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Scales of care and responsibility: debating the surgically globalised body

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#### Abstract

This paper initiates debate for geographers on the nature of care in relation to the self explored through the practices of aesthetic surgery. Central to debates on the meanings and relations of aesthetic surgery are a set of problematics related to the scales of care and responsibility. These are captured in the distinctions between caring for or caring about and between self-care or care of the self. Aesthetic surgery is a particularly ambivalent 'extreme care', which for many is always the expression of consent to an aesthetic hegemony or the exercise of disciplinary power. The paper draws out some of the spatial paradoxes involved in care related to the self in aesthetic surgery and proposes some routes forward. The framework of landscapes of care that enhances a temporal dimension and the concept of reworking the social relations of hegemony may help mediate the inherent tensions of scales of care and responsibility. Specifically, this combination may offer a way to allow for a limited, or bounded, care of the self without negating the networks of power within which the practices of self-care are enacted.

Key words: care, self, surgery, hegemony, discourse, landscapes.

## Introduction

The engagement of geographers with the spaces and practices of care mostly constitutes two discrete strands of work (Popke 2006; Raghuram, Madge and Noxolo 2009): the processes through which care comes to be provided, both formally and informally (Dyck, Kantos, Angus and McKeever 2005; Milligan 2009), and the possibilities for the expression of care at a distance and for unknown others (Smith, D. 2000; Smith, S. 2005). These engagements reflect and resonate with Noddings' distinction (1984) between caring for (a proximate, practical and interpersonal practice) and caring about (a more distant, emotive and abstract practice) and display a certain geographical discontinuity between the scales drawn into explanatory accounts. Recent work has begun to bridge these discontinuities of scale. The global mobility of care workers connects the interpersonal and proximate relations of care into other interpersonal but distanced relations of care (Lawson 2007). Restructuring of public social systems redistribute responsibilities for care across a different profile of scales (Milligan 2009). Milligan and Wiles have recently provided a rich review of geographical work around care and articulate a framing of landscapes of care as conceptually useful in drawing attention to both the 'complex embodied and organisational spatialities within and across which care and care relationships take place' (2010: 749). For example, the provision of hospice care in the home illuminates a series of spatial paradoxes of power located in the home as a site of care (Brown 2003). However, in contrast to the substantial output on the spaces and practices of care relationally defined between providers and recipients, geographers have given little attention to the scale of care of the self, 'the geography closest in' (Rich 1986: 212).

This paper explores potential geographies of care in relation to the self with respect to the practices of aesthetic surgery, drawing on published studies from other social science disciplines. There is almost no work by geographers on aesthetic surgery, which is particularly surprising since the practice explicitly re-imagines the very spatialities of the body, a theme that has increasingly received geographic attention (Valentine 1999). Moreover, this intentional and voluntary resculpting involves a particularly intrusive practice of working on the embodied self (Brush 1998) through the rapid increase in technological capacity to manipulate our bodily selves and the associated situated and shifting ambivalences towards this. The paper uses the distinction between self-care and care of the self (Murray 2007) in combination with geographically informed concepts to facilitate working through problematic debates around the scales of care and responsibility: the framework of landscapes of care (Milligan and Wiles 2010), the temporal dimensions in a related concept of 'caringscapes' (Bowlby, McKie, Gregory and MacPherson 2010) and the concept of reworking the social relations of hegemony (Katz 2004).

## Care related to the self

Geographers have mobilised metaphors of landscape to capture the inter-connections between individual, social, institutional and global scales to care. For Milligan and Wiles, landscapes of care are 'spatial manifestations of the interplay between the sociostructural processes and structures that shape experiences and practices of care' (2010: 739) and 'multilayered in that they are shaped by issues of responsibility, ethics and morals, and by the social, emotional, symbolic, physical and material aspects of caring' (2010: 740). McKie, Gregory and Bowlby (2002) draw particular attention to the temporalities of care

over the lifecourse in their depiction of a 'caringscape', which is sensitive to, 'the range of activities feelings and relationships that might exist in people's mapping and shaping of their routes through life' (Bowlby, McKie, Gregory and MacPherson 2010: 5). However, the value of these framings has not been explored previously in relation to care related to the self.

