members of the family (p. 59).
Dr. Webster notes that only Dr. Jafek evidenced disagreement and while praising his "sensitivity in supporting the patient's ego" lets us know that most surgeons feel, as he does, that this consultation calls for a "detailed analysis and discussion". He states: "I find it almost impossible to separate one defect from another because, in the aging face, almost all relate to each other directly or indirectly" (p. 59). Dr. Simon Fredricks, a Houston plastic surgeon, warns that: "There are some avaricious and unethical surgeons who will proceed to operate though they recognize the real problem is emotional. ... The result can well be a patient even more despondent and sometimes even suicidal" (Tutt, 1987, p. 2). Fredricks says that some doctors may take advantage of patients with high dependence and low self-esteem and continue to suggest further surgery. He gives this advice to his fellow cosmetic surgeons: "You should inform your patients when you have reached the point that plastic surgery has done all it can for them, and discharge them" (p. 2).

It may be that cosmetic surgeons are so conditioned by their training process with its emphasis on physical symmetry and perfection that they are "unable" not to suggest additional procedures. Dr. Russell Kridel states: "It's not advisable to rejuvenate part of the face and leave the rest alone -- if you're looking for an overall improvement" ("The Face", 1988, p. 38).

It would be beneficial to the potential seeker of cosmetic surgery if he or she could realize the fact that many, if not most, cosmetic surgeons will feel constrained to suggest multiple procedures to them, so that they might more nearly approximate the symmetrical and youthful beauty ideal visualized in the mind's eye of the doctor. They will suggest additional
cosmetic surgery for the patients' own good: a "good" that will be of no small benefit to the net worth of the surgeon.

Addicts

The foregoing discussion of physician ethics is closely related to the previously discussed topic of plastic surgery addicts (see Chapter IV). Marie mentions a "very sick syndrome" where "people think of nothing else" and "put too much emphasis on it" (physical appearance). When I ask her, however, if she has known anyone who might fall into this category, she answers me very quickly in the negative. "I don't, I don't" she emphasizes, "none of my friends are [overconcerned]."

When I spoke to Marlene, given her familiarity with the cosmetic surgery world, I asked her if she thought people might become addicted to changing themselves surgically, and if she had noted any such persons in her work. She said that this was definitely a reality and cited example patients from the practice of Dr. F. who has, "a large following" of such women.

[They] keep going back to him whenever they decide -- it's just like changing a hairstyle, they want to do something on their face. They're fairly wealthy women and that's part of their lifestyle. You know, I'm going to my cosmetic surgeon just like I'm going down to Dillard's and have my make-over.

A recent Oprah Winfrey show ("How Plastic", 1987) on plastic surgery dealt with the growing number of persons who seek repeated operations. Oprah states: "There are some people who have been such satisfied customers that they keep going back for more and more and more and more surgery. We call them plastic surgery junkies" (p. 2).

Oprah has three such guests on this show. The first, Robin, had six plastic surgeries in ten years: breast augmentation, upper and lower eyelid
surgeries, a chemical peel, a total facelift, and a cosmetic rhinoplasty. Oprah's second guest, Susan, at 42 has had her nose, chin, upper eyelids, neck, ears, forehead and mouth operated on, and most recently had a total facelift. She is planning her next procedure, a lower eyelid repair. Mary Jo, the final guest, has had a chemical peel, fat grafting, a total facelift, and gets collagen injections every three months. Mary Jo states that whenever her boyfriend tells her she's looking a little tired, she schedules her next appointment. In the interests of brevity I will not review all of these patients' statements. Robin, however, describes herself in such negative terms that I will relate a few of them. She describes herself as "disgusted" when she would look in a mirror and notes that her stomach, before the lift, was "hideous ... horrible". She describes her nose as "yuck" and elaborates that it had been broken, was "very fat" in one area, and had a "tip of flesh on the end that kind of hung down" (p. 3). All of these women were extremely conscious of each tiny facial and bodily characteristic, and viewed themselves very pessimistically. Susan says, "I don't mind being called a junkie; it's better than the alternative, you know, the O word, as in O - L - D, you know" (p. 5).

I will leave it to the reader to react to this information and factor it into the previous discussion of cosmetic surgical addiction. There are no figures on this phenomenon: only a growing literature that describes this trend, and offers no solution, as I cannot.

Informed Consent

Informed consent is a term that includes two concepts, according to Goin and Goin (1981). First, that the patient is the sole owner of his or her body and has a right to know what the doctor means to do for or to
it; and second, that on the basis of that knowledge the patient has the right to decide for or against the treatment. If the patient decides to undergo the treatment, he or she must give consent before it is carried out. The California Supreme Court, which has ruled on the characteristics of informed consent, has written that patients must be told the nature of the recommended procedure, what it is to accomplish, the risks inherent in having it, and the alternatives to having it. The Court ruled that it was not necessary to discuss every conceivable complication, but that the physician's major responsibility lay in disclosing risk of serious injury or death. There are two instances where a physician will not be held liable for not obtaining informed consent: the first is a case where a patient asks that the risks not be revealed, and the second is a case where a full disclosure would prevent a patient from "dispassionately weighing the risks" (p. 90). Doctors must also be aware that if a patient is not competent to receive all the information, then he or she may not be competent to give a valid consent.

Goin and Goin (1981) assess a prospective study of one hundred plastic surgery patients done by Leeb and her co-workers at Vanderbilt in 1976 (p. 94). The patients were told they were participating in a study and that they would be tested later over the content of the preoperative interview. Each patient was given five warnings about pain, infection, bleeding, scarring, and possible failure of the operation. All other "reasonably possible" complications of the specific operation were included in the informed consent. The patients were asked to describe their educations and to assess their mental state. A week later the original interviewer asked the patients to repeat what they had been told
preoperatively. Overall group retention was 35%. Better educated patients (any education past high school) showed markedly better retention than those with a high school education or less (41% vs. 32%). Patients who estimated their mental state as "calm" retained 30%, as opposed to 48% for those who evaluated themselves as "very nervous".

In 1976 Goin and Goin did their own study of twenty female facelift patients judged by the doctors to be "psychologically normal" or to have "mild character disorders" (1981, p. 92). Each had a 50-60 minute preoperative interview with the surgeon and was told in detail about the four major and six minor complications of the operation. These complications were handwritten by the surgeon on a sheet of paper as he talked to each patient. The paper was given to each patient -- or offered to each since some refused to take it. The Goins partially summarized their findings in the following statement. "Intensive preoperative and postoperative psychiatric interviews at 5, 14, 60 and 180 days showed an almost universal unwillingness on the part of the patients to acknowledge the possibility of post-operative complications" (p. 92). The psychiatrists were convinced that this went much beyond "mere forgetfulness", and that psychological coping mechanisms such as denial and repression were operating. Only three of the patients remembered three of the complications, eight could recall only one and nine were unable -- or unwilling -- to remember any! Goin and Goin state:

These reactions of fear, denial, repression, and the inner need to be in control probably explain why none of the women experienced a truly 'informed consent' even though they were 'given' one. Ten patients flatly denied that a complication could happen to them, or admitted deliberately putting the possibility out of mind (repression) (p. 92).
The Goins had other patients who remembered a few of the complications, but felt in complete control for other reasons, such as the fact that they "healed well", or meditated, or took mega-doses of vitamins C and E, or "found the right doctor". Only two of the twenty-eight women expressed any fear about complications. Goin and Goin express surprise that so many patients are "totally unaware that postoperative complications are an inescapable consequence of surgical operations". They feel the fact that many of the patients in their study were "assertive, perfectionistic" people who must feel themselves to be in control and the fact that it is difficult for an intelligent person who wanted a facelift to go ahead with it if they truly believed they might end up with a partially paralyzed face are explanations for the failure of informed consent in their study. This second point is the one I attempted to make in articulating my position of real fear to Sybil and Marlene. Marlene consoled herself with the knowledge that she knew Dr. F. personally and he would be extra careful with her, that he works extensively on faces, and that she has seen few complications that couldn't be remedied. Marie reassured herself by finding the "right" doctor who had a reputation in her circle as a meticulous technician. She "really left it up to" Dr. S., who is "supposed to be an artist". When I asked Sybil if she was afraid at all, she answered with an emphatic no. "When something bothers you that bad and you're gonna spend all that money to do it, you are not afraid." Sybil felt, in addition, that the doctor she chose, Dr. K. was "an artist" and he had done her mother's face as well. Both Sybil and Marlene were able to list several postoperative complications and therefore it would seem that some of their informed consent "took". Marlene characterizes Dr. F. as
"very good about explaining things to patients", and mentions his nurse who goes in after him and reinforces the information for the patient. Sybil feels Dr. K. explained what could happen afterwards "very well" and that he spent "a lot of time" with her. She remembers being warned about possible facial paralysis, itching, shooting pains, and numbness. Marie is less specific about the preoperative information she was given, stating she thought the surgeons varied in how much they told patients. She says that Dr. S. instilled confidence in her. Judging from their obvious intelligence, it would seem that these three women "thought positive" and reassured themselves with the factors I've mentioned. Dr. Julian Reich suggests that the drive to undergo a surgical improvement in appearance is so great that "many patients do not wish to hear anything that might put them off" (1975, p. 10). Dr. Reich noted that questions asked by his patients in the postoperative period made him aware that many patients were signing his consent forms without reading them or without absorbing their content.

Pre and Postoperative Photos of Patients

An intersection with the topic of medical informed consent is found in the pre and postoperative photo-viewing ceremony that is part of a visit to the cosmetic surgeon. Photographs of patients -- always women--have appeared in the media as part of advertising campaigns and also in "informational" articles for the lay public on cosmetic surgery. As I discuss in Chapter II, the use of such photos, ostensibly to provide the potential customer with enough information to make an informed choice, is fraught with questions of propriety and truthfulness. I have viewed hundreds of such photographs now, both in the media and in textbooks,
and have frequently thought them to be misleading or actually deceptive. The average viewer does not understand what can be done to maximize the difference between pre and postoperative photos. These pictures can be quite influential in a person’s decision to undergo cosmetic surgery, and also can contribute to the physician selection process. These facts are not lost on the physician-businessmen who see the potential of the picture vs. a "thousand words".

Cosmetic surgeons put their collections of pre and postop photos together very carefully, for these are on view in their offices, are used in textbooks, and are presented as evidence of extreme technical skill and "artistry" in professionals’ journal articles and at medical meetings. For this reason, photos of excellent results (or perhaps excellent photos of results) are presented to the exclusion of average and poor results.

In order to consider the opinion of an informed "insider", listen to the words of Dr. Robert M. Goldwyn, the editor of the Journal of Plastic and Reconstructive Surgery. Goldwyn makes a plea for the presentation of the full spectrum of surgical results in doctors’ talks to their colleagues, in their published articles, and in their discussions with patients. This complete disclosure should include not only the excellent result, but the average, the long-term, and the unfavorable result as well. Goldwyn makes the following comments in this editorial from which I quote (1987).

Average results or long-term results are almost never shown. Unfavorable results and complications sometimes are discussed, but then only minimally.

Sometimes also what appears by photograph to be an excellent result is not in reality as good as it seems. The photograph, which originally evolved in medical publications to document facts, has within the past few decade been "doctored" by doctors to dissimulate rather than to disclose (p. 713).
Goldwyn comments that it is relatively easy to maximize improvement photographically following a facelift. Preoperatively the doctor can use dark lighting and can instruct the patient to take off her makeup and tilt her chin downward. Postoperatively the doctor can take the photograph at four months rather than at fourteen months, can use bright lighting, and can tell the patient to wear makeup, have her hair styled, and tilt her chin up. The doctor will avoid showing a close frontal view of the submental area (immediately under the chin) where muscle bands or scarring may be just visible and soon will become noticeable.

Dr. Goldwyn offers the opinion that, for many surgeons, a presentation to colleagues becomes "an exercise in self-aggrandizement rather than a medical or surgical report" (p. 714). (This tendency, of course, is also evident in articles about cosmetic surgery in which these doctors are featured and quoted, and in advertisements). Goldwyn laments that "incomplete reporting" is prevalent and says: "Purposefully failing to describe a medical event as it happened is a distortion, a calculated omission of facts, a lie" (p. 714).

Although all of the women to whom I spoke had been shown pre and postoperative photos, I was most interested in the thoughts of Marlene on this subject, since she has been an actor on both sides of the cosmetic surgery stage: as a patient, and as a nurse working closely with several cosmetic surgeons. When I ask her about showing good and average results, she replies:

I don't think I would do that. ... I don't even know if I'd want to know that as a patient. You want to know that there are results. I don't think, psychologically, that's good to show a patient good, medium or bad results. ... Because that will -- preset in their mind a negative feeling, whether intentionally or not. You're gonna say, 'Oh, God, I'm gonna be that one in the million that's gonna have negative
results'. Then you're gonna have a patient going into surgery already fearful. You want a patient that's upbeat, that's thinking positive. I'm telling you -- attitude in this whole thing is important. You want a physician that keeps you upbeat.

What Marlene doesn't mention is that a person who views an average or a negative result might not necessarily go into surgery fearful, but might recognize that this could happen to her and could elect not to have the operation done at all. Marlene is linking the preoperative fear here with the medical myth that extremely fearful patients are the ones who "die on the table" for unknown reasons. She had told the story earlier of a patient she cared for years ago who was young and healthy but extremely anxious before surgery to repair a shoulder injury. This young male patient died, much to Marlene's shock and sadness. Many medical professionals believe that surgery should not be performed or should be rescheduled, when a patient evidences extreme preoperative anxiety. The solution in the case of cosmetic surgery, all of which is elective, is not to keep the patient "upbeat" by presenting only photos of excellent results and downplaying possible complications. The ethical course is obviously to present the patient with all the data: verbally in consultation, visually through a selection of photos that exhibit a true spectrum of results, and in writing via a listing of possible outcomes that is given to the patient when she leaves the initial consultation. This would represent the best effort that could be made to inform the patient, even though it is possible that patients' recall of presented information will still be low when such techniques are used. The Goins tell us the following:

So far, there does not seem to be any effective way to increase patients' retention of facts. Improving the quality and transmission of data to the patients doesn't seem to do any good. All that we, and others who have studied the process of informed consent, can do is to stress the importance of documenting the details of informed consent in
the patient's permanent record. ... It is the age of self-protection and stringent documentation is the surgeon's only option (1981, pp. 95-96).

Is it, doctor? Are you just going to give up on the quest for informed consent? And what about the truth and presenting a patient with her alternatives? What about less hype and exaggeration in media accounts of cosmetic surgery and in advertising? Perhaps if these questions are considered, the "surgeon's only option" will not be limited to "stringent documentation" of what the patient has been told in order to be legally defensible.

Use of Euphemisms

An interesting trend that I note in the dialogue of the three women is their tendency to use euphemisms in describing their surgical procedures. This convention is related to informed consent in that I believe that the using of these safe terms to describe plastic surgery represents a conscious -- or unconscious -- denial of the serious and potentially dangerous nature of the operations themselves. Nick-naming the operative procedures renders them de-fanged and harmless and the person is able to rationalize subjecting herself to possible morbidity and mortality. In discussing what future operations she might elect to have, Marie states "I probably will go for something or other, you know, a tuck". Sybil in her characteristically entertaining way, says that she will probably have something else done when she is 60. "Just some little thing you do to yourself", she says, "to make you feel like you made yourself -- more preserved". Marlene's dialogue is studded with innocent-sounding metaphors: "just a quick incision", "he went in and tucked up that muscle a tad", "it's just a little suture right up here", and "a little tack". She and I both use the distancing term "procedure" and Marlene speaks of
"cosmetic work" in discussing these same procedures or operations. When she begins to discuss how the facelift is done and says: "They skin your flesh", I introject the words: "they undermine", (a medical term for freeing the upper skin and fat layers from the lower muscle layers: in other words, surgical "skinning"). I am not comfortable with the image of a "scalped" woman. These tendencies to ameliorate the descriptive terms and to use distancing images are reminiscent of the trends that I described in the medical advertisements, where the medical and surgical reality is aestheticized in order to make the copy more acceptable to the public.

And so the patient protects herself by denying the dangers inherent in her quest for youth: and she is helped to do this by medical advertising and the doctors themselves. The doctor protects him or herself by documenting every word said to the patient on the preoperative form and having the patient sign this. Marie tells me that she can't imagine anyone being unhappy after facelift surgery unless the person had a really bad result. She herself has some residual numbness in front of both ears, but will probably have more cosmetic surgery. She is not happy that so many crow's feet remain. Sybil had numbness and itching, unpleasant tightness, and currently is unable to raise one eyebrow. These symptoms may improve partially or totally with time. She has a large reddened area behind one ear where a drain fell out and may have some scarring there. She is not unhappy with her outcome and predicts that she will have something else done as she approaches 60. Marlene, who had her surgery three years before I spoke with her, is left with some of the "wide-eyed look" that her upper facelift caused, but this is better than it once was. She has lost her forehead "furrows". She has white scars that are visible
inside her hairline and she states that she must wear her hair differently now since the surgery changed her hairline. She has permanent surgical sutures beneath the skin of her cheeks that have resulted in tiny palpable hard knots. She states that "some people would be upset" with this, but that she is not. These smaller complications are the aftermath for these three women: none of whom reports marked dissatisfaction with her outcome. I know I would have far different sentiments to report if one of them had had a major complication. I am glad that they did not: and I wish them well as they find their way through the maze of middle age in the youth culture we call American society.
CHAPTER VI: BEAUTY AND THE BREAST

Behold, thou art fair, my love; behold, thou art fair; thou hast doves' eyes within thy locks: thy hair is as a flock of goats, that appear from mount Gilead.

Thy teeth are like a flock of sheep that are even shorn, which came up from the washing; whereof every one bear twins, and none is barren among them.

Thy lips are like a thread of scarlet, and thy speech is comely: thy temples are like a piece of pomegranate within thy locks.

Thy neck is like the tower of David builded for an armoury, whereon there hang a thousand bucklers, all shields of mighty men.

Thy two breasts are like two young roes that are twins, which feed among the lilies.

Until the day break, and the shadows flee away, I will get me to the mountain of myrrh and to the hill of frankincense.

Thou art all fair, my love; there is no spot in thee.

Song of Solomon 4:1-7

Praise the plastic then and dacron and fiberglass as some hope against decay. Praise the falseness that is true.

Praise the lie that lasts.

Breasts have become, it seems, the icon: the metasymbol for femininity in the 80s. Women are taller, and stronger-looking -- most of them don't want to be considered "cute" -- and they must have breasts that show. As I discuss in Chapter III many models are enlarging their breasts. Female body-builders are also seeking breast augmentation, for they find as they become ever more muscular that their stored body fat shrinks tremendously and they are often left with very little breast tissue. And thousands of other women, most of whom are not in any "body" business, are having their breasts enlarged as well. Although published estimates vary widely, somewhere between 100,000 and 200,000 women probably have breast augmentation annually at present. Advertisements for such procedures are found in multiple media sources and articles about this operation appear regularly in newspapers and magazines. I chose to talk with some women who have undergone augmentation because so many women are having it done, because of my interest in their knowledge of the side effects and complications of this procedure, and because of the uniquely feminine nature of this operation and the symbolic nature of the breast.

