*Journal of the History of Medicine and Allied Sciences*, Vol. 00, No. 0, pp. 1–30
doi: 10.1093/jhmas/jrac003
Original Article





# Change Your Face, Change Your Life? Prison Plastic Surgery as a Way to Reduce Recidivism

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**ABSTRACT**

The paper explores the history and ethics of prison plastic surgery programs, which ran from the 1950s through as late as 1988 in the UK, the US, and Canada. I focus in particular on the Oakalla Prison, the Haney Young Offenders Correctional Unit, and the Kingston Penitentiary in Canada; the Huntsville Penitentiary in Texas; the Camp Hill Borstal in England; and the collaboration between Montifiore Hospital and Sing-Sing Prison in New York. Sometimes federally funded, these programs were designed to reduce rates of recidivism, operating under the notion that a changed face could lead to a changed character. The surgeries were rooted in a commitment to rehabilitation through medicine, offering participants access to surgery in exchange for good behavior, participation in an experimental protocol, and in some cases, providing training for medical students and residents. As I show, these programs were consonant with prevailing experimental and ethical ethos, and maintain deep continuity with the idea that changes in appearance could lead to changes in behavior.

**KEYWORDS:** plastic surgery, incarceration, recidivism, bioethics, makeovers, prison reform

Does fixing the broken and disfigured body fix the broken and disfigured soul? From the 1950s through the end of the 1980s, prison officials and plastic surgeons thought the answer might be yes. In prisons across the US, Canada, and the UK, doctors performed plastic surgery on incarcerated people to see if, by changing their faces, they could change how they felt. This change, they believed, would change how they acted. Which would, they hoped to prove, change who they were. Many of these plastic surgeons saw themselves as doctors of character, changing self-image through changing the soul. These experiments, designed to reduce rates of recidivism, were rooted in a commitment to rehabilitation that was deeply intertwined with the power of medicine

to fix what was broken and the power of doctors to determine how best to do it.[1] In this case, it was by making people look—and thus be—better.

Such programs also gave medical residents and young doctors training and practice on a vulnerable population who may have volunteered to participate, and who at the same time may have had no choice.[2] These medical experiments used prisoners for data and surgical practice. The vulnerable nature of the prison population makes them a complicated community for experimentation, though these practices were common, as Allan Hornblum chronicles, throughout the twentieth century.[3] Access to these procedures varied across prisons and programs: in some cases, participation was granted as a reward by prison officials, whereas in others prisoners volunteered and were randomized into various protocols.[4] In the UK, the programs were situated in "Borstals," or youth facilities, with the belief that early intervention was most effective. The details of these experiments may seem shocking today, given increased attention to prison experimentation, differential access to medical care, and interventions on young people.[5] While the instrument of reform in these cases was blunt, the underlying philosophy that our faces determine our lives maintains deep resonance today. The notion that our appearance in some way reflects who we are and how we behave has endured; the notion that prison itself can be a mechanism to help prisoners reform, largely has not.[6]

1 For more on the medical narrative of "fixing" in the twentieth century, see José van Dijck, *The Transparent Body: A Cultural Analysis of Medical Imaging* (Seattle: University of Washington Press, 2005). For a disability studies approach, see Rosemarie Garland-Thomson, *Staring: How We Look* (Oxford: Oxford University Press, 2009).

2 For a history of medical care in prisons, see Noga Shalev, "From Public to Private Care: The Historical Trajectory of Medical Services in a New York City Jail," *American Journal of Public Health* 99 (2009): 988–995, https://doi.org/10.2105/AJPH.2007.123265.

3 Allen M. Hornblum, "They Were Cheap and Available: Prisoners as Research Subjects in Twentieth Century America," *BMJ* 315 (1997): 1437–1441, https://doi.org/10.1136/bmj.315.7120.1437. Hornblum chronicles the use of prisoners for medical experiments in the US, but points out the global nature of these practices.

4 For a discussion of the history of the Institutional Review Board and protocols about research on human subjects, see Laura Stark, *Behind Closed Doors: IRBs and the Making of Ethical Research* (Chicago: University of Chicago Press, 2012).

5 There have been a number of discussions exploring the ethical implications of prisoner experimentation that consider the challenges of applying current frameworks to past experiments. There are some particularly high-profile examples of prisoner experimentation, including the Stateville Penitentiary Study. Given the compensation and reduced sentences that prisoners were offered in exchange for these highly dangerous procedures, these have been widely condemned. For more see Franklin G. Miller, "The Stateville Penitentiary Malaria Experiments: A Case Study in Retrospective Ethical Assessment," *Perspectives in Biology and Medicine* 56 (2013): 548–567, https://doi.org/10.1353/pbm.2013.0035; Barbara E. McDermott, "Coercion in Research: Are Prisoners the Only Vulnerable Population?" *Journal of the American Academy of Psychiatry and the Law* 41 (2013): 8-13.

6 For more on the beauty and makeover industry, including their relationship to perceptions of character, race, and gender, see Katherine Sender, *The Makeover: Reality Television and Reflexive Audiences* (New York: New York University Press, 2012); Sharrona Pearl, *About Faces: Physiognomy in Nineteenth-Century Britain* (Cambridge, MA: Harvard University Press, 2010); Daniel S Hamermesh, *Beauty Pays: Why Attractive People Are More Successful* (Princeton: Princeton University Press, 2011); Imani Perry, "Buying White Beauty," *Cardozo Journal of Law & Gender* 12 (2006): 579–607; Radhika Parameswaran, "Global Queens, National Celebrities: Tales of Feminine Triumph in Post-liberalization India," *Critical Studies in Media Communication* 21 (2004): 346–370, https://doi.org/10.1080/0739318042000245363.

Plastic surgery as a form of rehabilitation reveals a deep historical commitment to the possibility of medicalized fixability, rooted in models of the ideal face and ideal body to which we all can—and should—aspire.[7] Even prisoners.

The models for these programs differed in both structure and method in every state, every city, every prison, and every jail. In some locations, the programs offered plastic surgery as an incentive or reward for good behavior. In others, the operations were offered to pre-screened candidates as part of a randomized trial to test for recidivism rates. In still others, the surgeries were given on an ad hoc basis according to the will of the administrators and physicians involved. There were programs that divided up the kinds of surgeries into categories, from purely cosmetic to medically therapeutic, with a variety of intermediary options, while some were far less concerned about classifying the surgeries along a "necessity" spectrum. There were programs explicitly designed to give trainee physicians exposure to a variety of conditions they might not otherwise see, contrasted with those run and executed by one doctor as a public service project.[8] Aside from the scholarly literature on the topic written largely by doctors and prison administrators, there are few robust records of the programs and their protocols.

Plastic surgery remains a key component of neo-liberal makeover culture that people access across the socioeconomic spectrum as health care and a mechanism of self-improvement.[9] While plastic surgery is growing globally, its sanctioned used as a technique amongst the prison population has dwindled, alongside rehabilitation programming more generally in the US.[10] This model of rehabilitation was not a particularly effective one, nor by today's standards, an ethical one, but as we will see, those involved in them were deeply committed to the opportunity they represented both for the participants and the surgeons. They are now gone, and largely (and surprisingly) forgotten.[11] These experiments and the ways they were executed and discussed show how much practices around prison experimentation and personal rehabilitation have

7 Rosemarie Garland Thomson has theorized the idealized and impossible body to which we all aspire as "the normate." Rosemarie Garland Thomson, *Freakery: Cultural Spectacles of the Extraordinary Body* (New York: New York University Press, 1996); Sender, *The Makeover*.

8 For example, LA plastic surgeon to the stars Harry Glassman provided plastic surgery to formerly incarcerated women from 1977 as his personal public service project. Sharon Johnson, "Plastic Surgery for Women in Prison: It Can Mean a New Life," *New York Times*, 27 July 1979, https://www.nytimes.com/1979/07/27/archives/plastic-surgery-for-women-in-prison-it-can-mean-a-new-life-patients.html.

9 For more on the neo-liberal aspects of makeover culture, see Sender, *The Makeover*. For a discussion on access to plastic surgery, see Alexander Edmonds, *Pretty Modern: Beauty, Sex, and Plastic Surgery in Brazil* (Durham: Duke University Press Books, 2010). Sander L Gilman, *Making the Body Beautiful: A Cultural History of Aesthetic Surgery* (Princeton: Princeton University Press, 1999) explores plastic surgery as a kind of mental health intervention.

10 Scholars have pointed to the 1970s as the era in which punishment became the overriding focus of prisons, to the detriment of rehabilitation efforts. By the 1990s, rehabilitation programming had all but disappeared in favor of some minor measure of reentry training. Michelle S. Phelps, "Rehabilitation in the Punitive Era: The Gap between Rhetoric and Reality in U.S. Prison Programs," *Law & Society Review* 45 (2011): 33–68, https://doi.org/10.1111/j.1540-5893.2011.00427.x. There remains some minor re-entry programming in the US.

11 Zara Stone, "Turning Prisoners Into Model Citizens ... With Plastic Surgery," *OZY* (blog), 21 September 2017, http://www.ozy.com/flashback/turning-prisoners-into-model-citizens-with-plastic-surgery/80734.

changed, and equally, how much the underlying principles of self-transformation through physical transformation have remained the same.

In this article, I examine prison plastic surgery programs in the United States, Canada, and England from the mid-1950s through the end of the 1980s to excavate ideas about personal transformation, medical experimentation, and the perceived power of plastic surgery in prison. The multiple sites and countries demonstrate the pervasiveness of these narratives of self-improvement through surgery in a western context. Drawing on reports and academic literature written by the doctors and prison administrators working in these programs, as well as histories of medicine and psychology, I argue that these surgical interventions were motivated by two factors: a belief in the role of appearance in shaping personality and resulting criminal behavior, and a desire to expose clinicians to a variety of conditions and surgical opportunities that might not otherwise be available. In so doing, I highlight a moment in the history of prison experimentation, while exploring contextual and ongoing questions around what constitutes necessary medical treatment and how and if it should be accessed by incarcerated people.[12]

These programs started with a set of sincere questions on the part of plastic surgeons who were deeply committed to the positive impact of their work on their patients. If the removal of disfigurements might drastically improve the confidence, sense of self, and social functioning of mainstream patients, as they absolutely believed it did, could it have a similar effect on the prison population? Many of these doctors were later advocates of offering incarcerated people gender-supportive medical care, though gender confirmation surgery was not offered in US prisons until 2017, and even then it was very rare.[13] None of these surgeries involved this type of treatment. The theory behind these interventions, as we will see, was based on the principle that

12 The lack of robust health care for incarcerated people is an ongoing and deeply rooted crisis. The lack of access and conditions faced by women giving birth has received some attention in both the academic and journalistic literature; as I write this article, people continue to debate whether people in prison should be given priority access to the COVID-19 vaccine despite overwhelming public health imperatives, basic human rights, the disproportionate spread of the virus in prisons, and the resulting effect of daily isolation for prisons. See for example, Jennifer G. Clarke and Rachel E. Simon, "Shackling and Separation: Motherhood in Prison," *AMA Journal of Ethics* 15 (2013): 779–785, https://doi.org/10.1001/virtualmentor.2013.15.9.pfor2-1309; Lori Teresa Yearwood, "Pregnant and Shackled: Why Inmates Are Still Giving Birth Cuffed and Bound," *The Guardian*, 24 January 2020, http://www.theguardian.com/us-news/2020/jan/24/shackled-pregnant-women-prisoners-birth; Steve Coll, "The Jail Health-Care Crisis," *New Yorker*, 4 March 2019, https://www.newyorker.com/magazine/2019/03/04/the-jail-health-care-crisis; Emily Bazelon, "Why Inmates Should Be at the Front of the Vaccination Lines," *New York Times*, 3 December 2020, https://www.nytimes.com/2020/12/03/opinion/coronavirus-vaccine-jail.html.

