The Racial Politics of Plastic Surgery


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Abstract

This chapter examines the political issues raised by plastic surgery that alters so-called racial or ethnic features. It discusses the history of this medical practice in the US and how it has been practiced in two non-Western countries: South Korea and Brazil. Race is not a quality of the face or body given in nature, but rather has been enacted by surgery differently in different historical periods and nations. This comparative perspective shows that critiques of racial plastic surgery should take into account local contexts of practice. Some political concerns raised by this practice, however, cut across regions. Racial surgeries reflect wider social inequalities and an emerging medical discourse, which claims to reject the explicit whitening goals of the past, in fact continues to pathologize non-white facial features.

Introduction

This chapter examines the political issues raised by plastic surgeries that alter so-called racial or ethnic features. These features are usually taken to be the nose and eyes, and in East Asia, sometimes the jaw. Some surgeries also racialize the female body, though they are not usually termed “racial surgeries,” unlike operations on the face. Racial surgeries have been critiqued as a tool of ethnic homogenization that reflects and contributes to racism. The issue has become even more important in recent decades as plastic surgery has rapidly grown in
Asia, Latin America, and the Middle East, and is performed on a rising number of patients who are not white.

To evaluate the politics of racial plastic surgery it is important to inquire what race is for this medical specialty. Can facial features such as the nose or eyes even be said to “have” a race? Cosmetic surgeons generally believe they do. Their knowledge of race draws on other medical and scientific fields, but importantly diverges from some biological views of race today. In the post-World War II period new genetics research led some biologists to declare that the race concept was “biologically meaningless” (e.g. Livingstone and Dobzhansky 1962, 279). The clinal model in genetics held that differences in human morphology occur on a continuum and cannot be used to sort individuals into groups with hard boundaries. However, in the twenty-first century the race category has re-emerged in some areas of biology and medicine, but with much dissent (Fullwiley 2007). In other fields, however, such as forensic anthropology and plastic surgery, experts never stopped seeing race (M’Charek 2020). Wider societal understandings of race are just as diverse as expert or scientific ones (Wade 2010). For example, the US system of grouping people by hyphenated identities called “races,” such as African-American or Asian-American, is not universal (Yanow 2003). Thus, race has an uncertain status today and its meaning varies according to social and scientific context.

In this chapter we do not treat race as a quality of the face or body given in nature. This does not mean that race “does not exist”; after all many surgeons and patients feel confident that they can identify the race of a face (Hartigan 2008). Rather, we approach plastic surgery’s use of the race concept as a situated “technology of vision” (Haraway 1991). Drawing on available medical, scientific, and aesthetic techniques and knowledge (particularly anthropology and anthropometry) plastic surgery enacts facial features as operable racial traits.
However, surgeons do not consider all facial features to be “racial,” raising the question of how particular features come to be problems that need correction. In one of the earliest and most influential critiques of racial surgeries, Kaw (1993: 75) argued that North American racial prejudice “correlates” stereotyped Asian “physical features (‘small, slanty’ eyes and a ‘flat’ nose) with negative behavioural characteristics (passivity, dullness and a lack of sociability).” She argues that demand for double eyelid surgery results from the “internalization of a body image” produced by a racist society (1993: 78). Kaw’s forceful critique has led some scholars to wonder whether it depicts Asian patients as “mere victims of internalized racism” (Zane 1998:163-4). The political discussion of racial surgeries thus echoes a long-standing dilemma in feminist scholarship on beauty about accounting both for patient choice and the structural inequalities that constrain choice (Leem 2016a).

