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"Big eye" surgery: the ethics of medicalizing Asian features

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Abstract The popularity of surgical modifications of race-typical features among Asian women has generated debates on the ethical implications of the practice. Focusing on blepharoplasty as a representative racial surgery, this article frames the ethical discussion by viewing Asian cosmetic surgery as an example of medicalization, which can be interpreted in two forms: treatment versus enhancement. In the treatment form, medicalization occurs by considering cosmetic surgery as remedy for pathologized Asian features; the pathologization usually occurs in reference to western features as the norm. In the enhancement form, medicalization occurs by using medical means to improve physical features to achieve a certain type of beauty or physical appearance. Each type of medicalization raises slightly different ethical concerns. The problem with treatment medicalization lies in the pathologization of Asian features, which is oppressive as it continues to reinforce racial norms of appearance and negative stereotypes. Enhancement medicalization is ethically problematic because cosmetic surgery tends to conflate beauty and health as medical goals of surgery, overemphasizing the value of appearance that can further displace women's control over their own bodies. I conclude that in both forms of medicalization, cosmetic surgery seems to narrowly frame a complex psychosocial issue involving physical appearance as a matter that can be simply solved through surgical means.

Keywords Ethics · Cosmetic surgery · Asian · Medicalization · Blepharoplasty

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Introduction

There has been extensive news coverage of the rise of cosmetic surgery among Asian women in both western and Asian countries. "Asian cosmetic surgery" has become a catchall phrase for cosmetic surgical procedures that are directed at altering race-typical features, such as the jawline, nose, and eyelids. According to the International Society of Aesthetic Plastic Surgery, Asian eyelid surgery or blepharoplasty, in particular, is now one of the leading plastic surgeries performed worldwide [1]. The latest report states that over 1.4 million eyelid surgeries, also referred to as "big eye surgery," were performed worldwide in 2014. East Asian countries Japan and South Korea ranked second and fourth, respectively, in the world for total number of eyelid surgeries performed that same year.

In this article, I am specifically interested in framing ethical issues arising from Asian cosmetic surgery as an example of medicalization. Broadly speaking, the concept of medicalization refers to the process of defining non-medical problems using a medical framework. According to Peter Conrad [2], it typically involves using medical language to describe a problem, adopting a medical perspective to understand the problem, or using medical or surgical intervention to treat it. In a way, medicalization is considered a means for surgeons to justify the need to modify atypical features that deviate from time- and location-specific beauty norms [3]. Scholars have also alluded to medicalization in cosmetic surgery by describing how the practice depicts "ugliness as a form of disease," thereby framing beauty as a legitimate medical goal [4, p. 233].

The aim of this article is twofold: firstly, I will explain how medicalization in Asian cosmetic surgery can be interpreted as either treatment or enhancement. In treatment medicalization, cosmetic surgery can be understood as a form of remedy for a "condition" not previously considered medical. Here, race-typical facial features are portrayed as pathological and surgical intervention as the corrective. In enhancement medicalization, cosmetic surgery can be understood as altering race-typical features or characteristics that are considered normal but unwanted. It is important to note that based on the general discussion of medicalization, this distinction between the enhancement and the treatment models of medicalization has not been made explicit. Such a distinction seems to arise particularly in the context of cosmetic surgery.

My second aim is to argue that while each form of medicalization raises slightly different ethical issues, nonetheless, both types conflict with traditional medical goals, such as those articulated in Daniel Callahan's "The Goals of Medicine: Setting New Priorities" [5]. My intention is to offer a discussion that specifically evaluates the impact of medicalizing Asian features rather than a general discussion of the ethical implications of cosmetic surgery. In particular, I am interested in discussing the medicalization of Asian features not only as a racial issue but also as a gendered one. The racial discourse is based on the tendency of cosmetic surgery to sustain stereotypes that harm Asians. The gendered discussion reflects the disproportionately higher prevalence of Asian women compared with men who undergo cosmetic surgery [6]. Further, the discussion is influenced by feminist

scholars who argue that preoccupation with appearance still affects women far more powerfully than men [7–9]. I draw from published theoretical and empirical research that explores how medical framing occurs in medical texts [10], marketing brochures [11], and cosmetic surgery websites [12, 13], among others.