13 For more on the legal issues around transgender people in prison, see Rebecca Mann, "The Treatment of Transgender Prisoners, Not Just an American Problem–A Comparative Analysis of American, Australian, and Canadian Prison Policies Concerning the Treatment of Transgender Prisoners and a 'Universal' Recommendation To Improve Treatment," *Tulane Journal of Law and Sexuality* 15 (2006), https://journals.tulane.edu/tjls/article/view/2798; The details of the first surgical case in the US can be found in Kristine Phillips, "A Convicted Killer Became the First U.S. Inmate to Get State-Funded Gender-Reassignment Surgery," *Washington Post*, 10 January 2017, https://www.washingtonpost.com/news/post-nation/wp/2017/01/10/a-transgender-inmate-became-first-to-get-state-funded-surgery-advocates-say-fight-is-far-from-over/. While many of the physicians involved in the plastic surgery programs later

criminal behavior emerged in part from a poor sense of self-worth. Improve the self-worth through cosmetic interventions, mid-twentieth-century doctors believed, and cause the crime to be reduced. From at least the mid-1950s, prison administrators were willing to see if it worked.

At their peak in the late 1960s, prisoners were offered plastic surgery as a way to reduce recidivism in jails, prisons, and Borstal camps in 28 US states and across Canada and the UK.[14] At least one of these programs, in Montefiore Hospital, was funded in part by a federal grant from the Vocational Rehabilitation Administration in 1967, while many others received money and other support from various institutional sources including hospitals, prisons, and local governments.[15] As late as 1984, at least 25 of the plastic surgery residencies in the US did some form of medical work in prisons with an eye toward rehabilitation.[16] By exploring the published primary material written by

became advocates of gender affirming health care in the prison, there is no comprehensive history to date of this issue.

14 Michael L. Lewin, "Plastic Surgery in Rehabilitation of the Prison Inmate," *AORN Journal* 7 (1968): 65, https://doi.org/10.1016/S0001-2092(08)70265-5; G. Bankoff, "[Plastic surgery and criminology]," *Annals of Western Medicine and Surgery* 6 (1952): 448–450; Eileen Turcotte, "Can Surgery Reform Some Criminals?" *Maclean's*, 24 July 1965, https://archive.macleans.ca/article/1965/7/24/can-surgery-reform-some-criminals.

15 Richard L. Kurtzberg, Michael L. Lewin, Norman Cavior, Douglas S. Lipton, "Psychologic Screening of Inmates Requesting Cosmetic Operations: A Preliminary Report," *Plastic and Reconstructive Surgery* 39 (1967): 387. The records of this grant in the Records of the department of Health, Education, and Welfare, RG235 are no longer extant either online or in hard copy; the majority of Federal grant files are disposed of at the end of the project as they are not considered permanent. The National Archives and Records Administration only keeps 1-3% of generated records permanently. Richard Peuser, "[19-60625] Surgical and Social Rehabilitation Adult Offenders Project (SSR) Grants," n.d. I have tried to access other records of these experiments, including examining the private papers of the doctors involved, but the details of the grant seem to be lost.

16 Mary C. Bounds, "Plastic Surgery Reshaping Inmates' Faces and Futures," *Chicago Tribune*, 31 January 1986, https://www.chicagotribune.com/news/ct-xpm-1986-01-31-8601080691-story.html. It is important to note that these programs were fundamentally different in theory and in practice from post-incarceration tattoo removal programs in use today. These latter programs are always initiated after release and are based on an attempt to increase the employability of formerly incarcerated people: it can often be challenging to get a job with visible prison tattoos, particularly those with a racial, racist, or gang affiliation. Tattoo removal initiatives are motivated by pragmatic economic concerns, though the ancillary emotional impact of removing these affiliations can be quite powerful. While some of the prison plastic surgeries from 1950 to 1980 included tattoo removal, they were geared less towards employability than behavioral transformation. There are numerous post-incarceration tattoo removal programs across the country. Many offer vocational and educational services in conjunction with the process, and some require public service or class work in exchange. They are designed to help formerly incarcerated people find employment, and in additional the tattoo removal they may offer additional services to support these goals. Some of them are state-sponsored while others are private non-profits. For a non-comprehensive directory of these programs, see "Tattoo Removal," Jails to Jobs, https://jailstojobs.org/tattoo-removal-programs/. For more on tattoo removal, see Sander L. Gilman, "Historical Situatedness of Categories' Meanings in Medicine," *AMA Journal of Ethics* 20 (2018): 1188–1194, https://doi.org/10.1001/amajethics.2018.1188.; Renuka Rayasam, "'It's like a Baptismal': Prison Tattoo Removal Gives Ex-Offenders a Chance at a New Life," *Quartz*, 20 August 2016, https://qz.com/758241/its-like-a-baptismal-prison-tattoo-removal-gives-ex-offenders-a-chance-at-a-new-life/; Dominique Moran, "Prisoner Reintegration and the Stigma of Prison Time Inscribed on the Body," *Punishment & Society* 14 (2012): 564–583, https://doi.org/10.1177/1462474512464008.

those involved in these programs, we gain insight into ideas about criminal behavior and its motivation, as well as the administrative structures around mid-century prisons and the use of incarcerated people in experimentation.

## CONTEXT

Throughout the second half of the twentieth century, at least twenty-eight states and two other countries offered incarcerated people plastic surgery for cosmetic and therapeutic interventions as a way to reduce recidivism through an improvement of self-image.[17] Most of the literature on the topic is primary source material evaluating the success of these programs; there is one secondary article from 1990 that provides an overview of the programs to date and explores their outcomes from a policy implementation perspective.[18] Sander Gilman has touched on these interventions as part of a larger discussion on dichotomies in medicine, and Ray Bull and Nicola Rumsey have a review of the medical literature on prison plastic surgery in a discussion of appearance and psychology, but there has been no sustained critical discussion of these programs and their historical, cultural, and bioethical implications in the history of medicine.[19]

Both the history of these programs and the stories of its participants on the patient and physician side are rich and gripping. The dearth of secondary literature is countered by a number of newspaper articles, often sparked by a significant event related to one of the key participating physicians.[20] These pieces span the decades from 1965; most recently, there was a series of articles in 2015 about Edward Lewison, a prison plastic surgery pioneer in British Columbia. The articles about Lewison were prompted

17 According to Linton Whittaker, founding director of the Center for Human Appearance at the University of Pennsylvania, there were also a number of ad-hoc programs in which local plastic surgeons would donate some time to perform operations in prisons. There is no official record of these surgeries, so aside from the reports of participating surgeons, there is no way to know how widespread these practices were at the time. A large-scale interview protocol with Whittaker's generation of plastic surgeons would be a fascinating project that could provide a great deal of information about these practices. Whittaker, personal communication.

18 Kevin M. Thompson, "Refacing Inmates: A Critical Appraisal of Plastic Surgery Programs in Prison," *Criminal Justice and Behavior* 17 (1990): 448-466. I did not find evidence of any prison memoirs dealing with the topic. Participants in the program remained anonymous, and a scan of available prison memoirs do not seem to include any of the subjects of these experiments or procedures.

19 Gilman, "Historical Situatedness of Categories' Meanings in Medicine"; Ray Bull and Nichola Rumsey, *The Social Psychology of Facial Appearance* (Springer Science & Business Media, 2012).

20 Bounds, "Plastic Surgery Reshaping Inmates' Faces and Futures"; Turcotte, "Can Surgery Reform Some Criminals?"; "Can Plastic Surgery Transform a Criminal?," *The Ottawa Clinic*, https://www.theottawaclinic.com/about-dr-nodwell/can-plastic-surgery-transform-a-criminal/; Katie Daubs, "Change a Face, Change a Fate: When Prisoners Got Free Nose Jobs," *Toronto Star*, 28 June 2015, https://www.thestar.com/news/insight/2015/06/28/change-a-face-change-a-fate-a-mysterious-prison-experiment.html; Andrew Duffy, "Criminal Facelifts: Filmmakers Try to Track Prisoners Who Received 1960s Plastic Surgery," *Ottawa Citizen*, 22 May 2015, https://ottawacitizen.com/news/local-news/criminal-facelifts-filmmakers-try-to-track-prisoners-who-received-1960s-plastic-surgery; Johnson, "Plastic Surgery for Women in Prison"; David Halberstam, "Prisoners to Get Plastic Surgery," *New York Times*, 22 October 1964, https://www.nytimes.com/1964/10/22/prisoners-to-get-plastic-surgery.html.

by a BBC documentary on his prison work. The film itself was never completed, but the Canadian media covered the not-yet-made documentary and Lewison himself.[21]

These interventions can also be read in the context of Alex Edmunds's research on the framing of plastic surgery in Brazil as something that should be accessible across the socioeconomic spectrum rather than a privilege of the rich. In an environment of limited health care resources (such as prison or the US today), plastic surgery can be seen as an unfair luxury. The prison facial surgeries covered in this study from the 1950s to the 1980s challenged this ideology by situating plastic surgery as a form of treatment that was often available to those who needed and wanted it, an approach that falls in the tradition of troubling the binaries between cosmetic and therapeutic plastic surgery.[22]

Even within this understanding of plastic surgery as potentially medically and psychologically indicated, the complexities of experiments in prisons, on prisoners, must be considered in their historical context. There were numerous such experiments, including the infamous Stateville Penitentiary Malaria Study, Project MKUltra, in which prisoners and others were given hallucinogenic drugs in order to develop weapons, and the non-therapeutic dermatological experiments in Holmberg Prison chronicled by Allan Hornblum.[23] All of these examples were cases of clear harm, in some cases undertaken in exchange for various forms of compensation, and in other cases with no benefits at all to the subjects. In the case of the plastic surgery experiments and procedures I examine in this article, there was a genuine attempt to benefit the participants, though like all experiments the outcomes were uncertain. However, this example is unlike the others in that the danger presented by participation was significantly lower, and the outcomes seem to have been valuable to the participants in their own right.

