RISKY EMBODIMENTS:
MOMENTUM AND MEDICAL TRAVEL IN THE PARIS OF SOUTH AMERICA

by

Emily Anne McDonald

A Dissertation submitted to the
Graduate School-New Brunswick
Rutgers, The State University of New Jersey
in partial fulfillment of the requirements
for the degree of
Doctor of Philosophy
Graduate Program in Anthropology
written under the direction of
Fran Mascia-Lees
and approved by

New Brunswick, New Jersey
October, 2011
ABSTRACT OF THE DISSERTATION

Risky Embodiments:
Momentum and Medical Travel in the Paris of South America

By Emily Anne McDonald

Dissertation Director:
Fran Mascia-Lees

This dissertation examines the emerging phenomenon of transnational medical travel to Buenos Aires, Argentina based on fifteen months of fieldwork between 2006 and 2008. Ethnographic data were gathered through the observation of medical consultations and surgeries, interviews with doctors, patient coordinators, and hospital administrators, as well as living with transnational patients during their preparation for, and recovery from, surgery. Although crossing borders in order to seek out health has long existed under a variety of circumstances, with the turn of the 21st century, global biomedical services have emerged on a larger scale – wrapped within the neoliberal vernacular of the nascent “medical tourism” industry.

Despite industry claims to a uniform global market in health care, I argue that transnational patients’ choice of destination is shaped by long-standing, colonial-era conventions that divide the world between places deemed “safe” and those that are “contaminated” and “risky.” In Buenos Aires, assertions of biomedical expertise are embedded within claims that the city is a “European” and “white” alternative to other
“tropical” medical travel destinations. Tourists are additionally encouraged to think of the “Paris of South America” as a bargain destination, resulting from the economic crisis of 2000/2001 and the subsequent devaluation of the Argentine peso. Medical travel marketing ostensibly aimed at foreign patients becomes a potent site for locals to articulate the role of European heritage in Argentine identity, and debate the status of Argentina as a “modern” nation following the devastating economic crisis.

My work with transnational patients undergoing surgery in Argentina suggests that theoretical approaches to the relationship between bodies and movement would be helpfully reconceived within the context of medical travel. I focus on embodiment – and the perceptual experiences of “bodies-in-momentum” – to account for the spatial and temporal displacement patients experience as part of undergoing surgery thousands of miles from home.

I also examine how surgeons are being repositioned by the incoming flow of foreign patients, which they experience both as a source of recognition of their expertise, as well as a source of indignation in being relegated as “cheap” alternatives to doctors of the Global North.
Acknowledgments

While undertaking this project, I have been supported and encouraged by a staggering number of very smart, kind and generous people. Without their skilled mentorship, active participation, kind critique and unwavering love, this research would not have been possible.

My dissertation fieldwork in Argentina (2007-2008) was generously supported through a Fulbright-Hays Doctoral Dissertation Research Abroad grant from the U.S. Department of Education, as well as through a Doctoral Dissertation Improvement Grant from the National Science Foundation (NSF). Securing funding was a process made smoother through the substantive feedback and support I received from my committee members, as well as the tireless efforts of Teresa Delcorso of the Rutgers Chaser Resource Center for Graduate Student External Support.

Early support from the Rutgers Graduate School, as well as the Rutgers Department of Anthropology, made it possible for me to undertake initial research in 2006, setting the questions of this dissertation into motion. Additional support for preliminary research was offered through an NSF faculty grant made possible by Daniel Goldstein, for which I thank him immensely. Given the lack of anthropological work on transnational medical travel when I began this project, this initial funding was absolutely critical in making the case for the need for further research.

In Argentina, I was fortunate to have the encouragement of many wonderful colleagues and friends. Dr. Pablo Pozzi of the Department of History of the University of Buenos Aires was welcomed me as a student and connected me with a vibrant intellectual community. Ariel Dulevich Uzal of the Ministry of Tourism was enthusiastic about the
project from my initial research trip, and helped me to develop networks of connections. Anthropologists Martina Filinich, Ines Finchelstein and Dominique Gromez each contributed to this project extensively, and helped me to better put what I was seeing and hearing into the larger context of economic and political change within Argentina. Domi, in particular, was the sweetest interlocutor one could hope for, continually encouraging me to push my questions and discover new ways of thinking about what I was finding. Lorena Ines Gall encouraged me to see the unique possibilities of doing fieldwork in Argentina. Most of all, I am immensely grateful to all of the research participants whose experiences serve as the basis of the dissertation, but who must remain anonymous. I simply cannot thank you enough for bringing me into your lives, sharing your joy and pain, and opening up your world to me.

Collecting this data, however, is only one small part of the overall project of completing a dissertation, and once back in the United States, I had much help transforming and “writing up” these experiences. At Rutgers, my time was immeasurably improved by the great friendships I formed with other graduate students, especially Dillon Mahoney, Nell Quest and Assaf Harel. Special thanks goes to Chaunetta Jones, who began as my student mentor, but grew into a very close friend and comrade. I am incredibly grateful for the friendship of Drew Gerkey. Drew not only patiently read drafts of early versions of this work, but offered endless compassion and steady support, even from the other side of the world. Drew’s parents, Pat and Marty Gerkey, also deserve special recognition. In the summer prior to my year in Argentina, I waited desperately for my grant funds to come through before I had to depart for the field. In an act of deeply touching generosity, I received a small grant from the “Gerkey
Family Foundation” in support of this research, enough to make sure I could eat and
shelter myself while waiting for the bureaucratic smoke to clear. That they believed so
strongly in my ability to do this research was a major motivation to make it through that
initial difficult period of fieldwork.

My ongoing participation in New York University’s “Science Studies” seminar
offered many new perspectives on my research, and I have greatly enjoyed the engaging,
warm and exciting groups brought together by Emily Martin and Rayna Rapp. Most
importantly, my time at NYU allowed me to meet and grow to love one of my best
friends, Emily Yates-Doerr. Emily is a patient interlocutor of all things love, life and
work. Unabashedly genuine, with Emily, one is less afraid to think big ideas. She has
nourished me endlessly.

I have been blessed with an amazing committee, each adding to this research in
unique and wonderful ways. Peter Guarnaccia has been an advocate of this project from
its inception. Whereas many would have balked at the idea of suddenly changing a
project from Belize to Argentina, Peter whole-heartedly supported my excitement for this
new topic and worked to help me move from idea to reality. Louisa Schein has also been
a major influence on the development of this project, and her courses in gender and
sexuality were some of the most formative of my graduate career. Our long talks in her
office always left me with new directions to consider and ideas to explore. Daniel
Goldstein’s own expertise in Latin America fundamentally shaped the way I thought
about this project, including his insistence that I contextualize Argentina more broadly
within the landscape of Latin American history and politics. He has been a generous
editor, and provided much help in all stages of this project – from grant proposals to
imagining the book it will become. My outside member, Rayna Rapp, feels much more like an “inside” member. Ever since taking her “Cultures of Biomedicine” course my first year, I knew Rayna was a rare find: generous, insightful and endlessly kind.

My respect and gratitude for my primary advisor Fran Mascia-Lees is almost impossible to express. As often as people say that they could not have done it without someone, in this case that is very, literally true. In addition to her guidance, support and mentorship in writing the dissertation, she also encouraged me to publish a modified version of Chapter Four as part of the phenomenal Wiley-Blackwell collection *A Companion to the Anthropology of the Body and Embodiment* (McDonald in Mascia-Lees, 2011), for which she served as editor. To be a part of the process of the volume coming together, as well to have my words printed alongside the work of people I have admired for years, is an indescribably wonderful feeling. While the details of everything Fran has done to support me would go on for pages, I want her to know that I understand how very lucky I am to have her as my mentor, and that I have been transformed by the power of her belief in me.

Finally, gratitude to my parents for all the sacrifices made and love invested. More than anything, I wish my dad – Dan Harbour – could have been a part of this journey with me. I have carried him in my heart with every step I have taken, and his love continues to make each next step possible.
# Table of Contents

## Acknowledgements

Page iv

## List of Illustrations

Page ix

### Introduction: Huts are to Hospitals as Mayan Healing is to Cosmetic Surgery?

Page 1

### Chapter One: Colonial Medicine to Medical Tourism: Biomedicine and the Global Imagination of Risk

Page 44

### Chapter Two: Selling Surgery in the Paris of South America

Page 76

### Chapter Three: Unequal Expertise: Third World Surgeons treating “First World” Patients

Page 107

### Chapter Four: Bodies-in-Momentum: Experiences of Movement as part of Transnational Surgery

Page 151

### Chapter Five: Patients in Circulation: Argentina and the Transnational Politics of Health Citizenship

Page 184

### Conclusion: “To Govern is to Populate”/To Govern is to Operate

Page 208

## Bibliography

Page 221
List of Illustrations

1. Surgeons Clinic
   Page 1

2. Hospital Austral
   Page 45

3. Old/New Architecture, Buenos Aires
   Page 76

3. The Three Graces Media Campaign
   Page 93

3. Image from Medical Tourism Website
   Page 100

3. Image Taken by Medical Traveler
   Page 104

4. Carla Trying on Compression Socks
   Page 107

5. Snapshots of Images Shown by Dr. Jacovella
   Page 137

5. Post-Operative Blood Drains
   Page 151

6. Rogier Connecting to Online Forums
   Page 158

6. Melody Recovering
   Page 178

6. Street Corner in La Boca
   Page 184

7. Melody Posing
   Page 188
In the genre of twenty-first century anthropological entry narratives, it is perhaps a truism to say I arrived at the topic of “biomedical tourism” through a circuitous route. Reflecting the increasingly multi-sited, transnational preoccupations of anthropology, it would be more surprising, perhaps, to arrive at one’s theoretical concerns or field site in a manner that was not circular or emerging from a complex range of experiences. My first introduction to the idea of “global medical tourism” occurred while sitting at an old, bulky desktop computer, located in a cinderblock community center in rural Belize.

I had returned to Belize in 2005, during the first summer of my doctoral program, in order to reconnect with my undergraduate fieldwork site. Five years earlier, I had
conducted a summer of ethnographic research in the area, looking at the ways in which HIV/AIDS was affecting the small town of San Ignacio, with a particular focus on women and local forms of healing. I had returned with the intention of assessing the site for its potential as a long-term project, and to see whether or not any of the connections I had made so long ago remained. The person I was most anxious to reconnect with was Ms. Beatrice, a Mayan healer who had been at the center of my earlier research, and with whom I had kept in intermittent contact in the years between.

The seven-mile hike to her hut was hot and muggy, filled with both gnawing anxiety and biting flies as I worried whether or not she would remember me. Turning off the dusty road into the thick grasses surrounding her property, I was relieved that Ms. Beatrice greeted me genially. We spent the long afternoon cooking tortillas on her kamal, collecting herbs near her healing hut, and filling each other in on the major events that had taken place in our lives since we last met face to face. She told me about trips she had taken to the United States since we last saw each other, including the incredible occasion when, in 2002, she had visited my hometown of Denver, Colorado and had the opportunity to meet my parents. While I had been in school in Connecticut at the time, their meeting had meant much to me, especially Ms. Beatrice’s invocation of a Mayan prayer for my dad, who was at that time, struggling with what would ultimately turn out to be a fatal brain tumor.

Ms. Beatrice also told me of the increasing numbers of people coming to see her from Europe and the United States, seeking out her healing knowledge as a form of complementary care to the allopathic (biomedical) treatments they underwent back in their home countries. Drawn to this particular detail of our conversation as a possible
topic of research, I went later that week to the town community center to begin searching online for stories of people crossing borders in order to access healthcare. In an uncanny synchronicity, 2005 happened to be the year of the first real popular media explosion of the term “medical tourism.” There, in a barely cool concrete room filled with the loud hum of overworked computer fans, I found myself caught up in journalistic narratives of people traveling to places such as India, Thailand, and Mexico to undergo heart surgery, hip replacements and other “high-tech” biomedical interventions. As someone who had thus far organized my understanding of health disparities along fairly traditional geographical divisions between the Global North and the Global South, such travel seemed intriguingly counter-intuitive and rich as a potential site for inquiry. Rural Belize, of course, was not an emerging destination for these kinds of high-tech biomedical procedures. In stark contrast, I had recently worked with the local Peace Corps team in presenting an anti-smoking educational campaign to elementary students, in which one of the main prevention messages seemed to be *if you get lung cancer in Belize you will die, because the closest hospital with the technology you need to treat you is located in Mexico.*

I am not sure of the precise moment I realized that I would not be coming back to Belize for my dissertation research. This new phenomenon of medical tourism had caught my attention, and refusing to let go, I began to search and think through places where this practice could become the center of my research. People often ask me how I chose Argentina as the site for my fieldwork, and my answers are always inadequate, or rather, inaccurate in that they are reconstructions from the vantage point of what I now know about the country. Out of the many reasons for why Argentina is a fascinating
location to study transnational patients, almost all were unknown to me when I selected it as a site for research after returning from Belize. The most compelling reasons, in fact, were only hinted at during my initial visit in the summer of 2006, and came more fully into view during my year of research from September of 2007 to September of 2008.4

In many ways, I believe I came to choose Argentina as a field site in the way that many of the patients I ultimately worked with came to “choose” it as a place to have surgery: drawn in by romantic images of the city, I ultimately took a leap of faith and redirected all my energy and resources towards making the project work. It is also accurate to say that I was drawn to Buenos Aires precisely because it represented all that I imagined was different from my experience of Belize. In San Ignacio, my days felt hot and dusty, my skin transformed into a mottled texture of bleeding, raised bumps from so many mosquito bites. I slept on a thin foam mattress in a creaking wooden bed, a chirping gecko clinging to the mosquito net. While such images would ultimately come to haunt my research in Argentina as a sort of romanticized “authentic” field site I had disavowed, at the time Buenos Aires seemed to offer the promise of cosmopolitan excitement at the geographical extreme of South America, as well as the unique opportunity to conduct some of the first ethnographic research on what was fast emerging as a burgeoning market in “global medical tourism.” I began my entry, however, with this story of Belize, not only because it is central to how I ultimately found myself in the “Paris of South America,” but also because, as explored below, the traces of this research continued to persist into how I understood this new project, and how I came to question medical tourism as a “newly” emerging phenomenon.

**Methodological Approaches: From Networks to Blood on my Hands**
Field Notes
June 20, 2008
23:39 PM

My hands were covered in blood today. We ran out of the latex gloves Doctor B. gave us, but Melody was in so much pain and needed help holding her bandages as she emptied her drain. The tubes of the drain came right out from her abdomen, and ooze a constant flow of blood-colored liquid – but it’s thinner than regular blood. I need to pick up some more gloves at the pharmacy tomorrow – and cotton bandages too.

How does one go about studying something as nebulous as medical tourism or what I call “transnational medical travel” in Buenos Aires, Argentina? What approaches are necessary for understanding it as an emergent practice, a media phenomenon, or an ambiguous sign collapsing together a complex series of historical, political and ideological forces? What counts or is recognized as “medical tourism” in contrast to the broader category of medical travel I explore – and what are the practices that go unnoticed? Given that the methodological approaches to studying such diffuse practices proved so challenging, I will spend a bit of time setting up what I attempted to do upon arriving in the field, as well as the kinds of activities in which I ultimately participated.

I came to the project with primary theoretical interests emerging out of medical anthropology, including a focus on differing cultures of biomedicine, and the anthropology of neoliberalism and transnationalism. My initial research questions asked how this emerging market in biomedical tourism was situated within a larger neopolitical project, and sought to better understand the processes through which transnational connections were formed and enabled. Following the ethnographic and methodological approaches central to sociocultural anthropology, I designed my research to allow long-term immersion in the cultural milieu of people participating in transnational medical travel,
including a year-long period of fieldwork abroad. And yet, similar to many anthropologists currently studying transnational processes, the prospect of how to define a given “field,” access research participants, or limit my scope of inquiry remained challenging. As others have explored (notably, Gupta and Ferguson 1997), “the field” as a discrete, bounded and geographically specific location has always been a troublesome fiction within anthropology, and the artificiality of defining the scope of inquiry is becoming an increasingly pressing concern as anthropologists shift their focus to the processes of globalization and transnationalism more specifically.

And yet, for doctoral students undertaking anthropological research, the “problem” of the field remains a practical and highly relevant one. In the case of my research, the process of securing external funding to fulfill the expectation of fieldwork forced me to narrowly confine and describe my research in ways that emphasized the grounded “field” of my work, rather than transnational processes. While multi-sited work may be becoming more common, the realities of trying to plan and fund such research as a doctoral candidate remain problematic. The Fulbright-Hays grant I was awarded and which served as the bulk of my funding, for example, is a remnant of a Cold War era “area studies” approach to understanding global politics and social conditions and relies heavily on a location-specific approach. Though the description of the proposed project I submitted to the review committee was clearly transnational in scope, the requirements of the grant actually forbade me from leaving the country of Argentina for the entire duration of my fieldwork. So while the research I proposed was centered on forms of movement, I, as the anthropologist, was required to stay put.
Within these constraints, I wanted to be able to approach transnational medical travel as a process, working with a wide-variety of people situated within this emerging market, rather than, for example, focusing exclusively on doctors or patients. The methodological approach I designed before arriving in the field, therefore, was organized around the attempt to trace “networks” of actors involved in medical tourism in Buenos Aires, with the anticipated “actants” primarily imagined as doctors, patients, nurses, medical tourism coordinators, and medical tourism agency workers.

My methodological approach was by necessity experimental. Unlike medical travel destinations in which patients are primarily cloistered in hospital-hotel compounds, Buenos Aires did not provide such an obvious site of entry. I was thus faced with the significant challenge of figuring out how to find the doctors treating foreign patients behind their closed, clinic doors in a city with a population of over twelve million residents. The solution was, roughly, to find the doctors in the same way patients do: the Internet. I drew on a variety of online sources in order to make initial contacts in the field, including U.S. based websites such as plasticsurgeryjourneys.com, makemeheal.com, as well as an English-language travel listserv called Argentina Forums, on which there were literally hundreds of message threads dedicated to accessing surgery in Buenos Aires, and in particular cosmetic and dental procedures. In terms of methodology, this approach also raises intriguing questions about the nature of online research and the anthropological field. I explore several of my online research approaches in depth below, but it is worth highlighting how online spaces themselves became a primary “location” in which I conducted research. Such spaces, I found, were both rich with possibility and fraught with miscommunication and disconnection. The
online forums in which I participated were ripe with suspicion, with participants regularly doubting others’ claimed identities: was the recommendation for the doctor from a real patient, or an imposter trying to sell services? Was the woman seeking participants for her research really an anthropologist, or did she work behind the scenes with an agency to recruit new patients?

At the same time, the fact that these interactions occurred in an online space did not erase all forms of geographic embeddedness among the participants. People regularly tried to guess where someone was “really” located based on their writing style (or online “accent”), and at the same time, prospective patients seeking information flooded my inbox with questions based on the fact that I was located in Argentina. Many of the interactions and discussions that occurred online have not made it into the dissertation. Instead, reflecting the notion of “the field,” perhaps, in a more literal sense, I concentrated my research efforts on those people who I could meet with “face-to-face.” It was primarily those conversations that occurred in person that allowed me an intimate, embodied way of participating in their experiences: listening as doctors reminisced about the past and patients worried out loud about fast-approaching surgeries, watching closely as doctors examined and stretched patients’ skin upwards mimicking the effects of surgery, smelling the antiseptic odors of hospital rooms and tubes of antibacterial ointment, touching the bumpy, uneven edges of skin as I helped to clean healing wounds. Over the course of the fifteen months of research in Argentina, I was fortunate to have the opportunity to work with many different people, and have roughly outlined the broad categories of research participants below.

_Doctors:_ My first approach on medical travel oriented websites (which are
publicly accessible) was to record the names of surgeons that patients recommended to one another. Compiling lists of dozens of names, as well as the frequency with which they appeared, offered an excellent starting point of doctors to contact via phone and email. I followed up by contacting doctors’ offices directly, explaining where I had found their name, and requesting an initial time that I could meet with them to tell them more about my project and see if they were interested in participating in the research.

Several months into my research, I also became aware of an online directory of cosmetic surgeons practicing in Buenos Aires, and began contacting them directly, in the hopes of expanding my pool of informants to include doctors who were not actively seeing transnational patients.

Occasionally, during my first interviews with surgeons, they were surprised to learn that their names were listed on these websites, and requested the web address so they themselves could follow up and see what patients were saying about them. Others were already intimately familiar with the websites, including one doctor with whom I worked early on, whose medical competence had been the subject of a vicious online debate within the forum. Because the surgeons I approached were all intimately familiar with the ways in which scientific research is conducted, they were often fairly open to meeting with me. I often emailed or provided a paper copy of my curriculum vita during our first meeting as a sort of evidence of credentials, and although many were not familiar with Rutgers University specifically, they had many complimentary things to say about the research being funded by the National Science Foundation.

My time spent working with doctors engaged a range of methodological approaches, including qualitative interviews, reviews of their patients before and after
photographs, observing them as they performed consultations and examinations, and even observing surgery. While I interviewed twenty doctors over the course of my research (mostly cosmetic surgeons, but also a cardiologist, a dental surgeon, a fertility specialist, an ophthalmologist and two dentists), I worked most intensely with a smaller group of five. While I may have first imagined that these doctors would help connect me with the foreign patients they were seeing, none of them ultimately offered to do so. Instead, I had to find my own methods for getting in touch with patients, many of whom subsequently introduced me to their doctors or to other patients with whom they were in contact.

Patients: Online message boards also proved the most reliable way for me to make initial contact with patients, although the ethics of doing so seemed more fraught than with doctors. Unlike looking up the name of a doctor through public sources of information, I was unsure how best to approach patients to see if they would be interested in my research. My initial approach involved creating a user profile on these sites, and posting a description of myself, and my research, to the forums in the hopes that interested patients would contact me. In the description, I listed my institutional affiliations, the reasons for undertaking this research, and offered to provide patients with references or a CV should they want more information. I tried to be as transparent as possible, and made it clear that the research was voluntary and unpaid (although, while I offered no cash to patients, I did compensate them for their time by treating them to coffee, ice cream, or an occasional meal). All in all, I was able to undertake in-person ethnographic research with thirteen patients (although dozens more communicated with me online), with six of them emerging as key informants who allowed me to participate
in the full range of activities and experiences during their time in the city.

Connecting with patients for the first time produced a range of results, as well as a host of ethical questions inherent to the fieldwork. Many of the patients who initially contacted me were not interested in participating in the research *per se*, but would ask me for recommendations of doctors they should see in Buenos Aires. While I worked to distinguish my research questions from anything resembling a “how-to-guide” for seeking treatments abroad, such questions persisted throughout the research. Meeting patients face-to-face for the first time also produced a range of experiences, from guarded caution and requesting that our conversations not be taped, to enthusiastic reception of me as a researcher/confidant/fellow foreigner in a foreign city. In fact, it was those patients who most quickly warmed to me who seemed to produce the most ethical quandaries: for example, asking me to serve as advisor on things like implant size or whether I thought the doctor seemed like a good doctor. What remained difficult in my position was to determine what support and help I could offer as an acquaintance (and in some cases, friend) and of what areas I had to steer clear so that my position as a “researcher” would not be construed as a professional opinion on topics on which I had no expertise.

Once I had made a few initial contacts with patients, they were also fairly generous with putting me in touch with other patients they had met online – or in person, and “recommending” me as a credible researcher who could be trusted. As part of an online posting of her experiences in Buenos Aires, one patient I worked with wrote on *psjourneys.com*:

Last but not least, I should mention that I had the great privilege to meet Emily [with hyperlink to my profile]. She is a graduate student of Anthropology, who
was doing research on medical tourism in Argentina. She is one of the sweetest persons I ever met. She was genuinely concerned and very helpful to me before and after my surgery.

Postings such as this, as well as word of mouth recommendations, made meeting patients increasingly easy as my time in Buenos Aires continued. Other relationship to transnational patients, I soon learned, held the opposite danger of tainting me with their “difficult” reputation. One of the first patients I encountered upon landing in Buenos Aires was a middle-aged journalist from San Francisco, who wanted to undergo several cosmetic procedures and to then write about them for a popular website. Yet, I soon learned in tagging along with her to various doctors appointments throughout the city that while she initially presented herself as any other patient, she soon began to emphasize the power of her voice as a reviewer in what seemed like an effort to extort surgeons for discounted services. It took several meetings for me to restore and disassociate myself with this particular patient in the eyes of the doctors we had visited. Another “problem patient” was a high-strung middle-aged woman from Philadelphia who had flown to Buenos Aires to undergo extensive reconstructive surgery in spite of a known heart issue. As the anthropologist, I found myself in the uncomfortable position of being in the middle of her and her doctors, with each asking me to lend an “objective” opinion to why the other was wrong. While my initial research plan had envisioned tracing networks and exploring the links between actors such as doctors and patients, the reality was far more complex, and the relationships both richer and more fraught than my methodological approach had anticipated.

There were also many opportunities to gather data on patient experiences in ways that I would have never anticipated before leaving for the field. As described more fully
in Chapter Four, two patients with whom I had been in contact ended up sharing a three-bedroom apartment during their two month stay in the city. After our initial time together (including a period where one patient arrived before the apartment was ready and stayed with me for a few nights), they invited me to move into the third room in order to more fully appreciate the true experience of what undergoing multiple, intensive surgeries in Buenos Aires would be like. While initially this was simply discussed as a way to give me greater access to their experiences, as I describe more fully, this was the most intense period of participant observation during my fieldwork. Although only one of the transnational patients went on to undergo three major reconstructive surgeries, the amount of labor in which I participated in order to support her time in the city was tremendous, intense and generated much insight.

As an adopted member of their temporary household, my duties in the household eventually extended to doing all of the grocery shopping and errands, cleaning the apartment in between weekly visits from a housekeeper (which included loads and loads of bloody towels and sheets), cooking meals, making coffee, administering pain pills, wrapping bandages, setting up internet connections, washing wounds, rearranging pillows and emptying blood drains. Added to these duties was the ongoing emotional work of living with, and caring for, someone in tremendous pain and uncertainty. It is precisely because of the intensity and depth of these experiences that “Melody” has come to play a larger role in my analysis than other patients with whom I worked.

*Medical Tourism Coordinators:* Another key category of actor with whom I connected during my fieldwork was “medical tourism coordinators,” who were women (and all of the coordinators I worked with were women) hired by individual doctors or by
an agency, to orient patients, coordinate schedules, and provide affective care for patients during their stay. I was able to spend significant time with two coordinators (Sarah and Lola) and became close enough with them to meet their partners and children, as well as see how they worked with a number of patients during my time. I participated in the wide range of activities that the coordinators undertook as part of caring for patients, including picking patients up from the international airport, orienting them to the apartments they would be using during their time in the city, taking them out for a welcome dinner, helping patients exchange U.S. dollars for pesos, taking them to a surgical supplies store for garment fitting and implant selection, accompanying them to tango shows and city tours, bringing them to the doctor’s office, signing hospital contracts, as well as long hours spent in hospital suites, nervously awaiting an update on a patient’s condition. During recovery periods, the work continued, including such things as making chicken soup, connecting patients to their loved ones by phone, getting refills of pain medications, and chatting over tea in darkened apartments. In addition to time spent observing coordinators interacting directly with patients, I also worked with coordinators as they handled details of their work beyond contact with patients, which included answering potential-patient emails, strategizing how to handle working for multiple doctors at once, and, with Lola, filming, translating, editing and even doing the “voice over” to introduce a short YouTube video marketing the services of a local surgeon specializing in gastric bypass surgery, which at the time of writing has over three thousands views.

In some ways, my time spent shadowing medical tourism coordinators offered me the most comprehensive perspective from which to consider the many complicated
dimensions to successfully coordinating the care of a foreign patient during their time in Argentina. Sarah, in particular, was initially distrustful of my presence as a researcher, perhaps wary of the ways in which my activities would replicate the services she provided. However, both coordinators ultimately mobilized me towards their own ends, asking that I do “favors” for them to lighten their workloads, and thus integrating me more fully into their practices. Methodologically, one of the most difficult aspects of the research was to balance my association with any one person, so that my time spent with coordinators did not overly alienate me from my work with doctors and vice versa. The relationships between the people with whom I was working were often shot through with power differentials, including those of hierarchy within the workplace (doctor/coordinator, for example), as well as gender, race and nationality.

Methodologically, one of the challenges was how to pay attention to such power dynamics and negotiate the line between building rapport without being understood as an exclusive ally, and thus maintaining my ability to move relatively freely from person to person in my role as a researcher interested in the overarching process.

Medical Tourism Agencies: Another key domain of research during my time in Buenos Aires were the agencies that had been developed solely to try to attract and coordinate the care of patients from the United States and Europe. Such agencies ranged from small operations of two people in a home office to a large center employing over fifty administrative workers, in addition to dozens of doctors and other medical professionals. One of the methodological challenges of approaching these agencies was to make it clear that I was an anthropologist, and not interested in their agency as either a potential consumer or investigative reporter. The degree of access I received varied, but
most of my access to agencies took the shape of multiple qualitative interviews with various staff members, rather than unfettered access to the daily workings of the businesses. Ranging in size from small “start-ups” to multi-million dollar businesses with a “global” presence, I worked with a total of six medical tourism agencies during my time in Argentina. Additionally, I was able to make contact with several former employees of the largest (and most controversial) firm, which allowed me to corroborate some of my own observations, as well as gain insight into some of the everyday aspects of work to which I would not have been privy during my conversations with current employees. These conversations also offered insight into how employees were trained to work with potential-patients by phone and email, including written transcripts they relied upon to help them “sell” surgical packages and address patient concerns.

_Media:_ Emerging from this work with medical tourism agencies, I also did several interviews with media firms hired to create advertisement campaigns to attract U.S. and European patients to Argentina for surgery. While I only worked with two media firms directly, it offered me the chance to hear the logic behind the selection of particular images and narratives in the promotion of Argentina as a medical tourism destination, and how Argentina was imagined as distinct form other destinations in the region.

_Others:_ Finally, there were a number of people with whom I worked who do not fit easily within the categories outlined above. Included in this catch-all category are, for example, U.S. Embassy workers who invited me to their meeting on medical tourism regulation, expatriate Americans attempting to enter into the medical tourism market, local hospital administrators considering the possibility of increased international
regulation of their facilities, members of the Ministry of Tourism, and participants in an intra-Latin American patient program (explored in Chapter Five).

Gaining access to this diverse range of participants was not anticipated as part of my original research design, but was made possible by the serendipitous connections and referrals characteristic of ethnographic fieldwork. Such meetings were also filled with surprises, such as when my conversations with the employees at the Ministry of Tourism ended up feeling less like I was interviewing them, and more like they had brought be on board in the effort to expand their promotional tourism literature. Despite my best intentions and clear assurances, the non-commercial nature of my work seemed to remain a mystery to most. Doctors and agencies often were eager to provide information that would attract customers, and patients regularly asked that I provide information on which doctors were the “best,” which I explained I was not qualified to do. The language of medical travel is so thoroughly saturated in market logic that it seemed almost impossible to justify a position of interest outside one related to profit. That I was studying such a phenomenon as an anthropologist was also clearly confusing for my research participants, and I had several doctors, in particular, ask why I was not studying “los indios” in the rural areas of Argentina.

I conducted interviews in the language preferred by the participant, with many patients and patient coordinators choosing English, while nurses, doctors and agency workers were often conducted in Spanish. On occasion, doctors would initially request to speak in English, perhaps as a way of demonstrating their competency in the language, and then might switch to Spanish in subsequent interviews. Other times, surgeons who spoke eloquently when reflecting on their work in Spanish, would experience difficulties
communicating with their patients in English. Perhaps even more than in most contexts, language was a critical realm in which competency, status, education and “worldliness” were performed and enacted.

Beyond the language of the interviews, I also endeavored to pay close attention to body language, as conversations were punctuated with intimate gestures and forms of body proximity seemingly natural in Buenos Aires, but that took me (and other Americans) by surprise. I had to consciously retrain myself not to extend my hand upon meeting a doctor for the first time, or they might hold on to it, almost mockingly, as they made a joke about American formality and leaned in for the appropriate kiss on the cheek. At the same time, as I grew closer to a few Argentine-born patient coordinators, I also had to be careful not to hug them “closely” goodbye, as the hugs I offered my American friends were seen as too intimate of a touch.

I recorded hundreds of hours of interviews, and selectively transcribed and translated those conversations that were most relevant to my research questions. In addition to these interviews, I conducted extensive participant observation, which included extensive note taking on interactions, gestures, snippets of conversation, detailed sketches and reflections on shared experiences. My evenings in Buenos Aires were often spent looking over the various jottings and sketches I had produced that day, and sitting down to transform them into more extensive notes. In my experience, modes of “collection” and “analysis” are rarely distinct, and the process of recording my experiences bled very much into the mode of analysis, as I worked to recognize connections, identify emerging themes, and pay close attention to patterns. Beginning the
analysis stage of the project while in the field allowed me to further refine my research questions, and to probe into emerging themes as the research progressed.

Data Analysis: Culling through the large amount of data produced through fieldwork was a challenging task, and this dissertation necessarily focuses on those aspects of the research I found most intriguing, as well as those that spoke to broader theoretical issues beyond the specific case of medical travel to Argentina. A close reading of interview transcripts, field notes, as well as sifting through the many pages of marketing and tourism materials I collected, allowed me to code for major themes and discover points of connection between previously unrelated stories and experiences. In addition to the qualitative data I collected while in the field, I also gathered additional information by exploring medical travel websites, online forums, and performing a systematic review of articles on medical travel in major news sources (explored in more depth in Chapter One).

One of the greatest challenges was choosing which themes to develop as part of the dissertation, and what would be left out. Each of the stories I present below could have been expanded to encompass far more of the experience of the individual. My approach, however, was to be able to weave together these stories in a way that aimed to avoid redundancy, and instead, focus on overlapping edges of experience as points of illumination. Most challenging in this approach was not merely detailing the daily practices medical travelers, but rather, collecting together those aspects of the travel that seemed most salient – and had the potential to contribute more broadly to anthropological discussions.
Given the wide range of people and networks I examined during my time in Buenos Aires, not all of the fascinating stories I encountered have made it into the final version of this dissertation. I have, instead, tried to organize the dissertation in a way that allows for the exploration of what I saw as the most critical features of the experiences and practices I encountered during my time, as well as those that emerged as most theoretically compelling for understanding the complex picture emerging as part of a burgeoning global market in biomedical services.

In order to be able to clearly lay out the experiences to which I was privy, I have created a list of those people with whom I worked in Buenos Aires who emerge as key actors within the chapters that follow (Introductions below). Because these “actors” often move across the borders of the chapters within this document, I found it more useful to provide one place to offer comprehensive descriptions and biographical details of such key people, rather than continually introducing them as they appear across the various contexts of my research. While this may depart from a more linear narrative in which people are introduced and subsequently “developed,” in does it some way reflect the nature of how I collected these data: overlapping appearances and moments of insight that condensed and developed into more comprehensive pictures over the course of the many months spent doing fieldwork and writing up these results.

Chapter Overview and Organization of the Dissertation: To give a sense of the picture that emerged out of this research, I offer here a brief outline of the chapters to follow, including pointing to some of the key theoretical engagements that link them more broadly.
Chapter One offers an introduction to the larger phenomenon of global medical tourism and transnational medical travel. Drawing on the anthropology of transnationalism and neoliberalism, I examine the ways in which medical tourism is being imagined both in popular media as well as mainstream scholarly literatures. Most striking is the profoundly neoliberal logic and language that saturates descriptions of a global market in biomedical services, as well the ways that this logic is mobilized to encourage a re-imagination of the world in terms of risk and “safety.” Critiquing this literature, I argue that the term medical tourism is profoundly problematic, especially in so far as it evacuates such travel of complex political and historical dynamics, and effectively conflates transnational medical practices with leisure and tourism.

I then turn briefly to the anthropological literature directly concerning medical tourism and examine how anthropologists are engaging with transnational medical travel in ways that depart from broader scholarly and popular discussions. In the last part of the chapter, I explore colonial-era ways of imagining and dividing the world into safe and risky spaces, and consider how medical tourism may ultimately rearticulate deep seated anxieties about risks to white bodies through the language of biomedicine and the market. That is, even as patient bodies are moving and circulating in ways that seem counter to longstanding ideas about safe and risky spaces for biomedicine, their movement may ultimately engender emerging forms of neocolonial surveillance and reinforce the conflation of the Global North with biomedical expertise and safety.

Chapter Two turns specifically to the emergence of a medical tourism industry within Argentina. While the appearance of the industry itself is new within the context of Buenos Aires, I show how the marketing of medical tourism to Argentina invokes
longstanding national practices of positioning Argentina as a white and European exception within the space of Latin America. In particular, I look at how the formation of a medical tourism industry within Buenos Aires not only invokes this history, but also does so at a particular moment in a vulnerable post-economic crisis, as notions of a racialized European identity bolster claims to modernity undone through the processes of economic instability. This section draws on fieldwork I did with medical tourism marketers, medical tourism agency workers, as well as patient coordinators – in short – those people primarily responsible for “selling surgery in the Paris of South America.” Additionally, I offer a textual analysis of the marketing materials collected as part of my research and discuss the ways in which they draw on notions of “Europeaness” and “whiteness” to sell the notion of modern, secure biomedicine. While the Argentine nation as it exists today was fundamentally established through the massive migration of Europeans into the space of the nation at the turn of the twentieth century, I see transnational travel as a present day continuation of this travel: a post-crisis form of circulating “First World” bodies into the space of the nation as part of reasserting a transnational European, modern identity.

It is important from the outset to make clear that I understand the terms “First World” and “Third World” as problematic, reflecting a very specific history of dividing up and imagining the world since the Cold War, when “First World” countries took on this label in part because of their political and military alliance with the United States. Less concretely, the term popularly circulates as shorthand to designate the relative wealth (in capitalist logic) of countries, often alongside other fuzzy dichotomies, such as “developed/developing” nations.
The use of such terms have been actively critiqued by anthropologists and other social theorists, particularly by those adopting a Marxist or political economy perspective, which has a long history in the anthropology of Latin America. Eric Wolf’s (1982) *Europe and the People Without History*, for example, advocates an anthropological understanding of capitalism that accounts for the historical dimensions of global interconnection and exploitation. Wolf uses a sweeping review of world history since the fifteenth century to demonstrate that even the most seemingly isolated regions have become highly interconnected through external relations to other countries and peoples.

Equally important was the dependency theory elaborated by economist André Gunder Frank (1967). Through his focus on Latin America, Frank advances a critique of modernization theory by proposing a relationship of expropriation whereby developed, industrial nations (metropoles) profit at the expense of underdeveloped nations (satellite countries). In contrast to modernization theory, which associated the condition of “underdevelopment” or “backwardness” with a given society’s isolation from the world capitalist system, Frank challenges the very conception of “isolation” (Frank 1967:viii). Working through three case studies, Frank demonstrates that underdevelopment is instead produced through a particular (dependent) *relationship* to metropole countries, and that such relationships are inherent to capitalism. Importantly, Frank also argues that the metropolis-satellite contradiction found between countries can also be found *within* countries – between regions, industrial cities, and rural areas (Frank 1967:10). Conceptually similar to dependency theory, Immanuel Wallerstein (1976, 2004) posits the existence of a capitalist world-system, which is a world-economy divided into core-
states and peripheral areas (Wallerstein 1976:231). In this dissertation, I often rely on the terms Global North/Global South as a way of signaling a belief that disparities between and within countries are the result of longstanding and actively maintained relationships of inequality, rather than differences in “development” or progress. Yet, the terms First World/Third World also remain below, as it was often in this language that both patients and doctors articulated their relationship to one another.

Chapter Three examines surgeons’ experiences more closely, exploring in particular the relationship between “marginality” and “biomedical expertise.” In this chapter I seek to understand the surgeon’s experience of disconnection between, on the one hand, biomedical expertise and, on the other, the experiences of economic and political marginality, particularly following the 2000/2001 economic crisis in Argentina. I argue that this disconnect is brought into sharp relief in the specific context of medical tourism to Argentina, revealing the complex, and even contradictory, ways that doctors make sense of the practice of Third World surgeons operating upon the bodies of “First World” patients.