Treatment medicalization of racial features

In the 19th century, plastic surgery was largely reconstructive and aimed at correcting physical deformities caused by infectious diseases such as syphilis, congenital disorders, and physical trauma [14]. At the end of World War I in Europe, plastic surgery reached unexpected heights as the practice became essential for treating facial wounds, burns, and other related deformities of soldiers who survived their injuries [15]. Plastic surgery that serves a reconstructive function was considered to be consistent with the traditional medical model of treatment, whereby a disorder (in the form of disfigurement caused by injury or disease) is identified and reconstructive surgery offered as the treatment. It was viewed as consistent with the traditional clinical process of diagnosing, prognosticating, and treating a medical condition [16]. On my account, medicalization arising from this treatment model implies that a non-medical problem is managed in ways similar to a traditional medical condition, from diagnosis to therapy.

Following from plastic surgery's reconstructive functions, cosmetic surgery soon used and developed procedures that closely followed the treatment model by pathologizing certain types of physical features. Sander Gilman [14] claims that during the 20th century, pathologization was clearly directed at non-Caucasian features, such as the Jewish and African-American noses. The author claims that, more recently, similar pathologization has focused on Asian eyes. Asians living in western societies like the US, as the most recent subjects of pathologized racial features, have experienced derogatory portrayals based on their facial features [14]. The author alleges that Asian-Americans are stereotyped as being short people who have flat faces and slanted eyes, and that this portrayal motivates Asian-Americans to seek aesthetic surgery to appear "less Asian" [14, p. 99]. The eyes are the facial features most commonly modified to that end in cosmetic surgery procedures like blepharoplasty. "Asian eyes" is the term applied to a characteristic absence of a crease in the upper eyelid; when the crease is present it is called a double eyelid, a feature strongly associated with Caucasians. The absence of the double eyelid, considered a "deviant" feature in reference to Caucasian features, is made more apparent by a thicker fat pad in the upper lids of Asians [17]. Cressida Heyes argues that blepharoplasty, a surgical modification that creates an upper-lid fold, is often used as an example of Asian or ethnic cosmetic surgery [18]. The author explains that cosmetic surgeons have marketed this type of surgery as an explicitly racial procedure associated with specific technical or anatomical challenges that require specialist knowledge and skill.

Often, treatment medicalization takes advantage of medical jargon and scientific narratives to offer objective depictions of racial features as medical problems [10]. For example, Plastic Surgery Sydney [19], an Australian surgery website, identifies

three main "problems" in naturally occurring Asian eyelids that are subject to modification: (1) a single eyelid crease; (2) prominent Mongolian folds or "excess skin" in the medial corner of the eye; and (3) puffy or fatty eyelids. According to Eugenia Kaw's ethnographic study done in 1993, considered one of the seminal empirical investigations on the topic of medicalized Asian features, cosmetic surgeons commonly use words like "without" or "lack of" and "flat" or "dull" in pathologizing descriptions of Asian eyes [10, p. 81]. By using these terms, surgeons indicate that typical Asian eyes are problematic and should be corrected through cosmetic surgery. The study claims that other manners of pathologization in medical texts even go so far as to associate Asian features with a person's poor intellectual and behavioral capacity to succeed in life. Kaw notes that Asian features have, for example, been associated with negative personality traits such as passivity, lacking in energy, or sleepiness by a predominantly white American society.

In addition, other authors claim that cosmetic surgeons allegedly refer to ideal measurements and fixed ratios in order to "objectively" describe the supposed problem [20]. Surgeons' claims of objectivity often derive from the so-called golden proportion based on Greco-Roman ideals. These ideals were heavily popularized by Leonardo da Vinci's drawing of the Vitruvian man, identifying ideal proportions of different parts of the human anatomy [21]. However, such golden proportions have been heavily criticized as Caucasian-centric [20].

