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THE CONFESSION MIRROR: PLASTIC IMAGES FOR SURGERY

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I

The lucrative business of cosmetic or "plastic" surgery presents an intriguing site for the deployment of contemporary power relations.[1] The highly *material* "illness" of physical/aesthetic imperfection is "cured" through complex and overlapping mechanisms of confession and surveillance. A patient confesses inadequacy to a physician-confessor who sees and evaluates; in the confessional process, the patient is supplanted with the eye/I of the physician who functions together with the discourses of desire and consumerism.

As Michel Foucault tells us in "The Eye of Power," the evaluative gaze within institutional practices achieves its effects not because it emanates from an all-powerful individual, but because the gaze is housed in an apparatus of hierarchical power relations.[2] In this "complex play of supports", Foucault writes, the "summit and the lower elements of the hierarchy stand in a relationship of mutual support and conditioning, a mutual 'hold' (power as a mutual and indefinite 'blackmail')."[3] As in the case of Bentham's panopticon, power functions optimally when those who are imprisoned come to guard their own actions, to embrace the logic of surveillance in which they are caught and by which they are defined. Prision officials and convicts are equally trapped within the institutional gaze.

Cosmetic surgery as a cultural phenomenon, characterized by confession and surveillance, acquires particular significance for an analysis of contemporary power tactics with the realization that women, more often than

men, are the consumers of beauty enhancements and products.[4] Foucault suggests that, during Eighteenth Century practices, the bodies of women were thoroughly saturated with sexuality.[5] When integrated into social/clinical discourse, then, the bodies of women were viewed as inherently pathological or diseased because they were, in effect, "reduced" to sexual functions that were seen to account for a host of neuroses and maladjustments. At the same time, the reduction to sexual functions highlighted the danger posed by feminine sexuality. The female body, perhaps epitomized in the mythology of Adam and Eve, was capable of destroying its (male) victims. In the linkage between illness and danger, the bodies of women were deemed unhealthy and deviant, in need of ongoing scrutiny and surveillance. A diseased sexual identity placed the female body in a polarity of health and disease, legitimizing a host of efforts to monitor and correct the bodies of women, to make them whole while highlighting their fragmentation.

In her analysis of the female "look", Rosalind Coward notes that in contemporary culture, the appearance of the female body is linked to sexuality, health, and personal power.[6] The cultural obsession with the female body "makes women the bearers of a whole series of preoccupations about sex and health. For the exhortations to good health are exhortations to take control of your life, and are in no way separate from ideologies of working at becoming sexually attractive."[7] Similarly, Mary Daly's analysis of cross-cultural gynecological practices reveals an historical connection between feminine sexuality, clinical discourse, and a fixation on the appearance/exterior of female bodies.[8] Daly's investigation is important because it clarifies the operative ruse in feminine sexuality as defined androcentrically. Namely, in clinical efforts to correct and monitor the female body, the bodies of women in fact became "disabled." Corrective procedures *underscore* female disease and reposition women within the discourses of disease and sexuality. In the Chinese practice of foot-binding, for example, a "medical procedure" transforms the feet into sexual signs or fetish objects; the feet become unhealthy (completely non-functional) in the process of transformation. A woman who hobbles on "lotus hooks" is both a sexual vision and a disabled person.

In the scenario of the cosmetic surgeon's office, the transformation from illness to health is inscribed on the body of the patient. The reformed nose or breasts, similar to the bound foot, increase sexual desirability and thus, through the discursive linkage between feminine sexuality and health, are seen to empower the patient. The female patient is promised beauty and re-form in exchange for confession, which is predicated on an admission of a diseased appearance that points to a diseased (powerless) character. A failure to confess, in the clinical setting, is equated with a refusal of health; a preference for disease. A healthy patient, then, demonstrates a capacity for free will (choosing health) through the admission that she is unhealthy/unattractive, i.e., in need of cure. Yet she is not capable of enact-

ing her own state of health, as implied by her presence in the physician's office, much like the convict's presence in the penal system. The choice to alter oneself announces, simultaneously, health and disease because the cure signifies the hold of prescriptive beauty standards over the patient. A change in the body secures the patient's position within the discursive machinery that has deemed her unhealthy and dangerous.

