AG AboutGender
International journal of gender studies

https://riviste.unige.it/aboutgender

DOI: 10.15167/2279-5057/AG2018.7.13.496

Vol. 7 N° 13 anno 2018
pp. 165-184

Tailoring the perfect patient: Italian cosmetic surgeons between gender stereotypes and professional routines

Cinzia Greco

University of Manchester

Abstract

This article explores the views that cosmetic surgeons have of patients and the role they play in the selection of patients. The research is based on 17 in-depth interviews with surgeons conducted in Italy. It shows how the surgeons play an active role in determining if and how a patient will undergo a cosmetic operation, and how surgeons adhere to dominant gender stereotypes, but also partially redefine them in order to facilitate their professional routines. Surgeons use gendered criteria to describe the problematic patient, who might bring a lawsuit endangering their practice. The male patient is gradually legitimized through the use of a rhetoric of "virilization". Nevertheless, cosmetic surgery continues to be seen as a female-centred practice, and the image of the ideal patient is still a woman, counter-intuitively described by surgeons as young and beautiful.

Keywords: cosmetic surgery, surgeons, doctor-patient relationship, gender stereotypes.

1. Introduction

Feminist scholarship has devoted significant attention to cosmetic surgery in the last 25 years. Cosmetic surgery, as surgery in general, is prevalently practised by men, their clientele is still prevalently female, and the reasons for undergoing this kind of surgery are closely linked to social ideas of what a gendered body should look like. Other kinds of surgery, such as gender reassignment surgery (Davy 2011) and non-cosmetic breast surgery (Greco 2016) have been shown to be practices of gender construction, but the fully elective nature of cosmetic surgery has made it a privileged object in the study of agency and domination. Therefore, the subject has been fertile in increasing the understanding of the construction of gender, of the asymmetry in gendered professional relationships, and of the spaces of agency available to women. However, between patients, surgeons, and the social context, it is surgeons who have been studied less (Heyes and Jones 2009) and therefore less problematized. As the main debate in cosmetic surgery has concerned (patient-centred) agency versus (context-centred) domination, the risk lies in reducing surgeons to mere executors of the dominant ideals of gendered body appearance, or to underestimate the limits to agency the patients meet once they decide to contact a cosmetic surgeon.

In this article, focusing on cosmetic surgeons in Italy, I intend to show how putting the surgeons in the picture can add to the understanding of the context of cosmetic surgery. By engaging the existing literature, I will discuss how surgeons have an active role in guiding patients' expectations and in defining the ideal and the undesirable cosmetic surgery candidates. Moreover, I will highlight how surgeons apply dominant gender schemas and ideas of the gendered body, but also how they partially redefine them in order to facilitate their work routines.

2. Theoretical debate: how surgeons influence the picture

While cosmetic surgery aimed initially to conceal "ethnic" traits that could make social integration difficult (Gilman 1999), with time it increasingly developed into a female-centred activity (Dull and West 1991; Davis 2002; Löwy 2006), to the point that it came to be counted among female "beauty practices". Cosmetic surgery has attracted the attention of several feminist scholars who conducted important analyses of cosmetic surgery using different theoretical frames. A first group of studies placed the phenomenon within the system of domination represented by the fashion/beauty complex (Bartky 1990). These works underlined the power of normalization and control that the diffusion of this practice can produce (Morgan 1991; Bordo 2009; Dolezal 2010). A different current of feminist studies used the concept of agency to understand patients' motivations. Scholars such as Davis (1995) and Gimlin (2002) have conducted empirical qualitative studies and affirmed that the women who make use of cosmetic surgery are not motivated by vanity, nor are they cultural dopes: they instead considered cosmetic surgery a solution to an unbearable problem[1].

Surgery is a male-dominated medical speciality, and the ideal image of the surgeon displays an array of characteristics of the hegemonic masculinity, such as courage, determination, and heroism (Cassell 1991; see also Bruni 2012). The ideal of the cosmetic surgeon also shares, at least in part, those characteristics. Indeed, cosmetic surgeons have constructed themselves as heroes and their profession as a noble effort to give women beauty and all that accompanies beauty (Davis 2003). However, as cosmetic surgery is becoming more and more diffuse, and as media and new media are making medical information easily available to the patients, the surgeons' scientific authority has been partially challenged, forcing them to redefine their role (Jones 2009). One of the main problems for surgeons is to deal with disagreements with patients, and patients' recourse to litigation. Some researchers have examined the role of the surgeon in the decision-making process of the patient. They have highlighted how surgeons use