Critics of Asian cosmetic surgery claim that the practice preys on patients' sense of inadequacy [10]. The Advance Beauty Cosmetic Surgery website has a YouTube video embedded on its page that contains interviews with Asian patients living in Australia [22]. The video follows two patients from their consultation with Dr. Andrew Kim to the surgical operation and after-surgery care. One of the interviewees, a 20-year-old female patient, explains that she has suffered from racist comments due to her features:

> They say "chinky eyes," "slit eyes"… or they pull their eyes [to the sides]. And it makes me feel like there's something wrong with me. I feel insecure when I go to [job] interviews and think, maybe they won't pick me because I look Asian, you know. Maybe if I look less Asian I will look more confident [22].

Generally speaking, treatment medicalization in Asian cosmetic surgery pathologizes normal racial features such as having a single upper eyelid, as conditions akin to diseases or disorders. With the western features considered as the "normal" reference, the process of medicalization involves using allegedly objective tools in evaluating the problem and depicting cosmetic surgery as a remedy for the supposed deficiency of racial features.

Enhancement medicalization of racial features

In broad terms, enhancement is a process of providing interventions in the absence of disease to improve health beyond the normal state [23]. Since the normal state is the baseline, the enhancement model, in contrast to the treatment model, does not

depend on reframing a condition or feature as pathological. In the 1930s, aesthetic plastic surgery (another common label for cosmetic surgery) became a distinct practice focused on the surgical modification of a person's appearance in the absence of deformities caused by birth defect, disease, or injury [14]. As a separate subspecialty, cosmetic surgery eventually evolved to move farther away from traditional medical indications of surgical interventions into arbitrary aesthetic or beauty ideals. Due to this trend, Gilman posits that cosmetic surgeons attempted to expand the rationale for surgical intervention by claiming that physical beauty is a legitimate medical goal [14].

Various scholars depict Asian cosmetic surgery as enhancing normal but unwanted features rather than pathologizing race-typical features using western standards [6, 24]. The first reason offered in published literature is that Asians living in Korea or Japan do not necessarily aim for a westernized face, given their strong sense of national identity. Ruth Holliday and Joanna Elfving-Hwang claim that instead of being passive followers of western standards of beauty, Asian consumers are empowered by cosmetic surgery to improve—not correct—their features [6]. The authors claim that the procedures are not meant to make women look normal (understood as western), but are meant merely to create a look that "enhances" the body [6, p. 71]. Other scholars also claim that surgeons who specialize in modifying Asian features merely emphasize the social benefits of having a double eyelid [24]. These benefits are alleged to include improvements in academic performance, career opportunities, or lasting romantic relationships. Secondly, several scholars have quoted surgeons, particularly those practicing in Asian countries, as claiming that the double eyelid is not exclusive to Caucasians and occurs as a normal variation in 50% of Asians [10, 25, 26].[1]

Thus, in enhancement medicalization, the purpose of cosmetic surgery is reframed away from supposedly restoring "normal" western features to achieving a supposedly non-racial and universal beauty "ideal" [24]. This is further evidenced by trends in cosmetic surgery in Asia that mainly involve Asian celebrities as beauty ideals. In South Korea, many celebrities are rumored to have undertaken cosmetic surgical procedures. According to the US news channel ABC, one in five South Korean women have had cosmetic surgery, and they seem to copy the doll-like features of members of female Korean-pop, or K-pop, groups [27]. These celebrity idols apparently do not look like regular girls-next-door, and they are described in the article as having double eyelids and v-line faces.