It is fascinating -- and perhaps a bit unbelievable -- that studies report satisfaction rates of 95% when at least 33% of women having this operation have noticeable hardening of their breasts afterwards, in addition to other possible complications. What factors account for the fact that so many women are willing to pay so much for a less than optimal result? What do these women know about the questions that exist about breast-feeding and mammography to screen for breast cancer in patients who have had breast implants inserted? How do these women feel about their
bodies: now, and before they had these procedures? What overt reasons do they give for choosing to have this done, and how did they choose the doctor who performed the operation? What was their preoperative, intraoperative and postoperative experience? These are some of the questions I hope to address through speaking at length with three women who had breast augmentation and using the words of others collected from other interview sources.

**Augmentation Mammoplasty or Breast Enlargement**

Dr. Elizabeth Morgan (1988) declares the goal of cosmetic breast enlargement to be the production of "fuller breasts, with a bit more lift. As far as size is concerned, the surgery can make you as large as you want to be -- eventually" (p. 347). Morgan explains that if you wish to markedly increase your breast size, the breast skin must be stretched in stages using an expandable implant that is inflated, using gradually increasing fluid injections, over four to six weeks. Patients can have this surgery, according to Morgan, once the breasts have finished developing. If a person plans to breast-feed children, however, the doctor recommends postponing the surgery. She states that breast-feeding is possible after augmentation surgery, but that it shouldn't be done because the patient has a good chance of developing mastitis (breast infection). This infection can be passed on to the infant and can also cause hardening of the implants or capsular contracture. Women with a certain type of arthritis (the autoimmune variety) should not have this surgery as recent research suggests that some women develop arthritis after breast enlargement. It is speculated that the body's reaction to the silicone implant stimulates an underlying tendency to the disease. Breast enlargement is usually done on
an outpatient basis in a doctor's office surgical suite or in a day surgery center. This operation is most often done using local anesthesia together with sedation, which is less expensive than general anesthesia and requires less recuperation time. Morgan states: "Local/sedation may make this operation tolerable (you may not remember the pain or may have none). But when the surgeon pulls up the breast, you'll feel a heavy pressure" (p. 349). Therefore -- and understandably -- some patients prefer general anesthesia with its greater attendant risks such as the chance of anesthesia death, and increased bleeding tendencies.

Morgan describes the basic implant as an oval or round ball of semi-solid soft silicone in a solid silicone envelope. The average prosthesis weighs about 8 ounces and would fill a soup bowl, but great size variation exists. Thicker envelopes are now being used in many implants, according to Morgan, since silicone gel has been known to leak through the thinner outside envelopes of older implants. Dr. Richard Hausner and associates (1981) have also discussed the fact that silicone gel may "bleed" through a structurally intact implant envelope and subsequently migrate to regional lymph nodes. Other researchers have reported on this phenomenon as well (Jensen and Mackey, 1985). Another implant used is the "fuzzy" type consisting of silicone covered with polyurethane which makes the surface rough. The body tissue can actually grow into such an implant, which can cause problems. Morgan relates that infection is more common with these implants and that getting one out can be a major operation. She feels that this implant was very popular a few years ago, but is now much less commonly used. Water filled implants are a silicone envelope that the surgeon fills with water during surgery. Since these devices have a filling
valve, however, they can deflate, or the water can leak out. If such an implant does deflate, it must be removed and replaced. These are the least expensive, at about $150 a pair as opposed to $500 or more for a pair of silicone-filled implants or $700 to $800 a pair for double-walled implants. Implants with double-walled envelopes were developed for post-cancer breast reconstruction, but are now also in use for strictly cosmetic procedures. They consist of a standard silicone implant plus an outer or inner envelope that can be filled with water. One new type is expandable and can be made larger or smaller using a needle to withdraw or inject water. Some surgeons inject steroid drugs or antibiotics into this outer envelope in an attempt to avoid capsule formation around the implant. These implants are usually placed behind the pectoralis (chest) muscle instead of under the breast tissue, as the outer envelope rim can "rub and thin" the overlying skin.

Morgan explains the pros and cons of placing the implant between the breast and the muscle behind it (the pectoralis) or placing it under the pectoralis, between this muscle and the ribs. It seems that placing the implant under the muscle decreases the risk of capsule formation (or capsular contracture) which causes the implants and the breasts to harden. If such a capsule does form around an implant that lies under muscle, only reoperation can treat it. Placing the implant under the muscle "is a more painful, extensive operation and tends to require general anesthesia. There is more post-surgery pain, and recovery takes two weeks" (p. 351). Dr. John Graham (1982) describes a "greatly improved" complication rate when the implant is placed under the muscle and prophylactic antibiotics are used. However all patients done by this method in his practice are given
general anesthesia. Dr. Graham admonishes the surgeon doing this
procedure as follows (p. 12).

Particular care must be taken in the proper elevation of this muscle
as it is easy to go through the intercostals and into the pleural space
with a resulting pneumothorax [collapsed lung].

Particular care is taken to avoid injury to the long thoracic and
fourth intercostal nerves when doing the lateral dissection of the
pocket.

Graham lists possible complications to include: hematoma formation
(in 2% of his patients), infection, numbness, hyperesthesis [heightened
sensation] or permanent anesthesia of nipple, asymmetry or improper
positioning of implants, and capsular constriction of the implant. This last
complication, which leads to breast hardness and has occurred in as high
as 50% of these patients according to Graham, has "diminished in our
hands to 2%" with implant placement in the subpectoral area and the use
of antibiotics. Morgan assesses the procedure which places the implant
between the breast and the muscle as "less painful, [a] less extensive
operation, but it carries a higher risk (up to 30%) of capsular formation".
If a capsule forms and the implant is between the breast and muscle, it
can be treated, according to Morgan, by "pressure" on the breast that
"pops the capsule inside like popping a balloon" (p. 352). This is done in
the office, but only works temporarily: breast firmness returning within
three weeks to six months. And Morgan notes in another part of her
book that when this is done there is a "slight risk of damaging an implant
or causing bleeding" (p. 363). In an article in Ms. magazine (Nashner and
White, 1977), a woman describes the "simple, nonsurgical procedure" that is
used to break up the capsule around the implant. She states: "I just had
my first rupturing session. I never want to go through that again" (p. 54).
Nashner and White excerpt the following description of a rupturing session from the *Journal of Plastic and Reconstructive Surgery*. "The prosthesis [implant] is grasped tightly in both of the surgeon's hands. Maximum pressure is exerted and the hands are rotated 360 degrees, so that the expanding prosthesis literally ruptures the fibrous capsule in all directions" (p. 54). Dr. Morgan advises readers of her book to discuss capsules with their doctor before surgery: good advice in view of the prevalence of this complication and the fact that it must be treated by the "simple office procedure" above, or re-operation.

The possible incision sites are three: in the crease under the breast, in the lower half of the areola (the pigmented area around the nipple) and in the axilla (armpit). The first mentioned is the most commonly used. Morgan states that this approach allows the surgeon the best visualization of the space behind the breast and also allows for bleeding to be most easily controlled. The scar, however, tends to be up to 1/2 inch wide and may be pinkish-brown. The incision around the areola "tends" to heal with a thinner scar, but makes the operation more difficult for the surgeon. If a scar does form, and it does in some women, it may be "very troubling" as it will be quite visible on the breast. The axillary incision has become popular apparently on the West Coast, and is "the preferred incision if you plan to go topless on the beach." It seems curious that Morgan makes this statement, however, as her next one seems to negate it: "It can leave an indented or wide scar -- which will show in all sleeveless clothes" (p. 352). Also, this approach is more difficult for the surgeon in terms of control of bleeding and proper placement of an implant "pocket" far down on the chest. There is a risk that the implant will be placed
too high or may shift up toward the arm. However, intones Morgan, "None of these problems makes the underarm approach unusable" (p. 353).

In discussing the use of steroids around the breast implant in order to prevent capsule formation, Morgan says that they will stop the formation of scar tissue but that they will inhibit resistance to infection and healing. Steroids can also cause the patient's scar to stretch and redden, or can cause the entire breast to weaken and become "droopy".

Morgan describes the actual implant procedure as follows. The surgeon makes the incision through the skin and fatty layers until the muscle is reached. If the implant is to be placed between the breast and the muscle, he or she will lift the entire breast off the muscle by cutting all the fibers that attach it to the muscle. This, Morgan calls, "making the pocket". The surgeon looks inside, using an instrument that lifts up the breast tissue and has a light at the end. He will use an electric cautery to seal off bleeding vessels. The patient "may" feel the sting of the cautery or the pulling when the breast is lifted. Once the pocket is made the surgeon may put the implant in, or he may then make the pocket in the other breast and put both implants in at the end of the operation. If the surgeon is putting the implants under the muscle, he will first cut through the skin, fatty tissue and through the muscle -- down to the ribs. He will strip the muscle from the ribs, using a surgical tool. Morgan states that this "may hurt" if the patient is only under sedation, but that with this technique it is more likely that the patient will be asleep (meaning having had general anesthesia). If the patient is only sedated, she will feel considerable pressure (one patient likened it to an elephant sitting on her chest!) when the implants are put in their pockets. At the
end of the procedure the surgeon will put in the stitches. If the implant has been put under the muscle, a small plastic tube or drain may be inserted after surgery to allow collected blood to drain out. Bandages or steri-strips (very thin strips of clear adhesive tape) are then applied to the incision site.

Morgan states, unbelievably, that after surgery the patient will probably have little pain, other than the breasts aching the first day. She states that "a few" patients will develop an "intense burning" in the nipple, due to bruising of the nerves to this area. This may persist for two weeks. (Other sources list this complication as something to be expected for varying periods postoperatively.) If a patient develops swelling and sudden pain in one breast, she is advised to call the doctor immediately as this often means internal bleeding is occurring around the implant. The "normal" post-surgery swelling will take up to six weeks to disappear.

Morgan's assessment of fees is as follows. The surgeon's fee will be between $1,800 and $2,500. The implant cost will be between $400 and $800. The cost of anesthesia will range from a minimum of $800 for sedation to as much as $3,000 for general anesthesia. These totals, therefore, range from $3,000 to $6,300. Morgan tells us that with "rare" exceptions, insurance will not pay for this operation.

Morgan describes breast enlargement as the most common cosmetic operation performed. She states that the patient must "accept the risk" of forming a "capsule": that firmness to hardness of the breasts that occurs "10-30% of the time". This is not always bothersome", she says, "but capsules are difficult and often impossible to correct" (p. 360). She lists
the complications to include breast and nipple sensitivity, feeling too large until the swelling goes down, and scars that are "less than perfect: wide or pinkish-brown" (p. 361). All or parts of the breasts may be numb for weeks, months to a year, or permanently.

Nipple responsiveness to sexual stimulation may decrease for several months, but it "almost always" returns. Morgan terms infection "rare", occurring less than 1% of the time, but remarks that if it occurs the implant must be removed for three to six months while the infection is treated. If only one breast is involved the breast sizes will be lopsided during this period. It is possible, also, that an implant can be defective and leak silicone, or that it can be ruptured in the case of trauma to the chest. Morgan states that the leak will not be harmful to the patient, but will result in an "irregular, lumpy-looking breast" and the silicone may migrate to nearby lymph glands. She states that: "Treatment for this complication is simple -- removal of the gel (it sticks to itself and is pulled out like a string of taffy) and placement of a new implant" (p. 361). Another source, however, discusses the ramifications of implant rupture in a more serious tone. The rupture and resulting liberation of the silicone into the breast tissue can result in "pain, toxicity, or possibly an autoimmune disease, like scleroderma, lupus, or rheumatoid arthritis" (Goldrich, 1988, p. 22).

The Informants

Susan

Susan is the director of a local health club and agreed to talk to me about the cosmetic surgical procedure she has undergone. She tells me she is a certified aerobics teacher and is licensed as a cosmetologist in
three states. She is 38 years old and is attractive if not quite pretty, with a ready smile. She wears her brown hair long and held back with combs and wears makeup and lipstick. Since I'm talking with her at her workplace, she has on "sweats" and pink aerobic shoes. Susan is rather tall, 5' 6 1/2", and does not appear thin: she tells me she weighs 155 pounds. She was born in a small town in the midwest and was an only child. She has been married three times. Her first marriage was "right out of high school" and she has a son 21, and daughter 19, who were born during this three year relationship. During her first marriage, she continued to live in her hometown and bought her own business, a beauty salon. She states that she "did very well. I do real well with people as far as public relations and working with them one on one". When her first marriage ended, she sold her business and worked for someone else. She re-married, and this second marriage lasted three years as well. About six years ago she re-married for the third time, and moved to a large southwestern city with her husband. She was divorced again three years ago. In 1979, during a period when she was between marriages, Susan had a breast enlargement operation. She had no complications associated with this and has been happy with the results. At this time she is about to undergo rather extensive liposuction of her abdomen, thighs, and medial knees. She has been chosen by a local plastic surgeon as a demonstration patient to be featured in a training video for other physicians who wish to learn liposuction techniques. For this reason, the operation will be done at no charge to Susan. At the same time he will correct an umbilical hernia for her as well, and will perform a "tummy tuck" (abdominoplasty) which will remove excess abdominal skin, while the
liposuction will remove the abdominal fat. Susan is more concerned about the hernia operation than anything else and wonders about anesthesia and postoperative pain. She realizes she'll be having several procedures at once, but justifies this in terms of getting it all over with at one time and saving money on anesthesia, operating room costs, and surgeon's fees. She relates that she doesn't consider the tummy tuck and the liposuction to be "all that major". She is very enthusiastic about these procedures, telling me she has done all she can with her figure and still has "saddlebags". She shows me these areas and also the extra skin in her abdominal area. She makes a fist to demonstrate her very good arm tone and shows me her breasts, which are large and firm, but with no hardness. The surgical scar under each breast is a very thin white line. She is happy, now, with her upper torso, but not with her midsection and thighs. She is very committed to having these operations done, saying, to make her point, that she'd work as a prostitute to get the money to have them done if she needed to. Susan is thrilled that she has been chosen for this complementary surgery and states she "can't wait".

Kate

Kate is seated outside the bookstore of the academic center where we had agreed to meet. She is a very attractive woman: tall and slim, dressed in a knee length skirt, sweater, and blazer in pale hues. She wears her brown hair in a mid-length permed bob and light makeup. She has a beautiful smile and she moves her body with the easy grace of a natural athlete. She has a friendly manner, occasionally reaching out to touch me lightly when emphasizing a point. She seems to be comfortable with talking about her feelings and her operation, and characterizes my
Kate grew up in an all-female household, with her divorced mother and her grandmother. Her mother was divorced from her father when Kate was an infant and she had no brothers, no uncles, "no male influence" in her early life. She did not enjoy a happy childhood, and talked about the fact that her mother wasn't really able to cope well with having a child as a single parent. "I think I got off to a bad start", Kate says, "I don't ever remember being happy." She became, in her unhappiness, such a behavior problem that her mother, who had to work, couldn't keep baby-sitters. When she was 4 or 5, her mother put her in a Catholic orphanage during the week and took her home on weekends. This went on for two years, and Kate states that she felt abandoned. She never felt like she "fit in" because she was so different than what her mother had expected. She described her mother as having a "strong personality" and being "very dominant", and Kate "never felt like [she] was OK". Her mother never remarried and she and Kate moved around quite a lot, as her mother worked for the Air Force. She remembers at 12 or 13, when all the other girls were developing breasts and she wasn't that she was "ridiculed a lot by the boys at school". Nonetheless, she went on, graduating from high school and starting college, finishing her college degree over several years as she joined the army and worked concurrently. She met her first husband, who was one of her instructors, while in the Army; they married when they both left the service. She was 24 and he was 22. Unfortunately, this man physically and psychologically abused Kate. She says she set herself up by picking someone who reflected what her self-image was. "He had a problem", she states, "with flat-chested
women*. He would beat her up and had extramarital affairs: the latter he explained on the basis of Kate's small breasts. After enduring 3 1/2 years of this abuse, Kate left. She began working in academic counseling at a large urban university, liked the work very well, and decided to pursue a Master's degree in counseling. She graduated in 1983, and worked in various collegiate counseling centers. In 1988 she assumed her present position as director of counseling at a mid-sized college. Two years ago, while living with the man who has since become her husband, Kate underwent breast augmentation surgery. She had a great deal of difficulty making the decision to have this done, in spite of her lifelong feelings of inferiority related to her breast size. She has not been really happy with the physical and psychological aftermath of the operation. She has lost nipple sensation bilaterally, and has some mild hardening in one breast. She does not feel her implants, which are placed beneath the pectoralis muscle, look completely natural, but she describes them as looking "fairly nice". She states, though, that "knowing what I know now; I'd never do it".

Marlene

Marlene has been introduced in the preceding chapter on facelift procedures. Preceding her facelift she had augmentation mammoplasty performed, in 1979. She has been happy with the results of this operation and has had no complications. As will be revealed in the dialogue and discussion to follow, she credits having had this procedure with helping her to extricate herself from a destructive marital relationship. Her enthusiasm for this procedure, and her general support of the cosmetic surgery industry will be apparent. Her perspective is informative as it
represents, again, two viewpoints: that of the nurse who works with cosmetic surgeons, and that of the patient.

Analysis and Interpretation

Some Theories About the Patients

As we might expect, psychiatrists and plastic surgeons share an interest in studying the psychological and emotional makeup of the woman seeking breast enlargement surgery. I have serious personal questions about the more abstract and far-fetched theorizing that exists in this literature: notably that which conflates the small or absent breast with the unloving or absent mother. Some of the more common sense observations made about some groups of these patients, however, may be useful in stimulating thought and discussion, if limited as actual diagnostic parameters.

One of the earliest studies was that done by Edgerton and McClary (1958) in which 32 women seeking breast enlargement were evaluated and operated on using Ivalon sponges. These authors feel that this group represents a wide variety of "kinds of people" but that most of the study subjects presented "normal character structures". The authors mention the possible influence of "advertising propaganda and questionable publicity" (p. 279) on the development of a disturbed body image, but concluded that "personal symbolic meanings constructed from (the patients') own life experience" were more significant than cultural and social factors (p. 297). Two patients were noted to have "schizoid personality structure", two were described as having "character disorders of the passive-aggressive type", and one patient was, "actively schizophrenic, but well compensated" (p. 280). The authors postulate that the common denominator in this group of
patients is "an unrecognized depressive reaction which was disguised beneath their fixation of feelings upon the breasts" (p. 301). The small size of the breasts allegedly demonstrates to the world that the patients lack something, and indeed the patients described feeling: "empty inside", "inadequate", "hollow", and "unacceptable" (p. 297).

Edgerton, Meyer, and Jacobson did a further study of breast augmentation patients in 1961 that included Edgerton's first group of 32 (1958) plus 52 additional patients. They describe the majority of the patients as married Protestant women with an average age of 30, who have a strained marital situation. A minority of patients are professional entertainers who seek the implants to enhance their careers. The patients are described as "active, competitive, on-the-go, graceful, often pretty and socially at ease" (p. 310). The majority reportedly had unhappy childhoods. These authors state that 4/5 of the patients were assigned a "psychiatric diagnosis" (p. 301) preoperatively, but they do not specify what they mean by this term, which, of course, is terribly non-specific. They find, however, a "high proportion" of the patients gave a history of brief depressions and some of them had "enduring depressive feelings during adolescence" (p. 296). Clinical depression was diagnosed in 3/5 of the group at the time of the preoperative psychiatric interview.