There were some basic commonalities across the plastic surgery programs in the US, Canada, and the UK. In all cases, at least part of the stated goal was to improve the behavior of criminals by improving their appearance. There were always doctors—usually but not always plastic surgeons—involved.[24] They always happened in the context of incarceration, usually prisons and jails but with a very few juvenile detention centers participating in the UK. There were consistent screening procedures to eliminate those who had what the clinicians deemed unreasonable expectations as to the outcomes. Prisoners who expected a "miracle cure" were often told otherwise, as their psychological issues were significant enough to impede the success of this particular intervention.[25] In all facilities, rhinoplasty comprised the bulk of surgeries, though there were

21 See for example Daubs, "Change a Face, Change a Fate."

22 Edmonds, *Pretty Modern*. For more on challenging plastic surgery binaries, see Gilman, *Creating Beauty to Cure the Soul*; Kathy Davis, *Reshaping the Female Body: The Dilemma of Cosmetic Surgery* (New York: Routledge, 1995).

23 Allen M. Hornblum, *Acres of Skin: Human Experiments at Holmesburg Prison* (New York: Routledge, 1999).

24 The physicians involved in these programs are worthy of an extended study in their own right; I can only touch very briefly on their individual philosophies and character here.

25 For more on screening mechanisms, see Kurtzberg et al., "Psychologic Screening of Inmates Requesting Cosmetic Operations"; Holt and Marchionne, "Personality Evaluation of Correctional Institution Inmates Awaiting Plastic Surgery and a Control Group of Inmates"; Edgerton, Jacobson, and Meyer, "Surgical-Psychiatric Study of Patients Seeking Plastic (Cosmetic) Surgery."

also tattoo removals, ear pinning, mouth reconstruction, scar removal, and various other interventions.[26] There were programs that served both men and women, though some states had programs in only one or the other type of facility. Some studies noted racial distribution for those undergoing screening, including "Caucasian, Negro, Puerto Rican"; participants were overwhelmingly and non-representatively White.[27] The participating physicians and administrators largely seemed to believe in the social value of the project for both the inmates themselves and society as a whole. However, in critical ways, not all practitioners agreed that social value was the primary driver for these projects. Some, as I show below, deliberately used the narrative of transformation to access the prison population for medical training and experimentation. The outcomes measured were mixed at best, but were promising enough or useful enough for these programs to persist throughout the second half of the twentieth century. We see here a strongly paternalistic approach to health care and experimentation that persisted throughout the second half of the twentieth century. Even as Western practitioners shifted to a great emphasis on patient autonomy in private practice, prisons remained a site of experimentation and paternalistic approaches to care.

Participation was voluntary (as much as such a proposition is even possible in prison, as the IRB recognizes), and not always in the context of a formal experiment but, in some cases, as an incentive or reward for good behavior.[28] While prisoners actively signed up to participate, gave consent as per the Declaration of Helsinki from 1964 ("if at all possible"), could decline, and were not coerced or given incentives beyond the parameters of the programs themselves, many as we will see were tapped for inclusion by guards and administrators with fundamental control over their daily lives and access to basic necessities.[29] These programs were all initiated before the National Research Act of 1974, which explicitly laid out protections for prisoner experimentation, but even according to the principles of the Act, prison plastic surgery satisfied the ethical parameters for this kind of research.[30] Programs were required to improve the health and well-being of the population, and to intervene positively on conditions that had negative effects on the community as determined by experts in the field. There were no shortage of supportive experts to attest to the benefits of these programs, many of whom were directly involved in their execution. Based on the theory

26 D.A. Ogden, "Use of Surgical Rehabilitation in Young Delinquents," *British Medical Journal* 1: 5119 (14 February 1959): 433.

27 Kurtzberg et al., "Psychologic Screening of Inmates Requesting Cosmetic Operations." Race is not mentioned in most of the literature, which makes it likely that participants were White.

28 While participation in many of these cases was voluntary in some sense, the conditions of incarceration and the possibility of coercion make prison populations particularly vulnerable and limit (but do not necessarily preclude) informed consent. The IRB has long recognized experiments involving incarcerated people as requiring additional levels of oversight to guard against harm and exploitation. See Stark, *Behind Closed Doors*.

29 https://www.wma.net/what-we-do/medical-ethics/declaration-of-helsinki/.

30 "The Belmont Report," HHS.gov, 28 January 2010, https://www.hhs.gov/ohrp/regulations-and-policy/belmont-report/index.html. Prisoner protection from medical experimentation was also a part of the 1947 Nuremberg Code established after the horrors of the Nazi regime; the Code was largely ignored in many countries, as evidenced by egregious bioethical breaches such as the Tuskegee Syphilis Study.

underlying these operations, the best interests of the prisoners were at the heart of the programs. The programs were designed to help those inside the way the surgeons believed their work helped those outside. The model was paternalistic, but did require consent on the part of the participants, and there were indeed even wait lists in some cases. Between the sincere belief in the benefits of the intervention and the agreement of the subjects, these programs satisfied the ethical requirements of their time.

While I will be drawing on a wide range of programs in this article, I will now offer a detailed outline of the four best-documented different approaches. These represent different countries, varying levels of experimental protocols from non-existent to detailed, and different motivations ranging from social benefit to medical training. These approaches represent a cross-section of prison plastic surgeries to give a grounded historical framework on how some of these operations were administered in practice.

## OAKALLA PRISON, HANEY YOUNG OFFENDERS CORRECTIONAL UNIT, AND THE KINGSTON PENITENTIARY/PRISON FOR WOMEN

In Vancouver, British Columbia, Edward Lewison began offering plastic surgery in the Oakalla Prison and the Haney Young Offenders Correctional Unit from 1953 for those with "anomalies of appearance."[31] He first chronicled his project in a 1965 essay for the *Canadian Medical Association Journal*, which he opened by asserting that "the relationship of physical abnormalities to unhappiness and crime has probably always existed and has long been recognized."[32] This essay was brief, outlining general principles and selection mechanisms, and ending on an enthusiastic note that "the most obvious result of the surgery, and certainly the most gratifying, was the general behaviour of the inmates operated upon," which was so powerful in the life of the prison that "interest in the operation among the other inmates resulted in many requests for this type of surgery."[33]

In 1966, Lewison decided to conduct a more formal study of the effects of his intervention, tracking 100 post-surgical inmates for recidivism rates. He recorded his efforts in a 1974 paper that laid out the underlying principles of his project at the outset, arguing that while "anomalies of appearance" "may cause no functional disability," they "may have profound psychological effects" and "may actually cause anti-social behavior."[34] Lewison reasoned that "correction of these defects should tend to eliminate or diminish criminal behavior" which he saw to a greater extent in men, so he focused his energy on that population.[35] Based on these principles, "improving the inmate's

31 Edward Lewison, "An Experiment in Facial Reconstructive Surgery in a Prison Population," *Canadian Medical Association Journal* 92 (1965): 251.

32 Ibid.

33 Ibid., 253. There is a rich literature and the relationship between gratitude and well-being. See for example, Joshua Rash, Kyle Matsuba, and Kenneth Prkachin, "Gratitude and Well-Being: Who Benefits the Most from a Gratitude Intervention?" *Applied Psychology Health and Well-Being* 3 (2011): 350–69, https://doi.org/10.1111/j.1758-0854.2011.01058.x.

34 Edward Lewison, "20 Years of Prison Surgery-Evaluation," *Canadian Journal of Otolaryngology* 3 (1974): 42.

35 Ibid.

appearance as well as his functional ability, and bolstering his self-image, might facilitate his social integration."[36] Lewison extrapolated his theory from his general patient population, pointing out that "we have all seen that private patients seeking cosmetic plastic surgery, reveal that their motivation is to free themselves from a self-conscious preoccupation with their deformity."[37] He noted that the emotional and psychological challenges were exacerbated by structural ones, as "although most disfigured individuals may be employable, their disfigurements become an increasing vocational handicap when they seek higher-level jobs," particularly for the "facially disfigured."[38]

According to Lewison's definition, facial reconstruction worked. Results from his 20-year study showed that 48% of his patients returned to prison, contrasted with the 69% recidivism rate of those who did not benefit from his expertise.[39] While for Lewison, improvement of self-image was the primary driver in changed behavior, he also speculated that patients wanted to pay their gratitude forward, which was the theory of the former Oakalla warden Hugh Christie. Christie "believes that the subject who has received surgery may have been grateful for an unusual favour," prompting that person to feel "obliged to reciprocate."[40] This sense of gratitude was deepened by the "special type of human relationship" that emerged between prison inmates and the staff who offer them medical care, which "may have been closer" than normal and "may have contributed to the lower incidence of recidivism."[41]

In both the 1965 and 1974 papers, Lewison outlined his careful procedures, which note a strong preference for participants who were younger than twenty years old, had reasonable expectations about what changes the surgery could initiate, and had four or fewer convictions.[42] These conditions, he believed, created the greatest likelihood of seeing long-term change. As we will see, the programs that were explicitly working to reduce recidivism shared the preferences for younger participants with grounded expectations. Lewison did mention that "we have been selective in the candidates chosen for surgery, and that many of these may have recidivated at a lower rate than average even without surgery."[43] Although the 1966 study was designed to be, in Lewison's terms, more "objective," which is to say he kept closer track of the number of participants and their recidivism rates, the preselected nature of the recipients was not tested.[44] And while Lewison considered age, number of offenses, type of offences, and reasons that the inmates sought surgery in his selection mechanism, these were all contributing factors, none of which would alone limit participation. Indeed, even though it "was considered that the best results could be achieved among young people, i.e., under 20 years," "it was found that many inmates around the age of 40 seriously wished to

36 Ibid.
37 Ibid.
38 Ibid., 43.
39 Ibid., 46.
40 Ibid., 49.
41 Ibid.
42 Lewison, "An Experiment in Facial Reconstructive Surgery in a Prison Population," 253; Lewison, "20 Years of Prison Surgery-Evaluation," 44.
43 Lewison, "20 Years of Prison Surgery-Evaluation," 46.
44 Ibid.

