

**OPERATING IN EDEN: COSMETIC SURGERY TOURISM  
AND THE POLITICS OF PUBLIC AND PRIVATE MEDICINE  
IN COSTA RICA**

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## **ABSTRACT**

Sara Louise Ackerman: *Operating in Eden:  
Cosmetic Surgery Tourism and the Politics of Public and Private Medicine in Costa Rica*  
(Under the direction of William Lachicotte)

This dissertation offers an ethnographic account of North Americans' journeys to Costa Rica to undergo cosmetic surgery. I situate Costa Rica's booming medical tourism industry in a confluence of historical, economic and cultural conditions, through which Costa Rica is made attractive to North Americans, a regime of private sector expansion and state contraction is promoted, and the national medical program on which most Costa Ricans rely is transformed. In focusing on the everyday practices of patients, clinicians and workers at recuperation facilities, I consider how the desires and practices of middle class North Americans are intertwined with uncertainties about health care access and national identity in Costa Rica.

The ethnography is organized around three sets of spaces through which medical tourists and their caretakers pass. The first includes popular media and web forums, where specific imaginaries of Costa Rica are produced, medical travelers are mobilized, and cosmetic surgery is normalized as a technology of self-improvement. The second is the hotel, particularly recovery hotels that cater to visiting patients from North America. I consider how the affective labor of local caretakers combines with tropical landscapes, and a discourse of personal rebirth, to move guests through a period of post-surgical liminality and to de-politicize medical services. The third set of spaces, public and private hospitals and clinics where bodies are enhanced or repaired by plastic surgeons, reveals a shadow medical and

labor migration from Nicaragua that underwrites Costa Rica's affordability for North Americans. Throughout, I discuss areas of overlap, and tension, between public and private medical facilities, particularly the state's persistent subsidies of the private sector and the lived, material effects of neoliberal discourses on patients' desires, professional identities and medical practices.

The dissertation illustrates that a desire for a fully integrated self is not the only type of belonging negotiated by the various actors involved in Costa Rican cosmetic surgery tourism. A constellation of national, transnational, moral and aesthetic claims to membership intersects with the provision of private medical services for North Americans, and I examine how the successes or failures of these claims are embodied and lived.

*Dedicated to Scott MacPherson Stapleton*

*in memory of his intellectual curiosity and  
desire to explore the world in all its variety*

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## INTRODUCTION

### THE MANUFACTURE OF ENHANCED NORTH AMERICAN BODIES AND THE POLITICS OF BELONGING IN COSTA RICA

*Plastic surgery historically has been for the rich and famous. Now it's a whole new market. Costa Rica has this wonderful educational, medical background, which has produced wonderful surgeons. And it's close to North America. Journalists call Costa Rica "Beverly Hills South." The reality is, they can come here, have a face lift, spend a couple of weeks, go home looking good, for what it would cost them to go to Disneyland..."*

- North American resident of Costa Rica,  
and owner of a cosmetic surgery recovery retreat

In recent decades, Costa Rica has been marketed, imagined, and consumed as one of the world's most beautiful and accessible playgrounds for tourists, particularly North Americans.<sup>1</sup> A country of about four million residents, Costa Rica was visited by over a million and a half people in 2006, approximately half of them from the U.S. While most tourists' itineraries include beaches, cloud forests, volcanoes, and other "ecotourism" spectacles, a smaller—but growing—number of visitors seek the services of local plastic surgeons, private hospitals, and recovery retreats in and near the capital, San José.<sup>2</sup> This

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<sup>1</sup> Most visiting patients are from the U.S., but I use the term North America to include Canadian medical travelers as well.

<sup>2</sup> Official statistics for medical tourism activities are as yet unavailable. In part, this is because medical travelers (particularly those seeking cosmetic surgery) prefer to travel under the guise of leisure tourism. In addition, the state institution responsible for promoting and accounting for tourism activities (the Costa Rica Tourism Board, or ICT)

is not necessarily a new phenomenon. Middle class North Americans have been traveling to San José for cosmetic surgery since the 1970s, participating in a cottage industry of entrepreneur surgeons, family-run clinics, and home-based recuperation services.<sup>3</sup> More recently, however, internationally accredited private hospitals and recovery retreats financed by foreign capital have proliferated in the midst of an expanding private sector, as Costa Rica vies for a position in an emerging global industry popularly referred to as “medical tourism.” Deploying the nation’s status as a peaceful, democratic, hospitable paradise, state and private sector interests are refashioning Costa Rica as another kind of destination—a site of state-of-the-art, yet affordable, medical services for North Americans.

In the following chapters, I consider the products of this refashioning of Costa Rica—its bodies, subjects, spaces of medical consumption, and ideologies of health. My focus is cosmetic surgery, which is, after dentistry, the predominant form of medical consumption among North American visitors.<sup>4</sup> Cosmetic surgery is also growing in

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has only recently acknowledged the existence and economic relevance of cross-border medical consumption. In the 1990s, a University of Costa Rica study estimated that 14 percent of tourists in Costa Rica come for medical reasons (Castonguay and Brown 1993). More recently, the ICT estimated that 5,000 medical tourists came to Costa Rica in 2008, and that 95 percent of these visitors were from the U.S. (Magee 2008).

<sup>3</sup> See Gilman (1999) for an account of the differences between “aesthetic” and “cosmetic” surgery. Most North American patients in Costa Rica used the term “cosmetic,” as did their surgeons while speaking English. In Spanish, *cirugía estética* is most commonly used.

<sup>4</sup> There are numerous high-end dental clinics catering to North Americans in and near San José. Visitors often combine dental services with cosmetic surgery, or they undergo dental procedures at the beginning or end of a more conventional vacation in Costa Rica. Indeed, dentistry is more compatible with other forms of touristic consumption than cosmetic surgery, because it does not generally require a lengthy period of recuperation. At recovery retreats, I frequently met people recovering for several days from major dental procedures, including crowns, implants, root canals and veneers. They told me that

popularity among middle class Costa Ricans, prompting banks to offer personal loans for enhancement procedures, and surgeons-in-training to perform free breast augmentations at public hospitals. I approach this cosmetic surgery boom as both a metonym for broader cultural and economic transformations in Costa Rica, and as a “technology of the self” (Foucault 1988a)—a medicalized, corporeal intervention through which subjects are fashioned, in a context where social belonging increasingly entails self-governing via bodily discipline and participation in proliferating forms of consumption. In urban Costa Rica, these practices of self-making are increasingly sought by the middle class, and are tied up in notions of citizenship and progress.

By citizenship, I refer to a sense of national belonging or membership, but I also suggest a corporeal politics of membership that crosses national boundaries.<sup>5</sup> Visiting cosmetic surgery patients often told me that their journeys enabled them to belong. Before, they said, they felt out of place. This sense of displacement operates on several levels: the corporeal, or a person feeling that her body is out of alignment with her self-image; the social, in which she claims to be of diminished social value because she looks

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it was more affordable to fly to Costa Rica for these services than to purchase them in the U.S. In addition, whereas the majority of cosmetic surgery tourists are women, men predominate among visitors seeking dental services.

<sup>5</sup> A recent body of literature examines how identities and advocacy movements are negotiated through the use of biomedical categories and knowledge forms. See, in particular, Adriana Petryna’s ethnographic work post-Soviet Russia, where “biological citizenship” is constituted by “a massive demand for but selective access to a form of social welfare based on medical, scientific, and legal criteria that both acknowledge biological injury and compensate for it” (2002:6). See also the “biological citizens” of Rose and Novas (2005), for whom selfhood and health are increasingly experienced through somatic enhancement and optimization, and Heath, Rapp, and Taussig (2004) on “genetic citizenship” and the interactions between scientific knowledge and the public sphere.

“too old,” and the economic, in which the tempting fruits of medically mediated self-improvement are on offer in the U.S., but are financially inaccessible to many people.

For surgically inclined middle class North Americans, personal and social re-integration are promised via a journey through the clinics and residential facilities of Costa Rica’s cosmetic surgery and recovery industry. A potent blend of surgical expertise, hospitality, and beautiful landscapes offers a sense of passage to visiting patients—to Costa Rica’s social, economic, and medical elite, and to a privileged retreat from the schedules and anxieties of everyday life back home. A successful surgical journey, in other words, operates as a kind of realignment, in which mobile patients describe their post-surgical bodies as more connected to their “inner” selves.<sup>6</sup>

However, North Americans’ access to personal enhancement, and the private medical sector in which medical tourism activities are situated, have been constituted through recent, and profound, shifts in Costa Rica’s economic, political and cultural landscapes. A state-sponsored public health program has long dominated the provision of medical services for the majority of Costa Ricans, and is popularly associated with Costa Rican-style democracy and economic egalitarianism, national development, and an ethic of collective responsibility via strong state institutions. State investment in health care, education, and other social services has been one of the cornerstones of Costa Rican

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<sup>6</sup> The intersection of travel and the search for medical treatments and cures is certainly not a new phenomenon. Indeed, contemporary medical tourism has many antecedents in earlier forms of medical travel, even as a historically strong sense of connection between bodily affliction and place (including both etiological and epidemiological theories) persists in tension with a universalizing biomedical discourse. For example, an assumption running through contemporary medical tourism—that travel, leisure and exotic landscapes are inherently healing and edifying, recalls pre-20<sup>th</sup> century European and North American spa travel. See Hembry (2000) for an historical account of English spas from the 16<sup>th</sup> to the 19<sup>th</sup> centuries, and Gilroy (2000) and Wrigley and Revill (2000) for essays on 18<sup>th</sup> and 19<sup>th</sup> century medical travel.

national identity for over half a century, and has bolstered the nation's reputation as an exception among its war-torn, politically volatile neighbors. Indeed, life expectancy and infant mortality rates in Costa Rica are now closer to those of Europe and North America than other Central American nations, and are usually attributed to the efforts of state institutions (Vega 2001). Costa Rican exceptionalism, moreover, has been mobilized as one of the most effective marketing tools for the tourism industry—positioning Costa Rica as socially, politically and economically closer to the U.S., and promising visitors an experience that is exotic yet familiar, affordable yet not “Third World.”

Costa Rica's recent embrace of neoliberal governmentality, however, has resulted in a gradual disinvestment in social services, enthusiastic state promotion of an expanding private sector, and growing social ills such as poverty and violence—all of which fuel widespread fears that Costa Rica is becoming a typical, rather than exceptional, Central American nation.<sup>7</sup> The state institution that provides public health and medical services, in particular, has been subject to funding contractions, attempts at privatization and bureaucratic reform, and corruption scandals involving pro-neoliberal politicians. The private sector, meanwhile, caters to a growing economic elite, comprised

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<sup>7</sup> Neoliberalism is a discourse of market supremacy and state retreat from economic regulation and provision of social services. It emphasizes individual, rather than collective, responsibility, and its effects have been “both to include and to marginalize in unanticipated ways” (Comaroff and Comaroff 2000:298). The term neoliberalism is more widely and popularly used in Costa Rica than in the U.S., and is associated with trade liberalization, privatization, and growing economic inequalities. “Neoliberal is like Satan here,” a Costa Rican nurse—herself sympathetic to the Libertarian movement—told me. Throughout this dissertation, I approach neoliberalism as produced and lived at different scales, rather than as a singular ideology or economic regime.

I use Foucault's term governmentality to suggest that neoliberal economic policies can only be understood through attention to the rationality through which they are formed, and the ways in which they produce subjects (Foucault 1991).

of Costa Ricans who have benefited from the nation's turn to neoliberalism and foreign visitors and residents.<sup>8</sup>

Public hospitals have also had to contend with growing numbers of undocumented and uninsured patients, primarily labor migrants from Nicaragua. Nicaraguans' access to jobs and social services in Costa Rica has fueled a racialized identity politics, and they are popularly blamed for the festering deficiencies of public medicine, including long waiting lists for diagnostic and treatment procedures, deteriorating buildings and aging equipment. These conditions are particularly stark when contrasted with the high-tech offerings of a rapidly expanding private sector. Throughout Costa Rica, moreover, demographic and ideological shifts accompany widening income disparities and new forms of consumption, suggesting not only that "social value is transformed into the ability to buy," but the waning of once-dominant "principles of solidarity and universal services" under a neoliberal regime (Saenz 2004:172).

As these profound economic and cultural changes remodel Costa Rica, many middle class people feel that their previously taken-for-granted sense of belonging—to an exceptional nation and to modest prosperity—hangs in the balance, as does their desired participation in a global economic order. Among medical specialists such as plastic surgeons, enhanced earnings, international professional and institutional affiliations, and the latest technological innovations are all increasingly on offer in the private sector. These seductions, in concert with declining state investment in social services, have contributed to a climate in which many plastic surgeons' commitment to nationalized medicine as the seat of professional identity has been replaced by an embrace of medicine

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<sup>8</sup> Between 1988 and 2004 the income of the wealthiest 20 percent of Costa Ricans doubled, while the income of the poorest 20 percent increased by 7 percent (Foster 2007).

as business. Low-income migrants, meanwhile, are the participating non-members of the new economic and cultural order: they are denied legal and social belonging even as their labor contributes to the construction and maintenance of elite spaces of consumption—including medical tourism facilities. Mobile North Americans (tourists and expatriates alike), by contrast, are offered symbolic citizenship as envoys of globalization and prosperity.

The corporeal manufacture of belonging among visiting cosmetic surgery patients is, therefore, inextricable from a broader politics of medical, and national, citizenship in Costa Rica. If we conceive of bodies as a materialization of social, economic, and political orders, then the enhanced bodies of North Americans can tell us much about those who labor on their behalf, and the broader conditions that shape their daily lives.

It is important, however, not to make overly broad claims for Costa Rica's medical institutions and politics by way of an analysis of plastic surgery practices. As a highly commercialized medical specialty, plastic surgery is perhaps the most extreme form of medical privatization in Costa Rica. For example, while the proportion of Costa Rica's professionals and technicians who work for the state has fallen from 54 percent to 46 percent between 1987 and 1994 (Vega 1996)—suggesting persistent state contraction—the percentage of plastic surgeons practicing at public facilities has dropped much more precipitously.<sup>9</sup> Moreover, while most physicians in Costa Rica continue to be

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<sup>9</sup> According to the Costa Rican Social Security Fund, the state employed 4,127 physicians in 2006 and the 87.5% of Costa Rica's legal residents were enrolled in the state medical program. San José's four national hospitals employed 806 physicians, including 106 general surgeons and 14 (predominantly part-time) plastic surgeons. Over 40 plastic surgeons had private practices in Costa Rica in 2006, whereas before the 1990s, most plastic surgeons in private practice also worked for the state. See <http://www.cendeiss.sa.cr/investigacion/funcionarios.htm>.

employed by, and have a strong ideological commitment to, state-sponsored medicine, most of the nation's plastic surgeons could be considered dissident in their embrace of medical practice as a means of participating in and benefiting from transnational medical markets.

Plastic surgery, therefore, cannot be deployed as a straightforward predictor of the future configuration of public and private medicine in Costa Rica, or of the discourses of national identity that inform them. Nor is the expansion of private medicine, and the assemblage of mobile bodies and practices that constitutes cosmetic surgery tourism, an inevitable or fixed outcome of economic policies and rationalities. Throughout this ethnography, rather, I attempt to illustrate the complex contingencies that have come together, perhaps not permanently, to disrupt public medicine and produce Costa Rica as paradise of corporeal self-reinvention for North Americans. Through a close examination of the embodied commitments of visiting cosmetic surgery consumers and their caretakers, and competing institutional cultures of medical service delivery, I examine a politics of belonging and exclusion that is specific to Costa Rica and that further links the nation to its northern neighbors, Nicaragua and the U.S.

Below, I turn to a consideration of several theoretical frameworks that have shaped my analysis of cosmetic surgery consumption in Costa Rica. I do not offer a literature review, *per se*, since I weave theoretical and historical influences throughout the following chapters. Rather, I present my overarching approach to medical tourism, which is a complex phenomenon not easily reducible to a conceptual framework of economic development or biomedical outsourcing. Medical tourism, and medical privatization in Costa Rica more broadly, are more fruitfully studied as shifting, heterogenous

assemblages of actors, objects, imaginaries, and institutions, whose products are both expected and unanticipated.

I draw here on Aihwa Ong's and Stephen Collier's definition of assemblage as a "product of multiple determinations that are not reducible to a single logic" (2005:12). As a set of practices that is enmeshed with transnational movements of people, capital, and technologies, and a large state-sponsored medical system, medical tourism is contingent on specific conditions in Costa Rica, the U.S., and elsewhere, rather than being moored in a global (i.e. borderless) medical market. Indeed, medical tourists cross borders easily and their activities seem to take place outside the realities of daily life for most Costa Ricans. However, their crossings also participate in the transformation of how health, citizenship, and responsibility are understood in Costa Rica, and in the production of bodies and subjects that are *less* mobile and mutable. I ask how we might think about these different embodied subjectivities, as they are crafted through operations that invoke dreams of metamorphosis and movement.

### **Actually existing globalization**

The scholarly literature on contemporary cross-border medical travel is not voluminous. Nancy Scheper-Hughes (2002, 2005) and Lawrence Cohen (1999) have offered the richest and most provocative accounts thus far, in their analyses of the transnational, often illegal or quasi-legal, trade in human organs. Recently, other scholars have turned their attention to the growth of more visible cross-border medical migrations, and to the hospitals in developing countries that cater to patients from wealthier countries (Kangas 2007; Lautier 2008; Whittaker 2008; Wilson *forthcoming*). Alongside these

tentative forays into the world of medical outsourcing is a prolific, and often sensational, journalistic literature that has followed the adventures of medical tourists for the past decade or so. These accounts usually portray medical tourism as a beneficial, if risky, feature of economic globalization, with its cross-border movements of capital, consumers, and commodities.

Globalization's dominant economic-ideological partner, neoliberalism, is a tacit rather than explicit feature of most popular accounts of medical tourism. Neoliberal rationality, and the policies that accompany it, have led to sweeping changes in the activities—and definition—of the state. In countries where neoliberal regimes are dominant, the state's public sector activities have retreated in favor of privatization, deregulation and foreign investment promotion. In Costa Rica, however, a national commitment to the state's provision of health care for all citizens has persisted alongside this ideological sea change. Moreover, while private hospitals and medical schools have proliferated, the hands-on training of clinicians still takes place almost exclusively in the public facilities where the majority of Costa Ricans receive services.

Several mid-career doctors told me that globalization is to blame for the recent explosion in private medical services in Costa Rica, which they view as a strong threat to the future viability of the nationalized medicine program. What is their understanding of globalization, and how does medical tourism figure in its effects on the local distribution of medical services? Globalization is conventionally understood as a force that accelerates the spread of capitalist forms of production and consumption around the

world, largely unfettered by state intervention or regulation.<sup>10</sup> Alternately celebrated and condemned, globalization is imagined as an economic and technological juggernaut that shrinks and flattens the world and homogenizes cultural forms and practices—leaving a blanket of fast food restaurants and malls on top of the cultural rubble left behind.<sup>11</sup>

If globalization involves the transnational movement of production and services, cosmetic surgery tourism can be understood as a new kind of global medical outsourcing, in which the surgical manufacture of gender, age, and weight normalized bodies moves from North America, Europe, Australia, and Japan to countries with lower land and labor costs. This relocation of medical production involves the transfer of technologies and expertise to poorer countries, expanding tourism infrastructures, and a greater ease of international travel for wealthy countries' middle classes. It is also a response to rising health care costs in wealthier countries and increasing consumption of enhancement procedures.<sup>12</sup>

While globalization is often portrayed as synonymous with progress, the effects of economic liberalization policies and transnationalism are not uniformly celebrated.

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<sup>10</sup> In the U.S., perhaps the most popular and widely read proponent of this model of global capitalism is Thomas Friedman, whose books on globalization include *The Lexus and the Olive Tree* (1999) and *The World is Flat* (2007).

<sup>11</sup> Having traversed urban Costa Rica's consumer landscapes, featuring ubiquitous fast food outlets, American-style malls, and overfed consumers, I acknowledge that this framing continues to have some residual purchase on my imagination, despite my rejection of totalizing hypotheses and commitment to the nuances of cultural specificity.

<sup>12</sup> A recent body of literature examines an expanding range of enhancement technologies that aim to improve bodies and selves, and their effects on social forms and subjectivity. In addition to plastic surgery, these technologies include cosmetic neurology, bionic prosthetics, regenerative medicine, hormone therapies and genetic screening. For a review of various technologies, see Hogle (2005). Also see Chatterjee (2007) on cosmetic neurology, Dumit (2002) on pharmaceutical normalcy, and Hoberman (2005) on male hormone therapies.

Protests have been frequent and widespread, and have emphasized globalization's harmful effects on workers, the environment, and nation-state autonomy (Danaher 2001). In Latin America, specifically, anti-neoliberalism has spread in recent years, leading to the election of several populist candidates and the re-nationalization of privatized industries. Costa Rica, however, persists as an exception. On the one hand, government attempts to privatize large state industries have met with popular resistance, and this resistance continues (for the most part) to prevail (Edelman 1999). However, the state also continues its enthusiastic promotion of private sector growth, foreign investment and de-regulation. In other words, Costa Rica accommodates its own form of uncertain, and unstable, hybridity, or what might be called a neoliberal welfare state.

Despite the increasing interplay of public and private interests and actors, the doctors, patients, and small business owners I spoke with insisted that medical tourism projects are wholly outside of the state and its medical program. Consonant with neoliberal discourse, private sector activities are assumed to be subject to the universal laws of the "free market" rather than state control. In addition, successful medical tourism destinations have positioned themselves at the pinnacle of medical modernity, thereby extending biomedicine's presumed reach into global markets as an "immutable mobile"—or a constellation of standardized practices, knowledges, and objects that operate identically everywhere (Latour 2001). Indeed, medical tourism facilities are often marketed as politically and culturally neutral spaces that reside outside of local attachments, except as benign flavors that persuade travelers to choose one destination over another.

A universalizing, economistic approach to globalization and biomedicine, however, works to render local conditions and actors static. It does not tell us much about the particular circumstances through which projects such as medical tourism are constructed and lived, or how they affect local medical structures and practices. Cosmetic surgery tourism is successful precisely because biomedicine is, to some extent, an immutable mobile; yet its success is also dependent on local historical and cultural contingencies that shape biomedical practices and institutions, such as Costa Rica's extensive public medical apparatus. Furthermore, claims that globalization is an integrating, beneficial process that connects people, places, products and services obscure the actuality that the places produced by globalization, as James Ferguson (1999) and Neil Smith (1997) remind us, are as likely to be characterized by decline and disconnection from the global economic regime as by affluence and integration. These spaces, writes Ferguson, "reveal less the outside of the system than its underbelly" (2002:142). I ask whether public medicine in Costa Rica is precisely such a space of decline.

Thus, I approach Costa Rican medical tourism, and the private medical sector in which it is situated, through attention to its local "embeddedness," as opposed to starting with the assumptions of economic orthodoxy or totalizing globalization (Brenner and Theodore 2002:349). Medical tourism is an outgrowth of recent political, economic, and cultural transformations that link Costa Rica and the U.S., and its subjects, practices, and imaginaries are both translocal *and* locally contingent—and hardly identical to cross-border medical consumption elsewhere. Just as "subjectivity and experience is always constructed in social practice" (Lock and Farquhar 2007), a cosmetic surgery tourist is

produced through her entanglement with specific objects, institutions, practices, and histories.

To follow these specificities, I call on the pragmatic methodology of actor-network theory (Latour 1993), and suggest that cosmetic surgery consumption in Costa Rica is a web of far-reaching associations of people, things, and machines. This network may be embodied in a patient, a government policy, an image, a public hospital, and a surgical tool: all heterogeneous entities that are constituted through their associations (Callon 1986). The concept of a network, writes Latour, is “more supple than the notion of system, more historical than the notion of structure, more empirical than the notion of complexity...” (1993:3).

A North American woman’s ability to obtain an inexpensive facelift in Costa Rica, for example, results from local surgeons’ ability to position themselves and their clinics as part of the “first world,” which is, in turn, linked to the Costa Rican state’s sponsoring of surgical traineeships in the public sector. This same facelift enhances the patient’s symbolic capital in a transnational cultural regime that valorizes youth and self-improvement, and is facilitated by Costa Rican caretakers who may themselves desire (but have limited access to) the pleasures of participating in new forms of consumption and self-making.

Likewise, a hotel that provides recuperation services for medical tourists is an elite, transnational space that is ideologically and materially distanced from public institutions and other zones of disinvestment under neoliberalism. It is simultaneously, however, a site where Costa Rican national identity is constructed through nurses’ performance of a gendered hospitality thought to inhere in the nation and its people. The

same hotel may also be constituted through the flexible labor of migrant workers from other Central American nations—laborers whose citizenship in Costa Rica is denied, but who nonetheless contribute to the production of an authentic Costa Rican experience for medical tourists.<sup>13</sup>

In this ethnography, I approach medical tourism as a simultaneously local and global phenomenon, and agency as a dispersed operation, rather than something that is held (or not held) by individual humans or institutions (Latour 1993). Likewise, the actors and sites I discuss are multiple, diverse, and not easily attached to one “location,” although they are always materially grounded. Some reside in the realm of imagination and imagery, such as the utopian vision that sustains Costa Rican exceptionalism, and the Edenic images that seduce conventional and medical tourists and shape environmental policy. These widely circulating imaginaries inflect individual surgical journeys through Costa Rica and its private operating rooms. I suggest, therefore, that even the most “virtual” spaces of imagination and sociality have acutely material effects on bodies and lived experience.

Hospitals, clinics, and recovery retreats are another set of actors in my story. They figure not as mere settings or containers for biomedical practice, but as spaces of cultural production through which specific moral economies and understandings of health are woven. The people and objects who populate, and constitute, these institutions and enterprises are—in turn—shaped by the practices and structures of meaning that have come to inhere in them. Private hospitals, for example, are promoted as luxurious,

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<sup>13</sup> David Harvey identifies flexible labor as an increasingly dominant feature of contemporary labor markets. It is characterized by “part-time, temporary or sub-contracted work arrangements” (1990:150), including labor performed by undocumented immigrants.

commercial spaces resembling medical institutions in the U.S., whereas public hospitals serve as crowded sites of inclusion, collectivism, corruption, and national identity. Both accommodate cross-border flows of medical migrants, as laborers or patients, welcomed or unwanted. I examine these medical spaces as a site where a national politics of inclusion and exclusion is played out and transformed. In the private sector, for example, socioeconomic distinctions determine access to services but are de-politicized through a discourse emphasizing individual responsibility and medicine as a form of consumption. The national medical program, by contrast, was founded on principles of social equality and national collectivism, but in practice social relations and status are the axes along which access to services is frequently negotiated.

Plastic surgery is a medical specialty that resides in both the public and private sectors, either as a state service or a commercial enterprise, and is subject to formal efforts to keep its realms of production separate. Officially, reconstructive surgery is practiced in national hospitals, while cosmetic procedures are performed in private practice. Since many surgeons divide their time between the public and private sectors, however, unexpected hybrids of public and private practice, and reconstructive and aesthetic procedures, are formed. These include the performance of aesthetic procedures in public hospitals as favors for friends and colleagues, as training exercises for novice surgeons, and sometimes for an illicit fee paid directly to the surgeon. In order to justify these practices in an institution that officially prohibits cosmetic surgery, and to advance professional and personal interests, surgeons and patients (with the tacit approval of administrators) continually negotiate and re-fix the boundary between reconstructive and

aesthetic surgery. In chapter five, I discuss how these practices contribute to the public sector's management and subsidy of the commercial realm of private plastic surgery.

Surgically altered bodies are hybrids—a melding of nature and culture designed to pass as normal or natural. Among cosmetic surgery tourists in Costa Rica, I argue, a technologically shaped body becomes natural in part through a period of post-surgical recuperation and sociality. To frame my ethnographic exploration of this process, I turn to a literature that challenges entrenched dualities of mind and body, cognition and matter, while acknowledging the importance of asking “why oppositional dualities continue to captivate the imagination of the majority” (Lock 2002:40).

### **Manufacturing natural bodies**

In her book *Twice Dead: Organ Transplants and the Reinvention of Death*, Margaret Lock asks: “What is a person? What is the relationship of person to body? Does the person cease to exist when the physical body dies?” (2002:37). Similar questions arise for me in the world of cosmetic surgery. What happens to a person when the physical body is altered? How did it come to be that many people feel their bodies to be out of alignment with their selves, and that a “natural” coherence of mind and body only seems attainable through biomedical intervention? And, specific to cosmetic surgery tourism in Costa Rica, what do visiting patients mean when they describe Costa Rica and its people as inherently healing of the “inner” person?

To engage these questions throughout the following chapters, I draw on several comprehensive histories of cosmetic surgery, cultural analyses of contemporary cosmetic

surgery practices, and theories of embodiment.<sup>14</sup> Perhaps the preeminent historian of cosmetic surgery, Sander Gilman, locates the emergence of cosmetic surgery in the Enlightenment emphasis on the individual and individual transformability, and the formation of notions of the individual within biology and medicine (Gilman 1999). Bodies understood through biomedicine have become a site of social control and subjectivity formation, a shift that Foucault chronicled extensively. The soul, or self, is an effect of disciplinary power-knowledge—a form of subjectivity resulting from the ways in which bodies are studied, measured, disciplined, shaped, and invested. Foucault writes, “The soul is the effect and instrument of political anatomy; the soul is the prison of the body” (1995:30).

Cosmetic surgery discourses in the U.S. often position surgical body modification as a practice of self-care, premised on the search for equivalence between self (soul) and body, and the assumption that the expression of one’s “true” or “natural” self is inextricable from bodily appearance.<sup>15</sup> Indeed, many people describe their bodies as separate from—even as betraying, or undermining—their true selves, and the body as being reinstated (temporarily) as the site of the self through surgical intervention, as well

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<sup>14</sup> See Sander Gilman (1999) and Elizabeth Haiken (1997) for excellent historical accounts of the development of cosmetic surgery. Theoretically provocative readings of contemporary cosmetic surgery practices include Balsamo (1996), Blum (2003), Fraser (2003), Heyes (2007), Jones (2008), and Pitts-Taylor (2007).

<sup>15</sup> As I discuss in chapters one and five, the logics of cosmetic surgery are somewhat different among Costa Rican surgeons and their local and visiting patients. Plastic surgeons tend to reproduce a discourse that positions their services as a kind of psychotherapy with a scalpel, or a treatment for (primarily) women with “low self-esteem.” They are careful, however, to switch registers with their North American patients, particularly those who approach cosmetic surgery as a practice of self-improvement or realignment. Costa Rican patients, meanwhile, typically situate their desires for cosmetic surgery in a gender normative aesthetics of proportion and beauty, and as a means of participating in Costa Rica’s transnational economy.

as through other, less invasive technologies of the self, such as diet, exercise, and fashion. A wide constellation of body modification practices posits the “natural” body as a product of technomedicine, and the pre-modified body as out of alignment and in need of (continual) repair. Not only is this understanding of bodies and selves paradoxical, but it also relies on the notion that a stable, and authentic, self can be attained, while maintaining a dualistic separation of mind and matter. Body modification is practices in order to release, or improve, the essential, inner self. Cosmetic surgery’s interventions mold bodies according to normative standards that are historically and culturally contingent, but that surgeons and patients describe as natural, timeless properties of symmetry and proportion.

Biomedical technologies have contributed to the development of the episteme of the normalizable body in which cosmetic surgery practices are embedded. An aging, bulging, sagging body can be experienced as abnormal or wrong—as out of alignment with the self—precisely because it *can* be corrected (Hirschauer 1998). Cosmetic surgery offers to “fix” bodies, and these bodies can be experienced as mere matter because biomedicine intervenes in them materially—the body being objectified as separable, pathologized parts before an operation, and the person *in* a body being removed by anesthetics during an operation. Like the PET scans described by Joseph Dumit as constitutive of a “diseased brain,” plastic surgery techniques construct a body that is “experienced phenomenologically but is not the bearer of personhood” (Dumit 2004:96). Until, that is, a successful surgical transformation has been performed. Success, however, can only ever be temporary, since living bodies always proceed with their intimately material participation in the life course. Surgical transformation, moreover, reaches for an

ever-receding normalcy, which “contains both the meaning of an existing average and an ultimate perfection to which we may progress” (Lock 1995:377).<sup>16</sup>

The idea that surgical enhancement reveals who a person really is also obscures surgery’s intimate, material participation in the production of subjectivity. Subjects, or persons, are always negotiated and performed socially, and they are never outside of social practice or the materiality of the body. Because of this always material contingency, personhood can never be unitary or fixed. As Judith Farquhar writes,

Bodies are far from inert or passive slaves to the intentions of minds; they are inhabited by language and history and ever-responsive to specific built environments (2002:7).

This understanding of embodiment informs my investigation of the social and material landscapes of recovery in Costa Rica, through which recuperating patients learn to “be” their new body-selves. Tourists’ bodies are shaped through conditions that make commodified medical hospitality possible in Costa Rica, including surgeons’ and nurses’ professional and ideological defection from state-sponsored medicine, flexible labor, and public sector subsidies of private sector expansion. These actors both constitute, and are naturalized or obscured in, medical tourism’s spaces—facilities that are marketed and

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<sup>16</sup> Some recent discussions of biomedical interventions in bodies emphasize a move from normalization to customization (Rose 2007), and from authenticity to simulacrum. For example, José Van Dijck writes that “in our ‘culture of the copy,’ authentic and fake seem interchangeable, and their distinction is therefore obsolete” (2007: 651). Indeed, the majority of cosmetic surgery tourists I interviewed in Costa Rica were intent on achieving what they imagined and described as a natural or normal body—a normalcy only achievable via surgical intervention. In response to Rose, however, I suggest that cosmetic surgery is still dominated by normalization, while customization remains on the fringe. And although cosmetic surgery consumers enthusiastically participate in a rhetoric of individual choice, the discourse of enhancement technologies suggests that a person may be deemed abnormal if she does not opt to improve her body according to normative aesthetic standards.

experienced as modern, but are also reminiscent of Costa Rica's national parks and demarcated plots of "pristine" nature, where:

'Preservation' is most commonly accomplished by a physical and textual exclusion of sedimented layers of social activity and actors, past and present (Katz 1998:53).

Like natural landscapes, the material of enhanced bodies and private medical practices is taken as outside of local institutional and cultural politics, which hides the power relations by which they are constituted (Butler 1993). One of my tasks here is to excavate some of these social layers, tracing how the mutability of elite, border-crossing bodies is linked to local spaces and bodies—including those that are in stasis or limbo.

For example, I consider how plastic surgery creates and tends to liminal bodies, particularly the recuperating bodies of visitors, but also those of undocumented labor migrants from Nicaragua, who form a disproportionate number of the patients in the national (public) burn unit. "Those who are burned are not the owners of businesses, but their workers," a surgeon explained. The visible hybridity of these bodies can be socially disruptive, desired cuts and accidental electrical burns alike. The way this disruption is managed, however, and its consequences, are infused with a national identity politics and contests over access to medical services. "Thinking the body is thinking social topography and vice versa" (Stallybrass and White 1986).

Lest my discussion of normative medicine imply that cosmetic surgery is solely motivated by lack, absence, disjuncture, and desperation, I conclude this section with a consideration of desire and pleasure, and their entanglements with consumption. Cosmetic surgery tourism is about desire—patients' desires to be youthful and attractive, to pass as normal, and to participate in the seductive pleasures of travel to a country

widely portrayed as paradise. It is also about the nostalgic longing for affordable, and hospitable, medical services.

Among plastic surgeons in Costa Rica, some desire an escape from the indignities and austerities of state medicine to the international recognition and affluence of private practice, while others dedicate the majority of their professional lives to national service via reconstructive surgery. Recovery retreat owners, meanwhile, find satisfaction in shepherding other surgical pilgrims through journeys of self-transformation, and residing in Costa Rican-style paradise permanently, while medical tourism brokers hope to cash in on a booming market.

For many visiting patients, the pleasures of recuperating in Costa Rica include leisure, unscheduled time, effervescent sociality, the bodily ministrations of gentle caretakers, pharmaceutical painkillers, the anticipation of enhanced social capital, and tropical landscapes. Doctors, nurses, and other workers in the medical tourism industry, for their part, enjoy membership (or proximity to it) in an urbanizing and globalizing Costa Rica, including the material acquisitions that this membership affords. A consideration of how these desires and pleasures intersect, conflict, and produce commitments and alliances runs through this ethnography, as does attention to how the fulfillment of some desires is linked to the thwarting of others.

To conclude this section, I offer the poetic words of geographer Allan Pred, whose incisive reflection on desire and consumption is itself a work of textual seduction:

It is through situated practice,  
through social interaction at sites of work, education  
and other institutionally embedded activities,  
through formal and informal conversations  
participated in during the conduct of daily life,

through everyday discourses and representations  
    encountered in public spaces, private spaces and the mass media,  
through visual and aural observations  
    made in the course of site-to-site movements,  
that consumer knowledge is accumulated,  
that the desire to possess is aroused,  
that needs and wants are constructed,  
that requirements and usage possibilities become apparent,  
that tastes take shape.

(Pred 1998:151)

### **Research methods, obstacles, and positions**

Ethnographies conventionally begin with the trope of arrival. As the story opens, the anthropologist “lands” in a village, on an island, or—more recently—in a lab or clinic. As ethnographers turned their attention to persons, groups, and objects whose movements and practices reveal overlaps *and* disjunctures among space, place, and culture (Gupta and Ferguson 1992), however, “multi-sited” ethnography has become the norm rather than the exception (Marcus 1995). If culture is neither a thing nor a place, and the persons and objects of study are on the move, where does the anthropologist arrive?

My geographic arrival can be roughly situated in Costa Rica’s *meseta central*, or Central Valley. The area is home to the nation’s capital, San José, numerous smaller cities and towns, and over a third of the country’s residents. San José is approximately 3,800 feet above sea level and has mild temperatures year round and torrential rains between May and November. In recent decades, metropolitan San José has undergone rapid development and commercialization, intensifying the contrast between urban and

rural Costa Rica. I conducted fieldwork at a variety of sites in and near San José between September 2005 and October 2006.

The research methods on which this ethnography is based consisted of participant observation both in person and online, formal and informal interviews, and collection of archival materials. I conducted observations and interviews primarily in public and private hospitals, private clinics, and post-surgical recuperation facilities—the latter popularly referred to as recovery retreats or recovery hotels. My access to these sites was variously enabled or constrained by the roles or identities assigned to me by people I hoped to interview and interact with. Before I turn to a detailed description of my research activities, I consider the constraints that my ethnographic gaze encountered, and their connection to how people become patients in Costa Rica.

### *Access*

Costa Rica is an appealing medical tourism destination precisely because it is easy for North Americans to visit. Visas are not required for U.S. citizens to enter Costa Rica, flights between major cities in North America and San José are frequent and relatively inexpensive, the nation has a well-developed tourism infrastructure, and most Costa Ricans who work in the tourism industry speak at least some English. Costa Ricans also frequently told me that they like Americans and that American tourists are unlikely to encounter anti-U.S. sentiment in their country, despite popular disapproval of the U.S.'s war in Iraq and its self-serving international trade policies.

Costa Rica's accessibility to North Americans, and its popularity among U.S. expatriates, had a conflicting influence on how I was perceived by informants, and on my

ability to gain entrée to potential research sites. On the one hand, visiting patients usually welcomed me as a fellow-American, as someone willing to lend a sympathetic ear during their long hours of recuperation, and occasionally as an assistant in navigating medical encounters. In addition, although I interviewed several men, most of the patients I met and spoke with were women—as are the majority of people who fly to Costa Rica for cosmetic surgery (although the proportion of men is rising, several surgeons and recovery hotel owners told me). The women I met told me it was easy to reveal intimate bodily concerns to another woman, particularly since they were far from home and felt less socially constrained. “What happens in Vegas stays in Vegas,” one patient explained.

The medical tourism industry, however, is based in the private medical sector, where an ethos of patient privacy makes ethnographic investigation difficult without physician patronage (Inhorn 2004). Most surgeons I contacted were more than willing to grant me an interview; some, I suspect, did not make a fine distinction between anthropologists and journalists, and imagined that talking to a North American researcher might indirectly enhance their reputation among prospective patients in the U.S. When I asked about observing medical consultations or surgical procedures with cosmetic surgery patients (visiting *or* local), however, the answer was—almost without exception—an unequivocal “no.” Patient privacy had to be respected, they said.

Eventually, and gradually, I gained limited access to private medical facilities, usually through the back door. One strategy involved becoming acquainted with a patient at a recovery retreat or on an Internet forum, and then requesting permission to accompany her to a pre-surgical consultation at her surgeon’s office. This was difficult to arrange because most people undergo surgery shortly after arriving in Costa Rica (often

within a day of their arrival), so my first encounters with patients were usually *after* their procedures were performed and they were in the process of recuperating. When I did manage to meet and follow the activities of a recently arrived patient, it was usually as a result of my posting a solicitation for research participants in an online cosmetic surgery discussion forum. The people who contacted me had not yet embarked on their journeys, and they encouraged me to meet them at their recovery retreats (or even at the airport) upon their arrival, and afterwards accompany them to their first encounter with their surgeon.

When I accompanied a patient to a clinic or hospital, I always explained to the clinic staff and surgeons that I was an anthropologist conducting research on cosmetic surgery practices in Costa Rica. Most surgeons did not react to my disclosure. They were, understandably, focused on the patient, and they usually interacted with me as if I were her friend or travel companion. My status as a North American woman apparently worked to my advantage in these situations, transforming me into a tourist despite my self-identification as a researcher. Despite these maneuvers, however, I was still unable to gain access to the inner sanctum of operating rooms, which I was told were off limits to non-medical observers. My attempts were continually thwarted, until I found another back door, this time through public medicine.

While full-time private practice surgeons were extremely protective of their patients' privacy, and cautious about admitting outsiders, their colleagues at the plastic surgery clinics in San José's national hospitals barely blinked an eye when I asked to observe their clinic activities. This is public medicine, after all, where patients are accustomed to a lack of privacy, to not choosing their own doctors, and to being

observed, examined, and operated on by a constantly rotating cadre of physicians, nurses, residents, and students. When I observed plastic surgery consultations at public hospitals, clinicians rarely explained my presence or that of other observers to their patients, and these patients rarely showed surprise or concern at the commonplace sight of strangers filling the room.

Although I watched numerous patient-physician consultations and minor surgical procedures at public plastic surgery clinics, public surgeons were also reluctant to grant me access to their operating rooms. The reasons they gave were vague, but did not emphasize patient privacy. I suspect, rather, that their hesitation had more to do with the extra effort required to accommodate an observer not accustomed to the sterility rituals, and gore, that are routine in operating rooms. My persistence paid off only two months before the conclusion of my fieldwork, when a young surgeon (who told me he had learned to appreciate the challenges and relevance of social research while studying in Europe) unexpectedly granted me permission to observe aesthetic and reconstructive procedures in a national hospital's operating room. Several weeks later I was also able to observe a seven-hour facelift operation at his private clinic. These forays into the operating room were unfortunately curtailed by my return to the U.S., but they afforded me a glimpse of the rituals, labors, and sociality of surgical teams, and how they differ in the public and private sectors.

### ***The ethnographer's position***

Having been raised from my anthropological infancy in the various schools of post-positivist thought, I am convinced that the knowledge produced by an ethnography

can only ever be partial, and is always situated in the conditions through which it is generated. Objectivity and neutrality seem to me to be intriguing myths with complex historical genealogies, rather than methodological strategies.<sup>17</sup> While I was conducting fieldwork, however, the lessons I had learned about the entanglements of observation and participation were brought home to me more acutely than I could have anticipated. I discuss here two ways in which I was “involved” in my research activities, particularly during participant observation sessions, and how this involvement speaks to the micro-politics of power between clinicians and patients, and to the pervasive interpellations of “makeover culture” (Jones 2008a)—in which nearly everyone is invited to scrutinize, find fault with, and render operable, their bodies.

I was 40 when I arrived in Costa Rica—a problematic age in the world of surgical enhancement, as it turns out. Most North Americans who travel to Costa Rica for cosmetic surgery undergo procedures intended to rejuvenate aging skin and flesh. Although I met visiting patients in their 40s and even younger, the majority of women and men I interviewed and observed were in their 50s and 60s. And while they were usually forthcoming about their experiences in Costa Rica, several people told me that I was “too young” to really understand what they were going through. I would only grasp the desire for a facelift (and, consequently, the journey to obtain one), they implied, once my body has reached the age when I “need” the procedure.<sup>18</sup> It was my stage of life, more

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<sup>17</sup> See Daston and Galison (1992) for a fascinating account of the multiple usages and complex histories of “objectivity.”

<sup>18</sup> Facelifts, however, are increasingly popular among women and men in their 40s and even 30s (Rosenthal 1991). One Costa Rican plastic surgeon called these procedures “preventive,” and said that they reduce the need for more drastic facelifts later in life.

than my role as a researcher that positioned me as an outsider among visiting patients.

For many people, cosmetic surgery is a rite of passage, or a mark of distinction, and it seemed to operate as such on non-patient participants within its orbit. For example, a Costa Rican nurse in her early 30s told me that she was excited about the surgical “gifts” her employer (a plastic surgeon) had given her, while the 20-something daughter—and travel companion—of a facelift patient from the U.S. told me that she “couldn’t wait” to have cosmetic surgery herself, after seeing the transformations of her father and the other guests at the recovery retreat.

Simultaneously, however, I found myself subject to the suggestions (subtle *and* overt) made by several plastic surgeons that I needed enhancement procedures myself. These doctors, I should mention, were not typical, since most plastic surgeons I interacted with refrained from offering unsolicited evaluations of my body, and they were gracious in their accommodations of me as a researcher. Nevertheless, these occasional efforts to shift the power dynamic—to transform me from a somewhat more authoritative position of interviewer or observer to the more passive role of patient, was disconcerting. As Virginia Blum writes about similar encounters she had while conducting interviews with plastic surgeons in the U.S., “...my aging female body beckons the roles to revert to the normative—for me to become the patient and him the doctor” (2003:30).

My experiences being turned into a patient were usually gendered. For example, a male physician asked whether I had considered breast implants, and another insisted that an eyelid lift would help me to “preserve” my face. My glasses, meanwhile, were met with incredulity—why would a woman choose to wear glasses if she can afford laser eye

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These practices suggest that cosmetic surgery is morphing into a strategy of continual, corporeal management, rather than a repertoire of one-time, curative interventions.

surgery, they asked. Yet I was also subject to the surgical gaze of a female resident who told me that I could not possibly understand cosmetic surgery unless I was willing to undergo it myself. In these instances, I felt disconcerted, and too visible—the opposite of a detached observer. I realized, again, that there is no outside perspective in a fieldwork encounter, or in the cultural regime that has made cosmetic surgery a normal—and normative—practice, inserting its enchantments deeply into everyday social interactions.

In a conversation on fieldwork and writing conventions, Mary Louise Pratt writes about the experiential basis of research:

Fieldwork produces a kind of authority that is anchored to a large extent in subjective, sensuous experience... But the professional text to result from such an encounter is supposed to conform to the norms of a scientific discourse whose authority resides in the absolute effacement of the speaking and experiencing subject (1986:32).

These norms have changed in the intervening years since this statement was written, at least in anthropology. Therefore, my intention in bringing my experience into this text, here and at strategic points throughout the following chapters, is not so much to counter this effacement. Nor is it to unsettle what James Clifford calls the “privileged monotone of ‘scientific’ representation” (1986:103), although I do hope to avoid producing a sensation of monotony in my readers. Rather, these moments point to the sticky social entanglements of research, their subject-producing effects on researchers and participants alike, and the insidious infiltrations of discourses of medical normalization.

## *Sites of observation*

### *Recovery retreats*

Many, if not most, North Americans who travel to Costa Rica for cosmetic surgery spend a period ranging between several days to several weeks at a post-surgical recuperation retreat in or near San José. These tranquil and secluded spaces, and the social interactions within them, are frequently described by visiting patients as central to the personal and corporeal rejuvenation that a surgical journey to Costa Rica entails. Some of these facilities are situated in private homes, while others resemble quasi-medical hotels. At larger retreats, most services are provided by owners, on-staff nurses, cooks, maids, and drivers. I visited and was given tours of six retreats, and was allowed to visit two retreats repeatedly in order to conduct interviews with guests. At another, the owner generously welcomed me to visit, observe daily activities, and interview patients at my convenience. I spent one or two days each week at this ten-room facility, joining guests for meals, talking with them in common areas or their rooms, and observing the caretaking activities of nurses and occasional exams by visiting surgeons.

### *Private medical facilities*

North American cosmetic surgery consumers in Costa Rica typically pass through a private medical facility as a patient. Historically, most surgical procedures were performed in private clinics or one of San José's small private hospitals. Many surgeons—particularly the older generation of surgeons nearing retirement—continue to offer services in private clinics, as do surgeons who cater primarily to local patients. Younger surgeons, and their visiting patients, however, increasingly prefer to operate and

be operated on in one of Costa Rica's new, or newly expanded, private hospitals. I visited four private, multi-specialty hospitals in and near San José, and five private plastic surgery clinics, and was able to spend time observing pre-surgical consultations at four private clinics and one private hospital. In addition, I observed a facelift and chin implant operation at a private clinic.

### *Public hospitals*

Twice a week for seven months, I observed routine activities at four public plastic surgery clinics in San José, including the National Children's Hospital. Clinic activities included doctor-patient consultations, professional and social interactions among clinic staff, outpatient surgical procedures, examinations of acutely injured patients in the emergency room and intensive care unit, and staff lectures on plastic surgery for medical students. For five consecutive Friday mornings, I also attended "aesthetic sessions" at one public clinic, at which working- and lower-middle class Costa Rican women were granted, or denied, access to state-sponsored cosmetic surgery. In addition, I was able to observe several surgical procedures in the operating room at a public hospital, including: a tissue graft to treat a muscular disease, a combined rhinoplasty (nose job) and deviated septum repair, an abdominoplasty (tummy tuck), a breast lift, two post-mastectomy breast reconstructions—one using implants and the other the patient's flesh, and a gynecomastia procedure (male breast reduction) with liposuction.<sup>19</sup>

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<sup>19</sup> See chapter three for a list of popular cosmetic surgery procedures.

### *Recruitment meetings*

After returning to the U.S. in late October, 2006, I attended a recruitment meeting in Los Angeles for a Costa Rican plastic surgeon. The meeting took place at an upscale restaurant and was attended by approximately 20 women. The host was a cosmetic surgery “tour guide” whom I had met in Costa Rica. She recruited exclusively for one surgeon, having been inspired by her experience as a patient. On one of her trips to Costa Rica she generously allowed me to conduct an interview with her, follow her as she tended daily to recuperating patients, and conduct a group interview with her charges at a recovery retreat. The recruitment meeting, in conjunction with observations and interviews in Costa Rica and on the Internet, helped me to understand how Costa Rican medical services are promoted in contrast to those in the U.S., and how the decision to undergo cosmetic surgery is socially negotiated among U.S. consumers.