By exploring doctors’ turn to discourses of “aesthetics” and “warmth,” I trace a few of the less obvious ways that doctors assert expertise through cosmetic interventions on the bodies of transnational patients. Finally, by noting the dearth of paperwork in the treatment of transnational patients among some of the surgeons with whom I worked, I reflect on how such absence is understood in terms of an affect of trust between doctor and patient, in direct contrast to the “cold,” legalistic notions of documented liability and waiver that doctors perceive as common in the United States. In considering together these various dimensions of expertise and marginality, I argue that surgeries performed
by Argentine doctors on First World patients exceed the realm of mere biomedical intervention. They are also critical political interventions into the global hierarchy of biomedicine, serving as the grounds from which to critique a neoliberal marketplace which would position them as “cheap alternatives” to their First World counterparts. The experiences of doctors also connect to the overall theme of movement, as their personal experience of constraint and being embedded within Argentina are heightened as part of operating upon hyper-mobile, transnational patient bodies. I consider the ways operations on mobile bodies serve as an alternative form of movement and circulation, as doctors actively imagine the bodies they have transformed circulating beyond the space of Argentina.

Chapter Four turns to the experiences of patients undergoing medical care in Buenos Aires, with a particular interest in the embodied experiences of motion. In this chapter, I argue that current approaches to the anthropology of bodies and movement tend to either focus on moving bodies, analytically apprehended as they circulate through geographic space, or alternatively, body motion as the gestures of individual agents. Despite the valuable insights of these approaches, little is revealed about the embodied experiences of movement itself. I introduce the notion of momentum instead to better account for patients’ non-congruous temporal and spatial ways of being-in-the-world, and to shift our focus from the agentive actions of individual subjects towards the embodied experiences of intersubjectivity. I argue the concept of momentum draws awareness to how bodies move through, and are moved by, multiple subjects, spaces, objects, and temporalities, enabling us to more effectively grasp excesses of action, intention, and practice not captured in current approaches to understanding movement and subjectivity.
Chapter Five returns to some of the themes introduced in Chapter One by examining the political uses of biomedicine, but with a focus specifically on the transnational circulation of patients. By comparing the influx of U.S. and European patients with local Argentines participating in the Venezuelan and Cuban-led *Mision Milagro* program, I demonstrate how these seemingly disparate circuits of transnational medical travel reveal the ways in which biomedicine, and, more specifically, operations upon transnational patients’ bodies, are particularly potent tools of the state. Beyond the specific case of Argentina, I suggest that the movement of transnational patient bodies across borders has become an intriguing site of statecraft, with transnational bodies becoming increasingly *operable* – poised for surgery and deployed as part of reconfiguring borders and the spaces of sovereign nations. I reflect on how the *moving body*, as well as the *embodiment of movement*, are increasingly central sites for revealing new theoretical directions within anthropology, and comment on how this work on the travel of transnational patients between the United States and Argentina moves toward this direction.

Taken together, these chapters traverse a range of literatures, and speak to various debates both within anthropology and across disciplines. As I demonstrate in the dissertation, transnational medical travel reveals more precisely the ways in which neoliberal logics and processes of transnationalism articulate with one another. Transnational medical travel becomes an extremely rich site to unearth the neoliberal logics that saturate transnational processes, including, the displacement of risk onto individual patients as they serve as the experimental subjects of an emerging neoliberal market in healthcare. This focus further includes addressing a state reeling from
economic crisis turning to strategies of increasing privatization and the marketing of
disaster for transnational tourist consumption, including medical tourism. Finally, my
interest in everyday experiences of neoliberalism and transnationalism leads to an
examination of how Argentine doctors, newly constrained by the limits of financial crisis,
engage in an imagined transnational circulation through the surgical modification of First
World bodies. Through this research, I am able to show more concretely the ways in
which neoliberal logic and transnational flows come together, but perhaps more
importantly, the ways in which they are experienced, imagined, and materially embodied
through everyday practices.

Perhaps most saliently, the political and economic stakes of transnational medical
tavel are most clearly revealed in bringing together two seemingly dissimilar flows of
transnational patients into the same frame – U.S. patients traveling to Buenos Aires for
cosmetic procedures and Argentine patients traveling to Venezuela for restorative eye
surgery. In the concluding part of the dissertation, we get a sense of the power of moving
citizen-patient bodies across borders as a critical strategy of statecraft. What speaks to
the power of transnational medicine as a political strategy and form of governance, is the
fact that it is employed by two seemingly antithetical state projects: U.S.-based neoliberal
market politics, on the one hand, and on the other, a socialist project of regional solidarity
developed to challenge free market exploitation and the poverty that results. This signals
transnational biomedicine – and the forms of intervention and care it enables – as an
increasingly important mode of shaping political subjectivities, remapping state borders,
and laying claim to citizen bodies. Therefore, it is not only that I argue that emerging
forms of transnational medical travel be properly situated within a larger economic and
political context, but that they also be recognized as a key form of statecraft in and of itself.

In addition to speaking directly to the processes of neoliberalism and transnationalism outlined above, I see this work in conversation with a wide range of literatures within anthropology and in other disciplines, and in particular gender and women’s studies. It is critical here that I signpost my interest in this work speaking to theoretical approaches to gender, both as a socially constructed realm of power differentiation, as well as an enacted and inhabited mode of embodiment. I have chosen not to designate a specific “gender chapter,” but to allow my attention to gender to be woven, omnipresent, throughout the analysis. This research reveals intriguing ways in which gender is actively constructed and performed through the realms of biomedicine, such as my analysis of Argentine surgeons who draw equally on their masculinity and European identity as part of making the case for intervening surgically upon the bodies of cosmetic surgery patients from the United States, the vast majority of which are women.

Significant as well to our understanding of gender are the actual body modification surgeries that these women, and a few men, pursue. As I explore below, the literature on women’s choices of cosmetic surgery is oversaturated with arguments about cultural expectations of femininity within the confines of patriarchy. My hope is that this work will contribute to a more subtle understanding of how particularly gendered bodies are inhabited, experienced and transformed. To this end, my aim is that this research both nuances and complicates our understanding of the relationship between gender and body modification practices, while also offering increased attention to the practice of
cosmetic surgery, which has been largely absent from anthropological inquiry despite a long-standing interest in human body modification.

The debates on cosmetic surgery within feminist and gender studies, in particular, have been anchored primarily in a discussion of the role of women’s agency in voluntarily undergoing body modifications that often conform to oppressive, or patriarchal, forms of normalization. I argue that the transnational nature of seeking cosmetic surgery abroad fundamentally alters the terms of that debate. I point instead, to how transnational movement and the experiences of *momentum* described by the patients with whom I worked, complicate the notion of individual agency in seeking surgery and point instead to the rich, intersubjective forms of embodiment that move patients towards a surgical outcome. Our understanding of these practices, I argue, is best suited by moving away from a focus on agency towards capturing the experiential dimensions of travel and the intimate interconnections forged through and with other people, places and objects in the process. Thus, beyond the case of transnational medical travel, my research embraces the move towards the study of embodiment (rather than the body) and experiential dimensions of intersubjectivity, and it seeks to further complicate the ways in which anthropologist theoretically engage with subjectivity as part of our research.

In addition to adding to the anthropological literature on embodiment, this work also contributes more broadly to the study of beauty and aesthetics, which I do in several ways. First, I look at how aesthetics has become a key realm of claiming expertise by Argentine doctors denied access to privilege through more traditional avenues. My research points to how beauty, often disregarded as a less than serious anthropological object, can be recognized as a serious discourse through which complex political and
social claims are articulated. Secondly, I point to how discourses of “beauty” and “vanity” are precisely the mechanism by which transnational patients are rendered precarious and outside the responsibility of the U.S. state. Discourses of beauty, then, emerge both as a serious site of social commentary, as well as tool of dispossession, a means through which to deny political and legal protections.

Finally, I see my work contributing to literatures concerned with postcolonial racial formations in several key ways. Buenos Aires, long neglected as an anthropological fieldsite precisely because of its reputation as a “European space” within Latin America, offers a complex location from which to think through diverse forms of “whiteness,” as well as how claims to whiteness and “European” heritage may become increasingly important at times when other signifiers of modernity, such as economic health, come into crisis. And while a vast literature addresses how biomedicine served as a key regulatory mechanism and domain of governance as part of colonial occupation, this work reveals how associations between civilization, whiteness, and biomedical authority continue to be exercised as part of late-capitalist forms of neoliberal medicine. That claims to whiteness go hand-in-hand with claims to biomedical competence is not incidental, but rather reflects the continued persistence of a colonial imaginary dividing the world into spaces of safety and spaces of risk. In Argentina, such claims take on even more weight as “European identity” and scientific expertise have long served as two primary domains though which the nation has sought to situate itself within the larger world.

It is perhaps, ironic, then, that a study that began with an interest in broad transnational processes, rather than a particular location, ultimately ends up being so
deeply sited. And yet, my hope is that the dissertation is able to do both: hold up the lens of medical travel to reveal far-reaching processes of neoliberalism, transnationalism and embodiment that transcend the particular, and yet stay true to the rich ethnographic experiences and historical particularities that insist that this research could not have emerged in any other place or moment.

**Introductions: The People of Medical Travel to Buenos Aires**

As described above, I have organized the following chapters in terms of key findings and theoretical frameworks, rather than within a linear narrative. That is, instead of following the process of a patient moving from “departure” to “return” (as if such discrete points could be clearly delineated), I have instead interwoven the stories and experiences of a number of patients, doctors, coordinators and others in the effort to illuminate larger patterns and have my research speak to key concerns of health, race, neoliberalism, embodiment and movement. Given that these stories are interwoven in a nonlinear way, the people I work with appear and reappear at various moments throughout these chapters. As such, it is useful to begin with a brief introduction to the city of Buenos Aires, as well as to the key participants of my research.

**Buenos Aires**

Buenos Aires is the kind of city that can capture the imagination from afar. Even before I arrived, my mind was filled with romantic visions of the “Paris of South America”: tango dancers, elegant boulevards, fine wine and polo matches. And for those able to seek out such pleasures, the city is more than happy to oblige in reproducing this imagined city. During my fieldwork, I was swept away into seemingly impromptu tango shows in the cobblestone streets of Plaza Dorrego, I attended a symphony performance at
the famous opera house *Teatro Colon*, and even cheered on a polo match sponsored by the iconic brand *Rolex*, where women with oversized hats mingled in champagne tents and Robert Duvall and his Argentine wife were rumored to be in attendance.

Wandering the parks and botanical gardens of Buenos Aires – modeled after the “green lungs” of Paris – became a favorite pastime, as I took in the beauty of the expansive rose beds, picturesque lakes filled with rowboats, and imposing statues of revolutionary generals upon muscled horses. The semi-lush, but never quite tropical, climate of the city is comparable perhaps to a more extreme version of San Francisco or Athens, with snowless winters that are nevertheless bitterly cold, and humid, hot summers that push residents out to coastal and mountain towns for months on end. Nights in Buenos Aires are long, with family dinners (inclusive of small children) beginning at ten o’clock or later, and for young adults, evenings out on the town rarely begin until midnight and can go well into the next afternoon.

Buenos Aires is also an intellectual’s paradise. Teeming with bookshops, antique collections, and steeped in café culture, it is common to take an afternoon break in order to have lively, smart discussions with friends over small, *cortado* cups of espresso and *medialuna* pastries. One of the most common pastimes – gathering family and friends to share *yerba mate*, a tea made from the plant of the same name – is oriented around passionate, humorous, fast-paced conversation, rather than, as my friend Martina explained, “watching TV or something empty.” In a city I knew was saturated with “High Culture,” I was nevertheless amazed when during my second month I experienced *La Noche de los Museos* (Night of Museums), when over two hundred major art
museums and gallery spaces throw open their doors free of charge, allowing half a million culture-seekers to revel in aesthetic pleasure until three in the morning.

And yet, within this sophisticated and cultured milieu, there are other equally definitive aspects of the city not captured within this romantic ideal. As I explore below in more detail, a catastrophic financial crisis devastated the city in the early 2000’s. The widespread economic losses and devaluation of the peso have deepened already existing economic disparities and exacerbated poverty levels. Entirely invisible in the elegant, tourist images of Buenos Aires, are the significant numbers of people who live at the edges of the city, in housing conditions that often lack plumbing or legally sanctioned electricity, as well as the larger numbers of the former middle class who find themselves under-employed and financially insecure. Along the elegant, tree-lined boulevards it is not uncommon to see los cartoneros (often children, referred to as “cardboard people”) collecting paper scraps and empty bottles to be sold to recycling plants.

The economic crisis, and the political fallout that followed, is just one of the more recent major political upheavals in a country that has experienced dramatic shifts in rule, including a series of military dictatorships. Haunting the collective memory of residents of the city is the relatively recent Guerra Sucia (dirty war), a period of state-sponsored violence from 1976 to 1983, in which up to thirty thousand people were killed or “disappeared” (Taylor 1997). That such a horrific period stands at odd with the romantic, cosmopolitan images of Buenos Aires, the tourist destination, is not surprising. It is far more surprising the ways in which the memorialization and political activism surrounding the Guerra Sucia becomes folded into the tourist narrative, such as the large numbers of tourists who visit the Thursday afternoon demonstrations of the famous Las
Madres de Plaza de Mayo. The experiential dimension of living and moving through Buenos Aires, then, is inherently contradictory and complicated in ways that far exceed the romantic notions circulating abroad. While I explore the city in more depth in the chapters to come, this initial sketch should begin to contextualize the experience of my research participants.

**Melody**

Living in a small town in Central Florida with her husband and four children, Melody had been overweight since she was a very young age. Having made a good living working for a Health Insurance company that was relocated to Minnesota (she works remotely), she had decided several years ago to undergo a gastric bypass surgery in the effort to lost substantial amounts of weight. While she generally considered the surgery a success, she was disappointed with the large amounts of skin that remained, folding in flaps around her body. While she was eager to have skin removal surgery, the price of the operation was in excess in $100,000 in the Florida area. She researched accessing credit for cosmetic surgery, but was told that no doctors in Florida worked with the credit agency, thus requiring her to leave the state. Once travel was part of the picture, she began thinking more expansively about where she could undergo surgery, eventually settling on Buenos Aires, despite having only traveled outside the United States once before.

A doting mother, Melody had been able to secure a fairly good job given her high school education. Yet, she actively identified her spending as a source of worry, and spent much time worrying about how to support the lifestyle she had worked hard to provide to her children, including a spacious house, participation in sports and pageants,
and the latest generation of toys and technological gadgets they desired. At the time of research, she and her husband were facing foreclosure on their home, and regularly received calls from creditors seeking payment on overdue accounts.

**Carla**

I met Carla when I picked her up from the Ezeiza airport in April of 2008. She had flown in from San Francisco, where she lived in a small apartment near Union Square with her nineteen year old daughter and a boyfriend 21 years her junior. At 53, she often liked to joke, “I could have celebrated his birth with a legal drink!” She had been married once before to her daughter’s biological father, a man who was 25 years her senior and with whom she remains close.

Striking in appearance, Carla is almost five foot eleven inches in height, with bright blonde hair and piercing blue eyes. Her stylish dress gave off an appearance of polished sophistication, and perhaps even wealth. However, she attributed her style to her longtime employment traveling throughout the country to sell jewelry at hospitals. Her job, as she described it, was to convince nurses and other hospital staff members to purchase fine jewelry during their lunch breaks, and she worked with hospitals to offer “financing” in the form of monthly withdrawals from their paychecks towards their purchases. As an independent contractor, Carla purchased her own individual health insurance, which was far too expensive to use for anything other than emergency care, or “in case I get in a car accident or something.”

Carla understood her appearance as intimately tied to her ability to make a living, and increasingly important given the economic struggles over the past few years. Declining sales made her anxious about the precariousness of her employment, and was her most mentioned motivation for undergoing a “face lift” with Dr. Zimmerli. One of
the most striking moments of the time I spent with Carla was when, while observing her under twilight sedation during her surgery, she began repeating a single line over and over: “I can’t afford to be 55. I have to be 36.” Upon coming to, she didn’t remember trying to talk during her surgery.

During our time together exploring the city (trying out new ice cream shops together was a favorite activity) it also became apparent that her relationship with her much younger boyfriend had shaped her desire for aesthetic enhancement. A Filipino man seemingly “obsessed” with style, “Alan” actively encouraged Carla to style her hair in particular ways (even giving her a flatiron for Christmas), praised her when she wore more make-up, and was enthusiastic about her decision to undergo cosmetic surgery. She had originally considered undergoing cosmetic surgery in San Francisco, but as she explained “when I got the price, I sort of pretended… ‘oh yeah…thank you,’ and just listened to what he wanted to do knowing that I couldn’t afford it.” After emailing her pictures to Dr. Zimmerli in Buenos Aires, he responded to her inquiry suggesting many of the same procedures outlined by the California surgeon, which she interpreted as “a very good sign.”

Carla recovered in an apartment not far from my own in the Palermo neighborhood of Buenos Aires, and had the misfortune of being housebound during the period of intense smoke that filled the city in 2008 as a result of uncontrolled agricultural fires blazing near the city limits. During this period, the sky was filled with thick, acrid smoke and it was difficult to see more than fifteen feet or so. Laying on her couch in the darkened lower level of her rented apartment, Carla coughed constantly, choking on the thick soot. She was unable to take the prescription pain pills she had been given because,
when combined with the tingling sensation of the severed nerves reconnecting throughout her face, they gave her vivid nightmares of spiders crawling up and down her body. Yet, despite these challenges, Carla has very much enjoyed her time in Buenos Aires, and before her operation she had spent a few days exploring different neighborhoods and shopping at the *ferría* in San Telmo. During our trip to *Plaza de Mayo*, she was particularly moved by the cause of *Las Madres*, and was surprised to learn of the brutal violence of the military dictatorship that had occurred only a few decades before. On the day before she returned to San Francisco, we enjoyed our last meal together in a sun-drenched steakhouse, and she seemed genuinely disappointed to leave. Expressing her sadness at leaving, she also expressed anxiety about returning to San Francisco. While her bruises had faded from deep black to a green-yellow, her face still seemed swollen and the results of her surgery were not clear. She had requested that her daughter, rather than Alan, pick her up at the airport, as she was nervous about how he might react. I had coffee with Carla the following year at the American Anthropological Association meeting in San Francisco, and was finally able to meet Alan. She seemed please, overall, with her trip, and was planning a trip to Bangkok for intensive dental work.

**Sheila**

Sheila was initially reluctant to participate in my research when I first met her for tea near the hotel where she was staying in the northern part of the city. As a 52-year-old African-American woman from outside Boston, her initial search for a surgeon in Buenos Aires to perform a blepharoplasty (eye-lift) resulted in a racist evaluation in which she was advised to narrow the width of her nose. Subsequently, she began communicating with medical tourism coordination, Lola, who put her in touch with Dr. Babor. Sheila was an experienced traveler to this part of the world, an unusual trait among the
transnational patients I worked with. She had dated a Uruguayan basketball player in the mid-1980’s, and had spent some time touring the region. Her opinions on the space of the city itself reflected her extensive world travel, and as we strolled through the cobblestone streets, she remarked on the architecture, “They say it’s like Italy here…but I’ve been to Italy, and this is something else…something more ‘Third World.’”

Sheila’s understanding of her own trip to Argentina emerged, in part, from her occupation as a motivational coach and author. She self-mockingly described the purpose of her surgery as motivated by her “vanity,” but also spoke at length about the feeling of empowerment engendered as part of choosing the terms through which one’s life takes shape. Sheila was highly trained in reading astrological charts, and would spend long afternoons working up complex assessments of Lola and myself based on our astrological signs and the position of the stars during the year in which we were born. She oscillated between statements of self-determination and “shaping the course of life” with close attention to the signs of the world around her for “messages” that could shape her future. She and Lola, in particular, shared a strong bond, and continued to communicate over email for months after Sheila returned to Boston.

**Meryl**

A white, middle-class educator living in Philadelphia, Meryl connected with Melody while participating in an online forum for people who had undergone gastric bypass surgery. Although they had never “met” in person, both were interested in having full body skin-removal and breast reconstruction surgeries. Over the course of several months, they jointly crafted plans to share an apartment in Buenos Aires while recovering from their surgeries. As mentioned above, because they ended up renting a three-
bedroom apartment, I was invited to occupy the third bedroom and experience, first hand, their time in Buenos Aires.

Meryl also stands out as the only transnational patient I worked with who, much to her disappointment, was unable to undergo surgery during her time Argentina. Although she had sent advance copies of paperwork documenting her heart condition (but ostensibly clearing her to move forward with surgery), Dr. Banet enlisted his own cardiologist to complete an additional evaluation of her condition once she arrived in Buenos Aires. Despite several different types of tests, the cardiologist refused to clear Meryl. Distraught at the thought of not having surgery after traveling so far, I accompanied her to several other cosmetic surgeons’ offices throughout the city, but the only doctor willing to operate charged far more than she could afford. Bitter and disappointed, she left a hand written note reading “You Win” at the cardiologist’s office. Eventually, she did undergo cosmetic dental whitening, and spent much of her time sight seeing, and complaining about her experience.

Rogier
The youngest of any of the medical tourists I worked with, Rogier was only 22 when he arrived in Buenos Aires from Holland seeking gluteal augmentation (butt implants) and liposuction of the abdomen. Working in an electric company outside of Amsterdam, Rogier had saved up his own money for several two years to afford the surgery. Strikingly handsome, Rogier perfect an aesthetic that he self-identified as corresponding to his gay identity: short cropped hair, deeply tanned skin, bleached white teeth, as well as the use of blue contact lenses. Although white, most of Rogier’s friends back in Amsterdam were Black women, and he spent a lot of time talking about their beauty practices, such as getting hair weaves. With a large number of friends following
his progress online as well as through intermittent phone calls, Rogier received encouraging messages nearly constantly, as well as deliveries of flowers, fruit baskets and chocolates.

One of the most striking moments during my time with Rogier was his initial consultation with Dr. Banet. Handing the doctor several magazine clippings with photos of men’s bare buttocks, he informed the doctor, “I want my butt to look like this, but maybe a little bigger…” Dr. Banet, pointed out the rippling effect produced by the edge of the implant in one photo, pointing out that such large implants look artificial rather than natural. “I want to look artificial,” Rogier replied.

I accompanied Rogier to the Swiss Medical Center in the “Palermo Hollywood” area of Buenos Aires, and stayed with him through the night following his surgery. The first night was particularly difficult, as he was in a lot of pain and was frightened to see his blood backwashing into the intravenous tubing attached to his arm. In the two weeks that followed his surgery, however, Rogier was quite active in exploring the town, and together we went shopping, danced at gay nightclubs, and talked about his life at home. Extremely confident and sociable, despite his lack of fluency in Spanish, he ultimately asked out an Argentine man who had worked at a surgical supply store in the city, and enjoyed a brief romance for the remainder of his trip.

Dr. Babor

With his consultario in the well-to-do neighborhood of Vicente Lopez, Dr. Babor is regarded as a successful surgeon. A son of two recent immigrants from Germany, Dr. Babor was raised with a very clear sense of dual belonging to both Argentina and Europe, for example, speaking German before he learned Spanish. While driven by his artistic
passions, Dr. Babor was steered away from pursuing a career in art by his father, who insisted that it was for “hippies” and he should find a more “respectable” profession. Although he never gave up his interest in art, he instead pursued a career in medicine, finishing his undergraduate studies in the mid-1970’s and entering into medical school at the University of Buenos Aires. During the latter part of his training, he was able to travel extensively in Europe, receiving additional training in Spain and Sweden. As such, his medical formation occurred in a fundamentally international context. While he received training in a number of specialties, he eventually settled on cosmetic surgery as it offered him the chance to bring together his training in medicine with his passion for art and aesthetics.

**Dr. Banet**

One of the younger surgeons that I worked with, Dr. Banet also struggled the most with communicating with his patients in English. He began his career in emergency room care in 1995, transitioning to general surgery, and then plastic and reconstructive surgery in 1999. Rather than being drawn immediately to cosmetic surgery, he dedicated the early part of his career to reconstructive surgery with burn victims and reconstructive work with children with congenital facial deformities. He had also received quite a bit of international attention, and had spent considerable energy and resources investing in a English-language website to attract foreign patients. He runs his private clinic alongside his wife, who is a surgeon specializing in reconstructive surgery following breast cancer treatment. As part of his international experience, he reflected on his invitation to observe surgeries of “prominent” cosmetic surgeons in San Francisco, Los Angeles and “Beverly Hills.”
**Dr. Zimmerli**

The most academically prominent of the surgeons I worked with, Dr. Zimmerli received his M.S. from the School of Medicine of University of Buenos Aires in 1967, and completed a PhD in medicine in 1983, with a doctoral thesis awarded “outstanding honors.” He also serves as an Associate Professor of Plastic Surgery at the School of Medicine at the University of Buenos Aires.

In addition to his training in Argentina, Dr. Zimmerli counts a number of international experiences among his training, including time spent at the Mayo Clinic, the University of California San Francisco, The University of Alabama in Birmingham and Mount Sinai Center in New York. He was also the surgeon who most openly lamented the way in which his career had been limited by his living in Argentina, reflecting that if he lived elsewhere, he would be considered a far more prominent surgeon. While he was treating an increasing number of foreign patients, at the time of the research he did not have an English-language website and did not employ a medical tourism coordinator to work directly with patients.

**Lola**

Stunningly beautiful with long blonde hair and crystal blue eyes, Buenos Aires born Lola has been working as a medical tourism coordinator for a number of doctors over the past four years, including Dr. Babor. As a single mom to a seven-year-old daughter, Lola felt the pressure to work with as many doctors as possible as part of making ends meet. Extremely fluent in English and gregarious and outgoing, she was quick to befriend incoming patients and adept at arranging for patients’ through a wide network of
connections she had throughout the city. She also regularly demonstrated a caring spirit, for example, adopting a three small kittens we found abandoned on the street while touring a cemetery in the north of the city. She had been to the United States a few times, and was eager to return. She keeps in touch with many of her former patients, and is an active participant on social networking sites such as Facebook and online forums dedicated to travel for cosmetic surgery.

**Sarah**

Sarah had never expressed a particular interest in working as a medical tourism coordinator, but generally enjoyed the work she had been doing with Dr. Banet. Willowy and petite, Sarah has bright crimson hair and dresses in layers of fashionable skirts and scarves. From England, she had come to Buenos Aires only one year before I began my research, taking on the adventure on moving to Argentina to pursue her dream of learning to “dance tango” following a particularly painful divorce. As such, she was still relatively new to the city and did not have a comfortable command of Spanish. Yet, she had fallen in love with a local man, Pedro, who often accompanied us as we went out to dinner with patients.

Sarah is an active writer and artist, qualities she brought to her job as a medical tourism coordinator. Before Melody left the country, Sarah wrote her a long “story” chronicling the journey of her time in Argentina and reflecting on the friendship they had formed there.
Chapter One

Colonial Medicine to Medical Tourism:
Biomedicine and the Global Imagination of Risk

“There are two ways to get to the hospital,” he told me over the phone. Traveling along the highway by taxi, the Director explained, would bring me through the gated community of Pilar, and was a “much nicer” route. I could alternatively take a train and walk to the hospital from the nearby town of Derqui. This route, he warned, required a foreigner like me to “be careful.” And so it was on a hot autumn day in May that I found myself climbing down from an older-model train into the dusty center of a small town, traveling to meet with Daniel Vasquez, Director of International Development of a multi-million dollar hospital on the outskirts of greater Buenos Aires. I wove between the market stalls selling fruits and vegetables, and shouting over the blaring music, asked for directions to Hospital Austral. A vendor pointed past the edge of town, and I made my way along a stretch of road, pressing into the bushes each time a collectivo bus roared by, covering me in a cloud of dust and exhaust. After a half mile of trudging through the bright noon light the hospital came into view: a huge complex of cool, shiny glass in an oasis of green manicured lawns.
Staring up at this complex, I felt a world away from the public teaching hospital in the city center where I had been undertaking fieldwork over the past few months. That public hospital building was of a different era: regal architecture falling into disrepair, doctors lighting cigarettes in the break room, strategically placed buckets catching drips from a leaky roof in the main corridor. Hospital Austral, in contrast, was a monument to modernity: completed in 2001, it was a sleek teaching hospital sharing a gated compound with a small university and a business school. Austral was also one of the few hospitals I had found that was actively trying to market itself as a destination for foreign patients and was the first hospital in the nation undergoing an evaluation process to become certified by the U.S.-based *Joint Commission International* organization. Vasquez wore the elegant layers common among Argentine business men over the age of fifty: a navy blue sports jacket, under which he had layered a white shirt, a camel-colored sweater vest, and
a deep, red tie. As we met over the months of my fieldwork, he unabashedly shared his enthusiasm for what he referred to as “American” business practices, often starting our meeting by passing me a thick stack of printed out PowerPoint slides. “Always start with a cartoon!” he explained, pointing to the New Yorker style line drawings he had found on the internet decrying the high-cost of healthcare in the United States. He had enthusiastically welcomed me in my role as an anthropologist and half-jokingly remarked, “this will be very good… to apply for accreditation we need a complete cultural change.” He continued:

prevention, in terms of safety, is not something that exists in the culture of our country… here, no one plans in advance because there is no way to know what will happen…we are a country that is in many ways ‘undeveloped.’

Both physically and symbolically, Austral occupies a contradictory space within Buenos Aires: it is a space of aspiration and imagined transnational connection, even as such connections stoke anxieties about Argentina’s ambiguous status as a “developed” or “undeveloped” country. The process of accreditation that consumes the International Director’s daily life opens up claims to equivalence as part of a global biomedical landscape, even as such claims must be “accredited” through the disciplinary tactics and surveillance of a U.S.-based private organization. Even the two routes one can take to reach the hospital are symbolic: one passing by newly constructed “shoppings” (shopping malls) and the manicured spaces of gated communities, the other relying on a slowly-decaying public transportation service, arriving in one of the poorest communities of greater Buenos Aires. Given the richness of this site, I have woven my ethnographic encounter with Austral throughout this first chapter as a way to open up the intriguing questions posed more broadly by the emergence of a market in biomedical tourism.
In this chapter, I consider critical features of medical travel more generally, as a way of contextualizing my later arguments about how such processes work in Buenos Aires specifically. For example, how did countries once understood as spaces of contagion become the next generation of destinations for high-tech surgical interventions? How do countries designated to receive World Health Organization funds to combat malaria, tuberculosis and yellow fever, simultaneously offer cosmetic surgery and hip transplants to people from the United States, Europe and the Middle East? How, if at all, do these newly emerging geographies of health provision alter longstanding patterns of inequality and the relationship between biomedical authority, race and risk?

The first part of this chapter looks closely at the ways in which the “newly emerging” phenomenon of “medical tourism” is being imagined both in popular media, as well as mainstream scholarly literatures. Most striking is the profoundly neoliberal logic and language that saturates the promise of a global market in biomedical services, as well the ways that such logic is mobilized to encourage a re-imagination of the world in terms of risk and safety. Critiquing this literature, I argue that the term “medical tourism” is profoundly problematic, especially insofar as it empties such travel of complex political and historical dynamics, and effectively reduces transnational medical practices to leisure and tourism, a far-cry from the circumstances I observed.

In the second part of the chapter, I turn briefly to examine how anthropologists are engaging with transnational medical travel in ways that depart from broader scholarly and popular discussions. I question, however, whether or not the anthropological reliance on a critique of neoliberalism does not, in some ways, reproduce the notion of such travel as “novel” and new, thereby further obscuring the historical precedents of categorizing
the world into spaces of risk and safety. In the last part of the chapter, I advance my critique of understanding such travel as novel not by pointing to earlier forms of cross-border health seeking as other scholars have done (Kangas 2010; See also Hembry 1989 and Kevan 1993), but alternatively by arguing that current forms of transnational medical travel ultimately reproduce colonial-era ways of imagining and dividing the world into safe and risky spaces. That is, even in this novel moment, when people of the Global North are seeking surgeries in places long-understood to be dangerous, I ask in what ways medical travel may ultimately rearticulate deep seated anxieties about risks to white bodies and do so through the language of biomedicine and the market.

**Medical Tourism In The Media**

Narratives about the “new” phenomenon of medical tourism have regularly appeared in the media in recent years, prominently featured in newspapers, magazines and cable and online news programs (articles appeared in news sources as diverse as USA Today, Time, People, Good Morning America and more. For example, see Smerd 2006; Alsever 2006; Hewitt 2006; Kher et al. 2006). Such media sources offer an opportunity to examine more broadly the language and images through which medical travel is being explained, including how such discourses invite a fundamental re-imagination and conceptual mapping of the world. Drawing from Arjun Appadurai (1996), we can approach these texts as social practices of imagination, and a window into shifting “globally defined fields of possibility” (Appadurai 1996:31).

While it is difficult to determine the frequency of the use of the term precisely, a 2010 online search of popular newspapers and magazines for articles with “medical tourism” as a keyword produced over thirty-seven thousands hits, the vast majority
The term circulates even more widely when other types of online forums are considered, including not only articles from newspapers and online sources, but also blogs, journals, Wikipedia entries, chat rooms, and the websites of hundreds upon hundreds of companies and associations dedicated to medical travel: a simple Google search for medical tourism yields over eleven million results.

While a detailed analysis of the full range of ways in which current forms of medical travel are discussed and imagined is beyond the scope of this work, I would like to point to a few key themes that consistently emerge across the over one-hundred media descriptions that I reviewed from major North American sources. Initially, I had begun collecting news articles and other media clips on medical travel as part of trying to orient myself to the project. While the collection was not systematic at first, my initial collection of clippings revealed several key themes. During my time in Argentina as well as after returning to the field, I concluded that adopting a more systematic review of this media literature would help me to better contextualize the data collected while in Argentina. Evaluating media materials was important not only to make sense of how Argentina was described in comparison to other destinations, but more importantly, to look at how descriptions of “medical tourism” in various media outlets shaped the way in which the industry was imagined and designed within Argentina. The men and women within the Buenos Aires industry I spoke with regularly cited articles from Time, Newsweek and The New York Times as part of justifying how and why they were investing in developing a local industry.

Many of the pieces, which are on average only several hundred words in length, share the following key features: 1) introduction of the term “medical tourism” in a way
that signals its novelty, assuming it may be unfamiliar to readers; 2) an indication that
statistics on actual rates of travel are difficult to come by, followed by a (widely varying)
estimate of the number of U.S. citizens who go abroad for healthcare each year; 3) an
explanatory framework for why people are motivated to travel abroad for healthcare; and
4) an emphasis on what is described as a quickly expanding future market. While this
narrative structure is consistent across many of the articles I reviewed, here I want to
explore the conceptual categories that emerge throughout these narratives, which I have
organized into three broad categories: Novelty/Oddity, Market Logics, and Re-Imagining
Risk. While very few of the articles mention Argentina as a destination by name, many
of them invoke “Latin America” as a destination, or refer to a handful of countries in
vague terms that indicate the opening up of the larger global market of which Argentina
is a part.

Novelty/Oddity: One salient feature of these articles is that the term medical
tourism is almost always defined and explained in the opening paragraph, signaling a
perceived unawareness or unfamiliarity on behalf of an imagined audience. With only
the rare mention of historical precedents or other forms of cross-border medical travel
(for example, early forms of medical travel by people seeking gender reassignment
surgery), the term medical tourism is effectively mobilized as something “new” and
“novel” in need of explanation and attention. However, it is not simply that people
traveling abroad for surgery is new that seems to merit attention. The fact that people
undergoing surgery in places described in these articles as “developing nations” or
belonging to the “Third World” is also seen as odd and in need of comment, indicating
that such places are not commonly understood as safe for surgery.
In an early example of such media, a featured article *Nip, Tuck and Frequent-Flier Miles* in the New York Times Magazine covered the tremendous influx of foreign patients to one of the most famous medical tourism centers in the world, Bumrundrag Hospital in Thailand (Talbot 2001). Explaining that most foreign patients traveling to Thailand seek “discount plastic surgery” (particularly gender reassignment surgery), the author uses language that frames such travel as inherently strange: “How a developing country with a floundering economy and a significant H.I.V. problem managed to market itself as a center for medical tourism makes an odd, roundabout story.” Here the specter of poverty and disease (especially HIV), attributed to the space of Thailand, is seen to be at odds with the ability of Bumrundrag Hospital to provide safe medical services for foreigners. This same theme of novelty appears across many of the articles I reviewed, pointing to a seemingly perverse logic of traveling for surgery to places that require “shots before traveling” or pose danger in “drinking the water.” The oddity, it seems, is that countries popularly understood to be “developing” or belonging to the Third World would have advanced medical care at all, or that the care they have would be safe and adequate enough for the treatment of First World bodies. Often, the details of which biomedical services are available seem irrelevant alongside generalized characterizations of countries as a whole. For example, then-president of the American Society for Aesthetic Plastic Surgery (ASAPS), was quoted in the above New York Times Magazine article as stating, “These are third-world countries -- what more do I really have to say?”

What such examples reveal is an assumption that most readers, similar to the ASAPS President, imagine the world to be divided between countries they understand as belonging to the First World and the Third World, with a corresponding understanding of
the resources and risks attributed to each. Post-colonial scholars have long critiqued such simplistic divisions, instead pointing to how poverty and extreme wealth exist side by side in countries across these categories (Mohanty 1988). That such conceptual categories still hold popular analytic weight, however, is clear not only in the quote above, but also is reflected in the assumption across these descriptions of medical tourism: that the very idea of someone from the United States receiving healthcare in a country such as Thailand, India or Venezuela is, in and of itself, novel and worthy of media attention.

*Market Logics:* An equally pervasive narrative consistent throughout media accounts of medical tourism is the explanation of motivations for such travel through neoliberal market logic, one that acknowledges the failure of a privatized U.S. healthcare system to provide adequate coverage at the same time that it ignores the politics underlying limited coverage. This enables the market to emerge as a solution, but now it is a larger global market that is touted as capable of helping those struggling to pay for privatized health care insurance in the United States. Within this framework, patients seeking health care elsewhere are interpreted as “savvy consumers; “they are seen as individuals seeking lower prices as part of a competitive global market in health, not as victims of the market itself. Such accounts often begin with an identification of the problem, as the headline of one newspaper article reads: “Americans heading overseas to escape the high cost of U.S. care” (Houston Chronicle 2006). This is followed by a litany of price comparisons of medical procedures. Such comparisons are common, rarely providing contextual information beyond price. For example, an editorial piece in the *Miami Herald* invokes the motivation of price in this way:
The draw is easy to spot: A heart bypass procedure that costs $130,000 in the United States can be done for $18,500 in Singapore or $10,000 in India. A $40,000 knee replacement here is offered at one-fourth that cost in Thailand, all at accredited hospitals…

In this analysis, a “draw” is imagined as a force that moves patients to cross borders seeking healthcare. This force of movement is self-evident and easy to identify: it is simply a difference in cost. By comparing, side-by-side, nothing other than the prices of vague surgeries, the difference of tens of thousands of dollars becomes the motivating factor, one that is framed as a savings with the power to attract foreign consumers. An opinion piece in *The Economist* (August 21, 2008), similarly, mobilizes the language of “cost-savings” as a solution to the problem of rising healthcare costs, advocating a privatized, market solution to the unequal distribution of health services within the United States:

> With health-care costs rising 8 percent to 9 percent domestically, it's the kind of savings that can make medical tourism sound very appealing. On one estimate, Americans can save 85 percent by shopping around and the number who will travel for care is due to rocket from fewer than 1 million last year to 10 million by 2012 - by which time it will deprive U.S. hospitals of some $160 billion of annual business (italics mine).