Goin and Goin (1981) quote Druss' small but in-depth study as finding that every patient had "severely disturbed and difficult relationships with her mother" (p. 193) and often passive fathers. Feelings of inadequacy reportedly developed as the patients became aware of the differences between their own breasts and those of their better endowed friends and schoolmates. Baker's study is also mentioned, however, and the ten women
who were psychologically tested were felt to be "basically normal" (p. 193).

An interesting and novel study was done by Shipley, O'Donnell, and Bader (1977) which compared a study group of 28 breast enlargement patients to two control groups not having surgery. One control group had average breast size, and the other had small breast size. All subjects filled out tests and questionnaires and returned them by mail. The small-breasted control group, interestingly, exhibited a more liberal view of woman's roles, while the surgical group and the average-size breast group seemed more conservative and traditional. The augmentation patients scored higher on self-esteem tests but were more self-conscious about their bodies than either of the other groups. Eighty-nine percent of the augmented group had felt self-conscious about their breasts since puberty. In contrast to the Edgerton studies, this one scores the augmentation mammoplasty group as psychologically healthy based on the tests used. The authors conclude that these patients do not have lower self-esteem, or body-image disturbances. They show no evidence of depression, social problems, or of having increased gynecological surgery or psychiatric treatment.

A 1970 study of 20 Scandinavian augmentation mammoplasty patients (Goin and Goin, 1981) suggests that common findings among these patients are: pronounced shyness, avoidance of public bathing, difficulty in buying clothes, sexual problems, and teasing about their small breasts. Seventy percent of these patients are described as having "psychiatric symptoms or abnormal personality strictures" (p. 196). A Swedish study (Beale, Lisper and Palm, 1980) of 64 augmentation patients compared with 28 controls found the surgical patients to feel less certain of themselves and less
feminine. It is reported that the augmentation patients had unrealistic body images: often thinking that their breasts were smaller than they actually were. They were appraised as having "weak ego(s) and low self-confidence" (p. 137), and to have come more often from homes where there was insecurity, criticism and parent-child turbulence.

The final study that I will mention is reported by Schlebusch and Levin (1983). These authors compared a sample of 20 augmentation patients to a control group of 20 patients from a general hospital population (who were supposedly free of psychiatric illness) and found the augmentation group to have low self-esteem, depression, self-consciousness and anxiety, poor body-image, and psycho-sexual problems. Sixty percent of their patients traced unhappiness with their breast size back to adolescence. Sixty percent reported that their male partners repeatedly commented on their inadequate breasts or expressed preference for large breasts. Thirty-five percent of the surgical patients had been divorced or remarried compared with 5% of controls, and present marriages were reported to be unhappy in 50% of the surgical patients versus 15% of controls. Significantly more of the augmentation patients than the controls had low self-esteem, depression, feelings of extreme self-consciousness, poor body-image, clinical anxiety, and problems of sexual dysfunction.

Perhaps I might end this section, which has contained some recurrent themes but also some perplexing contradictions, with the summary statements of Goin and Goin (1981) in their chapter on augmentation mammoplasty. They believe that there are three distinct, but often overlapping groups of women who want their breasts enlarged. The first,
and largest, group is composed of:

women who feel fundamentally unsure of their femininity and believe that they are somehow incompletely realized as women. Some may have been deprived, either physically or psychologically, of adequate maternal nurturing. For them the full breast represents the mother they lacked and the mother in themselves.

This quote assumes that the reader can accept the theoretical position that a large number of augmentation mammoplasty patients are unconsciously driven to seek full breasts as a substitution for their missing or inadequate mother. In the Freudian framework, the mother's breast is the infant's first "object" or the first valuable entity that exists apart from the "self". As the infant develops psychically, this first important object, in reality only a part of the mother, is transformed into the total person of the mother. "Thus the breast", state Goin and Goin, "while consciously representing femininity, sexuality and womanly attractiveness to these adult patients, unconsciously really represents the mother" (p. 197). I find this position less than optimal as an explanation, not only because one's mother becomes more than a "completed" breast, but also because inadequate mothering is incomplete as a rationale for a person's feeling less than totally feminine. We are placed in a society that glorifies the breast and views a large bosom as the definition of womanhood. This culture-wide obsession with breast size is surely a major determinant of seeking breast enlargement as the woman is presented with multiple reminders that her own breast size is inadequate compared to media and advertising images. I am reluctant to blame only the ever-maligned mother for yet another unfortunate outcome in her children.

The second group, stated by Goin and Goin (p. 201) as "less complex" psychologically, includes women who perceive their breasts as normal prior
to pregnancy, only to have them involute (shrink) after childbirth and breast-feeding. These women seek to restore what was once present.

The third group are those women who seek this operation for purposes of "sexual exploitation or exhibitionism". These patients are pronounced by these doctors to be the most psychologically unstable group and should be approached with "some degree of caution" (p. 201).

The Goins mention the evidence from the medical literature indicating that a large number of augmentation mammoplasty patients are depressed at the time of their initial visit. They state that their own data point to the fact that an equal number of facelift patients are depressed preoperatively. They advise paying close attention to the cues indicating depression, and referring patients with "true depressive illness" (p. 201) to a psychiatrist. The Goins do not state here, however, that the surgeon should not operate on such a patient. They advise the surgeon and his staff to be prepared to provide a mildly depressed patient with a lot of reassurance and support postoperatively. Their final quote crystallizes their position on this subject:

Like the rhinoplasty, the primary effect of this operation is to increase the patient's self-esteem and to diminish or eliminate her fixation on a particular body part. When a patient some time after an augmentation mammoplasty says that she no longer thinks of her breasts, the surgeon can be assured that this is a psychologically successful result regardless of the physical nature of the augmented breasts (p. 201).

Patients Report Postoperative Feelings

The reason that Dr. Goin made the above-quoted statement that labels many augmentation mammoplasties "psychologically successful" regardless of the physical outcome, is the data from some published studies which indicates that most augmentation patients are happy with their
results. This in spite of the fact that a large percentage (usually quoted as 33% but sometimes much higher) of these women end up with very firm to hard breasts, and other complications as well. I am reminded of the Edgerton studies (1959 and 1961) where Ivalon and Etheron sponges were implanted, which according to Dr. Goin, produced breasts which "were almost invariably hard" and which did not "look particulary natural" (p. 198). Thirty of Edgerton's first 32 patients are quoted as "extremely pleased" (p. 198) with the results of their operations. Dr. Goin reports the results of Edgerton's 1961 study as very similar. In Hetter's study (1979) of 165 augmentation patients, an average of 64% of the women had breasts that became "firm" and 41% had a "noticeable change in nipple sensation", and 10% had a "shape problem" (p. 153). In spite of these, and other complications, 96% of these patients felt "the result of the operation lived up to their expectations", 88% said they were "satisfied with the result", and 96% reported they would "have the operation again" (p. 154). The authors mention that 20 of the patients were not satisfied, noting that all of these had capsular contractures (hardened breasts) and three also had nipple hypersensitivity.

In another study (Kilmann, Sattler, and Taylor, 1986) 75 women who had undergone augmentation three months to three years previously responded to a questionnaire that evaluated five areas of their personal and relational functions: 1) body and self-image, 2) attractiveness, 3) sensual sensitivity of breasts, 4) sexual life and 5) relationship with partner. The authors state that the 54 women in ongoing relationships reported positive effects of the surgery on their relationships, although not to the degree they had anticipated. These women are said to have
perceived surgery to have significantly improved their attractiveness, as well as their body and self-image. The partners of these women are represented as having a greater interest in sexual activity, as believing the sexual relationship to be enhanced, and as perceiving the woman to be more attractive. It should be noted that 75 women out of 250 returned their questionnaires and therefore became active participants in this study. It is very possible that women who had less successful results or who were unsatisfied for other reasons might elect not to participate in such a study, with the result that most responses come from patients who were pleased. This, of course, might result in a study "proving" that personal, sexual, and relationship functioning were better for everyone. Four women of the 75 who responded to this questionnaire reported some negative effects stemming from the surgery, which included: two women with decreased nipple sensitivity, three women with breasts which were hard and/or painful to the touch, and two women who were depressed for several months after surgery. The authors state that these negative effects for "a small percentage of women who underwent augmentation surgery are not inconsistent with the findings of others" (p. 377). I would suggest that the results of this study and others that depend on questionnaire response might easily be influenced by a tendency for satisfied customers to respond and dissatisfied customers to ignore the request for study participation. It has also been suggested that the patients who have had this procedure have invested so much energy and money in having the implants put in, that they cannot bring themselves to admit afterwards that it was a mistake or that they are not happy with the results. Additionally, it would seem that very few patients ask to
have the implants removed, unless an infection develops. Goin and Goin (1981) report only one patient in their practice of 17 years, a woman physician, who asked to have hers removed "for personal reasons" even though her breasts were "perfectly soft and natural" (p. 191). It is very difficult, it would seem, for women to go back to their previous small-breasted state after having had implants. Also, in the event that the implants were removed, the woman would then be left with scars and other possible complications and no end gain: no breast enlargement. Therefore women may often elect to keep even unsatisfactory implants in their breasts and may minimize or deny dissatisfaction and unhappiness as they know the only solution is implant removal. The patient is willing to trade hard breasts and other complications for increased breast size and the secondary gains this brings.

Goin and Goin (1981) suggest that if the patient is happy, then the surgeon should be happy, regardless of the technical result. I think that we should consider carefully the studies that claim such high satisfaction rates for augmentation mammoplasty patients, since many of them may feel their options postoperatively to be severely limited.

**Beauty Ideals: Mothers and Female Figures**

Mothers and female family members are important models for how a young girl should look and act, but they are not the only archetypes for appearance in a social vacuum. Marlene's mother was an immigrant from Germany who "had no beauty routines at all -- she barely wore lipstick". Marlene therefore states: "The only women of beauty in my life as a child were probably movie stars".
Susan describes her mother as "very attractive, tall, slender, sophisticated". She was, and is at 62, a woman who is "very interested in her appearance": someone who always wears makeup and has her hair "nice". Susan’s mother, however, "doesn’t really believe in plastic surgery". When Susan first told her about the liposuction procedures she would be having, her mother "didn’t even want to talk about it". Her mother feels that "these things are unnecessary" and that "people should be happy with the way they are". Susan mentions another influential female in her life, an aunt, "who is very close with me", who "was very beautiful". This aunt is 72 years old and has a husband who is 10 years younger. She attends senior citizen aerobics and Susan states: "If she could afford a facelift, I know she would get one".

Kate was raised in an "all female household", with her divorced mother and grandmother. Since I have asked her about the female models for beauty she looked to, and since our overall topic is her breast augmentation procedure, she playfully informs me that her "grandmother was a 42D" and her "mother was about a 38C". She goes on to discuss her mother and her childhood:

My mother was an extremely external person, and I’m an internal person. She valued things on the outside: The way people looked, the way they wore their clothes, the way they carried themselves. She was always dressing very -- sexual -- in a sense, but not by today’s standards -- but by 50s standards when I was growing up as a young child.

She had this vanity that was like this fairy-tale place -- all this lace falling from it. ... And she would spend a lot of time on how she looked. I kind of associated -- somehow -- by those interactions that this is something that is really important. As I got older, I didn't develop in the bust area. This is really funny now, but it wasn't so funny back then, and kids at school used to make fun of me.
Kate's mother became very concerned when she "still didn't have [her] chest" by the time she was 12 or 13, and took her to the family doctor. He pronounced that everything was "fine", and if necessary Kate could "feed a child". This didn't help much at school, though, when she continued to be "ridiculed" by the boys. She states that this was "just real painful". She relates a reassurance given her by her mother at this time: "'If someone really loves you it's not gonna matter'. It made me realize that someone was gonna have to care a lot about me -- to overcome this -- this was a problem."

Marlene had a no-nonsense, and I later learned a quite critical "old-country" mother who dressed her in clean but non-stylish clothes, contributing to her sense of not fitting in. She turned, therefore, to movie stars and day-dreams of her glamorous future: "You know, you imagine yourself eventually growing up and becoming a little princess or a queen, or something like that -- or a movie star". Susan had a model for beauty in her mother who she felt was "very attractive". This mother, however, doesn't believe in plastic surgery and leaves Susan unsupported in her quest for surgically-created beauty. She finds understanding in her aunt who was "very beautiful" and would seek surgery herself if she had the money. This aunt, we note, has a husband ten years younger than herself: a pattern Susan is repeating currently with her much younger boyfriend. Kate's mother, described as attractive and sexy, provides the most obvious model for a daughter growing up in America in the 50s and 60s. Interestingly, this "perfect model" mother seems to be one who has been unable to connect with her daughter on other than a physical plane. She is a single parent, and, it would seem, unsure of how to cope with a
child who is acting out in order to garner more attention. Kate remembers wanting to be "so bad" that her mother would stay home and care for her. Her plan backfired, and her mother, acting on the advice of the family physician, put her in a Catholic orphanage during the week. Kate states that she felt "abandoned". She also speaks of having missed the experience of being "daddy's little girl", where she would have been "O.K." just as she was. She speaks, too briskly, of that "early reinforcement" where "daddy loves you and you're perfect". This situation is somewhat reminiscent of Druss' study (Goin and Goin, 1981) which describes his group of breast augmentation patients as having difficult relationships with their mothers and passive fathers. Marlene, who found her mother "critical", reports a warm and supportive father-daughter relationship. Both Kate and Marlene report unhappy childhoods, a factor which has been mentioned in the early lives of some of the patients in the previously reviewed studies. Marlene currently, at 44, feels "confident, comfortable and happy". Kate who at 35 has a good second marriage and an interesting job, appears to be working toward happiness herself: although it seems obvious that she has more to overcome before she will be able to echo Marlene's statement.

Life and Self-Appraisals Before Surgery

Susan laughs as she relates that she was "probably considered a chubby little girl" and that is "why I developed all my fat cells". She was fed by a mother who had grown up on a farm and who therefore ate "bad", referring to consumption of red meat, eggs, refined sugar and other non-health-food items. It sounds like she never really considered herself
thin, but she credits having children with permanently changing her figure.

From the time I graduated from high school and I had my first child, I think, at 18, 19 -- I spread and never lost it. And I have been thin -- I've been down to a size 9, and still had the hip problem.

Now Susan is 38 and states:

I feel really young and healthy inside but then when I look in the mirror and see -- saddlebags, I go, God -- for as good as I feel I shouldn't have that -- or you know -- I've never really thought about a facelift yet, but I'm sure when the time is right I'll do it.

Another woman, a health club member, has joined our conversation (this is the woman with the alleged Karl Malden nose) and asks Susan if she could "work that off" (meaning her saddlebags). She continues: "I'd hate to come up here and work all the time if you could just go somewhere and have it all sucked out". Susan replies:

I've done as much as I can do! I teach six aerobic classes a week, I eat the right foods, this is just brown fat cells that will not -- even if I lost weight and got real thin I'd still have the bags -- it's just there.

Susan says she likes the way she looks but adds this:

Since this procedure's available, I want my saddlebags to be taken off and my stomach -- I would like to have my eighteen-year-old figure back -- who wouldn't? So, I can get it -- so I might as well. If they didn't have the procedure available, if nobody did it, I would just be satisfied with the way I am.

And since I've started studying about the body and the fat and the tissues through aerobic certification I realize that normal people don't have fat pockets so -- I want to get mine -- taken away. That's the bottom line.

I ask Susan about the breast augmentation procedure she had in 1979 and why she did it. She replies, "I just wanted to look better in my clothes". I ask her how she looked before the operation and she says:

Probably I would look in the mirror and think I had a saggy chest, as women have children their breasts -- kind of deflate and hang down and that's what I felt like.
I would go to parties and places with other people and I would see women in low cut dresses with lots of cleavage and I would say "wow!" You know, so when the procedure became kind of popular, I did it.

Marlene explains that when she got married at 23 she felt she was "overweight and heavy looking", and describes herself further as follows:

I was very thin built everywhere, I was small-busted but I had large hips. I had what they call the pear-shaped figure -- and I have very large European legs. And I always perceive myself as that fat little girl -- even to this day I have that image of being overweight.

Marlene also factors in the variable of relationships with other children. She felt different and ostracized. "When you are a child and you have these feelings ingrained into you and the reason it happened is because the children would make fun of you -- and I appeared to be shunned by my friends."

When I ask what the children made fun of, she answers as follows:

Your overweightness. I wasn't real, real fat, but I was European and had the rounded rosy cheeks and the rounded body. And that's very European-looking. And since we were first generation American-- and my mother was never into the real fancy clothes. So I was always dressed probably for my size -- uh -- not properly. My mother wasn't into fashion -- she wanted to be neat and clean, that type of look -- a decent girl.

Marlene never saw herself as very appealing. She states:

I never could undress in front of my husband -- I mean, I'd have to put my nightgown on or something -- 'cause I was always embarrassed because my breasts were very -- small -- not only were they small -- they were disproportioned. One was larger than the other.

The following is Marlene's response to my query about why she had the augmentation, and how it fit into her life.

I was married, at that time for 10 years, and I didn't have a real solid marriage. I'd had my children, and my husband was very into his career. And things were going not so well in the marriage. I had a real low self-image, because the husband I was dealing with was an alcoholic, and he dealt with me in a very critical manner. I never looked good enough, I never was good enough -- and that's
very ego-deflating, I guess, for a woman.

So I figured, well, I'll go and have this done because then my figure will be well-proportioned and -- So I went and had it done -- and I did it for myself -- but, I did it with the intent that possibly it would make the marriage better. You know, you have sometimes an underlying reason that you don't tell yourself you're doing it for -- you know what I mean?

And now, looking back, I'm sure that was the reason. I wanted the marriage to be saved -- I thought well, if I improve my appearance and I look better, then this man -- how can he say that I'm not the person that I think I am. I was trying to prove it to myself and to him at the time. But, at the time, I was telling the physician, 'well, I'm so flat-chested' -- which I was, I mean, I put a T-shirt on, and the problem was, my husband was a, I don't like to say the word kidder, but he would joke with me, all the time, about my appearance. And after awhile, the joke is a reality. This is how he communicated to me his displeasure in something. And I look back now, and I can see that these were the reasons that precipitated me going in to have that done.

Kate has never considered herself overweight, but felt, as has been previously related, very self-conscious and ashamed of her small breast size beginning in early adolescence when the other girls seemed to be developing and she was not.

When I asked Kate if she had considered having the operation earlier than she did, she said that she talked about it a lot in her early 20s, because she "always felt insecure putting on a swimsuit". When she was in the army she could have had the operation done for the cost of the implants, but she felt it was "experimental", that they were "looking for guinea pigs" and that she hadn't liked the idea of the scar she was told she'd have. "I guess I was never really sure that was what I wanted to do", she says.