### *Web-based discussion forums*

In addition to in-person participant observation and interviews, I joined several Internet news groups and cosmetic surgery information-sharing sites, after learning that many people participate in these groups in order to learn about medical tourism destinations, read the testimonies of returned travelers, and circulate “before and after” images of bodies and body parts. The sites I joined were PlasticSurgeryJourneys.com and a Yahoo group for a private plastic surgery clinic in San José. I used my first name, rather than an alias, and I identified myself to other members as an anthropologist doing research on cosmetic surgery in Costa Rica. Through PlasticSurgeryJourneys.com, I met at least eight people whom I was later able to interview and spend time with in Costa

Rica. I also joined a Yahoo group called Costa Rica Living, whose members are primarily expatriate residents of, or frequent visitors to, Costa Rica. After posting an explanation of my research project to this group, I was contacted by several North American residents of Costa Rica whom I was later able to meet. These conversations contributed to my understanding of the experiences of North American retirees in Costa Rica, and the contours of daily life which, for many, include U.S. cable TV, American-style shopping malls and supermarkets, and gated housing communities.

### ***Interviews***

In addition to my activities as a participant-observer, I conducted semi-structured interviews with a variety of people involved in the cosmetic surgery and medical tourism trades. Before the start of each interview, I explained the IRB-approved verbal consent form and obtained permission from each participant to proceed with the interview and to make an audio recording. On several occasions, participants (usually doctors) gave me permission to take notes but not to record, and once a surgeon asked me to turn off my recorder in mid-interview while he told me stories about unexpected links between the Sandinistas, the CIA, and cosmetic surgery.

My conversations with clinicians included interviews with 20 plastic surgeons, one general practitioner, one anesthesiologist, three plastic surgery residents, one general surgery resident, and one oral surgeon. I also interviewed four recovery retreat nurses, two private clinic nurses, two public hospital nurses, and two private clinic assistants. Most interviews with doctors took place in the medical office of the person being

interviewed; nurses and clinic staff were interviewed at clinics, recovery retreats, and on one occasion at a café. These interviews lasted on average an hour.

Among patients, I interviewed 21 women and three men visiting from the U.S., five U.S. expatriate residents of Costa Rica who underwent, or were considering, cosmetic surgery in Costa Rica, five Costa Rican cosmetic surgery patients, and three Costa Rican public hospital patients. I also interviewed five travel companions of patients, including spouses, parents, and children. In addition, I followed up by phone or email with four women several weeks after they had returned to the U.S., inquiring about retrospective and ongoing impressions of corporeal and geographic journeys. I conducted interviews with visiting patients at recovery retreats or public places such as cafés or restaurants, while meetings with local patients took place in private homes, in a private clinic, or in cafés. Interviews typically lasted between one and two hours.

Recovery retreat owners were also generous with their time as interviewees, including five current owners, one woman who had closed her retreat but was considering getting back into the recovery business, and seven people (six North Americans and one Costa Rican) who were considering building recovery retreats or other medical tourism-related businesses. These interviews were conducted at owners' hotels, in a private home, at a hospital, and at a conventional hotel. They lasted an average of 45 minutes. Some of these people were, or had been, patients of local plastic surgeons, and they offered useful historical context on the development of cosmetic surgery tourism, the recovery industry, and their links to conventional tourism.

My interactions with Nicaraguan workers in Costa Rica were limited by my delayed understanding of the important role they play as domestic and construction

laborers in the tourism industry, their near-invisibility in recovery retreats, and my lack of access to severe burn patients (Nicaraguans make up the majority of burn patients, but are otherwise rare in public plastic surgery facilities—their public medical access typically limited to emergency and obstetrics services). I did speak informally with several Nicaraguan migrant workers, and I visited Granada, Nicaragua for three days—a city not far from the Costa Rican border. While there, I spoke with local people about migration to Costa Rica and anti-Nicaraguan sentiments among Costa Ricans.

In addition to the above interviews, I met with a U.S. journalist whose cosmetic surgery tourism guidebook was published several years after he traveled to Costa Rica for extensive dental work. His comments and writing shed light on how Costa Rica is portrayed in the popular media, and what barriers Costa Rica faces in becoming a successful competitor in the global medical tourism market. I also interviewed a professor of economics at the National University, in order to gain a contextual understanding of the potential impacts of, and popular reactions to, trade agreements between the U.S. and Costa Rica, in particular the possible effects of CAFTA's (Central American Free Trade Agreement) insurance privatization stipulations on the nationalized medical program. Finally, I conducted informal interviews and conversations with approximately twenty expatriate residents of Costa Rica who were *not* involved in the cosmetic surgery or medical tourism industries. Their reflections gave me a glimpse into the wide range of daily activities pursued by U.S. residents of Costa Rica, and offered a partial portrait of expatriate conceptions of Costa Rica and its medical institutions.

Approximately half of my interviews with doctors and nurses were conducted in Spanish and the majority of these were with clinicians who worked for the public medical

system. Most plastic surgeons who work with North American patients are proficient or fluent in English, although several told me that they felt more comfortable being interviewed in Spanish. Interviews with North American patients and recovery retreat owners were exclusively in English.

Costa Ricans often told me that “*el tico vive de chisme*” [Costa Ricans live on gossip], and I learned quickly that most of Costa Rica’s plastic surgeons are acquainted with (and have much to say about) each other—either personally or by reputation. If even one of them reads this ethnography, he or she will no doubt see past my pseudonyms to the actual people I interviewed and observed; nevertheless, I have changed their names—and those of patients—to provide a degree of anonymity.

### ***Archival research***

Local newspapers and magazines provided an invaluable resource in my investigation of how state-sponsored medicine is popularly represented, and the tropes through which cosmetic surgery and other private medical services are marketed to locals and foreign residents. I also examined the web sites and promotional materials (including brochures and videos) of hospitals, clinics, hotels, recovery retreats, and the Costa Rican Tourism Board (ICT). These sources usefully illustrated how a consumable Costa Rica is produced via images of pristine nature, state-of-the-art technology, and gendered and racialized bodies.

I visited the offices of the Costa Rica Tourism Board, as well as the National Tourism Chamber (CANATUR), to determine to what extent state agencies were engaged in campaigns to market, or develop, medical tourism facilities. In addition, I

visited the National Institute of Statistics and Censuses (INEC) and the statistics office of the Costa Rican Social Security Fund (CCSS), in order to obtain information about health indicators, and the demographics of public and private medical usage.

### **Chapters outline**

In the following chapters, I trace the practices, discourses, and objects that transform individual bodies and ideologies of health and national belonging in Costa Rica.

Chapter one presents a history of medical institutions and national identity formation in Costa Rica, and offers a contextual account of the emergence of Costa Rica as a destination for tourism and foreign capital investment, and the politics of public medical consumption by Nicaraguan migrants.

Chapter two considers Costa Rica's spaces of private medical consumption in the context of the global expansion of medical tourism, and how these spaces are produced materially, textually and imaginatively. Costa Rica's elite private hospitals are designed to be both "in" and "beyond" on-the-ground conditions in Costa Rica, and as such they are subject to strategies that enhance their technological sophistication, cosmopolitanism, and hospitality. At the same time, undesirable circumstances associated with the Third World are excised from, or rendered less visible in, these spaces, including poverty, migrant labor populations, and the deficiencies of public medicine.

In chapter three, I account for the first stages of cosmetic surgery journeys, examining how bodies' mobility and mutability are mediated by images and Internet-based sociality. I then discuss arrivals in Costa Rica, and the pre-surgical encounters

between surgeons and patients, through which body modification itineraries are negotiated and patients are made operable. In this chapter I also offer an analysis of surgery itself, an unremembered, but acutely disruptive, experience for patients and a period of choreographed and routine labor for the surgical team.

The corporeal and social liminality of post-surgical recuperation is the focus of chapter four. I examine how this precarious state is translated into both a business opportunity and an experience of personal growth, leisure, and pleasure, through the labors and landscapes of recovery retreats. I consider how both clinicians and patients engage a politics of nostalgia and escape; among doctors and nurses this is in reference to the nationalized medical program, while visiting patients claim to be in retreat from a broken medical system in the U.S.

In Chapter five I discuss plastic surgery practices in national hospitals, and how state-sponsored medicine underwrites the expansion and capital accumulation of the private sector, via the training of new doctors and the management of public sector cosmetic surgery procedures. Through stories of plastic surgeons who divide their time between public and private practice, and the practice of cosmetic surgery in public medical facilities, I consider how plastic surgery in Costa Rica is shaped—and embodied—by a persistent tension between a discourse of market supremacy and individualism, and a nationalist logic of medicine as a project of social equalization.

I conclude by considering the recently elected government's enthusiasm for expanding private medicine and medical tourism in Costa Rica, and what consequences these projects might have for the future of nationalized medicine. I ask how medical services will be distributed among residents and visitors to Costa Rica, and what form

privatization's further inroads into the public sector might take. What kinds of bodies, subjects, and (im)mobilities will be produced by these changes that are simultaneously social and material?

## CHAPTER ONE

### FASHIONING A NATION: MEDICAL CITIZENS AND PRIVATE CONSUMERS

*A great act of medical creation lies at the heart of Costa Rica's modern polity.*

- Steven Palmer (2003:207)

*Before, the middle class had a dependable, secure system. Now, they are taxed but they don't receive services.*

- Costa Rican plastic surgeon (2006)

*There is a hospital around the corner from where I am staying and looks like it should be torn down... Clínica Bíblica [private hospital] is as modern as it gets.*

- U.S. cosmetic surgery patient (2008)

#### ***Prelude: betting on breasts***

In conversation with Costa Rican plastic surgeons, I often asked which aesthetic procedures were most popular among their patients, and whether there was variation between North Americans and Costa Ricans. There is not much difference, they said. Women from the U.S. generally want larger breast implants, but overall the desire for specific types of body modification has more to do with age than where a person comes from, they said. Older women (and, increasingly, men) want to reduce the visual effects of aging through lifts (eyelids, face, arms, stomach, breasts) and facial peels, whereas adults of all ages are drawn to the weight loss shortcut offered by liposuction. Young women, meanwhile, are desperate for larger breasts, they told me, and most breast

implant patients are from Costa Rica. (Breast augmentations are among the least expensive invasive aesthetic procedures, so North Americans do not have a strong financial incentive to travel to Costa Rica for implants unless they are part of a more extensive operation, such as a full body lift combined with implants).<sup>20</sup>

According to the American Society of Plastic Surgeons, almost 350,000 breast augmentation procedures were performed in the U.S. in 2007, a 64% increase since 2000 (2008). Statistics for cosmetic breast surgeries in Costa Rica are not available. However, based on conversations with doctors, patients, and acquaintances, I suggest that breast augmentation surgery is even more popular in Costa Rica than in the U.S. Silicon gel breast implants are routinely inserted in girls as young as 15, and the operation is a popular high school graduation gift from parents to daughters.<sup>21</sup> Augmentations are even performed in state-sponsored hospitals as training exercises or favors for colleagues and acquaintances, in addition to breast lifts and post-mastectomy breast reconstructions. The ceaseless media attention on cosmetic surgery in Costa Rica, moreover, often focuses on breast implants, including graphic, sexualized images of surgically feminized bodies. The authors of a Costa Rican beauty magazine article titled “Invasion of Large Breasts,” for example, write about breast implants as ubiquitous and as an almost obligatory “choice” for Costa Rican women:

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<sup>20</sup> This insistence on cultural homogeneity between Costa Rica and the U.S. occludes differences in perceptions of beauty, but it also points to the mobility of plastic surgery’s objects and techniques, and the assumptions about health, normalcy and well-being in which its practices are moored.

<sup>21</sup> The U.S. Food and Drug Administration banned the use of silicone breast implants in 1992 and re-approved them in November 2006 (United States FDA 2007) The ban helped enhance the attractiveness of Costa Rica to U.S. women seeking the more “natural” look of silicone implants, which were never banned in Costa Rica.

Voluptuous breasts seem to be in style. If we don't see them on TV, they are in magazines, advertisements, bars, and in general, in the street... Large breasts are being democratized. More and more models, actors, and mere mortals decide to magnify their sensuality... after all, who doesn't want to feel beautiful? (De Lemos et al. 2006).<sup>22</sup>

Breasts are even used to sell increasingly popular American-style fast food. A 2006 Costa Rican television commercial for Burger King, for example, featured a nurse with large, semi-exposed breasts who takes a crying child from its mother as she lies in a hospital bed. The baby immediately becomes quiet, while a deep male voice announces that “even babies like them bigger.” The scene shifts to a close-up of hamburgers and French fries. As an expression (and stimulation) of the interplay of desires for participation in new forms of consumption, the advertisement speaks to a new economic and cultural order in Costa Rica. To examine more closely the particular hold that this form of consumerism has on Costa Rican bodies and subjects, I present a story set in today's cosmopolitan San José. The protagonist is a woman who sought to heal *and* beautify her body through cosmetic surgery, and whose self-care practices can be situated in Costa Rica's changing conceptions of health and medical citizenship.

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On a warm afternoon in April, 2006, I arrive at a tall, modernist building facing San José's largest park, La Sabana. Occupying a former airfield, the park's sparse stands of trees and open, grassy areas are worn from human activity, and bear little resemblance to the images of lush, pristine nature deployed to draw tourists to Costa Rica. La Sabana is, however, surrounded on nearly all sides by affluence, and is comfortably removed from downtown San José's frenetic tangle of traffic and commerce. The building I am

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<sup>22</sup> All interview, newspaper, and archival translations are mine.

visiting is home to several foreign-owned businesses, and is one of the city's many architectural monuments to the ever-extending reach of foreign capital into Costa Rica. Its neighbors include a tennis club, upscale restaurants, two plastic surgery clinics, and several large government buildings. Traci, a 30-year-old woman who underwent breast augmentation surgery last year, waits for me as I exit the elevator on an upper floor. She works at a "sportsbook," whose call center jobs have become a common feature of Costa Rica's transnationalizing employment landscape. This particular sportsbook has an online casino, where people around the world (including many U.S. residents of Costa Rica) play poker and other virtual card games (their wins and losses are decidedly not virtual), and it also accepts wagers on sporting events. The company is based in the U.S., but has evaded anti-gambling laws by moving its offices offshore to Costa Rica, where laws are less restrictive.

Traci ushers me through a large room with banks of computers and several employees talking on the phone. They primarily take calls from people in the U.S. who want to place bets, so English fluency is a job requirement. Call center wages are typically US\$5 an hour, she says, which is higher than Costa Rica's average income but barely enough to be comfortably middle class in San José, where the cost of living is much higher than in rural areas.<sup>23</sup> Traci started working here ten years ago, taking phone wagers on horse races, and now she earns US\$800 per week as the president's assistant. We enter his office, a large room strewn with Asian rugs and expensive chairs, the walls lined with dark wood paneling and framed photographs of American baseball players and

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<sup>23</sup> In 2004, the average household income in Costa Rica was approximately US\$8,600 (State of the Nation Program 2005).

racehorses. Traci's desk is in the corner, and I wonder if she serves as another kind of trophy in this masculinized hyperspace of neoliberal success and mobility.

Traci tells me that she was born in the U.S. to Costa Rican parents. She lived there for several years as a child and again as an adult, but ultimately returned to Costa Rica to be closer to her family. She misses the U.S. "Costa Rica is pretty," she says, "but it's too Third World." Traci seems to reside in a space that is culturally, economically, and medically outside of this third-worldness. She tells me she would go to a *Caja* hospital for a serious health problem, but prefers to pay for private medical consultations. Throughout our conversation, Traci switches easily between English and Spanish, her verbal fluidity matching her ease with different cultural registers. She explains that the enthusiasm for breast implants in Costa Rica is "almost like an epidemic." Just at this sportsbook alone, she says, three other girls besides herself have recently purchased "new breasts" at local cosmetic surgery clinics. Years ago, cosmetic surgery was accessible only to the wealthy, she tells me, whereas now more people can afford it. And nearly everyone wants it, since Costa Ricans are strongly influenced by local and U.S. television shows promoting and sensationalizing biomedical techniques of body reshaping. I cannot help but think of the popular Colombian soap opera from the late 1990s, *Ugly Betty*, whose main character finds professional and romantic success only after undergoing a complete makeover in her appearance and social status: "In *Betty*, 'beauty' could be acquired by accommodating Western, 'white' middle-class patriarchal norms of femininity" (Rivero 2003:72).

Why did you want breast implant surgery?, I ask Traci. "I needed it, I wanted it, I could do it," she says, succinctly condensing the interplay of desire with its naturalization

as need, and fulfillment via medical commodification. “My body disgusted me,” she goes on, “and I felt like a little boy.” She was not searching for perfection, she insists, “I just wanted to be in proportion.” She conducted Internet research to find out about risks and benefits, interviewed several surgeons, and negotiated implant size with them (the surgeons she rejected were more paternalistic, and did not want her to participate in the decision about how many cubic centimeters of silicone gel would be inserted in her body). Her now ex-husband, whom she describes as a “hippie” from the U.S., tried to talk her out of the operation, but she finally decided to go ahead with it anyway. She explains her rationale further:

I’m not looking for attention; I did it more for me. I felt confident with my body, but why not make it better? At the beach, I get a lot more male attention now. People ask me if they’re mine, and I say, ‘yes, they’re mine—I paid for them!’

She paid \$3,100 for her new breasts, to be exact (in addition to two days of regret, which she tells me passed soon enough). Just as she weaves effortlessly between colloquial English and Spanish, Traci’s narrative (like those of most cosmetic surgery consumers I spoke with) veers between two, almost contradictory, logics. The first frames cosmetic surgery as part of a simple quest for normalcy; her body was outside of an acceptable range of gendered proportion, and plastic surgery offered a treatment to restore it to its proper shape and femininity. The second logic positions cosmetic surgery as a technique of self-betterment via consumption—a means through which Traci could make herself the person she had long imagined she could be.

As our conversation winds down and I am preparing to leave, Traci asks if I’ve ever considered getting implants myself. It is a trick question, meant kindly. I consider my feeling of repulsion at the thought of a surgeon cutting my body and shoving heavy bags of plastic gel into my flesh (I have seen this procedure performed in the operating

room, and “shove” is the most accurate term I can find to describe the vigorous activity of coaxing an implant through a much smaller incision). I cannot say this to Traci, however, since it might imply that her motives were based on weakness or vanity. Even the surgically disinclined understand the tacit agreement among women to approve of any efforts at self-improvement. If I say yes, on the other hand, I reproduce the cultural imperative of relentless work on the self, affirm the symbolic capital of conventional femininity, and contribute to the further naturalization of a widening arsenal of biomedical techniques for self-enhancement. I realize, not for the first time, that I am always interpellated, uneasily, by cosmetic surgery’s discourse.



Figure 1. “We Care More about the Size of Your Smile than the Size of Your Bust.” Advertisement for cosmetic surgery in *Perfil* magazine. February 2006.

## Introduction

I began this chapter with the story of a Costa Rican consumer of cosmetic surgery for two reasons: the first is to highlight surgical enhancement as a set of practices through which subjects are produced as agents of their own well-being. This regime has enfolded

both North Americans and Costa Ricans in its sticky embrace, while informing broader transformations in the contours of Costa Rica as a nation and a surgical destination. In the process of being surgically transformed, in other words, local and foreign bodies become condensed materializations of the economic and social re-fashioning of Costa Rica itself. My second goal is to point to the tensions and contradictions in Costa Rica's recent embrace of new forms of consumption via privatization and transnationalization, since the dominant national narrative persists in locating citizenship, and the production of healthy citizens, in the dominance of large state institutions and industries. What does it mean that Traci does not feel a strong affinity for this narrative? And how do other Costa Ricans navigate the shifting terrain of medical participation?

In this chapter, I address these questions by outlining the historical development of Costa Rican biomedicine, and considering the recent expansion of private medical services catering to tourists, foreign residents, and elite Costa Ricans. First, I discuss how biomedicine developed as a project of Costa Rica's model of social democracy, and a cornerstone of a national project that associates access to state-sponsored social services with development and modernization. I then turn to the ascendance of neoliberalism, through which ruling elites have promoted deregulation, privatization, and foreign investment. I consider the consequences of these changes, and the tensions between this new regime and continued public sector dominance in the provision of health care.<sup>24</sup> I conclude with a discussion of medical tourism's transformation from an informal cottage industry to a key branch of Costa Rica's fervent private sector expansion, and the

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<sup>24</sup> The public sector is also active in banking, insurance, telecommunications, and electricity.

connections between medical consumers' North-South migration and a less welcomed cross-border flow from Nicaragua.

### **Medical visionaries and nation building**

*Our song is solemn and vibrant  
it is the hymn of a better world,  
where everyone finds refuge  
in the law that protects them .*

*Nuestro canto es solemne y vibrante  
es el himno de un mundo mejor  
donde todos encuentran amparo  
en la ley que les da protección.*

*We are strong modern soldiers  
of a beautiful national project,  
that protects the children of the nation  
offering Social Security,*

*Somos fuertes soldados modernos  
de una hermosa función nacional,  
que protege a los hijos del pueblo  
ofreciendo el Seguro Social,*

*For a large and beautiful homeland  
with the faith that we put in God  
Social Security is a magnificent  
guarantee of a better world*

*Por la Patria más grande y Hermosa  
con la fe que ponemos en Dios,  
el Seguro Social es grandioso  
garantía de un mundo mejor.*

- Costa Rica's Social Security Hymn,  
first performed in 1964 (Caja Costarricense de  
Seguro Social 2008a)

Costa Rica is the exception in Central America, we are told by historians, tourists, and Costa Ricans themselves. Sometimes referred to as the “Switzerland of Central America,” Costa Rica is locally and internationally imagined as an oasis of democracy, egalitarianism, and prosperity in a region torn by war, dictatorships, and extreme inequalities in wealth. Costa Rican exceptionalism also contains a myth of racial purity—a “white legend” in which Costa Ricans are assumed to be of “pure,” European descent (Edelman 1999). Historians have reproduced this narrative, tracing Costa Rica's exceptional status to Spanish colonial rule, the territory's remoteness from colonial administrative centers, its small population, scarce (and geographically marginal)

indigenous groups, and its relatively less exploitive labor relations (Perez-Brignoli 1997; Skidmore and Smith 1997; Woodward 1985).

Recent scholars of Latin America, however, have generated compelling critiques of Costa Rican exceptionalism, emphasizing its erasure of a long history of social and economic inequalities and racialized oppression, particularly towards indigenous peoples, agricultural laborers and Costa Ricans of African descent (Harpelle 2002; Paige 1997; Putnam 2002). Nonetheless, exceptionalism continues to inform and animate prevailing understandings of Costa Rican national identity and nationhood. Deployed to attract tourists and foreign investors (Rivers-Moore 2007), the myth of Costa Rica as exception omits not only past complexities, but has recently run up against less-than-exceptional features of the nation's contemporary social, political and economic landscape. These include increasing air and water pollution, deforestation, poverty, popular disenchantment with the government and ruling elites, and large migrations of impoverished laborers from other Latin American countries. Nicaraguan migrants, in particular, are popularly perceived as a threat to Costa Rican exceptionalism, prompting "a public discourse centering on the defense of the racial purity of Costa Rica" (Molina-Jiménez 2005:106).

Costa Rican national identity is also bound up with state institutions, and their presence in the everyday lives of the nation's citizens. The largest state institution, the Costa Rican Social Security Fund (CCSS), administers the national health program, and its genealogy can be traced to the colonial and post-colonial formation of medical institutions and professions. In the 19<sup>th</sup> century, many physicians were members of the nascent government and the coffee producing elite, so medicine and politics have long been intertwined projects. In addition, according to medical historian Steven Palmer, a

longstanding accommodation among heterogeneous medical practitioners (including popular and indigenous healers) was gradually replaced by biomedical hegemony in the late 19<sup>th</sup> century—a process that was connected to the construction of the state:

The dramatic advances in surgery and the revolution in bacteriology that reshaped the scientific identity of medical doctors throughout the world during this period gave the Costa Rican profession a central symbolic role in the liberal polity... The rise of this vanguard and the professionalization of medicine was integral to the building of a modern Costa Rican state apparatus (Palmer 2003:67).

Although medical service provision was not dominated by the state until the 20<sup>th</sup> century, the roots of its social mandate include an 1871 addition to the Costa Rican constitution. The clause described the state's obligation to provide a fair distribution of wealth and a social security system for workers (Cruz 1991). This project was invigorated by way of a “medical populism” that spread through Latin America in the early 20<sup>th</sup> century (Palmer 2003:219). The state's control over the social, economic, and bodily health of Costa Ricans was institutionalized in the social security programs established during the presidency of Rafael Ángel Calderón Guardia, who was himself a physician. The largest of these programs was the CCSS, created in 1941 and now popularly referred to as the *Caja*, which translates as “fund” or “safe-deposit box”.<sup>25</sup> Health services for workers were a component of this program, acting as a “social tranquilizer” that smoothed tensions between labor and capital (Casas and Vargas 1980:263).

In 1948, Calderón was overthrown in a six-week civil war by the allies of José “Pepe” Figueres, a coffee grower who ultimately became Costa Rica's next elected

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<sup>25</sup> The Costa Rican Social Security Fund, or CCSS, administers unemployment, disability, and retirement insurances, as well as a national network of 240 health clinics and 29 hospitals.

president. Figueres' government nationalized Costa Rica's banks, granted women the right to vote, further expanded social security programs, and

...quickly decapitated the popular classes with a wave of repression against communists, trade unionists, and their supporters. But he also neutralized the threat of an oligarchic backlash by abolishing the army (Robinson 2003:134).

The growing state apparatus promoted public health care's path to nationalization—extending the biomedical reach of the state into everyday life and linking state-sponsored medicine with a broader project of national development (Miranda-Gutiérrez 2003).

I do not mean to suggest, however, that the populist trend in Costa Rican medicine in the late 19<sup>th</sup> and early 20<sup>th</sup> centuries was uniformly embraced by physicians. Many elites, including doctors, were opposed to the national medical program during the era of its implementation and expansion (Rosenberg 1982). Prior to this time, physicians performed charitable work at hospitals as a status-raising adjunct to more profitable private practice. Steven Palmer describes turn of the century private practices as consisting of:

...a mixture of office consultations, planned and unplanned house calls, management of a dispensary, surgery—occasionally in the home of the patient, but increasingly at a hospital—and if possible, a paying part-time public position... One also had to demonstrate public spirit through pro bono work (Palmer 2003:105, 98).

Public spirit notwithstanding, a nationalized medical program was perceived by many doctors as a threat to private medical practice. Physician-legislators, along with the newly formed National Medical Union, both resisted and curtailed the Calderón administration's plan for social security. The union also tried to block subsequent legislative efforts to extend medical coverage to a larger proportion of the population, and even forbade its members to work in social security hospitals and clinics (Casas and

Vargas 1980; Clark 2001). In the early years of social security, therefore, there seemed to be little accrual of symbolic capital for doctors who worked for the state.

In the 1940s, however, global events intervened in national medical politics, as World War II blocked access to European medical schools that had trained generations of Costa Rican doctors. Costa Ricans began traveling to other Latin American countries—Mexico and Chile, most popularly—to attend medical school. Students' exposure to these countries' national medical services may have contributed to a change in their attitude to social security employment and in their ethic of medical practice more broadly. Gradually, “the antagonism dissipated” between doctors and state medical institutions (Miranda-Gutiérrez 2003:101).

Social security programs were extended by a 1961 law mandating universal coverage over the next ten years. Although actual enrollment fell far short of this goal, the state remained committed to expanding access.<sup>26</sup> By the 1970s, all public medical services (including hospitals previously under the administration of the Ministry of Health) were consolidated under the CCSS (Morgan 1987). Social security was widely embraced as a project of nation building, modernization, and social equalization, as

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<sup>26</sup> Morgan (1987) explains that Costa Rica accepted financing from USAID and the Inter-American Development Bank in order to fulfill its mandate of universalization, and as I outlined in the introduction by the early 2000s nearly 90 percent of Costa Rica's residents were enrolled in the national medical program (a figure that does not include undocumented residents, many of whom receive CCSS services). CCSS enrollment is usually based on employment. By law, employers are required to contribute 9.25% of their employees' wages, while workers pay 5.5% of their wages for CCSS enrollment. Many businesses evade these payroll taxes by hiring workers on a contract basis. This shifts the financial burden of enrollment to workers and the state, since informal sector employees and the self-employed can join the CCSS voluntarily in exchange for between 5.75 and 13.75% of their wages, depending on their income (Clark 2005). All residents of Costa Rica—regardless of enrollment or immigration status—are entitled to medical care at public clinics and hospitals, and a hospital administrator told me that the CCSS now provides services for a greater number of non-enrolled patients than ever.

marked in a speech by the chief of medicine at the newly opened Hospital México in 1970:

... the necessity to grant the population of a country a high level of medical attention is clear, not only as a consequence or an imperative of social justice, but rather as a means to promote development and social progress (Miranda-Gutiérrez 2003:102).

This national commitment to medical intervention as a means of modernization and citizen formation accompanied an enormous project of state expansion. The number of employees in the “exuberant public sector” tripled between 1950 and 1970, with infrastructure, employment, and prosperity concentrated in and near the nation’s capital, San José (Palmer and Molina 2004:183).<sup>27</sup> The national public health and medical program emerged as the “crown jewel” of this project, with the number of employees increasing 15-fold between 1960 and 1981 (Clark 2001; Mesa-Lago 1985). Physicians were positioned as public servants whose professional identity was formed in part through an ethic of medical practice as service to the nation, while the health of individuals was linked to the political, economic, and social well being of the nation. For most Costa Ricans, in other words, “medical citizenship” was folded into national citizenship, since understandings of belonging were, and continue to be, mediated by access to biomedical services.

This joining of public institutions and citizens’ bodies was further consolidated with the opening of the country’s first medical school at the (public) University of Costa

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<sup>27</sup> The centralization of state institutions in metropolitan San José has contributed to an unequal urban-rural distribution of medical services. This institutional topography confers prosperity and professional advancement on clinicians who remain in or near San José, and relegates rural doctors to the technological hinterlands. This configuration also forces rural patients into their own form of medical migration, since long distances must often be traveled in order to see a medical specialist in the capital. I take up this theme again in chapter five.

Rica in 1961, and the subsequent assignment of all specialist training to national hospitals. The production of doctors, patients, and healthy citizens had become the business of the state. By 1975, over 90% of Costa Rica’s physicians were working full or part time for the state, whose national hospitals had become the nation’s center of biomedical prestige (Casas and Vargas 1980).<sup>28</sup> Indeed, state-of-the-art medical equipment, research, and opportunities for professional advancement into administrative or political positions, were all situated in the public sector.



Figure 2. National hospital in San José. Photograph from Wikimedia Commons, 2008.

This is not to suggest, however, that physicians abandoned private practice as an opportunity for financial prosperity. The key components of doctors’ implicit contract with the state included “clinical autonomy, unfettered opportunity for private-sector practice, guaranteed decent wages, and well-stocked hospitals” (Clark 2005:14). Many

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<sup>28</sup> The CCSS employs more people than any other state or private sector entity—approximately 39,000 in 2006. See <http://www.ccss.sa.cr/html/transparencia/estadisticas/actuarial/estadist/html/Anua0106.html>.

physicians cultivated private practices alongside state employment, and those who were successful retired early from the CCSS to a life of relative leisure and affluence. In general, however, private practice was conducted alongside state employment, rather than as an alternative to it.

Most of San José's private medical practices were, and continue to be, situated in small hospitals and clinics that cater primarily to middle class and affluent Costa Ricans, and increasingly to medical tourists and expatriate residents. San José, however, is also home to several former missionary hospitals. The largest is Clínica Bíblica, a multi-speciality hospital recently renamed Hospital Clínica Bíblica.<sup>29</sup> Founded by Scottish and Irish missionaries in 1929, its foreign doctors were tasked with supplementing the state's efforts to treat infectious diseases and reduce Costa Rica's high infant mortality rate.

A member of its board of directors told me that the hospital nearly closed in the late 1960s, when its primary mission was rendered obsolete by expanding national medical and public health programs. It was soon resurrected, however, as a private facility catering primarily to affluent Costa Ricans and North Americans, and the hospital's plastic surgeons have been among its busiest doctors since the 1970s. Although the hospital has retained its rhetoric of Christian charity, and does provide some services

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<sup>29</sup> In Costa Rica, "clinic" conventionally refers to a private medical facility, regardless of its size or scope of services, while "hospital" designates a multi-speciality state-sponsored facility. This taxonomy was strategically undermined by the private, for-profit CIMA Hospital (International Center for Advanced Medicine), when it opened in 2000. Other private facilities soon followed CIMA's lead: Clínica Bíblica changed its name to Hospital Clínica Bíblica, and Clínica Católica has been renamed Hospital La Católica (its newest wing is called Hospital Hotel La Católica). All three of these private hospitals actively court medical tourists, and the designation "hospital" has become a mark of medical cosmopolitanism and expertise in the private sector.

to low-income Costa Ricans, it continues as the hospital of choice for elite Costa Ricans and has recently become one of the most fervent recruiters of North American patients.<sup>30</sup>

Middle class Costa Ricans also purchase private medical services, usually as a supplement or alternative to the CCSS. At private clinics and hospitals, patient-consumers pay cash for consultations and diagnostic tests in less crowded, more discreet spaces, where they receive unhurried personal attention from a physician of their choice (the CCSS, by contrast, assigns physicians to patients).<sup>31</sup> The results of privately obtained diagnostic tests can be brought to a public hospital (often to the same physician), where prohibitively expensive procedures and treatments are undergone. This strategic participation in both public and private medicine has a long history in Costa Rica, but has intensified recently and since the 1980s has been sanctioned by the state and dubbed “mixed medicine.” As I discuss below, the state increasingly promotes and subsidizes the expansion of the private sector, both through its successes and its deficiencies. Frustrated with long waiting lists at public hospitals, for example, middle class Costa Ricans spend more money each year on private medical services, while many elites abandon state medicine altogether.

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<sup>30</sup> The hospital’s “mission” is inflected with religious, social, and ecological strains, but its financial reliance on cosmetic surgery is noticeably absent: “We are a general hospital offering quality medical attention to the whole person, with a capacity to integrate, in harmony with the environment, Christian principles with a strong commitment to strengthen its Social Action Program to benefit the poor.” See <http://www.clinicabiblica.com/>.

<sup>31</sup> The state’s Instituto Nacional de Seguros (INS) provides worker’s compensation insurance to approximately sixty-five percent of the population (Clark 2001), and also offers a health insurance plan that gives its subscribers access to private medical facilities. INS spending represents just over three percent of total health care expenses in the public sector (Miranda-Gutiérrez 2003).

## Plastic citizens

*It is not only that the healthy becomes the beautiful,  
but that the beautiful becomes the healthy.*

- Sander Gilman (1995:51)

Costa Rica's first plastic surgeon was employed at a national hospital in 1948, but plastic surgery as a specialty did not grow until the 1960s, when a small corps of foreign-trained surgeons operated in public hospitals (Feoli 2002). Clinical practice was limited to "reconstructive" procedures, which in North America and Europe were still strongly distinguished from "beauty" surgeries, and had enabled plastic surgeons to gain legitimacy among their medical peers. Historian Sander Gilman describes the professional marginalization of plastic surgeons in the 19<sup>th</sup> and early 20<sup>th</sup> centuries in Europe and North America, until the gruesome facial injuries of World War I gave them the opportunity to "...show the world how necessary and noble and redemptive their kind of medicine could be" (1999:157).

Although the development of new techniques during wartime further distinguished reconstructive procedures from those designed to beautify, aesthetic surgery was gradually normalized as a legitimate medical practice during the 20<sup>th</sup> century. This process was enabled by the 19<sup>th</sup> century development of anesthetics, which reduced pain and the risk of infection. According to Gilman, safer forms of general and local anesthetics "emboldened patients...they could now cease to be mere patients and create the new and different role of medical client" (1999:16). Aesthetic surgery was also legitimized through the growing influence of psychology, and concepts like "self-esteem" and the "inferiority complex," through which physical characteristics were linked to feelings of inadequacy. According to historian Elizabeth Haiken:

By the late 1930s, words like *deformity* had come to connote any and every physical attribute that might spark the feelings of inferiority that would threaten an individual's chances for social and economic security and success...surgeons were in almost universal agreement about psychology's relevance to their work and proud of themselves for the progress they made in incorporating these new ideas into their practices" (1997:123).

Aesthetic procedures were gradually incorporated into Costa Rican surgeons' training in Europe, North America, and Latin America (particularly Brazil, the longtime South American epicenter of aesthetic surgery consumption and innovation). The craft that young surgeons brought home in the 1960s and 1970s was modeled on Euro-American images of beauty and health, and it converged with a growing desire for surgical enhancement and cosmopolitan (i.e. youthful, slender, and large-breasted) bodies among elite women in Costa Rica—paralleling cosmetic surgery's increasing popularity in the U.S. By the late 1970s, at least four private cosmetic surgery clinics had opened in San José, each with a surgeon who performed enhancement procedures in the afternoons and evenings, after fulfilling his duties as a reconstructive surgeon at a state hospital in the morning.

The prevailing, conceptual division of plastic surgery was thereby mapped onto the socioeconomic distribution of Costa Rican medicine: damaged, or congenitally disfigured, citizens' bodies were "reconstructed" in public hospitals, while elite (primarily women's) bodies were beautified in private clinics. Despite this conceptual and clinical separation, however, both public and private plastic surgery practices participated in one national project: the production of healthy citizens and a modern Costa Rica via surgical participation. As a Costa Rican plastic surgeon put it:

Costa Rican patients have been improving their general culture by eliminating many myths and taboos that inhibit them from improving their physical appearance. We are no longer resigned to think like our grandparents, who said

‘God made you that way and you have to resign yourself to living in these forms as a divine plan’... (Chacón-Bolaños 2004).

This doctor is referring to aesthetic procedures, but he could just as easily be describing many of the reconstructive procedures that are now performed in national hospitals. The ambiguity here reminds us that the boundary between aesthetic and reconstructive surgery is not stable. Described by many surgeons and patients as clearly distinguishable, these categories are actually more flexible in practice, and are always contingent on (and productive of) shifting cultural aesthetics of weight, proportion, gender, and aging—as well as the techno-medical techniques devised to intervene in and reproduce aesthetic norms. Indeed, normative aesthetic evaluations are central to both reconstructive and enhancement procedures. For example, breast reduction surgery is often performed on women as a remedy for back pain, and is therefore designated as reconstructive. The attractiveness and shape of reduced breasts, however, is as important to both surgeons and patients as is the quantity of flesh removed and the alleviation of discomfort. In the operating room, moreover, surgical techniques are nearly always oriented towards both aesthetics *and* function (or the appearance of function), while understandings of function are as contingent as aesthetics.

As cosmetic surgery grows in popularity in Costa Rica, state-sponsored plastic surgery has expanded the range of its interventions in bodily appearance and function. Procedures previously classified as aesthetic (and as outside the purview of public medicine) have been normalized as routine medical treatments and are frequently performed in national hospitals. These “reconstructive” operations include: ear pinning (the taming of wayward ears), breast reductions (for women *and* men), breast augmentations, tummy tucks and nose jobs. State-sponsored plastic surgery thereby

participates in a regime of medicalization, in which healthy bodies are diagnosed and surgically treated, and social relations and cultural values are reified as individual pathologies (Taussig 1980).

Shifts in the aesthetic-reconstructive border speak not only to plastic surgery's contingent relationship with transnational beauty norms, and the pathologizing of bodies previously considered normal, but to the surgical valence of Costa Rica's state-sponsored health program. Lawrence Cohen's term "operability," or the "degree to which one's belonging to and legitimate demands of the state are mediated through invasive medical commitment" (2005:86), may be helpful in accounting for what I have come to think of as Costa Ricans' surgical disposition. Medical participation and national identity have long been equated in Costa Rica, as I described earlier, and surgery is popularly considered one of the most modern forms of medical intervention. If surgery is a proxy for, or shortcut to, modern participation, then the desire to participate (in the nation and in new forms of private consumption) might account for Costa Ricans' enthusiasm for surgery, and the scarcity of popular or feminist criticism of cosmetic surgery's growing popularity.

This framework might also help to explain why surgery (particularly operations that are not considered life-saving) is so frequently performed at resource-scarce public hospitals, where waiting lists for diagnostic and surgical procedures are months—and sometimes years—long.<sup>32</sup> A plastic surgeon at one public hospital, for example, bragged

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<sup>32</sup> Each CCSS member consulted with a physician an average of 2.48 times in 2006, and a total of 319,355 surgical procedures were performed in the same year, including biopsies and amounting to roughly one procedure for every 10 people (Caja Costarricense de Seguro Social 2009). These figures do not include the growing number of exams and procedures paid for by CCSS members in the private sector. Specifically, by 2006 nearly

to me that his department operates on “400 hands a year,” most of them belonging to exhausted women who work as domestic laborers and have been diagnosed with carpal tunnel syndrome. I rarely saw physicians prescribe physical therapy or changes in behavior—the former being costly to the CCSS and the latter being (likely) impossible for patients. With its requisite period of recuperation, surgery may even be a form of rest for low-income patients—an escape from the labors of daily life.

The surgical inclination of Costa Rican clinicians can be located in the public sector’s emphasis on doctoring as a hands-on craft. Several plastic surgeons explained to me that Costa Rican doctors do not receive as extensive an education in science and research as doctors in the U.S., but that surgical trainees spend many more hours performing procedures than do their U.S. counterparts.

In addition, surgical interventions also readily translate into statistical “truths” about the CCSS’s clinical activities, and surgeons often complained about the administration’s favoring of some procedures over others:

The *Caja* cares only about statistics, so they prefer surgeries that are quick, like eight carpal tunnel operations in 14 hours versus one upper arm reconstruction [a complex and lengthy operation on a severed, or partially-severed, limb]...so they end up doing more amputations.<sup>33</sup>

Costa Rica’s surgical culture, therefore, is embedded and naturalized in clinical practices and institutional structures. Below, I turn to a discussion of recent shifts in the

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one-third of Costa Ricans paid for private medical services at least once a year (PAHO 2008). See <http://www.ccss.sa.cr/html/transparencia/estadisticas/actuarial/estadist/html/Anua0106.html>.

<sup>33</sup> The institutional preference for “quick” surgeries results in the privileging of aesthetic surgeries over more complex reconstructive procedures, as I examine further in chapter five.

function of the state and its institutions, and the emergence of Costa Rica as a touristic and surgical sanctuary for North Americans.

### **National makeover**

In the early 1980s, Costa Rica's era of state expansion came crashing to a halt. Like many other low-income countries whose primary source of foreign exchange was agricultural exports, Costa Rica was faced with rising oil prices, falling prices for its major exports, high inflation and a ballooning foreign debt (Rovira-Más 2004). Drawn into the ideological sea change already underway in North and South America, Costa Rica was compelled to adopt economic policies that would enable the growth of the private sector, including projects to attract foreign investment.<sup>34</sup>

To some degree, however, Costa Rica persisted as an exception. The government negotiated a more gradual approach to economic reform than was typical with structural adjustment prescriptions. In particular, World Bank pressure on the state to fully privatize the CCSS and other large state institutions was unsuccessful.<sup>35</sup> Policies promoting privatization, foreign investment, and deregulation were implemented, however, and some scholars suggest that the influence of USAID (United States Agency for International Development) in this process was the price Costa Rica paid for refusing to

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<sup>34</sup> The primary agents of the neoliberal agenda in Latin America were the World Bank, the International Monetary Fund, and the United States Agency for International Development.

<sup>35</sup> For analyses of Costa Rica's gradual adoption of economic reform (in contrast to the "shock therapies" applied in many other developing countries), see Chamberlain (2005), Clark (2001) and Honey (1994). Specific effects of neoliberal reform on public health care services are described by Martinez and Mesa-Lago (2003), Mesa-Lago (2004), and Ugalde and Homedes (2005), while Edelman (1999) presents an ethnographic portrait of popular resistance to neoliberal policies in Costa Rica in the 1980s and 1990s.

declare an alliance with the U.S. and U.S.-backed Contras during the Nicaraguan war (Edelman 1999). Others suggest, to the contrary, that growing U.S. aid packages, and softer treatment by international financial organizations, were Costa Rica's reward for allowing the U.S. to conduct covert operations against the Sandinistas from northern Costa Rica (Barahona 2002; Robinson 2003).

Despite these contested histories, political and economic analysts generally agree that aid funds from the U.S. have contributed to the emergence of a "parallel state," consisting of non-governmental organizations and private associations and businesses that have weakened, or taken the place of, state institutions (Chamberlain 2005; Honey 1994). As an agent of neoliberalization, however, the state itself has not simply retreated, nor can it be conceived as a static, singular entity. Since the 1980s, some state entities have shifted their commitments to the expansion of "private capital, and within private capital, a reorientation of services from national to transnational fractions" (Robinson 2003:144). Other state institutions, including the CCSS, have persisted in their aspirations of universality and nation-building—albeit under increasingly austere economic conditions and subject to various "reform" efforts.

Indeed, after the crisis, Costa Ricans expected the state to continue to provide the extensive social services it established in the 1970s, and health services "became the focus of a nationwide debate which encapsulated many of Costa Rica's ideological and political schisms" (Morgan 1987:100). Efforts at wholesale privatization have thus far failed, in part because "there is a sense within Costa Rica that any alterations would need the consensus of the entire population" and "changes in this basic system would be seen as carrying profound implications for the entire Costa Rican society" (Chamberlain

2005:177). Nevertheless, the CCSS has been subject to “creeping privatization” through the private contracting of public services, and an idiom emphasizing “productivity” and “efficiency” that defines the CCSS bureaucracy as outdated and corrupt (Clark 2001).<sup>36</sup> Most recently, the contentious 2007 ratification of the Central American Free Trade Agreement (CAFTA) has introduced state institutions to the most extensive privatization effort to date.<sup>37</sup>



Figure 3. Middle class neighborhood in Heredia on national election day, with anti-CAFTA Citizens' Action Party flags waving from car. Photograph by Sara Ackerman, 2006.

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<sup>36</sup> See Clark (2005), Homedes and Ugalde (2005) and Mesa-Lago (1994) for analyses of partial privatization efforts and public-private hybrid projects within the CCSS.

<sup>37</sup> CAFTA is a trade liberalization treaty between Central America and the U.S., and has been the focal point of divisive popular debates about neoliberalism. Shortly after the election of Oscar Arias to the presidency in 2006, government-sponsored signs in support of CAFTA were ubiquitously posted in public spaces. For example: “Costa Rica cannot stay behind.” These slogans played on popular anxieties about the “Central Americanization” of Costa Rica by way of increasing crime, poverty, and inequality (Seligson 2002:162). The CAFTA-sponsored solution was a re-commitment to national “progress” through inclusion in a global economic order. In 2007, CAFTA was brought to a popular vote and ratified by a narrow majority. One of CAFTA’s first and most profound effects was a 2008 law subjecting the state-sponsored insurance industry to private competition, opening the way for private health insurance and possible further privatization of CCSS.

Corruption, popularly considered the state's *modus operandi* in its dealings with the private sector, and a rationale for reform, has become a persistent and complex assemblage of practices at the CCSS, and a “mechanism for the privatization of socially created wealth” (González and Solís 2004). A 1990s scandal involving former president Rafael Ángel Calderón Fournier (himself the son of President Calderón Guardia, the founder of social security), for example, allegedly involved the awarding of a large CCSS contract for medical equipment to a private company, in exchange for a payment of nearly half a million U.S. dollars to the president himself. (The trial was ongoing in May 2009, when Calderón announced that he would run for the presidency in 2010, with the campaign slogan *volver* [return]).

Meanwhile, waiting lists at public hospitals lengthen as state investment in health care shrinks, and patients resort to various strategies to enhance their access to CCSS services. As I mentioned earlier, queues can be bypassed if a patient pays for a private diagnostic test and then brings the results to a public facility for follow-up. This form of indirect privatization has become an almost routine practice among middle class Costa Ricans, particularly those who fear a diagnosis of cancer and do not want to months for a scan at the CCSS. Additionally, patients mobilize social obligations among friends and relatives employed at CCSS facilities. For example, a neighbor explained to me that two of her uncles worked at a *Caja* hospital and were able to secure a better room and more attentive services for her when she gave birth to her two children. Thanks to her relatives, “it was like being at a private clinic,” she said.

Also common is a surreptitious, and illegal, practice called *biombo* [folding screen], in which CCSS doctors solicit, or accept, cash payments from patients in

exchange for medical procedures or higher positions on waiting lists. *Biombos* are condemned by CCSS administrators, elected officials, and journalists as a form of corruption, and as an exception to normal institutional activities. They are usually, however, overlooked or tolerated, and some Costa Ricans told me that they are a good way around a rigid system that does not take care of people well or pay its doctors enough. These forms of privatization by way of corruption or illicit economic activities also lead to the perception among many Costa Ricans that the private sector is actually *more* fair than the CCSS. After all, everyone (who is able to pay, of course) receives equivalent services, without being compelled to resort to bribery or the mobilization of social connections.

Illegal or not, efforts to increase access to stretched social services often involve private gain at the expense of public resources, as well as Costa Ricans' increased participation in the private sector. In the early 2000s, 30% of national health care spending went to the private sector— 90% paid by individuals, and the remaining 10% by the state's workers compensation program (PAHO 2008).

While the forces contributing to the expansion of private medicine in Costa Rica are complex, they are inextricable from a gradual decrease in public spending on health care dating from the 1980s neoliberal turn.<sup>38</sup> Today, CCSS hospitals and clinics not only

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<sup>38</sup> Under pressure from the U.S. Agency for International Development (USAID) and the International Monetary Fund (IMF), the Costa Rican government reduced the national health budget from 11.4 percent of GNP in 1979 to 5.7 percent in 1989 (Honey 1994). According to a study sponsored by the Ministry of Health, the health budget was further reduced to 5.2 percent of GNP by 2001 (Organización Panamericana de la Salud 2003). In addition, evasion of social security contributions among private employers is common, and the state itself is consistently delinquent in paying CCSS contributions on behalf of its employees (Clark 2005).

operate under austere budgets, they treat a growing number of unsubscribed patients, resulting from increases in part-time and contract labor and undocumented migrants. The CCSS is inadequately staffed, moreover, to track down all non-enrolled, non-paying patients. “There are always gaps [*portillos*],” a CCSS administrator told me. Previously suppressed infectious diseases have also re-emerged, connected to intensifying urban poverty and inadequate living conditions. In addition, among people who have benefited from Costa Rica’s neoliberal makeover, the consumption of American fast food is wildly popular, leading to weight gain and an increasing incidence of “diseases of affluence” (particularly cancer and cardiovascular disease). In plastic surgery specifically, growing rates of obesity and the popularity of enhancement technologies have contributed to the introduction of state-sponsored bariatric (weight loss) surgery.<sup>39</sup> These embodiments of transnational forms of consumption have accompanied an expensive shift in CCSS priorities from preventive to curative (i.e. high-tech intensive) medicine (Mesa-Lago 2004).

