

Chapter 11

“Almost Invisible Scars”: Medical Tourism to Brazil

Alexander Edmonds
University of Edinburgh, UK

ABSTRACT

Taking Brazil as a case study this chapter analyzes the broader inequities and ethical issues involved in cosmetic surgery tourism. Brazil is the world’s second largest market for cosmetic surgery, behind the United States. In light of the international respect enjoyed by Brazilian plastic surgeons, and relatively low prices charged by some, it is not surprising that the country has also become a top destination for cosmetic surgery tourism. The growing demand for cosmetic surgery has often been heralded, in Brazil at least, as a national triumph. Drawing on ethnographic fieldwork conducted in Brazilian plastic surgery clinics, this chapter discusses the institutions, clinical practices, and medical construction of women’s bodies underlying cosmetic surgery tourism. Cosmetic surgery tourism to Brazil illustrates that a developing country is effectively competing in a global market of private medical treatments, but does so by utilizing economic and “human” resources provided by a state-funded healthcare system.

INTRODUCTION

News stories and policy reports often present medical tourism as a troubling instance of globalization. In these accounts wealthy westerners are portrayed as taking advantage of cheaper care available in the developing world (Roberts & Scheper-Hughes, 2011, p. 2). Yet, while medical tourism does indeed often reflect and contribute to health care inequities, the ethical questions posed by the practice are complex and unpredictable, and often upset familiar narratives of globalization as westernization.

Medical tourism challenges conventional representations of the geopolitical and economic relationships among the countries that participate in it for example. For example, a Mexican official in the US-Mexico border town of Juarez argued that medical tourism will be “bigger than the *maquila*,” arguing that the “biggest patient is the United States” (Cuddehe, 2009, p. 15). This metaphor reverses the narrative of the needy Mexican migrant traveling to the US in search of economic opportunity, and puts the wealthier of the two nations in the subordinate role of the patient. Some medical tourism networks are not based on

DOI: 10.4018/978-1-4666-8574-1.ch011

unidirectional relationships between center and periphery but are rather “rhizomatic,” this is, creating or following multiple links, sometimes *within* the global south. Brazilian hospitals, for example, target patients from the Middle East, designing brochures and websites in Arabic (Sarruf, 2007). One hospital in India attracts patients not just from Germany, Canada, and Australia, but also Oman, Qatar, Bahrain, Saudi Arabia, the Maldives, Sri Lanka, Nepal, East Africa, and Bhutan (Connell, 2006, p. 1096).

The term *medical tourist* presents the image of the westerner traveling to the developing world for medical treatment, perhaps combined with a holiday. It partly implies a frivolous or at best leisure and recreation oriented activity (Roberts & Scheper-Hughes, 2011), and as such, masks the fact that many so-called medical tourists are “poor and medically disenfranchised persons” in search of life-saving drugs or surgery that they cannot otherwise get. For example, many would-be medical tourists are Mexican and Central Americans who travel to the US without a tourist visa in order to get health care, often accessed via emergency rooms. Others are North Americans lacking health insurance, which the New England Journal of Medicine dubbed “America’s new refugees” (MacReady, 2007, p. 1849). Because the term medical tourism seems to minimize the economic and health hardships endured by patients, Roberts & Scheper-Hughes (2011) propose instead the more neutral “medical migrant.”

In the case of consumers seeking cosmetic surgery overseas, however, the term medical tourist may be appropriate precisely because of its associations with leisure. Cosmetic surgery is sometimes combined with a vacation or nature tourism (Ackerman, 2010). Moreover, it involves an elective procedure performed on patients who are already healthy, though they may become sick in the course of recovering from surgery. The cosmetic surgery patient’s absence of medical *need*, at least in any conventional sense, poses complex ethical issues about the fair use of health care resources (see Chapter 6, this volume).

Taking Brazil as a case study this chapter analyzes the broader inequities involved in cosmetic surgery tourism. Brazil is the world’s second largest market for cosmetic surgery, behind the United States. In light of the international respect enjoyed by Brazilian plastic surgeons, and relatively low prices charged by some, it is not surprising that the country has also become a top destination for cosmetic surgery tourism. The growing demand for cosmetic surgery has been heralded in Brazil as a national triumph, evidence of the country’s status as a *campeão* or “champion” of plastic surgery or, as the practice is simply called, *plástica* (Edmonds, 2010). Drawing on ethnographic fieldwork conducted in Brazilian plastic surgery clinics, this chapter discusses the institutions, clinical practices, and the ethics of the medical construction of women’s bodies that underlie cosmetic surgery tourism. This form of tourism to Brazil illustrates that a developing country is effectively competing in a global market for private medical treatment, but does so by utilizing economic and “human” resources provided by a state-funded healthcare system.

BACKGROUND

It is understandable that the ability of hospitals in developing countries to attract medical tourists has often been trumpeted as a national achievement. Countries such as Thailand and India have promoted not only low cost care and the tropical locales of their hospitals, but also their state-of-the-art medical facilities (Connell, 2006). And, in fact, the private health sector in Bangkok has more technological capacity in some important areas like gamma knife and computed tomography (CT) scans than the United Kingdom does (Ramírez de Arellano, 2007, p. 196). From this perspective we can perhaps understand

7 more pages are available in the full version of this document, which may be purchased using the "Add to Cart" button on the publisher's webpage:

www.igi-global.com/chapter/almost-invisible-scars/133644

Related Content

Taste of Tradition: Examining the Connection Between Gastronomic Heritage, Cheese, and Tourism

Adina Letitia Negrusa (2025). *Global Perspectives on Cheese Tourism* (pp. 199-222).

www.irma-international.org/chapter/taste-of-tradition/363398

A Case Study of Tourism in North Carolina State Parks Using Google Trends

Aaron Bradley Scott (2021). *International Journal of Tourism and Hospitality Management in the Digital Age* (pp. 1-14).

www.irma-international.org/article/a-case-study-of-tourism-in-north-carolina-state-parks-using-google-trends/298703

Inertia Stages and Tourists' Behavior: Moderator Effects of Zone of Tolerance, Switching Barriers and External Opportunities

Zhiyong Li, Rui Cui, Li Li, Yingli Huand Ruwan Ranasinghe (2018). *International Journal of Tourism and Hospitality Management in the Digital Age* (pp. 1-17).

www.irma-international.org/article/inertia-stages-and-tourists-behavior/201103

The Pathway of Critical Pedagogy in Tourism Education

Bar Çvuk (2023). *Critical Social Challenges in the Tourism Industry: Labor, Commodification, and Drugs* (pp. 224-243).

www.irma-international.org/chapter/the-pathway-of-critical-pedagogy-in-tourism-education/331264

Pattern Mining on How Organizational Tenure Affects the Psychological Capital of Employees Within the Hospitality and Tourism Industry: Linking Employees' Organizational Tenure With PsyCap

Donald Douglas Atsa'amand Ersin Kuset Bodur (2021). *International Journal of Tourism and Hospitality Management in the Digital Age* (pp. 17-28).

www.irma-international.org/article/pattern-mining-on-how-organizational-tenure-affects-the-psychological-capital-of-employees-within-the-hospitality-and-tourism-industry/269289