change their behavior."[45] A passionate advocate that "there is no such individual as a habitual criminal," Lewison did have some subjects even over the age of 40, and found that "when these individuals were selected the facial surgery frequently proved to be a turning point in their lives."[46] In the 1966 study, Lewison divided his applicants into three categories of deformities, what he termed minimal, moderate, and severe. Those with minimal deformities were rejected given the modesty of the potential impact. Moderate and severe candidates were accepted if the surgical outcome was projected to improve their appearance according to prevailing standards of the time, thereby improving participants' self-image, and the candidates were highly motivated with reasonable expectations. However, "should any deviant signs appear which might contraindicate surgery," Lewison argued, "the patient is told that surgery is not advisable at this time."[47] This was rare, however, as he noted that "only on two occasions has it be necessary to drop subjects from the project for psychiatric reasons."[48]

Lewison was, it appears, motivated by a desire to use his skills to improve the lives of others and make them, one at a time, into "a socially acceptable person."[49] He performed his surgeries entirely free of cost with support and personnel provided by the prison, including "well-trained graduate nurses," though "the ancillary personnel in the operating room is exclusively inmate."[50] This posed some staffing challenges; though many of the inmates "are able and well-trained," "frequent turnover is unavoidable."[51] Respect for prisoners—both patients and staffers—was at the core of Lewison's approach: he believed that most prisoners "respond well when treated with dignity and fairness," and that "there are no perfect individuals and few unreformable, but simply people who can be influenced to be better or worse."[52] For Lewison, surgery was the key mechanism by which he believed this change could be achieved, alongside "the atmosphere of the therapy, the individual relationship, attitudes of the patient towards society on one hand, and his concept of what society see in him on the other."[53] Important administrators within the prison system agreed: the Attorney General's Department offered full approval, and "the senior medical officer and the warden were particularly enthusiastic."[54] Indeed, former Oakalla Warden and ally of the program Hugh Christie threw his full support behind Lewison, saying unequivocally that "the usefulness of reconstructive surgery in providing an effective medium for the commencement and assistance of therapy is unquestionable."[55]

Christie agreed with Lewison that these surgeries were highly valuable, but differed in the underlying mechanism at play. Christie was particularly interested in the role

45 Lewison, "An Experiment in Facial Reconstructive Surgery in a Prison Population," 253.
46 Ibid.
47 Lewison, "20 Years of Prison Surgery-Evaluation," 44.
48 Ibid.
49 Ibid., 48.
50 Ibid., 44.
51 Ibid.
52 Ibid., 45, 69.
53 Ibid., 49.
54 Ibid., 44.
55 Ibid., 49.

that surgery played in facilitating other forms of communication that best aided a range of rehabilitation efforts. In particular, he felt that because surgery "has unquestionably been interpreted by most of the prisoner patients as a completely disinterested social act by a representative of society," "it has been possible to establish a relationship of communication and understanding." Due to that special relationship, "individual and group improvement, previously not possible, has developed."[56] Christie believed that the intervention helped recipients less by changing their self-image and more by creating relationships that facilitated therapy and rehabilitation, consonant with some strains of contemporary social psychology. Lewison did not comment on these differing perspectives; he was less interested in evaluating underlying mechanisms than demonstrating that they worked to steer recipients from a life of crime.

In Lewison's model, prisoners volunteered for surgery; from those volunteers, some were selected for additional screening by the senior medical officer.[57] Unlike the contemporary Stateville prison malaria study, no mention was made of any inducements or additional privileges granted participants beyond the surgery itself, though it is clear that recipients developed strong relationships with the medical staff who cared for them. Lewison performed around forty free operations year, and always had a waitlist. For the 1966 study, Lewison approved 200 prisoners for surgery, but ended up only operating on half of them.[58] Across both papers, Lewison remained optimistic about the possibilities of this intervention, noting in 1965 that "the surgical results have been most satisfactory."[59] While "the sociological results cannot be assessed in full," "of the 450 patients operated upon, the recidivism rate is 42%, whereas among the general inmate population it is 75%."[60] It was not all success stories, however, and Lewison confessed that "some of our patients, since their improvement in appearance and subsequent release, have given up ordinary forms of crime such as breaking and entering, or thievery."[61] However, rather than reforming, these few took advantage of their new good looks "and have undertaken 'higher' and more subtle antisocial efforts, such as those of the confidence men."[62] To assure everyone that his operations were not just creating the conditions of possibility for successful grifters, Lewison hastened to assure readers that "these instances are comparatively rare," reiterating that while there might be some outliers, the overall model was robust and effective in reducing recidivism.[63]

Lewison's arrangement with the prison was largely at his discretion, though they provided support and funding alongside his voluntary labor. Some programs were more formal, emerging from grants and residency training opportunities. We will explore two of those, including the largest and most organized version at Sing Sing/Montefiore, and a program in Texas that operated until the end of the 1980s. Others

56 Ibid., 49.
57 Ibid., 44.
58 Ibid., 46.
59 Lewison, "An Experiment in Facial Reconstructive Surgery in a Prison Population," 253.
60 Ibid.
61 Ibid.
62 Ibid.
63 Ibid.

were much more ad hoc. At least one program developed, quite literally, over a game of golf in the early 1960s. Ottawa plastic surgeon Lorne Burdett was having a round with "one of his best friends," Canada's commissioner of penitentiaries, A. J. MacLeod. MacLeod was "intrigued" by Burdett's idea that the confidence his patients showed after surgery might translate into a reduction of "antisocial attitudes" when applied to the prison population. MacLeod thought it was worth testing Burdett's theories, and urged Burdett to work with the Kingston Penitentiary and the Kingston Prison for Women to try them out on the population.[64]

Burdett agreed, and headed down to Kingston, Ontario for an initial screening. Like his fellow Canadian Lewison, Burdett's labor was voluntary, though he used the support of the prison psychiatrist and other authorities to screen his initial ten patients. Burdett paid careful attention to gender dynamics, relying on the prison psychiatrist's recommendation that deformities and defects had a greater detrimental effect on women than men.[65] In order to maximize the impact of his intervention, Burdett proceeded with seven women and three men for his initial experiment, which included tattoo and scar removal alongside nose reconstruction.[66] Burdett emphasized that "all they wanted was to look normal—not glamorous."[67] And if they looked, as Burdett put it, normal, they would feel normal, and less inclined to participate in abnormal—i.e., criminal—behavior.

Three years on, three of the seven women and two of the three men returned to prison. Burdett and MacLeod saw this as a victory, leading Burdett to continue the program in his spare time. A perhaps unanticipated outcome was an increase in new patients for Burdett's practice in Ottawa, a distance of about three hours from Kingston. At least two former inmates who were rejected by the prison psychiatrist for surgery while incarcerated came to Burdett after release to pursue procedures. Burdett treated these patients without charge.[68] These pro bono surgeries underscored his sincere commitment to helping incarcerated people with the best techniques he had at his disposal: surgical expertise.

## HUNTSVILLE PENITENTIARY, TEXAS

Plastic surgery is not cheap now, and it was not in Texas in the 1960s. Costs include the clinicians' time, equipment, medicine, follow-up care and treatment, and ongoing

64 Turcotte, "Can Surgery Reform Some Criminals?"

65 Ibid.

66 Ibid.

67 Burdett's framing is in consonance with Kathy Davis's research, which argues that often women undertake one procedure in an attempt to fix a perceived fault, and are usually quite satisfied with the results. The exception to this is with people who suffer from body dysmorphia, such that plastic surgery is the symptom rather that the cure, as outlined by David Sarwer and Canice E. Crerand, and Elizabeth Haiken. Eileen Turcotte, "Can Surgery Reform Some Criminals?"; Kathy Davis, *Reshaping the Female Body: The Dilemma of Cosmetic Surgery* (New York: Routledge, 1995); David B. Sarwer and Canice E. Crerand, "Body Dysmorphic Disorder and Appearance Enhancing Medical Treatments," *Body Image* 5 (2008): 50–58, https://doi.org/10.1016/j.bodyim.2007.08.003; Elizabeth Haiken, *Venus Envy: A History of Cosmetic Surgery* (Baltimore: Johns Hopkins University Press, 1997).

68 Turcotte, "Can Surgery Reform Some Criminals?"

monitoring of patients. It can involve major operations, and requires comprehensive medical care, which is often unavailable in prisons and certainly hard to access in the US once prisoners are released. Adherents argued that the opportunity to reduce recidivism and improve the lives of prisoners made the advantages for both prisoners and society clear; with limited resources for rehabilitation, doctors argued for surgery over school, consonant with the long histories of experimentation on prisoners and the role of doctors and medicine as fixers for that which is broken.[69]

Less discussed—but certainly of issue—were the advantages to doctors. A number of medical schools capitalized on the training potential offered by this patient population over three decades, offering plastic surgery to inmates through 1986 and even beyond. The Virginia program was amongst the more cynical; it was launched in 1970 in response to the "need to enlarge the population base from which residents in training could draw reconstructive opportunities." In a rather caustic note, the 1975 article chronicling this program noted that "Efforts to justify this clinical experience on more than education merits have focused on comparison of recidivism (return-to-prison) rates. . .plastic surgical involvement within correctional facilities, when it exists at all, is inevitably shrouded in a cloak of sociological inquiry, often based on inaccurate yardsticks."[70] While prisons have long been a site for specialized medical training more broadly, many of these programs have fallen into abeyance as part of a larger crisis of lack of prisoner access to health care, though there are recent attempts to bring trainee doctors back to prisons.[71]

According to a 1964 paper, plastic surgery residents at the Baylor Affiliated Hospitals Programme [sic] spent at least two days a week caring for prisoners transferred to the local prison farm hospital from the main facility in Huntsville. They averaged around 45 hours and 15 procedures a month in the prison, performing a wide variety of surgeries.[72] Presented as a necessary part of their training, "with the exception of a minimal travel allowance, these residents receive no compensation for the services save the satisfaction derived from their efforts."[73] The program was framed as beneficial

69 Dijck, *The Transparent Body* chronicles the heroic role of the physician as fixer. This narrative has significant implications for the field of disability studies, which challenges notions of the disabled or otherwise different body as broken and requiring fixing. Rather than always imagining a disabled or differently-abled body as in need of repair, the field advocates for more accommodations to allow people with impairments to flourish. Lennard J. Davis, "Constructing Normalcy," in *The Disability Studies Reader*, ed. Lennard J. Davis, 3rd ed (New York: Routledge, 2010), 9–28; Rosemarie Garland-Thomson, "Feminist Disability Studies," *Signs* 30 (2005): 1557–1587; David T. Mitchell and Sharon L. Snyder, *Narrative Prosthesis: Disability and the Dependencies of Discourse* (Ann Arbor: University of Michigan Press, 2014); Dan Goodley, *Disability Studies: An Interdisciplinary Introduction* (London: Sage Publications, 2011).