I spoke with a CCSS administrator who situated the CCSS’s financial problems in the high cost of drug treatments for patients with HIV (patients with HIV and AIDS are, along with Nicaraguans, a popular target of blame for various deficiencies in public medical facilities). She also said that increasing cancer rates, and the demand for high-tech diagnostic tests and treatments, have driven up the costs of medical services.

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<sup>39</sup> I met the CCSS’s first bariatric patient in 2006. He had lost much of his body weight in the several months after surgery, and had then undergone several operations to remove the excess skin that hung on his body in folds. His plastic surgeon proudly showed off the patient’s body to me as an example of the *Caja*’s medical advancement. State-sponsored “correction” of overweight bodies, however, seems to be another example of the socialization of the costs of private sector consumption, as well as the intensification of medicalization and surgical enthusiasm in Costa Rica.

As the CCSS struggles to keep up with the changing bodies and living conditions of its subscribers, and a medical paradigm that demands modernization via expensive equipment and technologies, it struggles to maintain and improve upon a deteriorating infrastructure. In 2005, a fire at one of the San José's largest national hospitals killed 18 people, and destroyed two floors in the oldest wing of the hospital, which was without fire escapes or an alarm system.

Clinician morale is also eroding, and many doctors and nurses describe their work at public hospitals as an assembly line over which they have little control. Indeed, unexplained absenteeism among physicians is high, and it appears that many doctors no longer feel beholden to the state as an employer or source of professional identity. Shrinking employment opportunities at the CCSS and private sector expansion are certainly linked to a changes in institutional culture. For example, although the CCSS employed more physicians in 2005 than any other year in its history, new private medical schools now produce more graduates than the CCSS can employ.<sup>40</sup> Moreover, in the early 1990s, approximately ten percent of health professionals worked in the private sector; by the late 1990s, this proportion had risen to 24 percent (PAHO 2008).

Popular frustration with the *Caja* spills into, and is shaped by, sensational news articles on the cover of the pro-neoliberal *La Nación*, Costa Rica's most widely read newspaper, and on the private television station *Teletica*:

Surgeons report that surgery services have collapsed at San Juan de Dios Hospital (Carranza 2005)

112,000 patients on waiting lists for surgery or exam (Ávalos 2006)

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<sup>40</sup> According to the CCSS's Department of Statistics, the number of physicians employed as clinicians in the public sector rose from 3,300 in 1999 to 4,127 in 2006. See <http://www.ccss.sa.cr/html/transparencia/estadisticas/actuarial/estadist/html/Anua0106.html>.

Serious lack of doctors and nurses in rural areas (Varela 2006)

Patients suffer torture in San Juan de Dios Hospital (Loaiza 2006)



Figure 4. *La Nación* article: “Patients Take on Waiting as Another Aspect of Suffering.” April 9, 2006.

In the midst of these ominous warnings about state failure, prominent CCSS physicians exhort Costa Ricans to remember the social democratic promise: that citizenship and health are created through participation in state institutions, not by market-driven consumption. In 2008, the president of the Costa Rican College of Doctors and Surgeons insisted that one of biggest challenges facing medical practice in Costa Rica is the “interference of the market economy and economic thinking” (Vargas-Baldares 2008). Indeed, the principles of collectivism and solidarity on which the CCSS was founded no longer have the purchase they once did on middle class Costa Ricans, many of whom feel that the *Caja* does not live up to its mandate and has become a charity service. A high-ranking CCSS employee, for example, told me that she prefers to

obtain medical services in the private sector because the *Caja* has been “taken over” by people who do not pay into the system and who undermine the once-strong sense of solidarity in public hospitals.

Despite shifting conceptions of entitlement and responsibility, however, most Costa Ricans do support the continued existence of large state institutions, particularly the *Caja*, even as their trust in politicians and political parties wanes. A poll conducted by the University of Costa Rica in 2004, for example, asked Costa Ricans about their “pride” and “confidence” in state institutions and national values. Overall, the people polled said they had more confidence in the *Caja* than in the justice system, the police, the national government, or the catholic church (Vargas-Cullell et al. 2005).

### **The birth of a medical and retirement arcadia**

*If you want to feel younger, look better and live longer with a more affordable lifestyle, a healthier diet and a lot less stress, then you might have just found your new home overflowing with stunning scenery, sunshine and smiles – Costa Rica!*

- WeLoveCostaRica.com

Costa Rica’s post-crisis economic restructuring included its refashioning into a desirable destination for tourists, North American expatriates, and foreign investors (Clark 2001; Honey 1999). Free trade zones, including tax incentives and flexible labor, have attracted multinational corporations, while a system of national parks has come to symbolize the nation’s commitment to U.S.-style conservation and environmentalism.<sup>41</sup> Costa Rica is now marketed internationally as a modern paradise, its infrastructure and

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<sup>41</sup> Luis Vivanco (2007) offers a rich ethnographic account of the politics of environmentalism and “ecotourism” in Costa Rica, and the local consequences of imagining and producing spaces of non-human nature.

tourist amenities connecting cosmopolitan San José with zones of agricultural production that have been re-imagined (and even re-planted, in the case of some plantations-turned-nature reserves) as pristine, pre-human nature.<sup>42</sup> In 1994, tourism surpassed coffee and banana exports as the largest source of foreign currency income, and in 1999, one million tourists visited Costa Rica, the most ever in the nation of approximately four million inhabitants (ICT 2004).

Cosmetic surgery tourism, on the other hand, has until recently resided quietly in the margins of conventional tourism. Most surgeons I spoke with agreed that San José's private clinics became popular with North Americans between the late 1970s and early 1980s. Most of these early, border-crossing patients were U.S. flight attendants, journalists, or Latin Americans who lived in Miami. Their bodies were transformed and tended to in a loosely connected web of clinics and residences—the latter providing housing, meals and nursing services to visiting patients for a week or more after surgery.

These services were not an organized industry, per se, since most surgeons and recovery workers practiced independently, and the presence of foreign patients did not attract the attention of state agencies or private investors until years later. Even in the 1990s, while medical travel to Costa Rica was becoming more popular among North Americans, the phenomenon seemed to be visible only to those who participated in it. Well into the 2000s, medical travelers have continued to tell airport pollsters that they are in Costa Rica for a “vacation” or “sightseeing,” so national statistics tend to underestimate the presence and economic impact of medical tourism—or they have until

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<sup>42</sup> See Rivers-Moore (2007) for an analysis of the operations of gender and race in Costa Rica's international tourism campaign, “No Artificial Ingredients.”

recently, when state-promoted expansion of the private medical sector has led to more optimistic estimates of cross-border medical consumption.<sup>43</sup>

Costa Rican plastic surgeons, nonetheless, have proved to be canny entrepreneurs—fashioning themselves as an appealing fusion of cosmopolitan expert and principled caretaker. Most doctors who have gained popularity among North Americans speak fluent English and have completed residencies or specialty training outside Costa Rica (primarily in Europe or the U.S.) Many are members of both Costa Rican and North American professional associations, and are therefore able to position themselves in the domain of “first world” medical expertise.

A certain flavor of strategically benign “otherness” also works to plastic surgeons’ advantage. Costa Rica’s affordable prices (relative to those in North America) are seductive to prospective patients and are taken as evidence that Costa Rican surgeons are benevolent doctors rather than businessmen. The other feature that distinguishes Costa Rican surgeons from their North American counterparts, or competitors, visiting patients told me, is the warmth, hospitality, and informality assumed to inhere in the Latin American “personality.” As I discuss further in chapter three, the affective labor engaged in by Costa Rican medical caregivers is highly valued, and is even embodied as “holistic” or “spiritual” healing, by visiting North Americans.

As I mentioned earlier, surgeons rarely advertised their services (either locally or abroad) when North Americans first started traveling to Costa Rica for surgical

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<sup>43</sup> In 2004, for example, the Costa Rica Tourism Board reported that only 380 visitors from the U.S. (out of a total of 633,640) listed their reason for travel as “health” (ICT 2004). Plastic surgeons told me, by contrast, that in recent years cosmetic surgery patients from the U.S. have numbered in the thousands annually, in addition to visitors seeking other medical and dental services.

enhancement. Advertising was illegal in Costa Rica—and still is, several surgeons told me, although it is now widely tolerated. Several older doctors explained to me, moreover, that public advertising is anathema to the practice of medicine. One plastic surgeon, long devoted to full-time private practice, situated Costa Rican doctors' moral decline in their adoption of U.S. regulatory standards:

We are falling into the same problems that affect American medicine. Plastic surgery is rapidly becoming a 'business.' The day the FTC [U.S. Federal Trade Commission] opened the way to advertising and converted medicine into a business was the beginning of a downturn in our speciality.

Some of these older surgeons were also reluctant to affiliate themselves with hotels or recovery retreats, insisting that they were also “businesses, not medicine.” Rather, they prided themselves on the art of navigating the “geography of person to person referral.” One surgeon showed me a map of the U.S. with numerous clusters of colored pins representing former patients. He explained that the clusters showed how patients essentially recruited each other, doing the work for him of translating Costa Rica from an unknown, developing country to a magnet for North Americans seeking affordable, modern medical services. Commerce, in other words, was equated with the public soliciting of patients, rather than private practice per se.

Of course, it is not only mobile consumers of cosmetic surgery who have produced Costa Rica as an accessible, and appealing, destination for middle class, North American self-fashioners. As the tourism industry expanded in the 1980s and 1990s, and the state promoted foreign investment and private sector expansion, a new infrastructure (including an airport, highways and hotels) enabled Costa Rican medical tourism to shift from a cottage industry to a burgeoning, transnational enterprise. Getting to and staying in Costa Rica became easier for North Americans, via frequent and inexpensive flights

and relaxed visa requirements (North Americans can stay in Costa Rica for up to three months without a visa). In addition, Costa Rica's international appeal was boosted by growth in the Internet as a medium for advertising and sociality; the nation was narrated via text and images as a natural and social paradise that was not too far from the U.S. (geographically, economically, and culturally), but was nonetheless exotic.

As the flow of short-term visitors increased, so did Costa Rica's desirability as a retirement destination for middle class North Americans. By the mid-2000s, between 30,000-50,000 U.S. citizens lived in Costa Rica (U.S. State Department 2009). Expatriate retirees living in Costa Rica told me that their North American pensions afforded them a more affluent lifestyle in Costa Rica than they had been able to access in the U.S., and that Costa Ricans' relaxed sense of time and simpler way of life provided an escape from the stresses of life in the U.S. Many of these migrants, moreover, have become enthusiastic consumers of private medical services in Costa Rica, including cosmetic surgery. With few exceptions, expatriates are welcomed by private clinics and hospitals as desirable consumers, and doctors generally do not distinguish between expatriate residents and "tourists" from North America.

During the growth of conventional tourism, plastic surgery clinics hosted a steadily increasing number of North American patients. Word of mouth (and the circulation of photographs as visual evidence) was the most common method of patient recruitment. Over time, however, clinics and recovery hotels began to post alluring images and testimonies on commercial web sites, while former patients started Internet forums to discuss and promote specific surgeons, hotels, and surgical procedures. Doctors

also began to advertise in local and U.S. newspapers and magazines, and, more recently, to hold recruitment seminars in the U.S.

The reach of this enthusiastic commercialization was not only transnational, but was linked to the growth in local private medical consumption, since plastic surgeons' advertisements catered to Costa Rican consumers as well. This brings me back to Traci, and the convergence of forces that led her to desire, and gain access to, cosmetic surgery. The popularity of cosmetic surgery among urban, upper-middle class Costa Ricans like Traci, has exploded in the early 21<sup>st</sup> century. Highly sexualized advertising for cosmetic surgery and other beauty industry products is ubiquitous, cosmetic surgery "reality" shows from the U.S. are dubbed into Spanish and are very popular (most Costa Ricans have televisions), and bank loans specifically for cosmetic procedures are readily available. A nurse who works with recuperating cosmetic surgery patients from North America told me, "We are being bombarded with propaganda...magazines, newspapers, television... People's mentality is changing...they say, 'I want to look like this, or like that'...and they are becoming fanatics" about changing their bodies.



Figure 5. “The Search for the Perfect Figure!” Advertisement for new liposuction procedure in *Ejercicio y Salud (Fitness and Health)* magazine, 2006.

As in other low-income countries, corporeal enhancement seems to be a conduit for, and a signal of, participation in a new economic and cultural order, in which private medicine is promoted as a healthy choice for discerning citizens-turned-consumers (Edmonds 2007). This order is shaped through a tourism-based economic-cultural regime, and the services and pleasures that it offers. A cultural historian of Costa Rica writes that many workers in the tourism sector essentially inhabit two worlds:

Daily life oscillates between two extreme poles: familiar surroundings dominated by austerities and difficulties, and workplaces with conveniences, luxuries, and patterns of consumption that are completely out of reach (Molina-Jiménez 2005:104).

### **Transnationalizing medical tourism**

Although many North American cosmetic surgery patients still patronize small clinics and recuperate discreetly in private homes, medical tourism in Costa Rica is increasingly dominated by large, private hospitals, and hotel-like, quasi-medical

recuperation facilities. I examine these spaces in chapters two and four, respectively. U.S.-based medical tourism brokers, transnational hospital corporations, and a variety of foreign investors have also entered the scene, hoping to capitalize on and expand a new market. Costa Rica's presumed political stability, along with economic policies encouraging foreign investment and capital accumulation, have contributed to a gold rush atmosphere among medical tourism entrepreneurs. I was occasionally invited to meals by these self-fashioned pioneers, who hoped that I would give them the "inside story" about medical tourism businesses' successes and failures. Among the characters I met were a businessman from the U.S. who wanted to combine cosmetic surgery with his golf tour packages for North American business executives; an anesthesiologist from New Mexico who was concerned about Costa Rican hospitals' lack of international accreditation; and a Costa Rican hospital administrator who planned to open a "holistic" retreat whose staff would help patients to "realign their meridians," which, she explained, shift during plastic surgery.

In other words, the business of providing cosmetic surgery for border-crossing patients is no longer the exclusive province of individual surgeons and local small-business owners, and state institutions now recognize medical tourism as a promising economic sector. Thus far, the most prominent monument to biomedical commodification and transnationalization in Costa Rica is a gleaming new private hospital on the outskirts of San José. CIMA (International Center for Advanced Medicine; *cima* also means peak) is administered by a Texas-based multinational corporation, and is spatially and discursively distanced from San José's growing poverty and crowded, austere state hospitals. When I visited CIMA's hotel-like buildings in 2006, over half of its resident

patients were international visitors or foreign residents of Costa Rica—most undergoing surgical enhancement procedures. Affluent Costa Ricans also frequent CIMA and other private hospitals in San José, paying cash for medical services and frequently opting out of the state-sponsored medical system (Clark 2002). CIMA embodies a “totally different philosophy” from other private hospitals, a plastic surgeon told me—suggesting that the charity discourse predominant at former missionary hospitals has been replaced by an unabashed commitment to profit.

CIMA is also a world apart from public medicine. “Here it is white, there it is black,” one of its doctors told me. Most of CIMA’s mid-career plastic surgeons, in fact, resigned from state employment shortly after completing their training in reconstructive surgery, to the disappointment of their mentors. “Globalization” is the reason that young doctors think only of money, the chief of plastic surgery at a national hospital complained, after I asked him about the exodus of plastic surgeons to the private sector. Indeed, incomes are often vastly different between public and private sector plastic surgeons, and CIMA’s luxurious amenities attract not only foreign residents, mobile patients, and elite Costa Ricans, but many of the nation’s medical specialists. By 2006, nearly one fourth of Costa Rica’s approximately 45, board-certified plastic surgeons operated at least part-time at CIMA, performing almost exclusively aesthetic procedures. Costa Rica’s four national hospitals, meanwhile, employed only 12 plastic surgeons, most of them performing reconstructive surgery on a half-time basis.

Is medical tourism reproducing what John Frow calls the “the logic of tourism...a relentless extension of commodity relations and the consequent inequalities of power between center and periphery” (1991:151)? I argue that it is, but as I discuss throughout

this dissertation, the terms center and periphery are not simply isomorphic with received North-South, First World-Third World geographies. Rather, tourisms' landscapes of status, material accumulation, and access to services, also cross through and unevenly contour Costa Rica itself.

One feature of this cultural topography is the revitalization of Costa Rican exceptionalism, as the scaffolding of a modern (yet affordable) medical oasis for North Americans. A key feature of this imaginary is its excising of specific local realities that threaten its mythology, including conditions that have emerged under the same economic regime that has promoted the expansion of medical tourism. These conditions include growing income inequality, increasing crime and violence, environmental degradation, and large labor migrations from Nicaragua. Indeed, many Costa Ricans fear that their country may be rejoining the Third World even as it “develops” (Aguilar-Hernández 2004; Ordoñez 2007).

For example, the medical tourism industry provides jobs and some tax revenue, but it also reproduces socioeconomic stratifications that have been widening since the 1980s' neoliberal turn. As I discuss in more detail in chapter five, for example, most plastic surgeons continue to learn their craft on the bodies of less affluent Costa Ricans, and many leave state employment for private practice earlier in their careers than the previous generation of surgeons. Recovery retreat owners and investors, moreover, are usually North Americans, Europeans, or elite Costa Ricans, while working and middle class Costa Ricans are hired as drivers, cooks, and nurses. Situated in the neoliberal production of flexible labor, many of these positions do not include employer-subsidized membership in the CCSS's health and pension programs. Nurses, meanwhile, are the

highest paid wage earners at retreats, but they generally earn less than their colleagues at national hospitals in terms of benefits and job security.

The lowest paid employees in the medical tourism sector include maids, gardeners, and construction workers, positions that are often filled by undocumented Nicaraguan laborers. Nicaraguans have been migrating to Costa Rica in growing numbers since the war—as anti-Sandinista political refugees in the 1980s (Alvarenga 2004), and more recently as illegal border-crossers fleeing economic breakdown in the midst of international boycotts and political polarization in post-Sandinista Nicaragua (Sandoval-García 2006). Popular and official estimates of the number of Nicaraguan migrants in Costa Rica vary widely. An employee at the CCSS office of statistics, for example, told me that a recent census report estimated the number of Nicaraguan residents of Costa Rica to be 226,000, whereas the “actual” number is closer to 350,000. In casual conversations with Costa Ricans, I was frequently told that there are one million Nicaraguans in Costa Rica—nearly 25% of the population. The people I spoke with did not distinguish between documented and undocumented Nicaraguans, grouping them together in one unwanted (but easily and cheaply employable) mass.

These estimates, and Costa Ricans’ preoccupation with the presence of Nicaraguans, reflect anti-immigrant sentiment and widespread fears about the erosion of Costa Rican exceptionalism, particular the nation’s presumed racial purity. Nicaraguans are racialized as indigenous or *mestizo* and are labeled a polluting invasion. They are also blamed for social ills, such as deteriorating conditions at public hospitals, reemerging infectious diseases, crime, prostitution, and low wages. They are, in other words, “inside the country but outside the nation” (Sandoval-García 2006:xviii). These reviled people,

however, also perform much of the nation's low-wage labor, including coffee picking, construction, and domestic work, while living in some of its most slum-like conditions. Several of the recovery retreats I visited employed Nicaraguans as domestic or construction laborers, as do many middle class and elite Costa Ricans and expatriate residents of Costa Rica. I suggest that these labor migrants form a flexible, low cost labor force that parallels, and subsidizes, the more privileged flow of medical tourists and private sector expansion. Since they are denied belonging, however, and are occluded from the medical utopia used to market Costa Rica to North Americans, the cross-border flow of Nicaraguans remains a shadow migration.<sup>44</sup>

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In this chapter, I have discussed the emergence of an economic and cultural order in Costa Rica, through which the activities and identities of state and private entities, individual Costa Ricans, and multiple flows of migrants, have been reshaped. Medical tourism is marketed and consumed as apolitical—as contributing to and benefiting from Costa Rica's successes, but not participating in its failures. I have argued, however, that the practices and spaces of mobile medical consumption are actually manifestations of Costa Rica's particular medical history, its recent economic and cultural transformations, and a contentious politics of medical (and national) inclusion and exclusion. In the following chapter, I turn to an exploration of how this new Costa Rica is produced through visual and textual representations, and how “global” medical spaces are participating in the transformation of Costa Rica's material and cultural landscapes.

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<sup>44</sup> Sandoval-García (2006) investigates how Costa Rican exceptionalism is mobilized in an identity politics that excludes Nicaraguan migrants from the belonging to the nation. For an account of another Central American migration to Costa Rica, See Hayden's (2003) portrayal of Salvadoran migrants' sense of place and displacement in Costa Rica.

## CHAPTER TWO

### MEDIATING MEDICAL TRAVEL THROUGH MOBILE REPRESENTATIONS AND BUILT ENVIRONMENTS

*Hospital La Católica has developed a new infrastructure and has remodeled its original facilities...aside from all this modernization, Hospital Hotel La Católica is the only medical institution in Central America and most likely in all of Latin America that has a hotel inside its facilities. Hotel “La Posada El Convento” [the Convent Inn] is an extraordinary colonial style inn, which offers all modern amenities.*

- from the web site of a private hospital in San José

Cosmetic surgery journeys are inspired by and infused with longing and hope—for imagined places, bodies and lives. In 2006, a 30-year-old woman from Colorado named Alice posted the following message to an Internet-based plastic surgery discussion forum, three days after arriving in Costa Rica and one day *before* she went to a private hospital to undergo a tummy tuck and liposuction:

...the peace here has given me the opportunity for a lot of meaningful reflection. I feel I’ll truly be a different person when I return home, more in tune with myself than I have been in a long time.

I met Alice ten days after her operation, while she was recuperating at a recovery retreat outside of San José. Her bruises and discomfort were evident, and she seemed stunned at how difficult the days after surgery had been, as if her body had been forced on an unpleasant detour from an otherwise smooth path to personal rebirth. A day earlier, she had ventured out of the retreat for the first time since her operation, to a nearby salon for hair and nail styling. The excursion was a turning point for Alice, and she seemed to

be actively resuscitating her narrative of positive transformation in the embrace of an idyllic Costa Rica. She rehearsed her story with vigor—explaining, for example, that she generally did not like male doctors in the U.S., but that she felt “totally comfortable” with her surgeon here. (Approximately ten percent of plastic surgeons in Costa Rica are women, but the surgeons who are most popular with North Americans are all men.) Moreover, she said, “the nurses at the hospital were so sweet and caring...they were much better than nurses in the U.S. and do not seem overworked.”<sup>45</sup>

The Costa Rica that Alice encountered was living up to (and exceeding, in some respects) her expectations, which she formed while searching the Internet for information about various medical tourism destinations. Based on her comparisons of several countries, she told me, Costa Rica was the “least different” from the U.S., and its medical system was not as “back alley” as that of Mexico or other places. “This is a *very* developing country,” she explained.

I am concerned here with how Alice came to desire and know Costa Rica and its medical services as exotic yet familiar, “developing” yet modern, before she ever entered a Costa Rican operating room. In other words, what were the constituting elements of Alice’s journey besides the surgical procedures she underwent, and what kind of Costa Rican imaginary provided the framework for her narrative of personal transformation? How, moreover, does this imaginary both rely on, *and* exclude, actual conditions of medical access and distribution for ordinary residents of Costa Rica?

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<sup>45</sup> While the proportion of women doctors is increasing in Costa Rica, men do not seem to be making similar inroads into nursing. Rather, nursing remains a profession dominated by women and with an emphasis on the affective care of patients.

The seductions of Costa Rica as medical paradise, I suggest, operate similarly to those of cosmetic surgery; both offer technologically-constructed “nature” (purified landscapes and surgically altered bodies, respectively) via an occlusion of their historical and social conditions of production, and these mythologies are partially constituted through a widely circulating constellation of images and stories. Scholars refer to these mobile assemblages variously as a “transnational public sphere” (Gupta and Ferguson 1992:76), or as “mediascapes” through which desires for “acquisition and movement” are shaped (Appadurai 1996:36).

In this chapter, I discuss how particular accounts and constructions of Costa Rica mobilize prospective medical visitors (as well as expatriate residents and Costa Ricans). I also examine how these accounts collude with the construction of material spaces, particularly hospitals, where border-crossing medical consumers are tended to, and locals are transformed into consumers, workers or invisible outsiders. Designed to compete in a globalizing medical tourism market, Costa Rica’s newest, private medical spaces appear purified of local politics and ideological struggles over the future of nationalized medicine. Costa Rican private medicine, however, cannot be understood as simply a site of unimpeded flows of bodies, technologies, and capital, as its commercial and state narrators suggest. Rather, the local always runs through and is constitutive of global projects, while globalization’s flows also produce friction, or “the grip of encounter,” that both enables *and* excludes (Tsing 2005:5). Medical tourism’s appeal is its mobilization of people who are unable to gain access to medical services in their home country, and its frictions emerge from a regime that couples disinvestment in social services with private sector growth, leading to deepening social and economic inequalities.

I begin with popular representations of medical tourism's services and activities, including journalistic reportage, patient accounts, and marketing campaigns. In order to situate Costa Rica's medical tourism industry in a context of global competition and universal aspirations, I also draw on examples from India and Thailand—perhaps the most popular medical tourism destinations. The bodies that pass through medical tourism destinations (and those that are excluded from its offerings), I argue, are operated on through specific reconfigurations of space, social status and medical practice. The specter of the Third World, for example, is romanticized or erased from depictions of medical tourism. This erasure is never complete, of course, since local and international inequalities are precisely what have enabled Costa Rica's explosive growth in private medical consumption, predominantly via low-wage migrant labor, state subsidies of the private sector, and less stringent regulatory regimes. Finally, I discuss medical tourism's material infrastructure in Costa Rica, and the interplay among proliferating enclaves of private consumption, atrophying public spaces, and an urban landscape increasingly characterized by exclusion and economic disparities.

### **Frivolous journeys or medical refuge?**

In 2005 and 2006, while I was conducting fieldwork in Costa Rica, middle class Americans' quest for affordable medical services overseas was a popular, and sensationalized, topic in television, print, and Internet news reporting in the U.S. Accounts proliferated of brazen adventurers who dared to sample medical services in countries where tourists had long hoped *not* to land in a hospital. The predominant tone of these reports was skeptical, emphasizing the risky prospect of seeking medical care in

the (implicitly dirty, dangerous, and pre-modern) “Third World.”

A widely circulated genre featured cautionary tales (simultaneously alluring and horrifying) about desperate women searching for inexpensive plastic surgery in developing countries.<sup>46</sup> In June 2005, ABC’s news program “20/20” produced a seven-part television series called “The Seven Deadly Sins,” devoting the first episode to vanity and three women’s journeys to Costa Rica for cosmetic surgery at “bargain basement prices” (ABC 2005). As the story opens, the reporter’s tone and rhetoric intimate that something is bound to go wrong—that these journeys are transgressive of both the “natural” body and the received global medical hierarchy. Indeed, upon returning home one of the women, Tammy, suffers a surgery-related infection, which is treated at a local emergency room (grudgingly, Tammy says, referring to U.S. clinicians’ vocal criticism of her medical defection). “Though it seemed like such a quick plane ride when she was healthy, Costa Rica and Tammy’s doctor now felt like a world away,” says the reporter. This statement suggests the contingent geographies of medical tourism (proximity is dependent on economic and bodily mobility), as well as U.S. health care institutions’ subsidy of medical tourism when recently-returned travelers find themselves in need of acute care.

Later in the program, ABC sponsors (and films) Tammy’s consultation with “a top New York plastic surgeon.” This doctor expresses disapproval of the Costa Rican

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<sup>46</sup> Cosmetic surgery is increasingly popular among men, and many North American men are now traveling to Costa Rica for facelifts, liposuction and other procedures. In general, however, cosmetic surgery is still popularly linked with a presumably feminine preoccupation with appearance and aging, and men are often reluctant to acknowledge or discuss their consumption of surgical enhancements publicly. News accounts, therefore, tend to misrepresent and underestimate men’s growing participation in cosmetic surgery tourism.

surgeon's handiwork, noting in particular the unevenness of Tammy's breasts (she had undergone breast augmentation and tummy tuck procedures in Costa Rica). He recommends "corrective" surgery in the U.S., which Tammy says she cannot afford. She has strayed, the reporter suggests, and the price for her parsimony and vanity is marked—perhaps permanently—on her body by the presumably botched surgeries.

Although the other two women express satisfaction with the results of their Costa Rican surgical journeys, the report concludes with a "buyer beware" statement that works to reposition the U.S. as a global center of medical knowledge and expertise, and Costa Rica on the margins. In this framing, Costa Rica has not yet been released from its association with "jungle medicine"—a term used by a Costa Rican plastic surgeon to explain his North American colleagues' prejudices against south-of-the-border clinicians and medical facilities. Finally, the report links higher prices in the U.S. with the quality and safety of medical services, while lower prices (in the U.S. *and* Costa Rica) are associated with the risk of clinical incompetence and unsanitary facilities.<sup>47</sup>

Several recovery retreat owners in Costa Rica told me they were concerned that negative media coverage might deter medical tourists from traveling to Costa Rica and cost them business. (The "20/20" program was only one of several North American and European media forays into Costa Rican private hospitals' operating rooms—their sterile boundaries apparently more porous to reporters and camera crews than to a curious, often thwarted anthropologist.) However, the flow of cosmetic surgery seekers to Costa Rica from North America seemed to be stimulated, rather than curtailed, by these sensational reports. Even the surgeon whose abilities had been called into question continued to

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<sup>47</sup> Some patients reported, however, that the popularity of cosmetic surgery tourism has forced U.S. plastic surgeons to lower their prices.

operate on a steady clientele of North Americans (and Costa Ricans) after the program was aired (and watched by millions), and he was frequently referred to by his U.S. patients as “the man of the golden boob,” in reference to his skillful breast augmentations and, implicitly, his prices, which were lower than those of other Costa Rican surgeons catering to North Americans.

Many desiring consumers are not warned off by cautionary tales about the Third World, I argue, because they so strongly want (“need,” patients often told me) to transform themselves via surgery. Their subjectivities have been formed through the promises, and successes, of a pervasive “makeover culture” in which the body has become almost endlessly modifiable by way of biomedical procedures that offer health and enhanced social status (Jones 2008a). Even Tammy insisted that she was “reasonably happy” with her surgical outcome; she may not have the body that the Manhattan surgeon could have offered her, but she did undergo a transformation, it was a bargain, and she visited an exotic country.

People recuperating after surgery in Costa Rica, in fact, explained to me that the effect of the 20/20 program was not unlike that of cosmetic surgery “reality” shows such as “The Swan” and “Extreme Makeover,” in helping average people to imagine that surgical transformation is both desirable and possible—that it is no longer the exclusive domain of celebrities and the wealthy. Costa Rica, among other cosmetic surgery destinations, offers middle class consumers a way to transform this sense of possibility into a material reality. Journalistic attention, therefore—even critical attention—has worked to mobilize medical consumers to cross borders, and has put Costa Rica more

decidedly on the medical tourism map.<sup>48</sup>



Figure 6. “Global Medical Tourism Destinations.” From the Costa Rica Council on Competitiveness’ slide presentation on medical tourism, 2007.

Since the mid-2000s, journalists have also reported that more U.S. residents are seeking “medically necessary” procedures abroad. Heroic portraits circulate about

<sup>48</sup> I have come across several such maps, including one in a report on medical tourism by a Costa Rican government ministry (see Figure 6). The map labels various medical tourism destinations, which are primarily nations that are neither the world’s richest nor its poorest. Each nation is reduced to a short list of features, including the number of medical tourists it attracts, the costs of its medical services in relation to U.S. prices, government investments in medical tourism infrastructure, and hospitals’ Joint Commission International (JCI) accreditation status. Although unlabeled, the U.S. and Europe are implicitly at the “center” of this map, in that they supply the majority of medical tourists. Costa Rica’s ability to compete, moreover, is depicted as contingent on its ability to reproduce U.S. medical conditions, while keeping costs low. The map only indirectly addresses questions of geographical proximity, and occludes specific cultural, political, economic, and historical conditions.

medical pilgrimages undertaken by desperate, middle class people seeking life-saving procedures that are unaffordable or unavailable in the U.S. In 2004, for example, reporters descended on Howard Staab, a contractor from North Carolina without health insurance who traveled to India for a heart valve replacement and was dubbed a brave pioneer. The cost of the procedure at his local hospital was \$200,000; his one month stay in India, by contrast, cost \$10,000, including medical, travel, and sightseeing expenses (Lancaster 2004). His surgeon was a former New York University School of Medicine professor who had returned to India to open a hospital specializing in heart surgery. This doctor claimed that surgeons at his private hospital in New Delhi were in general more skilled than their colleagues in the U.S.—a preemptive strike against possible accusations that Indian biomedicine does not live up to U.S. standards.

Cautionary tales about cheap plastic surgery abroad are still common, and are perhaps tied to a prevailing moral economy in which procedures assumed to be more frivolous are thought less worthy of risking death or disfigurement, let alone thousands of dollars. Nevertheless, Staab's journey, and its popular representation, both illustrates and contributes to a shift in the status of enclaves of private medical services outside the U.S. The search for inexpensive medical procedures in developing countries, in fact, is increasingly portrayed as a legitimate option for middle class people with limited medical access in the U.S., and a partial solution to what is frequently called the crisis of U.S. health care. Staab's medical quest, for example, was framed by journalists (and by his partner, who wrote a book about their experiences in India) as a heroic escape from a system characterized by escalating costs, inconsistent quality, and high rates of debt and bankruptcy among the medically uninsured (Grace 2007). Some health insurance

companies have even begun to offer their subscribers financial incentives for traveling outside the country for procedures recommended by U.S. doctors (Rabin 2008). Recent magazine and newspaper titles point to this new pragmatics of medical tourism:

*Medical Meccas: Beyond the Beaches* (Cochrane 2006)

*Outsourcing your Heart* (Kher 2006)

North American medical consumers in Costa Rica are similarly portrayed as pioneers and refugees, particularly in medical tourism promotional materials. Medical Tours International (MTI), a company that acts as a broker between Costa Rican doctors and U.S. patients, includes the following statement on its web site:

In January, 2002, when MTI first began sending patients to Costa Rica most of their patients admittedly hadn't told even their closest friends that they were doing such a "foolish" thing as traveling outside the USA health care system for their medical needs... Many of these first MTI patients would ask us where Costa Rica was located and often believed it was an island somewhere south of mainland USA. It doesn't take too much of a stretch of the imagination to see these patients in the same light as the early settlers of the United States, not knowing where they were going, thinking the world was flat, but finding it necessary to escape oppression; in this case fleeing from the financial oppression of an expensive, crumbling health care system in a First World country (MTI 2006).

Most of these early medical travelers to Costa Rica were seeking cosmetic surgery, and were escaping the "oppression" of expensive facelifts and breast augmentations in the U.S. The "stretch of the imagination" required by this narrative, therefore, might be more arduous for the reader than is suggested. The trope of the innocent pilgrim, moreover, is reminiscent of colonial discourses of "anti-conquest," in which European visitors (particularly naturalists) to the New World were positioned as "simultaneously innocent and imperial, asserting a harmless hegemonic vision that installs no apparatus of domination" (Pratt 1992:34). In the contemporary version of this discourse, medical tourists are transformed into apolitical, economic refugees, victims even, rather than

active participants in a dramatic material and ideological transformation of Costa Rica's medical landscape, as I discussed in chapter one. While telling me their own stories, many cosmetic surgery travelers in Costa Rica reproduced this mythology of innocent consumption, describing themselves as escapees from the injustices of U.S. medicine, and Costa Rica as a haven of medical fairness (among its other attractions)—even though they generally had little or no understanding of the growing difficulties faced by average Costa Ricans in gaining access to diagnostic and treatment procedures.

### **Uniting invasive medical procedures and the pleasures of tourism**

Despite a popular rhetoric in which cross-border searches for medical care are framed as a form of pilgrimage or search for refuge, these same journeys continue to be referred to as “medical tourism.” Medical tourism is generally thought of as a hybrid practice in which travelers undergo invasive medical procedures *and* enjoy the exotic pleasures of host nations. Mobile medical travelers, in other words, are imagined simultaneously as tourists, patients, and consumers. The exhortation to relax and participate in sightseeing or leisure activities is particularly common in reports about cosmetic surgery tourism, presumably because surgical enhancement is popularly assumed to have more in common with self-improvement practices such as exercise and diet than with other, similarly invasive biomedical procedures. Surgical body modification, furthermore, is embedded in discourses of health, aesthetics, and self-improvement, as is tourism, so the two regimes of subject-making appear to have an affinity through which their practices can be fused.

This logic works to both seduce and mystify aspiring surgical travelers. Many

cosmetic surgery procedures are invasive and painful, and require a long period of recuperation. The discomforts of surgery, however, are downplayed or even rendered invisible on hotel, clinic, and tourism web sites that emphasize the fun and relaxation of tourism. The cover of a book-length, North American guide to off-shore cosmetic surgery, for example, depicts a slender young woman from the waist down (Schult 2006). She is wearing a bikini and is lying on the beach on her stomach in a pose of playful seductiveness. Her body shows no evidence of recent (or past) surgical intervention. This image, like many others used to promote cosmetic surgery and medical tourism, trivializes surgery, and suggests that a youthful, desirable body is achievable, instantly and without discomfort, through a combination of biomedicine, tropical beauty, and separation from the constraints of home. It also performs an erasure of the isolation, boredom, and immobility that many people experience after surgery (Costa Rican surgeons, in fact, explicitly forbid their patients to spend time on beaches or in the sun for several weeks after surgery), and the bruising, swelling and oozing that mark post-surgical bodies. The textual joining of leisure and invasive surgery reinforces these visual seductions, and is common in newspaper titles about medical travel:

*Extreme Vacation: Surgery Safari* (CBS News 2004)

*Have Surgery. Go Sightseeing* (NY Times 2007)

*Sun, Sea, and Scalpels* (Time Magazine 2003)

The medical travel industry has also mobilized the aesthetics of pristine, timeless, unpeopled nature to position Costa Rica's biomedical expertise and technology as safe and sanitized, and to suggest that recuperation will be pleasurable, relaxing, and an escape from the managed time of daily life at home. A recovery hotel's web site, for

example, features a video in which scenes of waterfalls, beaches, and bikini-clad models are interspersed with photographs of MRI machines, white-coated physicians, attentive nurses and smiling patients. The narrator of this ecomedical seduction explains that “the Spanish explorer Juan Ponce de León was searching for the fountain of youth” and that “today, modern medicine has made this dream come true” (Plenitud Group 2008). This potent blend of colonial and technological imaginaries allays prospective patients’ anxieties about “Third World” medicine, positions Costa Rica as biomedically closer to the U.S. than to its Latin American neighbors, and offers the nation as an exotic, beautiful destination for intrepid international explorers. As a facelift patient from California explained: “You need to have adventure in your soul to come here...but this is not a grass hut, it’s a user friendly country.”

Travel can also produce a sense of temporal ambiguity. For family, friends and acquaintances back home, three weeks may pass by in a rapid blur of routine daily activities. Surgical journeyers, on the other hand, return home after the most acutely visible effects of an operation have receded, and are often perceived as having undergone a miraculous transformation. This apparent materialization of the pervasive photographic trope of “before and after,” in which side by side images are “read” for evidence of bodily and social transformation, reinforces cosmetic surgery’s myth of painless and rapid metamorphosis. It also contributes to the expectation among some travelers that cosmetic surgery is not “real” surgery (i.e. does not do bodily violence), and, consequently, to the seeming ease with which many people decide to undergo invasive procedures and the shock they often experience upon awakening after an operation. Many recuperating patients in Costa Rica (including a practicing nurse from California, who

was professionally quite familiar with the bodily effects of anesthesia, incisions, sutures and drains), for example, told me that they were surprised and dismayed by the ruptured and alien-like quality of their bodies after surgery, and by the excruciating wait to feel and appear healthy again—let alone rejuvenated. Several people even said they would have decided against cosmetic surgery if they had known in advance how physically uncomfortable and emotionally upsetting its immediate aftermath would be.

On the other hand, pain-reducing medications are readily provided by Costa Rican plastic surgeons, and discomfort tends to be forgotten after it has passed. As the breach of an operation recedes, travelers collectively rehearse cosmetic journeys as triumphant pilgrimages of self-improvement and productive leisure. In an article on “surgery and safari” packages in South Africa, for example, a woman from Colorado explains that she was an unhappy person who sought a radical change in her life through a journey that fused exotic sightseeing and surgical intervention:

The opportunity to see the animals in their natural habitat, to go where man originated, and at the same time, get the plastic surgery I need at a bargain rate is just fantastic (Leung 2004).

People I spoke with similarly articulated the transformative power of surgery with the self-making project of exotic, international travel. A woman from Wyoming, for example, told me that traveling to Costa Rica for a facelift and full-body liposuction was both a vacation and a personal “renaissance.” Another woman, a college professor, published an account of her cosmetic surgery journey to Costa Rica, during which she experienced surgical rejuvenation and pampered leisure as a period of enhanced academic productivity:

... I could open the glass door near my table and compose my essay on Shakespeare’s *Othello* as a breeze wafted over me. What a way to work! Also the

perfect way, I thought, to undertake extensive plastic surgery—far from the madding crowd and cared for so thoroughly that I had only to recover (Lewis 2005:19).

For many recuperating patients in Costa Rica, beautiful landscapes, hospitable locals, low prices, and a relaxed disposition among Costa Rican caretakers, all inhere in a successful surgical metamorphosis. Moreover, mobile self-fashioners learn to recognize their “new” bodies as in alignment with their “inner” self through camaraderie with other travelers, while describing a sense of liberation and relaxation in being removed from the obligations and financial worries of home. In order for this assemblage to be successful, however, certain strategic operations must be made on the Costa Rican tourist imaginary, in order to render it a place amenable to transnational medical consumption.

### **Keeping the third world (at bay)**

*Many people suspect that Costa Rica is a Third World country with a less than adequate medical community. This DVD will help to put those suspicions to rest.*

- promotional video for Costa Rican plastic surgeon

*Costa Rica's not some whacked out place like Thailand or India.*

- North American medical tourism entrepreneur

In her book *Friction: An Ethnography of Global Connection*, anthropologist Anna Tsing discusses the place-making effects of “globalist claims, with their millennial whispers of a more total and hegemonic world-making than we have ever known” (2005:57). She describes these claims as a “magic show,” in which economic projects (including, I suggest, medical tourism) do not merely operate at different scales, such as local and global, but must conjure the very scale and possibility of globality itself. Elite institutions of transnational medical consumption, and their constituting cast of

journalist-storytellers, commercial medicine-peddlers, hopeful patients, high tech equipment, and eager state conspirators, are precisely such conjurers. What magic tricks do they perform? One of the most mesmerizing—in its mobility, translatability, and anesthetized pleasures, is the hospital as hotel.<sup>49</sup>

Hospitals catering to medical tourists are often situated in countries seen as exotic and Third World by North Americans (India, Thailand and Costa Rica, for example). However, they are also designed, like airports and hotel chains, to exclude this Third Worldness, and to reside in a kind of global non-space—what Baudrillard calls “hyperspace” (1994), or a space that simulates, and exists through its reproducibility. A report in *Newsweek*, for example, describes a Thai hospital that offers “world-class medicine at developing-world prices. And patients get velvet-glove treatment redolent of a five-star hotel” (Cochrane 2006). The suggestion is that the hospital is somehow outside of the poverty, air pollution, traffic jams and sweltering heat of Bangkok—not to mention the multitude of daily routines and tacit knowledges that make Thailand mundane to Thais and exotically foreign to visitors. Such projects, however, are always a twining of local and global. The local may be visually and rhetorically excised, but it is also constitutive, since “developing world” prices require developing world labor, wages and living conditions.

A potent, universalizing term, “world-class” suggests equivalence to Western biomedical knowledge, institutions and practices. In Costa Rica, world-class status is tied

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<sup>49</sup> The terms hospital and hotel share a common origin in the Latin word *hospitalis*, meaning of a guest or host, and the historical development of medicine and hostelry is also intertwined. See Foucault (1995, 1994, 1988a) for a historiography of post-Enlightenment medical epistemology and an analysis of the transformation of the poorhouse into “the ‘well-disciplined’ hospital... a place of training and of the correlation of knowledge” (1995:186).

to presumed U.S. medical standards, and is performed by private hospitals' claims to affiliation with U.S. teaching hospitals, emphasis on clinicians' U.S. and European training, and hospitals' courting of accreditation by the U.S.-based Joint Commission International (JCI).<sup>50</sup> Hospital Clínica Bíblica was accredited by JCI in 2007, followed in 2008 by CIMA Hospital. On Bíblica's Spanish and English web sites, the JCI seal is featured more prominently than that of the Costa Rican Ministry of Health, which audits the nation's medical facilities—both public *and* private.<sup>51</sup> The hospital's privileging of its international credentials enacts a metaphoric transcendence of local standards and institutions—even though private medical practices are contingent on the state's training and employment of most of the country's doctors and nurses.

The designation of world-class, however, also suggests the possibility that not all clinicians and facilities in wealthy countries are, in fact, superior to those in the medical periphery. The Indian heart surgeon I quoted earlier, for example, claimed that the death rate among patients at his hospital was lower than that in U.S. hospitals. Many North American medical visitors, similarly, told me that private medical services in Costa Rica are not merely equivalent to those in the U.S., but are often superior—in terms of medical expertise, nursing care, and the availability of new technologies. The implication is that the U.S. is still one of the world's centers of biomedical knowledge production, and that this knowledge is now readily exported to economically peripheral countries, but that the

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<sup>50</sup> Institutional affiliations have high symbolic value, particularly among North Americans, but I had difficulty determining how (or whether) these claimed linkages translated into actual clinical or educational practices. At least one recovery retreat deploys, and exaggerates, such a connection in order to attract customers, describing CIMA Hospital as a “Baylor University extension.”

<sup>51</sup> See <http://www.hcbinternational.com/>.

U.S. is increasingly unable to deliver this expertise to many of its own citizens. The apparatus of Costa Rican medical tourism is thereby buoyed by a broader claim to medical modernity by regions of the world previously deemed pre-modern, or medically backward, and also by the problems of access to services in the U.S. and other wealthy countries.

Costa Rica's CIMA Hospital, for instance, claims on its website to be "fully compatible with North American standards," and to offer services "in a manner that is more responsive than most American hospitals" (International Hospital Corporation 2008). Some post-operative recovery facilities go one step further, promising more than hospitality, food, and transportation. The website of one retreat, for example, describes its facility as a place where "your every need and desire is attended to from your arrival to your departure," and where guests will "experience the culture, history, geography, cuisine and language of Costa Rica" under one roof.<sup>52</sup> In other words, medical travel to Costa Rica is sold as a culturally edifying, as well as medically restorative, experience.

Natural beauty and the affective labor of local caregivers, in particular, serve to localize the global biomedical modernity on offer, positioning Costa Rica as a *more* desirable (rather than merely equivalent) site of medical services. Low-cost labor, and large wage differentials between U.S. and Costa Rican health care workers, enable these attractions, and are marketed—and experienced by many medical travelers—as intrinsic to the country, and to its inhabitants' "simple" way of life, and therefore as not labor at all. "The less you have, the happier you are...they have what they need here, if not lots of money," a woman from the U.S. told me in explanation for the kindness and relaxed

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<sup>52</sup> See <http://www.worldheadquarters.com/cr/medical/florequilla/>.

manner of her Costa Rican caretakers. (She had just spent US\$7,000 on a facelift, airfare, and two weeks at a recovery retreat, which is almost double the average annual salary in Costa Rica.) World-class medical services, in other words, erase evidence of (and, in the process, re-naturalize) the social and economic divisions that are a condition of their production. The proliferation of elite medical spaces is particularly striking in Costa Rica, where the nationalized medical program has long been tasked with social and economic equalization through universal access to health care.

As I discussed in chapter one, many (if not most) cosmetic surgery tourists in Costa Rica purchase medical services in small clinics and family-owned recovery hotels. Recently, however, the construction and expansion of larger private hospitals catering to medical tourists has accelerated, and most plastic surgeons perform at least a portion of their aesthetic surgeries in these hospitals.<sup>53</sup> In promotional materials and news reports about Costa Rica and other medical tourism destinations, new private hospitals are frequently referred to as “five star.” This term suggests luxury and leisure—the hotel-hospital offering an elite seclusion from everyday life that is reminiscent of one of its historical antecedents, medicinal spas, and that stands in sharp contrast to another forebear of contemporary hospitals: “houses of seclusion” for the poor and socially marginal (Foucault 1988b:36). Medical tourists participate in these spaces as guests or consumers, rather than patients, for whom the globe is mapped as a biomedically homogenous marketplace. A CBS article on medical tourism, for example, uses enticing terms to portray a project that markets a hospital as a site of relaxation, pleasure and

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<sup>53</sup> Since I returned to the U.S. in late 2006, two of Costa Rica’s largest private hospitals have undergone renovations and expansions, as well as established departments devoted to attracting foreign patients and coordinating their services. A new CIMA Hospital is also under construction, as I discuss later in this chapter.

consumption:

The rooms look more like hotel rooms than hospital rooms, and that's no accident. The idea was to make the whole hospital look like a hotel and a five-star hotel at that. There are boutiques and restaurants to suit every taste and nationality (CBS 2005).

Where is this hospital? It could be anywhere, and the point is that such spaces appear to be segregated from local populations, public health care institutions, and funding vicissitudes, while enabling guests to combine medical and touristic consumption under one protective roof. The most celebrated pioneers of this trend are Bumrungrad Hospital in Thailand (to which the above description refers), and Apollo Hospitals in India. Costa Rica's private medical spaces are dwarfed (rhetorically and materially) by these giants, but, as I mentioned earlier, they have benefited from the successes of their foreign competitors, and have employed a similar strategy of building and representing hospitals as spas and hotels.<sup>54</sup> A full-page, English-language advertisement for Hospital Clínica Bíblica, for example, is framed by the shape of a hanging "do not disturb" door sign, typically found in hotels, with the following text:

Your health deserves more than a five star treatment...enjoy a relaxing, stress-free experience as we assist you with all your needs... (Hospital Clínica Bíblica 2007).