[1] A further line of research underlines how cosmetic surgery patients do not pursue a single dominant beauty model, but rather vary in their objectives according to cultural context (for example, Holliday and Elfving-Hwang 2012; Luo 2013) and class (Sanchez Taylor 2012). The surgeons I have interviewed have not recognized such differences.

both personal (that is, a subtly erotic attitude, Spitzack 1988) and technical means (that is, their best before and after photographs, Blum 2003), or the presentation of the patients' bodies as pathological (Mirivel 2008) in order to push the hesitant patient into undergoing the operation. As most of the researches in social sciences have focused on why patients choose to undergo cosmetic surgery, surgeons' depiction of "good" and "bad" patients has received less attention. Several medical articles warn cosmetic surgeons against operating on men. Indeed, a man who asks for cosmetic procedures is presented as immature and insecure, and thus potentially more problematic than women (Rohrich 1999; 2001; Gorney 2002; Dowling *et al.* 2010). This has been recognized by surgeons interviewed in the US (Dull and West 1991) and in Italy (Ghigi 2009). However, rapid changes have occurred in recent years in the domain of cosmetic surgery, with a growing number of men asking for cosmetic procedures, presenting the operations as investments in body capital (Holliday and Cairnie 2007), and redefining their choices in virilizing terms (Atkinson 2008). Other researches have shown that surgeons consider undesirable patients who look for the external approval, or who are considered "psychologically unstable" (Parker 2010). A research (Le Hénaff 2015) has identified two similar profiles as commonly refused by French surgeons: young women, mainly of working class background, who are considered to expect changes in social status from the surgery, and middle-aged women who fear to lose their partner's interest.

In the following pages, I aim to underline that cosmetic surgeons are not merely a link between societal beauty norms and the desire – or the need – of patients to achieve them. On the contrary, cosmetic surgeons have an active role in defining what the patient can demand from them and from cosmetic surgery. Moreover, surgeons have practical aims that filter both dominant societal norms and patients' requests to assure a functional professional practice. Several elements play a role in shaping surgeons' attitudes, including the juridical system of the country in which they work. Some of the results of my research are linked to the local context of cosmetic surgery (see Edmonds 2010; Luo 2013). In particular, the organization of the Italian juridical and healthcare systems can explain in part the attitudes of the surgeons.

3. The institutional context of cosmetic surgery

Medical literature presents most legal disputes as not caused by incompetence or technical errors. Instead, several articles discuss communication problems with the patients (Webb 1999) or problems in patient selection (Gorney and Martello 1999; Blackburn and Blackburn 2008). The goal of such advice is to protect the surgeon from the risk of legal action. Nevertheless, such action seems to be a common experience in the medical profession as a whole and in surgery in particular (for the Italian context, see Bilancetti and Bilancetti 2010). The juridical regulation of the discipline, and the legal obligations the surgeons have, also influence surgeons' behaviour. In Italy, there is a contradictory aspect of the juridical regulation of cosmetic surgery, namely the oscillation between the obligation 'of means' and that "of results". An obligation of means entails the patient having to prove that a negative result is due to a surgeon's erroneous work, while an obligation of results entails the surgeon having to prove that the result of the operation is congruous with what was proposed to the patient. Until the seventies, court rulings made explicit reference to an obligation of results in cosmetic surgery, but by the early eighties the authors treating the subject leaned toward the obligation of means. Generally, rulings today seem oriented towards the obligation of means, but since the nineties many seem to re-introduce, albeit surreptitiously, some degree of obligation of results in cosmetic surgery, also making reference to its non-curative purpose (Zeno-Zencovich 2008). In cosmetic surgery, both medical and legal literatures emphasize the importance of communication between surgeon and patient. According to Pizzetti (1998), the surgeon has to be clearly understood when talking with the patient, and should adapt his communicative style to the competence and educational level of the patient in order to be sure that the patient is fully aware of the risks of the operation.

Finally, cosmetic surgeons seems to lack institutionalization and cohesion in Italy. In her work on cosmetic surgery in the country, Ghigi (2008) has shown how the profession is characterized by a strong individualism and by surgeons' difficulty of identifying with a single professional group. This is influenced by the fact that there is no specific compulsory specialization required to conduct cosmetic surgery operations, which can in fact be conducted by any surgeon or physician. The only recognized specialization is

that of Plastic and Reconstructive Surgery, which also allows the surgeon to start a career in public hospitals. While this specialization shares several technical skills with cosmetic surgery, it is different in its goals, locations, and conditions of work**.**

4. Method and sample

The research is based on 17 in-depth interviews with surgeons – three women and 14 men – who practice in Italy. These were conducted between 2010 and 2011 in Central and Northern Italy. The surgeons were contacted by email, in almost every case from the list available at www.chirurghiestetici.it. The website was a database not officially linked to surgeons' associations; nonetheless, at the time it offered the most complete list fully open to the public.