Here the author identifies the problem—rising health care costs—and suggests medical tourism as the solution, without, however, offering an explanation for skyrocketing prices. Instead, in line with neoliberal thinking, the writer places the blame at the feet of the state and explicitly exonerates the market as in his discussion of possible medical tourist destinations: “the private sector cannot be blamed for the failings of state-run health bureaucracies in developing countries, which neglected the poor long before medical tourists arrived.” “Medical tourists” from the United States themselves are not,
however, similarly understood as part of an underserved population increasingly neglected by the state.

Even a report identifying the high cost of health insurance—and the resulting lack of coverage for increasingly growing numbers of people in the United States—as the impetus for medical tourism fails to acknowledge it as a political problem: “The reasons behind the slow-motion exodus of American patients from the United States is simple,” the report explains: “About 45 million Americans lack health insurance, and another 30 million are underinsured. In addition, many others who have insurance go abroad for cosmetic surgeries that are not covered by their U.S. insurance” (Miami Herald, July 13, 2008). No accompanying critique of U.S. inequities follows.

When rising health care costs are identified as problematic, a neoliberal logic still prevails. An editorial written by Josef E. Fischer, a Professor of Surgery at Harvard University, for example, states:

Unless physicians, surgeons, hospital administrators and health insurers get together to control costs, I fear that the health-care industry in the United States will rapidly continue down the same path as our indigenous manufacturing industries.

Here health care is framed as an industry that if uncompetitive can put the entire U.S. economy at risk. Medical tourism, in this case, can be seen as a cost-oriented consumer choice, but it is also a threat. For some, this threat to the U.S. economy is dire but inevitable once the floodgates of outsourcing are opened, as this quote from a September 3, 2008 Miami Herald illustrates:

This [medical tourism] is nothing less than the globalization of medical care. Economists used to say that healthcare was the one thing that couldn't be outsourced. Shortly after, American medical centers started sending X-rays to India for analysis. It was just a matter of time before the patients followed their photos.
Or as an August 21, 2008 piece in the *Seattle Post-Intelligencer* succinctly put it: “Health care has long seemed one of the most local of all industries. Yet beneath the bandages, globalization is thriving.”

*Re-Imagining Risk*: The last common theme in much media representation of medical tourism invites a fundamental re-imagining of how the world is to be divided into risky and safe spaces. As I explore later in this chapter in more detail, any imagination of a division of the world between spaces of risk and safety is produced with a particular body in mind, requiring us to ask: risky or safe for *whom*? Here I wish only to point to the most common way the danger of medical tourism is downplayed in many media accounts: through mention of hospital accreditation by the international subdivision of the Joint Commission (JC), which accredits U.S. hospitals. A piece featuring Dr. David Jaimovich, the chief medical officer of the Joint Commission International in a *Pittsburgh Post-Gazette* reveals this clearly:

The borders of health care have blurred. It is a very different world today than it was five years ago...[JCI accredited hospitals] are very comparable to the U.S. domestic standards. There are many hospitals around the world that would put some of our [U.S.] hospitals to shame.

The Joint Commission on Healthcare Organizations (JC) is a private sector “not-for-profit” whose accreditation process is offered for a series of fees. Today it is the gold standard in the United States and is a precondition for receiving federal funds, such as Medicaid. Having certified over eighteen thousand health care sites in the United States, the JC established an international division (JCI) in 1997 and began accrediting hospitals outside of the United States. According to its website, “JCI extends The Joint
Commission’s mission worldwide by assisting international health care organizations, public health agencies, health ministries and others to improve the quality and safety of patient care in more than 80 countries” (http://www.jointcommissioninternational.org/about). In doing so, the JCI created a potent language of equivalence to render “foreign spaces” as comparable, or even indistinguishable, from hospital spaces within the United States.

Although the invocation of JCI equivalency is a common feature of many media narratives on medical tourism, my fieldwork points to the complexity of such “accreditation.” Having worked closely with Daniel Vasquez, a hospital administrator, as he prepared for JCI certification, I learned that in addition to the fees paid for certification, the JCI also offers “consultation services,” which include pre-assessment inspections by JCI staff to advise hospitals on what changes need to be made in order to prepare for the accreditation process. On the whole, Vasquez estimated, the first phase of consultation in preparation for JCI accreditation had cost the hospital approximately thirty thousand dollars. While not technically required as part of the JCI accreditation process, not engaging the help of “consultants,” who are also the assessors, is understood as a risky move. When I asked Mr. Vasquez if he thought the quality of care the hospital provided would be improved by working with JCI consultants, he adamantly insisted “not at all…our quality is already very high . . . JCI is just a ‘stamp of approval’ so that patients from the U.S. won’t be afraid to come here.” As a self-described businessman, he understood JCI accreditation as an avenue to more effectively market the hospital’s services, and yet, he was resentful of the process. “It’s not just the fees,” he explained, “you have to pay to fly the consultants to come to the hospital…you have to put them in
four star hotels.” Thus, despite its near ubiquitous invocation in the media, JCI certification should not be understood simply as an assessment of medical quality, but as a complex commercial exchange affordable only to those hospitals willing to make the investment for “marketing” purposes.

Taken together, the above themes point to some of the particular ways in which the term medical tourism has circulated within the media. Rendered as a novel and even odd or strange practice by some, medical tourism is simultaneously understood by others as a logical choice enacted by healthcare consumers in a context of high U.S. prices and a lack of insurance. Whether celebrated as “innovative” or decried as detrimental to a “local health industry,” medical tourism is framed as an almost inevitable extension of globalization. Embracing this framing, such articles encourage readers to re-imagine a world in which global borders have become meaningless in the face of “cost-savings,” and the state has ceded its role as provider and caretaker of its citizens to ambiguously “not-for-profit” private sector organizations, which offer up a kind of de-territorialized surveillance for a fee. Medical tourism, as an industry, thus, profits from the production of equivalency, and by facilitating a re-imagination of the spaces of risk and safety.

**Medical Tourism Discourses In Scholarly Literatures**

During the last few years, academics have also caught wind of the shifting terrain of medical travel. The term “medical tourism” first began appearing more regularly, if as a source of concern, within medical and legal journals in 2005, with a particular focus on reproductive travel and “transplant travel” (Manna et al. 2005; Scholtz et a. 2005; Spar 2005; Heng 2006; an early example of this literature is Pennings et al. 2002) It spread with exuberance, however, among economists who were quick to translate such travel
into statistics of “savings” and other corporate-oriented euphemisms meaning “profit” (Cannon & Tanner 2005; Cohen 2006; Mattoo and Rathindran 2006; Owen 2007; Early examples include Goodrich and Goodrich 1991 and Laws 1996). From there, “medical tourism” made its way further into circles of scholars debating bioethics and new approaches to tourism, and then, as I describe below, to sociologists and anthropologists, who rightly pointed out the usefulness of understanding medical tourism as an observable practice, rather than a debatable concept. Like its emergence in popular media, the increasing appearance of medical tourism within academic discourse can be seen to have occurred primarily in the last six or so years.

At the moment that I began conceptualizing this project and undertaking initial fieldwork in Argentina in 2005, a keyword search for medical tourism in an academic search engine turned up a few dozen articles. Now, this landscape is starting to shift. Today, a search for the key term through the popular search engine “Academic Search Premier,” for example, returns hundreds of articles where this specific term is explicitly used as part of the author-supplied abstract. In this search, which was restricted to academic publications, over 80 percent of the articles were published in 2006 or later.

Just as in most media representations, so too in much of the academic literature outside of anthropology, medical tourism is primarily framed in economic terms, either as a form of “global medical outsourcing,” “medical off-shoring,” or as the “international trade in health care” (Mattoo and Rathindran 2006; Chaynee 2003). In an early article on the topic that was subsequently cited widely, economists Mattoo and Rathindran defined medical tourism as the movement of people from industrialized nations to “developing” countries in order to access highly-technological interventions at “third world prices”
Explicitly positioning health as a commodity, they ask “is healthcare so different from other goods and services that it cannot be regarded as tradable?” (Mattoo and Rathindran 2006:358). Although the majority of their analysis focuses on how First World industrialized nations will benefit economically from outsourcing their health needs, they briefly consider the implications of medical tourism on developing nations. In attempting to address the concern that an “inflow of industrialized country consumers [may] crowd out poorer local patients,” or significantly worsen health inequalities, they argue instead, “increased demand creates opportunities for developing countries to improve access to care for all citizens” (Mattoo and Rathindran 2006:167). They see medical tourism as a form of economic development that can serve as a palliative for the “brain drain” experienced by many Third World countries as part of an overarching pattern of economic migration: “a large number of developing country doctors and nurses emigrate every year to industrialized countries . . . inflows of rich-country consumers could lead to higher incomes at home and a reduced incentive to emigrate” (Mattoo and Rathindran 2006:167). The authors estimate that “health care destination countries” would gain approximately $400 million annually from medical tourism trade” which could potentially, they argue, be taxed in ways that allow for investment in public health infrastructure. Yet, even a cursory review of public health expenditures, at least within Argentina, points to the limitations of conceiving of medical tourism as “economic development.” This is clearly evident in the first academic book-length work dedicated solely to medical tourism published in 2007 by economist Milica Bookman and litigator Karla Bookman, *Medical Tourism in Developing Countries*. 
Because of its appearance as a monograph, *Medical Tourism in Developing Countries* was subsequently cited frequently in both academic and popular sources, and several of the tourism and hospital officials with whom I worked in Argentina had heard about or purchased the text. Perhaps reflecting Milica Bookman’s background as an economist, the monograph conceptualizes medical tourism entirely within neoliberal market language. The explicit goal of the text is to address medical tourism “as a strategy for economic growth” for developing countries entering into a global trade in high-tech medical services (Bookman and Bookman 2007:9). Bringing together a focus on “trade, services, health and foreign investment,” the authors explicitly state that they would like to see medical tourism adopted as a strategy of economic development. Yet, their vision of how such “development” would take place exceeds even the logic of a neoliberal “trickle down” model of promoting corporate profit. Bookman and Bookman propose mobilizing limited public resources towards the development of a privatized medical tourism sector, with the hopes that state support of corporate development eventually pays off. They explain:

…this book has a strong policy bias insofar as it emphasizes the role of the public sector in enabling medical tourism and then, once it is entrenched, in using macroeconomic policy to alleviate the chronic health concerns of developing countries (Bookman and Bookman 2007:10).

Problematic in their assessment is that while the transfer of public funds towards private investment in the medical tourism sector is clear, the mechanisms for the redistribution of corporate profits remains vaguely imagined as the use of “macroeconomic policy” once (if ever) a privatized medical tourism sector is thoroughly “entrenched.”
Bookman and Bookman also actively promote the conflation of medical travel with the more traditionally oriented “leisure” aspects of tourism, identifying such opportunities as “tie-ins” that can make medical procedures all the more attractive to transnational patients. Although offering little evidence for their speculative claims, they assert “while tourists view tie-ins as important components of their medical travel, suppliers of medical tourism view them as an important component of their marketing…they view tie-ins as a form of product differentiation, so the range of tourist experiences is improving and expanding” (Bookman and Bookman 2007:92-3).

Such discussions of medical tourism in mainstream scholarly literatures clearly reinforce neoliberal economic and political policies, including increased privatization of health care paired with an emphasis on “free trade” to facilitate corporate participation in the global marketplace. Yet, these mainstream academic discourses tend to posit a neutral, global marketplace that is inevitably transforming established healthcare patterns. Additionally, by conflating the provision of healthcare with the "leisure" oriented aspects of recreational tourism more generally, such analyses work to obscure the historical continuities and political stakes of such travel. That the term "medical tourism" is preferred within this literature signals its problematic use, reflecting not the experiences of transnational patients, but rather the privatized and development agendas of those within the industry. In adopting a more critical stance, I - like more recent anthropologists focused on this phenomenon - have instead favored the term "transnational medical travel" for its ability to center attention on the fundamentally medical nature of the travel and to signal, through the word “transnational” that such travel is not a diffuse, global phenomenon, but is contoured in accordance with the
particular historical, political and economic contexts of the sending and destination
countries (as explored in depth in Chapter Two). I turn now to some of the ways in
which anthropologists have addressed transnational medical travel, how this literature
departs from the above examples, and those areas that I still see as needing further
attention within this literature.

**Anthropology Of Transnational Medical Travel**

Emerging from literatures on globalization and neoliberalism, and situated within
medical anthropology and science studies, anthropological work on transnational medical
travel (also referred to as "bio-medical travel" and "medical migrations") has increased
significantly in recent years (Roberts and Scheper-Hughes 2011; Scheper-Hughes 2002,
2009; Mazzaschi & McDonald eds. 2011; Special issue of Medical Anthropology
Quarterly *forthcoming*; Kangas 2002, 2010). Anthropological work has tended to track
the international trade in organs, including research on people traveling to foreign
countries in order to access organs or to avoid prohibitions such as religious injunctions
against organ donation. Other thematic interests include travel used to circumvent the
political regulation of biomedical techniques, such as fertility treatments, or simply to
on the related topic of organ donation see Sharp 2000, 2001). This work was among the
first to use the term “medical tourism” within anthropology. In 2002, Nancy Scheper-
Hughes, for example, conceptualized organ movement within this framework, arguing
that “amidst the neoliberal readjustments of the new global economy, there has been a
rapid growth of ‘medical tourism’ for transplant surgery and other advanced biomedical
and surgical procedures,” one in which “a grotesque niche market for sold organs, tissues, and other body parts has exacerbated older divisions between North and South, haves and have-nots, organ donors and organ recipients” (Scheper-Hughes 2002:61).

Expanding her analysis of the global market for organs in the *Journal of Human Rights*, Scheper-Hughes (2003) offers a broad overview of the trade, elaborating the conditions of searching for an organ, the extreme contexts of poverty in which selling an organ becomes a feasible option, and the tacit acceptance in many medical and professional communities throughout the world of “renegade” surgeons and the illegal procurement of “fresh” organs (Scheper-Hughes 2003:197). She argues that the world has been reconceived along the lines of a new transnational circulation: “The ideal conditions of an ‘open’ market economy have thereby put into circulation mortally sick bodies traveling in one direction and ‘healthy’ organs (encased in their human packages) in another direction, creating a bizarre ‘kula ring’ of international body trade” (Scheper-Hughes 2003:197). Drawing on Girorgio Agamben’s (1998) *Homo Sacer*, she writes that “citizen life” (*bios*) underlies the logic that enables the global market in transplant organs: it is seen by consumers as their “right” in a global marketplace. The poor, who “donate” their organs, however, are conceptualized in terms of “bare life” (*zoe*), seen as valuable primarily in their ability to provide “fresh organs” (Scheper-Hughes 2003:204).

Her analysis critiques bioethical discourses of organ transplantation that are framed within notions of “altruism” and “the gift of life,” which, Scheper-Hughes argues, fail to capture the extreme inequality that influences such choices, as well as the extent to which free-market, neoliberal logic underwrites these exchanges (Schepher-Hughes 2003:204). 7 Maintaining the use of the phrase “medical tourism in contrast to representations of the
phenomenon in the popular media, and even in bioethical discourses that tend to emphasize the health benefits enabled through such travel, Scheper-Hughes focuses attention on the global inequities that enable it.

Lawrence Cohen has been particularly influential in extending this analysis by focusing on the distinctions between medical and other forms of tourism, as well as on how particular kinds of luxury spaces are produced as part of medical tourism. Specifically looking at the trade in kidneys in India, Cohen examines how such luxury spaces are produced through the creation of large-scale, private hospitals catering to foreign patients. Cohen writes:

the translocality of the elite clinic is literally inscribed onto the millennial landscape. . . Many of these Apollo hospitals [one of the largest health care groups in Asia] are designed with an adjoining luxury hotel, and the boundary between hospital and hotel is all but disappearing as [the corporation] experiments with the profitability of working the distinction between patient and guest. Apollo is not only a hospital that looks like a five-star hotel, it is a five-star hotel that looks like a hospital (Cohen 2002:16).

One common way of historicizing contemporary forms of medical travel is to point to earlier precedents of therapeutic travel and pilgrimage. Such an approach is exemplified by Roberts and Scheper-Hughes (forthcoming), who point, for example, to North African Muslims seeking treatment from Bori priests, medieval Mediterranean travelers journeying to the healing waters of Pamukkule, and therapeutic travels to the cold mountain air or healing waters of mineral springs (Miller 1962; Wrigley and Revill 2000 as cited in Roberts and Scheper-Hughes 2011). Roberts and Scheper-Hughes point out, however, that “those medical journeys are obviously distinct from the current production, conception and deployment of late 20th-century bio-bodies and bio-subjectivities...” which they understand as involving qualitatively different "bio-
medically governed bodies and logics" (Roberts and Scheper-Hughes 2011:5).

While I agree with the distinction between the past and present forms of medical travel identified above, I think the move to radically separate out current forms of travel from historical precedents of transnational biomedicine is equally problematic. Rather, I argue that the historical example of "medical travel" in which to situate current forms of transnational medical travel is not therapeutic spa travel or visits to healing priests, but rather fundamentally transnational tropical and colonial-era biomedical practices. Rather than arguing that the historical legacy of biomedical colonialism is disconnected from "medical tourism," I propose that it is fundamentally constitutive of it. As explored above, the "novelty" with which medical travel is discussed is symptomatic of what is perceived as the logical incongruity of white, First World bodies undergoing surgical and biomedical treatment at the hands of a Doctor/Other. The idea that such travel is somehow "odd," however, only makes sense if we understand that the prospect of having a First World body opened up and exposed in the space of the Third World only seems strange in so far as that these spaces have been constructed through colonial biomedical discourses: as spaces of racialized contagion and pollution in need of colonial surveillance and control.

As I discuss below, not only is the literature on colonial biomedicine crucial for understanding the ways in which medical tourism exists within an imaginative division of the world between spaces of biomedical safety and risk, but also because it is through situating medical tourism within these longer historical discourses that it becomes possible to more precisely reveal how contemporary "accreditation" technologies, such as those of JCI, may be more productively understood as neocolonial reconstitutions of
From Colonial Medicine To Medical Tourism

The anthropological literature has done much to nuance and deepen scholarly approaches to transnational medical travel, recognizing longstanding conditions of inequality that result in some forms of life being identified as “bios,” and other, as “zoe.” However, this literature has largely overlooked other continuities between historic practices of cross-border medicine and those of today that would deepen our understanding of biomedical travel. To add this depth requires not only an understanding of the inequities that have shaped how different bodies have been historically conceived, but also recognition that the emergence of a global market in biomedicine is not entirely a late 20th/early 21st century phenomenon. Focusing on tropical and colonial medicine does this, and, in so doing, brings into sharp focus the significant role played by an underlying discourse of risk and safety in contemporary conceptualization of medical tourism, which has historically operated as a mechanism of colonial control. Focusing specifically on how the cultural authority of biomedicine has historically served as a justification for economic and political intervention, I demonstrate in this section how the global market in biomedicine today offers both the reproduction of the relationship between biomedicine, racial belonging and claims to modernity and a surprising rupture to this long history.

Within this longer historical perspective, “medical tourism” emerges as the latest incarnation of the long-established project of opening up, circulating, and intervening upon human bodies as part of efforts to imagine nations, secure territory and produce citizens. As part of these interventions, biomedical risk becomes a key mode of
spatialization in mapping the world, and serves as a register through which to make claims to political authority and modernity. That such claims often map neatly alongside established hierarchies of racial privilege and marginalization indicates the degree to which the legacies of colonial domination remain embedded within biomedicine, shaping definitions of what constitutes risk, and who—precisely—becomes legible as an at-risk body.

*Colonialism and Biomedicine:* Masao Miyoshi (1993) usefully describes colonialism as the conquering of land and the drawing of borders by Western colonizers from the sixteenth to the middle of the twentieth century, with the effect of creating an “arbitrary cartographic form” joining or fragmenting previously coherent peoples and areas into administrative units on behalf of the distant metropolis (Miyoshi 1993:80; see also Cooper and Stoler 1989; Chatterjee 1986, 1993). Miyoshi is careful to stress that this process encountered much resistance; yet the presence of colonial occupiers was powerful enough to exert control and violence even in the face of such opposition. The process of colonialism was also deeply imbricated within the ascendance of the nation-state around 1800, which Miyoshi maintains is a modern Western construction propelled by the bourgeoisie’s desire for expanded resources and overseas markets following the industrial revolution (Miyoshi 1993:82).

As evident both in historical work examining colonial medicine, as well as in my own review of the emerging literature on medical tourism, the bodies of the “Other” are particularly potent in the realization of transnational political projects. As part of colonial medicine, biomedical interventions on subject bodies became a way to exercise control
over them, as well as a demonstration of knowledge and expertise used to legitimate colonial authority.

Numerous historians have demonstrated how the control of infectious disease, the enforcement of “hygiene,” and more generally, the definition and regulation of “health” have been central to the political, legal, and commercial projects of colonialism (Bashford 2006; Anderson 2006; Peard 1999; Macleod et al. 1988). Two very differently positioned categories of bodies served as the central points of intervention of colonial and tropical medicine. First, as a technology in the management of the “diseases of warm climates,” biomedicine was charged with fortifying and protecting the bodies of white colonizers against the threatening tropics, enabling physical occupation of colonial territory (Bashford 2006:4). Once occupation was established, the regulation of the hygiene and diseases of racially-other subject bodies became a mode of regulation, as well as a more generalized demonstration of the efficacy of biomedicine and, by extension, the modernity and authority of colonial occupiers.

Protecting Colonial Bodies and the Production of Civilization: Focusing on biomedicine as a prerequisite for the physical occupation of the colonies by white settlers reveals a particular way of imagining a racialized geography of biomedicine, disease and risk. I suggest that this particular imaginary persists today, and is one of the reasons medical tourism has been shrouded in the language of novelty, in other words, in that which was previously unimaginable.

The discipline of tropical medicine was codified in the late 19th century at institutions such as the London School of Hygiene and Tropical Medicine, Pasteur Institutes in Paris and the Johns Hopkins Medical School in the United States.
Established before the popularization of germ theory, tropical medicine emerged from the commonly held belief that certain ecological environments (particularly those of “moist heat”) were detrimental to white men’s constitution, thus making physical occupation of these spaces both difficult and dangerous (Anderson 2006:2). The danger of tropical spaces for occupying forces was indeed real; for example, the six principle British expeditions to West Africa from 1805 to 1841, for example, suffered a mortality rate of nearly fifty percent, primarily due to malaria (Macleod 1988:7).

The basic tenets of tropical medicine produced a deeply racialized topography in which the world was divided along the logic of categorical oppositions: temperate/tropical zones, disease/health, and, by extension, civilization/backwardness.

As historian Douglas Haynes (2001) writes on the dangers posed by tropical territories, the wide swaths of the tropics, ranging from Africa to South America to China, designated as the ‘white man’s grave’ testified to stubbornly high levels of mortality and morbidity among European imperial servants . . . in defining the boundaries of European civilization, this designation defined its comparative absence as well” (Haynes 2001:3).

Imagining the tropical world as diseased and atrophied produced a corresponding image of colonizing societies as healthy and advanced, and thus legitimated centers of rule.

And yet, if the discourse of the “white man’s grave” defined the parameters of that which was already civilized, it symptomatically called into question the potency of such civilization. As occupiers continued to die in large numbers once reaching foreign lands, the tropics became a space that was both simultaneously pathological and powerful.

While the racialization of territory and disease is clear as part of this process, it is also worth considering the role of imperialism in constituting biomedicine itself. The massive scale of global territorial conquest was intimately tied to an invisible scale
rendered knowable only through the scientific power of the microscope. As such, the history of tropical medicine became, in Macleod’s description,

[the] history of conflict in biblical dimensions, between the heroic endeavors of human beings and the vast microscopic armies and resources of the animal kingdom . . . memoirs of tropical doctors are the journals of medical Caesars confronting microbial Gauls, in lands never more than half won (1988:6).

Additionally, the health care needs of the empire abroad were central to the institutional development of the profession “at home” creating a “space for constructing the image of Britain as an advanced and healthy society and British medicine as a tool of modernity” (Haynes 2001:176). Thus a dual process was enacted: at the same time that biomedical science itself was folded into the logic of imperialism, the image of science as the “universal agent of progress” became the “hallmark of European empires throughout the world” (Macleod 1988:3).

Although colonial medicine, in the strictest sense, was initially reserved to treat expatriate populations, it was, in fact, “the natives, who suffered from the most profound effects of infections disease introduced through the intense contact brought about by colonial occupations” (Macleod 1988:8). Once the notion of infectious disease was in place, it was no longer the physical environs, but the now “diseased” natives inhabitants of the land who were understood as dangerous sources of contagion and in need of control. While efforts to create colonial enclaves to avoid infection were pursued, the most commonly adopted strategy was to attempt to regulate local practices of hygiene, and thus to purify the bodies and conduct of the native populations in ways that would limit risks to colonial occupiers. Using the example of the U.S. occupation of the Philippines at the close of the 19th century, Warwick Anderson (2006) argues that by
“framing disease potential, medical officers might also assemble a flexible, and sometimes unstable, framework for constituting racial capacities and colonial bodies” (Anderson 2006:2).

Important to this analysis is that, in instituting this particular “medico-moral” vision, both hygiene and contagion became explicitly racialized through the bodies of both occupier and occupied, no longer a matter of climate but of an imagined “contaminating racial type” (Anderson 2006:5-8). Such racialized assumptions did not remain restricted in their use within the colonies, but were also folded back into the central tenets of public health and biomedicine more generally as part of developing the nation both at home and abroad. As such, strong links exist between the late-colonial civilizing project and current health-based international development projects, and have been integrated into the practice and standards of biomedicine far more broadly (Anderson 2006:4). Looking, for example, at how British imperialism was central in constituting Victorian medicine and science as a domestic institution, Haynes argues that, “in a word, British medicine was imperial medicine” (Haynes 2001:6). Extending this analysis, numerous scholars have shown that contemporary campaigns of international and “global health” – such as those pursued by the World Health Organization branch of the United Nations – continue to work within a logic of distinguishing between zones of health and disease. What I have sketched in this historical summary are the mechanisms through which something that could loosely be described as “European” or allopathic medicine took on the weight of cultural authority. Such authority was not solely grounded in the notion of efficacy, but was instead built and strengthened through a deliberate campaign of colonial occupation and imperial rule. This history is important
to understanding the current shift to a global market in biomedicine for several key reasons. This history--and the longer history of international health campaigns emerging from it--points to the importance of biomedicine as a tool of political and economic management and domination between Europe and the United States, on the one hand, and those countries typically understood as part of the “Third World,” on the other. That is, biomedical claims have not only reflected, but have also often underwritten, broad political claims to national superiority and international dominance. Moreover, biomedical technologies were key to the circulation of First World bodies in spaces formerly considered the “white man’s grave,” and as biomedicine enabled such travel, it also served as the mechanism for justifying the extension of colonial rule. Spaces could be made “safe” for First World bodies, just as colonial subjects could be disciplined and brought closer to civilization through the practices of biomedical sanitation and the extension of “health.” That this logic directly contradicted the reality of colonial occupation, where the presence of First World foreigners did not “sanitize” spaces, but rather filled them with pathogens deadly to locals, did not fundamentally undo the association of civilization with biomedical authority. The goals of European conquest, instead, were woven into the very fabric of biomedical science itself, and folded into the everyday practice of biomedicine even outside of direct colonial encounters.

The “recent emergence” of biomedical tourism, thus, represents a moment of continuity as part of this 400-year colonial history. Even as medical tourism seemingly calls for a radical re-imagination of the spaces of safety and risk in the world, such a re-imagination betrays the earlier specter of the “white man’s grave.” Despite claims to novelty, the notion of oddity and strangenes through which such travel is approached
reflects not the impossibility of biomedicine in the Third World but the enduring legacy of understanding such spaces as poor, dirty and risky to white bodies. Yet, the presence of such bodies in these spaces of risk is justified through the economic logic of cost-savings, much as the bodies of colonizers underwent great risks as part of securing the economic growth of the center enabled by colonial occupation. I suggest then that these discourses of medical tourism do not so much imagine the unfettered travel of First World bodies to Third World spaces for medicine in so much as they propose the transference of the regulation and administration of such bodies from the State to a privatized, non-state entity, in this case, as discussed above, the JCI. In this regard, it is possible to suggest that the “consulting” and “assessment” techniques of the JCI do not significantly depart from the regulation of “hygiene” and “health” enacted as part of colonial medicine. Given the complex and disturbing history of anthropologists working alongside colonial regimes, it seems all too fitting, perhaps, that a modern day medical anthropologist would be sought out as an appropriate asset to a hospital working towards JCI accreditation. And yet, returning to my time spent in Austral, the kinds of disciplinary transformations encouraged were not limited to improved safety measures, but also included ideological and dispositional shifts. That such shifts were alien to the political and economic context of Argentina, however, was clear. “They told us,” Vasquez began, “that we shouldn’t store heavy things on shelves above where we keep certain kinds of important equipment, in case there is an earthquake… and the equipment would be needed.” This advice, he explained, was useful, pointed to an oversight – something that could be easily transformed by moving already existing pieces into new configurations.
Other changes, however, seemed impossible. “They want certain kinds of budgets in place, projections, estimates, five years, ten years…” he explained. “Here that is not possible…you wake up one morning and you have a new President… or the value of the currency in the budget has changed…there is no way to make these kinds of plans.” Requirements of a particular type of anticipatory thinking, such as predicative planning which assumes a certain kind of geopolitical stability, in the end, could only be only fictions. If JCI wanted to see these numbers “on the page” Vasquez noted, he could “give them numbers.” But he knew that they could not correspond with any real estimations of the future, which were to Vasquez, in the realm of the unknowable.

Perhaps most disturbing about the kind of neocolonial regulation enacted through JCI accreditation is the ways in which it departs from local standards and practices of excellence in favor of the symbolic weight of a “U.S.-based approval.” While Hospital Austral clearly benefited from an abundance of resources in comparison to public hospitals in the city center, doctors routinely told me that it was common practice for prestigious doctors to divide their time between work in a public institution and their own practice. Public institutions, in fact, were considered far more prestigious, and in terms of the doctors I worked with, tended to attract the most high-profile, research oriented medical practitioners, many of whom also held faculty positions at the University of Buenos Aires. Clearly, however, the hospitals with the leaking roof and the smoking doctors, would not be able to initiate, yet alone pass, such a costly accreditation process.

In a similar vein, several months into my fieldwork I was invited, through a personal contact, to attend a meeting at the U.S. Embassy in which the guest speaker would be a representative of the U.S. based “Medical Tourism Association.” Following
closely the logic of the JCI, this association was technically a nonprofit organization, and yet sustained itself by serving as a paid consultant to provide accreditation for “medical tourism coordinators” in destination countries. The representative, a lawyer, explained to a group equally split between Argentine and U.S. embassy workers, that the point of her organization was to provide standards that could be used to evaluate hospitals, doctors, and coordinators across countries to ensure patient safety when traveling abroad. At one point, as she described the kind of legal paperwork protocols they recommended doctors employ, I raised my hand and commented that many of the doctors with whom I had been working did not typically produce documentation or legal waivers to the same degree as was common in the United States (a theme I take up again when I look at doctors’ experiences in Chapter Three). Without missing a beat, she responded, “exactly…we’re trying to help patients find responsible doctors and avoid quacks.” That some of the doctors she maligned as “quacks” happened to be respected leaders in their field, including full professors at teaching hospitals with long publication records, did not enter into the logic of accreditation and equivalency she proposed.

Rather, this, and other ethnographic moments throughout this dissertation, point to the continued conflation of biomedical excellence with the space of the United States (and Europe), and shows how medical tourism encourages patients to travel abroad for lower-cost health services, even as such travel engenders and justifies emerging forms of privatized surveillance and discipline-for-purchase. Understood within a longer continuity of biomedical regulation and intervention, medical tourism promises a fundamental re-imagination of the world, but ultimately reproduces longstanding divisions between spaces understood as safe and those understood as risky.
Chapter Two

Selling Surgery in the Paris of South America

As explored in Chapter One, biomedicine has long existed within, and actively reproduced, a particular racialized geography of biomedical authority. Historically, the project of concentrating expertise and biomedical power in the hands of Europeans served not only to make colonial interventions technically feasible, but also became a central discourse and disciplining technique through which colonizing powers laid claim to the authority to rule. Biomedical expertise, therefore, has long been configured within patterns of existing inequalities, both emerging from, and reinforcing, a larger schema of social stratification.
This chapter shifts from a focus on the emerging global market in biomedicine today to the specific ways in which Argentina is positioned as a destination country for transnational patients. In my ethnographic examination of the creation and circulation of medical tourism marketing materials, I approach such practices as “contested, and often internally contradictory, public fields of representation and discourse” (Mazzarella 2003:4). Although marketing materials are ostensibly about selling surgery, they are simultaneously about crafting an image of Argentina as a safe space for surgery for foreigners, particularly in response to the colonial legacy described in Chapter One. As such, medical tourism promotional materials are not constrained within their intended marketing purposes, but also serve as part of internal conversations about the status of present-day Argentina, and particular the meaning of “modernity” in a post-crisis period. Thus, the marketing of medical services is a rich site from which to examine longstanding preoccupations and conflicts embedded within ideological constructions of the Argentine nation, including the ways in which Argentine citizenship and belonging is imagined. Drawing on the work of Edward Said (1979) and Judith Butler (1990), I suggest that these materials reflect the performative aspects of a national body constituted in relationship to the perceived gaze of Europe and the United States, one that requires a perpetual reconstitution of Buenos Aires as a “European space” of modernity in contrast to a racially “Othered” Latin America. By looking closely at the creation of these materials, my aim is engage more broadly with the processes of racial formation and exclusionary notions of citizenship engendered through participation in a global biomedical marketplace.
A close reading of marketing discourses and images is followed by an analysis of interviews with the creators of these marketing materials, which offers further insight into the ways in which Argentine historical narratives remain omnipresent in the consciousness of those who design these modern day advertisements. I then turn to my ethnographic fieldwork with medical tourism coordinators who continue the process of “selling the nation” even after patients have arrived. Through these distinct angles of analysis emerges a clear sense of the movement between Argentina’s exceptional status as the “Paris of Latin America” and as a destination in the global landscape of medical tourism.

**Histories of Movement: From Civilizing the Nation to Medical Tourism**

In making the case for why U.S. patients should consider Argentina as destination for medical tourism, the creators of a website called TrekaBella write:

Buenos Aires is the capital and largest city of Argentina as well as its largest port. Strongly influenced by European culture, Buenos Aires is sometimes referred to as the ‘Paris of the South’ … The so-called ‘Reina del Plata’ (Queen of the River Plate) is considered to be a city of European style, a characteristic that makes it very different from other Latin American capitals, more related to pre-Columbian traditions.

Even if one is not familiar with Argentine history, reading this description conveys a particular vision of Buenos Aires: a space set apart from the rest of Latin America through its cultural proximity to Europe, so much so, in fact, that it has taken on the name of the “Paris of the South.” The contrast to other spaces of Latin America is asserted both in terms of a cultural and temporal distance, with other Latin American capitals standing in as a “pre-Columbian” counterpoint to Argentina’s implicit modernity. Beyond the surface of this message about Argentina as a destination for medical
travelers, this description provides an intriguing site to explore why, in particular, these same visions of the city are performed again and again in the marketing of the nation.

To understand what is at stake in such a description, it is important to first outline some critical aspects of political and economic history within Argentina, particularly how the relationship between “modernity” and the nation has been imagined (Giddens 1991), and the effect of the recent 2000/2001 financial crisis on this relationship. I am particularly interested in examining the ways in which, historically, claims to modernity have been bound up with discourses of science and biomedicine, and how science has been granted a special status as a guarantor of “modernity” within Argentina, reflective of the broader links explored in Chapter One (Brown 2005; Rodriguez 2006).

While complex and contested, scholars point to several common features of the ideological construct of the Argentine nation that have emerged in relationship to Europe and the United States, with, historically, much effort undertaken in establishing a particular kind of trans-Atlantic national identity (Rodriguez 2006; Civantos 2007). In the postcolonial period following independence from Spain (declared in 1816, with the Constitution established in 1853), Argentina was an economic leader both within Latin America and in relationship to the United States and Europe. Emerging from the influential ideological categories set forth in Domingo Sarmiento’s monumental work Facundo, the narrative of Argentine national identity since the late nineteenth century has been articulated as the struggle between barbarism and civilization (Sarmiento 2003; Masiello 1992; Dodds 1993). 9

In the mid-nineteenth century, the state took on a “civilizing project,” which shaped immigration policies with the explicit intention of “whitening the nation.” This
massive political project intended to change the racial identity of the nation through waves of migrants from Europe, the logic of which was most clearly articulated by Juan Bautista Alberdi whose famous maxim was “to govern is to populate.” As Barbara Sutton (2008) notes in her article on race in Argentina, “the national narrative posits that Argentines ‘descend from the boats’ that brought (white) Europeans. . . .the ‘others’ who have also inhabited the country are seen as having conveniently disappeared” (Sutton 2008:107).

However, although Argentina’s constitution guaranteed rights to “all men” of the world who settled Argentine soil (not only citizens) it is not clear that mid-nineteenth century state policies were necessarily the impetus behind the great waves of migration. According to José C. Moya (2006), most European immigrants arrived after Argentine political elites had ceased ascribing to the ideology of civilization through European immigration. It was not until the three-year window preceding World War I that the majority of Europeans disembarked in Buenos Aires (1.1 million), more than had arrived in Spanish America in three hundred years of colonial rule (Moya 2006:2). Argentina was second only to the United States as a receiver of some of the more than fifty-one million European immigrants to the “New World” between 1840 and 1940 (Grimson and Kessler 2005:8; Moya 2006:6). As Moya points out, these new arrivals encountered xenophobic hostility, especially discriminatory in terms of categories of race and “racial stock.”

In contradiction to a national narrative that refers to the idea of the “European” migrants to the nation, the racial categories practiced at that time were far more ambiguous and exclusionary. The racial composition of “Latin” (Italian and Spanish) immigrants
was, in fact, extremely controversial at that time, with many of the newly arrived facing extreme forms of xenophobia, racism and accusations of criminal intent. Only much later was this history of discrimination against non-Anglo Saxon immigrants subjugated as part of a revisionist history that credited immigration for several decades of tremendous economic growth at the close of the nineteenth century (Grimson and Kessler 2006:8).

Argentina’s economic growth at the turn-of-the-century was significant, and as early as 1900 the colloquial phrase “rich as an Argentine” was used throughout the United States and Europe to describe a wealthy individual (Moya 2006:11).

This early movement of European bodies into the space of the nation as part of shoring up the notion of “civilization” did not simply end, but took on new forms and tactics throughout the twentieth century through until today. Emanuela Guano (2002, 2003, 2004) argues that the Argentine project of “importing modernity” continued to be distinctly European, even after the largest wave of immigration had ebbed. Turn-of-the-century ruling class porteños (from Buenos Aires city), Guano explains, explicitly claimed a modern status through the conspicuous consumption of European culture. In addition to fashion, food, music and sport, elite consumption of European goods even included hiring French and Italian architects in the building of extravagant mansions and manicured park spaces, soon after which Buenos Aires was branded the “Paris of South America” (Guano 2002:182-3). And yet, with the inability to sustain growth as the twentieth century wore on, Argentina’s seemingly privileged position within the newly industrializing global economy became increasingly tenuous. Political elites drew ongoing comparisons to North America and Europe, stoking anxiety that Argentina’s reputation
as a civilized nation would dissolve, and that the nation would slide into economic and cultural backwardness. These transnational economic dynamics, paired with existing anxiety about Argentina’s racial composition, led to the racialized legitimization of the elite as a European, civilized enclave in comparison to “gauchos, indigena, Afro-Argentines, and immigrant workers” (Guano 2002:183).

It was also at the end of the nineteenth century that the language of biomedicine was increasingly used to articulate racial conflict as a political disease. In this context of waning prosperity and racialized anxiety, the disciplines of science and medicine were called upon as part of the political project of curing the body politic (Rodriguez 2006). Out of this collaboration between science and the state, and the country’s growing reputation for excellent medical education, as well as local scientists’ contributions to the international community, Argentina increasingly performed modernity (See Leys-Stepan’s 1991 The Hour of Eugenics for the dominance of medicine within Latin American sciences, more broadly).

