AESTHETIC SURGERY: CUSTOM-MADE BODIES? TENSIONS BETWEEN EXPERT AUTONOMY AND PATIENT EXPECTATIONS IN ARGENTINE PLASTIC SURGERY IN THE FIRST HALF OF THE 20TH CENTURY

CIRUGÍA ESTÉTICA: ¿CUERPOS A MEDIDA? TENSIONES ENTRE AUTONOMÍA EXPERTA Y EXPECTATIVAS DE LOS PACIENTES EN LA CIRUGÍA PLÁSTICA ARGENTINA DE LA PRIMERA MITAD DEL SIGLO XX

CIRURGIA ESTÉTICA: CORPOS FEITOS SOB MEDIDA? TENSÕES ENTRE A AUTONOMIA DO ESPECIALISTA E AS EXPECTATIVAS DO PACIENTE NA CIRURGIA PLÁSTICA ARGENTINA NA PRIMEIRA METADE DO SÉCULO XX

Molina JOAQUIN[*]

ABSTRACT: Aesthetic surgeons deal with patients who have aesthetic expectations and who can evaluate the result of the operation at a glance. Starting from this premise, this article sets out to analyze a series of Argentine medical publications on rhinoplasty from the first half of the 20th century with the aim of identifying the practices, devices and routines devised by these professionals to manage the expectations of candidates for the operation. The article is organized into four parts, which account for different instances of doctor-patient interaction: the diagnostic examination and surgical indication; the psychological evaluation of patients; the "truth" and the "lie" in pre-surgical consultations; and the place of medical photography in the diagnosis, projection and evaluation of results. The article

[*] Doctor in Sociology. UNSAM-National University of San Martín. Buenos Aires - Argentina / EHESS-École des Hautes Études en Sciences Sociales. Paris - France Orcid: https://orcid.org/0009-0000-5416-8210 . Contact: joaquin_molina86@hotmail.com.

deploys an original approach by addressing an object of study that has been scarcely explored from a historical perspective.

KEYWORDS: Aesthetic surgery. Argentina. First half of the 20th century. Physician-patient relationship.

Introduction

In *Anecdotario de un cirujano plástico*[1] (1972), Argentine physician Ernesto Malbec recalls various dramatic and comical situations that arose throughout his career in aesthetic surgery. In one of these brief narratives, he notes that he was in the operating room about to begin a rhinoplasty (nose job) on a 20-year-old woman when a nurse approached him to inform him that the patient's father needed him urgently. Believing it was a serious matter, he went to meet him. However, before Malbec's astonished gaze, the man took out four photographs he had chosen from different magazines and inquired which of the four nose models was the best to do on his daughter. Immediately, and without waiting for a response, he rushed to explain his request: "I think this is it. It's, at least, the one I like the most. So, I ask you, please, to make my daughter a nose exactly like it." As a corollary to this story, Malbec concludes with the following reflection: "The man perhaps assumed that noses were made like tin soldiers, molded and made to order" (Malbec, 1972, p. 137-138).

Seemingly comical and inconsequential, the story reveals the tensions faced by aesthetic surgeons. They must deal with patients who have a predefined definition of their problem, expectations about the change they desire, and the ability to assess the outcome of the intervention at a glance. In this article, I propose to analyze Argentine medical publications on plastic surgery from the first half of the 20th century with the goal of identifying the practices, devices, and routines devised by these professionals to address the desire for aesthetic change among surgical candidates. I focus on the literature from the first half of the last century, as it was during this period that the specialty emerged and became institutionalized in Argentina. It is also worth noting that the empirical corpus analyzed focuses on rhinoplasty, as it was the most frequently performed procedure during the aforementioned period.

The article is organized into four parts, each of which describes different instances of doctor-patient interaction in aesthetic surgery. The first section analyzes the practices of examination, diagnosis, and surgical indication present in the medical literature of the first half of the 20th century. As we will see, far from aspiring to mass-produced bodies, the material examined reveals the importance of case-by-case examination and of making local corrections that harmonize with the patient's other

[1] Anecdotes of a Plastic Surgeon.

features. The second section addresses the process of categorization and "psychological" selection of candidates, embodied in a series of warnings and recommendations that help plastic surgeons distinguish "good" from "bad" candidates for aesthetic surgery. The third section examines practices aimed at modulating the expectations of those undergoing surgery, highlighting the central role of "truth" and "lies" in pre-surgical consultations. In closing, I explore the role of medical photography in diagnosis, screening, and the evaluation of results in doctor-patient interactions.

This article proposes an original approach to addressing an object of study that has been scarcely explored from a historical perspective. In Latin America, most publications on these medical practices come from the field of Brazilian social sciences. With rare exceptions, the focus of analysis is on the contemporary development of the tension between aesthetics and health that these procedures provoke (Antonio, 2008; Edmonds, 2010; Jarrin, 2017; Schmitt; Rohden, 2020). At the international level, some research from the North American and European social sciences adopts a long-term perspective, studying the process of legitimization of aesthetic surgery over the course of the 20th century (Haiken, 1997; Gilman, 1998; Guirimand, 2005; Barbot; Cailbault, 2010). These publications highlight the psychological and economic benefits that plastic surgeons sought to imbue their practices, giving them a therapeutic purpose. Although these are valuable contributions, I believe these works analyze medical publications as justifications intended to persuade others, neglecting the pedagogical nature of medical literature. The following pages aim to fill this gap, conceiving the empirical corpus as a reservoir of experience intended to convey diagnostic examination procedures and practical suggestions for managing the aesthetic demands of surgical candidates.