70 Fisher and Edgerton, "Plastic Surgical Rehabilitation of the Prison Patient," 845, 847.

71 See for example Sarah E. Wakeman and Josiah D. Rich, "Fulfilling the Mission of Academic Medicine: Training Residents in the Health Needs of Prisoners," *Journal of General Internal Medicine* 25 (2010): 186–188, https://doi.org/10.1007/s11606-010-1258-4. For more recent efforts see Sonia A. Alemagno, Margaret Wilkinson, and Leonard Levy, "Medical Education Goes to Prison: Why?" *Academic Medicine* 79 (2004): 123–127. For an overview of the state of health care in prisons in the US today, see "Know Your Rights: Medical, Dental, and Mental Health Care," American Civil Liberties Union, https://www.aclu.org/other/know-your-rights-medical-dental-and-mental-health-care-0.

72 Spira et al., "Plastic Surgery in the Texas Prison System," 364, 366.

to all involved: residents "realize that, as a very important segment of their training, they are given the opportunity to perform a great number of procedures which, by their very nature, would not be done at the local city and country hospital."[74] Prisoners got access to services that are "unusual in penal systems," and accordingly "exhibit a most appreciative attitude, making excellent patients."[75]

Patient gratitude was not just a sincere reflection of appreciation, but indeed a precondition for selection: in addition to "desir[ing] the surgery," "only those. . .who are willing to co-operate, are accepted by the residents and prison officials."[76] Cooperation was measured by prisoner behavior, with the surgery offered as a reward. The surgery "is not regarded as a 'right' or 'gift' but a privilege which is earned in terms of attitude and behavior." Eligibility was determined through a "Personal Incentive Point System," with benefit accrued by general compliance, positive performance at work, and participation in counselling programs such as Alcoholics Anonymous.[77]As these points were accrued through mechanisms that were both widely available and encouraged within the prison, they did place unfair limitations on participation and thus would not have circumvented the experimental ethics of the time. Given that the benefit of the surgery was itself at stake, it was not a necessity to which access was limited, but rather presented potential but not assured advantages to participants. However, so valuable was did many see this payoff that "a few prisoners have voluntarily postponed their paroles in order that long-term reconstructive surgery might be completed."[78] And while participation was framed as voluntary as inmates "make requests for a number of cosmetic and reconstructive procedures which, by word of mouth and personal contact, are familiar to them," often "a prison official makes the convict cognizant [sic] of his defect and will suggest the service which is available to him."[79] The inmate was free to ignore the suggestion, but it likely was not a good idea to do so.

In this particular program through Baylor, a select few prisoners were rewarded for good behavior—as determined by prison officials through a point system—with differential access to health care, given by trainee practitioners whose participation was a compensation-free part of their program. Prisoners were induced to volunteer by administrators who made clear, in no uncertain terms, how from their perspective the inmates' appearance was problematic, by which they meant ugly, unattractive, evoking fear in others, resonant of criminality and incarceration. These studies did not outline what standards of acceptable appearance they were working with, and indeed the nature of the surgical interventions varied across sites and practitioners. These operations were so important to prisoners that some chose to voluntarily remain incarcerated in order to access them, with no guarantee of follow up medical care upon release.

73 Ibid., 364.
74 Ibid.
75 Ibid.
76 Bounds, "Plastic Surgery Reshaping Inmates' Faces and Futures."
77 Ibid.
78 Spira et al., "Plastic Surgery in the Texas Prison System," 365.
79 Ibid, 364.

The most common procedure was rhinoplasty and septoplasty, followed by scar revisions and hand cases. Spira's 1964 article provided images of some of the corrections, including a "typical humped nose deformity."[80] The nose in question was large and had a bump, but no obvious deformity as such.[81] The inmate got a nose job. Such cosmetic interventions were, for these surgeons, as necessary as what was, to them, more medically-indicated procedures.[82] They conceded that "the value of that portion of the programme dealing with the treatment of acute injuries, tumors, and the correction of physical handicaps is unquestioned." But "the need for cosmetic surgery among the prison population" is significant and based on "statistics and evaluation by officials of the penal systems throughout the country," which "may help" the recipient "make a successful adjustment to society when released." Some of the assistance was a matter of employment, as "who can deny that there might be occasions of which a person with a facial deformity—be it a crooked nose, or distortion of features secondary to scarring—would be denied an opportunity which otherwise would be available to him." Equally significant, according to the essay, was the "definitely beneficial effect" from "the elevation of his morale, or self-esteem" which "is manifested by a less belligerent attitude toward others because of the new image of himself." This new image is borne of concrete physical changes visible to all and first "projected to the outside world by means of plastic surgery." Following this projection, the changes were "subsequently. . .reflected in the mirror of his own thoughts."[83] Like Lewison, these surgeons were engaged in changing self-image through changing appearance, and like Lewison, they believed surgery would change the tendency to criminal behavior. Change just was not their primary goal, which was training residents. Everything else was a bonus. Both ends were achieved together as "the consensus is that we are performing a needed service" on top of "enabling our residents to enter an extremely important phase of our Plastic Surgery Training Programme."[84]

The Texas prison plastic surgery initiative lasted a long time. In a review of these programs written for the *Chicago Tribune* in 1986, reporter Mary C. Bounds noted that in addition to plastic surgery residents at Baylor, operations in the Huntsville Prison were also part of the training for residents St. Josephs Hospital.[85] Those at the University of Texas Medical Branch practiced their skills at the prison hospital in Galveston. Prison plastic surgery was a cost-effective way to train students, as it "costs the state little" and at the same time "sharpens the residents' surgical skills."[86] Unlike the Spira article, however, Bounds found that the training opportunity these programs presented were less significant than the effect on prisoners. She chronicled advantages

80 Ibid., 367.

81 Noses occupy a particularly prominent role in physiognomical practices that correlate facial features to character and behavior. They also serve as a metonym for an Anti-Semitic tradition that reads Jewishness and Jewish deviance in the nose. Pearl, *About Faces*.

82 Spira et al., "Plastic Surgery in the Texas Prison System," 370.

83 Ibid.

84 Ibid., 371.

85 Bounds, "Plastic Surgery Reshaping Inmates' Faces and Futures." Once again, crooked noses are code for a particular kind of criminal; no need to be more explicit.

86 Ibid.

for prisoners that included allowing them to do things like "breathing effortlessly," in some cases "for the first time in years."[87] This too was, according to Bounds, subordinate to the implications for future behavior: "Perhaps most important, studies suggest that a man with a straight nose just isn't as likely to go back to prison as one whose nostrils sit sideways on his face."[88]

Bounds quoted (some of) the studies to date on recidivism, but also turned to psychological explanations, citing Dallas District Attorney Henry Wade, who "has never seen those studies."[89] They intuitively made sense to him, however, as "One of the biggest problems is that when people get sent to prison they lose their self esteem."[90] "Anything," including surgery, "that helps him establish a better image of himself could help keep him out of trouble."[91]

By 1986, operations were no longer offered as a reward for good behavior in Texas prisons. Inmates were prioritized for surgery based on what the prison defined as medical need, such that, for example, "if a lopsided nose obstructs a prisoner's breathing, he gets his nose fixed." Severity was not the only inclusion criteria, however: "in some instances, surgery is performed for purely cosmetic or psychological purposes," which, according to the philosophy of the prison plastic surgery program, amounted to the same thing.[92] The reasons for this shift are not documented, and ultimately are more of a change in language rather than policy.

At the same time, prison surgeries gave residents training for their future careers on a wide range of conditions. For Texas prison and medical administrators, this was a win-win.

## CAMP HILL BORSTAL INSTITUTION/OTHER YOUTH CENTRES ACROSS ENGLAND

If these interventions worked to lower recidivism rates on already convicted and incarcerated criminals who received them, how much more effective could they be if they were instituted even earlier? It stood to reason, based on the theoretical approaches underlying the plastic surgery initiatives and in accordance with Lewison's emphasis on youth, that the younger the (potential) delinquent, the greater the impact of a face alteration.

There were a number of plastic surgery programs in the Borstals, which was what youth detention centers were called in the United Kingdom and throughout the Commonwealth. Run by HM Prison Service, these institutions were designed to reform and educate offenders under the age of 23 and to keep them separate from hardened criminals. Sentences in these institutions were referred to as training, with a highly disciplined and authoritarian regime. The Borstals were abolished in the UK by the Criminal Justice Act of 1982, due in part to the harsh conditions and their effects.

87 Ibid.
88 Ibid.
89 Ibid.
90 Ibid.
91 Ibid.
92 Ibid.

One such condition that was a fact of life for those in the Borstals in the 1950s was, for those who agreed to participate, surgically altered faces.

From 1951-1955, the Camp Hill Borstal Institution in Portland attempted to reverse the effects of "neglect," observed "as a result of the physical and psychiatric examination of several thousand Borstal inmates over a period of years."[93] Consonant with prevailing psychological theories of the time such as the "refrigerator mother," prison authorities and other officials held parents (and especially mothers) responsible for the character and behavior of their offspring.[94] This observed neglect, as HM Prison Medical Officer D. A. Ogden wrote in 1959, "is now widely accepted by most workers in criminology to be basically one of lack of moral values and practical example in the family circle."[95] The stakes were not just behavioral, as "this neglect spreads also into physical matters" in that "squints, nasal deformities, and other varied disabilities are left uncorrected in childhood."[96] Ogden argued that facial differences could well "become either foci of resentment or of chronic irritation."[97] So, he and others reasoned, it was possible that "surgical rehabilitation, in removing these defects, could also produce secondary psychological effects which would be of use in combating delinquency."[98] Ogden decided to see if this kind of rehabilitation might work.[99]

Much like the other programs, the Camp Hill initiative had the explicit goal of improving the behavior of criminals and reducing their rates of recidivism. And much like in Texas, requests for participation were usually initiated by prison officials, because unlike "in normal medical practice" where "it would be reasonable to expect individuals to seek assistance when troubled by a disfigurement," "to rely on this in a young delinquent population would be unrealistic."[100] Ogden connected this seeming passivity to the "very sense of neglect and, in many cases, rejection" which "has usually long since buried any hope that something may be done."[101] Accordingly, "possible remedial action should be raised at the original examination" by medical officials "by a casual reference to the condition with the object of noticing the reaction, which varied from extreme embarrassment to an obviously over-defensive denial of any disturbance."[102] Even those who did not seem to mind their appearance were intrigued by the possibility of surgery, and "the offer of specialist opinion was usually greeted with obvious enthusiasm."[103] Ultimate access to surgery was granted on the basis of good behavior; officials made clear to the applicant "the need for proving trustworthy conduct while