The political aspects of racial plastic surgery have also gained new complexity as the practice began rapidly growing in Asia, Latin America, and the Middle East at the end of the 20th century. Brazil has the world’s second largest cosmetic surgery market, while South Korea has the highest per capita rate of surgeries (Heidekruger et al 2016). The problem of internalized racism that Kaw (1993) and others have raised in the North American context thus now has the potential to repeat itself on a global scale. But plastic surgery also raises new political questions in these regions. For example, since people of Asian ancestry are not a minority ethnic group in China, Korea or Japan should double eyelid surgeries in these nations be seen as evidence of internalized racism or an effort to “pass” into another racial group? And in many social contexts in Latin America the boundaries between racial groups are more fluid and porous than in the US. How does this cultural perception of difference – one which views racial identity as potentially “plastic” or malleable -- affect the politics of plastic surgery?
In this chapter we first discuss the history of racial plastic surgery in the US, followed by an analysis of this practice in two non-Western country case studies: South Korea (hereafter Korea) and Brazil. This regional focus reflects the fact that the majority of racial surgeries will likely be performed in Latin America and Asia in the future, and perhaps are already. In conclusion we draw on this material to return to the political problems entailed by plastic surgery’s efforts to “improve” racial traits.

**Race and the rise of plastic surgery in the US**

The notion of situated vision conveys that how you see depends on the position from which you look. In the case of plastic surgery the position has often been that of the white, usually Anglo, viewer. Only surgeries performed on non-white or non-Anglo patients are termed “racial.” Race then in this medical practice is seen as difference from a white, Anglo norm, a fact which raises political problems, as we’ll see below.

Vision is also situated in that different *kinds* of eyes yield different pictures of reality. Plastic surgery has generally seen race through a particular “eye”: the techniques and sciences of race available in Europe and North America in the period when the modern medical specialty arose at the end of the 19th and early 20th centuries. These included anthropology, eugenics, criminology and anthropometry. In that period plastic surgeons drew on this scientific racism in order to enact racial traits, such as the “snub” nose of the Irish, as marks of evolutionary backwardness that could be eliminated or masked with surgery, thereby enabling patients to “pass” into white or whiter categories (Gilman 1999). The use of plastic surgery for this purpose was controversial because it provoked the social anxiety that the racial other would “vanish into the crowd” (Gilman 1999:27).
Plastic surgery, however, began to gain greater public acceptance over the 20th century as a therapy that could boost self-esteem or enhance the patient’s social functioning. This therapeutic “optimism” was particularly strong in the US, a region where national identity was tied to a long history of immigration. Most racial plastic surgery patients were initially from what were deemed non-white or non-Anglo “races” (Jews, Irish, Southern and Eastern Europeans, and others), often later called “white ethnics.” But as plastic surgery was popularized in the post-World War II period, more patients with Asian, African and Latin American ancestry also became targets of racial procedures. By the mid-20th century, especially in the US, racial plastic surgery had become accepted as a legitimate means of helping minorities to psychologically adjust to their environment (Haiken 1997).

This therapeutic rationale was challenged by the rise of multiculturalism and ethnic and racial pride movements (Craig 2002). By the 1970s racial plastic surgery had become more problematic, a tool of ethnic homogenization that reflected discrimination. The problem was perhaps particularly pronounced in the US, partly because the “nose job” had long been routinized for Jewish and other white ethnics. Moreover, a multiculturalist “ethos of authenticity” had taken root, which stressed that ethnicity and race are important parts of identity that should not be effaced or diminished (Haiken 1997).

The negative perception of racial surgeries began to affect the reputation of the medical specialty. Surgeons justified their practice by stressing that they are simply responding to patient choice. They also adjusted their discourse about race. Some now speak of “ethnicity” instead of “race,” a term that refers to cultural identity. They also argue they no longer aim to “change” racial or ethnic appearance, though whiteness continues to be constructed as the default norm in this medical discourse (Menon 2017). Here is a typical statement of plastic surgeons’ turn in racial thinking: “Surgical philosophies have also
changed, shifting from the perspective of racial transformation … toward a view of racial preservation” (Sturm-O’Brien et al 2010:69).

This newer rationale of “racial preservation” seems to make a medical virtue out of a social necessity. Regardless of their underlying justification, racial procedures on the eyes and nose continue to aim at similar results, such as the “double eyelid” in Asians, and the narrower or more projected nose in many patients of Asian, African and Latin American ancestry. The problem of using surgery to inscribe dominant norms on patients thus remains as pertinent as ever. We now discuss this problem in two countries with booming plastic surgery markets and many non-white patients, but with different understandings of race than in North America.