The diagnostic examination of the patient

Aesthetic surgery is often problematized by the social sciences as a practice that aims to "normalize" patients by shaping their bodies according to a dominant and homogeneous beauty canon. From this perspective, rhinoplasty constitutes the quintessential historical example of the imposition of a white, Western canon on racially divergent noses. On this point, the work of Gilman (1999), an American cultural historian who coined the notion of *surgical passing*, stands out. This refers to the way in which aesthetic surgery (especially of the nose) constituted a strategy used by ethnic and racial minorities to assimilate to the aesthetic standards of the WASP (*White, Anglo-Saxon, Protestant*) in American society at the beginning of the 20th century. In this section, I aim to show that Argentine medical literature validates the Western, Caucasian nose as an archetype of perfection, but that this does not mean that this standard is imposed indifferently on all individuals. More

specifically, far from aspiring to mass-produce bodies, the publications analyzed urge surgeons to perform nasal corrections that harmonize with the race, physical build, and overall facial conformation of the patient.

To begin to delve into this subject, it is interesting to highlight that the examination of the nasal defect involves different senses of the expert, material conditions to carry it out and the disposition of the patient's body in different positions. Thus, according to Carlos Rivas (1946), initially the candidate for surgery must be seated facing the observer, with the head perpendicular to the shoulders and free of rigidity that impedes the rotation necessary for the study of both profiles. Secondly, the professional assesses the defect in the operative position: the patient lying supine, with a support that projects his head, and that keeps the chin and forehead in the same plane (Rivas, 1956, p. 55-56).

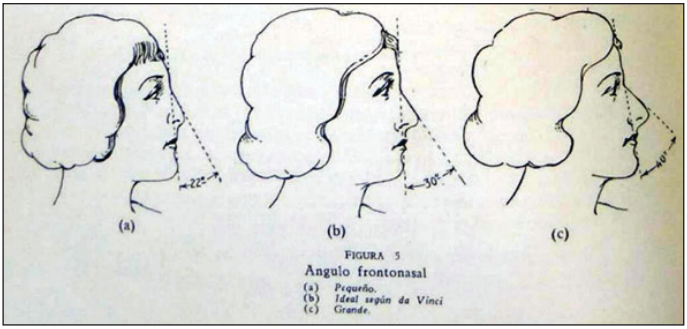
Each examination position allows the surgeon to assess the anatomical sector of the nose where the irregularity is located. Irregularities can be due to excess, deficiency, and/or asymmetry, and can affect one or more of the anatomical areas that comprise the nasal appendage. From the combination of these aspects, a diagnosis emerges, for which the use of expert categories is used. Classification schemes vary from one text to another and present different levels of complexity. One of the most obvious considerations is that the classification of nasal defects is relative in nature; that is, it is carried out in relation to an ideal model (the "normal nose"). There are two main sources from which the literature on plastic surgery constructs this model: art and biotypology. In line with this, it is no coincidence that the Argentine professional Juan Andrés Codazzi Aguirre points out that the aesthetic surgeon "must possess the qualifications of a medical surgeon, a biotypologist, and an artistic anatomist" (Codazzi Aguirre, 1938, p. 28).

This beauty standard finds practical expression in the dissemination of procedures aimed at measuring the patient's nasal appendage. These procedures consist of the study of facial profile angles, such as the fronto-nasal angle, the nasolabial angle, and the dorso-nasal angle or aesthetic profile angle. Within this framework, the ideal nose is defined geometrically, taking the canons of beauty provided by classical art as a reference guideline. Let's look at some examples. According to the Argentine surgeon Palacio Posse, "the Venus de Milo has an aesthetic profile angle of 27° 1/2," proposing the use of the profilometer devised by the German physician Jacques Joseph for its measurement (Palacio Posse, 1946, p. 31) (Figure 1). For his part, Viale del Carril states that the fronto-nasal angle "has been considered, since Da Vinci, to be an important sign of physiognomic harmony, with its ideal opening being 30." To demonstrate the relevance of this measure, the surgeon reproduces an illustration (Figure 2) in which he exhibits the "great changes in the characteristics of the profile" produced by variations of a few degrees (Viale Del Carril, 1935, p. 25).

Figure 1 – Jacques Joseph's Profilometer

Source: Forero, 1929, p. 29.

Figure 2 – Deviations of the frontonasal angle in relation to the canon established by da Vinci



Source: Viale del Carril, 1935, p. 24.

Based on what we have seen so far, aesthetic surgeons are nothing more than mass producers of ideal bodies. However, instead of appealing to the changing fashions of popular culture, they perform aesthetic modifications based on supposedly eternal and immutable models of beauty provided by classical art. The same assertion would apply to biotypology, the mere mention of which immediately points to the predominance of a white, Western canon as the reference standard for these practices (Vallejo, 2004). However, according to medical literature from the first half of the 20th century, the examination and modification of nasal defects should be carried out in "harmony" with the racial, physical, and physiognomic characteristics of each patient.

Regarding racial characteristics, Juan Andrés Codazzi Aguirre points out that "Aesthetic Surgery, within each type of bodily beauty in the respective races and to the extent that it is relative, corrects and rectifies deformities" (Codazzi Aguirre,

1938, p. 37). The Argentine Ramón Scavuzzo (1939) specifies this principle by pointing out that canons or ideals are not adjustable to all races and that it is not possible to apply the "Nordic white canon" to "a Mongolian" (Scavuzzo, 1939, p. 145). Finally, it is interesting to note that Lluesma Uranga (1958) contextualizes this reflection by pointing out that "contributions by apposition and successive crosses" typical of "alluvial societies have tended to blur archetypal racial characteristics. For this reason, he suggests that surgeons "know and consider the ethnic, social and racial background of their clinical 'cases'" to avoid "grotesque or unforeseen results, since they should only aim to correct and purify a personality, but not to change it" (Lluesma Uranga, 1958, p. 69).