All the surgeons were fully informed of the aims of the research, and the data collected were entirely anonymized. All the names used in the article are pseudonyms. All but one surgeon consented to the recording of the interview, the transcription of the interviews and the field notes were subjected to a software-assisted qualitative analysis. The main themes of the interview guidelines and those emerging from the interviews themselves have been compared across the interviews to find points of consensus among the surgeons' interviews or to build typologies where no consensus was found. To gain a larger picture of the field, I have also included an explorative analysis of how medical literature defines the surgeon-patient relationship and orients surgeons' practice.

5. Cosmetic surgeons and patients: a difficult relation

In a market-based, highly litigious, context, what matters for surgeons it is not just to increase the number of operations, but to operate on patients who will not became a problem in the postoperative phase. For these reasons, preliminary examinations are also moments when surgeons try to shape patients' expectations, both in terms of aesthetic results and the impact cosmetic surgery can have on their lives. One of the simplest ways to make the patients understand what could be the final result is to show them be-

fore and after pictures. Another way is to use software simulation. The ultimate purpose of these examinations is to ensure that the patient's expectations converge towards the results that are the best and/or the most achievable according to the surgeon. This process of communication and construction of expectations is the keystone of the doctor-patient relationship. Most of the surgeons, indeed, admit with reluctance that the operations they perform could be technically imperfect. In the majority of cases, they say that they have made a communication error – an expression used frequently in the medical literature – that could have created unrealistic expectations in the patient. However, surgeons often emphasize their efforts to explain the characteristics and limitations of the operation, and state that the patients have not grasped this information. In this way, the communication error is transformed in a comprehension error. Indeed, as Dr Giorgio put it:

> If it is really due to an error of mine, I try to remedy it, but in most cases they're not due to surgical errors, they are due to excessive expectations. That is, the patient continues not to like herself, even if the operation went well. It's a problem in the patient, not in the surgeon.

When the patient declares himself or herself dissatisfied, the problem shifts from the surgeon's work to the patient's perception.

While the surgeons state that it is important to recognize a potentially problematic patient, what problematic can be, however, varies. Previous social research has shown that medical literature pathologizes both unsatisfied and litigious patients, presenting them as psychologically fragile (Fraser 2003). However, some of the surgeons I have interviewed attach a moral stigma rather than a psychological one to litigious patients, defining them as dishonest. According to surgeons, the dishonest patient is ready to overemphasize the post-operative problems or to declare themselves dissatisfied with the result in order to avoid paying or even to «gain something». As Dr Federico says:

> There are some freeloaders, patients who already know that they will have the operation but that they won't pay […]. They come out perfect, and one can't under-

> stand why [they complain]; they have already prepared the whole explanation, photos, and maybe there is already a young lawyer behind [them] who already knows everything.

Several surgeons present cases that are similar to the one Dr Federico describes. Dr Biagio, for example, described one case of litigation as the retaliation of a patient who was unwilling to pay.

Moreover, surgeons describe themselves as having no protection against this dishonest behaviour; as Dr Biagio stated in the interview:

> informed consent is not a safeguard for the doctor, because if you don't make them sign it you're not protected, if you make them sign it, the patient can just say he didn't read it and you're not protected any more. It's appalling but it's like that.

Surgeons describe a legal landscape in which they feel less protected than their patients, maintaining that the patients can sue and obtain damages even after a technically perfect operation. As patients' dissatisfaction is part of the surgeons' everyday activity, they have a priority to control the frequency and the consequence of dissatisfaction, in order to protect their reputation and their incomes.

6. Middle-aged women

We have seen that cosmetic surgeons think that the Italian juridical context protects patients more than cosmetic surgeons. In this context, they try to redefine the role of cosmetic surgery and the ways in which patients should approach it. In doing so, they use traditional gender stereotypes of femininity and masculinity, reshaping them in more efficient way for their everyday activity. Dr Luigi's words are a useful description of the typical (female) patient surgeons encounter in their daily work:

> The preponderant majority of my patients are women, aged between 35 and 45, who have had one or more pregnancies, they breast-fed, the breasts have emptied, and they want to return exactly to some years before, with firmer breasts.