It would be too simple, however, to posit a straightforward association between notions of modernity and the deployment of scientific expertise. As Moya (2006) points out, Belle époque modernity within the New World encompassed a diversity of voices, ranging from the “hyper-rational to the sensualist” (Moya 2006:17). Yet, as Andrew Brown argues in Test Tube Envy (2005), science in Argentina has taken up a particularly ambiguous ground: there is ongoing anxiety that Argentine science is “absent” or less developed than in other parts of the world, and yet, science is simultaneously granted a great deal of cultural authority as the “guarantor of modernity” and as a means of
Two points relevant to my project should be emphasized here: historically, Argentine medicine has always been imagined as part of an international scientific community, and as a means of making transnational connections. Secondly, because of the particular historical development of medicine and scientific research within Argentina, it has taken on a special status as a means of performing Argentine modernity within a larger scientific community, and the country’s status as a “modern” nation more generally. It is the way in which science, and in particular, the practice of medicine, has, over time, become a culturally moderated signifier of modern identity that, I suggest, is still central to current efforts to stage a post-crisis modernity through medical tourism.

A number of scholars have demonstrated the continued salience of European heritage for members of the porteño middle class, who imagine themselves as “displaced from a more ‘civilized’ more ‘modern’ elsewhere to which they essentially belonged” (Guano 2002:184 emphasis original). In the 1940’s and 1950’s, porteño identity was explicitly contrasted to the large number of people from the interior of the country who migrated to urban centers, largely seeking work in an industrial sector newly invigorated through President Juan Perón’s import substitution economic policy (Grimson and Kessler 2006:12). That porteños claimed a racial identity in contrast to others within Argentina is discernable in the common term used to refer to these internal migrants during that time: cabecitas negras, or little black heads (Guano 2003:357). The racialized dichotomy, set out between “civilized” European-descendant porteños and “barbarous”
darker people of the interior, continues to manifest itself both explicitly and subtly in negotiating an Argentine identity (Guano 2003).

The more recent shift to economic neoliberalism, framed as the project of importing modernity by President Menem during the 1990’s, also became rearticulated through these same categories of identity. Guano argues that neoliberalism was not wholly foreign to Argentina, but rather, founded upon “a preexisting narrative of the self and its relation to an elsewhere – its exclusion from and desire for a First World to which most of the middle classes of Buenos Aires felt an entitlement” (Guano 2002:184). The disconnect between an identity rooted in the successes of the past and the realities of modern-day Argentina has produced an acute anxiety about First World/Third World status, as diverse groups of middle-class Argentines work to “produce themselves as ‘First World’ actors negotiating a global marketplace of practices, ideas, and commodities” (Jacobson 2006: 336). Shari Jacobson (2006) explores the uses of First/Third World categories through her focus on Ultraorthodox Sephardi Women in Buenos Aires, who point to their adherence to the strict discipline of haredi Judaism as a way of claiming a First World identity. More generally, Jacobson signals the practice – shared by many Argentines beyond the ultraorthodox community – to construct their shifting sense of Argentine identity as one of negotiating Argentina’s ambiguous First or Third World status within the larger world.

While these claims are primarily grounded in notions of modernity or the “First World,” they can also be read as racializing discourses grounded in particular notions of whiteness. As Galen Joseph (2000) demonstrates, porteños identify themselves as
occupying an ambiguous position as part of their national and transnational imaginary, that is, they are able to claim a historically privileged position within the space of the nation, even as they lament their marginal position in the world (Joseph 2000:333). Significantly, the notion of race does not operate neatly as part of middle-class understandings of self. As Joseph explains, middle-class porteños are far more likely to highlight class divisions in the creation of inequality while maintaining the myth of Buenos Aires as a place where racial differences are not significant. To this end, Joseph looks at the rhetoric of “seriousness” as coding whiteness in everyday expressions and practices. She argues, “in Argentina, an ideal white identity is implicit in the idioms of seriousness and civilization through which middle-class porteños discuss national identity and the dilemmas of economic development and democratic consolidation” (Joseph 2000:335). Race, then, becomes a mode of articulating Argentines’ power or lack thereof, with whiteness as a form of cultural capital and “a sign of belonging to an idealized European or first world community.” Importantly, Joseph argues that it is this particular sense of transnational whiteness as a form of European belonging that ultimately trumps other forms of national belonging in the production of a middle-class Argentine identity. In contrast to other Latin American countries, however, it is rare for porteños to articulate whiteness explicitly (e.g. self identifying as blanco) but instead substitute terms such as europeo, or cite a specific heritage, such as italiano.

Modernity in Crisis

As Galen argues that claims to European identity and modernity become increasingly tenuous during times of economic or political unrest, it is important to consider how the racialized performance of modernity has shifted since the 2001
financial collapse in which the peso, previously equivalent to the U.S. dollar, fell to the current rate of three or four pesos to a dollar. The crisis, which emerged from a series of complex events including pegging the peso to the dollar in 1991, the rapid withdrawal of foreign investments, extensive borrowing under Menem, and an ongoing recession due to the process of neoliberal privatization, produced immediate and serious effects. Among them was the dramatic resignation of President De la Rúa, who fled the presidential residence via helicopter and was succeeded by three subsequent presidents within two weeks, as well as the abandonment of dollar parity and the largest debt default of a nation to date (Uribe and Schwab 2003; Machlachlan 2006).

Locally, the effects of the crisis were devastating: millions of middle class people lost significant portions of their life savings as a result of a strained banking system, unemployment rates skyrocketed and many people were unable to meet the basic needs of their families. Shortly after the crisis, the Argentine National Institute of Statistics and Census (INDEC) indicated that by October of 2002 the percentage of people living below the poverty line in the marginalized suburbs of Buenos Aires was an astonishing sixty-four percent (INDEC 2003).

In addition to direct economic consequences, there were additional symbolic effects of the collapse, as the idea of the Argentine nation was recoded through images of the crisis circulated on global nightly news programs. Images of crisis focused on outraged Argentines taking to the streets en masse and smashing bank windows. Coverage also covered riots resulting in multiple deaths, and large, deafening crowds participating in cacerolazo (pot banging) demonstrations (Dinerstein 2002).
Academics, and in particular economists, weighed in on the events immediately. Some seemingly accepted the crisis as an inevitable event that would put Argentina back into its proper place within the global hierarchy of nations. Olivier Blanchard, a professor of economics at the Massachusetts Institute of Technology and then chief economist of the International Monetary Fund (IMF), describes the effects of setting the one-to-one exchange rate in this way:

This was to be the beginning of a new era, one in which a responsible, modern Argentina opened itself in a disciplined way to the United States and the world. But, as the ancient Greeks taught, the gods destroy by granting us our wishes or fulfilling them too completely… Argentina is a little economy of the Southern hemisphere; the US is a large and diversified economy of the Northern hemisphere. Argentina exports cows and raw materials, America exports high tech and services … For the two countries to have the same exchange rate is a crime against logic . . . (Blanchard 2006:2, emphasis mine)

Blanchard’s analysis almost delights in Argentina’s downfall, as if the country were an insolent child being punished for pretending it was something it was not: part of the “First World.” This rhetoric also serves to position the country as undeserving of any help from the United States or the IMF as it sank back into its rightful place in the Southern hemisphere. More recent, historically-oriented narratives have framed the crisis as the crescendo of a long fall from First World status, and as such, a space of economic contagion dangerous to developed countries worldwide. Take, for example, historian Colin Maclachlan’s (2006) analysis in *Argentina: What Went Wrong*: “The world has judged Argentina a failure … consequently, the first question people raise is, ‘What went wrong?’ Underlying the question is an unstated worry: can it happen to us?”

Trying to put to rest worries that the United States might become “another Argentina,” Maclachlan offers his version of the historical disconnect between the Argentina of years past and the current situation:
Around the turn of the last century wealthy Argentines toured the continent, delighting and impressing the sophisticates of Monte Carlo, Nice, Deauville, the spa at Baden Baden and other fashionable spots where the rich gathered to play. Argentines saw themselves as part of the Atlantic world. Who did not know of Argentina? Unfortunately, the second half of the twentieth century administered a harsh dose of reality, and in fifty years Argentina went from an economic leader to impoverished survival, as the economy collapsed in the worst crisis in its history and the world’s largest debt default” (Maclachlan 2006:xiii).

While economic recovery is underway, the enduring symbolic effects of the crisis, as well as the devaluation of the peso, have put into question Argentina’s status as a “modern” nation. Such symbolic effects are multiple: at the same time that the country became coded as a space of chaos and crisis, so too did the rapid devaluation of peso recast Buenos Aires as a “cosmopolitan bargain” on the international tourism market (Mount 2007). If the performance of a sort of European modernity has long been a feature of Argentina citizenship, such performances are rapidly shifting both in the context of the impact of the crisis, as well as being newly objectified as the object of the tourist gaze (Urry 2002 [1980]).

Marketing Medical Tourism to Argentina: Selling Surgery in the Paris of South America

Having looked historically at the intersection between claims to modernity, European identity and biomedical and scientific expertise, it is now possible to understand how such themes are emerging as part of transnational medical travel within Buenos Aires. While economic incentives are one major motivation used to encourage medical tourists to leave their home country and pursue surgery abroad, such incentives do not necessarily provide a rationale for choosing one destination country over another. Therefore, at the core of medical tourism marketing is the ability to balance an economic argument around “savings” with more complex factors such as “security,” “modernity”
and “cosmopolitanism” that position one country as the most desirable option among many.

As an orientation to the landscape of medical tourism marketing within Argentina, I first examine a sample of representative online narratives of websites designed to attract patients to travel to Argentina for surgery, before turning to my ethnographic work with the marketers themselves. My interest in advertisements as a site of inquiry reflects the increased attention such materials are receiving within anthropology (Sahlins 1976; Applebaum 1998; Miller 1997), although advertising has been an interest within cultural studies, and within structuralism in particular, for much longer (Baudrillard 1994; Barthes 1977; Benjamin 1999[1936]; Williams 2000 [1977]; Williamson 1978).

Drawing on Anne McClintock (1994) and others, I understand such advertisements not as limited to stimulating consumption, but as important sites for the circulation of ideas and discourses on central issues such as race, gender, and imperial domination (McClintock 1994:205; Burke 1996; Orlove 1997).

Online narratives are a potent place to begin, first because it is usually through the internet that most patients research the possibility of traveling abroad for surgery. Online marketing materials must convince patients to re-imagine the world in such a way that they are able to consider traveling to a country to which they have never been, as well as undergoing surgery at the hands of someone they may not be able to picture. How then, does one sell the idea of a country or a city as being a safe place for surgery? In trying to convince patients to trust their lives and bodies to the hands of foreign doctors, how do the lives and bodies of Argentine citizens themselves become represented and mobilized through online discourses? Following Volcic’s (2008) discussion of the marketing of
nations as part of tourism, I approach these online spaces as important sites of “representational practice and discursive imaginings” and look to how such narratives are part of constructing a particular “brand” of Argentina. Thematically, I will focus on two common tropes present across almost all of these websites. First is the idea that due to the devaluation of the peso as part of the 2001 economic crisis, Buenos Aires is newly “affordable” for consumers of the Global North. Second, drawing on the long-standing conceptualization of Buenos Aires as the “Paris of South America,” is the claim that the city can be understood as a European enclave in contrast to the rest of Latin America.

**Buenos Aires as Affordably Modern:** While locally experienced as crisis and hardship, the devaluation of the peso led Buenos Aires to be recast as a “cosmopolitan bargain” for foreign tourists. Described by travel guides, such as *Lonely Planet*, as “New York on Sale,” such recasting of the city as a “bargain” was often done in casual and celebratory tone. A strange equivalence emerged between the effects of the crisis and the luxurious benefits it afforded foreign tourists, such as this description from the *New York Times* travel section: “the financial meltdown emasculated the Argentine economy, but it also made Buenos Aires, the expensive cosmopolitan capital, an attractive and suddenly affordable destination” (Mount February 4, 2007). Discourses such as these have even more specific effects when applied to selling surgery. For example, one leading medical tourism site explains:

> Our international patients are able to achieve savings of up to 70% from the prices typically charged in the USA or Europe. As a result of the devaluation of the peso, plastic surgery in Argentina is very affordable and costs must less than a plastic surgery in Brazil or . . . Mexico (www.plenitas.com accessed May 10, 2009, which has now been re-branded as abcmedicaltourism).
Striking in this narrative is the way in which the economic crisis is imagined on behalf of a foreign audience, carefully obscuring any negative effects of the devaluation to local people, and instead framing it as an ability to “achieve savings” in healthcare. Unquestioned are the implications that patients of the Global North take advantage of the crisis aftermath, or any larger political and economic effects their participation in Argentine healthcare may have for local residents. Yet, the ability to “achieve savings” has the potential to be a double-edged narrative, attracting patients with low prices while potentially raising suspicions about the quality of the services offered.

In anticipation of such suspicions, the leading medical tourism agency in Buenos Aires responds to the possibility of patient anxieties about the low prices of surgery:

...the thing is that some countries have very low prices when compared to other countries, and this has to do with the exchange rate... a Big Mac in the US costs US $3 whereas in Argentina it costs US $1.60. The Big Mac is exactly the same, but the price is related to the economy of the country where it is sold.

Striking in this narrative is the absence of any historical memory of dollar parity in the decade before the economic crisis. Rather, echoing the arguments of the economists described earlier, this medical tourism company rearticulates the distinction between “some countries,” that is countries of the Global South, whose currency is understood as inherently less valuable than those of the Global North, as if such differences in value were inevitable or apolitical. Additionally, above and beyond the symbolism of drawing on the preeminent example of U.S. homogenization - McDonald’s - in arguing for biomedical equivalence, the language used here to justify a global, free market model of healthcare is remarkable, given how intimately U.S. neoliberal policies have been implicated in the financial crisis within Argentina.
In addition to obvious currency conversion advantage to foreigners, the crisis also offers an important way to differentiate Argentina from other medical tourism destinations. Most significantly, the language of crisis implies a temporal rupture that implicitly refers back to a pre-crisis state, allowing companies to market medical procedures as less expensive than in the United States and Europe due to a temporary financial situation, as opposed to a longstanding difference in the quality of expertise. Thus, the language of crisis circumvents (at least in part) the suspicious cost-differential upon which medical tourism hinges, and works to maintain claims of cultural and racial similarity between Argentina and Europe.

The trope of “European identity” is the most common theme across medical tourism marketing in Argentina, for example, describing the European “feeling” of the architecture in Recoleta, the tree-lined boulevards, charming cafes, or the interconnected green spaces of Palermo, modeled after the “green lungs” of Paris. Additionally, such claims to Europeaness are made in explicit contrast to other spaces within Latin America. The following excerpt already quoted above is exemplary:

The so-called ‘Reina del Plata’ (Queen of the River Plate) is considered to be a city of European style, a characteristic that makes it very different from other Latin American capitals, more related to pre-Columbian traditions.

Here we see not only a claim to Europeaness, but also the overt othering of the continent in which Argentina is located. This othering is not only racialized in the sense of placing other capitals in direct opposition to that which is “European” but temporal as well, relegating them to an ancient, traditional past in contrast to Buenos Aires’ assertions of modernity. This points away from tropes commonly associated with tourism
marketing, such as “auto-orientalism” or the promotion of “marketable difference” (Volcic 2008), and instead, favors drawing transnational connections around shared European identity.

This emphasis on the surgical treatment of white, European bodies can also been visually apprehended through this advertisement for a local clinic intending to attract patients from Europe, and most specifically Spain.

*The Three Graces* by Rubens (1577-1640), painting in the Prado Museum, Madrid (on left) Advertisement showing surgically enhanced bodies (on right).

While the majority of these websites seemingly create links between Argentina’s ability to provide biomedical excellence with their identity as a European, modern nation, some sites also explicitly point to the risks of receiving care elsewhere. One site claims that the number one mistake a person can make in choosing a medical tourism destination is to go someplace “tropical” such as “India, Malaysia, Costa Rica, or Thailand” because
these countries have “different infectious diseases than Europe and North America” and the country is risky for those without “natural immunity.” In trying to differentiate Argentina from other medical tourism destinations, this narrative adopts the historical tropes of travel medicine, invoking a colonial era, racialized geography of disease at the very moment of entering into a global market in biomedicine.

Overt examples of national identity anxiety emerge through medical tourism marketing. An excerpt from one company begins by claiming that Argentine beauty is “in the genes” which they attribute to a mix of nationalities that have made Buenos Aires the “New York of the South.” Looking historically, this website claims that 19th century waves of immigration brought people from all over Europe and the Middle East, but, ultimately they describe the “DNA base” of Argentina as being that of Italy and Spain. Claiming a particular cultural expertise in plastic surgery, the website questions why Argentine women bother to undergo such extensive cosmetic surgery given that “they are so beautiful in the first place.” “The answer,” the website continues, is that “like their country, they are confused about their identity: are they European, Latin American, or what? And their response to this confusion is to look ravishing. To them, plastic surgery in Argentina is a matter of patriotic duty.”

The anxiety over national identity expressed in the passage above is intensifying as part of a post-crisis Argentina in which imagined economic ties to First World modernity are increasingly elusive. What is striking about this passage is how this anxiety is explicitly manifested as a “female form,” which becomes understood as the unstable space through which national pride is embodied. Because of this instability, the plastic surgeon becomes a healer of the nation-state, charged with alleviating the disjuncture
between imagined identities and the reality of a post-crisis nation. Medical tourism, in which Argentine surgeons operate on foreign, ideally white, and primarily feminized bodies, can also be read as part of this post-crisis claim to modernity, and online medical tourism marketing sites as an important location for the performance of these claims.

Taken together, marketing discourses that position Argentina as a desirable destination for medical care attempt to overcome the connotations of risk and contamination associated with spaces outside of the United States and Europe through assertions of shared European heritage and culture similarity. Differences in the cost of care are explained not as a result of fundamental differences between Argentina, the United States and Europe, but rather as a delimited “crisis” that has temporally rendered Argentina as an affordable destination for sophisticated, cosmopolitan travelers. Yet, beyond the discourses and images themselves, my work ethnographically examines the ways in which such materials are imagined and created.

**The Marketers of the Nation: Whitewashing Surgical Spaces**

Although clear themes can be teased out through an analysis of online medical tourism marketing materials, one of the goals of my research is to understand how the people who design and create these marketing materials make meaning through their creation and circulation. I suggest that, beyond the goal of attracting foreign patients, the very process of imagining and creating these marketing materials is also a practice of engaging with, and making sense of, a shifting post-crisis Argentine national identity.

My interview with Pablo, the marketing director of a leading medical tourism agency, and his younger assistant David, took place at the company headquarters, in the northern neighborhood of Colegiales. Located on a pleasantly brisk commercial strip in
an otherwise middle-class residential area, the office was surrounded by pharmacies, restaurants and clothing shops. When I arrived, I was buzzed through the door by a friendly receptionist who spoke in heavily accented English. I was led to a waiting room stylishly decorated in white, where several patients in bandages sat flipping through magazines. At one point, a young woman called a patient’s name and led her into what looked like a small examination room. When Pablo came to greet me, he led me in the other direction, through a hallway and up a narrow set of stairs, opening up into a sparsely decorated room. In contrast to the stylish, medical aura of the waiting room below, this office was a plain, grey-carpeted room filled with young workers tapping on computer keyboards, many of them simultaneously speaking into headsets, some in English, others in Spanish, producing a cacophony of conversations.

As we sat at a large, round table in a bare conference room accented only with white vinyl blinds, Pablo began by telling me a bit about how he understands his role in bringing foreign patients to Argentina for surgery. He began by explaining that his agency does not “create the desire” for patients to leave the United States or Europe for surgery, but rather they try “to make them understand that in Argentina we have very good surgeons . . . medical excellence.” “And because of our economic situation,” he continued, “one dollar is three pesos, one Euro is four and a half pesos . . . there are excellent medical services at a price that you cannot believe.” Emphasizing the role of medical expertise in Argentina’s reputation, Pablo added, “we have really good [medical] professionals in Argentina, they are very well-educated and well-known throughout the world.”
Considering what distinguishes Argentina from other countries as a medical tourism destination, Pablo began by comparing Argentina to India, one of the current leaders in the emerging market in global biomedicine. India, according to Pablo, was “too far away” and dangerous given its political problems with Pakistan. Instead of referring to India’s capacity for offering biomedical care, he instead drew upon the ubiquitous discourse that symbolically marks India as the prototypical Third World space, explaining that the poverty in India is so unrelenting that “it makes you want to cry.” He thus relies upon established stereotypes of Third World nations as dangerous, politically unstable and poverty-stricken to work against the notion that they may serve as modern, secure spaces for medical interventions.

Asking him to compare Argentina to other Latin American countries, many of which are much closer to the United States and Europe than Buenos Aires (approximately 11 hours nonstop from New York City), Pablo admitted that such comparisons were a “problem” as part of his marketing strategy. He circumvented this issue by positioning Argentina as desirable given its “cultural characteristics,” which by implication, were denied to exist in other Latin American countries. Positing a direct spatial similarity to Europe and the United States, Pablo began, “Argentina is – with Uruguay - are the two European countries of South America . . . Buenos Aires is a big city . . . [it could] be in any part of the world . . . you can compare Buenos Aires with Madrid, Paris or New York.” Additionally, he directly referred to the ways in which this European identity was embodied within Argentina, commenting, “I don’t have . . . (a gesture of inclusion to his assistant David) we don’t have the aesthetic of a Latin American. We are white (his
emphasis) . . . when I used to have hair (pointing at his now balding head) . . . it was like David’s (medium blond).”

He elaborated on Argentina’s position as an exceptional country within Latin America by recounting his own experiences living in California, in which he understood himself as defying the embodied stereotypes assumed of a Latin American. He recalled introducing himself to people in California, remembering that they would respond with incredulity to the idea that he was from South America. He explained, “because I don’t have that ‘estereotipo’ – that is [North Americans] work with stereotypes . . . if someone is not dark in skin color, and his accent when he tries to speak in English is not ‘Spanglish’ . . . you are not Latin American . . . because the one’s who are Latin Americans are those – the ones that have a problem with spelling in English, and they are almost all dark skinned, those are the ones.”

When I pushed him as to whether Buenos Aires, and Argentina more generally, is as racially homogenous as he had presented, he admitted that it was not, explicitly mentioning the historical arrival of the cabecitas negras to the city. Yet, he also extended this rhetoric to the influx of darker people from the interior to include what he understood as more recent immigration from Bolivia, Paraguay and Peru (on this topic, see also Gauno 2003). Reflecting on porteño attitudes about racially marginalized people within Buenos Aires (in which the category of Argentine citizen entirely drops out of his response), he concludes that the problem was that “the people of Bolivia . . . the people of Paraguay and Peru have ‘black heads’ – it’s not that there is problem with the countries themselves – with Bolivia – it is this cabecita negra problem that is still in the structure of the [Argentine] society.” What is of note here is the way he is able to mobilize a
racially charged category to collapse the historical arrival of rural Argentines to the city with the perceived recent influx of migrants from neighboring Latin America countries. In this sense, he emphasizes the city as a space that does not belong to darker bodies, but rather a space preserved for those who conform to the idea of the urban citizen of European heritage.

Furthermore, Pablo admitted that a lot of poverty existed in Buenos Aires as well, and his descriptions of the *villa miserias* directly contradicted the earlier contrast he had established between Argentina and India. He insisted, however, that when it came to planning trips for medical tourists, “I think what [medical tourists] see is – here I have to be really – *sincera* – what they see is what we want them to see . . . they see the Buenos Aires that we want to sell them . . . we don’t take them to the [those parts of the city].” In many ways, Pablo’s comments reflect the problem or contradiction of the larger social and state position of the Argentine nation: formal political solidarity and mutual alliance with countries such as Bolivia and Venezuela coexisting alongside discriminatory attitudes toward the presence of racially marginalized peoples (including Argentine citizen discursively rendered as foreign) within the space of the nation, and in particular, the capital.

The medical tourism agency website aimed at prospective U.S. and European patients that Pablo designed also reinforced the ideals of national identity that he articulated in our conversations. For example, the website provides a simple blue and white chart that encourages medical tourists to “compare Argentina with other countries that offer medical trips.” It is significant that the very first category of comparison on the chart is “Ethnic Groups.” In this category, Argentina is described as being ninety-seven
percent white, with “Mestizo, Amerindian and other groups” listed as just three percent.

Out of the five countries compared, (Argentina, Colombia, India, Poland and Thailand) the explicitly racial claim to a majority “white” population appears only within Argentina’s description, where 97% are described as “White (Spanish and Italian mostly).

In comparison, the word white is not used to describe Poland, which is alternatively described as being 96.7% percent “Polish.”

### Argentina in figures

<table>
<thead>
<tr>
<th>Population</th>
<th>Argentina: 39,144,753</th>
<th>Colombia: 42,954,279</th>
<th>India: 1,065,070,607,386,635,144,465,444,371</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethnic Groups</td>
<td>White (Spanish and Italian mostly) 97%</td>
<td>Mestizo 58%</td>
<td>Indo-Aryan</td>
</tr>
<tr>
<td></td>
<td>Mestizo 58%</td>
<td>White 20%</td>
<td>Polish 72%</td>
</tr>
<tr>
<td></td>
<td>Mulatto 14%</td>
<td>Black 4%</td>
<td>Chinese 96.7%</td>
</tr>
<tr>
<td></td>
<td>Mixed Black-Amerindian 3%</td>
<td>Amerindian 1%</td>
<td>German 14%</td>
</tr>
<tr>
<td></td>
<td>and others 3%</td>
<td></td>
<td>Others 0.4%</td>
</tr>
<tr>
<td>Literacy rate (15 years old)</td>
<td>94.1%</td>
<td>92.5%</td>
<td>99.8%</td>
</tr>
</tbody>
</table>

Argentina’s population has a high level of literacy, is mainly white and from European descent. In Argentina, many nationalities live peacefully, without any racial or religious conflicts.

Image from Medical Tourism website

Official census statistics put the number of Argentines with self-described “European” descent at around eighty-six percent. Yet, these numbers have been subject to much criticism, as historically, national census data have been collected using the category of national origin rather than race. Critics argue that this practice leads to undercounting Afro-Argentines and mestizos, or people of mixed white and indigenous
heritage (See Andrews 1980 on Afro-Argentines; Lewis 1996). In fact, 2010 marked the first year that the census included the category of “Afro-descendant” as an option for selection, clearly reflecting the long-standing normative view of the country as mainly white in population (http://www.indec.mecon.ar/ accessed March 17, 2011).

In describing the medical tourists who come to Buenos Aires, the above website informs us that many tourists “claim that they did not feel foreign at all when walking down the streets of the city; they felt ‘at home.’” (emphasis added). Here, the concept of whiteness is used not only to visually render the space of Argentina as a European enclave, but also to make visible the bodies and identities of the tourists that would be “best suited” to walk down the streets of Buenos Aires. By attempting to fill the streets of Buenos Aires with transnational First World bodies, even if only as tourists, such marketing echoes earlier national efforts to literally fill the space of the nation with the white bodies of European immigrants. The movement of privileged bodies through the spaces of the city, I argue, also helps to reconstitute the notion of that space as somehow safe or suited for those bodies: that is, a space of the First World. Medical tourism thus encourages white foreigners to feel at home in the space of the nation, as racially marginalized Argentines are discursively erased, rendered invisible as part of the imagined social body that continually reasserts itself as the modern, Argentine ideal.

Moving through the City: Marketing the Nation After Arrival

While online marketing is a place in which to circulate images of the city for potential patients, the “selling” of the nation does not end once the patients have arrived. It is often the role of the medical tourism coordinator to gently introduce the newly arrived to the reality of Buenos Aires: from the most beautiful French-style turn-of-the-
century mansions and boulevards to smog choked streets and poor people begging for change on the sidewalks. The selling of the city as a safe place for surgery may in fact be far more difficult once removed from the realm of image and imagination, and instead grounded in the patients’ own senses and embodied experiences as they explore the spaces of the city accompanied by their coordinators. Yet, there is not one single experience to be had, and in their carefully crafted tours, medical tourism coordinators attempt to shape the perceptions and experiences of newly arrived patients in ways that reinforce the idea of Buenos Aires as a romantic, cosmopolitan city and safe place for a quickly approaching surgery.

While I was able to accompany patients and their coordinators on a number of tours, below I explore two of these tours. The first tour was given to Rogier the day after his arrival from Holland, by his coordinator, Sarah, a British expatriate, medical tourism coordinator and tango enthusiast. I focus on a few key moments where Sarah attempts to construct a particular experience for us, even if such constructions remained partial, and were even contradicted by the experiences before us. The second tour focuses on a tour given by Buenos Aires-born Lola, showing downtown to a medical tourist named K.L.

On the day of Rogier’s tour, we piled into a Radio Taxi from his apartment, and Sarah gave the driver an address in the Northern part of the city along Avenida Santa Fe.

As we zoomed along, Sarah set the scene for our encounter with the city:

Sarah: You will really love the shopping here!
Rogier: That’s good!..because I love to shop…and there are a lot of things I want to get…presents also, do you know where I can get whitener for my teeth?
Sarah: I’m not sure…but..I’ll try to see. I’m sure the shopping will be nice because of the exchange…
Rogier: How much is it again?
Sarah: Today it’s $3.10 to the dollar…but it goes up and down a little…
Rogier: I’m getting so confused already… I convert pesos to dollars and… dollars to Euros. I had a huge stack of bills today, and it felt like fake money, you know? [shared laughter]

As the taxi continues, Sarah strains to point out the most magnificent of the ornate French-style buildings as we speed along Avenida Libertador, her arm reaching across Rogier, as she directs his attention to the most impressive buildings. Because Rogier is hungry, our first stop is a small, dark bakery reminiscent of an Italian pastry shop.

Sarah’s voice is melodic and enthusiastic as she points to different kinds of pastries and tells Rogier that he has to try the alfajores – a locally revered treat made up of two sweet flat cookies adhered together with a thick, oozing layer of caramel-like dulce de leche.

Rogier makes a joke that he should eat everything he wants given that he is about to undergo liposuction, and then points to several different pastries he would like to try.

The shopkeeper wordlessly weighs the delicacies and wraps them in white paper, writing the total price in pesos on a small slip of paper and passes it across the glass case. Sarah begins to help Rogier sort through the various bills in his wallet, trying to find something small enough to pay for the bakery bill of eighteen pesos. “Can’t I just pay with one hundred, so I have change?” Rogier asks. “No, no…” Sarah explains as she tries to discreetly hunch over his wallet and sort through the bills he had exchanged. “Change is a bit of a problem here… they don’t have a lot of it, so you have to pay with a bill that’s pretty close… also, you need to check and make sure that you are not being given a counterfeit bill, especially in taxis.”

In this small moment, we see contradictory images of Buenos Aires emerging, as Sarah works to impress upon Rogier the romantic, European images of the city (pointing out the French-style architecture, encouraging him to experience a European-style
bakery), and yet having to situate such experiences within the constraints of a country of
the Global South: the chronic shortages of state printed currency that makes “making
change” a daily struggle, the ubiquitous circulation of counterfeit bills, and even in her
hunched over protective posture, the near constant vigilance required to hide one’s wallet
for fear of being targeted for theft. During my time spent with coordinators orienting
foreign patients to the city, this uneven tension between cultivating a “romantic”
experience of the “Paris of South America” and the need to impart “lessons” about safety
emerged again and again.

Image taken by transnational patient during a city tour
On a different city tour I shadowed, I observed an even stronger contradiction emerge surrounding a particularly ambiguous space within the city: the Retiro Train Station. As we strolled under the shade near the impressive, French-commissioned statue of war hero José de San Martín in the plaza of the same name, a patient named K.L. pointed across the boulevard, remarking on the impressive edifice of the Retiro train station. The building itself is a massive, French-style building that opened in 1915, and still serves as the city’s largest commuter rail hub, as well as being an official National Monument of Argentina. Echoing the turn of the century uses of architecture to produce “European space” discussed above, Retiro was designed by British architects, who, incredibly, ordered that the steel structures for the building be created in England and reassembled upon arrival in Buenos Aires. Yet, in explaining to K.L. why it was best not to tour this national monument, Laura said, “the building is very beautiful, yes? But, it is not safe, really. It is not a place that you should go.” While a striking example of the French-style architecture that gives Buenos Aires its Paris of South America reputation, directly adjacent to the Retiro station and nearby bus depot, is one of the Buenos Aires’ largest shanty-towns, locally referred to as a villa miseria (literally village of misery).

“Villa 31,” as this particular villa miseria is known, is made up of a range of homes, from concrete buildings with exposed rebar to more precarious structures assembled from wood paneling and tin roofing. Riding the commuter rails alongside Villa 31, I often saw groups of children playing soccer in the unpaved street, and it was common to see unleashed dogs sleeping on the sidewalks near the station. In terms of infrastructure, Villa 31 is largely excluded from municipal services, with few paved streets, as well as limited access to sanitation systems and extra-legal connections to
power grids. Official estimates of people living in this area are hard to come by, but it is common to see estimates of around 30,000 residents, with a total of 160,000 people living in villas throughout the city. (http://www.mundovilla.com/index.php?iCategory=1&iArticle=277 accessed March 17, 2011). Locally, such areas are stigmatized as violent places filled with crime and drugs, particularly since a potent and inexpensive derivative of cocaine, paco, has grown in popularity (Taylor 2008).

In many ways, this particular encounter between coordinator and patient exposes the difficulty of maintaining the “brand” of Argentina produced through medical tourism marketing materials. While images of regal European edifices are circulated to make claims about a particular kind of European identity, the reality is far more complex. Some of the very images deployed to sell the city as a modern, safe space, and thus suitable for surgery, remain off-limits to the patients upon arrival --- too risky for their foreign bodies. Such “risky” spaces of impoverishment have, of course, only intensified since the financial crisis, the very event so often cited in marketing the city as a place of affordable luxury. Thus, while the crisis may be effectively mobilized in branding the nation as part of selling surgery, maintaining the myth of the “Paris of South America” for newly-arrived, mobile patients is far more difficult. Rather, what is exposed in such ambiguous spaces are the longstanding tensions continually negotiated in locating Argentina as a part of the First or Third world, a space of Europe or Latin America, a national identity suffused with the continual movement between “civilization” and “barbarism.”
Chapter Three

Unequal Expertise:
Third World Surgeons treating First World Patients

He nodded thoughtfully, staring off into the space above my head as he considered my question. Given his eagerness to point out the virtues of Argentine medicine in comparison to medicine in other parts of the world, it hadn’t occurred to me that it could be impolite to ask Dr. Babor to compare the expertise of surgeons in the U.S. and Argentina. That today, rather than extolling the virtues of Argentine medicine, he would instead offer up words of bitter frustration, his body taking on a visible, heavy sadness. His response was subdued, but clear: “being a surgeon in Argentina is not the
same as being a surgeon in Europe or the United States,” he began, his gaze now firmly on me, as if to make sure I was taking careful notes.

**Being a Surgeon is Not the Same Thing**

This chapter begins with the assertion that being a surgeon in Argentina is “not the same thing” as being as surgeon elsewhere. That is, despite the neoliberal imagination of a global market in biomedicine in which expertise is differentiated solely by cost, the experiences and opportunities afforded to those who choose to “be a surgeon” vary widely depending on the particular historical, geographical and political contexts in which they train and work. But I also believe the point the surgeon was making with this statement goes deeper. It is not only that practicing surgery is different in different contexts, but also that an uncomfortable - sometimes painful - disjuncture exists between doctors’ own sense of biomedical expertise and the constraints of precisely where in the global hierarchy of the biomedical industry they are positioned. For the doctors I worked with, the *where* was not simply a metaphor for rank and privilege in their professional field, but was also understood tangibly in terms of geography: marginality expressed as both a feeling of professional constraint, as well as a particular sense of spatial embeddedness within the geo-political location of post-crisis Argentina.

Taking this attention to disjuncture within the global landscape of biomedicine as a starting place, this chapter explores the relationship between *marginality* and *biomedical expertise*. In particular, I seek to understand the ways in which the disconnect between biomedical expertise and economic and political marginality is brought into sharp relief in the specific context of medical tourism to Argentina, revealing the
complex, and even contradictory, ways that doctors make sense of the practice of Third World surgeons operating upon the bodies of First World patients.

This chapter speaks to several literatures within anthropology. First, it contributes to less researched areas within the anthropology of transnationalism and globalization, which have primarily focused on the effects of neoliberalism and transnational capital on the working poor and those who have been disproportionately affected by harsh austerity measures, fleet-footed capital and the dismantling of the state (Fernandez–Kelly 1983; Brennan 2004; Harvey 2006; Goldstein 2004; Edelman 1999). While critical in drawing much needed attention to the negative impacts of “free market” logic, this approach remains limited in so far as it continues to frame such issues as relevant only to the most marginalized among us. Anthropologists are only beginning to study the consequences for those who fit neither extreme of privilege nor marginalization, but take up the shifting, sometimes bewildering, ground between (Freeman 2000; Schein 2006; Cahill 2001; Krishnamurthy 2004). In a world imagined as consisting of ever-increasing transnational connections and cross-border movement, the story of Argentine doctors who lament the loss of international travel as part of their lives, and find themselves newly embedded and spatially constrained in relationship to economic crisis, offers an intriguing counterpoint to many analyses of mobility put forth in current ethnographies of transnationalism.

By opening up a space for doctors themselves to reflect on multiple “cultures of biomedicine,” this chapter also contributes to a body of literature concerned with the diverse ways in which biomedicine comes to be understood, practiced and consolidated in particular historical and cultural milieus (Kleinman 1988; Good 1995; Hahn & Gaines...
1985; Farquhar 1996; Cussins 1996; Taylor 2008; Lock 1993, 1998; Dumit 2004; Luhmann 2000; Irvy 2006, 2008). Specifically, I show how doctors in Buenos Aires identify notions of *craft* and *warmth* as that which sets apart a particularly “Latin” and Argentine biomedical approach, often described in direct contrast to the “cold” and “clinical” approaches they understand as typifying the United States. In addition to a warmer Latin approach, which relies on notions of *trust* rather than liability in configuring the relationship between patient and doctor, I argue that the notion of craft enables Argentine doctors to understand and perform their own biomedical expertise in a way that is distinctly counter to doctors of the Global North. It is doctors’ reliance on discourses of mastery of aesthetics, beauty, and the body, including the “taste” and “artistic” judgment mobilized in reshaping the bodies of foreign patients, that allows them to critique the “grotesque” aesthetics of U.S. surgeons, and counter their marginal position vis-à-vis the U.S. and European enterprise. By framing expertise as grounded in aesthetics, I argue that Argentine doctors are able to redefine the terrain of expertise through which they wish to be assessed, re-positioning themselves within the larger landscape of biomedical expertise as equal or superior to the cold, “tasteless” approach of doctors elsewhere.

Finally, underscoring those differences in biomedical culture highlighted by physicians themselves, I consider how their specific approach is further reproduced through material practice, including the conspicuous absence of documentation and legalistic paperwork collected as part of transnational patients’ files. This absence of material paper record-keeping is particularly striking in the context of Latin America, in which paper, and the bureaucracy it stands in for, often underwrites claims to modernity,
and, indeed, is often understood by anthropologists as a symbolic and material reference to aspirations of, and claims to, modernity (Giddens 1994; Power 1997). The absence of medical records and documentation, therefore, becomes a powerful – if entirely invisible – affront to bureaucracy and the cold and legalistic approach associated with biomedical cultures of the Global North.