Although enhancement medicalization does not depict Asian features as objectively pathological, the popularity of Asian cosmetic surgery normalizes procedures like blepharoplasty as a legitimate medical treatment. The supposed legitimacy of the practice is supported by visual representations of "scientific objectivity" that also reference the golden ratio. Unlike in treatment medicalization, the golden ratio is used to define a universal (non-racial) standard of beauty and not

[1] It must be noted that although various scholars have cited this number, I was unable to find any empirical studies that support it. It is also unclear whether "Asians" refers to the whole of Asia, including South Asia and Central Asia that have populations with facial features closer to those of westerners. Asians in these territories have "big" eyes and a "higher nasal bridge" that are different from typical East Asian features.

the "normal" reference for aesthetic deviations. For example, Wonjin Aesthetic Surgery Clinic clarifies that it is not the size of the eyes that is important, but the way the eyes fit the proportion of the face to create a "natural and beautiful" appearance [28]. Explicitly referring to the term "golden ratio," the website describes one feature of the "ideal eye" as having "symmetrical eye lengths as well as length between eyes" that ranges from 30 to 34 mm. Similarly, ID Hospital claims that the "eye line" (used interchangeably with eyelid crease) should suit the entire face by "carefully considering the proportional ration [sic] between your forehead, eyebrows, nose, cheekbone and jaw line" [29]. The website asserts that any surgery that fails to consider an individual's "aesthetic aspects" will result in patients feeling a "sense of awkwardness." Thus, the website argues that the correct treatment considers the various elements of the patient's eyes, including the size, shape, and thickness of the eyelid crease, as well as the presence of fat deposits.

I argue that this type of rhetoric, a combination of medical jargon and aesthetic references, employed by cosmetic surgeons have the tendency to conflate beauty and health. On the one hand, this tendency to conflate health and beauty trickles down to society, and on the other hand, such tendency is itself a result of pre-existing societal views of beauty and health as deeply entangled. Both treatment and enhancement medicalizations frame the goals of Asian cosmetic surgery medically, but in enhancement, there is a more overt depiction of a certain type of beauty as a legitimate medical goal. Treatment medicalization relies on pathologizing race-typical features, and cosmetic surgery as a way to restore "normal" western features. This type of medical framing may be an attempt to avoid criticisms of cosmetic surgery as merely subscribing to beauty as a goal. Enhancement medicalization, in contrast, avoids pathologizing racial features but relies on certain beauty ideals as its surgical outcome. Even without pathologizing typical racial features, this type of medicalization is problematic because modifying physical appearance to achieve this beauty ideal falls under the mantle of medical professionals (cosmetic surgeons). With the use of medical and scientific rhetoric, cosmetic surgeons, like all medical professionals, are expected to promote or restore health. Thus, the combination of the cosmetic surgeons' medical role and the use of medical and scientific rhetoric establish beauty and health as analogous or overlapping concepts and both as legitimate goals of medicine. Both the pathologization of racial features in treatment medicalization and the conflation of beauty and health as medical goals in enhancement medicalization lead to ethical problems that will be discussed in the next section.

Ethical implications of medicalized racial features

According to Callahan's article "The Goals of Medicine: Setting New Priorities," medicalization—along with driving factors such as technological developments, changes in cultural attitudes and social expectations, and pharmaceutical developments—puts pressure on the nature of medicine [5]. So, the article aims to respond to such developments by reformulating the goals of medicine, namely, (1) the prevention of disease and injury and the promotion and maintenance of health; (2)

the relief of pain and suffering caused by maladies; (3) the care and cure of those with a malady and the care of those who cannot be cured; and (4) the avoidance of premature death and the pursuit of a peaceful death. The aim is to create a practical approach to guide future priorities in biomedical research, the design of health care systems, and physician training.

In this ethical discussion, then, I focus on problems and criticisms associated with non-medical uses of medical or surgical technology, as is the case in cosmetic surgery. The problems discussed in this section arise in relation to the first two, on patient welfare, of Callahan's four goals of medicine. Specifically, I will frame the problems, first, as a racial issue in which cosmetic surgery becomes a source of or a tool for racial oppression, and second, as a gendered issue in which medicalization leads to further displacement of (Asian) women's control over their bodies. According to Sandra Lee Bartky, experiences of oppression that occur in racism are similar in many ways to those that occur in sexism [7]. For example, the kind of discourse on appearance-based stereotypes that perpetuate marginalization of one racial group (or inequality between or among groups) has similar features with the discourse on stereotypes that feed the imbalance between genders. In Asian cosmetic surgery, Asian women become simultaneously subjected to racial and gendered sources of oppression.

