

BODIES OF VALUE: TRANSNATIONAL DISCOURSES AND PRACTICES OF
PLASTIC SURGERY

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ABSTRACT OF THE DISSERTATION

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Proceeding through case studies of actors involved in transnational instantiations of plastic surgery practice or discourse, this dissertation demonstrates that a transnational lens illuminates new dimensions of plastic surgery's history and its contemporary manifestations. Examining plastic surgeons' development efforts after WWII, the transnational charity Operation Smile, and cosmetic surgery tourism to Johannesburg, South Africa, the dissertation examine how surgeons' and patients' involvement in transnational work affects their understandings race, gender, and health. I argue that, in all three cases, the demarcation between reconstructive and cosmetic surgery is racialized: On the one hand, cosmetic patients understood as paradigmatically white and from the "developed world," enacting forms of self-investment through medical markets. On the other hand, recipients of reconstructive surgery, associated with particular geographical areas and racialized as nonwhite, are understood as objects of external investment. I show that the concept of race operative in transnational surgical contexts is not, first and foremost, an anatomical one; rather surgeons produce a nonbiological but

still embodied conception of race that is linked to cultural and economic difference. Finally, I show that plastic surgery's expansive conception of health—incorporating bodily, psychic, and social dimensions—is precisely what allows it to engage in the forms of racialization I describe and what enables the specialty to incorporate itself into a variety of economic rationalities.

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Introduction

The statistics regarding the contemporary global trends in cosmetic surgery, while providing an impressive sense of the scale of the cosmetic surgery industry and its expansive global reach, they tend to conceal as much as they reveal. According to the International Society of Aesthetic Plastic Surgery (ISAPS), in 2011, there were over 1 million cosmetic surgery procedures performed in the United States, 900,000 in Brazil, 415,000 in China, 372,000 in Japan, 299,000 in Mexico, and so on. The *Daily Mail* (Bates 2011) notes that the ISAPS statistics, when analyzed on a per capita basis, demonstrate that South Koreans undergo more cosmetic surgery than any other nationality, followed by Greeks, Italians, and Americans. In discussions of these statistics, surgeons and media commentators alike are apt to mention the plastic surgery “industry” and discuss the changes in the amount of money spent within particular national contexts. For instance, in a story titled “Economy, Boob Jobs Grow,” ABC News notes that the 2010 figures are the first “uptick in cosmetic procedures ... since the recession began” (Conley 2011). The story quotes a surgeon explaining, “The market has recovered, so people are feeling a little more comfortable to spend money.” Similarly, CNN notes in a headline, “\$10 billion spent on cosmetic procedures despite recession” (Cafferty 2010).

But I’d like to pause at the outset to interrogate the assumptions underlying those statistics as a way of introducing the themes that organize this dissertation. What are the conditions that make possible their emergence, and what does that show us? First, the prevalence of monetary figures and references to the economy highlights the

entwinement of plastic surgery with capitalism. This entwinement is significant for several reasons, but the one most central to my argument is that the study of plastic surgery practice and discourse provides unique insights into medicine's integration with capitalist formations. In fact, cosmetic surgery has become paradigmatic of the commodification of medicine within the contemporary era (e.g., Frank 2004). What these statistics show, in my estimation, is that people are literally investing capital into their bodies and transforming them through that investment. The specific forms of investment and its effects on the micropolitics of bodies are what form the basis for the argument I advance in this dissertation.

Second, these statistics highlight the imbrication of plastic surgery with nation and the transnational; the aggregations take place through demarcating nation. They demonstrate that surgery is a transnational phenomenon situated within national contexts and economies. The organization of plastic surgery through the category of nation is again an obvious point, but it forms another important part of the argument developed here—that plastic surgery cannot be understood as a practice of capitalism's intersection with medicine without also interrogating the ways in which it both crosses national borders and shores them up (often simultaneously). These statistics point to not only differing rates of plastic surgery within different nations but also to the establishment of national plastic surgery boards and societies as well as international ones, differing insurance economies, international and national accreditation boards, tourism policies, and much more. What is less obvious within these statistics is how trans/national forms of plastic surgery produce what I will call bodies of value within a neoliberal medical economy. Viewing plastic surgery as a mode of investment in bodies, I argue that plastic

surgery is wedded to trans/national economic circuits in such a way that they enable us to see the intimate relation between the body, capital, and the nation.

The economic underpinnings of *cosmetic* surgery, as the above statistics show, are quite easy to discern (though the full complexities and implications of this are less clear). But how do economic forces shape *reconstructive* surgery, and how do they shape the bodies upon which surgeons operate, both cosmetically and reconstructively? How are economic globalization and transnational forms of capitalism articulated through both cosmetic and reconstructive surgery? How does the binary between cosmetic and reconstructive surgery, as untenable as it may ultimately be, inform how surgeons and patients understand the transnational activities that they are engaged in? And, when surgeons and patients are engaged in transnational work, how does this affect the way in which race and gender are understood by these actors? How do cases of transnational surgery exhibit continuities with or differences from the asymmetries of capitalism and the previous relations of colonialism prior to the postwar era?

To answer these questions, the dissertation proceeds through a series of case studies—surgeons' involvement in development projects after WWII, the transnational charity work of Operation Smile, and cosmetic surgery tourism to Johannesburg. Though the areas of emphasis necessarily differ from chapter to chapter, the dissertation makes three overarching arguments: First, that the division between reconstructive and cosmetic surgery—which supposedly marks the difference between repair and enhancement (Jones 2008)—functions as a racialized division within transnational forms of surgery. I argue that the dynamics of contemporary capitalism and (neo)liberal philosophies undergirding them function to correlate enhancement with the self-choosing, liberal subject, associated

with whiteness and economic privilege, and reconstruction with the illiberal subject who is subject to external investment through surgery and racialized as nonwhite. This is not to say that all subjects who are “enhancing” their bodies through the surgical market are white, but that the subject of enhancement, in these accounts, is paradigmatically white and from the “first world.” Within the transnational economies I examine, in fact, race emerges as the fundamental means of ascribing differential valuation to individual bodies or sets of bodies.

Second, and closely related to the first, the concept of race operative in transnational accounts, while fundamental to plastic surgery and while certainly embodied, is defined more significantly through cultural difference and the liberal/illiberal divide than through biological or anatomical conceptions of race. While surgeons continue to perform surgeries that shape bodies in ways that normalize their appearance in conformance with racialized and gendered norms, these surgeries do not emerge as the most significant dimension of racialization within transnational forms of surgery. Instead, in the cases I examine, race emerges through a culturalized understanding of difference. This difference is still embodied, but, in different ways throughout the chapters, these bodily differences are perceived primarily as products of culture. As I will show, this is related to plastic surgery’s postwar engagement with development discourse and the eschewal of biological understandings of race in the postwar period.

Third, the dissertation argues that plastic surgery’s conception of health—which incorporates psychic, social, and bodily dimensions in particular ways—is precisely what allows it to engage in the forms of racialization I describe above as well as what allows it

to address and incorporate itself into such a vast variety of economic and medical philosophies. An analysis of the conception of health operative within plastic surgery, which is itself linked to the specialization's association with the market, thus allows a unique window into the economic underpinnings of conceptions of health both within the era of liberal development and within the neoliberal context.

While plastic surgery has been a fruitful area of academic study for some time now, transnational analyses of the history of plastic surgery or its contemporary forms are few and far between. While cosmetic surgery's transnational history is briefly acknowledged by some critics (e.g., Haiken 1997; Gilman 1999; Jones 2008; Gimlin 2007), its transnational historical and present dimensions are often noted only in passing, as evidence of cosmetic surgery's growing presence around the world, and the ways that national borders and travel across them function to shape how plastic surgery and participants in it understand their practices is largely absent. While a small body of literature on transnationalism and surgery has recently developed, scholars have tended to eschew an intersectional approach to cosmetic surgery until recently, and gender and race have been the primary analytics through which scholars have viewed the politics of surgery. Nation as a category has been less obvious, perhaps because gender and race are more easily understood as embodied properties, whereas nation has not had the longstanding connection to bodies that an analysis of plastic surgery immediately suggests. Furthermore, a concern with intersectionality in literature on cosmetic surgery has been quite recent; instead, one axis has been privileged in most accounts. And while feminist authors have been the most prolific on the subject, for much of the 1990s, their scholarship was focused on debates regarding the agency of women who underwent

surgery and whether they should be viewed as perpetuating patriarchal standards, cultural dupes of the cosmetic surgery industry, or rational agents negotiating constrained choices. While these debates were useful in illuminating the disciplining aspects of the practice, the focus on norms of beauty and critique of mind/body dualism involved in these discussions did not leave much room for a discussion of the politics and economics of nation (except, tangentially, regarding whether national insurance schemes encouraged women to get surgery). By investigating transnational aspects of plastic surgery as a medical specialization, I show that by neglecting transnational dimensions of the specialty, scholars have missed key questions about the ways that plastic surgery functions to racialize particular bodies and populations, how its logic is linked to changing economic configurations, and how it forms a key arena for the integration of bodies into particular economies and the valuation and devaluation of bodies within contemporary capitalism. But not only does the dissertation argue that transnational frame illuminates new dimensions of the institutionalization of plastic surgery as a medical specialty and market, it argues that plastic surgery itself is a lens through which to view changes in contemporary bodily and medical norms. That is, because of plastic surgery's history, particularly its unique relation to the market (derived from the fact that its development has, from its earliest incarnations, incorporated a model of the patient as consumer), it can be seen as a perfect site for gaining insight into the broader trends of the commodification and neoliberalization of medicine and the formation of transnational medical economies.

Viewing plastic surgery as a mode of transnational investment by capital to produce what I term "bodies of value," this dissertation, "Bodies of Value: Transnational

Discourses and Practices of Plastic Surgery,” explores new paradigms of bodily management, forms of subjectification, and discursive formations surrounding bodies in the era of globalization. I argue that plastic surgery creates new processes of racialization by which transnational medical markets produce certain bodies as more socially valued. Demonstrating that plastic surgery has the capacity to make investments in bodies in ways that mix aesthetic, monetary, and social value, I begin by situating transnational forms of plastic surgery practice within post–World War II liberal humanitarian visions. I then move to discuss contemporary neoliberal practices, such as medical tourism and transnational charities that perform free reconstructive surgery in so-called developing countries, which produce new forms of racialization and gendering through transnational movements of patients, doctors, and discourses. I show that plastic-surgery markets integrate the body and economy in such a way as to exploit neocolonial economic arrangements and produce new forms of racialization alongside possibilities for self-enhancement. To answer the above questions, I examine three cases of transnational plastic surgery—surgeons’ involvement with post-WWII development efforts (which involve activities of surgeons from the United States, the United Kingdom, New Zealand, and South Africa in Vietnam, East Africa [Tanzania, Uganda, and Kenya], South Africa, Gabon, Japan, and a variety of other locales), the discourse emanating from the transnational charity Operation Smile (a US-based charity with activities in numerous countries), and cosmetic surgery tourism to Johannesburg, South Africa (involving South African surgeons and entrepreneurs and clients from the US and UK). At first glance, what unifies the cases is simply their transnationality. Scholarship that investigates the national and transnational dimensions of cosmetic or plastic surgery generally situates it

within national contexts, often noting the transnational forces that affect those contexts, whether in Japan (Haiken 1997, 202-4), Brazil (Edmonds 2007a, 2007b), Korea (Lee 2008), or Colombia (Taussig 2012). I have taken a different approach. My dissertation proceeds via case studies of explicitly transnational surgical practices, meaning cases in which doctors, patients, or institutions cross national borders to perform or receive surgery and where this crossing is somehow meaningful to the actors involved. I concentrate specifically on cases in which the boundaries crossed are not simply national but geopolitical—from North to South or West to East—in order to allow me to focus on the question of how the economic asymmetries within postwar capitalist formations are articulated within surgical discourse and practice. Because the transnational dimension, in these cases, involves travel to places that are relatively unfamiliar to at least some of the actors involved, these sites allowed me to find texts (defined expansively) in which surgeons and patients provide explicit meditations on cultural, racial, economic, and bodily differences.

Chapter Descriptions and Rationales

This section introduces the chapter structure of the dissertation, providing more detail regarding the content of the chapters, a statement of the originality of the research, and a rationale behind the selection of each case.

Chapter 1 reviews the literature on plastic surgery and contextualizes it within the historical and contemporary (neo)liberal practices through which bodies and economies are intertwined. Drawing on medical sociology, medical anthropology, historical, science and technology studies, and cultural studies scholarship concerned with theorizing the

commodification of bodies and the coimplication of medicine and capitalism, I show that plastic surgery is both historically intertwined with economic and market forces and contemporarily functions as a technology that promotes forms of medicalized self-entrepreneurship. This means that plastic surgery must be seen as a force driving the application of a market model to medicine, encouraging a view of the body as a project to be enacted through purchasing services and technologies in the market. But our understanding of the phenomenon is incomplete if we do not analyze both plastic surgery's transnational investments and how reconstructive surgery, which does not conform to a self-entrepreneurship model, is still productive of value.

In chapter 2, "Liberal Visions and the Traveling Surgeon: Race and the Value of Plastic Surgery to Development," I explore the post-World War II linkages between plastic surgery and the expanding arena of international medical development and humanitarianism. First, I analyze articles in surgery journals, primarily from the 1960s, that are self-conscious appraisals of plastic surgery's internationalism, especially programs designed to encourage doctors from locales with "developed" plastic surgery training to perform surgery in "developing" countries. The authors of these articles shared with other medical professionals of the period the understanding that medicine, through the alleviation of human suffering, could create bonds across nation, race, and culture. The professed liberalism of plastic surgery and its capacity to invest in the human capital of nations takes shape particularly strongly in surgeons' efforts in Vietnam both before and after the US war there, joining surgery to the fight against communism and the promise of freedom through integration into the capitalist economy. However, I argue that in fact plastic surgery's adoption of development frameworks incorporates and

sustains the economic inequality that it purports to overcome and represents the “developing world” as a site of disfigurement. These surgeons understand plastic surgery itself as a form of development capital—thus the labor of surgeons in underdeveloped countries is seen as a form of nation building, and the bodies that surgeons “repair” become part of the development project.

The chapter then turns to the organization The Flying Doctors of East Africa (founded by British, American, and New Zealand plastic surgeons in 1958), as well as the work of Dr. Jack Penn, South Africa’s first plastic surgeon. Analyzing memoirs of these surgeons, I use these two case studies to argue that race is a central organizing concept in plastic surgery’s humanitarian vision. The Flying Doctors, through their construction of the “African Patient” (Vaughan 1991), ultimately figure black Africans as sites of medical investment insofar as they are disfigured or their lives are in danger, while their cosmetic clients in New York are seen as engaging in a self-investment that produces *added* value rather than sustaining life. They locate race not primarily in terms of naturally occurring anatomical difference but through culturally produced differences in embodiment (through injury or through differing understandings of embodiment). Penn too, through his memoir detailing his many international travels, replicates a picture of black bodies as interrupting the liberal vision of international, cross-racial togetherness through their illiberal cultures and unwieldy bodies.

This chapter thus both contributes to pressing scholarly conversations on the politics of humanitarianism (within women’s and gender studies, medical anthropology, and cultural studies) and lays the groundwork for the understanding of neoliberal transnational surgical practice discussed in the following chapters. But it also

significantly expands the geographical range of sites that are considered integral to the development of plastic surgery as a specialty. While Vietnam is sometimes briefly mentioned in the historical literature (Gilman 1999, 105-6; Haiken 1997, 203-5), the surgical activities I analyze there have not been subject to any critical scholarly scrutiny. Indeed, plastic surgery's role in the economic development has not been subject to any sustained critical study. As I hint above, while scholars have been keen to examine the ways in which cosmetic surgery reflects underlying and shifting economic logics, the economic rationales of reconstructive surgery—through which, in this case, bodies are subject to investment as a means of enriching human capital—have not been subjected to analysis.¹ The section on Vietnam and the chapter as a whole thus contributes to this gap as well. Similarly, east Africa and South Africa are sites that have played virtually no role in the way that histories of plastic surgery have been narrated. As James Ferguson (2006) has noted, Africa itself is consistently erased or understudied in the literature on globalization. Its absence from the history of plastic surgery results both from the dearth of commentary on transnational forms of surgery generally and from the overall neglect of Africa within scholarship on globalization. The latter two examples in this chapter both concern Africa, but they do so in very different ways and involve very different actors, thus ensuring that a variegated and multifold representation of surgery in “Africa” emerges rather than a monolithic one (however monolithic the image of Africa that the surgeons themselves held might have been). While Sander Gilman does draw attention to the ways that colonialism has shaped understandings of anatomy through scientific racism, very few scholars have paid attention to the ways that colonialism and

¹ In the historical literature, the role of reconstructive surgery in general, let alone its economic dimensions, falls away as a sustained focus after World War II.

neocolonialism have structured the material organization of surgery's travels or the philosophies justifying surgical intervention into particular geographic locales.

Continuing the dissertation's discussion of humanitarianism but moving to neoliberal forms, chapter 3, "Healing Faces, Healing the World? Operation Smile, the Humanitarian Mission, and the Address to Human Dignity," takes up transnational the charity Operation Smile, an organization that primarily performs reconstructive surgery on children with cleft lips and cleft palates in locations where plastic surgery is not readily available or affordable, once again yoking plastic surgery to development and humanitarian discourse. Within a broader context of the NGO-ization of health care and the production of indebtedness, Operation Smile seeks to ameliorate the inequities of global capital through performing plastic surgery on particular sets of bodies. To justify their activities, they employ the concept of human dignity, a concept that has long undergirded justifications of humanitarianism and human rights. In Operation Smile's usage, however, dignity becomes at once somatized (that is, seen as stemming from the body itself, an inherent quality of nondisfigured bodies) and culturally embedded (that is, seen as in need of affirmation by the cultures in which bodies are situated). This tension within Operation Smile's deployment of "dignity" serves to pathologize both the "local cultures" into which it intervenes and the bodies of those upon whom it operates. By analyzing debates in surgery journals, I show how Operation Smile preserves the economic inequality upon which it is premised, belying its claims for the universal power of the smile to overcome national, cultural, and economic differences.

While some studies of Operation Smile do exist (Talley 2008), they do not focus primarily on the humanitarian or economic underpinnings of the practice. My focus on

the economics of this form of reproductive surgery again represents a significant intervention. Similarly, the in-depth examination of the role of dignity is unique to the plastic surgery literature. And the approach to racialization within this chapter—highlighting how the imagined geography of underdevelopment-related disfigurement represents the spatialization of race within plastic surgery discourse—is similarly not an approach that characterizes most critical scholarly approaches to plastic surgery. Indeed, while Gilman highlights the racial underpinnings of the development of surgical techniques to address particular body parts, the racialization of reconstructive surgery efforts has been little studied.

Chapter 4, “Surgeon and Safari: Medicine, Superfluity, and the Production of Valuable Bodies in Neoliberal Johannesburg,” continues my examination of the racialization of the contrast between cosmetic and reconstructive surgery. Drawing on fieldwork conducted with the Johannesburg-based cosmetic surgery company Surgeon and Safari, which caters primarily to clients from the U.S. and U.K., I illuminate how plastic surgery is again tied to discourses of economic development, this time through medical tourism. Medical tourism has garnered increasing attention from national governments and transnational organizations such as the World Bank, as well as from medical anthropologists. Through intensive field observation, I document how these larger economic processes affect the micropolitics of bodies, serving as a transnational process of racialization and bodily investment that produces clients’ bodies as particularly valuable. This process turns in large part upon a contrast drawn between private and public health in Johannesburg: On the one hand, clients enjoy a first-hand experience of commodified, luxurious medicine when undergoing elective surgery that is

seen as enhancing their bodies (despite the intense pain and limited mobility they experience after surgery). On the other hand, Surgeon and Safari represents the bodies of poor black South Africans, whose lives are said to be “cheap” by participants in the tourism company, as subject to only minimal state investment within public hospitals—they are not subjects whose bodies are subject to enhancement. This public/private division, and its attendant racialization, has deep roots in colonial and apartheid-era health policies, which played an integral role in racially segregating the city of Johannesburg. Clients’ travel to Johannesburg, as well as their travels within the city itself, thus depend on this history to enhance their sense of the value of their own bodies. This chapter speaks to postcolonial theorizing on the body and to burgeoning scholarly conversations about race- and gender-based inequalities in health care within globalization.

Medical tourism, including cosmetic-surgery tourism, is a rapidly growing area of research. However, South Africa remains an understudied locale within this literature. It is not self-evidently mapped within circuits of tourism or the existing scholarly discourse on medical tourism or cosmetic surgery. Aside from my own work (Mazzaschi 2011), I am not aware of any published sources that critically interrogate medical tourism in South Africa. The South African case, however, is a highly illuminating one, both because of its particular colonial history and contemporary dynamics of health care, which continue to be shaped by this colonial history and by the apartheid system that formally ended in 1994. South Africa is unique in the region for becoming a destination of medical tourism, at least for patients from the global North, enabled by its “role as a major economic and political force in the region” (Livingston 2005, 113), itself the result

of the so-called mineral revolution that occurred there. While the racializing function of public health is not unique to South Africa (see, e.g., Shah 2001), institutions of health have played an important role in shaping the racialized geography of Johannesburg in particular and South Africa in general. The dynamics among different South African health care actors, therefore, make for a fascinating case study of the interactions among gender, race, class, and mobility within contemporary neoliberal landscapes.

The transnational lens I employ thus makes possible numerous advances within current critical scholarship on plastic surgery by showing that cross-border movements, national and transnational economies, and geopolitical concerns are central to fully appreciating plastic surgery's history and present, as well its effects on the micropolitics of bodies. I show that a transnational approach necessitates more expansive understandings of racialization and gendering not present in the current field and that discussions of plastic surgery are vital to the exploration of the neoliberalization of health and health care that has interested scholars in a number of disciplines. Contributing to feminist, antiracist, postcolonial, and queer theory, the dissertation illuminates a global political economy of bodies infused with what Michel Foucault (1990) has termed "biopower," which has important implications for transnational practices of health management, bodily regulation, and cultural production.

Theory and Method

This chapter consists primarily of a review of the relevant literature that forms the background to my arguments regarding plastic surgery, neoliberalism, and race that unfold over the course of the dissertation. The first section explores methodological considerations, articulating a methodology that I label “transnational historical ontology,” and elaborates on the archive that makes up the sources of my analysis. The next section mines work on the history of plastic surgery, paying particular attention to its early associations with market economies, to the formative role World Wars I and II in its development as a specialty, and to the racialized anatomies that undergird many aesthetic procedures. I then proceed to a discussion of prominent themes within the feminist critical literature on cosmetic surgery, highlighting its deep interrogation of the gendered disciplinary mechanisms at work in cosmetic surgery discourse and practice, the complex accounts of race they have developed, and the emergent literature situating surgery within trans/national contexts. Neoliberalism is the topic of the next section, which explores neoliberal governance in general terms as well as with specific reference to the ways that neoliberal governance and marketization has affected the fields of health and medicine. The chapter concludes with a theoretico-historical meditation on the body as a site of investment, elaborating on the term “bodies of value” by drawing on literature that highlights the enmeshment of bodies and health within political economy.

A Note on Method

The method that I use might be termed, to riff on Ian Hacking (2004), a transnational

historical ontology.² Hacking's understanding of historical ontology is useful because, although less explicitly political and materialist than Michel Foucault's notion of genealogy, historical ontology has an understanding of the dynamic nature of subject constitution and the processes of becoming that are essential methodological considerations for my project. Historical ontology takes the view that what is given in the world (including modes of subjectification, material phenomena, and objects) is constantly shifting. However Hacking also adds that for any given phenomenon to fall under the category of historical ontology, it must have some bearing on how "we constitute ourselves" (3): "Historical ontology is not so much about the formation of character as about the space of possibilities for character formation that surround a person, and create the potentials for 'individual experience'" (23). In each chapter, as should be apparent from the chapter outlines in the introduction, I make clear how plastic surgery plays a role in the imagining of particular types of subjects and bodies subject to instability in different ways and for different ends. This is achieved primarily through discourse analysis of the multiple kinds of texts associated with plastic surgery, as well as fieldwork in the case of the chapter on Surgeon and Safari.

Historical ontology points us toward a way of reading texts that looks to the roles that they play in the constitution of subjects, and the implications for power, ethics, and knowledge that they are constituting. To do historical ontology requires tracing the circulation of ideas and institutional structures, so that one may investigate what modes of being and types of subjectivity are assumed in any given situation. To begin to

² Hacking is clear that although he draws on Foucault, his project is more archaeological than genealogical, stating that historical ontology "lacks the political ambition and the engagement in struggle that he intended for his later genealogies" (5). I hope it is clear that my own project does not accept the necessity of depoliticizing

approach these questions requires amassing a varied and large amount of source material that emanates from plastic surgery. As Hacking notes, historical ontology necessarily draws on a wide variety of source material irrespective of genre or type of media (Hacking 2004, 17). Although I am specific in the sites that I examine, I draw on a variety of primary sources in order to provide an analysis of plastic surgery as a flexible transnational phenomenon. That is, because plastic surgery has had far-reaching effects at levels both discursive and material, my analysis must also be far-reaching in the materials that it utilizes and the sites, geographical and institutional, that it explores. I therefore draw on medical texts, tourism documents, fieldwork with Surgeon and Safari in Johannesburg, charity documents, journalistic accounts, personal memoirs, and NGO reports.

These are the texts that it is necessary to examine in order to understand both the more easily imaginable incarnations of plastic surgery and its lesser-known variants. Transnational historical ontology, as I understand it, necessitates seeking out flows of information, representations, discourses, and practices that trace postcolonial, colonial, or neo-colonial routes, routes forged by international medical associations, nongovernmental organizations, individuals, and small- and large-scale capitalist enterprises. The sites that I have selected were chosen because they are sites that “breach the self-evidence” (Foucault 2003, 249) of feminist critiques of plastic surgery and that allow for the examination of the diversity of the forms taken by plastic surgery in different historical moments, different scales, and different locations.

In some senses, then, the object that I discuss as “plastic surgery” is a fiction brought into being through many more or less arbitrary factors. Meredith Jones’s

definition of “cosmetic surgery” (which might be extended to plastic surgery as a whole) is instructive: for her, “cosmetic surgery” is “a series of interlocking practices and discourses comprising medical and surgical techniques as well as many media forms such as academic analyses, advertisements, autobiographies, feminist writing, histories, medical literature, popular magazines, and regulatory/legal texts” (Jones 2004, 525). I would add to Jones’s definition that plastic surgery cannot be understood except as something that comes into existence through its interaction with individual bodies, institutions, technologies, and discourses. Thus, I hope that my dissertation avoids reifying “plastic surgery” as a unified field. Rather, “plastic surgery” refers to different institutional and discursive productions that are constituted within context-specific processes of racialization, state health policies, political economic systems, transnational capital flows, and institutional arrangements. From chapter to chapter, plastic surgery is considered within a particular configuration of these elements in order to understand the components that constitute it as “plastic surgery” in each instance.

Historical Scholarship

Histories of plastic surgery have shown that it has been entwined in the market, as well as social categories of gender and race, from its inception as a modern practice, and that this enmeshment has led to its questionable status as medicine. While surgery itself was not a high-prestige occupation within the medical field for much of its history (Doyle 2007), plastic surgeons especially have been associated with a commodity form of medicine that calls into question their status as legitimate medical professionals, which they have been at pains to combat throughout the specialty’s history. This section will give a brief

overview of these trends, incorporating a discussion of the gendered and racial politics of surgery, and discuss this dissertation's interventions into this historical scholarship.

Elizabeth Haiken and Sander Gilman's work in the history of plastic surgery has emphasized three overall themes: 1) the role of the divide between reconstructive surgery and cosmetic (or aesthetic) surgery, which also encompasses plastic surgery's liminal status with respect to "legitimate" medicine due to the fact that it operates on healthy bodies and is thus more explicitly linked to the market than other forms of medicine; 2) the role of war in the development of plastics as a specialty; and 3) the racialization and gendering of both particular forms of surgery and the rationales justifying operating on healthy bodies. While Haiken focuses on the US context, arguing that plastic surgery is paradigmatically American (1997, 288-89), the dissertation calls into question this status. It shows that surgical techniques and philosophies circulate within transnational economies, and that surgeons themselves traveled extensively as part of the project of legitimating and building plastic surgery as a specialty on a global scale. As chapter 2 notes, the first English-language journal devoted entirely to plastic surgery was founded in South Africa by Jack Penn. The second chapter also shows that US and UK surgeons' work in Vietnam and east Africa (in addition to other places) formed an important part of their work and how they made sense of their practices in their home countries. Although Gilman and Haiken do not incorporate a critical analysis of the role of nation, cross-border movement, or global capital in surgery, they are nevertheless highly instructive for my project, as the debates in the US and internationally that they do explore did serve to shape plastic surgery as a discipline and the conceptions of race that surgeons developed, though transformed when surgeons operate transnationally, are important points of

departure.

The division between reconstructive and cosmetic surgery has been the subject of much critical reflection, both on the part of surgeons themselves and of the secondary literature. This division is itself a politically charged and ultimately untenable binary. Reconstructive surgery has historically been less stigmatized than cosmetic surgery. As Sander Gilman notes, the American Society for Plastic and Reconstructive Surgery's 1987 description of the division highlights its ambiguity: "Cosmetic surgery is performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem. Reconstructive surgery is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance" (qtd. in Gilman 1998, 5). The division depends on a notion of a normal body that is not clearly specified or specifiable. When a rhinoplasty reshapes a "normal" nose, it is cosmetic; when it reshapes a nose deemed beyond the norms for noses, it is reconstructive. The question of what deviation from that norm constitutes sufficient cause to label an operation reconstructive is not founded on anything other than a set of norms that is derived from statistical averages and doctors' judgments. However, while reconstructive surgery does not always repair a physical injury or work to save lives, it is easier to justify because it generally treats a physical condition that is pathologized—cleft, burn scars, hypertrophy; all conform to some form of pathology that is recognizable to medical discourse despite the fact that such pathologization may be the result of relatively arbitrary human decisions without an outside grounding.

While many surgeons tend to emphasize the role of reconstructive surgery in the history of the development of plastic surgery, especially the role of WWI and WWII in advancing its techniques (discussed below), Haiken notes that “beauty surgery” in fact predates the world wars and is equally integral to the development of the profession of plastic surgery (1997, 4). Haiken shows that concerns about the association of plastic surgery with feminized consumer culture shaped debates about the formation of professional organizations and the conception of plastic surgery held by surgeons and nonsurgeons. Even before WWI, surgeons and other commentators on beauty culture were concerned with the problem of charlatans—unqualified and opportunistic individuals who would exploit the desire for beauty stemming from the new beauty culture by performing untested and dangerous procedures that would result in mutilation rather than the desired physical improvement (27). Dr. Charles Miller, himself considered a quack by some, argued that the problem of charlatans meant that professional surgeons, even if they did not desire their profession to be associated with beauty surgery, should reconsider their position because to refuse to carry out beauty surgery would lead unsuspecting women into the waiting arms of unscrupulous and greedy phonies (27-28).

Despite Haiken’s emphasis on beauty surgery, she does indeed note the formative role of WWI in the advancement of the techniques of surgeons and its importance in creating a shared sense among surgeons that theirs was a legitimate specialization in need of the legitimacy provided by the formation of societies and boards. Repairing deformities caused by trauma during WWI plays a significant role in the history of plastic surgery because the reparation of wounded bodies seemed a more legitimate use of medicine and because the bodies themselves that were repaired were bodies serving the

nation.

In Britain, Harold Gillies, a surgeon from New Zealand, became a prominent figure in repairing British soldiers at his unit in Queen Mary's Hospital, Sidcup. In France, Hippolyte Morestin also became well known. "Both [Gillies and Morestin] had chafed at the marginal status the medical establishment gave them before the war and they welcomed the opportunity to show the world how necessary and noble and redemptive their kind of medicine could be" (157). The noble and redemptive character of the medicine came from the status of the bodies on which they operated, who had been injured for a noble cause and whose reparation itself aided the war effort, since the soldiers could be returned to the war after recovering from surgery. This recovery, however, was not simply physical. It addressed both the body and psyche, specifically with regard to the conception of trauma that was emerging in war psychology (see Fassin and Rechtman 2009). As Sander Gilman claims, "With the restoration of function and the return of the visage to a 'somewhat human' form, the 'happiness' of the patient became central. Thus [Jacques] Joseph noted, at the conclusion of his first annual report (1917) as the director of the department for 'facial-plasty' at the Charité, that 'the discharged patients have all been cured of their psychic depression which the consciousness of bodily deformity always involves. These were patients horribly maimed in the war who, Joseph claimed, were made whole, both physically and psychologically'" (Gilman 1999, 168). The claim of mind/body interaction—though by no means disturbing the mind/body dualism—is important for understanding why reconstructive surgery becomes able to argue that it addresses itself to human dignity when that concept becomes prominent in discourses of human rights and humanitarianism. It is through the modification of the

body—explicitly framed during WWI in terms of its belonging to the category of the human itself—that patients are enabled to live lives that are more “human” physically, psychologically, and socially. One cannot be “happy” when one’s body is not human-looking. It is not only the life of the body that is operated on but the quality of that life, and the health that is operated on is not simply bodily. That these were men who had been dehumanized through trauma received in the name of the nation made this type of intervention legitimate, rather than the more questionable (feminized and racialized) desires for beauty and enhancement that characterized aesthetic surgery: “This masculinization of reconstructive surgery out of the cauldron of battle provided a new status for aesthetic surgery and newer satisfaction for its practitioners” (Gilman 1999, 166). The surgeons provided bodies that were physically and psychically prepared to go into battle, as well as providing bodies that would not suffer indignities based on their appearance when they returned from it.

Thus the privileging of the reconstructive end of the (fictive) reconstruction/cosmetic binary came about through its capacity to serve a legitimizing function for surgeons. But Haiken also draws attention to the way that the commercial orientation of cosmetic surgery still put pressure on the formation of this surgical specialty. “Surgeons,” she writes, “realized that the success of the reconstructive work they had undertaken during the war years enabled them to make a claim, however tenuous, for medical legitimacy” (35), and “the plastic surgical literature of the late teens and early twenties suggests a new self-consciousness, as sense of a profession with a shared past and common aims and goals for the future, that was seldom evident in prewar medical literature” (35). But, despite this newly formed sense of community, the

profession still contained tensions around the question of performing beauty surgery. The newfound legitimacy accorded plastic surgery was achieved precisely through distancing it from consumerism and the vanity of women, and many surgeons still dismissed aesthetic surgery as a corruption of the nobler work of reconstruction. Gillies, for instance, suggested that aesthetic surgery should be viewed as “subordinate” to reconstructive surgery (Gilman 1999, 13). In the United States, Haiken finds: “Those who were working to define the new specialty seriously considered ceding the cosmetic, or beautifying, territory to others, reserving as their own only the more conservative field of reconstructive surgery” (Haiken 1997, 48). However, it was precisely the economic considerations associated with cosmetic surgery that prevented them from doing so: “They realized, however, that Americans who were discontented with their features far outnumbered those born with congenital deformities or injured in later life, and that enterprising practitioners, with varying degrees of training and imagination, were busy staking claims in this growth industry” (48). Due to surgeons’ own realization of the economic potential of cosmetic surgery, then, it continued to be incorporated in the domain of plastics, ensuring that the profession’s association with the economic realm would continue to haunt it. Though, paradoxically, by officially incorporating the aesthetic into the profession surgeons lent legitimacy to it as medicine. The American Board of Plastic Surgery, formed in 1941, would incorporate consumer-driven practices in an effort to regulate those who could perform it (87).

So, then, what were the rationales for allowing intervention into healthy bodies by medical professionals? While the answer to this question is multifold, I will concentrate on three specific rationales: economic, racial, and psychological. Surgeons often justified

performing surgery on those who were unable to work because of their appearance (Haiken 1997, 38). The inability to work as a legitimate definition of illness goes back at least to the French Revolution (Cohen 2009, 156), and thus surgeons were trading on a long-standing definition. This definition highlights the body's importance to the economic order, but its novelty is that it begins to incorporate the psychic and social dimensions of appearance into the definition of health and the ability to work. It incorporates the social by drawing attention to the stigmatization of nonnormative appearance and the psychological because it also depends on the internalization of that stigma. While surgeons had hoped that economic independence might provide a stable criterion through which to judge the legitimacy of the need for surgery, they soon realized that it was “impossible to quantify concepts like ‘serious social or business embarrassment’ as it was to define what degree of irregularity in appearance might preclude economic self-sufficiency” (40).

Finally, Gilman in particular highlights the way that race functions within the logic of plastic surgery. Gilman's work is replete with examples showing that the development of particular techniques of beauty or aesthetic surgery, beginning well before WWI, were designed to eliminate markers of racial difference and signs of moral degeneracy. Plastic surgery draws on and extends the notions of embodied racial difference that were established through the comparative anatomy of Cuvier, Camper, and others. The idea that racial difference could be read through particular signs on the body—and that the body would always betray the truth of racial difference through these signs—led to the establishment of many forms of surgery. Particular body parts become centers where racial difference can be read. The nose, for instance, becomes, through the

work of anatomist Petrus Camper associated with particular racial types and notions of racial inferiority, and thus the nose becomes an important site for the expression of racial inferiority, especially for Africans and Jews (Gilman 1999, 88-89). Aesthetic surgeries to normalize particular body parts, are, for Gilman, linked to eliminating signs of racial inferiority that can be read from the body. Gilman notes that notions of the “ideal” breast shape that circulate within cosmetic surgery are also racialized, and that certain breast shapes were associated with “Hottentots and Bushmen,” being taken as a sign of primitivity (Gilman 1999, 221-24). Decircumcision, too, emerges as a method for eliminating a particular mark of Jewish difference (139). Racial difference can thus become the mark of harm or unhappiness that justifies undertaking normalizing surgery as a way of enabling the happiness of the patient who has become fixated on some mark that she or he believes will be read as a sign of inferiority.

Indeed the notion of “inferiority” is indeed key to the discourse of plastic surgery, for it provides an important rationale for the intervention into healthy bodies in order to address a psychological dilemma. Alfred Adler’s “inferiority complex” provides a lynchpin that connects body, psyche, and the social to provide such a rationale by the 1920s. Originally a physiological concept, in which the brain would compensate for the inferior functioning of a particular organ (Gilman 1998, 100), for Adler the inferiority complex comes to be reversed such that “the inferior organ ... marks the psyche” (105). From the psychological point of view, unhappiness concerns “what one imagines oneself to be” and thus the “imaginary body” that is the source of unhappiness can be modified in order to solve the psychological dismay. As Gilman puts it, “It is not that you are sick, it is only that you believe others about the ‘ugly’ nature of your body” (107). Here, we can

see that the social norms around appearance come to mark the psyche, creating the sense of inferiority, which can, through the plastic surgeon's lens at least, be ameliorated through eliminating that which the individual feels marks her or his body as inferior. Surgeons had noted the psychological benefits of plastic surgery during war (Haiken 1997, 115), and the inferiority complex crystallized their ability to claim a psychological benefit for surgery in many contexts. And, Haiken notes, advertising culture and women's magazines popularized the concept of the inferiority complex, encouraging patients to diagnose themselves and bring such a diagnosis to their surgeons as a justification for the sought-after procedure (126-28).

In drawing out this history of plastic surgery as fueled by consumer culture, Haiken reperiodizes some of the literature discussed below. While many critics of medical neoliberalism date the emergence of the "patient consumer" or self-entrepreneur through medicine to the 1970s or 1980s, the history of plastic surgery tells us that it dates much earlier, to at least WWI. And this history also demonstrates that plastic surgery was a key motor of the emergence and normalization of consumer-driven and consumer-evaluated forms of medicine. Plastic surgery's alliance with psychology, too, is important to my argument because while surgeons often trivialize or mock the psychological needs of cosmetic patients, the psychological benefits of surgery, the "discovery" of which emerged from surgery's pairing with psychological theories emerging from war psychology as well as popular psychology, are heavily emphasized as benefits that go above and beyond the simple repair of the physical injury or deformity in surgeons' development and humanitarian efforts. Finally, while Haiken rightly emphasizes the economics of patient-driven demand for beauty, neither she nor Gilman explore the

economic dimensions of reconstructive surgery. In chapters 2 and 3, I spend a good deal of time examining the economic rationality embedded in surgeons' reconstructive efforts that they put into the service of development and humanitarian goals.

Themes in Critical Literature

As Kathy Davis (1995) has noted, cosmetic surgery is often discursively constituted as a luxury (33). Davis further notes that “cosmetic surgery is the cultural product of modernity and of a consumer culture which treats the body as a vehicle for self-expression” (17; see also Fraser 2003). Davis’s *Reshaping the Female Body* is primarily remembered for its argument that women who undergo cosmetic procedures should not be viewed as “cultural dupes” (as was, Davis contends, implicit in early-’90s criticism of the phenomenon, especially Kathryn Pauly Morgan (1991), who argued that women’s bodies were being colonized by surgery), instead viewing them as rationally negotiating the sexist pressures they face that reduce them to their bodies. But her work also argues that cosmetic surgery and its treatment of the body are thus the product of a system of medicine in which the body becomes something that can be “endlessly manipulated—reshaped, restyled, and reconstructed” (17). Meredith Jones and Victoria Pitts-Taylor both note that the rise in the popularity of cosmetic surgery coincides with a postmodern discourse in which change, metamorphosis, and instability become privileged over stability and fixity, a “cultural logic of bodily freedom and personal choice” that is in fact “linked to the enormous economic, social, and political pressures surrounding women’s appearance” (Pitts-Taylor 2003, 51). In Jones’s view, we are in the midst of a “makeover culture” linked to “postmodern values of consumption, revision and the importance of

surface” (Jones 2008, 6). Critics have also noted the fact that cosmetic surgery disturbs the natural/artificial binary (Heyes and Jones 2009, 9)—with some arguing that it represents another extension of the cyborgian integration of technology and the body (Balsamo 1996). As a whole the feminist body of literature could be said to attend to the disciplinary mechanisms introduced by cosmetic surgery and its expansions of definitions of health and normalcy in ways that produce heightened scrutiny, pathologization, and opportunities for “self-improvement” that are consonant with but work to expand the disciplinary forces surrounding and regulating women’s bodies.