Bringing a geographical gaze on care related to the bodily self insists on attention to the temporalities and spatialities of a wider cultural and economic politics in recognition that 'The scale of the body . . . allows one to explore global processes as intimate phenomena' (Mountz and Hyndman 2006: 451). Thus, Domosh (2001) positions the historical moral ambivalence toward 'the New York woman's' practices of self-care into the need for differentiated values within an urbanising, industrial capitalism. Drawing on Foucauldian inspiration, Evans and Colls (2009) critique the monitoring techniques of the contemporary, international obesity debate as practices that mask disciplinary power as care of the self. Situating apparent caring practices of the embodied self within critiques of political relations foregrounds our bodies as potential battlefields of the interfaces of biology, society and politics (Simonsen 2000). As such, the framing of a landscape of care, enhanced with a temporal dimension of lifecourse pathways, seems particularly able to capture and highlight the situated practices and agencies of care related to the self.

Murray (2007) distinguishes two different models of selfhood, drawing on Foucault's late work, which he locates into on-going debates on how new biotechnologies may be transforming our conception of the self. Self-care captures the contemporary responsibilisation of the self for its own actualisation and wellbeing, a self-monitoring and disciplining of the body, conduct and being, and an obligation to make use of the available technologies and resources to do so, an accepted theme within analyses of late modernity (Rose 2007). This model is not only premised on a self that is rational and autonomously acting, but represents an express effort to reassert and reaffirm the self as such in the face of the apparent dominance of a genetic self (Murray 2007).

Rose (1996) usefully elaborates three categories of technologies of the self: epistemological (knowing oneself); despotic (mastering or controlling oneself); and attentive (caring for oneself). In particular, 'Despotism is often sold to us as care, and we owe it to the selves we might become to learn skepticism toward the former and a greater willingness to open to the latter' (Heyes 2007: 9). Murray (2007) elaborates his second model of selfhood as involved in an attentive care of the self which he defines as 'a self-self relationship that is inventive and open, as a self that questions the norms and constraints in and by which that self is said to be a self in the first place'. Moreover, the norms and constraints questioned include the everyday practices of disciplinary self-care. Murray's distinction can be criticised as underplaying the role of others in generating both self (Biesta 2007; Murtagh 2008) and an attentive care that may be associative rather than reflexive (Myers 2008). But armed with these caveats, the distinction affords a useful analytic in raising the question whether aesthetic surgery can ever facilitate an enhancement of capacities rather than limiting freedoms, a care of the self rather than self-care. Moreover, Murray's allowance that an attentive care for the questioning self does not

of necessity eliminate all coercive forms of self-care resonates with the geographer Cindi Katz's more broadly based discussion of resistance to hegemonic norms.

Katz offers the concept of reworking to allow for an agency that is less than resistance but not unaware or uncritical of the social relations of hegemony. This concept of reworking she defines as 'practices . . . that alter the conditions of people's existence to enable more workable lives and create more viable terrains of practice . . . This is not to say that those engaged in the politics of reworking accept or support the hegemony of the ruling classes and dominant social groups, but that in undertaking such politics, their interests are not so much in challenging hegemonic power as in attempting to undermine its inequities on the very grounds on which they are cast' (Katz 2004: 247). Katz's concept offers a possibility for informed agency that may respond to the disciplinary power that demands practices of self-care, but manipulates these strategically in the face of inequalities. Moreover, it may facilitate bridging the spatial discontinuities and challenges of caring for the self and caring about others where these may conflict.