The double eyelid procedure in South Korea

The “Caucasian eye” has a “double eyelid” or crease above the upper eye lid. Surgeons hold that some East Asians (about half) are born with such a crease, others are not. Plastic surgeons can create this crease in a procedure called “double eyelid” blepharoplasty. Should the surgery therefore be seen as a means to westernize the Asian eye?

It is one of the most popular cosmetic procedures Korea, as well as much of East Asia, and many media accounts of plastic surgery’s globalization in East Asia have portrayed it as a disturbing example of westernization. A CNN story, for example, was titled, “Plastic surgery boom as Asians seek 'western' look.” In addition to double eyelid surgery, other procedures seek to narrow and project the nose. As these surgeries seem to mold features to make them resemble more closely white facial features some surgeons in the past even termed them “Westernization” surgeries. But in Korea plastic surgery has rapidly grown over the past two decades, in the process becoming pervaded with desires and anxieties.
arising in Korean society (Leem 2017). To evaluate the ethics of this procedure it is thus important to situate it not just in a global but also a *national* context.

As plastic surgery established itself as a legitimate medical specialty in South Korea, it was shaped by modernization processes and Cold War relationships with the West. One reason that plastic surgery may have been seen as a technique to Westernize is that the medical specialty itself had western origins. A pioneer of the double eyelid surgery in Korea was a US plastic surgeon, David Ralph Millard (1955), who was stationed with the US Marines during the Korean War. Millard’s reflections on his work underline the importance of geopolitics in the development of racial plastic surgery in Asia. One of his patients was a Korean translator who asked for “a round eye” to alleviate suspicion caused by his “slant eyes.” Other patients were Korean women whom he claimed wanted to be more attractive to the American troops (Kim 2005). The US military presence in East Asia may also have influenced the rise of breast augmentation. Japanese sex workers catering to American servicemen injected themselves with industrial-grade liquid silicone, a technique that shows how sexual objectification and racial pathologization have often converged, with harmful consequences (Miller 2003).

Until the 1990s, plastic surgeries on the face in Korea explicitly aimed at white aesthetic ideals. Advertisements, for example, showed images of white models (Leem, 2016b; 2017). By the 1990s plastic surgery had become associated with affluence and a consumer lifestyle for younger generation of Koreans (Leem, 2016b). The goal of plastic surgery became to attain a more “modern” appearance, which is not necessarily the same as a Western appearance. Some patients began to seek surgery to have the “right face,” which is deemed to create economic opportunities and higher social status (Hopkins 2008). Illustrating a view of surgery as an investment, some parents fund their children’s plastic surgeries as graduation gifts (Karupiah 2012).
Changing Korean sexual and gender ideals also feed demand for double eyelid surgery. Blepharoplasty is said to create wider and rounder eyes. The “big eye,” though, was traditionally a negative symbol of female promiscuity, while positive feminine ideals valued a wide, moon face as a symbol of fertility. These symbols of femininity are now changing. Beauty techniques aim to “widen” the eyes and narrow the face (including through the high risk “jaw shaving” procedure). This new look reflects larger changes in women’s position in Korean society (Holliday and Elfving-Hwang 2012). Positive images of plastic surgery also began to permeate a celebrity-oriented pop culture. The K-pop band, 6 bomb, released a video, “Becoming prettier,” depicting a radical make-over of band members that included eye widening and face narrowing procedures. While the video was sensationalized in Western media, it was not in Korea, showing that extensive plastic surgery has been normalized in that country.

As plastic surgery became localized or “Koreanised,” aesthetic ideals were defined more in Asian terms, without white reference points. By the 2000s plastic surgery media routinely pictured Korean or Asian models, all with double eyelids, and rarely included white models. Indeed, explicit emulation of a white face was deemed an exaggeration, even pathological (Leem, 2016a; 2017). Most surgeons in Korea now advocate “natural looking” surgeries that claim to enhance beauty, not transform race. Plastic surgery in Korea, as in the US, has thus tried to distance itself from fantasies of racial passing. Racial boundaries, in this new medical discourse, should be respected.