Kate met her first husband while in the army: he was one of her instructors. Unfortunately he was "a real sicko" and abused her verbally and physically. She relates, with a tone of disbelief, that she actually had
married a man who "didn't like flat women", who used to tell her to gain weight so she would have more bosom. She divorced him after 3 1/2 years of marriage. Kate finished college and graduate school, and kept working in her field of academic counseling. Kate describes how she felt about herself when she met her second husband:

And I thought I had worked through it all. I really thought I was comfortable with my body, I was in shape -- When I met my husband I was in the best physical shape I've ever been in in my life. I weighed 114 lbs. I had cardiovascular endurance, my muscle tone was excellent. I was really in the best shape I'd ever been in my life and I felt really good about myself. I had a lot to feel good about-- having overcome in those five years since I left my husband -- the things that I'd accomplished.

When Kate and her second husband were dating, she began to realize, as she relates: "This man likes breasts!" One day she actually asked him if he'd prefer her with a larger chest. He replied that he was working on accepting people: "where they are, who they are and what they are" at that point. She states she had a "real hard time" with that and that the old feelings resurfaced.

I really thought I was a point where I felt good about who I was and it really wasn't an issue. It was masked -- it was underneath everything else, 'cause it came right to the surface and it brought back all this stuff from my ex-husband, my mother, all the kids at school. It was like I was right back where I was years before. And he would tell me that it didn't matter, but I became obsessed with it. Everybody I noticed -- I noticed their boobs, I noticed if they were like -- normal. And everybody, during that period, had large chests -- everybody I saw. [This was in 1985 or 1986] It was like everybody I noticed had them and I didn't and I was really feeling inadequate.

At this point I ask Kate to describe her breasts before the surgery.

Actually I thought they were rather cute before I ran into this situation. I felt like I had grown to accept them. Then I went through this like -- I couldn't stand to look in the mirror. That, there's nothing there.
Kate further elaborates on what she would see when she would force herself to look in that mirror:

Inadequate -- not attractive -- but, it be honest with you I didn't really feel unattractive either. I felt the shape was fine. There was nothing much to sag -- I was really small, obviously, so that wasn't an issue. And I was happy with the nipple color, nipple shape, and the areola -- some people are really uncomfortable with that and they have an ugly feeling about the whole thing. I didn't have any of that. I just felt inadequate -- small.

She relates an incident involving a bikini that became a turning point for her. This particular bikini looked "great" on her, and her husband, with whom she was then living, told her how nice it looked. She noted, however, that when she moved the top wouldn't stay in place. "I couldn't wear it", she says, "the top opened up". She was quite frustrated and changed, she relates, into a one-piece swimsuit that made her look "flat as a board". She was "really angry" and decided "next summer it's not gonna happen".

**Breasts as a Solution to Personal Unhappiness**

It is worthy of note that both Marlene and Kate report feelings of great unhappiness and alienation during childhood, as has been discussed. Marlene was ethnically different, overweight and non-stylishly dressed -- a series of characteristics that no doubt contributed to her ostracism by her peers. Her self-description includes: "large European legs", "large hips", "small, asymmetrical breasts", and a "pear-shaped figure", she was "that fat little girl" -- all of the images are negative and non-accepting. Kate was extremely self-conscious about her breast size from pre-adolescence on. She doesn't seem to find as many parts of her external self as unattractive as Marlene does, however. In the course of our talk she states she didn't really feel unattractive as a person, and talks about being
in excellent shape and having "great muscle tone". Her negative images are honed in on her breasts which are described as "inadequate, not attractive", "nothing there", and "flat as a board". The Shipley study (1977) reports the breast augmentation patients to be more self-conscious about their bodies than either of the control groups, and states that 89% of these women had been self-conscious about their breasts since puberty. Both Kate and Marlene's statements indicate marked bodily self-consciousness. Kate specifically states that it began for her at puberty. Susan doesn't describe an unhappy childhood, although she describes herself as "chubby", and didn't become upset about her breasts until after her pregnancies, when they became "saggy", "deflated", and "hung down". She would fit, with this description, into Goin and Goin's (1981) second group of patients: those who report no unhappiness with their breasts until after childbearing. These descriptive images of her breasts are reminiscent of those offered by the facelift patients and call to mind the used up/empty, symbolism that has been previously mentioned. She does, however, report another bodily imperfection which as been worsened by pregnancy: a certain "spread", and now "saddlebags". Part of her self-description focuses on her perception that "normal people don't have fat pockets": a link to the common perception in American that fat is synonymous with abnormality and disease. And since the procedure can be done, she wants it; haven't we seen ample evidence that whatever technology exists will be used? She is therefore obsessed with having extensive liposuction of hips, legs and abdomen, as the cure for her "medical" problem of "brown fat cells". Susan wants her 18-year-old figure back and is certain that the current plastic surgical technology will enable
her to regain it. She is not alone in wishing for the unattainable: thousands of women are opting now to have liposuction. Dr. Stallings tells us that his patients call the liposuction cannula (tube) "the magic wand", ("Plastic Surgery", 1988, p. 5) and he agrees with them. This image blurs the line between surgical technology and fairy-godmother transformation: denying the reality of surgical risks. The patient, who has never seen a wound infection nor the aftermath of bruising, swelling, and possible poor results, imagines herself instantaneously and miraculously bulge free -- and ready for the ball.

Breasts as a Social Phenomenon

Does the impetus to have one's breasts enlarged come from within or without? There are those who would agree with Edgerton and McClary (1958) that "personal symbolic meanings constructed from [the person's] own life experience were more significant than cultural and social factors" (p. 279). This viewpoint would form the basis for viewing augmentation mammoplasty patients as falling on a psychiatric continuum somewhere between depression and personality disorder on one end and schizophrenia on the other. Another viewpoint that can be entertained, however, would be that cultural and social factors are of pivotal importance in an area such as external bodily appearance, and that indeed the external pressures of a society obsessed with beauty determine the person's "life experience" and therefore control her "personal symbolic meanings". Studies such as Shipley's (1977), which finds the augmentation mammoplasty group psychologically intact, would tend to reinforce the hypothesis that this surgical beauty seeking is driven more by social forces than by personal neurosis. Plastic Surgeon Dr. Julien Reich believes that this may be the
case as well:

Our preoccupation with the individual psychology of our patients should be broadened to include certain aspects of social psychology—namely, the social changes which have occurred in our society and the ways in which people behave toward each other (1975, p. 5).

Dr. Reich, who is Australian, mentions several social changes which he believes to be increasing the demand for surgical improvement of appearance: The "worldwide" emphasis on youth as synonymous with capability, the increasing interest in physical fitness and a body that appears healthy, the popularity of outdoor activities and the abbreviated costumes that are part of such activities, and the fact that ready-to-wear clothes are available in a range of style and at much lower prices than custom-made clothing: this may be a strong economic incentive for the attainment of a standard figure. Reich quotes a previous study that he did in 1969 on psychological aspects of seeking cosmetic surgery which allegedly demonstrates that "less than 5% of the patients ... expressed a wish for magic beautification." According to Reich these women wanted a "tidy appearance, to escape being regarded as different, to have the normal physical endowments for their group, to reestablish a previously satisfactory appearance, or to avoid being discounted as a useful member of society on the basis of age" (p. 6). It is interesting that both Susan and Kate mention feeling that they are not "normal" or just want to be "normal". The question is: how is "normal" fat distribution and breast size defined in the late 80s, where the Barbie-doll cultural norm is being approached by more and more women through the aegis of cosmetic surgery? I feel that "normal" used to encompass a far wider spectrum than it does currently -- contributing to the "dysmorphophobia" of those of us who remain surgically unaltered.
It is apparent that the attitudes of the women I am quoting did not develop without continual barrages of negative feedback from not only nuclear family members but also from peers and marital partners. Marlene mentions the comments and cruelty of her peers, and it is obvious that this experience of being "different" made a lasting impression. She then married a man who made "jokes" about her body. It is hardly surprising, then, that she found it impossible to undress in his presence, and that her perception of herself as unattractive was strongly reinforced. Kate was "worried over" at home, but then continually "ridiculed" by the boys at school when she seemed to be developing no bosom. She married a man who made sport of her small breasts and who was abusive in general, worsening her sense of extreme inadequacy. Are the experiences of these two women unusual? I do not believe that they are. Most of us who have grown up female in America have experienced the commentary of pubescent and adolescent males on our physical endowments: either very negative or glowingly positive, but rarely neutral. If only this dialogue stopped when adolescence ended! It is apparent that most men continue endlessly to evaluate the bodies and faces of women: some of them using derisive comments about bodily "flaws" as a form of abuse. Kate's second husband, while not abusive, seems unable to reassure her that he is, indeed "OK" the way she is. Instead he lets her know he is trying to "accept" her the way she is, approves of her quest for augmentation surgery, and registers his approval of the outcome. It is interesting to note that although both Marlene and Kate speak in detail about what their husbands though of their bodies, neither of these women mention the physical attributes of any of their husbands.
The voices of other women who have had to endure comments and incidents having to do with their breast size can be found in various print and media sources. Oprah Winfrey did a program on "Breast Alterations", in which a woman named Phyllis, who describes herself as "too flat" was being interviewed. She tells the following story. She was buying some items in a store, and was wearing a sweatshirt, no makeup, and an afro hairstyle. The clerk, mistaking her for a man, said: "Is that all, sir?" (1987, p. 4). Although the clerk noticed her error and apologized, Phyllis was devastated. She also mentions her difficulty in buying clothes: speaking wistfully about wanting to wear a strapless dress but having nothing to hold it up. Another woman speaks of the mortification of having very large breasts at an early age and being fondled by a boy at school. Other psychological and physical difficulties associated with very large breasts are mentioned: clothes buying difficulties, feeling the stares of strangers, fatigue, and backache. These women can feel so conspicuous that they sometimes elect to have a reduction mammoplasty: a procedure that decreases breast size but often results in decreased sensation, marked scarring, and inability to breast feed. It would seem that either very large or very small breasts can pose an almost insurmountable social and psychological problem in America. Dr. Irene Kassorla, a psychologist speaking on this same Oprah Winfrey show, mentions that sometimes she recommends breast reduction surgery when women are really "suffering", and states "if a woman is absolutely flat and feels boy-like, you know, it [augmentation] seems to be justified" (1987, p. 5). It would seem that this is rather a prevailing belief in America: that an absolutely flat-chested woman, because of the trauma and feminine-identity crisis she may have to
endure as a consequence, should avail herself of the opportunities to have her breasts enlarged. It used to be the case that women could wear padded bras or "falsies", without too much trauma. Now that augmentation mammoplasty is becoming well-publicized and more common, this older solution is no longer adequate. External padding is not "real" enough—perhaps even worse than no breasts. And with no breasts, one moves into the category of "other", of anomaly, a place where one may feel herself to be physically incomplete and socially inert.

The Stated Reasons

Why do women say that they wish to have their breasts enlarged? Are there certain "correct" medical and social reasons that one must intone in order to be "chosen" as a patient? We have heard the statements of the surgeons, who, in print at least, seem wary of patients who are seeking the procedure for someone else or envision the operation as a solution to marriage, interpersonal, or employment difficulties. The evidence is in, however, that patients do realize what they are "supposed" to say -- they read the plastic surgeons' interviews on the subject -- and that they tell the doctors what they want to hear. Marlene tells us that she was, in truth, trying to save her marriage by having the augmentation. She feels, as do Goin and Goin, (1981) that many women simply will not reveal their innermost thoughts and motivations to the surgeon. What they can, and will do, is tell the doctor of problems that they have in finding clothes that fit and assure him that they are doing it for themselves. This is the very thing that Susan states in her conversation with me, she "just wanted to look better in her clothes". She says: "To me it's [plastic surgery] nothing that's so drastic! I think it's wonderful
if you can make yourself look better and be satisfied with it just for yourself, and not to suit someone else”. Susan may believe, as do so many others, that she has done it “just for herself”: that no one else figured in her decision to enlarge her breasts, and now to undergo liposuction. In truth these notions about how a woman should look are so pervasive, so interwoven into the fabric of our thoughts and the tapestry of our dreams that Susan underestimates the scope of her action: She meant to do it for herself, but she has done it for all of us.

The Decision and Doctor Shopping

Susan made her decision to have breast enlargement surgery after seeing the results of augmentation surgery on her sister-in-law and another friend, both of whom talked with her about the operation and what to expect. These two women showed their breasts to Susan, and after seeing their results and reading some books, she chose the surgeon they had used. He was a cardiovascular surgeon who did cosmetic procedures two days a week. She states that he showed her examples of saline implants so they could choose the correct size and showed her pre and postoperative pictures of other women who had had breast enlargement. All the photographs that she was shown depicted “good” results. He mentioned to her that “there could be some hardness”, and that this occurs if the implants are not massaged daily.

Marlene was working in the recovery room in 1978, and she would see augmentation procedures being done and the results. She says “breast augmentations are the nicest portion ... I guess to me it it’s the aspect of cosmetic surgery where you see results immediately”. She contrasts this operation to nasal and facelift surgery where there is a lot of swelling and
bruising and "you have to wait forever". She describes a scenario where the implants are "put in", the doctor puts an ace bandage on the patient for 24 to 48 hours, this is removed and a bra is put on and "you immediately have your results". Marlene goes on to describe the aftermath:

And therefore the pain that you go through for a few days is immediately relieved as soon as you see the results of how terrific you look. ... I mean, you just have that bra on and there you are. ... I mean, you're sticking out and you feel good, and they feel soft, and they makes you very happy ... and so you're delighted that you had it done.

Marlene goes on to discuss Dr. O., who did her augmentation:

[he] is one of the very few plastic surgeons -- he's not a marketing-type physician. He's a strictly plastic man -- he does what you tell him to do.

He's not a marketing-type plastic surgeon, he's a doctor. They're a strange breed, but they're out there. He does what you want him to do -- that's it.

I ask Marlene if she thinks any of these cosmetic surgeons are unethical.

Oh yeah! Sure -- there's a lot of them out there, that they're in it for the money. When you go in the office you'll think that they're just there to help you, and want you to look good. Bottom line is, they don't remember your name, they don't really care to ask too many questions. They just want to know what is it that you want, do you have the money, and I'll show you what can be done. But they do it in such a way that it sounds like they're sincerely interested in you. As I've said, these are men who are trying to market their business -- because that's what cosmetic surgery is, it's a whole marketing effort. And they're the first physician that have had to market themselves, because all other physicians, you go there when you're sick. Here you go when you're healthy! You're finding somebody to do surgery on you to make you look different.

Kate tried to educate herself about augmentation mammoplasty even before speaking with any surgeons. She visited a medical bookstore and looked at plastic surgery texts. After this initial preparation, she made appointments with three plastic surgeons. One of them tried to "fix her up" with one of his friends. She had "a hard time with that", and thought
him "unprofessional". She visited one surgeon who had operated on a friend. She chose Dr. R., a man she describes as "serious", and who didn't lie to her. She talks about her discussion with him as follows:

I knew it all when I went in. I asked him about all the side effects. I have a lot of respect for him as a professional -- he was good. When I said I'm concerned about the nipple sensation, he said: 'Well that is a problem for a lot of women and that's something that you have to consider when you make this decision'. Whereas the other guy said: 'Well sometimes women are more sensitive'. Yeah: more sensitive in a negative way. Everyone I know that has hypersensitivity -- it's painful.

Kate was very concerned about the possible loss of nipple sensitivity, and vacillated back and forth on whether to have the operation. She describes herself at that point as "totally confused". She states that she is "anti-surgery, anti-the medical profession, really. I think that cutting on the body is just insane -- and yet I did this to myself". A month before her scheduled operation, she called the doctor and cancelled the procedure. She still wanted it done, however, and a week before the originally scheduled date she again called the surgeon's office and asked if she could still have the operation done on that day. She was told she could, and this time she went through with it. And now, she states: "I've regretted it ever since".

All three women believe that the surgeon who did their operation was a skilled and ethical professional, but both Marlene and Kate speak of instances where a doctor could be or had been unethical. Their comments about these doctors underscore the fact that unprofessional and unethical conduct is frequently not clearly defined and may consist of instances that might be considered "grey" and not "black" such as attempting to arrange a date for a friend, being unclear about the meaning of terms such as "increased sensitivity" and only feigning interest in the patient as a person
apart from her checkbook. I was surprised that Marlene, who has been such an enthusiastic supporter of cosmetic surgery and its practitioners, would entertain the sentiments that she does about some surgeons who are in it "only for the money". She represents cosmetic surgeons as being the first doctors who really need to market themselves, since their patients are healthy and elect only to make themselves look "different". I was also most interested in the fact that she chose the word "different" and not "better". It is widely assumed that cosmetic alterations will make a person look somehow better, even though we must realize that the effect of any surgical changes will be subjective: judged positively or negatively in the eye of the beholder.

The Operations and Their Aftermath

Implant Placement Technique and the Consequences

All three of these women had their breasts enlarged, and two of them, Susan and Marlene, are unequivocally positive in their assessment of the experience. Kate remains conflicted about having had the procedure and its effects: even though she is beginning to recognize that her breasts might look nice, and that her husband finds her new breasts attractive. I would like to explore, in this section, each woman's responses to the surgery and her assessment of how she has changed, both physically and psychologically. In addition I will discuss the complications and concerns that the women speak of, interpreting them in the light of my own and others' knowledge of the issues.

All of the women speak of the pain that they had to endure after the operation. Susan describes the first 24 hours after the operation as "pretty painful". She had pain first "under the armpits and up in the
chest area. After about 3 days, when this soreness abated, she noted that under her breasts "where I had actually been opened up" was the painful area. She had "no problems", however, and that she "just bounced back" and went back to work in a week. She states that she never had any hardening, but that she did "exactly" what the doctor told her to do.

Marlene describes the postoperative pain she felt as follows:

It's like somebody had taken a hand and chopped you right in the center -- knocks the wind right out of you. And the pain -- I had my pain mid-chest, right above my waist. And your back kills you for abut six months until you learn how to get those muscles to support that front. Because you're putting about a pound or more--right in front and you feel like you're want to fall over. Especially the girls with the large implants.

Kate, who had subpectoral implant placement, is the most emphatic when describing her pain after surgery: "I wanted to be dead", she says, "It was horrible!" Dr. R., who did her implants, places them only under the muscle because of the frequency of capsular contracture with over-the-muscle placement. Kate, in fact, hadn't wanted them under-the-muscle but acquiesced when she heard his rationale. She bemoans the fact that under-the-muscle is much more painful and requires longer recuperation time. She spend the first three postoperative days in bed, feeling like she was on "the verge of death".

It is apparent that either type of enlargement procedure is painful and necessitates some recuperation time. It seems logical that the subpectoral procedure, an operation involving deeper placement of the implants, would result in greater postoperative pain for the patient. Kate's doctor does the augmentation procedure only in this manner because of the contracture problem. Dr. Franklin Rose, a plastic surgeon with a very busy practice in Houston, prefers the over-the-muscle placement and
gives the following rationale:

In my experience, implants above the muscle have a more natural feel and conform better to the patient's own breast. Particularly in women who exercise and work out regularly, the chest muscle can sometimes distort the implant if the implant is placed beneath the muscle. A few selected patients, however, will benefit from submuscular implants (1989, p. 40).