### Aesthetic surgery

The rising numbers seeking aesthetic surgery are well documented: in the USA 'In 2003, more than 8.7 million cosmetic procedures were performed, 32 percent more than in 2002'.<sup>1</sup> In the UK, the number of breast augmentations, the leading procedure, had risen by 275 per cent between 2002 and 2007.<sup>2</sup> Publication in the three leading international journals of plastic surgery has doubled since the early 1970s and work on rejuvenation and aesthetic surgery lead basic research, indicative of an expanding field (Loonen, Hage and Kon 2007). Data on procedures in other countries are few, but it is widely accepted that aesthetic surgery is fast becoming a global trend (Jones 2008). Iran has been dubbed the capital of the world for rhinoplasty, with estimates of around 50,000 procedures a year; in Korea estimates suggest as many as half the female population may have had blepharoplasty, or eyelid surgery (Scanlon 2005, cited in Suissa 2008). Aesthetic surgery has limited availability through public health systems or through medical insurance schemes in Europe and the USA (Davis 2003a; Pitts-Taylor 2007). By contrast, a number of Latin American countries provide extensive free surgery through the public healthcare system (Edmonds 2007; Suissa 2008).

In the USA, whereas the vast majority of clients are women (over 90 per cent), the vast majority of surgeons are men (just under 90 per cent) (figures cited by Jones 2008). As a result of this highly gendered distribution, feminist scholarship has led the social sciences in examining the meanings of aesthetic surgery. The first approaches to feminist explorations of aesthetic surgery tend to polarise around two axes of competing arguments: beauty work or identity work; coercive or agentic. Those who view aesthetic surgery as yet another oppressive patriarchal technology interpret a choice for surgery as the expression of a false consciousness that consents to an aesthetic hegemony (Kaw 1997; Morgan 1991; Wolf 2002). Others are uncomfortable with the blanket treatment of women opting for surgery as dupes and prefer to understand choice as a reflexive agency to enhance identity and alleviate distress within the constraints of a wider socially practised aesthetic (Davis 1995; Gimlin 2002).

More recent research moves beyond the polarisation of this debate in several ways. A more nuanced reading of both action and accounting for action is enabled by treating both as negotiating discourses (Pitts-Taylor 2007). The attention to discourse also makes explicit the tensions negotiated between different scales of responsibility, particularly to the self and to one's wider community. Others have troubled the main axes of the debate by arguing that the predominance of research from the USA and on the experiences of white and relatively privileged women has neglected the possibilities within more differentiated experiences to enhance capacities (Craig 2006). There is limited comparative research, but its value is already evident in illuminating the situated nature of the discourses mobilised, their inter-relationships with the ideologies of healthcare provision and the social contexts into which decisions for aesthetic surgery intersect (Edmonds 2007; Gimlin 2007). Similarly, little research explicitly connects practices of aesthetic surgery to wider debates of globalisation and the mobilisation of cultural, national or personal imagery of the body. Aesthetic surgery has been linked to the normalising and responsibilising roles of the media, a media that is increasingly globalised (Heyes 2007), but there is little empirical study beyond speculation of this process outside -the USA (Kaw 1997). There is limited exploration of the mobilisation of female beauty as part of national and cultural imagery which potentially positions aesthetic surgery into a broader geopolitics (Ahmed-Ghosh 2003; Crawford et al. 2008). The prominent voices and studies in these debates are reviewed both to summarise the issues for a geography readership and to draw out the intellectual purchase for a geography of care related to the self.

### Hegemony and agency

Essentialist variants of an aesthetic hegemony argument construct an authentic body as a natural body and describe the relations of a set of undifferentiated, generalised actors and processes including women, the body, the surgical procedures and the male gaze (Craig 2006). A more nuanced, non-essentialist variant draws on Foucault's conception of disciplinary power through which the beauty industry produces norms 'against which the self continually measures, judges, "disciplines," and "corrects" itself' (Bordo 1993: 25). Bordo, in particular, enables an early situated and differentiated understanding and experience of beauty ideals in which women's bodies are socially and categorically defined not only by gender but also by ethnicity and age.