However, while plastic surgery has effectively backgrounded the issue of Westernization and racial passing, it continues to racialize the face, though in new ways that stress the achievement of exceptional beauty through expert knowledge of racial anatomy (Leem 2017). Many surgeons in Korea (and other East Asian countries) claim to have a specialization in “Asian anatomy.” They use techniques such as anthropometry and
computer modelling to depict racial facial features in much more detail than in the past. For example, rather than describe the double eyelid as simply present or absent in Asians, some surgeons have identified eight sub-varieties of eyelid shape. Much of this racial knowledge, though, is used to identify race-specific defects. Korean websites now promote techniques to address multiple aesthetic problems, which are described in clinical or lay terms (e.g. “angry eyes,” “sad eyes,” “man’s eyes,” and “small eyes” (Aquino 2017). Plastic surgeons in Korea are thus positioning themselves as experts who know and improve “race specific” traits by moving the patient’s face closer to ideal beauty. But plastic surgery continues to pathologize race-specific traits, even if it has distanced itself from the explicit aesthetic hierarchies of the past which ranked white above Asian beauty.

**Nasal surgery in Brazil**

Brazil has had centuries of extensive mixture among peoples of European, African, indigenous, and Asian ancestry due to the experience of colonialism, slavery, and ongoing immigration. This history has affected how Brazilians perceive phenotypic differences between people as well the complex power dynamics around race. The legacy of mixture and colour hierarchies that pervade Brazilian society have also shaped beauty ideals. Plastic surgery has racialized the body in ways that reflect this history of the body (Edmonds 2007, 2010).

The most common plastic surgery procedure in Brazil that is explicitly considered racial is rhinoplasty. Many patients request to have their nose *afinado* (thinned but also “refined”) or to have the tip of their nose extended by inserting cartilage, often from their own ear. The technique is sometimes referred to as “correction of the Negroid nose” in Brazil and other parts of Latin America (Vidal and Vigil 2010), underlining that the racial
feature is itself considered a pathology. One difference between the Brazilian and US versions of this operation is that in Brazil it is sometimes performed on some patients who do not identify as Black. In fact, some patients requesting this surgery identify as white, or as moreno, a popular “color” term that means “brown,” and can refer to people of European ancestry and dark hair, as well as people of some African ancestry (Sansone 2004).

Vilmar (interviewed by Edmonds 2010) was one example of a morena patient requesting rhinoplasty. During her examination the surgeon described her medical indication as “Negroid nose.” Vilmar said she had one Black grandparent and one Italian one (and wasn’t sure of the origins of other grandparents). What kind of racial politics are at stake in this surgery, performed on a patient who wanted to “improve” what surgeons called a “Negroid nose,” but who was not considered to be Black in her society?

Brazil is said to have a folk taxonomy of appearance that recognizes gradations along a spectrum of color. It contrasts with a North American classification of appearance, which creates hard boundaries among racial groups based on ancestry. While racial identities also exist in Brazil and are preferred by a Black pride social movement, many Brazilians still describe themselves and others with colour terms, such as moreno, which leave ancestry unspecified (Hordge-Freeman 2013, Sansone 2004). Brazil’s classification of phenotypic traits is rooted in Brazil’s history of race-based inequalities. Influenced by European anthropology and eugenics, Brazilian elites in the late nineteenth and early twentieth century feared that a history of mixing on slave plantations had doomed the population to poor physical and “moral” health (Skidmore 1974). However, beginning in the 1920s, Brazilian scholars, artists, and eventually the state, reassessed racial mixture, celebrating it as a symbol of national identity. Brazilian historian Gilberto Freyre (1956, 1986) played a key role in this affirmation of mixture (Vianna 1999). His vision of a vibrant, mixed Brazil became a central, often eroticized, aspect of national identity in the twentieth century (Bocayuva 2001).
Freyre’s work helped establish a vision of the population as what he called a “meta-race” that defied racial categorization. But the discourse affirming mixture also stigmatizes Blackness as “excess” (Freyre 1986). It is also a gendered gaze that makes the mixed-race woman a symbol of Brazilian sensuality, and has been critiqued by Black social movements as sexual objectification. Black and brown Brazilians continue to face social and aesthetic prejudice and marginalization (Telles 2004).