Feminist scholars have also undertaken complex accounting of the ways that race operates within plastic surgery. Mirroring Morgan’s idea that cosmetic surgery represents the colonization of women’s bodies, Eugenia Kaw argued that the prevalence of Asian American women who undergo surgeries (blepharoplasty) to create a double fold in their eyelids represents not only the medicalization of race but also the stigmatization of Asian facial features, the internalization of negative stereotypes regarding Asian features on the part of the women who seek these operations, and, ultimately, “mutilation” in the pursuit of whitening (1993). Other critics have challenged this view. Kathleen Zane, for instance, notes that such views reinforce notions of “authentic” ethnicity and that “assumptions of the unnaturalness of these surgeries for Asians call into question received ideas about what Asians are supposed to look like” (2001, 356). She further notes that Asians have long been stereotyped as “cultural mimics,” which this discourse replicates. Heyes, too, points out that a focus on Asian blepharoplasty presents a blunt picture of ethnic surgery since it accepts the easy designation of what constitutes an “Asian eye,” ignoring variation, as well as accepting the plastic surgery industry’s definition of this procedure

as “ethnic” in opposition to other procedures that are racially unmarked (2009, 199-200). In her view, all surgeries could be considered ethnicizing in some ways. Davis similarly argues that by reading surgeries performed on ethnicized people within a framework of race rather than beauty, people of color are granted “less discursive space than their white counterparts for justifying their decisions to have cosmetic surgery” (2003, 94). Finally, Sharon Heijin Lee (2008) offers an incisive critique of the circulation of “Asian eyelid surgery” within neoliberal discourses that is instructive for the argument of my dissertation. Bringing in a transnational analysis, Lee examines a discussion of eyelid surgery in South Korea on Oprah Winfrey’s talk show, in which correspondent Lisa Ling and Winfrey’s conversation replicates the idea that these surgeries are undertaken as a mode of Westernization and whitening. Lee positions this conversation within a neoliberal, quasi-feminist discourse that emphasizes individual choice as the paradigm of freedom, a brand of neoliberal self-care of which Winfrey is herself the epitome. Within this discourse, “(unfettered) choice becomes a measuring stick for feminist liberation and Korean women fall short” (31). South Korean women are constructed as constrained by internalized racism, unlike white Western (and Brazilian) women, who, within this discourse, are free to consume self-enhancement in the pursuit of looking like themselves rather than another (see also Holliday and Elfving-Hwang 2012).

These discussions of the racial politics of cosmetic surgery demonstrate that scholarly critiques of race in cosmetic surgery primarily focus on how to interpret particular women’s decisions to modify their own bodies within a landscape of racialized aesthetic norms, a focus that my dissertation displaces via a broader transnational lens that views racialization as a structural feature of plastic surgery efforts that invest in

bodies. Lee's critique is useful to my argument because it demonstrates that within neoliberal transnational discourses on race, a salient distinction is between those (neo)liberal subjects who utilize surgery as a mode of self-enhancement and those illiberal subjects whose choices are subject to constraints based on their race/ethnicity. It is this dynamic that informs my analysis of racialization within transnational surgery projects involving both actors who invest in the bodies of (illiberal or improperly liberal) racialized others and those who seek enhancement through the transnational surgery market.

Other scholars have begun to illuminate how plastic surgery is embedded within racial, national, and transnational economies, broadening the Australian, US, and Western European concentration of most of the literature on cosmetic surgery. Alexander Edmonds's work on contemporary cosmetic surgery in Brazil treats the complex dynamics of *plástica* and how the practice aligns with and reshapes Brazilian racial ideologies as well as conceptions of health. Edmonds work displaces the sense that the global North is the site of the most "advanced" techniques or that it is in Euro-American contexts that plastic surgery has had the most impact on broadening conceptions of health: "Instead of being negatively defined as the absence of disease, health becomes a more amorphous state of aesthetic and sexual as well as physical, social, and mental well-being that can be actively—and continuously—cultivated. *Plástica*, then, can be seen as one technology among many in a sexual republic where citizenship requires participation in a consumer lifestyle, the medical management of sexuality and reproduction, and an aesthetic tinkering with the body for therapeutic ends" (2007a, 376). Susan Brownell (2005), too, notes the embeddedness of cosmetic surgery within national economic

frames. In her study of the Chinese context, she notes that cosmetic surgery, while associated with the bourgeois subject, a taint inherited from its development in the West, in post-Mao China the pursuit of beauty became valorized as a symbol of freedom from that which Mao suppressed. Debra Gimlin (2007) investigates how different national frames of health care (in her case, the US and the UK), produce different discourses of rationalization on the part of those who choose to undergo cosmetic surgery. And as I discuss in chapter 4, scholars of medical tourism have also extended the transnational dimensions of the literature on cosmetic surgery. Ackerman (2010), for instance, notes how cosmetic surgery tourism firms in Costa Rica trade in images of natural beauty while also papering over inequalities within the health care received by foreigners and local populations. And Aren Aizura usefully deploys Susan Stryker's concept of "somatechnical capital" in order to describe how "forms of embodiment circulate as commodities" (2010, 305) within the context of gender reassignment and other forms of feminizing surgery undertaken by white Western trans women in Thailand, reading racialization not only through the practice of skin whitening and cosmetic techniques but through the act of consumption itself.

Neoliberalism and Medical Neoliberalism

Contours of Neoliberalism

The intent of this section is to introduce and historicize neoliberalism, both in terms of logic of governmentality that it enacts and the economic effects that have come out of neoliberal policies. This discussion of the general characteristics of neoliberalism forms the background for my following review of neoliberalism's impact on medicine.

Neoliberalism, as it has come to be known in the academic literature, is generally attributed to shifts within global capitalism beginning before but solidifying as economic policies enacted in the 1970s, though some scholars (Foucault 2010; Rose 1999) note that it has roots going back to the 1940s. Lisa Duggan claims that neoliberalism, as an economic policy, originated with U.S. thinkers and economists, but quickly spread to the thinking of international financial institutions like the IMF, WTO, and World Bank. One general characteristic of neoliberalism the preference for privatization and shrinking states, as opposed to the more Keynesian welfare state and a broad array of state services. Neoliberal arguments for privatization and reductions in state services draw on classical liberal theories to make their case. As Duggan notes, “the architects of contemporary neoliberalism drew upon classical liberalism’s utopianism of benevolent ‘free’ markets and minimal governments. These earlier ideas provided a set of rationales, moral justifications, and politically inflected descriptions of the institutions of developing capitalism” (Duggan 2003, x). Neoliberalism draws upon but transforms the line of liberal thought that advocated for economic freedom and protection of private property as natural rights, but transforms them in important ways. The “culture of upward (re)distribution” (Duggan 2003, xvii) that neoliberalism inaugurates rests on the pillar of privatization. While Duggan notes that the welfare state never provided for the egalitarianism desired by progressive political factions—indeed it often served as a regulatory and disciplinary apparatus—she also decries privatization and the notion that the market should become the locus of formerly socialized services.

Of all of the moves that constitute neoliberalism, one of the most pervasive, upon which most commentators agree, is the economization of many different spheres of life—

that is, the introduction of market logic to an array of institutions and as a logic governing individuals as well. In the words of John Gledhill (2004),

Market liberalism and advocacy of free trade are not new. What makes neoliberalism something that a classical liberal such as Adam Smith would have found as disturbing as Pope John Paul II does is its elision of the distinction between a market *economy* and a market *society*, to the point where the latter seems to engulf life itself. Neoliberalism is not simply the response to a crisis of accumulation and a readjustment of the relations between capital and labor following the formation of truly global markets. It is the ideology of the period in which capitalism deepened to embrace the production of social life itself, seeking to commoditize the most intimate of human relations and the production of identity and personhood. (340)

This is not to say that neoliberalism necessarily captures all areas of life, but that it is a movement toward such a logic. As Foucault puts it, neoliberalism enables “a sort of economic analysis of the non-economic” (Foucault 2010, 243), thus allowing it to encompass more and more arenas of social life.

In Germany after World War II, neoliberal and ordoliberal thought emerged as a way of dealing with fears about totalitarianism on the one hand and the meaninglessness of labor on the other. Friedrich von Hayek, an Austrian economist, served as a common link between German ordoliberalism and US neoliberalism (Foucault 2010, 79). Hayek believed that the end result of state planning and welfare would be socialism and totalitarianism: “when the state takes on itself the role of planning society, planning production, housing, transport, welfare, it becomes an instrument for imposing a morality.... The only principles upon which true freedom can be based are those of classical liberalism, ‘freedom to order our own conduct in the sphere where material circumstances force a choice upon us, and responsibility for the arrangement of our own life according to our own conscience’” (Rose 1999, 137; quoting van Hayek’s 1944 *Road*

to *Serfdom*). We can see here the revitalization of the connection between freedom and the market that will become characteristic of neoliberal thinking and policy. Hayek believed that it was not the state's role to attempt to reduce income inequalities or direct the economy in other ways (Foucault 2010, 172). Rather, he saw Keynesian interventions such as the New Deal in the U.S. as the extension of state power to an undue degree, fearing that extensions of state power of this sort will lead to totalitarian rule (Foucault 2010, 110).

One feature that makes up neoliberalism, then, is deep suspicion of the state, a move that accounts for the neoliberal policy of privatization of state services even in countries where welfare states as such have never existed. State intervention into markets is viewed as both dangerous and as leading to inefficiency. One aspect of neoliberalism is a transformation of the relationship between the state and the market: the state's role becomes the promotion of freedom through introducing a set of formal rules that will allow the proper functioning of the market. The state must set the proper rules of the game but must not direct the game's outcome, and the players in this game are individuals (or, really, enterprises conceived of as individuals) (Foucault 2010, 173). Thus, the freedom of the market, as neoliberalism developed, was not to be a hands-off approach from the state, a la *laissez faire*, but rather, "a framework of institutional and legal forms had to be assembled to free the market from...public and private distortions" (Rose 1999, 137). This, Foucault and others note, is somewhat of a reversal of classical liberalism, for under neoliberalism, "the market is the organizing and regulative principle of the state" (Brown 2003).

One of the most salient developments to come out neoliberal thinking is the

Washington Consensus, adopted by the IMF in 1981 but heavily influenced by the neoliberal economic thinking that came before. The Washington Consensus distills neoliberal values into a standardized package that was foisted upon nations seeking loans to aid ailing economies. As Patrick Bond describes it, the Washington Consensus advises:

- Government budget cuts, increases in user fees for public services, and privatisation of state enterprises (including even municipal services);
- the lifting of price controls, subsidies and any other distortions of market forces;
- the liberalisation of currency controls and currency devaluation;
- higher interest rates and deregulation of local finance;
- the removal of import barriers (trade tariffs and quotas);
- and an emphasis on the promotion of exports, above all other economic priorities.

(Bond 2000, 23)

Thus, we can see that the neoliberal Consensus emphasizes free trade or trade liberalization, loosening of monetary controls, and the privatization of state services—the market as the state’s *raison d’être* and the setting of rules so that the market can be free. Through the Washington Consensus, of course, neoliberal policy takes on a new valence in which the policies forced onto some states work to the benefit of others, and it exacerbates inequalities within those nations.

Medical Neoliberalism

A variety of scholars have elaborated how neoliberalism inaugurates, at least in Western contexts, the proliferation of techniques for self-monitoring as well as self-entrepreneurship. Keynesian welfare states also contained a plethora of disciplinary

apparatuses, as Dorothy Roberts (1997, 2007, 2009) and others (e.g., Cohen 1997; Threadcraft 2014) have shown, that discipline and subjectify through systems of public health, welfare, and other institutions that both serve to racialize and gender subjects and rely on gender, race, and class divisions to focus their surveillance and profiling techniques. But neoliberalism's emphasis on the privatization and marketization of formerly public services transfers responsibility for health care largely to the individual. As Rose puts it, addressing neoliberal shifts in health, "within such a health-promoting habitat, the state tries to free itself of some of the responsibilities that it acquired across the 20th century for securing individuals' against the consequences of illness and accident. Thus we have seen an intensification and generalization of the health-promotion strategies developed in the 20th century, coupled with the rise of a private health insurance industry, enhancing the obligation that individuals and families have for monitoring and managing their own health" (Rose 2009, 6). Rose does not believe that the welfare state ever perfectly fulfilled the biopolitical goals set out for it, to tend to and foster the lives of the population for the benefit of society, but with neoliberalism's desire to privatize, and with the framing of privatization as enabling freedom of choice, comes what Thomas Osborne calls "responsibilisation" (Osborne 1997, 186), in which it is incumbent upon the individual to be responsible for her or his own health by utilizing the market to its fullest potential. The choice and care provided by the market represents the deletion of the choice for public health care, as well as the deletion of the possibility of remedying the welfare state's inequities because the welfare state is defined as inherently inefficient and enabling of laziness, creating dependency rather than personal responsibility. But despite this deletion of choice, neoliberal health care reforms are

framed as though choice, and hence freedom, are enhanced.

“Every citizen must now become an active partner in the drive for health,” Rose writes, “accepting their responsibility for securing their own well-being.... This new ‘will to health’ is increasingly capitalized by enterprises ranging from the pharmaceutical companies to food retailers” (Rose 2009, 6). This ‘will to health’ through the market not only responsabilizes but makes the market an active partner in this responsabilization (see also Petersen 1997). This puts more emphasis on the figure of the health consumer, which, as Haiken notes, has already been integral to how plastic surgery is legitimized and discussed. The health consumer is figured as an active shaper of her or his own health and well-being through making choices within the medical market (Petersen and Saras 2002, 1). Rob Irvine traces the emergence of the “health consumer” to the 1960s and 1970s, concomitant with the rise of neoliberalism (Irvine 2002, 32). He notes that this concept emerged within a discourse of patient dissatisfaction and empowerment. Rather than the passive patient who depends on the doctor who knows, the health consumer is active and able to make demands for satisfaction and “imagine alternative ways of thinking and talking about lay-professional relationships which were fundamentally different from the disciplinary regimes of the past” (Irvine 2002, 34). This reconfiguration of the role of expertise, wherein expertise is “located in the market” and “governed by the rationalities of competition, accountability and consumer demand” (Petersen 1997, 194) seemingly empowers patients to make more decisions while simultaneously contributing to the individual management of health through the market. So while health consumers can now feel entitled to get their money’s worth or to “shop around” for capable doctors, they are also expected to take on a certain responsibility for

their own health and be rational decision makers as individuals that purchase care on a fee-for-service basis. This, of course, exacerbates class inequalities since the ability to shop around is predicated on having enough money or insurance to access the market in the first place.

But Irvine also notes that this cultural shift to thinking in terms of health consumers is implicated in shifts within the organization of medical economies writ large. While the discourse of health consumption seemingly emerges as a bottom-up strategy to empower patients, it is also complicit with the reorganization of medicine as an enterprise following an economic rationality. In the face of resistance to economization from medical professionals, “consumer rhetoric created a point for the managerialist discourse to penetrate professional authority” (Irvine 2002, 37). Because “managerialism cuts into and contests professional power and authority by denying health care providers the professional autonomy that they had at one time enjoyed” (Irvine 2002, 37), professional resistance to neoliberal managerialism and economic rationality had to be overcome, and the figure of the health consumer was instrumental in this regard due to its appeal to “patients” and its seemingly empowering effects. The health consumer as a bottom-up force of resistance to the institutional power of doctors simultaneously enabled (and was, indeed, enabled by) top-down reorganization of medicine toward the market rationality of neoliberalism, and thus serves as one example of “pro-business activism” that Duggan discusses as key to neoliberalism. “In order to reshape professional and organizational culture and relationships, to make them compatible with their broad economic vision, health officials link and align managerial and technocratic policy initiatives and the rhetoric of consumer interests, consumer

demands and the satisfaction of consumer needs” (Irvine 2002, 38).

What the example of the health consumer shows, then, is that the culture of neoliberalism and the economic and institutional policies of neoliberalism are inextricably linked. Duggan notes that “the broadest cultural project of neoliberalism [is] the transforming of global cultures into ‘market cultures’” (Duggan 2003, 12). This transformation is not simply a goal but a necessary and integral corollary of neoliberalism’s economic project. If neoliberalism holds that the market is the most efficient mode of care, then it necessitates a culture that supports and accepts the free market as the locus of freedom and a method of care. This is not to say, as I hope that the example of the health consumer makes clear, that the market is the center from which all forms of power emanate but rather that an interplay between market and cultural forces is absolutely essential to the functioning of neoliberal policy. The health consumer illustrates this interplay between market and culture. Neoliberalism is a blending of market and culture to the point of indistinguishability, in which the market has subsumed nearly everything. This points to the way in which neoliberalism promotes a culture of consumption, in which even social reproduction takes place largely within the market, and in which identity can be constructed and transformed through consumption—including the consumption of medical services.

One consequence of this neoliberal culture is that the self turns into a project in continual transformation through the market. As Petersen puts it, “neo-liberal rationality emphasizes the entrepreneurial individual, endowed with freedom and autonomy, and the capacity to properly care for him- or herself” (Petersen 1997, 194). Many other critics (Jones 2008; Pitts 2003; Sullivan 2001) have also noted this trend toward the taking on of

the self as a project, as well as the use of medicalized and other forms of health services/technology as a means for doing so. So not only does neoliberalism produce or intensify forms of self-surveillance, but those forms of surveillance can simultaneously function as means of self transformation and enhancement. Within a market culture in which the market provides for the care of the self and in which the individual is responsibilized, the market becomes the space in which the project of health can become a project of self-invention (or self-repair). As Lee puts it, quoting Wendy Brown, “neoliberal subjects are interpellated as entrepreneurial actors in every sphere of life and are thus ‘controlled *through* their freedom’” (Lee 2008, 27). Biopolitical and welfare-state logics continue but through personal responsibility and the market.

Cosmetic (and to an extent, plastic surgery generally) has come to stand discursively as the paradigmatic instance of both commodified medicine and processes of self-making through medicalized means. There are several reasons for this: insurance does not cover cosmetic surgery in most cases (aside from in Brazil and, formerly, the Netherlands), therefore making it primarily a service that individuals purchase directly; it represents a medical procedure that goes beyond life itself to modify and transform the body in ways that do not directly address the health of the individual; and finally, it serves as a mode of care of the body that serves to value it differentially in relation to other bodies by mixing aesthetic, monetary, and social value. Meredith Jones, for instance, argues that “cosmetic surgery is [the] quintessential expression” (2008, 1) of what she calls makeover culture, in which “the process of *becoming something better* is more important than achieving a static point of completion. ‘Good citizens’ of makeover culture publicly enact urgent and never-ending renovations of themselves” (2008, 1).

While Jones does not heavily emphasize capitalism generally or neoliberalism specifically, her analysis certainly lends itself to be interpreted through a neoliberal framework, in which cosmetic surgery has become the exemplar of the entrepreneurial self. Similarly, Deborah Caslav Covino (2004, 87) makes clear how cosmetic surgery allows a supposed “expression” of the true self that lines up quite nicely with the values of neoliberal market culture (as well as the figure of the health consumer). The drive toward self-transformation through cultivation of the body or the self as a project of self-transformation is best exemplified for many cultural critics by cosmetic surgery.

In “What’s Wrong with Medical Consumerism?” by Arthur W. Frank (2002), a widely cited article on the commodification of medicine, the prime trope that he chooses to contrast against traditional understandings of altruistic doctors and patients in need of care for the sake of health is the interaction between cosmetic surgeons and their patients. Here, we can see that cosmetic surgery becomes paradigmatic of the commodification of medicine (discursively) in its contrast with both presumptions about how medicine *used* to work, through its purchasable status, and through its capacity to go beyond questions of life itself to questions of enhancement. Frank begins by noting that an advertisement for cosmetic surgery depicts the surgeon as a “‘gifted artist’ with the surgical skills to shape the human body to his aesthetic vision” (Frank 2002, 15). For Frank, this signals both the commodification of the body (he speaks of cosmetic surgery leading to the fragmentation of the body into upgradeable parts [24]) and the degradation of medicine into an *art of commodification* within neoliberalism. This art of commodification is driven by the ethos of consumption inaugurated by neoliberalism, in which entrepreneurial selves (though he does not use this term) “treat the whole of life as one

protracted shopping spree” (20, quoting Zygmunt Bauman’s *Liquid Modernity*). In the invocation of the “shopping spree,” we see that it is the purchasability of cosmetic procedures that signals their paradigmatically neoliberal valence. Cosmetic surgery illustrates the apex of medical neoliberalism because it is purely the exchange of money for medical service—no insurance middlemen intervene and the consumer uses the service purchased in an individualized attempt at self-improvement through the market. Frank sees cosmetic surgery as paradigmatic of commodification because it is premised on choice, one of the primary values of neoliberal market culture.

Jasbir Puar (2010) has written that the present moment is characterized by the simultaneous production of new forms of debility and capacity. Noting the “instability of the divisions between capacity-endowed and debility-laden bodies,” she writes that “neoliberal regimes of biocapital produce the body as never healthy enough, and thus always in a debilitated state in relation to what one’s bodily capacity is imagined to be; aging itself is seen as a debility, as some populations live longer but also live with more chronic illness” (167). This framing is especially useful for my argument because it prompts us to ask how plastic surgery’s redefinition of health produces both opportunities for enhancement, as described above, while also redefining some sets of bodies as in states of debility. For instance, with the rise of the cosmetic surgery and its mediatization, new norms of appearance are produced—norms around youth, breast size, and even anus skintone, for example—that produce new signs of pathology on the body and subject it to ever-greater and ever-more-detailed scrutiny at the same time that it produces the means through which to rectify those signs. But my analysis shows that plastic surgery also redefines certain sets of bodies as “debility-laden” in other respects and with geopolitical

inflections—for instance, the “discovery” of cleft palates as a problem in certain areas of the “third world” (which again justify surgical intervention into bodies, this time through development or charitable surgery initiatives).

Biopower and Bodies of Value

The previous section elaborated the myriad ways in which neoliberalism shapes conceptions of health and health care with a concentration on the commodification of care and the reconfiguration of the patient as a health consumer. But Foucault’s analysis of neoliberalism enables another line of thought, which is hinted at above—the body as a site of *investment* through the medical market. Foucault notes that, within neoliberal thought, “we can analyze medical care and, generally speaking, all activities concerning the health of individuals, which will thus appear as so many elements which enable us, first, to improve human capital, and second, to preserve and employ it for as long as possible. Thus, all the problems of health care and public hygiene must, or at any rate, can be rethought as elements which may or may not improve human capital” (2010, 230). The notion of human capital that gains ascendancy with neoliberalism allows the conception of a full range of activities, including health care but also education and recreation, as contributing to the appreciation of one’s human capital. As Michel Feher (2009) notes, the conception of human capital operative within neoliberalism is not simply about producing the self as a consumer but also about enhancing one’s own human capital as a practice of “self-appreciation or self-esteem” (27) and “self-valuation” (28): “neoliberalism in fact treats people not as consumers but as producers, as entrepreneurs of themselves or, more precisely, as investors in themselves” (30). Thus the

health consumer can be viewed as making a form of self-investment, and it is my contention that plastic surgery can be a particularly fruitful site for the examination of the dynamics of such self-investment within transnational contexts.

While many critics read cosmetic surgery as a normalizing and disciplining technology (and this is certainly the case), fewer have noted the ways in which normalizing technologies can also serve as modes of care and valuing the body. As Heyes writes, “disciplinary power enhances our capacities and develops new skills; it trains us and offers ways of being in the world that can be novel, transformative, or appealing” (2007, 8). I would draw an analogy between how cosmetic surgery might function contemporarily and how Foucault characterizes the eighteenth-century bourgeoisie’s “invention” of sexuality. He writes that they gave themselves a “sex” that was a “fragile treasure,” (Foucault 1990, 121), a “body to be cared for, protected, cultivated...so that it would retain its differential value” (123). He calls this a “self-affirmation,” and an “intensification of the body” (123). Thus, Foucault illustrates how normalizing, disciplinary power—what he calls biopower—can also function as valuation and affirmation of the body. While the point of departure for this section was the contemporary dynamics of neoliberal self-investment, the rest of the section is devoted to an examination of how bodies have historically become sites of investment (or disinvestment) by tracing some episodes in the history of Western medicine and political economy.

Etymologically, “value” itself might be seen as always-already connected to health, since it derives from the Latin *valēre*, meaning “healthy, strong, well.”³ Rather

³ *Oxford English Dictionary*, online edition, s.v. “value”; thanks to Ed Cohen for bringing

than a full genealogy of the body's investability and connection to value, however, this section elaborates on key moments and texts that demonstrate the body's investability and this investability centrality to medicine. I investigate the intertwining of political economy and medicine—how the body has been defined as that which produces wealth and value within a capitalist economy, how bodies then become worthy of investment by the state, and how bodies in themselves become bounded but investible entities. In once sense, plastic surgery presupposes and depends on what Ed Cohen has called the “modern body,” what Margaret Lock and Judith Farquhar call the “body proper,” or what C.B. MacPherson calls the possessive individual. Below, I explore the ways in which medicine and political economy affirm the body as investable and valuable and value-creating.

Without denying that medicine indeed serves an individualizing function, Foucault argues against the notion that capitalism and modernity have ushered in a purely individualizing medicine:

With capitalism, we did not go from a collective medicine to a private medicine. Exactly the opposite occurred: capitalism, which developed from the end of the eighteenth century to the beginning of the nineteenth century, started by socializing a first object, the body, as a factor of productive force, of labor power. Society's control over individuals was accomplished not only through consciousness or ideology but also in the body and with the body. For capitalist society, it was biopolitics, the biological, the somatic, the corporal, that mattered more than anything else. The body is a biopolitical reality; medicine is a biopolitical strategy. (Foucault 2000, 137).

Capitalism's “socialization of the body” provides, for Foucault, both an enhancement of medical power and its capacity to address new problems as well as the general conditions under which biopolitics can emerge: the socialization of the body provides a mechanism through which population management can arise as a form of control. Foucault clearly

this point to my attention.

articulates that the rise of capitalism brings with it a change in the status of the body and a change in the diagram of power that invests those bodies. The socialized body as a factor of productive force, for Foucault, is indicative of a change in modern understandings of political economy, wherein value is no longer understood as the outcome of the relationships between men's desires and the objects of desire, but in terms of populations and bodies, whether through the labor theory of value or the measurement of the nation's wealth in terms of population's health/productivity.

While previous work in political economy, Foucault writes in *The Order of Things*, had defined value with respect to exchange and "the equivalence of the objects of desire" (Foucault 2002, 225), Adam Smith and, especially, David Ricardo move toward a definition of value that stems from labor (Cooper 2008, 6). Value comes to stem from the fact that all men [sic] are "subject to time, to toil, to weariness, and, in the last resort, to death itself" (Foucault 2002, 225). The external measure of labor introduces bodily energies into the direct calculation of value and wealth. Catherine Gallagher (2009) calls this understanding "bioeconomics" because modern political economy's emergence depends on physiological understandings of the body (as well as its emphasis on population and the population's well-being and life). In articulating his theory, Smith relied on new, vitalist Scottish physiological research that begins to understand organisms and the "animal economy" as having their own self-directing principles and directedness toward healing (Packham 2002). "Smith's physiological imagery expresses his understanding that the wealth of the nation is rooted in the activity of the laboring bodies of economic subjects; far from being a source of oppression to human efforts and actions, political economy is in fact precisely the cumulative effect of the efforts men are always

already making in pursuit of self-betterment” (Packham 2002, 477). Smith at once posits that labor is the activity of physiological body, that this labor is the measure of wealth, and that labor is a natural activity of men.

Smith’s bioeconomic thought, as in the thought of other political economists, imagines the nation/economy itself as a body, thus naturalizing not only labor but the economy as a whole. The imagination of the economy as a body, too, was influenced by Scottish physiology, especially the understanding that “an unknown principle of animal life” (an understanding that mirrors Foucault’s discussion of the principle of organic composition that serves to reorient understandings of “life” in the same period) makes the organism follow “the ‘wisest’ course of action” (Packham 2002, 477). Smith imagines the economy as a “a body powered by internal forces and vital energies which steer it unconsciously and independently to well-being, ease, and *health*” (Packham 2002, 469; my emphasis). Smith’s adoption of the notion of health shores up political economy’s importance and to naturalizes political economy’s functioning, constructing it as subject to natural laws. Health becomes a metaphor enabling a conception of the national body as self-correcting and thus not in need of intervention from the state (Cohen 2009, 110), and it enables a conception of the economy as that which naturally supplements and leads to health both for individuals and the nation.

While Smith’s understanding of the economy as linked to health and the “unknown principle of animal life” may be influenced by (Scottish) vitalist theories, it also incorporates an understanding of vulnerability of the human organism. Smith understands the human organism as inherently vulnerable, and it is this vulnerability that necessitates economic activity and labor. “Whereas other animals have the capacity to

fulfill their desires immediately, consuming food ‘best suited to their severall natures,’ humans, being ‘of a more delicate frame and more feeble constitution,’ must transform what they consume by adapting it to their weakness” (Cohen 2009, 115, quoting Smith). Thus Smith’s linking of the human vitality to the well-being of the economy comes with a conception of the human organism as inherently vulnerable and economic activity and sociality in general as as means for bringing about the well-being that is lacking due to such vulnerability.

With Ricardo, the shift Foucault identifies goes deeper, for not only is labor the measure of value, it becomes its source. “Value has ceased to be a sign, it has become a product” (Foucault 2002, 254), and it is a product of human vital bodily activity: Ricardo “singles out in a radical fashion, for the first time, the worker’s energy, toil, and time that are bought and sold, and the activity that is at the origin of all things” (Foucault 2002, 253). The labor theory of value is thus one mechanism through which the body is taken into the economy as a vital object. Political economy makes the body, in its capacity to transform the world with its capacities and the expenditure of energy, its proximity to death, crucial to “the economy”, the production of value, the life of wealth. The question of life (and death) enter as a primary facet of the calculation of wealth and the driving of the economy. The body is socialized under capitalism as a necessary asset to the nation, an asset that warrants investment because it is the thing that produces capital—without healthy bodies and healthy populations (which themselves are figures for the nation), capital and the nation are weakened or even unsustainable. “In the Ricardian theory, human vitality pulses through every exchange” (Gallagher 2009, 23).

Prior to the emergence of the labor theory of value, however, state medicine

intervened into the nation's population. In Germany, in the eighteenth century, the medical police emerged as a way of strengthening the state. The medical police invested in the population so that the state could maintain its fortitude for military—political and economic—conflicts. Developing out of the economic-political theory of cameralism, advocates of medical police understood the population, and especially the population's health, as the state's wealth itself. "It was not the workers' bodies that interested this public health administration but the bodies of individuals insofar as they combined to constitute the state. It was a matter not of labor power but of the strength of the state in those conflicts that set it against its neighbors—economic conflicts, no doubt, but also political ones" (Foucault 2000, 141-42). The medical police's interest in health is so that the nation can be prepared for war, a militarized vision of health that understand the population as vulnerable to disease (Cohen 2009, 102). "Frank defines health as a different *and more fundamental* kind of wealth which the state must guard and preserve" (Cohen 2009, 101). Medical police thus both takes some of the state's authority for medicine, inaugurating an alliance between the state and medicine that includes the appointment of medical officials, and also introduces a logic wherein the citizen is tied to the state via the ability to "enjoy the advantages of social life" (Frank qtd. in Cohen 2009 102).

Medicine thus takes on the role of investing in health for the state, as an integral part of the constitution and augmentation of the state itself. It is not the direct link between economic processes and human vitality proposed by the (British) political economists' labor theory of value that was developed during the same period. But medical police links the calculation of the population's health—including but not limited

to birth and death rates—to wealth, understood more broadly as a state’s economic wealth and its preparedness for war.

Ed Cohen (2009) delineates a complex history in which the body emerges as a sort of property within liberal theory and particularly the logic it uses to explain and legitimize wage labor. Cohen demonstrates that wage labor requires the fiction of the body as a seemingly properly bounded object (74) as well as a “corporeal self-possession” that allows the “contractual...alienation” that wage labor presupposes. In John Locke’s thought, Cohen finds the “reimagin[ing of] human potentiality as a kind of property (labor) owned by its personification (laborer),” which “founds a legal self-relation of self-ownership that in turn defines both legal and economic rights as a form of proprietary investment” (87). Tracing a complex genealogy to which this short summary cannot do justice, Cohen argues that we have inherited a situation in which “*to be a person means to have a body*” (70), and that, in the contemporary era, this body is the site of myriad forms of investment: “Taking care of our bodies has become the cultural equivalent of maintaining our capital. The body represents a kind of property that we invest in—psychically and financially—because it gives us back to ourselves. We can exercise it, we can liposuction it, we can work it, we can neglect it, because it is ours to control” (71).

Eva Cherniavsky’s (2006) work also draws on Macpherson, as well as Cheryl Harris’s “Whiteness as Property,” to discuss the body as a site of self-possession and self-investment, but she argues that the ability to possess oneself properly—in her terms to be a properly “incorporated” subject—is the purview of white subjects. Using the concept of “incorporation” to discuss the profound violence of racialization, she argues that race is a

violence that undoes the proprietary relationship to one's own body. Bodies racialized as white, she argues, are fully "incorporated," which she defines as "a specific idea of the body as the proper (interior) place of the subject" serving as a protection from the alienating forces of capital (xv). However, "the raced subject, in general...is characterized by a missing or attenuated hold on interior personhood—by an openness to capital(ization) without the conventional protections (legal, social, political) of embodied individuals[. R]aced bodies notably fail to bind and envelop this (missing) core" (xx). Cherniavsky claims that the limit case for this openness to capital is chattel slavery, but adds that "where the European colonizer claims an inalienable property in the body..., the bodies of the colonized are made in varying degrees susceptible to abstraction and exchange" (84). Thus, while white bodies constitute sites of investment and are protected from the extraction of value from them, raced bodies are those who lack this fundamental protection. The property in the body that inheres in the conception of wage labor for white subjects—the laborer must first own himself in order to own his labor (Cohen 2009, 86)—does not inhere for what Cherniavsky terms "raced" subjects who are constituted through a lack of self-possession.

In some senses, then, it is this logic of investability and entwinement of bodies and political economy that this dissertation explores. The title's "bodies of value," though a concept that is unevenly deployed throughout the chapters, is meant to signal how certain bodies become objects of investment in relation to others. Returning to Foucault's conception of the "body to be cared for," the dissertation explores how, despite the periods of intense pain, immobility, and recovery that plastic surgery can often involve, it constitutes one way of caring about bodies and affirming some bodies as worthy of

attention in particular ways, and how caring for and affirming bodies is integrally linked to strategies of power that regulate them. While plastic surgery certainly can be involved in biopolitical strategies of population management, as is the case for chapter 2's discussion of the "discovery" of the need to invest in the health of the "developing world," as a practice that manipulates the appearance and functionality primarily of individual bodies, my analysis concentrates on the "anatomy-politics" of bodies historically (in chapter 2) and contemporarily (in chapters 3 and 4). Because value is an inherently differential concept, "bodies of value" always signals the questions, "in relation to what?" and "for whom?"⁴ The answers to these questions often involve processes of racialization, such that populations racialized as nonwhite, in transnational articulations of surgery, are either subject to disinvestment or to external investment. Indeed, while Foucault defines the "body to be cared for" as a form of *self*-affirmation, this dissertation investigates forms of self-affirmation and self-investment within neoliberal medical economies and also attends to the politics of such acts of regulatory affirmation when they are applied as a form of outside intervention involving actors who are unevenly positioned within transnational political economies.

⁴ "Somatechnical capital" (Aizura 2010; Pugliese and Stryker 2009) is a similar and highly instructive concept. I prefer "bodies of value" for its inherently differential character. Concepts such as biovalue (Waldby 2002) and biocapital (Sunder Rajan 2006) are also instructive, but they concern the direct commodification, circulation, and labor of biological or bioinformatic material, which plastic surgery does not.

Liberal Visions and the Traveling Surgeon: Race and the Value of Surgery to Development

That plastic surgery has been international since its inception is not a new insight. From Sidcup, a plastic surgery unit in the United Kingdom coordinated by New Zealander Harold Gillies during World War I, to East Grinstead, a plastic surgery unit in the United Kingdom led by New Zealander Archie McIndoe during WWII, to the founding of the American Society of Plastic and Reconstructive Surgeons (ASPRS) by two non-American surgeons, plastic surgery has been composed of transnational movements of surgeons and techniques, and the cooperation among surgeons of different nations. But scholars have not fully explored the ways that surgeons themselves understand the significance of their internationalism or how it influences their understanding of surgical practices. Internationalism is in fact central to the constitution of plastic surgery as a practice and specialization, as well as to the meaning that surgeons assign to their work. As I will show, the politics and economics of nations and racial formations pervade not only the institutionalization of surgery but also the articulations of health, vitality, and appearance that surgeons (and plastic surgery as a discipline) deploy in their writing.

By using the phrase “health, vitality, and appearance,” I mean to highlight what surgeons understood to be unique about their specialty. Plastic surgery developed a particular set of skills in surgeons that can be used to various ends: Plastic surgeons can save lives, both because they are trained in general surgery and because certain kinds of reconstructive surgery can prevent death. But reconstructive surgery can also be used, in surgeons’ view, to raise the quality of a person’s life, through providing enhanced

mobility (loosening scarred skin, for example; Barsky 1970, 432), improving the ability to eat or speak (through cleft surgery; Barsky 1970, 432), or providing a more “normal” appearance (what Jack Penn [1976] calls “the right to look human”). And plastic surgery, on the cosmetic end of the spectrum, can also be used to improve quality of life, not through restoring functionality but through making one aesthetically more pleasing and enhancing psychological health, though of course many surgeons were disdainful of surgeons who made careers of aesthetic surgery (see Gilman 1999, 13-14). A critical interrogation of these notions, and the ways that plastic surgery attempts to mark its importance and legitimacy, will make up much of the chapter. I am particularly interested how the division between reconstructive surgery and cosmetic surgery reflects and depends on geopolitical divisions, as well as the purported attempt to overcome these divisions through economic development. Within liberal surgery discourse, differing understandings of bodies, which are shaped by the bodies’ locations within a geopolitical and racial order, reveal both how surgery is meant to overcome bodily and economic difference and how it reproduces inequality in practice.

After I give an overview of development discourse and its relation to medical discourse, this chapter turns to three case studies of post-WWII efforts in transnational surgery to excavate the ways that plastic surgery, as a still-consolidating medical specialty, linked itself to development discourse and sought to define and legitimate itself via its unique capacity to transform bodies in particular ways. The first case consists of doctors who undertake surgery as a humanitarian project in Vietnam, before and during the Vietnam War. Through an examination of the institutional structure of the “missions” to Vietnam and through close readings of articles in surgery journals, I demonstrate that

surgeons joined their capacity to repair bodies to the emerging discourse of development, thus committing plastic surgery and the bodies upon whom surgeons operate to the project of global capitalism in the fight against communism. The second and third cases are surgical efforts linked to Africa, but in very different ways. The Flying Doctors of East Africa were a postwar surgical organization that provided care throughout Tanzania, Kenya, and Uganda. Primarily through a close reading of the memoir of one of the founders of this organization, I demonstrate the project's continuities with and differences from colonial health interventions and representational systems. I examine how the figure of the "African Patient" (Vaughan 1991) is constructed through the lens of a liberal plastic surgery organization doing development work. And finally, I turn to Jack Penn, South Africa's first plastic surgeon, who positions plastic surgery as an extraordinarily valuable force for the overcoming of differences of nation and race. Yet I demonstrate that not only are national and political borders necessary to the articulation of this vision but that it depends on the devaluation and exclusion of black Africans from the emergent liberal order.

The three examples in this chapter allow me to demonstrate the range, geographical and philosophical, that plastic surgery's merging with development involves. But they are united by a belief in the power of surgery to advance liberal goals of both development and political cooperation even as they all ultimately serve to reinforce differences of nation and race as well as the hierarchies among them. I have selected Vietnam because it demonstrates surgeons' active philosophizing regarding the development project and the status of nation within the pages of surgical and medical journals. Because it is related to the context of the Vietnam War, it also most clearly

demonstrates the differences in the role that plastic surgery plays after World Wars I and II. The FDEA and Penn were selected as examples in part because the existence of memoirs again allows me access to explicit reflections from surgeons on the meaning of their practices in transnational contexts. And while the surgical interventions in Vietnam clearly have links to US imperialism, the FDEA and Penn allow me to explore the connections of plastic surgery to practices and discourses of colonialism and the health care contexts inherited colonial relations.

This chapter therefore elucidates the concept of bodies of value—noting the economization of bodies and the practice of surgery (Vietnam) and then the value of the surgical repair of bodies to the creation of a more humane, modern, and healthy world (the FDEA and Jack Penn). Taken together, however, the case studies demonstrate the continuity of development and plastic surgery with colonial logics of intervention and colonial thinking about race. Throughout the chapter, I argue that race and geopolitical location are key determining factors in the division that these surgeons construct between liberal self-making subjects, who elect surgery, and illiberal subjects who are the recipients of surgery as an outside intervention. All three cases also, to greater or lesser extents, use the cultural tolerance for and humane appreciation of bodily difference as a measure of the capacity for incorporation into the liberal, developed world, and attribute to racialized others (particularly black Africans) an especially intolerant attitude toward bodily difference. Thus, while other scholars have attended to the raced and gendered ideas about the body that plastic surgery reinforces through normalization, these cases call for a more capacious understanding of how race operates within plastic surgery discourse. I argue that while the anatomical and biological understandings of race as

embodied are still operative, with the rise of development, culturalist understandings of race (which may still be articulated through the body) gain salience. Surgeons register race as a nonbiological but embodied difference produced by culture. I argue that these surgeons simultaneously bring phenotype into the scope of the post-WWII global economic order as an object of regulation and demarcation of difference while also reconfiguring race through culturalist lenses focused on the capacity of culture to produce both embodied differences (such as injuries or differences in perception) and differing understandings of the body itself.

The Logic of Development

A schematic overview of the characteristics of development discourse and its relationship to health efforts is necessary before proceeding to examine the specific efforts of the doctors and organizations discussed in this chapter. According to Arturo Escobar, development discourses emerged after World War II in the midst of both economic reorganization and decolonization. As Escobar has shown, the “breakdown of the old colonial systems [and] changes in the structures of population and production” are some of the “historical roots of” development (Escobar 1988, 428). The rise of development entailed a reimagining of global interconnectedness. Rather than a system of colonial extraction, capitalist development sought to reconfigure relations in terms of rich and poor nations. The invention of “the third world” and “underdeveloped countries” was premised on the “discovery” of “poverty on a global scale [in] the post–World War II period” (Escobar 1995, 22). When framed in terms of poverty, development could become a universal goal. “The aim of all the countries that emerged with this new status

in the global concert of nations was invariably the same: the creation of a society equipped with the material and organizational factors required to pave the way for rapid access to the forms of life created by industrial civilization” (Escobar 1988, 429). Development transforms colonial relations of control into relations of purportedly mutual benefit. The “discovery” of poverty is based in a postcolonial framework that views populations of the former colonies as possible sites of investment that can lead to enrichment (as opposed to “natives” whose capacity for labor and technological mastery could progress only up to a certain point). Yet at the same time, this investment often took the form of production of cheap goods for Western consumption. Because the imposition of the development framework saw industrialization as the key to enrichment, following the Western model, the goal of industrialization also saw the production of cheap goods as benefiting both the underdeveloped and the developed worlds. In this way development serves as a continuation of Western domination and exploitation.