Also, some patients turned to cosmetic surgery after a divorce or the end of a relationship:

> Then there's the one who may be already married, with children, and maybe wants to put her body a little into order, starts going to a gym, she wants to return a little fresher, and often she maybe has unfortunately separated, and therefore she is also looking for another partner, so she also wants to start a different kind of life, to be put back into form; now [these patients] are like 40 (Dr Federico).

Therefore, even if surgeons mention younger patients (for example, for otoplasty) and older ones (for example, for fillings with hyaluronic acid), the majority of the clientele seem to be middle-aged women below 50 – what these latter patients want is to get back an appearance lost because of pregnancy or ageing.

Most patients are middle class and can afford an operation, but they often have to make some economic sacrifices. Several among the surgeons interviewed have defined cosmetic surgery as becoming "more democratic": that is, increasingly pursued also by women with working-class backgrounds. They, however, underplay the fact that these patients often have to take loans from agencies.

Surgeons rarely express appreciation for the middle-aged women who seem to be the most common type of patient; on the contrary, they present them as overly demanding and unable to understand the limits of the physical changes achievable through cosmetic surgery. Surgeons consider the dissatisfaction expressed by patients – often female patients – to be due to their exaggerated expectations in cosmetic surgery (see also Parker 2010, 92-93). For example, Dr Giuseppe states:

> I mean, you can say everything, I can say, "Listen…", but once the operation is over, she looks at herself in the mirror, [and because] her expectations were different, she says, "Look, it sucks, I don't recognize it, [the breasts] are smaller, they're

> bigger, one is lower", and maybe she was asymmetrical at the start, we all have an asymmetry, and the expectation was to come out as, I don't know, as Belén[2].

Dissatisfaction, however, can also be linked to the fact that the corporeal modification has not produced the change the patient hoped for in her life (Parker 2010 and Le Hénaff 2015). The example frequently cited concerns the middle-aged woman who decides to undergo breast augmentation to get her husband back:

> Now, if one understands that behind that there is a problem which is not objectively relevant but is linked, I don't know, to the will of another person, "I want to improve myself, my breasts, because my husband cheats on me". "So I want to augment my breasts because my husband's mistress has a cup size 36, I have a 32, and…" This is not a motivation for [undergoing surgery] (Dr Maria).

A patient who links the achievement of non-aesthetic goals to cosmetic surgery is an inadequate candidate, because:

> [w]hatever one does, even if the final result, surgically, technically, is correct, excellent, the patient is not pleased, because maybe he did not obtain what he expected, not from the surgery, from the relationship with the rest of the world (Dr Maria).

Television programmes that helped popularize cosmetic surgery (*Extreme Makeover*; *The Swan*) presented it as an act that can improve lives and increase the self-esteem of the patients (Pitts-Taylor 2007). Moreover, cosmetic surgery is presented and justified in contemporary society as a way to reveal one's real, inner self (Heyes 2007). However, the surgeons I met think that, as Dr Giorgio says, «cosmetic surgery does not change your life» (surgeons interviewed in Pitts-Taylor 2007 expressed similar opinions), and they are often suspicious of patients that see cosmetic surgery as a way to change their lives radically. The makeover metaphor proposed by several media outlets sets the

[2] Belén Rodríguez, an Argentine showgirl famous in Italy.

stakes higher, increasing the risk for the surgeons of having to deal with a larger number of unsatisfied patients.

7. The male patient

If middle-aged women are considered to have unrealistic expectations of cosmetic surgery, several surgeons consider men to have a more realistic vision of cosmetic operations. That vision is in contradiction with medical literature, which summarizes the characteristics of the worst candidate using the male name S.I.M.O.N., denoting the «Single, Immature, Male, Obsessive, and Narcissistic» patient (Rohrich 1999). Yet, as already mentioned, men's recourse to surgery has increased in recent years; in particular, men undergo operations that are less invasive, pertaining to cosmetic medicine rather than surgery, such as injections of hyaluronic acid or tattoo removals, and this increase goes hand in hand with a partial rehabilitation of the male patient.