Like race, the patient's physical build and facial appearance are aspects that medical literature includes in the framework of diagnosis and surgical indication for rhinoplasty. The most frequently used notion to account for this overall morphological assessment of the patient is "harmony," according to which the parts must correspond to the whole. More precisely, nasal defects are relative to the patient's physical and physiognomic characteristics and must be corrected in proportion to these aspects. Carlos Rivas (1952) summarizes this point by stating that "the concept of harmony must always prevail" and that the important thing is not to achieve a "perfect nose" but rather to "scientifically master each of the sectors of the rhinoplasty, to adapt the new nose to the rest of the face" (Rivas, 1952, p. 35).

To support the preceding extract, I return to an article published by Ernesto Malbec in which he outlines a series of practical considerations regarding when and how an aesthetic surgeon should proceed when faced with different types of nasal defects. In "*Función del sentido estético en las intervenciones plásticas*[2]*"* (1940), Malbec begins by pointing out that defects must first be considered in isolation and then in relation to the other parts of the figure. The first practical consideration aims to assess the nasal appendage in its various component parts to establish where the defects are located and, in this way, obtain a proportionate nose without the need for further retouching.

The second consideration places the nose in relation to the other parts of the figure, assuming preeminence in examining the forehead and chin for the purpose of performing a rhinoplasty with a harmonious result. In order to instruct potential readers in this principle, Malbec formulates a series of hypothetical situations, from which he establishes that even when faced with the same defect, it is necessary to indicate different types of corrections. Let us, then, look at some of the examples he proposes. To begin with, "let us suppose we are dealing with a long nose." Considering its "irregular geometry," the appropriate indication would be to shorten it according to the criteria established by "correct geometry." However, the defect

[2] Function of the Aesthetic Sense in Plastic Surgery.

and the indication become relative when the physical build and physiognomy of the patient are introduced into the examination. Thus, while the elongated nose fits "within the anatomy of a tall individual, with light contours, [and] an elongated face," in people of "short stature, thick […] [and] a round face" it takes on a "grotesque" character.

Let us now assume, following Malbec's argument, that we are dealing with a nose "with a very pronounced curve." In this case, removing the nasal hump is the indicated procedure. However, to determine how far this correction should be carried out, it is essential to include the position of the forehead and chin in the examination. When the latter are not very prominent, the surgeon may aim to take the nose from convex to concave. The therapeutic approach should be more subtle for patients with a convex nose but a forehead and chin that exhibit a similar curvature. According to Malbec, the recommended course of treatment for these individuals is "to reduce the size of the nasal appendage [...] while ensuring that the nasal bridge has a gently arched shape so that it coincides and harmonizes with the rest of the image, which is entirely curved." Otherwise, there is a risk of "artificially creating a new imperfection or anomaly" (Malbec, 1940, p. 163-165).

Based on what has been expressed so far, we could point out that Argentine medical literature from the first half of the 20th century established certain "objective" beauty standards whose practical application requires a case-by-case examination to adjust them to the racial, physical, and physiognomic characteristics of each patient. However, the type of aesthetic correction indicated by this approach to medical examination does not necessarily coincide with the patients' perceptions and desire for transformation. I dedicate the following sections to identifying the practices suggested in the literature for addressing the expectations of surgical candidates.

Psychological evaluation

Aesthetic surgery has one characteristic that sets it apart from other branches of surgery: the visibility of the result. This contrast is eloquently summarized by Argentine plastic surgeon Julián Fernández in the pages of the *Argentine Journal of Plastic Surgery*: "...the general surgeon works in the back room, a place hidden from all eyes, while the plastic surgeon works in the display window, leaving his work exposed to the view, judgment, curiosity, and criticism of everyone, both lay and scholar." (Fernández, 1978, p. 36). The visibility of the results introduces a central tension into the practice of the specialty: plastic surgeons have expert criteria to establish the type of corrections most appropriate to the uniqueness of the case, but they must deal with patients who have specific expectations of aesthetic change and who can evaluate whether the result corresponds to what they had projected.

Within this framework, medical publications deploy a series of practices, devices, and routines aimed at identifying and managing patient expectations. A recurring theme in the literature examined relates to the importance of conducting a psychological evaluation of candidates. The intersection between psychology and aesthetic surgery has been extensively documented by the social sciences, either to reconstruct the history of the legitimization of these medical practices (Haiken, 1997; Gilman, 1998; Guirimand, 2005; Barbot; Cailbault, 2010) or to explore the justifications put forward contemporaneously (Antonio, 2008; Edmonds, 2010; Jarrin, 2017; Schmitt and Rohden, 2020). However, these publications have not given central importance to a finding that is ubiquitous in the publications of plastic surgeons: while a good portion of those who undergo aesthetic surgery resolve their complexes or boost their self-esteem, others are dissatisfied with the results of the procedure, generating conflictual situations. Therefore, for the authors of the medical texts analyzed in this paper, it was important to convey categorization and selection principles aimed at distinguishing between "good" and "bad" candidates for aesthetic surgery (Pitts-Taylor, 2007; Le Hénaff, 2013; Parker, 2009; Carpigo, 2016).