Because Western powers set the standards of industrialization and development, they also took it upon themselves to plan and intervene into economies so that the development project could be achieved: “The poor countries became the target of an endless number of programs and interventions that seemed to be inescapable and that ensured their control” (Escobar 1988, 430). Technical knowledge and planning was central to all aspects of development, and to the process of expanding development to encompass more and more aspects of life and segments of the population. The distribution of technical knowledge and the ability to proliferate and disseminate that knowledge (i.e., the construction of academic disciplines or programs dedicated to different aspects of development economics) was, of course, asymmetrical. In identifying

and inventing underdeveloped countries, intervention by Western powers was given a new justification—technocratic control in the effort to eliminate poverty: “Development was—and continues to be for the most part—a top-down, ethnocentric, and technocratic approach, which treated people and cultures as abstract concepts, statistical figures to be moved up and down in the charts of ‘progress’” (Escobar 1995, 44; see also Manji and O’Coill 2002). It is also important to note that development was equally enabled by the promise and hope provided by scientific rationality, to enable accurate planning and industrialization but also to manage population growth, enhance health, and provide resources. By the end of the 1950s, Escobar shows, development had become hegemonic, “extend[ing] its reach to all aspects of the social body” (Escobar 1988, 430). This task was aided by the expansion of not only of state activities but also humanitarian or charity work that was integral to the development project. Firoze Manji and Carl O’Coill (2002) and Erica Bornstein (2005) note the important role that NGOs have played in the development project. Bornstein claims that “in Zimbabwe and much of southern Africa, faith-based institutions such as churches and religious NGOs have historically been leaders of what is today considered economic development” (2005). In her study of contemporary Christian NGOs, Bornstein (2005) finds that missionary groups have changed their discursive practices such that “the ... ‘lifestyle’ advocated by Christian NGOs is closely tied to a capitalist lifestyle that echoes earlier missionary discourses in southern Africa about correct ways of living, about being ‘civilized,’ and about progress.” In explaining how charitable organizations took up development discourse, Manji and O’Coill identify two types of organization. The first group consists of those working in former colonies, now “the third world”—overseas missionary societies and

charitable bodies. Development discourse provided these organizations with the chance to retool their images, a necessary task since they were often associated with colonial paternalism, racism, and attempts to pacify resistance movements. Development allowed them to rearticulate their mission, “replacing the overt racism of the past with a new discourse about ‘development’” (572). The second group were war charities, which, after the end of WWII, had to reorient themselves and find new avenues and geographical areas through which to continue their existence. In the 1960s, the former war charities expanded their missions and scope to include development, and given that half the world was now considered underdeveloped, this enabled them to continue their work in many locales. War charities continued to understand their activities through the “idealist tradition of liberal internationalism of their founders”: “Idealists sought to promote world peace through international cooperation and actively encouraged people to gain a ‘truer understanding of civilisations other than their own’” (Manji and O’Coill 2002, 573). This is clearly a guiding principle for many of the groups and individuals I discuss below.

Manji and O’Coill, Bornstein, and Escobar thus highlight that development was always also, at least in some senses, a humanitarian project. In a way, the “discovery” of poverty in the former colonies was a mode of linkage consonant with the postwar ethos of debunking racial distinctions: populations that were previously seen as fundamentally different and uneducable were discussed frames similar to those used to discuss Western populations. Poverty was a universal framework that could theoretically encompass all of humanity. But as noted above, the division between developed and underdeveloped gives the lie to this universality by reinstantiating the division between self-governing liberal subjects and subjects in need of aid—with “aid” connoting not only monetary assistance

but also the incapacity to properly govern oneself. As Manji and O’Coill (2002) put it with regard to Africa: “It was no longer that Africans were ‘uncivilized’. Instead, they were ‘underdeveloped’. Either way, the ‘civilised’ or ‘developed’ European has a role to play in ‘civilizing’ or ‘developing’ Africa” (574). Development foreclosed the capacity for self-making and self-governance that is fundamental to the liberal line of thought from which development and the international ethos of care were wrought.

Although it does not deal explicitly with development per se, Jodi Melamed’s description of the “postwar liberal race formation” (2006, 2) and its relation to shifts in global capitalism is also instructive here. Melamed writes that in the postwar liberal order, despite the emergence of “official antiracism” as a dominant ethos within the postwar liberal order (2), “race continues to fuse technologies of racial domination with liberal freedoms to represent people who are exploited for or cut off from capitalist wealth as outsiders to liberal subjectivity” (2), a dynamic that I explore below in terms of surgeons’ constructions of liberal and illiberal subjects of investment. With the emergence of the US as a global superpower, official antiracism, as well as tolerance for and appreciation of racial difference, became evidence “to prove the superiority of American democracy over communist imposition” (4-5) and, by extension, the superiority of the free capitalist world over the communist system. “Official antiracism now explicitly required the victory and extension of U.S. empire, the motor force of capitalism’s next unequal development” (6). The hegemony of “racial liberalism’s model of race as culture” (8), while (unevenly) debiologizing race and officially distancing race from phenotype, turn the existence of racial intolerance and illiberalism within particular populations into justifications for intervening to extend liberal capitalism to those locales,

and development efforts become primary mode of this extension. The imputation of intolerance, in turn, comes to function as a mode of racialization itself (Atanasoski 2013), which Howard Winant might call an “anti-racist racism” that “reinterpret[s] racialized differences as matters of cultural and nationality” (2001, 35).

The hegemony of development coincided also with a scientific move away from biologized understandings of race: “After World War II, liberal ideologists, primarily through the UNESCO statement on race, rejected the typology of fixed racial categories” (Fausto-Sterling 2004, 1). But of course, as Anne Fausto-Sterling (2004) and others have shown, this “post-war liberal anti-racist consensus” (Stepan 2003, 334) did not so much eliminate race as translate it into other terms. In the field of health and health care policies, development and the eschewal of biological race wrought significant changes. Randall Packard notes these changes but also insists that they be viewed in terms of their continuities with colonial health policies. He characterizes colonial health as primarily concerned with the health of colonizers, with tropical medicine devoted primarily to ensuring that Europeans did not succumb to disease (1997, 94). Or, later on, health professionals would provide services at labor centers in order to ensure the continued availability of the labor power of indigenous or migrant working populations. He writes, “Finally, colonial health interventions reflected a view of local populations as inherently unhealthy and incapable of caring for their own health needs. Conversely, great faith was placed in western biomedicine, even when challenged by objective evidence of its limitations” (95; see also Harding 2011). We will pay closer attention to how this characterization of local populations as unhealthy continues within plastic surgery

development programs below, but for now it is enough to sketch this broad picture of colonial health policy and discourse.

After the universalization of development, health discourse underwent certain shifts that mirror those in the development world. First, the field of health and health care expanded, mirroring the increasingly expansive reach of development itself into different aspects of social life: “Health policies, as well as rhetoric, reflected a new realization of the need to extend the provision of health care to entire populations, not just select communities of productive workers” (96). Though Packard does not frame it in such terms, the link between economy and health becomes transformed once the “underdeveloped” world is understood as such based on its poverty. The link between health and wealth is longstanding (as I discuss in my introduction), and European public health emerged through an explicit concern with poverty and its connection to disease and ill-health, a connection that also justified policing and governing of populations. Once the cause of ill health is identified as poverty rather than racial difference, these intervention strategies can become applicable—though the racial valences of course in no way disappear.

As Packard notes, health care policy became “a prescription for social and economic change” and “was part of this growing faith in the ability of western science and technology to transform underdeveloped countries” (100). The emphasis on technical knowledge and technology was characteristic of development at large, and health care policy reflected the same asymmetrical structure of knowledge transmission and governance structures that characterized other processes of development (as well as, of course, colonial power dynamics): “it ... privileges the skills and knowledge of the

outside expert while placing local populations in a position of dependence and in need of guidance and assistance” (101). As the above indicates, health initiatives were embedded in economic discourse. The technological and governmental interventions were in the service of not only health but economic growth as well. The population’s health—and size (population control measures were a consistent concern of health officials)—was both a part of and dependent on the wealth of the nation. The capacity to labor and generate income—contribute to the GDP—was a large part of the rationale for international health efforts. “Health interventions after the war continued to be viewed as a prerequisite to development” (Packard 1997, 103). Packard uses the example of malaria eradication to show that disease was viewed as incompatible with economic development (105).

This chapter, then, explores plastic surgery’s interaction with the above dynamics, asking what happens with plastic surgery becomes part of the “forms of life created by industrial civilization” (Escobar 1988, 429) promoted and enabled by development. When plastic surgeons become part of the promotion of international health through their participation in medical organizations modeled on and/or funded through the organizational networks that Manji and O’Coill discuss as integral to the development projects, they translate development in such a way as to both legitimize plastic surgery as a discipline and promote the particular sort of investments in bodies that their specialty is capable of making as of unique value to development and humanitarian projects. Plastic surgeons, I will argue, “discovered” a poverty in health care just as other development practitioners did, and they discovered a specific form of poverty that they were uniquely suited to address. In other words, plastic surgery becomes a specific and special form of

development capital, and this is due to the ways that it can invest or intervene into bodies. The expansive notion of health that plastic surgery has developed in order to justify its own existence—its incorporation of aesthetic, psychological, and social factors—enters into development discourse in ways that expand the capacities of development itself. Contained within this transformation, however, are the same continuities and problems posed by the legacy of colonialism—both discursively and institutionally. Asymmetries are translated into new terms: between those with the technical knowledge to invest in health (a term that takes on very specific valences within plastic surgery discourse) and those who are subjects of external bodily investments in health. This is readily apparent in surgeons' earliest efforts to engage in international health care after WWII, their efforts in Vietnam both before and during the Vietnam War. But the contradictions at the heart of liberal discourse in general and development discourse in particular are especially apparent when surgeons engage with Africa, explored in the final sections.

Internationalism and the Vietnam War

One important but relatively unremarked upon example of internationalism in plastic surgery is the Plastic Surgery Education Foundation's (PSEF) exchange program. The PSEF was founded in 1948 by Dr. Jacques Maliniac, a Polish-born, Paris-educated surgeon who was also the cofounder of the ASPRS, to which the PSEF was attached. The exchange program was not established until 1964; it was designed to encourage the international education of plastic surgeons. The program emphasized the need for surgeons from the US and other countries with "developed" plastic surgery expertise to go abroad for short periods of time in order to educate surgeons in other parts of the

world in plastic surgery techniques. From the outset, then, the program valued international education, building from the wartime experiences of surgery—the understanding that different surgeons in different locations have different strengths, and thus international travel will provide for the sharing of knowledge (“this group of surgical specialists has as its hallmark fresh ideas from abroad”; Schultz 1967, 441). But the PSEF’s program introduced key new elements: in particular, the transfer of skill was now seen as more or less unidirectional, from something now called the “developed world” to the “underdeveloped world.” That the exchange program did not exist until 1964 is significant; it could not have established itself in the form that it did without the hegemony of discourses of economic development.

Dr. Richard Stark, delivering the presidential address at the annual meeting of the ASPRS in 1966 (later published in the society’s journal, *Plastic and Reconstructive Surgery*; Stark 1967) offered an appraisal of the exchange program, which illuminates the intertwining of issues of nation and health, as well as how internationalism was constructed (discursively and in practice) by this program. Stark writes that in order to gain the capital necessary to fund the exchange program, the PSEF established an affiliation with “Medico, a service of CARE” (Stark 1967, 541). This links the US-based plastic surgery foundation into a relationship with an already-established medical humanitarian program founded in 1958 by Thomas A. Dooley, an organization that was in turn linked to an existing political-economic network of humanitarian agencies with their own specific agendas and governing philosophies. MEDICO (which stands for Medical International Cooperation) was an organization established by Dooley, originally with the sponsorship of the International Rescue Committee (IRC), which later withdrew

funding and was replaced by CARE. MEDICO was “devoted to providing nongovernmental, nonsectarian medical aid to people who, in the words of a former Dooley aide, ‘ain’t got it so good,’ particularly those living in ‘developing nations’ threatened by communism” (Fischer 1997, 2). The organization is clearly, then, a part of the postwar shift to a postcolonial development framework, in which organizations “changed their ideological outlook, replacing the overt racism of the past with a new discourse about ‘development’ that was...tak[ing] shape in the international arena” (Manji and O’Coill 2002, 572). As Manji and O’Coill claim, while this discourse downplays race in favor of a purely economic rationale, it continues to advocate for European (and, in our case, American) intervention: “As with the racist ideologues of the past, the discourse of development continued to define non-Western people in terms of their perceived divergence from the cultural standards of the West, and it reproduced the social hierarchies that had prevailed between both groups under colonialism” (Manji and O’Coill 2002, 574). Thus, a brief discussion of Dooley’s work and MEDICO’s history is instructive in fleshing out the ways that the PSEF would come to frame its own objectives (as well as the general understanding of internationalism within plastic surgery discourse).

Dooley first became known through his work with the US Navy as a doctor in Vietnam just following the Vietnamese defeat of the French in the First Indochina War. Dooley worked aboard the USS *Montague* during Operation Passage to Freedom transporting refugees from the newly created North Vietnam to the South, an experience that formed the subject of his first book, *Deliver Us from Evil*. In that book, Dooley engages in highly conventional representations of the recipients of humanitarian aid.

Refugees on board the ship are described as stinking, ignorant, and pathetic. A typical example of Dooley's representation of the refugees—one which spills over into characterizing the nation of Vietnam as sickly—is as follows: “He was hunched over as if heavily burdened. When, nervously, he removed his head, his scalp showed patches of scaling fungus. His ribs stood out sharply, stretching the skin of his chest to shiny tautness. I had never before seen such utter dejection. Could this be Viet Nam?” (Dooley 1956). It is only through the doctors' and servicemen's compassion that the refugees' humanity emerges in moments of happiness, laughter, or familial love.⁵ For instance, children eating candy given to them by U.S. navy personnel allows them to become recognizable as children, rather than as tragic cases or as a “brown little bundle of baby” (Dooley 1956). Dooley uses these representations of Northern Vietnamese people in order to bolster his own image and, more significantly, the fight against communism in Southeast Asia. Illness, disfigurement (through torture), and lack of hygiene are indicators, in Dooley's account, of the failures of communism and the cruelty of the Viet

⁵ The navy even organizes a beauty contest for the refugees: Miss Passage to Freedom “was selected by the Captain, dressed in a surgical robe from sick bay, and given a crown fashioned by the boys in the radio shack.... All this delighted her and she rewarded us with black-toothed, betel-stained smiles” (Dooley 1956). Thus the plastic surgeons that would later travel to the region were not the only humanitarians concerned with aesthetics. It is also an instance in which women's bodies and the notion of beauty attached specifically to them enters into humanitarian discourse. As Mimi Thi Nguyen notes, “the ‘other’ has often been found under the sign of the ugly—which is to say the morally reprehensible, not necessarily to the exclusion of the aesthetically pleasurable—as the limit of the human and as the enemy of beauty. Ugliness, furthermore, has a civilizational dimension” (2011). In this case it is not that the other is inherently ugly but that the unfreedom of communism and underdevelopment have rendered ugly what should be beautiful.

Minh, and his medical practice is demonstrative of the vital superiority of the United States, and of capitalism more generally—the reverence for life held by the free world.⁶

Dooley's services were used to buttress Ngo Dinh Diem's legitimacy and to enhance the relationship between the United States and South Vietnam. By providing "medical aid," the bonds between South Vietnam and the United States could be strengthened. Diem even gave "the American doctor," as Dooley was known, a citation, stating (in a speech that was written for him by Colonel Edward Lansdale of the CIA) that he "show[ed] them [the Vietnamese people] the true goodness and spirit of help and cooperation that America is showing in Viet Nam and in all the counties of the world who seek and strive to achieve their freedom" (in Fischer 1997, 60). Here, then, is one place where a key difference between Dooley and Schweitzer emerges: While Schweitzer and Dooley are often invoked in the same breath as inspirational "jungle doctors," and while Dooley invokes Schweitzer's concept of "the fellowship of those who bear the mark of pain" (Dooley 1956), the framing and rationale behind their respective life's works are quite different. Whereas Schweitzer would speak of healing and sickness in terms of reparations for colonialism, Dooley's framing in terms of aid, development, and anticommunism explicitly links medicine to (liberal) international relations and to the politics of foreign aid, as well as the fight for the triumph of capitalism. Dooley also specifically objected to Schweitzer's missionary framing, believing that modern medical humanitarianism must break from a religious model and become secular (although in his early work, his own religious motivation did play a role). Thus medicine is put into the

⁶ "Reverence for life" is a concept from Schweitzer that Dooley invokes, yet Schweitzer would not have delimited the reverence for life geographically or culturally, since in his view Western civilization has forgotten the importance of the reverence for life.

service of a particular national, imperial, and economic agenda through invocation of the universal good of the now-dominant paradigm of development.

But Dooley's project was not only aimed at creating closer diplomatic ties between the U.S. and South Vietnam at the governmental level or legitimating the South Vietnamese government; it was also aimed at reaching "the people." That is, as Lansdale/Diem's remarks imply, the method for strengthening governmental and national bonds was intimate contact between the American doctor and his patients. Within the humanitarian aid framework, Dooley's practice was imagined as addressing not only the bodies of his patients but also their "hearts and minds" (Dooley 1956), a project that would also become key to Johnson's strategy during the Vietnam War, as well as to the PSEF's justifications for its actions (see Wilensky 2004; Atanasoski 2013; Nguyen 2012). Thus, even as Dooley was engaged in state-level diplomacy, the real value of his work and the real potential of U.S.-backed medical humanitarianism was in its ability to create love and friendship among the people. He advocated labeling all U.S. goods provided for aid to the Vietnamese people clearly with "Zay La Vien Tro My (This is American Aid)" (Dooley 1956) to dispel refugees' "mortal fear of the savage, inhuman Americans against whom they had been very often and very effectively warned [by the Viet Minh]" (Dooley 1956), replacing this fear with a feeling of friendship and love for Americans and the United States. Further, during his work in Laos following his discharge from the Navy (for homosexual activity), he insisted that his interpreters "precede every statement [with] '*Thanh Mo America pun va...* The American doctor says'" (Dooley quoted in Fischer 1997, 127). This insistence on being named as "the American doctor" is a specific strategy to manipulate the affective associations Laotians

have toward “America” in the service of weakening the Bamboo Curtain. Dooley understood medicine as a form of “‘T.L.C.,’ tender loving care” (Dooley quoted in Fischer 1997, 126). TLC becomes a strategy through which medicine as foreign aid invests in the population’s health, indicting communism and extolling capitalism as the sole economic system that can properly valorize life. Dooley’s philosophy effectively sought to associate medical expertise with the capitalist and freedom-loving United States, associating communist regimes with cruelty and indifference toward the lives of their populations, as well as with a lack of medical technology and expertise caused by their economic system itself. Thus rather than simply overcoming difference through the unity of those who bear the mark of pain, Dooley’s project in fact hierarchically organizes objects of and providers of care within a set of imperialist relations realized through medical humanitarianism. It is in this context that medicine becomes figured as aid and as an investment, an understanding that the PSEF will adopt wholeheartedly.

In order to continue his work in Laos, Dooley founded MEDICO, which was funded by the International Rescue Committee (IRC), an organization that was originally founded to “aid people fleeing Nazi-occupied Germany” (Morgan 1997, 16) and that was involved in supporting Diem and aiding Vietnamese refugees. On February 4th, 1958, MEDICO was founded, as the president of the IRC, Angier Biddle Duke stated, in order to send “teams of doctors and medically trained assistance ... into ‘underdeveloped’ areas of the world where they will build, equip and staff medical clinics and small hospitals.... These doctors will train indigenous staffs, and after eighteen months to two years, withdraw, leaving behind all their equipment and self-sufficient local staffs” (in Fischer 1997, 159). As the quotation illustrates, the language of international development has,

by this time, eclipsed any religious motivations, and medicine is wedded to the development project as the health of the population is seen as integral to the very definition of development (Packard 1997, 96). The structure of the project was influenced by the work of Operation Brotherhood, a Filipino undertaking in which doctors from the Philippines traveled to Vietnam to provide care; Dooley stated that the idea for his Operation Laos was “borrowed” from Operation Brotherhood (Fischer 1997, 100) and that MEDICO was “modeled” on Operation Brotherhood, since it would “behoove...Americans to copy some ideas from our Asian brothers” (Fisher 1997, 159). Ironically, though, Operation Brotherhood was in fact the brainchild of Lansdale and funded by the CIA—the doctors employed were intelligence gatherers.⁷ Dooley’s ostensibly anti-imperialist framing—and by extension MEDICO’s—inadvertently underlines the depth and perniciousness with which imperialism structures medical humanitarian efforts.

In 1959, however, the IRC cut its funding of MEDICO, which was subsequently funded by CARE. Thus, Stark wrote that in the PSEF’s case, “CARE supplies money and logistical support while Medico supplies skilled personnel for its overseas medical and surgical missions” (Stark 1967, 541). MEDICO’s imprint is evident in the both the PSEF’s institutional model and in its geopolitical orientation. The IRC’s description of MEDICO’s model, quoted above, fits almost perfectly the model followed by the PSEF’s exchange program. And MEDICO’s use of the language of development and its focus on

⁷ MEDICO also funded the work of Gordon Seagrave, the “Burma Surgeon,” but only did so because Seagrave had, in Dooley’s words, “broken with the church and is no longer proselytizing” (Fischer 1997, 159). And despite Dooley’s reservations about and differences from Schweitzer, in order to gain legitimacy, the organization did seek and obtain Schweitzer’s blessing, funding a dental clinic in Lambaréné while he became an honorary patron of MEDICO.

aid and training indigenous staff, are all translated into the foundation's mission. The geopolitical orientation of the program and its debt to Dooley are apparent in its first exchange, which sent surgeons to Vietnam. So, even as the PSEF was an international endeavor involving surgeons from Japan and many other nations, Dooley's history as a promoter of the United States and "American values" runs throughout the project. Dooley's rationale for and philosophy of "jungle medicine" remained alive in the justifications for the PSEF and the discussions of its work. And, finally, the PSEF's work was just as embroiled in the politics of the Cold War and the Vietnam War.

The politics of the Vietnam War run through Stark's appraisal of the PSEF, published in 1967. Vietnam was the first country in which an exchange program was established, in 1964. But by the time that Stark's article was published, the "American War" was in full swing. Surgeons' testimonies about their work with the PSEF in Vietnam reveal the war's centrality to their mission (though other surgeons working in Vietnam would seek to downplay the extent their treatment of war injuries). Stuart Landa, for instance, writes that "the vast majority of patients seen are war casualties. After 25 years of continuous war, the Vietnamese staff obviously has had considerable experience with the early treatment of gun-shot or other injuries" (in Stark 1967, 542). In Vietnam, then, plastic surgery is mobilized in a way that continues its historical role in repairing war injuries. In this case, though, because this practice is explicitly seen as a form of international medicine, Landa frames medical skill through national difference, with Vietnamese doctors being skilled in *early* treatment of gunshot wounds, but lacking in the skill to perform later reconstructive treatment. This requires outside intervention from surgeons from countries with more developed medical specialization. It is not the

lack of medicine tout court, as it was for Dooley, that signaled the need for Western intervention/aid. Rather, it is specialization that becomes both a sign of development and a means by which plastic surgeons can aid in the development of other nations. This should not simply be attributed to some actually existing historical process by which primary care had been developed in Vietnam through the combination of war and Dooley's activities. Rather, it must be understood as enabled by 1) the merging of medical and development discourses that Dooley and other post-Schweitzer, postwar medical humanitarians had enabled and 2) the specific vantage point provided by plastic surgery, from which surgeons see bodies in need of the secondary care that they can provide. Plastic surgery comes in, in this figuration, when life itself is not in question. This understanding was echoed by Arthur J. Barsky, a surgeon who set up a separate program in Vietnam, and other surgeons, discussed below. Plastic surgery thus refigures the human of humanitarianism, incorporating both aesthetic considerations and a primary concern with *quality* of life rather than life itself.

Framed as both foreign aid and war medicine, the exchange program functioned to put a human face on the war in Vietnam through operating on the local population. The program was thus integral to the U.S. hearts-and-minds strategy as it developed in the Vietnam War, part of the US's humanitarian component of war. Plastic surgeons, in forming the exchange program in Vietnam, were responding to an explicit call from President Johnson, who, at a 1965 press conference quoted in *JAMA* and reprinted in Stark's article, stated, "We will build clinics and provide doctors for disease-ridden rural areas. We will help South Viet Nam import materials for their homes and their factories, and in addition the members of the American Medical Association have already agreed

with us to try to recruit surgeons and specialists, approximately fifty of them. We are particularly very much in need of plastic surgeons to go to Viet Nam to help the wounds of war, as well as to help with the ravages of unchecked disease” (in Stark 1967, 546). Johnson’s call builds on a post-WWII liberal understanding of medicine, emphasizing its difference-crossing and understanding-building capacities, but it also draws on the traditional role of reconstruction that plastic surgery has played in war. In responding to Johnson’s call, the PSEF put plastic surgery in service of war, serving their allies but also participating in the military objective of winning the hearts and minds, a key strategy of Johnson’s—both waging war and creating understanding, with medicine being a key tool of “pacification” (Wilensky 2004, loc. 126) and representing the promise of capitalist development in the form of medical specialization. Johnson’s call evidences a newer logic whereby humanitarian action and war can form part of the same strategy (see also Atanasoski 2013; Nguyen 2012). This is the significance of the fact that surgeons are called not to operate on the bodies of soldiers (as was the prevailing practice in WWI and WWII) but on the civilian population. These are bodies suffering from forms of impairment that plastic surgery is uniquely situated to address, and as such they represent the Vietnamese population as embodying forms of difference produced not through biology but through, at least in a sense, social or cultural factors—both war-induced injury and congenital “deformity” that is not repaired because of the Vietnamese medical infrastructure. Investment in the population’s health, rather than the soldiers’, mobilizes these bodies in several different but interrelated directions: as part of the nations’ strength *during* wartime, as evidence of humanitarian impulse *despite* or *alongside* escalating war, and a general project of capitalist development *irrespective* of war.

These multiple valences then allow surgeons to argue that medicine is a force for peace even when it is part of war. In 1966, Stark published a more general call for doctors and surgeons of all kinds to engage in international medicine, which again accords with Johnson's call, and he explicitly invokes Eisenhower's philosophy of "person-to-person" philanthropy. Though clearly linked to the political realm, like most humanitarian actors Stark explicitly denies any politically motivated intent, relying instead on medicine's humaneness as a uniting force while at the same time reiterating that "American medicine is fast becoming a diplomatic force for peace" (Stark 1966, 831). The article, titled "Why Overseas Medicine?" is framed as a general meditation on the need for international cooperation, particularly for American doctors to fulfill their "humanitarian obligation" (831). But the occasion for writing it is clearly the Vietnam War, and it uses Vietnam as the foremost example of the U.S. forging humanitarian links. Stark invokes Dooley and MEDICO as exemplary of "the export of skilled civilian specialists to countries of acute need where no or too few medical schools exist" (832). Interestingly, though, Stark is disdainful of those doctors who travel with the explicit backing of the state or who explicitly propagandize: "Many emerging countries of the world are subjects of proselytizing propaganda which often is medical in guise. While foreign uniforms are an obvious indication of the bait, so too is the surgical team sent officially from an iron curtain country or even from the free world. The natives know that they are being wooed by a government, not necessarily by a people" (832). While Stark clearly believes that communists are more likely to engage in this sort of propagandistic medicine, the admonition clearly also harks back to Dooley's days with the Navy. Stark's appeal to the distinction between a "people" and a "government" depoliticizes through

constructing a fantasy of an apolitical people motivated by beneficence that would be separate from their state affiliation. Thus, in Stark's vision, medicine—and plastic surgery—is a truly “humanitarian profession” when not formally linked to any state interests.

In thus claiming a depoliticized and unproblematically humane interest for medicine, Stark locates the market as separate from the realm of politics, which is relegated to the state. “The civilian doctor who pays his way to help is appreciated for himself, not for propaganda” (832). Self-funded travels on the part of doctors, with logistical and program support from philanthropic institutions, put the state at a far enough remove to claim the apolitical character of humanitarianism at the same time that the aim of “overseas medicine” is admitted to be improving the image of the United States: surgeons at once represent the United States and transcend it through the mantle of their humane profession. Thus in his 1980 retrospective account of the PSEF exchange program, Stark wrote that “those who volunteered to teach and operate in Vietnam ... blotted out the arbitrariness of war and the iniquity of politics. They went solely to care for the maimed and injured in this faraway place and to demonstrate something of our national character that is good, generous, and humane” (Stark 1980, 78). The financial sacrifice—including sacrificing vacation time—becomes the measure of surgeons' purity of intentions and divorce from the state, which allows humaneness to emerge untainted.

The nonstate, market-driven nature of plastic surgery's international efforts somewhat paradoxically enabled surgeons to claim a return to their roots, of sorts. Many surgeons claimed that their overseas travels were a rejuvenating experience in the sense that they were able to practice more purely. Stark writes, for instance, that one colleague

says he “found in the country in which I served...the reasons for which I went into medicine. Frankly, I dread to return to my practice” (Stark 1966, 833). The implication here is that the overdevelopment of the West has corrupted surgical practice, infiltrating market relations into their practice. Vietnam, and the developing world more generally, was removed from the overdevelopment of medicine; the lack of medical infrastructure bumps surgery back down to the fundamentals.⁸ Despite the fact that surgeons are attempting to “advance” Vietnam toward a medical landscape more comparable to the West’s state of development in order to bring to the country the vitality-enhancing capacities that capitalism can provide, surgeons are also engaging in an implicit critique of the same capitalist system that enables their cosmetic enterprises in their homes. This critique, though, is clearly not of capitalism as such, for surgeons are heavily invested in both development and the form of surgical overdevelopment (their private cosmetic practices at home) that funds their excursions. The point to be made here is rather that the sorts of interventions into bodies that surgeons perform is mapped in terms of development, with underdeveloped people receiving the “pure” or basic forms of surgery, and those in the West receiving cosmetic surgery as a symptom of overdevelopment or burgeoning commodification.

The eschewal of the state in favor of the market also illustrates that it is the economic relations between nations as much as the political ones that are central to the

⁸ Rees claims another related benefit to surgical trips: “Another important dividend of these international activities is that of operative experience. A vast clinical reservoir of operative and research material exists which is virtually untapped” (Rees 1963, 88). In other words, one benefit of medical and economic “underdevelopment” is that surgeons will encounter conditions that “development” has largely eradicated. The vital superiority of the West paradoxically leads to a dearth of clinical resources. Thus the bodies of those in the “underdeveloped” world can serve as resources for professional development of surgical specialists.

internationalism that plastic surgery envisions—or, indeed, that the economic and political are inseparable. In an editorial published in *JAMA* in 1966, Stark wrote, “There is a desire among Americans to serve; there is a need; and there is commodity worthy of export—sophisticated, specialized American medicine” (Stark 1966, 18). In referring to it as a commodity worthy of export, Stark uses the metaphor of the (globalizing) market to express the importance and transportability of American medicine, despite the fact that this “commodity” is to be offered free of charge. It becomes clear, then, that medicine in general and plastic surgery in specific are figured as participants in an international economic network and that plastic surgery itself is a form of aid. Indeed, Thomas D. Rees, writing in 1963, stated that “the ubiquitous power of medicine has only recently been truly recognized by government sources as a *bona fide* modality of foreign aid” (Rees 1963, 86). In framing the issue as one of foreign aid, both the United States and Rees understand the provision of plastic surgery as a *form of capital* in itself, and specifically capital that is given to nations in need of aid. This construction of plastic surgery then already figures surgery as flowing from donor nations to nations in need. Plastic surgery thus becomes capital in an unequal world, and that inequality is itself integral to the becoming-capital of surgery. This inequality serves as a comfort to surgeons because it allows them to enact their practice as a form of beneficence. It creates the differentiation between forms of capital investment that lead to excessive consumption in the West, which threatens to undermine the purity of surgical practice and the beneficence of liberal aid, which is enabled precisely by the surplus capital generated by (over)development.

The measure of plastic surgery's humanitarian effects is also embedded in the economy. For instance, Stark quotes Shattuck W. Harwell, a plastic surgeon: "we are pouring billions of dollars down rat holes all over the world trying to buy people's friendship when a fraction of that money could demonstrate to the world the true nature of America" (in Stark 1981, 78). Thus the diplomatic effects of the humanitarian intervention made by overseas medicine are efficient when compared to other forms of aid. While there is an apparent economism in this assessment, there is also a way in which medicine is an invaluable commodity insofar as its affective potential is immeasurable. Plastic surgery becomes a form of labor delivering services as a commodity—but because it enhances life, because it addresses the body in a way that enhances dignity, its capacity for creating the desired effects of aid is vastly superior to the tried-and-true avenues of aid that are physical commodities devoid of "TLC." The intimacy between doctor and patient and the transformative capacity of surgery create the affective bonds that true diplomacy requires. It is value within capitalism, but a special kind that emerges from the specifics of the relation between scalpel and body.

Barsky, a plastic surgeon who established a plastic surgery unit for children in Vietnam separate from the PSEF (but also funded by the IRC), is illustrative of how plastic surgery is defined as a form of capital over and above the mere focus on sustaining life or providing commodities. In an article laying out the rationale for and experience of establishing the Barsky Unit at Cho Ray Hospital, Barsky puts the problematic thus:

One should hesitate about attempting to introduce this highly sophisticated specialty into a country where proper facilities do not exist, where there is not a great need for it. In a country where transportation is usually by horse or by bicycle, where the population is scattered and not concentrated, where

communications are poor and transportation difficult—should plastic surgery be introduced? In a country where infant mortality is from 4 to 40 times greater than in Western countries, where childhood intestinal parasitic infection is close to 100 per cent, where smallpox is common and malaria is endemic—where typhus, cholera, tetanus, diphtheria, poliomyelitis, and plague are present—it may seem pointless to introduce a surgical specialty. (Barsky 1970, 431)

Barsky makes several moves in this passage. Contrasting the sophistication of plastic surgery to Vietnam's lack of infrastructure, Barsky uses classic indicators of a society's underdevelopment to problematize the introduction of such an advanced medical practice. The contrast emerges precisely because plastic surgery is understood as a product of fully developed Western medicine. In recognizing that the introduction of plastic surgery (through traveling doctors) must be “designed to fulfill the in-country requirements” (431), Barsky also signals a sensitivity to the needs and differences among existing medical economies, framed through a national lens—that different medical economies, national contexts, and infrastructures create different needs and different systems of care. Plastic surgery is seen as care over and above the bare necessities, which might not be appropriate for all medical economies. Barsky represents plastic surgery as a potential superfluity in the context of limited resources and rampant disease—diseases that are, in this teleological model, representative of nondevelopment (that is, have been contained and/or eliminated in developed locales with standardized and widespread biomedical care), thus hearkening back to Dooley's figuration of Vietnam as a diseased space (along with, of course, many other participants in the discourse of tropical medicine). Health care is thus formulated as a problem of resource allocation in an economic context different than that within which plastic surgery was developed. In the context of plastic surgery as development capital, the question is whether plastic surgery is the appropriate sort of capital to introduce, whether it might be too advanced, wreaking

havoc on the natural evolution of the Vietnamese medical system. Measuring development by means of threats to vitality introduces, then, a ranking system in developing medical capacities and infrastructures, and plastic surgery is on top. Its ability to enhance dignity or quality of life is a double-edged sword, rendering it an (in)valuable tool for enhancing relationships across difference and a powerful symbol of development, but it risks displacing more basic development processes and medical training.

While acknowledging the war as informing his desire to set up a plastic surgery unit in Vietnam, Barsky also displaces the war's primacy, shifting focus to frame surgery as a problem of economic development. In acknowledging the war, Barsky of course was drawing on the reparative work done during World Wars I and II. But in linking surgery to economic development, Barsky is able to frame foreign/American presence as a humanitarian one above the particular concerns of wartime and national diplomacy. "Despite the furore about the prevalence of Napalm burns, we found that these were approximately 10 per cent of the total number of burns at that time. Cleft lip and palate seemed to be far more frequent than in Western countries" (432). Distancing the need for surgery from the direct effects of war, Barsky mobilizes the bodies of those with unreconstructed congenital conditions to illustrate the universal appeal of plastic surgery. Plastic surgery's absence, a symptom of undevelopment, leads to untreated clefts. So even in the absence of war-ravaged bodies, performing surgery can be reconciled with war in that communism threatens to forestall development and thus forestall the normalizing investments in bodies that surgeons can provide. Communism can thus be viewed as a force producing what I call nonbiological but still embodied forms of bodily difference that are a key means by which plastic surgery functions to racialize particular

populations and bodies in transnational contexts. The humanitarian work of surgery can augment the war strategy because capitalist development is seen as an overriding and apolitical good that is inextricably linked with provision of medical care and enhancement of populations' health and bodies. Barsky's work circles back to the rationales and the entanglements of medicine, imperialism, and capitalism that characterized Dooley's philosophy—all despite the fact that Barsky deemphasizes war's effects on bodies, which runs counter to Dooley's rhetorical strategies.

Again evincing commonalities with Dooley and MEDICO's guiding philosophy, surgeons engaged in overseas programs, especially in Vietnam, were concerned not only with enriching the health of the population through their own work on bodies but also through training local doctors—figured as enriching, again, the human capital of developing nations. In training other surgeons, the development project of plastic surgery was meant to enable the practice to proliferate as a defined specialty and thus—if plastic surgery is a signifier of medical advancement as a superspecialty—lessen the disparities in health care and enhance the dignity of their own populations. As Stark puts it, “In some areas, the case load is inexhaustible. This is why, as Medico insists, the intent and emphasis of the specialist export necessarily must be upon teaching one's counterparts, not in attempting to reduce the clinical stockpile” (833). Barsky, too, emphasizes the need for training.⁹ Plastic surgery's interventions/investments into the bodies of populations must be enabled to exist in perpetuity—the future continuance and growth of plastic surgery is the paramount goal, for this enables the continuing augmentation of health. It

⁹ Rees (1963), too: “it is virtually impossible for us as plastic surgeons to fulfill the demand, just as it is equally unthinkable that the combined efforts of all the doctors in the U.S. could tackle the medical problems of the world” (87).

again poses the problem of plastic surgery and medical development as a problem of limited resources and prioritization, where the war wounded and congenitally afflicted population cannot be aided through outside intervention alone—outside intervention must be in the service of a long-term plan to inculcate surgical skill and specialization among local medics. While this emphasis on training surgeons resembles what would today be called sustainability, it must also be seen in the context of the contemporaneously emerging notion of human capital—investment in training being analogous to capital investment. As Foucault (2008) notes, “currently an attempt is being made to rethink the problem of the failure of Third World economies to get going, not in terms of the blockage of economic mechanisms, but in terms of insufficient investment in human capital” (232). Here, the notion of human capital incorporates the constitutive asymmetry of development. In consequence, the local surgeons themselves, and not just the bodies they operate on, are dependent on external investment and are thus not liberal subjects of self-investment. They are also tied to the nation in ways that doctors from developed countries are not—their education is part of the nation-building project and the augmentation of the nation’s wealth both directly (direct investment in the surgeons themselves) and indirectly (training as enabling investment in the health of the population).¹⁰

While humanitarian activities in Vietnam exemplified the enmeshment of plastic surgery within capitalism through its development capacities for “free” nations, and

¹⁰ This is evident in the concern that, when surgeons from underdeveloped nations are trained in the United States, they would wish to stay there instead of returning to their home country, thus defeating the purpose of training them; the implication is that this is a betrayal. This understanding constructs even surgeons from developing contexts as improperly liberal: they are not properly untethered global capitalist subjects but seen as tied to their nation in ways that other surgeons are not.

exemplified the “best” and noblest aspects of professionalization of their superspecialty, another aspect of surgical activity in Vietnam realized anxieties that surgeons held regarding capitalism and the capacities of their profession. In 1973, nine years after the PSEF’s first mission to Vietnam and five years after Barsky’s surgical hospital in Saigon was completed, the *New York Times* ran a story on plastic surgeons in Vietnam who were performing cosmetic surgery on the country’s elite. In contrast to Vietnamese surgeons engaged in humanitarian work (for instance, in a different article highlighting humanitarian work, a Vietnamese surgeon is quoted as saying “I don’t count my salary” [Emerson 1971, 24]), surgeons performing cosmetic work are represented as concerned only with profit: “plastic surgeons are finding it more lucrative to run cosmetic surgery clinics for wealthy Saigonese” (Denmar 1973, 38). The training of surgeons as a humanitarian practice has resulted in a economy of healthcare that is skewed toward luxury care—an effect that is implicit in Barsky’s consideration of the overall healthcare picture when visiting Vietnam. Cosmetic surgery is represented in starkly economic terms, as an “industry.” Thus we see again the cosmetic/reconstructive divide in transnational context is the divide between external investment—surgery as foreign aid—and self-investment represented as enhancement and luxury. Cosmetic surgery operates according to the logic of the market, with “second-rate” Japanese and Korean surgeons reportedly operating a black market that exploits demand for surgery. Thus while humanitarian aid through *reconstructive surgery* avowedly functions within economic networks, it follows a logic of beneficence that expands the capaciousness of “humanitarianism” to encompass the “right to look human” as a sign of development. *Cosmetic* surgery, on the other hand, represents the competitive values of the capitalist

market unfettered from concern with human flourishing, instead enabling unnecessary enhancements against the backdrop of limited health care resources. The anxieties produced by this sort of market-driven surgery was not unique to forms of transnational medicine; Penn worried in 1962 that a black market in surgery was developing and argued that the only safeguard against such practices was to professionalize, establishing organizations that would certify surgeons.¹¹ But in the context of Vietnam and similar international surgical programs, the condemnation of the black market is not primarily about the potential harm to patients. It is rather the surgeons' brazen profit-seeking and the potential harm to the development project that bear the brunt of the critique. For the surgeons involved in humanitarian work, the scandal of cosmetic surgery is one of resource misallocation and (capitalist) moral values. The in/valuability of plastic surgery as form of development capital becomes naked market value in the quest for personal profit. And the carefully calibrated system of ranking medical specializations as more or less advanced forms of capital—developed through the connections between surgical superspecialization, appearance, quality of life or dignity—is knocked out of whack by excessive concern with enhancement and aesthetics over and above the “right to look human.”