The question is, how is a patient to decide which operative procedure to choose? Should she opt for under-the-muscle placement which involves greater surgical risks, and a necessity for general anesthesia in order to have a lesser chance of capsular contracture and a better chance that her screening mammogram for breast cancer will be accurate? Or should she have above-the-muscle placement for a more "natural" look and be able to have sedation and local anesthesia, only to find her breasts turning hard in over a third of cases? It would be a difficult decision if one had all the necessary information. I am certain that the average augmentation mammoplasty patient does not possess all of the information necessary to make an informed choice.

Patient Perceptions and Satisfaction

Susan

It would be very important to understand how these patients feel about their surgical outcomes and about themselves, since they have invested a great deal of time, energy and money in their quest for surgically enlarged breasts. Therefore in this section I would like to present the patients' statements indicating how they see themselves now, what complications they have had, and how they now feel about having had breast augmentation. I will utilize other literature sources, when it seems useful, to clarify issues or expand a point under discussion.
Susan says she "never did have a bit of problems". She credits her good fortune to having chosen the "right" doctor and to having done exactly as she was told. She relates that when she's gone for physicals other doctors ask her who did her implants and comment that they were very well done. "I have not lost my shape for my age", she states. Susan describes herself further as follows:

You can look in the mirror and your breasts don't sag -- If you're in a bathing suit or a low dress you have a lot more confidence: in the way you look, in the way you carry yourself. It's just a good feeling, a better feeling. Because I'm not a petite, little-bitty person. If I was, I would have probably never had it done. But with my -- I'm broad in the shoulders and I felt like I was too large for small breasts. I wanted more. At this point I'm very proud of my body -- even if I couldn't have the liposuction done I would just continue to work, work, work on my figure like I do. And, I like myself -- so, It's something I'm doing for myself and not for anybody, or any other reason -- other than just myself.

Here Susan justifies her need for larger breasts on the basis of being a large woman, and goes on to define the Protestant "body-work" ethic: one must continue to "work, work, work" on her figure. The problem is, that in spite of her statements, Susan is not proud of her body -- from the waist down. She states that she feels "really bad" about herself when she goes to aerobics seminars and sees the other aerobics teachers who "look like superwomen -- there's not a bulge anywhere". She feels she works just as hard as they do, and she doesn't look like them. This comparison, indeed, is probably a large part of the reason Susan will soon undergo liposuction.

When I ask Susan for her definition of a good-looking American woman, she answers as follows:

A woman that looks healthy, real healthy. A woman that's happy with herself -- and she looks good on the outside. But mainly: I think you have to be happy with yourself, and you have to be healthy, and then it comes out.
Here it is again: happiness and healthiness that "comes from within". I am still not content, however, and ask her how looking "good on the outside" would look.

In proportion. Their body would be in proportion ... they [there] would be -- no fat -- trim. You would look at someone and see them and there would be no saddlebags, or baggy skin under the arms, or maybe a saggy breast. It would all go together -- the body would be in sync, it would be symmetrical.

Back to the Golden Mean, and now it must be calculated horizontally as well as vertically: perfect symmetry in every plane!

Kate

Kate's description of herself after her subpectoral implant placement is disquieting, even though she qualifies it with some guarded optimism.

I thought I looked disgusting. First of all you're all distorted--that muscle has to stretch down and it takes a good six months for that muscle to stretch down. And so you have nipples underneath your breasts. [As the muscle stretches, the implant moves down.] I felt like a freak. I wasn't happy with them. I didn't think it was attractive -- I didn't think it was gonna be attractive. I'm just now getting to the point where I think, "Yeah they do look pretty nice". I'm just getting there. I'm just now getting to the point where I think they look nice. Fairly nice: I still don't like the way this one looks because of the contracture. I would also like to have them look a little more my age. There's no sag: they look like [a] 14-year-old's. People think I'm crazy when I say that, but I don't want to look younger; I want to look normal. That's just my whole thing, always feeling like I'm not -- normal. [She mentions that she was going to the left breast "fixed", but she's not going to now.] My husband doesn't find it distasteful that this one's a little lumpy. He likes it -- he thinks it's a definite improvement.

Kate doesn't want to stand out in a crowd; she wants to blend in. She is sure she is not "normal" now, and was not "normal" before, in much the same way than Susan felt she was not "normal" because she had some fat deposits on her hips. The irony is that having small breasts or some fat deposits is far more "normal" for the human female than having very large breasts and surgically sculpted thighs. As more of us make cosmetic
surgery our bodywork solution, however, we redefine "normal" to a point consistent with the superwomen Susan mentions.

I am interested in whether Kate would have the procedure again and I ask her this question.

Knowing what I know now -- I don't really think I'd do it cause if I'd have held on and passed through that stage of my life it would have been something I'd have worked through and I'd be OK with it. But I can't tell you for sure. Knowing what I know now; I'd never do it! And I discourage people when they talk to me about it. Because all I got was encouragement -- everybody thinks they're the best thing since sliced bread -- that they've ever done. I've just been crying: 'victim, victim, victim' but nobody hears my cries, because nobody feels the same way.

She mentions that she's run into only one other woman who has been dissatisfied after the operation, but states: "she had such serious complications". I feel that Kate's complications are serious, too, but I don't say this aloud.

Kate has stopped wearing some of her clothes now that her breasts are larger because she doesn't like the "attention" that she receives. Men, she says, often didn't, "look at her face" when she wore items she'd previously worn, such as tank-top dresses. She found this "degrading". She mentions that when she's dressed in her characteristic tailored style, that most people can't tell the difference. A previous boss still calls her "the president of the flat earth society".

I ask Kate what she would say to someone who was about to have breast augmentation done, and she says she would tell them "What lack of nipple sensitivity can do to your sex life. And the fact that they don't look normal -- they don't look natural".

Kate works out at a health club and mentions that she is now "self conscious" about it and must wear loose clothing because when she flexes
her chest muscles her implants shift positions. This is her description of the "disappearing boobs":

They [the pectoralis muscles] pull flat and push the implant up and out to the side so that it's flat and you've got this implant here and the little bit of breast tissue that's real is just hanging there.

Kate has larger breasts now, but her left breast has some hardening, and a little "lumpiness" and is a little "less full" underneath. She doesn't like the way the implants move and consequently how the breasts look when she works out. Finally, and most distressingly, her nipple sensation has not returned. Kate had read about all the possible complications beforehand, and this knowledge was then reinforced by the physician visits, so theoretically she should have been someone who was optimally prepared for any outcome. She alternated between thinking all the complications would happen to her and thinking that none of them would occur. In the end she wanted the procedure enough to override her anxiety and so was able to repress her fears for long enough to have the surgery. I ask Kate how she'd feel if she had a postoperative infection or major hardening of her breasts. "I can't imagining it being any worse than it's been", she says. "Because it really has been pretty awful. Even if everything had been fine it's been a problem psychologically".

At the end of our conversation, when we are discussing the length of time the implants must remain in a woman's body (20-30 years!) and the possible ramifications of this situation, Kate says she's "giving serious consideration to having them [implants] removed --in 10 or 15 years". She remains ambivalent about the implants. She has had physical and psychological complications as she has related: but she cannot give them up for the foreseeable future.
Kate is unhappy, and she was more or less "prepared" for the possible outcomes. What of the women who are relying on the data in media sources for their information? They are left with the confusing, conflicting, and misleading commentary of those who are marketing these operations.

Dr. Franklin Rose writes, in a recent article, that the implants used currently have been "bioengineered not to produce scar tissue around the implant, so that the breast can and usually does remain soft and natural (1989, p. 40). In another article Dr. James Moore states: "Occasionally, some patients experience breast firmness due to capsular contraction (excessive internal scar formation) but this, too, is treatable and shortly the patient is functioning as before the procedure only better" ("A Guide", 1988, p. 33). In this same article Dr. Seng Ooi states, about capsular contracture: "We see that complication. However, in more than 50 percent of these, the problem can be corrected through external compression, a procedure done without anesthetic" (p. 46). These statements are misleading to the reader. Neither Moore nor Ooi gives figures on the occurrence of this complication. Moore’s statement implies that all capsular contracture is treatable, which we know to be untrue. Ooi says he can treat 50 percent of hardened breasts. Even if we accept this and wish to be treated by an external rupture of the capsule (previously discussed), what happens to the other 50 percent?

Rose also mentions implants which have a "textured" outer surface, which can, "help the breast to remain soft" (1989, p. 40). He does not mention the potential problems with the polyurethane covered "Mem" implant. Marlene also mentions the use of this newer implant in our
conversation, saying that for some women she has seen the Mem implant to be the only one that has not become hard. Marlene doesn't mention potential problems with this product either, but others have. Dr. Timothy Johnson, speaking on an ABC News 20/20 broadcast on breast enlargement, says the following:

The newest competitor in the implant market is the polyurethane-coated implant called the Mem. It has a much lower rate of capsule contracture. But many surgeons are uneasy because they don't know what happens to the polyurethane when it biodegrades in the body ("Breast Enlargement", 1988, p. 11).

Dr. Irene Kassorla, speaking on the Oprah Winfrey show ("Breast Alterations", 1987) mentions that some doctors are worried about "liver problems, maybe, in 20 years, from the implant". Dr. Laurence Seifert, a plastic surgeon who answers her on the show states that this new type of implant is "reserved for the difficult and problem cases. There are mixed reviews in the literature, and we are all aware of it and counsel our patients. It's not the routine implant" (p. 7).

Perhaps not, for Dr. Seifert, but Dr. Gary Fenno, a Houston surgeon who does large numbers of breast implant procedures, states: "All I use is the polyurethane [implant] and I have less than six percent of patients with hardening of the breasts" ("A Guide to", 1988, p. 46). We see, here, that we can take nothing for granted. This new implant is represented as potentially hazardous by Johnson and Kassorla, is stated to be reserved for only difficult cases by Seifert, but is all that is used by Dr. Fenno!

Goldrich (1988) alerts us to an alarming fact about silicone implants: they have never really been approved by the FDA (Food and Drug Administration) because when implants first appeared on the market, in 1965, this organization did not require approval of "medical devices" before
they were marketed. When Congress gave the FDA the right to approve new medical devices, in 1976, those that had been on the market before that date were exempted. In December of 1985, according to Goldrich (1988) the FDA began a program called Medical Device Reporting, under which the manufacturers of breast implants are required to report failures when they occur. Each implant now has an I.D. number, in order to help doctors keep track of the devices. Unfortunately not much data has yet materialized: largely because implant "failure" is such a confusing description. This reporting system produced only 719 reports in 1987, most of them dealing with "broken" implants. No data on other implant problems, such as hardening, migration, or infection was reported, probably because some surgeons fear that a failed device will point out possible incompetence on their part. Another potential source of information that failed to yield any was Congressman Henry Waxman’s House Subcommittee on Health and the Environment which held hearings in 1987 on medical devices, but never heard any testimony on breast implants at all.

Recently, a federal advisory panel concluded that there is not enough data implicating silicone implants as a health hazard to warrant barring them from the medical market ("Silicone Breast", 1988). The seven-member committee has called for a three-step plan to study the safety of the implants over the next few years. First, a national registry of women who have breast implants should be established so long-range studies can be carried out to determine whether there is increased risk of breast cancer or other health problems. Second, the committee called for the drafting of a mandatory, standardized consent form to be signed by any prospective patient for a breast implant before the procedure can be done. Third, the
committee recommended an FDA policy to keep doctors and the public aware of any new information as it becomes available.

It will take several years to amass more data, and in the meantime silicone implants are still being used under this "exempted" category. The FDA has never approved them, but neither has it prohibited their use. New implant types are being developed, such as the polyurethane varieties, and they are being used at present for breast augmentation procedures. The patient must rely on the surgeon to explain the risks of the implant to her: for although she pays the doctor for the implants, she may never see their original packaging and will therefore not have any opportunity to read the manufacturer's inserts that will include information about possible problems associated with the product. As Paul Tilton of the FDA states: "The manufacturer considers the user of a breast implant to be the doctor, not the patient" (Bardach, 1988, p. 54). Tilton is quoted further as believing that many women across the country are clearly not being prepared for the dangers and complications. "Mammary implants are prone to failure. They do not last a lifetime. Plastic surgeons do not impress upon their patients that they may be subjected to repeat surgery, but in fact, that is the case" (p. 54). In speaking with some knowledgeable individuals who work with cosmetic surgeons, I have learned that in Texas, doctors must use a consent form that has been given to them by the state legislature. This form lists several complications of breast augmentation procedures, such as: scarring, capsular contracture formation, hematoma formation, changes in sensation, asymmetry of the nipples or breasts, and displacement or rupture of the implants. It does not list characteristics and complications associated with the various types of implants.
Therefore, although the patient will be made aware of risks listed on the operative consent form, she will not necessarily learn anything about the type of implant that is being placed in her body -- unless she asks for this information.

Marlene

Marlene discusses the aftermath of her breast enlargement procedure as follows:

So, with the breast augmentation, I went and had it done and it did no good for the marriage. It did a heal of a lot of good for me, though. After I had that done and this man was still not happy, then I realized: we've got a serious problem that we're not able to deal with. I think that was the beginning of me realizing I was a good person.

I think after the breast augmentation -- you can't help but your appearance changing a bit after the breast augmentation -- and yes, I did perceive that people noticed me a little differently.

I looked better in my clothes. If I was wearing a T-Shirt or a shirt, at least I had a chest on me! You can tell when a man is turning his head to look at you. I never perceived that before, but after I had that done, I did. Not that that meant a lot to me, but it did in that

[I mentioned that it was a subtle kind of affirmation].

Yes, you look good, because I'm going to turn once to look at you. I observed it more afterwards. So when I realized that, not that I acted upon it, then I sort of looked at myself differently. I said well, if other people can look at me and think I'm a good person and this person I'm living with -- he still doesn't like me the way I am. And I had enough confidence at that point -- and I said it was after the augmentation that I started to develop more self esteem. I think the breast augmentation was what triggered it all off, because at that point I developed a certain self confidence.

Marlene and her husband sought counseling, but were unable to save their marriage, and by 1981 Marlene was divorced. She goes on below to describe herself since this event.

And since then, I've been a very independent person. And realized I shouldn't have listened to him. I should have stood on my own two feet. And yes, I was a good person before and after the breast
augmentation. But, now that I have it, it's been a real great asset to my life. The other reason, the second reason, which is what I used to say was the first, is that I'd fit into clothes better.

She mentions that she has broad shoulders and broad hips and her breasts were out of proportion.

I needed the breasts, and I'm a 36C now. So I have a perfect figure. In fact, if my weight was at the right weight it was like a 36-26-36 -- it was a perfect figure to fit in a lot of size 8 and size 10 clothes. So, I just felt real good about myself. And from then on my career just began to take over -- I mean, I took care of the children and I've been career-oriented ever since.

You know, I think the best thing that happened to me, after my nose surgery, was having the breast augmentation.

Marlene has been pleased with the results of her breast augmentation, and has had no complications. When I read the transcript of her statements, I am surprised that she feels this operation was the beginning of her realization that she was a "good person", but this is indeed what she says. A woman might feel complimented to have men turn and look at her figure when this had never happened before, but Marlene conflates looking good with being good in this context. Unbelievably, she credits the new-found confidence that enables her to leave an unhappy marriage to her breasts, and not to her ability to work part-time as a nurse while successfully mothering three children and running a home. None of this is so surprising, however, when one considers the lack of prestige associated with all of the feminine activities in which Marlene was engaged. And she was failing in the one social relationship that she had with a man -- her marriage. Perhaps it is not so surprising, when one considers the context in which Marlene found herself, that even the affirmation of males who were strangers should make her feel "good".

I ask Marlene how she would have felt if the implants had turned
hard, and she answered "oh, terrible!" She mentions the frustration of women who must return to the doctor every three to six months to try to have the capsule ruptured manually, and that she has seen women undergo multiple surgical procedures to remove hardened implants and put in new ones. When I ask her about sensation to breasts and nipples, she says: "I think there's some reduction. Initially there's a lot, but I don't have any loss at all". Marlene is fortunate on this count as well: many women, like Kate, have permanent alterations in sensation. Physicians may downplay this risk however. When Franklin Rose is asked in a media interview if there is any change in feeling or sensation of the breast after augmentation, he says: "Usually nipple and skin sensation remains about the same. For a short period after surgery, there can sometimes be either decreased or increased sensation, but this generally subsides in a few weeks" ("Update on", 1988). The patient who reads or hears this reassurance is not likely to worry about this complication -- until it happens to her.

Marlene and I briefly discuss another complication -- one that necessitates implant removal -- postoperative infection. I have already discussed Morgan's assessment of this complication, which allegedly occurs less than 1% of the time, but which is very difficult and time-consuming to treat. Marlene describes a case of a woman who had a hysterectomy ten years after her augmentation procedure and developed an abdominal wound infection. The woman subsequently developed infections around both implants as well, the implants hardened, and they had to be removed. The doctors felt that the infectious process spread hematogenously (via the bloodstream) to the implant sites, which constituted "foreign bodies" within
the woman's body. An infection can result in permanent changes in the breasts which can be difficult or impossible to correct. In "Lisa's" case (Nashner and White, 1977) her first implants became "hard as a rock" (p. 53) and she agreed to a second operation when her doctor told her some better implants had been found. Two months later, her breasts swollen and painful, Lisa was told she had developed an infection and the implants would have to be temporarily removed. After this third surgery to clear up the infection, she noticed that one breast had shrunk down so that it was smaller than it had been before she had had the implants and had assumed a twisted shape. Even after her fourth implant surgery, her breasts remained very different in size and shape, and they have both hardened. She can't sleep on her stomach, comparing it to "balancing on two baseballs". But she states: "But I just can't stand to go through any more surgery. I guess I'll just have to learn to live with them" (p. 54). There are, very probably, hundreds or thousands of women who are "learning to live" with varying degrees of breast hardening and deformity due to complications of implant surgery.

Another questionable topic about which I query Marlene is the conflicting information appearing in media and medical literature sources about breast-feeding after augmentation mammoplasty. She states that breast-feeding is not recommended, and says, "I can't see why they would even want to. Why spend all this money on your breasts and then go and breast-feed a child; you're going to end up ruining your breasts". Marlene also mentions the chance of infection, as Dr. Morgan (1988) did earlier. She tells me that at least one of her twin daughters, who are both "flat as a board", has expressed a desire to have her breasts enlarged, and that
she has advised her daughter that she shouldn't breast-feed. Her daughter told Marlene, "Don't worry about that!" -- but this girl is 20 years old and unmarried. She can't yet know what she'll want to do when she is married and contemplating children. Not all plastic surgeons advise women to wait until they are finished breast-feeding babies to have implants. The ever-helpful Dr. Rose states:

Breast-feeding is usually not interfered with as long as the breast ducts are left intact. In fact, after pregnancy the breast retains its shape quite nicely because the implant can act like 'internal scaffolding'. Many women who breast feed without implants note that the breast loses its shape when they are finished, but the implant can help as a shape retainer ("Update on", 1988, p. 31).

Certainly Rose makes no mention here of increased risk of mastitis when a woman with implants breast-feeds a child.