Freyre’s ideas about race and beauty underline central contradictions in Brazilian plastic surgery practice. Color is a provisional classification in Brazil, subject to adjustment—hence the saying “Money lightens.” Because color terms are relatively fluid a change in the appearance of a facial feature can potentially nudge the patient in the direction of a more valued colour category, without “changing race,” which both patients and surgeons agree would be an inappropriate use of plastic surgery. This situation illustrates enduring color hierarchies and is reflected in the old Brazilian proverb: “The whiter, the better.”

In this national context plastic surgeons have promoted racial surgeries through the rhetoric of “harmonizing” facial features or body parts. Surgeons claim that mixture creates areas of disharmony that need “correction.” As the former president of the Brazilian Society of Plastic Surgery put it: “Due to the mix and match of different races . . . the nose sometimes doesn’t match the mouth or the buttocks don’t match the legs” (Gilman 1999: 225). Surgeons also racialize not just facial features, as in Korea, but often women’s bodies (and very rarely men’s bodies). Surgeons argue that African-European racial mixing has “blessed women with small waists,” an aesthetic ideal they try to achieve in so-called “body contouring” operations that redistribute fat from the waist to the buttocks and hips (Edmonds 2010).

Racial surgeries in Brazil thus reflect culturally specific aspects of the country’s racial and gender norms. But they are not therefore less politically problematic than in other countries. Surgeons laud mixture, but recalling Freyre’s discourse on mixture, claim to
remove “excessive” racial traits. As in Korea, “excess” is seen as more of an aesthetic problem in women, than in men, though some male patients do request racialized rhinoplasty. In Brazil’s “intimate” style of racism the greatest anxieties stem not from crossing racial boundaries, as in the US, but rather from “internal contamination” that manifests in the trace of Blackness in the individual’s body or in children (Segato 1998). As one surgeon said, while mixture is potentially beautiful, the patient always wants a nose that is more European than African. The existence of a fluid system of colour classification in Brazil and the cultural affirmation of mixture thus serves to legitimate plastic surgery’s racial procedures and stigmatization of Blackness.

**Concluding discussion**

This chapter has shown that the racial feature plastic surgery makes into an operable “defect” is not given in nature, but is enacted differently across time and region. In North America, plastic surgery has distanced itself from its former goal of “passing” into a white or whiter group. Medical discourse currently speaks a language of “racial preservation,” reflecting the rise of ethnic pride movements. However, the political issues raised by these surgeries remain as troubling and relevant as ever.

Heyes (2009) points out that “all cosmetic surgery is ethnic” yet in practice whiteness is a default norm. The very terms “ethnic” or “racial” surgery in US medical discourse only refer to procedures on non-white or non-Anglo patients. Cosmetic surgery performed on patients of Northern European ancestry is by definition not “racial” or “ethnic.” An exception would seem to be a few relatively recent procedures targeting white women, such as lip fillers, or buttocks enlargement, a surgery which ostensibly emulates the body shape of Black and Latina celebrities. These surgeries implicitly posit “whiteness” as a correctable
defect. However, while they also carry political concerns, such as the medical objectification of women, they do not inscribe wider racial inequalities on the body. In plastic surgery in North America then race is a difference from whiteness, reflecting the position of non-whites and non-Anglos as minorities.

The analysis of the politics of racial plastic surgery should also take into account the rapid growth of this practice beyond the West. Medical ethics has recognised the importance of “empirical ethics.” In contrast with more conventional ethical reasoning based in law or philosophy, empirical ethics is culturally situated and investigates how “ethics plays itself out on the ground.” Such an approach is particularly relevant to racial plastic surgery because the practice is so entangled with social inequalities and historically changing concepts of race. Empirical ethics does not necessitate a stance of moral relativism. But an approach to medical ethics that analyses therapies within their context of practice can help “provincialize” Western debate and identify problems that are more pertinent to practitioners.