Also unlike Western and white subjects of cosmetic surgery investment, Vietnamese elites are not liberal subjects of choice—they are said to self-invest not as a

¹¹ Also Barsky: “recently [we] have seen a trend by many away from reconstructive surgery toward a concentration on lucrative cosmetic surgery, so-called ‘esthetic surgery,’ in order to give it a better sounding name, ‘A rose by any other name’” (Barsky 1978, 1022). Gilman (1999) and Haiken (1997) both replicate this picture of cosmetic surgery in Vietnam in their histories of cosmetic surgery, choosing to emphasize the introduction of a supposed desire for Westernization on the part of Vietnamese women after the soldiers arrive rather than the development initiatives I discuss here.

sovereign decision but as a continuation of Western imperialism. The *Times*'s narrative is that eyelid-altering surgery in pursuit of a "Western" eye shape was driving the cosmetic surgery boom, and, what's more, that this desire stems from Western occupation. "The American presence in Vietnam created a trend for round eyes, curved contours, and a Western profile" (Denmar 1973, 38). The trend is said to have begun with "bargirls," who found that GIs preferred Westernized features, but extends to influential and fashionable women. Thus the nakedly market-driven story of cosmetic surgery is also undergirded by a gendered imperialist economy. It is a strange reworking of the gendered and national story of plastic surgery's legitimation through war: World Wars I and II legitimated plastic surgery through the reconstruction of soldiers' (masculine) bodies so that they might further serve the nation (or, after the wars, enjoy as "normal" a life as possible)—these are the preconditions for plastic surgery's emergence as a participant in humanitarian networks. In the case of cosmetic surgery in Vietnam, however, the bodies of racialized women come to stand for the excesses of medical free markets and the absence of developmental beneficence. Despite their many differences from the subjects who are represented as the target of surgical intervention for humanitarian purposes, these racialized women share a certain illiberalness. They are both subjects within a liberal discourse being generated from (primarily) the United States, and yet they are subjects of external intervention rather than actors in their own rights. They are economic subjects and subjects of war, but they are subject to and dependent on Western intervention in order to actualize either their development potential or their consumption of medical enhancement. This moment functions to historicize the scholarly discourse on "Asian eyelid surgery" differently; the notion of Asians as cultural mimics of Western

standards of beauty has, at least since the 1960s, been used to associate racialized subjects with illiberalness at the same time that it articulates surgeons own anxieties about their links to market medicine.

In using this example to close the section, I highlight both surgeons' pleasure in and anxiety about their own participation in capitalism. The two opposing trajectories of reconstructive and cosmetic surgery in the Vietnamese context illustrate that it would be mistaken to consider cosmetic and reconstructive surgery as easily separable phenomena. While they have differing valences—particularly with respect to gender and their relation to the overall medical economy—they are two sides of the same coin. They are materially so, since it is the training of surgeons in the techniques of reconstructive surgery that leads to the cosmetic surgery “boom,” and they are discursively so in that they are both framed within the tenets of liberal capitalist development.

The Flying Doctors of East Africa: Race, Culture, and the Humane Gaze

Now that we have explored the conceptual framework that surgeons used to understand and justify international surgery efforts, we will turn to examine a specific organization, the Flying Doctors of East Africa (FDEA). The programs run by PSEF and Barsky represented the postcolonial, postmissionary framework that combined elements of Dooley's philosophy of medical aid and the values of international cooperation with plastic surgery's unique position. The FDEA represents similar values—Rees, quoted above, was one of its founders, and his voice was one of the strongest espousing the view that medicine could be a force for international understanding and peace. The FDEA was founded in 1956 by Rees (an American), Michael Wood (a Briton), and Archibald

McIndoe (a New Zealander). It shares some characteristics of the organizations discussed in the previous section—the ethos of care and development, and the equation of surgery with capital enrichment. But the organizational structure relied more heavily on actually existing missionary health care systems, even as it also adopted a largely secular framework. It uses the postcolonial language of development but relies centrally on leftover colonial institutions (which, as Manji and O’Coill and Bornstein note, were in the process of redefining themselves in terms of development as well). It thus blended the two categories of development organizations that Manji and O’Coill identify: It consisted of decidedly “outside” elements (foreign surgeons from the US, UK, and New Zealand via the UK) but worked through existing networks to establish its own practice.

The FDEA aimed to use a plane to fly among East African nations to provide more-than-basic medical care to local populations in rural areas to fill a gap in medical care. While not explicitly acknowledged by anyone in the organization, this gap is a function of the colonial organization of health care that concentrated in urban centers where the care of Europeans and laborers was the primary concern (Ndege 2001, 134). The idea of using a plane to fly medical specialists who were capable of offering more “advanced” forms of care came from Australia. This form enabled the group’s development narrative by allowing them to position themselves as tackling existing deficiencies by bringing their more advanced medical knowledge and surgical techniques and dispersing it throughout East Africa via their plane. They are therefore making up for (unacknowledged) colonial neglect at the same time that—in addition to relying on colonialist/developmentalist tropes—they relied on the remnant of colonial systems of medicine and, as I will show, engaged plastic surgery and medicine in a kind of

pedagogical relationship to “natives” that retains continuity with past missionary practices.

The FDEA was the brainchild of Archibald McIndoe. As mentioned above, McIndoe was a surgeon from New Zealand who made his name during WWII when he ran the East Grinstead clinic, the main UK plastic surgery center during the war. This clinic was known for the camaraderie developed among the patients under McIndoe’s care, who facetiously referred to themselves as the Guinea Pig Club, a fraternal moniker that emphasized brotherly bonds across national difference (they were members of Allied armies from different nations). Trading on masculinity (they also styled themselves McIndoe’s Army), they transformed marks of war repaired by McIndoe’s innovative surgical techniques into marks of honor.

McIndoe’s virile surgical philosophy was to some extent shared by Rees. But Rees also incorporated a good deal of liberal internationalism and was one of this discourse’s pioneers in the surgery journals, as we saw. This vision has faded, somewhat, by the time Rees’s memoir was published (2002). Thus the development ethos that characterizes his ‘60s writings is more subtextual in *Daktari*. This might be because development discourse had—despite critique—diffused throughout everyday speech and the medical profession by the time of his memoir. Rather than needing to justify intervention and reframe it in anticolonial terms, by 2002, Rees can simply take it for granted that this project will be understood as worthy. The memoir form also discourages explicit reflection on the philosophical and economic justifications for surgery, preferring instead personal reflection and ruminations on humanity and cultural difference.

Rees's memoir is filled with colonialist tropes that Meghan Vaughan has identified as endemic to the "jungle doctor memoir" (1991, 159-61): associations of Africans with nature abound, as do images of the doctor as a heroic figure who overcomes both nature and the superstitions and ignorance of the "African Patients" (Vaughan 1991).¹² The term African Patient is drawn from Vaughan, who discusses how colonial medicine played a key role in constructing the African as an object of knowledge through a particular scopic regime that brings to bear an ethnographic gaze encompassing both culture and the body in the application of medicine. But as a project of the postwar development era, there are important differences in the significance of this construction from the colonial accounts Vaughan primarily analyzes, which I trace below. After giving a brief overview of the politics of the FDEA's founding and organizational structure, I examine several moments when bodies of East Africans are situated within (or entrapped by) culture, arguing that these moments demonstrate that the doctors constructed forms of embodied but nonbiological difference inflected by the plastic surgical gaze and necessary to plastic surgery's development project. In many ways the FDEA's project, as it emerges in Rees's memoir, is a pedagogical one; from the FDEA's perspective "the problem of ignorance" is responsible for many of the difficulties they encounter, which result from different understandings of embodiment and the challenge of translating Western biomedical understandings of the body to the "African Patient."¹³

¹² On "naturalization" as a strategy in representations of Africa, see Campbell and Power (2010, 7)

¹³ This pedagogical project is, I mean to suggest, continuous with the project of colonial public health. See, e.g., Olumwullah (2002, 253) on Kenyan public health in the 1930s as "teaching [Africans] the right way to live" and Campbell (2007, 67) on "public health education as a way of combating backwardness."

According to Rees, McIndoe began traveling to East Africa yearly to “escape the damp, cold English winter and to renew his energy with the healing powers of the African sun” (19-20). Rees further explains that “Africa was a strong source of spiritual healing for Archie” (20): “In England even God was civilized, but in Africa spirituality was primal; a place where the gods were capricious and unpredictable. It was a wide space where you could feel more and think less. In Africa it was quiet enough to hear your inner voice” (19-20). Thus, in Rees’s imagining at least, McIndoe was engaging in a time-honored tradition of using Africa as an escape from the pressures of metropolitan life, linking him to the nineteenth-century missionaries that “celebrat[ed the] preindustrial rural simplicity” found in Africa (Comaroff 1993, 312). Rees’s description of McIndoe also loosely draws on an image of Africa as a space of healing. Although Africa has also been characterized as a place of disease and decay (Comaroff 1993), particular climes have also been associated with health enhancement.¹⁴ But the healing power of particular locales in Africa, it seems important to note, functions only for whites—particularly whites who travel to Africa temporarily. Wood, too, is reportedly in Africa for health reasons: “Mike had originally emigrated to Africa because he suffered from bronchial asthma and believed that his condition would be improved in a warm, sunny climate” (20). As Victoria Pitts-Taylor (2003) notes, “modernity” has long been “uneas[y] with its own technological advances [and] ecological destruction” and thus has had a desire for the “authentic, natural, and communal” “primitive” that it constructs in opposition to itself. *The Flying Doctors*, then, begins from a place of vitality associated with colonial

¹⁴ See, e.g., Arthur Fuller’s *South Africa as a Health Resort* (1890), which, although it does not concern East Africa in particular, notes that warm, low-humidity environments with plenty of sunshine are good for the health of invalids, especially consumptives.

subjects who come there for their health, for a respite from the draining life in urban Europe provided by the simplicity and more naturalistic life they found (invented) in Africa. Rees also wonders, “Was Africa not only a place but a symbol? ... My mentor, Archie, and my friend Mike, had deeply-felt attachments. Would I form a similar attachment? Was this trip, in fact, a mission? Would New York be my career and Africa my ministry?” (29).¹⁵ Even a relatively secular actor such as Rees is cognizant of the links between his developmental project and Christian missions as well as the Christian underpinnings of development discourse that Bornstein (2005) articulates. Though Rees refers to Africa as his ministry, suggesting that his role will be a pastoral one of civilizing and educating, he also views Africa as potentially having an effect on his own personal development. While this theme does not reemerge prominently within the memoir, it is clear that he shares with the surgeons discussed earlier a sense that working in an underdeveloped locale has returned him to the “roots” of his love of surgery.

The Flying Doctors were, as mentioned, based on the model of the Australian Flying Doctor Service (AFDS). In *Daktari*, Rees says that the difference between the AFDS and the FDEA is that the AFDS “employed mostly general practitioners to bring medical care to remote areas. Transporting surgical specialists was not deemed practical

¹⁵ In addition to being enamored of Africa, Rees is also enamored of the figure of the white hunter in particular: “I had always been fascinated with Africa. I had read of the exploits of famous hunters and explorers like David Livingstone... Andrew Selous... and just about everyone else who had written about their adventure in the ‘dark content’” (2002, 28). These figures both embody masculine frontiersmanship and the view of Africa as a space of release from the strictures of civilization. Selous, who was not only a big game hunter but also led expeditions integral to expanding British Empire in Southern Africa as an employee of the British South Africa Company and British Army, wrote that he spent three years in Zambesia, “without ever experiencing the slightest desire to exchange my free wild life for the comforts and restraints of civilisation” (1893, 291).

in Australia at that time” (41). Locating the difference in terms of specialization exhibits a clear continuity with the earlier development efforts that plastic surgeons had undertaken. And while they do emphasize their specialization, the plastic surgeons that formed the group consistently performed operations that did not necessarily utilize their expertise in plastics, though in Rees’s account they did draw on their plastics training as often as not. Whereas the Australian model uses planes to deliver primary care, the FDEA relies on the patchwork of missionary medical institutions to provide the bulk of primary care. When the FDEA had scheduled a visit to a mission hospital, the hospital staff would gather surgical cases for the surgeons to evaluate and operate on. What the FDEA does not say about their difference from their Australian forbearers is that their model is politically different from the Australian model as it depends on foreign doctors and foreign money to operate. This political difference, however, cannot be separated from the surgical character of the care the Flying Doctors provided. As we’ve seen, plastic surgery is characterized by a geographic unevenness that partially explains why the Flying Doctors come from outside East Africa.

Daktari’s opening scene illustrates well how Rees and the FDEA’s reliance on a cultural notion of race that came to prominence in medicine in Africa with the rise of development discourse and eschewal of biological racial categories within postwar medicine, as well as how this notion of cultural difference turns on differing valuations and understandings of life and vitality. This opening scene—which also introduces the institutional differences between Western medicine in the West and Western medicine in Africa—is of Rees’s first surgery performed in Africa. A Maasai man who works on a neighboring farm has caught his hand in a tractor. McIndoe makes Rees take the lead in

the operation. The scene introduces several themes that run throughout Rees's account of the FDEA—the difficulties of “bush medicine” (including the difference between Africa and New York) as well as the nonbiological but still embodied differences between Africans and non-Africans.

When the Maasai man is injured, a “weather-beaten woman” named Joan, who “looked like farm women everywhere” (34), announces the emergency when Rees and Archie first arrive at Archie's farm. Rees's apprehension at having to operate in a farm setting was apparent, and Joan attempted to ease his fear by telling him, “if [the patient] is like most Africans around here ... his pain threshold is very high” (35). She elaborates:

Joan explained that Africans, especially rural Africans, are superb patients able to endure much pain without complaining. She believed that many Africans had mastered the art of self-hypnosis, a necessary strategy for dealing with painful and traumatic situations. Such tribulations were a normal part of life and therefore were tolerated without complaint. The closer to basics people are, she speculated, the less they were burdened with the excess emotional baggage carried by most westerners. (36)

This is a medicalized but nonbiologicistic conception of bodily difference as a product of culture. Rather than expressing difference in explicitly racial terms, the bodily and medical problems presented by “Africans” and the “African Patient” are attributed to markers of underdevelopment—rurality, closeness to basics—that are said to then influence relationships to medicine and to pain. As Julie Livingston has written, the racialization of pain has precedent reaching back to nineteenth-century colonialism: “pain had also long been a part of how people came to racialize one another and to judge one another's humanity, and thus action was often parsed along racial lines. Racial ideas about pain facilitated the trade in African slaves, the colonial management of black and brown subject throughout the British empire, and the development of medical

knowledge” (2012, 134).¹⁶ Taken as a sign of African “callousness” (137), the imputation of a high tolerance for pain served to make Europeans more indifferent to African illness and injury. By the 1950s, Livingston notes, Africans’ purported tolerance for pain was “increasingly understood as a function of culture” (139), which is consonant with Rees and Joan’s understanding in this scene. The idea of the “African patient” as having a different relationship to and capacity for pain than those people acculturated in the West and in the presence of Western medicine works for Rees both pragmatically (to keep his medical practice humane, since in most contexts performing surgery without anaesthesia would be considered cruel) and developmentally (to frame questions of racial difference as cultural and bodily without being deterministic). The Maasai worker’s ability to self-hypnotize—a practice outside the scientism of Western medicine—paradoxically allows the procedure to proceed relatively normally outside the developmental, geographical, and cultural locales within which Western surgical techniques were developed.

In a similar vein, Rees recounts an episode with a Maasai *morán* wounded by a rhinoceros. This too induces Rees to reflect on the strangeness of practicing Western medicine in Africa. This time Rees harks back to a colonial/civilizational discourse regarding the closeness of native Africans to nature—and Africa “as raw nature and patient” (Olumwullah 2002, 5). This is prompted by the nature of the injury itself, which allows him to introduce his observations on cultural differences, Western medicine, and impressions of the African landscape. Operating on the Maasai warrior injured by a

¹⁶ See also Olumwullah (2002), who quotes a missionary’s 1902 document titled “The Black Man as Patient”: “Taking a broad biological view of the different races of man, and regarding their relationship with the animal world, it is impossible not to remark that, starting from the more highly organized races and going down the scale, the acuteness of pain experienced seems to grow less and less” (3).

rhinoceros prompts Rees to reflect: “It must have been an exceedingly strange experience for this Maasai warrior, a man rooted in the natural world, to be suddenly thrust into the hands of Western doctors. For his illness was fate, not pathology, and traditional healers were practitioners of an art, not a technology. Yet there was art in what we had done too. And given the option, he did not choose blind faith, but sought the benefits, however incomprehensible, of Western medicine. How would this experience change him?” (27). Rees’s connection of the Maasai man to nature allows him to differentiate between his culture and Western medicine and to draw a similarity through the artistic impulse that makes surgery a unique and interpretive practice of molding, though Rees also uses the opportunity to represent surgery additionally as a modernizing “technology” and a means of overcoming the dangers to the body posed by nature. The strangeness that Rees imagines the Maasai patient imagining represents the collision of two incommensurate worldviews and conceptions of embodiment. Represented as trapped by his “blind faith” in traditional medicine, the *moran* is potentially beginning a trajectory toward a more enlightened state by trusting in the emancipatory potential of Western medicine, represented here by the plastic surgeon. Rees concludes the episode by noting that “It seemed as if I was suffering more for him than he was for himself” (37). This represents Rees’s medical practice as humane even in the context of causing pain. His medical practice is infused with his respect for humanity and, even if the Maasai men do not comprehend it, is a reflection of Rees’s bond with them as fellow humans.

Body-Culture Relations, Gendered Surgery, and the Bush Doctor

It is often in moments of gendered surgery that internationalism emerges as a framework that Rees uses to understanding his actions—that is, moments when Rees breaks into an explicitly comparative voice. This is not only because gendered practices are so closely linked to definitions of cultural difference under an anthropological gaze but also because gendered forms of surgery are themselves geographically marked: cosmetic surgery, feminized in Rees’s imaginary, is in his experience performed in the US, specifically New York City. Thus moments of gendered surgery—from the normalization of breasts to sex reassignment—provide Rees with opportunities both to reflect on cultural practices and to reflect on specifically surgical cultures, including comparisons of doctor-patient relations and material differences in surgical set up.

Rees’s memoir is as invested in expounding on East African culture and North/South cultural differences as it is in extolling plastic surgery’s virtues. Rees thinks through the intertwining of culture and medicine in ways that reflect both plastic surgery’s ethos of holistic health as well as more traditional medical and anthropological understandings of the ways that culture affects the body. Rees’s conception of the body-culture relation, however, furthers the reification of developmental difference rather than challenging it. The body thus comes to reflect developmental difference in ways both subtle and obvious. The fact that Rees and the Flying Doctors do not view medical practice or bodies as separable from culture should not be surprising, since rarely did missionary medical professionals in Africa understand culture and environment as wholly separable from health and bodies (Vaughan 1991). “Bush medicine” or “jungle doctors” were never solely invested in the business of improving the health of native populations; they also served as a site of interaction between colonial administration and native

populations, thus requiring both an understanding of health as culturally inflected and an effort to learn about cultural norms so that a pedagogy of discipline and medicalization might emerge. Plastic surgery, however, is situated differently than most public health initiatives because, as we saw in the previous section, its status as a superspecialty gives it an attenuated relationship to vitality.

The early days of Rees's travels in East Africa are full of tales of culture-based bodily injuries that require surgical intervention and of culture-based misunderstandings of the meaning and practice of those interventions. These incidents, especially at the beginning of Rees's travels in East Africa, often revolve around cleft palates. While these are not culture-based difference, Rees, ever the amateur ethnographer, is quick to connect clefts with culture, viewing them as a hybrid occurrence. In addition to yaws and *noma*, clefts are the most common malady addressed by surgery in Rees's account. Yaws, *noma*, and clefts are bodily evidence of both African and developmental difference: "day after day" Rees encounters bodies with these maladies that are, Rees says, much less common in the First World. Encounters with clefts, at this level, evidence geographical difference and the sparse distribution of access to Western medicine. Just as in the discussions of surgery in Vietnam outlined the previous section, cleft represents the uneven distribution of surgery as a proxy for developmental inequality.¹⁷

In a continuation of his efforts to constitute a profile of the African patient, Rees describes a scene of misrecognition in which gender, culture, and cleft intersect: "I operated on a particularly wide and deforming cleft lip in the infant son of a primitive Bantu woman" (64). After the operation, which was a success, the woman does not

¹⁷ Cleft will be viewed in a very similar light by Operation Smile, discussed in the next chapter.

believe that the child operated on is her own, since the child's appearance has changed so drastically. This leads Rees to a change in surgical policy: during subsequent cleft operations, Rees will insist that a mother hold her child's hand during the duration of a cleft operation so that she cannot later deny the child. The African Patient, above all defined by the capacity for misrecognition and ignorance of Western medicine and understandings of bodies, is here implicated in a misunderstanding that is gendered through the resulting disturbance of her kinship role. The mutability of the body enabled by surgery is represented as heretofore unknown to the mother of the infant. The transformation enabled by plastic surgery is, in Rees's representation, unthinkable to her. The culture of this "primitive Bantu woman" forestalls her capacity to relate to bodies in the way that plastic surgery, with its basis in Western medicine, does. Only through maintaining physical contact can African Patients maintain the proper kinship structures premised on the continuity of the body. Primitiveness extends to having an antimodern understanding of bodily relations and hence of nonfulfillment of kinship obligations.

In regard to clefts, Rees also claims that "for centuries," newborns with congenital deformities had been abandoned in the bush, a practice that missionaries attempted to end. "Such a tradition," he writes, "possibly accounted for the significantly lower incidence of cleft-lip in Africans. It was a brutal form of social Darwinism but its effect were measurable" (54). Not only do they exhibit a different relationship to the body than Western medicine would accommodate, but they exhibit a relationship to reproduction that is totally outside the biopolitical understanding of the need to preserve life. Kinship relations here are again disturbed by bodily difference. While plastic surgeons humanely affirm the dignity of the bodies with cleft across racial and cultural difference, the

“natives” themselves do not share such an empathetic understanding or the vision of the potential for normalization that surgery provides. Instead, they lack this humane appreciation for bodily difference and indeed for life itself.

Despite the imputation of different valuations of life and the attenuated relation to bodily pain that Rees emphasizes, in another episode Rees provides a counterexample of motherly love, and in doing so he encapsulates a common idea regarding “African life.” One night, Rees is awakened by an “inhuman” wailing sound (61). Rees finds that it is a mother’s reaction to her baby’s death. “The incident was both unnerving and incredibly sad. The woman’s wail seemed to come from some unfathomably deep place. Life might be cheap in the bush, but that woman still mourned the death of her baby with the same intensity that one would expect from anyone, anywhere in the world” (62). The universality of motherhood cuts through the cheapness of life. The cheapness of life in the bush is supposedly due to a lack of development leading to high infant mortality. Rees is referring to a cultural phenomenon—life becomes cheap because one cannot afford to invest in it. It is not necessarily that life is not valued by those in the bush, but that because of the context of the bush and the transience of life leads to an attenuated relationship to life and its valuation. Implicitly, though, Rees’s comment about the cheapness of life in the bush is indeed a statement about the relative valuation of life with regard to development, since the context of the bush is defined, given the hegemony of development discourse and Rees’s own US-Eurocentrism, by the sparse presence of the state, the lack of medical infrastructure, and the inhabitants’ closeness to nature (as defined through a colonial lens). The biopolitical ethos of public health, at this point merged seamlessly with development discourse, was in Rees’s understanding a

commitment that the state or indigenous civil society had failed to make—it is primarily the outside forces of the missionary doctors, colonial government, or traveling doctors like the Flying Doctors who value life and actively seek to enhance it biologically in a systematized and conscious way. This way of defining cultural difference speaks to, then, a deep-rooted difference that is fully framed within biopolitical understandings of vitality.

That “life is cheap in the bush” is precisely what the FDEA is meant to combat. They do so, in part, through defining themselves as “bush doctors.” In the scene of the Maasai *moran* gored by the rhinoceros, Rees writes of performing surgery “stripped of all backups” (17). After Rees has performed the surgery, McIndoe tells Rees, “You can call yourself a bush surgeon now” (37). Becoming a bush surgeon is a return to rudiments, stripped of backups, performing reconstructive surgery with the most basic of tools and to repair the most basic of injuries. Saving a life threatened by “nature” becomes representative of the true purpose of medicine since it addresses the realm of bare life rather than enhancement. If life is cheap in the bush, it is the bush doctor who attempts to value it—and one must go to where life is cheap in order to remember medicine’s true capacity to value life itself. For Rees, New York is where life is already valued and plastic surgery functions primarily to add surplus value. To wit: “Sometimes I felt ashamed that my work in New York seemed so inconsequential, while in Africa I knew that I was making a real difference no matter how small. Most of my patients in New York sought plastic surgery to improve their appearance for a variety of reasons, not the least of which was to conform to the concepts of physical beauty dictated by TV, motion pictures, or magazines” (168). In the context of the resource-poor, undeveloped South,

the primary value-adding labor of medicine emerges plainly, whereas New York's cosmetic surgery patients—clearly feminized in this description—represent the perils of overdevelopment in which the body is valued through consumption of medicine as a commodity.

One of Rees's most explicit meditations on the divide between New York and bush comes when he encounters a young Kenyan woman who has an enlarged breast. This episode comes in the midst of a chapter on the cases that Rees performed during his time at Kaimosi Hospital. The case of the fifteen year old with the hypertrophied breast is the only surgery in this chapter that is discussed as a cosmetic procedure. Relying on the classic distinction between cosmetic and reconstructive surgery, Rees reasons that because the enlarged breast does not threaten her physical/biological health, the condition should be classified as cosmetic and the breast reduction she is seeking as cosmetic surgery. He writes that at Kaimosi Hospital (a mission hospital), he encounters "a cosmetic breast reduction—something you wouldn't necessarily expect to be doing in a bush hospital—and an arrow wound of the chest (something you wouldn't expect to see in New York)" (70). The rhetoric of surprise serves to associate particular kinds of bodily manipulation or repair with particular geographies. This case is the exception that proves the rule. Rees's expectations derive from a previous set of associations of bodies, culture, and place: What is African is reconstructive, especially rhinoceros- or arrow-induced injuries. The reference to New York thus reinforces the association of cosmetic surgery with overdevelopment. Bush surgery is meant to sustain life, not to enhance it. New York is where enhancement and overdevelopment of the body is meant to stay.

However, Rees's expectations are managed and brought back into line through his description of the cultural context for the breast reduction, which serves to reentrap the young woman's body within a development framework:

The enlargement occurred after puberty and after she was married. At the age of fifteen an important local chief had fallen in love with her and married her. She was the youngest and most beautiful, hence his favorite wife amongst five others. In his eyes, her beauty was marred only by the marked difference in the size of her breasts. Her right breast was at least twice the size of the left. / The chief regarded this transformation of one of her breasts as hideous. It had completely turned off his sexual appetite. She was in very real danger of losing her privileged status as the favored wife and might possibly be banished from his compound. (70)

The girl's need for bodily transformation thus stems from her entrapment in a illiberal gendered kinship system.¹⁸ In this instance, the entrapment within culture and kinship functions to make the surgery make sense within an African context. Without the culturalist framework, the surgery would not be intelligible since Africa is so strongly associated with reconstructive procedures that a cosmetic procedure, such as a breast reduction for nonmedical reasons, would be an improper form of development capital to introduce, as Barsky was so concerned with. Because the procedure ultimately stems from a developmentally inflected cultural difference, it is appropriate for the context of the FDEA's project of developing Africa through surgery. Rees's representation of the chief's understanding of the girl's bodily difference demonstrates his lack of humane understanding of bodily difference that characterizes the surgeon's worldview (despite

¹⁸ On particular gender relations as markers of "tradition in relation to "modernity," see Scott's "Tradition and Gender in Modernization Theory" (2011). I am also drawing here on Rey Chow's understanding of "captivity narratives." Chow shows that for modernity to understand itself as emancipated and free, it depends upon the projection of a past in which the human was captive, "imprison[ed] within a condition of barbarism" (2002). This past of "primitivist intolerance" allows the modern subject to emerge as "peaceful, civilized, tolerant of difference." Chow argues that this condition of captivity is projected onto "the ethnic."

the fact that surgeons gaze humanely only in order to identify pathologies and correct them). Surgery is again tied to an African Patient's cultural kinship system, and Rees's amateur anthropology reveals the body as a key nexus within that system—as above, misunderstandings of embodiment emerge as the primary signifier of cultural difference. And Rees's surgical capacities emerge as precisely what allows the bodily malleability that would this time work to maintain kinship structures and the girl's place within them.

While most instances of surgery that are clearly gendered operate to restore shore up gendered kinship roles, reinforcing “traditional” gender relations and normalizing gendered appearance, one case involving a white expatriate in Kenya disturbs both the racialized spatiality of surgery and Rees's expectations around the gendered figures of mobility and colonialism. While in Nairobi, Rees and Wood encountered a muscular, virile, white safari guide during one of their residencies at a Nairobi hospital in 1958. The guide, called “Tony Adams,” seemingly embodies the great white hunter ideal, yet the encounter is remarkable from Rees's perspective because Adams is at the hospital to enquire about obtaining sex-reassignment surgery.

Adams approaches the doctors because, Rees says, she wants to begin the process of sex reassignment by getting breast implants in Nairobi. She was living in Kenya and planned to obtain a vaginoplasty sometime in the future from Harold Gillies, who was performing the procedure in India. Rees states that a psychological evaluation—a crucial component of transsexual medicalization—cannot be found in Nairobi. Thus the “underdevelopment” of medicine in Kenya—where, in this case, psychology in tandem

with plastic surgery represents a heightened level of development—means that the established medical procedure that regulates trans experience cannot take place.¹⁹

Accessing Adams's own understanding of the intersections between travel and gender transition (Aizura 2012) is impossible, since Rees does not report much of Adams's perspective and, in any case, it is Rees who is writing the story. But we can see some of the metaphors and gendered colonial dynamics that underpin Rees's account of Adams: Adams has traveled to Tanzania to become a safari guide, the modern version of the white hunter, a figure of masculinity based in colonization, the domination of "nature," and frontiersmanship (a figure that has also deeply informed Rees's relationship to Africa). Thus, when Rees encounters Adams's version of the white hunter / safari guide, he performs an interesting, though brief, set of rhetorical moves. Rees seems to paradoxically accept Adams decision to undergo sex and gender transition while also leaving the masculinity of the white hunter figure intact: "'Tonina' was discharged from the hospital and returned to the wilds of Tanganyika and a career of elephant hunting" (77), and Rees speculates that "somewhere in Tanzania there may still be a rugged elephant-hunting guide, posing in the guise of a man" (78). Rees partially respects Adams's status as a woman, and yet when enacted by this transsexual woman, the white hunter figure remains masculine. Thus, while Rees certainly engages in pathologizing and exoticizing rhetoric around Adams's case, dubbing her "Tonina," her status as a white Westerner seems to allow her access to the position of the liberal, self-choosing

¹⁹ Instead, Rees and Wood interview Adams's wife about Adams's psychological state and desire to be female. (This is important because, Rees claims, that mentally unstable people sometimes seek sex reassignment and then attack surgeons after the procedure is done.) Adams's wife validates that this is a longstanding desire and that Adams is not psychologically disturbed.

subject who is mobile and able to use surgery to enact identity through that mobility, as opposed to those trapped within cultural bonds and traditional gender orders.²⁰

Taken together, these moments of gendered and gendering surgery highlight both the feminization of cosmetic surgery and the simultaneous spatialization and racialization of the cosmetic/reconstructive divide. They reveal a complex web of associations between race, gender, place, culture, bodies, and subjectivity. The liberal subject of choice is paradigmatically Western and white, choosing to enact bodily change, while Africans are subject to forms of bodily difference that evidence their entrapment within culture or closeness to nature. This is an understanding of embodied difference that is consonant with plastic surgery's capacious understanding of health and with developmental understandings of the role of medicine, starkly illustrating its continuities with the colonial past. Though Rees's framing is less explicitly economic than the surgical efforts in Vietnam described above, less explicitly concerned with human capital development, he is clearly invested in the potentials of plastic surgery to enact a project of modernization that is simultaneously technological, pedagogical, and medical.

Jack Penn: The Brotherhood of Pain, the Value of Surgery, and the Denigration of Blackness

I now turn to an analysis of the memoirs of Dr. Jack Penn, South Africa's first plastic surgeon. In his memoir, published in 1976 and titled *The Right to Look Human*, Penn argues that the potential of plastic surgery is to create a worldwide community that

²⁰ In Aren Aizura's (2012) terms, these attributes give Adams the "cultural and racial capital to become socially mobile" and thereby enact her self-reinvention through travel according to the logic of "liberal individualism."

transcends differences of race and nation. It is my purpose here to examine his writings for both what he can tell us about the transnational history of plastic surgery and to note the ways in which his internationalist humanitarian thinking illustrates the integral role of race within this liberal vision. I first concentrate on fully elucidating the world-changing power that medicine in general and plastic surgery in particular have for Penn. I show that while Penn's liberal world order posits the capacity to overcome differences of nation and race, the surgical practices he enumerates in fact depend on and reinforce these categories. While in the previous section, I emphasized how the construction of the African Patient reveals the persistence of race within plastic surgery discourse, in this section I show that black Africans constitute a stumbling block in Penn's climb toward the lofty goal of universal brotherhood, a facet of his philosophy that is connected both to his borrowing from Schweitzer and his political stance as a white South African liberal. While a culturalist notion of race is at play here as well, I emphasize the constitutive role of antiblackness in Penn's otherwise (supposedly) all-embracing philosophy.

Penn writes that his journey to plastic surgery began when Harold Gillies's book recounting his surgical techniques developed during WWI, *Plastic Surgery of the Face*, found its way Penn's hands as a young man. It so inspired Penn partially because of the nobility of the cause that surgery was put toward and partially because Gillies himself was from a Commonwealth nation and his book described collaboration between other Commonwealth surgeons in Britain during the war. Penn's autobiography, written well after the establishment of the United Nations and the Universal Declaration of Human Rights, invokes a human rights framing through its title, and this framing is linked to the outward appearance of the body. Though Penn was too young to serve during World War

I (he was born in 1909 and is of British extraction), he did serve as a military doctor in Britain and South Africa during World War II and in South Africa after the war.²¹ Penn's book is infused throughout with his particularly humanitarian vision of plastic surgery. Penn views the world as fractured by war and antimony and in grave need of healing, and medicine generally and plastic surgery in particular are the forces that will heal it. "The brotherhood of pain knows no boundaries of geography or nationality, colour or sect," he writes. "Our heritage of love and social conscience, which may be exploded by the fulminations of dictators or politicians, may have to be laboriously reconstructed by those who would be spared to take their places in this brotherhood" (Penn 1976, 29).²² In his vision, it is the universality of pain and the ability of doctors to address that pain that unites mankind. The plastic surgeon's role is unique since it regards the right to look human, the actualization of which involves alleviating physical pain in some cases and alleviating affronts to dignity in all cases.²³ In his estimation, his profession is particularly humane due to its ability to go beyond the question of mere life or the physical health of the body into the question of the good life or the life worth living. Penn asserts that plastic surgery's greatest promise is its capacity to repair the "fabric of *universal* co-operation and sympathy" (2) that has been lost in a world fractured by war. Penn's feelings of marginalization, both as a South African (in relation to the international community of surgeons) and as a *plastic* surgeon (as opposed to other surgical specialties) are palpable throughout the book, and it is through plastic surgery's

²¹ Penn, too, has a McIndoe connection, as he served under him at East Grinstead during the war.

²² Penn is deeply influenced by the philosophy of Albert Schweitzer, from whom the concept of the brotherhood of those who bear the mark of pain is drawn.

²³ For more on human rights frames within plastic surgery and particularly the notion of human dignity, see chapter 2.

capacity to actualize the “fellow feeling” among men, “so distinctly civilized and human” (33), that Penn seeks to claim a legitimate place in modern medicine for both plastic surgery and South Africa.

Penn’s positionality as a South African is particularly important to understanding his relationship to postwar development discourse. Penn, writing in 1976, is all too cognizant of the fact that South Africa’s apartheid system has placed it outside of the dominant ethos of the “postwar liberal race formation” that Melamed identifies and has resulted in the widespread condemnation of South Africa from international bodies such as the UN. In Winant’s terms, “South Africa tended to disprove the liberal vision of race [and] undercut the lingering tendency among modernization theorists to treat racial oppression as atavistic or vestigial” (2001, 186-87), and Penn was keenly aware of South Africa’s marginal status that resulted from this racial illiberalism. Thus his desire to prove that he and his surgical skill, in fact, epitomize the liberal worldview must be understood as a result of Penn’s perceived marginalization. But Penn’s concern with the marginalization of South Africa is also linked to his anticommunist stance, which thus links his medical humanitarian vision to anticommunism as well. Seeming to buy wholesale the apartheid government’s anticommunist propaganda, Penn resents the United Nations (while admiring its ideals) for its acceptance of what he views as propaganda surrounding the 1960 Sharpeville Massacre, which initiated widespread condemnation of the apartheid regime. Instead, Penn claims that communists fomented the protesters, using “wretched Africans” as “cannon fodder” (1976, 242) to purposefully provoke the police, “the forces of law and order,” precisely in order to tarnish South Africa’s image abroad. Penn’s articulation of the potential for a South African actor

(himself) to affirm the bonds of all humanity across difference of race and nation through the application of humane medical attention must thus be contextualized within this complex of national and international politics; for Penn, any imputation of South Africa's illiberalism is also a blow to its status as a bulwark against the spread of communism.

Penn's Surgical Vision

Penn's recounting of his life is full of international travel, of both his body and others'. In its insistent motion from place to place, Penn's life and work makes any simplistic opposition between local and global impossible. Indeed, *The Right to Look Human* is full of bodies in motion and relating to each other across national boundaries. Penn himself travels to Britain, the U.S., Israel, Japan, Nigeria, Gabon (then French Equatorial Africa), Taiwan, and Iran, treating patients in most of those locations. In South Africa, he treats patients from South Africa, Italy, Portugal, Rhodesia, Britain, Greece, France, and Poland, plus other unspecified locations. Further, the surgical techniques that he developed or made original modifications to traveled via both publications—he began the first English-language journal devoted entirely to plastic surgery—and through his travels, where he demonstrated techniques and taught them to other surgeons. Clearly then, Penn's career problematizes conventional histories of plastic surgery that, while noting exceptions to the rule, generally conceive of the transmission of medical knowledge as moving from North to South or West to East.

Penn's international travel and encounters with non-South African patients, within the narrative of *The Right to Look Human*, are valuable insofar as they are instantiations of the abstract ideal that reigns supreme throughout the book, which is the capacity of

plastic surgery to actualize the bonds of humanity through treating *both* physical and psychic pain. Thus, Penn writes, “The Italian and the South African: the Jewish Israeli and the Modern Arab: the Occidental American and the Oriental Japanese: the black man and the white man: all have different appearances, traditions and habits, but all react in the same way to human understanding. Sympathy can bring all peoples together under the stress of suffering. Sympathy unifies those who do not wish to die: it could do the same for those who wish to live” (39). Penn’s travels to Israel and Japan, and his treatment of WWII soldiers, function in the service of an ideal of international brotherhood and community that can be created when doctors come together around human suffering. The world is, according to Penn, fractured and factioned, in dire need of healing, and he sees the creation of international communities of doctors—and it is indeed always doctors who form these communities and who are most sensitive to suffering—as the salve that might spark a sense of shared humanity and membership in a worldwide brotherhood. This understanding reveals Penn’s melding of Schweitzer’s philosophy of the “brotherhood that bears the mark of pain” and post-WWII emergence of human rights discourse. While this vision of a humane world community is the potential of medicine in general (Penn is usually the only plastic surgeon in these communities of doctors), Penn implies that plastic surgery has an especially vital role to play. While other doctors played absolutely key roles in the alleviation of suffering, and the prevention of death, the plastic surgeon is capable of offering something unique to the humanitarian mission. The right to look human implies that this right is at once a basic need, shared by all, and the right to live *in a particular way*, to live with dignity, not be stared at, not be embarrassed by one’s appearance. This should not be taken to mean that Penn never alleviates

physical pain or even saves lives, but should draw our attention to Penn's quest to legitimate his profession as a particularly humane. These are bodies of value insofar as they are visually recognizable as human, and they become valuable for Penn insofar as they are able to prove that plastic surgery can fulfill the most noble of philosophical and practical goods. As Penn puts it: "a person like myself, who works for weeks in treating peasants and soldiers, often in primitive conditions, teaching and advising, is also of value even though unspectacular, as he gets to the basic problems of humanity. The brotherhood of pain makes all the world kin" (162). As plastic surgery has expanded definitions of health to include both psychic and physical elements through the body-psyche nexus, psychic pain caused by inhuman appearance can now become part of the Schweitzerian concept of the brotherhood of pain.

On the first two pages of the book, Penn laments the "rifts which dishonesty and greed have torn in the fabric of universal co-operation and sympathy" (1), and mocks the fact that "from birth each human is taught that he has the best colour, belongs to the best nation and is a member of the best religion or sect" (2). Yet, following Schweitzer, Penn argues that medicine has a special role to play in healing this world: "The brotherhood of pain knows no boundaries of geography or nationality, colour or sect. Our heritage of love and social conscience, which may be exploded by the fulminations of dictators or politicians, may have to be laboriously reconstructed by those who would be spared to take their places in this brotherhood" (29). The ethics that Penn develops through pain privileges doctors, since medicine is able to address pain. And plastic surgery, in Penn's account, is unique in that its expanded definition of health, which encompasses the

psychic pain associated with abnormality of appearance, is holistic in its approach to pain.