I have organized the chapter as follows: First, I explore some of the contradictory ways that porteño cosmetic surgeons describe their own sense of medical expertise as situated within an imagined transnational community of cosmetic surgeons. I then look more closely at how the experience of expertise is paradoxically reinforced and destabilized by their participation in the medical tourism market. Next, by exploring discourses of “aesthetics” and “warmth,” I trace a few of the less obvious ways that doctors assert expertise – and even, perhaps, mobility itself - through cosmetic interventions on the bodies of transnational patients. Finally, by noting the dearth of paperwork in the treatment of transnational patients among some of the surgeons with whom I worked, I reflect on how such absence is understood in terms of an affect of trust between doctor and patient, in direct contrast to legalistic notions of documented liability and waiver. In considering together these various dimensions of expertise and marginality, I argue that surgeries performed by Argentine doctors on First World patients exceed the realm of mere biomedical intervention, but are also critical political interventions into the global hierarchy of biomedicine, serving as a grounds from which to critique a neoliberal marketplace which would position them as “cheap alternatives” to their First World counterparts.
**Porteño Cosmetic Surgeons and the Imagination of Transnational Medical Expertise**

I double-checked the address twice in my small, red notebook. This had to be it. Even though the brass plaque indicated my arrival at the locally-famous cosmetic surgery clinic, I was surprised that the “clinic” was actually a converted turn-of-the-century mansion. Buzzed through the front gate and perfunctorily kissed by a well-dressed receptionist, I was instructed to wait in the main seating area. I noted that the water cooler with paper cone cups looked strangely out of place within an otherwise gilded landscape of overstuffed couches, gold-framed mirrors, and most fantastic of all, a curving marble staircase punctuated with a single crystal chandelier. “This is a doctor’s office?” I jotted, underlining my own question in disbelief. Noting that the cornucopia of pamphlets and booklets spread across the center table were all written in Spanish, I wondered whether the clinic was oriented mainly toward local patients, perhaps just beginning to consider entering into the treatment of a foreign market. The only English I could see was printed on a handful of the dozens of framed certificates that hung so close to one another as to resemble wallpaper in the adjoining entryway. Taking a few quick jottings, I recorded the names of several well-respected U.S. Universities scattered within this sea of curling, ostentatious font. The size of the certificates seemed inversely proportioned to the brevity of the certification it signified, with near-poster sized prints standing in for plastic surgery “workshops” that lasted as few as three days. Gathered and arranged alongside dozens of local awards and forms of recognition, the embossed Harvard stood out against so much creamy white paper.
During my time in Buenos Aires, I had the opportunity to work with nearly twenty doctors; the majority were cosmetic surgeons, but also cardiologists, dentists and dental surgeons. All of these doctors were, in various ways, entering into a newly emerging market in medical tourism. Some of these encounters were limited to a few in-office interviews with the surgeons and key staff members, while others extended over many months, as doctors encouraged me to borrow their books, gave me their research papers, performed slide-show presentations they had perfected for conferences, encouraged me to sit in on consultations with patients and even observe their surgical teams as they performed surgery. These men (and they were all men save for one dentist) were generous with their time, and for a U.S. researcher, almost shockingly unguarded with their comments. Most of our conversations happened within the space of their offices, with a few conversations occurring elsewhere: afternoon coffee in a local café, a brother and sister dental team joining us at a Palermo bar to celebrate the departure of one of their favorite patients, a cardiologist whose house visits included pre-operative exams and long chats in the living room.

Yet, in other ways, even my conversations with doctors in the space of their offices opened up their personal lives to me in ways I had not anticipated. In addition to the professional materials mentioned above, I was regularly shown photographs of wives, children, and grandchildren, and on more than one occasion, asked my opinion of the various objects of art that the doctors crafted as a hobby. Most strikingly, in our conversations about why they chose to become cosmetics surgeons, many told long, engaging stories detailing their childhood, parents and grandparents; trips abroad to Europe and the United States as young residents; and the accompanying excitement of
seeing the world, meeting “girls,” and excelling at their chosen art. As I explore below, it was not until looking back on my notes from these conversations that I began to understand that such highly-detailed narratives were also subtle and meaningful avenues for doctors to reflect on much more than their own history, and instead reflect more broadly on their place in biomedicine, Argentina, and the world.

**Surgical Folktales: The Life and Death of Favaloro**

Asking cosmetic surgeons to share the story of how they became surgeons, a thread emerged across many of these conversations: the story of Dr. René Gerónimo Favaloro. More often than not, I would sit down to begin an interview with a surgeon and, within the first few minutes, he would invoke the name *Favaloro* with an air of palpable reverence. Although I dutifully jotted this name into the margins of my notes and asked a few brief questions, it did not occur to me at that time to dig more deeply for details about this omnipresent figure. It seemed sufficient to know that he became famous throughout the world in 1967, when he was the first person to perform a myocardial revascularization (coronary bypass) surgery. At the time, I interpreted the invocation of his greatness as shorthand for speaking of the excellence of Argentine biomedicine more generally. Only after having returned from the field did I learn more about Argentina’s most famous cardiovascular surgeon, and the conditions that provoked his tragically symbolic form of suicide in 2000: shooting himself in the *heart*.

Mythic in its themes of hardship and transcendence, the story of Favaloro’s life begins with his birth in 1923 in *La Plata*, a city just south of Buenos Aires, which at the time, was nothing more than a dusty, rural town (Captor 2004). The grandson of Italian immigrants, Favaloro’s father worked as a cabinetmaker, his mother as a dressmaker. He
graduated from the University of La Plata’s School for Medical Science at the top of his class with the title of Doctor in Medicine in 1948, and quickly began his surgical postgraduate training in Buenos Aires. His political affiliations and staunch anti-Peronist stance, however, forced him to resign a hospital post that required he sign a political declaration supporting the “national doctrine.” Later, under the advice of his mentor, he decided to pursue further training in cardiac surgery at the Cleveland Clinic in the United States. Legend has it, that after hearing no response to his repeated postal inquiries, Favaloro traveled unannounced from Buenos Aires to Cleveland, explaining the purpose of his trip in broken English. Eventually, Cleveland’s supervising researchers allowed him to take on the position of an observer, and after a lengthy bureaucratic process, he began working as a resident in training.

Like many of the Argentine surgeons with whom I worked, time spent in the United States or Europe as part of residencies was presented as the most prestigious route for accessing the level of training and experiences they desired, opportunities that would not be available to them at home. However, such displacements have profound effects. In the case of Favaloro, the myocardial revascularization surgery for which he became world-famous was not originally performed in his home country, but while in residency in Cleveland. Also like many of the surgeons with whom I worked, he did not remain in the United States following his initial training – despite the significant potential for greater pay and professional opportunities. Instead, Favaloro returned to Argentina in 1971, founding the Universidad Favaloro as part of a larger effort to replicate the model of biomedical research found at the Cleveland Clinic. The recipient of much
international acclaim, he was so well known in Argentina that his name was regularly circulated as a possible candidate for the presidency.\textsuperscript{19}

However, perhaps the reason Favaloro’s story seems to serve as such a powerful parable for so many of the surgeons with whom I worked is that despite his great accomplishments and international renown, his life would end in tragedy by virtue of his constraint within Argentina. In 2000, in the midst of Argentina’s economic and political crisis, Favaloro’s foundation was reported to be in debt more than US $75 million dollars. This “debt,” as an indicator of personal failure, however, was misleading, as it was largely a result of not being adequately compensated by the Argentine state for health services it had provided. In a climate of national economic crisis, austerity and social unrest, the Argentine government launched a lawsuit against the foundation for unpaid social security taxes. On July 29, 2000 Favaloro committed suicide by shooting himself in the heart, sparking a national period of grieving in which numerous media outlets openly criticized the way in which the country’s most talented citizens were undone by a reckless and unreliable state (Nagourney 2000). For the surgeons I worked with, many of whom were at that time experiencing their own practices erode as a result of the national economic crisis, the tragic tale of Favaloro seemed all the more poignant. Repeatedly appearing within my many conversations, I believe it is through the lens of this powerful story of international recognition, national constraint, and the double-tragedy of a nation and surgeon in crisis, that one can begin to understand Argentine doctors reflections on their place within the global landscape of biomedicine.
Dr. Babor, like many of the doctors I worked with, reflected at some length about the difference between being a surgeon in Argentina as compared to the United States or Europe. Lola (the medical tourism coordinator discussed in Chapter One) had first introduced me to Dr. Babor, meeting me at his office in the *Vicente Lopez* suburb of Buenos Aires. A distinguished looking man with salt-and-pepper-hair, he often wore his white coat as he relaxed in his office sipping a steaming *café cortado* during our chats. The office itself served as a sort of material testimony to his professional success, even if somehow arrested in an earlier era. The center of gravity of the room was a rich, brown oak desk, complete with a metallic and mesh intercom that crackled with the voice of his receptionist alerting him to arriving patients. Under foot, one felt the plush give of the royal-blue carpet, and the walls embellished with ornately framed oil paintings he himself had created. Patients were scheduled around his vacations, which were up to a month long, and his afternoon schedule regularly included leisurely coffee breaks and ample time to chat with Lola or the nurses.

The *Vicente Lopez* location itself indicated his success, his practice occupying a prime block in a peaceful, elite neighborhood about thirty minutes by train from downtown Buenos Aires. The small, residential area sits on top of a hill nestled between the commuter rail tracks and a commercial avenue, made up of overwhelmingly beautiful tree-lined blocks and large stucco walls protecting the homes behind them. Walking through the neighborhood, I was taken with the sensation that I had been momentarily transported to the hilly streets of an exclusive San Francisco neighborhood, except that in *Vicente Lopez* the corner of most blocks also had a small guardhouse in which private
security maintained vigilant surveillance, a practice increasingly common in many middle and upper-class neighborhoods throughout Latin America (Caldeira 2000). And yet, while Dr. Babor’s office may have been an ideal location for porteño patients who could easily recognize and enjoy its exclusive address, the space was far more bewildering for the transnational patients who visited him there. Without sufficient familiarity with the city to take the commuter rail (which cost approximately U.S. thirty cents), transnational patients were required to hire a comparatively costly taxi to an area of the “greater” city that was clearly, and even suspiciously, removed from the tourist zones.

It was during one of our afternoon chats that Dr. Babor first told me that being a surgeon in Argentina is not the same as being a surgeon in Europe or the United States. “Even if you are very good,” he explained, “there are limitations.” This striking comment emerged as part of a longer conversation in which I had asked him to reflect on differences between medicine in Argentina and other parts of the world. Interestingly, he began not with a comparison, but by establishing himself as a mobile, cosmopolitan subject, offering up evidence of international travel and training, as well as referring directly to his German heritage. In a statement that seemed to disavow himself of something called an “Argentine” identity, he explained, “both of my parents were born in Germany…I spoke German and French before I learned Spanish!” He confirmed the importance of such European roots more generally, explaining, “It is like that here…no one ever says, I am Argentine.” As he vividly recounted medical training trips he had undertaken to France, the Netherlands and Spain decades before, it became clear that Dr. Babor not only held these journeys up as evidence of a worldly self, but that such travel
also connected to his understanding of the ways in which his surgical skills mapped onto a broader, international context.

Expanding from his personal experiences, he clearly saw Argentine medicine as occupying a special status in transnational professional circles. “[Doctors in Europe] would always say *there are so many of you here!*” he recounted, smiling widely at this memory. As if to make sure I understood the significance of this statement, he clarified that Argentina is known for having surgeons with “excellent training,” and similar to the surgical training expectations of the United States: “our surgeons *practice* …our training involves a lot of *doing*, not just *studying* the *idea* of surgery as is the Continental tradition.” As this last statement indicates, Dr. Babor was not only comfortable locating himself within a larger, professional sphere, but he was also ready to offer his assessment of various biomedical traditions, praising the practice-based approaches found in Argentina and the United States, above the more theory-oriented scholarship traditions he identified throughout other parts of Europe, and in particular France.

Dr. Babor’s international travel and training was not unusual among the surgeons with whom I worked, and many happily remembered such experiences. I was repeatedly asked, for example, to closely inspect framed, gold-sealed certificates hanging on their walls, indicating training workshops at prestigious institutions throughout the United States and Europe. I was told of doctors’ passion for cities such as San Francisco and Paris, or why the climate of Boston was uninhabitable during the winter. And yet, while doctors such as Dr. Babor clearly ranked their own training favorably within this imagined landscape of biomedical expertise, such reflections were also commonly accompanied by a counter-narrative lamenting the ways in which expertise remained
limited within the confines of Argentina. For every gold-sealed certificate on the wall, there were also expressed frustrations: the lack of nationally funded scientific grants, the crumbling infrastructure of public hospitals, and the bias of international medical journals toward publishing scholars located in the universities of the Global North. Moreover, especially among the more established surgeons with whom I worked, the narratives mobilized to assert cosmopolitan forms of expertise seemed decidedly tinged with nostalgia, and involved past glories of travel and training extending back one, two or three decades into the past.

When I asked Dr. Babor, for example, about the last conference he attended outside of Argentina, he responded with a dismissive wave of the hand and a vague indication that it had been a few years. While the amount of current international travel varied among the doctors with whom I worked, it is no surprise that international travel, whether for pleasure or in order to participate in the “most prestigious” medical conferences held in the United States and Europe, was limited by the devalued peso. Such memories indicated that a strong currency – and later, dollar parity – meant that even a doctor of modest success would have most likely been able to finance occasional trips. It was still a fairly recent event that such international travel, that such movement, would no longer be accessible in the same ways. Both in terms of the limitations of Argentine medicine, as well as the economic constraints on circulating within a broader biomedical community, doctors expressed what I came to recognize as a particular sensation of confinement: confinement both as being embedded in place, but also, limited in the degree to which one’s own talent and intelligence could be transformed into professional success.
Often, it was only after our initial conversations in which such tales of cosmopolitan greatness had been thoroughly performed, that many of the cosmetic surgeons revealed to me the ways in which their professional aspirations and economic opportunities within medicine had been curtailed by virtue of remaining in Argentina. As Dr. Zirlinger told me during one of our conversations in his office, “doctors in the U.S. can afford nice things. In Argentina, our lives are not extravagant. I live in a normal apartment. I drive a very normal car.” Shifting focus to professional opportunities, Dr. Zirlinger added:

I could go to the U.S. and be much more successful, a well-known surgeon… given my level of experience, my record of publishing, if I were to have the same post I have at the University of Buenos Aires at an institution in the United States, my career would be very different.

Translating expertise across diverse contexts, however, is not so straightforward. The two major forms of symbolic capital available to doctors – publishing and conference presentations--are tied to politics beyond the virtue of having a good idea or the development of a novel surgical technique. “In this country I am very well known, but to publish in English … it takes a lot more effort,” Dr. Zirlinger began. “I know English … I can write English, but it is not the same as for doctors with English as their first language.” While Argentina, and Latin America more generally, has its own thriving market of academic medical journals, there is still an acute “we read theirs, but they don’t read ours” sentiment about how such texts may circulate in a broader context. The politics of publication are certainly not new; Argentine doctors always had to express their findings and claims to expertise in languages other than Spanish in order to gain wider, international circulation. Pairing these limitations, however, with the increasing difficulty in participating in other forms of the symbolic exchange of expertise – such as
participation in international conferences and training workshops – seems to compound the sense of confinement.

That the crisis and devaluation of the peso has exacerbated doctors’ sense of confinement within Argentina is even more poignant when one considers that it is also the crisis itself that has enabled a burgeoning market in medical tourism to grow in Buenos Aires. Put differently, it is at the precise moment of decreased mobility for surgeons in Buenos Aires that they find themselves treating hyper-mobile transnational patients. This intersection of stasis and hyper-mobility proved to be challenging for the doctors I worked with, often forcing an uncomfortable reassessment of their place in the global landscape of biomedicine. No longer neatly fitting the ideal of the cosmopolitan surgeon, Argentine doctors suddenly found themselves being marketed as a “bargain” surgeon or a “cheap” alternative for patients who could not afford the services of First World doctors.

“Only now they come because it is cheap for them…”: Medical Tourism Emerging Out of Crisis

As discussed in Chapter Two, the effects of the 2000/2001 economic crisis in Argentina were both serious and widespread. While many doctors did not face the same degree of hardship experienced within others sectors of the economy, physicians expressed the contradictory ways in which the crisis had affected their ability to practice medicine within the local market. It was difficult for me to access precise data on how the crisis had affected their practice. Often, when asked to provide estimates of their income, doctors would stiffen or offer me vague answers. Explaining that rather than needing exact figures, I was trying to assess the impact of the crisis on their medical practice, a few opened up with anecdotal stories. While the effects of the crisis have been
experienced unevenly, the crisis generally led to loss of income as local patients scaled back on expenses. In some cases, the crisis was felt so acutely that it motivated more dramatic changes, such as in the case of Dr. Pelcman, a cosmetic dental surgeon with a now thriving practice on Avenida Santa Fe:

After 2001, things were such a mess that we went to California. I became licensed there…many Argentine people were moving at that time. We lived for a while in San Francisco and also Los Angeles…but after some time, we decided to come back home [to Buenos Aires].

Counter-intuitively, a handful of doctors I worked with seemed to see the opposite effect: a number of local patients, they hypothesized, turned to “investing” in the relatively secure space of the body, and underwent additional cosmetic procedures, a theme I also explore in relationship to U.S. patients in the following chapter. As a cosmetic surgeon named Dr. Martin clarified, “after the crisis, I had more patients coming – both from Buenos Aires, and more from overseas.”

Abundantly clear, however, is that all of the doctors I interviewed agreed that the dramatic scaling up of the “medical tourism” industry, and the influx of foreign patients from abroad, was clearly linked to the crisis and the depreciation of the peso. As Dr. Martin stated:

Without a doubt people come for surgery because of the crisis… before, there was no motivation…only now they come because it is cheap for them.

As I asked each surgeon to walk me through the timeline of when they began treating foreign patients, the vast majority of them recalled having treated transnational patients prior to 2001. Yet they were careful to specify that many of these transnational patients were Argentines returning from living abroad, often coming to spend time with family and undergoing healthcare procedures as part of these trips. More rarely, doctors
also mentioned patients from nearby countries within Latin America (especially Mexico and Chile) coming to Argentina, ostensibly because of the reputation for excellent cosmetic surgery. As one surgeon I worked with explained of his entry into the market:

I started the website in English...in 2003, I think... to be visible outside of Argentina. I heard about medical tourism on the radio, and thought, okay. If you know something about the socioeconomic conditions of this country, then it makes sense...because we have a very prestigious medical system, but for you... (leaning back in his chair with a mocking smiling)...it is very cheap.

Given that medical tourism discourses describe medical tourists as an unmitigated gain to Third World doctors, it is important to consider the contradictory ways in which their presence as patients was felt. When asked to reflect on the benefits of transnational patients, many surgeons mentioned the importance of increased numbers of patients to their practices. Yet, when I turned our discussions directly to the topic of income, the conversations became highly charged and sometimes uncomfortable. Perhaps it is not surprising that given the presence of a researcher most surgeons would claim that they did not raise prices for foreign patients, even openly bristling at the suggestion. Rather, many insisted that local prices were comparatively “inexpensive” (or sometimes they invoked the self-mocking word “cheap”) to foreigners in comparison to prices in their home countries, with inexpensive rates maintained at such levels as part of attracting foreign patients from overseas.

However, more specific information on the economics of these practices was hard to come by. As one famous cosmetic surgeon curtly explained as I tried to pursue this line of questioning, “this is not a question for a doctor.” He instructed me instead to see his office manager in order to discuss anything related to the pricing of surgery, promising that there was a price list that could be accessed. Such a list, however, never
appeared, and the manager instead, offered me only a few vague estimates. I observed this same practice over and over again, as doctors repeatedly referred me (or the patients I accompanied) to other office staff in order to discuss the financial details of the procedures. Conversations about pricing were held between office staff and patients, symbolically separated from the space of the doctor’s consultation room.\textsuperscript{22} That the particular topic of price was treated as a taboo by the surgeons with whom I worked directly contradicts the ways in which they are produced as subjects of a medical tourism industry, their value as surgeons over-determined by discourses of “cost” and their relative “cheapness” to foreign patients.

While it proved difficult for me to gather numerical data on the impact of the crisis on doctors’ incomes, or what role medical tourism was playing as part of the recovery of their practices, anecdotally, surgeons repeatedly emphasized the value of foreign patients to their practice, expressed the desire to continue to attract increasing numbers of overseas patients, and, without exception, attributed the growth in such a market to the 2000/2001 crisis. The limits of medical tourism as a response to the crisis, however, were also clear. When I asked Dr. Pelcman to comment on whether he thought “medical tourism” would become a major source of revenue for Argentina, as economists such as Bookman Bookman (2007) predict of medical tourism in “developing countries” more generally, he quickly disregarded the suggestion, “no, no, no…this is not a big thing…(adding sarcastically), in Argentina…we have cows also, you know.”

**Man vs. Machine: Credit, Crisis and Technology in Argentine Surgical Practice**

One very practical concern for doctors in attracting foreign patients was their ability to obtain the kinds of new technologies and equipment-based procedures that
patients seek, or that would quickly signal their practice as being on the “cutting edge” of surgical practice. As one doctor explained, while physicians in Europe and the United States can purchase new technological equipment on credit (e.g. laser-based liposuction equipment), Argentine doctors are unable to do so because there is not a similar extension of credit and they lack sufficient capital to pay for such large up-front costs. This lack of credit reflects broader trends of credit and cash use, including increased caution in using credit following the 2000/2001 crisis, during which time credit card debts remained in U.S. dollars even as the pesos people used to pay down these debts were suddenly worth one-third or less of their original value. According to several of the physicians with whom I worked, investing in a new piece of equipment requires that doctors pay for at least half or more of the machine up front and often in cash, with monthly payments thereafter.

While some foreign patients inquired about these kinds of technologies, surgeons were able to counter such requests in several ways. Most obviously, the “latest generation” of laser therapies and other minimally-invasive laser-based procedures are not usually effective methods of treating foreign patients as they require multiple visits made over the course of two or three months. More interestingly, the inability to purchase the latest technology was reinterpreted by surgeons not as a sign of their inferior biomedical competence, but rather, precisely a positive sign of their personal surgical expertise. I watched one surgeon deftly handle an inquiry from an aggressively questioning patient on whether or not he – or any surgeon he knew – offered a laser-based therapy called SmartLipo. “SmartLipo?” he asked in an exaggeratedly mocking tone, “how can a machine be smart? No, you do not want the machine to be smart…you
want the surgeon to be smart.” In relocating the focus of expertise to the surgeon’s own body and skill, he was effectively able to redirect her attention away from her assessment of what he lacked towards his expertise built over years of surgical practice. Even in a context of limitation, I heard doctors repeatedly invoke a supposed Argentine quality of “creativity” or “making do.” That is, they saw a particular kind of ingenuity emerge from constraint, whereas they perceived doctors of the Global North becoming “lazy” or lacking in creativity and skill precisely because of the abundance of resources to which they have grown accustomed.

Interestingly, multinational corporations offering the latest generation of laser-based equipment do not sell their products at fixed prices, but rather take into account global disparities in national economies when determining their pricing structure. For example, I attended an upscale steak-and-wine dinner at a well-known country club hosted by an Israeli-based multinational company that markets a laser aesthetic surgery technology called UltraShape. As the young medical residents with whom I sat rushed to the dance floor for an evening of malbec-fueled fun, I was left to chat with the Latin American regional marketer. Originally from Texas - and obviously happy to be chatting with a fellow North American - he admitted to me in a hushed voice that he knew the equipment he was selling was “very expensive” by local standards. As a result, he explained, the company had decided to price the machines “several thousands” of dollars less when they sold in Argentina versus throughout the United States and Europe. Whether or not this enabled Argentine doctors to purchase such technology with their devalued pesos, it certainly signals an awareness within this multinational corporation of the contours of economic inequality that saturate the global market in biomedicine.
More immediately relevant to the medical tourism industry was the example of prosthetic teeth told to me by several cosmetic dental surgeons. Doctors in Argentina were charged hundreds of dollars less per implant than their counterparts in the United States, despite the fact that all doctors purchase the implants directly from their German manufacturer. These pricing differentials offer additional evidence of the global inequality of resources differentially positioning surgeons in the Global North and Global South, further reinforcing the insights the doctors provided. While these adjustments to pricing structures could seem to “level” the global biomedical “playing field” in some respects, the vast majority of structural inequalities experienced by doctors remain unaffected by such nominal “discounts,” access to research grants, public hospital infrastructure, or the ability to participate in international conferences due to a comparatively weak currency.

In a particularly ironic material artifact of this disconnect, our “gift” from the company that evening was a luxurious leather airline ticket and passport holder with the UltraShape logo stamped into the lower-right corner. On one level, one might question whether the very materiality of the gift, stamped “Genuine Leather,” conveyed the same sense of symbolic luxury that it might elsewhere in the world, as leather is an everyday material of Argentina, a commonplace artifact of a long history and continued importance of the Argentine beef industry to the nation. Secondly, just as the technology advertised through the gift remained largely inaccessible, so the passport holder itself seemed a somewhat thoughtless token in a context of a reduced mobility and often-lamented post-crisis constraint. As the gift itself revealed, even as doctors participated in this prestigious event hosted by a multi-national biomedical company, so too did there remain
an ever-present contradiction between the possibilities and realities of their participation in this global market.

The Paradox of Participation in an Emerging “Medical Tourism” Market: Surgeons’ experiences of embeddedness within transnationalism

While the literature on medical tourism is small, it is perhaps still surprising how little of it addresses the experiences of doctors as they endeavor to market their expertise within a global market that has rendered their services “cheap” or “affordable” alternatives. While scholars of globalization and neoliberalism are comfortable addressing outsourcing as it affects poor workers (for example, the extensive work on maquiladoras), only more recently has the focus also included highly-educated workers providing “highly-skilled” labor for companies undertaking transnational outsourcing. Additionally, the case of medical tourism currently differs from traditional outsourcing models. Most critically, current ways of thinking about transnational healthcare imagine the global circulation of patient bodies as an unmitigated gain for surgeons of the Global South: U.S. and European patients are thought to be comparatively wealthier than local patients, bringing valuable business and resources to local markets.

Yet, the more complex, double-edged nature of treating transnational patients soon became apparent, with participation in an emerging medical tourism market often producing contradictory meanings for the doctors with whom I worked. On the one hand, building a thriving practice in foreign, transnational patients seemed to be a point of prestige among colleagues. Several surgeons commented that foreign patients travel to Argentina because they knew of the excellent reputation of the country for cosmetic surgery or the exceptional quality of medical professionals. In some ways, this reflects the earlier discussion of how Argentine doctors imagined their expertise as fitting into the
global landscape of biomedicine. Many were clearly secure in their own expertise and competent training, and were able to imagine that this stellar reputation circulated widely among both doctors and patients beyond Argentina. While my research did not assess how U.S. and European doctors perceive Argentine medical expertise (or if they even think of it at all), among the patients I worked with, knowledge of “Argentine excellence” in medicine was often something cultivated only after the process of searching for a surgeon had begun, as I explore further in the following chapter. At other moments, the doctors I worked with contradicted these earlier statements, emphasizing instead the devaluation of the peso, and the lack of prior knowledge of medical excellence, motivating patients to seek out their services.

When asked to reflect on why there had been a sudden emergence of a medical tourism industry within Argentina, surgeons often used a political-economic explanatory framework that understood such travel as a direct outcome of the devaluation of the peso, and thus the differential economy produced between Argentina and those in the Global North. Some even bristled as they explained that their services were “cheaper” than what patients would be required to pay in their home countries. With an exaggerated sense of candor, Dr. Filinich explained to me, “I know that people aren’t flying all this way just because I’m the best surgeon . . . they are coming here because we are cheap.” This assessment seems especially true in light of the fact that patients do not meet face-to-face with their doctors (and thus cannot fully assess/appreciate their qualifications) until long after they have made the decision to fly to Argentina for surgery.

While at first glance the act of treating foreign patients has the potential to lend an aura of prestige to doctors’ reputations, as well as more broadly bolster the reputation of
Argentine medicine, the actual experience of treating foreign patients is far more complex. Directly contradicting a heightened sense of prestige are precisely the conditions that motivate foreigners to travel for surgery, compelling Argentine surgeons to reflect upon their positioning as “cheap alternatives” to First World doctors. Doctors are put in the unenviable position of selling their services at bargain prices as a “value” option in relation to those available in the United States, even as such discourses ultimately devalue their expertise as less than that of surgeons practicing in other countries. One older surgeon explained the situation in this way,

“I know I am a very skilled surgeon…but I do not pretend that the patients can know this while they are in Boston or New York…I can hope that they will come here, and when they leave, they will have a whole new perspective on Argentina.”

While doctors continuously asserted their expertise as equal (and even superior) to that of surgeons in other countries, these discussions also indicated the degree to which they understood their own ambitions and skills circumscribed by an unjust distribution of scientific resources and infrastructure as part of a global hierarchy of biomedicine.

This “double-edged” nature of treating transnational patients reveals the ways in which Argentine doctors are intensely aware of how their reputation is understood as part of the larger, global biomedical landscape. As explored above, they articulate an acute sense of marginalization, in which doctors’ own sense of excellence is constrained by virtue of their location within a Third World country with limited institutional and infrastructural support resources. Such self-positioning, I argue, does not merely draw attention to their peripheral status, but also serves as an active critique of a particular political and economic hierarchy of medicine in which expertise is distributed along the lines of larger economic and political inequalities of power. And yet, surgeons also
ultimately reproduced inequalities of power as part of claiming expertise and prestige, by for example, contrasting their “elite” Argentine patients with the “not-so-elite” patients who traveled from the Global North.

Most importantly, the surgeons I worked with did not stop at simply pointing out the differences in opportunity and constraint as part of a global biomedical landscape. Rather, they actively asserted and described expertise as a *craft*, one that emerged from within a context of limitations requiring the cultivation of skill areas in which they understood themselves as equal or superior to surgeons of the Global North. By claiming particular expertise in the realm of *aesthetics* and *warmth*, many of the surgeons I worked with reconstituted their expertise as part of what makes their care superior – even if cheaper- than their First World counterparts.

**Crafting Expertise/Circulating Beauty: Aesthetics, Taste, and Bodies that Travel**

Thus, where technological advances and institutional resources were lacking, a notion of craft and aesthetics emerged as an important source of pride and biomedical authority. Dr. Babor argued that in contrast to the Continental, overly-theoretical approach to medicine found in Europe, or the *cold*, legalistic approach of the United States, Argentine plastic surgery was a *craft* – something that must be practiced and experienced for years in order to get a sense of how to do it correctly. As he explained:

Plastic surgery is like painting: you have to have a feeling of what is good…it is not only putting something inside – making the breast bigger. I think that plastic surgeons must have an artist’s eye in what they do – because you need an imagination…especially an imagination of what is beauty… because it is difficult to define beauty.

Ethnographically tracking how the surgeons with whom I worked imagined and defined beauty is a tricky undertaking. If there is one area of biomedical intervention in which it
is most possible to attribute – or even expect – something along the lines of “cultural difference,” cosmetic surgery would be that field. Popular media accounts have honed in on cultural differences in aesthetic preferences, focusing attention on the “Asian” double-eyelid surgery, or more recently, on the ways in which patients in “ethnic enclaves” of New York City seek out distinct body enhancing procedures, such as earlobe injections among the Chinese, breast enlargement for recent immigrants from Russia, and “Hispanic” women seeking curvy bodies that do not fit the norms of white, thin ideals (“Ethnic Differences in Plastic Surgery” New York Times, February 18, 2011).

Yet, the specificity of these surgery-seeking practices is obviously far more complex than conveyed in popular media, where the term “Hispanic” is used to gloss the desires of woman from the Dominican Republic to maintain a “curvy” body through breast implants, but fails to mention the vast diversity of nationalities, as well as racial, class and beauty subjectivities collapsed within the term. Also left unexplored are the ways in which ideals such as “curvy” may reflect notions of a racialized femininity that is part of, not radically distinct from, images of white beauty that have circulated from colonial-era casta paintings through modern globally televised beauty pageants (Loren 2007; Katzew 2005; Rogers 1998; Reisher 2004). Anthropologists have published a small literature on the topic of the cultural specificity of cosmetic surgery, exploring, for example, double-eyelid surgery among Asians-Americans (Kaw 1993), and the practices of working class Brazilians to access free or heavily discounted plastica in public hospitals in Brazil (Edmonds 2007, 2011). As Edmonds points out in his nuanced treatment of this topic, it is insufficient to merely search for cultural differences in aesthetic desires, in so far as desire and body modification must be understood as part of
a far more complex nexus that brings together historically particular gender ideals, notions of beauty and racial passing and authenticity, as well as the value of beauty as a form of social mobility in neoliberal economic landscapes (Edmonds 2007). What has remained largely unexplored in this research, however, is the role of cosmetic surgeons in “defining” the ways in which patients’ bodies are made more “beautiful,” and how the notions of beauty espoused by surgeons are themselves culturally and historically contingent.

Turning to the role of the cosmetic surgeon in deciding how bodies “become beautiful” opens up a series of difficult questions, only some of which my research begins to answer. For example, in what ways are the notions of beauty invoked by the surgeons I worked with imagined by them to be “Argentinean” or “porteño” in their orientation? How could the Argentine sense of beauty to which they often referred be untangled from powerful forces including the legacy of European occupation, or how Argentina is imagined to be an exceptional space within a “darker” and more “indigenous” Latin American continent?

Understanding the purposefully generic images of “Hispanic Beauty” circulated across the Americas, often after being designed in the United States for a perceived Mexican-American audience (Davila 2001), is helpful in answering such questions. If the stereotype of “Latina Beauty” is curvaceous, Buenos Aires would seem to offer a counter example, evident not only in the physiques of the extremely thin women participating in a locally thriving fashion industry, but also the city’s popularity as a location for studying the cultural specificity of anorexia nervosa and other eating disorders (Miller & Pumariega 2001). Moreover, in a city with enduring and highly-
visited monuments to political icons of the past, how is beauty understood in relationship to the specter of the blonde, fair-skinned, fashionable “Evita” Peron, and how is this image read alongside the long, flowing cinnamon-colored hair, brightly painted nails, and (most likely) medically enhanced lips of hyper-feminine President Cristina Kirchner? How would one begin to locate cosmetic surgeons’ ideas of beauty within this intricate aesthetic landscape? While any sufficient response would require additional fieldwork and archival research with this particular question in mind, I want to point to some of the partial glimpses I observed into these processes, with the aim of highlighting the particular ways in which doctors invoked aesthetics, and the ability to define beauty as a form of biomedical expertise.

Early on in my research, I was chatting with a surgeon about why he thought patients came to Buenos Aires for surgery. After he had listed the most obvious reasons, including the prices of surgery and the reputation of the surgeons, he offered up the following reason, “I think one of the reasons that people come here for cosmetic surgery is that patients (gesturing to me)…and doctors (gesturing at his own face)…we share a similar European aesthetic.” As a white, blue-eyed, blonde haired man, I interpreted his words to also point to a shared white aesthetic.

That whiteness was at least part of the aesthetic created by cosmetic surgeons was also evident in a story told to me by one of the patients with whom I worked. Shelly was a Black motivational speaker, living in the greater Boston area who had decided to travel to Buenos Aires for eyelid surgery. While still in the early stages of selecting a doctor, Shelly had corresponded with several surgeons by email, and after a series exchanges, sent a set of pictures so that the surgeon could more closely examine what she perceived
as the drooping skin around her eyes. One Argentine surgeon wrote her back an enthusiastically polite email, informing her that he thought she was a good candidate for the eye surgery, and that he also thought she would benefit from a surgery intended to reduce the width and refine her nose. As Edmonds (2007) and Gilman (2000) have shown, the nose has been a symbolically potent site for coding “African-ness,” and as Edmonds witnesses in modern-day Brazil, surgeons still practice a cosmetic surgery called the “correction of the Negroid nose” (Edmonds 2007:347). Ultimately, she decided to work with a different surgeon.

Another site in trying to understand the particular aesthetic that doctors’ used to imagine and define beauty is a book published by one of the cosmetic surgeons I worked with, Dr. Patricio Jacovella. En el Consutorio de Cirugia Plastica: Todo lo que necesita saber para decidirse (“In the Plastic Surgeon’s Office: Everything You Need to Know to Decide) is written for a local lay audience considering various plastic surgery treatments and is intended to educate potential patients about courses of treatment, outcomes and recovery. In addition to outlining the most popular surgeries, it also offers an intriguing set of line sketches that Dr. Jacovella himself has rendered to make the possible changes clear. Taken alongside the many before and after photos that doctors displayed for me, these drawings offer some visual insight into some of the more common ways in which cosmetic surgeons in Argentina imagine and define beauty.
Breast lift and reduction reflects particular aesthetics of breasts that doctors identify in contrast to U.S. Models.

European aesthetic serving as standard for face proportions
Dr. Jacovella, who also uses the image of a peach skinned mannequin on the cover of his book, is clearly invoking patterns of beauty that would be more closely aligned with notions of whiteness and European ideals, than, for example, facial shapes or hair and skin shades identified with either an indigenous or Afro-Argentine aesthetic within Latin America. While perhaps less recognizable than facial shape or hair and skin coloring, breast shape has also long been used as a racial marker. As the historical work of Sander Gilman (2000) shows, the breast often functions as a racial sign. It was, in fact, breast reduction that was the preferred surgical alteration of breast tissue in nineteenth and early twentieth century Europe as it was seen as moving away from an aesthetic associated with the more “pendulous breasts of African and Jewish women” (Gilman 2000:223). While Gilman’s historical work reveals how breasts served as a racial marker during a time of explicit colonial occupation and the uses of bodily aesthetics to clearly demarcate between the bodies of people to be dominated and those of the “civilized,” he does not read his analysis onto a current landscape of surgical bodily modification. Extending Gilman, several complex dynamics emerge in reading the preferred “smaller” breast size visually rendered by Dr. Jacovella, and, as I explore below, expressed by Dr. Babor.

The above images become particularly revealing when read alongside a conversation I had with Dr. Babor, in which he compared the Argentine aesthetic common to cosmetic surgeons to that of the United States. By understanding aesthetics within the realm of taste and judgment following Bourdieu (1984), I argue, Dr. Babor’s specific vision of beauty can also be understood as a language in which he is able to affirm his own biomedical expertise, as well as critique the biomedical expertise of
surgeons in the United States and elsewhere. “Cosmetic surgeons in the U.S. . . . ,” he began, “I cannot take them seriously when I see these surgeries . . . One thing is big breasts—another thing is that they look like—like cow udders” he sputtered, his face contorting into a grimace of disgust.

Although his assessment of U.S. doctors could be dismissed simply as a colorful, inflammatory comment, we might also take seriously his invocation of the ways in which a lack of aesthetic judgment leads U.S. doctors to use biomedical skills in order to render women’s bodies within the realm of the non-human and grotesque. Here, moving beyond Gilman’s analysis, we see a complex echo where one could simultaneously read Dr. Babor’s expressed preference for smaller breast implants as adhering to an earlier distinction between smaller “European” breasts as historically contrasted to larger “ethnic” breasts, while at the same time, the preference for smaller “more serious” Argentine breast shape is contrasted to the stereotype of the overly-exaggerated, hyper-artificial breast implants preferred by U.S. women (or, more precisely in this view, the U.S. surgeons who treat them).