93 D.A. Ogden, "Use of Surgical Rehabilitation in Young Delinquents," *British Medical Journal* 1: 5119 (14 February 1959): 432.
94 Deborah Weinstein, *The Pathological Family: Postwar America and the Rise of Family Therapy* (Ithaca: Cornell University Press, 2013).
95 Ogden, "Use of Surgical Rehabilitation in Young Delinquents," 432.
96 Ibid.
97 Ibid.
98 Ibid.
99 Ibid.
100 Ibid.
101 Ibid.
102 Ibid, 432–433.
103 Ibid., 432.

awaiting attention," a message underscored by "a ruling body in the background."[104] The final application for surgery "must be accompanied by good conduct reports," and while "this might well be taken to be no more than a bribe," there was a pedagogical and training impetus to this process "in that it affords to a delinquent a clearly appreciated example that the lasting things in life have to be earned and do not fall into the lap."[105]

Ogden was aware of the potential challenges in taxing the National Health Service with requests for plastic surgery on juvenile delinquents, noting that "it is not reasonable to request undue priority for remedial cases competing for hospital bed accommodation with other surgical cases."[106] To that end, he suggested that "it is expedient to start action early enough to allow time on waiting-lists," which, alongside the advantages of early intervention, explains why this option was raised upon the initial examination of youth entering the Borstal.[107]

Ogden's approach was in congruence with the procedures and theories in the Texas prison system at the time and the widely-cited literature on the "Quasimodo Complex."[108] In addition to the role of the authorities in suggesting and facilitating access to the surgery, Ogden emphasized the potentially powerful relationship between inmates and medical staff, warning that "some calf-love attachment to staff seems almost an 'occupational risk'" and an unsurprising one, given that in contrast to their supposedly neglectful mothers, "young delinquents see for the first time in their lives practical evidence that there are women of a high sense of calling in the world."[109] While Ogden did not suggest exploiting that relationship for counselling rehabilitation efforts except in the most general of ways, he believed that the surgery left the participant more open and better able to engage in education and reform. His model was not purely rooted in the idea that surgery itself changes character; he was careful to note in his conclusion that "it is not claimed that remedial surgery in itself is a cure for delinquency."[110] Instead, "it renders the individual susceptible to the normal character training processes, by removing the foci of resentment and physical irritation and by demonstrating that society is prepared to help."[111]

The numbers in this case were small: 55 treated cases, of which 30 (54.5%) were not, as far as the author knew, reconvicted in the intervening four years. Amongst those who were not "treated," 34.5% were not reconvicted. From this sample, the author concluded that it is "immediately apparent that the chances of success were much higher in those inmates who had received the benefit of remedial surgery."[112] Ogden's rhetorical framing is powerful: plastic surgery was not just "treatment," but "remedial." And a

104 Ibid.
105 Ibid.
106 Ibid., 434.
107 Ibid.
108 F. W. Masters and D. C. Greaves, "The Quasimodo Complex," *British Journal of Plastic Surgery* 20 (1967): 204–210, https://doi.org/10.1016/S0007-1226(67)80037-7.
109 Ogden, "Use of Surgical Rehabilitation in Young Delinquents," 434.
110 Ibid.
111 Ibid.
112 Ibid, 433.

"benefit."[113] As in all other programs, the range of interventions was wide, though Ogden was less specific, offering a table that included: General Surgery, Orthopaedic, E.N.T., Plastic, and Ophthalmic."[114] He got granular about those results, comparing the effects of each surgery category and outlining surprising results, including that "it was anticipated that squint operations would probably show the highest success rates after release, but this did not prove to be the case."[115] By contrast, "the general surgery group was. . .more successful than anticipated," given that the category encompassed treatment for "varicose veins which would not have received attention if assessed purely on direct symptoms."[116] Other surgeries included "closure of a congenital cardiac foramen," and "excision of facial scars."[117] Like other programs, the "nasal remould series" was "the most striking" in that "only one in the series of nice cases is showing evidence of recidivism."[118]

Ogden's confidence in the program was impressive, especially considering the short time allotted between intervention and measurement of recidivism. He did not compare his sample to programs in adult facilities, nor did he discuss the question of consent amongst minors and young people, though his participants may have been as old as 23. We do not know for sure, because their ages are not listed. However, given his general theoretical approach, he advocated for surgery on younger people, as that would, he believed, stand the best chance of success and maximize benefit for the remedial treatment of criminal behavior and character.

Participants volunteered; we may query how much incarcerated youth could be considered to volunteer for anything, particularly when the mechanism was facilitated by the suggestion of the authoritarian administrators in charge of their lives, but that was not a part of the discourse at the time. Not only did these young people volunteer, but also they were asked to improve their behavior to qualify, and "in every case this challenge was accepted," though "some individuals did display irregularities of conduct that required punishment."[119] However, those who misbehaved were "very perturbed that the lapse might spoil their chances" and in all but two cases these youths were still allowed to participate.[120] In a fascinating side note, Ogden wrote that even those two who were kicked out of the program were eventually given access to this treatment, as "arrangements were made for medical attention in the home area after release."[121]

The British context matters here: in the US, which unlike the UK had no universal health care, some of the prisoners who received plastic surgery had little or no follow-up care available to them after they were released, sometimes quite soon after their

113 Ibid.
114 Ibid.
115 Ibid.
116 Ibid.
117 Ibid.
118 Ibid.
119 Ibid.
120 Ibid.
121 Ibid.

interventions.[122] Cosmetic surgery "that is not medically necessary" is not and has never been covered by Medicaid.[123]

The Camp Hill Borstal program was the most systematic delinquent youth plastic surgery intervention, but it was far from the only one. Right around the same time that D.A. Ogden was piloting his first Borstal procedures in 1950, George Bankoff wrote about his own, similar projects, in various sites across England, publishing his findings in 1952. These were a less formal set of initiatives, based on "the opportunity of dealing with several of these cases" of "the inveterate criminal" who "more often than not," "has deformed features."[124] Bankoff's theories were similar to those of other plastic surgeons working with incarcerated people, with a particular focus on youth. He wrote that "often, children born with ugly facial deformities are turned through ridicule by their schoolmates into social outcasts."[125] The effect of being "barred from the normal community of man" was that "these children, when they grow up, become weaklings in character and are unable to earn an honest living."[126] Inevitably, "they resort to subterfuge, lying, and petty larceny." Bankoff was not opposed to punishment at this stage, noting that "the law has the right to deal with such criminals."[127] He was surprised, however, that "little attention has been paid to the physical appearance," and, in particular, that "seldom has the help of plastic surgery been invoked."[128]

But it should have been. So Bankoff believed, and so he wrote that "a lot of suffering would be spared these unfortunates, and many a useless life would be turned into a fruitful and helpful one, if they were given the chance of a plastic operation." He was not talking about anything complicated; indeed, "these plastic interventions, in the majority of cases, are very simple and do not involve a major operation or endanger the patient's life."[129]

Bankoff was actually a bit radical here, challenging prevailing carceral approaches even as he operated in classic paternalistic medical mode, determining what is best for patients without consulting them.[130] While he granted the importance of incarceration for the safety of society, he offered plastic surgery as a viable alternative route. To that end, he suggested that plastic surgeons be part of the criminal justice administration, and should be consulted during the trial process. Specifically, "the plastic surgeon's

122 The NHS (National Health Service) was founded in the UK in 1948.

123 "What Are Some of the Services Covered by Medicaid? | Dhcf," https://dhcf.dc.gov/service/what-are-some-services-covered-medicaid. Medicaid was enacted in 1965; prior to that, there were limited federal funds distributed to the states for public health care assistance. "A Brief History of Medicaid," ASPE, 3 December 2016, https://aspe.hhs.gov/report/using-medicaid-support-working-age-adults-serious-mental-illnesses-community-handbook/brief-history-medicaid.

124 Bankoff, "Plastic Surgery and Criminology," 448.

125 Ibid.

126 Ibid.

127 Ibid.

128 Ibid.

129 Ibid.

130 Paternalism remains a trenchant practice in modern medicine, despite its disavowal in Western medical practice. Health ethicists continue to debate its value and note the cultural specificity in the ways that it is applied. See for example, Brian C. Drolet and Candace L. White, "Selective Paternalism," *AMA Journal of Ethics* 14 (2012): 582–588, https://doi.org/10.1001/virtualmentor.2012.14.7.oped2-1207.

advice should be incorporated into the sentence when the law deals with criminals and minor delinquents."[131] The surgeon's suggestion would bear quite a bit of weight, such that "on his advice, the magistrate, instead of committing the youthful offender to a reformatory, should send him to an appropriate hospital."[132] Once there, "the surgeon's knife can remove the cause of the criminal tendencies in the child."[133] And once the cause was removed, so too would be the behavior and the need to protect society from this deviant.

Bankoff offered the case studies to prove it. His chronicle started with Jimmy, son of a "Jewish emigrant from Poland" whose debilitating disfigurement was a "grotesque saddle-nose deformity" resulting from a broken nose suffered as a baby.[134] This "facial deformity" caused Jimmy to "be ridiculed at home and at school with the inevitable result that he revolted and took to crime in self-assertion," to demonstrate that "in spite of his ugliness he was the cleverest of them all."[135] The connection between Jimmy's nose and his life of crime was first raised by a judge after one of Jimmy's hearings and institutional stints for robbery. During Jimmy's second incarceration, the prison doctor "hit upon the idea of consulting a plastic surgeon."[136] This consultation became an operation. Jimmy's ideas on the matter were not mentioned, though the benefits he reaped were, as "from an ugly rascal he became a very attractive youngster." And, in classic physiognomical terms, beauty does as beauty is, certainly in Jimmy's case, whose "change was remarkable in both his physical and mental attitude."[137] Indeed "Jimmy became, almost overnight, a model prisoner, [improving] his behavior such that eight months of his sentence were remitted."[138] Jimmy got a new face and new freedom, the system got rid of a prisoner, and society remained protected. Bankoff's only lament was the time it took for Jimmy to access this opportunity, as "if this boy's face had been corrected earlier, how much suffering to the boy and his parents would have been spared, not to mention the expense to the State of maintaining him in correctional institutions!"[139]

Bankoff's other cases ranged across the country and all had different histories, different crimes, and different operations. But in the end, they all got surgery, and in the end, according o Bankoff, they all got better. They all *became* better, turning away from a life of crime to be productive and producing hard-working citizens. While Bankoff's mechanism was the same as the other doctors chronicled here, and his lack of concern about