In the chapter titled “Sympathy: The Common Denominator,” Penn details specific experiences that concretized his understanding of medicine’s power to overcome difference and heal fractures. Penn gives four examples of the sort of pain he is talking about, all of which come from his international experiences as a plastic surgeon. Interestingly, in all cases, it is primarily a community of doctors, not patients, which forms the international community based on pain. The examples he gives are, first, his correspondence and meetings with Italian surgeons who became known to him through their treatment of Italian soldiers wounded by South Africans during WWII at the same time that he was treating South African soldiers wounded by the Italians; second, the community of doctors formed in Israel during the Arab-Israeli war in 1948, who were drawn to aid Israel by their feelings of justice and sympathy; third, his treatment of survivors in Japan of the atomic bombs dropped on Hiroshima and Nagasaki; and fourth, his 1956 visit to Albert Schweitzer’s hospital in Lambarene, Gabon (then French Equatorial Africa). In all of these cases, those caring for the wounded were able to overcome any national, political, and racial differences through their moral and “civilized” desire to care for those in pain (a desire that black Africans are said to lack, as we shall see). In his role as plastic surgeon, which brought him into contact with this international community of doctors, he alleviates the psychic pain that comes with the disfigurements and losses of bodily capacities caused by war (a restoration which is clearly an attempt to regain the previous status of racialized, sexualized, and nationalized male bodies). This healing of national wounds through plastic surgery often seems to

efface other bodies in the process. The bodies of injured Israelis, for example, serve to legitimate Israel as a nation-state, whereas the injury, death, and displacement of Arab bodies merit no mention.

The case of Penn's involvement in the treatment of victims of the atomic bomb in Japan is especially interesting. In the US, a project called the Hiroshima Maidens was undertaken to bring a group of Japanese women who were, under the impetus of a Japanese Methodist minister, Tanimoto, and Norman Cousins, the American editor of the *Saturday Review of Literature*, brought to the US in 1957 to receive plastic surgery to normalize their appearance. Penn is critical of some aspects of this project, but in many ways his views on the case concur with those prevalent at the time, which David Serlin notes were shaped by an association of plastic surgery with the technical advancements of the West, and particularly the United States, and, from within Japan, the pursuit of a "cosmopolitan postwar Japanese identity" (Serlin 2004, 62). In Japan, the emphasis on progress and modernization after the war meshed accorded with the efforts to secure plastic surgery for bomb victims. Left-wing papers in Japan, Penn notes, asked why victims were being treated in New York and not in Hiroshima and why only young girls had been selected. He criticizes the fact that the Atom Bomb Casualty Commission set up by Truman had instructions to investigate the effects of the bomb but not treat victims. Thus Penn places himself beyond the various nationalisms shaping the project, reconceiving his surgical efforts as in pursuit of brotherhood and healing the wounds that war has rent in that brotherhood.

The Hiroshima Peace Centre Associates, which had organized the Maidens' trip to the United States, invited Penn and his team to come to Hiroshima to treat victims and

train doctors and nurses in surgery. Penn reports that Japanese are not keloid formers (contra their nickname Keloid Girls). In noting this, Penn uses the description of their bodies to reinforce his own position as a cosmopolitan subject capable of avoiding prejudices of nation and race. While some parties in the US sought to avoid the appearance of atonement (Lindee 1994, 138)—and the State Department wanted to “maintain belief that ‘the death and mutilation inflicted by the atomic bombs are no different than those caused by conventional weapons’” (Serlin 2004, 67)—Penn was explicit that he believed that plastic surgery could play a major role in allowing Americans to “make up for the devastation created by the American bomb” (158). This makes sense given Penn’s investment in cosmopolitanism and noninvestment in US nationalism. Though Penn does not emphasize the economic role, if as Serlin notes, plastic surgery was seen in Japan (and elsewhere) as a technological modernization, Penn’s efforts incorporate plastic reconstructive surgery, as a technological capacity, as a form of modernization capital in the effort to reconstruct and restructure Japan’s economy. Penn’s valuation of the practice of plastic surgery is extraordinary: After advising American officials to invite fifty Japanese surgeons to train as plastic surgeons in the U.S., Penn writes, “I considered that this American contribution to Japan would more than make up for the devastation created by the American bomb. I was saddened by the fact that my recommendation was not taken up” (157-8). Beyond a simple investment in modernization, then, plastic surgery becomes a powerful act of medical diplomacy, a type of foreign aid capable of suturing the rifts of war. And this is enabled in part because reparation of bodies damaged by war is viewed as also the restoration of

national bodies: America can make reparations to Japan as a nation by helping them to repair the bodies of their citizenry.

While Penn's comments about the development of surgery in Japan are perhaps his most hyperbolic valuation of the power of surgery to overcome the fractures of war, this sort of valuation of bodies and surgery occurs throughout Penn's memoir. He offers similar comments about the value of surgery to Israel, this time figuring surgery as self-sufficiency: "it was obvious that Israeli doctors should be trained so that the country should not always have to rely on foreign aid. It was therefore part of my function to see that in the three main cities of Jerusalem, Tel Aviv and Haifa, trained plastic surgeons should be in charge of units in the major hospitals" (183). These valuations concern not only the capacity to repair the bodies of these nations' citizenries; they also affirm the importance of establishing plastic surgery as a legitimate and global medical specialization that is accorded the same respect and institutional status as other forms of medicine. To this end, he pursues the idea of building an international center for the exchange of plastic surgery knowledge, pursuing leads to build it in Jerusalem, Switzerland, and Iran. In Iran, he meets with the queen, who asks him why Iran was his choice of location. He responds, "because [Iran] is rich, but not *nouveau riche*, and that this would be in the nature of a renaissance of technology" (201). He uses the rhetoric of internationalism to attempt to persuade the Shah's adviser by stating that it would be a "gesture of goodwill towards the world and addition of prestige to Iran" (200). Again, Penn acknowledges the economic nature of plastic surgery training, framing it as human capital enrichment and technological modernization, but the ultimate goal is always the enrichment of kinship among nations.

In individual cases of aesthetic surgery, Penn holds a fairly conventional view of the function of elective surgery: positing that plastic surgery's innovation is the inversion of the "mind over matter" formula, he writes, "Sometimes, however, the psychological reasons for physical alterations are not based on a desire to excel in good looks, but to be accepted as a normal person which, if denied, may cause unhappiness or even tragedy" (21), thus framing individual investment bodies as in the service of eliminating psychic suffering. But in several individual cases in the text, it becomes clear that the bodies that he operates on cosmetically are situated in relation to national and racial norms, and the normalizing surgery that he performs on them reinforce those norms rather than breaking down difference. In one instance of surgery performed in Galilee, he writes of a case in which a young boy's nose was eaten by a rat, and he constructs a new nose for the child. In what I can only assume is a harmlessly intended anti-Semitic joke, he writes that "the fact that this was a little Israeli boy might have helped" (8) him cope with the fact that Penn has constructed an oversized nose that the child will grow into. In another case, an attractive woman, whom Penn presumes is white, from the Cape comes to his office, wishing that her nostrils be narrowed. Penn does not see the need, and tells her so, which impels her to recount the story of her engagement to a white man. The very happy girl informed her parents, to which her drunk father responded, "today no man would marry a coloured girl" (5). The girl is shocked, and her father continues, "Ask your mother, and look at your nose, and you will see what I mean" (5). The girl's mother explained that while her father was white, she—the mother—was from a coloured family and had not told her daughter in order to increase her daughters chances in life. After hearing the story and realizing why her nose has become an obsession, Penn agrees to perform the

surgery. The surgery is perfect, and the woman and her husband lived happily ever after. This story of normality through properly achieved race and heterosexuality is meant as part of a series that illustrate the inconsequence of race and nation. In fact, though, the story works at odds with Penn's goals: the alleviation of suffering in this case entails shoring up the national racial order.²⁴ Penn's argument that plastic surgery is a somato-psychic form of medicine (229), key to his vision of its potential to increase human understanding through addressing a holistic concept of health and dignity, is perturbed by instances in which racial difference structure the terms of valuation.

Interruptions of Blackness

Penn in fact rarely mentions performing surgery on black South Africans or indeed any black Africans. In this section I argue that this is because Penn's philosophy operates within a framework of antiblack racism that assigns black bodies, individuals, and populations to the role of the illiberal subject par excellence, as those bodies, individuals, and populations that cannot be incorporated into the particular postwar liberal vision that he emplots plastic surgery within.

First I turn to the material underpinnings of Penn's Brenthurst Clinic, one of his proudest achievements, to show that the restorative care he provided there was enabled by the subjugation and exploitation of black miners in South Africa. As Penn is apt to disregard the material underpinnings of medicine in his quest to elevate plastic surgery as fulfilling a lofty and abstract principle, it behooves us to recall the material underpinnings

²⁴ This story is a perfect distillation of Sander Gilman's arguments regarding racial injury as integral to the history of cosmetic surgery, and indeed Gilman uses this same story to illustrate the significance of the notion of permanent racial markers that betray the "truth" of race on the individual body (1999, 114).

of his work. Brenthurst was Penn's brainchild, as it was he who, as an officer in the Medical Corps of the South African Army, requested control of the facility, which Ernest Oppenheimer had donated to the Red Cross for use during World War II, despite being told that if he continued practicing plastic surgery, there would be no chance for promotion (74), and he would indeed not be promoted from his rank of major. As a military hospital, he treated South African, British, Greek, French, Polish, and American men serving in various branches of the military, who were taken to South Africa after sustaining injuries in the Middle East and Mediterranean. For Penn, his work at Brenthurst provided an ego boost of sorts, as the healing power of plastic surgery as applied to these bodies went far to raising the status of plastic surgery as a profession, while his practice simultaneously served to provide a cosmopolitanism center in the Transvaal (his own version of McIndoe's East Grinstead) where persons of different languages and nationalities could interact through their shared experience of disfigurement, with Penn as the uniting humanitarian force behind it all.

As already mentioned, Brenthurst, which was later converted to Penn's private clinic, was owned by Ernest Oppenheimer. Oppenheimer funded the improvements made to the estate so that it could function as a hospital, and after Brenthurst was partially destroyed in a fire in 1944, Oppenheimer donated money to the University of the Witwatersrand in order to fund plastic surgery at their facilities, and Penn was promoted to Chair in Plastic, Maxillo-Facial, and Oral Surgery (the first person to hold this position). Oppenheimer also funded Penn's research into wound healing for 18 months beginning in 1951. I emphasize Oppenheimer's financial support for Penn, as it points to an effaced set of bodies that undergird Penn's career advancements and his treatment of

European soldiers, as Oppenheimer's immense wealth came from diamond and gold mining. Founder of the Anglo American Corporation in 1917 and chairman of De Beers from 1929-57, Oppenheimer was a beneficiary of the labor of thousands of South Africans and migrants from neighboring areas, the vast majority of whom were black. Black mine workers were confined to compounds, where living conditions were overcrowded and unsanitary; this system was not dismantled until the 1970s (Davenport and Saunders 2000, 609).²⁵ Work in the mines posed its own set of dangers, most pointedly pneumonia but also bodily mutilation and death.²⁶ While it's possible that Penn may have operated to repair forms of mining-induced debility (Livingston 2006), if they occurred they play no part in *The Right to Look Human*, thus suggesting that such operations would not contribute to the building of the liberal humanitarian ideal Penn espouses.

Penn's views on racial politics in South Africa, though not immediately connected to his surgical practice, shed light on the ways that he interprets the racial schema of liberalism and the visit to Schweitzer's clinic I discuss in the conclusion to this section. Advocating a view that was relatively common at the time, he largely concentrates on black South Africans' (and other Africans') intolerance as a justification for not

²⁵ Not only did this labor system help to keep wages for blacks low and profits high (in 1920, 21,000 white workers earned 10.64 million pounds in the gold mines, while 179,000 blacks workers earned 6 million; Davenport and Saunders 2000, 293), but doctors played a key role in the compound system and mining industry more generally: "Along with the creation of the De Beers monopoly over diamond mining in Kimberley came the establishment of tightly enclosed compounds for black labourers. Both they and other De Beers employees had recourse only to practitioners on the company list. Colonial doctors were often closely associated with this economic expansion, lending middle-class respectability to processes which brutally incorporated indigenous societies into waged labor" (Deacon et al. 2004, 225).

²⁶ Interestingly, Ernest Oppenheimer's son, Harry, funded a flying doctors program of his own, dubbed Harry's Angels.

supporting the immediate end of apartheid, thus suggesting consonance with the liberal racial schema Melamed outlines. He writes, “When Schweitzer said of the African ‘He is my younger brother’, he summed up in one sentence the true relationship between the sophisticated White and the emergent African. As the elder brother, it is our duty to teach him what is for the benefit of his own welfare and towards the development of his own maturity” (252). He positions white South Africans as instructing black South Africans through a pedagogy of liberalism and the capacities to be self-governing subjects. He notes that white South Africans’ racist policies weaken the country’s position in the fight against global communism, but primarily blames “detribalized South Africans,” along with “professional anti-South African propagandists” for creating “a situation where it is almost impossible to get the average American or Englishman to believe anything good about us” (162). Whites must remain in power in South Africa because “even if European control of this country were removed and African power were to take its place there would be no unification of the tribes, but they would fight each other and the strongest tribe would take all. The story in the rest of Africa leaves no illusions on this score” (235). Thus black South Africans’ intolerance paradoxically justifies the maintenance of an explicitly racist system of government.

This justification helps to explain why the black patients who Penn does explicitly treat in the text play no role in his liberal vision of humanitarian surgery. If at the political level, Penn believes that black subjects do not share in the tolerant vision of the modern era, at the level of the body-mind nexus they do not share the capacity for sociality that would make plastic surgery a force for the overcoming of difference. That is, since plastic surgery depends on social norms of appearance for the psychological effects of

normalized appearance to be registered, and, in Penn's view, black Africans do not have this capacity. The most prominently featured work that Penn performs on black African bodies occurs not in South Africa, but French Equatorial Africa (now Gabon), in Schweitzer's leper colony at his hospital in Lambaréné. At Lambaréné, the modernity and enlightenment Penn elsewhere associates with medicine is nowhere to be found. Instead, he portrays the scene as filthy, without running water and electricity except in the operating room, and with animals running around. While Penn was aware of critiques of the quality of care offered at Lambaréné, he does not, ultimately, share them, despite his horror at the scene: modern medicine does not suit the African temperament. "Strangely enough," Penn says, "it all worked. Schweitzer realized that the inhabitants of central Africa lacked a social conscience, and that one tribe distrusted and hated the other" (137). Here, those who are suffering from horrible illnesses are decidedly not the occasion for sympathy and understanding nor are they agents of them. Rather, they form the shadowy underside to the vision of international community that Penn espouses so lovingly. Because they lack social conscience in Penn's eyes, their suffering cannot inspire the trust that it should, dissolving into an unappreciative morass of suffering that can never form the basis of a transcendent appreciation of the brotherhood of man. This view of Africans as lacking social conscience is taken directly from Schweitzer: "They are indeed wanting in the direct sympathy with their fellows which compels us to action, a sympathy to which we have been educated by the command of Jesus. Compared with us Europeans, the African is an almost non-social entity" (Schweitzer [1939] 2002, 134). Schweitzer is lauded for his efforts to alleviate African suffering, but because Penn's entire philosophy, which follows Schweitzer directly, is based on the value of sympathy for overcoming

difference, Africans' lack of that quality excludes them from Penn's liberal vision, and Penn's labor at Lambaréné is, from a moral standpoint, "fruitless" (138), despite his best surgical efforts.

Conclusion

We have now seen how three overlapping cases of postwar transnational surgical intervention linked themselves to development discourse and, in so doing, produced ideas about bodies that incorporate health, culture, and appearance into the development project. In Vietnam, surgeons found a place where surgery, as a form of human capital investment, could advance the cause of capitalism against the forces of communism. In East Africa, the FDEA found a sparse medical infrastructure where their expertise in general and plastic surgery could invest in bodies in ways that local doctors could not. And Jack Penn found a world in which plastic surgery could bring together races and nations at the same time that it modernized medical infrastructures and affirmed the right to look human. Consonant with liberal capitalist understandings, these development projects also emphasized the humaneness of the plastic surgeon's gaze and their own respect for difference, bodily and cultural, while simultaneously pathologizing not only individual bodies but also cultural differences in the understanding of embodiment. They elaborate a world in which political, national, economic, and cultural differences produce differing distributions of debility and conditions of unfreedom, and use these to justify both intervention in the name of development and plastic surgery as a medical specialization capable of making important contributions to the world. In Vietnam, surgeons found that war, communism, and lack of infrastructure were producing injuries

and meant that easily reparable conditions went unrepaired. The FDEA finds that the natural setting of East Africa itself, the cultures of native populations, and the “ignorance” regarding biomedical understandings of the body were producing bodies in need of surgical intervention. And, drawing on Schweitzer, Penn found that “the African’s” lack of social conscience makes him incapable of appreciating the way that plastic surgery’s beneficent and world-changing intervention into bodies. In different ways, then, the three examples in this chapter demonstrate the attribution of race through nonbiological but still embodied differences produced by culture.

Plastic surgery’s capacious understanding of health, I have argued, allows it to articulate itself as especially attuned to the development project and humanitarian goals of promoting dignity, bringing phenotype and questions of morphology into the scope of the post-WWII global economic and geopolitical order as an object of regulation and demarcation of difference, as well as a site of investment. I have argued that surgeons use race and racial difference to designate which bodies can and cannot contribute to the formation or be members of the liberal order, whether because they lack the capacity to appreciate bodily difference humanely and understand the mode of embodiment of Western medicine (as Rees believed), lack the capacity for sociality and fellow-feeling necessary to build bonds across difference (as Penn believed), or lack the capacity to become agents of their own development along the technocratic path to modernization (as US surgeons and media believed of the Vietnamese). The three examples above demonstrate that plastic surgery continues the racialization project of development by dividing the world into liberal subjects who invest in themselves (Rees, Barsky, or Stark’s clients in the US) and illiberal subjects who are subject to external investment.

Healing Faces, Healing the World? Operation Smile, the Humanitarian Mission, and the Address to Human Dignity

This chapter is unpacks the discursive strategies used by the organization Operation Smile in order to explore how it understands the bodies upon whom it operates as linked to contemporary practices of humanitarianism. Operation Smile is a charity that was founded in the United States in 1982 with the mission of performing facial reconstructive surgery around the world in places where that surgery is unavailable to large numbers of people. The discourse that they construct through their public relations materials, annual reports, newsletters, and other documents forms the primary object of my investigation here. At a general level, I want to understand what Operation Smile's discursive techniques can tell us about how plastic surgery is enabling relationships between nations and how plastic surgery forms a way in which bodies are invested by capital. Operation Smile provides such an opportunity not only because it is a transnational NGO but especially because it frames its project in humanitarian terms. It justifies its activities through recourse to humanitarian ideals of alleviating suffering and affirming human dignity. It therefore presupposes universals that are imagined as uniting nations and cultures despite differences, and it enacts these universals through its investments in the bodies of children upon whom it operates, sending international teams of doctors on humanitarian missions.

While the previous chapter explored the political economy of humanitarian surgical efforts in the postwar years, embodying a liberal development ethos of the era and articulating its surgical efforts within that framework, this chapter moves to the

neoliberal present, exploring how plastic surgery operates here as a mode of investment in and valuation of bodies. This chapter traces out Operation Smile's logic and operating assumptions to understand how it maps cultural and economic relationships through investment in the bodies of children. I am interested not in the children's subjectivities nor in the subjectivities of the doctors who travel to operate on them. Rather, I am interested in how Operation Smile understands its own activities and how it those activities come to make sense both within the logic of the organization and the way it expresses that logic in its efforts to secure donations from individuals and corporations. I look at the discursive strategies and assumptions that undergird even the contentious debates about humanitarian missions within the surgical community. Although Operation Smile performs more than just surgeries to modify cleft lips and palates, I focus on these procedures because they dominate Operation Smile's mission and discourse. The bodies of children with cleft palates and lips are the most visible and do the most discursive work to justify Operation Smile's practices.

While in the following chapter on the Johannesburg-based cosmetic-surgery tourism company Surgeon and Safari, I argue that transnational travel to obtain cosmetic surgery serves as a form of self-entrepreneurship and investment of value into the body for oneself, in Operation Smile's case, as in the efforts discussed in the previous chapter, bodies are invested not through self-investment in a medical marketplace but by a transnational actor that deems bodies worthy of investment only insofar as they are suffering and not valued within their own cultural context. That is, although it operates within a neoliberal context, Operation Smile does not follow the model of neoliberal self-entrepreneurship. Rather, they step in to invest in bodies that would otherwise not be

invested by either themselves (through paying for surgery) or by the state (through providing surgery). That is to say, these bodies are productive for Operation Smile—and they are immensely productive—to the extent that they justify humanitarian intervention, the rationale for which is suffering or indignity. For Operation Smile, bodies with clefts reveal a problem not just of biology but of humanity itself and the divisions within it; they reveal a geography that poses questions of bodily, cultural, national, and economic difference that demand answers. While Penn, the Flying Doctors of East Africa, and surgeons who traveled to Vietnam were concerned with injuries caused either by war or by the newly constituted problem of poverty in the postwar geopolitical order, Operation Smile is concerned primarily with the embodied inequalities of global capitalism and restoring dignity to bodies whose cultures do not value them.

This paper begins with an examination of Operation Smile’s official origin story as a way of introducing the major themes that characterize Operation Smile’s larger discursive practices. The origin story introduces both the problem of geographical division, where certain locations are mapped as containing more “deformity” than others, and the matter of human dignity, where the cleft and deformed body calls the dignity of that body into question. I then move to a discussion of some themes from the history of plastic surgery to illuminate the precedents that enable thinking plastic surgery as a force for the alleviation of suffering and the tightening of the bonds of humanity across national difference. I also examine how reconstructive surgery imagines itself as particularly attuned to dignity. The following section outlines the general contours of the contemporary humanitarian ethos, as well as its attendant representational practices, in order to set the stage for the in-depth discussion of Operation Smile that follows. After

this general sketch, I discuss the larger political-economic issues within which Operation Smile is imbricated by examining debates among surgeons and Operation Smile personnel regarding the economic underpinnings of the mission model and its political consequences. I argue that despite dignity's supposedly universal status, these debates demonstrate that it is in fact embedded within geopolitics and global political economies. Despite its claims to bridge difference, Operation Smile cannot help but come up against histories of colonialism and power differentials between nations, and its representational and organizational practices often reinforce such differentials. The next section examines the duality inherent in Operation Smile's notion of dignity. I argue that Operation Smile relies on a notion of human dignity that is both embodied in the individual body and also dependent on cultural affirmation. Operation Smile's deployment of cultural explanations reinforce the purported difference between the medical missions who affirm dignity and the local cultures who deny it.

Origin Story

Operation Smile was founded in 1982. Today, Operation Smile is one of the 200 largest charities in the U.S. In 2005, it took in \$41 million and spent \$40 million (Forbes 2005). It has won numerous humanitarian awards, including the Conrad Hilton Humanitarian Prize, the Liberian Presidential Medal of Honor, a Presidential Citation for Private Sector Initiatives (presented by President Ronald Reagan), the American Red Cross Overseas Association's International Humanity Award, and the President's Call to Service Award (presented by President George W. Bush). And the organization has received praise from numerous well-known figures around the world, including Corazon

Aquino, Mother Teresa, and Pope John Paul II (Operation Smile n.d.).

Operation Smile's official origin story begins with a picture of familial and professional travel: "In 1982, Dr. William P. Magee Jr., a plastic surgeon, and his wife, Kathleen S. Magee, a registered nurse participated in an event that would forever change their lives—and the lives of thousands of children around the world" (Operation Smile 2013). Dr. Magee is quoted: "In 1982, we traveled to the Philippines with a group of medical volunteers to repair children's cleft lips and cleft palates. We discovered hundreds of children ravaged by deformities" (Operation Smile 2013). This experience convinced the Magees that something had to be done, since they could not operate on all the children in need that they encountered. "Everywhere we turned, there was a sea of deformities," states Kathy Magee. "People pushed their babies at us, tugged at our sleeves with tears in their eyes and begged us to help their children" (Operation Smile 2013). Operation Smile was, in this account, born of a desire on the part of the Magees to help, and a desperate need on the part of the Filipino families that they encountered.

Significantly, it is through the figure of the child's face that this need is articulated. The "sea of deformities" is first and foremost a visual registering of bodily difference, where the call to action is precipitated by the emotional response of those who encounter a child's deformed²⁷ face. Key for my argument is the emphasis on the visual appearance of deformity. This visual appearance is the only negative consequence of cleft palates and other injuries and defects encountered by the Magees in this short official origin story.

²⁷ Throughout this paper, I use the term deformity without scare quotes, but clearly my use of the term is critical, since deformity is a pathologizing term that seeks to posit a fictive normal body from which it deviates. In using this term to reflect Operation Smile's discourse, I take the risk of reinforcing the stigma attached to so-called deformed bodies.

This focus on visual difference pervades all of Operation Smile's promotional materials—from the organization's name, to the images used to raise funds, to the personal stories related in annual reports, it is the lack of the perfect smile, the visible difference from the normal body that matters most, rather than the physical impairments caused. The origin story does say that the deformities are “life-threatening”, which serves to reinforce the need for intervention through a risk to vitality, and to invoke physical suffering. The life-threatening nature of the deformities serve to reinforce the importance of reconstructive surgery as well, reminding readers of the specialization's ability to save lives and thus legitimate itself by linking itself to the more-traditional function of humanitarian action, which is to directly address the biological life of the human. However these deformities are immediately apparent to the Magees through a regime of visuality that emphasizes visible bodily difference.

In additions to the emphasis on bodily difference, clearly there are geopolitical questions at stake here as well. The “sea of deformities” encountered by the Magees indicates a difference from the home from which the Magees come. The fundamental difference is a question of economics and medical infrastructure. The deformities found in the Philippines are found, and in need of correction by a U.S. surgeon, because they are untreated. They are untreated because, it is implicit in the Magees' account, the Philippines does not have the resources—in terms of technology, medical expertise, or public infrastructure—to perform the surgeries necessary to correct them. This is a characteristic assumption of all of Operation Smile's charity work, and is indeed a reason for its being. What the origin story does here, by leaving implicit the socioeconomic backdrop that informs the difference encountered in the Philippines, is to produce a

geopolitical mapping through differences in bodily morphology. When viewed in the context of Operation Smile's discursive strategies, these documents produce a map of deformity, wherein the national spaces with a relatively high number of people with "deformities" are overlaid onto a map of global economics. Political-economic questions are thus expressed through bodily difference. This spatialization of deformity is, of course, produced by differences in the availability of funds for public medicine, colonial histories and neocolonial presents, and restructurings of economies by global financial institutions and the production of indebtedness—but they are primarily expressed, in Operation Smile's literature, as morphological difference (read: deformity). Thus it is not only a regime of visibility premised on bodily difference but a regime of visibility that is produced within a humanitarian framework that sees through the lens of cultural and national difference as well. The bodies before Magee come to be seeable as a "sea of deformities" not only because they are bodies that challenge bodily norms but also because they are found in this particular space, a space that is not home but rather the site of charitable humanitarian intervention.

The origin story also introduces the concept of human dignity with the sentence, "The promise Bill and Kathy Magee made years ago will not be fulfilled until every child with a correctable facial deformity is given the chance to live their life with dignity, and for those suffering from cleft or other facial deformities, dignity begins with a smile." While I will spend considerable time fleshing out the concept of dignity below, for now it is important to note that the Magees represent dignity as embodied—as something affected by the morphology of the body—and that dignity is imagined as reachable through plastic (reconstructive) surgery. That is, this humanitarian vision that is premised

on the restoration of dignity is to be carried out through the bridging of cultural and national difference through surgery. It is to the historical precedents for this way of thinking to which I now turn.

Reconstruction and the Humane: Historical Precedents

Part of what I would like this chapter to show is how reconstructive surgery imagines itself as especially well-suited to address the matter of human dignity, as if that matter is framed through the body and as something roughly equivalent to quality of life. As explored in the previous chapter, reconstructive surgery is particularly well-suited to address dignity because it does not, typically, address life itself. That is, reconstructive surgery does not generally understand itself as saving lives or preventing death. Rather, it addresses the body in ways that reshape it to appear normal if it is “malformed” or to restore bodies’ shapes after physical trauma (“deformation”²⁸). Thus, while plastic surgeons are quick to emphasize their general surgical skill, it is the ability to affect and normalize outward appearance (which, it is assumed affects psychic well-being) that marks plastic surgery’s *unique* contribution and its expansion of the conception of the human in humanitarianism.

As discussed in the introduction and first chapter, the division between reconstructive surgery and cosmetic or aesthetic surgery is itself quite unstable, historically variable, and informed by social understandings of gender and race. However, deformations, or abnormalities caused by an outside force, seem to form a

²⁸ Operation Smile tends to use “deformation” when referring to any nonnormative bodily configuration, not necessarily one caused by trauma. Clefts would technically be malformations, but Operation Smile and surgeons liberally apply the word deformation.

clearer standard by which to judge a procedure repairing that deformation reconstructive. And the face in particular, Operation Smile's primary area of concentration, is especially important to the legitimization of reconstructive surgery. As a marker of individuality and individuation, the face is especially integral to constituting the human. For instance, during World War I, when plastic surgery itself began to become a less marginalized medical profession, it was in particular the *faces* of soldiers whose repair became a factor in legitimating plastic surgery: "Whole bodies and all parts of bodies were being shattered in the war, but the facial wounds were often the worst, because in the trenches the face was the most exposed part of the body" (Gilman 1999, 157). Reconstructive surgeons played a very important role in repairing these damaged faces, as well as other body parts. Their role, however, was not to save lives in most cases, but to repair bodies whose conditions were already stable in order to restore as much as they could of their former appearance and functionality.

Jack Penn's mobilization of "the right to look human," explored in the last chapter, and his insistence on the importance of human dignity prefigure the humanitarian vision that will later be proffered by organizations like Operation Smile. In his account, plastic surgery lends itself to a particular form of humanitarianism and has effects on understandings of humanitarianism itself. While Penn did not, to my knowledge, influence Operation Smile or other charities directly, it is nevertheless the view he espouses that these charities express: that reconstructive surgery is means through which human dignity itself can be directly addressed.

Penn himself did take an interest in cleft surgeries: he met with Robert Ivy, a doctor that made cleft lip and palate surgery his life's work. Ivy, who had served in

France during WWI, had humanitarian visions for cleft surgeries. Penn writes that the “Ivy Plan” consisted of a scheme “whereby any child with a congenital deformity such as a cleft lip, or palate, may obtain the best possible treatment at the expense of the State. By so doing, every deformed child has a chance of growing up into a normal and well-integrated individual” (1976, 101). This fits well with Penn’s understanding of the potential of surgery, and he claims that “long before the Ivy plan was heard of,” he had made efforts to establish such a program in South Africa, though he was unsuccessful. Ivy had more success: by working with state representatives, he established the first free clinics in the U.S. that specialized in treating clefts and brought together doctors with different specialties to more fully address the cleft (Costello and Ruiz 2004, 840). Penn, though, believed that something similar to the Ivy Plan should be implemented by the World Health Organization “so that every malformed child in the world will stand a sporting chance of growing up into a normal adult” (Penn 1976, 101). Though no such plan ever materialized, Penn’s vision, or at least the philosophy underpinning it, closely mirrors the discourse of Operation Smile, as we will see.

Surgery to repair clefts, however, has not consistently been considered reconstructive surgery until the twentieth century (Gilman 1998, 13). Because malformed clefts are “congenital,” they are not the result of a trauma, and thus their classification as reconstructive is not as easily assured. However, since reconstructive surgery is now imagined as reconstruction of some fictive normal body, the body that should have been but never actually existed (that is, it exists only as a potential body), surgery to “correct” cleft palates are now understood firmly as reconstructive surgery. But their straddling of the boundary between reconstructive and cosmetic surgery—between being performed

for reasons of bodily incapacity (difficulty eating, difficulty speaking) and for reasons of “looking human”—means that it is imagined still as repairing a trauma, the trauma of not looking normal as well as the physical impairments. Whereas contemporary forms of *cosmetic* surgery are often viewed as acts of voluntaristic self-enhancement enabled through commodified medicine (see, e.g., Frank 2004), Operation Smile’s activities (perhaps the most visible form of contemporary reconstructive surgery being performed) are viewed as necessary reparations to a damaged body, reparations that address both the body’s capacities as well as the humanness of the body’s appearance.

Humanitarianism, Representation, Politics: A General Sketch

Now that we have seen how reconstructive surgery imagines itself as expanding the human of humanitarianism to encompass morphology and the psychic and social well-being that is imagined to result from the normalization of that morphology, particularly the face, I turn to a general outline of the concerns that have been recently raised by contemporary forms of humanitarianism, and medical humanitarianism more specifically. While Operation Smile’s operations differ from the organizations discussed below in important respects, it is useful to have in mind a critical outline of humanitarian logics and their attendant representational practices before moving on to a more specific discussion of the ways in which Operation Smile both extends and departs from these logics and representations.

Many scholars have expressed concern about the rise of humanitarianism as a form of global governance in the contemporary era. Scholars have noted that humanitarian rationalizations for war and other forms of neocolonial intervention have

become prominent (Fassin 2007; Atanasoski 2013; Chandler 2001). Both Susan Koshy and Neda Atanasoski link the rise of humanitarian and human-rights-based interventions to the end of the Cold War and the ascendancy of the liberal market. As Koshy writes, “Neocolonial strategies of power are increasingly articulated not through the language of the civilizing mission as in the nineteenth century, or through the American-sponsored discourses of anticommunism and modernization that superseded it, but through a new universalist ethics of human rights” (Koshy 1999, 1). Thus, within the neoliberal context, human rights and humanitarian regimes have come to replace or supplement the rationalizations for intervention that were explored in the previous chapter, such as development and anticommunism, and Operation Smile exemplifies this trend. In Atanasoski’s account, US humanitarianism, in particular, is linked to a “postsocialist imperial project” that is contingent on a multicultural ethos that aims to save “illiberal regimes” who do not appreciate “racial, religious, and cultural diversity” (2013, 5); “racialized intolerance, illiberalism, and homogeneity” are understood as “inhuman states” (12). Such an understanding of humanitarianism as operating through a liberal/illiberal divide is instructive for Operation Smile, since, as is discussed in detail below, Operation Smile quite often portrays the cultures where cleft is prevalent as illiberal—intolerant of bodily difference.

Miriam Ticktin’s analysis of the politics of humanitarianism in France, although it treats quite a different context than I am discussing here, is instructive for my discussion of Operation Smile. Ticktin excavates the logic of the French state’s decision to enact “a humanitarian clause in French law—... the ‘illness clause’—that gives people [undocumented migrants] with serious illnesses the right to stay in France and receive

treatment” (2009, 132). The law, however, does not give sick migrants the right to work or participate in other forms of civic and political life. Ticktin sees this fact, which forces migrants to work on the black market in the name of human dignity (138), as a result of the humanitarian logic that holds that tends “to recognize the universality of biological life above all else; that is, to find common humanity in apolitical suffering” (139).

Drawing on Giorgio Agamben and Liisa Makki, she contends that the humanitarian logic of the illness clause depends on producing the migrant as, and reducing the migrant to, a form of bare life or “pure victim” (Malkki quoted in Ticktin 2009, 139) in order to for them to emerge as part of the universality of biological life and as “objects of charity” (139). Humanitarianism thus removes these subjects from the political sphere. Thus, while Ticktin’s case is somewhat removed from the discourses of Operation Smile, it uncovers that within medical humanitarian understandings, politics are evacuated in favor of the construction of charitable cases based on a form of bare life. The body is incorporated into migrants’ citizenship claims insofar as it is a site of injury/illness in need of repair. In Operation Smile’s case, we will see how their discursive practices and somatization of dignity follow a similar logic that evacuates politics and constructs proof of victimhood through photographic evidence and written testimonials. Ticktin also documents that the compassion that ill migrants received from the medical professionals that they interact with is often a product of particular configurations of gender and race; that is, compassion was more likely to emerge if patients conformed to certain expectations about victimhood (i.e., “pitiful Muslim woman”; 146). Ticktin links the production of value within humanitarian discourse also to political economy, noting that those who are most dispossessed by global capitalism often find that their biology is “one

of the few sources of value” in which they can trade (Ticktin 2011, 144).

Didier Fassin has also noted the asymmetricality of the subject positions produced within medical humanitarian discourse and practice. He calls humanitarianism a “politics of life” because, despite its explicit disavowal of politics, it “give[s] specific value and meaning to human life” (2007, 500). He writes, “The humanitarian politics of life is based on an entrenched standpoint in favor of the ‘side of the victims.’ The world order, it supposes, is made up of the powerful and the weak. Humanitarian action takes place in the space between the two, being deployed among the weak as it denounces the powerful. It therefore relates to only one part of humanity—the one on the wrong side of life. It intervenes ‘in places where life is not worth a dollar’” (511).²⁹ Thus humanitarian logic constructs asymmetrical positionalities that, while they are meant to transcend national and racial divisions, in fact cannot help but reproduce them. Fassin details three divisions within the structure humanitarian logic: expatriate humanitarians are subject to greater protection than those people who work for the organization who live in the nation where the intervention is being undertaken; the division between “lives that may be risked (humanitarian agents)” and “lives that can only be sacrificed (the populations among whom they intervene)”; and the division between “lives that can be narrated in the first person (those who intervene) and lives that are recounted only in the third person (the voiceless in the name of whom intervention is done)” (519).³⁰ Thus, despite the fact that

²⁹ Fassin is quoting Jean-Herve Bradol in a piece for the MSF newsletter, and Laurence Hugues, also for the newsletter. Interestingly, the quotation for Hugues serves as a premonition of my analysis of the next chapter, which takes up the racializing consequences of the phrase “life is cheap.”

³⁰ Redfield also notes, in a similar vein, that “an inherited politics of race, class, and citizenship lies beneath patterns whereby largely European expatriates disappear more easily as agents of truth, transmitting the less mobile voices of largely non-European

MSF was founded in opposition to the Red Cross's imbrication in nationalist politics and national borders (Redfield 2006), it too remains enmeshed in national and global economic divisions. While MSF's activities are in many ways not comparable with Operation Smile's, it is again useful to note that Fassin's work, as well as that of Peter Redfield (2006), demonstrates that the logic of humanitarianism depends on the divisions that it disavows and constitutes a political stance even as it may also, as we have seen above, evacuate the population into whom it intervenes from the political. Operation Smile's workers are surely not putting their lives at risk the way that MSF workers sometimes are; nevertheless they do replicate certain logics and strategies of representation common to medical humanitarianism in general.

Fassin hints at these representational strategies in his comments on testimony and when he writes that "[victims are] essentialize[d]: against the thickness of biographies and the complexity of history, [humanitarian discourse] draws a figure to which humanitarian aid is directed. This construction is certainly necessary to justify humanitarianism, and it is also sufficient to it in that it has no need for the point of view of the persons in question" (Fassin 2007, 512). Other scholars have noted the centrality of images of suffering in historical and contemporary forms of humanitarianism. Kevin Rozario goes so far as to claim that humanitarianism is "in fact a creation of a sensationalistic mass culture" (418-19). He shows that display of the images of bodies emerged in the aftermath of WWI as a way of soliciting donations for the American Red Cross (though the practice had existed prior to this date), and, it was thought at the time,

victims. At rhetorical moments, the entire, complex transnational organization disappears into the nominal image of a biomedical doctor, historically not only white but also male" (2006, 16).

the more “vivid” (420) the image, the better. As my discussion of Operation Smile will make clear, they too depend on and continue the representational conventions associated with humanitarianism, with the consequence that they replicate racialized tropes of victimhood. Rozario also notes that an important component of the visual culture of humanitarianism is that the compassion that the viewer feels when viewing images of suffering are taken as evidence of the *viewers’* humanity. In a slightly different register, Tavia Nyong’o has recently noted that the “viral” online campaign calling for those in the US and the West to oppose the anti-gay legislation in Uganda similarly produces the flattening effects of humanitarianism’s scopic regime: the “death-bound African figure—a paradox distilled in the humanitarian West’s preferred image of Africa as an emaciated and starving child” (2012).³¹ Depictions of indignity (written or photographic), primarily expressed in the visual register, through depictions of the injured, “deformed,” or dead body, are essential to the evocation of the charitable and compassionate response required for organizations such as Operation Smile to function and receive donations.

The Political Economy of Smiles

Keeping in mind these divisions within humanitarianism’s supposed universality, this section begins to examine how Operation Smile’s seemingly apolitical, and, indeed, depoliticizing agenda is in fact embedded within global capitalism and the divisions it constructs.. By further investigating Operation Smile’s spatialization of “deformity,” as well as the positionalities it constructs, I demonstrate how Operation Smile rearticulates

³¹ Nyong’o’s work also adds a dimension not considered here: the ways in which the use of social media has affected humanitarian appeals, where the channels of “communicative capitalism” transmit affect in political objectives’ stead, and where clicking produces the sensation of action.

and depends on neocolonial economic relations and representational strategies.

If humanitarianism's idealist vision depends on "the creation of a new model of coexistence among the various cultures, peoples, races and religious spheres, within a single interconnected civilization" (Fox 1995, 1607), Operation Smile's vision for that new model is emblemized by the smile. As Heather Talley notes, "To claim to create smiles is also significant because smiling is often thought of as something that is universally human. Those who study facial expressions claim that virtually everyone everywhere smiles" (Talley 2008, 238). The notion of "Changing lives one smile at a time," Operation Smile's slogan, carries with it the assumption that smiling is that which is valued universally and thus that which can be a sign under which everyone can organize. Given that Operation Smile's *raison d'être* includes the inequalities produced by global capitalism, the smile forms part of their solution to ameliorating those inequalities—ameliorating the uneven global distribution of smiles. Smiles thus bridge both cultural difference and economic inequality. As Bill Magee puts it, in a line that could have been written by Jack Penn, "the real power is in the betterment of the human spirit, the fellowship it creates between people of different cultures, different races, religions and nationalities" (Operation Smile n.d. "About"). This section turns to examine the various ways in which the issues of economic inequality both sustain Operation Smile's mission and produce problems in carrying it out.