Through the small opening this comment offers into something we could describe as an Argentine aesthetic, it is possible to see a complex picture that extends beyond a simple preference for whiteness. Rather, there are multiple “others” circulating in the production of the ideally beautiful body, including, but not limited to, the imagined “dark and short” indigenous Latin America landscape (Leys-Stepan 1991) in which “European” Buenos Aires is located, and further North, an exaggerated, grotesque form of whiteness that is also, somehow, not civilized enough. Simultaneously, Dr. Babor’s critique of the American-style of breast implant can also be interpreted as a disruption to the established
hierarchy of global biomedicine: although U.S. cosmetic surgeons may occupy a superior position in relation to the wealth and resources of the biomedical enterprise, without sufficient aesthetic judgment, they become inexpert, inept, and perhaps even dangerous. It is also important to point out that in his assessment, of course, Dr. Babor does not attribute the preference for large breasts to U.S. women themselves, but rather U.S. cosmetic surgeons whom he maligns for enabling the transformation of human bodies into a near-animal, and perhaps even racially-othered, state.23

It is noteworthy that both of his claims – to his own expertise as well as to the limitations of the expertise of surgeons in the Global North – are articulated within the language of beauty. In a global biomedical landscape in which the resources of scientific grants and technological innovations become concentrated in the hands of few, transforming the bodies of First World patients through the definition of beauty held by marginalized doctors is a medium for staking such claims to expertise. Moreover, Dr. Babor’s assessment of the ability of his vision of beauty to translate across a variety of contexts speaks to the power of his aesthetic, and thus, his expertise. As Dr. Babor explains:

My woman…can go to New York, to Sweden, Helsinki, wherever – believe me. She must be thin. She has to have ninety (centimeter) breasts…not big breasts – important breasts. And she has to have two buttons unbuttoned – wait – with a silk shirt. Blonde? No I prefer dark hair – with big green eyes. What I’m saying to you is that some women are a pattern of beauty.

This description is revealing of several key aspects of how Dr. Babor imagines his own expertise as a form of (racialized) aesthetic taste. His pattern of beauty is saturated with markers of a European sense of aesthetics, and yet, perhaps not in a totalizing sense – she is, after all, specifically not blonde. In his imagination, his vision of beauty is
“welcome” to travel the world and cross borders, her body and beauty translating equally across the cosmopolitan spaces of New York, Sweden, and Helsinki. It is this imagined circulating patient body that is additionally intriguing in his invocation of aesthetic ideals. By actively imagining the circulation of his vision of beauty – the material product of his biomedical expertise – is he not also engaging in a kind of circulation? In a post-crisis Argentina in which he can no longer easily circulate his own body across borders as part of accruing and performing biomedical expertise, how might enacting surgery on the bodies of transnational patients bodies be an alternative way to claim expertise and engage in circulation? Here, I propose that the practice of cosmetic surgery may also be approached as an act of transnational mobility for Argentine surgeons. In this way, I suggest, that the First World bodies upon which these doctors intervene may serve as a material means of collapsing the distance between aspiration and actuality in a context in which the very mobility of the doctor is constrained. Before returning to this point below, it is important to consider another realm of expertise that emerged across my conversations with doctors.

**Warmth and the Affect of Expertise**

Another key way in which doctors distinguish medicine in Argentina from that in the United States is through invoking the concept of “Latin Warmth,” a phrase used by many of the physicians with whom I worked. This notion was primarily described as an affective stance that infused the everyday interactions between doctors and patients, in explicit contrast to the ways in which Argentine doctors imagined such relationships occurring in the United States. A set of contrasts was invoked, in which “warmth” in
style was set in opposition to “cold” and “clinical” approaches and “human touch” was seen as superior to medicine shaped by fear of malpractice.

Practices of warmth are manifold in the relationship between Argentine physicians and U.S. patients. They include intimate styles of touching, sharing of personal information, and overt sexualization of patients. This warmth is also displayed through less obvious ways, such as not collecting formal patient histories or using informed consent forms, which are seen as material objects betraying the affective mode of trust established between doctors and patients. Such invocations of difference in biomedical style serve as a way for doctors to reassert their worth in a global economy in which they have been severely devalued, and offer a counter narrative that explains the flow of transnational patients to Argentina in a way that highlights the seeking of care, rather than “cheap surgery.”

To better convey the sense of “warmth” that I both witnessed and heard numerous doctors and patients describe, I offer a description of a single patient, Carla, meeting with her surgeon, Dr. Zimmerli, for the first time. While the details are specific to their meeting, the images and experiences described below point to the most common features of how these dynamics unfolded as part of my broader research.

Before the initial consultation, Carla and Dr. Zimmerli had exchanged a series of brief emails. She had sent him digital photographs of those parts of her body she most wanted to transform, and after looking at these photos on his desktop computer, he replied to her with his recommendations. Whatever list of surgeries he outlines for patients are always accompanied by the caveat that he will need to evaluate them in person before he can make a final determination of the procedures they will need.
Sometimes he finds himself writing with more specific instructions on what he needs from the photographs – patients shouldn’t wear makeup, the lighting needs to be even, no need to smile – it makes it more difficult to see the way the skin droops and hangs. Such email exchanges rarely mention money – this is not a surgeon’s job. Despite the fact that he is the owner of his own private cosmetic surgery practice, only his receptionist corresponds with patients about the price of each procedure, and offers them instructions on how to bring large amounts of U.S. currency into the country. In addition to these brief email exchanges, patients might request the chance to speak to the doctor by phone. Most often, such conversations – aimed at putting them at ease before investing in such an expensive and time consuming trip–have the opposite effect. Whatever limitations exist in the surgeon’s English-language fluency, they are almost always magnified as part of an international phone call. Carla admitted she had second thoughts after their first phone conversation, recalling how she was unable to get the kind of “read” on his personality she had hoped for.

Now, on the day of her first consultation with the surgeon, Carla is nervous. She has a list of carefully prepared questions written on three index cards that she carries in the front pocket of her large, leather purse. As we walk to catch the subway to the doctor’s office, Carla makes me promise that if she forgets to ask one of her questions, I will nudge her and remind her to get through them all. Although I’ve already cleared my presence at this initial meeting, I worry that once we arrive, Dr. Zimmerli may have second thoughts about letting this anthropologist and her digital recording device into such private conversations.
Arriving at the address Carla has scribbled onto the margin of her city map, she rings the intercom buzzer. A woman’s voice, distorted by static and volume, asks us who we are in Spanish. Although she does not speak Spanish, Carla leans forward and simply states both her and Zimmerli’s name, with these words proving sufficient to be buzzed through the door.

As we pass into a darkened hallway, a young, attractive woman opens a second, internal door, greeting us effusively and planting a soft kiss on each of our right cheeks. As I have now been living here for some months, I find myself leaning in almost automatically – only a slight twinge of consciousness remaining from when I had to actively remind myself to participate in this greeting ritual. Carla is far stiffer – leaving a large gap of space between her body and that of the receptionist, hesitating a bit too long before leaning in. As another patient explained to me, “In Argentina you have to greet everyone you meet with a kiss…if you try to put out your hand they will laugh at you…even with a doctor…. a kiss is how you introduce yourselves.”

For twenty minutes or so, we sit in a waiting room filled with soft classical music and large stacks of magazines, mostly in Spanish. Carla glances at her watch every few minutes, taking out her index cards and running her fingers along their crisp edges. The receptionist had not given her any forms to fill out, or long lists to review and check, and without such purposeful tasks, time seems to tick by more slowly. Finally, footsteps and a deep male voice (in Spanish) is heard from the receptionists desk just outside the room, and a white-coated doctor enters the waiting room and moves over to the couch where we are seated. Dr. Zimmerli is tall, with salt-and-pepper hair and a palpable sense of confidence. As we stand, he approaches Carla to lean in for a kiss to the cheek, and then
turns to me and does the same. “Shall we go into my office?” he asks in accented English. We follow him down a hallway, and as we walk, Carla looks back at me over her shoulder, her lips parting into a smile and her eyes growing momentarily wide, although I cannot tell if it is in excitement or fear. When Dr. Zimmerli reaches the door, his body slides to the side and fills one half of the door jam, and he extends his right arm into the room, a gesture that seems both direct and welcoming. As we walk past his body into the office, he does not draw away or shift. He leaves us no other option but to pass by his body very closely, and I notice that I can smell his mix of mint and cologne.

His office is spacious and carefully decorated, a row of windows filling the space with late afternoon sun. There is nothing particularly “medical” about the feel of the space, and instead, the sanitized “examining room” with its butcher-paper covered table and antiseptic smell is hidden away in an adjacent room. Although there is a plush, deep brown leather couch in the center of the office, he motions for us to settle into the chairs at his desk, his hand lightly directing Carla with a slight touch to her back of her shoulder. She observes out loud that his office is “very beautiful,” and I nod my head in agreement. He gestures at his tall bookcases brimming with leather-bound volumes and to a collection of bronze statues decorating the coffee table, explaining “it is important for me to be surrounded by beautiful things … by art.…” He mentions that he paints in his spare time, and points to a small, abstract watercolor in the corner. We both nod, dutifully complimenting his choice of colors. Physical gestures of what he calls “Latin Warmth” and intimacy have been established from his initial greeting: kisses on the cheek, light touching of the body to direct us within his space, as well as a clear comfort with close proximity – his ability to maintain closeness in moments where I felt the force
of habit drawing my body away in the effort to create more space between us. Another
surgeon would later mention in an interview, “I know that for my patients kissing the
doctor as a greeting is not what they are accustomed to…but it is how we are here in
Argentina, and I think they really enjoy this way.”

The feelings of warmth also extended beyond small gestures of physical intimacy.
Sitting down at the desk, Carla immediately notices pictures of the doctor’s daughters and
grandchildren, which were facing not in his direction, but instead displayed out towards
those sitting at his desk. “My oldest daughter, Ines, is thirty-two,” he says, pointing to a
picture of a beautiful woman with round, brown eyes and curly hair. “And my grandson
just turned two,” he remarks, smiling broadly as he points to the small child the woman
cradles on her lap. “My other daughter is twenty-five,” he explains, gesturing to a softly-
lit photo of a woman leaning against a wall, brown curls escaping a colorful, bohemian
scarf wrapped around her head. “And your wife?” Carla inquires. He nods, and
responds, “we are divorced … about five years ago.” “Yep, I know what that’s like,” she
chimes, “it’s actually part of the reason I’m here…My ex-husband was much older than
me … but my boyfriend, Alan … well I like to tell people that I could have celebrated his
birth with a legal drink!” She laughs loudly, and Dr. Zimmerli joins in, although I also
think I see his eyebrows raise in surprise that Carla is dating a man more than twenty
years her junior. But if he is surprised, he does not say so, but instead comments, “you
are a very beautiful woman – and we’re going to help you look younger.” In this
example, the doctor’s willingness to point to his life beyond that of a medical
professional through personal photographs opens up a space in the doctor/patient
relationship in which concerns can be framed in ways that exceed biomedical narratives
or therapeutic frameworks. This creates a feeling of intimacy, not just in terms of physicality, but also through personal disclosures, allowing doctors to bridge the distance between their patient’s biomedical desires and the larger constraints and issues of their lives.

Many of the doctors with whom I worked engage in practices similar to these specific examples described above. It is common for doctors to share stories about their families, including their family members upon whom they had operated. Other practices of Latin warmth on the part of surgeons include giving patients their personal mobile telephone numbers as opposed to office numbers or those of answering services. One doctor I work with routinely told patients, “call me even if just to tell me you are doing okay…I like for you to feel free to call me anytime.” Doctors insisted that this was part of their normal practice, and not limited to foreign patients. In fact, many seem unaware of the difficulties that using mobile phones hold for non-Spanish speaking patients, who struggle to add credit and check messages in automated Spanish systems.

**Of Paper and Trust: Absence, Materiality and the “Latin” Doctor**

Latin Warmth – qualities used to distinguish Argentine medicine from U.S. medicine – also includes the use and non-use of medical paperwork. While paperwork practices vary from doctor to doctor, I found several examples where forms considered “standard” in the U.S. were not used. For example, Dr. Zimmerli did not have patients sign consent to treatment forms, or fill out a medical history. Alternatively, he collected their medical history orally during the initial conversation, making small notations to himself. However, even this practice is flexible, such as when Carla mentioned a U.S. brand-name antibiotic to which she has an allergy. After a few moments searching for
the generic name of the drug on his computer, he finally declares, “well…I don’t think you will need an antibiotic with this procedure…for now we will not prescribe one.”

When I later ask Carla what she thought about his decision not to prescribe an antibiotic for a brow lift procedure that involved cuts along her hair line and along her ears, I was surprised that she was not made uncomfortable by the practice. “I felt like I could really trust him…American doctors want you to sign a million pieces of paper so that you can’t sue them if something goes wrong…instead, he concentrates on making sure he’s taking care of me.” Her assessment of the situation was particularly surprising to me, given how unclear her rights to malpractice protection were in a country in which she was not a citizen, or in which it would be very difficult to pursue legal action.

Asking doctors to comment on these same paperwork practices, I found a variety of results. One doctor actively mentioned that such paperwork is not as “important” in Argentina, but he was interested in replicating U.S.-style document trails specifically for use with foreign patients. An older surgeon mentioned that while malpractice suits were becoming increasingly common in Argentina, that it was very different than the U.S. culture in which “everyone is afraid that they will be sued by everyone else.” Dr. Zimmerli’s approach was one of identifying such document trails as a symptom of a lack of a proper patient/doctor relationship. He commented, “I don’t need to have everything in writing because my patients trust me.” In so far as documentation signals the potential of liability, then by refusing to engage in the production of such documents, Dr. Zimmerli indicates his commitment to patient care through an ethic that exists outside the legalizing framework of malpractice.
Through these multiple and diverse ways of practicing and demonstrating “Latin Warmth,” Argentine cosmetic surgeons are able to claim a particular practice of patient care in explicit contrast to the practices they imagine to exist within the United States. Not only is this central to their claim to an autonomous “culture of biomedicine,” but such practices also enable them to position themselves as superior “experts” in patient care above and beyond their privileged counterparts within the First World.

**Mobile Expertise**

This chapter began by looking at the disjunction that exists between Argentine doctors’ own sense of biomedical expertise and the constraints of where in the global hierarchy of the biomedical industry they are positioned. As revealed by Favaloro’s life story, this disjunction is not necessarily new. Yet, the landscape of biomedical expertise is shifting rapidly as surgeons in Argentina find themselves increasingly constrained in a post-crisis world at the precise moment that they are increasingly called upon to operate upon the bodies of patients from the Global North.

This complex scenario of Third World surgeons being rendered as “cheap” alternatives to their First World counterpart produces deeply contradictory conditions within which to make meaning of one’s own work and sense of expertise as an Argentine physician. Increased opportunity to rebuild one’s practice by attracting and treating foreign patients ultimately reiterates the very conditions of one’s marginal status within the larger situation of biomedicine. My research reveals that surgeons counter their marginal status by mobilizing counter-discourses that allow them to reclaim expertise in the face of such serious limitations. Through this counter logic, it is the absence of the latest “smart” technology that testifies to the confidence of the surgeon in his own
training and skills. It is the absence of excessive paperwork that speaks to relationships of trust and affection. The ability to deftly weave between personal and professional spaces is interpreted as a kind of warmth that sets them apart from the “cold” medical style of doctors from the North. And finally, it is through the realm of aesthetic taste and judgment that doctors reveal expertise in excess of that of their North American counterparts. In their claims to imagine and define a pattern of beauty, doctors mobilize racialized aesthetic ideals as a kind of currency that circulates and translates far beyond the borders of Argentina. Given that much of the literature on transnational medicine focuses on the mobility of patient bodies, it is worthwhile considering multiple forms of mobilities and circulations as part of this travel. I suggest that in a context in which Argentine surgeons’ expertise has been largely immobilized, the imagination of beauty and the practice of surgically altering the material bodies of transnationally circulating foreigners may also be understood as part of rendering one’s expertise mobile.
Chapter Four

Bodies-in-Momentum: Experiences of Movement as part of Transnational Surgery

1. *broadly*: a property of a moving body that determines the length of time required to bring it to rest when under the action of a constant force or moment
2. strength or force gained by motion or through the development of events

- *Definition of “Momentum,” Merriam-Webster’s Dictionary*

If studies of the body and embodiment are now central to anthropology as a result of the turn to Foucauldian, phenomenological, and feminist approaches (Foucault 1977, 1978, 1980; Grosz 1994; Bordo 1993; Butler 1993; Martin 1987; Csordas 1994, 1997; Turner 1984) the explicit focus on the relationship between bodies and movement has entered into anthropological theory in more problematic ways. The majority of “moving
bodies” are now analytically apprehended as they circulate through geographic space, or alternatively, as studies of “body motion” that aim to reveal signifying gestures and bodily techniques. Despite the valuable insights of both of these approaches, little is revealed about the embodied experiences of movement itself.

One common thread across diverse studies of “moving bodies,” for example, is the foregrounding of bodies physically traversing large stretches of space, including analyses of migration (Sassen 1998), diaspora (Gilroy 1991, 1993; Clifford 1997), displacement (Holtzman 2000; Malkki 1995), and tourism (Desmond 1999; Bruner 2005; Smith ed. 1989), alongside work on transnationalism more generally, including the circulation of bodies and their parts within circuits of labor, citizenship, media, and capital (Schepere-Hughes 2000, 2001; Tsing 2005; Ong & Collier eds. 2005; Basch et al. 1994; Ong 1999; Ferguson and Gupta 2002; Appadurai 1996). These studies provide critical insights into changing patterns of movement at multiple scales, and add to our knowledge of the complex ways in which subjectivity and everyday practices are restructured through various forms of rupture, exchange, and embeddedness. Yet, precisely because of the importance of contextualizing such movement within larger historical, economic, and political processes, accounts of shifting modes of embodiment—or how movement itself might constitute a particular way of “being-in-the-world” (Heidegger 1996 [1927]) have been rare.

In addition to studies of “moving bodies,” the explicit focus on “body motion,” has long existed within anthropology (see Marcel Mauss’ *Techniques of the Body* 1973 [1935]) and has included such areas of inquiry as the study of body motion as part of physical labor (Keller & Keller 1996), sports (Dyck & Archetti 2003; Brownell 1995),
and dance (Williams 1997; Birdwhistell 1985) among others. Unlike studies of moving bodies that forgo embodied experience in order to reveal the patterns and effects of collective circulation, many studies of body motion too closely treat the motion of material bodies as signifying acts. In collapsing motion with meaning, gesture with semiotics, and rendering such movement more “meaningful,” studies of body motion remain uncomfortably lodged within existing notions of the liberal individual subject.

One of the clearest examples of this approach is that of Brenda Farnell (1994, 1999, 2000), who argues that despite widespread interest in the body, anthropologists have yet to come to terms with humans as “moving agents” (Farnell 1994:931). While Farnell usefully points to the ways in which human bodies have too often been treated as static entities when approached as cultural constructs and social texts, her effort to recuperate the moving body faces equally difficult theoretical limitations.

Farnell’s goal is to understand social actors as “enacting the body,” which she defines as “using physical actions in the agentive production of meaning; actions that may be either out of awareness through habit, or highly deliberate choreographies” (Farnell 1994:931, emphasis mine). Although drawing on Bourdieu’s theoretical innovations, which include an analysis of conscious bodily practices as well as the “practical mastery” of everyday tasks through the gestures, postures and stances that make up a body hexis (Bourdieu 1977; Bourdieu & Wacquant, 1992), Farnell argues that a problematic dualism remains between thought/language and bodily praxis (Farnell 2000). She additionally critiques phenomenological approaches grounded in the subjective experience of the lived body, arguing that such approaches do not account for causation, agency or a “genuine conception of the person” (Farnell 1994:932). Yet,
Farnell’s attempt to account for agency problematically conflates body movement with the agentive production of meaning, reconstituting the normative subject through the analysis of individual, material bodies.

Within anthropology, poststructuralist critiques such as those developed by Michel Foucault (1977, 1978, 1980), Judith Butler (1990, 1993) and more recently, Saba Mahmood (2001, 2005) have pointed to the dangers of reproducing the normative subject as part of our research. In line with these theoretical shifts, individuals are often understood as subjects who discipline and alter their thoughts, bodies, actions, conduct, and ways of being within historically particular discourses, with increased anthropological attention to the relationship between power and subject formation (Foucault 1997; Mahmood 2005:211).

Yet, if we have moved away from notions of the transcendent subject, this effort is at least partially undone by current approaches to understanding the relationship between bodies and motion, many of which still clearly rely on understanding movement as the agentive production of meaning, or, alternatively, within the techniques of subject formation enacted by individual bodies. Even nuanced approaches such as Mahmood’s reconceptualization of agency as part of the cultivation of Islamic piety, focus on the body in relation to the creation of the self, as she interprets bodily acts, gestures and habituated postures as a means of “being and becoming a certain kind of person” (Mahmood 2005:215). Fundamental aspects of being and moving in the world, however, remain unexamined through such approaches. In my own work, individual “agents” as such are often difficult to locate, and rather than enacting motion, they are also caught up and enacted by motion, both generating and being moved within forces of momentum.
clearly in excess of any single body, object, or subject. The patients who travel to Buenos Aires in search of surgery suggest this relationship: they are bodies that move through, and are moved by, multiple subjects, spaces, objects, and temporalities,

To get at this, I depart from the two approaches outlined above, and focus, in this chapter, on the perceptual experiences of transnational medical patients’ “bodies-in-momentum.” I suggest that this focus can better account for the spatial and temporal displacements many transnational patients experience as part of undergoing surgery thousands of miles from home in ways that traditional approaches cannot. Drawing on phenomenological theories of embodiment, I propose that in attending to experiences such as momentum, anthropologists are better equipped to account for non-congruous temporal and spatial orientations to, and ways of being in, the world (Miyazaki 2007). Such an approach allows us to capture perceptual experiences of movement and modes of embodiment, while reading such experiences onto analyses of the larger socio-economic contexts on which scholars of transnationalism tend to focus. Additionally, I show that focusing on momentum enables us to more effectively grasp the excesses of action, intention, and practice revealed in the wake of the decentered subject.

**Transnational Surgery as Momentum**

While accompanying transnational patients during their daily activities in Buenos Aires, it became clear that undergoing cosmetic surgery abroad presents patients with obstacles that they would not encounter if seeking treatments closer to home. Most critical are the significant limitations to what is knowable and imaginable for patients prior to arrival in Argentina, making the “choice” to have surgery one that is nearly impossible to enact from a distance. Within this landscape of imperfect knowledge,
transnational patients often defer any clear moment of choice regarding surgery, and instead, embody a stance I characterize as “waiting-and-seeing.” While patients may suspend any decisive moment, they nevertheless initiate and surrender to a decisive momentum – that is, they engage in momentum generating activities such as meeting and forming friendships with people connected to the medical tourism industry, embarking on international travel and purchasing the material objects needed for surgery – often before meeting with the doctor in person.

This distinctly non-sequential ordering of activities (e.g. buying a post-surgical garment before finalizing surgical options) is particular to the complex ways in which time and distance must be managed in order to successfully operate upon transnational patients. Doctors and other medical travel specialists must structure the timing of such visits to allow for a maximum period of recovery and follow-up care in order to enable patients to heal “enough” before journeying thousands of miles back home. As a result, opportunities to plan and discuss the surgery itself often come only after other, more immediate, details are undertaken. And yet, it is the momentum inherent to these seemingly mundane details that immerses patients within increasingly complex webs of social obligation, and lead them to cultivate relationships with people and material objects that lend themselves to a surgical outcome.

As explored in Chapter Two, the marketing materials circulated in the effort to attract foreign patients are carefully crafted and endeavor to produce a particular way of imagining Argentina. In my interviews with transnational patients, however, it became apparent that they did not evenly adopt such messages, however consistently they appeared throughout marketing discourses and tourism literatures. For many patients,
knowledge of Argentina and its medical expertise remained partial and uneven within the
landscape of imperfect knowledge they inhabit prior to departure. It is only with travel
and movement that the possibilities of surgery begin to be fleshed out as part of a wide
array of connections to people, objects and spaces that are moved by, and in turn move,
transnational patients. Travel, and the forces of momentum it generates, is fundamentally
part of the surgical experience, and as such, cannot be viewed as a separate moment of
embodied practice.

**Bodies-in-Momentum**

While the experiences of the transnational patients I worked with in Buenos Aires
differed, there were many shared “moments” in common that can be usefully traced as
part of examining movement and momentum at the heart of transnational surgery. Here, I
use the term “moment” in two senses. First, in the colloquial usage, I highlight those
experiences that emerged as common features of transnational medical travel, such as the
moment of “arrival” and “meeting with the doctor.” Secondly, pointing to the forces of
momentum I want to trace as part of such travel, I draw upon a second meaning within
physics, which refers to a force acting, rotating or turning an object from a distance. I
suggest this second definition points away from a locus of action and agency within any
one subject or object, and instead, allows us to more expansively consider how a variety
of forces enact, and are enacted, at any given “moment.” Offering snapshots into each
step in the process, I then link these moments to a broader set of experiences to
demonstrate the momentum at play in transnational medical travel. Although a sort of
artificial linearity comes with presenting these experiences sequentially, they offer an
introduction to the complexities and particularities of transnational medical travel while revealing the ways in which intersubjective momentum is generated and embodied.

**First Contact**

Rogier using online forums to share his experience on PlasticSurgeryJourneys.com

Meryl was accustomed to going online to gather and share information about her health. A white education administrator living in urban Philadelphia, she had been an active participant for several years on an online message board for people who have undergone bariatric surgery for weight loss, and was intrigued when she began seeing posts about going overseas for the follow-up full body skin removal surgery. “Skin removal surgery is considered elective,” she explained, “I knew I couldn’t afford to have it done in the U.S.” From her home in Philadelphia, Meryl used patient-centered websites
such as PlasticSurgeryJourneys.com to connect with people living in Florida, Boston, San Francisco, and even as far away as London and Amsterdam, all of whom were considering or had undergone surgery abroad. While she read positive comments about Costa Rica and Mexico, it was descriptions of Argentina that caught her eye. In particular, she kept seeing one doctor’s name appear on the message boards. “At the time,” she recalled, “it hadn’t occurred to me that people might be paid – or get discounts on surgery or whatever – to write a positive review. Seeing his name over and over again, it just started feeling like something I should look into.”

As Meryl began considering the idea of traveling to Argentina, she discovered another member of her online bariatric support group who also wanted to go abroad for surgery. She recalled thinking, “This is great!… we could go to Argentina together, share an apartment, cut down on costs, and stagger our surgeries to help each other during recovery.” She felt relieved that the trip would be something she could undertake with someone else, which would certainly make traveling “half way around the world” less frightening. While Meryl clearly engaged in extensive online research, she ultimately chose Argentina because it “seemed like the pieces were falling into place.” Before even leaving her home in Philadelphia, movement was underway in the form of such falling pieces: a doctor’s name repeatedly appearing just as she began searching, chance encounters online, connecting with someone who just happened to want the same surgery as she did, with a travel schedule that matched up with her own. Skype video chats with a woman in Florida, who she had never met in person, lent a face and a voice to a process that had previously existed only in her own mind. “I guess having Melody doing this at the same time, really made it… I might have gone on my own… I don’t know…” she
trailed off. And as the coordination of their mutual plans became more complex and detailed, so too did the obligation to one another grow. Even though Meryl’s pre-existing cardiac condition gave her pause, she began to feel as though she was bound up in Melody’s ability to undergo surgery. The plans, even at such an early stage, were no longer simply her own.

While the conventions of social obligation have long been at the heart of the anthropological project (Malinowski 1922; Mauss 1990), what is striking about Meryl and other patients’ moment of “first contact” is the strength of both affect and obligation resulting through connections that, nevertheless, remain nebulous, intangible and geographically remote. What starts as mere exploration and the gathering of information soon leads to long-distanced connections with strangers also pursuing journeys that remain largely unknown. What begins as mere online “chatting” with a stranger to whom they are not obligated, may become – before they themselves even realize it – a felt obligation. Such obligations need not be understood as burdens. As Meryl indicates, she was comforted by the prospect of companionship that her obligation to Melody entailed. And yet, such obligations also produce a particular force, a momentum that sets patients into motion in ways that may not occur otherwise. As obligations accrue, the force required to slow or stop the body in motion often feels stronger than the energy required to keep moving forward.

**Care and Intersubjective-Planning**

During our first conversation, Shelly clarified that it was not Dr. Bruno who moved her to come to Argentina. “If I had to say, the person who *really* made me comfortable was Lola” she told me, referring to the Argentine medical travel coordinator
who worked with Dr. Bruno and his patients. As described earlier, prior to connecting with Lola, Shelly had reached out to several doctors, all of European heritage, with less than pleasing results. As a middle-aged Black woman, the racist undertones of their unsolicited surgical advice encouraged Shelly to search elsewhere. It was significant, then, that Lola was able to put her at ease and facilitate her connection to Dr. Bruno.

When I interviewed Lola about her experiences working with Shelly and other transnational patients, she pointed out that although her official job was to help patients plan for surgeries, in reality, it is not possible to finalize surgical plans prior to the patient arriving in Argentina for an in-person consultation. Emailed photos, even when taken from multiple angles and under appropriate lighting conditions, rarely give doctors the information they need to evaluate skin texture, underlying bone structure, or patient lifestyles. “Planned” surgeries, thus, can be understood as convenient fictions that hold an ideal result in place, while Lola coordinates the logistics surrounding the yet-to-be-determined outcomes. As Lola observed, “[patients] want you to tell them exactly what will be done and what it will cost. But if I did that, I would be lying… there are companies here in Argentina who will tell you want you want to hear… they will take your money from you up front, and only after you are here in Buenos Aires they say the [specific] surgery is not possible and you need to stay for one more month.”

Alternatively, Lola’s approach is to focus on giving potential patients information about Dr. Bruno, and to educate them about Argentina more generally: “Some people already know that Buenos Aires is what the they call the ‘Paris of South America’… like a European country, it is the food, the wine…and it is clean…and safer” than other destinations, she explained. Lola also offers those intangible extras that put patients at
ease, helping to arrange for apartments, for example, as well as offering to cook soup or run errands for medication once they arrive. When asked about the time spent with Shelly, Lola reflected, “She was a very cool woman… I spent a lot of time at her apartment. She did my astrological chart – not a normal one – but a very, very detailed one… we talked and talked.” In short, Lola offers potential patients like Shelly not only logistical expertise, but affective ties – a warm and caring friend who just happens to work for their doctor.

My aim is not to question the sincerity of Lola’s warmth and friendship, but to see how such friendships grow even as the economic transactions of such connections remain obscured. Patients are not required to pay directly for Lola’s time, as she receives a per-patient fee from the doctors with whom she works. Crucial to this economic arrangement is the fact that unless a patient moves forward with her plans for surgery, she will not be paid. While connecting in ways that exceed the language of market logic, this excess - of warmth, and kinship – also comes with increased ties and obligations that move patients along towards undergoing surgery abroad.

Many transnational patients reflected upon the pulling sensation of such affective obligations to an ever-expanding network of people and places, and how they experienced the creation of such ties as they considered undertaking surgery abroad. That such a pull is experienced and embodied as a force of movement was evident in the metaphorical language many patients invoked, commonly described as taking a “leap-of-faith.” Embedded in this telling phrase is both the sensation of movement conveyed through the description of leaping, as well as the acknowledgement that such movement occurs within a larger force, faith, located outside logical reason or careful research.
Rather than an individual decision, “faith” implies a surrender or submission to a force larger than oneself, a giving over to the pull of affective ties, the synchronicity of chance encounters, and to a network of widely dispersed people whose stakes are increasingly tied up with one’s own future. To “leap” is to enter into movement, to accelerate the moving pieces – people, places and objects – that surround oneself, as their motion, in turn, moves you. More than merely a decision or choice, leaps-of-faith presume a particular way of being-in-the-world, the experience of sensing and feeling the forces at work beyond oneself while simultaneously generating momentum that sets other pieces into play. Or, as one patient explained to me after reflecting on her leap-of-faith in coming to Argentina: “I was moved to come here.”

**Arrival in the not-yet-known**

“It’s June!” Melody exclaims, pulling her thin, cotton jacket tighter, her capri-style pants exposing several inches of bared ankle above white athletic shoes. Although she had “read up” on Buenos Aires before boarding her flight from Miami, the opposite seasons of the southern hemisphere appeared disorienting. “I just can’t believe it can be this cold in summer,” she complained, her arrival coordinating with the coldest period of the Argentine winter.

Melody’s Florida aesthetic cannot be explained away as simple ill-preparedness. Rather, her miscalculation of hemispheric seasons seems to reflect other things that had remained unknown prior to her arrival. Having only ever traveled with her family as part of a Disney Caribbean cruise, Melody admitted, “I thought that Argentina… South America… is a lot more like Mexico.” In her tropically infused imagination, Melody had expected if not sandy beaches, at least warmer temperatures, unsafe drinking water,
darker skin. “I really didn’t know what to expect,” she admitted, as we sat in my living room during her first evening in the city.

Despite Argentina’s intense marketing efforts to position itself as a “European” tourist destination within Latin America, many transnational patients seemed only to partially “know” such images, if at all. For every mention of the tango or European-style boulevards, there were expectations of coming face-to-face with a gaucho, as well as anxieties about whether or not to eat the fruits and vegetables sold in the capital’s high-end grocery stores. That such anxieties are experienced as sensations as patients move through the world became clear during an afternoon snack of sliced fruit I prepared at Melody’s apartment. Chewing slowly, a concerned look spreading on her face, Melody asked several times, “does this taste right to you?” That Argentine pears and organic garlic are a common staple of U.S. supermarkets, speaks to the pervasive remainders of a colonial imagination: for every fruit deemed safe to consume and literally incorporate into the body within the borders of the United States, this same fruit was suddenly suspect as disease-causing when found within the country of origin. If the space, climate and safety of the city remained difficult to anticipate before arrival, even harder to imagine were the doctors, nurses and clinics upon which patients’ health and well-being depended.

That such crucial information remained uncomfortably vague was also apparent in a joke I overheard one evening as a patient chatted over speakerphone with her business partner in Colorado. Having called to solicit help setting up her Internet connection in her rented apartment, the in-the-know colleague turned the conversation to the surgery at hand, teasingly asking whether she had “seen the veterinarian yet.” While clearly offered
in a playful tone, the subtext highlighted what remained disturbingly unknown: the quality – perhaps, even the very existence – of a “real” doctor.

As these moments of arrival reveal, most journeys do not follow a straightforward trajectory, in which confidence and ease accrue with each experience. Rather, patients’ arrivals to Buenos Aires were marked with the ruptures of surprise, anxiety, and mounting questions. That patients move – and were moved – through such discomfort points to the forces of momentum at work in their travel. In a casual aside as we relaxed over a cup of coffee during her second night in the city, Melody remarked “if I really stopped to think about all of this – I don’t know if I could go through with it.” Nothing is more central, so it seems, as the experience of not stopping – of already being-in-motion.

**Preparing for Post-Surgery through Objects**

Before Melody even had a chance to meet with her doctor, we spent the first few days following her arrival tackling a series of errands: sorting through and signing the apartment rental contract, searching for the best exchange rates at casas de cambio to convert large stacks of dollar bills into pesos, figuring out how to accommodate her particular tastes and restrictive diet within the confines of unfamiliar foods, buying cheap bed sheets that could be thrown away once they were inevitably stained with blood, and visiting a surgical supply store for post-surgical garments and implant sizing. Although at this point in her journey Melody had not fully “decided” whether or not to move forward with her surgery – and did not entirely know which procedures would be possible – she moved closer towards a surgical outcome, propelled by these moments of preparation.

Our visit to the surgical supply store is a particularly clear example of the momentum at work in patients’ experiences in that it shows the power of objects to move
patients into a particular way of imagining and experiencing their yet-to-be bodies. I joined Melody, another medical tourist, Rogier, and their British patient coordinator, Sarah, at an unassuming store on a quiet block in the upper-middle class residential area near Parque Las Heras. The purpose of the store was not immediately clear to anyone other than Sarah, who had accompanied other patients there before. “They sell this to anyone?” Rogier wondered aloud, joking that he might purchase extra implants and boxes of Restalyn filler to sell back in the Netherlands. When asked if they needed a prescription, Sarah explained, “you don’t need an actual piece of paper, but I think they talk to Dr. Banet and he lets them know we are coming.” The two attendants behind the long counter were both working with customers, so we browsed the glass cases that filled the first third of the store.

The first case seemed innocuous enough, filled with various objects such as surgical hats and masks in a variety of prints and colors. We chuckled softly, pointing to the jungle-print surgical cap, covered with brown cartoon monkeys and striped zebras. The next cabinet, however, was not so comforting. Our eyes followed row after row of surgical tools: razor sharp scalpels of various sizes and thicknesses gleamed off the back mirror, followed by piercing metal hooks, small pointed hammers and jagged, sharp-toothed saws. “What are they sawing?” Melody asked, eyes widening. Interspersed among truly torturous looking instruments were various Disney and Japanese anime figurines, including a three-inch high rendering of a young woman with impossibly large eyes, bare breasts and exposed underwear. Rogier exploded in laughter upon seeing the figurine, asking, “what is that?” The set up of the shop was perplexing – bizarrely split between selling surgeons the tools of their trade and helping patients choose implants and
garments for their body. Only surgeons, I mused, would be so nonplussed gazing upon these sharp, menacing tools that cartoon figurines might provide a moment of amusement in an otherwise mundane shopping trip. For the two patients waiting to consider implants and garments, however, this display seemed gruesome and macabre, objects that simultaneously elicited humor and fear.

When the attendants were available to assist us, they did so through Sarah’s laborious and slow translation from English to Spanish. Our first order of business was trying to sort out which post-surgical compression garments Melody and Rogier would use. We flipped through magazines featuring gorgeous models absent of swelling, bruising or stitches, bound into smooth looking black and peachy-flesh colored garments. Melody was instructed that she would need as much coverage as possible, something that began at her knees, compressing her entire body, stopping just below her neck and extending to her elbows. Initial preferences such as color and lace detailing soon gave way to the reality that the store’s in-stock merchandise was far more limited than the pages of the thick, glossy catalogue might lead one to believe.

The attendant pushed two beige wetsuit-shaped garments across the counter and suggested Melody try them on in the small dressing room. “I was imagining something more like a bustier,” Melody laughed, as Sarah took the garments and thanked the attendant. The garment was made of a recalcitrant, foamy skin meant to squeeze and hold the body tightly in place, smooth stitches and maintain even pressure over bloated, swelling limbs. Far from straightforward, attempting to find the right size for Melody proved challenging. Cursing under her breath, she attempted to twist and fit her body into the narrow, restrictive holes of the garment, as it, in turn, stretched and pulled at her skin
with a rubbery grasp. One major challenge of choosing the right size was that it required trying to imagine future changes to her body that remained unclear and unknown. “This is really tight,” Melody started, “but I guess a lot of this (gesturing to the flesh of her torso) is going to be gone.” “Right,” Sarah confirmed, “but don’t forget about the swelling…it’s all going to swell up.” The unpredictable calculus of soon to be missing flesh and fat, counteracted by puffy, swollen post-surgical wounds proved difficult.

Without having yet finalized the surgical options at hand, the purchase of the material object of the garment incurred additional obligations to, as well as momentum towards, a surgical outcome. Beyond the financial obligation and investment in the garment itself, fitting one’s body into its tight, unforgiving grasp required the temporary embodiment of a future moment, a way of feeling and moving inside an outcome that could not yet be fully imagined. In order to successfully purchase the garment, for example, Melody had to select which size of breast implants she wanted to receive, and yet, had not been aware that the choice of implant volume would be hers to make. “One option is 475 cc’s the other is 525 cc’s,” Sarah explained, holding out two lumps of crystalline gel for us to pinch, stretch and consider. As the four of us crowded behind the curtain of the dressing room, we slipped various sizes of implants into her bra, remarking upon the effect of each. “Of course it won’t look like this,” Sarah reminds her. “The implant will be under the skin and muscle, and some of what you have now is going to come off, I imagine…”

Our four bodies bumped and pressed against each other in the small space of a dressing room designed to accommodate a single body, despite the fact that it was not unusual to have patient coordinators, store clerks and others working intimately with
patients in determining garment sizing. We squeezed and pulled at the implants now tucked against her chest without restraint, as the sacks of silicone held tightly by the constricting, flesh-colored garment did not yet seem like part of “her” body. In that moment, with the blur of the grabbing hands and gabbing mouths, the collective strain of envisioning what could come of her body using only the flesh, silicone, cloth and mirror before us, it became increasingly difficult to feel where Melody’s individual body ended, and where it began.