131 Bankoff, "Plastic Surgery and Criminology," 448.
132 Ibid.
133 Ibid.
134 The anti-Semitic construction of the connection between the supposed Jewish nose and criminal behavior has a long history as outlined in Sharrona Pearl, "The Myth of the Jewish Nose," *Tablet Magazine*, 3 February 2019,/sections/community/articles/the-myth-of-the-jewish-nose; Sara Lipton, "The Invention of the Jewish Nose | by Sara Lipton," *New York Review of Books*," https://www.nybooks.com/daily/2014/11/14/invention-jewish-nose/.
135 Bankoff, "Plastic Surgery and Criminology," 449.
136 Ibid.
137 Ibid. For more on physiognomy see Pearl, *About Faces*.
138 Bankoff, "Plastic Surgery and Criminology," 449.
139 Ibid.

operating on young people overlapped with Ogden's, his theoretical underpinnings were less essentialized. He thought that a corrected face led to a corrected life, and he thought that surgeons should absolutely be the ones to determine the need for correction, but he paid much more attention to social interactions as structural determinants of behavior. For Bankoff, an ugly face led to neglect, and neglect led to crime. A less ugly face reduced neglect. It was less about the relationship between appearance and character, and more about appearance and experience. Which is to say, in Bankoff's model, there could be other solutions. But he was not interested in exploring them. He had a normative view of ideal appearance, freely describing the face of one of his cases, 16 -year-old Elise, as "being transformed into a normal, good-looking one."[140] Elise's physical transformation and the resulting change in her experience meant that "there is every prospect that she will develop into a useful young woman."[141] And this is, indeed, is the goal of all make-overs: to transform those who are in some way deviant into model citizens.[142]

Bankoff did not set out to change society, but he had no problem indicting it for the "failing" "that a man's crime is considered only as an outrage and is punished by imprisonment." Consonant with Lewison, Bankoff was committed to people's ability to change; he believed that "deep down some of" what he calls "these unfortunate people" were "decent, honest people, who, because of some congenital or acquired physical defect, feel they have a grudge against the world." As a way to exact "revenge, they commit crimes, trying to get even with both nature and society." Punishment may have been due to them, but, perhaps, "one should also sentence the people who have contributed to his downfall." Bankoff did not propose a way to alter people's attitudes, but he did offer a policy change in conjunction with his treatment, arguing that if "the plastic surgeon were consulted" during hearings, "more often than not the root of the trouble would be found to lie in some deformity, real or imaginary, which has played on the mind of the individual."[143]

Bankoff did not suggest also adding a psychiatrist or psychologist to the evaluation proceedings. His comfort with evaluating the root causes of behavior demonstrates not just his theoretical framework but what it is he believed plastic surgeons do. If psychiatrists are doctors of the mind, for Bankoff, plastic surgeons are doctors of the soul. And they access the soul through the face.

While Bankoff exhibited a great deal of sincerity and compassion for his subjects, he was less concerned about their autonomy.[144] That was neither omission nor accident, but deliberate policy. He wanted plastic surgeons to wield judgment, and, as he wrote, "plastic surgery is in itself punishment."[145] Or plastic surgery was at least part of the punishment: "people must pay for their misdeeds according to the law."[146] But, he

140 Ibid.
141 Ibid.
142 Sender, *The Makeover*.
143 Bankoff, "Plastic Surgery and Criminology," 450.
144 Autonomy, along with beneficence, nonmaleficence, and justice, comprise core principles of bioethics. Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 7th Edition (Oxford: Oxford University Press, 2012).
145 Bankoff, "Plastic Surgery and Criminology," 450.

argued, if they underwent surgery, that should be calculated into their total sentence and they "should afterwards be treated with leniency and with shortened sentences," both to recognize their surgeries as a way to pay a debt, and also—because he is sincere in his attempts at rehabilitation – "in order to give them a chance to take up a normal life."[147] It worked in all six of the cases that he wrote about. But he only wrote about six cases. What happened when these programs were examined across the prison population as a whole?

## MONTEFIORE/SING SING

Most of the prison plastic surgery programs had one, or maybe two, articles published in peer-reviewed literature chronicling their efforts, motivations, and outcomes. There were also more casual or ad-hoc arrangements that were not specifically documented, and whose details ought to be investigated.[148] There was, however, at least one large-scale, federally funded program to systematically chronicle the effect of plastic surgery on criminal recidivism across various prisons in the New York City Department of Correction. A joint project between the Montefiore Hospital and Medical Center and the Staten Island Mental Health Society Inc., the 1966 Surgical and Social Rehabilitation of Adult Offenders Project (SSR) was partly supported by grant RD 1568M from the now-defunct Vocational Rehabilitation Administration through what was the United States Department of Health, Education, and Welfare.[149] While the actual numbers in the study were relatively modest, with around 650 inmates "judged to have reparable defects" through available surgical interventions of the 1570 who made "application for correction of deformities," these participants provided a rich potential source for experimentation and quantification.[150] The motivating logic for the project was explicitly "the study of the value and efficacy of plastic surgical operations in the social rehabilitation of chronic offenders."[151] Indeed, "the relationship between the improvement in self-image and successful rehabilitation is one of the main hypotheses being tested."[152]

The underlying logic is familiar, based on the observation that "many inmates with physical traits as dissimilar as a prominent hump nose, protruding ears, crude "jailhouse" tattoos, conspicuous facial scars or needle tracks have one factor in common."[153] Specifically, "these inmates, lacking a sense of self-worth, feel that their physical traits thereby stereotype them as boisterous, mean, aggressive, immature, addicted to violence, of low intelligence or a narcotic user."[154] To fix this personal

146 Ibid.
147 Ibid.
148 For example, plastic surgeon and founder of the Center for Human Appearance at the University of Pennsylvania noted in an e-mail to me that "The Chief of Plastic Surgery here at Penn (and at other medical centers) in the 1960s and 70s occasionally operated on prisoners, with the general idea that it would help with self-image and psychologically." Linton Whittaker, "Prison Plastic Surgery," 27 June 2019.
149 Kurtzberg et al., "Psychologic Screening of Inmates Requesting Cosmetic Operations," 389.
150 Ibid.
151 Ibid., 387.
152 Ibid.
153 Ibid.

dignity deficit, Kurtzberg proposed, fix the physical traits. So his team did, working on the "premise that rehabilitation of the prison inmate depends in large measure on helping him develop a feeling of self-worth," achieved by "the correction of these cosmetic deformities."[155] Specifically, "the purpose of offering plastic surgery to offenders is to effect changes in self-concept which will ultimately result in less antisocial behavior."[156]

There is not a lot of detail in the published papers about the selection mechanism, though all participants were "short-term male offenders who were inmates in institutions of the New York City Department of Correction." While the reasons for selecting male inmates were not detailed, they represented the overwhelming number of incarcerated people. Inmates were somehow "appraised of the availability of plastic surgical services."[157] Around 1570 inmates in some way volunteered to participate.[158] Of those 1570, those who were accepted were "subject to only two conditions, as follows: (1) that the defect had to be reparable from a purely surgical point of view and (2) that there could be no significant psychiatric contraindications."[159] To guarantee the first and the second, "inmates were screened by a plastic surgeon and underwent intensive psychological evaluation while in prison."[160] After the initial screening, 1424 inmates were examined in depth, and 663 were ultimately selected.[161]

The 663 participants who opted into the program differed in important psychological ways from their fellow incarcerated people, as "all groups of inmates requesting correction of cosmetic disfigurements showed a higher physical self-concept than the control group of prisoners."[162] The control group, like the overall "prison population ranks much lower in self-esteem, both over-all and physically, than do normal persons."[163] With two exceptions: "the over-all self esteem of the inmates requesting rhinoplasties and removal of needle tracks," it turned out, "is significantly lower than that of the prison control group."[164] Both these groups also had the highest levels of depression, which in the latter case was noted to be "a frequently observed personality characteristic of the narcotic addict."[165] The program was not designed to treat underlying depression or poor self-image in any way outside the surgery itself; according to the theory motivating the intervention, the surgeries alone could well be enough.

The 663 participants were randomly sorted into two groups, one "which received surgical treatment and social and vocational services," and another which received only

154 Ibid.
155 Ibid.
156 Richard Kurtzberg, Howard Safar, and Wallace Mandell, "Plastic Surgery in Corrections," *Federal Probation* 33 (1969): 46.
157 Kurtzberg et al., "Psychologic Screening of Inmates Requesting Cosmetic Operations," 389.
158 Ibid.
159 Richard L. Kurtzberg, Howard Safar, and Norman Cavior, "Surgical and Social Rehabilitation of Adult Offenders: (473742008-326)," 1968, 688, https://doi.org/10.1037/e473742008-326.
160 Ibid., 326.
161 Ibid.
162 Kurtzberg et al., "Psychologic Screening of Inmates Requesting Cosmetic Operations," 391.
163 Ibid.
164 Ibid.
165 Ibid.

surgical treatment.[166] One control group "received no services whatsoever," while another, we learn in a different article, received social and vocational services but no surgery.[167] In total, four groups were studied and tracked for rates of recidivism in order to measure the effect of plastic surgery and services, plastic surgery and no services, services and no surgery, and no intervention at all. These groups were further tracked by type of surgical intervention and by whether or not they were addicts, which itself could play a role in rehabilitation outside the prison.

Additional social services were offered to two of the groups, but they were practical rather than psychological in nature, designed to help subjects navigate the world outside prison. These consisted of four parts: "a. Drug rehabilitation and detoxification; b. Liaison with New York City Department of Welfare; c. Vocational services; d. Other services."[168] The various services were accessed unevenly by subjects due to both their own inclination and some challenges with the institutional bodies. In the case of the Department of Welfare, for example, the SSR made a referral on behalf of the subjects, but acknowledged that "some difficulties were encountered," specifically that "many welfare personnel seemed to regard offender-clients, particularly addicts, as individuals highly likely to misuse funds."[169] SSR also offered referrals to community vocational agencies, but for these too, "the legal and addiction history of SSR clients often made acceptance into vocational programs difficult." Compounding this challenge, "most vocational training programs in New York City limit eligibility to those aged 16-21."[170] The larger structural issues around access to services that this finding raises were not discussed further, nor was there a consideration of how and whether the difficulty subjects had in availing themselves of these resources may have affected the outcomes of the "services" groups. It does, however, highlight the difficulty in using these data to draw conclusions about the efficacy of plastic surgery while underscoring the numerous structural barriers that former inmates had to overcoming recidivism, particularly when their status as offenders is known.