To begin our introduction to the subject, it's worth noting that medical literature defines "good" candidates as those patients who are grateful for the outcome of surgery. In contrast, "bad" candidates are those who are dissatisfied and, rather than undergo surgery, are more appropriately referred for psychiatric consultation. The question that arises at this point is: what are the indicators that would allow this distinction to be made? The most frequently mentioned criterion refers to the distance between the severity of the "objective" defect and the level of subjective "suffering" experienced by the patient. According to most professionals, when there is a correspondence between these two levels, surgery is advisable. The opposite occurs when it comes to candidates who attribute excessive importance to minimal or nonexistent defects. In line with this, the Argentine plastic surgeon Humberto Bianculli points out the advisability of operating on "those with large nasal deformities" and warns about "those with small defects" who "have the obsession that their nose is not perfect" (Bianculli, 1931, p. 21). On the same date, Alejandro Forero warns about this last profile of patients whom he defines as "truly demented people who never abandon the mirror; who exaggerate their defects, or find the one they don't have; for whom neither one nor several operations will cure their obsession" (Forero, 1929, p. 1468).

More systematically, in his book *Cirugía estética (Aesthetic Surgery)* (1946), Ramón Palacio Posse classifies candidates into four categories: "I) Those with a subnormal or hypo-aesthetic aesthetic sense. II) Those with a normal or ortho-aesthetic aesthetic sense. III) Those with a supernormal or hyper-aesthetic aesthetic sense. IV) Those with a perverted or para-aesthetic aesthetic sense." Candidates who fall into the first two categories are those who "feel the deformity markedly,

but without being overly oppressed by it; after the operation, they feel as if they have been relieved of a heavy burden and are grateful to the operator." The third category refers to "patients in whom, although the physical disorders are not severe, the psychological manifestations are considerable." Palacio Posse warns that these individuals "are very difficult to treat due to their high demands for success, which is why when the deformity is not very severe, it is better for them and for the doctor not to operate on them." In closing, he identifies the candidates "who complain of a deformity that they do not really have," suggesting that the best thing in these cases "is to indicate a healthy life of sports and entertainment to improve their mental background" (Palacio Posse, 1946, p. 22-23).

Another categorization principle that emerges from the publications also relates to expectations, but no longer in aesthetic terms, but rather in relation to the patient's expressed aspirations for change in their economic or emotional situation. Plastic surgeons often point out that patients expect to resolve their romantic or professional failures through surgery. However, since the underlying problem lies in the candidate's psychology, the surgery will not bring any positive changes, and the patient will vent his frustration on the operating physician. Mario Berta, in a presentation given at the *Fourth Latin American Congress of Plastic Surgery* (1947), provides an example that perfectly illustrates this point. The case in question involved a 28-year-old single young man who was always worried about "allusions to his nose" and who expressed a "feeling of inferiority" in his romantic relationships ("he never had girlfriends and solved his sexual problems with professionals"). Although the operation resulted in a "clear aesthetic improvement," the patient displayed "a state of genuine anxiety with thoughts of self-elimination and heteroaggression toward the doctor who operated on him." Berta's lesson from this case is that the candidate's "self-important ideal" must be taken into account, given that if his ideals are too high, he will experience constant dissatisfaction that can "lead him to pathological reactions that are dangerous for him and his doctor" (Berta, 1947, p. 318).

The same warning is present in the area of economic expectations, as stated by plastic surgeon Carlos Rivas: "it is inexcusable to know in advance what the patient's anxiety is" and to show caution towards "those who want to beautify their appearance to become artists or improve their social status, and the achievement of physical improvement, if not accompanied by other success, makes them dissatisfied" (Rivas, 1952, p. 24). From this last point, it does not follow that aesthetic surgery cannot contribute to improving job placement, but for this to happen it is essential that the patient demonstrate a willingness to work and make an effort.

In this section, we observed that medical literature from the first half of the 20th century aspired to convey principles of categorization and selection that would help distinguish "good" from "bad" candidates for surgery. The latter exhibits a series of characteristics that are at odds with the virtuous victims that aesthetic surgery

seeks to redeem: they are unreasonable, undeserving, and ungrateful. On the contrary, they tend to see flaws where none exist and are demanding to the point of distorting their perception of results. They are failures, not because of their aesthetic defect, but because they take refuge in it to disguise their inherent lack of will to progress. Finally, when their expectations for aesthetic and socioeconomic change are not realized, they blame their own frustrations on the surgeons, generating conflictual situations. They are, in short, problematic individuals who should not be operated on. In the next section, we move beyond the realm of contraindications in aesthetic surgery to analyze practices aimed at dealing with patients who may require surgery.

"Truth" and "lies" in aesthetic surgery

As mentioned above, the psychological evaluation of surgical candidates is a fundamental pillar of plastic surgeon practice. But in addition to warning about a certain profile of problematic individuals, the medical literature offers a series of practical suggestions on how to modulate expectations in pre-surgical consultations and reach intersubjective agreements in the evaluation of the outcome. Addressing this point is relevant not only because it constitutes a contribution to the field of historical studies of these practices in particular, but also to the extent that it allows us to introduce a nuance to the way in which the doctor-patient relationship is usually problematized in the social sciences. A good part of these works describes a historical change that consists of the transition from paternalism (Parsons, 1951) to the consumer-patient model (Lupton et al., 1997; Henwood et al., 2003) or the co-production of medical care (Cathy, Gafni; Whelan, 1999). However, as evidenced by the analysis of the sources, patient participation in the surgical planning process is a consistent characteristic of the way the doctor-patient relationship is structured in the specialty.