The history of aesthetic surgery provides support for an aesthetic hegemony that is both gendered and racialised. The practices of plastic surgery developed in Europe and the USA partly in response to racial anxieties provoked by an unabashed anti-semitism in which the physical form of a so-called Jewish nose was categorised as a deformity (Gilman 1999; Preminger 2001). Although ethnic aesthetic surgery in the USA is an important and growing market and 'Despite a seeming diversity of procedures across ethnic groups the end results often aim for homogeneity that fits a "whiter" ideal' (Jones 2008: 33). Moreover, aiming for a homogeneity that fits a 'whiter' ideal appears to be enacted at global scales as the availability of aesthetic surgery spreads. The increases in eyelid surgery (blepharoplasty) in Asians and surgery on the nose (rhinoplasty) amongst Middle Eastern clients are just some of the procedures that have been interpreted as reflecting an ideal of beauty that is premised on European values. In a mirror argument of the feminist, gendered critique of 'the beauty myth', practices of selfcare through aesthetic

surgery are exposed as a false consciousness that consents to the reproduction of oppressive global power relations (Kaw 1993, 1997).

Responsibility, and blame, for the reproduction of an aesthetic hegemony are largely placed on the mediascapes (Appadurai 1990) formed by flows of images and discourses through the global media networks. The increased visibility of aesthetic surgery through make-over programmes serves to normalise both the practice of self-care through surgery and the surgical procedures themselves on to a convergent, homogeneous bodily aesthetic (Heyes 2007; Markey and Markey 2010). Through this lens, aesthetic surgery is alien to any notion of care. It constitutes a form of self-harm which responds to the psychological disturbances of anxiety, insecurity and self-hatred that accompany the internalisation of self-alienating beauty standards (Davis and Vernon 2002). At the same time, recourse to surgery reproduces the pathologisation of the authentic body and a subjugation of an agentive self to processes of socialisation, both localised and increasingly globalised. Those choosing aesthetic surgery are positioned as victims and absolved of moral responsibility for the reproduction of an aesthetic hegemony; they are nonetheless constructed as both pathologised and dupes of powerful interests.

The demonisation of a monological globalisation in which the dominance of US-owned global media companies produces a homogeneous worldview has been critiqued (Jones 2008). The complexities of the interfaces between global processes and local cultural diversity apply equally to the flows of images of beauty, although there is little research to date. In the USA, Craig (2006) critiques much of the research on a racialised aesthetic hegemony as only examining non-white women's beauty experiences in relation to dominant white ideals. 'The standards of beauty circulating within non-white communities have been neither monolithic nor identical with dominant standards. They have taken shape in dialogue with dominant standards, challenging some aspects of dominant ideals and incorporating others' (Craig 2006: 167). By insisting on a situated and differentiated account of women's beauty experiences and choices, Craig retrieves the power of reflexive agency for women. However, allowing for agency also constitutes women as, at least in part, responsible for choices that consent and reproduce dominant and alienating standards of beauty (Gagne' and McGaughey 2002). Here then is an inherent tension between the scales of caring practice and responsibility; it seems impossible to care for the self to enhance capacity through aesthetic surgery without being care-less about reinforcing oppressive structures on all women (Frank 2004).

Other feminist researchers have constituted the agency of women in a different direction. Davis (2003a) and Gimlin (2002), who both value women's own accounts of their choices for surgery, found many women who were adamant that they sought aesthetic surgery for themselves and particularly as a route to improve self-esteem. Women chose aesthetic surgery not just to produce a more desirable body, but to symbolise to oneself and to others 'important meanings about their personal worth, their position in a field of social relationships, the merit of their lifestyle, and perhaps, most saliently, the degree of control they had over their lives' (Thompson and Hirschman 1995: 151). As such, women's own accounts suggest that the self-care undertaken is less for beautification in response to an aesthetic ideal, but for the construction of identity (Craig 2006; Davis 2003a; Gimlin 2002).

Central to these accounts is a highly spatialised account of the embodied self in which aesthetic surgery may resolve a mismatch between the inner and outer self and constitutes part of the contemporary project of becoming or self-actualisation.