Practices such as cosmetic surgery are difficult to criticize precisely because they are seen to be elective and empowering. In his later work, Foucault demonstrates that contemporary power strategies function not through bodily repression, but through stimulation or desire.[9] "Mastery and awareness of one's own body can be acquired only through the effect of an investment of power in the body: gymnastics, exercises, muscle-building, nudism, glorification of the body beautiful. All of this belongs to the pathway leading to the desire of one's own body . . ."[10] As Coward explains, the investment of power in the female body is cast in the language of deficiency and desire: "dissatisfaction [with the body] is constantly recast as desire, desire for something more, as the perfect reworking of what has already gone before — dissatisfaction displaced into desire for the ideal."[11]

Beautifying one's body is premised on the assumption of free choice, unlike chemotherapy, for example, where the "option" is death and thus the patient is powerless in making a choice. Concomitantly, the choice to repair an unsightly physical feature is met with the approval of society, particularly when the choice is made by a woman. The choice is connected to personal strength and self-love — seeing oneself as desirable. As Susan Brownmiller writes, a woman who is judged to be unattractive within society is seen as a person who does not care about herself.[12] An illustration is provided by comments directed toward the woman whose appearance is not socially sanctioned: "she must not like herself." The irony in concepts of beauty and health that fundamentally efface and deny the bodies of women, recasting them in images of the ideal, remains veiled by the promises of power and self-love; the promise of uncovering the real.

In pondering my diagnostic tools for an analysis of cosmetic surgery as a confessional phenomenon, I initially consulted published texts. I wanted to find out what numerous experts had said about the practice of surgical body beautification. I also paid close attention to media advertisements for cosmetic surgery, most of which are given credibility through medical or "expert" endorsement. Cosmetic procedures are regularly marketed for mass audiences, distinguishing them from many other medical procedures (e.g., gall bladder surgery). In fact, an important shift in the domain of cosmetic surgery is that cosmetic procedures are no longer restricted to the very wealthy or famous: carving the body for social sanction is now mundane and available to everyone.[13] In addition to explicit advertisement, news programs and talk shows regularly include segments on cosmetic surgery. Physicians typically appear with "before" and "af-

ter" success stories; the patient relays her positive experience with surgery and encourages others to follow in her footsteps. Finally, I considered more subtle forms of encouragement for increased attractiveness, such as the pervasiveness of anti-aging creams and the models used in advertising who represent physical "perfection": the ideal.

While collecting data, I wrote to several cosmetic surgery clinics and requested further information, posing as a prospective patient. In response, I not only received pamphlets which provided cursory overviews of specific procedures, also enclosed were invitations for free consultations. Initially I discounted the invitations, finding them useful only as a case of the urgency that accompanies modern consumerism. In several cases, I was even sent bank loan application forms, underscoring the easy availability of a physical transformation. Upon further reflection, however, I decided to go to a clinic for a consultation. In part, my decision was based on an academic desire for thoroughness in my investigation; but another part of me, in pouring over the information concerning cosmetic surgery, had become intrigued by the prospect of a changed appearance. Although I trusted my critical faculties to prevent me from agreeing to surgery during my first visit, I was very interested in the clinical mechanisms that encourage the fabrication of a new identity.

I was fully prepared to let my own clinical experience serve a tangential function in my research on cosmetic surgery. Like most academics, I had been trained to view the personal as an intrusive and distorting presence in scholarship. During and after my visit to the clinic, however, I began to see that the workings of confession and surveillance are far more visible in the clinical setting than in disparate sources such as books, advertising, and cultural beauty standards. I was able to keep a distance from these sources and thus my own entrapment within cultural discourse remained safely hidden from view. I trusted an actively critical "self" to keep at bay any "common" or politically incorrect desires. The clinical experience coalesced numerous support mechanisms which fuel confession and consumption, and prompted a realization of my own entrapment. The following is an account of my experience, the subtle splitting and jarring that prompts intense self-scrutiny, leading to an externalization and internalization of disease.

II: A Visit to the Cosmetic Surgeon

With a newspaper coupon for my free consultation gripped firmly in hand, I step into the elevator. In the mirrored ceiling overhead, I inspect myself, liking my reflection but also knowing the perceptual limits of bending back and looking upward. I look like I look when lying down, impassive. The elevator door opens onto a floor, a faint perfume odor engulfing me as I walk to the correct(ive) office. Strange, I think, for a medical building. Ground floor offices smelled of antiseptics and rubbing alcohol,

familiar signifiers. My sensibilities encompass beauty and medicine. The door leading into the fourth floor office presents a list of names — physicians, psychologists, and people whose names are not followed by degrees. Another medical aberration or supportive gazes?