Among the surgeons interviewed, a surgeon specializing in breast surgery, Dr Luigi, is the only surgeon who expresses a strong negative opinion of the male patient, saying that: «There is a difference between men and women, in the sense that we work better with women than with men». Later, he used the S.I.M.O.N. acronym to designate the categories of patients to avoid, using male examples for many of the characteristics:

> "SIMON" [who is:] Single. The single man or woman is a person at risk. Especially if he is of a certain age […]. Because the mere fact that he has not found the companion of his life, and so on, means that he is an extremely difficult person […]. And M is for male. Men are the patients more at risk. Males, I repeat it, there's no doubt, especially for sensitive operations like face-lifts […]. N, narcissist. The narcissist, who also in this case is most of the times the man, is the one who passes three quarters of his day in front of the mirror nit-picking for a defect, and is the one you will never satisfy because of that.

Dr Luigi perceives a man's desire to conform to the beauty standard as unusual, and he describes the male patient in a grotesque way – as a man who passes his day in front of the mirror. Ghigi (2009), in the interviews she conducted with Italian cosmetic sur-

geons between 2005 and 2006 has found negative accounts of male patients. However, with the exception of the aforementioned Dr Luigi, most surgeons I met in my research, which took place a few years after that of Ghigi's, had much less negative and much more nuanced opinions about male patients.

Dr Andrea says that male patients often contact cosmetic surgeons because they cannot bear a complex anymore, and «at a certain point [they] decide they want to do something». «Therefore», he continues, «when a man arrives, I know this man has already taken a decision». Men's resolution was highlighted by the majority of the surgeons I met, but provided different explanations. Dr Alessandro affirms that, contrary to what he expected, male patients are more decisive than women and Dr Paola affirms when a man has trust, «he lets himself really go, does what he has to do, and it's much simpler, I don't know how to explain it, women are more complicated, ask more questions». The pragmatism of the male patient is also appreciated:

> It's unlikely for him [the male patient] to have excessive expectations. How can I say it? From a certain point of view he is more of a realist. Women on the other hand surround this thing [the cosmetic operation] with [other expectations]: they [want to] change their existence, find another husband, find another boyfriend, these are real problems. […] When a man enters the office of the plastic surgeon, he has already broken a taboo […] he's more determined. When a woman enters she is still not determined, because she's there waiting, going around, goes to many surgeons, a man […] if he has trust, he has trust (Dr Giorgio).

The difference between my research and Ghigi's may be a sign of a rapidly changing image of the male patient. As the number of men requiring cosmetic surgery is growing, creating a significant market for male cosmetic surgery, it becomes disadvantageous for surgeons to keep considering male patients as an unpleasant exception. Men undergoing a cosmetic surgery operation «may tactically reframe cosmetic surgery along established masculine lines of power and authority» (Atkinson 2008, 83). The opinions of the surgeons I have interviewed seem to point in the same direction. A man who wants to change his body by undergoing cosmetic surgery is still an exception, but he is turned into an acceptable patient by a virilization of his choice, using stereotypes that are in-

tended to differentiate masculinity from femininity. The presence of men does not seem to call into question categories of gender. It rather reaffirms them, through the utilization of characteristics of hegemonic masculinity.

8. The ideal patient

As we have seen, the S.I.M.O.N. acronym, although still used, leaves room for a less negative vision of the male patient. Even if regarded with much benevolence, men are far from being considered the ideal patient in cosmetic surgery. The ideal patient is still S.Y.L.V.I.A., that is, the female patient who is a Secure, Young Listener, who is also Verbal, Intelligent, and Attractive who «tend[s] to do much better after cosmetic surgery procedures» (Rohrich 1999, 220). Surgeons make reference to precisely these characteristics when they describe the kind of patient they prefer. For example, Dr Federico says:

> she's a very neat girl, who keeps her whole body in order, who diets, keeps herself fit, does sport, is very neat in her whole physical appearance, and who therefore usually does not want to have pockets of fat, [wants] to have a fair nose, and to have well-proportioned breasts, not so big, otherwise if she was completely flat… the typical patient is one who is 20, 21, and wants to have adequate breasts.

Dr Antonio's opinion is similar:

> Well, we can say, [what] makes the patient, male or female, ideal… the young girl who's cute, pretty, proportioned, who has beautiful skin, and who maybe has a 30 breast cup. And that poor girl needs, has necessity of an augmentative mammoplasty. And we can be sure that this is a patient whose problem we will resolve. [The ideal patient] is the one who is able to localize a problem, and in the majority of cases they are girls, even if young, but with very clear ideas.

The ideal candidate for surgery seems to be the patient who already adheres closely to the aesthetic standards and to the rules of the fashion-beauty complex. The ideal pa-

tient is beautiful, young, determined, and informed, and lacks only one element to achieve the ideal physical image. In this case, the surgeon can help to complete a work of art that is already almost perfect. In the surgeons' opinion, in this case the woman "needs" an augmentative mammoplasty, or a proportioned nose. The role of surgery is to remove a single defect that ruins an otherwise harmonious body image, not to completely modify the woman's image.