Before I identify how medicalization of typical Asian features conflict with the patient welfare aspects of Callahan's goals of medicine, it is important to criticize the way that Callahan classifies cosmetic surgery under "acceptable non-medical uses of medical knowledge" [15, p. S15]. The article acknowledges that there are situations when medical knowledge and skills are not used to achieve goals directly related to health. The author offers reasons as to why such uses may be deemed acceptable, which I find unconvincing. First, the report claims that the practice of improving a person's appearance apart from repair of injury or deformity has long been accepted. I believe that it is not sufficient to justify the practice solely as a matter of historical precedence. Ethically, the fact that a practice is widespread is not an automatic justification for its acceptability; socio-cultural and scientific developments can change the societal as well as the moral value of a certain practice. Some mainstream medical practices that enjoyed widespread use in the past, such as the application of lobotomy to treat some mental health conditions, were banned once society and medicine became concerned with the safety and ethics of the practice. Second, Callahan's article claims that cosmetic surgery does not pose any threat to the general welfare, and is often paid for personally. This completely misses the point, since the general welfare can include issues that involve racial discrimination, which is arguably fostered by at least some forms of cosmetic surgery. In addition, the fact that the procedures are paid for personally does not detract from the wider societal effects of the choice to undergo the surgery. It is ironic that the same article admits that one of the sources of stress or pressure that challenges the goals of medicine is how western societies are treating bodily health as a type of religion that aims to "hold on to youth and beauty and a perfectly functioning body" [5, p. S3], which I have to admit seems like a popular understanding of the goal of cosmetic surgery. In contrast to Callahan's article, I

argue, in the next section, that based on the two forms of medicalization, Asian cosmetic surgery conflicts with the goals of medicine.

Medicalization as a racial issue

Treatment medicalization goes against the interest or welfare of the patient because the depiction of Asian features as pathological is racially oppressive. When it comes to appearances, the complexity of the issue lies in the source of oppression. As Carl Elliott points out, moral dilemmas as a matter of oppression would be easier if we could identify an individual oppressor (or a specific source of oppression) [30]. He argues that for cosmetic surgery of racial features, the oppression is more diffuse and the oppressor is more abstract. The oppression appears to exist in people's minds, to the extent that the Caucasian standards of beauty are internalized as part of the self. I extend Elliot's claim and argue that Asian cosmetic surgery, as a practice, seems to embody this kind of oppression by using supposedly scientific and objective evaluations of appearance concerns.

As previously mentioned, treatment medicalization relies on pathologizing race-typical features to depict surgical modifications as legitimate and specialized treatments that are consistent with traditional medical goals. However, I argue that this type of specialized medical framing is harmful as it promotes a stereotypical portrayal of Asians, its target consumers, as physically inferior. The problem with this specialized framing is that it provides a greater incentive to "discover" or perhaps "create" new problems that can then be corrected. According to Heyes, this trend of sub- or hyper-specialization may be due to surgeons wanting to add new niche markets to distinguish their services from those of "less qualified or skilled competitors" [18, p. 201]. The author adds that the "large clinical literature on Asian blepharoplasty is written by specialist surgeons who are at pains to represent themselves as skilled in understanding both the technical and cultural needs of their patients" [18, p. 201]. Thus, it is no longer enough to be a qualified plastic surgeon to perform Asian cosmetic surgery, justifying the need to hyper-specialize. The danger with hyper-specialization is that it tends to expand armaments, procedures, and techniques for identifying, and then correcting, more "problems" in more patients.[2]

Various Korean websites illustrate additional eye concerns apart from the absence of upper lid creases. ID Hospital [29] and Pitangui [31] websites enumerate multiple eye issues, including "eyes with thin eyelids," "eyes with thick eyelids," "asymmetric eyelids," "sleepy eyes," "angry eyes," "sad eyes," "man's eyes," and "small eyes." As a consequence, these new eye problems have led to the development of additional types of procedures that can be offered by cosmetic surgery clinics. Some websites differentiate blepharoplasty from other surgeries

[2] Hyper-specialization as a criticism is also applicable to enhancement medicalization, since commercial interests that push surgeons to justify beauty as a medical goal also motivates them to develop more services and identify problems. However, the identification of specific problems and establishment of Asian cosmetic surgery as a distinct subspecialty seem to be more pronounced when cosmetic surgeons depict their surgical interventions as remedial.

such as epicanthoplasty, lower blepharoplasty, revision eyelid surgery, and sub-ocular brow lift.

