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Refashioning Race: How Global Cosmetic Surgery Crafts New Beauty Standards. By Alka Vaid Menon. Berkeley, CA: University of California Press, 2023, 304pp., $95.00 (cloth); $29.95 (paper).

Refashioning Race explores the racialization of cosmetic surgery in the United States and Malaysia. The book foregrounds the shift from racist hierarchies and presumed whiteness to racially tailored “niche” biomedicine. Celebrating difference and diversity, contemporary surgeons seek to affirm ethnicity (and expand potential markets), through ethnic sensitivity, rather than erasing or whitening appearance. In the United States, however, an unacknowledged white referent often remains, and features are divided into “African,” “Asian,” and “Oriental” and measured by their difference from a “Caucasian” norm.

Menon contrasts the United States with East Asian medical knowledge where surgeons categorize many types of “Asian noses” and only a single European one, highlighting the role of location in the medical construction of racial features. “Ethnic noses” also intersect with gender—EastAsian noses, marked as “feminine,” for example. In both countries, “ethnic cosmetic surgery” is aimed at preserving, rather than erasing or challenging “race” and enhancing gender—larger noses for men, smaller ones for women. Biomedicine tends toward subdividing categories, rather than acknowledging (widespread and growing) hybridity. Patients of mixed heritage present a problem for niche medicine.

Menon notes how race congeals around certain surgeries: while “Asian Cosmetic Surgery” emerges as a positive brand, “African” surgery does not—leaving African bodies largely excluded from beauty norms. Such brands depend not only on aesthetic judgments, but also on clinical ones. Rib harvesting for nose reconstruction is usual in the United States’ insurance-based system, increasing revenues for surgeons without increasing costs for patients. However, in East Asia, where procedures are paid for out-of-pocket, synthetic gauzes or hardened silicone are preferred for their durability. While American surgeons accuse East Asian ones of introducing synthetic objects into the body, East Asian surgeons critique the invasiveness of U.S. techniques. Thus, not just aesthetic norms, but “best practice” often cannot be agreed upon across different locations.

Surgeons in the United States and Malaysia acted as “ethnic gatekeepers,” refusing surgeries that blurred or crossed racial lines, often connecting such requests with poor mental health. Further problems emerged from translating the literature into clinical practice: few surgeons were able to navigate patients with mixed heritage, and some went ahead with “westernizing surgeries” if the patient avoided labeling it as such, inhabited a more global milieu, or if the desired procedure remained within reasonable limits. Finding the line between a 6 mm (Asian) eyelid height and a 10 mm (western) one to create an “enhanced” Asian eyelid proved extremely difficult in practice. Also, while noses and eyelids are racialized in the medical literature, breasts are not. But in Malaysia large breasts were associated with sex workers or “unnatural” (working-class) white women. Local patients were advised to “go small” to comply with respectable femininity. Surgeons acted as “cultural intermediaries” negotiating patient requests, drawing on a racialized science of bodies, and on ethnic, gendered, and classed norms.

While “racial preservation” offers a lucrative niche, some surgeons worried it would put off white patients, or that embracing racial categories was itself racist. To circumvent this, Malaysian surgeons used more ambiguous descriptors such as the (pre-“Latinized”) “Miami look” hinting at less white, more curvaceous figures. On the other hand, the “LA look” emphasized more obvious (stretched) surgical intervention.

In Malaysia's post-colonial context of racial diversity, surgeons felt freer to discuss race. There "European" was just one more ethnic group targeted for an "ethnically sensitive" surgical tourism market encompassing Caucasian, Korean, Indian and Malaysian looks, and marketed sensitivity to Muslim clients for both Malaysians and medical tourists—developing Halal product ranges including implants and fillers. The surgeon's own ethnicity was assumed to help in attracting patients from the same ethnic group, but medical tourists from Australia and New Zealand were problematic, occupying lower socio-economic status, and sometimes deploying colonialist myths against surgeons. Our work on U.K. surgical tourists traveling to Tunisia demonstrated similar patterns (Holliday et al. 2019).

Patient "wish pics," taken from social media, represented another technology that surgeons had to navigate. While they worried such images promoted unrealistic expectations, they usefully communicated patient desires. Surgeons limited expectations by deploying expertise in what Book Review 3 could feasibly be achieved with the patient's body and directing them towards images from the patient's own ethnicity. Surgeons also generated before and after pictures and were consequently "joint authors of the visual world they have come to inhabit" (p. 190), reproducing race through a technological gaze. Overall, Menon's book is a fascinating read. Decentering a U.S.- centered racial(izing) gaze through careful comparison with Malaysia, she offers us an incredibly rich and nuanced exploration of "ethnic cosmetic surgery." Dispensing with cruder constructions of "whitening" or "westernizing" she demonstrates that even in globalized multiculture medical "ethnic preservation" or "cultural sensitivity" can be both celebration of diversity AND inadvertent reinscription of racial (and gendered) genotypes and hierarchies.

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Reference

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