Floating beneath the sign is a folded white towel cushioning several fresh, pink orchids, alongside a series of images of a volcano, a beach, an MRI machine (with a white-coated, male physician and a supine, gender-nonspecific patient), and two smiling young women—one in a hospital bed and the other holding her hand. These images

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<sup>54</sup> Whereas Clínica Bíblica and Clínica Católica have undergone renovations in order to render them more appealing to North Americans, CIMA was specifically built to cater to expatriate residents, foreigners, and elite Costa Ricans. Several CIMA employees told me that the main building was designed to function alternately as a high-end retirement facility, in the event that the hospital was not profitable.

seduce viewers with an alchemy of medical expertise, beautiful landscapes, and local hospitality. The hospital-as-spa hotel is offered up as a soothing, pampering space where medical procedures are life and health-enhancing.



Figure 7. Hospital Clínica Bíblica advertisement in *Medical Tourism* magazine. December 2007.

There are certain realities of Costa Rican medical services that are not depicted in these images, however, including: average Costa Rican and Nicaraguan patients, long queues for public medical services, and re-emerging infectious diseases.<sup>55</sup> These absences work to reconstruct the hospital as a transnational space that is disconnected from Costa Rican state-sponsored medicine, except as a “free-market” alternative to its crowded,

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<sup>55</sup> The promotion of medical tourism facilities as life enhancing also occludes the risk of death or disfigurement as a consequence of invasive procedures. While deaths among cosmetic surgery travelers in Costa Rica are rare, they do occur. An American women in her 40s, for example, suffered a fatal blood clot in a Costa Rican hospital in 2006, shortly after a 12-hour operation that included a tummy tuck, breast lift, and liposuction. Her death was discussed on Internet forums, but did not appear to affect the flow of North American cosmetic surgery patients to Costa Rica thereafter.

deteriorating buildings, equipment shortages, and long waiting lists. Indeed, a new hospital building is featured in the center of the Clínica Bíblica advertisement, its vaguely ecclesiastical architecture and enormous stained glass representation of a tree suggesting strength and longevity, as well as symbolizing a partial shift from the hospital's missionary origins toward a more ecumenical (and market-based) inclusiveness. The effect of this commercial montage is a harmonious fusion of nature, technology and medicine as commodity. In their seductive realism, this and other portraits of an idealized Costa Rica are reminiscent of the 19<sup>th</sup> century “panoramas,” or lifelike replicas of scenes from nature and history, critiqued by Walter Benjamin as ahistorical and illusory, and from which “all evidence of incompatibility and contradiction...is eliminated” (Buck-Morss 1991:67).

Constructions of medical expertise, race, and gender are also strategically deployed to market medical tourism services, and to enact a purification of potentially disruptive local characteristics. For example, *The Medical Tourism Association* (MTA), a U.S.-based trade organization that promotes the medical tourism industry, devoted the first issue of its *Medical Tourism Magazine* to Costa Rica. The opening article, titled “Costa Rica: from Ecotourism Leader to World Class Healthcare Provider” (Cook 2007), offers a brief historical account of medical tourism in Costa Rica. The author (an executive at Clínica Bíblica) claims that uninsured or under-insured North Americans who need “life-saving medical procedures” now outnumber visitors seeking inexpensive cosmetic surgery. More hopeful than factual, this statement acts to rhetorically reposition the Costa Rican medical tourism industry as more medical, and less frivolous, and highlights

cosmetic surgery's contested status as a legitimate medical specialty.<sup>56</sup> The author then assures readers that Costa Rican doctors are not “quacks,” a claim that is accompanied by images of people of European descent in scrubs and white doctors' coats.

The models in these images look more like seductive runway stars than doctors (the same stock photo, incidentally, appears on the web site of a “medical tourism” hospital in Kansas).<sup>57</sup> These, and other, medical tourism images, reproduce the “white legend” of Costa Rican exceptionalism, which links presumed European ancestry and skin color with national identity (Edelman 1999). Costa Rica's state-sponsored international tourism campaign deploys a similar racial mythology, historically and geographically marginalizing people of indigenous, *mestizo*, and African descent (Rivers-Moore 2007). This re-racialization of Costa Rica presumably renders the nation less threatening, and more consumable, to middle class, white North Americans. It also articulates with cosmetic surgery's history of racial normalization based on European beauty ideals (Gilman 1998).

Costa Rica's private medical spaces and practices are also normatively gendered. This is particularly true of plastic surgery, whose predominately male clinicians remodel female (and some male) bodies, based on conventionally gendered norms of

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<sup>56</sup> According to clinicians and administrators at San José's largest private hospitals, elective procedures were still by far the most popular form of medical consumption among visiting North Americans in 2006.

<sup>57</sup> U.S. hospitals have long catered to elite patients from outside the U.S., but Galicia Heart Hospital (2009) may be among the first U.S. hospitals to promote itself explicitly as a full-service medical tourism facility. Their web site slogan is: “No wait medical tourism for Kansas, the U.S. and the World.” See <http://www.ghhospital.com/>.

appearance.<sup>58</sup> Costa Rican plastic surgeons, moreover, generally refuse to perform procedures that they call “unnatural,” such as sex change operations, even though competing medical tourism destinations (most notably Thailand) specialize in these procedures. One surgeon told me that gender-altering (versus gender normative) procedures are “against Catholicism,” and that a clinician who performed them would be “playing God.”<sup>59</sup>

In addition, hospital-based services are marketed as modern, Western (surgeons’ foreign training has high symbolic capital among mobile patients), and dominated by male physicians, while the post-surgical embrace of nurses, recovery hotel workers, massage therapists, and restorative nature is characterized as Costa Rican (i.e. local) and feminine. Medical travelers frequently make reference to the beauty of Costa Rican women, suggesting the proximity of medical hospitality to Costa Rica’s thriving sex trade and other forms of “caring” for foreigners. “Here they are these beautiful people who will do anything to make you happy,” a North American facelift patient told me. Costa Rican

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<sup>58</sup> Several surgeons told me that these norms are based on a fusion of Latin American and North American beauty types. Specifically, women with large buttocks are considered more attractive in Costa Rica, which is not generally the case in the U.S. However, buttock implant surgery (commonly performed in Brazil and Mexico) does not seem to be popular in Costa Rica, and several surgeons refuse to perform them—presumably because of their high rate of “failure.” Another difference between cosmetic surgery in Costa Rica and the U.S. is its growing popularity among men in the U.S. In Costa Rica, by contrast, few cosmetic surgery patients are men.

<sup>59</sup> Costa Rica is a predominantly Catholic country, and several private hospitals have missionary origins and ongoing Catholic or Protestant-based mandates. Religious understandings of personhood and life, moreover, have influenced medical practices in Costa Rica via legislation, particularly through the national ban on in-vitro fertilization and most abortions. Except for the example I cited above of procedures that are thought to transgress conventional gender norms, however, I did not encounter any religious arguments against cosmetic surgery in Costa Rica. See chapter five for the story of a Costa Rican woman who received the “blessing” of a Church representative before undergoing a facelift.

women and nature thereby operate as an embodiment of the nation's status as politically and culturally benign, and as a gendered catalyst for the various forms of consumption engaged in by visiting and resident North Americans.

The MTA article also offers several "facts to consider": 1) Costa Rica has achieved a higher health status ranking than the U.S. by the World Health Organization (WHO); 2) the country's infant mortality rate is similar to that in the U.S.; and 3) Costa Ricans have a higher life expectancy than residents of the U.S. Attributing these statistics to Costa Rica's "health system," the author writes:

To its credit, Costa Rica also has a long tradition of offering high quality medical care to all its [sic] citizens through a national public healthcare system. Besides the public health system, the country has a strong private health system with hospitals and clinics of great prestige and reputation (Cook 2007).

Indeed, laudatory statistics from the World Bank and WHO are frequently used by medical tourism promoters as evidence that Costa Rica has a healthy populace, and is politically and economically closer to the U.S. and Europe than to its poorer neighbors. In addition, Costa Rica's impressive health statistics are often paired with images of gleaming new private hospitals, suggesting that Costa Ricans are kept healthy and long-lived through a harmonious (i.e. natural) blend of public and private medicine. Costa Rica's achievements in lengthening the lives of its citizens, however, are generally attributed to the now-waning project of strong state institutions, which articulates national identity and middle class prosperity with the provision of social services, including education, public health programs, and pensions. Private medicine, on the contrary, has until recently served primarily as a supplement to public services, and as a domain of elite consumption, so new private hospitals can hardly be credited with enhancing the longevity of average Costa Ricans, or the political stability of the nation. Some analysts

argue, rather, that the expansion of private medicine is a cornerstone in ruling elites' project to dismantle the welfare state, and is thereby contributing to the erosion of the Costa Rican middle class (Barahona 2002; Ordoñez 2007).

The rapid growth of the private sector is, moreover, economically and politically inextricable from policies—founded on neoliberal ideology—that have contributed to funding deficiencies, infrastructure deterioration, and the defection of clinicians from the national medical program. For example, the state trains most of the country's doctors, but in 2006 national hospitals were hemorrhaging plastic surgeons, anesthesiologists, and other specialists to the private sector, where salaries are often higher. And as I discussed in chapter one, middle class Costa Ricans are forced to consider going into debt in order to pay for medical procedures in the private sector, rather than wait for months or years for the same service at a public hospital. Relatively affluent visitors and elite Costa Ricans, meanwhile, are offered an expanding array of state-of-the-art technology and timely and attentive care in elegant private clinics and hospitals. Portrayals of the Costa Rican health care apparatus as an integrated, stable system, caring equally for citizens and visitors alike, thereby produces an elision of ongoing political and economic transformations, conflicting ideologies of healthcare as a right or a commodity, and deepening inequalities in access.

Nevertheless, this Costa Rican medical imaginary continues to be productive in shaping the desires and practices of mobile patients. The emerging genre of medical tourism guidebooks, for example, attempts to convince readers of Costa Rica's peacefulness, prosperity and modernity, in order to assuage any residual fears that Costa Rica might reside in the Third World. One author briefly mentions poverty, only to

dismiss it as irrelevant to tourists, who are often sequestered in Costa Rica's protected, transnational spaces: "There is certainly poverty in Costa Rica, but it is mostly invisible to a tourist in San José" (Schult 2006:152). Since I found poverty impossible *not* to see in San José, except in the most affluent neighborhoods (and even in those areas I encountered migrant laborers), the author seems to be granting permission to prospective medical travelers not to see, or think about, how poverty arises, and how it may be linked to the self-transformations of medical tourists.

The author of *Patients Beyond Borders: Everybody's Guide to Affordable, World-Class Medical Travel*, tries a different approach. He suggests that U.S. consumers are so ubiquitous in Costa Rica that "many 'Ticans' [sic] wonder if their country won't soon become the U.S.'s fifty-first state" (Woodman 2008:215).<sup>60</sup> I did not meet any Costa Ricans who mentioned such a concern or hope, but I did speak with people who were worried that their country was being sold to the U.S. in the form of cheap labor and a U.S.-influenced ideological dismantling of the welfare state. "Costa Rica is not for sale!" a popular graffiti slogan read. What the author of the guidebook fails to acknowledge are the complex structural conditions that enable clinics and hospitals to keep prices low enough to attract North Americans, including a legal system that provides fewer protections for patients.<sup>61</sup>

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<sup>60</sup> Costa Ricans affectionately refer to themselves as *ticos* (masculine) and *ticas* (feminine), not "Ticans." Nicaraguans are commonly called *nicas*, although this diminutive is often used in disparaging statements and jokes about migrant workers, such that it seems to me to have a more derogatory connotation.

<sup>61</sup> Costa Rican physicians, for example, rarely carry malpractice insurance since they are hardly ever sued by patients—primarily because civil trials are contingent on a criminal conviction, and because courts usually do not award large monetary damages to the victims of malpractice.

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The medical tourism marketing and informational campaigns that I have discussed tend to target uninsured, underinsured, or merely middle class U.S. residents. Many are compelled to undergo biomedical procedures, but do not enter a hospital (or plastic surgery clinic) near their home without fear of financial ruin, and few have enjoyed the comforts of “five-star” spheres of consumption. At a hotel for recuperating patients in Costa Rica, for example, the proprietor told me that half of her guests were middle class people who had never traveled outside the U.S. before their sojourns in Costa Rica. Of course, the mobile patients I talked with could afford the price of international airfare, two weeks at a hotel, and medical expenses in Costa Rica, and they were certainly not among the most medically marginalized residents of the U.S. Yet most were not affluent either, and several people I spoke with had sold or taken out a second mortgage on their homes in order to pay for their cosmetic journeys.

While in Costa Rica, many middle class visitors seem to enjoy an instant elevation in their financial and social status, which includes not only the intoxications of previously inaccessible forms of consumption, but a sense of personal liberation and possibility. Below, I quote from a travel narrative posted to an Internet forum whose members discuss cosmetic surgery destinations outside the U.S., by a woman who underwent a facelift in a private hospital in Costa Rica. Her account is inflected with a sense of having been transported from economic and medical marginality to the pleasures of honorary membership in a more elite social class in Costa Rica. Like many cosmetic surgery visitors, she even yearns for a permanent move to the utopian comforts of neoliberal Costa Rica:

i personally feel u are much safer getting surgery in this country than the us.they are not in such a hurry here as to jepordize your health and safety

[the hospital] is as modern as it gets  
i had a big private room,it was very clean,every time i pressed the buzzer someone responded immediatly.

i have gone years w/out health insurance or marginal coverage @best which is pretty worthless  
i hate the us so much right now u have no idea.

normally i hate hospitals and being in them.

they do not rush u to leave,like they do in the us.

they will just keep bringing u food and whatever u ask for

they have really tasty food for a hospital

they even serve tea around 4pm,  
actually it is coffee and pastries

i needed a chapstick and they brought me one.

i asked for a diet coke w/a straw and they brought me one.

the rooms are air conditioned,and they have brand new flat panel tv's in the room.u control the temp in your room w/ur own thermostat.

i like it here so much i may never return to the states  
just long enuf to put my stuff in storage

I met many North American expatriates who had made the migration that this patient is contemplating, some of them inspired by a cosmetic surgery journey, and most of them enjoying enhanced social and economic status. The majority of expatriates I encountered were retired, and while some were committed, paying members of the *Caja*, many more were enthusiastic consumers of Costa Rica's private medical services, including cosmetic surgery. For some wealthy expatriates, in fact, living in Costa Rica seems to be a kind of extended, medicalized vacation.

North Americans in Costa Rica are thereby positioned as both elite and as culturally and politically neutral or innocent. Their elite, outsider status enables them to remain apart from local contests over medical funding and access, and yet to purchase, and benefit from, local medical and hospitality services. Their innocence arises from their role as patients—as damaged bodies (and souls, as I explain in chapter four) in need of intimate care. Like the colonial naturalist Humboldt, whom Mary Louise Pratt (1992) describes as excising human inhabitants from detailed drawings of populated landscapes, medical travelers often see Costa Rica through a lens that backgrounds the complex historical and institutional production of Costa Rica’s medical apparatus, while emphasizing the utopian foliage of the gardens and neutralized spaces of elite medical consumption.

### **Consuming landscapes**

*Behold a conurbation with few green spaces, a chaotic traffic picture, a lack of effective vehicle pollution controls, grossly inadequate sewage facilities, and utterly inappropriate development governed by quick returns and paved by corruption and overmatched public institutions.*

- Description of San José by Steven Palmer and Iván Molina (2004:276)

*I have slept better here than I have in a long time and there is no noise to disturb you—maybe the passing of some native bird...you have nothing to worry about...*

- U.S. woman recuperating from a facelift in San José

As I have discussed, private medical spaces in Costa Rica—particularly the hotel-like hospitals and recovery retreats that serve medical tourists—are designed, built, and depicted as global spaces with local embellishments. Hospital web sites, for instance,

feature exterior photographs that are taken at an angle from the ground up, such that little else is visible beyond hospital buildings and the sky. Through such strategies of decontextualization, medical structures appear to be unmoored from place and time, except for characteristic features that render them more appealing to consumers. We cannot disregard, however, the neighborhoods where these buildings are (and are not) constructed, and we should also attend to the bodies and objects that pass through them. Below, I consider the very specific locality of private hospitals, and how their material-ideological construction participates in the “creative destruction of political-economic space” initiated by Costa Rica’s neoliberal turn (Brenner and Theodore 2002:349).

As state-of-the-art private hospitals promote themselves as “the future of medicine” (from the caption to a building expansion plan in CIMA Hospital’s lobby), their constituting neoliberal discourse relegates public medicine to Costa Rica’s inefficient, bureaucratic, state-dominated past. Free-market triumphalism has eroded, but not eliminated, large state institutions, as I explained in chapter one; it is, however, prolifically materialized in Costa Rica’s rapidly changing urban landscape. This is particularly visible in the central plateau, where San José and neighboring towns have merged into an unplanned conurbation. Since the 1980s, this area has hosted a multiplication of industrial free trade zones, malls, gated housing subdivisions and private medical facilities.

I saw this process firsthand in Heredia, a middle class town approximately ten kilometers from San José, home to one of the nation’s two national universities, and my place of residence for nearly a year. Heredia was once known as “the city of flowers” (whereas the epithet is now used humorously to refer to the migration of transvestite sex

workers to Heredia after being routed from San José by the police). Before 1980, economic activity in Heredia was dominated by coffee production, and the city was linked to San José by a narrow road (and a now-defunct railroad) that wound through hills blanketed with coffee fields. By the time I arrived in Costa Rica, however, the outskirts of Heredia and San José had fused in a patchwork sprawl of private development, with the same narrow road serving as a traffic-clogged artery for the growing numbers of commuters traveling to the capital every day.

One of the area's few undeveloped spaces is a deep ravine, through which an abundant, frothy river runs. The bus between Heredia and San José laboriously descends this ravine and crosses the river on a narrow bridge, so I studied it often as I made my way to hospitals and clinics in San José and its affluent suburbs. It must have been a stunning landscape once, but the river and its banks were littered with trash and crowded with ad hoc dwellings—a shantytown of sorts, precariously close to the river and pummeled by tropical storms during what Costa Ricans call the green season. It did not seem to be recognized as a neighborhood by municipal agencies, and had become a site of social marginality and a place to dump garbage. Such human and environmental abjection is incongruous with Costa Rica's reputation for prosperity and ecological responsibility, but I suggest that the enclave (and many others like it in and around San José) is the constitutive underside, rather than the outside, of Costa Rica's refashioning as a site of pristine and consumable nature. Unwanted objects, and marginalized humans, are products of the new order, and they have to live somewhere.

Heredia still had vestiges of the central plateau's declining, coffee-centered, agrarian economy, but these patches of agricultural production (or lapsed production)

were being consumed almost overnight by rising land prices and private development. For two months, I lived next to one of the few remaining coffee fields near the town's center, my bedroom window overlooking an expanse of dark green bushes. The field's tranquility offered refuge for residents and assorted birds and small animals, particularly from the noise, pollution and traffic that characterize an urbanizing Heredia.<sup>62</sup> One morning, however, I awoke to the sound of bulldozers. I looked out the window and saw the coffee bushes going under, one by one, too easily loosening their grip on the soil in order to make way for a new housing development. I was reminded of older Costa Ricans' nostalgia for an era when such fields were ubiquitous in San José and coffee was central to the nation's economic prosperity and identity. Daily life, they told me, had been simpler and more relaxed, and the city's residents were less cosmopolitan and more "Costa Rican."

Today, much of Costa Rica's coffee is picked by laborers from Nicaragua, and many new, luxurious housing "communities" cater to North American retirees who reside part or full-time in Costa Rica. These enclaves are usually enclosed by gates and walls, and are patrolled by armed guards. (Costa Rica has not had an army since 1948, but its growing ranks of private security guards seem to constitute an army in their own right). Gated communities, I suggest, create a privatized version of Costa Rican exceptionalism. They contain "natural" landscapes that are purified of wild animals and other tropical inconveniences, and they tacitly promise social and economic homogeneity. They

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<sup>62</sup> As automobile ownership increases in Costa Rica, traffic laws and emissions regulations are for the most part not enforced, such that choking air pollution and dangerous road conditions are a regular feature of daily life in urban areas. Elites are able to seal themselves in air-conditioned cars and gated neighborhoods as a buffer from these assaults, but most residents of urban Costa Rica find themselves navigating dense traffic and noxious fumes on foot and on public buses.

exclude that which mars exceptionalism—including potholed roads, poor migrants (except as laborers), public institutions (roads and other services are privately maintained), and commercial traffic. Subdivisions, in effect, divide space and people into separate realms: public-private, inside-outside, success-failure. Their names (many are in English) evoke a nostalgic escape from San José’s urban blight into an imagined past. Toucan populations are dwindling due to development and climate change, but they continue to perform imaginative labor in the selling of Costa Rica:

Toucan’s Perch

Palmas del Pacifico (Pacific Palms)

Las Nubes (The Clouds)

Estrella del Pacifico (Star of the Pacific)

La Reserva (The Reserve)

Ocean Breeze

Enchanted Bay

Meanwhile, public buildings and urban parks are deteriorating and have increasingly become the domain of socially and economically marginalized persons, such as the rural poor and Nicaraguan migrants. Just minutes from Costa Rica’s largest private hospital, for example, is a sprawling neighborhood called *Desamparados* (The Forsaken). The area’s potholed, and sometimes unpaved, roads, crumbling dwellings, active drug trade, and violence render its name bleakly apt, as if state institutions have decided that the district and its inhabitants do not exist. Not only *do* its inhabitants exist, however, they are often the lowest paid laborers in the construction and service industries that have been mobilized to build spaces of transnational consumption. A Nicaraguan man who worked on the construction of luxury homes, for example, told me that he does not feel welcome in Costa Rica and that he does not earn much more than subsistence wages. But at least it is work, he said, whereas in Nicaragua there are no jobs for people like him.



Figure 8. House in San José, with bars and razor wire to keep out intruders. Photograph by Sara Ackerman, 2006.

Architecture and urban landscapes, says David Harvey, are a form of communication (1990:67). How, then, do we interpret the spatial and architectural utterances of urban Costa Rica's dissonant landscapes? The very materiality of elite buildings and private spaces, I argue, contain the labors, the handprints, of those they would exclude from participation in the pleasures and forms of consumption on offer. Perhaps the most glaring (visually and metaphorically) container of this paradigm is CIMA Hospital.



Figure 9. CIMA Hospital. Photograph by Sara Ackerman, 2006.

As I discussed in chapter one, CIMA is a transnational project that appears to be outside of the growing social and environmental problems in San José. It is situated on former farmland, adjacent to an affluent suburb, but made proximate to the city and international airport by a new, state-funded highway. Its buildings are described on the hospital's web site as "Spanish-colonial," through which "a sense of tradition, trust and stability is conveyed while also showcasing the high level of medical technology used through out the entire complex" (International Hospital Corporation 2008). This architectural posturing includes sealed, reflective glass windows that do not allow outside climate conditions or traffic noise to pass through, but afford a tinted view of nearby volcanoes from within. Like the Los Angeles hotel in Frederic Jameson's (1984) discussion of postmodern architecture, the hospital's façade both repels and dissociates the structure from its surroundings. A hospital employee told me that the building design was informed by North American assumptions about seasonal climate change, and that it has to be continually cooled or heated. The imperviousness of its architectural skin is not only wasteful, given San José's mild climate, but it is a materialization of the hospital's social and economic exclusivity.

Outpatients generally arrive at public hospitals in San José on foot or by public transit. This is not a trivial fact in Costa Rica, where road conditions are notoriously dangerous for pedestrians (most traffic accident casualties are pedestrians). Poignantly, several of San José's handful of functioning crosswalks are in front of public institutions, including state hospitals, the *Caja's* towering administrative buildings and national universities. These crosswalks are heavily used, collectivizing and emboldening bodies that elsewhere make their way individually and furtively among fast-moving cars, trucks

and buses. The majority of visitors to CIMA, by contrast, arrive by car and park in a guarded lot in front of the hospital. Workers who do not own cars, and visiting anthropologists on a shoestring budget, are obliged to alight from the public bus on the other side of the highway and scurry frantically across four lanes of speeding traffic like rodents panicked about their possible transformation into road kill—not exactly the corporeal mutability most of us desire. The effect is acutely unwelcoming of non-elites.

For those who make it inside, however, CIMA is an oasis of calm, friendly service. One side of its marble-floored reception area has a waiting section with comfortable chairs and an international insurance claim desk; nestled on the other side is a restaurant with uniformed waiters, linen tablecloths, and congenially socializing doctors and patients. The hospital is rarely crowded, and its atmosphere is relaxed and friendly—in striking contrast with the hurried austerity at busy public hospitals. On one visit, the public relations officer, Ofelia, tells me that over half of CIMA's patients are foreign (including tourists and expatriate residents). When I ask about CIMA's main competitor, Clínica Bíblica, she concedes that Bíblica does have a new building, but that it is in an unsafe neighborhood in San José. CIMA, on the other hand, is in an affluent neighborhood popular with North American expatriates, has an open MRI, and is completely private (i.e. it does not accept government contracts), she brags. Their principle objective is to make patients feel better, she continues, and this includes emotional care, flowers, and good food (presumably the absence of state-subsidized patients is also healing). Even the janitors know patients' names, she tells me, referring to the wide spectrum of affective labor that is performed at CIMA. When I ask about the *Caja*, she sighs. "It's too crowded, and there are too many *nicas* [Nicaraguans]," she

says, so the middle class is increasingly turning to private medicine. “The *Caja* is better at dealing with emergencies,” she concludes.

There are, of course, ruptures in CIMA’s attempt to position itself as an island of luxurious private medicine in a sea of public decline. Most of the hospital’s doctors are trained in the public sector (as yet, fellowships and residencies are unavailable in the private sector), and its promotional materials situate the hospital’s mission within the nation’s (state-sponsored) dedication to providing comprehensive social services for all citizens. CIMA’s claim to being a “completely private” facility, therefore, obscures the state-sponsored medical apparatus that underwrites its ability to attract cash-paying patients to Costa Rica.

Another point of disjuncture at CIMA is the provision of services for U.S. military veterans who reside in Costa Rica, many of whom receive services at CIMA, as it is the only private hospital in Costa Rica with a psychiatric clinic. The U.S. veterans’ office occupies choice real estate in the hospital’s main building, a prominence resented by many elite Costa Ricans. As a former CIMA administrator put it:

... the U.S. vets don’t look good and aren’t well dressed...some of them don’t treat people well, they aren’t clean, and they bring young women or prostitutes into the hospital with them.

In other words, these patrons do not appear or behave like elites. The administrator went on to say that CIMA doctors often come into the veterans’ office to threaten that they will no longer provide services for U.S. veterans because of delays in reimbursement from the U.S. government. The agency in the U.S. that processes claims, meanwhile, has countered that CIMA staff do not fill out claim forms properly (part of the problem is that they are in English). Unruly behavior, overlapping and intertwined forms of licit and

illicit consumption, and transnational bureaucratic incommensurability, all collude to produce some foreigners as contaminating agents in the hospital's purified atmosphere.

Private medicine's unanticipated products also emerge in the realm of small plastic surgery clinics. In particular, the growing popularity of cosmetic surgery among middle class Costa Ricans intersects with an overproduction of medical graduates—the latter emerging from a recent proliferation of private medical schools and contractions in the national medical program. These conditions have contributed to a shadow private sector populated by general practitioners with minimal training in plastic surgery, and subject to lax regulatory discipline by the state.<sup>63</sup> These physicians fashion themselves as plastic surgeons and offer prices that appeal to middle class Costa Ricans, whereas board certified plastic surgeons cater primarily to wealthy Costa Ricans and North Americans.

Several career *Caja* surgeons told me that these entrepreneurs threaten plastic surgery's status as a legitimate medical specialty, particularly by way of their unrealistic claims about the miracles of cosmetic surgery, explicit and tasteless advertisements in local newspapers and magazines, and poor surgical performance. Self-fashioned surgeons offering procedures at lower prices also pose an economic threat to board-certified surgeons, a point that most doctors I spoke with were reluctant to make; after all, even doctors for whom medical practice is a business do not want to appear more concerned about money than helping patients. More broadly, inadequately trained doctors threaten to mar Costa Rica's international image as a place of medical modernity and expertise.

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<sup>63</sup> Costa Rica's reputation for corruption and lax enforcement of laws and regulations is precisely what draws many North Americans to live there full or part-time. I heard many rumors that Costa Rica is a haven for people fleeing arrest warrants in the U.S., and others hoping to remake themselves—legally, socially, and/or corporeally. This status, however, is changing along with new extradition agreements between the two countries.

“It’s the wild west here...Costa Rica needs to focus more on safety,” said a visiting doctor from the U.S. Costa Rican medical consumers, meanwhile, complain that *gringos* are driving up prices among private plastic surgeons, forcing middle class locals to turn to inadequately trained doctors for cosmetic (and, less often, reconstructive) procedures.

Thus, rogue doctors, misbehaving veterans, languishing public spaces, socially and economically marginal laborers, and murderous roads, are among the disruptive material-discursive forms produced through the economic and cultural regime that also fosters medical tourism. These mixtures show the “multiple links, the intersecting influences, the continual negotiations” between the public and private sectors, between markets and state institutions, and between local and transnational forces (Latour 1993:13). What, and where, will they produce next?

### **Conjuring the future**

*In a Corner of Costa Rica, a Beachhead for Luxury*

- New York Times headline (Brown 2006)

Shortly before I returned to the U.S., I attended a party at the house of some friends in Heredia. In many ways, their family is typical of the Costa Rican middle class. The owner of the house, Marta, is a retired schoolteacher who lives with her brother, his son, and various cousins who seem to come and go through the revolving door of familial obligation. Most members of Marta’s extended family are well educated and have steady jobs as professionals or small business owners. Still, they feel an increasing sense of financial uncertainty and constraint. Marta takes in Spanish-language students from the

U.S. as boarders in order to earn a little extra money, because, she told me, her government-guaranteed pension no longer stretches as far as it once had.

At the party, I find myself in conversation with Marta's son-in-law, Jonathan, and his father. They are discussing the northern province of Guanacaste, an expansive region of cattle ranchers, cowboys, and, more recently, luxury beach resorts bordering the Pacific Ocean and Nicaragua. They told me that development projects in Guanacaste are turning the entire province into a playground for *gringos*—a place that middle class *ticos* like themselves cannot afford to visit. They spoke of festering inequalities in Costa Rica, and *gringo*-inflated land prices that prevent more and more members of the middle class from being able to buy a house of their own. Their quiet anger and frustration surprise me because most Costa Ricans tend not to express anti-American feelings when in the presence of *gringos*—projecting instead an unflagging disposition of politeness and hospitality.

Their perceptions, nevertheless, are familiar, and are widely shared among members of Costa Rica's once-strong middle class. Many people find their incomes shrinking as opportunities for new forms of consumption multiply and beckon, and as more *gringos* flock to Costa Rica as tourists or to take advantage of “bargains”—medical, residential and sexual (Costa Rica has a thriving sex trade). Many middle class Costa Ricans are ambivalent, therefore, about the dollars that *gringos* bring to Costa Rica, even if their livelihoods depend on them.

Guanacaste, in other words, is not only a site of large-scale private development, but of contestation over the imagined future of Costa Rica. It is perhaps ironic that the province was a part of Nicaragua until 1825, since today many Nicaraguan migrants cross

the border into Guanacaste to find work, only to feel the heat—and social and political consequences—of Costa Ricans’ resentment and frustration about the shifting ground beneath their feet.

In 2006, the New York Times acknowledged Guanacaste’s transformation, albeit in a more sensational, and celebratory, tone:

All up and down the coast, bulldozers are at work. Three major developments, including a project anchored by a Four Seasons hotel, are already selling luxury condominiums for \$500,000 and up... In the airport lines, Americans talk in urgent tones about the money to be made, about "Wild West" opportunities. Never mind that Guanacaste is still a region of cattle ranchers and rutted roads. The new homesteaders envision a beach, golf and spa destination equal to the Puerto Vallarta corridor in Mexico or Wailea Beach on Maui—without, so far at least, the high-rise blight. The area's promoters have taken to calling it the new Gold Coast (Brown 2007).



Figure 10. Photograph from property listing at [propertiesincostarica.com](http://propertiesincostarica.com), 2009. The caption reads: “Gorgeous, Gated and Golf! Go For It!”

Thus far, I have suggested that leisure and adventure tourism, luxury housing for North American retirees, and medical tourism, are economically and ideologically intertwined projects. In Guanacaste, recently, these neoliberal “successes” have been more explicitly, and materially, fused. In 2007, the state-sponsored Tourism Board

announced plans for a residential and medical tourism complex in Guanacaste, to be accessible by direct flights between the U.S. and Liberia, the province's largest town:

The North American company 'All American Homes RPC' will build a hotel specialized in health tourism, with an investment estimated at \$34.5 million dollars. The Ailanto Wellness Resort and Spa Hotel... will offer to its guests a wide range of medical and holistic services, such as plastic surgery, nutrition, homeopathy, dentistry, and massages. In addition to its 400 rooms, the hotel will have especially designed residences with several rooms and condominiums for sale (ICT 2007).

More recently, CIMA announced plans to construct a new hospital and commercial center in Guanacaste "for locals as well as foreigners here on medical vacations" (Garnica 2008).<sup>64</sup> It is certain that cowboys are turning into waiters and tour guides, but less certain that they will be able to afford medical treatment at CIMA. Will they undertake medical migrations of their own in order to see a specialist at a national hospital in San José, or will they be awarded medical citizenship in Costa Rica's burgeoning private sector? What other consequences will arise from this most recent conjuring of Costa Rica's medical future and the flight of medical tourism from San José?

The future cannot be foretold, but for now the private sector in Costa Rica is in a frenzy to build, and sell to border-crossing elites, what is imagined in many parts of the world as the good life. This is a life lived in luxurious private spaces maintained by acquiescent local labor, and one of its defining practices is the consumption of enhancement technologies. Perhaps it is not surprising that cosmetic surgery continues to be the most popular product among mobile medical consumers in Costa Rica, and is also

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<sup>64</sup> In 2009, a visiting anthropologist in Costa Rica told me that Clínica Bíblica also plans to open a new hospital near a large development on the Pacific coast that caters to North American retirees.

popular among expatriates. Surgical enhancement holds out the promise that the body can be transformed from an archive of a life lived, to a site of self-determination and individual transcendence of constraint—corporeal, temporal and social. In the next chapter, I turn to the enactment of this promise of the perfectible self. I consider image-mediated itineraries of cosmetic surgery travelers, their passage toward surgical participation in Costa Rica, and the invasions (and evasions) of surgery itself.

## CHAPTER THREE

### VIRTUAL CUTS AND CLINIC OPERATIONS

Much feminist discussion of surgical body modification has revolved around (and, quite often, reproduced) the received dichotomies of natural and artificial bodies, and agency and victimhood—the latter containing the “two sides of sovereign subjectivity” (Fraser 2003). Most authors in this prolific literature agree that cosmetic surgery is a cultural apparatus through which age, race, and gender-normalized subject-bodies are produced in an intersection of consumer culture and biomedical techniques and knowledges. Where they differ is the question of whether the surgically altered are objects of a cultural and techno-medical assault on a pre-social body (Morgan 1991), or are agents of their own selfhood via a “post-human,” infinitely malleable and modifiable body—“a vehicle for individual freedoms” (Pitts 2003:155). In other words, does cosmetic surgery signify “the grip of culture on the body” (Bordo 1993:260)—a body often assumed to be natural, or prior to culture—or is it a practice of corporeal self-creation and agency whose medium is the body’s compliant materiality (Davis 1995)?

Along with some recent theorists of the culture of cosmetic surgery, and scholars of embodiment more broadly, I suggest that debates over natural versus artificial bodies, and agency versus victimhood, do not tell us enough about the cultural and material processes and structure through which presumably individual bodies and subjects are shaped (Jones 2008a; Lock and Farquhar 2007; Negrin 2002). Foucault’s re-theorization

of power and subjectivity is a helpful start to this discussion. He suggests that subjects are produced and become desiring and self-regulating (while perceiving themselves to be autonomous individuals) through a form of power that controls and normalizes bodies through surveillance, categorization, and disciplinary knowledge—including, of course, biomedicine (Foucault 1995, 1988b). Subjectivity is thereby inextricable from bodily existence, since our very materiality is constituted through social structures and historical processes. Conceptions of a natural, pre-cultural body, or an endlessly mutable, post-human body, by contrast, rely on a dualistic framework that separates social processes and the body's materiality. This does not mean, however, that embodied subjects are simply products of the discursive formations, or systems of knowledge, in which they are formed. Bodily disposition, as Bourdieu (1977) eloquently explained, is always a dance of constraint *and* improvisation, such that a person's inclinations, habits, and "choices" are both inside the social field in which they were made possible, and potentially productive of a transformed social field. Cosmetic surgery consumers, in other words, are neither autonomous agents of their own embodied subjectivities, nor are they simply dupes of the potent assemblage of beauty norms, biomedical techniques, and cultural assumptions about an "authentic," perfectible self.

In this chapter, I approach the question of embodiment and subjectivity formation among cosmetic surgery consumers and their surgeons in Costa Rica, before and during their excursions into the operating room. Building on chapter two, where I discussed how Costa Rica is produced—both imaginatively and materially—as a medical refuge for North Americans, I discuss the social practices through which bodies and subjects are intimately operated on—made surgically transformable, as it were—before and during

cosmetic journeys in Costa Rica. Drawing on Charis Cussins' reconceptualization of clinical agency and objectification (1998), and science studies' emphasis on the material heterogeneity of social practices, I examine how medical tourism's actors embody and enact multiple, contingent forms and identities. Cosmetic journeys, I suggest, are formed through patients' desires for wholeness and integration, and through Costa Rican plastic surgery's promise to (affordably) reunite bodies and selves. They are also run through with a visuality that enables the "diagnosis" of normal bodies,<sup>65</sup> and by the very "malleability and incompleteness of corporeal being" and subjectivity that makes surgical intervention possible (Shildrick 2008:34).

I begin by discussing how the itineraries of cross-border consumers are mediated by online sociality and digital photography, including images' performance as a mobile proxy for patients' bodies. Then, I examine how patients' and doctors' subjectivities are shaped by travel to Costa Rica and the clinical ritual of pre-surgical consultations. Finally, I discuss the activities and objects (and, for patients, the lapse, or absent experience) of surgery itself, in which healthy bodies are cut in order to be made whole.

### **Imaging bodies**

*The Photograph is the advent of myself as other.*

- Roland Barthes, *Camera Lucida* (1981:12)

*Without the camera, there could be no cosmetic surgery.*

- Virginia Blum, *Flesh Wounds* (2003:200)

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<sup>65</sup> Gillian Rose, a geographer and theorist of the visual, defines *visuality* as the way in which vision is constructed. The way we perceive, she argues, is not prior to cultural and historical conditions, but it shaped by them (Rose 2001).

If a tourist returns from a vacation without a series of photographs documenting her or his adventures, did the journey really take place? This depends, of course, on how a journey is defined and socially validated; photography has become a key actor in this process. Snapshots are almost obligatory in contemporary tourism; they structure, narrate, and offer evidence for touristic experiences, and also operate as a medium through which tourist services and spaces are marketed and consumed. For cosmetic surgery travelers in Costa Rica, photographic records include—indeed are usually fervently centered on—images of bodies, which patients and doctors deploy as a mechanism of objectification and persuasion, as proof of personal transformation and surgeons’ artistry (or incompetence), and as a stand-in for less static and contained bodies and identities. A woman I met at a recovery retreat, for example, poignantly expressed the desire to look more like (indeed, to “be”) a photograph, when she showed me a snapshot of herself taken after she had recovered from facelift surgery, and said, “I wish I could paste this to my face and walk around.”

The dominant photographic trope through which cosmetic surgery patients learn to “see” their bodies, and to imagine the bodies they desire, is the optimistic visual narrative of “before and after.” The magic of before and after is its depiction of a remarkable—and seemingly painless—change from pathological to normal, or ugly to beautiful. Since the popularization of cosmetic surgery in the 19<sup>th</sup> century, before and after pictures have been integral to cosmetic surgery as a medical and commercial practice. Contemporary plastic surgeons continue to offer before and after images as authentication of their artistry and competence, and as an object of clinical persuasion, as I discuss below, but with the proliferation of digital photography the trope has been

increasingly appropriated and transformed by medical consumers themselves. Before I turn to an examination of how digital images mediate the subjectivities and consumption practices of medical travelers to Costa Rica, however, I offer a brief historical account of the intertwined development of photography and cosmetic surgery.

Shortly after its emergence in the first half of the nineteenth century, photography gained status as an objective recorder of reality. Part of the power of photographs was their indexicality—the presence on a photograph of a material emanation or trace of that which it represents, by way of reflected light hitting the surface of the film and being etched there by chemical changes. Charles Sander Peirce said that indices “furnish positive assurance of the reality and the nearness of their Objects” (quoted in Doane 2007a:135). However, Mary Anne Doane reminds us, indices “provide no insight into the nature of their objects...hence, the ‘real’ referenced by the index is not the ‘real’ of realism, which purports to give the spectator knowledge of the world” (ibid). Indeed, it was not always self-evident that photographs were more truthful than any other type of image (Tagg 1988). Photography, rather, was established as a tool of objectivity through the interplay of its material properties and its use in developing new disciplinary knowledges, particularly in courts and medical records to create and classify criminals, the mentally deviant and racial “types” (Daston and Galison 1992; Sekula 1989). In portraiture, photographs served as an “‘after’ picture of class accomplishment, intended to represent how far one had progressed from one’s roots” (Blum 2003:198). Photography’s realism, in other words, was inextricable from its participation in social and institutional structures:

Photography is considered to be a perfectly realistic and objective recording of the visible world because (from its origin) it has been assigned *social uses* that are held to be 'realistic' and 'objective' (Bourdieu 1990:74).

The popularization of photography, and its use as a mechanism of medical normalization, was linked to Western scientific empiricism's privileging of the visual, and to what Foucault called "the clinical gaze" (1994), in which a clinician's knowledge of a patient's body is bound up in the act of seeing (into) that body. The dominance of the visual in clinical practice contributed to the aestheticization of illness, through which health was increasingly associated with beauty and illness with ugliness (Gilman 1995). Nineteenth century plastic surgeons participated in and benefited from photography's growing stature as an instrument of objectivity, and from the ease with which photographs could be manipulated. They produced "before and after" images that documented the effects of surgical techniques, depicted transformations in patients' character, and served as advertisements for their services (Gilman 1999). "After" pictures were blatantly enhanced (and still are) with more flattering lighting, makeup, and hairstyles, but these alterations did not seriously undermine the received truth of their visual narrative. Science and aesthetics were united to a common cause, and the camera became as indispensable to plastic surgery as the scalpel. Plastic surgery, in effect, became "the cultural allegory of transforming the body into an image" (Blum 2003:61).

The joint seductions of image and scalpel are inextricable from photography's operations on time. "For it is another nature that speaks to the camera than to the eye," wrote Benjamin, referring to the camera's dissection of the embodied activity of walking into "the fraction of a second when a person *steps out*" (1979:243). Photography, in other words, is a technology that breaks the flow of events and lived experience: "The click

that makes a photographic negative (*cliché*) stops life in its tracks to re-present it to itself” (Saunders 2008:132). This re-presentation is the transformation of a fragment of time into an image that far outlasts the events and bodies that it portrays—although we have learned to perceive such images as equivalent to (or even exceeding, in appeal or persuasiveness) “the real.” “Cameras, in short, are clocks for seeing,” wrote Barthes (1981:15), and, like the internalization of disciplined “clock time” (Thompson 2007), photography’s freeze-frame division of lived time has gradually been embodied as perception. Photographic visuality, in other words, is a kind of “history turned into nature” (Bourdieu 1977). This “nature” equates bodies with images.

There is, of course, a perceived gap between the lived body and the photograph (a chasm, when the body no longer lives), but cosmetic surgery promises to close this gap—“to reconcile the body with the image” (Blum 2003:200). In the visual grammar of “before and after,” moreover, cosmetic surgery requires photographs to offer evidence of a miraculous change or movement through time—time travel, as it were.

The naturalization of photographic realism accelerated in the twentieth century, when photographs began to be mass-produced and to permeate everyday life. Benjamin argued that photographs’ reproducibility unmoored them from prevailing rituals of ownership, craft, and expert appraisal, through which works of art are assigned cultural value, and that they were therefore more amenable to democratic control and mobilization as a tool of revolutionary politics (Benjamin 1969). Photographs’ reproducibility has also, however, enabled their prolific commodification. Producing a kind of “second nature” (Buck-Morss 1991:59), moreover, photography has populated “a dense historical environment of mass-produced images, symbolic objects, spectacles and

signs,” in which “...the photographic image gains its meaning by a continual borrowing and cross-referencing of meanings between images” (Lister 1995:13). Photographic images, in other words, have not only permeated popular culture, but have become more densely intertextual; as I discuss below, for example, patients’ images are almost always in tacit conversation with those produced and deployed by plastic surgeons.

Although cosmetic surgery practices have long been inextricable from the clinic-based production and manipulation of photographic images, growing popular desires for surgical body modification cannot be accounted for without attention to the circulation of images via electronic media (including television and the Internet). Digitally perfected images (and, more recently, television “reality” shows that celebrate cosmetic surgery’s potential to enhance social status through changes in appearance) are powerful agents in a culture of celebrity worship and emulation, in which beauty and youthful appearance are afforded high symbolic capital and are marketed as attainable through biomedical intervention.

A Costa Rican surgeon, for example, told me the story of a patient who brought a picture of Cher with her to her pre-surgical consultation, to show him what she wanted to look like. “You’re not Cher, you’re you!” he told her in frustration. Their exchange raises the question of what it means to be one’s self, when desires for transformation are nearly always run through (with) images of other bodies, even as plastic surgery promises to “reveal” one’s true self. Why *not* strive to look like Cher, within the limits of surgical technique? She is, after all, wealthy and famous—residing at the pinnacle of cultural success in North America (and she has reputedly undergone numerous cosmetic surgery procedures, so she serves as an appealing model for hopeful consumers). If appearance

and identity are amenable to transformation via surgery, subjectivity is certainly not stable or fixed, and the desires of ordinary people for recognition and status—distinction, as Bourdieu (1984) would put it—are understandable in their explicit or implicit reference to celebrity photographs, which “have become the after pictures for the culture,” (Blum 2003:198).

Contemporary commercial and personal photographic images are almost exclusively created with digital, rather than chemically-based, photography. Digital images are more easily altered, and can be created without a material referent. Indeed, the growing dominance of digital images has contributed to skepticism and concern about the truth status of photographs—an anxiety that photography has “lost its credibility as a trace of the real” (Doane 2007b:1; also see Kember 1998). Almost two centuries of photographic realism, however, have shaped the very ways in which we perceive and order the world, and these embodied dispositions are not easily altered. Even in the midst of highly manipulated digital imagery, photographs continue to be read as records, albeit contestable, of reality. Moreover, using Bruno Latour’s terms, the “network” of realist photography is extensive and has enrolled complex institutional and conceptual apparatuses, in addition to a wide landscape of humans and non-humans (most of us will never visit the earth’s poles, for example, so we rely—in part—on photography for evidence of the reality of melting ice caps).

Rather than being disconnected from “the real,” therefore, the digital images used to sell, imagine, plan, and document cosmetic surgery are an extension of photography’s

realist project.<sup>66</sup> Digital images structure the experiences of many cosmetic surgery consumers, and many people I spoke with seemed to feel that appearing attractive, or “normal,” in an imagined, static, two-dimensional site of truth, offers more concrete evidence of productive work on the self than one’s unpredictable, ever-changing, all-too-three-dimensional body.

Simultaneously, however, consumers are skeptical about the truth status of commercial imagery, including plastic surgeons’ web sites and before and after albums. Moreover, inexpensive, home-based digital technologies have enabled consumers to appropriate and rework the visual narrative of before and after—to make it more “realistic,” as they put it. This includes depictions of bodies that are somewhere between before and after. Such images enable detailed scrutiny of surgical techniques and outcomes, and are often situated in online biosocial communities whose members assert medical expertise and a constrained agency as consumers. I now turn to a closer examination of these image-mediated negotiations of subjectivity, knowledge, and surgical commitment.

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<sup>66</sup> The one notable exception that I encountered in the course of my research is a software program that enables physicians to digitally manipulate images of prospective patients in order to visually approximate their post-surgical appearance. Patients distrusted these images even more than before and after images, presumably because they bypass the material engagements of actual surgery. Plastic surgeons, for their part, were outspoken in their dislike of, and refusal to use, the software. They told me that such images were a recipe for dissatisfied patients, since bodies (and photographic self-portraits) almost never looked exactly like (or as good as, they implied) a digitally enhanced “before” image.

## Virtual transformations and medical consumers

*Design your own image.*

- Costa Rican plastic surgery clinic advertisement

*I would never, ever have considered going out of the country for surgery...  
if it were not for this board.*

- Subscriber to online cosmetic surgery forum and  
medical tourist in Costa Rica

For many middle class North Americans, cosmetic surgery has become a normal, even expected, medical intervention. I spoke with recuperating surgical travelers in Costa Rica who casually compared a facelift or tummy tuck with the purchase of a new car or remodeling a house. And while the same people also described surgery as a necessary medical “treatment” for misaligned bodies and selves, surgery as therapy is also framed through a discourse of choice and individual empowerment. For commodities to work their magic, indeed, “consumers must believe on some level that their individual attitudes, tastes, and desires are independent of the forces that surround them” (Elliott 2003).

These presumably individual needs and desires, I suggest, are often socially constructed through interactions on the Internet. Online discussion forums operate as venues where people are mobilized as consumers, travelers, and patients, and where images function as a multi-faceted medium of persuasion. Considering photography’s transformation of art and its social and political meanings, Benjamin wrote that the mechanical reproduction of images has led to the displacement of “cult” value by “exhibition” value, which is based on reproducibility and exchange (1969). Although the

Internet is an apparatus through which the exhibition value of images predominates, and where images serve primarily as devices of commerce, I suggest that images also function as a medium of sociality among cosmetic surgery consumers. They are read as evidence of gendered identity and self-discipline, and as such they are ritualistic or “cultic.” I examine here how these rituals are performed and embodied.

At least half of the patients I spoke with in Costa Rica had participated—or were participating—in one or more Internet-based discussion sites for people considering traveling outside the U.S. for cosmetic surgery. At these sites, people disguise their off-line identities by adopting aliases and avatars.<sup>67</sup> Online communities are conventionally understood to exist in the realm of “virtual reality,” which is assumed to be apart from, or other than, “the real,” or material, world. I resist contrasting the virtual with the real, however, since the artifice of online identities and images is always in conversation with, and co-constitutive of, the (always hybrid) materiality and cultural forms of “the real” (Boellstorff 2008; Wilson and Peterson 2002). Materiality and information, in other words, are always bound up with each other (Hayles 1999).