The final issue related to augmentation mammoplasty that I wish to discuss, and the one about which Marlene and I had the most animated conversation, is the question of breast cancer screening in women who have prosthetic implants in their breasts. Epidemiologist Robert Smith believes early detection -- far more than attempts at prevention -- will save women's lives. "It's simple", he says, "The data show routine mammograms (breast X-rays) increase a woman's chances of surviving breast cancer". "By contrast", he asserts, "there's still no clear breast cancer prevention strategy" (Henig, 1988). Henig (1988) reaffirms that 57 million American women -- more than ever before -- are now 35 or over. This is of concern because the Center for Disease Control (CDC) researchers tell us that 40 is the age at which there's a natural upswing in breast cancer cases. As the several age waves of "baby boom" women cross this 40 year mark, the CDC expects a sharp increase in breast cancer cases. I knew this prediction, and I had read some preliminary
data indicating that some physicians felt it was more difficult to read and interpret mammograms in women who had had implants. I was interested in discussing this issue with Marlene, because of her background in nursing as well as the fact that she herself has implants. Marlene answers as follows when I asked her about cancer screening.

Well, I have a mammogram about every year. And, we don't find any particular problems -- these are quite easy to do mammograms on. My tissue is in front of the implant, so early detection of a tumor is rapid.

Marlene has looked at her own mammograms and she says one of her implants appears to have leaked some saline, and she has "like a wrinkle, in one of my implants". She can't feel this change, but the saline bag on one side is more wrinkled than on the other. Her plastic surgeon has told her this is nothing to worry about, that the silicone itself appears intact, but that some of the saline in the outer envelope of the implant has either leaked out or has been absorbed.

Marlene and I discuss the operation itself, which she has watched and I have not, and she explains that the surgeon places the implant directly against the chest wall, so that the woman's breast tissue is all out in front of the implant. She feels that this insures the fact that a cancerous lesion would be visualized or palpated very early.

I've seen my mammograms, -- I can see behind the implants even-- I'm right on the chest wall. I don't see any other breast tissue, and you can really see that on those mammograms. ... So if you're going to end up with a breast problem, with cancer, to me psychologically, I would feel much more relieved if I found a tumor and here all this is involved and the mass is right here. You can feel this so quickly. I mean, I can tell any changes in my breast immediately. It doesn't take a lot of moving around.

I mention to Marlene that some of the physicians writing about this issue state that there is a possibility that some of the breast tissue is
obscured by the implant. Marlene answers me by impuning the technique of some of the physicians who perform these procedures:

Maybe some physicians' technique, in their urgency to put the implant in, they're not as careful. I've worked with some very careful physicians. And they're very careful about the way they put them in and the reason why -- I mean that could be it. It's a technique.

Although I know that it's not a question of technique, but rather that the implant is radio-opaque (unable to be X-rayed) I don't debate Marlene on this point. I mention that I'm "a little worried" about the mammogram interpretations for women with implants, and that I need to gather more data on what is being said by radiologists who routinely read such X-rays. I cannot resist mentioning to her that some physicians are recommending a more exacting mammogram for women with implants, hoping that she will request more than the routine screening mammogram for her next check-up.

Another troublesome note, for me, occurs when Marlene begins to discuss a friend of hers, who has a similar figure type: wide hips, small waist, and very small breasts. Marlene states that this woman:

needs a breast augmentation for her appearance. She would look much more proportioned if she had it. I've been trying to encourage her, but she's such a worry-wart. Her mother died of that breast cancer -- and so she's a fanatic about that breast. She doesn't want to do anything to interfere with the breast tissue for fear of something like that happened to her.

At this point in our conversation, I remember thinking that I was thankful that Marlene's friend is a "worry-wart": since she is at a higher risk of developing breast cancer by virtue of having a close relative who had the disease. Breast implants are not recommended for any woman in a higher risk category.
Since my discussion with Marlene, I have found some literature supporting my fear that screening mammograms may indeed be less effective in women with breast implants, especially those placed above the muscle. Jensen and Mackey (1985) did an eight-year review of mammography at one institution and identified 30 patients who had undergone a previous breast augmentation procedure. Of the 30, six had had silicone injections, 20 had had silicone-filled implants, and six saline-filled implants. Both free (injected) and encapsulated (within an implant) silicone were found to obscure underlying breast tissue because of density and associated calcification, which would have interfered with detection of subclinical carcinomas. Melvin J. Silverstein, M.D., medical director of the Breast Center in Van Nuys, California, recently completed a retrospective study of augmented and non-augmented breast cancer patients treated at the Center. He concludes:

Augmentation mammoplasty with silicone-gel-filled implants reduces the ability of mammography, our best diagnostic tool, to visualize breast parenchyma [tissue]. When compared with our own nonaugmented breast cancer population, augmentation patients with breast cancer presented with more advanced disease; they had a higher percentage of invasive lesions and positive axillary nodes, resulting in worsened prognosis (Hanson, 1988, p. 8).

Silverstein states that women who are augmented give up their access to the "state-of-the-art in breast cancer detection" (Hanson, 1988, p. 8). Currently, with the best mammographic screening 94% of breast cancers can be detected before they metastasize to the axillary nodes, reducing the number of women with positive (cancerous) lymph nodes, and consequently more advanced disease, to 6%. By contrast, 13 of the 20 augmented patients Silverstein's study included presented with positive nodes. Silverstein reports that implants cause a radio-opaque shadow that
obscures good visualization of a significant portion of the breast. In the smallest breasts, 50 to 75% of the tissue may be obscured as they wrap around the implant, while in larger breasts, this figure ranges from 20 to 50%. Implants also complicate diagnosis because the surrounding tissue is compressed and therefore denser than before, making palpation for breast changes more difficult. Dr. Silverstein recommends sub-pectoral augmentation unequivocally, whenever it is possible, as better mammography can be accomplished.

Since Dr. Silverstein's findings were quoted in the lay press and also on ABC News' 20/20, the American Society of Plastic and Reconstructive Surgeons (ASPRS) formed a task force to analyze his research, headed by Garry Brody, M.D. Brody believes Dr. Silverstein's message is an "important one", but doesn't think the problem is as "ominous" as he makes it sound. Brody states: "I think he would agree with me that the main cause of delayed detection is not the implant, but ignorance, denial, and neglect" (Hanson, 1988, p. 8). Brody does not specify whose ignorance, denial, and neglect, however. He takes issue with the fact that the augmented patients came to the Breast Center with palpable masses, while a number of the non-augmented patients were being screened routinely. Brody does introduce one new point of caution, however, in mentioning that scars left by the augmentation procedure can also interfere with diagnosis by mammography. John Martin, M.D., a diagnostic radiologist at M.D. Anderson Cancer Center who is also quoted in Hanson's article, agrees that the study compares "apples and oranges", because the two populations presented with non-comparable stages of disease. Martin does state, however, that when augmented patients are screened
mammographically, a certain number of patients with palpable masses are missed due to compression of the breast. He feels that implants impede breast self-exams done by the women as well, because they are no longer compressing the breast against the hard surface of the chest wall. Herman Zuckerman, M.D., disagrees, noting that on palpation, what is being felt is a narrow rim of tissue against a solid block, so there is a better chance of detecting the tumor. Zuckerman states, however:

You never do know what you're missing in these cases. When performing mammography on augmented patients, there are some disadvantages: you can't surround or compress the entire area. But it's something that you live with, because for some women, their happiness depends on their appearance. These women are willing to take the chance (Hanson, 1988, p. 8).

I am not sure that the women would be "willing to take the chance" if they understood that they are forfeiting their opportunity for accurate cancer screening. Unfortunately, many women have implants in their 20s and 30s, at ages when mammograms for breast cancer are not done. Silverstein reminds us that most of the women having this procedure done are in their twenties and are willing to take a chance, since at this age they feel invincible. Many of these women will not consider the issue of reduction in mammogram acuity until it is too late. Hanson quotes two other physicians on this issue: Philip Strax, M.D. of New York and Gerald Dodd, M.D. from the M.D. Anderson Cancer. Strax doesn't think this "is much of a problem". He's seen many patients with implants and has had "no trouble visualizing the breast in these cases". Dodd, on the other hand, states that "obviously, when you put in an implant, you add density to the area, the tissue that is left is crowded together, making it more difficult to see the problem" (1988, p. 8). The ASPRS recommends a pre-implant mammogram and regular screening thereafter by a radiologist who
has experience with surgically enlarged breasts and will take extra views customized to the patient. A final disquieting possibility, mentioned by Dr. Silverstein, should be introduced for consideration: and this is that the "presence of the implant may in some way impair the natural mechanical or immunological characteristics of the lymphatic or vascular system, contributing to earlier nodal or systemic metastases" (Hanson, 1988, p. 31). Silverstein recommends that these patients be totally informed, and that they then make their own decision -- a reasonable position. I wonder, however, how many of the 1 to 1.5 million women who have had implants fully considered the impact of the procedure on later cancer screening. None of the three women I quote in this chapter had done so. Marlene, who has a nursing background, believes that having implants will increase her chance of detecting changes in her breast tissue. This position is also adopted by the ever-present Dr. Rose who states: "Some plastic surgeons feel that perhaps there is even a decreased evidence of breast cancer in patients who have breast implants because the breast tissue is pushed more toward the skin, making self-examination easier" (1988, p. 6). I can only hope that as the population of women with augmented breasts ages, and more studies are done to determine the relationship between augmentation and cancer screening, that these results will be disseminated -- in the popular as well as the medical press. Perhaps with repeated exposure to the knowledge that some women have died as a consequence of having their breasts enlarged, some of those contemplating breast augmentation will decide that the long-term risk can decidedly outweigh the short-term gain.
CHAPTER VII: RITUAL, SYMBOL, MYTH, AND COSMETIC SURGERY

Although I have explored the literature that attempts to explain the need that many women feel for cosmetic surgery in terms of their own psychological deficits, I do not believe that this approach will provide us with a theoretical scaffolding that will be broad enough to encompass causative factors that go beyond the individual's psychic reality. Inasmuch as I believe that a person is perhaps more determined by the nuclear and extended groups in which she finds herself -- although I do not deny the inescapable influence of genetic makeup and individual differences -- I will look at the burgeoning phenomenon of cosmetic surgery as a series of rituals in which women engage within American society. These rites serve to connect the participating women to the social structure as they reaffirm its dominant ideals. The operations these women undergo are not isolated acts of technology, scientifically accomplished in a sterile vacuum, but are surgical ceremonies where the surgeon/priest alters a part of the woman's body that is, by some definition, out of sync with the current cultural ideal.

Ritual

All human societies are partially defined by the rituals, or prescribed formal ceremonies, that "attend the great turning points of life" (Lincoln, 1981, p. 2), whether these be individual: such as birth, puberty, marriage or death; or society-wide: such as governmental changes, and the celebration of the new year. In more traditional societies, for example among the Ndembu people who have been studied by Turner, ritual constitutes "prescribed formal behavior for occasions not given over to technological routine, having reference to beliefs in mystical beings or

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powers" (Turner, 1967, p. 19). The Ndembu, according to Turner, have two major categories of public ritual: the life-crisis rituals and the cults of affliction. Life crisis rituals are performed to signify "important points in the social or biological development of individuals ... as these developments are interpreted by Ndembu culture" (Turner, 1957, p. 292). These rituals also provide a mechanism to handle disturbances in the social structure caused by the social status changes of the ritual subject, provide occasions for the demonstration of Ndembu unity, and re-establish ties between villages. The three most important life-crisis rituals are the boys' circumcision ritual, the girls' puberty ritual, and the funeral ritual. The rituals characterized as cults of affliction are preformed for individuals who are said by the Ndembu to have been "caught", or afflicted with various types of bad luck, by the spirits of deceased relatives who have been offended or ignored. For the purposes of this work, my parallels will be drawn with the life-crisis ritual as defined by Turner, most particularly those ceremonies or rituals that mark the transition from one life phase to another.

Rituals in traditional societies such as the Ndembu are easily recognized by their aura of being set apart from everyday activity and by the intricate rules for behavior and dress which are observed by those involved. We can observe similar characteristics in religious rituals within American culture, such as baptisms, confirmations, and marriages. Lincoln (1981) maintains that non-religious rituals may lack the external trappings that mark them as such, and may still be ritually significant: for example repairing a drum in a traditional society, or shaking hands in America. Lincoln posits, in addition, the existence of what he terms "unconscious
rituals" which are:

traditional patterns of behavior that are like ritual in all other respects -- using symbolic action, transforming the individuals involved, endowing mundane existence with some grander meaning, and reaffirming the abstract values of the society at large -- but that for one reason or another are not recognized as rituals by those who practice them (p. 34).

He takes the following examples from American society: graduations, debuts, sweet sixteen parties, bridal and baby showers and weddings, and asks how many Americans would consider these as ritual events, even though they might well be discussed in this light. Lincoln's objective is to set the stage for the consideration of scarification among the Tiv of Nigeria as a puberty ritual, even though the Tiv themselves do not regard it as such. The pubescent girl is the recipient of this practice, in which decorative incisions are made on the belly and rubbed with charcoal so that a pattern of scars remains. The Tiv assert that the purpose of scarification is to make the woman more attractive, especially to her lover. The scars are also said to make the girl's belly "tender and erogenous ... a woman who has them will demand more sexual attention" (Lincoln, p. 36). Therefore there is little evidence to support a view of Tiv scarification as an initiatory rite, as the scars are created in a perfunctory manner and anyone may watch, but Lincoln believes that it is. Deeper religious meanings may be forgotten, he states, or informants may deliberately conceal information they consider sacred. It is also possible that the ritual significance of an act is quite generally understood and therefore rarely made explicit. Such is the case, he suggests, for our handshake and for most unconscious rituals. Lincoln goes on to allege that this scarification "ritual" accomplishes much more than the explanations of the Tiv people would indicate. The lines and circles of the patterns may
represent the "structure of time, placing the pubescent girl at the intersection of past and future" (p. 48). Beyond this it may be a representation of the pattern of genealogical descent and also may be seen to represent the tar, or inherited plot of land. More significantly, the pattern of scars is not merely a mechanism for the display of important Tiv cultural beliefs, but is, at a deeper level, transformative for the girl: it is the means whereby she becomes a woman. The scars are said to promote fertility, in terms of both human life and agriculture, for which women are also responsible. Thus, according to Lincoln, accountability for the fertility of people and crops becomes the province of Tiv women when they receive their scars. Since the woman bears the same decorative patterns as the sacred owl-pipes or Imborivungu which are relics of ancestors, she herself may be said to have been transformed into a sacred object or Akombo: a link, as is the pipe, between the present and the beginning of time. Thus, for several reasons, Lincoln interprets scarification quite differently than do the persons who practice it, and with evident good reason.

Turner (1967) would justify, as well, the legitimacy of the social anthropologist's interpretation of a society's ritual symbols in more depth than the actors' descriptions would seem to warrant. The anthropologists can "place this ritual in its significant field setting and describe the structure and properties of that field" (p. 27). Each participant in a ritual views it from his or her own perspective, and this vision is circumscribed by a given social position. He or she is likely to be influenced by social interests and needs which impair the ability to understand the total situation. An even more serious obstacle against objectivity is the fact
that the actor "tends to regard as axiomatic and primary the ideals, values and norms that are overtly expressed or symbolized in the ritual" (p. 27). On these grounds Turner defends the anthropological legitimacy of finding deeper meaning in the symbols and events that make up a people's rituals.

Although when viewed from without America may appear to be ritually impoverished, this is not actually the case. We are, apart from our private participation in many and varied religions in America, a secular society: and as must follow, many of our rituals are secular. Lincoln (1981) concurs that ritual endures in secular societies, recognizing ritual structure in events such as greeting a friend or writing a footnote, not to mention more elaborate examples such as athletic contests or psychoanalytic practice. He describes such occurrences as follows:

This is not just to say that these acts are habitual, although repetition is undoubtedly a hallmark of the rite, but also that they are set apart from mundane existence, governed by strict rules of procedure, marked by an elaborate symbolism, and invested with a significance that transcends their strictly physical importance (p. 2).

Healing practices are examples of secular rituals in modern American culture, although healing rituals have magico-religious elements in other cultures: for example in the Mexican-American curanderismo rites. To people who have a background in more traditional healing systems, biomedical health care practices can seem cold and bereft of meaning. The modern medical care system may seem to contain no symbolic or mystical elements, and the overt ritualistic structure and function of many of its practices can be overlooked. On closer inspection, however, many parallels can be drawn between health care encounters in American society and encounters with healers or priests in traditional societies. American medical care and surgical practice cannot take place without the high-
priest of secularism, the physician. As Aronson tells us in his book: "We think of the doctor as the priest of our time. Certainly the politician is not the priest, nor is the priest the priest" (1983, p. 176). Made "sacred" (translate "expert") by years of medical training, he or she alone is licensed to conduct certain healing ceremonies such as bodily examination, laboratory testing of body products, prescription of antibiotics and "controlled substances" (narcotics), and surgical operations. He or she sits in a holy place (office with high overhead), removed from the everyday surroundings of the patient. Even more alien and "non-mundane" are the high-tech out-patient surgical suites or hospital day-surgery suites. The practice of these licensed priests and priestesses is dictated by strict rules of conduct toward the patient: the professional must be objective, professional, and distant. These biomedical shamans don sacred robes (coats and/or surgical garb in "designer colors") and currently wear thin synthetic hand coverings (latex gloves) which increase their physical and emotional distance from the "patient" or "client" (the appellation chosen is based on whether the consumer pays before or after the service is rendered). The patient is often addressed by the first name only, while the physician is addressed as Dr. Smith, again increasing the gulf between patient and doctor. It is often quite expensive to receive the services of this professional, and people often must give up other things in order to afford medical care. One might assume that a "primitive" ritual would be a bargain, but it can be quite expensive to hold a ritual in traditional societies, as well: Turner (1967) describes the considerable cash, time, and labor involved in Ndembu society. It can be, therefore, a luxury to receive biomedical health care or to conduct a ritual. Some elective
surgical procedures (for example cosmetic surgery) are viewed as status symbols, marking the recipients as upper class and privileged. And if the initiand in a more traditional ritual is "made over" or "transformed", the patient after certain cosmetic surgical procedures is seen to be equally changed: one need only read the many accounts by cosmetic surgeons of women whose entire personalities changed after cosmetic surgery. Perutz (1970) quotes a cosmetic surgeon, "Dr. B." whom she interviewed.

I've seen dramatic changes in people, especially girls with the breast implants. They come in little mousy-looking things like this -- he demonstrated by hunching over his chest, trying to imitate a chicken-breasted female -- and you see them after they've been discharged and they've gone out and they have a new wardrobe. Oh, it's not a normal breast, there is a difference. But in clothes you can't tell. Can't tell even in a brassiere. You'd have to palpate it. Amazing thing that happens with a woman who has breast surgery -- she loses all modesty. I've seen girls that have had their breasts built up practically show them to you in the elevator. And talk about it as if, you know, they had painted their nails (pp. 123-124).

Dr. Thomas Rees (1987) writes the following in the first chapter of his book.