Stepping into the office, I am transported into another world, devoid of clinical overtones. Elegant Oriental sofas and chairs, vivid oranges and blues, a beautiful featureless woman positioned at a reception desk, sipping espresso from a delicate china cup. I notice that the deep amber birds on the cup match her nail and lip color. All around her are what appear to be prospective clients. I say "prospective" because I can't imagine why these women are here. Each woman is finely dressed, following closely the dictates of seasonal hemlines and shade combinations. Great care has been taken to replace the natural face with one streaked by man-made color and definition, without evidence of fabrication. They know the secrets, they have mastered the look. Susan Griffin writes that the "objects" of male sexuality are "somehow magically . . . reduced to only matter."[14] I see these objects before me, seemingly pure surface, carefully orchestrated and magical.

I feel as though all eyes are on me as I approach the desk. Here disease is worn externally, detectable even to an untrained gaze. The receptionist surveys me, asking, "How may we help you?" I trade my coupon for a medical history chart and find a seat in the corner, near a television set.

I think initially that video equipment in a physician's office is out of place. I imagine a soap opera blaring, the woes and triumphs of fantasy life, ironically placed in the "serious" world of medicine. But I soon realize, this television has an instructive purpose, a medical function. Complete with Hollywood actresses, beauty consultants, and the team of physicians from this particular clinic, a videotape presents the miraculous transformations afforded by cosmetic surgery. Phyllis Diller, the comedic actress and recipient of some 50 surgeries, hosts the show. After a general presentation of before and after photographs of herself and others, Diller begins a series of engaging interviews.[15] Among her guests are several sets of identical twins, only one of whom has had cosmetic surgery. The unaltered twin is made to see her own possibilities by being presented with her beautified double, in their first "post-surgery meeting." Several variations of the prearranged chance meeting are played out. In one instance, the unsightly twin bursts into tears, overwhelmed by her sister's beauty and lamenting her own comparative unacceptability. Another case shows the beautified twin crying, mourning the pitiful existence of her formerly unattractive self staring back at her. The ugly twin ("ugly" I imagine, is the term they would use to contrast beautification) exhibits embarrassingly high levels of self-consciousness, to the point of speechlessness, while the corrected twin proceeds through the interview with ease and grace, an uninhibited outpouring of discourse. A lengthy moment of silence occurs as the ugly twin decides her fate, the camera inspecting her closely. Her desired iden-

tity or twin appears in a split screen so that viewers can intervene to judge, to divide themselves like a pair of twins, seeing for themselves the only reasonable option.

The ugly twin, we learn, has always been more cautious and skeptical. She has a tendency to avoid challenges and would rather have others make decisions for her; she lacks motivation and self-confidence. Her clothing is outdated to the point of looking tragic. They say it's worse, I remember, to appear fashion conscious and fail than to seem oblivious. Moreover, she fears change, which manifests itself in rationalized excuses having to do with pain and financial cost. In the space of a few minutes, she is embued with powerlessness and an absence of will or strength, which surfaces in physical unattractiveness and social ineptitude.

Diller asks the beautiful twin, "Did any of your surgeries hurt?" "Not a bit, not even a tiny bit," is the response, underlined with a broad smile. The cost of specific operations is not discussed directly, but the interviews are laden with subtle references: "I can't put a price on the way this has made me feel"; "I was always using some excuse, money or time"; "For a long time I didn't even bother to find out that insurance can cover these costs." At the end of the inteview, the ugly twin is converted. The positive rewards stare her in the face, dressed and packaged to minimize resistance. Her double is everything she is not, everything she can become. With support from her sister, and the silent interviewer, she promises to schedule an appointment for consultation/catharsis.