One of the most popular sites among cosmetic surgery visitors to Costa Rica is called “Plastic Surgery Journeys” (PSJ). When I joined PSJ in 2006 (using my actual first name and identifying myself as an anthropologist), the site had approximately 8,000 members, a number that has grown to over 13,000 in 2009. At country-specific and regional forums, PSJers (as members refer to themselves) discuss surgical procedures, the merits and shortcomings of particular surgeons and recovery retreats, and the intimate,

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<sup>67</sup> Avatars are graphic images generally thought to be in some way representative of their bearer; in cosmetic surgery forums, avatars are often landscapes or depictions of idealized women’s bodies.

bodily details of post-surgical recuperation.<sup>68</sup> One of the most popular destinations on the site is the “galleries,” where members post photographs of their bodies and body parts, before and after surgery. (I have yet to see a depiction of an operation in progress on PSJ. Some surgeons take photographs while operating, but they do not share these images with patients. At least one PSJ member, however, posted images of flesh that had been removed from her abdomen and was positioned on a hospital table as a kind of grotesque trophy, or material evidence, of her accomplishment.)

PSJ’s founders describe the site as an alternative to the “biased information on doctor web sites...here, the people and experiences are real!”<sup>69</sup> Most consumers seem to agree with this ontological privileging, since they tend to search for “evidence” of a surgeon’s skill, and Costa Rica’s suitability as a medical destination, from friends, acquaintances, and patient-run web sites rather than commercial sites hosted by doctors and clinics—even as their assumptions about Costa Rica are simultaneously shaped through the commercial images and narratives I described in chapter two. Promotional images tend to feature idealized, airbrushed images of young, slender models, whose bodies do not appear to have been altered by invasive surgery, let alone age. Most patients, however, are not seeking perfection, and want to see (i.e. to know) exactly what a surgeon will do to their bodies—including, for example, the position of incisions and type of sutures, and the number of cubic centimeters of silicone to be inserted in each breast. Despite these assertions of consumer autonomy and expertise, however, much of

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<sup>68</sup> Mexico, Costa Rica, Colombia, Brazil, and the Dominican Republic each have their own forums. The rest of the world is divided into “More Latin America Countries,” Europe, Asia, and “Other Countries.” This taxonomy suggests the global contours of off-shore North American cosmetic surgery consumption.

<sup>69</sup> See <http://www.plasticsurgeryjourneys.com>.

the visual material circulated among patients, and the narratives that accompany it, are “real” insofar as they reference and are informed by biomedical ways of seeing and knowing bodies. These include depersonalized, decontextualized portrayals in which bodies are separated into operable parts and are “diagnosed” via normative categories of gender, age, and weight.

Consumer-patients learn to see, and feel, their bodies as amenable to biomedical intervention, in fact, long before entering a plastic surgery clinic, and this recognition often involves a photograph. A North American woman in Costa Rica told me that she had not considered cosmetic surgery until she saw a photograph of her face and realized that she would look like (and therefore in her mind “be”) her mother in a few years if she did not have surgery. “That was my mother’s chicken neck,” she said, dividing her body into operable parts and seeing the hated part as something monstrous or animal-like that needed to be cut out like a disease.

On sites like PSJ, this process of objectification becomes a form of almost religious sociality, in which the baring of one’s imperfect body to strangers serves as a confession that potentially leads to surgically-mediated redemption and transformation. These confessions are performed visually, usually in the form of a close-up photograph taken in unflattering lighting and without airbrushing or other digital manipulation. Guilty body parts are isolated, bodies are visually decapitated, and faces are depicted without bodies. A woman contemplating a facelift, for example, posted a picture of her face and asked fellow PSJers for comments. Responses included visual dissections to help her “see” aspects her face as in need of surgical correction:

I'm so excited for you. I looked at your before picture and you already look great. I think the area that stands out to me is your eyes. I think an upper/lower bleph [eyelid lift] will make a big change.

By turning their bodies into a visual medium, and fragmenting them into separate parts amenable to repair, aspiring patients reproduce biomedicine's dualistic discourse in which the body is thought to be separate from the person. (The paradox of cosmetic surgery is that it promises to reunite the errant body with a more beautiful, inner self [Balsamo 1996; Blum 2003]). The bodies depicted on PSJ, moreover, are not only fragmented, but are detached from the activities and sociality of their daily lives. The portrayed seem vulnerable in their decontextualized nakedness, harsh lighting, and visual dismembering. In another setting—an art gallery, for example—these two-dimensional bodies might be seen as beautiful in their material exposition of life lived, but here, viewers are invited to scrutinize, diagnose, and render operable depicted body parts, and to admire and envy bodies that are captioned as post-surgical.

The operation, in effect, is already underway. The first step in becoming a cosmetic surgery patient is to be transformed into a “before” image, and surgeons are both central and peripheral to this project. Becoming surgical, of course, does not begin with online forums, as the medicalization of beauty, aging, and weight has permeated popular culture. Nevertheless, at PSJ the objectification of bodies is actively negotiated among consumers who experience the process as self-actualizing, and this process allows them to more easily pass through the plastic surgery clinic (Cussins 1998). By dissociating parts of their bodies from their “inner” or “true” selves, and receiving the approval of a “community” (in addition to a broader community that assigns greater symbolic capital to youth and beauty), subjects become operable. A caption to a series of

“pre-op” photos posted by a woman who traveled to Costa Rica from the U.S. for a tummy tuck, for example, reads:

Here you can really see how much stuff just isn't me. My abdomen protrudes badly...I look pregnant all the time and none of my clothes fit right because of this!

“That poor woman,” another member wrote as a caption for her before picture.

I should mention here that many PSJ members post photos that are not labeled as before or after, and as an observer, I often struggled to see exactly which procedures a person hoped to (or already did) undergo in order to change her body. Most bodies looked to me to be well within a “normal” range (normal, of course, is an ever-receding horizon in cosmetic surgery), and I searched for perceptible “deformities” in vain. Apparently even veteran PSJers encounter this occasional visual unmooring from the certainty that cosmetic surgery is always a desirable practice of self-improvement—the “we all need something done” narrative that prevails among both producers and consumers in the cosmetic surgery tourism industry. For example, the following message was posted in response to an uncaptioned image of naked buttocks—the author tacitly referring to the insult in mistaking an after picture for a before picture:

I don't know if this is a pre op or post op, but your “Fanny” is perfectly round!!! IT looks amazing!! Wish I had your curves...

Most gallery participants, however, faithfully post narrative captions with their photographs, using a mixture of colloquial and biomedical terminology that contributes to the fracturing of bodies and medicalizing of persons, and to PSJers' identification as informed consumers rather than passive patients. In fact, rather than identifying themselves by personal interests or employment status, members' “biographies” often read like medical charts:

I had fl, nl, upper and lower bl, temporal brow lift, and deep phenol peel around mouth... Then mini TT with lipo of inner and outer thighs, hips, flanks and upper abs, BA and buccal cheek fat pad removal and full face phenol peel...

To roughly translate, this woman (the only indication of her gender is the facial peel, which is more common among women than men) underwent extensive surgical removal of skin and fat from her face, abdomen, and legs.

While most PSJers similarly objectify their bodies as in need of surgical procedures, they also claim to undergo a shift in subjectivity after surgery and a period of recovery. The after picture, in effect, is the unveiling of a “new,” re-unified self, and post-surgical images posted by PSJers operate as a cue for other members to help the depicted to embrace and embody her or his transformation. These are not, generally, the glamorous studio images circulated by plastic surgeons to suggest the success and happiness brought about by an operation. Rather, most PSJers attempt to portray their post-surgical bodies “realistically,” although some (women, in particular) re-gender and re-sexualize their bodies by dressing in lingerie and striking seductive poses. However, even gruesome and corporeally liminal images (the “during” of “before and after”), featuring close-ups of sutured, scarred, and bruised flesh, elicit comments such as, “You look like a new you!”, “I know you are so happy now,” “Looking really good...the boobs will settle a bit,” and “Well done. You should feel very proud of the progress!” People with “lifted” faces are told that they look younger and more beautiful, and women with breast implants are reassured of their femininity and sexual desirability: “your girls look so good.” PSJers collectively learn to perceive, and feel, that their surgically altered bodies are in alignment with their “true” selves, even if the results of surgery are not quite what they expected or hoped for.

A man I will call John, for example, was an active PSJer before, during, and after his trip to Costa Rica for a facelift. I spoke with John on the phone a year and a half after his operation. He told me that, at 69, he had reached “the invisible age.” “I would look in the mirror and not see me,” he said. Facelifts were too expensive in the U.S., he said, and after looking into various medical tourism destinations he chose Costa Rica. After the operation, John spent two weeks recuperating at a recovery home. “I never had two weeks off in my working life!” he said, suggesting that his Costa Rica sojourn had been a pleasurable, as well as transformative, vacation.

Upon returning to the U.S., John posted a link on PSJ to a series of images that served as a visual narrative of his passage through cosmetic surgery’s bodily disruptions. Transgressing the before and after convention, John’s photos represented his face at weekly intervals, starting before surgery and continuing immediately afterwards. He said he wanted to present a realistic view of plastic surgery recovery, and his visual project included close-ups of discolored, swollen, and sutured flesh. Perhaps most disturbing was that John’s face was not recognizable as “him.” I understood then that part of the appeal of sites like PSJ is the presumed anonymity of fellow members, who (unlike many family members and loved ones) are not horrified at the bodily damage and unfamiliarity wrought by plastic surgery.

By the time we spoke, the most acute phase of John’s recuperation had passed, but he still had a strange sensation in the severed nerves around his eyes, and he said his skin had lumped up unattractively behind his ears around the surgical incision. Still, John told me, he had come to like his new face; in his words, it helped him “retain a sense of who I am.” Several months after we spoke, he removed the liminal pictures from PSJ and

posted more conventional before and after photographs in their place, which continued to attract praise and admiration from fellow PSJ members. For John, corporeal transformation was bound up with visual transformation—and its witness by other cosmetic surgery enthusiasts at PSJ. The public display of his pictures, and the praise and admiration of other PSJers (none of whom had ever met him in the flesh) helped him to “become” his surgically altered face.

Not all cosmetic surgery journeys, however, conclude with a successful reuniting of inner self and recalcitrant body, despite the persuasive apparatus of surgical subject-making that I have outlined. Photographs are also posted to PSJ by people who are strongly dissatisfied with the results of their operations, and readings of these images among PSJers are lively and conflicted. Some community members attempt to re-insert the unhappy traveler in a narrative of positive change, insisting that she or he misperceives the results of the procedure, while others enthusiastically work to discredit the offending surgeon (or even the country in which the surgeon practices). The following comments by five different PSJ members spanned several months after a photograph of a swollen, bruised and unevenly sutured face was posted by a facelift patient 12 days after her operation in Costa Rica:

- Did you heal up okay?? You were perfect before surgery...are you ok now???
- WOW... I'm sure time will heal it some more but why did he cut it so low!!
- This looks excessive. I pray for a beautiful recovery for you.
- Your skin actually looks very tight and smooth to me... Its way too early for you to be dissapointed!! ...wait about 3 months, before you judge your result...I think you will be even more beautiful.
- I would perform a surgery on him free of charge and I'll bet I would do a better job!

In effect, the image becomes a site of reassertion of the project of cosmetic surgery as self-improvement. The surgeon's skills and competence are under question (in other cases, Costa Rican medicine's status as modern is contested), as is the success or failure of the operation, but the practice of cosmetic surgery itself is tacitly reaffirmed.

Another example of how the temporal narrative of before and after is inverted by dissatisfied patients is a series of close-up, mug shot-type photographs posted to PSJ, through which a woman tried to convince other PSJers that the facelift she had undergone in Costa Rica made her look worse than she had before. Accompanying the images was a wrenching verbal lament: "bad, awful, terrible, unsuccessful, poor unsatisfactory, facelift, necklift, TCA, peel, [name of surgeon], [name of clinic]." I carefully examined her before and after images, assuming that I would easily identify the features that she was unhappy with—what she described as "the slack around my mouth and the 'crepe paper' extra skin around my eyes." I was not an astute enough observer, however, since all I saw was a woman, probably in her 50s, whose frowning face and downcast eyes suggested dismay and defeat.

Was this woman's surgery botched or was her desire to escape the stigma of middle age unattainable? This question brings me to the absent presence of doctors in these negotiations of surgical success and failure. This woman's surgeon was called upon in the queries of other PSJers: "Is the Dr. willing to do anything regarding your lack of results?"; "Have you heard from the dr yet? Is he willing to reimburse you?" Many plastic surgeons in Costa Rica, in fact, offer surgical revisions to patients at no additional cost, in the event that she or he is unsatisfied with her appearance. For most North Americans, however, distance and travel costs make a return trip to Costa Rica

impractical, and many are afraid to return to the operating room of a surgeon whom they feel has demonstrated incompetence or sloppiness. If a patient does negotiate a revision (reimbursements are generally not offered to dissatisfied customers), the doctor's pre-operative evaluation is most often conducted via digital images, sent to the surgeon as evidence of a failed procedure and serving as a mobile proxy for the patient's body.

It is at this point that doctors' and patients' interests diverge, and the before and after narrative of success is called into question. Surgeons, for example, may read after images differently than patients. They often insist that more time for healing is required before the patient's new appearance can be discerned, or they may claim that dissatisfied patients have unrealistic expectations of surgery. The increasing circulation of patient-generated after images on the Internet, however, means that surgeons' control over the truth status of particular before and after sequences is, to some degree, contested or undermined by expert consumers. Indeed, images are now used not only to sell surgeons' services, and convince prospective patients of the miracles of plastic surgery, but to discredit individual surgeons or surgical techniques. In response to the images posted by the dissatisfied woman I described above, for example, a PSJer wrote:

I was considering Dr. \_\_\_ as a possible surgeon but after reading posts and viewing pictures of his surgeries, I think I will research other possible surgeons. Do you have any recommendations?

The meanings assigned to images, in other words, are shifting and contingent—even as they are situated in a realist epistemology informed by the intertwined disciplines of biomedicine and photography. I now turn to Costa Rican plastic surgery clinics, and a discussion of how the virtual, two-dimensional consumer is translated into an acceptable plastic surgery patient, through appraisals of “health” and “mental stability.”

## Healthy patients

Photographic images of patients reside in clinics long after the actual patient has left. A select few are featured in albums that surgeons show to prospective clients as evidence of their artistry and surgical skills—clinical persuasion at its glossiest. “Come see one of my best creations,” a surgeon says to me and an expatriate resident of Costa Rica who is visiting his office for a facelift consultation. He opens a thick book and turns to the first page; we are suddenly faced with two large images representing a disorienting reversal of the typical life course: on the left, a photograph depicts the face of a woman who is (was) probably in her 60s; on the right she appears at least 20 years younger. I probably would not have known that the pictures represented the “same” face if they had not been paired. “This is my mother!” the surgeon informs us enthusiastically. The images are several years old, and I ponder the temporal and material contortions implied. Does his mother now resemble the before image more than the after image, or neither? How does he reconcile his aging mother with the fixed, two-dimensional woman that he also identifies as his mother—a woman who looks almost as young as the surgeon himself? It is a strange reversal of the expected life course, that he has become his mother’s “creator.” Like the rest of us, however, he has no doubt learned to accommodate the disjunctures between two-dimensional images and actual bodies, particularly since the reach of his mother’s image (both imaginative *and* economic) does not require her bodily presence.

Another surgeon regularly took pictures of his patients before, during, and after procedures (I served as his photographer on several occasions when his hands were busy

cutting and suturing). When I asked him why he took pictures during surgery, he said, “because I want my work to last.” The sense of images exceeding bodies was unnerving to me, as I stood in the operating room next to bodies that seemed to hover between life and death.

With the expansion of cosmetic surgery tourism in Costa Rica, photographic images now also *precede*, and are often examined by surgeons in lieu of, actual bodies. Prospective patients in North America typically contact one or more Costa Rican surgeons via email, attaching close-up pictures of the body parts they hope to have surgically altered, and requesting price quotes and suggestions for procedures. Consumer-patients often describe this process as a kind of shopping, or research—a means of gauging which surgeons (and countries) offer the best prices, surgical expertise, and artistry.

In order to gain access to a plastic surgeon’s services, a prospective patient must display her or his body as deficient, deformed, or out of proportion. Even if the goal of surgery is enhancement of a normal body part, hopeful patients attempt to portray their bodies as visually grotesque in order to be deemed operable. Achieving a “normal” appearance, therefore, requires prospective patients to collude in the objectification and pathologization of their bodies.

For physicians, virtual or in-person encounters before surgery provide an opportunity for a kind of triage, or patient screening. During process, the physician decides whether a patient is physically and/or mentally robust enough for surgery. After all, many plastic surgeons told me, one of the best parts of their job is that they work with patients who are healthy. “O.k., so they have mental problems,” said one surgeon, “but

they're not sick." A healthy patient, according to doctors' criteria, does not smoke, have high blood pressure, heart disease, or diabetes, and is not obese. Whereas other medical specialities manage and treat these problems, they are criteria for exclusion from plastic surgery. "They are our enemies," a cosmetic surgery nurse told me emphatically. Before a person travels to Costa Rica for an operation, her future surgeon attempts to determine whether her body adheres to this formula, and the detective work relies on patients' self-reported "histories," medical tests performed in the U.S. or on arrival in Costa Rica, and the scrutiny of photographs for evidence of surgical suitability.

Most surgeons, however, are unlikely to turn a patient away once he or she arrived in Costa Rica. I met patients whose surgeons had recommended that they lose 25 pounds before undergoing surgery, but who were welcomed in clinics and operating rooms without having lost any weight.<sup>70</sup> Cosmetic surgery patients' shifting demographics, moreover, have rendered the vague term "health" even more problematic. For example, people who have undergone weight loss surgery are increasingly common among cosmetic surgery travelers to Costa Rica (approximately 15-20% of the patients I interviewed in Costa Rica were weight loss surgery patients, and all were women).<sup>71</sup> These are people who have shed a considerable proportion of their bodies' weight, and whose insurance plans do not cover the surgical removal of large folds of loose skin that are a common result of rapid, and massive, weight loss. Despite having reached a "healthy" weight, however, many people who have undergone weight loss surgery suffer

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<sup>70</sup> Patients who hope to obtain cosmetic surgery in the public sector must pass through a more rigid process of bodily discipline, as I explain in chapter five.

<sup>71</sup> Weight loss, or bariatric, surgery refers to a set of surgical procedures that "aim to limit the body's ability to consume and absorb food through the reduction of stomach capacity and/or intestinal length" (Throsby 2008).

from malnutrition and intestinal and digestive problems, calling their status as healthy into question (Throsby 2008).

In Costa Rica, moreover, weight loss patients typically undergo “body lifts,” which usually include several invasive procedures combined in one or two surgical sessions. These marathon operations are a collaboration between (over)confident (and, some say, greedy) surgeons who have begun performing body lifts only recently, and patients hoping for a rapid, and affordable, transformation. A plastic surgery nurse, for example, told me that some surgeons are overwhelmed by the amount of money they are able to make in the private sector, and this sometimes translates into overwork, taking on too many patients at a time, and trying to do too many procedures in one operation. Surgeons who are critical of this trend told me that “body lifts” would be more safely performed as a series of shorter operations with more time for recuperation in between, particularly given these patients’ particular vulnerability to post-surgical complications. However, a lengthening of the time required for surgery and recuperation would reduce Costa Rica’s appeal among North American medical consumers.

Plastic surgeons I spoke with were also concerned about the emotional stability of their patients. Of course, they assumed that most of their patients suffered from “low self-esteem” and other problems of self-perception (and they were tasked with curing these afflictions, while simultaneously profiting from their prevalence). The patients they worried about, however, were those described as “unbalanced,” or prone to dissatisfaction and even a desire to damage an offending surgeon’s reputation. A plastic surgery nurse, for example, told me that some patients “are obsessive and take surgery way too seriously.” She mentioned a woman from Florida whom I had interviewed

several months earlier. Cathy was in her late 60s and had previously undergone weight loss surgery. She had traveled to Costa Rica for a tummy tuck and ended up staying for almost a year, her optimistic journey transformed into a seemingly endless saga whose chapters included multiple (and failed, by her account) surgeries, protracted recuperations, and long narratives on the shortcomings of Costa Rica posted to Internet discussion forums.

Cathy was every plastic surgeon's nightmare, and many doctors I interviewed had similar stories of patients who haunted them and their aspirations to financial success and transnational stature. "Only unhappy people get cosmetic surgery," a nurse told me, "but we have to screen out the really unhappy ones." These "strange people," as one clinician described undesirable patients, were mostly visitors or residents from the U.S.; some used fraudulent credit cards and others cancelled checks after deciding that they were not satisfied with the results of an operation. One couple, a surgeon told me, had received a death threat and wanted to change their appearance in order to adopt a new identity.<sup>72</sup>

Although some doctors told me they were considering psychological tests and other "objective" measures of patients' surgical suitability, pre-operative screening was still an ad hoc practice among plastic surgeons in Costa Rica. One popular surgeon's method of screening involved showing prospective patients a macabre inversion of the before and after narrative; his photo album included unpleasant images of incisions and sutures, reminding the viewer that cosmetic surgery *is* surgery and will result in scarring—a certainty that many people seem unaware of, thanks to pervasive myths of

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<sup>72</sup> As in the U.S., private medical services in Costa Rica are usually paid for after they are performed, although most plastic surgeons require payment in cash from (both foreign and local) patients *before* an operation. This policy is presumably an attempt to forestall non-payment by dissatisfied patient-customers.

plastic surgery as a form of cosmetics rather than invasive surgery. He also included close-up images of blood clots and broken blood vessels, and an accompanying narrative of suffering, disobedient patients who insisted on flouting his instructions by drinking alcohol, smoking, or becoming agitated after surgery.

Despite concerns about unruly and disruptive patients, however, a surgical momentum is engaged once a consumer-patient is on her way to Costa Rica, and this momentum usually leads to a meeting of bodies and images in the pre-surgical clinical encounter, and to the operation itself. I now turn to a discussion of this pre-surgical negotiation of interests, and a consideration of how mobile consumers become immobilized patients, and bodies are transformed into a medium of plastic surgery as craft.

### **From the arrival gate to the clinic**

*'I am remaking myself.' 'We're remaking you,' he said sourly.*

- Fay Weldon,  
*The Life and Loves of a She-Devil* (1985)

In chapter four, I discuss a period of post-surgical liminality that is managed by the labors of local caretakers. The social and corporeal in-betweenness produced by cosmetic surgery is not, however, limited to the aftermath of surgery. When medical travelers arrive in Costa Rica, and before they are wheeled, supine, into the operating room, they continue to negotiate their status as consumer, patient, and artistic medium. The surgeon, in turn, is called upon to enact a final persuasion—convincing the (possibly reluctant) patient that her or his body can, in fact, be transmuted into an after image, and that he is the appropriate technician-artist to undertake the task. This strategic imbrication

of flesh and image, and the performance of clinical subjectivities, is ritualized in clinical encounters shortly after travelers arrive in Costa Rica.

To understand this ritual, I turn to a woman whom I will call Pam. In July 2006, Pam and her husband flew to Costa Rica from their home in Alabama. She had scheduled a tummy tuck, liposuction, and a breast lift and augmentation with a Costa Rican surgeon, who quoted her the price of US\$6,600 for all medical expenses. I initially met Pam on PSJ in May of the same year, after I had posted a message asking if anyone planning to travel to Costa Rica for surgery would be willing to let me observe her initial surgical consultation. Pam responded warmly to my request shortly after I posted it, and we arranged to meet on the morning of her pre-surgical consultation in San José.

When I arrive at the recovery retreat where Pam and Bob are staying, they are having lunch, and Pam has a bottle of vodka on the table beside her. They arrived the night before, and seem dazed and as if they do not yet have their bearings. Pam tells me that she found out about Costa Rica because she was researching it as a vacation destination. She is impressed with what she read about her surgeon, whom she says is “supposed to be president of something” in Costa Rica. She is 50, and says she has wanted a tummy tuck since she had her first child. After her third child, she had liposuction, but the doctor was “wacko” and did not do a good job, so she still has a visible dent from the procedure. Still, she tells me, she is not scared to undergo plastic surgery again, although she admits that she feels nervous now and wants to “get it over with.” The scariest part, she tells me, is whether she made the right decision; is her surgeon, Dr. Rojas, the right doctor? She has read a lot of good things about him, but

there are also people telling bad stories about him on the Internet. “I would have had a sign if it was the wrong decision,” she says.

Pam, like other patients I spoke with, told me that she “researches things to the bone” before making a decision, but that at a certain point her commitment to a particular country, doctor, and procedure becomes an act of “faith.” Indeed, revoking a clinical commitment after arriving in Costa Rica would be costly of money and time, since a change in surgeon or hospital would likely entail an extended stay (most people remain in Costa Rica for the minimum amount of recovery time recommended by their surgeon). Also, most patients base their surgical decisions primarily on the visual and written testimony of other patients, which is almost never exclusively positive or negative about any particular surgeon. Additionally, while plastic surgery techniques are fairly standardized (with some variation in tools, incision placement, and suturing styles), surgeons themselves differ in their aesthetic inclinations; some prefer a “natural look” (which translates clinically to a more conservative excising of skin and flesh, and a less stretched or tight appearance), while others practice techniques that result in more profound alterations in appearance. These differences can be difficult, and time-consuming, for consumer-patients to discern and sort through, and Pam’s spiritual pragmatics help to propel her into the operating room, in the face of a plethora of choices.

In the absence of faith, ambivalence and indecision can set in. A retired, North American resident of Costa Rica, for example, invited me to accompany her on her quest for the “best” facelift surgeon in San José. After meeting with (and being “diagnosed” by) eight surgeons, Lynn drew up a spreadsheet that divided her face into distinct, unwanted features, including “crow’s feet,” “frown lines,” “lip lines,” and “jowls” (see

Figure 11). Specific facelift techniques were listed as potential solutions to these fleshy reminders of aging. In addition, Lynn identified surgeons by their preference for general or local anesthesia, the number of hours they predicted the operation to take, their prices, and whether they recommended a one-night hospital stay following the operation (some surgeons send patients directly home).

	A	B	C	D	E	F	G	H
		Dr. A	Dr. B	Dr. C	Dr. D	Dr. E	Dr. F	Dr. G
1								
2								
3	Forehead Lift	Yes	Not Needed	Not Needed	Not Needed?	???	Not Needed	Not Needed
4	Brow Lift	DD	DD	DD	Yes	???	Yes	Yes
5	Frown Lines	DD	Fat (permanent)	DD	Cut Muscle	DD	Cut & Fat	Cut & Fat
6	Crow's Feet	Exoderm	Dermabrasion	DD	NCBD	DD	DD	DD
7	Upper Eyes	Yes	Yes	Yes	?	???	???	Yes
8	Lower Eyes	Yes	DD	Yes	Not Advisable	???	Yes	Yes
9	Cheeks-Lines	Exoderm&FL	FL	FL	NCBD	FL & TCA Peel	FL	FL
10	Lip Lines	Exoderm	Dermabrasion	Med Peel	NCBD	TCA Peel/Dermabrasion/Fil	Fat	Laser
11	Jowls/Neck	Lift	Lift	Lift	Lift	Lift	Lift	Lift
12								
13	Anesthesia	DD	Local	Local	?	Genl	Local	Local
14	Time in Surgery	DD	?	3 - 3 1/2 hrs	5 hrs	3 - 4 hrs	2 1/2	5 hrs
15	Overnight	Biblica	Small Priv Hospital	Private Clinic	Cima	Private	No	Cima
16								
17	Cost	\$6500-7000	\$4,050	\$3,195	\$4600-4800	\$4,230	\$3,000	\$4,825
18								
19		DD = Didn't Discuss			Red = Negative reaction			
20		NCBD = Nothing Can be Done			Green = Positive			
21		FL = Face Lift						
22								
23		Dr C's quote includes 10% cash discount						
24		Dr Es quote includes 5% cash discount						
25		Dr G's quote includes 5% cash discount on his part of bill (other than Cima)						
26								
27		Forehead vs Brow Lift: Didn't realize until Dr F that there was a difference. He mentioned just needing						
28		a lift of the outside of the eye brow as opposed to lifting the forehead. Need to verify if the other doctors						
29		were suggesting this brow lift or the upper eye procedure.						
30		SMASS: Dr E mentioned that the face and neck lift would be the SMASS technique. Need to research this.						
31								
32	Attitude Toward:							
33	Peels & Derma	Exoderm	Dermabrasion	Med Peel: No	Does Not	TCA peel whole	Does Not	Prefers
34	Whole Face	Whole Face	Lip & crow's feet	discoloration/ 50% improvement	Like	face &/or derma- brasion lips	Like	Laser
35				?	Does Not	Mentioned; what	Fat in lips &	Fat in
36	Fillers	Only helpful if	Fat in frown lines		Like	kind?	frown lines	frown line
37		Skin still elastic	(Says Permanent)				(lasts 2 yrs?)	
38								
39								

Figure 11. Comparison of Costa Rican plastic surgeons by U.S. expatriate retiree.

This evaluation process went on for several months, and while Lynn hoped that the result would be a decisive formula telling her which surgeon she should choose, she was instead faced with a bewildering array of seemingly incommensurable variables. In a sense, her face had become too material; it was pulled and lifted by surgeons in so many different ways that the magical, two-dimensional allure of before and after had waned.

When I returned to the U.S., Lynn had not yet made up her mind about a facelift, but she

had quit smoking in case she decided to go through with it. The anticipation of enhancement had encouraged her transformation into a disciplined surgical subject, even though she told me that she was considering spending the money she had set aside for the facelift on a trip to Spain. If she had sent the surgeons a photograph of her face instead of visiting them, would the path to surgery have been straighter and smoother, rather than twisted and strewn with obstacles?

Pam, meanwhile, has not conducted as extensive a comparison of surgeons as Lynn, but she and her husband have paid for their plane fare and hotel room, her surgeon has seen her photos, and in a few minutes the hotel's driver will arrive to transport us to the clinic. She seems reluctant, as if contemplating an escape from the surgical cut to Costa Rica's many less-invasive touristic pleasures. Backing out now, however, might be interpreted as an act of cowardice by her husband, her family (except for her sister, who is worried that she will get "butchered" by "Third World medicine"), and her PSJ acquaintances, who have been urging her along. She is not the only person invested in her journey, and their interests accompany her along the way.

She asks me what I think about her surgeon, clearly wanting reassurance, and I suddenly feel awkward. As I discussed in the introduction, the detached observer is a myth that has long been critiqued by anthropologists, and as a researcher of cosmetic surgery I was constantly being called upon and positioned as an expert, an outsider, or a patient. Pam looks to me as an expert, and I grope for an answer that will not work to transform my interests into hers (I am still striving for disinterest, despite my claim that we are all interested). I tell her that her surgeon is very popular with both North Americans and Costa Ricans, which is true, but I say nothing of the rumors I have heard

among other plastic surgeons—that he is infamous for “short-cuts” and “half-done” surgeries. “There isn’t one surgeon in Costa Rica who hasn’t fixed one of his complications,” another surgeon told me several months later. He is popular with patients, I was told, because he is cheap, nice, and fast. Granted, Costa Rican surgeons are competitive with each other, and most of the criticism of Pam’s surgeon came from younger doctors who feel that their tools and techniques are more “cutting edge.” However, I suddenly feel more drawn more intimately into Pam’s story, and as if I will be partly responsible if her operation does not go well.

An employee of the hotel drives us to downtown San José in the hotel’s van. It is a twenty minute journey, and at the clinic we wait another twenty minutes for the surgeon. He is popular among Costa Ricans for his inexpensive and well-placed breast implants, and the waiting room is full of young women with large breasts. When the doctor comes out to greet Pam, he says, “Are you Pam? Oh, you’re beautiful!” We file into his large office and sit in chairs on one side of his expansive desk, while he positions himself on the other side. Without any preliminaries, the doctor launches into a medical history: “Do you heal well?” “Any prior surgeries?” “Problems with anesthesia?” The doctor does not ask about their journey to Costa Rica, and Pam is suddenly transformed from consumer and international traveler to an object of clinical scrutiny and paternalism, and her husband and I to peripheral observers of the ritual.

After completing his list of questions, and without explaining how her answers might bear on the operation itself, the doctor leaves the room. Another man enters the room, dressed in scrubs, and hands Pam a cotton gown. She asks if he wants her to remove all her clothes, but he does not speak English, and there is a pause. I step in as

interpreter, and find out that yes, she should go down the hall to another room to remove her clothes, and that Dr. Rojas will meet her there to discuss her procedures. Her husband and I are not invited to the inner sanctum where Pam will bare herself to the gaze of her surgeon—a visual operation that precedes the actual cutting. As in her before images, Pam is expected to shed her modesty along with her clothes.

Several minutes later, Pam (still wearing the gown) and Dr. Rojas return to the office. The doctor shows her sample breast implants that are in boxes on a cabinet next to his desk. Pam says she likes the silicone gel implants. We take turns holding them, and they are surprisingly heavy, cold and inert. Tomorrow two similar objects will be inserted into her body, and, if they and her body are mutually compliant, will become her “new” breasts. She renders them less threatening by calling them “gummy bears,” but then reasserts their potentially invasive, alien status by explaining to her husband and me that if they break the silicone will not leak into her body, unlike the contents of previous implant models.

Dr. Rojas brings up the question of size. “I don’t want to be Dollie Parton or Pamela Anderson,” Pam says, and it is not clear whether the doctor understands these references. (Throughout the course of this encounter, in fact, I notice that his spoken English is more fluent than his comprehension, and there are numerous moments of disjuncture in the conversation that Pam and Bob do not seem to notice and that I hope do not result in misunderstandings about surgical goals). Pam says that she thinks 200 cubic centimeter implants are what she needs. The doctor counters he will probably use a slightly larger size. Bob says he is worried that Pam’s breasts will be too big. “You don’t want that fake look,” he says. Dr. Rojas does not respond to this interjection, and, after a

pause, there seems to be a tacit agreement that the doctor will have the final word on the size of Pam’s newly enlarged breasts.

In this moment of awkwardness there is a disconnection between image and materiality. The surgeon, after all, can stimulate Pam’s desire for larger breasts by showing her before and after pictures, but he cannot show her exactly how her body will look with the different sized implants. The solution, for Pam, is to become a disciplined patient in order to make herself operable, although other patients I spoke with argued more insistently with their surgeons about the “natural” size of augmented breasts—some women wanted larger implants than their doctors thought was proportionate to their bodies, while others wanted small implants that seemed hardly worth the effort to surgeons. From what I could discern, patients’ desires usually prevailed, and “nature” was remade to order.



Figure 12. Private plastic surgery clinic in San José, established in the 1960s.  
Photograph by Sara Ackerman, 2006.

At the point in a clinical encounter when a patient's unclothed body is appraised, measured, pinched, and tugged, some Costa Rican surgeons suggest procedures that their clients have not previously considered, and these procedures are often provided at discounted prices or even without charge. "I didn't come here to get my lips done, or my hands. The doc just threw them in for free," one woman told me about the fat she had removed from one part of her body and then injected into her lips and hands. Supplemental surgeries enhance surgeons' status as altruistic, a topic I take up in more detail in chapter four. They also suggest the increased mutability of bodies as they pass through the clinic, and the disinhibiting effects of travel and release from the constraints of everyday life in the "real world," as travelers referred the U.S. "People let their hair down when they travel," a recuperating patient explained about the extra procedures she had indulged in.

Even gratis surgeries, however, often require clinical persuasion, and one of the agents in this process is the full-length mirror found in every plastic surgeon's office. Standing next to the patient in front of a mirror, a surgeon transforms the patient's body into a two-dimensional "other" to herself. The doctor lifts and pulls back skin to show how its wrinkled appearance or "excessive" looseness is masking the patient's underlying beauty. Like the visual dissection performed on images, patient's mirrored bodies are fragmented and pathologized through the manipulation of flesh and verbal diagnoses, after which they are assured that these disorders are treatable. The mirror colludes in the persuasion that it is a patient's image, rather than her presumably stable self, that will be altered by the surgical cuts.

Dr. Rojas tells Pam that he will use liposuction to remove 800 cubic centimeters of skin from her stomach, and 2000 cubic centimeters of fat from her abdomen. Quantifying her body and its excesses presumably demonstrates the surgeon's expertise, as well as his sculptural sensibility. Pam asks about the fat on her back. The doctor grabs the flesh on her back and says, "this isn't fat, this is skin." They argue about this for a few minutes and Pam finally concedes defeat. His knowledge of her body predominates, and her back remains inoperable for now. She reasserts her status as a consumer, however, with her next request, which is that the doctor save the suctioned fat after the procedure so that she can be sure that it has been removed. "Maybe I could donate it!" she jokes, raising the specter of medical waste as luggage that medical tourists leave behind for Costa Rica to dispose of. Dr. Rojas does not show whether he has understood her request or accompanying jest, and he proceeds to show Pam where the incisions for her tummy tuck and breast lift will be.

The rift between Pam's perception of her body's mutability, and Dr. Rojas's ability to reshape her flesh to her specifications, is a central theme in pre-surgical encounters between patients and doctors. Sometimes, tension results from a gap between image and flesh. I met a recuperating arm lift, eye lift, and liposuction patient from California, for example, who had sent her surgeon pictures of her body before arriving in Costa Rica ("side, front, back," she said, about her body's transformation into a series of mug shots). By email, the physician explained that he could perform a buttock lift procedure, but when she arrived in Costa Rica and consulted with him, he said that she did not have enough extra skin for the procedure. Instead, she explained, he removed fat from her thighs and transferred it to her buttocks. He told her that there was no guarantee

it would stay (where would it go, I wondered), so he saved a bag of her fat in case she wanted to come back and have it redone. She told me that she laughed at that and said to her surgeon, “Just give me my bag of fat and I’ll be on my way home! I came here for a butt!” In a sense, then, this was a failed medical journey, but the failure was attributed to the surgeon rather than to cosmetic surgery as a desirable technology of self-improvement.

At this point in a pre-surgical consultation, most surgeons bring out a book of before and after images. Whereas other aspects of the consultation demonstrate a surgeon’s medical expertise, this performance is a persuasive reminder that the surgeon is also an artist who must sell his or her craft. Except for the doctor I mentioned earlier, who exhibited gruesome images of surgical failure as evidence of patients’ failure to comply with his behavioral regime, before and after albums are a compilation of a surgeon’s artistic, and medical, successes. They are gendered and racialized (almost exclusively women of European descent are depicted) stories of social mobility, personal success, and biomedical triumph over aging (and, implicitly, mortality). We may not know the women who are represented, but we recognize our own fears and desires in the portrayal of their old and new selves. It is this sense of enduring triumph that lends before and after pictures a “cultic” quality, calling again on Benjamin’s concept. Even when their purpose as agents of commerce has been fulfilled—when the patient, for example, has committed to surgery, the visual narrative of before and after performs a kind of magic as doctors and patients sit side by side during a viewing. Plastic surgery is re-enchanted, is re-invested with a power to reshape lives, while patients and doctors are

reminded of their affinity in this enterprise. Living, changing, unpredictable bodies cannot perform this magic as faithfully.

Dr. Rojas seems ready to conclude the consultation; he stands up and opens the door—a tacit assertion of authority and control over the clinical encounter regularly exhibited by doctors in the U.S. and Costa Rica. Pam and Bob, however, do not appear ready to leave, and I cannot blame them. We have been in the office for about 20 minutes, and Pam is scheduled to go into surgery at 7 a.m. the next morning. I am feeling disoriented, confused, and full of questions, and it is not my body that will be cut open tomorrow, so I can hardly imagine the state she is in. She tells Dr. Rojas that she might want to return to Costa Rica to have her face “done,” and I wonder if this comment is Pam’s way of asking for more time with, or reassurance from, the surgeon. “You can’t touch your face,” Bob says, pointing to a competing moral economies of surgical enhancement which I discuss further in chapter four. Bob asks Dr. Rojas when they should pay for his services. The doctor says they can pay now or tomorrow before the surgery. Bob pulls out a thick bundle of traveler’s checks and begins signing them. The doctor walks back to his desk and sits down, with a barely perceptible sigh of resignation. Bob hands the checks to Dr. Rojas, who counts them and appears satisfied. He then tells Pam that he will see her tomorrow morning, and that he lives close to her recovery hotel, so during her recuperation he will visit her every night at 6 p.m. on his way home from work.

Dr. Rojas then explains that Pam needs to have blood and EKG tests, and he escorts us back to the waiting room. After sitting for 15 minutes, Pam and Bob say that they are sure they have been forgotten. I assure them that things run a bit more slowly

and casually in Costa Rica, so I am sure they have not been forgotten. Several minutes later, a man in street clothes walks through the waiting room into an adjoining exam room. He emerges a few minutes later to collect Pam, wearing a white coat and a stethoscope around his neck. When she returns several minutes later, she says that the EKG test was very different than in the U.S.—that the doctor put unfamiliar clamps on her skin rather than sticky electrodes. The specter of not-quite-modern medicine suddenly hangs in the air, but Pam keeps her thoughts to herself.

The new doctor tells her that she will be on a breathing tube during surgery, which she says she did not expect and does not like. Like many cosmetic surgery consumers, Pam did not realize the extent of the surgical take-over of her body. Television shows and magazine articles about body modification contribute to the transformation of surgery into an “everyday event,” and thereby act on consumers as a “cultural anesthetic” (Jones 2008a:53). Dr. Rojas reproduced this anesthetic by eliding the operation itself in his conversation with Pam; the breathing tube, and its suggestions of bodily incapacity and even death, jolts Pam out of this anesthetic state, although not enough to make her relinquish her surgical commitment.

By the time we return to the hotel, it is almost evening. I wish Pam luck with her operation, and ask if I can pay her a visit later in the week. She agrees, distractedly; she has more important things on her mind, and perhaps cannot yet imagine herself after surgery. The compelling visual narratives that helped to propel her on her journey have been overlaid by disruptive bodily sensations: the shame of being naked in front of a surgeon and aesthetically evaluated by him; the fear of being anesthetized, cut, and remolded by a man she just met; and the doubt with which most acts of faith are laced.

## **Surgical operations**

*To conceive of subjectivity as definable and experienced through the body—a body understood as comprising different organs and parts, as both whole and fragmented—is to experience the body as a surgically defined form.*

- Julie Doyle, *The Spectre of the Scalpel* (2008:26)

*Aesthetic procedures commonly performed on North Americans in Costa Rica:*

<u>Biomedical</u>	<u>Popular/commercial</u>
Abdominoplasty*	Tummy tuck
Blepharoplasty	Eyelid lift
Mammoplasty	Breast implants, breast lift, or breast reduction
Glutealplasty	Buttock lift
Rhinoplasty	Nose job
Rhytidectomy	Facelift
Liposuction	Liposuction (surgical fat removal)
Chin augmentation	Chin implant
Brachioplasty	Arm lift
Belt lipectomy	Lower body lift (includes tummy tuck, buttock lift, and thigh lift)

\*From Greek, “-plasty” means molding or formation

“Tucks,” “lifts,” and “jobs”—these terms lend an impression of benign industriousness to cosmetic surgery, while biomedical labels suggest the standardized

treatment of morphological disorders.<sup>73</sup> Enhancement and treatment are thereby merged into one project. Neither popular nor biomedical taxonomies, however, prepare the uninitiated, un-anesthetized visitor for the sensory onslaught of the operating room.

At 9:30 a.m. on a weekday, I arrive at one of Costa Rica's oldest private plastic surgery clinics (it was established in 1966) to observe a facelift and chin implant operation.<sup>74</sup> The term facelift covers a number of procedures ranging in complexity and invasiveness; some are completed in under two hours, with the patient given sedation and a local anesthetic, whereas today's operation involves general anesthesia and will last almost seven hours.<sup>75</sup> The clinic is a family operation situated in a large, two-story building in one of San José's more affluent neighborhoods. The head nurse, doña Mayra, is the wife of one of the clinic's surgeons and the mother of the other. She shows me around the clinic, explaining that doctors "only fix skin," whereas nurses have to "get at the heart" of the patient. She hands me scrubs and a white coat and takes me to a room at the back of the clinic where I am to change my clothes; one wall is lined with a set of lockers and facing them is a baby grand piano—evidence that the clinic also serves as the

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<sup>73</sup> North American cosmetic surgery patients in Costa Rica also use metaphors such as "road work" and "tune up" to describe the procedures they undergo, suggesting that bodies—like cars—are commodities that can (and should) be continually maintained.

<sup>74</sup> I was not allowed to observe surgical procedures at any of Costa Rica's larger, private hospitals, so this account offers a partial observation of the similarities and differences between surgical practices in a *Caja* operating room and those in a small, private, family-run clinic.

<sup>75</sup> My impression is that many of Costa Rica's older plastic surgeons prefer to use sedation and local anesthetics for facelifts, while general anesthesia is more popular among younger surgeons. Does this trend indicate that cosmetic surgery is becoming a more commercialized, more corporate strategy of medical intervention, as it moves from local to general anesthetics, out-patient to in-patient surgery, and clinic to hospital?

family's home (their residence is upstairs). When I emerge, today's patient (Marta) and her daughter have arrived.<sup>76</sup> I meet them in the room where Marta will spend the night after her operation; it has an attached bathroom, a television, a hospital bed, a daybed, two chairs, a high ceiling, and bare walls.

The room is comfortable but austere, and outside, beyond the curtained window, a high metal fence topped with razor wire separates the building from a busy street. When I spoke with Dr. Torres on a previous visit to the clinic, he complained that the building looks like a prison and he doubts that the clinic will continue to attract enough patients (particularly from North America) if they do not remodel. His father, he said, is content to leave the clinic as it is—his generation does not believe that medicine is a business, and he consequently shuns advertising of any sort, including architectural.<sup>77</sup> Dr. Torres, however, feels compelled to keep up with the commercialization of cosmetic surgery, and of private medicine more broadly, so he plans to rent an office in CIMA Hospital's new medical tower—a space that most doctors agree is more appealing to elite Costa Ricans and North Americans.

After Marta changes into scrubs, doña Mayra spends several minutes counseling her on relaxation techniques, and explains that when she wakes up after the operation, she will feel as if she has a motorcycle helmet on. Dr. Torres, Marta's surgeon (and doña

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<sup>76</sup> In chapter five, I move briefly back in time, reintroducing Marta during her pre-operative consultation with Dr. Torres approximately a week before today's operation.

<sup>77</sup> This building stands in stark contrast to some of San José's newer plastic surgery clinics and multi-specialty private hospitals. For example, a recently built plastic surgery clinic, several blocks away from Dr. Torres's clinic, is an architectural confection lined with marble, glass, and white furniture. I interviewed the surgeon-owner of this clinic, and as I waited in the reception area, I felt the building operating on me as seductively as the beauty magazines strewn about to inspire prospective patients.

Mayra's son), arrives and takes his patient to an exam room. He sits her in front of a white wall and renders her face two-dimensional with a digital camera. She frowns, and he aims the camera at her from the front and side, as if producing mug shots of a criminal rather than photographic portraits. He then draws on her face with a blue felt-tip pen, making a series of straight lines under her chin and cheekbones, on her temples, and on her forehead. He jokes with her about the markings, tacitly acknowledging the strangeness of a defacement preceding an enhancement, and assuring her that he will be able to correct an asymmetry he has noticed in her face. In English, he tells me that the pen markings indicate the "vector" of the operation, and they strike me as akin to the perspective lines in painting, except that in this case the canvas is three-dimensional and prone to bleeding and pain. Dr. Torres brings Marta back to her room, and hands her a couple of pills, which he says will help her feel calm before she is brought into the operating room. "Your job is to relax," doña Mayra tells her.

The pre-surgical attentions that Marta is offered, and her pharmaceutically-mediated transition from nervous patient to inert material, are common rites in private practice and are a reminder that the patient is also a customer whose good opinion must be cultivated constantly during her passage through the clinic. In the public hospital where I observed operating room activities, by contrast, the transition from person to operable body is much more abrupt. Patients are wheeled, fully conscious, into operating rooms crowded with machines, sharp tools, and masked people. During pre-surgical preparations one morning in a public operating room, for example, a patient about to undergo a tummy tuck was lying supine on the operating table and started crying—presumably in fear. The surgical resident glanced at her and ordered one of the surgical

assistants to calm her down—her display interfered with routine and was a transgression of her expected presence in the operating room as both central *and* peripheral. In both spaces, the surgeon’s role in the operating room is to attend to his patient as a body, not as a person, but Marta is more carefully protected from witnessing her own metamorphosis.

*Caja* surgeons are also sent patients whom they have never met before, which is uniquely problematic with an aesthetic procedure.<sup>78</sup> Just prior to an operation combining a rhinoplasty (nose job) and deviated septum repair, for example, a surgeon complained that he had just met the patient and was not sure how he wanted his nose to look. (It was safe to assume, however, that the patient wanted a more “European” nose, and the surgeon insisted on showing my nose as an example to the observing medical students). He added that he did not have much experience with the deviated septum procedure, and that it would have been more competently performed by an otolaryngologist (an ear, nose, and throat specialist). Nonetheless, the CCSS administration had sent him this patient, so he would perform the procedures as best he could.

On another day in the operating room, a patient who was about to undergo a tummy tuck asked the surgical resident where her surgeon was. Dr. Hernández, one of the more experienced plastic surgeons on staff at the hospital, had previously told her that he would perform her operation. The resident told her not to worry, that Dr. Hernández was probably nearby. Once she was under anesthetic, however, he casually told me that Dr. Hernández does not work on Wednesdays, and that he would perform the procedure

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<sup>78</sup> I discuss the availability of cosmetic surgery in national hospitals in chapter five.

himself. The patient would never know the difference, he said. This is a paternalism of a different order than that encountered by patients, like Marta, in the private sector.

Marta's sedatives are taking effect by 10:20 a.m. She is much less talkative, and seems to be almost asleep. The nurses bring her into the operating room—a large, brightly illuminated space with a window facing the smaller room where the surgical team and observers wash their hands. At this point she becomes the responsibility of the anesthesiologist, who puts a mask on her face until she is unconscious and then puts a tube down her throat that will control her breathing and feed anesthetic gases into her body. Cabaret-style music is playing on a tape recorder, its sounds layered with the rhythmic beeps of the anesthesia machine's aural marking of the patient's heartbeat.