Cosmetic surgery, in and of itself, will not transform you. It cannot make you look like Cheryl Tiegs or Tom Selleck. On the other hand, it can make you look so much better, so much more attractive, so much more to your own liking, that your whole personality can be transformed. Sometimes, the change in a person's looks is so spectacular that he or she truly blossoms. I have seen men change from shy, insecure, even withdrawn personalities to friendly, outgoing people; I have seen women transformed from self-effacing, socially uncomfortable, and often timid people into jolly, warm, and confident achievers. As you read on, you will learn what cosmetic surgery can do to improve your looks ... and how it can give you more than just a pretty face. Then, if you get to the point where you feel that cosmetic surgery may well be for you, ask yourself, 'Why not?' (p. 10).

Implants and Ritual, Facelifts and Liminality

As regards the specific nature of the cosmetic surgical procedures with which I am dealing, breast augmentation might be considered an extension of, or a grand finale to, the elaborate feminine pubertal rites
that are part of movement into adolescence in the United States. Lincoln (1981) states that:

the pattern of female initiation is one of growth or magnification, an expansion of powers, capabilities, experiences. This magnification is accomplished by gradually endowing the initiand with symbolic items that make of her a woman, and beyond this a cosmic being (p. 104).

In St. Louis the pre-pubescent girl waited in the wings of her life, watching mother adorn herself with the appropriate markers of femininity. And then, magically, it was time for her: she had her first period and learned from her mother the mechanisms of "feminine hygiene": rather complex at first, but secret and mystical. Near this time, when she was 12, she received her first brassiere, the training type, and she wasn't ready for it yet. She agonized over her inability to fill its extremely modest cups, at last resorting to a bit of Kleenex to round out the contours. She longed for lipstick and "blush-on" (powdered rouge), but Mom said she was still too young. She felt she would never be allowed to grow up in this rather traditional family. She had to wait a year and a half, until the Christmas she was almost 14, to receive her first pair of nylon stockings, with a garter belt, and red kid pumps with a tiny heel. She also received her first "grown up" outfit: a red wool "straight" skirt and a matching red sweater with a collar and pearl buttons. She wore all of this finery to the large family Christmas party and hoped the older cousins would notice her. They did. Cousin Ellery told her that she should stop pulling her stockings up, which she thought she was doing surreptitiously. She was mortified, but felt glamorous nonetheless. Shortly thereafter she received her first pink lipstick and a small compact. By the time she was sixteen she was allowed to wear mascara and a bit of eye-shadow, blush-on and lipstick when she went out on a date: all
subject to maternal inspection, of course. She loved make-up and clothes
and boys and going out; it was great fun to fix oneself up and have the
boys notice. It was a different world than home and the family. She was
herself: separate from her family, emancipated from the ever-watchful
eyes of the nuns at school. It was going to be a great life. These are
feelings I remember as I think about the "symbolic items" that were
gradually bestowed on me as I moved into adolescence. I always had small
breasts, but I was small in general, and fairly well-proportioned. I looked
at a friend down the street who had very large breasts, even when she
was a young girl, and thought it would probably be fun to be so "sexy".
All the boys were awe-stricken in her presence: She was a goddess. I
realized, years later, how much fun she hadn't been having when she had
a reduction mammoplasty done. Breast development, however, is an
absolutely central event for the pubescent girl. She watches them as they
first "bud" and then grow gradually, converting her upper torso into the
body of a woman and allowing her to leave undershirts (ugh!) behind
forever. She knows how she "stacks up" vis-a-vis her friends, and even
if she didn't notice herself the boys would keep her appraised. If a girl
feels that her breasts are for some reason inadequate, and if this feeling
is reinforced from without, she might easily feel very threatened during
this developmental period. She might long for breast enlargement surgery
so she would feel "normal". Breast augmentation surgery might be seen in
this context as an adjunct to an erring puberty: one which is not
delivering enough breast tissue to symbolically convert her into a woman.
She might be menstruating and have other secondary sex-characteristics,
but if she lacked "big enough" breasts to "prove" she was a woman, what
good did it do? No one could see the other things that were happening. In the context of female adolescence in America, if the girl's breasts don't "show", she may feel cheated by nature and her own body. If her mother agrees and helps her seek augmentation surgery this might be viewed as an extension and an elaboration of the ritual social process that has already granted her the "right" to wear make-up and other trappings of femininity. This operation, itself a further ritual, would complete the ritual physiologic process for her, conferring on her the metasymbols of "femaleness" in America -- breasts.

In the case of the facelift, classification as an initiation ritual doesn't work, but it is quite intriguing to think of this operation in terms of van Gennep's work on rites of passage. Van Gennep's thesis is that all rituals involving passage from one state to another share a three part structure determined by the need to separate from one status and reincorporate into the new one, with a "liminal" or marginal period in between (Huntington and Metcalf, 1979). During the "liminal" period, as described by van Gennep, the person has lost his or her previous status category and has not as yet gained a new one to replace it: the person exists in a "no-man's" land. Huntington and Metcalf (1979) mention van Gennep's insight that this "transitional phase sometimes acquires a certain autonomy from the rest of the ritual" (p. 11). This is directly related to the ritual journey that the facelift patient is making back to a state of relative youth. This, of course, already differs from the traditional ritual passage where one is moving on to a new stage such as the married state, or the state of mature womanhood. In this case the woman has already experienced her youth, but wishes to have it recreated through the
surgical ritual of facelift. As much as she may wish for this outcome, however, it seems to be elusive. Many women in the literature state, as does my informant Sybil, that they do not feel, afterwards, that they look any younger, only "rested" or "refreshed". They find that they cannot now compete any better, in terms of physical stamina, with much younger persons, even if this was a secret wish. Women in the literature report surprise that they aren't infused with new energy, and that they become just as tired as before the surgery. These women move, I would suggest, into a liminal or transitional category between youth and old age: a period of extended middle age as we define it in America. Marlene, at 44, mentions liking the way she looks at this point and wanting to stay this way. She doesn't mind the changes associated with maturity that are visible on her surgically lifted face, for she looks "good for her age". She becomes, for as long as she can sustain it, a woman of "a certain age". One may be not able to guess the age of the facelifted woman. She may present a face that will be relatively unlined, but other parts of her body, such as hands and legs, may exhibit changes that are more congruent with her chronological age. Some women may feel comfortable dating men much younger than themselves after facelifts, but this is only a superficial phenomenon, as their generational experience and energy level will be chronologically determined. I do not know how these women will now locate themselves in terms of their former contemporaries: whether they will feel comfortable or not with their former age-mates. These are the persons with whom the woman has life experience and knowledge in common; how will she relate to them during this period when she is attempting to extend her middle age? Only these women know how it
feels to exist in this hazy area of indeterminant age. One would guess however, that many might prefer such a zone to the category of "older woman": a category to be sure, but one in which no status is found.

Ritual Pain and Danger

Lincoln, in writing about women's initiation ritual, suggests that four basic types of such rituals exists. One of these, what he terms the "bodily mutation" ritual, seems the best parallel for the discussion of cosmetic surgical initiation or transformation in American society. In the bodily mutation ritual, "the initiand's body is taken as the locus of her very being, and the transformation desired for her is affected on her physical self" (Lincoln, 1981, p. 94). The ritual action is suggested by the events of puberty, in which the body transforms itself, and is usually performed at the time of menarche. It is felt that while nature may effect such changes as breast development, widening of hips, or appearance of pubic hair, human action may also effect bodily changes as well as changes in the "inner being" of the girl. Lincoln gives, as one example, the Navajo practice of "molding" the adolescent girl at the initiation rite called the Kinaalda (first menstruation). This ceremony is performed for each girl at her first two periods, and is believed to bestow the ability to bear children. This ceremony ritually transforms the girl before she takes her place as a woman in Navajo society. The girl's body is "molded" or shaped by the hands of an ideal woman, a model of all virtues. The girl's body is shaped so that it and she will be beautiful, but being beautiful in this case means more than having a good figure. The girl's personality is being molded at the same time so that she will possess all manner of worthy characteristics such as: strength, ambition, endurance, friendliness,
unselfishness, and cheerfulness. It is not the girl's body that is transformed, but the girl herself. This is true, according to Lincoln, for the Tiv girl as well, who has the pattern of time placed upon her belly. As the pattern is etched upon the initiand's body, her flesh is altered and at the same time her very being is transformed. Lincoln also mentions the female initiation ritual of the Tukuna people of the Northwest Amazon where part of the rite involves ceremonial depilation of the young girls. At one point during the ceremony the paternal uncle of the girl pulls out the first lock of hair, and then a group of women sit around the girl and pull her hair out in little bunches. Lincoln tells us: "Painful though this must be, most girls bear it calmly, and the last lock ... is pulled by the uncle" (1981, p. 65).

Lincoln does not speak of the practice of clitoridectomy in pubescent girls, although he could have, for this custom has been an initiation ritual for many, many tribal groups in East Africa. Morowitz (1988) relates that Irwa (circumcision) was "the rite of passage that admitted children into participation in the adult life of the community" (p. 98). This event was carried out before menstruation began. The girls spent 1/2 hour bathing in cold river water to numb their genitalia before being brought in a group to a designated site where a cowhide rug was spread on the ground. Each girl sat with legs spread and behind her sat her sponsor, an older woman who held her for the operation. The coldest water available was used to rinse the genitalia, and then the moruithia or ritual circumciser, cut off the tip of the girl's clitoris with a single razor stroke. The wounds were treated with milk and herbs, and the girls were taken to a special hut for a period of healing. According to Morowitz' informants,
this practice is still widespread in East Africa, and sometime involves excision of the labia minora as well as the clitoris. Clitoridectomy has apparently been outlawed in Egypt and the Sudan.

Dworkin (1974) discusses the "gynocide" of Chinese foot binding, which began in the 10th century, and was a custom that demonstrated and perpetuated the lowliness of women and insured that they would remain only "sexual objects and breeders" (p. 96). The object of the footbinding process was the achievement of a 3 to 4 inch "Golden Lotus" foot, obtained through an approximate 2 year process. The girl's mother applied the bindings to her feet which forced the toes in towards the sole. The bandage was also wrapped forcefully around the heel so that the heel and toes were drawn closer together. This binding was not removed except to wash the feet, apply alum, rebind the feet, and place ever smaller cloth slippers on the victim. This process was very painful for the girl, as the flesh became necrotic and parts of the foot and toes sloughed off. Walking was very painful during the process, and very difficult for the rest of the girl's life. The natural lines of the woman's body were distorted by this process, causing the thighs and buttocks to become somewhat swollen, a condition found "voluptuous" by men. A myth developed among Chinese men that footbinding caused extra folds to develop within the vagina leading to "supernatural exaltation" during intercourse (Dworkin, p. 102). The style of tightly bound feet was set by the nobility and copied by persons in classes below them. The upper classes bound the feet severely and these women needed rich husbands who could keep them idle, for they could do no useful labor. The lower a woman's class, the less she could afford such idleness, and so the larger
the feet. Although the feet were still bound, it was done more loosely, allowing the woman to work. The "Golden Lotus" became the primary sexual fetish in China for 1000 years: various exercises involving the foot were always a part of the sexual act. When a marriage was being arranged, prospective inlaws inquired first about the feet and then about the face of the bride-to-be. Concubines for the Imperial harem were chosen at tiny-foot festivals (China's ancient counterpart to the Miss America pageant). The perfect Golden Lotus, the most beautiful foot, was 3 inches long, perfect in form, and quite useless.

Commonalities

The initiation ritual for Tiv girls makes them beautiful and sexually desirable, according to indigenous informants, and reaffirms many of the culture's most basic values according to Lincoln (1981). The Tukuna female initiation ritual, one of the most elaborate initiations practiced in South America, has as its main purpose the transformation of girl to woman. The initiand also gains a "cosmic perspective" as she explores every realm of the universe in her journeys, learning that all of these parts constitute one world. Lincoln tells us that the guests, who have masqueraded as demons, are transformed as well: they change back to the mode of human existence when they discard their costumes. On the subject of clitoridectomy, Morowitz (1988) quotes Jomo Kenyatta, the first president of Kenya, and a former student of Malinowski, as follows. "The real anthropological study, therefore, is to show that clitoridectomy, like Jewish circumcision, is a mere bodily mutilation which, however, is regarded as the conditio sine qua non of the whole teaching of tribal law, religion and morality" (p. 98). Chinese footbinding has not been
represented as embodying the fundamental cultural beliefs of the traditional Chinese, but in reality it did so. According to Dworkin (1974) the Chinese believed that being born a woman was a person’s punishment for sins committed in a previous life. This practice insured that a woman would need the protection and support of a man, for she could not support herself. She was a virtual prisoner in her home: allowed to cook, supervise the household, and embroider shoes for the Golden Lotus. This patriarchal society, recognizing the necessity of marriage, wife, and family to its existence, mandated footbinding of millions of women over 1000 years. Women were crippled by this custom, and then, perversely, the deformed part was venerated and sexually fetishized. Dworkin (1974) recounts that periodically, during the millennium of footbinding, attempts were made to "emancipate the foot" (p. 95). These efforts by certain artists, intellectuals, and women of power were failures because "footbinding was a political institution which reflected and perpetuated the sociological and psychological inferiority of women; footbinding cemented women to a certain sphere, with a certain function -- women were "sexual objects and breeders" (p. 96).

It can be seen that footbinding, and the initiation rituals of the Tiv, the Tukuna, and the tribes of Kenya have been defended as integral and necessary parts of the cultures in which they are found. They display and reaffirm aspects of the social life of the group and help to maintain its structural integrity. Although it is culturally impossible to understand fully the practice of another group, it seems humanly necessary to ask about the woman who have undergone such practices. What were, and are, the experiences of the initiands themselves? In the case of the Tiv girls,
Lincoln tells us nothing about how the girl endures the incising process. We are told the resulting wounds are bathed "after they have festered", by a "man of good blood" and that they are then dressed with palm oil and powdered camwood until they heal (p. 35). We are not privy, however, to any information on local infection or systemic sepsis that might result from this practice. Does anyone ever bleed excessively or become ill and die as a result of these incisions? In the case of the Tukuna, Lincoln mentions that the hair-pulling must be painful, but that "most girls bear it calmly" (p. 65). Again, we are told nothing of the aftermath for the girl left with the denuded scalp. Kenyatta defends the practice of ritual clitoridectomy without alluding to the after-effects for the woman. When this is performed under unsanitary conditions, it too can cause bleeding and serious infection and illness. The variants of this practice, such as excision of the labia minora, can result in problems associated with menstruation, intercourse, and childbirth. (Ritual circumcision for males can be dangerous as well when done under unsterile conditions, leading to infection and death. Bleeding, scarring, and accidental penile injury can also result, leading to death or functional problems in later life. The circumcised male, however, is able to fully experience sexual pleasure, unlike the circumcised female.) It is apparent that the footbinding procedure would have been excruciatingly painful. Dworkin (1974) provides quotes from a Chinese woman who did endure this process. She describes the pain as "unbearable" and chronicles the beatings she was given for loosening the wrappings. It is obvious from the descriptions of blood, pus, and necrotic tissue, that the feet of the girls were seriously infected and gangrenous. How many became seriously ill or died as a result of
footbinding may never be known. Clearly all of these "exotic" rituals, which resulted either in the attainment of culturally defined beauty or in the symbolic and actual beginning of a new phase of life, or both, involved and in some cases continue to involve great pain, suffering, deformity, and danger to the victims. These victims, though, are largely silent in the service of cultural reaffirmation. They are brought to these ceremonies by those closest to them, most often their mothers, who desire no pain for them, but see the ritual as the only way their daughters can find a husband and a satisfying life. "People", says Edward T. Hall, "are tyrannized by their own culture" (Blonston, 1985, p. 79).

**Beauty Ritual in America**

Many Americans do possess some knowledge of the initiation rites of "exotic" cultures, for not only *National Geographic* but also satellite media transmission and public television offerings familiarize the fascinated citizen with "others" around the globe. Indeed we have patterned some rites in our culture after the idea of these exotic rituals, notably "initiations" for organizations and clubs such as fraternities, sororities, and military groups. Unfortunately, as witnessed by the deaths and injuries that have been reported due to "hazing" activities, we have borrowed not only the elements of ritual that inspire the individual and unite the group, but also the previously discussed elements of pain and danger. It is common parlance to speak of "beauty rituals" in this country, as well, and to mean by this terminology the innocuous ceremonials in which women engage in order to remain attractive and young. Most of us do not associate these rites with any of the "bizarre" or "mutilating" customs of traditional peoples. If we consider our own history carefully and
dispassionately, however, we can find many beauty rituals, some past, some still current, that integrate elements of pain and risk. At the turn of the century when the wasp waist was in vogue, women laced themselves into whalebone corsets -- so tightly that their circulation and respiratory status was impaired. The ultimate method used to attain this tiny-waisted ideal was the actual surgical removal of the lowest rib, despite the risks due to rudimentary asepsis, surgical technique, and anesthesia (Lakoff and Scherr, 1984). Another example of a painful fashion item is the high-heeled pointed shoe for women. Wearing these for long periods is painful and can cause the tendons in the legs to contract permanently, making it difficult to wear flat shoes. Continual wearing of very high heels can also cause chronic back difficulties and pelvic mal-alignment that results in abdominal problems. When the toes of the high-heels were very narrow and pointed in the 50s and early 60s, women naturally had problems inserting their feet into such footwear. Unbelievably, a surgeon in Texas found a way for these unfortunates to experience high fashion: little-toe-ectomies! This doctor performed thousands of these operations, which enabled the women, minus a toe, to "step into fashion" (Lakoff and Scherr, 1984). We can document another surgical procedure that has come, and gone, after many women had terrible complications: silicone injections into the face and breasts. Nashner and White (1977) report that although it was never clinically tested, silicone liquid nevertheless was widely used in the 50s for injection of facial wrinkles and to enlarge breasts in Japan. By the mid-sixties it was being injected into many women in America and evidence existed that the silicone-injected breast could not be palpated to check for masses nor could the breast be X-rayed for cancer detection due
to the opacity of the silicone. The substance also seemed to migrate and become infected, yet the use of this non-FDA-approved substance went on. In 1971 the FDA reported 4 deaths and unknown numbers of serious complications related to these breast injections, but the silicone "pumpers" continued to flourish, especially in Las Vegas and California. When complications from such procedures reached epidemic proportions in 1975, Nevada enacted emergency legislation to make silicone injection a felony. In September of 1976 California passed a similar law, making breast injections a misdemeanor. Before these laws were passed, and also in other states where no such law existed, thousands of women had silicone breast injections which formed painful lumps, migrated to other parts of the body, and caused infections in the breasts. These infections can occur up to 15 years later, and sometimes to avoid gangrene or spread of the infection, mastectomies must be performed. There are no national statistics on the number of women who have had mastectomies due to complications from silicone injections. One San Diego physician, however, who saw 400 breast complications between 1967 and 1974 reported that 20 percent required breast removal (Nashner and White, 1977, p. 84). Bardach (1988) relates the story of a young woman who had silicone injections to improve her facial contours. The silicone moved and began distorting her face. She has had surgery and steroid injections, but with limited success. The physician who performed her silicone injections had done similar procedures on 2000 patients and many of them sued him. Eventually this doctor committed suicide, but his patients are still alive. What seems unbelievable is that all of these patients had to sign a consent form that indicated that the silicone injection procedure was experimental, and they
submitted to these injections in spite of this! These three surgical beauty rituals: rib removal, little-toe-ectomies, and silicone injections, caused pain and were dangerous, sometimes even resulting in death. All were done to conform to the fashion of the time, which is ever subject to change. All were done exclusively to women, who lived in a "complex" and enlightened society.