After waiting just long enough to see the video from start to finish, I am led into a room to have my photograph taken. Enlarged covers from *Vogue* magazine grace the walls of the room. All around me, one who does not know, the eyes of judgment, from persons who know. The receptionist carefully places her mane of black curls behind her, so as to see clearly through the photographic lens. Everything about her now, engaged in a mundane task, seems non-functional. In motion she looks artificial, like a doll impersonating a woman. She is another cover from *Vogue*, except she cannot fully manage the image because she has to move while taking my picture; she is inhibited by the fact that she is human. I can see black marks on her cream-colored high-heeled shoes. One of her amber nails is crooked too. More signs of her "failure." She says, "We take pictures because the doctors remember faces in addition to written histories. Please smile for the first one and look serious for the second." I had known from feminist work that smiling is a particularly feminine activity, but had never had its contrast so vividly articulated for me. "Can I be both at once," I ask jokingly. She smiles and says nothing, answering my question.

We remain in the small room until the Polaroid photos are developed. Upon seeing the results, she remarks, "Dark colors don't look very good in these pictures . . . they tend to drain you." "You" doesn't necessarily mean me, I think. Yet, as I look down at my gray sweater and black trousers, I recall that a sales clerk once said I should not wear dark colors be-

cause they are unfeminine, and it occurs to me that the receptionist's observation does refer to me.[16] Looking slightly annoyed with my questionable taste, a bit sympathetic actually, she ushers me to a third room.

The next room is an absolute study in contrasts, a symphony of imagery placed so carefully that it looks, and may be, haphazard. Signs of medical authority are plentiful. Enlarged, framed medical degrees cover one wall, along with awards for recognized excellence in the practice of cosmetic surgery, and magazine reviews outlined in silver. A second wall consists of floor-to-ceiling bookshelves, making me slightly uneasy. Doctors are supposed to *know* these things, the technical secrets of their profession. They should not, in mid-surgery, have to consult the written word, the doctrine. But in an odd way, the secrets are demystified, no longer frightening, when placed so clearly in my visual field. Adding to the demystification is another video machine; this one showing actual surgical procedures. A staff of happy professionals surrounding a relaxed patient, the needles and knives almost beside the point, fading into the background, into the skin, the body. The patient appears happy about the prospect of her own effacement.

My eyes shift back to the bookcase and I see a row of intimidating and impressive titles, mostly having to do with the reconstruction of body parts — eyes, nose, breasts, thighs, chin, stomach, neck, ears. Suddenly I see other kinds of expertise, *The Psychology of Body Image, Beauty through The Ages*, telling me that my potential judge is schooled in the ways of mind and culture as well as physiology. To underscore cultural and political acuity, an eye for historical shifts, there before me are also the biographies of Henry Kissinger and Gerald Ford, among others. Covering a third wall and much of the table space are magazines of many varieties: *Playboy* and *Penthouse* to *Better Homes and Gardens*. Mother and whore, wife and mistress in the same room, confront one another. As Elizabeth Janeway observes, the images of virgin and whore, entrapped in each female body, serve to fragment a woman and perpetuate a seemingly self-imposed mistrust of her body: "Female a priori knowledge, then, cannot be taken as valid by the female self who is required by the laws of otherness to live as a displaced person not only in man's world but also within herself."[17] Here, in the physician's office, the mistrust works to encourage confession and consumption because the male physician, the "other," is both knowlegeable and "centered." He, unlike the fragmented female patient, is in a position to render an a priori judgment.

The scope of reading materials in this room gives the impression of an omniscient inhabitant, both streetwise and well-schooled. There must be little he does not see, little he does not know.

On a table in the center of the room is an array of pastry and sugar-free beverages, displayed on fine china. The receptionist appears and offers me to partake. She watches as I select my refreshments, coffee and a packet of sugar, then leads me back to a different chair, next to a desk, placing the tray of sweets before me, asking, "Would you rather have Sweet-n-Low

for your coffee?" Collecting my used packet of artificial sugar and positioning the tray of pastry within my grasp, she leaves the room, missing completely the irony of her actions.

At the very corner of the desk, only inches from me, is an intriguing mirror. Two panes of glass are bent inward, touching one another, to form a 90 degree angle, with two additional panes at the top and bottom. Any slight turn toward the desk, facing the doctor, requires a simultaneous look into the mirror. And the mirror's construction insures a reversal of the image, such that the reflection is my face as others see it. Looking into the mirror, everything seems wrong, distorted and somehow displaced. The face I had come to recognize in my own bathroom mirror now looks like the face of a familiar stranger, a double of sorts. The twins. The intrusive double invades my perception as I turn to face the doctor's chair. Now there are two judges in the room: the doctor's felt presence and my double. Thankfully, I realize, the lighting has been dimmed to provide some escape from myself, from his keen vision. I recall the comment regarding my color sensibilities, wondering if he will notice, wondering if she would notice.