As we saw in Operation Smile's origin story, the organization produces a mapping of the globe by locating bodily deformity as prevalent in particular places and as less present in others. This configuration is supposed to be the product of the absence of corrective surgery in locations where some combination of economic factors ranging

from the inability of individuals to pay for surgery, the lack of medical infrastructure, the lack of skilled professionals, the lack of technology, and the lack of public health care prevents surgery from becoming available. This difference is also expressed in Operation Smile's division between "resource countries, which raise funds and provide medical volunteers"³² and nations in which "Operation Smile has a presence," meaning that these are places in which operations are carried out, including both destinations for international medical missions and places in which Operation Smile has a "second-generation" organization. This division conforms with the idea that humanitarian action takes place in places where poverty reigns, which is mapped onto the "developing world," and funded by "developed" nations with excess capital to invest in bodies of children that are not "their own." But this contradicts other information put forth by Operation Smile. For instance, Operation Smile claimed, in 1999, that they had performed twenty to twenty five thousand surgeries within the United States (Abelson 1999). Though these numbers were questioned on the basis that they were actually carried out with very little involvement with the organization, Operation Smile still claims that it "provid[es] reconstructive surgery and related health care to indigent children and young adults in developing countries and the United States" (Operation Smile n.d. "Overview", 1), and it touts its U.S. Care Network, a "referral service" that helps people in the U.S. find surgeons, by noting that "cleft palate and other facial deformities know no geographic boundaries" (Operation Smile n.d. "U.S. Care"). This seems to implicitly acknowledge both that the geographic mapping that would have seas of deformities existing only outside the U.S. might not hold and that that economic

³² These countries are listed as Australia, Canada, Hong Kong, Ireland, Italy, Singapore, Switzerland, the United Kingdom and the United States.

inequality might exist *within* the U.S. Furthermore, the international organization's newsletters also contains accounts of fundraising galas occurring in locations that are not given the status of "resource countries." Nevertheless, Operation Smile maintains its distinction between resource countries and mission countries, which reproduces a neatly divided world of deformity-prevalent and deformity-free spaces and nations.

This points to another idea that is often implicit (and sometimes explicit) within Operation Smile's activities, which is the relationship between NGOs and the role of the state. Operation Smile is an NGO that imagines itself as filling in the gaps left by states that are unable to properly invest in "their own" citizens. This is most clear in Bill Magee's 2006 pronouncement that "Now more than ever, it is crucial that the United States support private sector programs that exhibit the truly compassionate nature of its foreign policy objectives. Working closely with humanitarian organizations like Operation Smile, which have developed a proven track record of cross border friendships and trust, should be one important feature of a broader strategy to secure peace in the 21st Century" (Operation Smile 2006). In this vision, humanitarianism can be simultaneously a private sector activity and an arm of state policy, fulfilling a medical diplomatic role. Rather than a humanitarian organization that might intervene against the wishes of a state, like MSF, Operation Smile intervenes as a representative of a nation that espouses humanitarian values and with the permission of the nation into which it intervenes. It is thus in complete conformity with the view espoused by the U.S. Treasury that "international charitable work fills critical gaps in the global socioeconomic infrastructure" (Treasury Guidelines Working Group of Charitable Sector Organizations and Advisors 2005, 1). Unlike the Penn's vision of state-funded cleft surgeries

worldwide, Operation Smile imagines worldwide surgeries provided through charitable activities and public-private partnerships. It is thus the humaneness of medicine that calls doctors (not solely ones based in the U.S.) to perform charitable surgeries and the private sector that comes to supplement or stand in for the state's investment in its citizenry's bodies.

But Operation Smile has also worked hard to cultivate an image as something of a development organization as well. They have established, since 1989, second-generation organizations that perform intraregional missions either as a supplement or a replacement for the international missions of the first-generation umbrella organization. They also emphasize the role of Operation Smile in teaching surgeons cleft-repair techniques in whatever place they perform a mission with the rationale that this will "empower" the local surgeons and move toward "sustainability." And they have newly begun establishing permanent care centers in locations throughout the world, where free surgery and physicals are available. All of these efforts are portrayed as supplementing international missions, since the missions themselves do little to build up a lasting surgical infrastructure that can provide cleft surgery without the aid of the U.S. organization.

With these issues in mind, I want to turn now to a fascinating debate that occurred in the pages of the U.S. journal *Plastic and Reconstructive Surgery* about the relative merits of and problems caused by humanitarian missions to repair clefts. This debate was carried out among surgeons through a series of editorials, and they revolve around the issues outlined above regarding the particular power dynamics that interrupt Operation Smile's claims to the universal power of the smile and the bridging of national

differences. Though they do not all directly concern Operation Smile, they do concern the model of the humanitarian mission that Operation Smile has popularized³³ and that has served as a model for many other organizations. The first letter in the exchange is by Dr. Christian C. Dupuis, a Belgian surgeon, and titled “Humanitarian Missions in the Third World: A Polite Dissent.” He begins the letter by raising the of neocolonialism: “We think that Western colonialism is a thing of the past. I am afraid we may have switched to a new humanitarian colonialism of a different kind.” (2004, 434). Dupuis’s accusation that humanitarian missions participate in a kind of neocolonialism is based on several factors: the accusations that missions provide substandard care, that mission doctors assume that “local” doctors are incompetent, a failing to provide follow-up care, and inefficient spending.

“We believe that we are the good guys because we help the poor. Are we? Our big teams are geared toward the ‘body count’” (Dupuis 2004, 434), he writes. In this framing, humanitarianism’s focus on the poor seems to be providing an investment that enables dignity but actually instrumentalizes children in an effort to perform as many surgeries as possible so that this number can be used as evidence of beneficence. In the quest for numbers, visiting teams hog operating tables. Worse, he says that mission teams are not properly qualified: on one mission in Southeast Asian, he claims that out of a team of twenty visiting doctors, only two performed adequate surgeries and the rest “were not [okay], but they were training their residents using the poor kids of Southeast Asia” (Dupuis 2004, 434). Again, children are being instrumentalized for the surgeons’ own benefit, and this exploitation is enabled precisely through humanitarian discourse

³³ I should be clear, though, that missions were occurring on a smaller scale well before the advent of Operation Smile.

that would see “local” contexts as unable to provide such surgeries vs. the international team whose aim is beneficial. But “being a volunteer does not necessarily mean you’re qualified. Being a good plastic surgeon is not a qualification per se either.” Rather, “one should never perform operations abroad that one would not do on one’s own private patients at home” (Dupuis 2004, 434). Against Operation Smile’s claims of enhancing dignity, he opposes instrumentalization; against the implication that “resource countries” possess knowledge and technology to invest in and affirm the dignity of children with clefts, he opposes both a lack of skill and a defense of “local” surgeons’ knowledge (“The local colleagues know infinitely more than one assumes,” Dupuis 2004, 434).³⁴ The lack of follow-up care is also evidence of missions’ failures to fully invest in the bodies of children, a failure that does not occur when surgeons perform surgery “at home,” and in fact leads to complications that detrimentally affect the health of patients. Ultimately, Dupuis’s critique reverses the tenets of Operation Smile’s discourse. The universality of the smile and the discourse of the affirmation of human dignity by those in the missions, a discourse that is used to paint the missions as ameliorating the inequities of global capital, are actually exacerbating them. The overcoming of borders and building of “bridges” through smiles that Operation Smile lauds is ultimately a front covering over the still-existing power differentials that exist within humanitarianism—humanitarianism’s political and economic underpinnings.

In one response to Dupuis, an Italian surgeon, Fabio M. Abenavoli (2005), counters that not all medical missions prioritize the number of surgeries performed, but

³⁴ Despite the fact that Operation Smile is not named in Dupuis’s critique, I am fairly certain that the organization is one of his targets. Dupuis’s references to the deaths of patients in 1999 and the location of those deaths strongly suggest that it is Operation Smile (see Abelson 1999).

have more sustainable goals. In deploying the language of sustainability, Abenavoli mirrors Operation Smile's positioning of itself as not only invested in medical missions but in long-term goals of development. Indeed, Abenavoli uses Operation Smile as his counterpoint to Dupuis's examples of shoddy care and exploitation. After stating that he volunteered independently in Africa, he writes that he "began to follow the humanitarian objectives of an organization called Operation Smile in 1996. I was so impressed with the sustainable development goals of this organization that I helped to grow a resource chapter of the organization in Rome...." (2005, 356). "Our purpose is to work together in a way that empowers the local medical community to organize and continue on its own with the support of the parent organization" (356). By deemphasizing the effects of surgery on the *patients* and instead emphasizing the effects on medical infrastructure and knowledge, Abenavoli is able to argue for medical missions in terms of development, once again portraying Operation Smile as building bridges and lessening inequalities. This vision of development is still one whose end result is a more even distribution of smiles, but that distribution is achieved not directly through operating on the bodies of patients but building the infrastructure that allows the creation of those smiles and the "local" affirmation of dignity. What Abenavoli does not address, however, is the more general air of humanitarian beneficence that Dupuis critiques, produces a picture of the Western humanitarian organization bestowing knowledge and technology on the "locals."

The final letter I will discuss is by Dr. Luis Eduardo Bermúdez, a Colombian surgeon that has worked with Operation Smile missions in Colombia and argues in their favor. Bermúdez has no hesitation positioning himself as a surgeon from the "undeveloped world" addressing those from the "developed world" (Bermúdez 2004,

1688). Accepting this division, he goes on to position himself as a pragmatist and criticize Dupuis in terms that are strikingly materialist compared with the sort of humanitarian discourse articulated by Operation Smile, Abenavoli, and even Dupuis himself. “The public health care system in undeveloped countries spends most of its resources treating life-threatening conditions...” (2004, 1688). In other words, the economic situation is such that biological life, rather than social and psychic life, becomes a priority. Bermúdez does not, however, chalk this up to a lack of knowledge on the part of the local medical community—it is strictly a matter of the prioritization of where those skills are directed given economic constraints. Against Dupuis’s condemnation of condescension and disdain for local physicians on the part of mission surgeons, Bermúdez counters, “who cares about how ideal the motivations are if you are able to conduct them to a good final outcome?” (1688). This pragmatic approach even leads Bermúdez to defend the lowered standard of care that Dupuis accuses Operation Smile of: “A 40-year-old patient does not care about perfect symmetry of his Cupid’s bow or nostrils” (1688), he writes, acknowledging that Operation Smile’s international missions performed less-than-exemplary work. In his reply to Bermúdez, Dupuis (2004b) objects to this sentence on the grounds that it implies a double-standard in which poor people are expected to accept a lesser standard of care, again driving home the point that humanitarian work should not instrumentalize the bodies to which it seeks to restore dignity.

In many respects, however, Bermúdez’s argument reiterates many of Operation Smile’s talking points, albeit in much more starkly economic terms—the state unable to provide and apparatus that affirms dignity, the lack of capacity to provide cleft surgeries,

the technological lag positioning the undeveloped world as behind the developed, and even the logic in which the private sector of developed nations supplements the medical care in undeveloped nations with excess capital. Bermúdez also reproduces Operation Smile's teleology of development almost perfectly. He outlines four stages: being dependent on international missions, establishing local missions that supplemented international missions, the elimination of international missions altogether, and finally the establishment of integral care centers (1688). This is a teleology of self-sufficiency, empowerment, and the achievement of modern surgery through the private sector.

Where Bermúdez's productive shift in discourse lies, however, is in the simple shift in tone he enacts. This shift is most clearly signaled by his claim that "In South America, a great part of our gross domestic product has to be used to pay our external debt; it is a fact almost impossible to change, so we do not have enough in money to help the cleft palates" (2004, 1688). This sentence marks an important modification to Operation Smile's discourse. In stating outright the cause of the incapacity to perform cleft surgery in a widespread way, in laying blame, Bermúdez moves away from Operation Smile's framing that in effect naturalizes poverty as the background against which humanitarian action takes place and names global capitalism explicitly as a cause of the indignity borne by these bodies. Operation Smile's discourse on poverty mirrors Rony Brauman's description of some forms of humanitarianism that "no longer" depicts poverty as "a product of a dominant social order but [as] the equivalent of an unforeseen catastrophe, something like a climatic disaster.... This 'naturalization' of injustice is inscribed within a certain conception of humanitarianism..." (Brauman 2004, 400). While Operation Smile does not necessarily naturalize poverty by analogy with natural

disaster, it naturalizes it as the background condition against which the interplay of dignity and indignity is enacted. Indignity is associated with economic difference, but, rather than viewing indignity as the consequence of an economic system that necessarily produces inequalities, Operation Smile both somatizes and culturalizes dignity and indignity, a tension that I explore in the next section. What Bermúdez achieves, in contrast, is a shift in tone that is unafraid of discussing the ways in which the affirmation of dignity is based in capital rather than opposed to it. Rather than framing capital as a necessary evil that allows Operation Smile to operate, Bermúdez shows us that the humanitarian project is itself infused with capital through and through.

Operation Smile and the Address to Human Dignity

I now turn to examine Operation Smile's conception of dignity in further depth. This concept is central to their justification of their humanitarian intervention and to their success in mobilizing individuals and corporations to donate money. The concept is also central to human rights discourse and is written into the preamble of the Universal Declaration of Human Rights (1948): "recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world." Article 1 states, "All human beings are born free and equal in dignity and rights." With this declaration, then, human dignity became "the *a priori* foundational principle of human existence"³⁵ (Rabinow qtd. in Redfield 2006, 7). The idea of human dignity thus placed at the center of the question of humanity is a neo-Kantian concept, and in Kant's thought, "dignity is contrasted to value—one

cannot ascribe a price to a human and thereby make that person substitutable for another in a system of exchange. There is no equivalence among humans other than perhaps moral equivalence, which is therefore fundamental worth rather than monetary worth” (Khanna 2008, 54). But while dignity may be opposed to the valuation of human bodies in monetary terms, Operation Smile (as well as other humanitarian organizations) shows that the question of money and investment is never separate from how dignity can be enhanced or affirmed. For my argument is that it is precisely insofar as the bodies of children are said to lack dignity or to not have their dignity affirmed that they are invested by Operation Smile and that they serve as a means through which Operation Smile attracts investments. However, before exploring this theme, this section explores how dignity is deployed by Operation Smile, paying special attention to how it is embodied and what this embodiment means about the way in which Operation Smile imagines human difference based in both bodies and cultures. This section is thus a partial response to Ranjana Khanna’s provocative question, “If dignity is the category through which bodies attain humanness, how does that concept shape the way alterity is understood?” (2008, 44).

At bottom, Operation Smile’s logic in employing dignity mirrors that of other humanitarian organizations: because human dignity is a universal, and because Operation Smile’s activities enhance dignity, they have a right and an obligation to enhance and preserve dignity wherever it is threatened. But unlike other humanitarian organizations, for Operation Smile dignity is related to the morphology of the bodies of children rather than their vitality in the strict sense. Though many humanitarian organizations and human rights organizations justify their interventions on the basis of saving lives, Operation

Smile's humanitarianism is one that addresses dignity and alleviates suffering through the transformation of the body's surface. This is not to say that performing surgery to eliminate a cleft palate is not life saving; as I have noted, it can be. But Operation Smile's concentration on the smile and the physical appearance of the children on whose faces they operate results in deemphasizing the more "vital" effects of cleft palates—malnutrition and difficulty eating being primary among them.

In Operation Smile's newsletters, press releases, and annual reports, references to dignity are ubiquitous: "The promise Bill and Kathy Magee made years ago will not be fulfilled until every child with a correctable facial deformity is given the chance to live their life with dignity, and for those suffering from cleft or other facial deformities, dignity begins with a smile" (Operation Smile n.d. "History"). A similarly worded sentence appears in many other of the organization's publications, and the concept of dignity pervades all discussions of humanitarian medical missions in the vein of Operation Smile, even if Operation Smile is not specifically discussed. And dignity mobilized not just in U.S.-based discourse but is also adopted in Operation Smile chapters not based in the U.S.

Dignity serves as a compelling framework in part because of the contentless nature of the term itself. As Pheng Cheah argues, "dignity by itself is not the source for rights. Dignity is rather some contentless human attribute that is the basis of freedom in the world" (1997, 242). Dignity's contentlessness, in the medical humanitarian frame of Operation Smile, allows Operation Smile to fill in it the content of dignity around the nonnormative body. That is, they are able to equate dignity with a normal smile, a normal body freed of "deformity" and disability (see Aspinall 2006). Because Operation Smile is

a medical humanitarian organization that does not treat disease or mortal injury, they relate dignity to the body in ways that justify the intervention that they are able to make. Dignity is embodied, and it is embodied by the non-cleft face, or the non-burned hands, or the non-club foot. For Operation Smile, dignity ensures that “every child has the right to a smile” (Operation Smile 2009, 17). By defining dignity as morphologically embodied, Operation Smile and those others who participate in the construction of a humanitarian discourse around reconstructive surgery missions are reorienting dignity as something into which they can intervene. If dignity is located in the body, then the plastic surgeon can intervene into that body to enhance human dignity. In doing so, they also redefine dignity away from its more abstract, contentless notion and reorient it toward a medicalized notion of quality of life.

Because the concept of human dignity, as inherited through neo-Kantian visions of human rights, contains within it a tension—dignity inheres in every human but requires institutional structures to ensure and bring about the rights that follow from it³⁶—Operation Smile’s mobilization of dignity contains a similar tension. Reframed through medical humanitarian discourse, the tension is expressed in Operation Smile’s vacillation between the notion that dignity is inherent in each person or that it is only through the emplotment of bodies within cultural contexts that dignity can be enhanced or denied. Thus, in certain moments, Operation Smile and those participating in cleft-palate medical humanitarian discourse tend toward the complete somatization of dignity,

³⁶ As Pheng Cheah explains, “since rights only come into existence via political instruments which specify and protect them, dignity by itself is not the source for rights.... Human rights are the enterprise by which reason persistently affirms human dignity. We are entitled to them because we are born with dignity but, more importantly, because we possess the rational capacity needed to reaffirm dignity” (Cheah 1997, 242).

a risky maneuver since it borders on reifying particular bodies as not possessing dignity, while at other moments the emphasize culture as the only means by which dignity can be preserved and/or affirmed. Khanna's question above astutely notes that the question of dignity is both embodied and always a question of responsibility to the other, and raises the question of how the other is imagined as other—what kind of other is this? In Operation Smile's framing, dignity frames the other's body as necessitating an immediate response when that body shows visible evidence of deformity. The "sea of deformities" that Kathy Magee encountered in the Philippines is one example of this—visible bodily difference calling for a response. Another comes from Dr. Morton H. Goldstein, an Operation Smile volunteer: "I shall never forget the broken faces looking up at us in front of the screening clinic on that first day" (Operation Smile International 1992, n.p.). Broken faces call out to be repaired. These kinds of statements figure the cleft face itself as denying access to full dignity.

A particularly egregious, but instructive, example of this somatized conception of dignity comes from an essay that won an honorable mention in a U.N.-sponsored essay contest on Human Rights and Poverty. The writer, Elisabeth Claire Rivard, is a high school student who traveled with Operation Smile to the Philippines. Her essay clearly articulates the discourse that Operation Smile has developed around the issue of dignity. She applies the human rights understanding of dignity to argue that human dignity will not be fully affirmed until cleft palates are eradicated. In making this argument, she writes, "The first right listed in the Declaration states that 'all human beings are born free and equal in dignity and rights'. How can these innocent children, born with disfigured faces and with no means of fixing them, be equal to other children who are free of facial

deformities? How can a child be free to live, love and achieve when their most basic physical form of expression is dramatically flawed?”³⁷ Here, inequality springs directly from the bodies of the “disfigured.” Freedom and equality, those bases upon which human rights are built, are impaired by the physical appearance and functioning of the body. Sociality is implied through the reference to expression, yet the inability to express oneself is linked to the face itself. The body itself is that which produces indignity.

Lest readers think that I am picking on a high school student too harshly, let me be clear that the reason I have quoted Rivard’s essay is that she encapsulates with great skill the problematic that Operation Smile itself has laid out. Consider for instance, that in one iteration of Operation Smile’s justification of its mission through dignity, the organization claims, “Operation Smile builds trust, bridges cultures and bestows dignity at home and abroad” (Operation Smile n.d. “Mission Statement”). Again, while “culture” clearly forms part of the picture, to “bestow” dignity indicates dignity is lacking and in need of restoration through intervention into the body. One example that bridges the tension between this somatized notion of dignity and the notion of dignity as in need of cultural affirmation is William Magee’s statement that “any child with a correctable facial deformity which goes uncorrected—for any reason—is always and forever a tragedy, for if it is not, then life itself has become one.”³⁸ What is to be made of such a statement coming from a doctor who both performs surgeries himself and has founded an organization that pulls in millions of dollars to perform surgeries on children in developing countries? In the first place, it is an extreme example of the self-legitimizing

³⁷ Rivard’s 2006 essay was available online at the time of writing but has since been taken down.

³⁸ This quotation is prominently displayed on the website <http://www.cleft.org>.

(and fundraising) function of the idea of the loss of dignity. Not only are their lives undignified but are themselves a tragedy if their faces are not “corrected.” This idea contains the kernel of the cleft as inherent indignity, for in stating that it is the child’s very life that is a tragedy, it asserts that the inhabitation of the body of a facially deformed child so destroys the quality of life that it must indeed be not worth living. But in invoking futurity—“always and forever a tragedy”—I think that Magee’s statement also plays on the necessity of cultural affirmations of dignity by suggesting the contexts—familial, social, cultural—that the body will inhabit as it grows up. The body of the child contains the kernel of indignity that will be allowed to flourish (rather than be extinguished through surgery) within the milieu in which the body lives.

Before moving on to discuss how the second half of this tension—dignity’s cultural emplacement—plays out in Operation Smile’s discourse, I want to pause for a moment to revisit the discussion of how Operation Smile’s deployment of humanitarian discourse is both continuous with and different from other humanitarian organizations and ethoi. This may help to shed some light on the significance of this somatization of dignity. If we accept, with Fassin, that humanitarianism is “in favor of the ‘side of the victims’” (Fassin 2007, 511), then the “victims” in this case are the children, and they are victims of their own bodies first,³⁹ and (as the conclusion to this chapter demonstrates) the cultures in which those bodies live second. Thus, as a congenital deformity, the victimization these children suffer is rooted in their very bodies rather than external forces (disaster, war, or infectious disease). And yet, because the indignity that arises from the body is not, at

³⁹ Operation Smile also has a genetics program in which it takes samples of DNA from those with clefts in order to further research into the genetic basis of clefts so that they might be eliminated.

least in Operation Smile's dominant representational schema, viewed as life threatening, the "victim" is not totally reduced, as in Ticktin's assessment, to bare or biological life. While their suffering (such as it is) may be "apolitical," it is not asocial. Because plastic surgery presupposes an interrelationship between the body and the social—because "the right to look human" encompasses how one looks to others and oneself—Operation Smile's conception of in/dignity necessitates not only the somatization of dignity but its culturalization as well.

Indeed the most common way in which Operation Smile plays out the other side of this tension—the idea that only through emplacement of bodies within cultural contexts can dignity be enhanced or denied—is through positing "local" culture as especially stigmatizing of those with atypical faces. Peppered throughout the newsletters, annual reports, and testimonies from those who have participated in missions are stories of individual children who have been abandoned by their parents (usually emphasis falls on the mother), whose parents keep them away from others in their communities, or whose parents are accepting but whose communities "shun" them. Discussing Operation Smile's World Care Program, which brings especially complex surgical cases to Operation Smile's headquarters in Hampton Roads, Virginia, for treatment, Bill and Kathy Magee write, "Most of these children have been shunned in their own communities or villages. When they arrive in Hampton Roads, they feel welcomed and loved, not only by their host families, but by the visiting PTP [Physicians' Training Program] participants and the volunteer doctors and nurses who provide them with surgeries that will bring them hope and forever change their lives" (Operation Smile 2004, 2). The children's own communities, in this version, deny them dignity. And if, within a human

rights (or humanitarian) framework, dignity must be affirmed by reason to ensure freedom, clearly these cultures that shun do not do their part to affirm dignity and in fact act to stifle it. This example is interesting because it explicitly includes the U.S. as the more rational space. But in fact it is not simply the U.S. that affirms dignity but the medical community located there. Medical personnel—and this is true in whatever location—see past the indignity that the body presents to the “local” community and affirm that dignity in their demeanor, even before surgery. In Operation Smile’s medical humanitarian vision, reconstructive surgery and its apparatuses are the institutions that affirm dignity.

More typical of the way in which this narrative of shunning emerges—the narrative in which the kernel of inherent human dignity is not recognized by local culture but is affirmed by Operation Smile—is the testimonials from medical mission volunteers. One such story comes from a volunteer named Katelyn (apparently not a surgeon, perhaps a college or high-school student) on a mission in Vijayawada, India, in the summer of 2008. The writer describes the scene:

Vasu came in on our second day of screening, Friday, and then had his surgery on Monday. The other people on my team would hear us students talking about our favorite patients and they would ask, “well do they have a lip or palate?” and I had to stop and think the first time I was asked this. I had seen right past his cleft lip, to me he seemed just like any other little boy who loved to color and throw paper airplanes. But to his society, he was shunned away and so our playing with him just made his day, and you could see that in his smile and eyes. Seeing him so happy had let me see past the lip and to the Vasu who just enjoyed life. (DeFord 2008-9, 78)⁴⁰

In this scenario, we have something similar to Bill and Kathy Magee’s narrative, wherein

⁴⁰ This source was originally posted on Operation Smile’s website as part of their “From the Field” blog, but has since been taken down; the original URL was http://www.operationsmile.org/living_proof/from-the-field/india-6192008.html.

the children are shunned and dignity is left unrecognized. In this account, however, the member of the humanitarian team is so diametrically opposed to the “local” “society” that she does not even acknowledge the visible difference that Vasu embodies, seeing past it and acknowledging him as a normal—fully human—boy.

Thus, Operation Smile’s deployment of the concept of human dignity enables a double move: Operation Smile can mobilize individuals and corporations to donate money and volunteer their services based on the idea of restoring dignity to a bodies that do not possess it while they simultaneously position themselves as the institution that enables and affirms the dignity of those same bodies. This doubleness results in an irony whereby the Operation Smile is at once able to make claims about the severe deformity of these bodies, the impossibility of children ever being happy without normal faces, even the “monstrous” (Operation Smile 1992, n.p.) nature of the children’s faces, while at the same time condemning the stigmatization of these bodies by the “local communities.” To return to Rivard’s essay, she also writes that “in third-world countries, children and their families cannot access treatment, and as a result, the consequences are appalling. Shunned by their local communities, children with uncorrected facial deformities are abused, neglected, or even hidden away. They are taunted as ‘demons’ or ‘monsters’” (2006). Within Operation Smile’s dignity discourse, the description of the children’s bodies as “monstrous” by a medical professional can be seen as part of his humaneness at the same time that the taunting of children in the “third world” as “monsters” can become evidence of their unreasonable unwillingness to recognize and enhance dignity. The full quote from Dr. Morton H. Goldstein, in which he uses the term monstrous, reveals, though, that Operation Smile understands that the a kernel of dignity is inherent in every

body: “Despite monstrous facial distortion, their wide-eyed innocence staring up at us revealed an inner beauty shared only by children” (in Operation Smile 1992, n.p.). The eyes contain and express the dignity that the deformed face cannot.

As noted earlier, these sorts of representations of recipients of humanitarian aid are not unique to Operation Smile: the construction of the “essentialized victim” is “necessary to justify humanitarianism” (Fassin 2007, 512). Operation Smile’s promotional materials do contain some one-paragraph testimonials nominally written by recipients of surgery, but these testimonials are framed in exactly the same terms that Operation Smile uses.⁴¹ The portrait that Operation Smile gives of the children they treat are also conveyed photographically. These photographs appear everywhere in Operation Smile’s publications—their website, annual reports, newsletters, and even a book, *A Smile is the Beginning* (Operation Smile International 1992). These photographs are sometimes of children alone (perhaps with a tear dripping from one eye), sometimes with parents, and sometimes with doctors or in hospital beds. These photographs continue a tradition both of the humanitarian deployment of images of suffering (see Rozario 2003; Boltanski 1999) and of representing the disabled (see, e.g., Garland-Thomson 2005;

⁴¹ For instance, this story comes from a Venezuelan boy named Thailer: “Like most mothers, my mother was filled with happiness when she first set eyes on me. Her happiness was quickly replaced with shock when she saw my mouth; it was twisted. It was broken. As I grew older, my teeth appeared, making my cleft lip and cleft palate even more obvious. Of course, I had no control over the way my mouth looked. But because of it, I was shunned by people around me, both children and adults. The sparkle in my eyes dimmed and my heart was hurt by this constant rejection. When Operation Smile came to Venezuela in 2002, I was chosen for surgery. My transformation seemed like a miracle to my mother. Now, she is filled with happiness, just as she was when she first saw me. And me, happy me, I have a smile that beams brightly, attracting other children to my side while we play all day” (this quotation is taken from Operation Smile’s 2005 Annual Report, which was available through their website but has since been taken down). Thailer’s age is not given, but judging from his picture he seems to be about 10 years old at most.

Longmore 2005). Photographs of children alone seem to evoke the loss of dignity that is located in the body itself, while photographs with parents remind the viewer of the context in which the child lives, and photographs with doctors remind viewers of Operation Smile's humane affirmation of dignity.

Given the visibility of so-called local cultural attitudes in Operation Smile's publications, it is unsurprising that studies have been conducted gauging "cultural and societal attitudes regarding the cleft deformity" (Weatherley-White et al. 2005, 560). In R.C.A. Weatherley-White et al.'s study, researchers associated with Operation Smile conducted a survey regarding such attitudes in "native populations." What is surprising, however, are the claims of this study that "rarely are cultural attitudes and assumptions relating to deformity discussed" (Weatherley-White et al. 2005, 563). They are indeed discussed ubiquitously, at least within Operation Smile's promotional and public relations discourse. This irony shows an interesting mismatch in the ways that Operation Smile's popular discourse figures culture vs. the way that these are understood in more professional surgical discourse (the study was published in *The Cleft Palate–Craniofacial Journal*). It is not so much that the terms of inquiry differ, or their concerns, but the empirical data that is given different emphasis.

For instance, the study, conducted in Deesa, India, found that 90% of the parents of children with clefts either placed no constraints on their children's social interaction (64%) or "exercised some constraints and reported anxiety about exposing the child to new situations, such as when the child first goes to school" (26%) (Weatherley-White et al. 2005, 562). Regardless of the theoretical problems with describing the question in these terms—i.e., "local culture" and "native population" remain uninterrogated

categories, the reduction of complex questions to percentages—it would seem that these numbers contradict Operation Smile’s public discursive strategy on its own terms. They should then have some sort of truth effect within that discourse, but as yet they have not, at least as far as I can observe. Rather, the discourse of shunning remains ubiquitous, I would argue precisely because the portrayal of children as victims of their own bodies and of their cultures is necessary to the logic of the humanitarian project Operation Smile wants to perpetuate.

Somewhat ironically, the study also finds that “In some cases, [parents’] expectations [of the results of surgery] were unreasonably high, anticipating that surgery would change the child’s life in all aspects” (Weatherley-White et al. 2005, 563). Operation Smile’s own inflated discourse regarding transformation (children that “suddenly have a new life” (Operation Smile n.d. “About”)), happiness, and the restoration of dignity evidences their humaneness; parents’ inflated desires are evidence of their ignorance of medical possibilities.

The study also finds that parents’ main hopes for the surgery were an improvement in marriage prospects and in educational opportunities, with marriage prospects being mentioned by 25 of 52 parents and education by 16. Again, we find the same area of interest—quality of life—as in Operation Smile’s promotional discourse but a different area of emphasis. For marriage does not come up in Operation Smile’s newsletters or annual reports, but education is often emphasized.

For Operation Smile, life after surgery is improved in a multiplicity of ways. The effects of surgery include increased ease of eating and drinking, increased ease of speaking, increased educational opportunities, and increased self-esteem. While their

discourse of change still tends toward emphasizing visibility—that children now appear normal to others—they do, then, address other areas. Education, as I mentioned, is a prominent theme. But increased educational opportunity is often framed through visual difference. For instance, in the case of Eman, a girl from Iraq who “suffered from hypertelorism, a widening of the eyes... her deformity was so severe that when Eman was seven years old, her teacher in Iraq told the family she could not come back to school because she scared the other children” (Operation Smile 2004). This effectively situates Eman’s social life as a problem of her visual interpretation by others, falling in line with Operation Smile’s own emphasis on the visual difference of the bodies that they operate on. Interestingly, educational opportunity is not understood through linking surgery to the effects that may hinder education itself, such as speech impairment, a common problem caused by a cleft palate. In the story of sisters in Kenya, Operation Smile writes, “Since receiving surgery, they are happy and very social. Asinyen has now resumed school in class 2, and her ambition is to become a nurse so that she can help other children. Unfortunately, Nameyan is too old to return to school now” (Operation Smile 2008). Thus, Operation Smile recognizes the significance of both sociality and education in the enhancement of dignity and frames the possibility of succeeding at both as premised on a normal face. By removing the kernel of indignity within the body, Operation Smile enables normal sociality and takes away that which prevents cultures from affirming dignity.

Basic bodily needs play a surprisingly small role in Operation Smile’s narration of the lives of those with cleft palates. For instance, in the nine testimonials provided in a 2009 packet of case studies—really, testimonials of sort described above—only one

mentions eating and drinking as concerns before surgery, but even this one case does not mention easier eating and drinking as being an benefit after surgery.⁴² All mention education, and none speech. In the discourse of Operation Smile, nutrition is often mentioned in fact sheets about the effects of cleft (e.g., Operation Smile n.d.), and it is often mentioned in a list of effects that cleft palates have (e.g., “Many have difficulty eating, speaking or even smiling and in some parts of the world, they are hidden away, kept from socializing, attending school or playing an active role in their community”; Operation Smile Ireland n.d.). But because reconstructive surgery addresses biological life, social life, and psychic life, Operation Smile uses this holistic approach to emphasize what is unique about their own form of surgery—that it goes beyond matters of biological life to address the dignity of the child.

Conclusion

This chapter has provided insights into a particular form of humanitarianism operating within the current moment as viewed through and implemented by the lens of plastic surgery. While the simultaneous processes of the culturalization and somatization of dignity that I identify above may initially appear to be in tension, in fact they work in tandem to strengthen plastic surgery’s claim to legitimate humanitarian status. While Operation Smile might appear to address matters more trivial than an organization like MSF, examining the specific ways that plastic surgery appeals to humanitarian ideals and to the concept of human dignity sheds new light on contemporary forms of humanitarianism and the contemporary mechanisms through which plastic surgery is

⁴² This refers to a report by Operation Smile dated 2009-10 and titled “Blue Peter Appeal: Case Studies,” which was available on their website but has since been taken down.

reconstituting itself in the present. Papering over the conditions of indebtedness on which the geopolitical production of indignity depends, Operation Smile articulates itself as addressing arenas of humanitarian practice and human life that other forms of intervention into bodies cannot. The phenotypic concerns that fall under Operation Smile's purview address the somatized notion of dignity that the organization deploys; the humane gaze of the surgeon affirms dignity as the cultures of surgery recipients do not. Both culture and phenotype are pathologized precisely because of plastic surgery's supposedly more capacious understanding of health and its humanitarian framing. Such pathologization replicates the spatialization of racial difference that I explored in the last chapter—a racialization that proceeds not through the demarcation of bodily difference alone, but through the combination of bodily and cultural pathology Operation Smile invents. It is the spatialization of bodily difference mapped on to geopolitical divisions that enables both Operation Smile's racializing discourse and its articulation of plastic surgery as a unique humanitarian actor in the first place.

Surgeon and Safari: Medicine, Superfluity, and the Production of Valuable Bodies in Neoliberal Johannesburg

This chapter examines the phenomenon of cosmetic-surgery tourism in Johannesburg, South Africa—specifically the company Surgeon and Safari and its clients. Surgeon and Safari was founded in 1999 by Lorraine Melvill, a white South African woman. The story of its origin begins after Melvill’s divorce, when a male relative who lived in the United States visited Melvill but had to return to the U.S. because he had a facelift scheduled. Melvill told me that this was her “lightbulb moment”—“Why are you doing that? Why aren’t you having it here?” From here, Melvill formed an association with the Orient Express Group (a high-end hotel group) and safari lodges, “also internationally known.” She chose the name Surgeon and Safari because “part of the tourism aspect of South Africa is safaris.” These associations and the name were, Melvill says, in order to overcome the “negative connotations” attached to South Africa, such as crime, AIDS, and the history of apartheid. In 2008, at the time of my fieldwork, Surgeon and Safari was bringing in about thirty clients per month. When Surgeon and Safari began, clients stayed in luxury hotels, but since 1999, Melvill has built guest cottages on her property, and most clients now stay in these. Melvill’s home is located in Bryanston, an affluent northern suburb of Johannesburg. The majority of clients come from the U.K., followed by the U.S.; most are women, and, in Melvill’s estimation, 90 percent are white. Melvill books their appointments with doctors, drives them to those appointments, helps cook meals for them, arranges whatever tourist activities they like, takes them shopping, and provides counsel both before and after

surgery. Melvill's domestic worker, Rebecca,⁴³ a twenty-three-year-old black woman from Zimbabwe, helps cook and also cleans Melvill's home as well as the guest quarters. Rebecca lives on the property with her husband, Ronald, a black man also from Zimbabwe, who maintains the buildings and gardens. Surgeon and Safari has relationships with several doctors, whose ranks include plastic surgeons, cosmetic dentists, ophthalmologists, and orthopedists. One of the plastic surgeons travels to London twice a year to hold both pre- and postoperative consultations with former or prospective patients.

This analysis of Surgeon and Safari illuminates the differential valuation of bodies and lives that characterizes the geography of the city of Johannesburg as well as the politics of neoliberal medicine and medical tourism, both global trends. By unpacking and traversing networks of transnational travel and movements through domestic, commercial, and medical spaces of the city, I argue that the Surgeon and Safari's spatial practices produce what I call "bodies of value." This term is meant to signify the enmeshment of bodies with capital through processes of "investment" in the body through both surgery and travel. Key to the valuation of clients' bodies are gendered and gendering forms of surgery as well as emergent gendered practices of entrepreneurship, labor, and care. These forms of entrepreneurship are linked to the geography of the city in two ways: first, this entrepreneurship produces the city as a tourist destination; second, the touristic practices involved take place within particular neighborhoods, cityscapes, and routes of intra-city travel that build on and entrench the racialization of Johannesburg's geography and function to value clients' bodies through the racialized

⁴³ All names are pseudonyms, except for Melvill's and the surgeons mentioned later.

spaces they inhabit. Indeed, since value is always-already a differential concept, the term bodies of value necessarily implies that these bodies emerge as valuable through contrast with other bodies who are not subject to processes of valuation, paradigmatically represented in this context by black South Africans and migrants.

Surgeon and Safari is a site through which women—as clients, entrepreneurs, and care laborers—are participating in an economy that shapes a world city. This chapter concentrates primarily on the way that the city (re)shapes clients, particularly as racialized-gendered subjects, through a series of multilevel and complex contrasts. The medical and touristic practices in which clients engage serve to value their bodies in ways that depend on and reinforce neoliberal Johannesburg’s “aesthetics of superfluity” (Mbembe 2004), in large part through associating black Johannesburgers’ lives with cheapness in contrast to the clients’ bodies, which are enriched by intimate care and attention in private medical spaces. Examining these dynamics, which were crystallized by the phrase “life is cheap in South Africa” (repeatedly stated in association with black life in Soweto and spaces of public health), the chapter traces spaces in which life is said to be cheap versus spaces where bodies are valued or associated with luxury. I trace how concepts of both “value” and “cheapness” circulate through these spaces and how these concepts form relationships between bodies, producing intimacies and distances, as well as pleasures and fears.

Rather than reading racialization through cosmetic surgery’s normalization of bodies according to racialized norms of beauty, as in much of the literature on cosmetic surgery, I argue that, in this context, it is better understood through spatialization. As Gene Elder has written, “Racialization occurs at numerous scales and is better understood

as a process supported by networks of meanings [and] inscribed at all levels of analysis, from the macro-scaled nation state, through the city, into the neighborhood, home and, finally, onto the bodies of racialized subjects. This conceptualization of identity formation does not ‘hierarchize’ scale, but rather points to the interconnected spatial mechanisms which include the body; a site of identity construction” (1998, 115). The analysis here discusses the transnational, national, and city scales to examine the anatomo-politics (Foucault 1990) of cosmetic surgery tourism, showing that these more macro scales are inseparable from the microscale of the body. My research shows that the revitalizing city plays a key role in shaping the experience of medical tourism and that medical tourism depends upon and to some extent reshapes the city. While the national and transnational scales are indeed important, the city of Johannesburg and travel within, in my experience, does as much work as the other forms of travel involved. This chapter, then, seeks to understand the role that space and travel play in constructing the somatechnics of medical tourism—and the attendant processes of racialization, gendering, and classing. It also demonstrates how the bodies (of clients) and forms of gendered entrepreneurship are instrumental in shaping efforts to revitalize the city through touristic practices. As in previous chapters, I will demonstrate that transnational economies of surgery operate through a racialized mapping of space within which certain forms of surgery are associated with bodies that inhabit certain spaces—spaces of reconstruction versus spaces of enhancement. In the context of *Surgeon and Safari*, this division operates primarily through the city scale. The neoliberal transnational economy of medical tourism intersects with the landscape of neoliberal Johannesburg to infuse value into bodies through processes of racialization that rely on the geography of the city.

The first section discusses the significance of the suburban location of Melvill's home in creating bodies of value. The second section investigates how this suburban location fits into the racial economies of the city. The third section provides an overview of the neoliberal transnational and national contexts in which the city of Johannesburg and Surgeon and Safari's practices are embedded. In the fourth section, I discuss how the racialized risk associated with Johannesburg intersects with the risks associated with surgery. The fifth section discusses how the inequalities embedded in the city produce experiences of surreality and how the desire to see the "real" Johannesburg, both in terms of medical and city spaces, itself serves to produce both touristic and bodily value.

This analysis is based on fieldwork conducted in January 2008, during which I conducted interviews with clients, spent my days at Melvill's home, accompanied clients to their doctors' appointments, and joined them on tourist trips. During my time there, there were a total of ten clients, former clients, or relatives of clients that visited Melvill's home. I conducted semi-structured interviews with eight of them, ranging from 1.5 hours to 20 minutes, all in Melvill's home. I conducted multiple interviews with two clients. I also interviewed Melvill, her son, two plastic surgeons, an anesthetist, an ophthalmologist, and a dentist. Because I am interested in reading Surgeon and Safari's activities (and the activities of clients and doctors linked with the company) as discursive practices, I inserted myself into the tourism circuit established by Surgeon and Safari, working exclusively with that company, and I was treated in ways like a client—tourist trips were arranged for me, and I even had a small (unplanned) surgical procedure performed on me by one of the surgeons affiliated with Surgeon and Safari (I had an infection in the skin on my nose, and the surgeon asked if he could remove it). By

aligning myself so closely with one institution, I employed a method that on the one hand provided a rich experience of tourism and the discourses constructed by Surgeon and Safari, while on the other hand, this experience was achievable only through deeply implicating myself within this particular tourism circuit, both economically and personally. This analysis also, to a significant extent, reproduces the representation of Johannesburg as “nothing but the spatial embodiment of unequal economic relations and coercive and segregationist policies” (Mbembe and Nuttall 2004, 353). Mbembe and Nuttall argue instead for concentrating on “its extracanonical leakages, its lines of flight” (354). This is one unfortunate consequence of so closely aligning myself with one organization and sticking closely to its circuits. The picture that I present of the city and its health landscapes is a very particular one. It contains very few lines of flight, leakages, or disruptions to the geography of inequality, which is symptomatic of the spaces in which we traveled and of Surgeon and Safari’s practices, which themselves endeavor to avoid unexpected encounters (as illustrated below) and provide a particular vision of the racial-spatial order. However I am aware that this picture of the medical geography of the city is thus one framed through tourism and more specifically through whiteness—my own and that of the people that I interviewed.