The roots of this fragmented relation of self to self can be traced from the history of aesthetic surgery which is again instructive in extending debates beyond gender. Jacques Joseph, one of the earliest pioneers who worked in Berlin at the turn of the twentieth century, explicitly recognised that social reaction to physiological characteristics within the context of an overtly anti-semitic society caused individual emotional and psychological distress (Gilman 1991). The argument that appearance, or the 'dys-appearance', of features discriminated against (Gimlin 2006 following Leder) is a significant determinant of emotional and psychological wellbeing enabled a medicalisation of aesthetic surgery that ensured its growth as a reputable and respectable branch of surgery. This argument remains the dominant justification by the medical profession for aesthetic surgical intervention. What is particularly interesting for geographers is that the argument gains its strength from a paradox that reflects a spatialised disjuncture between the social and medical domains within which aesthetic surgery is enacted. A social reading of the body effectively proposes that the outer physical body indicates inner moral character; the inner self shaped the outer self. The medical reading recognises the social importance of this argument but inverts it by proposing that the outer self (and the social reading thereof) shaped the inner self. The widespread ambivalence that still exists towards aesthetic surgery despite its increasing popularity (Gimlin 2007) can in part be seen as reflecting this social reading within which the permanent alteration of the outer self conceals expression of a true inner self. The medical reading, by contrast, discursively locates responsibility on to the individual to enact caring practices of their own embodied self, and particularly to align their inner and outer selves, in a project of self-actualisation. The health-promoting benefits of the medical reading notwithstanding, social science's engagement with an agentive self-care shares a foundational assumption with the work on an aesthetic hegemony that all surgical intervention reflects a form of pathology. This pathology takes contrasting spatialities in different approaches; it may be located in the woman herself who internalises a bodily self-hatred or in society which pathologises and valorises different body standards.

## Discourse and differentiation

Recent feminist scholarship attempts to sidestep the impasse of structure and agency and the construction of aesthetic surgery as necessarily pathological by shifting attention on to the various competing discourses of aesthetic surgery (Craig 2006; Pitts-Taylor 2007). Taking women's accounts of their aesthetic surgery as narratives of a rational, situated agency (Davis 2003a) underplays the complexities of how accounts are constructed in the first place (Gimlin 2006). Women's accounts are better understood as strategic mobilisations of arguments to inform and to justify choices in the face of pre-scripted discourses about surgery current in any time or place. As such, all choices and all accounts are inter-subjectively produced (Butler 2005). A comparison of the discourses commonly drawn upon by women in the USA and the UK demonstrates how these are informed by wider cultural repertoires of values. In particular, discourses reflect contrasting

ideologies underpinning the healthcare systems regarding the value of individual autonomy and medical intervention in the USA compared with a concern for collective welfare and limited intervention in the UK (Gimlin 2007). The internalisation of discourses drawn from the healthcare system enables women to present a socially, and medically, acceptable account of their surgery choices. Within the health system, the would-be surgery patient must strategically mobilise a narrative that can convince the surgery team that she represents a good candidate. Aesthetic surgery has confronted negative associations related to surgery addiction. Yet another strikingly spatialised contrast is evident in different readings of responsibility for surgery addiction. Feminist scholarship implicitly locates addiction as a corollary of surgery, through the pursuit of an unattainable aesthetic ideal (as in an aesthetic hegemony), or through the performance of an unattainable control of the self (as in a Foucauldian disciplinary power). By contrast, the medical and legal domains locate addiction within the susceptible personality which in turn must be protected from itself by a professional ethical practice. New medical practices require the legitimacy of new disease categories; Body Dysmorphic Disease (BDD) is now recognised within the World Health Organisation's International Disease Classification and the psychiatric classificatory system, DSM-IV (Heyes 2009; Suissa 2008). Women seeking aesthetic surgery are screened for BDD and to pass must mobilise a narrative without an excess of psychological distress and conforming to the medical reading of the need to align the outer and inner self. That this narrative appears routinely in women's accounts is unsurprising.