Once again, plastic surgeon Ernesto Malbec underscores this point when referring to patients' common demands for aesthetic changes and the approach the surgeon should take in response to these requests. He argues that many patients are influenced in their aesthetic aspirations by "the prevailing plastic trends in film or theater, and they want to resemble this or that star on the screen or this or that star of the stage." They also demand radical corrections, without considering the disproportion that would result: "It is well known that the golden dream of every big-nosed person is to be blunt-nosed. The most common recommendation we hear from all of them is always the same: to shorten their nose as much as possible." Given this situation, far from proposing a closed-minded approach that reaffirms expert autonomy (Freidson, 1978), he highlights the centrality of pre-surgical consultations to negotiate the type of correction to be performed: "Despite everything, this does not mean that the surgeon's judgment is final or that it must necessarily prevail in the

last instance. Consultation with the patient is usually very beneficial and convenient" (Malbec, 1940, p. 1006-1007).

According to the empirical corpus examined, one of the important aspects of the pre-surgical consultation concerns the necessary balance between "truth" and "lies" in the projection of results. Unanimously, all the texts identify a strong rejection of the so-called "commercial lie." The latter is generally attributed to people without medical training who offered beauty products through grandiloquent advertisements. In this sense, Malbec criticizes the "salons and institutes" that, run by "beauty teachers," guaranteed spectacular transformations with insignificant procedures. He also warns of a booming market for "ointments, plasters, ointments, and cleansing products" that only defrauded hopeful buyers and enriched "unscrupulous merchants who miserably traffic in moral pain" (Malbec, 1938, p. 38-39). A year later, he summarized this position as follows: "If the patient is deceived from the outset, one is undoubtedly starting from a false point, because promising what cannot be done is deceiving the patient, surprising him in his good faith, dishonestly lying to him, which is what the doctor cannot and should not do" (Malbec, 1939, p. 88).

However, although "honesty" is positioned as a practical and moral standard that should guide the conduct of surgeons, this does not mean that the physician should resort to "brutal honesty." In line with this, the Argentine plastic surgeon Miguel Correa Iturraspe (1978) suggests that the professional's explanations should not be tinged with "black pessimism," since giving a "gloomy and dramatic account of all the mishaps and failures recorded in the literature for the operation" would only "horrify the patient," depriving them of the possibility of accessing the benefits of plastic surgery. Equally inconvenient is the opposite attitude, which, based on "temperamental enthusiasm" or the "fear of losing the client," paints a picture marked by "rosy optimism." Proceeding in this manner encourages excessive illusions that can lead to anguish and complaints "if the result does not match the chimerical dreams they were encouraged to conceive." From here, the author concludes that the "truth" in aesthetic surgery must "have and know how to transmit a reasonable confidence in the resources of its art" (Correa Iturraspe, 1978, p. 5-6).

Returning to Correa Iturraspe's approach, we can say that a reasonable "truth" is one that neither instills too much pessimism nor too much optimism in the patient. Regarding the aesthetic result that can be achieved through the operation, this general principle can be summarized in a formula frequently mentioned in the literature analyzed: "always promise less than what can be achieved" (Palacio Posse, 1946: 23). In this way, the candidate is encouraged to undergo the intervention, but expectations are moderated so that there is a margin of tolerance for contingencies, and the evaluation of the result is based on a modest reference point. In the next section, we will see that the modulation of expectations transcends words to materialize in a key device in the plastic surgeon's office: medical photography.

Promises on paper: the role of photography in medical consultations

In 1928, Ernesto Malbec published *Cirugía Estética. Conceptos Fundamentales*[3], a book aimed at disseminating the problems addressed by the nascent surgical discipline. As he recounts in the second volume of his *Anecdotes of a Plastic Surgeon* (1972), at that time he sent copies of this publication to various colleagues. In response, he received several letters expressing varying opinions about the quality of his work. Among them was a lengthy letter from a French plastic surgeon, in which he warned him about the moral character of an "illustrious doctor who, by dint of promoting himself in newspapers and writing books, had achieved extraordinary fame in Paris." According to the sender of the letter, this supposed "master" whom Malbec cites in his book was "absolutely a scientific charlatan."

To support his criticism, the French surgeon invites Malbec to examine the "charlatan's" photographic records, which reveal obvious manipulations upon closer inspection. On the surface, the eminent French surgeon argues, these visual documents certify brilliant results. Thus, for example, on "page 64," two photographs of a child can be seen: "In the first shot, he appears… with his ears extremely separated from his skull, as if they were a pair of screens, while in the second, after surgery, the result obtained is unquestionable." But a closer look with a magnifying glass reveals "that the ears were skillfully tied with very fine thread to keep them in the correct position for the camera" (Malbec, 1972, p. 139-142).

What emerges from the preceding account is that photographs in aesthetic surgery aim to represent the change experienced by the patient based on the contrast between the pre- and post-intervention records. In this way, medical evidence is constructed regarding the effectiveness of a particular technique in the hands of a particular operator. Tampering with these records implies, within the framework of expert meetings and publications, brandishing false evidence, thereby compromising the recognition of colleagues. In turn, appealing to these devices in popular meetings and publications fosters false expectations among potential surgery candidates. Malbec himself elaborates on this point when describing the behavior of "charlatans," noting that candidates "are promised false things, shown false photographs, which are nothing more than photographic tricks, which encourage them to undergo the operation, driven by the logical and human enthusiasm produced by seeing a monster so perfectly transformed by an operation" (Malbec, 1938, p. 37).