In the midst of my scrutiny, a well-dressed man enters and introduces himself as my consulting physician. To my self-conscious displeasure, he asks me to follow him into a room with "more adequate lighting." This room has no books, no food or drink; only the business of serious body work represents itself here. Several enlarged photographs of "real" women (not fashion models) reflect his work in the form of before and after contrasts — mostly face-lifts, fatty tissue removal, and breast augmentation. I am disappointed. The real women look ordinary, as though they clean and cook and care for children. In being more than "only matter," the real women become less attractive, flawed, imperfect.

On the split screen of an elaborate computer system are pre- and post-operative sketches of nose surgery. Instead of positioning himself in the chair behind his desk, the doctor sits directly across from me, no more than three feet away. He studies me for a seemingly endless moment, up and down, saying "hmm" and "ahhum," waiting for me to speak. Flashes of the Freudian blank screen run through me and I decide to remain stubbornly silent. He doesn't want to rule anything out. Yet I also fear that I might not identify my problem correctly, which would certainly not be missed by this man who sees and knows. Finally, with a sigh, he says, "So, what brings you to us today?" I reply, "I'm unhappy with my nose."

He briefs me on the psychology of self-esteem, emphasizing that most people are unaware of their own problems, then leads me to a blank wall. Did I make a mistake in problem identification? I studied his face when I said "nose" and he hadn't seemed surprised, but perhaps he sees additional imperfections. Almost miraculously, he pulls from the wall three full-length mirrors, framed in fluorescent lights. The two outermost mirrors are brought forward so that we might see me from multiple angles. He

places his hand on my back, holding me gently in place, only inches from the mirrors. He asks me to remove my jacket so that we might see what he calls the total picture. Pictures are representations, not reality. My comfort in theoretical knowledge is diminished by seeing my own body, the "reality" of me in the glass before my eyes. Now I am conscious of many *parts* of my body. I can no longer see a whole person in the mirror.

Each feature must be seen in relation to the others, he says, interrupting my thoughts. Musn't fragment the body. He says, "Yes I see what you mean . . . your nose is quite unfeminine . . . would you like to have a more feminine nose?" I stammer, "um . . . I don't know, more feminine? I never thought of my nose as being unfeminine, just asymmetrical." Yes, he intimates, "you probably inherited your father's nose." A masculine feature contained in a female body. With a single utterance my gender identity is called into question: my otherness is suspect. I recall Brownmiller's discussion of the feminine difference, "It must constantly reassure its audience by a willing demonstration of difference, even when one does not exist in nature.[18] He surveys my face with the same look the receptionist had when taking my photograph — judgmental and sympathetic. I say the lighting is severe; I don't really look like that. "You're not used to seeing yourself so *clearly* is all," he observes.

My nose can be dislocated or broken, he says blandly, then carved and reshaped with minimal difficulty. Having one's nose broken calls forth violent imagery; physician as bodily harm, as villian. By this point, I am feeling awkward, slightly fearful, and attempt to step back, away from the mirror. My fear is oddly directed at myself. The villian is my mirror image, which he is either forcing or enabling me to confront, piece by piece. His hand holds me in place as I try to back away from myself. I decide to ask him a question, figuring it may distract him from my now criminal reflection. "Oh, I also wanted to ask you about," I am interrupted and he finishes my sentence for me, "your skin" he offers.

A new insight. "What about my skin?" I ask cautiously, knowing it is too late. Skin is a big category, covering my whole body. Before giving him a chance to respond, I find myself confessing to a history of skin problems and attempted remedies. I want him to know that I am aware of my deficiencies, particularly after his lecture about the psychology of ignorance, blindness. More silence on his part, more speech on mine. I am careful not to spare any details. How can he render a diagnosis if I am not honest with myself? With him? With the creature in the mirror? At the end of my confession, he explains that he can see I am extraordinarly bothered by my skin. I say, "Well, actually, I usually don't think about it." But you just showed me that you do, is what he is thinking. She agrees.