Hyper-specialization that relies on pathologizing race-typical features directly conflicts with the first goal of medicine, that is, to prevent disease and injury, as it appears to do the exact opposite. In addition, the practice seems to increase the sources of anxiety or insecurity that patients might have with their appearance, directly contradicting the second goal. For example, even if patients are initially concerned only about their upper lid creases, the supposed identification of other problem areas may influence patients into believing that there are more eye problems that they should deal with.

Asian cosmetic surgery then further establishes the notion that Asian appearance, especially in comparison to western features, is akin to a disfigurement that can be (or should be) corrected through surgical modification. This misconception results in the perpetuation of negative stereotypes and racial norms of appearance that already marginalize Asians living as minority groups in western countries. Medicalizing Asian features is very far from correcting this notion, and instead, perpetuates the idea that Asians are deficient in that they do not conform to the Caucasian ideal.

Medicalization as a gendered issue

Although an increasing number of men are preoccupied with the way they look [8], appearance concerns continue to have a larger impact on women [7]. As Margaret Olivia Little argues, men and women may both face pressures regarding their appearance, but such pressures have never been symmetrical or equal [9]. Asian cosmetic surgery is consistent with such gendered discourses, given that procedures have a disproportionately higher uptake among Asian women than men [6]. Here, I discuss how the pathologization occurring in treatment medicalization and the conflation of beauty and health arising from enhancement medicalization contribute to a particular oppression of Asian women. Specifically, I argue that the oppression consists in the fact that medicalization further displaces women's control over their own bodies.

Women, throughout history and in many cultures, have been subjected to practices that focus on physical attractiveness [32]. Women's dissatisfaction with their physical appearance has a long-standing history and is influenced by a myriad of complex socio-cultural factors [32]. They are often bombarded by beauty products and services emphasizing the importance of physical appearance. For example, in advertisements made by the beauty and fashion industry, women are advised on what brand of makeup to buy or which clothes to wear, and such advertising does indeed influence women's choices [9, 21]. However, in cosmetic surgery, the persuasion is framed in the context of medical advice, and thus carries significant authority compared with obviously commercial advertising.

Given both types of medicalization, the recommendation to enhance physical appearance is easily viewed as something that needs to be taken seriously, as if it were an obligation or pressing health need. For enhancement medicalization, Asian cosmetic surgery identifies the "ideal" pair of eyes and labels naturally occurring

single eyelids as undesirable and problematic. For treatment medicalization, the issue is more pronounced because the naturally occurring eyelids are not only depicted as undesirable but also as pathological or abnormal. In both cases, medicalization does not merely imply that surgical alteration of natural (racial) features is a matter of personal choice about appearance, but rather, it also frames the choice in terms of health. Thus, medicalization gives the impression that cosmetic surgical procedures are a necessary means to achieving improvements in health through the improvement of one's physical appearance.

Further, the medicalization of appearance illustrates a form of oppressive "fragmentation" that women often experience. Bartky argues that fragmentation is the splitting of a person into mind and body—and further, the splitting of the self into a number of personae [7]. The author attributes fragmentation to the tendency of society to value a woman based largely on her body. Various social forces contribute to the process of fragmentation. In medicine, health interactions become a potential force as they constantly put women under scrutiny [33]. Women, more than men, have increasingly been exposed to regular medical surveillance after the medicalization of the female anatomy, female reproductive system, and female sexuality. Such regular surveillance reaffirms the notion that expertise on women's bodies lies with the medical profession and not with the woman herself. In Asian cosmetic surgery, the fragmentation does not only refer to the separation of a woman's body from her person, as Bartky puts it. I add that the process of pathologizing racial features further dissects a woman's body into smaller parts that can be targets of surgical intervention. As discussed above, hyper-specialization illustrates how Asian cosmetic surgery has "discovered" more facial features that it can consider problematic, creating more features that can be surgically modified.