In other cases, the elimination of a defect is seen as an event that can drive the patients to start or intensify the activities of adjustment to beauty standards. The surgeons usually judge this kind of behaviour positively, up to the point of considering it an element that allows the operation to be considered successful:

> In aesthetic surgery […], we take pre-operative and post-operative photos, and sometimes when some time has passed, I look at the photos and I realize not only the difference, that the breast is beautiful, it was a cup 30, it is a 34, a good 34, but that the patient is different. I mean, these are things that do not concern the operation, but the patient before was faded, without make up, with unkempt hair, and she returns tanned, with make up, so it is a patient who gains […] a greater attention to her body's aesthetic, this is a beautiful [thing], it is a patient who… well, in the pre-operative photo, she didn't have make up on, but you notice it also on the day of the operation, in front of you, that she is not satisfied with herself, and you see her, well, apart from the make-up, but you see, well, so to say, a woman… you see the hair, maybe done, well, this is satisfactory to see, so yes, I acted on a single part of the organism, but there was a positive repercussion on everything.

In this case, the change of breast size is considered an element that leads the patient to begin a number of modifying activities (a greater attention to make up, hairstyle, and clothes). The ideal patient is, therefore, the one who already adheres to various practices with the common goal of adjusting to current beauty standards, or who can eventually adhere to them after the intervention.

9. Conclusions

Most of the feminist research has analysed cosmetic surgery from the point of view of the domination or the agency of the patients, giving less attention to the role of the surgeons. In my research, I have focused on the ways in which surgeons define their relationship with patients, the practice of cosmetic surgery, and its limits, in order to understand how gender schemas influence, and are (re)produced through, cosmetic surgery itself.

In a context in which the heroic stereotype of the surgeon is challenged (Jones 2009) and in which lawsuits are not rare, the surgeons try to take measures to make their work less problematic. The medical literature links explicitly the profile of the worst and best patient to the need to reduce litigation from unsatisfied patients. The surgeons I have interviewed explicitly affirm that the Italian legal context protects patients much more than surgeons, claiming that patients are allowed to sue a surgeon who had performed a technically perfect procedure.

Medical literature advises the surgeons on how to avoid problematic patients. This general warning, however, is interpreted differently according to the context. Parker (2010) found that the surgeons she interviewed in Australia were only avoiding patients believed to have psychological problems, but Ghigi (2009) found an aversion to male patients among Italian surgeons and Le Hénaff (2015) in France found hostility towards middle-aged women who wanted to regain a partner through surgery and young women of working class background who were looking for social advancement. My research confirms the hostility towards middle-aged women, but shows different attitudes towards male patients and younger women.

The surgeons that I met do adhere to the dominant gender schemas, and to dominant ideals of appearance of the gendered bodies. However, they also redefine partially these ideas in ways that facilitate their professional activity. Men are gradually being considered less problematic and are being rehabilitated by the surgeons. In a shifting context, old opinions coexist with new ideas, and in the case of Dr Luigi the male patient is still considered the worst candidate for cosmetic surgery. However, as male patients are a new clientele that can increase the surgeons' profit, there is incentive to partially rede-

fine the gender schemas in ways that legitimate men who undergo cosmetic surgery. This situation, however, does not entail a reduction of gender stereotypes, which are on the contrary emphasized. The male patient is indeed presented as sure and determined and as brave for breaking a taboo by entering the surgeon's office. It can be also hypothesized that the male patient who enters the cosmetic surgeon's office is welcomed because many surgeons have not yet experienced him as problematic. That is, many surgeons have not yet had malpractice litigations involving male patients.

Moreover, the legitimation of the male patient does not touch other stereotypes about who should make use of cosmetic surgery. The ideal patient remains S.Y.L.V.I.A., a woman who curiously is also young and attractive. In the medical literature, and for the surgeons interviewed, the best candidate for cosmetic surgery is someone who in fact already meets the present aesthetic standards, except in one detail. The task of surgery, as it emerges from these interviews, seems therefore not to be the creation of perfection, but the perfecting of what is already beautiful. The best candidate is the one who asks less from the surgery (and, therefore, from the surgeon). This candidate is the one who does not expect a radical change in her or his social and emotional life from the operation[3], but wants only to correct a well-defined defect. On the contrary, surgeons describe the middle-aged woman, who seems to be the most frequent profile among the clientele, as a problematic patient: she is presented as having unrealistic expectations of the surgery. The stereotyped description is that of a divorced woman undergoing cosmetic surgery to gain her lover back. These discourses do not say much about the real patients entering cosmetic surgeons' offices. However, they can be useful in understanding how surgeons consider their activity, its limits and, thus, what kind of evaluative processes are at stake in the legitimation of the different typologies of patients.