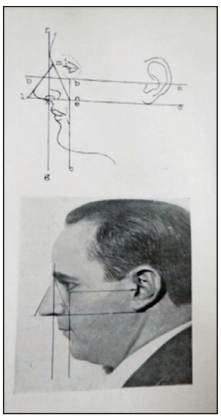
From the above, it follows that medical photography can be used to modulate the expectations of aesthetic surgery candidates and that, to fulfill this purpose, it must faithfully record the patient's aesthetic change. This fidelity is defined by a

[3] *Aesthetic Surgery. Fundamental Concepts*

set of practical principles that establish how to capture the aesthetic change and the conditions under which the record must be produced to ensure comparability. Regarding the documentation of rhinoplasties, it is common to depict the patient's entire face in different examination positions, the most common being frontal and profile shots. In this way, it is possible to appreciate the shape and volume of the components of the nasal appendage, and their relationship with the rest of the facial features. Furthermore, it is worth highlighting a series of requirements that must be rigorously repeated, such as "the conditions of light, focus, distance, background, size, plane, and orientation of the images" (Lluema Uranga, 1958, p. 76).

Having a record that meets these characteristics ensures intra- and intercase comparability, allowing its circulation in expert circles. Furthermore, according to the publications analyzed, it enables its use in different stages of the medical consultation: diagnosis, projection of results, and evaluation of postoperative aesthetic change. Regarding diagnosis, patient photographs would allow for a detached and thoughtful reading of facial geometry. On this point, Argentine plastic surgeon Cora Eliseth suggests using photographs that capture the profile of future surgeons to perform an angular study of the nose and, thus, perform a correction that involves all components of the nasal appendage (Cora Eliseth, 1938, p. 28) (Figure 3). In a more relational vein, the distancing effected by photography can be leveraged by the plastic surgeon to show the patient the nature of their defect and, thus, convince them of the appropriate type of modification. In this regard, Alejandro Forero points out that there are people who request a correction that is not exactly the one that best fits their face and to persuade them about "what the real defect of their nose is" he suggests using photographs of the patients themselves (Forero, 1929, p. 1461).

Figure 3 – Use of photography for the study of nasal angles.



Source: Eliseth, 1935, p. 28.

Photography is also identified as an element that allows for consensus and projection of the outcome of rhinoplasty. Some publications describe the use of the image of the surgical candidate as a visual aid that allows for collaborative planning of the type of surgical corrections to be performed. Thus, according to Ildefonso Giganti and Juan Castellano (1947), "determining the future shape of the nose is of fundamental importance and largely determines surgical success," suggesting the following procedure for this purpose: "We take a profile photograph from which we make two copies, and on one of them we 'correct' any defects in pencil in agreement with the patient (Castellano; Giganti, 1945, p. 7). In other publications, the outcome is not planned through photographs of the patient himself, but rather through records of previous cases. These cases are not chosen at random but rather based on a criterion of affinity with the defect presented by the candidate. For this purpose, the file constitutes a useful device that organizes the history of interventions according to body region and type of defect, allowing rapid access to the record of cases that best suits the work of coordination and aesthetic education that the surgeon wishes to perform (Kirschtein, 1956, p. 55-57). Education Aesthetics, because the selection and display of this record acts as a visual aid that illustrates the type of defect the patient has and the type of aesthetic modification that best suits their particular case. Coordination, because photography allows for anticipating the outcome of the intervention, adjusting the patient's expectations to what can be achieved.

In addition to being used for diagnosis and the projection of results in the preoperative period, several medical publications highlight the usefulness of photography in the evaluation of aesthetic changes. As we have seen on several occasions, this stage is particularly problematic, given that many patients undergo surgery may find their expectations dashed, leading to conflict. To protect themselves from these types of complaints, photographs allow the surgeon to remind the patient of their appearance "before" the intervention and to comparatively demonstrate the change in their physiognomy "after" the operation. In line with this, Ernesto Malbec states that people often do not remember what they looked like before and discuss the most notable corrections, highlighting the usefulness that photography provides in bringing forgotten physiognomy into the present (Malbec, 1938, p. 38-39). Estanislao Lluesma Uranga, for his part, points out that there are patients who, over time, begin to believe "not only that they were better before, but that they are still not well enough" (Lluesma Uranga, 1958, p. 67). In this way, postoperative photography allows not only a detailed study of the achieved result, but also the correlation of this result with the initial defect.

Ramón Palacio Posse complicates matters a bit further by introducing new perspectives on the intersubjective construction of results in aesthetic surgery. In this sense, in addition to suggesting a prior study of the patient's family and work

environment, he advises that the patient not receive visitors during the first week postoperatively, "whose prudence and discretion cannot always be counted on." These last words, which seem to refer to the need to maintain a calm environment for the convalescent, take on another meaning when reading the following reflection on photographic documentation in rhinoplasty: "For most of my patients, I take a frontal and a profile photograph, which is very useful for the doctor's file and for the patient themselves. With the 'before' and 'after' images, they can defend themselves against selfish friends who assure them they have hardly changed at all" (Palacio Posse, 1946, p. 32-33). In this way, photography emerges once again as evidence that allows for the arbitration of potential disagreements in the doctor-patient relationship.

Based on what has been presented in this section, we have been able to observe that medical photography is an element used by surgeons in the moments before and after surgery. Photographic archives of previous cases allow patients to get an idea of the outcome. Images of the patients themselves are used to plan the intervention and function as "impartial" third parties in resolving disputes in the event of disagreement with the aesthetic result obtained. Both observations contribute to supporting the thesis that, far from cementing an asymmetric relationship, plastic surgeons in the first half of the 20th century implemented certain practices aimed at projecting, planning, and evaluating the outcome of aesthetic interventions in dialogue with the patients being treated.