Like the forms of affective obligation explored above, material artifacts of a future surgery also exact their obligations. The price of transnational surgery is not limited to the thousands of dollars spent on international plane fare, apartment rental (paid in cash at the start of the lease), the cost of hospital rooms and doctors fees, as well as the loss of wages for weeks or even months absent from work. Patients additionally invest in a multitude of material artifacts: post-surgical garments, implants, bed sheets, towels, rolls of cotton bandages, compression socks, sitting pillows, ointment, pain pills, antibiotics, and a variety of other supplements and creams recommended by patient websites. Beyond the mere price of such material objects, they also incur a kind of future-oriented obligation – their very usefulness negated if the surgery does not move forward. Put differently, the momentum of transnational medical travel activates a diverse range of actants (Latour 1987, 2005): doctors, implants, nurses, planes, medical travel coordinators, contracts, compression garments, other transnational patients, bottles of pills. Scattered across geographic space, and with a variety of interests and purposes, the multitude of actants collectively generates forces of momentum in excess of any
individual patient, and works to spread the boundaries of the subject across multiple people, places, and temporalities.

**Meeting the Doctor**

Carla had prepared a list of questions and written them on index cards in advance of meeting with Dr. Zirlinger or “Dr. Z,” as she referred to him. If she did not get the answers she was looking for, she informed me, she would not go through with the surgery. “To be honest, I just really hope I like him, but I guess if I don’t get a good feeling, I can just tell myself that this is a vacation… a long, expensive vacation.”

Following their initial meeting in which they exchanged personal stories (as described in the previous chapter), Dr. Zirlinger examined Carla’s skin, asked her questions about her medical history, and then, after leading her into the adjacent clinical room, began to take pictures from all angles. “We cut here … and here….” he said, tracing invisible lines on her face with his fingertip as she watched intently in a mirror she held with both hands. Later during her stay in Argentina, Carla would try to explain the loss of feeling of the nerves in her face after surgery by having me press my right index finger against her own, and run the fingertips of my left hand up and down the outside of our pressed fingers. This exercise produces a strange sensation of disconnect, as if I had lost sensation in my right hand, or suddenly stopped understanding which hand was mine and which was hers. Watching Dr. Zirlinger touch Carla’s face in this way produced a similar effect of disorientation. As he confidently asserted the path of the cuts his scalpel will soon make upon her skin, it was the light tracing of his fingertips that became her only chance to witness and feel the sensations of the impending surgery. Staring intently at a reflection of her own, unsmiling face, she watched as the doctor
mimed surgical slicing, enacting and bringing the gestures of a future surgery into the moment at hand. The next time he touched her face in this way, she would be unconscious.

As Carla and I walked out into the lovely sunny afternoon, she seemed genuinely excited by the meeting, rhetorically asking, “wasn’t he so nice?” and “didn’t you think he was handsome?” While her assessment of Dr. Zirlinger as “handsome” did not explicitly draw attention to race or his European identity, her invocation of appearance in a moment of reflecting on expertise speaks to the slippages between race, aesthetics and biomedical authority. Such conflation occurs not only within the processes of cosmetic surgery (Gilman 1999), as seen with the unsolicited advice given to Shelly to narrow the width of her nose, but also within the consolidation of biomedical authority more generally. Several of the doctors I came to know unabashedly claimed the value of a shared “European aesthetic,” which they believed allowed them to better understand the desires of U.S. and European patients.

I inquired whether Carla felt she had received answers to her questions, the index cards now buried somewhere deep within her purse. Not having referred to the cards during her conversation with Dr. Zirlinger, she simply explained, “it just feels right…I mean, this is why I am here, right?” The logic underlying the question, “this is why I am here, right?” was expressed by a number of the patients I worked with. While on the surface the statement seems straightforward (why else would they have traveled so far but to get surgery?), it also reveals the power of the force of momentum inherent to their journey. While many of the patients I worked with insisted they would not go through with the surgery if they were not comfortable with the doctor or did not approve of the
clinic, often by the time their meeting with the doctor took place, the very fact of their being in Argentina was enough to justify moving forward. What begins as a slow, exploratory process saturated with unknowns and uncertainty, gradually cultivates obligations among a variety of people, places and objects. After a given point, it is no longer possible to distinguish whether it is the desire for surgery that justifies the long journey or the journey itself that justifies surgery.

The Day of Surgery

Carla and I returned to Dr. Zirlinger’s office on Thursday morning. She had wanted to ride the subway over, as the cost was only sixty centavos (twenty cents), allowing her to save money for a taxi ride to her apartment following surgery. Meeting just outside the entrance, I noticed that Carla looked a bit less polished than her normal self, no make-up or jewelry allowed on this day. She wore a buttoned-down shirt, as requested by the doctor, enabling her to dress without pulling anything over her face and risk damaging what was soon to be freshly-sutured skin. The fluttery excitement that had saturated her voice only a few days before, was noticeably dampened, her speech slow and even.

Unlike many destinations where transnational patients are sequestered in “five star” hotel-hospital compounds, patients in Buenos Aires move about the city, shop at local markets, recover in apartments, and, like Carla, even ride the subway to their surgery. Ironically, it is far more likely in India – a medical travel destination country that must overcome a public image of endemic poverty – that foreign patients are likely to be secluded within sanitized spaces and offered round the clock care (Cohen in Ong & Collier 2005:89). In Buenos Aires, where the city itself is marketed as a European space
of modernity, transnational patients move along everyday routes, experiencing firsthand
the disconnect between the image of cosmopolitan modernity and the reality of the post-
crisis city that surrounds them.

The subway car was characteristically crowded that morning, and we huddled
close together, crushed on all sides by men and women in business suits, as well as loud
packs of students blasting music in their headphones. Whenever we rode the subway
together, Carla would animatedly point to the people around her, commenting with
fascination at men hawking just released DVD’s and children in worn clothing selling
stickers and batteries for two pesos. Once, while casually chatting about her plans for
surgery, she had been horrified to see a badly burned woman, her copper skin marbled
with white and red scars, shuffling up and down the subway car begging for change. But
on this morning, Carla kept her eyes closed, and together with the mass of morning
riders, our bodies swayed and jolted in rhythm with the train until we arrived at the
Agüero station.

After an initial conversation with the receptionist, we were led upstairs to the
second floor of the clinic and into a small, dark room with a single hospital bed and a
chair. A woman we assumed to be a nurse or medical assistant (she simply introduced
herself as “Maria”), brought a pale blue hospital gown, gauzy sterile cap and booties.
“Nothing but these” she said, placing the garments onto the bed. “But what about my
compression socks?” Carla asked, suddenly startled. Carla, who had read online that such
socks could be worn during surgery to reduce the risk of embolism, pleaded her case until
the woman promised to check with the doctor. As Carla disrobed, it seemed as though
this slight deviation had unnerved her, and she sat nervously, on the bed, gripping the white and grey compression socks, explaining their virtues to me.

Soon, a large man we had never met entered the room. In broken English, he introduced himself as the anesthesiologist, and told us they were almost ready to begin the surgery. “Where is Dr. Z?” Carla asked, but he only nodded silently. A clipboard in hand, and speaking in very slow English, he inquired about prior surgeries, allergies and medical history. When she informed him of her allergy to an antibiotic using the English brand name, he stared down at the floor, tapping his pencil against the clipboard. “I don’t think this will be a problem,” he finally said, scribbling in the margins of his paper. As he walked from the room, Carla observed, “you think they would have asked me all those questions before now! Look at me… I’m already in the gown!”

Sitting on the bed, stripped of her layers of makeup, clothes and jewelry, deprived of her morning caffeine, wrapped in a thin blue material, and thirsting from a lack of liquids, she did seem somehow “poised” for surgery. What other direction would now be possible? After a few more minutes, Dr. Zirlinger arrived in the room, handing me a pair of scrubs and gauzy hair net so that I could observe the surgery from inside the operating room. Carla, almost shaking with nervous energy, again pleaded her case for wearing her compression socks, and Dr. Zirlinger agreed that it would be fine for her to wear them. After rolling the tight socks up to her knees and slipping the booties into place, they left the room and crossed the short hallway, Dr. Zirlinger holding open the operating room door for Carla to enter. I quickly changed into the scrubs and hurried after.

It was warm inside the operating room, much warmer than I had expected. The anesthesiologist sat to my left, working on a crossword puzzle as the surgery progressed,
only occasionally rising to check on a tube or read a machine. Assisting Dr. Zirlinger was a much younger plastic surgeon who was training alongside him. We had not met him before entering the surgical suite, and it seemed to make Carla a bit uneasy – but she politely shook his hand and made a wry comment about how young and handsome he was. There were also two young women – Maria and one other medical assistant – who seemed to be there primarily to hand instruments and roles of gauze to the doctor.

Carla was laid out flat upon the table after they had administered “twilight sedation” meaning that she would be largely “out of it” but not completely unconscious during her surgery. I leaned against the far wall, scrubs and white facemask on, notebook and pencil clutched to my chest. I kept my elbows in and my back flat against the wall in the effort to make myself as unobtrusive as possible in the tiny room. Often, my view of the surgical table was obstructed by the bodies of the doctors and assistants, but at other moments, very suddenly, everything would become visible. I jotted snippets of conversation, trying to record the order of movements, watching the nurse and medical assistant interact with the doctors.

As if talking in her sleep, Carla began mumbling, nothing intelligible, just the murmur of her voice cutting through the chatter of the doctors. “It’s okay, now, try not to move your head,” Dr. Zirlinger said to her in a strong, calming voice, as he went back to making an incision along her right temple. He spoke to her in slow, accented English, and the quickly switched back into more rapid Spanish, asking the nurse to hand him an instrument from across the other side of the table. “Thirty-six….” she mumbled again, this time her words coming out more clearly. “I need to look thirty-six…” she said again, her head moving slightly back and forth. Perhaps unsure his younger colleague had not
understood, Dr. Zirlinger translated her statement into Spanish, and both doctors began to laugh. “We will do our best,” Dr. Zirlinger reassured warmly, “but we need you to relax right now…and try to stay still.”

I watched the surgery for a few more moments, noting the growing heat. Each time I saw something new or disturbing, I would simply write it down in my notebook. Everything became simply a fact: a concrete moment that I had recorded. Fact: Dr. Z just took a scalpel and positioned it on the left side of Carla’s chin, just under the jaw. Fact: Dr. Z moved the scalpel slowly to his right, dragging the blade in a straight line across the soft spot of her neck, just underneath her jaw. Fact: Dr. Z used a shiny, forceps-like instrument to spread apart the space created between the newly cut flaps of skin. My mind was taking these actions in coolly, as if watching myself writing notes, congratulating myself on not letting the scene get to me. My body, however, was registering the event far ahead of my mind. Sweat began to pool in the recesses of my back and across my forehead. Noticing the sweat, I reminded myself I was just taking notes and observing the scene, and I would be fine.

Soon, however, the room started to fill with the sounds of static, imperceptibly at first, like a low-humming air conditioner had been turned on. Then, in the corners of my eyes, came what seemed to be like shadows cut through by fast moving sparks of light, pink, green and purple. I remember looking at the nurse and saying, “I think I need to step outside for just a minute…” The next moment I remember, I was stumbling, heavy, blind, and very suddenly sitting in the hallway outside the operating room, with the medical assistant pulling the white sterile mask off of my face.
Carla and I rested in the patient room for a couple of hours before trying to head back to her apartment. She was groggy, tired and couldn’t remember anything from the surgery. As we chatted softly, I began to tell her how she had started to talk to the doctor spontaneously during the surgery, as if talking in her sleep. She stopped me, patiently but with forceful emphasis, insisting she didn’t want to hear any details of what had happened during her operation. When it was time to go home, we carefully wrapped a cream colored scarf around her head in an attempt to camouflage the bulky, white layers of bandages used to protect the stitches. I hailed a taxi, and as I helped Carla in the back seat, Maria explained to the driver that he couldn’t smoke cigarettes as he drove us home. Once back to her apartment in Palermo, I gently led her to the living room couch, as she could not make it up the stairs to her bed. She swallowed a couple of pills of pain medication she had brought from home. And in the dim, barely lit living room of a rented apartment, surrounded by the framed family photos of people she did not know, the healing began.
Moments of Stillness: The Recovery

Melody in bed as I try to configure her computer connection

During her time in Buenos Aires, Melody underwent three separate surgeries for skin removal, liposuction and breast reconstruction. Following each surgery, she convalesced in a three-bedroom apartment she rented with Meryl, which they asked me to share with them for the month and half of their stay. I agreed, not fully understanding the ways in which I would be intimately connected to Melody’s recovery. In certain respects, the “recovery” after each surgery served as a beat of “rest” in contrast to the other momentum generating activities and experiences that move patients along towards surgery.
Recovery also offered one of the clearest experiences of the intersubjective modes of embodiment within the experiences of transnational surgery. Although ethnography is inherently an intersubjective process, the momentum of our own projects and travel agendas remains largely undertheorized within the literature. While most patients did not have an anthropologist willing to take on the duties of post-surgical care in the name of participant observation, it was not unusual to receive care from patient coordinators, other patients, or hired medical assistants in the case of more complicated or multiple surgeries.

I became intimately familiar with her every wound, cleaning her morning and night with soapy pads that I ran over the oozing scabs of her breasts, as well as the lines of stitches that ran up and down both arms and legs, encircling her midsection. I, myself, did not bleed or experience the searing pain of recently cut flesh, but I carried heavy bags of drained blood and fluid and emptied them into the toilet, reconnecting them to the tubes that sprouted from her abdomen. I came to know the bruises of her body, including the ones on her lower back that she herself could not see, where the doctor’s five fingered hand imprint was clearly visible, outlined in the purple, red and yellow of her tender skin.

While I initially used the latex gloves her doctor had provided, the gloves proved cumbersome, and our small supply soon ran out. With my bare fingers, I ran antibiotic ointment over her wounds, and wrapped her arms tightly with cotton pads and compression bandages, becoming familiar with which angles hurt the most, and how much pressure was too much or not enough. Melody would tell me how to rearrange the pillows, adjust the blanket, turn up the air conditioning, or draw the blinds to adjust the chill, heat, ache or drowsiness of each moment. When her compression garment became so tight it was unbearably painful, she begged me to get a steak knife from the kitchen.
Responding not to the doctors instructions, but the intensity of her discomfort, I ran the blade closely along her skin, shredding the tightest sections of fabric from her arms and legs, my relief in not cutting her blending into her relief in being released from the garments tight grasp.

My presence as a separate individual gradually diminished, and she no longer requested privacy during long conversations with her husband and children, asking instead that I undertake the lengthy process of changing her bandages as she chatted about intimate family life. Although I never took my coffee with anything but milk, my taste buds became accustomed to the generous amounts of sugar she preferred, as I sampled each cup to make sure it met her tastes before serving it to her. Once, when I experienced a blindingly intense migraine headache, she insisted I take one of the pain pills she had been prescribed, explaining “if you’re in pain and can’t move, there is no one here to take care of me… so I’m in pain too.”

Through the moments outlined above, I have aimed to show how transnational patients both generate – and are moved by – intersubjective forces of momentum as they travel abroad for surgery. I have turned to the metaphor of momentum to more closely capture the embodied experiences of travel and movement in ways that current models of transnational “moving bodies” or the agentive gestures of “body motion” do not. These initial experiences of momentum were described to me in a variety of ways: the intersubjective pull of affective ties forged over great geographic distance, the sensation of having the pieces and details of travel “fall into place,” the initiation of travel despite imperfect knowledge as a kind of “leap-of-faith.”
The metaphor of momentum, I suggest, allows us to better see how such movement is in excess of individual patients, and encourages us to apprehend the collective forces generated along a range of people, objects, places, and temporalities. Felt as affective obligations building towards a surgical outcome, patients’ modes of being-in-the-world were saturated by momentum as they whirred about Buenos Aires exchanging dollars for pesos, squeezing into dressing rooms to collectively imagine a future body, sipping hot coffee over long chats with medical travel coordinators, and nervously assessing safety and expertise, experienced as a gentle kiss to the cheek from a “handsome” doctor.

Objects, too, enacted their force upon patients, often in ways that pulled them into a future moment in which an object’s usefulness could be realized: the pressing weight of a suitcase handle, heavy with the artifacts needed to care for a post-surgery body; the tight, grasping sensation of an unforgiving compression garment, its pressure requiring a reorientation to a future body that had yet to be created; money belts strapped tightly around the midsection, heavy and bursting with U.S. dollars to pay doctors and hospitals; bottles of pain pills and tubes of antibacterial ointments that would need to be used, or would remain as remnants of a surgery that did not occur.

The city of Buenos Aires itself exerted a force upon some patients, conjuring up romantic images of the “Paris of South America” and trading on connotations of cosmopolitan modernity and white, European heritage to ease patients’ biomedical anxieties. Once within the city’s borders, however, the sensations of being in Buenos Aires also produced experiences of dislocation: the suspicious taste of a potentially contaminated fruit, failed and frustrating internet connections that elicited jokes about
“seeing the veterinarian,” crowded subway rides demanding close proximity to the poverty of a city reeling from crisis. And yet, the very fact of “being” in Buenos Aires also served as a force of momentum, moving patients, encouraging them to ask of themselves, why are you here, if not for surgery?

By attending to these aspects of transnational travel, it becomes possible to better apprehend the ways in which patients did not simply enact movement, but simultaneously moved – and were moved by – forces in excess of themselves. Such an approach is useful not only as a way to better understand the dynamics of movement and motion in relationship to bodies, but also in order to shift our focus from the agentive actions of individual subjects towards the embodied experiences of intersubjectivity. If anthropology has largely succeeded in de-centering the normative subject from our theoretical assumptions, we still have much work to do in order to ethnographically capture the intersubjective experiences and modes of embodiment that remain.

Throughout the dissertation, various forms of overlapping movement have emerged: the movement of First World bodies into the space of Argentina as imagined and cultivated through medical travel marketing, the affective “movement” of patients through warmth and trust of doctors, as well as alternative forms of mobility enacted through the circulating bodies of transformed patient bodies. In this chapter, I have tried not only to trace patient movement, or embed it within larger political and historical movements, but to instead seek to reveal the experiential dimensions of movement itself. Here, I depart from a focus on the mere physical movement of bodies through space that serves as the focus for so much of the literature addressing transnational medical travel, but rather uncover how momentum not only more closely captures the ethnographic
experiences shared with me by transnational patients, but also redirects our attention to more subtle, and theoretically challenging, experiences of movement.

If various forms of movement have occupied the anthropological imagination over the past two decades, what can this focus serve to reveal at this particular moment? I suggest that movement as an analytic retains much possibility, including the capacity to more carefully explore the complex dimensions of intersubjective experience. In the next, and concluding chapter of the dissertation, I pull back from the level of intimate embodiment and intersubjectivity, and return to the broader themes outlined in Chapter One. With a renewed focus on the analytic of movement, this final chapter explores how transnational patients bodies are increasingly circulated as part of diverse political projects endeavoring to move both bodies and borders.
Eyes glowing, hands fluttering into the space between us, she works to impress upon me the unusual nature of his travel: “he had never been to Buenos Aires . . . it was his first trip on a subway, his first trip on a plane!” Maria, a program coordinator at the Embassy of the Bolivarian Republic of Venezuela in Buenos Aires tells the story of one of the first patients she worked with as part of the Misión Milagro (Mission Miracle) project. Pedro, an impoverished agricultural worker from rural Northern Argentina was largely blind due to la nube del ojo (“the cloud of the eye” or cataracts), a degenerative eye condition linked to his many years working under the sun in dusty fields. Unable to see or work, Pedro visited a doctor in his hometown only to have the relatively
straightforward sight restoration surgery remain elusive in the face of long waiting lists and small – yet unaffordable – fees. Maria, her voice now lowered to a reverent hush, emphasizes that the program truly is a miracle, flying Pedro all the way to Venezuela so that skilled Cuban surgeons can restore his sight. “He pays nothing,” she beams. Instead, the Venezuelan and Cuban governments cover the cost of transportation, passport fees, hotel accommodations, consultations, prescription medications, and of course, the surgery itself. After two weeks in a Caracas Hilton, Pedro returns to Argentina, once again able to see the world in which he lives.

As we saw in the last chapter, Melody had never visited South America, let alone Buenos Aires, before she arrived for her surgery. Her experience of transnational medical travel was qualitatively different from Pedro’s. She had traveled to Argentina, alone, for a two-month stay in which she would eventually undergo three surgeries, two blood transfusions and months of excruciating recovery in the face of difficult financial constraints. Unlike Pedro, her surgeries were classified as elective, and her health insurance would not cover their cost. The political dimensions of restoring Pedro’s vision are clear, perhaps even overdetermined: his participation in Misión Milagro is unequivocally framed as part of the Venezuelan and Cuban-led strategy of Bolivarian socialist consolidation within Latin America. Melody’s travel, on the other hand, is seemingly stripped of historical context and political consequence as she is subsumed within the category of “medical tourism,” which, as discussed in Chapter One, indexes leisure, individual consumption, and a particular sense of risk-taking frivolity, particularly when applied to women traveling overseas to undergo cosmetic surgery (Bookman and Bookman 2007; Balch 2006).
The differences in circumstance that have led Melody and Pedro to travel for surgery are self-evident. I suggest, however, that reframing these seemingly contradictory flows of transnational patients as overlapping literal and figurative “operations” in power reveals how the circulation of transnational patient bodies across borders is now a central technique of statecraft, deployed as part of differing political projects organized towards seemingly contradictory ends. To do so requires an examination of the underlying logics of each form of transnational medical travel, which I explore here as the “politics of risk” and “the politics of care.” I understand the politics of risk to refer to the ways in which individuals, such as Melody, take on the risks of transnational travel as part of their role as patient-consumers in a global free market in biomedicine. Patient risk-taking, while enacted individually, fits within a larger organization of risk distribution as precarious transnational patients serve as the early “experimental bodies” through which the political project of off-shoring privatized healthcare may be advanced. Alternatively, the politics of care seeks to consolidate individuals within a larger political collective through the active care and healing of their bodies. By providing care to citizens of other nations, as well as performing the spectacle of care giving (Goldstein 2004), the politics of care enables new forms of expanded sovereignty to be enacted through transnational patient bodies.

Through a critical examination of different forms of “transnational surgery” circulating within Buenos Aires, and the differing politics that underpin their logics, this chapter highlights the political imaginaries enacted through the surgical treatment of transnational patients’ bodies. Ultimately, I point to how throughout both of these examples, transnational bodies serve as the operable sites for re-imagining the
relationship between nations, the borders of the Argentine state and the value of the citizen-bodies within.

**The Politics of Risk: Risky Vanities/Corporeal Investments**

To make this argument requires returning to my discussion on the “politics of risk” in Chapter One and understanding how the conflation of risk with vanity---the “cosmetic” and “elective” nature of the surgeries undertaken---obscures how patients serve as the “experimental” bodies of the neoliberal political project of “off-shoring” healthcare. As part of this political project, as we have seen, post-crisis Argentina is reimagined as an “affordable destination” for travelers from the United States and other wealthier nations, masking the neoliberal logic of the marketplace. Although transnational patients are perceived as “risk-taking” in violation of their role as responsible citizens, they are, in fact, exposed to risk as part of the calculated development of a global market in health services. Definitions of “medical tourism,” as a form of risk-taking, divert attention from the larger political and economic context of insecurity and precariousness in which transnational patients live, including the retraction of state responsibility for health (see Fassin 2007).
“I Did This To Myself”

Melody posing against a black sheet we hung over her closet door

It is around two in the morning when I am woken from a deep sleep by the sound of my name being softly called from the other room. Shaking off the last bits of dream, I groggily head across the hall – this ritual having become a regular part of our nightly routine. I open the door, and through the darkness I can make out Melody, wrapped in bandages and propped up into a semi-reclining position, surrounded by a fortress of pillows. “Sorry,” she whispers, “I just have to pee so bad.”

Melody and I move in slow-motion tandem, working her body inch by inch into a sitting position. I lean all of my weight against her back, pushing hard as she whimpers in pain. One hand supporting Melody, I grab at a series of thick pillows, using them to fill the spaces between her body and the bed. Finally, grasping both of her hands firmly,
we take a simultaneous breath – and on the count of three she jolts forward into a
crouched, half-standing position, hissing through clenched teeth. Catching her breath,
she looks at me and forces a half-smile: “I can’t complain . . .” she explains, “I did this to
myself.”

I take Melody’s statement, I did this to myself, as an opening into the larger
politics of risk that frames transnational medical travel. In this example, it is possible to
see the ways in which "suffering" has been denied (or self-denied) to those seeking
elective surgical enhancement through the discourses of vanity and risk, which are
heightened in the context of transnational travel. The charge of “risky vanity,” as
opposed to surgery undertaken for “health,” is an effective mechanism to transfer risk
onto patients as individuals, rather than examine a fuller range of risks and precarious
positions that patients may occupy.

As numerous medical anthropologists have shown, “objective” determinations of
what is “healthy” or “unhealthy” often reveal underlying normative cultural standards,
regulating socially imagined differences within categories of gender, class, sexuality and
More recent research has examined the shifting standards of those norms, as well as the
relationship between “necessary” and “elective” interventions as our abilities and means
to transform the human body grow daily (Hogle 2002). As sociologist Victoria Pitts-Taylor
argues, the distinction between “aesthetic” and “health” interventions has been
unclear since nineteenth century conflations of mental health with outward appearance,
and may be increasingly ambiguous as the cosmetic surgery industry introduces a range
of services geared toward “cosmetic wellness” (Pitts-Taylor 2007: 25; also Haiken 1997;
Gilman 1999; Sullivan 2001; Pitts-Taylor 2003). Similarly, in her examination of changing forms of “enhancement technologies,” including cosmetic surgery, anthropologist Linda Hogle (2005) argues:

The pursuit of enhancement technologies also indicates the kinds of decisions being made about the appropriateness of using biology to solve social problems such as aging, fairness and inequality of opportunity, and care of the self. As is the case with all technological innovations, enhancements exist in a nexus of complex social, political, and historical relations, media representations, and medical and legal definitions of disorder and well-being…They are a manifestation of changing ways of thinking about biological and social life that is fundamentally transforming institutions, economies, and meanings (Hogle 2005:696).

And, yet, beyond the realm of anthropological interrogation, everyday distinctions between health and aesthetics carry evaluative weight, shape moral judgments and alter practices. Those seeking cosmetic surgery - the majority of who are women - often find themselves embodying the larger social contradictions that exist as part of the sanctioned use and prohibition of aesthetic enhancement (Davis 1995, 2003; Blum 2003). On the one hand, technologies of “limitless improvement and change” have become a common feature of late-capitalism (Bordo 1993), with enhanced forms of embodiment increasingly tied to what it means to conform to proper forms of consumerism and citizenship. And yet, particularly when cosmetic surgery “goes wrong” – resulting in disfigurement or death – or when surgery is taken to “extremes,” such as in the case of so-called “surgery junkies” (Pitts-Taylor 2007), critiques of cosmetic intervention as superficial and unnecessary risk-taking are evaluated alongside the supposed moral good of health for health’s sake (also see Sullivan 2004 on the cosmetic surgery practices of Michael Jackson).
The moral tension embedded in the distinction between aesthetic enhancement and health is more precisely revealed within the context of those seeking affordable cosmetic surgery abroad. As explored in Chapter One, the practice of traveling across national borders for cosmetic surgery takes on the added weight of an imagined risk by virtue of such surgeries taking place in the spaces of the Third World. Reflecting longstanding colonial divisions between spaces of safety and risk, medical travel abroad is freighted with the symbolic weight of an imagined poverty and contamination that extends far beyond the clinical encounter. With the stakes of biomedical risk thus significantly raised, the decision to undergo “unnecessary” and “elective” aesthetic surgery becomes increasingly problematic, as I explore below.

**Friends/Families Critiques of Medical Travel**

Family and friends express strong opinions to patients before they make their choices to undergo surgery abroad, as well as while they are in Argentina. It is important to note that while there are exceptional cases of support, many patients have to negotiate the judgments and manage the fears of others in ways that extend beyond the biomedical risks of surgery. While such fear can be read as an affective expression of care, the framework of risk, blame and vanity through which concern is expressed reflects larger cultural sensibilities about the right to suffer and what kinds of risks, precisely, position patients either as vulnerable citizens or reckless risk-takers.

Shelly, a fifty-two year old woman from outside of Boston, decides early on to keep the purpose of her trip a secret, not even telling her best friend or mother, with whom she is very close. She instead tells them she is going to Buenos Aires for a vacation, and plans to explain the surgery only if they notice her eye-lift upon her return.
Although she admits that her secrecy is in partly not wanting to tell too many people about her cosmetic enhancement, she says the larger problem is that they would be “too worried” and would ask her a “million questions” to see if everything was safe - the hospitals, doctors, and city itself. She explains, “I know they would try to convince me not to do it – and I would spend a lot of my time trying to explain this place to them . . . and in the end, they wouldn’t believe me anyway . . . they would say – the surgery isn’t necessary, so why take the risk?” An equally difficult omission, she explains, was not telling her primary care doctor – a man she respects and trusts deeply as part of the ongoing management of several health issues. “It would have been nice to get his opinion, but there is no way he would have let me leave the country,” she tells me. “I already felt like he wouldn’t like me getting surgery for something that wasn’t . . . wasn’t medical . . . but to do it half-way around the world . . . no way . . . all I can hope is that nothing goes wrong.”

One consequence of the differential moral weighting of health and aesthetics in seeking surgery are patient practices to counter critiques through secrecy, strategic silence and the denial of suffering. Unfortunately, this reinforces the notion that the risks of seeking surgery abroad should, in fact, be understood as individualized, and ultimately further isolates patients. On a broader level, such silence also erases the larger context of why increasing numbers of people feel compelled to leave their home country in order to modify their bodies aesthetically.

This different valuation naturalizes the decision to provide insurance coverage for “health” medical interventions, while keeping those deemed “aesthetic” purely in the category of “the elective,” and thus making it financially prohibitive for many people to
access such surgeries closer to home. Interestingly enough, in Argentina, some health plans actually offer coverage for periodic cosmetic surgery. Anthropologist Alexander Edmonds reports that in Brazil, cosmetic surgery is offered free of charge to the poor in public health clinics (Edmonds 2008). The point here is not to advocate for the widespread provision of cosmetic surgery, but to emphasize the ways in which the distinction between the “necessary” and the “elective” continues, for the most part, to be naturalized in material practices, the distribution of resources, and the modification of some bodies and not others.

In the United States, the number of cosmetic procedures performed each year has risen dramatically. According to the American Society for Aesthetic Plastic Surgery, over 10.2 million cosmetic surgical and non-surgical procedures were performed in the United States in 2008, which represents an increase of 162 percent since the collection of the statistics first began in 1997 (www.ASAPS.com accessed March 27, 2011). Given that aesthetic surgeries are an increasingly common practice as part of conforming to expectations of an ever-youthful femininity (and increasingly masculinity as well), the charge of “vanity” effectively displaces and individualizes social expectations, and in the case of medical travel, makes it possible for states to absolve themselves of responsibility for these circulating, vulnerable bodies. While vanity is not always seen as a moral failing per se, the physical and emotional suffering that accompanies such surgeries is often understood as the “price” of vanity, something that women are responsible for doing to themselves. Here, the work of historian Gwen Kay (2005) is useful, as she traces the ways in which cosmetics came to be federally regulated in the U.S. during the early twentieth century. Showing how a gendered notion of “vanity” was used to dismiss the
serious health concerns of women using cosmetic products, suggests why cosmetic surgery is not currently understood as a public health issue, and why there is no federal or international regulation that exists to provide systematic information to patients about the risks and benefits of having surgery abroad.

In part this is tied to the role that individuals currently play as “experimental bodies” in testing this newly emerging global market in biomedicine, and individuals continue to do this to themselves, even as U.S. corporate interests watch closely as part of considering “medical off-shoring” as a strategy of cost reduction (Petryna et al. 2006). That a number of corporate and governmental groups are following such travel closely is not surprising given the “potential” for “savings” identified in the literature on medical travel.

This same logic also frames ongoing U.S. policy discussions of medical travel, evident in the hearing before the Special Committee on Aging of United States Senate, “The Globalization of Health Care: Can Medical Tourism Reduce Health Care Costs?” (June 27, 2006).25 Testimony at the hearing clearly reflected a market-solution to rising healthcare costs. It included testimony from an uninsured patient and “patient advocate” who had traveled to India for heart surgery, a business consultant hired by several large corporations in the United States to develop medical travel as a cost saving strategy, a corporate benefits manager of a worker-owned paper products company in North Carolina considering offering care in India as part of their insurance coverage, and the CEO of the IndUSHealth, a North Carolina company that specializes in arranging medical trips to India. The only dissenting voice, not surprisingly, was the President of the American Society of Plastic Surgeons, who argued that the practice of medical travel
was one of “significant risk,” although one could argue that the risk was both to patient bodies as well as to the economic interests of U.S.-based cosmetic surgeons (Senate Hearing 109-26:45). The tone of the meeting constantly reiterated the value of bringing the “outsourcing” model to healthcare as a way to reduce costs, primarily as a benefit to large employers. However, medical travel was additionally used as an argument to “check” the profit earnings of major health related corporations. Although seemingly a contradiction, anthropologists Steven Collier and Aihwa Ong (2005; see also Ong 2006) explain, “neoliberalism today remains a pervasive form of political rationality whose formal and ‘global’ character is allowing it to enter into novel relationships with diverse value orientations and political positions” (Collier and Ong 2005:17).

This is clear in the case of the West Virginia state legislature in 2006, which considered (but did not pass) House Bill 4359, which would have offered incentives such as free airfare, lodging and a “rebate” of up to twenty-percent of the cost savings to state employees willing to travel abroad for healthcare. In his introduction of the bill, Delegate Ray Canterbury explained the logic of the plan as “using the global free market to fix the American health-care system” (Dailykos.com, February 4, 2006).26 This statement is a clear expression of “a new relationship between government and knowledge through which governing activities are recast as non-political and non-ideological problems that need technical solutions” (Ong 2006:3). But not all of the transnational patients I worked with accepted this configuration of risk, aesthetics and the body.

In When Bodies Remember, anthropologist Didier Fassin examines the lives of South African mine workers confronting HIV/AIDS, and questions the ways in which biomedical risk comes to overdetermine the notion of the precariousness of their lives.
He suggests that the risk of infection from HIV is one of many everyday risks to which miners are exposed and expected to confront as part of their everyday livelihoods.

Drawing on his own work, as well as that of Catherine Campbell (2007), Fassin writes that:

> part of the miner’s daily experience of being exposed to accidents or to witnessing the accidents of others [which is] also part of the omnipresent ideology of [masculinity and] virility, consist[s] in having to face danger and never show fear…the less visible and more remote risk of being infected by AIDS is considered a mundane sort of danger (Fassin 1007:187).

Even Melody, who acknowledged the limitations of her right to suffer in moments of extraordinary pain, offered a contradictory – and perhaps even transgressive– understanding of the multiple kinds of risks at stake. In order to explore the multiple and omnipresent forms of risk and precariousness patients face, I consider the story Melody told me about her husband’s reaction to her desire to go abroad for surgery in the next section.

**Alternative Imaginations of Risk: “The Bank Can’t Repo Your Body”**

Melody’s husband, Will, was largely supportive of her surgery, despite the increased burden of taking care of their children during the two months she would spend in Argentina. His enthusiastic support was particularly surprising to me, given Melody’s descriptions of their financial affairs, which could only be described as precarious: excessive credit card debt, possible foreclosure on a home they had been in for fewer than two years, mortgage payments far exceeding their means, as well as the daily expenses of raising four children between the ages of three and seventeen. With collection agencies regularly calling their home, Will had encouraged Melody to undergo the surgery she desired with these words: “The bank can’t repo your body.”
In contrast to their home and material possessions, which were under constant threat of repossession, both Will and Melody understood her body as a secure space – an embodied shelter from an entirely different kind of risk. Whereas the discourses on the dangers of medical travel focus exclusively on perceptions of biomedical risk – a risk compounded through the dangers of foreign, Third World hospitals – Melody’s narrative refocuses attention to the precarious vulnerabilities of existing in a late-capitalist United States in times of financial crisis. To see how the relationship between risk, precariousness and citizenship is embodied and enacted through transnational biomedical travel thus requires us to abandon the frameworks of “risk and vanity” or “necessary/elective” surgery in favor of a focus on neoliberal bodies in motion – the practice of the already-precarious. By contrast, Misión Milagro’s life-transforming operations seek to integrate Argentina within an imagined Latin American regional space of political and economic solidarity in express opposition to U.S. neoliberal interventionist policies. In contrast to a neoliberal “politics of risk,” which understands transnational patients as healthcare consumers who make choices and take on the risks of undergoing surgery abroad, the Misión Milagro project in which José participates is organized around a distinct “logic of care.”

The Politics of Care and the Restoration of Vision

Misión Milagro leads to an interweaving of international society. It completely modifies the idea of the border. These Chiefs of State (Chavez and Castro) understand that the change will happen through new concepts of borders.

Maria, Program Coordinator, Venezuelan Embassy

Misión Milagro’s politics organized around a “logic of care” (Mol 2008) aims explicitly to heal the bodies of “Latin Americans” located in Argentina. Yet, the provision of such care remains ambiguous: joyously welcomed by the patients I spoke
with, using surgery to remake Argentine patients into Latin American compatriots has encountered official resistance. The conspicuous circulation of impoverished, suffering Argentine patients across national borders challenges the comparative modernity of the “Paris of South America,” while claims to regional solidarity rest uneasily alongside the forms of racial exceptionalism and cultural privilege embedded within narratives of Argentine nationalism.

In contrast to Foucauldian scholars who focus on the disciplining effects of medicine, Dutch philosopher Annemarie Mol argues that doctoring relies upon a “logic of care” which establishes “attentive, inventive, persistent and forgiving” practices in living with and coping with disease (Mol 2008:55). Mol’s critique of how scholars have framed the medical encounter between patients and doctors reveals some of what is missed in the traditional literature, including the eagerness of patients to “be cared for” rather than enacting “choices” as healthcare consumers, as well as experiences of care-giving by medical practitioners. I suggest that this logic is being adopted in the case of the Misión Milagro program. What distinguishes Misión Milagro’s discourse and practices focusing on care from those oriented toward the “politics of risk” explored above is not that the doctors are necessarily more caring (as explored in Chapter Three, Argentine cosmetic surgeons invoke “warmth” as a trait that informs their practice), but that the care they offer operates within, and symbolically reflects, a greater level of care imagined as part of Latin American solidarity.

I first heard about the flights to Venezuela for surgery while visiting a youth and worker center in an impoverished area of a neighborhood called La Boca. The neighborhood itself embodies some of the contradictions of current-day Buenos Aires –
home to El Caminato and the Soccer stadium “La Bombonera,” two of the cities major
tourist attractions, and yet, beyond these contained spaces, the neighborhood is generally
understood to be unsafe for foreigners (Guano 2003). Guidebooks regularly cite the
dangers of the neighborhood, and I had several close friends inform me that I should be
careful when walking through La Boca alone – and never to go at night. Wanting to
become familiar with the spaces of the city beyond the central zones in which my work
was taking place, I had decided to attend a volunteer training at the center.

The center, which provides food and job training services to the urban poor,
occupies a massive, once-regal stone building that has slipped into disrepair. Inquiring
about several posters tacked to the walls featuring a broadly smiling President Hugo
Chavez in his signature red button-down shirt, I learned the Center had received some
funds through the regional initiatives of the Venezuelan state, although it was also a
favorite of Populist then-Senator Cristina Kirchner. I described my research to the
volunteer director rather generally, telling her I was interested in people who were
traveling to receive health care. Unaware of the rise of medical travel in Buenos Aires,
she suggested I should look into the Misión Milagro program that was taking Argentines
to other countries for eye surgery.