Further, medical surveillance places women in positions of physical exposure that exacerbates already existing power inequalities, with the power mainly residing with the medical professional [33]. While medical professionals have always taken responsibility for most medical conditions (from diagnosis to therapeutic management), cosmetic surgery appears to be subsuming physical attractiveness or specific types of beauty as part of the expertise of medicine as well. Thus, Asian cosmetic surgery reaffirms the notion that medical professionals, not women themselves, are considered to be the best judge of their own bodily appearance—and the objective evaluation of their physicality lies with the cosmetic surgeons as medical experts on beauty. Given the already existing power inequality in health care, cosmetic surgery expands the medical professionals' roles by displacing women's control over their own bodies.

In both forms of medicalization, a common issue is the inappropriate and ethically problematic use of medical interventions for what is considered a complex psychosocial problem. The racial and gendered discourse on Asian cosmetic surgery does not mean that oppression is exclusive to Asians or Asian women. Other minorities, Caucasian women, and men take part in the consumer culture associated with cosmetic surgery. Little explains that categories other than race and gender (for example, individuals with visible signs of disability) have been the target of oppression, especially in terms of appearance concerns [9]. Elliott also argues that beyond racism and sexism, the problem lies with the fragility of individuals who

"depend so intimately on the good opinions of others" [30, p. 207]. In any case, Asian cosmetic surgery illustrates how the medicalization of appearance tends to decontextualize racial and gendered aspects associated with physical appearance concerns. According to Conrad [2], decontextualization is common in other examples of medicalized conditions, resulting in the narrow medical framing of issues that ignore the wider social contexts that drive the problem. Asian cosmetic surgery, then, can be seen as focusing on the individual without challenging the social structures and expectations that motivate people to conform to certain standards of appearance.

Conclusion

In this article, I proposed that the medicalization of race-typical features, such as having single upper lids, in Asian cosmetic surgery can be understood in terms of either treatment or enhancement. In the treatment model, the process of medicalization relies on pathologizing racial features by using Caucasian standards as the "normal" reference. In this case, cosmetic surgery is considered a remedy for the pathologized feature. Enhancement medicalization, on the other hand, does not pathologize race-typical features, and instead highlights a specific standard of beauty as an ideal surgical outcome. This frames cosmetic surgery as a way to improve naturally occurring features that are merely considered unappealing, possibly conflating health with beauty.

My analysis has questioned the role of cosmetic surgery in using medical procedures for non-medical ends, that is, the use of surgical interventions to improve physical appearance in the absence of pathology. While treatment medicalization raises more pronounced ethical issues than enhancement, both, nonetheless, appear to conflict with the goals of medicine, specifically those related to patient welfare (such as promotion and maintenance of health and relief of pain and suffering). First, I posited that cosmetic surgery works against the interest or welfare of the patient because the depiction of Asian features as pathological is racially oppressive. I specifically identified the phenomenon of hyper-specialization, which creates or "discovers" new problematic racial features that can be subjected to surgical modification. Second, I argued that medical framing undermines the welfare of Asian patients, mostly women, by further displacing their control over their own bodies. This problem is associated with the tendency of cosmetic surgery to conflate beauty and health, with the medical rhetoric portraying cosmetic surgery as a medical need rather than a matter of personal choice.

In both forms of medicalization, Asian cosmetic surgery employs medical means to manage complex psychosocial problems that motivate Asians to modify race-typical features. These outcomes are inconsistent with the goals of medicine related to patient welfare since the practice perpetuates social structures and expectations that make people conform to certain standards of appearance. The inconsistency of Asian cosmetic surgery with respect to the goals of medicine is just one of the important ethical implications of the practice, which highlights the need to establish strategies to promote social harmony without resorting to surgically removing

physical reminders of racial differences, and the need to use medical scientific narratives to defend such strategies.

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Compliance with ethical standards

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