Two operations, one on my nose and the other on my skin, are necessary if I am to demonstrate my self-knowledge, my free will, my otherness. The total cost is five thousand dollars and we can say the surgeries are necessary so that insurance will pay the fees. We will be cohorts in

deception, like lovers committing a crime. Deception is a small price to pay for wholeness, for the death of my flawed/fragmented reflection in the mirror, for his/our approval. His knives and business acuity will cure me/us at a minimal cost. I will be able to love myself, without self-deception.

I am mystified by the skin operation and ask, "But wouldn't my skin have two different shades if you take off the top layers in specific areas?" He explains that I'm a perfect candidate for the operation because "your skin is naturally very pale, oily, and has very little color," shaking his head sadly. Encouragement through insult, I tell myself. We are back in our chairs and with his observation, he moves closer to me, leans forward, almost whispering, "You could do with a bit of make-up, it would make you look more naturally feminine . . . so the surgery won't produce shading problems." Make-up and natural femininity, he said, in the same sentence. I demand, "I want to know if there will be a difference in skin tone if I am *not* wearing make-up." Yes, he offers, there will be a difference, but not if you wear cosmetics which, in the long run, will enhance your femininity.

The problem of skin tones in his scheme, I realize, rests with me, with my insufficient femininity, not with his medical competence. Part of me resists his oppressive view of femininity, but another part of me is in doubt, ready to acquiesce. He is, after all, the expert. And he is simply reiterating the views within my culture: he makes sense. I have heard this before. I have felt this before. A staff of experts, he says, again invading my thoughts, can help me to learn about the secrets of cosmetics, under his supervision. "And perhaps some about fashion, too," he adds, scanning my choice of clothing. I lower my head and see a designer insignia on his brown stocking. Christian Dior, I think it is, the "C" and "D" locking in an embrace.

He switches into another reflective mood and says, "The nose would be done for yourself, the skin for other people." The "irregularities" of my nose are probably not extremely noticeable to others, but my skin, he explains, is blatantly problematical, "distracting" is the word he uses. I think momentarily about the word "distracting." Clearly his word choice is meant to criticize, but is not "distracting" precisely what I want to be? Beautiful women are meant to distract, to draw attention, to preoccupy. He explains, "The skin you were meant to have is buried underneath the surface and unfortunately people cannot see it." My own body has betrayed me, as I feared when I saw my reflection. My body distracts me such that I cannot be distracting. Or am I confused? Momentarily, I imagine skin as volitional, even vindictive, making me look foolish by hiding itself from others. Or a battle of two skins; one visible and one suppressed. Both of my personages surface.

The procedure, this attempt to uncover my real skin, sounds horrid. Several layers of skin surface are sanded away, left bleeding, and eventually new layers replace them. One must avoid the sun for several weeks because ultraviolet rays cause post-operative disfigurement. "Some people

are sun-worshipers and that causes problems," he says, again absolving himself of responsibility. I can have it done during spring break, during the rainy season, he suggests, because the healing process begins immediately and my students would hardly notice the wounding upon returning to class. Even if they do, they will find the scars less offensive than my current skin, than me, "They'll probably appreciate your efforts to better yourself." I say I have to think about it. "I wouldn't wait too long," he cautions, closing my file and cueing my departure.

I make a quick exit, head lowered, refusing to look at the fashion models hung on walls or the immaculate-while-motionless receptionist. My entire being seems deficient, in spite of myself, apart from my critical sensibilities. My body is cumbersome. It does not want to move. Each step pulls me in two different directions: toward me and away from me. Two women sit in the first waiting room, laughing. I am certain that I am the object of their laughter. I enter the perfumed corridor, step into the elevator and don't look up this time. Upon reaching the street, I put on my sunglasses, though the sky is overcast. As perhaps a meager gesture of protest, I light a cigarette . . . throwing it into the street almost immediately: smoking causes the skin to age.

III: Afterward

Why, you might be wondering, have I chosen to address confession with confession? Where or to whom does my critical finger point in the confessional process? I do not believe that particular individuals within the clinical setting control and/or mandate patient perceptions of deficiency. I was not forced into a confessional mode by anyone and herein lies the power of contemporary domination strategies. Specifically, I am interested in the extent to which hosts of subtle, visible, material artifacts work together to produce a desiring subject; a subject in need of absolution, of cure. My own perception of deficiency comes (seemingly) from within, prompted by my willful ability to act as a free agent for myself. I demonstrate my health by confessing to its absence. I am divided in this process. I bear witness against myself. When I point to material markers — lighting, carving procedures — I demonstrate resistance to cure, further evidence for my disease. When I say to the physician, "Yes I am unfeminine. Yes I should wear make-up. Yes I need fashion advice. Yes I have my father's nose," I have transformed myself into a subject of clinical discourse, a *needy* subject.