I write the term patient, rather than Marta, because she is being transformed into an inert, operable body, and no one refers to her by name once she has become an absent presence in the operating room. As the doctors paste electrodes to her chest, they comment appreciatively on her breast implants (which they inserted several months ago), but their remarks seem to come from technicians rather than leering men. Once this task is complete, Marta's body is draped with a cloth, with only her head exposed. She is now a moldable non-person that must be kept alive. When Dr. Torres makes the first cut, he does so decisively and without hesitation. “Wounding somebody has become wounding some body, and so it appears undramatic,” writes Stefan Hirschauer (1991 299).

The assemblage of people and tools that will perform today's operation include a scrub nurse, two surgeons (the patriarch of the clinic serves as Dr. Torres's surgical assistant today), and the anesthesiologist and his beeping machine in a corner of the room near the patient's feet (in the *Caja's* operating room, I encountered nurse anesthetists

rather than anesthesiologists). It also includes a cauterizing scalpel, suturing needles and thread, and an array of supplementary cutting, scraping, and lifting instruments. The surgeon explains that the room is divided into two zones—sterile and non-sterile, and that I, and a physician who is here to observe, must remain exclusively in the non-sterile area.

The surgical team strikes me as small, perhaps because I have become accustomed to standing shoulder-to-shoulder with multiple observers and a more populous surgical assemblage in a small operating room at a public hospital. At one operation in the *Caja* hospital, I counted 14 people in the room, including the patient, four medical student assistants and observers, an observing physician, a surgeon and a surgical resident, a nurse anesthetist and her trainee, two nurses, the operating room assistant, and myself. These are teaching spaces, after all.

At the public hospital, moreover, the boundary between the operating area and the hospital outside seems to be more porous than in the private clinic. The public operating rooms, for example, are situated next to each other on either side of a long hallway lined with counters and sinks. Each operating room also has a door that leads to the recovery room and other areas of the hospital. This door is supposed to remain closed during an operation, although occasionally another plastic surgeon pokes his head in to consult or banter with his colleagues, finally withdrawing after being politely begged by the senior operating room nurse to please close the door. Doctors from outside the department also try to enter through this door, in the hopes of consulting one of the surgeons about another patient, although they are usually waved away through the small glass window. The other door, leading to the hallway that connects the suite of operating rooms, is the portal through which a near-constant flow of people, equipment, and body parts moves.

People step out into the hall to chat with colleagues, and other doctors arrive to observe plastic surgeons' techniques (they also, sometimes, tease the same surgeons for their questionable ethics in performing aesthetic procedures at the *Caja*). The mood in the surgical unit is reminiscent of a hard working, collegial assembly line (between six and eight operations a day were typical for plastic surgery, the operating room nurse explained). The activities at Dr. Torres's clinic, on the other hand, are more leisurely and ceremonial, and are rarely interrupted by intrusions from the outside.

The surgeons spend almost an hour preparing Marta's body to be cut. With elastic, they laboriously tie her hair into numerous little clumps on her head. Dr. Torres explains that plastic surgeons avoid shaving patients' heads (which is standard prior to most surgical incisions on the scalp) in order to mitigate what they describe as the "stigma of surgery" and make their patients "presentable" as soon after surgery as possible. This concession, however, also lengthens the time a patient spends in surgery, potentially increasing the risks associated with anesthetics.

At 11:20 a.m., after injecting Marta's face with a solution that works to constrict blood vessels and prevent bleeding, Dr. Torres picks up a scalpel and makes a cut inside Marta's mouth. His goal is to make an opening in her chin between bone and skin, into which he will insert a piece of silicon that will give Marta a more prominent chin. Dr. Torres's father sits directly next to him, holding a device that suctions blood from around the incision. The sound of suctioning accompanies the smell of burning blood, as the electric scalpel cuts flesh *and* cauterizes severed blood vessels. The sound of scraping then joins this gruesome concert, as Dr. Torres stands up and labors to separate tissue and skin. He and his father then discuss how to trim the implant, which is made in a

standardized size and must be shaped to fit the patient's actual—and imagined—face before insertion. Their work as silicon sculptors is completed in a few minutes. Dr. Torres quickly fits the white object into the opening just below Marta's bottom lip, and then sutures it shut with a surgical needle and thread. At 11:45 a.m., the chin implant procedure is complete. The surgeons' quiet concentration is briefly replaced by joking and chatting about sports. They change gloves while the nurse puts out new tools.

At 11:50 a.m., Dr. Torres begins the facelift by cutting a large piece of skin from Marta's head. He then uses a scalpel to separate skin from underlying tissue, his scraping and cutting covering the area between her forehead and eyes. Next, he begins to make incisions around one of her ears. As he cuts, he jokes about the influence of his ancestors—referring, presumably, to an indigenous person “scalping” a European. Indeed, he does seem to be detaching Marta's scalp, and by 12:30 p.m. the flesh on which they are operating barely resembles a face. Marta's ear appears to be floating in a sea of exposed, raw flesh, the loose skin around it hanging like a piece of cloth. The flesh under her skin is pink and yellow and white. With a needle and thread, the surgeon reaches under the skin to hoist fascia (tissue just under the skin) to a higher position on Marta's face.

During the procedures, the doctors' hands are busy, and occasionally they are silent in concentration. More often, however, they converse—with each other and with me—on a wide range of topics. Their labors seem to be second nature to them, and they appear to enjoy the diversion of having a foreign anthropologist in their midst. The anesthesiologist calls me over to his corner frequently. He says plastic surgery is boring for him, because there is “not enough to do” with healthy patients. In other surgeries, he

says, there is “more action.” He tells me about his experiences at the *Caja*. The *Caja* employs the country’s worst doctors, he says, and 50 percent of the country’s specialists are not skilled enough to get work in the private sector. Doctors stay at the *Caja* until they are 62 because they get a pension, he says. After a few minutes with the anesthesiologist, the surgeons insist that I return to their domain so that they can show me specific surgical techniques. “There are as many techniques as surgeons,” says Dr. Torres. Dr. Torres’s father calls me over to his side and asks the nurse to turn out the overhead light. In front of a smaller light, he holds up a swath of Marta’s skin with a paddle, in order for me to see living blood vessels.

There are many of these teaching moments throughout the day. Both junior and senior seem to enjoy adopting the role of pedagogue; perhaps it breaks up the tedium of a long operation, and perhaps private practice—for the most part cut off from medical education practices in Costa Rica—stimulates nostalgia for the apprentice-expert relations in the *Caja*. Regardless, I am surprised by their volubility, having read Stefan Hirschauer’s impressive ethnography of surgery, in which he insists that surgeons and patients are “very bad informants” during an operation. Patients’ participation is curtailed by being under anesthetic, he writes, while surgeons’ concentration and “dull daily routine seems to have put them under local anesthetic towards many sensorial impressions in the operating theatre” (1991:282). I find, to the contrary, that Dr. Torres and his father are quite enthusiastic narrators of their surgical activities, even if they have become habituated to practices that are shocking and dismaying to newcomers in the operating room. *Caja* surgeons, for their part, are also adept at performing surgical procedures while teaching, gossiping, listening to music, and cracking jokes.

It is I, the lightheaded and queasy anthropologist, who struggles to remain cognizant of the choreographed practices around me. At the start of today's operation, I have already watched hours of surgical cutting, burning, scraping, hammering, tugging, lifting, detaching, and weighing of flesh and bone. Yet I still find myself unable to objectify the body lying prone in front of me. A recurrent sensation washes through me, as if I, too, am being eviscerated. I have to look away periodically, and sit with my head between my knees, to regain my ability to stand, watch, listen, speak, hear, and smell. Is this what Julia Kristeva refers to when she writes about the abject (1982), or what Giorgio Agamben calls "bare life" (1998)? Is my reaction, my bodily recoil, produced by the threat of dissolution between self and other? Perhaps, but what I am certain of is that my powers of observation of the activities around me are both heightened, and diminished, by my horror.



Figure 13. Surgeons and anesthesiologist at work on a facelift in a private clinic's operating room. Photography by Sara Ackerman, 2006.

I join the anesthesiologist in the kitchen for a quick lunch at 1:00 p.m., and the scrub nurse also takes a short break. The surgeons remain in the operating room, and they do not eat or otherwise pause from their activities for the entire, seven-hour operation. Surgeons often brag about their lengthy stints in the operating room and ability to deny their bodies rest and nourishment. There is an almost militaristic discipline in these practices, as if the operation were a kind of battle. And although the intent of surgery is to preserve, or enhance, the patient's life, bodies often seem to resist the surgical invasions with which they are confronted. For example, surgeons are sometimes squirted by blood from errant blood vessels, scalpel blades that are dulled by resistant flesh must be frequently changed, and flesh that is being detached from the body is heavy—demanding labor from the person tasked with holding it up. Marta's body also resists. When the surgeons begin to make incisions around her other ear, the beeping coming from the anesthetic machine suddenly accelerates. The proxy for her heart rate tells the anesthesiologist that he must increase the dose of narcotic, whereas I hear the sound as her body's protest against its dissection.

When I return to the operating room, the surgeons are holding a ruler up to the flap of loose skin around Marta's ear. They are trying to decide how much skin to remove, and I am surprised to see that the alleged artistry of cosmetic surgery involves such crude measurements as inches or centimeters. After they detach a piece of skin, the nurse removes it on a tray. For the next three hours, the surgeons cut and measure and suture and talk—about religion, medical school, sports, surgical tools, and whether they should operate on patients who smoke. The smell of burning blood still fills the air. The

surgeons leave a drain poking out of the incision behind each ear, through which fluids will leak for at least a day after the operation.

By 4:30 p.m., they have wrapped Marta's bleeding head with gauze. The tray next to them is full of bloody tools, and they begin the final procedure—an eyelid lift. They make a cut on each eyelid, remove white globules of fat and a sliver of skin, and then close each cut with sutures. Marta's eyes are open during this procedure, and they stare disconcertingly and vacantly at the surgeons. They rub a bit of ointment on each eye to keep it from drying. By 5:20 p.m., Marta's pulse rate has begun to accelerate again, and the anesthesiologist says that she is reacting. To what, I wonder? The scalpel, the needle and thread, the noise or lights or smells in the room—or to all of these sensations in concert? At 5:30 p.m., Dr. Torres injects Botox into Marta's forehead between her eyes, almost like a chef adding the final, decorative flourish to a meal. “Inject me!” jokes the nurse, a young woman in her late 20s or early 30s.

Finally, they finish wrapping Marta's head with gauze, and then tape her eyelids and suction her mouth. Her bandaged, swollen, and bruised face is gruesome, and looks nothing like the woman who walked in the clinic with her daughter this morning. “She will be so happy,” says the nurse. Now, however, she is beginning to wake up, and coughs and gags on the tube that is still down her throat. The anesthesiologist makes sure that she is breathing on her own, and then removes the tube. It takes four people to move her to the gurney, on which she will be taken back to her room. *Caja* patients are also transported to a recovery room, although their journey into the state of post-surgical awakening is a more communal one—the recovery room I visited having 20 beds and five nurses.

As Marta is wheeled out, the surgeons' work is complete, and as long as a "complication" does not arise, she will be in the care of doña Mayra until she returns home. Dr. Torres and the observing doctor, in fact, have shifted their attention, and are discussing a complicated reconstructive procedure that Dr. Torres will perform tomorrow at a public hospital. It will involve transferring bone from one part of the patient's body to another, and Dr. Torres's face lights up as he says that "everyone is coming to watch." Today's operation was routine; facelifts, breast implants, and tummy tucks are Dr. Torres's bread and butter. Tomorrow will be his chance to shine, and to demonstrate his hard-earned expertise and spirit of public service.

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I return now to Pam. Four days after her operation, I pay her a visit at the recovery retreat. She is lying in bed in a darkened room that is littered with medical supplies and empty food containers. She is both well and not well. She tells me that she had a headache and felt nauseous yesterday, and that the stomach pain she is experiencing is worse than having a child. "I wouldn't do it again," she says, "but so far it looks good and I'm happy to have a flat stomach." She also says that she is relieved that her breasts are not too big. I asked her about her day at the clinic. Before the operation, she said, the surgeon marked all over her body with permanent pen and he took a lot of pictures. As with Marta, Pam's surgical alteration is inextricable from the re-shaping of her body into a graphic medium. Although Pam spent seven hours in the clinic, these hours were compressed into an interval that seemed not to have been experienced by her. "The next thing I knew," she said, "I was waking up." Her surgeon does not keep patients overnight after an operation, so Pam was driven home that day in the hotel's van. The

fifteen-minute ride, over San José's deeply potholed roads, was excruciating, she said, "but at least he drove slowly."

The central experience of Pam's journey, the hours in which her body was cut, excised, remolded, and sutured, were absent for her, but she acutely felt the effects of the activities they contained. She went into surgery feeling fine, and came out aching, sick, and barely able to walk. She had no memory of the long hours of surgery, but she suffered its corporeal violence and it is forever marked on her body. She was a "virtual participant" in the invasive practice of her own remaking (Hirschauer 1991:305). In her submission to anesthetic and the surgical team's control over her body, she passed through the operating room as an object and emerged as a liminal subject for whom the re-integration of body and self (the goal of cosmetic surgery, after all) was, as yet, elusive.

In the next chapter I turn to this period of in-betweenness and consider how Costa Rican recovery services have become integral to the transformative experiences described by many visiting patients. A patient embodies changes wrought by surgery, I suggest, through picturesque landscapes, pampered leisure, the "heart work" as described by doña Mayra, and a nostalgic camaraderie with other surgical journeyers.

## CHAPTER FOUR

### EMBRACING RECOVERY

*But here, at Shangri-La, all was in deep calm. In a moonless sky the stars were lit to the full...Conway realized then that if by some change of plan the porters from the outside world were to arrive immediately, he would not be completely overjoyed at being spared the interval of waiting.*

- James Hilton, *Lost Horizon* (1990 [1933]:103)

*People think their lives should be more like this.*

- Recovery retreat guest

#### ***Prelude: Teri's journey***

Teri has spent two weeks at a hotel in Costa Rica that caters to people who have traveled to Costa Rica for medical and dental procedures. A woman in her 40s from Texas, she has been recuperating from multiple body modification procedures, including arm, leg, stomach, breast, back, and chin lifts, as well as breast implants, liposuction, and a nose job. A local plastic surgeon performed these procedures during two daylong operations. Nearly a week after her most recent operation, I meet with Teri in the living room of the recovery retreat where she is staying, and whose stairs she still navigates gingerly. She tells me that the worst is over, although her body still shows the marks of a violent encounter—including dark bruises on her face and bright red scars running almost the entire length of the inside of her upper arms. The first few days after surgery were particularly difficult, she says; discomfort was accompanied by a persistent fear that her

incisions would re-open or that her body would not look the way she hoped. “I just wanted to be normal again,” she says, suggesting that normalcy was only available through technomedical intervention, and reminding me that “normal” or “natural” bodies are always hybrids of “technical and organic” (Haraway 1990:178).

Teri’s regime of surgically mediated self-discipline did not begin in Costa Rica. She explains that she underwent weight loss surgery in Texas two years ago, after which she lost 140 pounds. Her bariatric surgeon had not warned her about the “cosmetic” side effects of rapid and massive weight loss, so she was surprised and dismayed to find skin hanging on her “new” body like a large, loose bag. This excess skin was a reminder of what she calls her “old self,” which she had expected to relinquish along with her appetite. Teri subsequently heard about “body lift” surgeries on television and Internet chat rooms, and she decided that her body could only be normal again if she had the excess skin surgically removed. Her insurance company did not agree; as far as they were concerned, Teri’s obesity had been successfully treated and her loose skin was not a medical problem. (In some cases, however, U.S. health insurance companies designate—and pay for—tummy tucks as a reconstructive procedure because loose, hanging skin can become infected or irritated).

In the U.S., the cost of Teri’s desired surgeries approached US\$100,000, which she says was beyond her means. Determined to complete her transformation, she searched the Internet for more affordable options, and she learned about medical tourism on patient-run forums like [PlasticSurgeryJourneys.com](http://PlasticSurgeryJourneys.com). She had not traveled outside the U.S. before, and most destinations seemed “too far and too foreign.” Costa Rica, however, was only a four-hour flight from Texas, and it appeared to Teri to be an

“Americanized” country. She also saw a television program about Costa Rican recovery retreats, which appealed to her because she would not have to worry about caring for herself (or her family) during the most difficult phase of her recuperation. The total cost of Teri’s surgical journey, including hotel expenses, plane tickets, and medical services, was approximately US\$15,000.

Now, almost a week after her final operation, and three weeks after arriving in Costa Rica, Teri is a convert. She tells me that Costa Rica is not a Third World country after all, but a real paradise. Doctors are more caring here, she says, and less concerned with money than U.S. doctors. Her surgeon even makes “house calls” to check in on her, which she cannot imagine a doctor in the U.S. doing. The U.S. medical system, she tells me, is demoralizing; fighting with insurance companies and encountering arrogant doctors and brusque nurses does not really feel like medical *care*. Her Costa Rican surgeon, on the other hand, actually gave her his cell phone number and kisses her on the cheek when he greets her, so she feels he really cares about her as a person.

The retreat staff, Teri says, has also been essential to her recovery. “When I had my Linda Blair episode,” she says, “I looked in the mirror and said, ‘what have I done? This isn’t me!’”<sup>79</sup> But the hotel’s owners, or one of the staff nurses, have always been there to comfort Teri, and reassure her that her anxiety and gruesome appearance are normal and that she is becoming a much more attractive person. They have helped her to realize that her “true self” is emerging, Teri says, so she can be happy at last. The path

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<sup>79</sup> Linda Blair is an actress who appeared in the 1973 film *The Exorcist* as a young girl possessed by the devil. Through this analogy, Teri suggests that she was not “herself” when she reacted to changes in her body’s post-surgical appearance, but that she later recovered her self when she learned to see and feel her transformed body as normal and attractive. As I explore throughout this chapter, recovery hotel sociality and affective labor facilitate the recuperation of surgically disrupted body-selves.

has also been smoothed by the friendships Teri has formed with other patient-guests at the retreat. They spend a lot of time comparing the visual and sensory stages of recovery, debating the advantages of different painkillers and scar creams, and reminding each other that they look beautiful and have made the right decision, even when they are swollen, bruised, and in pain. Her group of friends calls themselves SOS (Sisters of Surgery), and Teri says they have already decided to return to Costa Rica together someday for surgical “tune-ups.” It is hard for me to imagine what other enhancement procedures she might want (the surgeon encouraged her to “hold off” on her forehead and eyes, she says, so perhaps they are the next frontier in her regime of normalization), but it is clear that she is looking forward to her next plastic surgery vacation in Costa Rica.

In the meantime, she plans to bring her daughter to Costa Rica to have her “uneven” breasts “fixed.” “It’s heaven here,” she says. “The prices for everything are affordable, the climate is perfect, and the people are so beautiful and kind.” She tells me that she is thinking about talking her husband into retiring, or buying a second house, in Costa Rica. “I’m going home a totally different person. Weight loss surgery gave me my health back, but plastic surgery has given me my life back,” she says.

## **Introduction**

In his discussion of colonial travel as a “peculiarly modern activity,” historian Nicholas Thomas writes that traveling is more than “movement across space.” Rather, it is constituted by “self-fashioning exercises that discompose and recompose the traveler” (1994:5). As an emerging form of mobile self-fashioning, however, cosmetic surgery tourism brings a more radical materiality to the self-fashioning and discomposure of

travel. Indeed, the developing countries that cater to cosmetic surgery seekers are sites where the bodies of tourists are suddenly, and violently, disrupted, as I discussed in chapter three. When patients awake from anesthesia, they are usually in pain and their faces and limbs are often unrecognizable. One's sense of bodily integrity, and selfhood, is destabilized. What then, of the processes through which person and body are recomposed?

For travelers like Teri, the recuperation of a sense of self takes place by way of a liminal passage through a recovery retreat. Retreat guests often narrate an “inner” or “spiritual” healing that surpasses their expectations of surgical enhancement, and they attribute this healing to Costa Rican caretakers, other guests, and landscapes that offer temporal and spatial escape from daily life back home. In this chapter, I consider the labors, landscapes, and socialities through which travelers are socially and corporeally recomposed, or recuperated. Recovery, I argue, is a nexus of feminized care of the soul that works in concert with surgeons' masculinized labor on the body—although economic and social rewards are unevenly distributed between these two domains. Below, I discuss the complex assemblage of post-surgical care, starting with a history of recovery services, then moving to a consideration of social and bodily liminality, affective care, and nostalgic longings for imagined medical and personal pasts. Throughout, I argue that recovery, and its practices of medicalized leisure, are condensed materializations of changing economic and cultural conditions in Costa Rica.

### **Cottage industries and transnational enterprises**

*An affordable answer to your desires.*

- Recovery retreat web site

According to Costa Rican plastic surgeons, the first wave of North Americans seeking cosmetic surgery arrived in the mid to late 1970s, before the small Central American nation was transformed into a tourist paradise. Many of these early medical travelers were flight attendants and journalists, nearly all were women, and they patronized private cosmetic surgery clinics in San José that were already popular among elite Costa Rican women. Clinics were typically founded and staffed by doctors who had started their careers performing reconstructive surgery at public hospitals. As cosmetic surgery grew in popularity among affluent Costa Ricans, and word of mouth among North Americans increased the flow of patients from the north, most doctors from this cohort eventually resigned from state employment to devote themselves exclusively to private practice. Among the plastic surgeons I interviewed, this shift in craft and clientele was understood as a financial and professional reward for long years of public service to ordinary Costa Ricans, and as an escape from the oppressive, bureaucratic behemoth that they felt the state medical system had become.

Before post-surgical recuperation was transformed into a business in Costa Rica, North American patients typically spent a week or two after surgery at conventional hotels in San José. This is still a common practice among visiting patients, although doctors and recovery retreat owners frequently told me horror stories about the inadequacy of conventional hotels for surgical recuperation. Before residential recovery services were available, they said, medical visitors suffered infections and other post-operative complications in their hotel rooms without knowing how (or whom) to call for help. Making matters worse, hotel staff often asked guests to stay away from common areas so that their visibly bruised and swollen flesh would not disturb or frighten non-

surgical guests. Early medical travelers, in other words, were often denied status as tourists—indeed, they were considered a potential threat to the success and expansion of conventional tourism.

Hoping to monitor patients more closely after surgery, while enhancing their clinics' and Costa Rica's desirability as a surgical destination, surgeons translated the days and weeks of post-surgical recuperation (which typically involves feelings of anxiety, boredom, and isolation) into a new form of commerce in the late 1980s and 90s. Some built hotel-like rooms or residential wings in their private clinics, and enlisted family members and acquaintances to cook, drive, and provide nursing care and companionship for medical visitors. Other doctors outsourced patient care to friends or former patients, primarily middle class (often divorced or single) women in or near San José whom surgeons trained in basic nursing skills. Popularly referred to as “recovery homes,” these informal enterprises provided rooms, meals, dressing changes, medication reminders, and the maternal ministrations of their *dueñas* (women owners). Like a medical version of the ubiquitous “home stay” industry for visiting students, recovery homes link the economic well-being of middle class Costa Ricans to the self-improvement practices of elite (by local standards) North Americans, via the commodification of hospitality and family life.<sup>80</sup>

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<sup>80</sup> I lived in a town with a large public university and several private Spanish language schools, and nearly every middle class family I met hosted visiting students for several weeks or months each year. Home stays are marketed as the best way to gain access to “authentic” Costa Rican life, and students are promised honorary membership in a typical Costa Rican family. For the families or single women (reflecting Costa Rica's high rate of divorce) who host students, providing a room, meals, and companionship for foreign visitors is a regular feature of daily life. Hosting can be a burden, but can also be pleasurable and a strategy of social and geographical mobility (some home stay families are invited to the U.S. by former guests). Most importantly, hospitality for hire is an

Recovery homes do not employ web sites or other marketing devices, attracting clients primarily through referrals from doctors and other patients. Several members of the older generation of doctors still affiliated with recovery homes (their younger colleagues prefer to affiliate themselves with larger, more luxurious retreats) told me that marketing medical services is unethical. “Medicine is not a business,” one surgeon stated emphatically, even though his clinic operated on a fee-for-service basis, suggesting that for him a “business” is constituted by advertising. Although larger, more commercial retreats now dominate the recovery industry, as I discuss below, several recovery homes still operate, accommodating between one and four guests at a time.

The business of transforming and tending North Americans’ bodies, in other words, emerged through a loosely connected web of locally owned clinics and residences. During the early years of its development, the recovery industry operated for the most part outside of the reach and interest of international investors, large-scale tourism promotion projects, and state and international regulatory agencies. Of course, Costa Rica became more accessible to medical travelers through its development of a tourism infrastructure and its status as a tourism destination. However, when tourism surpassed bananas as Costa Rica’s largest source of foreign exchange in the 1990s, foreign medical consumption was still situated (and largely ignored by those who were not directly participating in it) in the obscure background of tourism’s broader landscape.<sup>81</sup>

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important source of supplementary income for middle class Costa Ricans, as they face stagnant wages and rising costs for housing, food, and gas.

<sup>81</sup> When I visited the state-sponsored Costa Rica Tourism Board in early 2006 to ask about medical tourism, I was handed a dusty—but prescient—masters thesis on the potential for Costa Rican’s plastic surgeons to attract more foreign patients. Otherwise, the institute did not seem aware of the thriving medical tourism sector just outside its

As I discussed in chapter one, an infusion of foreign capital into the private medical sector in the late 1990s and early 2000s accompanied neoliberal policies designed to promote foreign investment; these transformations intersected with the global emergence of what is now popularly referred to as medical tourism. While the flows of leisure and medical tourists to Costa Rica increased, many North Americans and Europeans also migrated to Costa Rica seeking retirement havens or investment opportunities. In the mid-1990s, expatriate entrepreneurs (most of them women and clients of local plastic surgeons) were encouraged by low land and labor prices to build larger, more luxurious residential retreats for visiting patients, primarily in affluent neighborhoods near San José. Today, most retreats have between 10 and 15 guest rooms, and they offer a wide menu of amenities, including Internet access, American-style food, U.S. cable TV, communal activities, transportation to and from clinics, English-speaking nurses, exam rooms for physicians, and lush gardens. They also attempt to preserve the home-like atmosphere and around-the-clock nursing and affective care that characterize recovery homes.

Approximately six or seven retreats have a steady clientele of visiting patients, primarily from the U.S. At least half of the retreat guests I met were traveling alone, while others were accompanied by family members or friends. Guests typically arrive at a retreat a day or two before their scheduled operation, and remain for about two weeks afterwards. Rather than rushing from cloud forests to volcanoes to beaches—a typical itinerary for conventional tourists—recovery retreat residents typically remain within the

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doors (literally—a small inn popular with cosmetic surgery patients was just across the street). More recently, however, the government has moved medical tourism to the top of its agenda to promote private sector expansion and foreign capital attraction.

facility's walls, except for visits to a hospital or clinic or an afternoon adventure at a local mall. Most guests have traveled to Costa Rica for cosmetic surgery or dental procedures (women dominate the former category, and men the latter), and some non-surgical travel companions become “accidental” medical tourists during their stay, lured by low prices and the easy availability of surgical appointments, as I discuss below.

Since 2006, several new retreats have opened—projects of foreign investors hoping to profit from Costa Rica's medical tourism boom. The names of retreats, as well as the seductive images posted on hotel web sites, suggest a protected enclave in which limits on corporeal and personal mutability are relinquished, and guests are freed from the economic and social constraints of their regular lives in the U.S. Retreat names include: *Paradise Cosmetic Inn*, *Las Cumbres* (The Heights), *Casa de la Mariposa* (House of the Butterfly), and *Villa Plenitud* (Villa of Abundance).



Figure 14. Advertisement for recovery retreat in *Medical Tourism* magazine. December 2007.

Most people in the recovery business told me that there are “plenty of patients to go around” between retreats and home-based recovery facilities, but larger, North American and European-owned retreats now dominate the industry (and it appears that the hospital-hotels I described in chapter two are now offering recuperation facilities as well). The economic contours of medical tourism, indeed, increasingly resemble the social and economic stratifications found in the conventional and eco-tourism sectors, where larger and more profitable businesses tend to be owned by North Americans or Europeans and staffed by Costa Ricans and Nicaraguans—the latter typically working as undocumented, “flexible” labor. Meanwhile, recovery is being professionalized, as more retreats hire registered nurses and seek recognition and regulation by the state as medical facilities.<sup>82</sup>

I do not mean to suggest, however, that recovery retreats are consistently profitable. All-inclusive prices at private homes range from US\$35-60/night, while hotel-like retreats charge US\$75-150/night, which is not much higher than rates at conventional hotels of comparable quality that do not provide transportation, food, or nursing care. Several hotel owners told me that they are barely “breaking even,” and that running a retreat requires Herculean efforts:

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<sup>82</sup> Retreat owners were equivocal when I asked about government inspections, and I found little evidence that recovery homes or hotels have historically been subject to regulation as medical facilities. One retreat owner told me that his was the only hotel in the country registered with the government as a medical facility. He said the government had a lax approach to the recovery industry: “People open businesses...hang a shingle outside—‘Ma and Pa’s Recovery Retreat.’ Nobody bothers them.” With the recent scramble for JCI accreditation among private hospitals in Costa Rica, and newer retreats marketing themselves as clinic-hotel hybrids, it seems likely that regulatory surveillance will increase.

Many [people] think that it's a simple, ten-hour a day job. But it isn't. It's 24-7... I came here to retire, but I don't think I'll ever retire. I had no idea what I was getting into.

Recovery retreat owners also emphasized, however, the non-economic benefits of recovery work. In the face of uncertain financial reward, the care of patients was often located in a spiritualist ethic of service, which I consider in more detail below.

### **Healing landscapes**

*A place filled with majesty and nature, a place to rest and be renewed...an environment that promotes peace and healing.*

- Recovery retreat web site

It is not easy to find *Las Cumbres Inn Surgical Retreat* the first time I visit. The public bus extracts itself from the dense, polluted tangle of downtown San José and speeds down a new and unusually pothole-free highway linking expensive shopping malls, CIMA Hospital, and a landscape of commercial construction sites on plowed-under coffee fields. We turn off the highway into Escazú, an affluent suburb of San José known for its U.S. chain restaurants, luxury housing, and popularity among North American residents. Escazú, in fact, was not always the playground of cosmopolitan elites that it is today. In the early 20<sup>th</sup> century, landscape painters were drawn to the town's "rural air," adobe houses, and "essence of authentic Costa Ricanness" (Molina-Jiménez 2005:91). In the 21<sup>st</sup> century, however, nostalgia for Costa Rica's rural past is less easily indulged in Escazú, which has become the country's exuberant center of privatization, transnational consumption, and North American settlement.

After climbing for 15 minutes, the bus reaches its final destination in Escazú's *Bello Horizonte* neighborhood. I walk steeply uphill from the bus stop, musing on the

aptness of Las Cumbres' name (the peaks, or summits) and passing *Hotel Relax*— its meticulous landscaping and lofty perch reminding me that I am indeed in a place where fantasies might be realized. (This idea is not so easily conjured in the “ecological catastrophe” of San José [Palmer and Molina 2004:276], or in the adjacent, densely populated town where I live.) Like most recovery retreats, Las Cumbres is walled and gated, resembles an opulent private home, and is surrounded by a carefully tended simulacrum of tropical paradise (poisonous snakes are not welcome). The common spaces inside feature floor-to-ceiling windows and panoramic views of San José and Costa Rica's central plateau. This elevated vantage point transforms the multitude of vehicles, buildings, and human lives in the streets and buildings below to a serene, non-threatening tableau, framed by green, cloud-wrapped volcanoes.



Figure 15. American-style consumption on offer in Escazú, a suburb of San José.  
Photograph by Sara Ackerman, 2006.

Las Cumbres opened in 1989 as a bed-and-breakfast inn that accommodated a mix of tourists and cosmetic surgery patients. When I first visited in 2006, Las Cumbres had become one of Costa Rica's most popular recovery retreats and no longer welcomed

non-medical tourists. In its early days, the owner told me, non-surgical guests had been horrified by the appearance of recuperating facelift patients, particularly at mealtimes. Now, all of her guests are cosmetic surgery and dentistry patients and their companions. (The owner told me that she would welcome patients who were undergoing other procedures, but so far she has not heard from any).

The recuperating patients I met at Las Cumbres, and other recovery retreats, infrequently—if ever—sampled the pleasures of Costa Rica’s internationally famous national parks or beaches. Nonetheless, Costa Rican landscapes figure prominently in the marketing of medical services to North Americans. Medical tourism promotions borrow from the opulent images and adventure narratives of ecotourism, which emerged from Costa Rica’s 1980s refashioning as a tourist paradise. Featuring lush, pre-human nature and feminized hospitality, this imaginary has become the dominant form through which North American visitors desire and consume Costa Rica. The Costa Rica Tourism Board (ICT) has distilled this imagined place in its slogan, “No Artificial Ingredients,” part of an international campaign that deploys scenic landscapes as a metaphor for political stability and a healthy, educated populace (Rivers-Moore 2007).<sup>83</sup>

Guests associate recovery hotels’ privatized nature and cultivated tranquility with “stress reduction” and “spiritual renewal,” and some travelers insist that their personal transformations cannot be attributed to cosmetic surgery alone. “Just with the view you

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<sup>83</sup> Recovery hotels and medical tourism packages frequently offer pre- and post-surgical side trips to cloud forests, volcanoes, and beaches. As I discussed in chapter two, this contributes to the expectation among some travelers that they will be able to engage in adventure tourism shortly after invasive surgery. Surgeons encourage their patients to plan time for sightseeing before surgery, but most people told me they were nervous about surgery, and therefore wanted the operating room to be their first “foreign” destination after arriving in Costa Rica.

will heal,” a North American resident of Costa Rica explained, conjuring 18<sup>th</sup> and 19<sup>th</sup> century spa travel and Romantic understandings of landscapes as inherently healing (Kautz 1999). “Our facility is a tranquil, spiritual place. People come here uptight and are more relaxed when they leave,” a retreat manager explained. Many retreat guests told me that they had stepped outside of “reality” or “the real world” during their weeks of recuperation, and that they felt more “in touch with” themselves as a consequence. A recovery hotel owner put it this way:

Nine out of ten patients...they’ll say to me or write to me and say the surgery was great, I’m so pleased with the results, but the real winner was the fact that I recovered in this wonderful environment that allowed me to get in touch with myself, that allowed me to totally relax. They often talk about it as being spiritual. Because a lot of people, before they come here, probably never spent time alone. And we have places where people can sit and gaze and breathe in and relax. And that is what people really love. And nature is very important. The word spiritual comes up all the time... Sometimes it’s hard to say goodbye...they’re going back to reality.

The value of a Costa Rican cosmetic surgery journey, therefore, is not exclusively based on cost or the transformative effects of surgery itself. Rather, a successful recuperation of the self is produced, and embodied, through a complex recipe that includes a spiritualist aesthetics of place, a sense of retreat from everyday life, and—importantly—the labors of local caretakers and other cosmetic surgery patients, through which guests are able to navigate a period of acute bodily and social liminality. “Those other countries do nothing more than business,” a recovery home proprietor said about competing medical tourism destinations. The Costa Rican recovery industry, by contrast, positions the nation and its people as inherently healing. I now turn to a discussion of emotional labor (Hochschild 1983), liminal bodies, and the enactment of personal and social recuperation.

## Shepherds and brokers

*The doctors do the physical work, and my nurses and staff help you with your after-surgery rest and recuperation.*

- recovery retreat web site

*...the magic, the miracle, is what you did to feed and nurture my broken heart and spirit, and bring them back to the world of the living...*

- patient testimonial on recovery retreat web site

At recovery retreats, nearly everyone is involved in the social and material recomposition of guests. Nurses, drivers, maids, and cooks, all participate in recovery retreats' material and affective labor; some tend to painful and oozing flesh, others to cravings for familiar foods, and still others remind guests daily that they have made the right decision and are certainly becoming more beautiful every day. Even the lowest-paid actors in the recovery business (most often undocumented Nicaraguan laborers) tend to patients' feelings, even if by merely evoking pity.<sup>84</sup> Many retreats now employ registered nurses, who lend an aura of professionalism and expertise, and whose labors I discuss below, but the legacy of family-run recovery homes lives on in the maternal presence of retreat owners. Typically residing in or adjacent to their hotels, owners are ever-present in the daily lives of guests, and they told me that their labor on behalf of guests-patients far surpasses the usual duties involved in running a hotel. As one retreat owner put it, "it's being father, mother, sister, brother, confessor to everybody...to all those patients." Many also have first-hand knowledge of what it is like to undergo cosmetic surgery, which enhances their authority as retreats' senior confessors.

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<sup>84</sup> Nicaraguan maids were so elusive at recovery retreats that I only learned of their presence during interviews with guests. One woman told me about the "poor" Nicaraguan maids who lived in the barn on the grounds of a ranch-like retreat, and who were "grateful and embarrassed" by the tips she gave them.

I use a religious metaphor because retreat owners do not describe the affective labor they engage in as work. Rather, it is a “service” or “calling.” Some even suggest that they willingly sacrifice financial gain in order to care for their guests, whom they often describe as family.<sup>85</sup> “People are seeking something,” a retreat owner told me. “Women come to heal from broken relationships. I help them get in touch with their feelings. I listen to them.” Another host described herself as a “mother hen,” guiding her charges, around the clock, through the process of “giving birth” to their new bodies and selves. This guidance includes dressing changes, medication reminders, and talking guests through periods of depression and regret. She told me that she works hard to produce a family-like atmosphere in her hotel, and that it can be a challenge sometimes: “People regress and are like children. We try to bring them out and tell them, ‘why don’t you come and join the others?’ which lightens up the whole thing.”

Another retreat manager explained that the management of guests’ medication schedules, anxieties, and leaking bodies was “24/7”:

People bleed on their sheets; their towels get all bloody. You have to help people do things, like go to the bathroom and wash their hair and shower – and sometimes you have to be right in there with them.

These intimate ministrations to the daily needs of recuperating bodies contrasts sharply with surgery’s more ritualized, authoritative interventions into inert, depersonalized bodies. These two domains, and the metaphors of childbirth and family that circulate in retreats, suggest the ways in which medical tourism practices are gendered, and the division of labor along gendered lines. Generally, patients are “born” in

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<sup>85</sup> Some hotels do in fact forfeit profit in order to keep prices low enough for bargain-hunting visitors, which is not the case among plastic surgeons, many of whom have become very wealthy through private practice.

a normatively gendered family, with an elusive but worshipped surgeon-father, a protective and ever-present mother (retreat owners and nurses), and patient-siblings with wisdom to impart and lessons to learn. The ministrations of retreat staff are feminized as nurturing and hospitable—traits that are assumed to be inherent to Costa Ricans. When a surgeon visits a retreat, it is primarily to examine bodies, not souls—even though such visits do perform a sort of emotional labor, as I discuss below. Patients’ “inner” world, by contrast, and the process of subjective accommodation to a changed body, are the domain of recovery workers. This division of labor parallels the dualism of plastic surgery, which paradoxically turns the body into modifiable matter, while promising to reunite mismatched bodies and selves (Balsamo 1996).

The performance and commercialization of emotional labor also extends beyond the walls and practices of recovery retreats. Cosmetic surgery tourism in Costa Rica has spawned a colorful collection of missionary-entrepreneurs, some of whom I encountered in the course of my fieldwork. They included: a journalist, inspired by his purchase of a “new smile” in Costa Rica to write a guidebook for mobile cosmetic surgery and dentistry patients; “concierges” hired by transnational medical tourism brokers to accompany patient-travelers; and two women from California hoping to transform their cosmetic surgery journeys into a new life in Costa Rica, through which they would be able to “give something back” to other surgical pilgrims by facilitating personal “rebirths.” “Our hearts and our spirituality are leading us here,” one of them said, and in 2007 they opened a recovery retreat near San José.

And then there was Didi. So many stories about Didi circulated among patients and recovery staff that I felt as if I knew her before we met. No one knows more about

the business than Didi, they said. She ferries small groups of women between California and a local plastic surgeon several times a year, I learned, and she has such a devoted following that there is a waiting list for her tours. When I heard the name of her one-woman enterprise, “Didi’s Sleepaway Camp for the Terminally Vain,” I decided that I had to meet her. She responded almost immediately to my email, telling me that she had found her calling accidentally after having cosmetic surgery in Costa Rica eight years earlier with Dr. Valverde, the surgeon she now recruits for. She writes:

When I came home, all my nay saying friends were there lined up to check me out and see if my nose was still attached to its proper place on my face. They were all incredibly impressed with how natural I looked and the beautiful work that was done by Dr. Valverde, so they all wanted to go and wanted me to go with them and I did. That’s how this all got started...[now] I book 12 groups a year (one a month on the average) and go along with three groups a year...visiting with them while they recover after surgery.

About a month after our initial exchange, Didi brought her next group to Costa Rica and invited me to follow her on her rounds. When she walks through the door of the private hospital where her “campers” are operated on, I immediately recognize her even though we have never met. She is cheerful and wears bright clothes, and like many of the women I have met who have had facelifts, she looks youthful but not young. This is both disconcerting and intriguing—it is as if the usual corporeal markers of age have been altered, rather than erased. The effect is somewhat like encountering a transgender person, since the tacit rules of social interaction with conventionally defined categories of people seem suddenly obsolete.

Didi and I have lunch in the hospital, and every few minutes she extracts herself from our conversation to greet a doctor or administrator who happens to be walking through the dining area. Costa Rica has an “impressive medical community,” she says,

and the surgeon and recovery staff she works with are “like family” to her. Dr. Valverde pays for Didi’s travel expenses, but otherwise she does not accept money from him or from patients. She describes her work as “a gift from the heart,” and says that it complements her husband’s services as a rabbi in Los Angeles. (She does accept free medical and dental services for herself and her family, however, and says that she has an “account” at the hospital with no fixed limit). Didi tells me she loves being intimately involved in people’s transformations. Some of the women she brings here are divorced, and others have had cancer or a death in the family. “Loss is a tremendous impetus for this move,” she says; people want to “wipe the slate clean,” and cosmetic surgery offers them the opportunity. Unlike the recovery home *dueña* who told me that changing one’s body does not fill the “emptiness” that bring many North American women to Costa Rica, Didi embraces—and embodies—cosmetic surgery’s promise of “inner” revitalization. She is a mobile missionary for cosmetic transformation; she tends to souls, while Dr. Valverde works on bodies.<sup>86</sup>

After lunch, Didi invites me to accompany her as she goes upstairs to check on a patient who will be returning from the operating room soon. She always likes to be with her charges when they wake up, she says. From the lobby, we go up a short flight of stairs to a wing of private patient rooms. Didi pauses at the nurses’ station, but the English-speaking nurse she is hoping to find is not there (Didi does not speak much Spanish). Undeterred, Didi purposefully walks to the supply closet and takes a packet of

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<sup>86</sup> Dr. Valverde is one of the most financially successful plastic surgeons in Costa Rica, and I should mention that Didi’s insistence on working without monetary payment is not (entirely) a comfortable arrangement for him. He has tried to pay her for her recruitment and after-care services, but she insists that money would introduce undesirable social and legal complexities to her relations with Dr. Valverde and their patients.

gauze and a container of ice. I am surprised that no one questions our presence or Didi's presumption with hospital supplies, but perhaps they have seen her here before.

The patient's room is large and comfortable, with armchairs, a sign in English with the name of the patient's nurse, and a window facing the steep green hills that embrace Costa Rica's central plateau. After a few minutes the patient is wheeled in by a nurse and her assistant, who carefully transfer her from wheelchair to hospital bed. She has undergone a facelift, and her face is grossly disfigured by bruises and swelling. Her head is covered with gauze and bandages, and a large pool of blood is soaking through at the back. I feel queasy, but Didi greets the woman cheerfully and says that the surgery was a success and she will call her family to let them know. Didi makes the call, speaking briefly to the woman's husband and offering him reassurances. The patient has difficulty moving her lips, but she tries to ask for ginger ale. No, Didi says cheerfully, but you can have some ice chips. She jokes about how bad the patient looks, telling her, "The best you can hope for now is to be uncomfortable. Visualize where you would rather be right now. Think about Hawaii!" (Costa Rica's reputation as paradise has apparently been revoked for the time being). It's important to be realistic with patients, she tells me, "I don't want to sugarcoat it." But she also tries to calm them with reminders that they will look great very soon, she says. She is so effective at helping people transition from surgery to recovery that the hospital's nurses occasionally ask her to sit with foreign patients she has not met before, when there are no English-speaking staff on shift.

Didi's work continues into the days and weeks after surgery, until her group returns home. She shepherds them through a period of post-surgical liminality, her work a kind of social service for upper-middle class women who have suffered life's

disappointments. Days later, I interview several of the women who have accompanied Didi on this trip, and they tell me that they came to Costa Rica for “road work” but found that “this is actually a life-altering experience.” How did they find Didi? I ask. “Through the underground railroad,” one woman tells me, lending a sense of transgression and adventure to the process of surgical transformation.

I am curious how the uninitiated are inducted into the cult of Didi and Dr. Valverde, so after returning to the U.S. several months later, I attend one of Didi’s recruitment brunches (or “show and tells,” as she calls them) at an upscale restaurant in the San Fernando Valley, north of Los Angeles. About 20 women between the ages of 50 and 70 have gathered, including returned and prospective journeyers. Didi offers a seductive narrative about Costa Rica, Dr. Valverde, and the recovery retreat, and she then asks seasoned surgical travelers to testify. “Do you want to stand up and show us your tummy tuck?” she asks one woman. The group is boisterous and friendly, and cheers go up when veterans offer a travel narrative or remove an article of clothing to show the group their enhanced bodies. “I’m 63,” says one woman, and the crowd gasps in disbelief and awe. She continues:

When I was 53 I had a total facelift. Seven years later I was getting the chicken thing and it was dropping. I was not happy with my after care here...the cost of it all...I didn’t know there was something better. There’s still this attitude about Central America. It is so wrong—I want you to know it is the best, there’s no egos—not the crap that goes on here with the cost and attitudes and all that. When I met Dr. Valverde my original thing was just to have my neck done...I met him the day before surgery and I said, can I show you my boobs and can you tell me what you think? And he said, sure! So I did. And he said, you’re fine under here but you don’t have enough here...let me do an implant here. You’ll look very natural. [she removes her shirt to oohs and ahs from the group]. I have lost 15 pounds since then and everything is still in great shape. There is nothing better than to just totally relax...no stress...it’s such a wonderful feeling being there.

I have never attended a church revival meeting, but I can sense some of the women around me being “converted” to the cult of Costa Rican cosmetic surgery journeys. They may have desired surgical rejuvenation for a long time, but Didi and Costa Rica offer a less expensive, guided path to the realization of this dream. Perhaps I will meet some of these recent converts in Costa Rica in the coming months, as they are wheeled out of the operating room.

### **From rupture to rebirth**

*In sickness we confront the inchoate. Bodily suffering distorts the landscape of thought, rendering our previous constructions incoherent and incomplete.*

- Lawrence Kirmayer (1992:329)

Cosmetic surgery is increasingly normalized as an uplifting and optimistic (in the words of border-crossing patients) middle class practice of health maintenance and personal improvement. As my portrait of Didi’s patient—fresh from the operating room and bleeding, bruised, and incoherent—illustrates, however, surgical intervention itself disassembles bodies, and exacerbates the sense of disjuncture between outward appearance and the “inner” self—a misalignment that so many people describe as the primary reason they seek surgery. The hours and days immediately after an operation can be disorienting; people who have been operated on may perceive their bodies as grotesque, unpredictable and incoherent, and the promise of a new or even normal body seems more uncertain and elusive than ever. Recuperation may be particularly unsettling for cosmetic surgery patients, since their bodies are damaged by the very techniques that promise corporeal improvement. Indeed, it is the only phase of the cosmetic surgery process in which a patient is actually sick—made sick by the operation itself.

As I discussed in chapter three, moreover, flawed (i.e. all) bodies are interpellated by a dominant before and after narrative, in which the passage from abnormal to normal, ugly to beautiful, outsider to insider, is depicted as instantaneous, and the violence and discomfort of “during” have been elided (Blum 2003; Gilman 1999). Surgery’s violation of the perceived boundaries of the body, and the visual and sensory effects of its cuts and manipulations, can therefore be a shock to many patients who expect surgery to fix, rather than damage, their bodies. Retreat guests and staff describe the days after surgery as infused with panic, depression, and feelings of “what have I done?,” in the words of one facelift patient. “They don’t see ‘the between,’” said the proprietor of a recovery home, referring to her guests’ unrealistic expectations of instant and painless transformation.<sup>87</sup>

This period of “in betweenness,” I suggest, becomes fertile ground for the collective, normalizing ministrations of the recovery industry precisely because of its liminality. Patients reside in a state of social and corporeal vulnerability (Turner 1974), between (they hope) abnormal and normal, old and young, or ugly and beautiful. In the U.S., patients are usually expected to remain socially isolated during this period, so as not to horrify strangers and worry family members. By contrast, Costa Rican recovery retreats (and, to some extent, all of Costa Rica’s spaces of consumption, since the presence of recuperating North Americans is now commonplace and rarely commented

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<sup>87</sup> The activities and objects of operating rooms are, however, increasingly open to public viewing, as in the gory depictions of surgery on television “reality” shows like *The Swan* and *Extreme Makeover* (Jones 2008). People who have traveled to Costa Rica and other medical tourism destinations, meanwhile, circulate images of bruised and bandaged flesh on plastic surgery web sites, producing visual counter-narratives of post-surgical recovery. Nonetheless, among the patients I met in Costa Rica, the received narrative of miraculous transformation continued to shape individuals’ expectations of surgery, as well as their reactions to its invasive disruption of bodily processes and appearance.

on by Costa Ricans), visiting patients told me, feel more like a “support group” in paradise.

A frightful-looking support group it is, particularly considering how appearance-conscious cosmetic surgery consumers are. The first time I met a group of recuperating facelift patients at Las Cumbres, I was surrounded by bruised, swollen, and bandaged faces and limbs, appearing as if they had been “run over by a truck,” as one hotel manager put it. Newcomers are often frightened by this macabre scene, but gallows humor lightens the mood, as surgical veterans tacitly instruct newcomers in the rites of recovery sociality.

One of these practices is a kind of corporeal confession. In retreats’ common areas, new guests display and discuss detested body parts with post-surgical guests, who offer reassurance that surgery (and, particularly, surgery in Costa Rica) is indeed the proper remedy for wayward flesh. When Amy, a retired marketing executive from Florida, first arrived at Las Cumbres, for example, other guests asked her what procedures she planned to undergo. She said she initially felt offended by the intimacy of the question. She had only just met these people, after all. By that evening, however, after hearing the others’ confessions, she said, “I was flashing my breasts” to fellow guests. In the dance of the pre- and post-operative, surgery itself looms, unremembered but ever-present. Newcomers applaud veterans for their bravery and admire the visual progress of their recuperating bodies; the recently arrived are offered membership by way of objectification—separating their bodies into operable parts, and submitting these parts for review by their peers.