Whether plastic surgery is seen to reinforce racism is shaped by the societal politics of difference. The US has an ethos of authenticity, where boundaries between racial groups are emphasized. Racial plastic surgery in this national context raises the political problem that it may cause a patient to “betray” racial identity. This problem is less culturally salient, however, in both Korea and Brazil. In Korea the “big eye” is now culturally envisioned as an Asian look -- one that is elaborated in a thriving consumer culture, not just in Korea, but in other Asian countries too. In Brazil, on the other hand, cultural perceptions of mixture have fed into a view of plastic surgery as a valid, even a “necessary,” tool for correcting “disharmonies.”

While critiques of plastic surgery as racist may therefore seem less relevant to Korea or Brazil, other critiques of plastic surgery have arisen in these countries, which can also be brought to bear on racial procedures. In Korea, for example, plastic surgery has largely been
considered anti-feminist, rather than racist, with Korean feminists highlighting the problem of medical commodification and objectification (Leem 2017). And in Brazil, despite high levels of acceptance of plastic surgery, there has been more scrutiny of unethical and “exaggerated” uses of the practice (Edmonds 2010).

Racial plastic surgeries also raise concerns which cut across regional context. Perhaps the biggest political question raised by the wider practice of plastic surgery is its link to gender inequalities. Women comprise the majority of plastic surgery patients, in most countries the vast majority. Plastic surgery medicalizes normal aging and reproductive processes in women, turning them into pathologies needing correction (Edmonds 2013). Moreover, women are subjected to gendered pressures (such as workplace demands to be youthful), which augment demand for a medical service that exposes them to risks of complications, and often medical debt.

These political concerns pertain to racial plastic surgery as well, and can even be compounded by this class of procedures. The racial trait in men may be seen as ugly. Yet it does not necessarily threaten masculinity. For women, on the other hand, the racial trait – the “too wide” nose or jaw or the “too small” eye -- is often seen as a threat to femininity. The terms and metaphors that describe the alteration of the racial trait – such as “softening features” – have gendered connotations. Taken to its extreme, plastic surgery makes race itself into a masculinizing feature of the face, one that beauty work can diminish.

Moreover, plastic surgery racializes the female body much more so than the male body. In Brazil, surgeons fetishize some kinds of racial mixture in women’s bodies, claiming they create full hips and narrow waists, a body shape that they assert can be surgically achieved in women with the “wrong” kind of mixture. Korea, and other East Asian countries, did not fetishize large breasts prior to modernization. The rise of breast augmentation in those countries was fed by a view of “deficiency” in the Asian female body
that arose partly through military and cultural contacts with the West. Thus race is intersectional with other qualities of the person, especially gender. While plastic surgery fragments and quantifies the body into discrete parts, the non-white, female body is most subject to these processes (Edmonds 2010).

We have analysed here the “work” (a common idiom to talk about beauty procedures) that plastic surgery does on the racial face, but also the work that the race concept does for plastic surgery. Surgeons claim a detailed knowledge of racial phenotype, one based in their clinical experience as well as medical publications that use anthropometry to describe racial traits. This expert knowledge serves surgeons well as it buttresses their claims to offer “more natural results” or “harmony” to a growing population of non-white patients. Moreover, surgeons have adapted to current sensibilities around race and beauty, eschewing the more explicit racial passing goals of the past, and promising to achieve beauty ideals defined in a celebrity-oriented pop culture. The race that plastic surgery sees is thus unstable and shifting. It is enacted differently according to different identity politics, national contexts, and the changing state of medical knowledge.

Perceived defects in appearance can seem to inhere in the body’s genes, tissues or physiological processes. But if race is “situational,” then so too is the racial defect: the race-specific deficiency or excess is made by the “eye” that visualizes it. And what is made can be unmade potentially by a different politics of difference or by the rise of new aesthetic ideals in global pop culture. As plastic surgery grows beyond the West, racial surgeries will likely continue to rise as well. But there is also the possibility that new forms of resistance to a practice that pathologizes non-white features will emerge. The very conditions that have created fertile ground for the growth of plastic surgery globally – a rising consumer culture in the non-Western world – may ultimately undermine the dominance of white aesthetic ideals that make racial surgeries legitimate and desirable.
References