Surgeon and Safari and Valuable Bodies

To begin to unpack the role of the specific figurations of space and cosmetic surgery that take place within Surgeon and Safari’s operations, I begin with an anecdote. On my fourth day in Johannesburg, I found myself in the home of a former CEO of a

South Africa-based diamond mining company⁴⁴ with Melvill, one current client, and two former clients. The current client was Jean, and the former clients were her sister and brother-in-law, Emily and Greg. All were white and originally from Scotland, though Jean had lived in the U.S. for the last thirteen years. Emily and Greg were joining Jean while she underwent eyelift surgery and recovered before they all went to Madikwe to go on safari. Melvill wanted to take them to see the “diamond lady,” as she called her, because she thought that it was something that they would enjoy. The diamond lady was Eugenia, the wife of the former CEO, a Cypriot woman of about sixty. We pulled up to the gate in front of her home, and it was opened by men in uniform. We parked in the courtyard and walked into the main house looking for Eugenia. The foyer of the main house contained a marble fountain. We then walked through the dining room, set with fine china and silverware, before finding the diamond lady. Eugenia and Melvill embraced, and Melvill introduced Eugenia to Jean, Greg, Emily, and me. We then proceeded to the building where the jewelry was housed. Eugenia unlocked the case containing the precious-stone jewelry, and Jean, Emily, and Greg began pulling items out to look at. Eugenia explained that her prices were better than anyone else’s because she gets the stones as cheap as possible. Melvill encouraged Greg to buy Emily a tennis bracelet. While Greg and Emily discussed prices and quality, Melvill and I went out for a cigarette, where I told her that the house made me nervous, and I felt that it was like a museum-house where the rooms should be roped off and you can only peek your head in to look. She replied that the style of the house wasn’t her thing, but that clients liked coming because it’s a unique experience. The last time Melvill was here, she said, there

⁴⁴ The company is officially registered in a Caribbean nation.

were plastic buckets of raw emeralds set out in the courtyard, and six-year-old children were grabbing handfuls and letting them rain back into the buckets.

Greg and Emily had decided to hold off on purchasing the bracelet for the moment, so everyone gathered outside around a table, and Eugenia's cook, a black man from Benin, brought us Greek coffee and cake. The discussion turned to the difficulty of finding "good help." Melvill and Eugenia agreed that it was difficult to find people that were trustworthy, but that people from outside South Africa were more trustworthy than black South Africans. Melvill's "help," she said, is from Zimbabwe, and have never taken anything, and are very honest, and even ask permission to keep tips guests leave for them. Jean took pictures of the buildings, as did I, and we left. Two days later, Greg and Emily had dental evaluations for cosmetic dentistry work, an impromptu decision. Greg joked that he'd either buy Emily the tennis bracelet or buy her the teeth, but not both.

The production of value in this scenario is manifold. The visit to the diamond lady is clearly designed to produce a luxurious tourist experience catering to the taste of the two particularly wealthy clients, an experience of lavishness and indulgence that is not available in the home from which they come. I open with this anecdote not because it necessarily typifies Surgeon and Safari's practices but because the flows involved complexly traverse city, national, and transnational scales. First of all, at the level of the architecture of the house, the emergence of the walled compound in the northern suburbs of Johannesburg is related to the postapartheid landscape of white fear of crime (discussed in greater depth below), as well as to the wealth produced by the mining industry that was so instrumental in creating Johannesburg, enabled by the brutal exploitation of migrant black labor. The employment of migrants as domestic help is also

connected to the ongoing economic and political crisis in Zimbabwe, and to the white South African discourse that holds South African black workers to be too entitled as a result of Black Economic Empowerment programs and the contemporary state of party politics.⁴⁵

Though the diamond lady's house may appear quite distant from the operating room, the spaces through which these bodies move are part of an overall experience, orchestrated by Melvill, that functions to reflect back upon the experience of surgery. Indeed, in the long view, South African medicine's development is intertwined with mining, exemplifying both the commodification of medicine and medicine's complicity in colonization and racism. Deacon writes that it was "in Kimberley" (the earliest site of diamond mining in South Africa) that another aspect of health care was introduced to South Africa—the hospital as luxury hotel" (Deacon et al., 2004, 235), while, at the other end of the spectrum, Alexander Butchart shows that medical evaluations also served as an intense form of surveillance and humiliation of black mine workers (see Butchart 1996).

And it turns out that the surgical body is not that far away after all, as Greg's jibe to Emily suggests. The commodified medical care they were receiving was understood as interchangeable with other precious commodities that were part of the experience of

⁴⁵ Johannesburg was established in 1886 as a mining camp after the discovery of gold. While not all miners were black, black miners' wages were considerably less than whites, as they served primarily as a pool of cheap labor: "African labourers were exploited not only through low and lowered wages on the mines owned and managed by non-Transvaalers, but in the means of social control that were utilized to restrict labour's freedom of movement and association. The latter restrictions came late in the century, when labourers recruited from afar were increasingly forced to live in virtually closed compounds on mine premises. In addition they were required to sign contracts with the mines for periods of between six and twelve 'shift' months, the breaking of which would render them criminals" (Beavon 2004, 33).

luxurious space (enabled precisely by the dynamics of the devaluation of black miners), and the husband played on associations of women with consumption and on the commodification of his wife's body. The visit to the diamond lady is about the production of a touristic experience outside of one's usual routine, yet the experience subtly adds value to the body as well, or more precisely, to the transformative experience that the body has undergone or will undergo. Objects of value circulate and rub off on one another in this space, carrying with them their own (political, national, transnational) histories, and shooting off into other spaces (the dentist's, Melvill's, the mines, Zimbabwe).

* * *

Surgeon and Safari is invested in the production of bodies of value, a production that is inseparable from the complex ways that race, gender, class, nation, and the transnational are produced within the Surgeon and Safari experience. Surgeon and Safari, in many ways, exemplifies the rise of self-entrepreneurship through medicine and the emergence of the health consumer subject discussed in the first chapter of this dissertation—clients might be viewed as health consumers within a global marketplace, transnational participants in Jones's (2008) "makeover society." But given that cosmetic surgery is largely a feminized practice, we must be cautious about the possibility that the representations of cosmetic surgery as the paradigmatic form of neoliberal medicine might replicate (sexist) associations between femininity and consumption, which, in the context of cosmetic surgery, often also bleed into representations of women as

particularly vain. Feminized forms of medical consumption and the commodification of women's bodies are key to neoliberalism, but we must be mindful of the ways that the feminization of the consumption of luxury medicine replicates certain problematic associations. In what follows, I attempt to avoid this by noting instances in which women clients were self-conscious about the implications of their practices and its association with vanity. Clients from the UK in particular (though not exclusively) were apt to worry that they would be seen as vain.⁴⁶ Though the analysis does show that these gendered forms of consumption are key drivers within this neoliberal economy, I attempt to also show that the women who partake in these consumptive practices (as well as Melvill, as an agent enabling and promoting these forms of consumption) are aware of their gendered associations and problematize the discourses of commodification and vanity that accompany this feminization.

For the purposes of this chapter, it is also necessary to further complicate the discussion of self-entrepreneurship—and the possessive individualism that undergirds it (Cohen 2009)—that I undertook in the first chapter, in order emphasize how colonialism and racialization proceed through the dispossession of property in the body. To do so, I will combine the theoretical insights of Eva Cherniavsky and Achille Mbembe. I will combine Cherniavsky's concept of "incorporation" with Mbembe's insights into the dynamics of superfluity that characterize Johannesburg. By combining their accounts, I will be able to more fully account for the racialization processes at work in Surgeon and

⁴⁶ The tendency of UK women to be more concerned with associations of vanity as compared to Americans is confirmed by Debra Gimlin, who also notes that British women were more likely to hide surgery from their friends and family, which Gimlin explains as a result of the UK's nationalized healthcare system and medical conservatism (2007, 53). She also notes that UK women's emphasis on their own "cautiousness" is a way of presenting themselves as "responsible consumers of cosmetic surgery (2012, 94).

Safari's practices. Cherniavsky's discussion of the foundational violence of race certainly has relevance to the diamond mining referenced above and the gold mining that founded Johannesburg. I want to note that what differentiates the opening of the "shell" of incorporation that occurs during cosmetic surgery (which I claim is an investment in that body) from the openness of the raced body to capital is that the opening of the body within cosmetic surgery is an infusion of value into that body rather than the extraction of value from it. The body opened within the medicalized context of cosmetic surgery is enhanced through the actualization of capacities and cultivated through its transformation. The incorporated body within liberalism and neoliberalism is subject to investment insofar as that of an autonomous subject who chooses when to open the body to investment and when to close it again.

Cherniavsky's understanding of incorporation resonates strongly with Achille Mbembe's discussion of Johannesburg's aesthetics, which is instructive for understanding not only bodies' openness to investments but also the dynamics of Johannesburg's contrasts that play an important role in the experience of tourism. Mbembe writes about the function of race in South Africa, and mining in Johannesburg in particular:

Racism was not only a way of maintaining biological differences among persons.... More fundamentally, racism's function was to institute a contradictory relation between the instrumentality of black life in the market sphere, on the one hand, and the constant depreciation of its value and its quality by the forces of commercialism and bigotry, on the other.... In a context in which native life had become the new frontier for capital accumulation, superfluity consisted in the vulnerability, debasement, and waste that the black body was subjected to and in the racist assumption that wasting black life was a necessary sacrifice—a sacrifice that could be redeemed because it served as the foundation of civilization. (380-81)

In Cherniavsky's terms, race functions to render the "shell" protecting the body from invasion by capital nonexistent, rendering black bodies exchangeable, superexploitable, and ultimately expendable. But Mbembe also uses the concept of superfluity to connect the brutal treatment of gold miners in the nineteenth and twentieth centuries to the spectacle of consumer culture and conspicuous consumption occurring in the city, epitomized, for him, by the Melrose Arch (a private development, encompassing housing, offices, and shopping) and Montecasino (a casino, mall, and hotel complex [located, not incidentally, about a ten-minute drive from Melvill's home]). Mbembe connects superfluity to both "luxury, rarity and vanity" *and* the creation of a class of "superfluous men," black miners. In the realm of medicine, it is precisely cosmetic surgery that is discursively constituted as superfluous—as value-added, enhancement, luxury, and, indeed, vanity; it is precisely the bodies of those in public hospitals that are constituted as superfluous within Surgeon and Safari's discourse—their lives are cheap.

Two examples should demonstrate how the dynamics of superfluity relate to medicalized or health-related contexts. Contemporarily, Frédéric Le Marcis has demonstrated in his narrativization of Johannesburg through the travels of patients living with HIV and AIDS, health care in the city involves a variety of spaces, public and private, communal and solitary. But if "the body afflicted with AIDS" is "an archetypal figure in the city of Johannesburg" that "acts as a place of mediation and meeting between the public and the private," as Le Marcis contends, the cosmetic-surgery tourist, in her movements to and around the city, exemplifies the superfluity of medicine from the point of view of luxury. While Le Marcis's demonstrates that the AIDS patient's travels through the city involve both visible and hidden spaces, cosmetic surgery tourism

could be said to engage the same. But while the spaces that Le Marcis describes are spaces where the “sick retreat and hide” (475), the spaces of cosmetic surgery are hidden in a different sense—they are visible only to those who can afford to access them.

A second, historical example might be South African medicine’s historical connections with the mining industry itself, discussed briefly above and in chapter 2. After the discovery of diamonds in Kimberley and gold in Johannesburg, doctors congregated in both places, as these were where profit came most easily. The wealth from mining contributed much of the capital to the development of hospitals, as well as the ability of doctors to specialize. Cecil Rhodes himself liked to have doctors as part of his “inner circle” and “demanded their constant medical attention” (Deacon et al. 2004, 244). But beyond medicine’s deployment in the service of Rhode’s own proclivity to fine-tune his own health through (exceedingly) private care, he also invested in creating private hospitals in Kimberley, and the race- and class-segregated Kimberley Hospital was considered the most advanced in the country (Deacon et al. 2004, 233). As Deacon et al. put it, “In Kimberley ... could be found the extreme ends of the scale of health care in the Cape in the late-nineteenth century. On the one hand black mine workers had one of the highest death rates in the country; on the other the wealthy could obtain the best and most luxurious care available” (235). But it was not simply that black mine workers were not subject to the same level of care or that they were subject to perilous working conditions but that medicine and doctors were intimately involved, too, in producing black workers as superexploitable populations from which wealth could be extracted. Alexander Butchart (1996) demonstrates medicine’s role in incorporating miners into wage labor and constructing “the body of the African mine worker” (186). “Heat chambers” were

devised to recreate mining conditions as an experimental arrangement in which doctors could monitor African workers' response to these conditions and sort them into "different 'acclimatization' groups" (187). Due to the ever-present threat of epidemic in such close working and living conditions—especially as contact with "civilization" was thought to weaken the African "constitution"—workers were subject to close surveillance and examination that tracked their movements and relationships and determined whether particular groups (based on "tribe" or on engagement in certain customs or paths of movement) were more susceptible to disease. Thus mining medicine played a key role both in the production of death, debility, and superexploitation for black mine workers and in the technological advancement of South African medicine and its ability to produce high-quality care and function as a form of bodily upkeep and investment for those who can afford it. This is a late-nineteenth-century example of the dynamics of superfluity's connection to medicine that I will explore in the contemporary context below.

Intimate Labor and Johannesburg as a Home away from Home

Melvill firmly believes that Surgeon and Safari's success is linked to personal attention to clients: for her, it is personal attention that is her edge over the competition. Melvill's experience with surgery patients gives her the ability to reassure and minister to the needs of her clients. Her investment in her clients' bodies takes the form of a "home away from home," the production of a space where clients feel looked after and ministered to but not inhibited by formality or by the presence of medical professionals. The healing bodies of postsurgical clients are validated, medicated, discussed, and given

fruit acid peels, and clients are reassured that they can ask Melvill about their healing process. The presurgery fears of clients are similarly discussed and managed as well as possible. This space's sense of comfort is undergirded by its location in an affluent suburb of Johannesburg, as well as the presence of others undergoing similar experiences with surgery, whose bodies are sites of similar investments and pains.

The emergence of cosmetic-surgery tourism agencies in competition with Surgeon and Safari led Melvill to capitalize on the possibilities offered by her home:

And then I started to realize, and then clients were just saying that this is such an ideal setting, set-up, because you've got a home.... It's just easier to recuperate in this kind of environment. So then I started refurbishing, adding on suites. And then it made financial sense: why—you know I could offer everything that I was offering somewhere else, why not do it in my own backyard? ... I think down the line it's become the, the competitive edge that I actually have.

In this portrayal, the hotel environment is too far removed from the intimacy required to properly care for bodies in recovery. Hosting clients in her own home allows Melvill and Rebecca to perform the gendered intimate and affective labor that adds market value to her services by creating a space in which bodily norms are relaxed at the same time that a feeling of luxury is produced.⁴⁷ Rather than the space of the everyday, the space of Melvill's—produced through Rebecca and Melvill's unequally visible caring labor—is attentive to the needs of the postsurgical body. This home away from home is at once firmly located in a particular upscale neighborhood while also being just as firmly situated within a transnational tourist economy. The creation of this physical space is crucial to the production of luxury through intimate labor. For one client, Martha, this

⁴⁷ Melvill's practice thus joins in an increasing reliance on gendered forms of affective labor in the global economy. For other examples of affective labor as “foster[ing] the security of foreign visitors” in medical travel, see Wilson 2010 (124); see also Lee, Kearns, and Friesen 2010.

alternative domestic space represented a release from the pressures of her own domestic life that led to unhealthy eating habits and neglect of her body (see Valentine 1999), and Melvill's home and her surgeries thus came to represent a self-indulgence and practice of self-care. For another client, Laura, it was the prospect of sharing space with others undergoing surgery that made her choose Surgeon and Safari: "What really tipped the scales for me was when [Melvill] said there would be other people staying here. [I would] have the support of other people going through the same thing. Other ones offered nice hotel or guesthouse, and they check on you, but it's not the same as spending your days around people doing the same thing." This home away from home is one in which bodies are expected to transform, become projects of self-improvement, and experience pain and limited mobility during recovery, all met with understanding and anxiety-reducing attention from Melvill. While cosmetic surgery may be pursued most often in the service of bodily normalization or conformance to aesthetic norms, the processes involved in surgery and recovery themselves are facilitated, in this instance at least, by the creation of a space in which many kinds of bodily norms—including aesthetic norms, norms of mobility, and norms of sensation—are relaxed and in which such relaxation is experienced as a form of luxury and care, aided by the fact that this space is in a home away from home.

Martha, a thirty-nine-year-old white mother of four from the United Kingdom, had lost over 100 lbs through diet and exercise, and came to Johannesburg to have a tummy tuck, breast augmentation, breast lift, and liposuction. In our first interview, which occurred before her surgery, I asked her what made the surgery worth the risk, as she was very apprehensive of going under anesthesia. She responded: "I mean maybe

I've realized that I am important in my life as well. You know, just having brought up four children, I've never ever put any importance on myself, and now I've given myself the time for me. And reaching my fortieth birthday is a big milestone... Yeah, I thought 'Let's go and do it. For me.' Yeah." The idea that "I'm doing it for me" has become a well-worn, and much critiqued⁴⁸ idea in cosmetic-surgery discourse, and especially in reality television. Aside from being an example of the neoliberal rhetoric of autonomy and consumer choice, I want to emphasize here that Martha's usage of "time for me" and "I am important in my life" seems to be a statement that her body is worth caring for and that this care adds value to her life. Surgery is the actualization of that value—investment in the body acts as a surplus over the previous phase of her life. Clearly, this is a particularly gendered construction, as it represents both a 'break' from the responsibilities of heteronormative motherhood, which includes thinking and caring about others rather than herself, and pregnancy and eating habits that were affected by the lifestyle of a working mother.

In addition to the suburban geography of Melvill's home, the fact of travel itself played a key role in creating Melvill's as an ideal recovery space. Though Martha did not have a great deal of interest in participating in any traditional tourist activities, after she had stayed at Melvill's for several days, she emphasized the difference in the characters of the space of "home" and the space at Melvill's. I asked Martha about why she chose South Africa over the other places she had considered. After she discussed why she did not choose a location in Eastern Europe or Thailand, she stated:

[Surgeon and Safari] had everything I needed, so why did I then have to look elsewhere? And also the fact that you're away from home to recuperate, I think

⁴⁸ For one such critique, see Bordo (1993, xxvi); Frazer 2003.

that's quite important as well. Having the surgery back at home, I would have been in hospital a couple of days. Back home, everybody thinks "well, she's obviously well enough to be out of hospital, she can come home and go back to work" and do all the things that I would normally do. And probably the recuperation, and the recovery would take longer. Would I recover as well? I don't know.

Brenda, a 68-year-old client originally from Canada but now living in California, noted that the aftercare she experienced in the US after her first blepharoplasty was quite shoddy in comparison to the level of care offered at Melvill's. Without aftercare, "How do you know what's a problem? I mean the fact that I'm blue down to here is that a problem? I mean I don't know. You know?" At Melvill's, however, such questions were commonplace, and obtaining advice about them did not require that one be in a formally medicalized setting such as a hospital. South Africa as a specific destination was of varying degrees of importance to different clients, but for Martha, Laura, and Brenda, the space that Surgeon and Safari provided is a space that is not "home," that relaxes certain bodily norms, and affirms bodies in recovery. This non-home space is part of the care for the body that the practice of cosmetic surgery tourism enacts. For Martha especially, the space of Melvill's home provides an opportunity for relaxation and, especially, recuperation through the allowance of free time.⁴⁹

National, Transnational, and City Health Landscapes

As a product of globalizing and neoliberal trends within medicine, medical tourism sits at the juncture of many economies: economies of care, of medicine, of

⁴⁹ This also runs counter to the claim that tourism is more dangerous because of lack of aftercare, which is ubiquitous in journalistic writing on medical tourism.

tourism, of national development, and of urban regeneration.⁵⁰ I now turn to a consideration of how participants in the cosmetic-surgery tourism industry negotiate neoliberal development discourse and how these macro discourses inform the micropolitics of the bodies involved in the industry and the different scales involved in the production of such practices. A rich literature on medical tourism has illuminated the complex relations between medicine, travel, bodies, capital, nation, risk, and race (Edmonds 2011; McDonald 2011). Because of the dominance of tourism as a strategy of national development globally, medical tourism is most often viewed on a national and transnational scale. Ara Wilson has shown that medical tourism, in the case of Thailand, shores up the scale of the nation by “using cross-border mobility to revitalize a nation in crisis” (2011, 134; see also Judkins 2007). As Wilson also notes, a market rationality is a key prerequisite for contemporary forms of medical travel, “rendering health care a service purchased in a competitive capitalist economy. A general pattern associated with neoliberal policy is that responsibility for health has been increasingly allocated to individuals, figured as a consumer making choices in a marketplace” (2011, 122). The market orientation is reflected in myriad ways—the calculation of differential risk among

⁵⁰ I use the term medical tourism, despite critiques of the flattening aspects of the term, because it reflects Surgeon and Safari’s self-representation and its intersections with other touristic practices within the city. It does not necessarily reflect the complexity of clients’ desires and imaginations. Some clients held no particular attachment to Johannesburg or South Africa; much of Surgeon and Safari’s business consists also of intra-Africa travel and South African expatriates who return for medical care. Others have criticized the tendency of the literature on medical travel to concentrate on patient flows from North to South, as I do here (see, e.g., Kangas 2011). However, documenting and analyzing these flows remains an important task for analyzing the contemporary processes of neoliberalization and globalization of medicine, even if this picture is not complete. For a detailed analysis of the complex flows within South Africa, which is outside the scope of this chapter, see Crush, Chikanda, and Maswikwa 2013.

varying locales on the part of clients, the different capacities of national medical economies (which, in the case of South Africa results in much intraregional and intra-Africa travel to the country, as it contains the most ‘advanced’ technology), and the nearly exclusive reliance on private medical facilities. Aren Aizura nicely conveys how this market in medical tourism, particularly cosmetic surgery, serves a racializing and gendered form of consumption. He details how medical travel for gender-confirming surgery and cosmetic surgery enhances the “somatechnical capital” of patients through processes of racialization. Aizura reads racialization not only through the practice of skin whitening and cosmetic techniques but through consumption itself—where the act of consuming beauty as a commodity functions as an enhancement of somatechnical capital (what I call investment in or valuation of the body) that is associated with the white female the paradigmatic modern global consumer.

Almost all of the literature on medical tourism is written within the realms of development studies and popular journalism. What I am calling “cosmetic surgery tourism” is generally viewed within this discourse as a subset of the umbrella category “medical tourism.” Medical tourism is composed of a diverse array of practices, encompassing visiting friends and family (“VFF”) tourism that includes medical care of some sort, “border medicine” (where patients seek care just across the border of a neighboring nation), intraregional travel for medical care, and long-distance travel for medical care. All these forms of travel may or may not be combined with more conventional tourist activities, and all have different class characteristics. It is important to note the complexities of the flows of people and capital that compose “medical tourism,” as it complicates the view that “globalization” or even “transnationalism” is

constituted through links between “First World” and “Third World,” “North” to “South.” Many of those traveling for “border medicine” are not economically privileged, and destination sites like Jordan market themselves primarily to sites within their own region.

Medical tourism has become a concern for a variety of national and international actors, as it is viewed as a potential source of income and infrastructural development for “developing nations.” The United Nations, World Health Organization, World Trade Organization, World Bank, and International Monetary Fund have all expressed interest in the phenomenon, producing various publications on the subject.⁵¹ While borders are crossed through medical tourism practices, those borders are not transcended through those practices. As Gabriel Judkins succinctly writes, “The existence of medical-tourism is dependent on the persistence of economic, administrative and/or legal disparities across geographic space” (13). The recent creation of medical visas by nations like India and Malaysia highlights a striking interplay between the national and the transnational. Despite the plethora of articles about medical tourism that share the term “Patients without Borders,” the salience of borders is revealed in every case. So while international trade policy, currency exchange rates, international flows of people and capital, the transnational circulation of medical technology and surgical techniques, and other “inter-” or “transnational” phenomenon are integral to the practices of medical tourism, these all assume a priori the existence of national borders.

One of the issues raised most often by the literature on medical tourism is what UNESCAP and others call “internal brain drain”: “An increase in the number of private hospitals due to rapid economic growth or an investment in medical tourism can create a

⁵¹ See, e.g., Bernal (2007); UNESCAP (2007); Chinai and Goswami (2007); Helbe (2010) for the WHO; Brenzel (2007) for the World Bank.

demand for doctors that leads to internal brain drain from the public health system to private hospitals” (UNESCAP 2007, 34). Annette B. Ramírez de Arellano critiques medical tourism in similar terms, claiming it produces “the siphoning off of health personnel from the public to the private sector” (2007, 196). The division between private and public hospitals has long been a concern in South Africa, a concern spanning the transition from apartheid to the “new South Africa.” In one fell swoop, Cedric de Beer, writing in 1986, indicts the apartheid system (and the racial segregation preceding it) both for denying equal access to health care for blacks and whites, and for resulting in the differential distribution of ill-health:

The commodity nature of medicine under capitalism means that doctors sell their scientific skills at the highest rate and are not primarily concerned with the promotion of human well being. The medical profession’s control of the sphere of health partially explains why we do not ‘see’ that most obvious of facts: illness is caused as much by exploitation as by germs, and that its cure requires a large dose of social justice as well as some wonder drug (de Beer 1986, 69)⁵²

With the legacy of apartheid and colonialism still obviously lingering in South Africa, the uneven distribution of ill-health and the division between public and private health remains a pressing concern.

In order to fully understand the historical and contemporary significance of the divisions between public and private health of such concern in the medical tourism

⁵² In 1944, the Gluckman Commission indicted South African health services, noting that services provided by private doctors “are totally inadequate for the great mass of the people, to whom they are supplied in the main, not according to their needs, but according to their means” (qtd. in de Beer, 1986: 19). The Medical Association of South Africa rejected the Gluckman Commission’s suggestion that a public health system should be developed and the suggestion that free health care should be available for all, and the National Party’s victory in 1948 forestalled any hope of implementing the Gluckman Commission’s recommendations.

literature, it is necessary to understand more about the inequalities in funding and about the populations they serve. De Beer's analysis clearly shows how the politics of race played out through the differences between public and private health systems. In addition to the many ways in which public health was used as a tool of segregation,⁵³ the Gluckman Commission found in 1944 that, nationwide, there existed one hospital bed for every 304 whites and one hospital bed for every 1,198 blacks (de Beer 1986, 18). "The commission tells us that at the time, there was one doctor for every 308 white people in Cape Town, as compared to one doctor for every 22,000 people in Zululand and one for every 30,000 in a reserve area in Northern Transvaal" (de Beer 1986, 20). Didier Fassin

⁵³ Public health's racialization is rooted in a deep history of the racist uses to which medicine (especially public medicine) has been put in South Africa. While I cannot do justice to the full history here, it is imperative to note that the history of medicine in South Africa is deeply intertwined with the history of racial inequality and division. In addition to the divisions within medicine surrounding the mines, medicine has played a significant role in shaping the city of Johannesburg itself. The first piece of legislation that allowed for the forced removal of "Africans" was the Public Health Act of 1897 (Youde, 2005). It was thus concerns of public health that enabled Johannesburg to force nonwhites to the so-called Locations in what Maynard Swanson has famously called the "sanitation syndrome" (see Beavon 2000, 78; Swanson 1977). Indeed, the first forced removal in Johannesburg—a removal of "Africans" to Klipspruit, which "effectively determined the future site for clustering Johannesburg's (African) Locations in what would be collectively known as the south-western townships or Soweto" (Beavon 2004, 78)—was carried out under the authority of the Public Health Act. Beavon notes that in terms of the effect on public health the relocation "would...turn out to be a disaster" (2004, 78) for those who were relocated. In Didier Fassin's words, "Sometimes [public health] plays on the fear of contagion, thus condoning ideology a priori. Sometimes it legitimates a posteriori the decision to get rid of a social peril. Always it provides arguments used to justify the rejection of the other, mixing strict rules of hygiene and moralistic remarks" (2007, 131). The rationalizations behind these uses of public health make use of a racialized vision of germ theory, which allowed whites to understand "pockets of 'black misery'" as a threat to "white cities" (Fassin 2007, 132) because Africans were more prone to disease and racial mixing could spread disease to whites simply through contact. "Black bodies now constituted a direct threat to the health of whites" (Youde 2005, 424).

notes that in Johannesburg during the 1980s, “the daily expense per patient came to 37 rands in the Baragwanath Hospital in Soweto and to 107 rands in the all-white Johannesburg Hospital” (Fassin 2007, 133). Thus, both before and during apartheid, health care spending was highly unequal, and the racialized nature of those with access to private facilities, including both hospitals and private insurance, indexes the profound effects of racialized capitalism on access to health care and the infrastructure of the health care system itself.

Despite the fact that the right to health is written into the constitution, the economic means of implementing that right have proved elusive. The imposition of neoliberal economic reforms during the 1980s under the apartheid government, as well as the neoliberal turn of the postapartheid government in the wake of rising budget deficits,⁵⁴ have done little to reverse these larger trends and in fact have led to a largely deregulated private sector and vast inequalities in spending between the public and private sectors. The rise of neoliberal economic logic in the 1980s meant that the apartheid government adopted policies influenced by Margaret Thatcher and Ronald Reagan encouraging privatization of the health system, while medical scheme (insurance) administrators pushed against regulation, using the U.S. as their model. “The end result is that the government that came to power in 1994 inherited a substantial and powerful private sector, which was very weakly regulated” (McIntyre, Thomas, and Cleary, 2004: 138). Thus, “by 2003/04 the share of total health care financing captured by private and public intermediaries had changed to an estimated 62 and 38 per cent, respectively with the private sector now serving less than 20 per cent of the population” (McIntyre et al.,

⁵⁴ On neoliberalism’s effect on South Africa and the ANC government’s turn toward neoliberal policy, see Bond (2000).

2006: 438). And according to the 2005 figures, “the state spends some R33.2 billion on health care for 38 million people while the private sector spends some R43 billion servicing 7 million people” (Sinclair 2006, 24). Given the still profoundly racialized character of class in South Africa, it is clear that this inequality between public and private health care systems not only exacerbates class inequality but racial inequality as well.⁵⁵

Thus, the fact that medical tourism further entrenches private medicine and the commodity nature thereof is of real concern. Furthermore, the concern about internal brain drain from the public to the private sector intersects with the ongoing move of South African doctors from the public to the private sector after 1994. As Fassin notes,

⁵⁵ During the time that I conducted my research, debate was occurring over the comments of Minister of Health Manto Tshabalala-Msimang, who advocated placing regulations on the private health sector to slow the rising costs of health care. She cited concerns that if people currently privately insured cannot continue to afford it, it would put further strain on the public sector. She declared that “2008 will be the year of regulating private health care,” while officials in the private health care industry argued that regulation is price fixing and would lead to the closure of hospitals (Pile, Mzolo, and Rose 2008). Tshabalala-Msimang has also stated, “It cannot be just or ethical for the per capita expenditure in the private sector to be seven to eight times that of the public sector” (South African Press Association, 2007a), and critiqued the private sector for being “largely driven by the profit imperative as many companies in the sector are listed” (Mail and Guardian 2007). The problem of both internal and external brain drain is also pressing: “Gauteng Health MEC Brian Hlongwa recently admitted that government was not doing enough to retain medical professionals in the public sector. This has resulted in many being poached by the private sector or going overseas for better wages” (Matlala, 2008). A controversial figure due to her and Mbeki’s statements on AIDS, Tshabalala-Msimang’s policy efforts regarding private insurance need to be understood in the context of these neoliberal pressures on the South African health system both during and after apartheid. For more on the inequality produced by the entrenchment of private insurance, see MacIntyre and van den Heever (2007). See also Sinclair (2006) for a discussion of how the World Trade Organization’s General Agreement on Trade in Services, entered into by South Africa’s apartheid government, places limitations on the current government’s ability to implement the National Health Act.

“since the ANC came to power, threats of expatriation have often been voiced and in fact a large proportion among them have left. Of the thirty thousand practitioners [*sic*] in the country, over two-thirds are in the private sector, a tendency that has grown over the past ten years” (2007, 107; see also Matsebula and Willie 2007, 168). While doctors are required to work in locations assigned to them by the government during and immediately following their training, they often leave. And many of the doctors I spoke to told me that their ability to make it in the private sector, including their ability to attract foreign patients, was responsible for their decision to remain in South Africa at all.

Within the contemporary South African health care landscape, the neoliberalism’s differential valuation of lives is often viewed as being epitomized by the ongoing HIV/AIDS crisis that emerged in the immediate aftermath of apartheid. Many scholars have analyzed how what Nikolas Rose calls a “political economy of vitality” (2009, 58), through which lives are subject to “judgments of value” (58), is articulated through the South African response to AIDS. From Thabo Mbeki’s AIDS denialism to the successful efforts of activists to overcome the narrow restrictions on antiretroviral drugs imposed by the Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS), AIDS dominates.⁵⁶ Didier Fassin, for example, has understood HIV/AIDS as an example of the differential value of lives, linking this to the long history of racism and apartheid in South Africa: “The affirmation that all lives have the same value—on which, taking off from very different premises, both the activists seeking to save those who can be saved and the government trying to defend an ideal of social justice may agree—is belied by the

⁵⁶ See, e.g., Comaroff 2007; Mindry 2008; O’Manique 2004. For a nuanced discussion that complicates the nearly ubiquitous condemnation of Mbeki’s comments on AIDS, see Cohen 2008.

biological evidence of premature deaths (young adults and their children as AIDS victims, but also as victims of other illnesses, homicides, and accidents); it is also contradicted by the political evidence of lives that have never really counted (for a long time, even their deaths went unrecorded under the apartheid regime)” (Fassin 2007, 270).

For Fassin, AIDS calls for a moral intervention into the discourse on biopolitics—Foucault, he notes, rarely commented on inequalities in life chances in his writings and lectures on biopolitics. Fassin (2007) instead suggests that the differential valuation of lives within contemporary global and national economies—and the racism that undergirds these, historically and contemporarily—is pressing. Jean Comaroff, too, notes that “from the vantage of the privileged, [the burden of suffering from AIDS has moved to places where] misery is endemic, life is cheap, and people are disposable.” Comaroff also notes, however, that AIDS activism in South Africa is a site of biopolitical struggle through which the sacrificial value of the life of the AIDS patient is reasserted. Against representations of the “Third World HIV/AIDS sufferer” as a *homo sacer*, “a scarcely human being condemned, in an age of humanitarian empathy...to death without meaning or sacrificial value” (Comaroff 2007, 207), within the neoliberal health care, Comaroff notes that AIDS activism combats the neoliberal drug economy and is a site of democratic struggle (for the emergence of other resistant strategies and alternative epistemologies in relation to AIDS in South Africa, see Mindry 2008; Cohen 2008). These scholars use the AIDS crisis to demonstrate the sociopolitical dimensions of health and how it is intertwined with racial capitalism that produces immiseration and uneven life chances. This understanding—without the acknowledgement of the activist dynamics that Comaroff proposes—also functions within Surgeon and Safari’s discourse. As I will

show, the notion of the cheapness of life is operative somewhat critically within the characterization of Johannesburg's health geography, pointing to how long-term inequality has served to both produce unequal health care systems (private and public) and to make black life cheap. And as Colleen O'Manique's (2004) work shows, the individualism that characterizes the neoliberal discourse on health is not confined to the health consumers that Surgeon and Safari's clients represent. Rather, she shows that the "'Western' understanding of AIDS deriving from biomedicine...and its articulation with a neoliberal...discourse" (50) has resulted in a view of health as "largely a private and individual responsibility regardless of the social and economic conditions in which sick bodies find themselves" (51). Thus those suffering from AIDS in South Africa are also often viewed as "clients" who need "empowerment" (65) as a solution.

My analysis is also informed by feminist and health geographers who have analyzed the effects of space on health, the effects of health care economies on the organization of space, and the effects of neoliberal policies on health disparities. To a large extent Surgeon and Safari relies upon and furthers the neoliberal spatialization of medicine that geographers have identified elsewhere, and Melvill's domestic space is but one form of space involved in Surgeon and Safari's practices. For instance, Robin A. Kearns and J. Ross Barnett have shown that the neoliberal restructuring of medicine has created "a trend away from private interior locations for health care provision to publicly prominent places in terms of the sites and visibility of health care services. To generalise, this is a shift in the predominant locus of health care from the world of the service user to the world of the consumer" (1997, 172). The "mall of medicine" (Parr 2003, 214) has produced new spaces of care that align with its commodification. In health care tourism,

this has seen the creation of new megahospitals or hospital cities that cater to foreign patients (see Cohen 2011). In Surgeon and Safari's case, though, operations primarily take place within smaller private hospitals or rooms in office parks. Importantly, Melvill's "health-care entrepreneurship" (Parr 2003, 215) also involves touristic travel within Johannesburg, visits to animal reserves, and care in the space of her home. As Hester Parr notes, health geographers "have been open to human experiences of 'care' that go beyond the medical, and are bound up with particular qualities of therapeutic environments and landscapes" (Parr 2003, 213). In examining "the social construction of health 'in place'" (Dyck 2003, 362-63), then, it becomes important to consider the city spaces, local tourist economies, and imagined geographies of risk that the transnational travel to Johannesburg for medical care depends on if we are to fully understand how "bodies are a product of the complex interaction of discourses, social relations, and practices constituted in relation to wider locations" (Valentine 1999, 348).

Spaces of Risk, Race, and Bodily Valuation

Before examining how the dynamics between spaces of private and private health care work to engage a medicalized aesthetics of superfluity, let's return to Melvill's home to examine how cheapness and value work in racialized risk associated with Johannesburg. By virtue of its location in Bryanston, it serves as a place of valuation, part of a touristic network of somatechnical enhancement. Despite the attraction that staying in Melvill's home created for many clients, for some, Johannesburg itself produced a sense of risk. Clients with little knowledge of Johannesburg were often fearful of crime, but they were more or less put at ease when they arrived at Melvill's, both because of the friendly and laid-back atmosphere of Melvill's home and because of the feeling of the

neighborhood itself, in which homes, including Melvill's, were protected by walls. Clients with more knowledge of the city, such as Laura, were less fearful before arriving at Melvill's; as Laura stated, "I knew that Sandton was a nice area so I wasn't worried about [crime]." The walled homes of Bryanston—an overwhelmingly white neighborhood—provide the comfort necessary for the intimate care that Melvill and Rebecca provide and the construction of the "home away from home." The tensions among luxury tourism and fear of crime thus highlight the city- and neighborhood-specific dynamics of Surgeon and Safari's practice—tensions between bodily risk and bodily enhancement.



Figure 1. A walled home in Bryanston. Photo by author.

These suburbs that allow such a space to emerge are themselves products of the racialized postapartheid landscape of Johannesburg. The walls have been theorized as

responses to the fears of white South Africans of crime and political violence. As Lindsay Bremner has argued, for white South Africans, crime “has ... become the imaginary through which [the transition from apartheid] has been interpreted. Feelings of anxiety, impotence, loss, social decay, frustration and anger have been re-ordered through the rubric of crime” (2004, 461). This discourse of crime has led to the walling in of houses and the creation of gated and “boomed in” communities. The walls in the northern suburbs were built in response to the fear produced by the breakdowns of the legally enforced racial divisions of the apartheid era (and previous to it)—an ordering of space that reflects the continuing “socioeconomic fragmentation of the city” (Mbembe and Nuttal, 2004, 365). The creation of the maintenance of these suburbs as a primarily white space has also been the result of political struggle at the neighborhood level on the part of white residents, who have resisted efforts to create a single tax area for Johannesburg and often eschew an explicit language of race and invoke concerns about property values or middle-class values (Clarno 2013, 9).⁵⁷

⁵⁷ Though the northern suburbs have roots going back to the 1890s, the modern northern suburbs are the result of the creation of Sandton and Randburg as separate municipalities in 1959 and 1967, respectively. Throughout the 1970s, large shopping malls opened in Sandton and Randburg, and by 1978, “one-third of all white shoppers were making their purchases in the suburban centres alone.” In the 80s, department stores began moving from the central business district (CBD) to the suburbs, which Beavon sites as the beginning of the decline of the CBD. “What followed in the 1990s was a virtual shopping explosion that substantially reinforced the earlier pattern.” In 1998, the Johannesburg Stock Exchange moved from Johannesburg CBD to Sandton. Beavon writes of the residential areas after apartheid: “Although the only barrier to entering any residential area is price, in reality that alone creates a form of de facto apartheid. Of course there are a significant number of well-positioned and wealthy black people now living in many of the expensive northern suburbs. Yet the overwhelming majority of black people remain literally and figuratively on the margins, largely as a consequence of the cards dealt them in the apartheid years” (Beavon 2000).

This is one way, then, in which the production of touristic domestic space and the valuation of clients' bodies that it enacts is enabled through the racialization of space at the city and neighborhood scales. The predominantly white space of the suburbs and the racialized geographical history that created them provide a locale in which alternative possibilities for embodiment emerge and within which the quasi-medicalized attention to the body enacts the luxurious home away from home. The walled suburbs cohere with the bodies that become sites of investment and value, as the visit to the diamond lady exemplified. In another example of the suburban spatialization of medicalized superfluity, a white British expatriate man whom I met on a tour of Soweto remarked that if I wanted to see lots of women who've had cosmetic surgery, I should visit Sandton City, an enormous, high-end mall. Medical consumption and luxury consumption are once again linked through the spatialization of superfluity within the city that associates feminized practices of luxury consumption with feminized investment of somatechnical capital.