Patients I interviewed frequently described cosmetic surgery as a positive project of “mental health,” “transition” or “rebirth.” This project is predicated on a split between an inner self and outward appearance, and plastic surgery’s ability to realign these disconnected aspects of a person. Since rupture, rather than realignment, is the immediate outcome of surgery, recovery sociality is oriented towards helping people to realize—or embody—this expected reintegration, and to relinquish “old” bodies that do not match more youthful, or beautiful, inner selves. Hotel guests perform this rite of passage over the long hours and days that they are cooped up together in a retreat. During meals, while watching U.S. cable television, and in the midst of social gatherings in retreats’ common areas, guests scrutinize their own and each others’ bodies for signs of improvement—for the inner beauty (or normalcy) that has been waiting to come out. Aiding in this search are retreats’ nurses and staff, as well as before photographs that are circulated and examined for differences from post-surgical bodies. Some guests also spend hours each day with their laptops, posting photos and travel narratives to online discussion forums, and awaiting responses that confirm the success of their journey.

These rituals of subjective recuperation, perhaps surprisingly, involve looking *at*, rather than *away from*, guest-patients’ appearance, which among the uninitiated may invoke “the disgust, fear and horror that is summarily caught up in the response of shudder” (Radley 2002:20). Asymmetrical healing, hematomas (collection of blood near a wound site), and leaking sutures are common, and recovery sociality works to normalize the appearance of damaged, uncontained bodies, and to refigure the wounds inflicted by surgery as psychic injury brought about by the life course. “We’re wounded birds,” a facelift patient said. Concerns that a facelift might be too tight, or breast

implants too big, are met with reassurances that the changes will feel natural soon and confirmations that the person in question really does look better than she did before surgery. Guest-patients' teach each other that numbness and tingling (in places where nerves are severed) are "normal" for up to six months after surgery, and anxieties about scarring prompt reminders that the part of the body she hated is now gone. When a hotel guest who underwent a facelift several weeks earlier said, "Now I look like me again," her statement condensed days of socially mediated adjustment to the bodily changes wrought by surgery. In other words, she learned to feel that her surgically altered body was herself, despite scars, new sensations, and (for some patients) an impression that their surgeon's skills did not match their own desires and expectations.

For many guests, additionally, Costa Rica's beautiful landscapes and nurturing hospitality articulate with local surgeons' tendency to favor the "natural look" that I described in chapter three. The result is an aesthetics of the natural that resonates with discourses of self-improvement, personal growth, and "wellness," such that even people who previously rejected cosmetic surgery as an unnatural tampering with bodies find themselves converted by Costa Rica's surgical vacations. A 55-year-old yoga teacher from California, for example, told me about undergoing a facelift and breast implant surgery, followed by several weeks of recuperation and reflection at a recovery hotel. She told me that her surgical journey was consonant with her "holistic" approach to self-care, and that she had become more positively inclined towards biomedicine thanks to her Costa Rican medical vacation:

Coming to Costa Rica was like a fantasy. I'm a wellness person—haven't been in the hospital since I was a kid and don't even get vaccinations. But here it was so gentle and loving. It wasn't like going to the hospital, it was like going on an

adventure. Now I don't even feel afraid of drugs.

This sense of adventure is often shaped through a feeling of kinship among guests. Some travelers arrive with companions, but many travel alone, and retreats offer a temporary, proxy family. Guests, particularly women, find camaraderie with each other, and many people told me that this “bonding” was critical to their personal, spiritual, and corporeal recovery. A sense of being unmoored from familiar surroundings without any responsibilities, long hours spent in the company of new acquaintances, and the ministrations of hotel staff, all contribute to an effervescent hotel sociality that many guests describe as reminiscent of childhood summer camps.

I should note, however, that not all medical travelers participate in the Costa Rican recovery industry as I have described it. I spoke with recuperating patients who explicitly avoided the social intimacy offered at retreats, preferring instead to remain more anonymous at a conventional hotel or to save money by staying at a smaller recovery home or one of San José's numerous budget inns. For example, I interviewed a woman from South Carolina who was staying at a \$15/night pension on the outskirts of San José. When she first arrived in Costa Rica, she stayed at a recovery retreat. However, the social atmosphere, and what she described as the “constant talk” about the minute details of recovery, were intolerable, so she moved to a budget hotel catering to backpackers and other non-medical tourists.

This same medical journeyer, however, continued to interact with other recuperating patients via frequent postings to Plastic Surgery Journeys, the Internet forum I described in chapter three. During our conversation in the pension's living room, moreover, two additional cosmetic surgery patients (and residents of the pension) sat

down to join our conversation. At the conclusion of our discussion about sutures, bruising, antibiotics, painkillers, beauty, aging, and desires for additional procedures, I was reminded that recovery sociality is a network that extends far beyond the walls of retreats and hospitals. As I was leaving, the owner of the pension told me that she has had so many surgical patients staying at her hotel in recent years that she and her family are considering opening *un recovery* in order to care for them properly. The medicalization of tourism in Costa Rica continues to extend its reach.

For many patient-travelers, retreat sociality is such that many people feel reluctant to leave their confessional, quasi-medical embrace in order to return to what they call “the real world.” “The most stressful thing is reentry into regular life,” a facelift patient told me. Many people, in fact, return to Costa Rica in the future for additional enhancement procedures and “R & R,” as one frequent surgical tourist put it. A retreat owner told me that almost half of his guests have returned at least once, and over the course of a year I met two women who had returned for “adjustments” after only six months. For these medical consumers, recuperation from invasive surgery has become a form of leisure. Others medical visitors were enthusiastic about returning to Costa Rica as conventional tourists, and some people told me that they aspired to move there permanently.

Some retreat guests, particularly dental patients and companions of cosmetic surgery patients, are drawn into retreats’ collective celebration of what Nikolas rose calls the “optimization of one’s corporeality” (2001:17). They often schedule previously unplanned enhancement procedures, intoxicated by surgeons’ prices and informal scheduling practice. These spontaneous enhancements range from eyelid lifts to

liposuction to facial peels, and their consumption is encouraged by other guests. “It’s OK to be vain,” facelift patient said to me, and insisting that “people in the U.S. are taking better care of themselves”—presumably by way of biomedical interventions in appearance.

Integral to this sense of collusion, liberation and retreat from everyday life, among visiting patients is the fact that many hide their journeys (or the reason for them) from family, friends and healthcare providers back home. Loved ones’ anxieties about the potential dangers of surgery in a poor country, and a degree of embarrassment about undergoing cosmetic surgery, are the primary reasons for secrecy among women. Men, on the other hand, are sometimes concerned about cosmetic surgery’s reputation as a “feminine” strategy of self-improvement and whether it will threaten masculine subjectivity.<sup>88</sup> Among both men and women, anxieties about being judged for participating in a self-improvement shortcut (particularly in comparison with exercise regimens and diets) are also common, perhaps because cosmetic surgery is still popularly perceived as a form of self-care that can be purchased, but is not necessarily worked for (Heyes 2007).

As a condensed sociality of the converted (to the notion that cosmetic surgery is a legitimate form of self-care), the recovery industry works to banish feminist and other critiques of cosmetic surgery. Its pro-surgery idiom acknowledges the anxieties and discomforts of recuperation, while framing cosmetic journeys as courageous, self-motivated quests for a better life. “We’re going down fighting,” a woman in her 60s

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<sup>88</sup> This is particularly true for Costa Rican men, among whom cosmetic surgery is not popular. By contrast, surgical body modification is growing in popularity among North American men, and one recovery retreat in Costa Rica has reputedly hosted frequent visits by male police officers from a large city in the U.S.

explained, portraying her generation's embrace of self-improvement techniques and resistance to aging and death as heroic.

Despite attempts to excise cultural politics, however, retreat guests and staff continually engage in a kind of moral triage, collectively negotiating the boundaries and limits of cosmetic surgery. At what point, for example, does cosmetic surgery consumption become excessive? I frequently heard the term “junkies” applied to women who undergo numerous procedures, suggesting a dangerous and unclear boundary between self-improvement and self-destruction, and between normal and transgressive body modification.<sup>89</sup> The management of this boundary is a project engaged in by recuperating patients and recovery staff, among whom rumors about excessive surgical consumption circulate. “After 30 surgeries, are you even yourself any more?” asked one retreat guest. Another popular topic of discussion is the socially acceptable age to undergo age-defying operations; women under 50 are frequently told that they do not need facelifts, even though “preventive” facelifts are becoming increasingly popular among women in their 40s.

The shifting distinction between reconstructive and aesthetic procedures is another medium through which symbolic capital is negotiated among retreat staff and guests. Women who have previously undergone weight loss surgery, and travel to Costa Rica for body lift procedures, for example, often garner more sympathy from fellow patients and hotel staff. The procedures they undergo—tummy tucks and arm lifts, for

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<sup>89</sup> See Victoria Pitts-Taylor's *Surgery Junkies: Wellness and Pathology in Cosmetic Culture* (2007) for a thorough analysis of “body dysmorphic disorder,” or surgical addiction, and the cultural production of surgical excess and acceptability. For portraits of surgical self-fashioners whose bodies are a material hyperbole of cultural beauty norms, see Jones (2008b) and Hirschorn (1996).

example—are collectively deemed reconstructive, or medically necessary, whereas they would be considered aesthetic on a woman who had not disciplined her body through a procedure that limits her ability to eat or digest food. A retreat owner said she felt more affinity for “reconstructive” patients, particularly those who have lost a lot of weight, because they are more appreciative of her care and attention than patients who come for “vanity” surgery. Often, however, recovery workers and guests were reluctant to make this moral distinction; they suggested, rather, that all plastic surgery is, in effect, reconstructive, because it improves people’s lives. As one patient said:

I’m not trying to look younger. I want to look the way I look. The way I looked and want to look. I’m taking care of myself...it’s not cosmetic surgery, it’s restorative surgery.

The moral economy of recovery, therefore, not only works to normalize socially liminal bodies, it colludes with biomedicine’s attempt to draw a line between normal and pathological, by which medical necessity is determined. Surgeons may be peripheral to recovery, but retreats’ “support group” sociality is always inflected with the biomedical appraisal and division of bodies into categories of need.

### **Medical nostalgia**

*These people have nothing, but they’re more gracious.*

- U.S. cosmetic surgery patient

Thus far, I have discussed the specific forms of affective labor and sociality that characterize spaces of post-surgical recuperation in Costa Rica. Here, I turn specifically to the emotional work performed by nurses and surgeons, and how their success in treating visitors from the U.S. is predicated on the presumed failure of U.S. medical

services. In Costa Rica, I argue, recovery is inflected with a discourse that attributes more expertise and caring to Costa Rican clinical and recovery workers than to their counterparts in the U.S. (Of course, the specter of “pre-modern” medicine always lurks, and is sometimes invoked by patients who are unhappy with the results of surgery).

The perception that Costa Rican medical services are a more compassionate, less profiteering version of U.S. medicine, is the central narrative in what I refer to as medical nostalgia. In these stories of exclusion, loss and longing, people traveling to Costa Rica for biomedical procedures simultaneously journey to an imagined past of U.S. medicine—before insurance companies, malpractice lawsuits, and high costs became intrusive mediators of patient-clinician interactions. What do I mean by nostalgia? John Frow (1991) writes that nostalgia is a kind of estrangement, and I suggest that medical tourists are not only estranged from the “broken” medical apparatus in the U.S. and the historical development of its excesses and deficiencies, but also from the local consequences of private medical consumption in Costa Rica. Susan Stewart writes about nostalgia as follows:

A sadness without an object...hostile to history and its invisible origins, and yet longing for an impossibly pure context of lived experience at a place of origin, nostalgia wears a distinctly utopian face, a face that turns toward a future-past, a past which has only ideological reality (Stewart 1993:23).

One of the hallmarks of medical tourism’s utopian future-past is affordability. An operation’s price is the primary preoccupation of most cosmetic surgery tourists. The assumption among medical consumers that surgical body modification is both enhancing *and* necessary is linked to their sense that high medical prices in the U.S. have excluded them from full social participation. Recuperating visitors told me that U.S. doctors are greedy, and are “robbing people,” and they expressed anger that being a patient at a U.S.

healthcare facility can be financially devastating. Costa Rica's lower prices, by contrast, were often attributed to doctors' lack of greed and genuine concern for patients' welfare. This impression was reinforced by free or discounted procedures offered by surgeons in conjunction with those that are purchased.

Most cosmetic surgery patients from the U.S., however, are not aware that their surgeons are among the most prosperous doctors and businessmen in Costa Rica, and that their prices reflect low land and labor (including nurses and other clinical staff) costs, Costa Rica's legal framework (which, as I discussed in chapter one, renders malpractice insurance unnecessary for doctors), and widespread income tax evasion among elites.<sup>90</sup> Clinics and retreats also work to occlude medical tourism's unevenly distributed rewards among doctors. As I discuss in more detail in chapter five, many *Caja* doctors say that the growth in private medicine is creating huge income differences between themselves and their private sector colleagues, as well as a two-tiered professional structure, wherein private sector physicians are able to access cutting-edge equipment and knowledge, and their colleagues at public hospitals remain on the professional and economic margins.

For visiting patients, however, plastic surgeons' relaxed, friendly manner, and low prices are potent and seductive. Patients emphasize their doctors' amiability, generosity, kindness, and charm, in addition to their surgical handiwork. One woman said about her surgeon: "He loves you, he nurtures you, he takes care of you...and he is one of the most

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<sup>90</sup> One doctor told me that plastic surgeons, and other specialists in private practice, typically pay income taxes on less than ten percent of their private sector earnings, even though all of their income is taxable. As I mentioned in chapter three, many plastic surgeons offer discounts for cash payments, presumably because cash transactions are less likely to be audited by tax collectors. Palmer and Molina report: The "estimated amount of taxes evaded by political, business, and professional elites in 1996: (US) \$1.4 billion," while the total budget of the Costa Rican government in 2001 was US \$4.1 billion (2004: 362).

brilliant surgeons.” Travelers’ devotion to, and camaraderie with, individual physicians, invokes images of small town family doctors from an imagined past in the U.S. By contrast, I was told that U.S. doctors no longer possess “the personal touch.” “I have no use for American doctors,” one woman stated bluntly. A man recuperating from a facelift, meanwhile, told me that doctors are “great” in the U.S., but that hospital staff in general are more kind and attentive in Costa Rica:

...[In the U.S.], once you’re back in your room, if you still have a nurse you’re lucky. You’ll see a janitor more often than you’ll see a nurse. They come in with their mop and just spread more disease around.

Medical journeys, in other words, were conceived as a temporary (and therefore bittersweet) escape from the economic and social injustices of U.S. healthcare to the competence, kindness, and leisurely pace of Costa Rican medicine. Yet the fulfillment of this nostalgic longing, of course, is dependent on the commercialization of medicine, and many visiting patients did not seem aware that their consumption practices positioned them at the most elite level of medical care in Costa Rica. And although doctor-patient relations *are* typically more informal in Costa Rica than in the U.S., this is particularly true in the private sector. As one surgeon put it, “the way patients are treated is much more important” than in the public sector. Indeed, as conditions at public hospitals become more overcrowded and rushed, private medical services are increasingly valued and purchased (by those who can afford them) for the personal attention and time that doctors devote to their patients. Patient-centered clinical sociality is, therefore, a consumer product in Costa Rica—scarce in the public sector, readily available for a price in the private sector, and a sign of privilege and higher status among patients. Costa Ricans expect that doctors in private practice will chat informally during unhurried

consultations, and even hand out their cell phone numbers, while these practices are interpreted as signs of compassion and benevolence by North Americans.

Aware that attentiveness and solicitude enhance their symbolic capital among mobile patient-consumers, and facilitate the word of mouth recruitment of new clients, some surgeons provide services for foreign patients that are not commonly performed for locals—even elites. Especially popular with North Americans are regular house calls at recovery hotels, during which surgeons perform post-operative examinations and socialize with their patients. I even met a surgeon who occasionally gives his foreign patients tickets to the National Theater. Costa Rican medical hospitality is thereby doubly effective: for surgeons, it is a powerful marketing strategy, since their clients tell friends and acquaintances about Costa Rican kindness once they are home; patients, meanwhile, bask in, and are rejuvenated by, the expert attention they are not used to receiving at home.

While North American medical consumers in Costa Rica often imagine themselves to be refugees from a system in decline, local private sector doctors and nurses also narrate a story of escape. In interviews, they frequently told me about leaving behind the material deprivations and social indignities of public medicine. One nurse told me that the public hospital where she used to work was chronically overcrowded, and that she was responsible for 60 patients at a time—a routine that she found “mechanical and dehumanizing.” Of course, private employment does not offer nurses the considerable financial rewards that it does to surgeons. Nurses told me that recovery retreat wages are generally equivalent to those at the *Caja* (although benefits and job security are greatly diminished in the private sector), whereas CIMA Hospital’s wages

are lower. However, some nurses insisted that gratuities, “happy patients,” and escape from stressful conditions at public hospitals compensate for the uncertainties of flexible labor.

Recovery retreat nursing, particularly when compared with descriptions of nurses’ duties at *Caja* hospitals, is not very demanding. Nurses typically care for fewer than ten patients at a time, and relatively few medical procedures are required. Rather, nurses spend most of their time managing their feelings, and those of their patients, in order to bring about an “emotional cure,” as one nurse put it. Nursing, moreover, is gendered as feminine in Costa Rica (I did not meet any male nurses); their quiet, deferential presence, and white-uniformed dress, perform a model of nursing that is now perceived as outdated in the U.S., and it weaves another seductive strand into the fabric of patients’ nostalgic longing.

The affective care of patients is, however, an aspect of nursing that most private sector nurses learn during their training at state schools and hospitals, and is associated with Costa Ricans’ national identity *and* with an ethos of medicine as public service. “Costa Ricans have always been recognized for their kindness...in hospitals, we learn that patients have to be given emotional support,” a nurse explained. Most nurses I spoke with had trained and worked in the public sector for years, and had found satisfaction in working with Costa Ricans from all walks of life. Some even expressed a nostalgic yearning of their own, particularly nurses who had worked at the National Children’s Hospital. “The progress, the future of the country is there,” a nurse told me.

Without exception, however, they felt that their duty to the nation was thwarted by overwork, the CCSS’s bureaucratic culture, and the lure of easier work at private

clinics and hospitals.<sup>91</sup> In fact, several nurses told me that that they were able to be more “Costa Rican” caregivers in the private sector, where they attend to, and become acquainted with, patients in ways that they were unable to in public facilities. “At the *Caja*, you give an injection, or put in an IV, and then leave,” said one nurse, whereas at the recovery retreat she has time to show her patients the kindness and care that are assumed to be intrinsic to Costa Ricans.

In addition to their relocation to the private sector, Costa Rican hospitality and high-tech medicine are increasingly associated with the care of “healthy” patients, whereas sickness and poverty are relegated to state services. One nurse explained her preference for working with foreign cosmetic surgery patients this way:

I much prefer working here to my previous job at a public hospital. That place was unclean, crowded and full of bacteria, and it was just too sad how sick and uncared for the patients were. Here the patients are healthy, and their surgeries make them so happy.

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<sup>91</sup> In addition to the medical tourism sites I discuss in this chapter, private sector employment is available to Costa Rican nurses at retirement homes, on international cruise ships, and at clinics for U.S. veterans in both Costa Rica and Panama. Many Costa Rican nurses have also sought work in U.S. hospitals (Baxter-Neal 2006).



Figure 16. “Health Costa Rica!” *La Nación* advertisement for new private medical clinic in San José. April 23, 2006.

For many Costa Ricans, the growing number of undocumented Nicaraguan migrants who received care at public hospitals is particularly indicative of a shift in medical citizenship to the private sector. As I discussed in chapter one, North American visitors and migrants are popularly associated with economic development and prosperity, whereas Nicaraguans are blamed for criminality, misuse of public services and national decline. Even doctors who disavow the rampant xenophobia aimed at Nicaraguans insist that non-paying Nicaraguan immigrants are breaking the back of public hospitals. I was told by nurses, doctors, and hospital administrators that “they” have too many babies, are bringing previously eradicated diseases like dengue fever and cholera into the country, and run international contraband operations with the cheap drugs obtained at national hospitals.

Nicaraguans’ medical participation, or visibility—they are deemed too visible in the public sector, and are all-but socially invisible as laborers in the private sector—is, in

a sense, a mirror image of the project of cosmetic surgery tourism, which offers North Americans privileged membership in a transnationalizing Costa Rica. State decline, the politics of citizenship, and unequal access to the fruits of privatization, are all, therefore, bound up in Costa Rica's commodification of *el calor humano* (human kindness) and production of a privatized medical utopia for elite consumers. Medical tourism's corporeal and economic desires and mobilities, in other words, are inextricable from its production of excess and exclusion. Additionally, while the Costa Rican state promotes medical tourism as a strategy of economic development, intensified private medical consumption has thus far not led to a more equitable distribution of services among residents of Costa Rica. Instead, the private sector relies on state subsidies—not just the explicit subsidies of tax breaks and other economic policies that promote investment, but on-the-ground practices that tie private interests to public services. In the following chapter, I turn to plastic surgery's participation in this public-private entanglement, and the bodies and subjects that are produced along the way.

## CHAPTER FIVE

### THE INTERPLAY OF PUBLIC AND PRIVATE PLASTIC SURGERY PRACTICES AND IDENTITIES

*The student became a Physician and returned to his homeland with youthful fire and optimism. And what did he find?...His people, living in a rich and fertile land, were dying of pain and suffering. How many nights did that hopeful man have to hang his head and feel in his heart a good measure of responsibility for the agony and vulnerability of the dispossessed?*

*The social project is the great edifice that must be built by the Costa Rican nation to secure its future progress and culture.*

- Dr. Rafael Ángel Calderón-Guardia, President of Costa Rica and founder of the state-sponsored medical system (2004 [1941])

*Younger doctors don't have the knowledge gained from experience working in the hospital [no tienen vivencia del hospital] and they aren't as dedicated to social service. Globalization has made them think only of money.*

- Chief of plastic surgery at a national hospital in San José, 2006

*I want to serve my people and I want to live up to my training and be challenged. I didn't do such a long training to just do implants and face lifts, but I can earn more with two Botox injections [in private practice] than I can here [public hospital] in a month. The Caja [state-sponsored medicine] is the best place to be a mediocre doctor – people don't care about research or improving the quality of services, but I want to be somebody in a larger, more international arena. La Caja is the biggest asset [riqueza] of the country, it's what makes us different from everyone else, but I will never put my life into it.*

- Plastic surgeon who divides his time between public and private practice, 2006

What is medical tourism's connection with, and impact on, state-sponsored medical and public health programs in developing countries such as Costa Rica? Scholars who analyze global cross-border medical consumption tend to take sides while answering this question. Champions of neoliberalism promise that the expansion of private medical services for local and visiting elites will result in greater tax revenues and the redistribution of these revenues to the public sector, bolstering social services (Bookman and Bookman 2007). Others sound the alarm that private sector development may come at the expense of public sector services, since the growth in private medicine may prompt an "internal brain drain" and reinforce "a two-tiered health system, with different standards for different economic classes" (Ramírez de Arellano 2007:196).

In this chapter, I align myself provisionally with the latter analysis. However, my intent is not simply to demonstrate that medical tourism is contributing to the dismantling of social security and the resurrection of a pre-social security model in which medical services were divided into charity for the poor and private practice for the affluent. On the one hand, I discuss how many plastic surgeons continue to learn their craft in public hospitals, only to leave state employment for the greener pastures of the private sector. I connect this trend to deepening disparities in access to medical services among residents of Costa Rica and a gradual disinvestment in state-sponsored social services. However, I also suggest that both critics and proponents of medical tourism tend to treat the state and commerce, and the public and private sectors, as distinct, separate, non-overlapping regimes within which medical practices are understood and distributed. I argue, rather, that on-the-ground practices reveal more complex, contingent, shifting accommodations between state-sponsored and private medicine. In Costa Rica, articulations between these

two domains shape clinical activities, professional identities, conceptions of the public good, and popular desires for invasive body modification. Specific points of juncture and disjuncture between the state and private sector, I argue, have profound material effects on bodies, livelihoods, and medical practice.

I begin with an ethnographic portrait of a typical morning in a public plastic surgery clinic. My goal is to narrate the ways in which some CCSS plastic surgeons are animated by both resentment towards their employer *and* a sense national obligation, and how the operability of low-income patients' bodies can be both contingent on and beneficial to the market for private medical services. I then discuss contested understandings of surgical expertise, craft, and prestige, primarily among surgeons who divide their time between the public and private sectors. Finally, I consider the *Caja's* subsidy of—and competition with—the private sector, primarily in the form of cosmetic surgery procedures that are performed in public hospitals. I suggest that medical tourism is imbricated with the transformation (not necessarily the demise) of public medicine in Costa Rica, and I consider how this process plays out in an embodied politics of inclusion and exclusion.

### **Obligation, solidarity, equality, universality, unity and equity**

- The CCSS's philosophical principles  
(Caja Costarricense de Seguro Social 2008b)

Hospital San Juan de Dios (Saint John of God), Costa Rica's oldest and largest hospital, opened in 1845 as a missionary hospital.<sup>92</sup> For the next decade, the building “went virtually unused, and came to function as a giant but sparsely populated municipal jail and madhouse as well as a refuge for a smattering of destitute individuals” (Palmer 2003:105). In the 1860s, it was reopened as a public hospital, staffed by doctors whose “charitable work raised their stature, and thus in the long run, their earnings in private practice” (ibid). Since the founding of the national social security program in 1941, the discourse and practice of public medicine as charity has been replaced by a program of national development via universal, state-sponsored health care, as I discussed in chapter one.

When I visited in 2006, San Juan de Dios was an aging, nearly 700-bed monolith situated in what was once the commercial heart of San José, not far from a neighborhood of large, decaying, colonial-era homes. In recent decades, affluent residents have abandoned San José en masse, moving to suburban spaces that I described in previous chapters. Before my visit, I was warned by Costa Rican acquaintances to be careful in the neighborhood facing the entrance—an infamous warren of bus terminals, small shops, bars and brothels commonly referred to as *Coca Cola*, in recollection of a bottling plant that used to operate nearby. On the other side of the hospital, Nicaraguan immigrants gathered to socialize in La Merced Park, popularly—and somewhat disparagingly—referred to as “Nica Park” among Costa Ricans. The hospital was besieged by the constant roar and thick fumes emitted by cars, trucks, and local and long-distance buses. In 2005, in fact,

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<sup>92</sup> There are seven national hospitals in Costa Rica, all of them located in San Jose. Four of these hospitals have plastic surgery clinics: San Juan de Dios, Calderón Guardia, México, and the National Children's Hospital. The ethnographic material I present in this chapter draws on interviews and observations at all four hospitals.

researchers at the University of Costa Rica gave the street in front of San Juan the unfortunate distinction of having the most noxious air in all of Costa Rica. The hospital and the spaces that encircle it were thereby a materialization of the neglect, marginalization *and* inclusion characteristic of Costa Rica's public domain.

Behind the hospital's aging façade, old and new buildings were linked together in a maze that was difficult for a newcomer to navigate. The hospital's structures, and the materials and bodies they house, seemed to poignantly embody Costa Rica's history of 19<sup>th</sup> century charity medicine, ambitious 20<sup>th</sup> century expansion of social welfare programs, late 20<sup>th</sup> century economic crisis and its neoliberal aftermath, and the ongoing, beleaguered persistence of an ambitious state medical program. A cavernous 19<sup>th</sup> century Catholic chapel, for example, was linked by a maze of hallways to a recently completed medical tower. The hospital's nearly 700 beds were distributed among large, open wards and private rooms available to patients able to pay an extra fee. Patients were wheeled across worn, decorative ceramic tiles from the early 20<sup>th</sup> century, on gurneys and wheelchairs that have not been replaced for decades, on their way to well-equipped operating rooms or a new MRI suite. The push to keep up with the exigencies of technology-intensive medicine is strong in the *Caja*, but demand always outpaces supply, and the hospital's infrastructure seemed to be crumbling around its new and heavily used machines (Clark 2005).

As I discussed in chapter one, the early 21<sup>st</sup> century has been an era of shortfalls and austerity for the CCSS. It is still, however, the largest provider of medical care in Costa Rica, with almost 90% of Costa Rica's legal residents enrolled. Most Costa Ricans I met expressed pride in the *Caja*, often comparing it favorably to what they perceived as

an unjust medical system in the U.S. They blamed the *Caja*'s long waiting lists and other troubles on a variety of individuals, groups and institutions, including Nicaraguan immigrants, AIDS patients, government corruption, nepotism, and individual political parties. Still, they said, they believed in the institution.

A woman who had a thyroid tumor removed at a national hospital, for example, told me that her path to surgery was not an easy one. She had had to pay for a diagnostic ultrasound with a private physician, and was then placed higher on the surgical waiting list by a cousin who worked at the hospital—reducing her waiting time by months. Once she passed these obstacles (which she seemed to accept as an inevitable aspect of public medicine), she received excellent care, and her eyes filled with tears as she told me how important the *Caja* is to Costa Ricans. Her fervor, however, is not shared by everyone. “Remember,” a plastic surgeon in private practice told me, somewhat cynically, “The *Caja* is a big symbol. It keeps the population at peace, but they don’t realize that the government isn’t doing a good job.”

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When I arrive at San Juan de Dios shortly after 7:30 a.m. on a sunny morning, the hospital’s workday is already in full swing. The small entryway and sidewalk outside is crowded with employees, patients, security guards, and vendors selling newspapers, lottery tickets and plastic toys. Patients and visitors are asked to show written evidence of the reason for their visit, possibly in the hope of curtailing theft, which is rampant in public hospitals. I later learn that the interior of San Juan’s new medical building is

particularly austere because patients, family members, and people posing as patients had taken furniture, linen, clothes and medical equipment shortly after it opened.

Inside the stark building, I am caught up in a tide of moving people. Medical staff and patients hurry through high-ceilinged halls, and waiting rooms are nearly full. A three or four hour wait for a consultation lasting just a few minutes is common in CCSS hospitals, while waiting lists for diagnostic tests, surgical procedures, and appointments with specialists are often as long as six months to a year or more. Patients on gurneys line the hallways in the overcrowded emergency department downstairs, and upstairs in the outpatient area many people have arrived as early as 5 a.m. to secure a place on their doctor's roster (the order in which patients are seen is determined on a first come, first served basis).

Patients do not choose their doctors at the *Caja*, and most of the country's specialists practice at national hospitals in San José. For Costa Ricans who live outside the central valley, a consultation with a specialist usually entails a long journey. These internal medical migrations can take up to a full day, and frequently involve poor road conditions, crowded buses, heavy traffic, and torrential rain. Not only do these journeys challenge North American tourists' assumption that Costa Rica is a "small" country, they are often more arduous (bodily and financially) than the medical travels undertaken by North American medical tourists.

The shared waiting area for plastic surgery and ophthalmology is a drab, windowless room with plastic chairs. I am struck by the unadorned walls, peeling paint and absence of literature—popular *or* medical. The waiting rooms in private plastic surgery clinics in Costa Rica—like those in the U.S.—are usually crowded with the

accoutrements of surgical seduction, including framed paintings, sculptures, beauty magazines, brochures for *Botox* and other cosmetic procedures, flowers, piped-in music and comfortable furniture. The *Caja*'s spaces, on the other hand, are utilitarian—they bear patients, rather than enticing or mollifying them.

Through a door marked “cirugía plástica,” the busiest plastic surgery department in Costa Rica is housed in three small, adjoining exam rooms, with a tiny nurse’s office in between. The country’s only adult “burn unit,” where patients with severe burns are treated, is upstairs. The department is positioned on the ground floor of the hospital, next to Paseo Colón, the busiest street in San José, and a set of louvered, opaque glass windows offers a flimsy boundary between clinical space and the deafening traffic outside. During my observations at this clinic over the next few months, doctors continually opened and closed these windows—seeking an ever-elusive balance between the stuffy air inside, the noise and fumes outside, and a desire to provide some privacy for patients. Quiet, privacy, and clean air, I quickly learn, are commodities that fetch a high price in urban Costa Rica and are more readily available in the private sector than at public hospitals.

In the nurse’s office, two surgeons and a resident are chatting about a promotional article in the daily tabloid newspaper, *El Día*, for a local doctor who performs liposuction. The title of the article is “Boom in Aesthetic Surgery,” and it tells the story of a local schoolteacher who had seven liters of fat surgically removed from her legs and abdomen. The surgeons are disturbed that so many general practitioners are taking professional advantage of the growing popularity of cosmetic surgery among Costa Ricans. Only a board-certified plastic surgeon should perform enhancement procedures,

they say, not to mention that the featured doctor is risking patients' lives by recklessly using liposuction as a substitute for more gradual weight loss strategies. Also, they complain, this type of promotion damages plastic surgery's status as a legitimate medical speciality, since marketing medical services is unethical and illegal (of course, several board certified plastic surgeons also advertise their services in magazines and newspapers).

As I have discussed, some plastic surgeons in Costa Rica (particularly older surgeons and those who are committed to a career at the *Caja*) make a morally inflected distinction between medicine and commerce. They are not suggesting that clinical medicine should be practiced exclusively in the public sector, but that the private sector is more prone to opportunism and the victimization of patients. Costa Ricans should not be left to the "untender mercy" of private doctors, "who charge whatever they want," a plastic surgeon explained to me (himself in private practice at a large hospital). For some doctors, the line seems is drawn between hospital-based medicine and independent doctors in private practice who are presumably more interested in money. A *Caja* surgeon said to me, for example, that there may be money in *la calle* [the street], but "one feels more like a doctor here." The *Caja*, therefore, remains the professional, clinical, and ideological home for many plastic surgeons, even as younger doctors embrace the commercialization of medicine.

In the exam room, an enormous stack of dog-eared patient charts sits precariously on the one exam table. I wonder if there will be room for patients to sit or lie down; paperwork is so ubiquitous and voluminous in CCSS hospitals that at times it seems to overshadow the bodies it records, measures, and maps. The surgeon I will be observing

today, Sánchez, explains that the charts are for the patients he will be seeing this morning, and that he has no idea how many he will see or which conditions he will be faced with. This lack of control over clinical activities is frustrating to many surgeons, who invoke a logic linking financial reward with good doctoring when they implicitly compare their activities at the *Caja* with the “freedom” of their private sector colleagues: “They pay us the same whether we see one hundred [patients] or ten. So there is no incentive.”

Doctors’ feelings of demoralization in the face of the *Caja*’s relentless bureaucratic control over their daily activities is condensed in what they call the “arrive late, leave early” imperative, and in the rushed atmosphere of clinical encounters, which are friendly but rarely last longer than five minutes (in contrast with private sector consultations, which are typically unhurried). When I requested interviews with physicians, in fact, they often suggested that I arrive during the morning “coffee break,” a vaguely defined period before the start of patient consultations. Almost without exception, the physicians seemed perfectly relaxed and unhurried during our encounters, and were sometimes glad to have an unexpected distraction. On the other hand, I was uncomfortably aware that dozens of patients sitting outside would have a longer wait that day because of my conversation with their doctor. Several patients told me privately that they felt disrespected when they heard medical staff laughing and joking during a prolonged break, while for physicians such pauses seemed to be a form of resistance to perceived indignities inflicted by the CCSS, including low pay, promotions based on seniority rather than merit, and the privileging of the status quo over new medical techniques.

Most part-time doctors fulfill their CCSS duties in the morning, and in a sense, “private” afternoons haunt “public” mornings at the *Caja*. Doctors imagine the freedoms that await them in private practice, and they perform small gestures of resentment towards the paternalism and privations of the *Caja* each time they usher a patient out the door too quickly. Patients are aware of this tension as well, and they sometimes try to offer money to *Caja* doctors in exchange for better services. As I discuss in more detail below, an economy of favors and illicit payments pervades the *Caja*, and effectively privatizes public services.



Figure 17. Nurse in the outpatient operating room at a public hospital’s plastic surgery department. Photograph by Sara Ackerman, 2006.

I chat with Dr. Sánchez for 20 minutes, and then several medical students arrive to observe today’s consultations. We stand awkwardly, filling the small room, and the doctor begins to call patients in. His manner is simultaneously informal and paternalistic; most of the patients are women, and he greets those he knows with a kiss on the cheek and diminutives such as “my love;” he then moves quickly through each consultation

with little explanation of his behavior and brief, even brusque, responses to patients' questions.<sup>93</sup>

Patients arrive and depart as if through a revolving door, each one assigned to call the name of the next person in line. Dr. Sánchez diagnoses almost half of today's patients with carpal tunnel syndrome, as a result of repetitious domestic or other manual labor. All of these patients are women, and most work as domestic laborers for wages and in their own homes. The doctor jokes with one patient about making *tamales*, a nostalgic reference to rural life and to the hard labor engaged in by the poor, and a tacit acknowledgment of the embodiment of class and gender. He prescribes surgery for most of these patients, and no one asks him about alternative therapeutics.<sup>94</sup> Later, he explains to me that plastic surgeons don't usually work with carpal tunnel patients, but that the *Caja* doesn't have enough orthopedic surgeons, so plastic surgery departments have had to expand the range of procedures they perform and teach—even though they are chronically under-staffed as well.

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<sup>93</sup> Until 1973, when all public hospitals were transferred to CCSS administration, Calderón Guardia and México were administered by the Ministry of Health and San Juan de Dios by the CCSS. Ministry of Health hospitals developed from earlier Catholic charity services, whereas CCSS hospitals arose from the populist ideology and policies of the 1940s Calderón administration. According to Setha Low (1982), these distinct histories led to strikingly different physician-patient interactions in the two types of hospitals, with social security hospitals being characterized by a more informal, patient-driven interaction, and Ministry of Health hospitals by an extension of coffee plantations' authoritarian *patron-peon* relations. Public hospitals had been unified under the CCSS umbrella for over 30 years when I started fieldwork in Costa Rica, so differences in the clinical practices, pedagogy and hierarchical structure of CCSS plastic surgery clinics cannot be easily (or solely) attributed to this institutional legacy.

<sup>94</sup> In chapter one I discussed the embrace of the surgical among Costa Rican doctors and patients. For patients, surgery is a medium of participation in the state's modernizing project. For surgeons, operating enhances professional and institutional status, and is the craft around which their professional subjectivity is formed (particularly given the dearth of research opportunities for Costa Rican clinicians).

In addition to painful wrists, CCSS plastic surgeons attempt to mend bodies that have been burned or electrocuted in house or industrial fires, crushed in traffic accidents, and marked by illness. In recent years, a surgeon told me, breast reconstruction has become standard practice for women who have had mastectomies—whereas the procedure was rarely performed only ten years ago. In the children’s hospital, plastic surgeons insert weights into the eyelids of children with palsy (a condition that makes it difficult to open and close one’s eyelids), construct ears for children born with only one, and offer breast implants for teenage girls thought to suffer from self-image or “quality of life” problems, among other procedures.

Although plastic surgery clinics are chronically short-staffed, and waiting lists for procedures stretch into the next calendar year, the drive to keep up with medical advancements contributes to the expansion of plastic surgery’s repertoire of normalizing techniques. Plastic surgery’s goal is to make bodies work not just physically but socially, and this is where function meets aesthetics. Indeed, surgical “solutions” arise alongside—and are co-constitutive of—perceived abnormalities of appearance, rather than being devised as a response to them. This may help to explain the widening range of interventions by plastic surgeons in CCSS hospitals, and their designation as reconstructive rather than aesthetic (although the latter may also be related to CCSS accounting regimes).

The stream of patients through the exam room seems without end. People ask Dr. Sánchez if parts of their bodies can be visibly improved via surgical intervention: an overweight adolescent boy with breasts whose mother wants him to have a gynecomastia (male breast reduction) procedure; a man with a torn ear; a girl with burn scars; women

with breasts that are “too large” or “too small.” The physician’s evaluation of whether an operation is really needed must take into account the length of the waiting list for surgery, which is contingent on the availability of operating room time, which is inextricable from the presence or absence of anesthesiologists. This last problem has become particularly acute since 12 anesthesiologists resigned, en masse, from a national hospital over disputes about work conditions and salaries. These doctors easily found work in the private sector; San Juan de Dios, meanwhile, was only able to keep a third of its operating rooms open in 2006, and rumors circulated about anesthesiologists running between operating rooms in order to attend to multiple, simultaneous surgeries.

Dr. Sánchez’s diagnoses tacitly refer to the availability and popularity of private medical services. Some patients are deemed operable. Others may be told that their problem is “aesthetic,” and therefore better suited to the private sector. (It is at this point that some physicians recruit patients to their private practice, although CCSS policy prohibits this practice). Other patients are encouraged to lose weight and return for another consultation in six months. Later, Dr. Sánchez tells me that 60% of Costa Ricans are overweight, and that many of his patients are convinced they need plastic surgery when what they really need is to lose weight. The disciplining of excessive bodies is far less stringent in the private sector, where surgeons (often the same physicians as those who prescribe weight loss as a prerequisite for plastic surgery at the *Caja*) frequently perform operations on patients who have not achieved the recommended weight loss.

Few *Caja* patients have the financial means to pay for private operations, however, and during a moment between patients, Dr. Sánchez tells me about his frustrations with long waiting lists and staff shortages:

The truth is that to be here every day explaining to a patient why I can't operate on her or him...and [the patient is] crying...and I can't do anything...it's overwhelming.

Not only is it stressful and exhausting to be a *Caja* surgeon, he tells me, but his salary is terrible. Still, he says, this is “work from the heart,” and the (non-financial) rewards are much greater than those in the private sector. We help *la gente humilde* [the humble, or poor, people], he tells me, suggesting that serving average Costa Rican people is more satisfying than performing cosmetic procedures for visiting North Americans or affluent locals.<sup>95</sup>

On a similar morning at another hospital, a patient is called into the exam room and says something that I have not yet heard in a CCSS plastic surgery clinic: her nose is too large. Without much discussion, the surgeon schedules her for a rhinoplasty (nose job) in six weeks. She then asks about the possibility of a Botox injection, but the surgeon's answer is an unequivocal “no.” After she leaves, I mention that I am confused; he had explained to me earlier that aesthetic surgery is not performed in *Caja* hospitals, and that surgery waiting lists only have places for cancer and trauma patients. That's true, he says, but the surgery does not take long and she was sent by the chief of medicine (one step above him on the hospital hierarchy). The only way to survive in the *Caja* is to make deposits in “the bank of favors,” he explains. He needs new equipment in an operating room, and knows that if he performs this favor, he is more likely to get approval for its purchase. “That's how the country works,” he says. It's not a *biombo*, he assures me—he

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<sup>95</sup> *La gente humilde* is a term frequently used by doctors to describe typical CCSS patients. It evokes the economic and social marginalization of low-income, rural Costa Ricans, as well as nostalgia among urban cosmopolitans for a pastoral way of life popularly understood as the core of Costa Rican national identity.

would never engage in such an unethical practice.<sup>96</sup> Moreover, assisting with the procedure will be good practice for his surgical resident, who will no doubt be performing many nose jobs when he goes into private practice in the future. Cosmetic surgery is thereby positioned as a form of institutional currency, as well as a strategy to enhance surgeons' ability to compete in the private sector.

Back at San Juan, a hospital employee enters the room and puts a new stack of patient charts on the exam table. Dr. Sánchez frowns at it, like Sisyphus watching his rock roll down the hill. Then his cell phone rings, and while he is talking he gestures for the next patient to be called in. He seems anxious to go, but he continues his parsimonious and informal interactions with patients until the last one departs, shutting the exam room door behind her. At 10:30 a.m., after two hours and nearly 20 patients, the surgeon tells me that his consultations are over for the day. He will now go upstairs to check in on several patients with severe burns, and in the afternoon he will drive to a more upscale part of town to meet with cosmetic surgery patients at his private practice. His day has just begun; he is tired, but he has served the nation.

### **The politics of craft and expertise**

My story of a morning in a CCSS hospital suggests various points at which public practice is infused with the desires, currencies, and exclusions of private medicine. These tensions may be more acute for plastic surgeons than other clinicians, since plastic surgery is a relatively new specialty that has already become the most profitable arm of the expanding private medical sector. It has also become one of the most desired careers

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<sup>96</sup> As I explained in chapter one, a *biombo* is an illegal monetary arrangement between CCSS clinicians and patients.

among medical students. In the public sector, plastic surgeons are a locus of envy, admiration and resentment among CCSS doctors, in part because they have become less dependent on the CCSS for employment than general practitioners and other specialists. Their independence comes at a time when physicians face greater competition for CCSS jobs and traineeships, while unregulated private medical schools produce more medical graduates every year.<sup>97</sup> In 2006, the CCSS employed 14 plastic surgeons, most of them part-time, while there were over 40 plastic surgeons in private practice.

National hospitals, however, need plastic surgeons, in part because of the expanding range of abnormalities and treatments for them that I mentioned earlier. Also, the incidence of disfiguring injuries from traffic accidents has increased as Costa Rica “develops” and poorly maintained roads are increasingly clogged with vehicles and pedestrians. According to statistics from Costa Rica’s Roadway Safety Council, there were nearly 33,000 traffic accidents in San José in 2005, and the number of serious injuries as a result of traffic accidents increased by 135 percent between 1996 and 2005 (COSEVI 2009). The treatment team for such injuries often includes a plastic surgeon.

All specialist training continues to be located exclusively in CCSS hospitals, and most plastic surgeons—even those who complete residencies abroad—start their careers in national hospitals. However, medical students and residents explained to me, the life of a Costa Rican doctor no longer follows the predictable trajectory it once did. Somewhat nostalgically, as if uncertain about the shape of his own future professional life, one

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<sup>97</sup> According to the Pan American Health Organization, the proportion of the country’s physicians who were employed by the CCSS fell from 85% in 1990 to 51.9% in 1999. Meanwhile, the proportion of medical workers in the private health sector in has grown from 9.9% in 1990 to 24% in 1999, while unemployment among health care workers tripled during the same period (PAHO 2008).

young surgeon visualized the “ideal career” of a plastic surgeon as a pyramid. He explained that the bottom of the pyramid represented the start of a doctor’s career at the *Caja*, while the apex consisted of a successful private practice performing relatively simple cosmetic procedures. Service to the nation and the complex work of reconstructive operations, he suggested, gradually gave way to financial reward, autonomy from the *Caja*, and a more leisurely schedule. What does it mean to Costa Rican medicine that more doctors are cutting short their national duty and moving directly to the top of the pyramid, he seemed to be asking.

CCSS employment had once been all but guaranteed for recent medical graduates, but even the CCSS’s rite of passage for recent medical graduates has shifted from the “year of obligatory social service” to a raffle whose coveted places are always fewer than the number of applicants. A young general surgery resident (and aspiring plastic surgeon) lamented this change and told me how his year of service in a small, rural town had contributed to the formation of his professional *and* national identity:

[In the past] everyone had to go on the year of service because it was part of our training. But now, unfortunately, there are many medical schools and there aren’t a lot of spaces for everyone...the year I went there were 550 applicants and only 110 places. The internship is service in a rural area. I went to Cañas [a small town in the north]. There is no technology...but it’s a lovely year. I learned a lot. The people live very differently in the countryside. People don’t get sick a lot. There isn’t much stress...people get around by bike, by horse...[but] where I was I couldn’t do what I wanted to in order to get a residency...I couldn’t take classes, practice languages, or publish...so for that reason I came back. But in reality one could stay there for many years. It’s lovely.

Young doctors are conflicted; they are “formed” [*formado*] through their *Caja* training to feel an obligation to serve the nation by tending to citizens’ bodies, even if this means practicing medicine in a remote province. On the other hand, career advancement

and new medical technologies are located in the capital, and competition for positions is fierce. New doctors unable to find employment at the *Caja* feel shut out of their obligation to serve, while those brought into the fold are frustrated with deteriorating conditions, an unwieldy bureaucracy, and a medical culture that is hostile to innovation. “Most *Caja* doctors prefer to stay with what they know,” a young surgeon told me.

Plastic surgeons, particularly, are increasingly able to locate career advancement and prestige in the private sector, where soaring incomes—particularly among doctors who work with North American patients—present opportunities to join international professional associations and attend conferences and training sessions abroad. As I mentioned earlier, most plastic surgeons start their careers at national hospitals, but more of them resign from CCSS employment earlier than their predecessors did. This exodus leaves public plastic surgery clinics chronically short-staffed, since the CCSS cannot afford to train additional surgeons to take their place. One surgical resident was already planning his defection:

I like the institution. And I want to share, like many doctors, half time on one side and half here. But I don't know... things are getting bad and they're always demanding more of you and giving you fewer things to work with. And the time will come when everyone is going to emigrate from the *Caja*.

Several young surgeons I spoke with expressed a desire to reframe this dilemma by performing “pro bono” reconstructive procedures or volunteering one day a week at the *Caja*. They wanted symbolic credit for public service as well as the material benefits of private practice. However, the model of medical practice in which they felt this was possible detaches doctors' duty to the people and the nation from a contractual agreement with the state. It is a model of private consumption for some, and charity for the rest—

recalling Costa Rica's 19th century medical regime, and hardly reflecting the egalitarian dream of the *Caja*'s founding principles.

When I asked the chiefs at several public plastic surgery clinics why the *Caja* did not open additional residency positions in order to supply public hospitals with the number of plastic surgeons that it wanted, they responded that such a strategy was undesirable because it would “flood the market.” They meant, of course, the market for private sector cosmetic surgery, which nearly all CCSS plastic surgeons have a stake in—along with anesthesiologists, nurses, and internal medicine physicians (who are often hired by plastic surgeons to perform pre-operative tests). In other words, the provision of services for *Caja* patients is always balanced with doctors' interests in promoting their private practices.

As I have discussed, the market is not the only factor in national hospitals' shortage of plastic surgeons; the CCSS also lacks sufficient funds to train additional surgeons, and is beset by shortages of equipment and anesthesiologists—forcing surgeons to cancel operations even if they are on staff and available. Nevertheless, these absences and deficiencies collude to help the “needs” of private practice prevail in the struggle within the *Caja* between the market and the state—overcrowded public clinics thereby providing a shadow subsidy of highly profitable private practices.

There were, certainly, other CCSS stakeholders besides those reaping the benefits of a profitable private practice, and their interests were not served by training specialists only to lose them to private practice. Thus, in 2006, the state institution that administers graduate medical education began requiring all new medical residents to sign a contract committing them to a specific length of CCSS employment after completing their

training—nine years for plastic surgeons, one resident told me. Responses to the contract vary, but among aspiring plastic surgeons it has produced resentment, defiance (some are determined to buy their way out of the contract), and further disillusionment about the *Caja* as a site of national service and professional identity, particularly since their commitment would be imposed rather than chosen. For some, in other words, service was beginning to feel more like indentured servitude. And choice, after all, is Costa Rica's neoliberal mantra.