Conclusions

Aesthetic surgeons deal with a body, but also with people who have a perception of their physical appearance and expectations about the change they aspire to achieve. Medical literature shows that this constitutes a fundamental concern in the practice of the specialty, promoting a series of practical tips and tools to address candidates' perceptions and desires for change. To introduce ourselves to the subject, I began by showing that medical literature from the first half of the 20th century sought to transmit expert knowledge to diagnose a bodily defect, establish the appropriate type of surgical correction, and manage patients' aesthetic expectations. In the case of rhinoplasty, the aesthetic indication is based on a comprehensive examination of the patient's body, in which the anatomical area to be treated is compared to the face and overall body conformation. The objective of this examination is to indicate a surgical rectification of the nasal appendage that harmonizes with the body as a whole. The aesthetic indication speaks to us of a specialty that, far from aspiring to the mass production of bodies responding to the whims of fashion or the eternity of classical canons, aims to carry out interventions tailored to each case.

The second section aimed to explore the principles of patient categorization and selection established in the analyzed publications. We found that the medical literature emphasizes the need to conduct a psychological evaluation of candidates in order to identify and avoid operating on a profile of people who are likely to be dissatisfied with the outcome. From the analysis of the documentary corpus, it was observed that a first category of "bad" candidates includes those who express excessive concern over minimal or nonexistent "objective" physical defects. A second category relates to candidates who expect a radical change in emotional or economic spheres through aesthetic surgery. In both cases, even when faced with a good aesthetic result, those operated on will remain dissatisfied because their expectations are impossible to meet. In short, from the perspective of the literature examined, these individuals require psychiatric care rather than surgical care.

In the last two sections, I analyzed the practices and devices used by surgeons to modulate surgical candidates' expectations. One of the issues that emerges from the publications is that this is an extremely precarious relational endeavor: the specialist must not instill too much confidence or too much pessimism in the candidate. Rather, they must inform them about crucial aspects of the surgery and promise less than they can achieve. Concern about patients' perceptions and expectations also appears materialized in a series of practical appropriation devices and routines aimed at incorporating the patient into the surgical planning process. Among these, we can highlight the use of medical photography in the consulting room, which can be used to persuade the patient about their aesthetic defect; to project and agree on the outcome of the surgery; and to certify and arbitrate the obtained result.

This article proposed an original approach to addressing an underexplored object of study. On the one hand, it is worth noting that in Latin America, there are virtually no studies reconstructing the history of plastic surgery. On the other hand, while there are publications that have undertaken this endeavor in North America and Europe, all of them exclusively analyzed the role of medical discourse in legitimizing these medical practices. This work demonstrated another way of reading medical publications that, by emphasizing their pedagogical nature, allows us to describe the practices, devices, and routines devised by these specialists to address patients' expectations of aesthetic change. In other words, the article sought to construct a microsociological approach to the sources with the aim of showing that medical literature constitutes a reservoir of experiences aimed at transmitting ways of being and doing in plastic surgery to future generations of specialists.

Finally, it is possible to establish some open lines for future research. First, it would be extremely fruitful to explore the doctor-patient relationship in the contemporary Argentine aesthetic surgery market, seeking to identify continuities and ruptures in the way aesthetic surgeons deal with candidates' expectations for change.

Second, due to the centrality of medical photography in the development of this specialty, I believe it is pertinent to explore the circulation of these images outside the medical world. Given the commercial nature of the discipline in recent decades, analyzing the use of "before" and "after" photographs as promotional strategies aimed at fueling the desire for bodily change in the digital world is relevant. Finally, to the extent that this article focused on the deployment of a specific practice in the Argentine context, it would be important to develop similar research on other medical interventions in diverse national contexts.

REFERENCES

ANTONIO, Andrea Tochio de. **Corpo e estetica: um estudo antropologico da cirurgia plastica.** Orientadora: Guita Grin Debert. 2008. 153f. Tese (Mestrado) – Instituto de Filosofia e Ciencias Humanas, Universidade Estadual de Campinas, Campinas, 2008.

BARBOT, Janine y Cailbaut Isabelle. Figures de victimes et réparation des violences faites aux corps: Quand la chirurgie esthétique se donne à voir. **Politix**, Paris, n.2, v.90, p.91-113, 2010.

BERTA, Mario. Importancia de la psicología en la cirugía plástica. *In:* **Cuarto Congreso Latinoamericano De Cirugía Plástica**, 4., 1949, Montevideo. Uruguay: Monteverde y Cía., 1949, p. 316-320.

BIANCULLI, Humberto. **Cirugía estética de nariz**: **Corrección de las deformaciones nasales.** Orientador: Santiago Luis Arauz. 1931. 85f. Tese (Doutorado em Medicina) – Facultad de Ciencias Médicas, Universidad Nacional de Buenos Aires, Buenos Aires, 1931.

CARPIGO, Eva. À la rencontre du malentendu: stratégies d'approche medicale en chirurgie esthétique. *In*: HINTERMEYER, Pascal; LE BRETON David; PROFITA Gabriele (ed**.). Les malentendus culturels dans le domaine de la santé.** Nancy: Presses universitaires de Nancy - Editions Universitaires de Lorraine, 2016, p.163-176.

CATHY, Charles; GAFNI Amiram; WHELAN Tim. Decision Making in the Physician-patient Encounter: Revisiting the Shared Treatment Decision Making Model. **Social Science & Medicine**, Amsterdam, n.5, v.49, p.651–661, 1999.

CODAZZI AGUIRRE, Juan Andrés. **Posibilidades en la Cirugía Estética**. Rosario: Editorial Ruiz, 1938.