Understanding choices for surgery as the navigation of discursive landscapes opens the possibility to engage theoretically with the differentiated experiences called for by Craig (2006) and demonstrated by Gimlin (2007). There is little research on the choices for aesthetic surgery amongst non-white and non-European or non-US populations beyond face-value accounts. The exception is the work of Eugenia Kaw (1993, 1997) with Asian-Americans. Kaw's analysis of women's own accounts of their choices for aesthetic surgery illustrates the on-going tension between an argument for aesthetic hegemony and the expression of agency. Kaw's informants strongly reject suggestion that they seek to modify their facial features, particularly eyes and nose, to appear more Western. Moreover, they locate their decision into various discourses including those of beauty and identity, but also of social status and employability. In the USA, eyes formed with one fold, as is common in Asians, has been shown to be read as indicative of passivity or sleepiness, even within the positive discourse of Asian entrepreneurship of recent decades (Reischner and Koo 2004). Kaw, whilst sensitive to the nuances of her informants' accounts, ultimately interprets these into a framing of aesthetic hegemony, practised through a Foucauldian disciplinary power, in which the bodily capital of ethnic minority populations is devalued, 'Rather than celebrations of the body, they are mutilations of the body, resulting from a devaluation of the self and induced by historically determined relationships among social groups and between the individual and society' (Kaw 1993: 78). But what is also evident from Kaw's informants is a sense of investing in the body, not just to alleviate distress and pass the dominant norms, but also to stand out, to compete with one's peers socially and economically (Kaw 1997). Moreover, Davis draws attention to how, 'cosmetic surgery, when undertaken by people of color or the ethnically marginalized, is framed in a political discourse of race rather than beauty' such that they 'generally have less discursive space



than their white counterparts for justifying their decisions to have cosmetic surgery' (2003b: 81). Davis' observations resonate with Craig's call for research to incorporate 'the lessons of theorists who have specified and attended to the social location of the women whose lives they study' (2006: 165). A choice for aesthetic surgery may constitute both empowerment and resistance in both reclaiming access to resources otherwise denied and insisting on an identity that is multi-faceted beyond ethnicity. Davis effectively opens up for scrutiny the processes of how we as researchers handle and interpret the accounts of informants.

Gimlin (2000) comments how feminist critiques of aesthetic surgery tend to understate the multiple domains of power relations beyond gender that include race, age, ethnicity and class. Recourse to surgery to enhance social status and success in the labour market in terms of class seem particularly underplayed. Yet social functionality has clear importance in the history of aesthetic surgery (Gilman 1999). Plastic surgery emerged as a specialism during the First World War and the associated demand for maxilla-facial reconstruction for a 'normal' and gendered male face able to get work following the war (Haiken 2000). The logic of medical intervention to enhance an individual's ability to function within occupational and social public spaces rapidly extended to surgical modification of other stigmatised features that might similarly disadvantage the owner in the labour market (Preminger 2001). However, the pursuit of social status is not limited to access to labour markets. Anecdotal reasons for the rapid expansion of rhinoplasty in Iran indicate the use of aesthetic surgery as an expression of social status but not directly linked to increased employability (BBC News 2006; Channel 4 News 2006). Moreover, rhinoplasty patients show no association with measures of mental health or self-concept challenging the universality of the argument that surgery addresses a psychological mismatch between inner and outer selves (Zahiroddin, Shafiee-Kandjani and Khalighi-Sigaroodi 2008).

Western feminist engagements with aesthetic surgery require more critical reflection on our own historical and discursive landscapes. Asian women opting for eyelid surgery argue that a more open (for which some read Caucasian) shaped eye is more attractive but reject the suggestion that this reflects an internalised over-valorisation of an Anglo-Saxon aesthetic. The quotation below from an on-line discussion (publicly available) expresses an angered resistance to the discourse of a hegemonic globalised aesthetic: just because many Asians, including Koreans, wish to attain character traits that are considered more 'Western' (such as big eyes and a more shapely nose) does not mean that they want to be/look Western . . . You would never say that Westerners want to look East Asian . . . But how come recent trends in the US and Europe are straight hair (most definitely an Asian trait), a smaller "button" nose (also Asian), skinniness (Asians are on average thinner than Westerners), tan skin ( . . . a 'golden glow'), and prominent cheekbones (Koreans, Mongolians, and certain Northern Chinese ethnicities are strongly identified with this trait).<sup>3</sup> Feminist politics have been informed by oppositions within a history of Anglo-Saxon beauty norms between male beauty, power and rationality and female beauty, deception and emotionality (Holliday and Sanchez Taylor 2006) such that, 'It is easy to see . . . why a largely white, middle-class feminism has until recently tended towards favouring a desexualization of the body in favour of claims to rational thought and moral superiority' (2006: 183). A more situated understanding of how women navigate a discursive