And so it seems that as our society becomes more complex, we elaborate more painful and potentially dangerous beauty rituals. We diet dangerously, starving ourselves, and use laxatives and diuretics for good measure. We sometimes die as a result, but at least we die thin. We exercise to the point of compulsion and absent menses. We pluck our eyebrows and submit to electrolysis for unwanted facial and bodily hair, and both of these processes hurt. We shave our legs and underarms as men shave their faces -- the only uncomfortable body ritual they share with us -- and all of us regularly nick ourselves. We color or bleach or "streak" our hair, although many of us have skin reactions and a burning feeling when these procedures are performed on us. Dworkin (1974) remarks that in American culture no part of a woman's body can be left untouched or unaltered, and she is correct. No feature or body part is spared the art and science of improvement, and this process is never ending. At least the pain for our sisters in less modern societies may be less enduring. We learn what Dworkin terms the "technology of beauty" (p. 114) and the message it carries, from our mothers. Dworkin speaks of mothers "forcing" their daughters to do "painful things" to their bodies, but I know here she is wrong. Most of our mothers needed no coercive measures to ensure our compliance with even the painful beauty
routines such as plucking and shaving. On the contrary, we counted the days until we were "old enough" for each eagerly anticipated parts of our "grown up" toilette. We watched mothers and aunts and older sisters and pined for the chance to similarly "transform" ourselves. We noted that fathers and uncles and sisters' boyfriends noticed and appreciated these beauty ministrations. We didn't think about the fact that the boys and men were doing very few painful things to themselves so that we would notice them! Dworkin states that it is not accidental that pain is an essential part of our grooming process. This pain, she states teaches an important lesson: "no pain is too great, no process too repulsive, no operation too painful for the woman who would be beautiful" (1974, p. 115). Judging from just the few examples that have been presented from other cultures, Dworkin would seem to be correct on a world-wide scale. Although some men are ritually scarified and circumcised in other cultures (and circumcised in our own) this circumcision process removes only the foreskin, unless a mistake is made, and the male is fully capable of a complete sexual response. The circumcised woman, of course, feels little during intercourse and thus her chastity is assured. Nowhere has there been any beauty ritual done on men to compare with 1000 years of footbinding in China. We may have found, in twentieth century America, however, a viable parallel with footbinding in the surgical augmentation of the female breast. One to one and a half million women have had their breasts augmented by various types of implants or injections since the 1950s. This practice, like footbinding, isolates a female body part that is different from the male body part (in size) and accentuates that difference. Breast augmentation, like footbinding, demands a leisure class
with plenty of disposable income. The Golden Lotus was such a potent erotic symbol that 58 varieties were described by one essayist, each one graded on a nine-point scale (Dworkin, 1974, p.96). Breasts are the premier erotic symbol in late 80s America, and even though our classificatory system pales in comparison to that of the Chinese, we do have a rudimentary grading system for breasts, revealed in our descriptive terms. "Fried eggs" and "flat-as-a-board" describe very small breasts. Large breasts may be called "jugs", "bazookas", "knockers" or, ecstatically: "quite a pair" or "quite a set". All breasts are "boobs" or "tits". The perfect breasts are large, supple, and non-sagging. Pregnancy and breastfeeding are known to "ruin" breasts; who among us wants to end up like our sisters in National Geographic, with flattened shrivelled teats that hang to the waist? The solution for too small or pregnancy-ravaged breasts is surgical augmentation, which produces (if one is very lucky) breasts of perfect beauty and functional uselessness -- like the Golden Lotus.

Key Symbols

It has been my intention to establish a connection between traditional ritual and cosmetic surgical ritual. I have also attempted to illustrate the commonalities these events share in the area of pain and potential danger. At this point I would like to explore, with the help of two well-known semioticians, the meanings of the body parts central to the rituals I am discussing: the face and the breast.

Turner (1967) defines a symbol as "a thing regarded by general consent as naturally typifying or representing or recalling something by possession of analogous qualities or by association in fact or thought" (p.
19). A myriad of factors within a ritual situation can be symbolic: objects, activities, relationships, events, gestures, and even spatial units. We can infer the structure and properties of symbols by observing their external form and characteristics, and by utilizing the interpretations offered by laymen and specialists -- and anthropologists may figure in the latter category due to their ability to socially contextualize these symbols. This gloss by Turner provides a good starting point on recognition and categorization of symbols, but Ortner (1973) offers further guidance with her list of "indicators of cultural interest" (p. 1339). She provides us with a methodology for recognizing "key symbols" (Turner calls them "dominant symbols") within a culture. First, the natives, or actors in the social system tell us that X is culturally important. Second, the natives seem positively or negatively affected by X, rather than indifferent. Third, X crops up in many different contexts: in varied situations, conversations, and symbolic domains (myths, ritual, art, rhetoric, etc.). Fourth, there is a noticeable elaboration of details and vocabulary about the nature of X, compared to similar phenomena within the culture. Finally, there are increased cultural rules and sanctions having to do with X. Based on Turner's definition and Ortner's schema, it would seem quite appropriate to discuss the symbolic nature of the two body parts altered in the cosmetic procedures I have chosen for study: the face and the breast.

The natives do indeed tell us that these two body parts are important, pivotally so. They tell us this in words, as have my informants, and in actions as they queue up at the cosmetic surgeon's door. They are not indifferent to these body parts as indicated by the number of consumer products available to improve or enhance each one:
makeup of all types plus creams and emollients for the face; undergarments of multiple descriptions and padding for the breasts. The face and the breast do indeed figure into several different cultural contexts: they are showcased in fashion articles and photographic (and pornographic) layouts, they are surgically corrected in thousands of operations annually. The cultural elaboration around the meaning of both faces and breasts is marked. I have spoken previously of the many figures of speech that exist in America English usage in which the face is mentioned. The informants have provided a sample of the numerous descriptive terms for both the face and the breasts in their dialogue. No one in our culture is at a loss for words when asked to characterize either of these body parts. It is a bit more difficult to elaborate cultural restrictions that surround the face and the breasts. Among middle-aged and older women, however, there does seem to be an unwritten rule that one should not go out without makeup. We wear no veils except this layer of cosmetic color between ourselves and the world, however; faces are always visible in America. We have more restrictions about the display of breasts, at least in "polite society". During the day and in the business setting breasts are downplayed, while after 5 p.m. and on the beach we reveal them with gusto. Nudist colonies and topless beaches are set apart, in order to protect the easily offended among us. Topless dancers and strippers are generally considered quite erotic in our culture, for the breast, in general, is a covered and forbidden entity in American society. On the basis of these multiple indicators of the cultural significance of the face and the breast in America, it would seem appropriate to term them key or dominant symbols in our society.
Spectrum of Referents

Few would deny the importance and symbolic nature of these body parts, but great differences of opinion might indeed emerge if persons were asked what their faces or breasts mean to them. Turner (1967) relates that an important property of symbols, especially ritual symbols, is their polysemy or multi-vocality: a single symbol may stand for many things. Each dominant symbol has a "fan" or "spectrum" of referents which are usually linked by a simple mode of association. When we speak of the meaning of a symbol, 3 levels are possible: the indigenous interpretation or exegetical meaning, the operational meaning, or what the group does with it, and the positional meaning or how it relates to other similar symbols in a totality. The symbolism seems less complex in the case of the face, which has been referred to as our "mobile billboard", that which we present to the world. It functions to attract -- or repel -- those with whom we interact; it "personalizes" us, revealing our feelings and sentiments; and it discloses "our approximate age, enabling others to react to us in a socially appropriate way. It has been suggested, at a more abstract level, that our face is the part of us which is least like other animals, and therefore, that it is the part which "humanizes" us externally. This might further underscore the crucial importance of an attractive face.

The true meaning of female breasts is a more layered phenomenon in American society. Many women, when asked, relate to their breasts as an architectural support, speaking of needing them in order for their clothes to fit appropriately. Indeed, all of the women to whom I spoke, those whose words I quoted and others I did not quote, mentioned the
importance of breasts for looking attractive in clothing -- quite a concrete and reasonable answer. Not all women would be as direct, but Marlene equated her small breasts to a concomitant lack in femininity. In the study done by Beale et al. of augmentation mammoplasty patients, they state that 81% of the women who had had their breasts enlarged had felt *conspicuously unfeminine with their small breasts and sometimes even pointed to masculine features in themselves, such as their broad shoulders. They also emphasized that women with bigger breasts were more feminine than those with smaller breasts (1980, p. 136). I believe that breasts are the metasymbol for femininity in 1989, more than legs or buttocks or total body shape. I am rather afraid that Dr. Canada is correct when he states:

I have discovered that the female breast has much greater importance to women than I had ever dreamed. Mentally, they grade themselves in terms of well-developed, shapely breasts, and their own self-image of femininity and sexuality are based accordingly (p. 39).

Totally unrelated to clothes-wearing or baby-feeding and therefore not as readily admitted, is the function of the breast as an organ of seduction, serving to entice the male. Another aspect of this idea of the sexual nature of the breast is the concept of the breast as a site of erotic satisfaction for the woman. Few women talk about either of these functions of the breast, however, unless they feel comfortable and safe in the conversational setting. Two of the subjects, Kate and Marlene, spoke of their breasts in this context, but only after we had been talking for 1 to 1 1/2 hours. Susan, who maintained a more distant position, never spoke of her breasts in this way, although she did mention that her current partner found them attractive. Many women, when asked to elaborate on the meaning of the breast, will mention motherhood and breast-feeding a baby. None of the women with whom I spoke were in a
current situation where childbearing and infant feeding were an issue. I have noted, however, that women quoted in media sources regularly ask about breast-feeding after breast augmentation procedures. As I mentioned in the preceding chapter, however, the answer to the question of breast-feeding is a confusing one for these women. It seems clear that there are several reasons why a woman should not breast-feed after augmentation mammoplasty, but doctors and other health care workers assure them that this is indeed possible. The irony is that the augmentation procedure, which converts small breasts into the larger size that our culture finds attractive, also frequently interferes with both breast-feeding and sexual responsiveness. These breasts look great, but they are likely to be partially or totally anesthetic and nonfunctional as feeding organs. What we are left with is the post-modern breast: what you see is an illusion, a three-dimensional simulation that one can see and touch, but not use. In this case, form has destroyed function. Brownmiller (1984) asserts that it is men who have made a fetish of the breast and enshrined it at an altar where size and shape are worshipped. We women know that the ability to breast-feed has nothing to do with external size, and that the pleasurable sensation that is possible is a function of the erectile tissue of the nipples only. Brownmiller blames "male erotic satisfaction" for the "myth that the flat-chested woman is nonsexual or un给了我" (p. 41). At the other extreme, a woman with very large breasts is often assumed to be flaunting her sexuality and is regarded with interest as a probable font of great responsiveness in bed. At the abstract end of the symbolic spectrum, the place where symbolic transparency is lost for many "natives" and the anthropologist takes over, the breast symbolizes the most deep-seated and
emotionalized attributes of femininity in 1989 America: the warm and loving woman who is capable of deeply satisfying her man and being personally satisfied simultaneously, the fertile female who is able to bear many children and feed and care for them all generously. This woman, however, like her counterpart in the 1950s, is having a difficult time meeting the demands that her breasts impose upon her. She struggles to become the apotheosis of femininity, even to the point of creating synthetic monuments to it on her own chest, but the twin towers that have been erected are useful only in the elaboration of fantasy.

Although these two dominant symbols for women, the face and the breast, would seem at first to be unrelated, their meanings coalesce at the "unattractive" pole for each. I think I have established that an older face is considered ugly by many in America, to the point that they will undergo surgery to revise this. Equally unattractive, as we have seen, is the "flat" chest in a woman. Why is this so? I believe that an aging face and an absence of breasts are seen by men and felt by women to negate their femininity. We have all witnessed the fact that older men and women seem to grown more similar in appearance as they age. The smaller features of the woman often seem to "grow" such that her face loses that refinement of angle that differentiates it from the more "rugged" features of the male. Of course this androgenous facial appearance occurs only in the very old, but this fact does not prevent the woman from regarding it with particular dread. That which differentiates her from men, and therefore makes her attractive to them, is no longer present. A woman with very small, seemingly absent breasts is similarly afflicted. The female breast polarizes the sexes: A man may feel more masculine when
compared to a woman with full breasts. Therefore, it is not only the case
that an aging face and absent breasts are found unattractive, even ugly,
but more than this: they are found masculine. Sexual differentiation is
everything in the 80s, the unisex look is but a dim memory in fashion’s
past. Brownmiller (1984) reminds us that women in the 80s are competing
for two scarce resources, men and jobs, so that the current resurgence of
interest in feminine looks and pursuits can be easily understood. A
feminine women is reassuring to a man: she needs him and cares about
him enough to keep herself looking the way he wants her to look. The
consequence of not doing so may be Everywoman’s worst fear:
consignment to the slag heap of anomaly. Certainly biologically female,
but socially in a category somewhere in between the sexes, she is
threatening and consequently unattractive to men. Her aging face and/or
small bust make her ambiguous and confusing to males, and worst of all
-- indistinguishable from them. She watches the players, the women who
hold the social and sexual cards, and they have "youthful" faces and
noticeable breasts. If she decides to have her face lifted or enlarge her
breasts, she does so in order to regain what seems to her a lost -- or in
the case of breasts, never attained -- sexual identity. To exist on the
margins of American society, to watch what goes on while in limbo
herself, these are harsh consequences indeed: and liberation from this
non-existence seems worth the risk and pain of cosmetic surgery.

Symbols Coalesce Into Myth

Why is it that we are unable to resist the siren song that entices us
with images of greater beauty and rediscovered youth? I would suggest
that this song is not being sung only in our own unconscious, but on loud-
speakers throughout American society. Ortner suggests that in trying to determine meanings within a culture, we might be helped by seeking out the "underlying elements, cognitive distinctions, and value orientations" (1973, p. 1338) that can be found. Some examples of these, which Ortner groups under the "summarizing symbol" of the American flag, are: democracy, free enterprise, hard work, competition, and progress (p. 1340). The Protestant work-ethic is alive and well in America in this last year of the 80s. We still believe in this, and see examples of those who "make it" in our free-enterprise system because of their ability to work hard and delay gratification. If we "try harder", we will progress: "Where there's life, there's hope". This same set of cognitive distinctions is applied, I believe, to the idea of bodily improvement for the American of today. Both men and women are caught up in the quest for the ever-improving body, but women are more enveloped in this enterprise, partly because many of them have fewer areas of endeavor in which to achieve. The American woman is told, and believes, that she has only herself to thank if she is unattractive. Why isn't she dieting, exercising, changing her hairstyle, trying new make-up, having her colors "analyzed" (a process of determining the colors that look best on a person)? Most of us believe that while not everyone can be beautiful, every woman can be attractive. This attractiveness may not be easy to achieve, but we Americans love a challenge. Instead of viewing the human body as a finite collection of cells that replaces itself at a gradually slowing rate until we cease to be, we regard it as a machine whose parts can be replaced as necessary and which can be lubricated, overhauled, waxed, and buffed -- interminably. Many have written about our cultural concept of the body as machine, and
Ortner would term this substitution a "root metaphor": the body as machine concept is one with great "elaborating power" for us (p. 1340). As I have submerged myself in the media explosion dealing with female beauty and cosmetic surgery, I have found, as previously mentioned, many examples of General Motors imagery applied to the female body. Women have been called "last year's models", "old klunkers", and "old heaps". They have been said to have "too many miles" on them and have been judged to need some "body work" or a "new paint job". We all need our "check ups" every so many miles, and our periodic trips to the "body shop". All of this imagery, while a bit appalling, is, nevertheless, quite optimistic, for it gives new life to the concept that the human body is endlessly perfectible. We cannot be excused for walking around in a body needing rejuvenation any more than we should be excused for driving a dented scratched jalopy. It is our obligation to ourselves, our families and society to "keep America beautiful": It is our patriotic duty.

Another major type of elaborating symbol identified by Ortner is the "key scenario": a symbol which "implies clear-cut modes of action appropriate to correct and successful living in the culture" (1973, p. 1341). These key symbols are our cultural myths and Ortner proposes the Horatio Alger myth as a formulation, in actable forms, of a series of our most deeply felt value orientations. Alger is a poor boy of low status who believes in the American system, works very hard, and ultimately becomes rich and powerful. This myth suggests that hard work is the key to American "success", which is defined as power and wealth.

Women in America have a "key scenario" as well. To begin, I will present it as Marlene and Susan described it to me. Marlene depicts this
as follows.

I was always obese and never really thought of myself as pretty, but, you know, you imagine yourself eventually growing up and becoming a little princess or a queen, or something like that -- or a movie star.

Susan presents both the positive and negative outcomes for this scenario.

Also, if you watch T.V. -- if you have good looks -- they -- well, if you're beautiful you can go further in life. This is the way you see a movie and that's what it's like. The pretty girl gets the nice guy and is rich. The ugly girl gets the dumb, poor guy and gets nothing.

What Marlene and Susan are telling is the story of Cinderella. Through this fairy tale we learn that if we are only sweet, hardworking, and diligent enough, a fairy-godmother will transform us into a breathtaking apparition in a designer dress, whose foot is exactly the size of the glass slipper carried around by the Handsome Prince. (I won't go into what might be wrong with the prince at this point.) The important factor here, is that this story, upon which many variations are possible, is a transformation myth, and within this tale are found the secrets of Cinderella's success. She is beautiful on the inside from the beginning, but her external beauty is hidden by dirt and ragged clothes. A moral of this story, according to Bruno Bettelheim, is that goodness will be rewarded regardless of external appearance. But, as Freedman tells us, "even the most naive child knows intuitively that Cinderella could never have been loved by the prince while dressed in rags. The hidden message ... is that packaging counts, no matter how worthy the inner woman" (1986, p. 66). She might have remained in her condition of cheerful servitude if the fairy-godmother hadn't worked a little magic. It does not require a great imaginary leap to transport poor Cindy to the 1980s and imprison her in a body that does not "measure up" to the current Barbie-doll cultural ideal. In this post-modern tale, the fairy-godperson is, of
course, the plastic surgeon, liposuction cannula ("magic wand") poised and ready. The fairy contours her hips, augments her breasts, and reshapes her nose. At her next co-ed high-impact aerobics class, she meets a sheik, trying for an "American experience" and carrying a glass Adidas. It fits, and Cindy is taken to Bahrain, where she lives happily ever after behind veils and high walls.

This, perhaps, is too light a note considering that this Cinderella tale is something we all, at some level, believe. It fits with our previously identified American cultural characteristics. We can "perfect" our faces and bodies through beauty techniques, diet, exercise, and finally, through cosmetic surgery. What's the harm? Why shouldn't we look as "good" as we can? Perhaps there would be no harm if we were in possession of endless material resources, if there were no greedy and avaricious surgeons and all patients were told the truth, if all of the surgical techniques and implant materials were safe, if there were no complications associated with the surgical procedures we have subsumed under the category of beauty rituals, and if we were not creating and endorsing an impossible bodily norm by having these operations. At present the potential for harm still exists: Caveat Emptor.
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