Therefore, when assessing what spaces of agency cosmetic patients have, the role of the surgeon should be considered in its complexity. While the patient always has the option of pursuing her aims by contacting other surgeons, in the end a certain amount of negotiation will be necessary. This negotiation will probably will be influenced by dom-

[3] The young women disliked by the surgeons interviewed by Le Hénaff (2015) in France on the other hand hoped for improvements in their social standing.

inant gender schemas and dominant beauty standards and, while the patient should not be considered the passive victim of these dominant ideas, it should be also considered that surgeons will also actively implement their own schemas, those that can help them to make their work routines easier.

References

Atkinson, M. (2008), *Exploring Male Femininity in the 'Crisis': Men and Cosmetic Surgery,* in «Body & Society», vol. 14, n. 1, pp. 67-87.

Bartky, S.L. (1990), *Femininity and Domination. Studies in the Phenomenology of Oppression*, London, Routledge.

Bilancetti, M. and Bilancetti, F. (2010), *La responsabilità penale e civile del medico*, Padova, Cedam.

Blackburn, V.F. and Blackburn, A.V. (2008), *Taking a history in aesthetic surgery: SAGA – the surgeon's tool for patient selection*, in «Journal of Plastic, Reconstructive & Aesthetic Surgery», vol. 61, n. 7, pp. 723-729.

Blum, V.L. (2003), *Flesh Wounds. The Culture of Cosmetic Surgery*, Berkeley, University of California Press.

Bordo, S. (2009), "Twenty Years in the Twilight Zone", in Heyes, C. and Jones, M. (eds. by), *Cosmetic Surgery. A Feminist Primer*, Aldershot, Ashgate, pp. 21-33.

Bruni, A. (2012), *Attraverso la maschilità: posizionamenti e sconfinamenti di genere in sala operatoria*, in «About Gender», vol. 1, n. 2, pp. 152-174 - http://www.aboutgender.unige.it/index.php/generis/article/view/33.

Cassell, J. (1991), *Expected Miracles. Surgeons at Work,* Philadelphia, Temple UP.

Davis, K. (1995), *Reshaping the Female Body. The Dilemma of Cosmetic Surgery*, New York, Routledge.

Davis, K. (2002), *'A Dubious Equality': Men, Women and Cosmetic Surgery*, in «Body & Society», vol. 8, n. 1, 49-65.

Davis, K. (2003), "Lonely Heroes and Great White Gods: Medical Stories, Masculine Stories", in Id., *Dubious Equalities and Embodied Differences. Cultural Studies on Cosmetic Surgery*, Lanham, Rowman & Littlefield, pp. 41-57.

Davy, Z. (2011), *Recognizing Transsexuals. Personal, Political and Medicolegal Embodiment*, Farnham, Ashgate.

Dolezal, L. (2010), *The (In)Visible Body: Feminism, Phenomenology, and the Case of Cosmetic Surgery,* in «Hypatia», vol. 25, n. 2, pp. 357-375.

Dowling, N.A., Honingman, R.J. and Jackson, A.C. (2010), *The Male Cosmetic Surgery Patient. A Matched Sample Gender Analysis of Elective Cosmetic Surgery and Cosmetic Dentistry Patients*, in «Annals of Plastic Surgery», vol. 64, pp. 726-731.

Dull, D. and West, C. (1991), *Accounting for Cosmetic Surgery: The Accomplishment of Gender*, in «Social Problems», vol. 38, n. 1, pp. 54-70.

Edmonds, A. (2010), *Pretty Modern. Beauty, Sex, and Plastic Surgery in Brazil*, Durham, NC, Duke University Press.

Fraser, S. (2003), *Cosmetic Surgery, Gender and Culture*, Basingstoke, Palgrave Macm.

Ghigi, R. (2009), "I complessi di Narciso. Gli uomini e la chirurgia estetica", in Ruspini, E. (ed. by), *Uomini e corpi. Una riflessione sui rivestimenti della mascolinità*, Milano, FrancoAngeli, pp. 227-242.