*Misión Milagro*’s goal of restoring sight to the people of Latin America is part of
a larger social and political movement. Structurally, *Misión Milagro* forms one part of the
Cuban and Venezuelan jointly led *Alternativa Bolivariana para las Américas* (Bolivarian
Alternative for the Americas – ALBA, or “dawn” in Spanish). Conceived of as a
network of trade partnerships and an alternative to the U.S.-backed Free Trade Area of
the Americas (FTAA), ALBA is a model of “South-to-South” collaboration,
encompassing numerous projects ranging from literacy programs to oil exchange. As part of ALBA, for example, Cuba receives 90,000 barrels of Venezuelan oil a day in exchange for “over 30,000 doctors, medical personnel and specialists in fields such as education and sports” (Azicri 2009:100).

The goal of offering healthcare to the poor entered into ALBA in 2000, when Venezuelan patients began traveling to Cuba as part of hundreds of “health flights” offering specialized medical treatment free of charge. *Misión Milagro* was initiated in 2004, with an exclusive focus on providing reconstructive eye surgeries throughout the region. According to the program website, fifty-seven ophthalmologic centers have been created in fifteen countries in Latin America, the Caribbean and Africa, and over 1.3 million patients have undergone operations (Cuban Governmental Cooperation in Health Sector, *[http://www.cubacoop.com](http://www.cubacoop.com)*. Accessed July 30, 2009).

Initiated in Argentina in 2006, *Misión Milagro* transports Argentines to Cuban-staffed medical facilities in Caracas, Venezuela and southern Bolivia for surgery. The program hopes to treat six to ten million people by 2020, no doubt a year chosen for its symbolic weight in the effort to restore vision.

In order to learn more about the *Misión Milagro* program within Argentina, I met with Maria, a program coordinator at the Venezuelan Embassy. As she spoke passionately of her work with the patients, she described a project in which the overall experience clearly exceeded the medical benefits of the eye surgery. “The trip” she explained, is transformative – enabling many of the *campesinos* (agricultural workers) to leave their home province for the first time. Participants become “conscious of their rights – of the importance of human rights.”
At the time of our interview, Maria was arranging the fifth health flight between Buenos Aires and Caracas, which would transport more than fifty patients living in Santiago del Estero, an impoverished province in northern Argentina. The flight would also include a handful of other professionals supportive of the project, including teachers, college students, journalists and a priest. The campesinos, Maria explained, suffered from cataracts or abnormal growth of the corneal tissue because of the conditions of their work: “the wind, the sun, the dust - in the fields and factories.” Although sometimes contacting the embassy on their own, patients more often were connected to the program through social and political organizations already existing within their communities. Additionally, Misión Milagro coordinators, some of whom are former patients themselves, often accompany groups of patients throughout the entire process, including initial doctor screenings, passport processing, and to and from the clinical destinations abroad.

When I asked why such treatments were not available locally, Maria sighed heavily. She laid the fault with PAMI (Programa de Atención Médica Integral), a federally run program providing services to children, the poor and those over sixty-five. Patients wait for years, she explained, suffering in blindness when their sight could be restored through a simple operation. Furthermore, PAMI often fails to cover all of the expenses related to surgery, leaving the cost of items such as medication or bandages to the patient. Public healthcare has faced cutbacks following the economic crisis, and the disparity between those who can afford private supplemental insurance and those who rely solely upon public programs is increasing.
However, there is a stigma, Maria explains, against traveling to Venezuela for this surgery. She suggested that Argentine doctors like to think of themselves as superior to other doctors within Latin America and after approaching several hospitals in the area, she was convinced that there was very little support for the program. The Argentine state, Maria complained, does not actively collaborate with the project. “They don’t really care, except maybe by streamlining the processing of the passport, but they do not cover any costs.” Everything, she emphasized, is the responsibility of Cuba and Venezuela. This responsibility can be read as a political strategy. Returning to the quote that opened this chapter, Maria explained:

*Misión Milagro* leads to an interweaving of international society. *It completely modifies the idea of the border.* These Chiefs of State [Chavez and Castro] understand that the change will happen through new concepts of borders.

Following this initial meeting at the embassy in which I expressed a strong interest in meeting doctors and patients involved with the program, I was, in effect, “screened” as part of trying to gain access. My screening process included weekly meetings with a staff member of the Cuban embassy to Argentina, in which we discussed my research in more depth. I was also given regular “homework assignments,” which included watching a DVD about Cuban health outreach programs throughout the world and reading and discussing Fidel Castro’s 1953 speech *History Will Absolve Me*. After a series of these meetings, I was finally connected to an Argentine ophthalmologist working with *ALBA* to screen potential cataracts patients.

Doctora Badaloni’s office was located in a small town in the greater Buenos Aires area, about a forty-minute train ride from the city center. Finding her office was a bit of challenge, and I passed by the entrance several times before realizing her office sign was
hand-painted in graffiti fashion, which I later learned was the artistic expression of a sixteen-year-old who worked behind her reception desk after school.

I arrived at Dr. Badaloni’s before any of the patients from the program were scheduled to arrive that day, giving us a chance to chat before she began her examinations. She was a warm and gregarious woman, with coffee-colored hair and several strands of gold jewelry hanging around her neck, framed by the white collars of her doctors’ coat. She made me a cup of tea, and we began chatting. She described her role in the program thus:

Not all conditions can be operated on, right? The doctor has to determine whether or not a patient is a good candidate for surgery. The doctor is going to determine if [the patient] is able to travel, to tolerate the flight, to tolerate the surgery. If I think so, then I give this report to the coordinator and then, we are going to give him a chance to see…

After about fifteen minutes of chatting, the bells on the front door rang loudly and in came a group of ten people, their bodies quickly filling the extremely small reception area. The patients who were there to be screened were a diverse group: many were middle-aged or older, and they were slightly more men than women. Several wore oversized sunglasses, and one man had such difficulty seeing that he grasped tightly to the arm of another patient as he shuffled to an empty seat. Accompanying the group was a middle-aged woman serving as the coordinator, wearing a satin union jacket and a bright red hat she had received from ALBA. I continued to meet with her for some months after this office visit, and learned that she was responsible for coordinating every aspect of the trip, from checking travel documents, accompanying patients and their companions on the flight, staying with the group at the hotel in Caracas, and accompanying them to doctor’s visits such as these.
That these patients came from backgrounds with limited educational opportunities and faced extreme financial constraints emerged clearly in the course of their screenings, which Dr. Badaloni began by asking whether or not the patients knew their number and letters so that they could be tested with an eye chart. The following exchange between Dr. Badaloni and an elderly man undergoing his screening also reveals the degree to which his sight was limited, and the physical constraints he faced:

Doctora: -¿Conoce las letras o los números?
Do you know the letters or numbers?

Paciente: Sí...
Yes...

Doctora: Bueno. Tápese un ojo y dígame qué letra ve.
Good. Cover one eye and tell me what letter you see.

Paciente: No lo distingo… es lo mismo.
I can’t distinguish it (I can’t tell) . . . it is the same.

Doctora: Bueno, el otro ojo ¿Ahí lo ve?
Good, the other eye. There what do you see?

Paciente: No...
No...

Doctora: ¿Mi mano… ve ahí?
My hand… see it there?

Paciente: No… ahí … sí.
No… there… yes.

After more tests, she turned to the man and exclaimed, “Good! You are a candidate. I can recommend that you go for the surgery.” The man smiles widely, touching her arm. But not every assessment goes in this way, she told me. At the beginning, Dr. Badaloni recommended patients unequivocally for surgery. Not every patient, however, is a good candidate for this kind of travel. As she explains:

I sent everyone for operations and later they were rejected. Look at me! Do you see this enthusiasm! But…we arrived in Venezuela and it was “no, not this one.” Sometimes one operates and it does not go well… in fact, to operate they all have to have cataracts, but there are many that have other associated diseases, and even if you operate, you will not see the results you hope for.
In this assessment of her role in caring for patients, Dr. Badaloni reveals how an individual doctor’s logic of care comes up against the larger politics of care central to the Misión Milagro program. While there are certainly factors that a doctor needs to consider in recommending surgery, Dr. Badaloni points to the probability of success that needs to be calculated in assessing whether or not an operation should move forward. In addition to the medical success, there is a drive to “see the results you hope for”: the spectacle of vision restoration around which the political rhetoric of the program operates. The movement of patients’ bodies across national borders involves not just the restoration of the individual’s vision, but the restoration of a social vision, the ability to make people “see” and recognize the suffering of the socially marginal. Moreover, the spectacle of care giving and restoration of social suffering engenders a deeper political vision, one that imagines Latin America not along the contours of existing borders, but forming alliances and consolidating power in relationship to the Global North. That such spectacle of care and restoration takes on an almost fervent tone is evidenced in the documentaries produced by ALBA, including Hágase La Luz (Let There Be Light). It invokes not only an image of the light that the patient will finally be able to see, but also, in religiously resonant language familiar within the shared culture of Catholicism, the awakening of a new world vision.

These political aspects of the ALBA program were a source of contention among some of the cosmetic surgeons with whom I worked. Many had not heard of the program, but among those who had, most reacted negatively. For example, one cosmetic surgeon asked, “Bolivia? Why would they go to Bolivia to have surgery?” marking the space of Bolivia as “other” and risky in comparison to his imagined Argentina. This is
particularly problematic given his position of comparison from the urban space of Buenos Aires: geographically and economically-marginalized borderlands of Northern Argentina may have more in common with Southern Bolivia than with the capitol city. His statement similarly echoes the ambivalence of the Argentine state in assisting the *ALBA* program, as mentioned by Maria, the Embassy Program Coordinator.

The reluctance of the Argentine state to participate in *Misión Milagro’s* interventions fits within the precarious modernity currently negotiated in post-crisis Argentina: the program transfers patients across national borders producing a profound displacement of biomedical authority. Given the historical importance of biomedicine to national claims to modernity and exceptionalism, *Misión Milagro* calls into question the very ways in which Argentina has traditionally been imagined.

As seen above, both forms of transnational travel for health can only be understood as part of larger political projects: medical travel is evacuated of its overt political valence through a reliance on market-based discourses of choice and risk while *ALBA* is characterized entirely by the political nature of its care for transnational patients’ bodies. Significantly, however, these seemingly contradictory political projects both enact their aims through the movement and surgical alteration of patients’ bodies. By bringing together these two very different cases of operating on transnational patients’ bodies, the underlying logics of both are revealed more precisely than if considered separately. The way in which *care* is deployed as a method of solidarity and political consolidation through *ALBA* exposes more clearly the absence of care for the vulnerable bodies of U.S. transnational patients. In contrast to *ALBA*’s imagined political solidarity, the neoliberal logic of medical travel entrusts patient care to the market, while individuals
take on the risks of traveling to destination countries. The travel of U.S. patients to
destination countries, in turn, engenders the surveillance of the U.S.-based Joint
Commission International, whose power of accreditation operates as a sort of neo-
imperial sovereignty within countries of the Global South attempting to market
themselves as desirable surgical destinations.

At the same time, the clear privileging of the market over the logic of care within
traditional discourses of medical travel draws attention to the fundamentally uneven
practices of care offered through *ALBA*. As seen in my conversations with Dr. Badaloni,
not every *body* is equally positioned to be cared for. Rather, patients are selectively
screened so as to reduce the risk of a less than desirable outcome. Only by reducing this
risk, can *ALBA* produce the maximum spectacle of healing and the effective performance
of caregiving. Revealed through this comparison between transnational flows is how
*ALBA* circulates miraculously restored bodies as a way of marketing a particular
redistribution of political power and sovereignty within Latin America.

In the next section, I move towards a conclusion by bringing together what is
revealed by these two transnational flows of medical travel, and using their intersection
as a place from which to reflect more broadly on the complex political, economic and
ideological dimensions of transnational medical travel and the theoretical questions it
presents.
Conclusion
“To Govern is to Populate”/To Govern is to Operate

Stepping back from the two flows of transnational medical travel explored above, it is worth examining a bit more closely how these two forms of medical travel can tell us about new configurations of medical travel emerging at this moment, and what this may reveal about the larger theoretical concerns of the dissertation.

Considered together, these two flows of transnational patients circulating through the space of Buenos Aires point to how transnational medical travel is folded within larger efforts to re-imagine sovereign spaces and transform borders through the surgical circulation of patient. As discussed in Chapter One, an impressive body of scholarship examines how biomedicine has been used throughout history to imagine and secure the space of the nation and empire (Bashford 2006; Anderson 2006; Peard 1999; Macleod et al. 1988). Biomedicine remains that potent domain imbued with the power to enact changes upon the borders of nations by rendering operable the material bodies of patients. What is significant about interventions around transnational patients, however, is that it signals the importance of moving non-citizen bodies across national borders, insisting upon their visibility as they undergo ritual acts of transformation at the hands of another state.

Throughout this dissertation, I have pointed in different ways to the complex political, historical and economic dimensions of transnational medical travel. In Chapter One, I demonstrated the inadequacies of how medical tourism is discussed in the media and mainstream scholarly literatures, in which the term is either depoliticized through the valences of “leisure” associated with tourism or is understood as a market solution to the problem of inadequate healthcare coverage. Missing from these accounts is attention to
how this travel uniquely departs from – while simultaneously reproducing – long-standing uses of biomedicine to imagine and divide the world into spaces of safety and risk. On the surface, the market logic of medical tourism proposes a sort of radical or even liberatory equivalency of biomedical expertise. The prospect of India or Thailand becoming known as the global center of cardiac care, for example, promises a break with normative traditions of imagining the Global South as a space of contamination, risk and poverty. Yet, I moved to situate transnational medical travel within a longer colonial history of the conflation of whiteness and civilization with biomedical excellence to problematize the promise of a sort of neoliberal democratization of access to healthcare. Rather, I proposed that such travel will most likely further instantiate, rather than fundamentally break from, colonial era conflations between the Global North and biomedical expertise. Even if the racial identities of the doctors who are authorized to operate upon First World bodies fundamentally change, the ways in which such doctors and the countries in which they operate come under new forms of neo-imperial governance is troubling. Rather than actively disciplining colonial bodies to meet the requirements of civilized sanitation, inspectors from the Joint Commission International are now invited and compensated as part of the project of symbolically conferring the status of a secure space.

And yet, official accreditation may not be the only way destination countries make claims to be secure spaces in which to operate upon First World bodies. In Chapter Two, I turned specifically to how Argentina has been positioned as a destination for transnational medical care. While seeking JCI accreditation was one strategy pursued by large-scale institutions, medical tourism companies, as well as doctors who do not have
the capital to purchase the symbolic rights to security, are able to mobilize other
discourses as part of making such claims. Echoing the arguments in Chapter One, I
showed that rather than generic claims to biomedical excellence, medical tourism
marketers in Argentina draw upon a colonial-era conflation between whiteness and
biomedical excellence as part of their argument for why patients should consider surgery
in the “Paris of South America.” Not only does this reflect the ways in which
transnational medical travel may ultimately reproduce historical divisions of the world
into racially distinct spaces of safety and risk, but it also shows how such discourses
serve as a lens to understand ongoing negotiations of Argentine identity, particularly

Importantly, the logic underlying medical tourism cannot be understood as
hegemonic or all-encompassing, as such discourses are creatively interpreted within local
projects of rethinking the Argentine nation in a post-crisis era. I propose that the
marketing materials I explore not only be considered as a means of attracting foreign
patients, but also as a space in which to continue to stake claims about Argentina’s status
as a “modern” and “European” nation in comparison to a racially othered Latin America.
Put differently, it is not only that Argentina must market the nation as part of trying to
participate in an emerging market in biomedical tourism, but also that this emerging
market provides a stage upon which to perform longstanding ideas about Argentine
identity at a time when such claims are increasingly tenuous. That the language of these
claims about racial identity and modernity are articulated within the language of
biomedicine exceeds the demands of the medical tourism market. Rather, I have tried to
show how biomedicine, and science more generally, has long served as a potent realm for performing modernity and staking a transatlantic, rather than regional, identity.

Doctors, too, negotiated this tension, as I explored in Chapter Three. With the ability to secure their professional authority through sanctioned rituals, such as international conference participation, increasingly constrained within a post-crisis era, cosmetic surgeons now find themselves cast as the “cheap” version of their First World colleagues within a newly organized global market in biomedicine. Both resentful of, and resistant to, the discourse of “cheapness” underpinning the logic of medical tourism, Argentine cosmetic surgeons find unique ways to reassert their identity as competent, modern surgeons operating within the space of Argentina. Drawing on notions of aesthetics and warmth, for example, doctors attempt to shift the very parameters of evaluation by which their biomedical competence is assessed. By shifting the categories of analysis, cosmetic surgeons not only make claims about their own value vis-à-vis U.S. and European doctors, but more radically, challenge a hierarchical biomedical system that privileges a First World cultural formation of biomedical expertise over those of the Global South. Such contestations, however, are only ever partial, as I also found doctors nostalgic for participation in the very systems of privilege and expertise granting that they had come to resent.

Increasingly constrained and limited as embedded subjects within a struggling state, cosmetic surgeons also creatively re-imagined the very forms of mobility required for participation, sending out into the world – in their place – the surgically transformed bodies of the mobile transnational subjects upon whom they operate. Their understanding of how their patients’ bodies circulate, and are “welcomed” across borders
as testimony to their excellence, ultimately foreshadows the larger forms of political circulation of transnational bodies across borders explored in this last chapter. And yet, such novel forms of mobility remain partial, as surgeons simultaneously embrace and resent their participation in the emerging market in the care for transnational patients.

If doctors actively imagine the movement of patient bodies, it is patient experiences of movement itself that served as the focus for Chapter Four. Here, I attempted to disrupt the discourses of risk that frame patients “choice” to undertake surgery abroad, not by questioning the historical construction of the specter of risk, as I do in other parts of the dissertation, but rather, by questioning the “choice” itself. Patients’ own experiences of movement – best expressed as a kind of momentum – fundamentally complicate the models of agency scholars often turn to in order to understand the decision to take on of risk of “elective” surgery. Instead, I show how a series of small, seemingly inconsequential movements and connections put into motion a complex range of people, places and objects, which in turn, also serve to “move” patients towards a surgical outcome. In part, I do this to complicate other discussions throughout the dissertation in which patient bodies are understood to “move across” borders. I also, however, turn to momentum as a useful heuristic device in revealing those aspects of embodied experience often obscured in anthropological analyses of movement. The experience of momentum described by the patients with whom I worked speaks to larger theoretical concerns of how to conceptualize subjectivity in relation to movement, and the ways in which this emerging form of transnational travel may help to sharpen longstanding engagements with questions of agency, embodiment and the self.
Finally, the fifth chapter has sought to return to the larger significance of anthropological inquiries into transnationalism. Over the past two decades, anthropologists have collectively demonstrated the importance of international and transnational movement as a central feature of late 20th/21st century human experience. As discussed above, we have more recently looked to the importance of biological forms of subjectivity and citizenship as a central organizing logic of late-capitalism. Thus, furthering our understanding of the stakes in circulating biologically operable citizen bodies across borders seems central to the task of 21st century anthropology (Mascia-Lees 2010). Here, I have approached transnational medical travel not as my object of inquiry, but rather, as a lens revealing a series of expansive techniques through which new ways of imagining, defining and governing the world are enacted. The movement of operable bodies, I argue, is a potent site for anthropological inquiry into emerging formations of power, and new ways of linking bodies, sovereignty and the state.

Taken together, these chapters add to and complicate a number of literatures, and speak to current debates both within anthropology, as well as those outside the discipline. Returning to the original aim of the dissertation, I demonstrate how transnational medical travel reveals more precisely the ways in which neoliberal logics and processes of transnationalism articulate with one another, and how they become inhabited, practiced and embodied. The experiences of patients such as Melody, Carla, and Shelly reveal different embodiments of risk, and how patients take on the silent suffering of “doing it to themselves” even as, in fact, their experiences are the experiments upon which the future outsourcing of U.S. healthcare will be built. Their travel becomes problematic, and even deviantly risky, within a landscape in which racially othered “Third World” countries are
imagined as dangerous, all risks are collapsed into biomedical risk, and “vanity” and “beauty seeking” become the justification for denying state protection. And yet, such travel is not “elective” so much as it is the result of “selective” forms of coverage and denial, the naturalization of some conditions as related to health and others to mere individual preference. Cultural constructs of the necessary and the elective, however, reveal deeply gendered fault lines of risk. It is not only that bodily interventions sought out by women continue to be more closely associated with beauty and the elective, but also that the weight of normalization and incitement to body modification disproportionately affects women and people of color. Some of this may be shifting as more and more men seek out cosmetic procedures, and it will be interesting to see how, and if, the protection of precarious patients shifts if more men undertake transnational travel for cosmetic surgery. Yet, I remain skeptical that men’s mere participation in a cosmetic surgery market will necessarily undo its trivialization.

Another dimension revealed through this research is the connection between neoliberal economic policies and the everyday experiences of economic crisis. Interestingly, my research occurred roughly during the period linking the fallout from the 2000/2001 Argentine economic “crisis” with the beginning of the U.S. economic “recession.” As explored above, Argentine doctors entered into a medical tourism market with the aim of recovering local losses, and as part of a broader state-led move of repackaging economic disaster as a mode of consumption for foreign tourists benefiting from the disparity caused by currency devaluation. And yet, doctors’ experiences of recovery exceeded the mere infusion of cash that foreign patients provided: their aesthetic interventions onto foreign patients’ bodies also became an alternative mode of
negotiating crisis, that is, a materialized form of imagined mobility in the face of increasing economic and geopolitical constraint. On the other side of the equation, the story is not as simple as foreign patient/tourists exploiting Argentina’s economic crisis in the effort to transform their bodies. The stories of Carla and Melody, among others, show patients engaging cosmetic surgery as part of protecting their viability as workers and using the physical body as an economic shelter and space of investment in the face of increasing volatility and risk. “The bank can’t repo your body” becomes not simply an offhand joke, but an opening into the reconfiguration of the embodiment of risk and safety in times of crisis. Transnational medical travel appeals precisely to those who cannot afford such surgeries at home. And yet, the degree of economic vulnerability and unemployment experienced among the patients who came to Argentina reveals transnational medical travel as a bellwether of neoliberal crisis, with body modification emerging as an increasingly important form of negotiating the experience of economic precariousness. That the Argentines I worked with regularly referred to “la crisis” in the United States long before it was referred to in those words by the mainstream U.S. media points to the linkages of neoliberal failure across borders, and asks us to reconsider multiple forms of participating in a transnational market in cosmetic surgery as a mode of embodying and negotiation crisis.

Bringing together this analysis of transnational surgery as a form of negotiating neoliberal economic vulnerability with my analysis of the power of moving citizen-patient bodies across borders as a critical strategy of statecraft demonstrates how my research contributes to theorizations of neoliberalism and transnationalism more broadly. Specifically, this research moves in the direction of addressing the intersection of
neoliberalism and transnationalism as processes of embodiment: perceptual, affective and intersubjective modes of being in the world, as well as practices that simultaneously modify the materiality of bodies themselves. To this last point, biomedicine, and the gendered, raced and classed forms of authority it authorizes, remains a key strategy both of neoliberal statecraft, and the everyday practices taken up as part of negotiating the crises that result.
Endnotes

1 Unless otherwise noted, all names used in this dissertation are pseudonyms.
2 I use quotation marks here to indicate the way in which I want to complicate the term medical tourism, but cease using these marks after this initial use. Later, I make an argument for using the term transnational medical travel, but continue to use the term medical tourism where it highlights the way in which the market enters into popular and scholarly discussions.
3 Throughout the dissertation I alternatively use the phrases Global North/Global South, as well as “First World” and “Third World.” While both divisions are problematic, I employ the first set of terms when offering my own analysis of the relationships of economic and political marginalization that continue to shape the relationships of power between nations. The terms “First/Third World” are used when they are invoked either by the texts that I analyze or by the people with whom I worked. They signal a common way that people continue to conceptually divide the world between relative spaces of wealth and poverty, although such divisions are ultimately problematic as pointed out by Chandra Talpade Mohanty (1998). Yet, they continue to hold analytic weight. Most importantly, however, it is important to remember that such terms do not refer to a given set of characteristics or resources, and may be used very differently by, for example, patients speaking of their experiences traveling abroad in comparison to Argentine doctors reflecting on their own experiences of marginalization living in Argentina.

4 My dissertation research was funded through grants from the National Science Foundation (REG in 2006/Doctoral Dissertation Improvement Grant in 2007-2008), the Department of Education Fulbright-Hays (2007-2008), as well as grants through Rutgers University, including funding from the Graduate School and the Department of Anthropology for research travel funds (2005, 2006, 2007), and a Bevier grant through the Graduate School for dissertation write up (2008-2009).
5 Modernization theory, developed in post-WWII context of U.S., argued that poverty in Latin America was primarily a result of “tradition” and “culture,” leading to the reform of such practices (particularly in agriculture) that were not scientifically modern or efficient. The logic of modernization theory, out of which the Green Revolution emerged, was that the application of “modern” techniques (e.g. petro-chemical fertilizers) would lead to the economic and social advancement of the region (Miller 1977; Escobar 1991).
6 This number is misleading however, in that many newspaper run syndicated columns. For example, an Op-ed written about medical tourism by a journalist at the Wall Street Journal, might turn in up in dozens or more newspapers across the country.
7 Drawing on the discourse of critiques of anthropology as the “handmaiden of colonialism,” Scheper-Hughes charges that bioethicists are the “handmaidens of free market medicine,” in that the development of bioethics paralleled the development of the biotech industry (Scheper-Hughes 2003: 204-5).
In this section, I use the term “medical tourism” when explicitly referring to the emerging industry in Buenos Aires. This is in contrast to my use of the term “medical travel” in other chapters to signal the self-referential use of medical tourism by the marketers and agencies involved. This use of the term by agencies differed by use, for example, by patients or doctors, who used a variety of terms to refer to medical travel. The use of “medical tourism” is meant to index the anticipated commercial aspects of such travel, and is often used by those providing hospitality and travel services, rather than medical services directly.

In *Between Argentines and Arabs*, for example, literary historian Christina Civantos explores the idea of a “Euro-Argentine” Orientalism as part of her study of Arab-Argentine connections. She is particularly interested in the ways in which the categories of barbarism and civilization were mobilized in producing images of the “Orient” as part of the construction of Euro-Argentine identity. While Civantos argues that Sarmientos use of the categories is more ambiguous than may first appear, she locates the text as the primary cultural reference point of an Argentine “Orientalism” that strongly shapes patterns of representational practice and ways of defining particular constructions of Argentine identity (Civantos 2007:77). While explorations of these categories are not unusual among literary historians, current ethnographic work exploring the use of these categories is less common.

Brown playfully uses the term “Test Tube Envy” in an allusion to Freud’s “obviously flawed” construction of feminine identity, in order to get at the desire to appropriate science, which is serving in Argentina as an “absent power” (Brown 2005:14).

These practices, however, are not exclusively oriented to the European gaze of Argentina’s past, but increasingly to a U.S. model in which, like many North American cities, Buenos Aires has experienced an increase in spatial segregation and social polarization, including the expansion and growing poverty found in the *villas miserias* (Guano 2002:185).

Claims to whiteness may be increasingly important in the context in which “the recent instability has compounded the national nostalgia for Argentina’s former wealth and status” (Joseph 2000:337). However, because Joseph completed her fieldwork between 1994 and 1997, this research does not address the ways in which such processes have intensified since the 2001 financial collapse and resulting debt default.

Alternatively, *porteños* work to define the nation in ways that preserve their own sense of racial claims, despite the realities of racial differences that exist in Argentina. Many will even go so far as to claim that Buenos Aires is a *crisol de razas* (racial melting pot), but on further inquiry, are actually referencing the great mix of European nationalities at the turn of the century (Joseph 2000:338). From this claim about the role of race in the city, *porteños* often quickly scale claims up to encompass the space of the nation, arguing that “racism does not exist in Argentina because ‘we are all the same’” (Joseph 2000:336). Joseph’s interviews with people from the interior and immigrants not considered Argentine, however, reveal a very different understanding, including experiences explicitly framed in terms of racism, particularly if those being interviewed self-identified as “bajo y morochito” (short and a little dark) (Joseph 2000:336).

During the time of my fieldwork, the peso hovered at three-to-one, but the rate varied while writing this paper, with one U.S. dollar roughly equivalent to Arg$3.80, and one Argentine peso equivalent to about twenty-six cents. This rate is according to xe.com,
which I accessed on July 31, 2009. The rates of actual exchange in the various casas de cambio throughout Buenos Aires may be slightly lower. However, it is worth noting that many services related to medical tourism, such as the cost of surgery, apartment rental, etc. are quoted in U.S. dollars (which is the preferred form of payment) to avoid the vagaries of inflation. However, other services, such as hospital related charges, taxis, medications, implants, etc. are charged in local currency.

According to the INDEC (Instituto Nacional de Estadistica y Censos de la Republica Argentina) website (Accessed August 4, 2009: http://www.indec.gov.ar/indec/ingles/i_anuario.asp), the concept of extreme poverty (indigencia), is that income of a household is too low to be able to afford a “basic food basket (Canasta Básica de Alimentos), which would provide household members with their daily calorie and protein requirements. Calculations of the poverty line (línea de pobreza) take into account caloric consumption, as well as non-dietary goods such as clothing, transportation, education and health. INDEC: Encuesta Permanente de Hogares.

All names are pseudonyms.

Given that Pablo is originally from Uruguay, but has lived in Argentina for over a decade, many of his answers also presupposed a parallel between the two countries, which was not challenged by his Argentine business partner, David. However, it would be interesting to further compare the nuanced distinctions and similarities ascribed to Uruguay and Argentina by differently positioned people.

Even studies that have looked to the transnational movement of the global elite, such as Aihwa Ong’s Flexible Citizenship (1999), have demonstrated the ways in which the normal constraints of territoriality and citizenship are increasingly transformed by highly-mobile neoliberal subjects. See also Sassen’s (1998) The Mobility of Labor and Capital: A Study in International Investment and Labor Flow and Dana Nelson’s (1998) National Manhood: Capitalist Citizenship and the Imagined Fraternity of White Men.

His awards included the U.S.-based John Scott Prize (1979), a University Chair of Cardiovascular Surgery in Tel Aviv, the Canadian Dairdner Foundation International Award, and the Prince Mahidol Prize, granted by the King of Thailand in 1999, among others.

While this is obviously an important area for further research, I was unable to do so within the confines of my networks and research period in Argentina.

To complicate the question of price further, it is crucial to note that surgeons who employ “medical tourism coordinators,” such as Dr. Babor and Dr. BanetBanet, compensate coordinators out of individual patient fees in the form of a commission, not in the form of a set salary. So while doctors can technically claim that they charge foreign patients the same price as local patients for similar surgeries, how such surgeries come packaged with the care of a coordinator increases that price significantly.

While two of the patients I accompanied did receive printed contracts outlining anticipated fees, most received only verbal descriptions of how much cash they would need to bring as well as a hand-written receipt detailing following payment. Surgeries were often paid for in cash in U.S. dollars, a practice that is not unusual in a variety of high-stakes transactions in Argentina (e.g. renting an apartment) in part because the dollar, at least prior to the U.S. crisis, was still seen as relatively stable compared to the fluctuating Argentine peso.
The question of how doctors and patients come to agreement on a plan for ideal bodily change is complex. Time and time again, I witnessed tension in the consultorio as doctors attempted to “manage” the “expectations” of their patients. When such surgeries involved “lifting” (with the English word widely used by Spanish speakers to refer to lifting procedures), for example, a doctor might hand his patients a mirror, or seat them at desk with a standing mirror, and ask them to describe and point to the changes they envisioned. Yet, unlike the metaphors of art invoked by the surgeons in describing their “craft,” the human body is not infinitely malleable, and much work went into explaining to patients that their desired changes were not actually desirable or even possible.

This hearing was chaired by Senator Gordon Smith of Oregon.

House Bill 4359 was introduced on February 2, 2006 by Delegate Ray Canterbury (R-Greenbrier). The bill would have allowed state employees covered by the West Virginia Public Employees Insurance Agency (PEIA) to go to foreign hospitals for health services. The complete list of incentives included: 1.) Waiver of co-pay and deductible; 2.) Round Trip airfare for covered employee and one companion. 3.) Lodging expenses during time of procedure and up to seven days post-procedure; 4.) Payment of 7 days of sick leave not counted against the employees total sick leave days and 5.) A rebate of twenty percent of the cost savings paid to the employee. According to tracking available on the West Virginia legislatures official site, the bill never made it out of its considerations by the Finance Committee. While not passed, the introduction of the bill incited a flurry of newspaper articles and political blog postings, many expressing disapproval of the bill.

Costs for the program can be difficult to estimate. According to New York Times reporter Simon Romero, “Precise figures on how much Venezuela spends on Mission Miracle are hard to calculate, since the services of Cuban doctors in the program are considered barter in exchange for subsidized Venezuelan oil sent to Cuba.” (February 26, 2008).

That the Misión Milagro program is gaining visibility through media exposure is clear, although the messages vary from state produced documentaries such as the 2005 Hágase La Luz (Let There Be Light) to more skeptical analyses in high profile international press sources, such as The New York Times. A February 26, 2008 article in The New York Times was titled “Free Eye Care From Chávez, All the Better to See Him.”

This same sentiment was noted in a 2008 New York Times article on Misión Milagro, which reported that Argentine medical associations “expressed alarm” at reports that approximately seventeen thousand Argentines had been taken across the border to Bolivia, and that “Argentine ophthalmologists claimed the Cubans lacked proper training” (February 28, 2008).
Bibliography

Aaditya Mattoo and Randeep Rathindran

Alsever J

Anderson, Warwick,

Appadurai, Arjun,

Applbaum, Kalman

Azicri, Max

Barthes, Roland, and Stephen Heath

Basch, Linda G., Nina Glick Schiller, and Cristina Szanton Blanc

Bashford, Alison,


Baudrillard, Jean,

Benjamin, Walter, and Rolf Tiedemann

Birdwhistell, Ray L.
Bishop, Rachel A., and James A. Litch

Blum, Virginia L.,

Bookman, Milica and Karla R. Bookman

Bordo, Susan,

Bourdieu, Pierre,


Bourdieu, Pierre, and Loïc J. D. Wacquant

Brennan, Denise,

Brown, J. Andrew,

Brownell, Susan

Bruner, Edward M.

Burke, Timothy,

Butler, Judith,

Caldeira, Teresa

Cancel, Daniel

Cannon, Michael F., and Michael Tanner

Chatterjee, Partha,


Civantos, Christina

Clifford, James

Cohen J.

Cohen, Lawrence


Connell, J.
Csordas, Thomas J.
1997 The sacred self a cultural phenomenology of charismatic healing.


Cussins, C.

Dávila, Arlene

Davis, Kathy,


De Vos, P., W. De Ceukelaire, M. Bonet, and P. Van der Stuyft

Delmonico, Francis L., and Nancy Scheper-Hughes

Desmond, Jane C.

Dinerstein, Ana

Douglas, Mary

Dumit, Joseph

Dyck, Noel, and Eduardo P. Archetti
Edelman, Marc
Stanford, Calif.: Stanford University Press.

Edmonds, Alexander
2007 ‘The Poor have the Right to be Beautiful’: Cosmetic Surgery in Neoliberal Brazil. The Journal of the Royal Anthropological Institute 13(2):363-381.


Farnell, Brenda


Farquhar, Judith

Fassin, Didier

Fernández-Kelly, María Patricia,

Foucault, Michel


Foucault, Michel and Colin Gordon

Foucault, Michel and Paul Rabinow

Frank, Andre Gunder
Freeman, Carla

Giddens, Anthony


Gilman, Sander L.

Gilroy, Paul


Ginsburg, Robert

Goldstein, Daniel M.

Good, Mary-Jo DelVecchio
1995 American medicine, the quest for competence.

Goodrich, Jonathan and Grace Goodrich

Grimson, Alejandro, and Gabriel Kessler

Grosz, Elizabeth

Guano, Emanuela


Gupta, Akhil and James Ferguson.

Hahn, Robert A., and Atwood D. Gaines

Haiken, Elizabeth

Haynes, Douglas Melvin

Heidegger, Martin, and Joan Stambaugh

Hembry, Phyllis May

Heng, Boon Chin

Hewitt, Bill
2006 The Doctors is in...India. People 65(24):131-135.

Holtzman, Jon
Horowitz MD, and Rosensweig JA  

Inhorn, Marcia C., and Pasquale Patrizio  
2009 Rethinking Reproductive Tourism as Reproductive Exile. Fertility and Sterility. 92(3):904.

Jacobson, Shari  

Jacovella, Patricio  

Jameson, Fredric, and Masao Miyoshi  

Joseph, Galen  

Kangas, Beth  

Kangas, Beth  

Katzew, Ilona  

Kaw, Eugenia  

Keller, Charles M., and Janet Dixon Keller  

Ker, Unmesh, et al.  
2006 Outsourcing Your Heart. Time 167(22):44-47.
Kevan SM

Kleinman, Arthur

Latour, Bruno


Laws, Eric

Lock, Margaret M.


Luhrmann, T.

MacLachlan, Colin M.

MacLeod, Roy M., and Milton James Lewis
1988 Disease, Medicine, and Empire: Perspectives on Western Medicine and the Experience of European Expansion. London; New York: Routledge.

Mahmood, Saba


Malinowski, Bronislaw,
1922 Argonauts of the Western Pacific; an Account of Native Enterprise and

Malkki, Liisa H.

Manna C, and Nardo LG

Martin, Emily
1995 Flexible Bodies: Tracking Immunity in American Culture; from the Days of Polio to the Age of AIDS. Boston: Beacon Press.

Mascia-Lees, Frances E.

Masiello, Francine
1992 Between civilization & barbarism women, nation, and literary culture in modern Argentina.

Mauss, Marcel

Mazzarella, William,

Mazzaschi, Andrew, and Emily Anne McDonald
2010 Comparative Perspectives Symposium: Gender and Medical Tourism. Chicago, IL: University of Chicago press.

McClintock, Anne, and George Robertson

Merleau-Ponty, Maurice,
Miller, G.

Miller, Daniel

Miller, M. N., and A. J. Pumariega

Miyazaki, Hirozaku

Miyoshi, Masao

Mohanty, Chandra Talpade

Mol, Annemarie

Moya, J. C.

Oakes, Tim, and Louisa Schein

Ong, Aihwa


Ong, Aihwa, and Stephen J. Collier
Orlove, Benjamin S.  

Owen, John Wyn  

Peard, Julyan G.  

Pennings, G.  

Pitts-Taylor, Victoria  

-  

Rapp, Rayna  

Roberts, Elizabeth and Nancy Scheper-Hughes  

Rodríguez, Julia,  

Sahlins, Marshall David,  

Said, Edward W.  

Sarmiento, Domingo Faustino, Kathleen Ross, and Inc ebrary  

Sassen, Saskia  
Schein, Louisa

Scheper-Hughes, Nancy


Scheper-Hughes, Nancy, and Margaret M. Lock

Scholtz, H., and S. Pretorius

Sharp, Lesley A.


Smerd, Jeremy
2006 The Insider - Medical Benefits - A (Long) Trip To The Doctor - Thousands of Americans each Year Travel Abroad for Lower-Cost Elective Surgeries. but
Employers, Concerned about Liability and Public Perception, are Hesitant to Try Medical Tourism. Workforce: 1.

Smith, Valene L.

Sobo, E.J.

Spar, D.

Sullivan, Deborah A.,

Sutton, Barbara

Talbot, Margaret

Taylor, Diana.

Taylor, Guy

Taylor, Janelle S.,

Tsing, Anna Lowenhaupt

Turner, Bryan S.

Uribe, Juan Pablo, and Nicole Schwab
2003 El Sector Salud Argentino En Medio De La Crisis: Producido Por La Oficina

Urry, John

Volcic, Zala

Wailoo, Keith, Julie Livingston, and Peter Joseph Guarnaccia

Wallerstein, Immanuel


Whittaker, Andrea


Williams, Drid,

Williams, Raymond

Williamson, Judith,

Wolf, Eric

Wrigley, Richard, and George Revill
2000 Pathologies of Travel. Amsterdam; Atlanta, GA: Rodopi.

York D
2008 Medical Tourism: The Trend Toward Outsourcing Medical Procedures to...