CORA ELISETH, Felipe. Rinoplastia. **Revista Argentina de Oto-rino-laringología**, Buenos Aires, n.9, v.10, p.1-15, 1938.

CORREA ITURRASPE, Miguel. El error en cirugía plástica. **Cirugía Plástica Argentina**, Buenos Aires, n.2, v.2, p.7-12, 1978.

EDMONDS, Alexander. **Pretty Modern**: Beauty, Sex and Plastic Surgery in Brazil. Durham: Duke University Press, 2010.

FERNÁNDEZ, Julián. La formación ideal del cirujano plástico. **Cirugía Plástica Argentina**, n.1, v.2, p.36-38., 1978.

FORERO, Alejandro. Cirugía plástica de la nariz (Detalles de técnica). **La Semana Médica**, n. 8, v.5, p.1461-1474, 1929.

FREIDSON, Eliot. **La profesión médica**. Un estudio de sociología del conocimiento aplicado. Barcelona: Península, 1978.

GIGANTI, Ildefonso; CASTELLANO, Juan. **Cirugía plástica y estética**. Buenos Aires: Talleres Gráficos de la Institución Fernández, 1945.

GILMAN, Sander. **Creating beauty to cure the soul**: Race and psychology in the shaping of aesthetic surgery. London: Duke University Press, 1998.

GILMAN, Sander. **Making the Body Beautiful**: A Cultural History of Aesthetic Surgery. New Jersey: Princeton University Press, 1999.

GUIRIMAND, Nicholas. De la réparation des «gueules cassées» à la «sculpture du visage»: La naissance de la chirurgie esthétique en France pendant l'entre-deux-guerres. **Actes de la recherche en sciences sociales**, n.1-2, v.156-157, p.72-87, 2005.

HAIKEN, Elizabeth. **Venus Envy**. A History of Cosmetic Surgery. Baltimore: The Johns Hopkins University Press, 1997.

HENWOOD, Flis; WYATT, Sally; HART, Angie; Smith, JULIE. "Ignorance Is Bliss Sometimes": Constraints on the Emergence of the "Informed Patient" in the Changing Landscapes of Health Information. **Sociology of Health & Illness**, New Jersey, n.6, v.25, p. 589-607, 2003.

JARRIN, Álvaro. **The biopolitics of beauty. Cosmetic citizenship and affective capital in Brazil**. Berkeley: University of California Press, 2017.

KIRSCHEIN, Manuel. Fichero y archivo en cirugía plástica. **Revista de la Sociedad Argentina de Cirugía Plástica**, Buenos Aires, n.1, v.2, p. 55-57, 1956.

LE HENAFF, Yannick. Catégorisations professionnelles des demandes masculines de chirurgie esthétique et transformations politiques de la médecine. **Sciences sociales et santé**, Arcueil, n.3, v.31, p.39-64, 2013.

LLUESMA URANGA, Estanislao. **Los Fundamentos de la Cirugía Estética**. Buenos Aires: Editorial Americalee, 1958.

LUPTON, Deborah. Consumerism, reflexivity and the medical encounter. **Social science and medicine**, Amsterdam, n.3, v.45, p.373–381, 1997.

MALBEC, Ernesto. **Cirugía Estética. Conceptos Fundamentales**. Buenos Aires: La Semana Medica, 1938.

MALBEC, Ernesto. Función del sentido estético en las intervenciones plásticas. **La Semana Médica**, n.10, v.7, p.997-1008, 1940.

MALBEC, Ernesto. **Anecdotario de un cirujano plástica**. Segunda Parte. Buenos Aires: Artes Gráficos Bartolomé U. Chiesino, 1972.

PALACIO POSSE, Ramón. **Cirugía Estética**. Buenos Aires: El Ateneo, 1946.

PARKER, Rhian. **Women, Doctors and Cosmetic Surgery: Negotiating the 'Normal' Body**. New York: Palgrave Macmillan, 2010.

PARSONS, Talcott. Illness and the role of the physician: a sociological perspective. The American journal of orthopsychiatry, Washington, v. 21, n. 3, p. 452–460, 1951.

PITTS-TAYLOR, Victoria. **Surgery Junkies. Wellness and Pathology in Cosmetic Surgery**. New Jersey: Rutgers University Press, 2007.

RIVAS, Carlos. **Cirugía correctora de la pirámide nasal**. Orientador: Oscar Ivanissevich. 1952. 160f. Tese (Doutorado em Medicina) – Facultad de Ciencias Médicas, Universidad Nacional de Buenos Aires, Buenos Aires, 1952.

SCAVUZZO, Ramón. Cirugía estética de la nariz. Algunos criterios o cánones artísticos. **La Semana Médica**, Buenos Aires, n.9, v.6, p.144-146, 1939.

SCHIMITT, Marcelle; Rohden, Fabíola. Contornos da feminilidade: Reflexões sobre as fronteiras entre a estética e a reparação nas cirurgias plásticas das mamas. **Anuário Antropológico**, Brasilia, n.2, v.45, p.209-277, 2020.

VALLEJO, Gabriel. El ojo del poder en el espacio del saber: los institutos de biotipología. **Asclepio**, Buenos Aires, n.1, v.56, p.219-244, 2004.

VIALE DEL CARRIL, Atilio. **La rinoplastia por vía endonasal**. Orientador: Oscar Ivanissevich. 1935. 76f. Tese (Doutorado em Medicina) – Facultad de Ciencias Médicas, Universidad Nacional de Buenos Aires, Buenos Aires, 1935.