Ghigi, R. (2008), *Per piacere. Storia culturale della chirurgia estetica*, Bologna, il Mulino.

Gilman, S.L. (1999), *Making the Body Beautiful. A Cultural History of Aesthetic Surgery*, Princeton, Princeton University Press.

Gimlin, D.L. (2002), *Body Work. Beauty and Self-Image in American Culture*, Berkeley, University of California Press.

Gorney, M. (2002), *Cosmetic Surgery in Males*, in «Plastic and Reconstructive Surgery», vol. 110, n. 29, p. 719.

Gorney, M. and Martello, J. (1999), *Patient Selection Criteria*, in «Clinics in Plastic Surgery», vol. 26, n. 1, pp. 37-40.

Greco, C. (2016), *Shining a light on the grey zones of genders construction: breast surgey in France and Italy*, in «Journal of Gender Studies», vol. 25, n. 3, pp. 303-317.

Heyes, C. (2007), *Self-Transformations: Foucault, Ethics, and Normalized Bodies*, Oxford, Oxford University Press.

Heyes, C. and Jones, M. (2009), "Cosmetic Surgery in the Age of Gender", in Id. (eds.), *Cosmetic Surgery. A Feminist Primer*, Aldershot, Ashgate, pp. 1-17.

Holliday, R. and Cairnie, A. (2007), *Man Made Plastic. Investigating men's consumption of aesthetic surgery*, in «Journal of Consumer Culture», vol. 7, n. 1, pp. 57-78.

Holliday, R. and Elfving-Hwang, J. (2012), *Gender, Globalization and Aesthetic Surgery in South Korea*, in «Body & Society», vol. 18, n. 2, pp. 58-81.

Jones, M. (2009), "Pygmalion's Many Faces", in Heyes, C. and Jones, M. (eds. by), *Cosmetic Surgery. A Feminist Primer*, Aldershot, Ashgate, pp. 171-190.

Le Hénaff, Y. (2015), *«Je ne vous opérerai pas» Registres argumentaires des refus d'opérer en chirurgie esthétique*, in «Travail et Emploi», n. 144, pp. 61-80.

Löwy, I. (2006), *L'emprise du genre. Masculinité, féminité, inégalité*, Paris, La Dispute.

Luo, W. (2013), *Aching for the altered body: Beauty economy and the Chinese women's consumption of cosmetic surgery*, in «Women's Studies International Forum», vol. 38, n. 1, pp. 1-10.

Mirivel, J.C. (2008), *The Physical Examination in Cosmetic Surgery: Communication Strategies to Promote the Desirability of Surgery*, in «Health Communication», vol. 23, n. 2, pp. 153-170.

Morgan, K.P. (1991), *Women and the Knife: Cosmetic Surgery and the Colonization of Women's Bodies*, in «Hypatia», vol. 6, n. 3, pp. 25-53.

Parker, R. (2010), *Women, Doctors and Cosmetic Surgery. Negotiating the Normal Body*, Basingstoke, Palgrave.

Pitts-Taylor, V. (2007), *Surgery Junkies. Wellness and Pathology in Cosmetic Culture*, New Brunswick, NJ, Rutgers University Press.

Pizzetti, F.G. (1998), *Chirurgia estetica e responsabilità medica*, in «Giurisprudenza italiana», vol. 150, n. 3, pp. 1817-1819.

Rohrich, R.J. (1999), *Streamlining Cosmetic Surgery Patient Selection-Just Say No!*, in «Plastic and Reconstructive Surgery», vol. 104, n. 1, pp. 220-221.

Rohrich, R.J. (2001), *The Man as a Cosmetic Surgery Patient: The Weaker Sex?*, in «Plastic and Reconstructive Surgery», vol. 108, n. 7, pp. 2098-2099.

Sanchez Taylor, J. (2012), *Fake breasts and power: Gender, class and cosmetic surgery*, in «Women's Studies International Forum», vol. 35, n. 6, pp. 458-466.

Spitzack, C. (1988), *The Confession Mirror: Plastic Images for Surgery*, in «Canadian Journal of Political and Social Theory», vol. 12, n. 1-2, pp. 38-50.

Webb, M.S. (1999), *Failure in Communication: the Common Denominator*, in «Clinics in Plastic Surgery», vol. 26, n. 1, pp. 41-51.

Zeno-Zencovich, V. (2008), *Una commedia degli errori? La responsabilità medica tra illecito e inadempimento*, in «Rivista di Diritto Civile», vol. 54, n. 3, pp. 297-340.