The identities of the subjects were well-publicized amongst both criminal justice officials and the hospital staff, as "successful participation is helped when the candidate's parole or probation officer is informed of the candidate's participation in the program."[171] While in many previous interventions, clinicians willingly volunteered their services, this more well-funded program worked directly with hospital staff, who may have had reservations about working with this particular population. Kurtzberg advised that "physicians, nurses, and other hospital staff who must deal with the candidate should be informed as to the nature and goals of the program." This breach of confidentiality was worth it, as it would serve "to ensure their co-operation" more effectively "than attempting to keep the offender-candidate anonymous."[172]

166 Ibid., 388.
167 Ibid; R. L. Kurtzberg, N. Cavior, and H. Safar, "Plastic Surgery and the Public Offender," *Rehabilitation Record* 8 (1967): 11.
168 Kurtzberg, Safar, and Cavior, "Surgical and Social Rehabilitation of Adult Offenders," 692.
169 Ibid., 693.
170 Ibid.
171 Kurtzberg, Safar, and Mandell, "Plastic Surgery in Corrections," 46.
172 Ibid.

The challenges of undergoing surgery were themselves wielded as part of the treatment process in an approach similar to Ogden's: the program was designed to take advantage of the fact that "the period of surgical treatment is a traumatic one for offenders."[173] Given that "the candidate often is seen in a relatively unstable or stressful state," the post-surgical time is "often a period when he is more amenable to other attempts at rehabilitation."[174] The program offered the means to access prisoners at their most vulnerable, which "provides a good opportunity to initiate a total rehabilitation program."[175] Counselors were urged not to wait for subjects to recover "before initiating vocational counseling," but rather "to begin such contacts in the hospital."[176]

By far the most systematic of the plastic surgery programs, the SSR data are spread across a series of papers by Richard Kurtzberg, the director of the psychological services for the project, and Michael Lewin, the lead plastic surgeon. Coauthors included Norman Cavior, the project's research psychologist, Howard Safar, director of field services, and psychologists Douglas S. Lipton and Wallace Mandell. Kurtzberg, Safar, and Mandell were all research staff at the Louis M. Wakoff Research Center, affiliated with the Staten Island Mental Health Society. The analyses in the papers ranged from an in-depth look at psychological screening techniques for participants, to an overall discussion of the project, to a series of case studies. But in each piece, the findings were clear to those studying its impact: plastic surgery, as a means to improve self-image and thus reduce recidivism, worked. At least for some.

In a follow-up essay published in 1968, Kurtzberg and his team laid out the findings of the SSR experiment in quantitative and qualitative detail.[177] The discussion section focused on two key questions: "1. Do the treatments differentially reduce the proportion of inmates in the various groups returning to prison within the follow-up period?" and "2. Do the treatments delay return to prison?"[178] The data were analyzed in multiple ways, but the first result is perhaps quite surprising: the "Incidence of Recidivism as a Function of Treatment for Addicts" showed that in group I, which received both surgery and service, recidivism rates were 50%. Those who received only surgery reoffended at a rate of 67%, while those who had only services had 48% reoffending rates. The highest category of recidivists was among group IV, who received no intervention of any kind.[179] That was to be expected. Less obvious was the finding that those who received only services had the lowest rate of recidivism—even lower than those who received surgery and services. Surgery alone had the second lowest effect in this grouping. The article suggested a number of possible reasons for this result, many of which focused on the specific characteristics of the disfigurements in this group, but ultimately concluded that "further investigation of this issue with larger samples is

173 Ibid.
174 Ibid.
175 Ibid.
176 Ibid., 46–47.
177 Kurtzberg, Safar, and Cavior, "Surgical and Social Rehabilitation of Adult Offenders," 688–700.
178 Ibid., 695.
179 Ibid.

needed."[180] The writers speculated that perhaps removal of the "traumatic facial disfigurements" might itself contribute to some of the challenges, noting that there may be "positive as well as negative psychological and social effects associated with traumatic disfigurements or tattoos."[181] While this observation conceded that the positive or even identity associations with one's appearance were not taken into account in the original experimental design beyond assuming that anyone who volunteered for the surgery wanted their appearance in some way altered, this was a significant acknowledgment that what others might view as traumatic disfigurement may well not be experienced in that way by those who have it.

That was a big shift, but one that, in the context of this particular experiment, was never entirely assimilated. The article went on to evaluate the effect of tattoo removal in particular, as it was only addicts who requested this intervention, "there was no benefit demonstrated as a result of surgery or any combination of treatment for individuals who had requested removal of tattoos."[182] While the possibility that tattoos had some positive psychological benefit was hinted at above, the study suggested that "their addition may have been the factor which mediated against positive effects of the surgery," especially given that "surgery for the removal of tattoos is followed by a long period during which the results are not aesthetically pleasing."[183] Needle track removal recipients, on the other hand, did show "a tendency to recidivate less than controls" to a small and statistically insignificant degree.[184] The difference in how people treated these track-less addicts created an internal shift, such that "for the first time since they began using heroin, they no longer felt like addicts" because "they were no longer recognized as addicts because of the lack of identifying stigma."[185] Unlike tattoos, there were no apparent positive psychosocial benefits to track marks.[186]

The non-addict surgical subgroups saw more successful results, with 33% of those receiving surgery and services reoffending. Those who only received surgery had a recidivism rate of 30%, which was surprisingly even lower than those who also had other services. Those who got services alone reoffended at a rate of 89%, which was significantly higher than the rate of 56% amongst those who received nothing. For non-addicts, services seemed to actually cause harm, a finding that was "similar to those reported recently which indicate that traditional counseling and placement techniques often have null or even negative effects when applied to problem populations."[187] Here, again, the article teetered on the edge of a rather major analysis of some of the structural shortcomings of traditional approaches to the prison population, suggesting that the non-addict group had some selection similarities including "receiving

180 Ibid., 697.
181 Ibid.
182 Ibid.
183 Ibid.
184 Ibid.
185 Ibid.
186 For more on prison tattoos and identity see Michael P. Phelan and Scott A. Hunt, "Prison Gang Members' Tattoos as Identity Work: The Visual Communication of Moral Careers," *Symbolic Interaction* 21 (1998): 277–298, https://doi.org/10.1525/si.1998.21.3.277.
187 Kurtzberg, Safar, and Cavior, "Surgical and Social Rehabilitation of Adult Offenders," 698.

sentences which involved parole upon termination of imprisonment."[188] The writers considered that while "they may have been poorer rehabilitation risks to begin with," they "may have been subject to pull in different directions from the parole and SSR counselors."[189] The multiple different expectations and obligations that these subjects had to balance could certainly have presented particular challenges, if not, then "a more serious examination must be made of the counseling process."[190]

## CONCLUSION: NO SERIOUS EXAMINATION WAS MADE

Facial surgeries in prisons from the 1950s to the 1980s were consonant with standards of the time, offering a clear potential benefit to the participants according to leading experts in the field. While in some cases these benefits were not the primary motivation for the program, the possibility of transformation and self-improvement could yield rich results to the advantage of the participants, the surgeons, and society as a whole. The chosen mechanism of self-transformation—plastic surgery—reveals a deep commitment the role that manipulation of the face and body plays not just in behavior but also in the ways that relationships are established and supported. In a way, that has always been true, as the physiognomical and makeover literature makes clear.[191] But in another way, these particular approaches are intimately tied to a moment in the history of psychiatry and psychology that saw transgression as rooted in both self-image and familial (and especially maternal) treatment.[192] The accompanying insights into the history of criminal behavior are quite powerful, and show that both the mechanisms of criminal justice and the imaginary around mechanisms of personal change have perhaps not changed all that much. These programs are no longer extant in this form (though tattoo removal and track remediation programs remain an important and widespread part of rehabilitation) for a variety of reasons including: changing protocols for prison experimentation and what counts as consent, a decline in funding for rehabilitation more broadly, significant decreases in prison medical care, and a lack of a clearly demonstrable positive benefit and indeed possible negative outcomes.[193] Perhaps attitudes toward plastic surgery have also shifted such that it is no longer seen as a kind of hard work and potential punishment in the way that Ogden and the SSR project described.[194] The potential around changing appearance to change character, however, remains robustly supported through and indeed driven by the big business of beauty and makeover culture at large.

External appearance continues to carry with it a whole host of meanings about the person who lies beneath; changing how you look can, so a global beauty and makeover industry demands, change who you are, or at least your experience (and the experience

188 Ibid.
189 Ibid.
190 Ibid.
191 Pearl, *About Faces*; Sender, *The Makeover*.
192 Weinstein, *Pathological Family*.
193 Phelps, "Rehabilitation in the Punitive Era."
194 For more on plastic surgery as "cheating," see Sharrona Pearl, *Face/On: Face Transplants and the Ethics of the Other* (Chicago: University of Chicago Press, 2017).

of those around you) of who you are.[195] But according to current neo-liberal logics, people need to put in the work for this change as part of their responsibility as capitalist consuming citizens.[196] Plastic surgery is a kind of shortcut that undercuts this labor. It may be necessary (or so some believe), but it is, in this framework, far from sufficient.[197]

But some people are no longer allowed to change. Or at least, the state is certainly not going to help them. Amongst the many striking features of this story is the very fact of rehabilitation itself, or more specifically, the idea that rehabilitation is not a possible feature of prison but a goal. However problematic the proposed mechanism seems in the current historical context, *very* coercive and unequally distributed health care is offered in many cases as a reward. However troubling its execution in light of modern IRB protocols, *highly* experimental or otherwise, prisoners cannot be said to consent ot procedures suggested by administrators with the possibility of threat or retaliation for their refusal. And however suspect its framing, *quite* particularly in Texas and Virginia, where prisoners were used essentially for medical practice, the notion that rehabilitation efforts could be touted as both motivation and advantage for a costly prison program is worth noticing. If not quite worth celebrating in this case, it is worth at least analyzing, in part because of how dominant the narrative of medicine as the fix for what is broken was. . .and still is. That, certainly, has remained the same.

195 Pearl, *About Faces*; Pearl, *Face/On*. For more on the strategic benefits of beauty and how they have been accessed, see Hamermesh, *Beauty Pays*; Perry, "Buying White Beauty"; Parameswaran, "Global Queens, National Celebrities."

196 Sender, *The Makeover*.

197 For more on the social pressure around plastic surgery, see Sharrona Pearl, "Renée Zellweger, Isabelle Dinoire, and the Stakes for Changing the Face," Nursing Clio, 20 September 2017, https://nursingclio.org/2017/09/20/renee-zellweger-isabelle-dinoire-and-the-stakes-for-changing-the-face/; Sharrona Pearl, "The Assumptions of Makeover Culture," *Culturico*, 10 July 2020, https://culturico.com/2020/07/10/the-assumptions-of-makeover-culture/.