The racialization of space as white at the neighborhood level thus both enables the production of value within the tourism economy and the production of value in the bodies of clients. This space of the "home away from home," built on the neighborhood level, is also situated within a transnational network that intersects with the spatialization of Johannesburg's tourist economy. Sandton is both a value-producing tourist destination and the site where clients feel valued against other potential locales for surgery.⁵⁸ Their

⁵⁸ Efforts to revitalize the city of Johannesburg have involved the encouragement of both international and regional tourism. The racial economy of tourism in the city mirrors the superfluity and racialized history discussed above. As Christian Rogerson and Lucy Kaplan have noted, "tourism has been identified potentially one of the most important sectoral drivers for the economic regeneration of Johannesburg" (2007, 265). They

confidence in the South African private spaces of care and the particular surgeons to be found there was constructed by way of comparison to other locales that were judged less favorably. Notions of risk were informed by conceptions of cheapness and value.

Johannesburg, for those who had never experienced the city—or, rather, for those who had experienced in a mediated fashion, through anecdotes from friends who had been crime victims or through news outlets reporting on it as the crime capital of the world—was a site of fear. Johannesburg’s visibility in the uprisings against apartheid and its subsequent construction as the “crime capital of the world” has produced fear not just within the space of Johannesburg itself but also within “the world” of which it is the “crime capital.” As I mentioned, Melvill has explicitly constructed the image of Surgeon and Safari in opposition to such images of Johannesburg. Martha experienced warnings of danger in Johannesburg from her friends and family in the U.K., and was quite affected by the image of Johannesburg that had been constructed for her.⁵⁹

While clients were motivated to come to the city to invest in their bodies, the notion that black South Africans treated life as cheap—that they’ll “stab you for a cigarette” in the words of one surgeon (discussed below)—produced gendered fear of

further note that “localities such as Sandton, Rosebank, and Fourways are the city’s ‘new tourism spaces’ that have benefited from the growth taking place in the overall tourism economy of Johannesburg” (275), while the central business district is marked as a “difficult area” in decline. “The major tourism nodes within Johannesburg are concentrated in the city’s richer (formerly ‘white’ space) areas” (Rogerson 2004, 250) and “the Black spaces of South Africa ‘have largely been terra incognita for the tourism industry and, consequently black South Africans have been given little opportunity to participate as partners or leaders within this industry sector’” (Rogerson 2004 quoting Goudie et al. 1999, 250).

⁵⁹ My own aunt, who had traveled to Johannesburg on holiday, gave me grave warnings about my safety, and an extended monologue on the supposed strategies used by criminals and what I could do to protect myself; she was not the victim of a crime while she was there.

bodily harm. In one incident that disturbed the racial spatial order, Martha, a client from the UK, was in the car with Melvill, her son, and I, coming home from dinner. A black man was standing outside of Melvill's gate, and as the car approached, he gestured at us. When we stopped outside the gate, Martha was visibly frightened, and as Melvill asked her son to roll down the window, Martha protested, saying "no, don't open it." Daniel opened it, and the man wanted a ride to the nearest taxi stand. Eventually, Melvill gave the man R100 and he left. We sat in the car for a few moments as Martha expressed what a scary experience that was for her, while Melvill attempted to calm her, saying that "he was just trying to get home. We did a nice thing by giving him money."

Why would Martha come to a place that had the potential to produce such intense, bodily fear? Here, I want to draw a connection between the fears engendered by the city of Johannesburg and the fear engendered by the contemplation of surgery, and especially complications from surgery and anesthesia. First, Martha was motivated to come to Johannesburg through the recommendation of a friend (which is how she first heard about Surgeon and Safari), and especially her initial consultation with Dr. Rick van der Poel, Surgeon and Safari's most popular plastic surgeon, which took place in London. Martha repeatedly emphasized the importance of her friend's recommendation of Van der Poel, and emphasized his ability to calm and allay fears. Martha described her preoperative consultation in Johannesburg this way:

He's a very special person, and I think, even yesterday, when I went to the pre-op assessment, I was a bag of nerves, I was absolutely petrified, but I came out of there feeling so much calmer. I think if you'd have taken my blood pressure before and after, there'd have been a huge difference because he is just so reassuring. I don't know... I feel confident about putting my life in his hands.

Van der Poel's ability to convince Martha that he will treat her body with care salves the fears that Martha had about placing her body as the object of surgical treatment. This calming force, which itself might be considered a form of affective labor, reassures Martha and other clients that they are investing their capital in the right place, and that they are entrusting their bodies to the right person. In Martha's case, especially, her experiences with "Dr. Rick," as he's called, allayed not only fears about the possible costs of investing in her body through surgery, but the value Van der Poel invested in her body and the bodies of his patients was so great that it convinced her that Johannesburg was where she needed to have surgery. The fears of violence being inflicted on her body through (a racialized vision of) crime were outweighed by Dr. Rick's capacity to make her feel her body to be extraordinarily valuable. His ability to convince patients of their (relative) safety in his hands comes to render bearable the fear of crime created by the economic disparities that exist in that same city.

The production of *Surgeon and Safari* as a particularly safe and value-enhancing enterprise that takes place through the discourse surrounding van der Poel's surgical skill as well as the home away from home created by Melvill and Rebecca's domestic, affective labor is crucial to convincing clients to choose *Surgeon and Safari* (and Johannesburg) as the destination for their surgery, as opposed to the plethora of other options available within the medical tourism marketplace, both globally and within South Africa. The competition that Melvill discusses as the impetus for inviting clients to stay in her home is not only from South African companies, but also India and other "third world countries." The competition within South Africa, she said, could only compete with *Surgeon and Safari* by "offering a cheaper alternative [...], some in terms of quality

of medical service they were offering, and in many ways also in terms of an inferior, well a cheaper recuperation option other than a five star hotel.” The cheapness of the alternatives, especially in terms of the quality of medical care, reflects not simply Melvill’s desire to place Surgeon and Safari above her competition but also the belief that her competitors value the bodies of their clients less than she values hers. One of the themes that was repeatedly impressed upon me by Melvill, clients, and doctors alike was that despite the plethora of choices for the consumption of surgery and the financial motivations for medical tourism, one should never choose a surgeon or destination based solely on price.⁶⁰

From the client’s perspective and Melvill’s, the choice of destination country has not only to do with price, but also with the quality of surgeon to be found at the destination, as well as the quality of care in general. According to Melvill, Surgeon and Safari’s clientele were more educated and monied than typical medical tourists and therefore less likely to shop only on “value for money,” but rather take into account the difference in *quality* that Surgeon and Safari offers. In our interview, for instance, Melvill stated that “clients who really do their homework [...] are looking for value for money but they don’t, are not prepared to compromise in terms of quality. Those are the kind of Americans that we’ll get. The Americans that are purely looking for value for money, they won’t come here. Those are the ones that’ll go to India, they’ll go to Costa Rica, not to say that they’re not getting [a good product there] but that’s what they’ll do—they’re

⁶⁰ Melvill herself was highly critical of South African surgeons that she considered to be unconcerned with patient well-being, as were the surgeons I talked to. She was also very concerned with the commodification of medicine in private hospitals, as from her perspective, private hospital groups only care about “butts in beds” rather than the quality of care that patients receive.

purely shopping on price.” Within this imagined global geography risk, clients’ choice to have surgery in South Africa were rationalized as ways of lessening risk, thus portraying them as savvy consumers who also value their bodies. Martha told me that her father suggested coming to Thailand (where he lives) for surgery: “But I think he was speaking more because it would have been cheaper. [...] And cheaper doesn’t necessarily mean better.” Brenda and Corrine (a sixty-year old American), who I interviewed together, went through a laundry list of possible destinations that included Thailand, India, Argentina, and the Caribbean. Part of the reason that Brenda decided on South Africa included the advanced state of surgery in South Africa, evidenced for her by the fact that Christiaan Barnard performed the first successful heart transplant there. Martha also stated that the reputation of South African doctors was part of the reason she came, whereas “you read in magazines about people going to Eastern European countries and coming back and everything going wrong. Infection, dirty hospitals, cockroaches. So that wasn’t even gonna be an issue for me.” Similarly, Jean stated in our initial interview, “I think it would be a little bit more risky to do it in an Eastern bloc country. I think it might be a little cheaper but...you don’t really wanna mess with you know, something as serious as...plastic surgery, so....” Through the market choices made by patients, there is a mapping of international relations through the valuation that medical institutions and individual surgeons place on the bodies on which they operate, which reflects back on the client’s own choice of South Africa as the differential valuation of her own body as opposed to those who undergo surgery in Eastern Europe or Thailand. Thus Melvill’s affective labor to create a home away from home in the suburbs combined with Van der Poel’s surgical skill and affective labor in instilling confidence and easing fear work to

both value the body and dissociate from cheapness, providing protection from two potential sources of injury: “cheap” surgeons and life-cheapening criminality. In contrast to those who would treat their bodies as cheap (those who would shop only on value for money) Surgeon and Safari’s surgeons and the space of Melvill’s home mitigate the (racialized) risk associated with Johannesburg as a destination, even if the racial spatial order is occasionally disturbed.⁶¹

Another factor in the mediation of fear through medical tourism is Martha’s fear of contracting MRSA or *C. difficile* in a hospital in the U.K. Fears of infection in U.K. hospitals are widespread: London’s *Daily Mail*, for instance, published an article in April 2007 titled “Britons Go Abroad to Beat MRSA” (Hope 2007). The fear of infection in the U.K. (as well as the long waiting lists, and general concerns about the functioning of the National Health Service) represent the failure of the U.K. welfare state to properly care for the bodies of its citizens: instead, you go into a hospital for a minor procedure and never come out. As in the discursive construction of Eastern Europe, the modern function of the hospital to foster and enhance life is failing. Brenda also faulted the failings of the US health system for its callous treatment and minimal investment in actually caring for

⁶¹ From this perspective, statements about the risks of going abroad for surgery from U.S. and U.K. plastic surgeons and their professional organizations would be interpreted as a bid to retain their own national business through both the designation of destination countries as less medically advanced, but also less invested in the health of bodies who are not citizens of that country, whereas the modern welfare state, for all its flaws, is more able to and more invested in the bodies of its citizens. Here, it is the doctors in destinations like Eastern Europe and South Africa that are seen as caring only about making money, whereas modern British and American doctors are more invested in enhancing the life and body of citizen patients, the idea being, If you value your body, you will spend more on it. From the perspective of the U.K. and U.S., the outsourcing of medical care is also the cold logic of the market, rather than the modern biopolitical mandate to foster life embodied by U.K. and U.S. doctors.

patients. Her first blepharoplasty, which she had in the US, “was extremely expensive, it was horribly painful, I was purple in the face for over a month.” She explained this as a function of the surgeon that operated on her and the context of the (also neoliberal) economy of care in the US: “according to Dr. Rick ... American doctors tend to be very rough with tissue. They’re not gentle. They don’t go slowly and be very careful. They sorta slash and rip and get it over with real fast.” Later in the interview, she stated, “I never saw the surgeon. He was some guy that came from New York, I never met him. I have no idea who he is.” The drive for profit in the US is here depicted as leading to the devaluation of the body from the standpoint of the patient. The emphasis on speed, reinforced by the lack of any aftercare options, leads to mistreatment of the body and a longer-than-necessary recovery period because of that mistreatment. Dr. Rick’s capacity to care for and value the body again emerges to make Johannesburg desirable as a locale for surgery in contrast to the failures of the home health care system to provide adequate care due to bureaucratization and profit seeking. In contrast to the US and UK systems’ failures, South Africa, Dr. Rick, and the private hospital in which he operates emerge as a new site in which medicine can function as it should.⁶²

Elite Spaces, Surreality, and the Authentic Johannesburg

Interestingly, in my experience of Surgeon and Safari, discourses of authenticity circulated quite differently than in accounts of surgical tourism in other locales. In Aizura’s account of gender reassignment surgery in Thailand, for instance, he notes that

⁶² Ackerman (2010) also notes that for many clients who travel to Costa Rica for cosmetic surgery, their travel is viewed as an escape from or route around the difficult-to-navigate US medical system.

“becoming a woman *surgically* sometimes involves emulating or appropriating Thai, or Asian, symbolic representations of beauty and femininity” (2010, 2). In other contexts, the climate in the surgical locale is emphasized as part of the healing process (Ackerman 2010, 405). Sara L. Ackerman (2010) has found that cosmetic surgery tourism to Costa Rica relies on an “aesthetic of pristine, unpeopled nature” (412) and that “medical travelers frequently refer to the beauty of Costa Rican women” (412) and their natural hospitality. In these contexts, then, the touristically imagined culture (and nature) of the destination shapes the experience of surgery by allowing guests to appropriate certain “authentic” differences in order to imagine themselves differently. Thai and Costa Rican women’s femininity and beauty in particular help to make the destination seem a particularly appropriate locale for the consumption of beauty as health through surgery.

In Surgeon and Safari’s case, however, reliance on South African culture or environment in this way was not emphasized. While the Surgeon and Safari materials do indeed quote Nelson Mandela saying “Each time one of us touches the soil of this land, we feel a sense of personal renewal,” this notion of connection to the land or climactic difference did not, in my experience, play a large role in the discourse Surgeon and Safari constructed for patients, even though the Johannesburg climate was indeed said to promote healing, given its lack of humidity; the notion of Africa’s healing power has historical resonance in colonialist discourses of health and within the history of cosmetic surgery (see chapter 2’s discussion of the Flying Doctors of East Africa). Again, though wildlife safaris did play a role in constructing the image of the company through associating it with South African nature, Melvill downplayed this aspect of the company, and though some clients did go on safari trips after surgery, in the one case I observed,

this was perceived as mostly separate from the experience of surgery rather than helping to make sense of the surgery itself. And while Melvill did casually invoke the ethos of *ubuntu* (belief in a bond uniting humanity) in an interview with me, noting that the term is used broadly in the overall South African tourism industry, this aspect of South African culture did not play a prominent role in the discourse she presented to clients.

Similarly, no notions of the natural beauty of South Africans—nor, as in Brazil, the cosmetically enhanced beauty of the population—circulated within Surgeon and Safari. When the aesthetics of South African bodies were discussed, which was rare, it was in the context of the need for normalization via surgery due to racially marked excesses of the flesh. One surgeon remarked on the need to reduce “Bantu bottoms.” In another instance, clients and Melvill reviewed (faceless) before and after pictures, including one of a black South African woman who had acquired a breast and buttocks reduction. These instances demonstrate the pathologization of features that are designated as characteristically black—in continuity with a long history of colonial racism that locates racial difference in the black woman's body, Saartje Bartman being the paradigmatic example.⁶³ For white foreign clients, these incidents may have played a minor role in their experiences of their own transformation, as a contrast to their own bodies that, while a source of real dissatisfaction and (in some cases, at least) a deep sense of shame, remained the norm against which a pathologized blackness was judged. These experiences, however, were rare. I suggest that the pursuit of “authenticity” within

⁶³ For classic analyses of Baartman, see Gilman (1985); Fausto-Sterling (1995). In her recent work on the history of intersex in South Africa, Zine Magubane (2014) has also found that the typical intersex case was racialized as black due to beliefs about the sexual ambiguities of black bodies.

South Africa had less to do with the aesthetics of the bodies of South Africans or the natural landscape than with the racialized geography of the city.

Neither Melvill nor clients were uncritical regarding the aesthetics of superfluity they were experiencing in their travel to and travels within the city. Indeed, if in other contexts, medical tourism effectively functions to paper over inequalities existing at the destination site (Ackerman 2010), Surgeon and Safari actively pointed out the city's (and country's) inequalities. Melvill encouraged clients to go on a tour of Soweto, and to visit the apartheid museum, and, given my interest in medicine, she encouraged me on at least two occasions to visit Baragwanath in order to see the "real" face of South African medical care, rather than the elite spaces of the private hospitals in the northern suburbs. Laura was one of the few clients who had direct previous knowledge of the health care in South Africa. She had traveled to South Africa previously to do work in HIV/AIDS care in "the poorest places" where there was "almost no formal health care," and she credited that work with an appreciation of "the fancy side of health" in South Africa and with knowing that there was "good private health care here." She thus points to the division that, for other clients without such direct knowledge, served to produce the surreality of their Surgeon and Safari experience. Indeed, the upscale Bryanston setting of their stay and the exclusive use of private medical facilities led to a perception of unreality among many clients, which was often reinforced by Melvill. This sense of surreality stemmed from the contrasts, real and imagined, that exist in the city: between the haves and the have-nots, the suburbs and the townships, private spaces of medical consumption and luxury care and underfunded spaces of public medicine. These linked contrasts were implicitly and explicitly racialized. "Elite" spaces of medical care that were associated

with the clients' experiences, especially, were contrasted to the "real" and "authentic" experience of health care for the majority of Johannesburg's residents. The portrait of public health care painted by Melvill and Surgeon and Safari surgeons associated public health spaces with blackness, which was figured as necessitating only basic level health care to sustain it. Bryanston, too, was said to not reflect the reality of the city. Soweto and central Johannesburg, again associated with blackness, were said to be more authentic, and yet were also spaces where "life is cheap."

In an interview with Melvill, she referenced Chris Hani Baragwanath Hospital, a 3,000-bed public hospital on the edge of Soweto: "We only work in the private health care sector we don't work in the public health care sector at all. You know you can hardly expect someone from New York to go to Baragwanath hospital." While the contrast between Baragwanath and the private health system in South Africa is here presented in a lighthearted manner, at other times Melvill was quite somber about the health disparities between rich and poor and white and black South Africans. I have chosen this quotation because it reflects a particular production of luxury and whiteness through the contrast between public and private health. The contrast between a hypothetical client from New York and the environs at Baragwanath represent tacit assumptions about race and class that serve to bolster Surgeon and Safari's production of the experience of luxury and privilege through a particular kind of investment in the body. Baragwanath serves here as the contrast to the luxurious experience of medicine that enhances the life of the patient-client rather than maintaining the bare life of the public hospital patient.

Public health care's racialization as nonwhite, and in particular Chris Hani Baragwanath Hospital's racialization as black, provides a contrast that serves to elevate

the value of the clients' bodies, indirectly correlating their racialization as white with value. Dr. Chris Snijman is a plastic surgeon now in private practice, but who had worked extensively within the public health care system in Johannesburg during his training and afterward, specifically working in Baragwanath and Helen Joseph Hospital. In my interview with Snijman, he noted Baragwanath's predominantly black patient base, coming from Soweto, and he described the hospital as a "bloody juggernaut." In terms of his plastic surgery work, Snijman said that his cases in Baragwanath and the public sector more generally were reconstructive cases necessitated by injury or birth defect, while his private practices were associated with cosmetic procedures that address a psychological need to address a perceived defect. So, while Sander Gilman (1998) has convincingly argued that, historically, the discipline of plastic surgery has constructed signs of racial difference on an individual body as a point of injury in need of repair through surgery, by viewing racialization spatially, we can see that the divide between reconstructive and cosmetic surgeries is racialized in other ways as well. The spaces of public health in which black South Africans seek surgical investment so as to restore function are not implicated in the enrichment of somatechnical capital that predominantly white foreign clients are.⁶⁴ The cosmetic/reconstructive divide, in this context, reflects the

⁶⁴ The contrast between the physical spaces of care are also instructive here. The Carstenhof Clinic, the private hospital at which Dr. Snijman has one of his two private practices, is lavishly decorated, with a vaulted ceiling in the main atrium, and very large glass windows. To enter, one walks on a wooden bridge over a koi pond. According to Lorraine, this hospital was built especially for foreign patients. On the other hand, Dr. Snijman repeatedly bemoaned the severe lack of resources (from technology, to anesthetists, to beds) at Baragwanath. Like some of the surgeons discussed in the chapter 2, however, Dr. Snijman credits his time in public hospitals with his ability to develop his cosmetic expertise. Due to the range of traumas seen in public hospitals, he got a good

asymmetrical geography of the city: spaces that produce injury contrast with spaces where individuals with the means to become health consumers purchase elective procedures in the private, exposing the uneven potentials for bodily investment within neoliberal city, national, and transnational medical economies.⁶⁵



Figure 2. The lobby of the Carstenhof Clinic, where Dr. Snijman has one of his private practices. Photo by author.

education and was able to perform a vast variety of procedures, which developed his skill as a generalist plastic surgeon.

⁶⁵ The discursive exclusion of black South Africans from the capacity for somatechnical enhancement was furthered by the comments of a dentist, who stated that he had very few black patients. While the emergence of a black middle class meant that there is a potential black patient base for his services, he said, his only patients came from the very upper echelons of society, probably because blacks still lacked the “dental IQ” to avail themselves of his services. However, Melvill’s son, in an interview, offered an alternative and less pathologizing explanation for the predominantly white client base of Surgeon and Safari: “I think it’s just because vast majority of people on covers of magazines are aimed more at white upper class than at a black one or Indian one or coloured one.” Noting that the white upper-class market in South Africa is bigger than the still-emerging black middle and upper classes, he explained the whiteness of the client base in terms of both the gendered disciplinary pressures of the media market as well as the comparative lack of access to participation in medical consumption based on income.

Dr. Snijman's differing experiences within the private and public health care field prompted me to ask, "was it difficult for you to see the trauma and this stuff, and to do those—more difficult than here [his private practice]?" He responded by describing the process of developing a veneer to shield himself from negative effects of witnessing trauma, and then stated:

That's the challenge of it, essentially, it's to save a life or repair a limb, whatever it is. Um, but some of the stuff is very, very gross. Very gross. You know, what people do to each other. Life is cheap here in South Africa. They'll kill you for a cigarette. You know. Um... So, look, there are times, I mean I, I developed a—I used to go for, for counseling, just to de-stress, just offload, get it going, and that was it. Because it builds up, you see. Builds up, it builds up, builds up and you become a very bland sort of individual—nothing shocks you anymore. And then every now and again, something will get through the veneer, and then, and then you'll crash. [...]

The phrase "life is cheap in South Africa" is one that I had heard before during my stay in Johannesburg, always in connection to discussions of impoverishment among racialized populations, especially black South Africans (and migrants) in certain areas of Johannesburg CBD and the townships. In this instance, the phrase crystallizes the link between geography, racialization, and the valuation of life. The phrase "life is cheap" circulates as a form of nonbiological expression of racial difference within Johannesburg (Allen 2002), and in Surgeon and Safari's context it denotes the devaluation of life tout court by black South Africans and migrants attributable to long-term impoverishment, associating black sociality with death, decay, criminality, and violence.⁶⁶ This

⁶⁶ "Life is cheap" appears several times in the interviews of women in Danielle Burger Allen's "Race, Crime, and Social Exclusion: A Qualitative Study of White Women's Fear of Crime in Johannesburg" (2002), sometimes with reference to black spaces in Johannesburg, and sometimes in relation to Africa as a whole. As discussed in chapter 2, the phrase also appears in the memoirs of Thomas Rees (2002), a member of the Flying

representation projects superfluity onto black life outside the context of white racism, as in Mbembe's account: that is, blackness comes to represent the denigration of life foreign to both whites in general and the life-affirming power of medicine in particular. In this instance, then, it functions representationally to racialize Johannesburg's health geography and to constitute a form of embodied but nonbiological difference.

Directly following the words quoted above, Snijman continued:

S: I mean, you know, what is more shocking would be ... potentially the requests of cosmetic patients.

A: Really?

S: Yea sure. You know, you look at her and you think "wha- [stuttering]?" ... "What's the matter with you?" You know? "Don't fix what's not broken. You know, you've got a beautiful pair of B-cup breasts, *why* do you want to mess with silicone?"

In a surprising connection, the shock of witnessing trauma induced by the cheapness of life in one population is paralleled by the shock of witnessing (presumably white) women's desires to enhance what is an ostensibly unproblematic body. The commodification of the white female body—the desire to enhance a body that is already perfectly normal, taking her role as paradigmatic global consumer too far—serves to render the woman's request for a breast augmentation a sign of superfluousness, when juxtaposed with the cheapness of life in Soweto that reflects the superfluity of black bodies. Here, the paradigmatically female patient-consumer is represented as overinvesting in herself, while the black body has no such opportunity to invest or invent itself but rather can only maintain its own life.

Doctors of East Africa: he states that "life is cheap in the bush," demarcating native life from the humane and life-affirming power of Western medicine. Interestingly, one of the most controversial uses of the phrase in a US context comes from an American general during the Vietnam War, attributing the attitude that life is cheap to the Vietnamese people as an implicit justification for the war, mirroring the discourse of plastic surgery during the period, also discussed in chapter 2.

The uneven investment in spaces of health correlates with the spatialization of Johannesburg's tourism economy at the neighborhood scale. The private health care facilities that clients of Surgeon and Safari visit are congruent with the spaces of revitalization of the city through other practices of tourism. The racialized "decline" of downtown Johannesburg—that is, the process of white flight and capital disinvestment from the CBD—has resulted in its designation as a "difficult area" for tourism to develop in part due to international travelers' fear of crime (Rogerson and Kaplan 2007, 265, 275; see also Beavon 2000; Clarno 2013). Instead, the northern suburbs—the location of Melvill's home and of most private hospitals and doctors' offices—have become the more successful tourism destinations. Melvill herself, who Christian Rogerson and Lucy Kaplan interviewed for their study of Johannesburg's efforts to revitalize through tourism, reinforces this tourist geography, noting that "the more lucrative element of health tourism—involving high value international health visitors seeking elective surgery—takes place outside of the inner city" (284). Thus, within Johannesburg's tourism economy, the primarily white northern suburbs have become the location of "high value" tourism—spaces of luxury and value infusion through foreign capital, while the black space of the CBD becomes figured as the site of decline incapable of regeneration. Spaces in which clients' bodies become sites of valuation and care are also the city's spaces of regeneration. Thus, investment in the body is an investment in the continuing revitalization of nonblack areas (and continuing disinvestment in "difficult areas"), and these spaces of city revitalization—populated by markers of high-value consumption, medical and otherwise—are themselves part and parcel of how these bodies emerge as objects of special value.

One variation in such dynamics is the practice of tourist visits to Soweto, which are often “styled as a form of ‘justice tourism’” (Schevyvens quoted in Rogerson 2004, 251). While these tours to some extent disrupt clients’ tendency to move within the spaces of luxury/enhancement, the trip to Soweto still functioned within the overall aesthetics of superfluity. Soweto served as a foil against which their own bodies emerged as subjects of special value in contrast to spaces of “cheap life.” These tours often involve visits to key sites of antiapartheid struggle, including the Hector Petersen Museum, Winnie Mandela and Desmond Tutu’s homes, and Chris Hani Baragwanath hospital (the guides that Surgeon and Safari contracted with to provide the tour did not include a visit to Baragwanath, though they did include a visit to a traditional medicine shop in downtown). This is the second way in which the feeling of surreality associated with Bryanston was countered by seeking out the authentic experience of the city. One client, Jean, sought to see “the real South Africa” by taking a tour of Soweto before she, her sister, and her brother-in-law went on to tour wine country and visit Madikwe. Her tour of Soweto produced both fear and guilt. While the tour guide drove the van, she said, she was thinking, “please don’t let that be a red light” so that they would not have to stop. She described herself as “scared” and “nervous” at the sight of “mean-looking guys.” The morning before she was leaving, she told me that, rather than feeling glad about her surgery, she felt guilty because it “seems like an indulgence, you know? Especially, you drive around South Africa and, you know, haves and have-nots, and... It’s a bit like, just because I have, maybe I shouldn’t be using my money to improve myself, but I don’t know.” Entering a space where life is said to be cheap produces fear for her own safety, again reviving the association of blackness with crime. But in conjunction with fear,

travel through this area also drove home the sense of luxury that she had heretofore experienced in Johannesburg. When juxtaposed with black life, however, the valuation of her own body through engagement with the private medical market seems to become an indulgence—self-improvement through surgery provokes guilt in the context of the “have-nots.” Both sides of the aesthetics of superfluity are glimpsed clearly when surrounded by bodies of others who inhabit the realm of superfluity associated with (in the racial imaginary constructed by Surgeon and Safari) disease, violence, and death. Jean’s recognition that “two percent of the population probably has 99 percent of the wealth” provokes a meditation on the political economy of the touristic body project in which she is engaged. Yet within this neoliberal economy, her guilt and the visible inequality that produced it can also function as a form of affective labor that folds back to produce her own experiences as rarified.

Thus, Melvill’s insistence on making clients aware of the “elite” picture that they receive can simultaneously serve as a reminder of the inequalities within the city, national, and transnational economies in which they are enmeshed as well as the persistence of racial capitalism’s maldistribution of life chances, even as these inequalities are also part of the system of value production, of both high-value tourism and high-value bodies. Jean’s experience illustrates how the apartheid past and the neoliberal present converge to produce a complex set of experiences—feelings of fear and guilt, of being both distant from and too close to the “real” Johannesburg—all centering around her own body and her choice to cosmetically alter it. It shows us how the aesthetics of superfluity in the revitalizing city work through discourses about and experiences with the medical systems in Johannesburg, and that the question of medical

self-entrepreneurship is never far away from the question of the differential valuation of life. As we have seen, the neoliberalization of medicine can work in conflicting directions, simultaneously enabling individuals to invest in their bodies while also exacerbating inequalities in health care.

The discourses and practices engaged in by Surgeon and Safari demonstrate not only the integral role of cosmetic surgery in the neoliberalization and globalization of medicine but also the importance of a multiscalar level of analysis in discussions of medical tourism and racialization. Previous chapters have shown how racialization operates through spatializing the reconstructive/cosmetic divide in the context of transnational surgical endeavors that reproduce systems of racialization. While in the schema of previous chapters, these racialized spatializations have occurred at the scale of the nation—surgeons and other actors in transnational surgery activities figure particular nations and national populations as in need of investment through surgery—this chapter has shown that the scale of the city reproduces similar dynamics. Spaces of reconstruction are racialized as black, while spaces of enhancement are racialized as white. In the particular case of Johannesburg, I have linked this spatial schema to the histories that have produced particular medical geographies within South Africa and the city itself, drawing on Mbembe's notion of superfluity to connect the bodies of those who are subject to a bare minimum of investment to those who are constructed as self-investors. Jean's experience of guilt derives from the recognition of such a connection, even if her experience in Soweto also served to cement, for her, the cheapness of black life and the relative value of her own.

Conclusion

Now that we have made our way through the three case studies that make up the substantive chapters of this dissertation, we can fully appreciate how the transnational lens I have employed and the focus on explicitly transnational actors has enabled me to illuminate new dynamics of racialization and gendering within plastic surgery. The case studies that formed the chapters, each of which concerned the ways in which plastic surgery is deeply embedded within networks of transnational capital and differing forms of capitalist development, have allowed me to address questions about which the current critical literature on plastic surgery is largely silent. The way that the division between reconstructive and cosmetic surgery functions in transnational forms of plastic surgery--that is, forms in which some of the actors consciously move across national borders and geopolitical divisions to perform or receive surgery--has not heretofore been explored. An examination of these case studies has allowed me to make three crucial interventions:

- 1) I have argued that the division between reconstructive and cosmetic surgery is not only shaped by but also informs how surgeons and clients imagine both geopolitical divisions and racialized ones. Liberal subjects of choice, understood as paradigmatically white, mobile, and economically privileged, are associated with elective surgery, while reconstructive surgery is associated with subjects who require external intervention and are racialized as nonwhite.
- 2) I have shown that the concept of race within transnational accounts is not tied exclusively or even primarily to the anatomical body but rather to notions of cultural difference and to embodied but nonbiological differences.
- And 3) I have argued that plastic surgery's conception of health, which incorporates bodily,

psychic, and social elements, both allows it to engage in the culturalist form of racialization that it does and to link itself with varying transnational economic rationalities.

Findings

The findings from the three substantive chapters have demonstrated the main arguments in different ways throughout the dissertation. Argument 1, for instance, runs through the three examples in chapter 2, “Liberal Visions and the Traveling Surgeon,” showing that when surgeons take on the development project, geopolitical and racial divisions structure how they view the bodies that are targeted for surgical intervention. In their efforts regarding Vietnam in the 1960s, US surgeons imagine their reconstructive intervention into the Vietnamese civilian population as a means of investing in human capital; reconstructive surgery exclusively is appropriate as a form of external investment of development capital, and Vietnamese are racialized as illiberal subjects such that cosmetic surgery is inappropriate. In the case of the Flying Doctors of East Africa, Thomas Rees in particular constitutes East Africa as a space of reconstruction in contrast to his New York practice, which is characterized by paradigmatically white Western women who seek largely unnecessary cosmetic procedures as a sign of overdevelopment, and Africans are understood as entrapped within their cultures. For Jack Penn, this division was apparent most prominently in his understanding of black Africans as illiberal subjects par excellence, whose betterment through reconstructive surgery cannot contribute to lofty vision of liberal cooperation and brotherhood that he articulates. In chapter 3, I demonstrated that Operation Smile’s humanitarian project relies on racialized

tropes of victimhood that justify the reconstructive procedures they perform and make those procedures seem particularly valuable, meaningful, and important. They similarly understand the cultures into which they intervene as particularly illiberal in their appreciation of bodily different. And finally, in the case of Surgeon and Safari, the division between reconstruction and cosmetic enhancement is transformed into slightly different terms: it is not spaces of reconstruction but more generally spaces of public health that serve to contrast with the private spaces of enhancement through elective surgery. And rather than mapping these spaces transnationally, they are mapped at the level of the city, with the public health recipient portrayed as poor and black and the cosmetic surgery client as paradigmatically white, mobile, and from the global North (primarily the US and UK) seeking to value and enhance their bodies through surgery.

Argument 2--that the predominant concept of race within transnational surgical discourses and practices was not anatomical but tied to cultural difference--comes through in different ways in different chapters. In chapter 1, we see that it is cultural differences and underdevelopment as such that leads to the production of bodily difference and the necessity of surgical intervention in particular geographical areas. In Vietnam, surgeons must intervene to repair injuries as Vietnamese surgeons (and Vietnam's medical infrastructure in general), it is supposed, cannot provide for the types of reconstruction that surgeons see as necessary for the full maximization of the Vietnamese population's human capital. Rees and the FDEA, on the other hand, used colonialist tropes of the jungle doctor memoir to both construct an image of the African Patient as closer to nature and entrapped within her or his culture, exemplifying forms of nonbiological but embodied difference ranging from particular forms of injuries produced

by culture to different perceptual capacities and understandings of embodiment. And Penn, drawing on Schweitzer's valorization medicine's potential for activating sympathy across differences of nation and race, constructs black Africans as roadblocks in the path to such a vision, not because they are biologically different but because they lack the social conscience and capacity for sympathy upon which such a vision depends. Like Rees before it, Operation Smile depends on constructing itself as bringing a humane medical gaze to bear on the form of bodily difference represented by cleft lips and palates, and has discovered a "sea of deformity" produced not through anatomical racial difference but through anatomical difference produced by uneven medical development. Finally, unlike other forms of cosmetic surgery tourism, Surgeon and Safari does not emphasize the anatomies of black South Africans but draws a contrast through the forms of investment that poor black South Africans and clients are subject to--sustenance of bare life vs. luxurious cosmetic enhancement. The notion that "life is cheap" for poor black South Africans similarly functions as a culturalized form of racial difference that results in different forms of injury and the application of different forms of medical investment to differently racialized bodies.

Finally, argument 3--that plastic surgery's conception of health is that which allows it both to engage in the above culturalist forms of racialization and to link itself into the variety of economies that the dissertation examines--is, in chapter 2, evident in surgeons' conception of plastic surgery as a distinct form of development capital that must be carefully calibrated in relation to Vietnam's existing medical economy. This was, as we saw, precisely because its conception of health was addressed to primarily toward quality of life rather than to vitality itself, thus making the specialty a particularly rarified

form of aid. The FDEA uses reconstruction to ameliorate injuries supposedly caused by the cultures of East African populations, injuries caused by markers of underdevelopment, and the incorporation of the social in plastic surgery's conception of health means that it treats not only perils to life itself but the peril of expulsion from cultural positionings related to morphological difference. And for Penn, it was precisely plastic surgery's status as a modern, advanced form of medicine that allowed it to become both a beacon of hope for a war-torn world and representative of a form of technical modernization. It allowed him to valorize the right to look human through to plastic surgery's modification of morphology, now defined as part of a holistic definition of both health and the human. In chapter 3, plastic surgery's conception of health, which incorporates both the body and the social, allowed Operation Smile to both claim a unique ability to affirm human dignity through their surgical interventions and to simultaneously somatize and culturalize dignity. In Surgeon and Safari's case, contemporary cosmetic surgery's association with luxury--through association with the consumption of bodily enhancement--serves to link it to a high-value tourism economy that can attract foreign capital. Similarly, its status as enhancement serves to valorize clients bodies as sites of investment (achieved in part through the contrast to the health care being received in spaces of public health).

Beyond the specific arguments advanced above, the dissertation makes several other interventions at the empirical and theoretical levels. First, as discussed in the introduction, it significantly expands the geographical and archival scope of most studies of plastic surgery. In the same vein, it situates plastic surgery within a very different set of geopolitical and economic contexts than most other studies of plastic surgery--each

chapter shows that plastic surgery is linked to the project of development, whereas most other studies of plastic surgery have concentrated on its role during war or its role within the neoliberal commodification of medicine. Moving beyond a demonstration that plastic surgery's conceptions of race are tied to the scientific racism at the anatomical level developed by comparative anatomists, throughout the dissertation I have demonstrated linkages to colonial and neocolonial discursive formations and material structures, whether through the reliance on existing missionary networks, labor patterns established under colonialism, colonialist representational tropes, asymmetrical networks of transnational capital flows that replicate colonial relations, or the remnants of colonial geographies of race and public health regimes.

Directions for Future Research

While this study has covered a good deal of ground in bringing to light aspects of plastic surgery that have been understudied or entirely unstudied, there remains much work to be done to fully explicate the implications of the arguments that I have put forth. The dissertation has focused on carefully articulating the surgeons' (and patients'/clients') understandings of their own transnational practices; I have employed discourse analysis as a tool within the transnational historical ontology I lay out, which has allowed me to trace how actors make claims to truth around questions of nation, bodies, race, and gender; to draw out their logics and the linkages or contrasts they make; to identify shifts in the terms of debate in their struggle for legitimation; and to examine the borrowings and transformations of discourses originating in other spheres (i.e., economics). However, this emphasis cannot help but replicate to some extent surgeons' own picture of

the globe and the actors who are significant to transnational surgical efforts. While I clearly have not taken the claims of surgeons and patients at face value, there is nevertheless a sense in which they have dictated the particular mapping of plastic surgery and its discourses that I have laid out here. As I pointed out in chapter 4, for instance, the picture of Johannesburg that I construct (and that was constructed for me by Surgeon and Safari), contained few “lines of flight” (Mbembe and Nuttall 2004, 354; quoting Deleuze). A similar observation could be made of the other chapters. More research into potential lines of flight or complications to the discourses examined here could be fruitful areas of development: resistances to certain forms of transnational surgery on the part of Vietnamese surgeons during the 1960s, perhaps, or a further exploration of the resistances to Operation Smile’s characterization of the recipients of surgery or of the “local” medical landscapes into which they intervene. Similarly, in Johannesburg, more research needs to be conducted on whether governmental actors, who in one sense have an incentive to promote surgery, might also be interested in imposing methods of wealth redistribution through taxation strategies. Interviews with a greater variety of actors related to Surgeon and Safari--not only clients, surgeons, and managers but nurses, domestic laborers, and public health workers--would, I’m sure, reveal cracks in the methods through which Surgeon and Safari values bodies and in the racialized portrait of the city and the spaces of care that it constructs.

The methodological decision to concentrate on forms of transnational surgery that cross geopolitical divisions between West and East and North and South has also resulted in a limited picture of transnationalism within surgery. Though it was necessary for me to highlight these forms of travel in order to find the strongest examples of surgical

discourse imagining national and economic differences, as well as its tracing of particular neocolonial transnational routes and its attendant racialization of the reconstructive/cosmetic divide. But the focus on these particular routes has somewhat flattening consequences. Though I have tried to acknowledge in passing the routes that do not conform to such West-East or North-South flows--the origin of Dooley's model of overseas medicine in the Philippines (albeit funded by the CIA), Penn's impact on the global articulation of surgery, and the fact that many of Surgeon and Safari's clients are in fact from other regions in Africa or are expatriate South Africans--a fuller examination of the intraregional and East-East or South-South forms of transnational plastic surgery would produce a more complex picture of plastic surgery's creation of bodies of value and the political and racial valences thereof. For instance, Japanese surgeons were also involved in the development efforts in Vietnam, and an exploration of the ways that intra-Asia political dynamics played out within this surgical effort might transform the complex ways in which bodies emerge as sites of investment in the development project--and how that project itself is (re)imagined and takes on different valences for different groups. Similarly, examining the intraregional dynamics of Surgeon and Safari's practices, involving clients from elsewhere in Africa and South Africans living overseas would also complicate the discussion of how value circulates within the medical and bodily economies centered on the company.

Despite these limitations, the transnational focus of the dissertation has contributed greatly to providing new understandings of plastic surgery. I have shown throughout the dissertation that plastic surgery has played a key role in a number of areas of concern to contemporary scholarship. Conversations around humanitarianism, for

instance, have proliferated in recent years as humanitarianism increasingly becomes the rationale for neocolonial interventions, including war. The “right to look human” and plastic surgery’s general intervention through humanitarian discourse serves to significantly expand its reach as it became capable of addressing newly “discovered” forms of debility, thus inserting a new set of normative judgments regarding appearance into the purview of humanitarianism and development. Taking aesthetic normalization as a universal good, plastic surgery’s extension of health, its inclusion of aesthetic criteria, simultaneously became an extension of humanitarian development’s justification for intervention. This opens up a host of possibilities for future research, not just into the role of plastic surgery in the extension of the forms of interventionist humanitarianism that scholars have identified but also into how particular (re)definitions of health and debility occurring contemporarily through genomics, regenerative medicine, or tissue economies serve to extend or restrict the reach of medical humanitarian interventions.

At the theoretical level, I have demonstrated plastic surgery’s role in the constitution of bodies as sites of investment within different capitalist formations. Bodies of value are constituted in myriad ways for a variety of transnational actors, signaling plastic surgery’s capacity to mix aesthetic, monetary, and social value within these contexts. Aesthetic value, which becomes epitomized by the right to look human within earlier postwar discourses of development and by the normalization or enhancement of appearance within more contemporary forms of surgery, is enacted precisely through the investment of capital into bodies, whether through development efforts to enhance human capital of particular populations, the modification of appearance so that particular individuals will not be “shunned,” or the valorization of one’s own body through elective

surgery. Rather than the direct commodification of bodies as such, I have used “bodies of value” to demonstrate how conceiving of bodies as sites of investment allows medical intervention through plastic surgery to become part of transnational circuits of capital. And the difference between the subjects of self-investment and objects of external investment is also the difference between the election of surgery and the reconstruction of deformity or injury, between the paradigmatically white subject of the developed world and the racialized others of the underdeveloped.

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