I describe my experience here because I want to give credence to its materiality. Critical attention is then turned outward, onto the world as I take up spatial environments, making them my own, making them me. The merging of myself with patriarchal institutions is a struggle observed by Haunani-Kay Trask, "The more woman struggles against patriarchy, its institutions and ideology, the more she finds her struggle to be an internal

one."[19] My own motility requires confrontation, myself facing directly the institutional parameters that divide and conquer me. The markers promising my distinction are shared, inviting consumption by all. My *sameness*, my complete lack of distinction, sanctified womanhood, is promised within the domain of cosmetic surgery. This, I hope, is what my critical confession makes visible because here lies the groundwork for another kind of demystification. Sheila Rowbotham writes, "As we begin to know ourselves in a new relation to one another we can start to understand our movement in relation to the world outside. We can begin to use our self-consciousness strategically. We can see what we could not see before."[20] By training our collective and personal female vision to acknowledge the subtle jarring, the splitting, the silencing endured each time we embrace the other's I/eye, we emerge as *truly* empowered and compassionate critics.

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Notes

1. An article entitled "Snip, Suction, Stretch, and Truss" in *Time Magazine* (September 14, 1987, p. 70) reported that in 1986, $250 million U. S. dollars were spent on cosmetic surgery in the U. S. A.

2. Michel Foucault, "The Eye of Power" in *Power/Knowledge*, ed. Colin Gordon, (New York: Pantheon Books, 1980), pp. 146-165.

3. Ibid., p. 159.

4. Although men are also consumers of cosmetic surgery, albeit to a much lesser extent, the marketing strategies designed for male and female consumers vary tremendously. For women, strategies center on a correlation between surface beauty and self-knowledge; for men, surgeries function to provide competitive advantages, but are quite removed from the so-called pleasures of becoming a fantasy-ideal based on appearance alone.

5. Michel Foucault, *The History of Sexuality, Vol. I: An Introduction*, trans. Robert Hurly, (New York: Vintage Books, 1980), pp. 102-104.

6. Rosalind Coward, *Female Desires: How they are Sought, Bought, and Packaged*, (New York: Grove Press, 1985), pp. 19-84.

7. Ibid., p. 21.

8. Mary Daly, *Gyn-Ecology: The Meta-Ethics of Radical Feminism*, (Boston: Beacon Press, 1978).

9. For an explanation of Foucault's shift from repression to stimulation see, Michel Foucault, "Body/Power" in *Power/Knowledge*, pp. 55-62.

10. Ibid., p. 56.

11. Coward, p. 13.

12. Susan Brownmiller, *Femininity*, (New York: Fawcett Columbine Books, 1984), pp. 13-19.

13. Although it is arguable that cosmetic surgery is still restricted by economic circumstances, the shift in emphasis from elite to ordinary is significant as a power issue. The shift *implies* easy availability; hence the rationale of "I cannot afford it" is discounted as psychological blockage.

14. Susan Griffin, *Pornography and Silence: Culture's Revenge Against Nature*, (New York: Harper Colophon Books, 1982), p. 37.

15. The before/after imagery is seductive because it contrasts the real and the ideal. For an extended discussion of this phenomenon see, Carole Spitzack, "Confession and Signification: The Systematic Inscription of Body Consciousness," *The Journal of Medicine and Philosophy*, 12 (1987), pp. 357-369.

16. For a discussion on the internalization of "fashion sense," see Coward, pp. 27-36.

17. Elizabeth Janeway, "Who is Sylvia?: On the Loss of Sexual Paradigms" in *Women: Sex and Sexuality*, eds. Catharine R. Stimpson and Ethel Spector Person, (Chicago: University of Chicago Press, 1980), p. 6.

18. Brownmiller, p. 15.

19. Haunani-Kay Trask, *Eros and Power: The Promise of Feminist Theory*, (Philadelphia: University of Pennsylvania Press, 1986), p. 28.

20. Sheila Rowbotham, *Women's Consciousness/Man's World*, (New York Penguin Books, 1973), p. 28.