landscape with respect to care of the bodily self opens a space for both understanding how aesthetic surgery may enhance capacities but also extends critique as to the extent, or when and where, this may viably be viewed as constituting resistance. Apparent resistance to the pressure for beauty work, and aesthetic surgery in particular, may merely reflect situated values: 'Middle-class white women are expected to appear thin, young, and wellgroomed while conforming to class-laden, moral expectations that they be natural and unconcerned about their looks' (Craig 2006: 166).

The critical point is that this aesthetic ideal informs not only individual women's choices, but the production of our academic discourse on aesthetic choices. Feminist politics tends to reject technologies for beautification or identity as oppressive, favouring the natural, unmodified body as both authentic and an expression of resistance. Moreover, approaches that allow some positive value to aesthetic surgery, by recognising agency and discursive navigation in decision-making, validate this by repositioning the care work undertaken as psychological, in some way related to the mind, rather than as beauty work (Davis 2003a; Holliday and Sanchez Taylor 2006). Positioned into a more globalised framing, Western feminism may emerge as characterised by a profound reluctance to recognise the possibilities of care related to the self and particularly through attention to beauty. In the UK, other practices to makeover appearance or conduct on reality shows appear to position middle-class values as the neutral norm, the so-called universal-particular (Savage, Barlow Dickens and Fielding 1992; Skeggs 2009); interestingly, the practices of aesthetic surgery may show a contrasting, or at least more complex, class relationship.

## Global engagements

Whilst the concept of negotiating discourses brings inter-subjectivity to the fore, it also risks focusing down and revaluing negotiation as an individual activity. There is emerging work on collective dimensions to care related to the self, albeit fragmentary. One theme concerns the relationship of beauty and beauty work to a wider national and global politics. This work moves away from individual practice and considers beauty performance in relation to status and competition. Ahmed-Ghosh (2003) and Crawford et al. (2008) both highlight the geopolitics of beauty through the role of beauty pageants in India and Nepal, respectively: 'women are being defined by a nation that simultaneously wants to revert to an image of the 'Sita/Savitri' woman to reflect India's 'traditional' (read: Hindu) roots and also show the world that India is a liberal, modern nation. The projection of Miss Indias to attract global attention necessary for expanding trade, business, and international recognition is crucial to this trade' (Ahmed-Ghosh 2003: 224). Negotiating the tensions involved in national identities between traditional and modern gives far greater attention to a global geopolitics and to class relations than is typically the case in debates around aesthetic surgery. The geopolitical focus entails an explicit encounter between scales of care practices and responsibilities for individuals and families, for values and for the nation.

A second emergent topic is the logic for providing aesthetic surgery through public healthcare systems seen in several Latin American countries (Suissa 2008). Brazil,

perhaps more than anywhere else, positions aesthetic surgery as therapy for the psyche rather than the body. But despite this stress on the mental wellbeing of appearance, Edmonds' (2007, 2009) ethnographies in the hospitals and clinics of 'plástica' identify the complex situated practices around aesthetic surgery as gendered, racialised, classed and globalised. Directly contrasting middle-class, white aesthetic denial or Western differentiations of racialised and segregationist aesthetics, a corporeal female beauty constitutes a central symbol of Brazil's national identity and projection (Edmonds 2007). This is based on racial mixing and harmony (*morenidade*, *mesticagem*), a unique national tropicity (*brasilidade*) and happiness (*allegria*). Part of this aestheticised national patrimony includes a distinct body culture characterised by a heightened observation of bodies, an explicit inclusion of aesthetics into notions of wellbeing and, rather than a body alienation, an ethos of 'compulsory body love' (Edmonds 2009: 486). Women seek surgery not only to feel ordinary or normal but expressly to enhance their beauty, to reunite the traditional division between sexuality and motherhood, and to remain competitive sexually, socially and economically. In the highly unequal structure of Brazilian society, beauty as a form of body capital is a resource that is unequally and unfairly distributed in ways that cut across and may undermine other structures of inequality (Bourdieu 1984). Whereas access to education and other investments in social mobility are limited, investment in the body is critical as the site for identity and social status. Moreover: 'beauty can influence the rich and powerful, becoming—like the samba parade—a popular form of hope' (Edmonds 2007: 378).