To discuss these shifting allegiances, and how they shape understandings of surgical craft and expertise, I now turn to the story of a young doctor who was pursuing a joint career in the public and private sectors, and was—like many of his peers—troubled by an ambivalent pull between his obligations to the nation and his aspirations to “international” expertise, and financial success, via work with private (foreign and local) patients.

### ***The “harmonic scalpel”***

I have become accustomed to observing Dr. Torres in non-stop motion in the crowded, austere public plastic surgery department where he works three days a week, so it is strange to see him calmly sitting in a large, elegantly decorated office in one of San José's older, affluent neighborhoods. He and his patients have given me permission to observe a consultation, and when I enter his office, I notice that street sounds do not penetrate the carpeted space and that the waiting room outside is nearly empty—in striking contrast with the more permeable boundary between public hospitals and their noisy environs. While the trappings of medical prestige are all but absent in public clinics, here they are abundantly displayed in Dr. Torres's framed diplomas, the

expensive furnishings that decorate his clinic, and the clean white coat he wears (most plastic surgeons wear street clothes or scrubs in public hospitals, where they are fully immersed in their craft and do not need to advertise their expertise). Colorful, abstract paintings hang on the wall, subtly reminding patients that he is a technician *and* an artist.

On the glass and chrome desk sit two thin, crisp files, a laptop computer, and a sample breast implant that I initially mistake for an abstract sculpture. Dr. Torres offers me a chair adjacent to his desk and introduces me to his patient and her friend, who sit in comfortable chairs across the desk from him. I will call them Marta and Laura. They are expensively dressed women in their 50s—although I cannot be certain of their age, since wealthy Costa Ricans tend to look younger than everyone else, not to mention that guessing the age of people who have had cosmetic surgery can be particularly challenging. They appear to be enjoying their visit with Dr. Torres, and they discuss cosmetic surgery procedures as if trying to choose a new hairstyle.

Marta underwent breast implant surgery with Dr. Torres three months ago, and she has come today to schedule a facelift. She also asks about the possibility of putting in larger breast implants, and Dr. Torres suggests waiting six months from the initial surgery. Some doctors would do the surgery sooner, he says, but he prefers to be more cautious—implicitly positioning himself as doctor first, businessman second. Marta asks if she can donate the smaller implants to someone in need at the *Caja* once they are removed— a cancer patient, perhaps? Dr. Torres doesn't flinch as he explains that the reuse of implants does happen sometimes in the *Caja*, but that it should not and that the implant manufacturer's warranty is rendered invalid by such a practice. He thanks her for her charitable intentions, tacitly acknowledging both their duty to the less fortunate and

the advantage of being here, in the privileged embrace of a private clinic, where implants are purchased rather than circulating in a dubious state of sterility and ownership.

After discussing scheduling and preparations for Marta's facelift, Dr. Torres turns to her friend, Laura, who declares that she does not like her *panza* [belly, or paunch]. They discuss her concerns about water retention, seafood allergies, menopause symptoms and attempts to quit smoking. Dr. Torres reassures her that smoking a cigarette every now and then is like having a glass of wine or walking in downtown San José (apparently a reference to the city's noxious air pollution). "It's just enjoying life," he says. This discussion establishes both the patient's suitability for surgery and the surgeon's flexibility (some doctors insist that patients quit smoking entirely before surgery). It also sets the stage for the biomedical diagnosis and treatment of her sagging flesh.<sup>98</sup>

In a back corner of the office sits a folding screen and behind it a large mirror. Dr. Torres invites Laura to stand behind the screen, and asks her to remove her blouse, while he waits discretely on the other side. When he joins her in front of the mirror, he formally diagnoses her with an "excess of skin" and suggests that an abdominoplasty (tummy tuck) would be the appropriate treatment. She mentions detesting her arms as well, for which the surgeon suggests liposuction. After she has dressed and returned to the front of the office, Dr. Torres politely suggests that she lose some weight before surgery, without specifying exactly how much. He turns on his laptop and shows Laura and Marta a series of before and after pictures of previous tummy tuck patients, although she seems to need

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<sup>98</sup> As I explained in chapter three, most North American patients justify their participation in cosmetic surgery in terms of personal improvement or the realignment of mismatched inner and outer states. Most Costa Rican surgeons, however, told me that people seek cosmetic surgery in order to cure a "complex" or "low self-esteem." Part of their task in screening potential patients, therefore, is to weed out the mentally unstable from the merely unhappy.

little further convincing of his expertise. The newly enlisted patient asks the price of the procedures and he discretely writes, “\$4,200, everything included” on a sheet of clinic letterhead and slides it across to her.<sup>99</sup>

The doctor then explains to the two women that he uses a new surgical tool. Manufactured by a U.S. company, it is called the “harmonic scalpel,” and Dr. Torres claims to be the only surgeon in Costa Rica who uses it. The name resonates with the ideals of proportion and balance so fervently pursued by cosmetic surgery patients and their doctors, and its promise of reduced bleeding during surgery and faster healing afterwards suggests a less invasive process of transformation. Dr. Torres does not use this scalpel at the *Caja*; his patients and I know this implicitly (and through observation, on my part). The scalpel is an object, in other words, that is more mobile between countries (presumably between Costa Rica, North America, and Europe) than between the public and private sectors in Costa Rica. Not an inert object, it acts as a lever to fix Dr. Torres’s status as a “cosmopolitan” surgeon, while also further relegating *Caja* equipment and practices to the medical outside or Third World.<sup>100</sup>

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<sup>99</sup> U.S dollars are the currency of choice for plastic surgeons and in elite spaces of consumption more generally in Costa Rica, mainly because of the ongoing devaluation of the Costa Rican *colon*.

<sup>100</sup> Non-human actors worked to position other private surgeons and operating rooms as modern, including a new liposuction canula and laser scalpel wielded by Dr. Torres’s colleagues. While most of these objects and substances were exclusive to private practices, they occasionally made illicit forays into spaces of public medicine. A CCSS plastic surgeon, for example, reputedly offered Botox injections for a discounted price at a public clinic. The border-crossing neurotoxins (surgeons told me that Botox is not available to plastic surgeons at the *Caja*) enhanced the surgeon’s income, and demonstrate the permeable boundary between public and private practice.

After Marta and Laura leave Dr. Torres's office, I speak with them briefly in the waiting room. They tell me that older women are taking better care of themselves in Costa Rica than they used to, and that cosmetic surgery is akin to going to the gym. Their rhetoric resonates with that of North American cosmetic surgery patients, except for Marta's concern about the Catholic Church. Whereas North American visitors did not mention religious belief as an impediment to cosmetic surgery, Marta says that she was worried about the Church's possible disapproval of practices that alter the body God gave her. She visited a friend of hers who is a Catholic nun, who assured her that cosmetic surgery is acceptable to the Church since "God made doctors to help people and these doctors are helping people feel better about themselves."<sup>101</sup>

Would they ever go to a public hospital for medical care?, I ask. Absolutely not, they say. "The *Caja* doesn't work." They complain about how much they are required (by law) to pay to cover their employees' CCSS enrollment, then recount a story about a 95-year-old aunt who had to wait five days before her fractured leg was treated at a public hospital. The "human touch" is lacking at the *Caja*, they insist. I am struck by this comment, since older private practice surgeons had used similar terms to explain their nostalgia for clinical practice at the *Caja*. Again, I wonder when and how caring attention has become a commodity.

The patients leave the clinic and I return to the doctor's office for a brief conversation and tour of the clinic's operating, exam, and recovery rooms. Dr. Torres tells me that he attended medical school in Costa Rica, then trained as a plastic surgeon in

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<sup>101</sup> This logic presumably applies only to plastic surgery procedures that reproduce conventional gender norms, since, as I discussed in chapter two, most Costa Rican surgeons refuse to perform sex change and other gender-altering operations.

France for seven years. He returned three years ago, and now works half time at a public hospital and the rest of his time here, at the clinic his father opened 30 years ago. Even if he wanted to work full time for the *Caja*, he tells me, it would be impossible to support his family on his CCSS income; the monthly tuition for his children's private school is more than his salary of \$1,300. His desire to spend more time performing cosmetic surgery for private patients, therefore, is inextricably linked to the imperative of socioeconomic mobility (and segregation) among Costa Rican professionals, and their participation in the privatization of education, recreation and health care.

What about prestige, I ask. (Several doctors have told me that it is more prestigious to work for the CCSS than solely in private practice). "You can't eat prestige," he responds, but then equivocates, explaining that he could never leave the *Caja* completely because he wants to serve his people and wouldn't be able to live up to the breadth of his training in private practice, given the narrow range of enhancement procedures performed for the majority of private patients. The operations he leads at the national hospital are so much more challenging and complex, he says, and he is proud of them and the attention he gets from his colleagues. Some fellow CCSS doctors tease him that cosmetic surgery is done just for vanity and isn't really medicine—and he himself has doubts sometimes, he says. He seems caught in a bind, trying to be two very different types of plastic surgeon at once, but frustrated by the constraints of both. A wave of nostalgia for France suddenly seems to wash over him. In the French plastic surgery community, "everyone learned from each other." Here, surgeons are either isolated in private practice or under the bureaucratic thumb of the CCSS. "Small town, big hell," he says.

I ask Dr. Torres about the boundary between public and private medicine. He says that some of his CCSS colleagues invite private (Costa Rican) patients to the public clinic for follow-up examinations and minor procedures. His objection to this practice is a concern for the health of his private patients, rather than ethical qualms about the use of public facilities for private services. “The hospital’s plastic surgery clinic is really unpleasant and not very sanitary,” he says. He acknowledges, however, that the flexible boundary between public and private boundary can benefit patients who know how to work the system and can afford a private consultation.

A patient he had just seen that afternoon, for example, was a man with a cleft lip who paid for a private consultation with him at his clinic, after being assigned to a CCSS surgeon whose work he didn’t like. Dr. Torres told the patient that he would add him to his patient roster at the public clinic, since the procedure he needed would be expensive and the *Caja* would pay for it. This patient had, in effect, used the private sector to maneuver his way to the CCSS surgeon of his choice—and possibly to a higher position on the waiting list for surgery.

A couple of months after my tour of Dr. Torres’s clinic, I ask him again whether he imagines leaving his position at the *Caja* someday. He surprises me by saying yes, and it will probably be soon. He is frustrated by what he describes as the mediocrity and lack of incentive in public hospitals:

There are two kinds of doctors in Costa Rica—those who get training outside the country, and those who are content with what they learn here, even if it’s deficient or not up to date. They count by numbers in the *Caja*, not by quality, and they’re used to being big fish in a small pond. Here they think they know a lot. There [in other countries] they [would] know nothing.

Dr. Torres's words point to competing economies of expertise in which international affiliations and knowledge are either assets *or* liabilities. They are assets to the extent that his credentials as a European-trained surgeon bring him status and prestige in the private sector. This is particularly true among North American cosmetic surgery patients, who are more likely to patronize a surgeon who has European or North American training.<sup>102</sup> In the *Caja*, on the other hand, foreign training can work against a surgeon. Dr. Torres went to France on a state scholarship that obligated him to work for the CCSS for several years upon his return. Precisely because of his foreign training, however, he feels he is looked on with suspicion and even hostility by career *Caja* doctors. Promotions within the *Caja*, moreover, are based on seniority and internal politics rather than technical skill or medical outcomes, so the advanced techniques he learned in France bring him little prestige at the national hospital where he works—except among colleagues whom he describes as forward thinking.

Another CCSS plastic surgeon had recently returned from a residency in Europe and made a similar case, telling me that he was routinely barred from using the microsurgery techniques he brought back with him. The jealousy and ignorance of his superiors, he argued, resulted in the unnecessary amputation of injured fingers or limbs, while justifications for these procedures was couched in rhetoric about cost savings (amputations are usually less time and labor-intensive than surgically reattaching a limb).

In other words, foreign-trained doctors present a challenge to local structures of status, prestige and skill. Impudent showoffs are disciplined, several surgeons told me, in

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<sup>102</sup> The symbolic capital of North American and European medical credentials, combined with lax state regulation of medical advertising, is such that overseas training is often exaggerated or even invented, as in the case of surgeons who market themselves as “U.S.-trained” after attending a one or two-week workshop in the U.S.

the manner of *bajar el piso* [to lower the floor], referring to an attempt to lower the footing of one's opponent rather than improve one's own position. *Bajar el piso* is a particularly Costa Rican trait, many people told me, and the appeal of solo practice in the thriving private sector was enhanced by such collective attempts to reinforce the status quo at CCSS hospitals.



Figure 18. Hallway linking operating rooms at a public hospital, where staff scrub up, take breaks between procedures, and socialize. Photograph by Sara Ackerman, 2006.

Doctors on the state payroll, for their part, often feel left on the sidelines of biomedical advancement. One plastic surgeon, for example, complained that keeping up with current medical knowledge at the *Caja* is like “trying to paddle upriver.” His colleagues in the private sector—particularly those who operate on North Americans in private hospitals—spend time traveling to workshops and conferences around the world, where they learn about the latest developments in cosmetic surgery. He should be going to international burn meetings to hear about research and learn new techniques, he said, but he could not afford to travel abroad on his state salary.

It is precisely such “advanced” reconstructive plastic surgery techniques that are (as yet) rarely performed in the private sector, however, and herein is the painful (if profitable) bargain often struck by young plastic surgeons. Since cosmetic procedures form only a very small part of a plastic surgeon’s repertoire, and they are relatively easy to perform, a surgeon who resigns from state employment relinquishes the most complex and, some feel, the most expert part of his or her craft. As three CCSS surgeons put it:

Reconstructive and hospital work are more of a challenge...one needs a more integrated, mentally dynamic training, and to be more manually agile.

Aesthetic work is like the artistic, pretty part. It’s not the same to arrive and find a collapsed house and have to build it up again, than to find a finished house and have to paint it.

When one stops doing it [reconstructive surgery], one loses not only the vision, but the ability and the concept, no? It is something that...if it is not used, one is left behind...

Another surgeon told me that only six months of a three-year plastic surgery training program is devoted to cosmetic procedures. On the other hand, he said, some reconstructive procedures are so complex that they last 14 hours—suggesting stamina and prowess on the part of the surgery team. Doing liposuction all day, he joked, “you suck your life away.” Another surgeon told me that private practice doctors will always insist that what they do is interesting, but in reality it is very limited. “Aesthetic surgery is more about business...it’s like selling clothes. Would you like some new clothes?,” he said, grabbing a breast implant and putting it on the desk in front of me. Such limitations—even humiliations, in some cases—are, however, the price many surgeons are willing to pay for affluence and an escape from the *Caja*. A surgeon who is now famous for his facelifts, for example, spoke to me about his nostalgia for his days as a public sector surgeon:

I spent ten years at San Juan de Dios. I liked reconstructive surgery—it gave me more satisfaction than cosmetic surgery does. But the situation at the *Caja* is impossible. Everything is upside down. It's not an academic environment. I stopped learning there, and advancement is based on brownnosing rather than merit. I felt pushed out.

Plastic surgery, therefore, has become a site of contestation over the location of biomedical knowledge and professional expertise. Because it is primarily practiced at national hospitals, reconstructive surgery is thought by many surgeons to be a quintessentially *public* craft, one that requires not only skill and training, but commitment to national service rather than individual financial gain. One surgeon described in stark terms his daily participation in the gendered embodiment of economic inequality that public and private plastic surgery reproduce (or remold): in the morning, he said, he and his colleagues operate primarily on poor women who work too hard (referring, presumably, to diagnosis and treatment of carpal tunnel syndrome); in the afternoon, they operate on rich women who do not work hard but want to look good. Another surgeon explained his ambivalence this way:

What I make in one private surgery is five times my monthly salary in the [CCSS] Hospital. But from the point of view of work for a good cause, it [public medicine] is very important because I work on very interesting reconstructive cases. What's the point of becoming a millionaire just by doing breast implants if I'm not doing plastic surgery as charitable work?

### **Plastic surgery at its most medical: caring for burn patients**

Reconstructive procedures, because of their complexity, predominance in the public sector, and attention to the bodies of average Costa Ricans, are claimed by some doctors to be more “medical” than aesthetic surgery. “The plastic surgeon who beautifies

is not the plastic surgeon who cures,” a surgeon told me.<sup>103</sup> Perhaps the most medical (certainly the least beautifying and commercial, and the most focused on saving lives) of all plastic surgery practices is the treatment of severe burns. All patients are treated at the national burn unit, since private hospitals are not (yet) capable of treating life-threatening burns. This means that patients’ social and economic status do not operate as strongly here as they do at other sites (public and private) of plastic surgery, nor are patients’ bodies as easily mobilized between the public and private sectors.

The burn unit is staffed by four part-time plastic surgeons (one of them semi-retired and disengaged from clinical practice), several surgical residents, and numerous nurses and auxiliary staff. Three of the surgeons are from Colombia and Panama, having stayed on as CCSS doctors after completing medical residencies in Costa Rica.<sup>104</sup> Two of the surgeons are women, an unusually high proportion in a male-dominated specialty (there are six or seven women plastic surgeons in Costa Rica, and approximately 40 men). In my interviews with these surgeons, all three expressed a clear preference for reconstructive surgery and public sector employment, and a concern about what they described as the popular obsession with cosmetic surgery. They also situated their preference for reconstructive surgery in an ethic of national service:

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<sup>103</sup> How do we reconcile this statement with surgeons’ rhetoric about cosmetic surgery as curative of “low self-esteem,” and with reconstructive surgery’s expanding repertoire in pursuit of an ever-receding normalcy, as I discussed earlier? Once again, the medical categories of aesthetic and reconstructive show themselves to be highly contingent on moral economies of need and desire.

<sup>104</sup> Costa Rica opened medical residency positions to foreign applicants in the mid-1990s, when local medical schools were not yet producing the large number of graduates they are today. In my estimation, approximately 25% of plastic surgeons practicing in Costa Rica are from other Latin American countries – including Panama, Colombia and Cuba.

If I were a millionaire, and did not have to work to live, I would dedicate myself to reconstructive surgery, nothing more...I feel more affinity, more identification here [the *Caja*]. And maybe that is why my practice is not very large on the outside.

In our case, for example, in *quemados* [the burn unit], it does not matter to us if someone is insured or uninsured. If they are burned, then there is no problem and they are received.

While they are known among their colleagues for their “social charisma” and “spirit of public service,” however, the burn unit doctors are also imagined by other plastic surgeons to be outside the successes of private medicine—particularly the growth in medical tourism. This positioning was related not only to these surgeons’ reluctance to aggressively build their private practices, but also to the perceived distance between the care of patients with burns and the beautifying practices of cosmetic surgery. As one surgeon pointedly put it, “they ooze secretions and get infections. Most doctors would rather work with patients who are not sick.” Even the burn unit surgeons themselves were described as somehow unwell, as when their private sector colleagues explained to me that a plastic surgeon without a thriving private practice must be lacking in talent.<sup>105</sup>

There is an even more powerful symbol of public plastic surgery’s disconnection from Costa Rica’s neoliberal medical “advancement,” however, and this is burn patients’ bodies themselves—marked not only by fire or electrocution but perceived racial inferiority. Burn patients are disproportionately Nicaraguan immigrants—injured in fires in substandard housing or at unsafe job sites. One surgeon explained that all eleven of the burn victims he had cared for the previous year were undocumented immigrants from Nicaragua who lived in “slum conditions.” He said that some doctors—and most Costa

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<sup>105</sup> The National Children’s Hospital is also considered an undesirable workplace among plastic surgeons, primarily because there are fewer opportunities to recruit private patients.

Ricans—were resentful of Nicaraguans because they used *Caja* services without being enrolled or paying taxes, while receiving extra sympathy and money for their plight as poor immigrants (one of his patients—a child—was sent to a hospital in the U.S. for treatment, and the child’s family was offered financial support from U.S. charities).

Some of the most afflicted bodies that Costa Rican plastic surgeons care for, in other words, are not turned away from public hospitals, but they *are* denied citizenship by popular opinion among Costa Ricans. As I discussed in chapter one, Nicaraguans are popularly depicted and perceived as a racially polluting invasion rather than a legitimate migration. Many Costa Ricans blame Nicaraguans for driving down wages and stealing jobs from locals, and for spreading violence and squalor that tarnish the country’s image as peaceful and racially homogenous, and therefore attractive to tourists. That many Nicaraguan migrants received *Caja* services without paying is often interpreted by Costa Ricans not only as an affront to the very definition of citizenship via medical inclusion, but as an indication that the *Caja* is waning as a project through which a bond between citizens and nationhood is forged.

Thus, a clear line between desire and need, and between commerce and medicine, seems to be drawn by the hardworking doctors at the burn unit. As I discussed earlier, however, plastic surgery always strives to produce (or restore) “normal” appearance. The boundary between enhancement and reconstruction, moreover, is contingent on the perception of normalcy and the techniques available to approximate it, as well as by the tensions between commercial medicine and public service. Like many attempts at purification, CCSS’s official prohibition of aesthetic surgery masks the proliferation of hybrid offspring, a process to which I now turn (Latour 1993).

### **Gifts, favors, and chances: cosmetic surgery in national hospitals**

At a public plastic surgery clinic in San José, a sign was posted prominently on the wall in the exam room: “The Reconstructive Surgery Service announces that it does not perform any aesthetic surgery procedures.” This sign was unremarkable, particularly given CCSS’s policy prohibiting aesthetic surgery, as well as the long waiting lists for procedures not intended to enhance appearance. On several consecutive Friday mornings in 2006, however, I observed “aesthetic sessions” in the very room where the sign was posted. Openly attended by plastic surgeons, residents, medical students, aspiring patients, and now myself, these gatherings were described by the affiliated hospital’s chief of surgery, Dr. López, as a “filter,” or a means by which to reject—or redirect to the private sector—the majority of patients who hoped to obtain state-sponsored cosmetic surgery:

If we did all the aesthetic surgeries that people ask us to, we would be in the newspaper as an example of the misuse of *Caja* services. It gives them a chance, like the lottery.

The chance that these low-income women were hoping for was a tummy tuck, breast reduction, or—less commonly—breast augmentation. I learned that all of these procedures are performed at San José’s three national hospitals, in addition to other enhancement procedures such as breast reductions for boys and breast augmentations for girls (under 18 years). The hospital hosting the aesthetic sessions, however, seemed to be the most overt in offering cosmetic surgery to *Caja* members.

A surgical resident told me that about half of the plastic surgery operations performed at the hospital were aesthetic, although another doctor insisted that aesthetic

surgery was just as common at another public hospital. Many truths circulated (and were hidden, as I discuss below), but it is clear that cosmetic surgery has become a more accepted practice at CCSS hospitals in San José and that it is regularly designated as reconstructive for CCSS accounting purposes. To understand how these practices translate enhanced bodies into healthy citizens, operate as a form of currency in the *Caja's* economy of social obligation, and subsidize private practice, I now turn to one of the sessions.



Figure 19. Public plastic surgery clinic in a former single-family house, with patients waiting on benches in the garage area. Photograph by Sara Ackerman, 2006.

The plastic surgery clinic is a half block from the main hospital building, in a small, converted house on a residential street. A former carport—one side open to the street—is fitted with benches and served as a waiting area for patients. When I arrive at the clinic at 6:50 a.m. on a Friday, a small group of women are already seated in the hot sun. I join them and begin to chat with my neighbor, a woman whom I will call Nancy. She explains to me that she has arrived early to secure a place in the aesthetic session.

She really wants a tummy tuck, she explains. Everyone is getting cosmetic surgery in Costa Rica these days, and it is on TV all the time.<sup>106</sup> She has been to the aesthetic session twice before, and both times they refused her, but she thinks it is worth trying again.

At 7:10 a.m., a staff member opens the doors of the clinic, and the women who have been seated around me rush in to the appointment desk, where they each receive a small piece of paper with a number on it designating the order of appointments.

Wondering if the doctors have arrived, I go into the clinic's kitchen, where the staff having a breakfast of beans, rice and coffee. After chatting for 15 minutes, two surgeons, an intern, several medical students, and I leave the kitchen to gather in a small examination room. The room is bare, except for a desk, two chairs, an exam table, and the sign on the wall that I mentioned earlier—its message strengthened by the absence of other images or literature in the room. The surgeons sit in the chairs, and the rest of us stand in a cluster, trying in vain to be unobtrusive in the tiny room.

Before calling the first patient in, Dr. López, explains that the aesthetic session brings cosmetic surgery to regular Costa Ricans—people who otherwise cannot afford surgical enhancement. Poor women also pay a high price for motherhood, another surgeon says, referring to upper middle-class and wealthy women's ability to purchase the “correction” of sagging breasts and bellies: “We are giving them back the possibility to be as well as they were before.” In addition to pathologizing the life course, this

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<sup>106</sup> U.S. television programs depicting surgical transformations, such as “Extreme Makeover” and “The Swan,” were regularly broadcast on local TV channels (dubbed into Spanish) and on the U.S. channels available to cable subscribers.

statement suggests that the state is responsible for enlisting and “healing” Costa Ricans who are otherwise on the margins of an emerging cultural and economic order.<sup>107</sup>

Nancy is the first to enter. The surgeons pass her file between them and glance at it briefly while she stands before them like the accused before a jury. She explains that she needs a tummy tuck. She has had eight pregnancies and has sagging skin in her abdominal area. Her husband would also like her to have a more attractive stomach, she says. “Where do you live?” asks Dr. López. “Don’t they have televisions or electricity there?” This comment positions Nancy as overly reproductive and socially inferior. If the physician deems her operable, she may be able to reposition herself socially and economically by way of a less excessive body.

“Please remove your shirt,” one of the surgeons says. She hesitates. She must have known this would be asked of her, since she has been here twice before, but her immediate subjection to the clinical gaze catches her off guard, particularly as it comes on the heels of the doctor’s humiliating comment about her sexual behavior. The room is silent. “There are so many people here!” she protests. “Welcome to the *Caja*,” one of the surgeons responds wryly. She removes her shirt. The loose skin of her belly is on display, and almost immediately Dr. López announces that her case is “very aesthetic.” He proceeds to explain to her that aesthetic surgery is not allowed at the *Caja*. “Haven’t you seen the sign on the wall?” he asks. “I’ve spoken with a psychologist,” she responds,

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<sup>107</sup> In his study of state-sponsored cosmetic surgery for low-income women in Brazil, Alexander Edmonds (2007) suggests that beauty practices offer a means through which women compete in “a neoliberal libidinal economy where anxieties surrounding new markets of work and sex mingle with fantasies of social mobility, glamour, and modernity” (366). This analysis is relevant to Costa Rica, where popular fervor for cosmetic surgery crosses socioeconomic divisions but access to new forms of private consumption does not.

“and he agrees that my problem is not just aesthetic.” Dr. López insists that her case *is* aesthetic, and that she would be better off going to a private clinic for the procedure.

“You have a mental, not a physical, problem,” he says.

Nancy is sent on her way, and she is followed by one woman after another, each auditioning for a tummy tuck, breast reduction, or breast implants. Need is performed through the demonstration of physical pain, the enlisting of psychologists who attest to mental suffering caused by sagging or deficient flesh, and by adherence to physician-prescribed weight loss regimens.<sup>108</sup> If patients discipline their bodies as requested, they may be put on a waiting list for the desired procedure. During today’s session, successful inductees are reminded of their debt to the surgeons, and of aesthetic procedures’ quasi-legitimate status in the *Caja*:

- We will give you the operation because you lost weight and have been cooperating with us.
- Your surgery will be low priority. If a surgery needs to be suspended to make way for another operation, it will be yours.
- This is practically a favor that Dr. López is doing for you.

In the slippery logic of the session, a problem defined as physical is amenable to state-sponsored, reconstructive surgery. A condition located by the physician in the mind of the patient, on the other hand, is treatable by an identical procedure—except that it would be performed, and paid for, at the doctor’s private clinic. There is much slippage within these physical-mental and reconstructive-aesthetic dichotomies, until the diagnosis is made—based primarily on the surgeons’ aesthetically inflected evaluation of the

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<sup>108</sup> See Kathy Davis’ (1995) account of cosmetic surgery practices in public hospitals in Holland, where women who are determined to be “suffering” as a result of small breasts are offered state-subsidized breast implants.

patient's body. At the moment of diagnosis, session participants are reminded of the now-absolute distinction between need and desire, and between public and private medicine.

The sessions, therefore, serve not only to enlist low-income women in a surgically mediated project of self-improvement, they mobilize patients for the consumption of private medical services.<sup>109</sup> Moreover, by limiting the number of aesthetic operations in public hospitals, clinicians are able to quell the protests of their private sector colleagues that *Caja* doctors are “stealing” potential private patients. (Even surgeons with a steady stream of North American clients court local patients, both as an income supplement and as security in the event that the flow of medical tourists dwindles). In this way, surgeons balance the *Caja*'s imperative of public service, local patients' demands for *Caja*'s services, and the “needs” of private practice.



Figure 20. Surgical team performing an aesthetic procedure on a patient in an operating room at a public hospital, with medical students looking on. Photograph by Sara Ackerman, 2006.

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<sup>109</sup> Personal bank loans for cosmetic surgery are widely marketed to working and middle class Costa Ricans, offering aesthetic citizenship via medical consumption and debt.

I should mention that plastic surgeons at other national hospitals (including chiefs) tended to portray Dr. López as a renegade who has gone too far in importing cosmetic surgery into the *Caja*. Doctors close ranks at the mention of *biombos*, or corruption, however, and no one suggested to me that Dr. López (or anyone else, for that matter) might be earning extra money by charging patients for enhancement procedures at the *Caja*. However, two years after I left Costa Rica, an investigative reporter hid a camera in her purse, made an appointment at the *Caja* clinic I described above, and filmed Dr. López offering her a Botox injection for a fee. Days later, television reports showed the police removing the surgeon and one of his colleagues from the clinic in handcuffs, and featured interviews with patients who had been waiting months for medically necessary procedures. According to a newspaper report, the two doctors were suspended from the CCSS for six months, and were under investigation for *biombos*, including: “using *Caja* work hours to perform private surgeries” and “using *Caja* facilities to perform procedures paid for by private patients” (Avalos 2008).

I am surprised not that Dr. Hernández was caught, but that he was not caught sooner. His arrest no doubt serves as a victory in the CCSS’s highly publicized “war” on *biombos*, but it also suggests that private sector incursions are assumed to be the exception rather than the rule at the *Caja*. I suggest, rather, that the very fabric of the *Caja*’s clinical and institutional practices are woven with interests that link public and private medicine. For example, as in the case of the nose job I mentioned earlier, cosmetic surgery serves as a form of currency in the *Caja*’s “bank of favors.” This economy mobilizes the exchange of social obligations, prestige, medical equipment, and bodies. It even shapes the practices at a hospital whose chief of plastic surgery insisted

that he only had room for cancer and trauma patients, and that “even just with them, the waiting lists for surgery are into next year.” He conceded, however, that cosmetic surgery had become so popular that it was a valuable currency in the “bank,” and therefore must be performed on occasion. The only way to survive in the *Caja* is to make deposits in the bank, he explained. “That’s how the country works.”

Surgeons in training, meanwhile, insist that learning cosmetic procedures is essential to their future success in private practice. Some surgeons apprentice with well-known private practice surgeons, and others learn cosmetic procedures during fellowships or other training programs abroad. For those without access to these options, the *Caja* is the only training venue available, they told me. In addition, *Caja* patients want cosmetic surgery as desperately as everyone else, so why not offer it to them and teach students in the process? Breast augmentations, in particular, are popular among young women, relatively fast and easy to perform, and a large source of income for plastic surgeons in private practice. Surgical residents are eager to learn the procedure, and offer it to friends and acquaintances at national hospitals, provided patients purchase their own implants (apparently these surgeries are approved by the *Caja* administration, although I do not understand how they are designated and approved as reconstructive).<sup>110</sup> These learning cases are a form of quasi-private consumption, and they ultimately serve to enhance surgeons’ marketability to elite cosmetic surgery patients, including North Americans.

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<sup>110</sup> Breast implants cost approximately \$600 in Costa Rica, and are available from independent vendors who import them from Europe and North America.

The public subsidy of commercial medicine is, therefore, constitutive of routine clinical practices, patients' bodies, and private gain. Anxieties about being left behind or outside the spaces and pleasures of Costa Rica's transnational consumer culture intersect with continued popular expectations that the nation's largest state entity will persist in producing citizens via medical inclusion. In the interplay of public and private medicine, the desires of elite, mobile consumers mingle with those of undocumented labor migrants, low-income and middle class Costa Ricans, and ambitious surgeons. Costa Rica's interconnected spaces of clinical practice, however, produce distinctly different embodiments of belonging and exclusion, even as plastic surgeons themselves operate across the social and institutional spectrum.

## CONCLUSION

### THE NEW FACE OF MEDICAL TOURISM IN COSTA RICA

For North American cosmetic surgery seekers, Costa Rican clinical and recovery services offer an appealing package: an imagined and yearned-for return to a younger body and a restful interlude of pampered recuperation, all at an attractive price. Along the way, many journeyers feel they have arrived in a nation not yet beset by the stresses and complexities of modern life, and imagine that they have returned to an era when doctors and nurses had patients' best interests at heart, and clinician-patient relations were unmediated by bureaucratic institutions. In this ethnography, I have followed the constellation of bodies, practices, objects, spaces, institutions, and imaginaries that propel these medical mythologies and their very material commitments. My goal has been to examine how Costa Rica is produced, and embodied, as a simultaneously "modern" and "traditional" facilitator of personal change and fulfillment for middle class North Americans, and to discern the cultural, political, and economic transformations that are entangled with this field of productivity.

My central focus has been on the production of cosmetic surgery tourists' bodies and subjectivities. I have looked closely at how bodies are invested with meaning, not only by way of surgical procedures, but via differently situated forms of sociality, local hospitality practices, and imaginaries of Costa Rica's political and natural landscapes. I have argued that North Americans' desires for bodily enhancement intersect with a

complex politics of belonging in Costa Rica, and that access to medical services is a medium through which various claims to participation are negotiated. Contests over access and inclusion are by no means settled, and I examine spaces of corporeal and social production—hospitals, clinics, retreat facilities—that have divergent *and* overlapping interests. One of my intentions has been to show how medical tourism intensifies these connections, rendering medical privatization both dependent on the state and its institutions and a threat to the principles on which these same institutions were founded.

For example, private medicine in Costa Rica is popularly understood as both a needed alternative to, and a corrosion of, the national medical program. Public and private domains are held to be ideologically and spatially distinct, and recent public-private hybrid projects in medical service delivery are interpreted by many Costa Ricans as a gradual form of privatization. In pointing to the interplay of practices and interests in the public and private sectors, however, I have demonstrated how the consumption of cosmetic surgery by North Americans—widely assumed to be located exclusively in the private sector, or more distantly in the global medical tourism marketplace—is underwritten by, and constitutive of, public sector medical practices and bodies.

As private medical facilities proliferate, however, the state-sponsored program that has provided public health and medical services for the majority of Costa Ricans for over half a century, as well as training most of the nation's clinicians, struggles to live up to its mandate of universal access and biomedical modernity. The presence of Nicaraguan labor migrants in public clinics and hospitals also contributes to many Costa Ricans' belief that the CCSS is no longer a site of national identity. The state institution that has

long been tasked with producing citizenship by way of medical participation, in other words, is under siege; its fraying edifice sits in uneasy and ambivalent relation to a private sector that is increasingly infused with foreign capital, and promotes medical consumption as a new form of transnational participation *and* a more caring, essentially Costa Rican practice.

My analysis has traversed scale and space. I have examined national identities and routine daily practices. I have considered bodies' corporeal, geographic, and social movements, and local points of stasis and disjuncture that intersect with medical tourism's mobilities. I began my discussion, in chapter one, by situating the emergence of medical tourism in the historical co-development of state-sponsored and private medicine in Costa Rica. Since the 1940s, centralized state institutions have promoted, and materialized, particular understandings of modernization, democracy, and citizenship. The Social Security Fund (CCSS) is the largest of these entities, and has intervened intimately, and often surgically, in the lives of Costa Rican citizens. Plastic surgery was introduced to Costa Rica through this state apparatus, and I traced the expansion of its normalizing project in both the public and private medical sectors. I then discussed the ways in which average citizens and their clinicians navigate between public and private medicine, including practices of quasi-privatization—encouraged or illicit—that have become routine in public medical facilities. This analysis paved the way for my consideration, in chapter five, of how the commercial market for cosmetic surgery, in conjunction with plastic surgery's expanding normative reach, is reshaping medical categories, clinical practices, and local bodies in national hospitals.

Chapter one also situates the emergence of cross-border surgical migrations from the U.S. in a context of Costa Rica's post-1980 neoliberal turn, and the nation's subsequent refashioning as a paradise for conventional and "ecotourists" and a site of transnational consumption. The growing popularity of Costa Rican plastic surgeons and recovery facilities among visiting and resident North Americans, I argued, has been intimately intertwined with national economic and cultural transformation, a rapid increase in local consumption of cosmetic surgery, and precipitous growth in the private sector. These changes, moreover, have accompanied a large wave of migrant laborers into Costa Rica from Nicaragua. In San José, the employment of undocumented migrants as low-wage construction and domestic workers supports the expansion and profitability of medical tourism. At the same time, however, these laborers' claims on the state, particularly for medical services, has incited a racialized politics of national identity in which Nicaraguans are identified as a cultural and biological threat. The north-south movement of Nicaraguans, I suggested, is a shadow medical migration that parallels and undergirds the middle class surgical migration from North America.

In chapter two I looked beyond Costa Rica's borders to situate medical tourism as a global phenomenon, and to consider how Costa Rica is promoted alongside its competitors. U.S. popular media depictions of medical travel have tended to equate cosmetic surgery journeys with frivolity and leisure, while persons who seek "necessary" procedures outside the U.S. are increasingly portrayed as pioneers and refugees from a medical "system" in crisis. I discussed how, for both "refugees" and cosmetic surgery seekers, medical tourism (the term itself says a lot) is popularly expected to include much of the pleasure and edification associated with leisure travel. I considered the ways in

which these expectations translate into a both a trivialization of invasive surgical procedures, *and* personal experiences of metamorphosis through “exotic” travel that transcend the changes expected by surgery alone.

Hospitals catering to North American medical tourists are primarily situated in developing countries, and the most successful have been promoted as hotel-like spaces with “world-class” services. I continued chapter two by looking at the discursive operations involved in producing hospitals as global spaces. These are sites, I argued, where medical modernity is effectively transferred from its presumed “first world” home, and is enhanced by local forms of hospitality and luxurious hotel-like amenities, in conjunction with prices affordable to local elites and middle class visitors from wealthier countries. Such spaces contribute to cosmetic surgery travelers’ experience of upward social mobility even before their bodies are surgically transformed.

Medical tourism hospitals’ status as global, however, depends on the erasure of evidence that these spaces are linked to conditions such as poverty, hunger, infectious disease, pollution, and violence—all associated with the Third World. I looked closely at these rhetorical and material purification efforts at private hospitals and recovery hotels in Costa Rica. To seduce North American medical consumers, hospital and hotel promotions deploy Costa Rica’s myth of racial homogeneity, normatively gendered portraits of expertise and hospitality, natural landscapes, and even the statistical successes of state-sponsored public health programs. In terms of architecture and urban development, Costa Rica’s newest hospitals are situated apart from San José’s public spaces of social disinvestment, and in proximity to private shopping malls and gated housing “communities.” The medical tourism apparatus thereby contributes to spatial

segregations in San José, following the contours of growing socioeconomic disparities, while relying on the labor—and local migrations—of low-wage workers.

One of the most recent medical tourism projects is in one of Costa Rica's northern provinces, and I concluded chapter two by considering the ambivalence of average Costa Ricans to the development projects in this part of the country. I asked how these transformations will affect local residents, and whether private hospitals in the north are a harbinger of medical tourism's flight from an increasingly blighted San José, where most of the country's medical specialists and tertiary care are now situated.

In chapter three, my focus shifted from medical spaces to the bodies that pass through them, and the geographic and corporeal departures and arrivals of mobile North American cosmetic surgery consumers. Rejecting dualistic notions of “natural” and “artificial” bodies, I examined how bodies' status as operable is mediated by cosmetic surgery's historical imbrication with photography and the visual narrative of before and after. Cosmetic surgery's operations on bodies and subjects, I argued, are not confined to the operating room; bodies are produced as in need of surgery long before they enter a plastic surgery clinic, and many are rendered transnationally mobile and surgical through the sociality of patient-run web forums. I closely examined sites where patient-consumers' interrogate surgeons' expertise, narrate countries' desirability as surgical destinations, and where cosmetic surgery is collectively reproduced as a desirable—even expected—technology of self-care.

Health is a slippery concept in cosmetic surgery. Surgeons consider the ideal patient to be healthy before surgery; this same patient, then, is made temporarily sick by surgery, and then later emerges as a happier, more attractive (i.e. healthier) person. I

continued chapter three with an examination of Costa Rican plastic surgeons' determination of the pre-surgical health of prospective patients, often by proxy via email and photographs. I also considered shifts in understandings of health and surgical excess, as a growing number of weight loss surgery patients from the U.S. travel to Costa Rica for cosmetic surgery. I then followed the pre-surgical and surgical rituals at a cosmetic surgery clinic, including negotiations between desiring consumers and paternalistic surgeons. During operations in which surgeons cut open and remold a patient's body, the patient figures as an absent presence. In the final section of chapter three, I examined this spectral subjectivity, and the intimate, material interventions of the surgical team and its scalpels, sutures, and gasses, through which a patient's body is cut open so that she may feel like a complete person.

In chapter four, I continued to track North Americans' surgical journeys, looking closely at the period of discomfort and uncertainty that often follows an aesthetic procedure. I argued that post-surgical recuperation facilities in Costa Rica offer affective cures that are, for many patients, a crucial aspect of the embodied recovery of one's imagined self. A concoction of bodily attentions and reassurance by local staff, camaraderie among guest-patients, and beautiful landscapes, retreat-based recuperation reaffirms cosmetic surgery as a middle class practice of self-maintenance. The attentions of nurses, and house calls by physicians, also contribute to patients' nostalgic longings for more attentive, affordable medical services in the U.S.

Costa Rican surgeons and nurses in private practice, meanwhile, described having learned their craft at the *Caja*, but eventually having escaped the austere and overcrowded conditions at national hospitals. The kindness and hospitality assumed to

inhere in Costa Ricans has, to some extent, become a private sector commodity, and is a key component in medical tourism's appeal. Clinicians' narratives of escape from the *Caja*, however, were often inflected with a sense of nostalgia for public service—a nostalgia that was tempered by a popular, and negative, association between Nicaraguan migrants and overburdened social service programs. Visiting patients, expatriate hotel owners, local clinicians, and migrant workers, are all enmeshed in a multi-dimensional politics of belonging that is being worked out in part through medical institutions and services.

In chapter five, I turned my ethnographic gaze to public hospitals—institutions that loom large in the lives of most Costa Ricans but that most medical tourists are not even aware of. Examining the daily practices of doctors who divide their time between national hospitals and private practice, I discussed the complex professional and ethical compromises that are involved in a plastic surgeon's decision to devote a significant proportion of his or her career to the *Caja*, or to resign from state employment altogether. Public hospitals engage plastic surgeons in complex and personally rewarding tasks; increasingly, however, the private sector offers enhanced access to international professional affiliations, state-of-the-art equipment, and high salaries. I discussed how surgeons navigate this uneven terrain, and how the distinction between reconstructive and cosmetic surgery is brought into play as a moral dimension of plastic surgery practice. I also considered how private plastic surgery clinics reproduce a spatial and ideological boundary between public and private medicine, such that the latter is increasingly perceived as more modern by Costa Ricans seeking medical services.

I continued chapter five with a discussion of cosmetic surgery's inroads into state-sponsored clinical medicine. Although complicated reconstructive surgeries are rarely performed in the private sector, cosmetic surgery is surprisingly available and even routine in Costa Rica's overburdened national hospitals. I looked closely at state-sponsored cosmetic surgery's operation as a form of currency between hospital staff, and a medium through which lower-income Costa Ricans make claims on the state. I argued that state-subsidized aesthetic procedures are a form of privatization and state subsidy of the private sector. The state's production of gender-normalized breasts and bellies, and "European" noses, is an uneasy fusion of citizenship via passage through state institutions, and participation in a neoliberal economic and cultural order that emphasizes individual pleasures and responsibilities. The *Caja*, I argued, is a site of unexpected fusion and productivity.

### **(Im)mobilities of medical travel**

Elite spaces of private medical consumption in Costa Rica produce and valorize a conception of health that is based on notions of individual responsibility and corporeal mutability. The bodily practices of the cosmopolitan shape shifters (visitors and residents alike) who frequent cosmetic surgery clinics, however, diverge from those of average Costa Ricans, particularly those awaiting basic medical services at public hospitals (while possibly desiring surgical enhancement as well). The moving limbo of Nicaraguan migrants—denied citizenship, popularly reviled as diseased, dark, and polluting, and often desperately trying to pass as Costa Rican (Alvarenga 2004)—also contrasts with the more unfettered flow of North Americans. Pampered tourists, waiting Costa Ricans, and abject Nicaraguans: their medical participation in Costa Rica is not commensurate, but

they are readily mobilized to join the expanding medical tourism project as patients, consumers, or workers.

This is an ethnography of mobility, disjuncture, and stasis. As such, my analysis contributes to anthropological discussions of transnational movements and migrations, and associated practices of consumption and production—particularly in terms of biomedicine as an increasingly mobile site of cultural practice. It also joins a growing body of literature on the uneven, local effects of neoliberal ideologies, by suggesting that the state cannot be understood as a monolithic entity that is either evacuated, or uniformly coopted, by free market supremacy. A close examination of plastic surgery practices in Costa Rica, rather, demonstrates the conflicted commitments of the state and of Costa Ricans themselves, and the effects of these ambivalences on bodies, desires, and understandings of citizenship.

In discussing citizenship and the politics of belonging, I hope to contribute to anthropological work exploring the biomedical categories through which claims to identity and membership are increasingly framed. How is it that North Americans seeking tummy tucks and facelifts are welcomed as desirable individuals in Costa Rica's most elite spaces of medical care, while laboring Nicaraguan migrants are resented *en masse* for seeking emergency care at public hospitals? In Costa Rica, I suggest, several modes of belonging are in tension. A kind of transnational belonging is based on a desire to participate in a burgeoning consumer culture; its offerings include individual self-enhancement products like cosmetic surgery, private medical services, and luxury housing. Both North Americans and elite Costa Ricans are easily able to access this type of belonging.

For the majority of Costa Ricans who participate in the nationalized medical program, on the other hand, access to state-sponsored medical services (including, increasingly, enhancement procedures) is considered a national birthright, and the *Caja* is thought to be one of the pillars of the nation and a container of Costa Rican identity.

Undocumented immigrants, however, are denied membership in the nation by virtue of their economic status, nation of origin and skin color. Their (strongly contested, and sometimes denied) access to medical care is not based on national citizenship, or on their ability to participate in a transnational consumer culture (except as laborers). Their claim to belonging, rather, is moral, and is based on bodily suffering and Costa Rica's reputation as a prosperous, liberal nation. It is the state, however, not the nation, that tends to the afflicted bodies of migrant laborers, whose labor contributes to the expansion and affluence of the private sector.

My analysis of belonging is also in conversation with theories of embodiment, which move beyond mind-body, culture-nature dualisms to investigate how bodies are formed and lived through social interactions, and how the social is always also material. I suggest that cosmetic surgery is not an identical cultural formation everywhere that it is practiced, and that it can only be accounted for by close examination of the institutions, interests and imaginaries in which it is situated. Contests over the future of Costa Rica as a nation and a destination are embodied in the variety of hopeful and desperate persons who pass through the public and private spaces of plastic surgery, seeking repair or enhancement or both. Therefore, medical tourism is not only a global phenomenon, but an intimately local apparatus, since the practices that sustain it reach into the very habits and structures of local bodies and lives.

### *Postscript*

Over two years have passed since I returned to the U.S. from Costa Rica. During this time, medical tourism has attracted renewed interest from the state. The Arias administration (Oscar Arias was re-elected president of Costa Rica in 2006 by a narrow margin) sees the large number of medically uninsured U.S. residents as a business opportunity for Costa Rica. In a press release, The Ministry of Production's "Council on Competitiveness" acknowledged that state agencies have not taken medical tourism seriously as a "niche" in the growing service sector. Thus, it has announced medical tourism as new, state-sponsored project that will require more "support" from the public sector. The council states:

Medical tourism will no longer be just a cost-savings opportunity in plastic surgery, but will become the only solution to the health problems of millions of [U.S.] patients without insurance (CONACOM 2009).

The state's goal is to unite medical tourism's disparate actors in a "health park" or "medical services cluster," with internationally accredited hospitals and luxury hotels. This "park" would cater to North American visitors and residents, particularly retirees and people over 50. The state's Costa Rican medical tourism makeover includes renovations on existing private hospitals, the construction of new, for-profit hospitals, international marketing campaigns for a broader range of medical specialties (beyond, but not excluding, plastic surgery), and private hospitals' insertion into international insurance regimes.<sup>111</sup> The intent is a shift in the medical tourism industry's scale and

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<sup>111</sup> Hospital Clínica Bíblica's web site, for example, claims affiliation with 20 different (presumably North American) insurance companies, and describes itself as a member of the "Blue Cross Blue Shield World Wide Network."

focus, from small, loosely affiliated plastic surgery clinics whose patients are still recruited primarily through referrals, to a landscape of globally recognized, multi-specialty hospitals under the regulatory supervision of U.S.-based institutions. In other words, refashioning Costa Rica as a medical refuge for mobile patients involves remaking private medicine in the image of U.S. medical ideals, while keeping prices low enough to maintain a competitive advantage over equivalent services in the U.S.

By transforming its private sector into a haven for “medical refugees” from the U.S., is the Costa Rican state turning private medicine into another kind of free trade zone or *maquiladora* [off-shore assembly plant]? If so, how will the state balance its continued commitment to health care as a national project, equally accessible to all, with its promotion of private medicine and export of enhanced bodies to the U.S.? Will financial and labor subsidies flow from private to public medicine as well as from public to private? And what about middle class Costa Ricans, who insist that U.S. tourists and expatriate residents are “driving up prices” for medicine, real estate, and other private sector goods and services? The complexities, and consequences, of these commitments require disentangling and close scrutiny, and the prognosis for Costa Rican medicine is uncertain. The nation will no doubt persist as an exception in relation to its Central American neighbors and other low-income countries, but the nature of its exceptionalism is still under construction.

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See <http://www.hcbinternational.com/>.

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