#### Scales of responsibility and care related to the self

At the core of debates on the choice for aesthetic surgery is whether this may ever be viewed as an attentive care of the self rather than a disciplinary self-care. The spatial paradoxes of care identified by Brown (2003) in relation to the home have resonance in relation to the embodied self which can be seen as both a good and bad site for caring practices related to the self, allows control over the care involved but that care is also highly controlled and entails both autonomous agency and disciplinary practices; moreover, the embodied self enacts both selfcare and care of the self. These paradoxes have a further spatial manifestation in that caring for the self conflicts with caring about others by simultaneously enhancing the structural inequalities that prompt such action.

The place of first-hand accounts is central to examining how the different scales of both influence and responsibility are negotiated. The tensions between giving voice to research participants and the interpretative role of a critical analyst are prominent in the research on care related to the self through aesthetic surgery. Geographers can well contribute to the second-generation research that adopts a discursive approach. The approach offers socially and spatially differentiated landscapes through which each individual journeys, can allow for the multiple interactions of differently embodied social categories, including ethnicity, class and age, can allow for multiple goals for the choice for aesthetic surgery, including passing within dominant norms and competing, enhancing self-worth and performing successfully socially, with the focus on beauty, identity and social status. Agency is accorded to the process of negotiation; indeed the nature of care related to the

self may be the way the self is constituted inter-subjectively through negotiation of a discursive landscape.

There are other interesting spatialities for geographers here: the reach of the global media; the positioning of responsibilities for choice of surgery or the production of surgery addiction; the manipulation of a spatial disjuncture between inner and outer selves in medical discourse which is then blurred and reconfigured in a way that enables both medical respectability, clients' own justification beyond vanity and the repackaging of social inequalities as individual subjectivity. However, agency as negotiating a landscape of others' pre-scripted discourses tends to negate informants' expressed view that they have enhanced their capacities (Gimlin 2000). At the same time, recognition of the positionality of the academic researcher risks reduction of critical analysis to an enveloping cultural relativity that negates relations of power.

The landscapes of care framework foregrounds the relational dynamics and the different scales of responsibility and influence that underpin the spatial paradoxes of care. Katz's concept of reworking the relations of social hegemony within a particular landscape of care allows value and agency to be accorded to first-person accounts. Investments in bodily capital through aesthetic surgery can be allowed as positive actions, as the intentional choice to effect an alternative future life-route (Bowlby, McKie, Gregory and MacPherson 2010). However, the structural inequalities within which decisions are made remain a powerful critique of those medicalised and media-ised discourses which act to reframe structural inequality as subjectivity. In combination, these appear to offer a starting point for geographers to explore the possibilities for a limited or bounded care of the self that is reflexive, possibly associative, and can enhance capacities when informants say it does but without negation of the power relations that simultaneously infuse the different scales in which such care of the embodied self is performed.

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#### Notes

1. ASPS website, [http://www.plasticsurgery.org/About\\_ASPS](http://www.plasticsurgery.org/About_ASPS) (last consulted 30 March 2010).
2. BAAPS website, <http://www.baaps.org.uk/about-us> (last consulted 30 March 2010).
3. Ask a Korean website, socult contribution, posted 12 October 2009, <http://askakorean.blogspot.com/2007/11/korean-women-fixer-uppers.html> (last consulted 30 March 2010).

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